Acknowledgment

The evaluation team would like to acknowledge the valuable work of Cambodian Red Cross in contributing to the protection of the lives of most vulnerable population in underserved villages of Cambodia. The willingness of its managers at national headquarters and provinces to learn from projects like this is also recognized as essential in keeping the organization relevant and responsive to the people it desires to serve. We are grateful to Cambodia Red Cross for entrusting us to undertake this final evaluation of the CBHFA project in Kratie province.

The team would like to thank the managers and staff and volunteers of CRC, IFRC and external partners at the central and province level for their insights and inputs which enabled us to document the experience, capture practices and lessons and propose steps to be considered in CRC's future Community Health Development programming.

We are very thankful to the Red Cross volunteers of this project who worked hard to make us accessible to conduct FGD with our target beneficiaries. Without their accurate management, this wouldn't have been possible. We appreciate the information provided by them and have incorporated them in our findings and recommendations.

Sincere gratitude also goes to the FRC for funding the evaluation and for its continued support to the CRC in its community health development program through the CBHFA approach.

Dr. Sushma Bhusal

Ms. Sanna Salmela-Eckstein

List of acronyms and abbreviations

AFH	Action for Health
ARI	Acute Respiratory Infections
CBHFA	Community Based Health and First Aid
CRC	Cambodian Red Cross
CBDRR	Community Based Disaster Risk Reduction
CHDS	Cambodia Demographic Health Survey
CMDG	Cambodia's Millennium Development t Goals
FGD	Focused Group Discussion
FRC	Finnish Red Cross
IFRC	International Federation of the Red Cross and Red Crescent Societies
I/NGO	International/National Non Governmental Organisations
MoH	Ministry of Health
NHQ	National Head Quarters
MCH	Mother and Child Health
MoFA	Ministry of Foreign Affairs
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
ORS	Oral Rehydration Salt
PFD	Partner for Development
RCY	Red Cross Youth
VCA	Vulnerability and Capacity Assessment
WHO	World Health Organisation

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Executive Summary

With its humanitarian mission, over decades, the CRC has been very active in providing health and care services to the most vulnerable communities across the country. In 2010, in response to increasing mortality and morbidity due to disease outbreaks and poor mother and child health indicators of rural communities, as auxiliary to the government, CRC with support from the FRC extended its humanitarian arms to eight deprived communities of Kratie. The project was placed under CRC's core area "Community based health development" and implemented through the CBHFA approach between 2010 and 2012.

During this period, the project reached 10,817 people of the eight villages in Prek Prasob and Kampong Kor communes of Kratie province. It made historical milestones not only in reaching to the most vulnerable and providing services but also made a place for CRC in the hearts of thousands. The project was implemented through a 'bottom up' approach and all activities were discussed with communities prior to implementation. Tools such as VCA were used to ensure that communities were capable of prioritizing their most important concerns. he project was able to identify and address the burning concerns which were mainly water, sanitation and hygiene – specifically threats of diarrhoeal diseases, ARI, dengue hemorrhagic fever and malaria. Mother and child health was another issue which was crucial in these communities and some of these were addressed by the project.

The project objectives:

1. Health status of vulnerable communities and especially women and children are improved.
2. The Kratie branch has increased capacity to deliver high quality services to higher number of vulnerable people

The three year project was also successful in strengthening the capacities of the CRC at the central and branch/sub branch level to manage similar projects in the future. The project supported the concept of decentralization and good governance which the CRC has initiated over the last few years. It enabled the CRC to move forward in their role as the largest humanitarian organization in the country, enhance its visibility across sectors and mobilize its resources for the benefit of the neediest.

The evaluation was commissioned by the FRC to contribute to CRC´s and FRC's learning and to improve mechanisms implementing such programs in the future. It was carried out by a two-person evaluation team who reviewed relevant documents, visited project area and interviewed key people and focus groups. Considering the local situation, time constraints and to avoid evaluation fatigue, the team visited adjoining villages which could be easily reached. Efforts were made to interact and consult different segments of the community.

Key findings

- ***Relevance and appropriateness***

The project was relevant and appropriate as it contributed to efforts to address public health threats that continue to negatively impact people in these underserved villages. A number of activities were included with a view initiating behaviour change and permanent access to improved water and sanitation in communities and enhanced awareness on MCH, although it was also recognised that these efforts required a long-term development approach and could not be fully realised within the project timeframe. CRC worked closely with government authorities as well as partners, and while doing so, has carefully considered its internal strategic directions and further aligned them with the national priorities.

- ***Effectiveness***

CRC employed strategies and approaches that enabled the achievement of project outcomes and objectives. By closely coordinating with health authorities and partners at different levels, duplication of services was prevented. The construction of latrines also had synergies with the government's efforts to prevent disease outbreaks; this was well appreciated by the government and beneficiaries. Intensive health promotion campaigns, coupled with assistance in latrine construction had a immense influence on people's motivation to change behaviour – an achievement made in a relatively short timeframe, however the sustainability of this behavioural change could be quickly lost if no further investment are made in continued software activities. Similarly, support to improve mother and child health and increased institutional delivery was also a significant change the project contributed towards.

- *Efficiency*

The project was considered efficient in terms of contributing to the improvement of health behaviours and practices as well as in preventing overlaps and duplication of efforts. The project was also carried out by qualified and experienced staff, as well as Red Cross volunteers who were highly-regarded and respected in communities. This approach enabled CRC to implement activities with minimal supervision and mentoring to the facilitators and village health committees. However, it is to be noted that communities felt that volunteers needed more capacities to continue their contributions with changing environment and needs.

CRC managed activities well by mobilizing volunteers from within the target villages and by used existing local resources such as local networks, infrastructures like pagodas, raw materials for latrine constructions and indigenous knowledge in the implementation of activities. A total of 10,817 people, out of which 3620 were women were reached with key basic health care messages. Besides other support within CRC, government sectors and other partners, FRC provided substantial support during different phases of the project. With some exceptions mainly related to delayed fund disbursement, all project activities were accomplished in the given time frame.

- ***Impact***

There was a marked improvement in health behaviours such as hand washing after critical times; consuming boiled or treated water, maintaining environmental and personal hygiene as well as improvement in mother and child health. Communities revealed that they now get less frequently sick and attend health centres, and when they do, they rush for services immediately. They also feel happy that now they spend less out of their pockets for health expenditures. Reports from the health centres suggest the significant increase in patient flow and utilisation of services. This was not the case before the project.

- ***Connectedness and sustainability***

The project was focused on interventions essential to the communities. The components and key activities of the project were identified in close coordination and consultation with health authorities and partners at various levels. In the design of its communication materials, CRC used messages prepared/approved by the MoH – brochures, flexes, flip charts– for its awareness campaigns.

The project was successful in engaging the Red Cross Youth of a high school. Though the school was not located within the target villages, it was effective to mobilize students who were willing to serve as volunteers. The positive awareness and practices gained through the project can be considered significant, and can be potentially sustained particularly if more investments and support are made to improve drinking water and sanitation facilities in these villages.

However, resource constraints are factors that prevent willing communities from committing their contribution on the long term sustainability of the project gains.

Evaluation purpose and methodology

The evaluation was commissioned by the FRC to contribute to the learning for the CRC as well as other partners at the national and local level in their effort to improving project and coordination mechanisms in implementing programs contributing to improve health conditions of the most affected people in rural villages of Cambodia. The evaluation was carried out to assess whether the project met the objectives and delivered the results in the target areas as outlined in the project proposal, as well as assess the utility of the RCRC standard tools and approaches. It was also asked to provide guidance to CRC in improving its capacity for implementing community based health development programs, specifically in relation of disease outbreaks and mother and child health. The IFRC Framework for Evaluation was the reference document for this evaluation. The terms of reference (*see Annex 1. Terms of reference*) also highlighted relevant criteria and key questions which were used as parameters in formulating evaluation recommendations.

The evaluation began with a desk review of annual plans and reports, organizational development plans, policies and strategic frameworks (*see Annex2. Documents consulted*).
This was followed by almost two-weeks of field work which included visits to the provincial health authority, health centres, and CRC branch and sub-branch and project villages.

Due to time constraints, only four villages out of the eight of the first phase of the project were selected for the field visit. These were, Prek Prasob Krom and Dey Dos Krom of the Prek Prasob Commune and Chroy Sneng Krabey Leu and Kampong Kor of the Kampong Kor Commune. This was also because the remaining four villages Prey Kou, Dey Dos Leu, Chroy Sneng Krabey Krom and Tamao Leu were part of the field visit at the Asia Pacific CBHFA workshop in October 2012 during which the participants went to villages in groups to observe the work of volunteers and do quality monitoring. They interacted freely villagers and volunteers. The workshop also provided recommendations for improved programming which is incorporated in this report. During these, observations were also made; group discussions with branch management team, staff volunteers and beneficiaries.

In Phnom Penh, interviews with key senior management officials, key staff of CRC NHQ and IFRC were also undertaken (*see Annex 3. List of interviews and group discussions, and Annex 4. Evaluation schedule*)

Semi-structured interviews and group discussions were guided by a set of questions: for Communities, branch staff and volunteers, for CRC NHQ and IFRC representative, and for external partners (see *Annex 5. Guide questions for interviews and group discussions*). These questions were formulated and based on the evaluation questions highlighted in the TOR. Interviews and group discussions taking place in the province and villages were longer due to translations done alternatively by CRC staff assigned to the team.
Team members also took detailed notes; completing each day, conferred with other members key themes which came up during these interactions and field observations. To ensure that salient points were noted, debriefings were made for further clarifications.

The evaluation has a number of limitations. For evaluator security reasons, there was a rush to complete the evaluation before the general elections in July 2013. Therefore, the schedule was not flexible and the team had to ensure that all objectives of the evaluation were met during the timeframe.
The team also chose villages which were adjoining and/or could be reached more easily in an effort to have more time to interact with respondents in villages as well as to observe activities supported by the project and further to avoid evaluation fatigue . Additionally, the Regional CBHFA workshop and visit to the field then, gave some opportunity to all 8 villages to share their views on the project. Efforts were also made to reach and consult different segments of community in an effort to generate a range of perspectives. Despite the above limitations, the evaluation team felt that it has gathered valuable qualitative data to support its findings and recommendations. These data were compared with findings of the endline survey commissioned by the project.

The evaluation was carried out by Dr. Sushma Bhusal, Independent Consultant from Nepal and Ms. Sanna Salmela-Eckstein, FRC Regional Disaster Management Delegate for Asia. CRC staff at NHQ and branch also assisted the evaluation team. The frankness with which the opinions were shared was highly appreciated and in the report we have consciously avoided to use names and quotes to maintain confidentiality.

Background

The General Population Census of 2008 put Cambodia's population at 13.4 million. The male-to-female ratio is gradually normalizing after the distortions caused by 30 years of war during the last century. The average household size is 4.7 people, with 80% of the population living in rural areas. In spite of the conflict, Cambodia has made significant positive changes in its health indicators. Early mortality declined and life expectancy increased in the period from 1998 to 2008 from 52.0 to 60.5 years for males and from 56.0 to 64.3 for females.

Figure 1 Map of Cambodia (Source: One World-Nation online)

The total fertility rate dropped from 4.0 births per woman in 2000 to 3.4 in 2005 and decreased further to 3.0 in 2010, achieving the Cambodian Millennium target for 2010, predominantly as a result of a decline in fertility among rural women. The preliminary results of the CDHS 2010 show a decrease in the infant and child mortality rates and continued progress in maternal care, exclusive breastfeeding and immunization[1]. However, like many developing countries, Cambodia faces a range of vulnerabilities and health and environmental risks. These risks originate from unsafe water and inadequate sanitation and disease-vector transmission. Only of 56% of the rural population had sustainable access to an improved water source and only to 18% in rural areas had improved sanitation[2].

Cambodia's MMR has remains stagnant at an unacceptably high level of 461 per 100,000 live births. There are multiple reasons for the high MMR, of which inadequate access to services, the low level of knowledge, the low facility-delivery rate, the low level of modern contraceptive

[1] http://www.wpro.who.int/countries/khm/4cam_pro2011_finaldraft.pdf

[2] WHO/UNICEF Report on Drinking Water and Sanitation, published in 2010

use (28% in 2009) and the high rate of unsafe abortions are the most important. This is of grave concern to the Government, particularly as it contrasts to the significant improvements seen in other socio-economic and health indicators over the same period. The newborn mortality is becoming an increasing proportion of the under five mortality. The MoH is committed to reducing the number of maternal deaths and recognizes that the country is currently at risk of failing its MDG 5 (CMDG 5) commitment to reduce the MMR to less than 250 deaths per 100 000 live births by 2015[3].

[3] Fast Track Initiative Road Map for Reducing Maternal & Newborn Mortality 2010 to 2015

Evaluation findings

1. Relevance and appropriateness

This section tries to assess whether the project was in line with the needs and priorities of most vulnerable households and villages in addressing the public health concerns. It also looked at its alignment to policy directions and strategies of government and partners, as well as CRC organisational strategies, programming and project frameworks. The appropriateness of interventions to local situation and context was also explored.

Ø *Communities' priorities and CRC's response*

The project is relevant to the local context and addresses the needs of the people living in the eight target villages of Kampong Kor and Prek Prasob communes. The VCA findings and reports suggested water, sanitation and hygiene related problems, ARI, malaria/dengue, diarrhea and mother and child health as the major health concerns in these villages. Additionally, the baseline survey findings highlighted similar priorities and needs in the villages. These were associated with poor level of knowledge and awareness and access to available services.

Following discussions with villagers, all priorities were allocated with the same rankings. This could be because all villages had similar context and were adjacent. Nevertheless, in order to address these health issues, driven by its humanitarian mission, guided by the experience and lessons gained through the past community based interventions, the CRC swung into action in 2010 using the CBHFA approach. This approach was adapted to local context and communities were empowered to address their priority health needs and take charge of them. It mobilized its local trained Red Cross volunteers in the conduct of health awareness namely; communicable disease prevention, mother and child health, water sanitation and hygiene promotion. By assisting in referring communities to health facilities, the Red Cross Volunteers contributed to the increased health service utilization. Currently, the project is being scaled up in 40 other villages in Kratie province.

Ø ***Project in line with Government and partner strategies***

The project broadly aligns with the priorities of the national health strategic plan 2008-2015 which clearly emphasis on the control of communicable diseases as one of the key MDG. The national health strategic plan suggests scaled up access and coverage of health services, especially comprehensive reproductive, maternal, newborn and child health services both demand and supply side. Amongst others, preventing communicable diseases, strengthening public health interventions to deal with challenges, especially hygiene and sanitation, mother and child health and encouraging community engagement in health service delivery activities are of major focus. The project also had components which aligned with IFRC's Strategy 2020, mainly in the Strategic Aim 2 focusing on better personal and community health. The project's

contribution to community resilience for sustainable development is through strengthening their ability to adapt and cope with recurrent or prolonged crises.

- ***Project aligned with CRC strategies.***

Health and care in the community is one of the strategic priorities of CRC. CRC's Strategic Plan 2011-2020 states its objectives towards reducing general morbidity and mortality by strengthening the community capacities to prevent and respond to public health threats. As supplementary to the national efforts, CRC in its development plan 2011-2014 outlines its commitment to contribute to reduce morbidity and mortality related to mother and child health and communicable diseases. Recognizing its limited capacity, the CRC is committed to 'save lives' by mobilizing all available resources to improve the health status of vulnerable people. The CRC Strategy and development plan is supported by all donors.

- ***Project aligned with donor strategies***

The Finnish Red Cross's three year framework for MoFA support 2010-2012 also emphasizes on strengthening holistically the capacity of the most vulnerable populations to address health problems in their own villages through an active and trained Red Cross volunteer network. The FRC framework also stresses linkages between health and disaster preparedness programmes and actions in the villages.

Recommendations related to relevance and appropriateness

The project was largely relevant and appropriate in the context of preventing disease outbreaks and improving mother and child health. In designing and implementing a similar project in the future, it is recommended that the following be considered:

- While program managers incorporate national priorities and objectives into such interventions, it is worth that implementers at district level are also aware of the policies and strategic directions.
- CRC should maximize the use of the project in disseminating CRC strategic plan, CRC development plan, Strategy 2020. These guiding documents at local level were not fully utilized.
- Ensure that relevant technical departments or partners, including district branches, are consulted when planning interventions to ensure that these are not only relevant to beneficiary needs, but also up to levels that are meaningful and make a difference to their lives.
- Where already initiated, CRC should continue activities targeting vulnerable communities.

- After creating the ground, expansion of villages should be introduced in a small scale and later accelerated after basic quality was secured. Other wise there is a common risk for too high quality expectations by staff, volunteers and beneficiaries at the expense of quantity which then limits the coverage of the project.
- Being member of various national and subnational health committees, CRC should also approach and work with the other partners at the central level to review and improve diseases outbreak control and mother and child health.

2. Effectiveness

This section explores whether the project has met its objectives as outlined in the plan of action. In so doing, the strengths and weaknesses of the tools and interventions are identified and the processes employed are discussed here.

The project was implemented to contribute to the reduction of communicable diseases such as diarrhea, ARI, malaria and dengue through effective means such as latrines and sustainable behaviour change strategies. It also intended to strengthen CRC capacity in responding to public health issues and in undertaking longer-term activities to improve community health. The evaluation team feels that, despite various challenges, the expected outcomes and objectives were met.

Ø *Vulnerability and capacity assessment(VCA)*

The project conducted a VCA's in all eight villages during 2010 which focused on determining the priorities of the communities. The VCA was accomplished using some of the tools of the IFRC VCA guidelines, namely; secondary data review, focus group discussions, participatory observations/transect walk, village mapping and seasonal calendar. It was observed that though communities' health priorities were identified, the VCA procedures were not accurately followed. The role of DM department to support the project to roll out the VCA and further analyze the findings might have been more effective. Integration of DRR knowledge in software and hardware planning at the village level would also be important. The common area for any sectoral community based project (whether health or DM) lies in strong needs analysis, support for good programming and mainstreaming DRR and/or Risk Reduction in Community Development (where long-term and connectedness considerations form part of any shorter term action), in addition to the area of integration of sectoral approaches as defined by the responsible actors. VCA provides a good base for this thinking and planning process.

One relevant example would be to ensure that latrines are constructed high enough to safeguard them from flooding also in the future. A holistic VCA process linked to community development would support connectedness and sustainability of the project activities.

Ø *Baseline and end line survey*

Following the VCA, with support from the community volunteers, the project also commissioned a baseline survey to capture communities' knowledge, attitude and practice regarding water usage and sanitation, mother and child health and frequently occurring communicable diseases like diarrea, ARI, dengue and malaria. The baseline findings were used to set the indicators, majority of which were reached by the end of the project period. However, since the achieved endline targets were very high as compared to the baseline targets, it is important to point out that indicators must be realistic.

Ø *Beneficiaries' selection, geographical coverage and project design*

The beneficiaries were identified and enrolled into the project based on the information provided by the local government authorities and Red Cross volunteers. Selecting the most vulnerable was challenging, given the fact that these communities were amongst the most deprived ones. Nevertheless, the beneficiaries' selection, and clustering them into groups was appropriate. The number of beneficiaries to be reached and their geographical coverage was justifiable. The core idea of the project was to raise awareness on health, hygiene and sanitation and mother and child health and improve sustainable behavior changes.

The project design was effective in reaching the target population. Beneficiaries are convinced that they have gained knowledge on health, hygiene and mother and child health and now are better empowered. However, this modality addresses only some of the issues related to maternal and child health improvement. Since mere ANC increasement cannot guarantee the comprehensiveness of the change in maternal and child health approaches to address all issues pertaining to mother and child health would have been ideal.Moreover, being auxiliary, CRC can support in the governments Fast Track Initiative roadmap for reducing maternal and new born mortality(2010-2015).

Ø *Qualified and experienced project staff*

The project achieved its targets and contributed to preventing disease outbreaks in the villages where activities were carried out because of the assignment and mobilization of staffs at NHQ and districts that were qualified and experienced. These staffs have training and experience in community-based health for many years. This meant that staffs leading the implementation were aware of CRC systems and procedures and had been exposed to working with authorities and different partners at national and provincial level. Red Cross volunteers led activities with commitment and purpose which reflected in the communities' knowledge of health care-mainly prevention and treatment measures. The same was true with village health volunteers, village heads and representatives of local committees. The involvement of these people – who were considered community leaders, and who were respected members of the community – in the project was an excellent approach as this gained the trust and support of villagers. However, it was quite evident that staffs and volunteers were overloaded. Having adequate

number of volunteers on the ground based on the coverage would have been beneficial in reaching all.

The orientation trainings and session provided to branch staff coordinators and field facilitators as well as volunteers were considered a worthy investment as they ensured that all people involved in implementation had a good understanding of the project as well as made volunteers confident to disseminate messages and conduct activities and convincing them of the potential positive outcomes of the project. However, with emerging changes in disease patterns and guidelines, staffs and volunteers should have been updated on regular basis.

It was felt that the project would have benefited from additional technical expertise and advice on water source improvement and latrine construction to ensure value for money, quality and lasting impact. Though the provincial rural development department was on ground when these construction initiatives started, however, their involvement was event based.

Ø *Going the CHBFA way*

With first aid as the entry point, the CBHFA approach was effective in sensitizing the communities.This approach enabled CRC to set up a modular way of working in the commu ities. Further, it strengthened CRC's capacities in working together with partners at the local level. The approach was useful in bring out the most from limited resources. Being simple, understandable and to the context, it helped volunteers to understand and internalise technical issues related to health and hygiene. Now, since this model is fully accepted, it will be beneficial to design future projects on its base.

Ø *Finance - fund transfers and regulations*

Delays in the transfer of funds from FRC to NHQ to district branches resulted in delays in the implementation of activities. These delays were mainly due to reported internal delays at the FRC NHQs. There were many situations when the branch used its own funds for local level payment. Instances of the Kratie branch using its relations with traders and villagers to agree to postponement of payments without delays in the delivery of goods are well noted. All financial procedures were guided by the CRC financial procedure guidelines (2006).

Ø *Monitoring and reporting*

A monthly report was submitted by the branch project team leader highlighting progress and challenges during the month as well as priority actions for the incoming month. In order to have data and information to be forwarded to NHQ, monthly meetings were organized with facilitators and volunteers to gather updates, issues and challenges in detail.
It was noted that, after reviewing few examples of field reports, facilitators and volunteers provided comprehensive monthly information: for example, a work plan of the month, detailed activity reports, including minutes of meetings. The CRC further acknowledge FRC's encouragement in using its financial reporting formats. However, it is to be internalised that

monitoring and reporting is part of project management and should be encouraged to bring out the best results rather than being taken as a donor requirement.

Ø *Visibility*

There is a positive perception of CRC across all communities as it has an impressive network of volunteers and members unlike any other organization. As the CRC presence came closer to the community, the sense of belonging and bonding between the volunteers and community was also seen as getting stronger. Numerous examples of this were shown in almost all visiting sites. Their high level of engagement and close identification with the community and the pride they took in their work and achievements showed the ownership at this level. The volunteers are very much committed and have been eager to learn and to disseminate what they have learned. However, there is a divide in opinions on whether the logo of CRC and FRC should be visible in hardware contributions like the latrines. In Kampong Thom, logos of CRC, IFRC and FRC were visible in all latrines and water systems provided by the project, this was not the case in Kratie. Since the project's contribution for construction was partial, it is worth taking inputs from communities regarding logos. The IEC materials distributed by the project were adapted from those disseminated by the MoH. There were times when these materials were insufficient and volunteers could not disseminate information effectively.It is to be noted that the project supported the construction of sub branch offices. Having a proper place to work in motivated the staffs and volunteers and also made visibile to the communities that CRC is with them, at their service all the time.

Ø *Volunteer management*

It is repeatedly stated by the external organizations and governmental structures that the strength of CRC is its widespread network and volunteers. Still most cost is spent on central level, with very little financial and other appreciation directed to the field except for basic trainings. The project selected 115 volunteers from the eight target villages, among them 65 were women. Volunteer management still leaves much to be improved, in this as in other programs in CRC, to increase attractiveness and retainment after initial trainings. Some positive examples have to be highlighted. The first and foremost is the commitment of the volunteers, who even with small incentives contributed as much as they could. Students, especially in their upper teens were provided with knowledge and skills and abilities to share information with their peers and families.

Ø *Coordination*

a. Internal

Communication lines between NHQ, branches and sub-branches were well maintained. Branch coordinators and facilitators reported frequently to the project coordinator throughout the project. The Red Cross volunteers felt well-supported and had a clear idea of the program objectives and understood their roles and responsibilities to achieve the objectives. At NHQ, a DM working group was created which served as a good information-sharing platform among key departments involved, particularly disaster management, health and organizational

development. A TOR and SOP are currently being developed to effectively integrate these sectors. In spite of all these, to the evaluators, it seemed the coordination was event or activity based.

However, even if the need for partnerships and coordination were highlighted in the proposal, this has been limited, on the national and local level. Further, analogies with the DM, where the CRC has many achievements to count on, has however not been fully explored.

b. External

Red Cross volunteers and village health workers worked together to disseminate health messages. The village health committee established by the project constituted of four members; village chief, vice village chief, health centre staff and a Red Cross volunteer leader. This committee added value to the ongoing health promotion activities and established linkages with other external partners like Action for Health(AFH), Partner for Development(PFD), and Action Aid. However, there was less initiative from the CRC to engage these NGOs in their activities, nor use the opportunities to work together.

Therefore, even if the need for partnerships and coordination was strongly emphasized in the proposal, this has been quite limited, on the national level, to information and acceptance by government authorizes. Most of the "partnerships' have been mainly used for information sharing rather than common planning.

Recommendations related to effectiveness

- Standardize the visibility of donor and partner logos in all hardware support like latrines and water systems in all projects of CRC.
- Collaborate closely with the DM department to draft VCA practical guidelines for staff and volunteers on how to conduct a holistic VCA that further supports needs based programming and sustainable community development that has integrated DRR as a cross-cutting element.
- Cash the experiences of DM department in VCA and ensure that they are part of the VCA in all future project areas.
- Engage external partners and use their expertise on issues like water source improvement and water testing.
- Ensure that indicators are realistic. Having low set indicators might lead to the risk of losing the credit.
- Meaningful involvement of partners in planning activities is critical to market the project's objectives and see where potential partners could come in to take over.

3. Efficiency

The project was considered efficient in terms of contributing to the improvement of health behaviours and practices as well as in preventing overlaps and duplication of efforts. The project was also carried out by qualified and experienced staff, as well as Red Cross volunteers who were highly-regarded and respected in communities. This approach enabled CRC to implement activities with minimal supervision and mentoring to the facilitators and village committees.

FRC's support to the project for additional quality assurance was also accessible when needed. The project also intended to strengthen CRC capacity in responding to public health issues and in undertaking longer-term activities to improve community health. While efficiency is often compromised in an environment characterized by remoteness and weather conditions, CRC's internal mechanisms and systems related to project assessment and planning, finance, monitoring and reporting could be adjusted to improve the efficiency of future projects. The evaluation team feels that, despite challenges, the expected outcome and objectives were met.

- *No service overlaps with partners*

As discussed elsewhere, close coordination with the local authorities and coordination committees enabled partners to deliver services and prevented overlapping. Coordination with partners also facilitated the sharing and better use of resources; for example, IEC materials were adapted and reprinted in consultation with MoH. On the other hand, service overlap was probably not visible due to limited number of partners and inadequate coordination.

- *Challenging remoteness and weather conditions*

With little vehicular access and remoteness of villages, the cost for the delivery of water systems and latrine construction materials items were understandably high. The regular monitoring visits by social mobilizers and volunteers were also highly commendable. Access to villages became a bigger problem during the rainy season where floods become a constant threat, and could virtually cut-off villages during this time of year from the rest of the communes. CRC managed activities well by mobilizing volunteers from within the target villages and by used existing local resources such as local networks, trained human resources, raw materials for latrine construction and their indigenous knowledge in the implementation of activities. These personnel were supported with orientation trainings, demonstration and visibility items –to ensure the activities were carried out as scheduled.

- *Reach and budget*

A total of 10,817 people, out of which 3,620 were women were reached with key basic health care messages. 346 out of 1,271 households had access to latrines, contributing to reduced practice of open defecation in the first 8 villages selected in 2010. A review of the project's statement of expenses reveal that majority of the budget were allocated for intended beneficiaries through the delivery of items and activities related to mainly water and sanitation, and hygiene promotion/behaviour change components; as well as investment on human resources and volunteers to ensure effective delivery of these items and activities according to plan. The table below shows the details of the target beneficiaries which are also the people reached by this project.

Commune	Villages	Families	Population			
			Total	Female	Male	Children(<12 yrs)
Prek Prasob	Prek Prasob Kroum	281	1261	493	455	313
	Prek Kou	215	1020	422	377	221
	Deydos Leu	234	983	385	360	238

	Deydos Krom	334	1507	597	567	343
	Chroysneng Krabey Leu	340	1373	511	466	396
	Chroysneng Krabey Krom	219	1009	298	290	421
	Kampongkor	512	2512	541	533	1438
Kampong Kor	Tamao Leu	228	1152	373	367	412
	TOTAL	2363	10817	3620	3415	3782

Table 1: Target beneficiaries (Source: Project Annual Report 2010)

S.N	Budget Head	Total Expenditure		
		2010(USD)	2011(USD)	2012(USD)
1	Core cost for CRC/HQ	12,840.19	12,744.51	16,950.77
2	Core cost for RC branches	9,461.38	12,761.19	13,116.81
3	Fixed Asset	15,524.80	900.00	5,885.00
4	Expected Result 1	30,070.59	51,884.82	68,051.46
5	Expected Result 2	20,343.00	10,997.55	9,773.90
6	Expected Result 3	5,001.65	18,164.23	21,821.48
7	Expected Result 4 (OD)	28,321.25	24,175.70	27,004.75
8	Supervision/follow up Activities	14,228.19	18,442.52	19,827.98
9	Coordination and collaboration	4,254.32	1,178.30	1,723.50
10	Contribution to CRC core cost	00	7,143.25	7,354.84
	TOTAL	140,045.37	158,392.07	191,510.49

Table 2: Summary of expenditures (Source: Project Financial reports 2010-2012)

- **Back-up support provided**

Besides other support within CRC, government sectors and other partners, FRC provided substantial support during different phases of the project. It facilitated the CRC thinking process on how to respond: identification of priority activities and the resource mobilization strategy to be applied. A delegate was initially stationed in Cambodia to support initial planning and implementation of the project. Further, the FRC regularly conducted monitoring visits and supported in trainings and workshops. The FRC played a key role in supporting the project in proper financial reporting according to the CRC's financial reporting guidelines.

- **Timeliness and timeframe**

The project was launched in August 2010, almost at the peak of the rainy season. In the first few months staffs at the NHQ and branches were engaged in planning. Therefore, the actual implementation of the project activities started only in early 2011. However, with some exceptions mainly related to delayed fund disbursement, all project activities were accomplished in the given time frame. Since the project was launched amidst relatively poor

health indicators, specifically ones related to MCH, it could expect support both from the international organizations and national governments.

Recommendations related to efficiency

Recommendations related to the development of assessment and planning standards, the development of a package of services is relevant to improve efficiency. In addition, the following are put forward:

- Ensure effective and regular consultation with national and provincial health authorities for quality assurance.
- While addressing health issues during normal situations, it is also important to ensure that branches/sub-branches and communities are aware of the possible outbreaks and prepared for the same.
- Coordinate with local health authorities, find roles for volunteers and link them with services as project phases out.
- Ensure that regular reporting formats – from volunteers report format to national consolidated report format – are developed, tested and put in place as part of on-going preparedness efforts; and that these are included in orientation sessions provided to staff and volunteers at the start of the project.
- Ensure resource mobilisation and donor relation efforts are continuous activities of the CRC NHQ and branch.

Impact

This section explores the contribution of the project in efforts to save lives of individuals and protect the well-being of communities from various health threats. It also looks into the project's potential wider effects and consequences on communities as well as CRC.

Ø *Focus on essential interventions*

The project was credited for its efforts in promoting hygiene awareness and influencing positive healthy behaviour, and in ensuring safe drinking water and good sanitation are supported at household level. It also contributed to improve health of mothers and children. While the evaluation team endorses this observation, it emphasises that projects like this need to focus on high-impact interventions.

Ø *Effective behaviour change support to all households in the villages.*

CRC realized that in order to maximize the potential to protect and save lives of people, the project should be able to reach all households in the village. Therefore, the project was designed so that every household in the eight villages would be provided with knowledge and skills to support and bring about positive changes in health behaviours. One of the highly credited aspects of the CRC contribution to the priority activities was the intensive health promotion activities. Each volunteer was assigned a cluster of 18-20 households. Through various approaches like demonstrations, community sessions, home visits and clean up campaigns, CRC was able to reach different segments of the population. Community sessions

were organized on monthly basis and detailed information on prevention of communicable diseases like ARI, dengue, malaria and diarrhea and mother and child health was provided. The communities also received knowledge on water and food safety, environment and personal hygiene and mother and child health. The standard flip chart with all detailed information was used by the volunteers in all target villages.

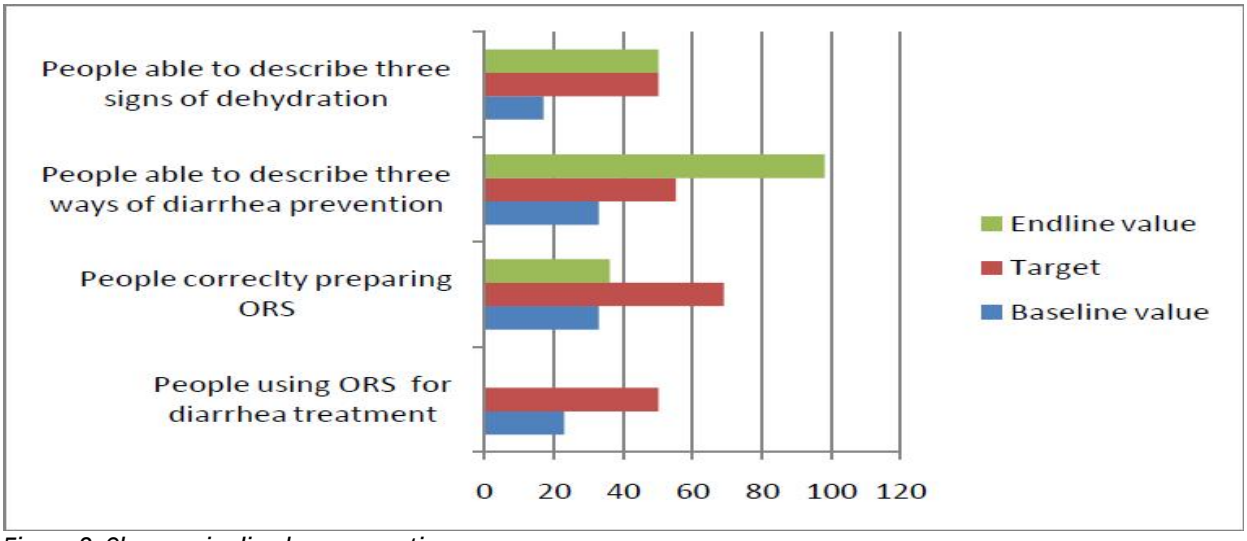

Figure 2: Changes in diarrhea prevention

Hand washing, ORS preparation and household water treatment was demonstrated to all villagers. Volunteers regularly visited households in every village to deliver hygiene and health messages, and to follow up/monitor the progress for the water systems and latrine construction and other behaviours and practices. However, during discussions with communities, it was noticed that majority of them could not prepare ORS confidently.

The support for construction of 346 latrines in the targeted eight villages of the phase of the project was a hallmark igniting its demand. It made communities realize the risks of open defecation to themselves and the community. However, the significant increase in proper use/maintenance of household latrines found from the endline survey doesn't seem to be realistic. Further, the latrine construction support criteria (which was different from those in the CBDRR), didn't give a fair reflection as to who were the most vulnerable and who in these villages should have received the support. There were many cases where people who received the construction support of USD 70 further went on to construct latrines worth from USD 100 to even USD 500.Almost 20-25% of the latrine went to the volunteers as incentives.This was a good way to exhibit volunteers as role models . Further, these volunteers were also from the poor category and it was rational to support them. Even if community people agree on such issues, it is important to note that such support should be done cautiously in order to ensure that the project's decision was impartial.

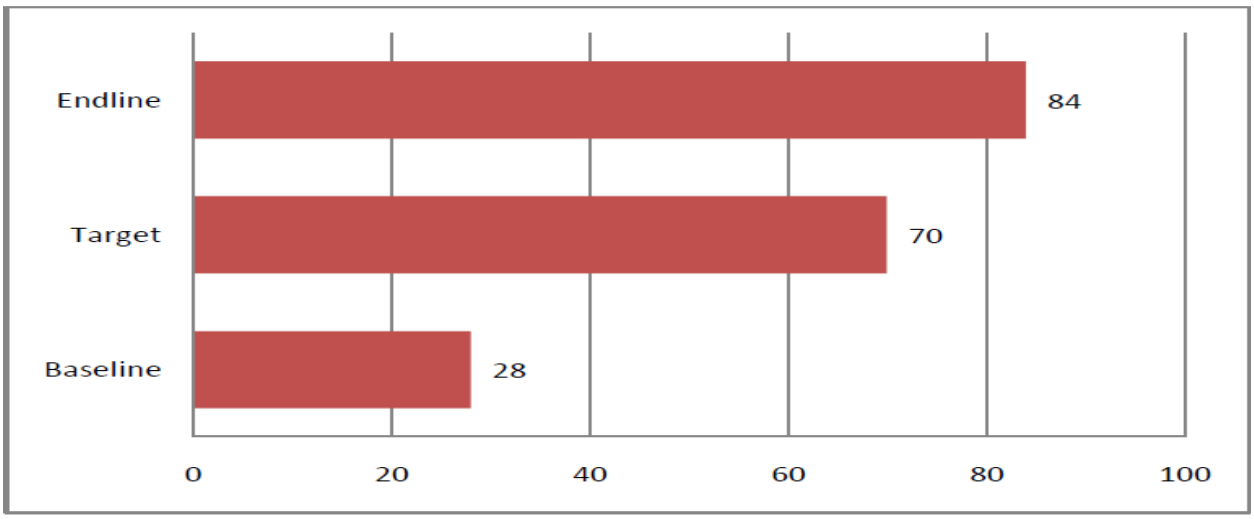

Figure 3: Percentage of households with latrines

Consequently, there was a significant marked improvement in health behaviours such as hand washing after critical times, consuming boiled or treated water, maintaining environmental and personal hygiene. Communities revealed that they less frequently get sick and need to attend health centres and when they do, they rush for services immediately. They also feel happy that now they spend less out of their pockets for health expenditures. Reports from the health centres suggest the significant increase in patient flow and utilisation of services. This was not the case before the project. However, among those who did not receive latrine construction support, at least now do not have the intention to construct one without external support. Therefore, it is most likely that this chunk of the population will continue to defecate openly no matter how much the efforts to reinforce positive practices are carried out.

Mother and child health concerns were also identified as a major priority by the community, VCA and baseline survey and were also backed up by the existing secondary data. Though exclusive breast feeding practices were enhanced and people's knowledge on danger signs improved, the project's efforts to increase ANC and institutional delivery couldn't make major changes. Efforts related to mother and child health awareness is well acknowledged by the community. However, at the same time, the project doesn't address mother and child related issues comprehensively because comprehensiveness reflects inclusion of all MCH components according to the Fast Track Initiative roadmap for reduction of maternal and newborn mortality.

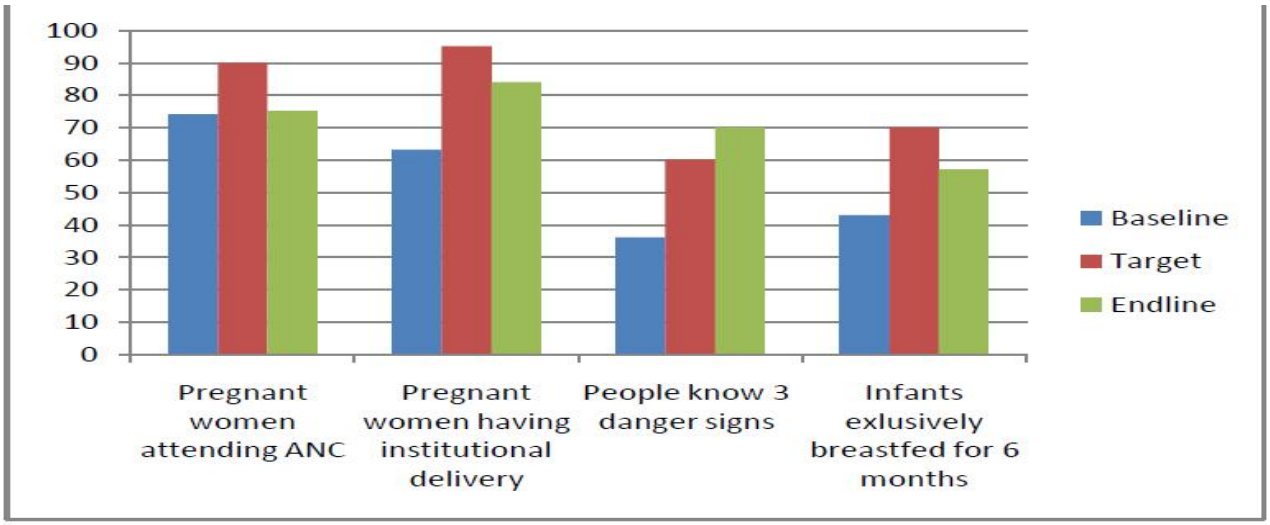

Figure 4: Mother and child health

Knowledge on prevention of ARI and vector borne diseases, specifically dengue and malaria was significantly enhanced. Communities were very well aware of the signs and symptoms of these diseases and majority knew their preventive measures. Communities have access to "Abate"-a chemical substance used to kill larvae in water pots available at the health centres and is free of cost.

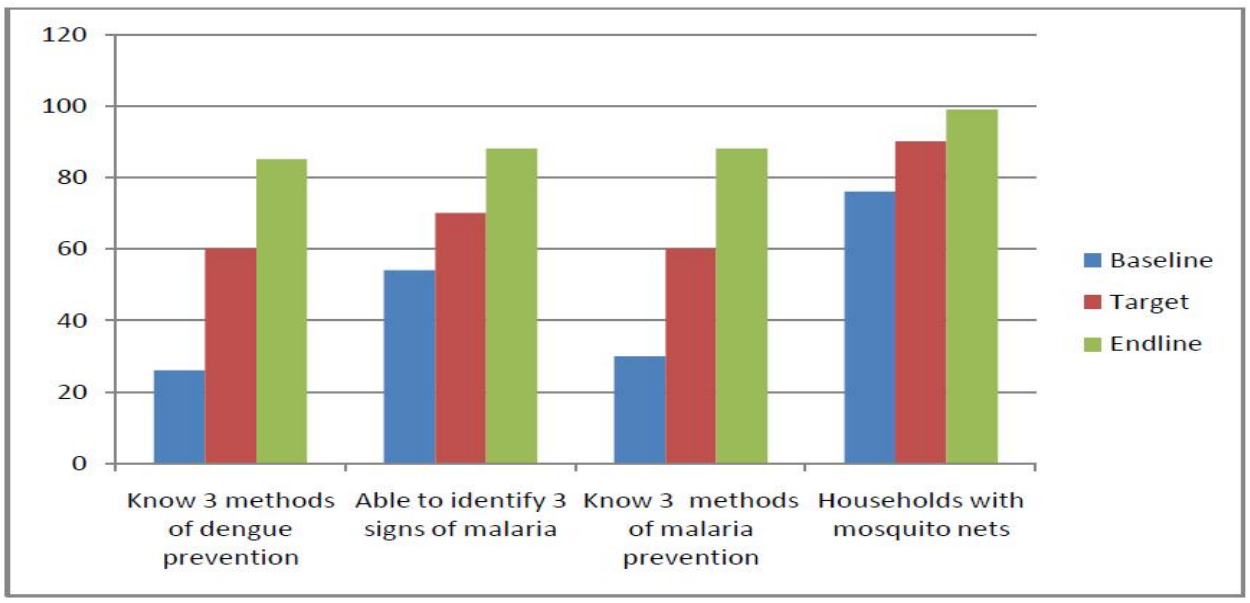

Figure 5: Dengue and Malaria prevention

A significant progress was marked towards ARI and TB awareness. Communities were well aware of the signs and symptoms and complications of these diseases. Health centres also reported increased utilization of these services during the past years.

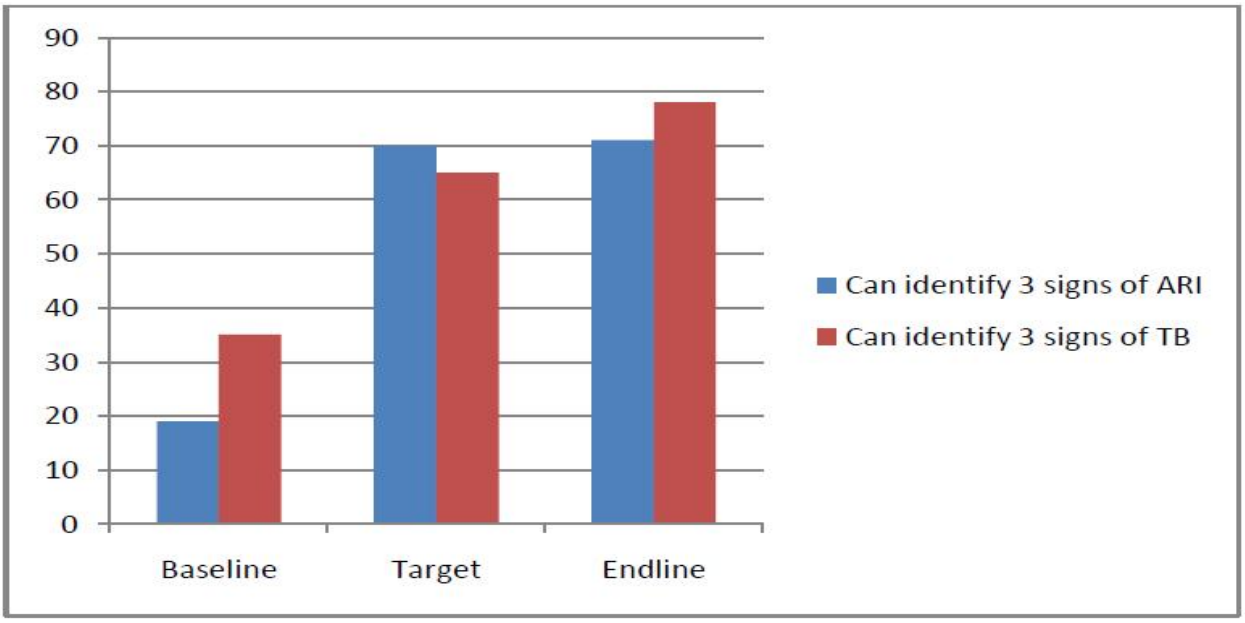

Figure 6: ARI and TB prevention

Given the socio demographic context, though the endline survey reflects grave improvements, it is still too early to state that all these changes were initiated through the project. However, it would still be fair to appreciate the contributions made and challenges CRC confronted in trying to bring about behaviour changes, which in fact is complex in such contexts.

Gains are fragile and still to be engrained

While awareness improvements and behaviour changes reflected in the end-line study are dramatic and would certainly contribute to the prevention of ARI, dengue, malaria and diarrheal diseases, malaria and diarrhea in households and communities, CRC and partners felt that it is too early to claim long-term achievement. These gains are delicate since households and communities in districts covered by the project continue to be effected from inadequate safe drinking water supply and latrines, comprehensive knowledge on mother and child health as well as other developmental inputs.

The variability of the end-line findings – particularly the examples of lack of change in skills on ORS preparation, standard number of ANC visits as advised by the MoH, the perceptions on available health services, also indicate that health education needs to be continued. These elements need to be put in place to encourage the population to adopt health behaviours in a sustained manner. As these developmental inputs take some time, interim mechanisms are needed to ensure that awareness and behaviour change gains are supported. Through social mobilisation and communication tools employed during the project, disease prevention awareness campaigns may be undertaken as part of CRC branch disaster preparedness.

- ***Demand for permanent solutions***

While appreciating the efforts of district authorities and CRC in raising awareness on common communicable diseases and improving mother and child health, there were high hopes from community leaders as well as members that authorities and partners would make efforts to deliver permanent solutions on the ongoing practical problems faced by these under-developed communities. It was also noted that communities expectations from the CRC are not limited to water, sanitation, hygiene and health promotion.

Recommendations related to impact

Recommendations related to effectiveness are relevant to the improvement of project impact. In addition:

- Since disease outbreaks are one of the most feared outcomes of frequently faced natural disasters like flood, conduct preparedness, campaigns to remind vulnerable villages of measures to prevent and treat diarrhea and other water-borne diseases that may potentially increase during the monsoons.
- Reinforce demonstrations on hand washing, ORS preparation, and household water treatment.
- Ensure and follow up that all latrines have soaps.
- Mother and child health awareness should be comprehensive including other aspects such as nutrition and immunization.
- Ensure that Red Cross volunteers not only refer pregnant women and mothers with their children to health centres but also make a point to follow up their health concerns during home visits.
- Supporting hardware components such as latrines construction increases dependency of beneficiaries-this was very prominent in this project and should not be encouraged in the future as even large projects with latrine constructions around the world have failed to bring in longer term impacts.
- These infrastructures should be part of the government's responsibility and organisations such as CRC can have a major role in advocacy and facilitate communities' access to such support providing institutions.
- Impacts tend to sustain more when project activities are linked to village development processes.
- Impacts tend to sustain more when livelihood components are incorporated in such development projects.

Connectedness and sustainability

This section attempts to look into whether the project has links to long-term efforts. It also analyzes to what extent the project has contributed to limiting future disease outbreaks in target areas, improved mother and child health and to what extent the experience of CRC in gained through this project, can be sustained.

- Ø *Project in line with broader and long-term priorities*

The components and key activities of the project were identified in close coordination andconsultation with health authorities and partners at various levels. In the design of its communication materials, CRC used messages prepared/approved by the MoH – brochures, flexes, flip charts– for its awareness campaigns. During the implementation period, based on the poor level of community made by government, the CRC branches engaged with the local authoirities, mainly village chiefs, , red cross volunteers, and villagers at each village in the selection of households as recipients for latrine consruction.The commune plan has further prioritized the identified health concerns.

- *Involment of Red Cross Youth*

The project was successful in engaging the Red Cross Youth of 2 high schools in period of 2010-2012. Though the school was not located within the target villages, it was effective to mobilize students who were willing to serve as volunteers. The awareness messages intended by the project were effectively and efficiently disseminated through the RCY. Further, RCY also mobilized them for fundraising through which they supported poor students/families in their school. They were additionally involved in regular clean up campaigns.

It was encouraging to see the support they received from the school authorities- a room within the school premises which they refer to as "club" and conduct all their planned activities. Even such a small entity was well organized and had all reports in place, has monthly meetings and reviews the progress on regular basis.

The 50 selected RCY, majority of which were girls were proud to be Red Cross Volunteers. The level of enthusiasm they showed towards CRC's humanitarian mission was outstanding. To appreciate their contribution, they were provided with trainings such as first aid. Further, the Red Cross also recognized them as active humanitarian workers and provided scholarship schemes for further studies. It is important for CRC to cash the investment made by the RCY and ensure that they are retained to be further mobilized to contribute to sustain the connectedness the project has brought along.

- ***Gains in villages need further support***

The positive awareness and practices gained through the project can be considered significant, and can be potentially sustained, particularly if more investments and support are made to improve drinking water systems and sanitation facilities in these villages. There is realisation among villagers that there are permanent solutions to their recurring problem and are willing partners to the water, sanitation and hygiene and health development efforts. While there were villagers who claimed that they are already aware on what to do during normal times and crises, other parties also indicated that they will need continued support, particularly on behaviour change. Some of the latrines are used by several families (as recommended by the project) and fill up sooner than others. Long-term latrine maintenance, e.g. what to do when the latrine fills-up, and long-term maintenance costs, however, had seemingly not been

discussed with the beneficiaries. On asking what they would do in such situations, while some mentioned about ordering systems that pump out and clean the tank from Kratie City, many didn't have any idea. Further, resource constraints are factors that prevent willing communities from committing on the long term sustainability of the project gains.

Ø *Phasing out and exit strategy*

This three year long intervention had as an important objective, to strengthen the technical and coordination capacity of CRC. If this had been performed in an intended and proper way, it could have contributed to a sustainable program even after funding from FRC ceased. This is however not purely the case. Creating effective partnerships-partnerships which contribute resources has been regrettably absent from the agenda and there are therefore no other organizations that can take over part of or full responsibility for the activities. Alternative funding has been looked for neither from external donors nor as core funding within the CRC. This is even more peculiar as the CRC recognition is so often stressed by both governmental, INGO and NGO representatives, who would make it possible to tap into resources. Funding could have been possible where the program in fact took over some corporate social responsibilities from potential donors.

Unfortunately, there is no where an exit strategy or phasing out plan which in worst case scenario can lead to an abrupt end of activities. Additionally, trained volunteers and staff can be lost as many of them have not been integrated into other programs.
All this taken together can negatively influence the perception of CRC and taint the strong branding in the eyes of communities as well as other actors.

Recommendations related to connectedness and sustainability

By improved awareness and practices in disease prevention, and enhanced awareness on mother and child health it contributed to empowering villages to protect households in the coming monsoon season from the threats of diarrhea and other water-borne diseases and further reduce maternal and child morbidity and mortality by enhancing their knowledge and directing them to appropriate places of service. However, villages need continued support – particularly in addressing the long-term health needs – to ensure that these initial gains are sustained.

- Discuss with communities about options to manage the evacuation of septic tanks.Though such tanks take 4-5 years to fill up, options such as recycling of the fecal sludge as fertilisers or biogas could be worth exploring.
- Ensure to seek further technical advice on the long-term latrine maintenance from local technical agencies and authorities. Discuss this with all latrine beneficiaries to sustain the positive impacts and to reduce future risks.
- Improve human resource management accordingly to retain and integrate volunteers and staff from this project into CRC's core activities.

- Conduct post evaluation review in about two years to see what has been the impact at a later stage.
- Better support to staff continuity planning and exit strategy right from the inception of the project.
- Build on the efforts made and link the CBHFA project to related projects such as CBDRR and PHiE.
- Emphasize efforts on more long term and meaningful rather than short lived structural integration.
- Since communities claimed that funds are required consistently to ensure sustainability, CRC should explore innovative, creative and marketable fundraising ideas.
- Advocate to relevant authorities (and donors) at national and local levels the need for more aggressive investment in the development of water supply systems and environmental sanitation facilities and comprehensive MCH packages.
- There is need for honest and realistic estimation of the capacities on different levels, when it comes to management, fundraising and monitoring.
- While making efforts to sustain the impact, it is necessary to analyze and identify only those aspects of the project which are possible and realistic to sustain.
- Secure the gains of the project with continued health promotion activities.
- Identify the priority actions that deliver the expected organizational roles and contributions and confirm with national health authorities and relevant partners, the areas of health in which CRC can contribute and add value.
- As an active partner rather than a donor, FRC can also support in exit and sustainability plan and provide inputs on the same

Conclusions and key recommendations

The CRC initiated this project in response to support the national efforts and needs of the communities. It recognises that longer-term interventions are needed in safe drinking water supply and sanitation facilities in communities to address the recurring problems of diarrheal diseases, malaria and dengue. Further, a comprehensive MCH package is the focus of the government and CRC is preparing its self to support these in the long run. The project did contribute to the prevention of impending disease outbreaks during 2010-2012 in the eight targeted villages of Kratie, successfully contributed to improving mother and child health and increased utilization of health services. This was mainly due to the high awareness and positive behaviour of villagers on disease prevention, treatment and control and improved health service seeking behaviour resulting from an intensive and multi-pronged communication campaign carried out by CRC.

Through the project, many households in villages have started using boiled or treated water, hand washing, demanding for latrines and heightened bringing further knowledge of better mother and child health. It also created a demand for sustained health awareness, which is an opportunity for CRC to further serve the most vulnerable. However, the above are temporary achievements – fragile and not yet engrained – and may be eventually lost if timely health communications are not continued as part of community health development initiatives, and if water supply and sanitation infrastructure development and a comprehensive MCH package is not invested in.

CRC has made a significant contribution in providing health and hygiene promotion knowledge and skills in villages where the project was implemented. Through the project, CRC gained valuable practices and captured lessons which can empower itself in addressing future public health threats. The evaluation puts forward the following key recommendation for similar programming in the future:

- Be innovative in marketing the capacities of CRC but at the same time be realistic because behaviour change approaches are challenging.
- Longer-term programmes need to be built upon the increased awareness and interest of target communities to address the underlying causes of their health concerns
- Use VCA as a holistic process to engage and empower community members, including vulnerable groups, to participate in good community based programming that allows them to build community resilience.
- Where already initiated, CRC should continue activities targeting vulnerable communities.
- Allow linkages to networks to further build confidence and dedication.
- Standardize the latrine construction support criteria based on the economic vulnerability of the community people.
- Effective and regular consultation with national and provincial health authorities is inevitable for quality assurance.
- Coordinate with local health authorities, find roles for volunteers and link them with services as project phases out.
- Ensure resource mobilisation and donor relation efforts focus on partnerships to reach scale.
- Advocate to relevant authorities at national and local levels the needs for more aggressive investment in the development of more water supply and environmental sanitation facilities for the vulnerable population in these villages.
- Assess jointly with local authorities the whole life-cycle of especially hard ware support, identifying and evaluating the impacts of relevant and significant inputs and releases to land, water and air; in addition, assess options or alternatives that could reduce negative impacts, if relevant, and strengthen positive co-benefits e.g. through environmentally sustainable hardware options.

- Ensure that mother and child health is addressed through a comprehensive package of services.
- Consult and use the expertise of departments consistently. Share expertise, knowledge and best practices with the DM department on how to address public health threats for the benefit of the most vulnerable populations in Cambodia.
- Better information systems and management at NHQs such as data bank is useful to avoid duplication of efforts and resources.

Annex 1. Terms of Reference (Summary)

1. Purpose and Scope of the Evaluation

The purpose of the evaluation is to analyze and comment on the achievements of both community based projects and review the process of implementation of the CBDRR and CBHFA approach in Cambodia country context. The evaluation will identify significant factors that are facilitating or impeding the implementation of the CBHFA project and the delivery of their outcomes. Evaluation is expected to lead to recommendations and lessons learned for the future. Evaluation upholds FRC commitment to accountability and organizational learning and will be used while programming new initiatives in the field of DRR, health and social services.

The evaluation will cover a period of 2010–2012 and will be conducted in the first 8 villages of the CBHFA project sites.

Inclusion of all participants, either directly or through their true representatives, is considered essential hence the evaluation methods will be varied accordingly to facilitate this participation. Evaluation outcomes will be shared with FRC and CRC who in turn will take the responsibility of disseminating the outcomes to relevant interested parties. FRC will be responsible of sharing the outcome with the Ministry of Foreign Affairs of Finland. The outcomes are expected to provide lessons learned and concrete recommendations to guide FRC and RCST future programmes and to influence the ways of working and promote the best practice in using the CBDRR and CBHFA approach.

2. Evaluation Objectives and Criteria

2.1. Objectives *Identify specific objective(s) about what the evaluation will do to fulfil the purpose of the evaluation.*

The main objectives of the evaluation are:

- To evaluate the Kratie community health program 1st 3 years phase in its relevance, effectiveness, efficiency, impact and sustainability and to recommend improvements for the 2nd program phase covering 2013 – 2015.

2.2. Evaluation criteria and specific evaluation question

The basic evaluation criteria of the OECD/DAC will be used: 1) relevance, 2) effectiveness, 3) efficiency, 4) impact, 5) sustainability. Additional evaluation criteria from the IFRC Evaluation Framework can be used as appropriate: adherence to Fundamental Principles and Code of Conduct, coverage, coherence, connectedness (see Annex 1 for IFRC definitions). Formulate the evaluation questions relating to the appropriate criteria. Consider the Finnish Red Cross value added as a criteria.

1. Relevance (The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor. Retrospectively, the question of relevance often becomes a question as to whether the objectives of a project or its design are still appropriate given changed circumstances.)
2. Effectiveness (A measure of the extent to which an aid activity attained its objectives.)
    - Ø To what extent the intervention/project objectives have been attained?
    - Ø Evaluate how the overall project plan and its subsequent annual plans were implemented. What worked, what did not work?
3. Efficiency (Efficiency measures the outputs -- qualitative and quantitative -- in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results.)

4. Impact (The positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended. Relates to the goal level of the log frame hierarchy.)
5. Sustainability (Sustainability is concerned with measuring whether the benefits of an activity are likely to continue after donor funding has been withdrawn. Projects need to be environmentally as well as financially sustainable.)

The evaluation team should consider and examine the inclusion of the cross-cutting issues (gender, environment) in the project implementation.

2. Evaluation Methodology

The evaluation will use the following data sources *[identify relevant documents]:*

- *partners' agreements previous mid-term review report, evaluations of previous project phases, monitoring reports [IFRC Annual reports (2009, 2010, 2011, 2012, mid-term, programme updates)*
- *all project related documentation provided by the program co-ordinator Tytti Vartiainen (plans, budgets, financial and narrative reports, guidance documents, etc.)*
- *baseline data available, previous evaluations*

Reference documents:

- *Federation strategy 2020, policies, guidelines*
- *CRC Strategy 2011-2020*
- *Integrated Programming Guideline, March 2013, Danish Red Cross??*
- *[Name any particular tools to be used for analysis]*

Methodology

Methods of data collection and analysis to be discussed and defined by the evaluation team, but should include at least *[define the requirements]*:

- Briefing at the FRC to discuss the TOR and the time schedule
- Briefing at partner CRC Headquarters
- Document analysis/review; a critical review of documented materials including project plans, reports, baseline and endline.
- An assessment of the degree to which recommendations from [previous mid-term review/evaluation/monitoring visits] have been implemented
- (Key informant) Interviews with key stakeholders [staff and volunteers in the governance and management, authorities, other partners] at [national, regional, branch] level

- Focal/ Focus Groups interviews with beneficiaries
- Workshops with branch staff
- Field visits to Kampong Thom and Kratie branch

All findings should be evidence based and methodology used explained in the final evaluation report.

3. Deliverables

The evaluation team will provide:

a. A feedback session outlining the key preliminary findings to CRC HQ.
b. Review report highlighting key conclusions and recommendations. The draft report will be submitted 15 days after the conclusion of the review and final report submitted no later than 1 month after the review (with 5 days allowed for feedback).

4. Proposed Timeline (or Schedule)

Team composition deadline:

- Briefing at the FRC (team leader only): May-June 2013
- Desk review:
- In country evaluation: xx to xx [Month] (not including travel days) Beginning of June
- Report writing and delivery of deliverables:

<u>Proposed evaluation plan in the country:</u>

Prior to the work in country: desk review, baseline data collection by the xxxx

Day 1: Briefing on the context and the study background, presentation of the findings, identification of the main successes and challenges

Day 2: Evaluation team building, definition of the evaluation program

Day x: Interviews, field trips

Day x: Debriefing at the xxxx HQ

Day x: Evaluation team to compile the learning, organise the skeleton of the report and agree on the next steps and timeline to complete the report.

<u>Debriefing and drafting of the evaluation report:</u>

- Debriefing at the FRC in Helsinki on to present the main findings, conclusions and recommendations.
- The draft final evaluation report to be ready by [date= within two weeks from return from the field] for comments from FRC, CRC and [ECHO], other PCRC and IFRC.
- Comments for the draft report to the Consultant by
- Submission of the final evaluation report on
- A presentation of the evaluation findings at the FRC IOP.

6. Evaluation Quality and Ethical Standards.

The evaluators should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of people and the communities of which they are members, and to ensure that the evaluation is technically accurate, reliable, and legitimate, conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards of the IFRC.

1. Evaluation Team and Qualifications.

The team will consist of a maximum of X participants/consultants. This will include;

- One participant nominated by each National Society as their representative;
- Any other team members [representative from the] …;

The representative of xx is assigned as a Team Leader?

The evaluation team shall jointly have: e.g.

- University degree/s at the post-graduate level in relevant field of study (e.g. health, water and sanitation, disaster management, social sciences).
- Experience with technical knowledge of relevant programme delivery using community based and participatory methods in developing countries.
- Solid knowledge and experience of project monitoring and evaluation methods and approaches.
- Proven experience in evaluating development co-project programmes or projects, incl. analyzing development impacts and cross cutting objectives. Preferably at least 2-3 reference projects, each reference being at least 20 days long. Experience from working as a Team Leader is an asset.
- Excellent analytical, writing and presentation skills.
- Sound knowledge of the Red Cross and Red Crescent Movement and it works preferred.
- [Language requirements] Good knowledge of written and spoken

The team leader will be responsible for the coherence of the evaluation report.The evaluation team will report to the Evaluation Manager NN at the FRC.

Annex 2. Documents consulted

CRC

- CRC's Proposal for CBHFA project in Kratie
- Project Annual Narrative and Financial Reports 2010-2012
- Baseline survey 2010
- Endline survey 2012
- Vulnerability and Capacity Assessment report, 2010
- CRC Development Plan 2011-2014
- CRC Strategic Plan 2011-2020
- CRC Financial Procedure Guidelines 2006

IFRC

- Strategy 2020
- VCA tool box
- IFRC Handbook for M and E
- Global Water and Sanitation Initiative Programme 2005 – 2015

Various sources

- Cambodia-National Health Plan 2008-2015
- Fast Track Initiative Road Map for Reducing Maternal & Newborn Mortality 2010 to 2015
- Cambodia- Country Profile(WHO)
- WHO/UNICEF Report on Drinking Water and Sanitation, published in 2010

Annex 3. List of interviews and group discussions

CRC NHQ

- H.E. Pum Chantinie, Secretary General
- Dr. Sok Long, Director, Health Department
- Mr. Hang Chan Sana, CBHFA Project Manager
- Mr. Tou Seng, Finance Officer
- Ms.Vantha Dim, Project Officer
- Mr. Molin Plan, Project Officer

CRC Kratie branch/sub-branch

- Mr. Thun Kri, President
- Mr. Thong Virada, Director
- Ms. Prak Sopheap, Deputy Director
- Mr. Chab Chean, Secretary
- Mr. So Sakan, Project Team Leader
- Mr. Choun Darat, Admin/Finance Officer
- Ms. Kung Lim Ho, Deputy District Governor and President of sub-branch
- Mr. Moun Virak,Facilitator
- Mr.Mel Manith,Facilitator
- Mr. Min Song, Facilitator

In the project villages

- Village head of each of the four villages
- 32 Red Cross Volunteers
- 24 Red Cross Youth

IFRC

- Mr. John Entwistle, Country Representative

FRC

- Ms. Sonya Björklund Regional Representative, Asia(20008-2012)

Partners

- Dr. Cheang Syvutha, Provincial Health Director, Kratie
- Mr. Touch Phalla, OPD Consultant, Prek Prasob Health Centre
- Mr. Lao Houy, EPI in charge, Prek Prasob Health Centre
- Mr. Hout Cheany, Registration and Information Officer, Prek Prasob Health Centre
- Ms.Chean Sreyou, Midwife, Prek Prasob Health Centre
- Mr. Seng Kim Leng, Deputy Director, Tamao Health Centre

Annex 4. Evaluation schedule

Date	Activity
14/06/2013	Arrive in Cambodia
15/06/2013	Evaluator meet with CBDRR and CBHFA Project Managers and discuss about the schedule and other issues
16/06/2013	Evaluators Meet to discuss on field visit and procedures
17-20 /06/2013	CBDRR Project evaluation
20/06/2013	Meeting with branch committee and project team involve with CBHFA project Meeting with Provincial Health Director
21/06/2013	Meeting with project staff to review the project processes &progress
22/06/2013	Discussion with 1 target high school Discussion with beneficiaries and volunteers in Dey Dos Krom village Meeting with Prek Prasob Health Centre
23/06/2013	Discussion with beneficiaries and volunteers in Kampong Kor village Meeting with Visit sub-branch
24/06/2013	Discussion with beneficiaries and volunteers in Chroy Sneng Krobey Leu village Discussion with beneficiaries and volunteers in Prek Prasob Krom village
25/06/2013	Meeting with key persons of Tamao Health Centre Debriefing meeting with Secretary General
26/06/2013	Meeting with Health Director Continue discussions for remaining issues with CBHFA project manager
27/06/2013	Departure to Nepal

Annex 5. Guide questions for interviews and group discussions

CRC, NHQ and FRC

Introduce the team. Acknowledge work. State purpose of meeting/discussion. State process. Emphasize confidentiality. Summarise project objectives, results and activities.

Relevance and appropriateness

1. Do you think the project design was appropriate to meet the needs of the target population?
2. How useful do you think the project was to needs of communities? How has the project taken account of the different needs of men and women? What about vulnerable people?
3. How were communities involved in the design, implementation and monitoring of the project? What would you change to promote increased participation in the future?
4. What determined the priority activities of the project (drivers and decision making). Who was involved in the decisions concerning the key activities of the project?
5. If you could do the project again, is there anything that will be changed? And would anything be different if money was not a problem?
6. In what ways was the project accountable to communities? To what extent did recipients give you feedback (specific examples)? How was this acted on? What more could CRC do on this in the future?

Effectiveness

1. How successful was the project overall?
2. To what extent has the project achieved its objectives? How are you measuring this? What do you think the contributing factors to success are? What may have been an obstacle to even more effective results? Were there any changes midway? How did the changes in impact on effectiveness?
3. How effective was the management structure? What of this would you keep for the future and what would you change? How effective were the processes to establish, deliver and monitor the project e.g. assessment, priority setting? What monitoring tools were used and by whom?
4. How was coordination implemented (a) internally and (b) with external stakeholders? What of this was successful and what would you change for the future? Besides the CRC, were other organisations contacted and coordinated with to avoid gaps and duplication? Were there any other organizations doing similar work in the project areas?
5. How has the CBHFA project supported or responded to CRC's development plan?

Efficiency

1. How efficient do you think the project was? How are you measuring this?
2. How were decisions taken in the project? How was consultation undertaken within CRC between CRC and volunteers; between CRC and beneficiaries; and between CRC and relevant government agencies?
3. Could the support (information, tools, resources) from the FRC secretariat to the project be improved? What kind of support would be required?

Sustainability

15. How has CRC built its capacity through the project? In what way did the project reinforce longer term strategic goals for CRC? Did the project undermine those goals in any way?

16. To what extent has the project contributed to resilience for the future? What could have been done differently in regard to this? How ready is the community to face the threats of diseases?

Impact

1. How would you describe the impact of the project? How sustainable do you consider the impact to be?
2. Were there any negative consequences arising from the project? What priority issue would you address to bring about more impact in similar projects in the future?

Interview with CBHFA coordinator and project staff

A. General
   1. Do you know situation on health status at National and province level, and trends over the project cycle - in brief
   2. Availability health services in the program province?
   3. How the project aligns with national/local health programmes
   4. What were the main challenges? How were they overcome?

B. Coordination

Internal

1. Who are the internal stakeholders?
2. What are the internal coordination mechanisms?
3. What issues / challenges were noted in relation to the project coordination?
4. What efforts were made to minimize the challenges?

External

1. Who are the main external stakeholders?
2. What other Health/Disaster Management projects are currently being implemented in your CRC/province?
3. How do you collaborate with them? Any joint activities so far?
4. Have CRC representatives been invited to deliver talks or conduct workshops or workshop sessions in the programmes of other organisations working on health and

disasters? How many times has this happened at National level? Province level?
5. What were the challenges faced and how were they overcome?

C. Volunteer mobilisation
1. How many volunteers are there in the programme (M/F)
2. How are the volunteers selected and mobilised?
3. Has gender sensitivity and ethnicity been taken into consideration?
4. Since the program started, how many been trained? Which trainings?
5. How many community members have been trained CBHFA?
6. How many of these were already RC volunteers involved in other programmes (HIV, disaster preparedness, etc.)?
7. How many of the trained volunteers are still active?
8. Estimated drop-out rate/year (absolute number/percentage)? Do you keep a record? How do you replace?
9. What is the motivation level of volunteers?
10. How much time (on average) is spent on an individual, on a group session?
11. How often is monitoring performed? How is it done?

D. Project design:
1. Does the project design meet the needs of the target groups?
2. Did the volunteer involve in activities design?
3. How were the target groups selected?
4. How is planning done? Are all stakeholders involved?
5. Do you see an effective linkage between CBHFA and DM programmes?
6. Should CBHFA be vertical or integrated in other programmes? How is that possible?
7. How are gender issues addressed?
8. Does local government provide subsidies? Any approaches made for the same?
9. Are there plans for scaling up?
10. Do you think this project design is suitable for replication?
11. Were IEC materials designed or adapted from national materials? Are they effective in your community? Which languages are used?

E. Project Management:
1. How many staffs and volunteers in total?
2. Are their recruitment centralised? What was the recruitment process?
3. How was the staff turnover? Do you know the reason?
4. Was the project management efficient? How effective was the leadership? Do core staffs have sufficient skills and capacities for the job? How do you see the decisions making process? Is it quick and effective?
5. How many programme coordinators have changed during the course of this programme at NHQ level and province level?Were reports obtained and submitted on time?
6. How effectively was the financial management carried out?
7. How was the procurement carried out? What materials are procured under this project?
8. Has the project met its targets?
9. How are communities involved? Are feedbacks from them looked into and incorporated

where feasible?

10. What about sustainability of project activities?

F. Monitoring/Supervision and Reporting:
   1. Is there an M and E system in the CRC? A brief description please.
   2. Does the coordinator have a good control over the project?
   3. How is the progress of the project monitored? What are the tools used?
   4. How often is monitoring done?(from all levels)
   5. Have you done joint monitoring with local government authorities?
   6. Has reporting been regular? Is there a reporting format? Please show. Do you get feedbacks on your reports?

G. Publicity/Partnerships and fundraising:
   1. Has the project been able to enhance the image of CRC?
   2. What publicity materials have been used?
   3. Does the branch have income generation activities? Does it contribute to the CBHFA project?
   4. Has further partnerships at national/local level been sought?
   5. Have there been efforts for resource development at national and local levels? When/with whom and how?
   6. Any proposals submitted? Any grants?

H. FRC Support:
   1. What support was received by FRC?
   2. Was the support effective?
   3. Did you get feedbacks on various issues?
   4. Did they help you in planning/monitoring?
   5. Was anyone sent for trainings/workshops through their support?

I. Capacity development and sustainability:
   1. How has the project contributed to:
      -Human resource capacity development
      -Infrastructure
      -Visibility
   2. How will the achievements be sustained beyond the support of FRC?
      -Is there a sustainability plan in place?
      -How will the trained volunteers be retained and mobilised?
      -What is the exit strategy?

J.Examples of lessons learnt and good practices.

Health Director

1. How has the project aligned with the strategic priorities of CRC policy/strategic and development plan/ S2020
2. How does CRC look at future CBHFA programming
3. What has been the strength of CBHFA in implementing such interventions

4. What capacities have been strengthened from this project?
5. What is the senior management's take on such interventions? Will CBHFA continue such in the future?
6. What was the level of support from FRC and IFRC country office?
7. How does this project contribute to the national efforts of improving health of vulnerable people? Has it aligned with National policy and strategy?
8. What is the status of resource mobilization for CBHFA programming? What partners have been approached?

Beneficiaries

What's your name? How many people are in your family?

Relevance to needs

1. What have you received from CRC to improve yours and your family's health?
2. If you had not received anything, how would things be different?

Appropriateness

1. Did you receive any information/ materials? When did you receive them? What did you do with them? Were they useful to you? How?
2. Could any of the information/materials have been different either in terms of: Timing? Content? Quantities? Way these were delivered? Should there be other information/materials included?
3. Were the messages in IEC materials and campaigns appropriate and easily understood by community members?
4. Could the information /materials and activities have been better adapted to the different needs of men and women? How?
5. Were the information/ materials distributed and activities carried out offensive to the local culture in any way? Were there cultural consideration that the CRC intervention should have been aware of? What are they?
6. Were you or anyone in the community not happy with what you received? If yes, why? To whom did you raise this, and how did you raise this?

Beneficiary participation

1. How involved were you in designing the CBHFA activities of CRC?
2. How did you feel about the selection of beneficiaries – how involved were you in this? After you were involved in the project with CRC, did your relationship with other people in the community change? How?

Effectiveness

1. How often did you or your family members get sick after being part of the project?
2. Can you recall some of the messages of the CRC from brochures, household visits, street drama, radio program etc?

3. How have you changed your healthy behaviour?

Efficiency

1. Do you feel that activities were done on time?

Sustainability

1. If CRC did not bring this project to your community, would you have started something similar yourself? How?
2. Do you think you will continue using your knowledge and skills to keep your self and your family healthy?
3. Looking to the future, are you more prepared now to protect your community/household from the dangers of diseases?
4. What are the three priorities you think CRC should focus on to help communities/households to improve their health?
5. How would you describe the impact of this CRC project on your family and community? Were there any negative consequences arising from the project?
6. How did you feel about the CRC before the project, and how do you feel about them now?

Others

Do you have any questions for us?

External partners

Introduce the team. Acknowledge aspiration. State purpose of meeting/discussion. State process. Emphasize confidentiality. Summarize project objectives, results and activities.

Effectiveness

1. To what extent has the local authorities/partners achieved its collective objective in addressing the health situation during the last few years? What has been achieved and what remains to be done? What has contributed to successes, and what obstacles have prevented the project being even more successful?

2. What perception do you have of the CRC and FRC contribution of this project?

3. How do you view the coordination mechanisms in general? What of these were successful and what would you change for the future? How has CRC participated in these mechanisms? How has CRC coordinated with your organization?

In your opinion what is CRC's strength? Does it add value to your joint efforts with RC?

4. In the context of improving health of communities, to what extent do you consider CRC has fulfilled its auxiliary role to the Government. Can you give an example?

Relevance and appropriateness

5. In general was there agreement across the humanitarian sector about what was needed for vulnerable populations/communities? How it determined what was to be included in the project activities?
6. How does your organisation determine household/community needs? How well do you perceive CRC met those needs?
7. How were beneficiaries involved in the activities and overall efforts of the project ?
8. To what extent are feedback mechanisms established within the community? What perception do you have of the extent to which CRC encourages feedback from vulnerable households and communities it served?

Efficiency
9. How efficiently do you think your organization addressed and community needs? Were there any areas of overlap or duplication?

Sustainability
10. To what extent have efforts of different actors contributed to a body of knowledge within the humanitarian community in Nepal in improving the health status? Has CRC contributed to this?
11. To what extent have efforts contributed to resilience for the future? What could have been done differently in regard to this? How ready is the community to face the threats of health issues?

Impact
12. How would you describe the impact of the project? How sustainable is that impact? Were there any negative consequences arising from the project? What priority issue would you address to bring about more impact in future projects?

Volunteers

Introduce the team. Acknowledge work. State purpose of meeting/discussion. State process. Emphasize confidentiality. Summarise project objectives, results and activities.

Relevance/appropriateness

1. How useful were the materials/knowledge/skills provided to the communities and households?
2. How useful were the activities carried out? (Could this be more specific?)
3. Were you or the branch involved in identifying activities/priorities of the project?
4. If you could do the project again, would you change anything? Would anything be different if money was not a problem?
5. Did the project take into account the different needs of men and women in the community? What about vulnerable people?
6. Were there any cultural considerations that the project should have taken account of?

7. Were you aware of any beneficiaries who were not happy with the project? Who did they raise this with and how? What was done as a result of that feedback?
8. How were beneficiaries involved in the design of the project?
9. How often did you visit the beneficiary after the assistance was given?
10. What were the criteria for the selection of households and communities? If you were involved in the selection, can you explain how the criteria were verified?
11. Did relationships among households in the community change because of the CRC project? How?
12. How did your relationship with the community change because of being involved in selection of households? What would you change in setting the criteria in future?

Effectiveness

1. How successful was the project overall? What other projects are there in your area?
2. What linkages do you have with any of these?
3. Do you often meet with other organizations? Have there been opportunities to work with them?
4. To what extent has the project achieved its objectives?
5. What factors contributed positively to the achievements?
6. What factors hindered the implementation of the project, and how were they overcome? Which activities and support to the communities and households made a significant contribution in the objectives of the project? How?
7. *(For participants of trainings undertaken through this project)* How useful do you feel were the trainings? How did you use what you learnt in the training?

Efficiency

1. How were decisions taken in the project? How clear were you on what your role and responsibilities were? Was there any area where you needed more clarity?
2. Were there any materials procured? Was the procurement centralized? How many days would these materials take to be procured? Were the materials easily distributed? Was the quantity adequate?

Sustainability

1. What have you learnt as a result of being involved in the project? What do you feel now about your and your chapter's involvement in the project? What would you suggest CRC could do to sustain the experience through the project? What would you suggest CRC could do to prevent such health issues in the future?
2. How ready is the community to face the future health threats?

Impact

1. How would you describe the impact of the project? Were there any negative consequences arising from the project? How does the community view CRC now?
2. That's the end of the interview – is there anything you would like to ask us?