Corporate Unit Evaluation Central Project Evaluation

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Central project evaluation

Social Health Protection Project III, Cambodia

PN 2013.2137.1

Evaluation report

On behalf of GIZ by Klaus Peter Jacoby (iSPO GmbH) and Chean Rithy Men

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List of abbreviations

BMZ	*Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung* *Federal Ministry for Economic Cooperation and Development*
CBHI	*Community-based health insurance*
CD	*Capacity development*
CDPO	*Cambodian Disabled People Organization*
CSES	*Cambodian Socio-Economic Survey*
CSS	*Client satisfaction survey*
DAC	*Development Assistance Committee of the OECD*
D&D	*Decentralisation and deconcentration*
DPO	*Disabled people organisation*
GDC	*German Development Cooperation*
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH*
HCMC	*Health Center Management Committee*
H-EQIP	*Health Equity and Quality Improvement Project*
HSP	*Health Strategic Plan (different periods)*
LNOB	*Leave-no-one-behind principle*
MPA	*Minimum Package of Activities for Public Health Centers*
NCD	*Non-communicable diseases*
NGO	*Non-governmental organisation*
NSPC	*National Social Protection Council*
NSPPF	*National Social Protection Policy Framework*
OECD	*Organization for Economic Cooperation and Development*
QAO	*Quality Assurance Office of the MoH*
QEMT	*Quality enhancement monitoring tool*
SDG	*Sustainable Development Goal*
SHPP III	*TC measure: Social Health Protection Project III*
TC	*Technical cooperation*
USAID	*United States Agency for International Development*
WHO	*World Health Organization*

Abbreviations for the citation of interviews

INT-P	*Interviews with project staff of SHPP*
INT-D	*Interviews with other representatives of German development cooperation*
INT-DP	*Interviews with representatives of international development partners*
INT-G	*Interviews with representatives of national government institutions (MoH, MEF, NSSF)*
INT-S	*Interviews with representatives of sub-national administrations (provincial health departments, operational districts, commune associations)*
INT-H	*Interviews with staff members of health facilities*
INT-N	*Interviews with representatives of NGOs*
FGD	*Focus group discussions with members of disabled people organisations*

Project number	2013.2137.1
CRS-Purpose Code	12110
Project objective	Poor and vulnerable groups have more equitable access to health services of appropriate quality
Project term	1.9.2015 – 31.12.2018
Project volume	8,732,280 euros including 700,000 euros in co-funding from USAID
Commissioning party	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (BMZ)
Lead executing agency	Ministry of Health (Cambodia)
Implementing organisations (in the partner country)	Ministry of Health (Cambodia)
Other participating development organisations	United States Agency for International Development (USAID), co-funding

1 Summary

Description of the project

The object of the evaluation is the technical cooperation measure Social Health Protection Project III (SHPP III)[1] implemented by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH on behalf of the Federal Ministry for Economic Cooperation and Development (Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung – BMZ) with co-financing from the United States Agency for International Development (USAID). The **module objective** of SHPP III is that 'poor and vulnerable groups have more equitable access to health services of appropriate quality'. The project concentrates on **three intervention areas with the following four output goals**:

- **Health system financing:** Social health protection systems are strengthened (output A)
- **Health service delivery:** Mechanisms for improving the quality of health services are strengthened (output B)
- **Health system governance:** Forms of citizen participation are well-proven for enhancing the transparency and accountability of health services (output C) and Self-representative organisations promote the rights of persons with disabilities and older persons (output D).

In the area of health system financing, technical advice is provided to the Ministry of Health on implementing policy directives on the financing of health care and the setting up of a social health protection system. For the strengthening of health service delivery, the emphasis is on the development and implementation of various instruments, including accreditation, licensing, continuous quality improvement, complaints management and performance-based payment. Interventions related to health system governance focus on citizen participation in the health sector at the sub-national level to increase the transparency and accountability of health services while the Ministry of Health is supported in disseminating knowledge from the field and in delegating functions in the context of decentralisation and deconcentration (D&D). Across all areas of intervention, the project promotes the inclusion of persons with disabilities and older people. It also supports the involvement of self-representative organisations, whose experiences are fed into the policy dialogue. The SHPP III interventions at the sub-national level concentrate on three provinces (Kampong Thom, Kampot and Kep). The current project term is three years and four months (09/2015 to 12/2018). The budget for the current project term amounts to 8,732,280 euros, including 700,000 euros in co-funding from the United States Agency for International Development (USAID).

Evaluation design

To adequately anticipate (relevant and likely) results and direct the focus of data collection and analysis, a theory-based approach has been applied, based on a reconstructed results model of the project. For results at systemic level and the level of individual organisations, the evaluation design is based on the principles of contribution analysis and relied predominantly on qualitative methods (mainly semi-structured interviews). Since results processes at this level are non-linear and to a certain degree unpredictable, the use of semi-structured interviews allows a record of unintended occurrences and results to be kept.

[1] For better readability, only SHPP will be used instead of the full acronym SHPP III, except in Section 5.6, when the current module must be distinguished from predecessor modules.

The evaluation strategy has been gradually different for the measurement of results at the level of health facilities and local administrations where results variables are rather quantitative (with indicators such as patient satisfaction, quality scores achieved by health facilities). The intention was to analyse the results indicators quantitatively and comparatively. However, due to the lack of current and/or comparative data; qualitative methods (particularly semi-structured interviews) still played the most important role in gaining an understanding of change processes.

The above-mentioned evaluation strategies were applied independently of the results level (output, outcome, impact). In the specific case of the impact level, i.e. regarding target group-related developments at a national scale, it would be desirable to compare national statistics over time; unfortunately, statistical data at this level is time-displaced and project contributions at this level would rather be expected at the long term. Baseline comparisons therefore have limited informative value and had to be triangulated (or even substituted) with stakeholder judgements regarding the estimated project contributions to changes at impact level.

Assessment of relevance

All project intervention areas contribute to the implementation of national policies and strategies. The project is closely aligned with the objectives and intervention areas defined in the Third Health Strategic Plan (HSP) 2016-2020 and supports the respective implementation processes. The concept is also in line with international standards, particularly regarding its orientation towards universal health protection. The objectives are of relevance to the health-related Sustainable Development Goals (SDG), particularly SDG 3.8 on universal health protection. The project corresponds with the relevant sector, regional and country strategies of German development cooperation.

The intervention strategy aims to address the core problems/needs of the target groups. However, social health protection schemes for the voluntary enrolment of vulnerable groups (e.g. near poor, informal sector), which were initially supported, were not compatible with new sector reform initiatives in Cambodia and had to be abandoned. The focus of the project intervention was redirected towards the operationalisation of the new Cambodian policy framework for social health protection, which will benefit target groups in the longer term. The leave no one behind (LNOB) principle is inherent in the concept of universal health coverage. Despite the strategic shift in health financing, the project design fully responds to the module objective which since it was adapted in a pertinent manner to changes in the sectoral strategies. Altogether, relevance is rated with 91 out of 100 points (Level 2 – successful).

Assessment of effectiveness

Due to the strategic shift mentioned above, effectiveness is assessed according to the partly adjusted indicators and assessment criteria for the outcome level. In the **intervention area of health system financing,** the social protection schemes supported by the project were based on the assumption of (transaction) cost sharing with the existing social health protection scheme for the poor, the Health Equity Fund (HEF). Under the new H-EQIP programme, however, implementing NGOs ceased to function as Health Equity Fund operators, rendering the GIZ-supported scheme obsolete (original Indicator 1: not achieved). Instead, SHPP has contributed to the operationalisation of the NSPPF. Among other areas, progress has been achieved in developing the capacities of key stakeholders (e.g. Ministry of Health, National Social Security Fund as the designated future single payer, Ministry of Economy and Finance) and the establishment of costing mechanism that will enable the Ministry of Health and Ministry of Economy and Finance to seek the right balance between supply-side funding through budgetary allocations and demand-side funding through fees for service (complementary success criterion for Indicator 1: achievable during the project term).

In the **intervention area of health service delivery**, the project has contributed to the formulation of the new National Strategy for Quality and Safety in Health (Indicator 3: achieved) and the updating of the Quality Improvement Master Plan (QIMP) which guides implementation, monitoring and evaluation of the revised policy. At sub-national level, SHPP has supported health managers and health care providers in the implementation of quality improvement processes, which will be combined with performance-based incentive payments under H-EQIP. The Ministry of Health is currently rolling out the H-EQIP assessment mechanism, which has also been supported by SHPP.

In **the intervention area of health system governance**, SHPP has helped to raise awareness of patient rights and increased public participation in governance mechanisms such as the Health Center Management Committees (HCMCs). At the time of the evaluation, approximately 90% of the HCMCs (hardly functional in the past) were conducting meetings at least once per quarter and feeding back the client perspective into the health facilities' quality improvement processes. Client satisfaction surveys, though not yet meeting targeted threshold values, are scoring well in many aspects of the client-provider relationship (such as privacy, confidentiality, communication with the health staff; Indicator 4: partially achieved and mostly achievable during the project term). Regarding the specific needs of vulnerable groups, self-representative capacities of disabled people organisations (DPOs) and older people's organisations have been strengthened and the DPOs have reached more than 2,500 target group members (approximately 1,200 women) through quality-assured training and sensitisation activities.

Social health protection coverage, service quality improvements and a stronger focus on patient's needs are intended to have a positive effect on service utilisation rates. The increase, however, is significantly smaller than expected (Indicator 2: positive tendency but missing the target value). Overall, goal attainment at the time of the evaluation is medium. Nevertheless, the project has achieved a broad range of outcomes related to the national reform processes which exceed the scope of the formally agreed indicators. Altogether, effectiveness is rated with 85 out of 100 points (Level 2 – successful).

Assessment of impact

Evidence for intended changes at impact level (indicators for the programme goal of German development cooperation) is relatively weak since the data required is mostly time-displaced and therefore not applicable to the project term. A contribution to the reduction of catastrophic health expenditure (Programme Indicator 1 of the programme goal) is plausibly assumed depending on the extent to which SHPP successfully contributes to the operationalisation of the NSPPF and increased social health protection coverage for its target groups. There is also sufficient evidence to assume that the project's contribution to quality improvement-related processes at national and sub-national level will increase the number of health facilities offering services which meet national quality standards (Programme Indicator 3).

For three indicators, positive but slower than expected trends are assumed based on available data (Programme Indicator 4 regarding the quality of diagnoses and treatment of non-communicable diseases) or stakeholder estimations (Programme Indicator 2 regarding the care-seeking behaviour of beneficiaries of social health protection, and Indicator 5 regarding the reduction of maternal and neonatal mortality rates). Relevant contributions by SHPP can be plausibly assumed (though not measured) to a varying extent for most indicators. Altogether, impact is rated with 82 out of 100 points (Level 2 – successful).

Assessment of efficiency

The use of instruments and resources is mostly in line with the provisions of the project offer. The most relevant deviation has occurred due to the policy shift in the intervention area of health system financing where subsidy contracts with local NGOs for the implementation of social protection schemes were not renewed and resources were reallocated within the same intervention area to policy advice and CD interventions under the

new policy framework. A development advisor is still placed in the national umbrella organisation of NGOs related to social health protection, but options for a reassignment are evaluated.

The other intervention areas are implemented as planned, with some technical adjustments due to external changes (e.g. the adaptation to the assessment methodology of H-EQIP for the quality of service delivery). Since the stakeholder landscapes are very diverse, resources are allocated to a varied set of interventions with many stakeholders in order to use synergies and interdependencies at all system levels (national level, provinces, districts, communes) and relevant social sectors (public administration, health professionals, NGOs, general public, vulnerable groups). Nearly half of the contract value (47%) is dedicated to output A which equals the intervention area of health system financing. Approximately a quarter of the resources (26%) is allocated to output B (health service delivery). In the intervention area of health system governance, output C (citizen participation) absorbs 12% and output D (vulnerable groups) 15% of the overall budget. So far, the project management has been able to avoid a dilution of the project's efforts and has fostered the linkages between its interventions and its stakeholders. The resources allocated to each output reflect the relative importance of each intervention area for the attainment of the module goal. No suggestions have been identified as to how the outputs or the outcome could have been maximised by a different distribution of resources or a different use of instruments.

The linkages between the intervention areas are convincing (e.g. establishing the link between social health protection, performance-based payment and assurance of service quality, feedback of the client's perspective into quality improvement processes, mainstreaming of vulnerable groups' issues into the other outputs). Resources are adequately distributed among the intervention areas and reflect the relative weight regarding their contribution to the attainment of the module objective. Effort and resources invested in the upscaling of an approach that became unsustainable lowers the score for the allocation efficiency. Cooperation with other international development partners and with other German development measures is intense and synergies are exploited to a satisfactory extent. Altogether, efficiency is rated with 90 out of 100 points (Level 2 – successful).

Assessment of sustainability

From a conceptual point of view, the project focuses consistently on the development of partner capacities at all levels (individual, organisational, networks and policy field) in order to ensure that intended medium and long-term effects can be achieved by the partners themselves. All three intervention areas follow multi-level approaches that consistently combine policy advice, organisational development measures for key stakeholders and a wide range of HCD interventions. Interventions at the different levels are closely related to each other in order to ensure that the partner system (instead of isolated system components only) is strengthened; occasional deviations from this principle occurred due to changes of the framework conditions and the need to follow the flow of developments in the partner system (e.g. intensified CD measures for the National Social Security Fund not yet oriented by an organisational CD strategy, project provinces not yet covered by the roll-out of H-EQIP assessment tools).

The Cambodian Government is increasingly taking over financial responsibility for previously donor-driven programmes and financial resources are available to a growing extent. Nevertheless, bottlenecks do exist regarding personal and organisational capacities at different levels (for example: the National Social Security Fund still overburdened by the new mandate under NSPPF, ubiquitous shortage of adequately qualified health professionals, leadership of the Health Center Management Committees challenged by fluctuation of local political leaders, dependency of supported NGOs on external funding).

The degree to which advisory elements of the project are already anchored in the partner system varies among the intervention areas. In health financing, the NGO-managed voluntary community-based health insurance (CBHI) schemes were not sustainable without cross-subsidies from other functions performed by the NGOs; regarding the operationalisation of the NSPPF, on the other hand, it is too early to forecast the integration of

project outputs into the partner structures and the durability of project results since the process is still in an early phase.

In the intervention area of health service delivery, the national strategy, the QIMP and the H-EQIP provide a positive context for further development of the intended national accreditation system. Quality assessments and incentive payments under H-EQIP have a proven effect on service quality and there is no reason to suspect that health facilities would not be able to maintain improvements implemented on their own account. It is unclear, however, whether the same facilities will keep improving in future assessment rounds or whether improvements will be constrained to early quick wins. Sub-national administrations and health facilities in the project provinces should have a comparative advantage since they have received additional coaching during operational planning and quality improvement processes. But there is still no evidence to sustain or reject this assumption.

In the intervention area of health system governance, citizen participation is supported within existing structures which have absorbed the CD support and strengthened participatory mechanisms to a reasonable degree. Results could be maintained if there is a continued presence of leadership for the dialogue spaces and a sufficient quality of vertical communication and support from the provincial health departments down to the communal level.

Due to a mixed outlook regarding the durability of project outcomes, sustainability is rated with 87 out of 100 points.

Criterion	Score	Rating
Relevance	*91 points*	*Level 2 – successful*
Effectiveness	*85 points*	*Level 2 – successful*
Impact	*82 points*	*Level 2 – successful*
Efficiency	*90 points*	*Level 2 – successful*
Sustainability	*87 points*	*Level 2 – successful*
Overall score and rating for all criteria	*87 points*	*Level 2 – successful*

100-point scale	6-level scale (rating)
92-100	Level 1 = very successful
81-91	Level 2 = successful
67-80	Level 3 = rather successful
50-66	Level 4 = rather unsatisfactory
30-49	Level 5 = unsatisfactory
0-29	Level 6 = very unsatisfactory

2 Evaluation objectives and questions

2.1 Objectives of the evaluation

The previously decentralised evaluation system of the *Deutsche Gesellschaft für Internationale Zusammenarbeit (*GIZ) GmbH is currently undergoing reform. The responsibility for the steering of project evaluations is centralised and assumed by the Corporate Evaluation Unit in order to increase the independence of evaluations and stimulate more ambitious evaluation designs. Thus, the new evaluation system aims to (a) improve the verification of (net) effects of development projects, (b) increase the credibility of evaluation results, (c) increase GIZ's capacity to respond to current trends in the field of international cooperation (e.g. Agenda 2030) and (d) provide more useful information for decision making.

Before the implementation of routine procedures, several pilot evaluations are carried out to test (and if necessary adjust) the new processes, guidelines and instruments. The evaluation of the technical cooperation measure Social Health Protection Project III (SHPP III) in Cambodia is one of these pilots and will contribute to validation and fine-tuning of the new evaluation system.

Beside this specific situational objective, the main function of the evaluation is to provide a valid and reliable assessment of the project success according the evaluation criteria of the of the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD/DAC) and inform decision-makers, stakeholders and change agents in the project context and/or German development organisations. Taking place approximately one year before the end of the current project term (12/2018), it is an intermediate evaluation which will also generate conclusions that enrich the process of planning an anticipated follow-on-measure and inform the stakeholders responsible for the planning process (project director, officer responsible for the commission and political counterpart) and decision-makers in the relevant German development organisations GIZ and BMZ.

2.2 Evaluation questions

Each project is assessed based on standardised evaluation criteria and questions provided by GIZ to ensure comparability. These are based on the OECD/DAC criteria for the evaluation of development cooperation, or the evaluation criteria for German bilateral cooperation: relevance, efficiency, effectiveness, impact and sustainability. The evaluation dimensions and analysis questions derived from this have been specified by the GIZ Evaluation Unit and can be found in Annex 2 (Evaluation matrix). In the medium term, GIZ also aims to provide more concrete evaluation indicators, which are to be developed and tested in this pilot phase together with the evaluators. In addition to these evaluation criteria, the contributions to Agenda 2030 and its principles (universality, integrative approach, leave no one behind, multi-stakeholder partnerships) are also considered. The evaluation questions also relate to cross-cutting issues such as gender, the environment and human rights.

The GIZ project staff and partner institutions have been asked to formulate additional or concrete evaluation questions if desired. According to the feedback given and reported by the officer responsible for the contract, the above-mentioned criteria capture all relevant information needs which is why no further evaluation questions have been raised.

3 Object of the evaluation

3.1 Definition of the object of the evaluation (evaluand)

Framework conditions

Following more than two decades of strong economic growth, Cambodia has attained lower middle-income status as of 2015, with gross national income per capita reaching USD 1,070. It sustained an average growth rate of 7.6% in 1994-2015, ranking sixth in the world (see World Bank 2017a). Economic growth is expected to remain strong (6.9% in 2017 and 2018, see IMF 2017a). Poverty rates have fallen from 47.8% in 2007 to 13.5% in 2014. However, the vast majority of families who escaped poverty were only able to do so by a small margin and remain near-poor and thus vulnerable to economic shocks.

Economic growth is leading to higher public spending (total budget of the Royal Government of Cambodia in 2014: USD 3,400 million, in 2017: USD 5,000 million, forecast for 2018: USD 6,000 million). During the same period, the health share of the budget has risen from 7.2% (2014) to 8.4% (2017, see MoH 2017d). The performance of the health system and the health status of the population have largely improved over the last decade (e.g. nearly all health-related Millennium Development Goals achieved by 2015, see GIZ 2016a: 4ff), but poor and vulnerable populations still don't have readily available and affordable access to quality-assured health services (**core problem**). Therefore, the Health Strategic Plan (HSP 2016-2020) defines the sector priority as '(i) sustaining and improving access and coverage with a renewed focus on quality of health services across geographical areas; and (ii) increasing financial risk protection across socio-economic groups when accessing health care' (MoH 2016a: 4).

Cambodia is committed to moving towards universal health coverage. Out-of-pocket payments by patients make up more than 60% of national health expenditure (see USAID 2016a: 1) and pose a serious challenge to achieving this goal. Consequently, several demand-side financing schemes to increase social health protection, including the Health Equity Funds (HEF), voucher schemes, voluntary community-based health insurance (CBHI) and private health insurance, have been piloted and implemented, mainly funded by international development partners. Social health protection coverage, however, is limited and the schemes are not integrated or aligned with one another, resulting in administrative inefficiencies, gaps and overlaps in the provision of benefits. While the Health Equity Funds[2] provide financial protection for the poor, covering approximately a quarter of the population (see Annear 2015 et al.: 45ff), people near the poverty line and other vulnerable groups face the same risks. However, they currently do not have access to social health protection. Led by the Ministry of Economy and Finance, Cambodia has recently launched a policy reform for the establishment of a National Social Protection Policy Framework (NSPPF, see RGC 2017a) which outlines the vision for a comprehensive system of complementary social assistance and insurance elements, which would comprise separate insurance schemes for specific target groups (formal sector employees, civil servants, integration of the Health Equity Fund and schemes for the informal sector). With the development of NSPPF, the Ministry of Economy and Finance intends to gradually shift from the present supply-side funding of public providers to more demand side-focused funding with accredited public and private providers.

Social health protection is a cross-sectoral topic. As mentioned above, the recent policy framework has been developed under the leadership and coordination of the Ministry of Economy and Finance and in consultation with several ministries, among them the Ministry of Health, the Ministry of Social Affairs, Veterans and Youth

[2] Initially, Health Equity Funds were donor initiatives; however, with support from donors (World Bank, Australia, Germany and Korea), the government set up a national Health Equity Fund. The Royal Government of Cambodia has increased its contribution over time to more than 50% and will take full ownership at the end of the H-EQIP project in 2021.

Rehabilitation, which is responsible for various types of social assistance programmes, and the Ministry of Labour and Vocational Training. Multi-sectoral coordination for the operationalisation of the new national policy framework will be ensured by a National Social Protection Committee (not yet formed as at November 2017). The entity mandated with the implementation of the various social protection schemes is the National Social Security Fund, which operates under the technical supervision of the Ministry of Labour and Vocational Training and the financial control of the Ministry of Economy and Finance.

Regarding the institutional landscape of the health sector, the Ministry of Health is solely responsible for the provision of public health services. It is mainly responsible for the development of policies, legislation and strategic plans, for resource mobilisation and allocation and for health information. Public health administration is centralised, with responsibilities for service delivery assigned to ministry officials at provincial and district level (provincial health departments and operational districts). The provincial health departments are responsible for the equitable distribution and effective use of available resources and implement the national health strategic plan via annual operational plans. They link the ministry with the operational districts which are responsible for health service delivery.

Basic health services are offered by around 1,250 public health facilities (in 25 provincial departments and 81 health operational districts, each with a referral hospital and several health centres complemented by 8 national hospitals in the capital Phnom Penh) and a growing private sector. This mixed health system, composed of numerous service providers and with various funding sources, presents a significant regulatory challenge for policy-makers. Quality of care leaves much room for improvement (e.g. frequent misdiagnoses, over-prescriptions, wrong treatments, poor patient safety, see GDC 2016a: 4). A recently formulated National Policy on Quality and Safety in Health (see MoH 2017b) links accreditation with internal quality improvement, licensing, registration, complaints management and performance-based payment mechanisms, although its operationalisation still faces various obstacles (e.g. overburdening of the responsible area at the ministry level, scarcity of financial and human resources at the level of health facilities). Several international development partners (World Bank, Germany, Australia, Korea) support the Cambodian Ministry of Health with financial and technical contributions through the Health Equity and Quality Improvement Project (H-EQIP 2016-2021, see MoH 2016c). Responding to the above-mentioned challenges, the programme aims to improve access to quality health services and protection against impoverishment due to the cost of health services.

Another relevant aspect of the framework conditions is the ongoing decentralisation and deconcentration (D&D) process. It envisions the gradual transfer of responsibility for public service delivery from central-level institutions to sub-national administrations as a way to enhance public sector accountability and performance. For the health sector, a current roadmap will begin transferring responsibility for the provincial health systems in three provinces/municipalities (Battambang, Kampot and Phnom Penh) in 2017 and will extend this process to other provinces/municipalities in 2020 (see GIZ-SHPP 2016c).

The general political environment is shaped by the outcome of the latest local government elections in June 2017 and the subsequent disbanding of the main opposition party (Cambodia National Rescue Party/CNRP). The election results gave the ruling Cambodian People's Party (CPP) a sound majority, but by a smaller margin than expected. The political agenda before and after the election did not directly affect the implementation of the health sector reform agenda; on the contrary, the ruling party's need to show that economic success and political stability are feeding into improved social services was a driving force behind recent political decisions (see GDC 2017a: 6). On the other hand, several development partners have expressed their concern about the intimidation of the opposition and restrictions on civil society's expression of diverse political opinions. The dissolution of the Cambodia National Rescue Party has resulted in the replacement of affiliated local commune councillors. Nearly all seats were reallocated to candidates from the list of the Cambodian People's Party.

Technical cooperation measure: Social Health Protection Project III

The evaluation object is the technical cooperation measure Social Health Protection Project III carried out by GIZ on behalf of BMZ in Cambodia. The **module objective** of SHPP III is that 'poor and vulnerable groups have more equitable access to health services of appropriate quality'. The project concentrates on three intervention areas with the following four output goals:

- **Health system financing:** Social health protection systems are strengthened (output A)
- **Health service delivery:** Mechanisms for improving the quality of health services are strengthened (output B)
- **Health system governance:** Forms of citizen participation are well-proven for enhancing the transparency and accountability of health services (output C) and
  Self-representative organisations promote the rights of persons with disabilities and older persons (output D).

In the intervention area of health system financing, technical advice is provided to the Ministry of Health and its sub-national structures, particularly regarding the implementation of political directives on health care financing and the setting up of a social health protection system. In the intervention area of health service delivery, the emphasis is on the coherent development and implementation of various instruments including accreditation, licensing, continuous quality improvement, client satisfaction, complaints management and performance-based payment. In the intervention area of health system governance, citizen participation in the health sector is strengthened at the sub-national level to increase the transparency and accountability of health services. At the national level, the Ministry of Health is supported in the dissemination of knowledge from the field and in the delegation of functions in the context of decentralisation. Across all areas of intervention, the inclusion of persons with disabilities and older people is fostered. The involvement of relevant self-representative organisations is supported, and their experiences are fed into the policy dialogue. The interventions of SHPP III at the sub-national level concentrate on three provinces (Kampong Thom, Kampot and Kep).

The current project term has a duration of three years and four months (09/2015 to 12/2018). It builds on the results of two previous technical cooperation measures which have been implemented from July 2009 to August 2015. During that time, the above-mentioned intervention areas have remained unaltered. The cost of the current project term amounts to 8,732,280 euros, including 700,000 euros in co-funding from the United States Agency for International Development (USAID, see GIZ-SHPP 2016a).

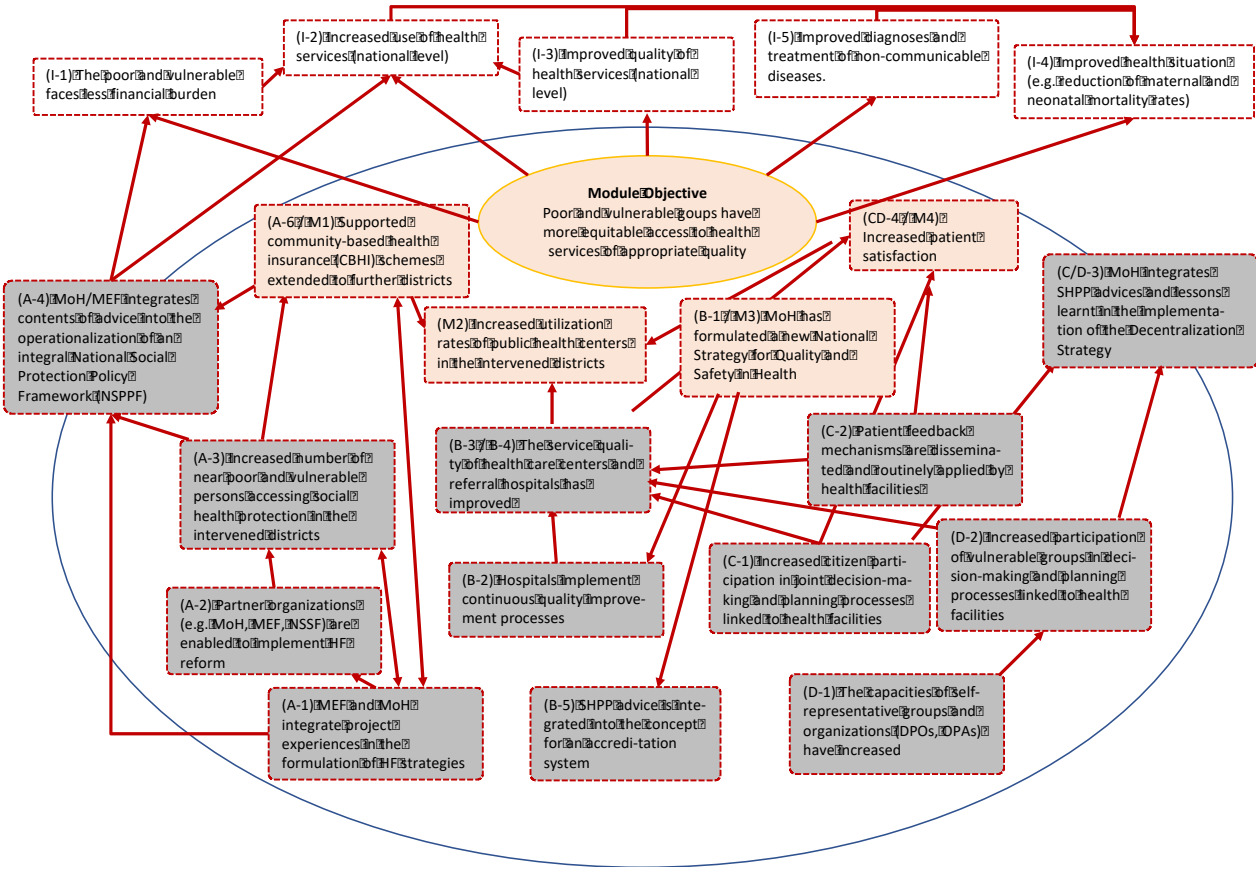
3.2 Results model including hypotheses

The available project documentation contains (a) generic versions of the results model for the overall module that only depict the output objectives with its interrelations and contributions to the module objective or (b) results models of individual intervention areas with more detail than needed for the general results model. Therefore, this chapter summarises a results model that was reconstructed during the Inception Phase of the evaluation and was based on the methodological approach in the project offer (see GIZ-SHPP 2015a). The numbering of described changes refers to the visualisation of the reconstructed results model in Figure 1.

In the intervention area (A) of health system financing, the two international and four national long-term advisors assist the Ministry of Health, the Ministry of Economy and Finance and the National Social Security Fund in **health financing strategy formulation (A-1)** (e.g. through process consulting, stakeholder consultations, providing opportunities for South/South peer learning), focusing on the formulation of the **National Social Protection Policy Framework.** Additionally, two integrated experts are placed in the Ministry of Finance and the National Social Security Fund to build related internal capacities**.** A wide range of capacity development measures, short-term consultancies and financing agreements are intended to **enable partner organisations**

to implement the reform (A-2). At the sub-national level, NGOs in the field of social health protection are supported through local subsidies to **expand existing social health insurance schemes covering (near) poor and vulnerable groups in the intervention districts and increase their membership (A-3).** Operational research funded by the German contribution analyses the effectiveness of the piloted schemes and the results are fed back by GIZ into the policy advice for the **operationalisation of the above-mentioned National Social Protection Policy Framework (A-4)** which comprises several insurance schemes for specific target groups. Due to the current strategic shift (see chapter 5.1, section Adaptability to the framework conditions), providing knowledge and lessons learnt for the operationalisation of the national framework is prioritised over the **extension of social health insurance schemes to further operational districts (A-6)**; this was facilitated by the above-mentioned NGO support and the placement of a development advisor in the national umbrella organisation of related NGOs, the Social Health Protection Agency.

***Figure 1**: Results model of SHPP (reconstructed)*



In the intervention area (B) of health service delivery, three long-term national advisors support different departments and committees of the Ministry of Health in developing a policy framework for an accreditation system. The project has assisted the Ministry in the formulation of a new **National Policy for Quality and Safety in Health (B-1)** and the new Quality Improvement Master Plan/QIMP (e.g. moderating the Ministry's Quality Improvement Working Group, assisting stakeholder consultations and providing a short-term consultancy for the policy draft)**.** Furthermore, at the provincial level, five technical advisors advise sub-national administrations and health facilities on approaches for health service quality improvement. Short-term consultants combined with local subsidies were used for specific technical matters, training events and workshops for health care providers and managers to build capacities in various aspects of quality and safety in health care. On this basis, and with further process consulting by the project's national advisors, the health care providers and managers of hospitals and health care centres **implement continuous quality improvement processes themselves (B-2),** thus **increasing the quality of care of health centres (B-3)** and **referral hospitals (B-4)**. The project

advises the Ministry of Health regarding the **conceptualisation of elements of an (external) accreditation system (B-5)**.

Intervention area of health system governance is managed by a national team leader and a further five national advisors for the output citizen participation (C) and two for vulnerable groups (D). For the output citizen participation, the project supports local training events (local subsidies to NGOs) on client rights to improve the citizens' and local administrations' knowledge and assists the various stakeholders with the aim of **increasing citizen participation in joint planning of health centres and referral hospitals (C-1)**. The project promotes the dissemination of standardised client satisfaction surveys and other **feedback mechanisms (C-2)** as routine instruments. In output (D) vulnerable groups, the project focuses on the needs of people with disabilities and older persons through support for self-representative organisations (e.g. local subsidies for training measures and advocacy activities) which **increases their capacity to promote awareness of these groups' rights (D-1),** leading to more **involvement of these groups in local decision-making and planning processes linked to health facilities (D-2)** (e.g. active participation in public forums, Health Center Management Committees). Participatory planning processes and the use of feedback mechanisms, both methodologically assisted by the project, facilitate more needs-oriented service delivery, resulting in **higher patient satisfaction (C/D-4).** At the national level, the experiences are fed back by GIZ to the Ministry of Health and National Committee on Decentralisation and Deconcentration to **inform the decentralisation and deconcentration process (C-3).**

Each intervention area contributes to one specific dimension of the **module objective** (Poor and vulnerable groups have more equitable access to health services of appropriate quality). Their respective module indicators (**M1, M3 and M4**, see the indicator assessment in chapter 4.2) are already referred to in the above-mentioned results model. Furthermore, **Indicator M2 referring to increased utilisation rates of public health centres** is a combined result of the reduction of financial barriers through social health protection, patients' perception of improved quality and increased patient satisfaction through better consideration of patients' needs.

Important synergies also exist regarding the project's contribution to overarching development goals, since the removal of financial barriers can only have an effect on the health situation of the target groups if the quality of services corresponds to certain standards and if needs-oriented services are used by the relevant target groups. Thus, the project significantly contributes to the programme goal with its indicators (I1 – I5) of German development cooperation in the health sector in Cambodia. This includes the **reduction of financial burden for the poor and vulnerable population (I-1) and an increased use (I-2) of health services of improved quality (I-3)**, altogether resulting in an **improved health situation for the target population (I-4)** at national level. Recognizing the epidemiological transition in Cambodia, the project puts a focus on non-communicable diseases (NCD) in the intervention area of health service delivery, thus highlighting this fundamental change for the health system and contributing to **improved diagnoses and treatment of NCD (I-5)**. At first glance, the impact variables look similar to some outcome indicators of SHPP. It must be considered, however, that they are situated at the national level, and thus beyond the system border of SHPP. SHPP can initiate quality improvement and participatory processes at the local level and also contribute to institutional and organisational capacity development at the national level. The upscaling of experiences and nationwide implementation of policies and strategies depend on a variety of other factors and stakeholders.

The results have implications for cross-cutting issues in the areas of **poverty reduction** (reduction of financial hardship through social health protection, marker AO-1), **good governance** (increased needs orientation of public planning processes through citizen participation, marker PD-/GG-1) and **gender mainstreaming** (consideration of gender-specific needs in the design of social health insurance schemes and service quality standards, marker GG-1). Regarding Agenda 2030, besides the health-related Sustainable Development Goal (SDG) 3, the project contributes to SDG 1 (End poverty in all its forms everywhere) and SDG 5 (Achieve gender equality and empower all women and girls).

Due to the complexity of political reforms in the areas of social protection, accreditation and quality improvement, goal attainment is challenged by several **risks.** Two preconditions for more equitable access to health services – as postulated by the module objective – are (a) the continuity of coverage for poor people by the HEF and (b) the extension of social health protection to further vulnerable groups. A key risk in this context is the lack of continued (public) financing for their respective protection schemes. Discontinuities can occur when the Cambodian Government and international development partners do not set clear strategic priorities and align their efforts accordingly. **Unintended results** of discontinued financing of existing development schemes would not only affect the registered target groups (i.e. less coverage, increasing costs), but might also reduce the target groups' confidence in the general principle of social health protection. Regarding the quality of health service, goal attainment depends on the degree to which the Cambodian Government engages in a truly systemic approach (combining accreditation, internal quality improvement, licensing etc., instead of working on single, isolated elements of the system). A general **risk** faced in this context is the difficulty in predicting the willingness of the government to allocate sufficient resources to the health institutions, or more particularly, to allocate resources in a functional manner (i.e. directly to the facilities instead of indirect allocations through the national budgetary process, with exposure to adverse interests). Furthermore, although the number of health workers has increased from below 100 in 1979 to more than 20,000 in 2016, low skill levels of the available manpower and the absence of professional training and licensing practices may challenge the success of project interventions.

The results model has been validated with the project staff and the evaluation team concludes that the underlying hypotheses are plausible, consistent and complete (i.e. covering all result levels). It is based on a sound analysis of the framework conditions of the Cambodian health sector and requirements in the intervention areas (e.g. experiences of previous projects, see GIZ 2014a; explicit references to sector studies such as Kelsall et al. 2014, Annear 2015, NIS & MoP 2014, NIS 2015, NIS et al. 2015). Each intervention area addresses direct results at target group level, at least in the three project provinces, although contributions to overarching development goals are expected from feeding back pilot experiences into systemic change processes.

3.3 Target group analysis

The project's target groups are poor and vulnerable populations in Kampong Thom, Kampot and Kep. According to the BMZ health sector strategy for Cambodia (see GDC 2014b), vulnerable populations are defined as populations close to the poverty line (near poor), older persons above 60 years and persons with disabilities. Approximately 1,350,000 inhabitants live in the three project provinces, with 16% of the population in Kampot, 18% in Kep and 31% in Kampong Thom living below the poverty line (IDPoor Poverty Incidence according to ADB 2014: 29). Despite significantly decreased poverty rates during the last decade, a large share of the population has moved only very slightly above the poverty line so that poverty rates are highly sensitive to very small changes in the poverty threshold. Unlike people categorised as poor, the near poo" are not covered by the Health Equity Fund but are exposed to the same potential financial hardships in of the event of illness (see World Bank 2014). Regarding the share of older persons and disabled persons, no reliable statistical data exists, and estimations differ significantly (e.g. the proportion of disabled persons, which is reported at 2% by the Ministry of Planning (see NIS & MoP 2014) and 5% by Handicap International, according to GIZ-SHPP 2015a). Taking these inaccuracies into account, the project covers a target group of approximately 600,000 people.

Although the project offer refers primarily to direct target groups in the three provinces, indirect long-term results of the project – in line with the programme goal of German health sector development cooperation in Cambodia (see GDC 2014b, 2015a) – may benefit the total (vulnerable) population of Cambodia since lessons learnt from the local pilots are systematically fed into policy advice at the national level.

4 Evaluability and evaluation design – data sources, data quality and evaluation methods used

4.1 Data sources, data quality

Basic documents

All basic documents as defined by the GIZ Evaluation Unit (see GIZ 2017b) have been available (offers to BMZ, yearly progress reporting, relevant BMZ and Cambodian strategies, GIZ standard documents, cost-obligo-data, among others). The information provided was exhaustive and the overall quality of the basic documents was good and met the requirements of the evaluation. The quality of the GIZ standard project documents, too, was generally high, with minor exceptions for the relatively generic graphical results model and CD strategy. Analysed and screened documents are listed in Annex 1.

Baseline and monitoring data including partner data

Project progress is well-documented by the project in GIZ's web-based monitoring tool. Data for the pre-defined outcome and output indicators was generally available, based either on national health information systems (e.g. utilisation rates of health services in the intervention provinces) or on other routine processes in the Cambodian health systems (e.g. patient satisfaction surveys, quality assessments based on national standards and agreed procedures). Therefore, primary data collection by the project for results monitoring could be kept to a minimum. In the case of qualitative indicators, processes, milestones and results are documented comprehensively by GIZ project staff. Additional internal GIZ progress reports and presentations for each intervention area complement the monitoring data. Baseline data for output, module objective and programme objective indicators is generally available, so that changes over time can be followed-up properly. For some indicators, however, current data was not yet available at the time of the evaluation (for details, see the analysis of goal attainment in chapter 5.2). Since data collection is tied to routine processes within the health system here, the evaluation could not generate equivalent quantitative primary data, but had to rely on qualitative analyses, in order to understand and document ongoing change processes. In total, the available baseline data and the results-oriented project monitoring data are of good quality and therefore used for this evaluation.

Further data which was collected

Further documents (e.g. sector analyses, health sector data, documents of other development partners) were researched during the inception phase and the field phase. Analysed and screened documents are listed in Annex 1. Collection of additional primary data during the field phase of the evaluation was aimed at a better understanding of the perspectives (needs, expectations, value judgments) of stakeholders and of results processes, particularly to the contributions of project interventions to observed changes. Therefore, further data collection was primarily based on qualitative methods (semi-structured interviews, group discussions). Based on the stakeholder maps of the project (see GIZ 2014b) and the results model, the evaluators determined the organisations and stakeholder groups that should participate in the evaluation; the list was submitted to the project in order to identify and add the specific interviewees and to discuss the pertinence and completeness of the list. In some cases (particularly the Ministry of Health), GIZ cooperates with several departments within the same organisation and interviewees were selected on the basis of the extent of their involvement in the areas of intervention (not necessarily the project interventions themselves). All relevant stakeholder groups were covered. The coverage of the organisational landscape that interacts with the project was comprehensive, with the exception of operational districts and health centres where only a few exemplary cases could be considered for the evaluation agenda. Since it was not intended to generate quantitative data at this level, but rather obtain an

understanding of the implementing and change processes, as well as their potential outcomes at health facility level, health facilities were selected to cover the different layers of health care (health care centre, hospital, referral hospital) while the selection of the specific facilities followed logistical criteria (i.e. avoiding long distances between sites).

- SHPP project staff (9 interviewees)
- Decision-makers and operational staff of involved departments of the Ministry of Health (7 interviewees)
- Decision-makers and operational staff of other relevant sector institutions at national level (e.g. Ministry of Economy and Finance, National Social Security Fund) (4 interviewees)
- Decision-makers and operational staff of the sub-national health administration (provincial health departments, operational districts) and local administration (6 interviewees)
- Representatives of non-governmental organisations (NGOs) involved in social health protection or in citizen rights awareness-raising (6 interviewees)
- Staff of health centres and referral hospitals in the project provinces (4 interviewees)
- Representatives of disabled people organisations (DPOs) at national (1 interviewee) and local levels (9 focus group members)
- Representatives of other development projects and international development partners (6 interviewees)

4.2 Evaluation design, basis for assessing OECD/DAC criteria and methods used

Evaluation design

Each results-oriented evaluation must respond to two key challenges: (a) the adequate measurement of relevant changes associated with the evaluated project and (b) the measurement and/or qualitative explanation of the specific contribution of the project to these changes. To adequately anticipate (relevant and likely) results and direct the focus of data collection and analysis, a theory-based approach has been applied using a theory of change (see chapter 3.2). The elements of the theory of change are contrasted with evidence and the difference between the assumed vs. observed results and causal relations largely determines the evaluation judgement. Different approaches have been applied for different types of intended results (which coincide with the different levels of capacity development):

- results at the systemic level (i.e. formulation and operationalisation of national policy/strategy)
- results at the level of supported organisations
- results at target group level in the intervention districts

Results at the systemic level

According to the results model in chapter 3.2., the project contributes to systemic health system strengthening. Intended changes at this level are predominantly qualitative and thus require the use of a qualitative evaluation approach. Strategy and policy formulation are determined by multiple stakeholder interests and their implementation depends on multiple systemic factors. This means that the challenge is not so much the measurement of changes, but the understanding of the underlying processes which include the specific contribution of the project. The same applies to the counterfactual situation (i.e. the hypothetical situation without project intervention) which – in the case of systemic changes – cannot be approached through comparative (control or comparison group) designs.

Therefore, the evaluation design is based on the principles of contribution analysis (see GIZ 2015a). In step 1, the evaluation team anticipated intended outcomes and identified intended project contributions and possible external factors. In step 2, the elements were related to each other, forming a theory of change (as already formulated in chapter 3.2). In step 3, during the data collection period, the evaluation gathered empirical evidence

for the extent to which results have been achieved and to which project contributions or contributions of other factors have taken place. In step 4, the information has been analysed with the aim of formulating the so-called contribution history, i.e. the documentation of project context, intended vs. achieved results and the hermeneutic analysis of the extent to which the evidence supports the hypothesis of the theory of change. A complete contribution analysis would proceed with additional cycles of gathering additional evidence to validate (or disprove) the contribution history (step 5) and formulate a more robust contribution history (step 6). However, since primary data collection was concentrated in short field phases and reporting deadlines were immediate, the application of comprehensive validation cycles was excluded in the Inception Report.

The evaluation strategy for this level relied predominantly on qualitative methods (mainly semi-structured interviews) that capture the knowledge, perceptions and judgments of involved stakeholders who understand the significance of changes as well as the underlying processes and interdependencies. Since results processes at this level are non-linear and to a certain degree unpredictable, the use of semi-structured interviews allows record-keeping of unintended occurrences and results instead of merely verifying the theory of change.

Results at the organisational level

At the level of supported organisations, two types of results must be distinguished: (a) the development of capacities of key stakeholders (such as the Ministry of Health and the National Social Security Fund) and (b) contributions to broader-scale capacity development for a significant number of comparable organisations (such as health facilities, sub-national administrations) and outcomes regarding the quality of health services.

Regarding the strengthening of single key actors, the evaluation strategy resembles the strategy for the evaluation of macro-level results since the object of the evaluation are also qualitative systemic changes. For the same reason as mentioned above, that kind of evaluand cannot be approached through comparative (control or comparison group) designs. The evaluation relies on principles of contribution analysis (see the section above) and on qualitative methods, particularly semi-structured interviews with specific stakeholders.

The evaluation strategy differed gradually for the measurement of results at the level of health facilities and local administrations where quantitatively measurable and comparable results are pursued through uniform interventions targeting a higher number of comparable organisations and stakeholders (examples for related indicators: utilisation rates of public health centres, patient satisfaction, quality scores achieved by health centres and hospitals). The intention was to quantitatively and comparatively analyse the results indicators. In several cases, however, no current and/or comparative data was available (see the indicator analysis in chapter 5.2 for further details) so that qualitative methods (particularly semi-structured interviews) still played the most important role for the understanding of change processes.

Results at the level of target groups

The theory of change comprises two different target group-related changes: (a) benefits for the target groups in the intervention provinces that are within (or at least, not far beyond) the scope of SHPP, and (b) indicators related to overarching target group-related changes at the impact level. Direct target group benefits were mainly pursued in the health financing intervention area through the upscaling of community-based health insurance (CBHI) schemes which were scaled down under the new policy framework of the NSPPF. Operational research done by the project and based on a quasi-experimental design (comparison of intervention and non-intervention districts) provides estimates of net effects during the time when the intervention was still ongoing.

At the impact level, i.e. regarding target group-related developments at a national scale, the evaluation exclusively relies on available national statistics that should be compared over time; unfortunately, statistical data at this level is time-displaced and contributions at this level would be expected over the long term. Therefore,

baseline comparisons have limited informative value and were triangulated (or substituted) with stakeholder judgments regarding the estimated project contributions to changes at impact level.

Presentation of the basis for assessing the OECD-DAC criteria

The evaluation dimensions of the **relevance criterion** cover (a) the congruence of the project objectives with relevant strategic frameworks, (b) the suitability of the project strategy to address core problems/needs of the target groups, (c) the pertinence of the project design (results logic) and (d) the pertinence of conceptual adaptations to changing framework conditions.

With regard to the relevant strategic frameworks, the analysis will consider the Third Health Sector Strategic Plan 2016-2020, the goal system of the current sector programme H-EQIP, the National Social Protection Policy Framework, the national Strategy for Quality and Safety in Health (and subsequent documents such as the current Quality Improvement Master Plan) and several other more specific national policies, strategies and programmes. Relevant international standards are the concept of universal health coverage and the Declaration of Alma Ata. For German development cooperation, current sector concepts, the regional Asia strategy and the country strategy paper for the priority area health are taken into account.

Regarding the **assessment of effectiveness**, the module objective indicators (dimension a) are technically well-formulated and mostly comply with the SMART criteria. However, the strategic adjustments of the project to H-EQIP and the National Social Protection Policy Framework also require adjustments of the indicators or complementary success criteria, particularly in regard to the scaling-up of community-based social health protection schemes (Indicator 1 of the module objective) which was no longer supported by SHPP III at the time of the evaluation:

Table 1. SMART analysis of the module objective indicators

TC measures' goal indicator according to the offer	***Evaluation according to SMART criteria/assessment***	***Adapted TC measures' goal indicator***
Module objective indicator M1: *'Social health protection schemes in 10 of 81 districts cover both poor and vulnerable groups'* *Baseline (2015): 2 out of 81; Target: 10 out of 81; Source: Review of the annual National Health Financing Report*	Due to changes in the framework conditions (in particular, stopping NGOs as designated change agents from acting as operators of the Health Equity Fund), the indicator is no longer attainable and does not reflect the adjusted project strategy.	*Since the project has invested significant effort in supporting social health protection schemes until 2016, the indicator will still be assessed. However, it will be complemented by a new evaluation basis according to current partner priorities, referring to the project contribution to the required institutional capacities for the NFPPS operationalisation:* *'Increased ability of the Ministry of Health to use costing data to inform the National Social Security Fund and the Health Equity Fund payment rates'*
Indicator M2: 'The utilisation rate for outpatient consultation in public health services increases on average to 0.66 per capita (…)	Technically, the indicator complies with the SMART criteria. Due to external interference (the temporary disruption of	*The indicator has been maintained and assessed based on the latest data available. However, the value judgment includes*

per annum in Kampot, Kampong Thom and Kep provinces' *Baseline (2015): average rate 0.42; Target: average rate 0.66; Source: Analysis of Ministry of Health statistics*	operations of the Health Equity Fund), the indicator is not achievable at the time of the evaluation, despite anticipated positive contributions on the longer run.	*additional qualitative analysis of anticipated changes in the longer run (assessed with key stakeholders, particularly project staff and representatives of the Ministry of Health).*
Indicator M3: 'A new national framework document for quality improvement in the health sector was adopted by the Ministry of Health' *Baseline (2015): 0; Target: 1 new framework document adopted; Source: New national framework document published by the Ministry of Health*	The indicator is specific, measurable, achievable and time-bound. Formally, it is not fully relevant in the sense that it does not measure the module objective (equitable access to health services of appropriate quality) but is a necessary precondition (strategy formulation).	*As a consequence of the recent strategic shift, the factual module objective is to strengthen policy development at the national level rather than to pursue target group benefits in selected districts. From that perspective, the indicator is fully relevant and can be maintained.* *Nevertheless, available data and stakeholder opinions on quality improvement at health facility level (score in quality assessments, see indicator B.1) complement the analysis.*
Indicator M4: 'The number of hospitals obtaining a minimum score of 85% for each criterion in the client satisfaction survey (…) increases from 0 to 3.' *Baseline (2015): 0; Target: 3 of 8 hospitals; Source: Routine Client Satisfaction Surveys*	The indicator complies with the SMART criteria.	*The indicator will be maintained.* Beyond the measurement variable (number of hospitals reaching a certain threshold in satisfaction surveys), the development of survey results over time complements the analysis.

The assessment of the **impact criterion** is based on (a) the attainment of superordinate development results, in particular the indicators of programme goal of German development cooperation for the health sector ('The poor and vulnerable population of Cambodia is healthier and faces less financial burden by using quality health care services', see GDC 2017a) and the contribution to national development indicators as defined by the Health Strategic Plan 2016-2020 (which includes the national indicators for Agenda 2030, see chapter 5.1 for details), (b) the specific contribution of SHPP III to the observed changes at impact level based on the contribution analysis and (c) not formally agreed additional unintended positive and negative impacts.

Regarding the GIZ programme goal, each dimension of the programme goal is addressed by one specific indicator: (1) for the reduction of financial burden: incidence of catastrophic health expenditure for poor and vulnerable groups; (2) for the increased use of health services: utilisation rates for health services of members/beneficiaries of social health protection; (3) for the improved quality of health services: number of health facilities offering services according to national quality standards; (4) for improved diagnoses and treatment of NDC: number of screenings and (early) treatments for diabetes and hypertension; (5) for an improved health situation: maternal and neonatal mortality rates. The GDC programme goals and its indicators are closely aligned with the Cambodian Government's strategic objectives (see also chapter 5.1) and coincide with objectives and indicators of the national Health Strategic Plan. The same applies to results related to the markers for poverty orientation (AO), gender equality (GG) and participatory development/good governance (PD&GG), which are already covered by relevant module or programme indicators.

The **efficiency criterion** will be assessed on the basis of the (a) production efficiency, i.e. the appropriate use of resources with regard to the achieved outputs and (b) the allocation efficiency, i.e. the appropriate use of resources with regard to the goal attainment and additional results at the outcome level. As a basis for data analysis, the GIZ tool for assigning costs to outputs has been used.

The starting point for the assessment of the **sustainability criterion** is the extent to which the project results are anchored in the partner structure. For SHPP, this requires analysis of the extent to which (a) supported social protection schemes are applied, (b) lessons learnt from these schemes are integrated in the operationalisation of the NFPPS, (c) government interventions in the area of service quality are based on the national strategy advised by SHPP and (d) health governance mechanisms are adopted as routine by the partners. The assessment continues with a forecast of the durability of project results and an analysis of the balance between the three sustainability dimensions (social, economic, environmental).

Methods used

Since data collection methods and evaluation methods for each OECD/DAC criterion are documented in detail in Annex 2, the methods applied for this evaluation are just briefly summarised:

- **Document analysis** has been applied for all OECD/DAC criteria, all evaluation dimensions and results at all levels. Analysed and screened documents are listed in Annex 1.

- **Semi-structured interviews** have also been applied for all OECD/DAC criteria, all evaluation dimensions and results at all levels. The focus of the interviews varied according to the perspectives and involvement of the specific stakeholders (see the list of interviewees and the evaluation schedule in Annex 3 and Annex 5).

- **Analysis of secondary data**, including the monitoring data of the project, was essential for the quantitative indicators for the module objective (outcome level indicators) and the programme objective (impact level indicators). Target group-related results were assessed based on secondary data; the same applies to some degree to results at the organisational level.

- **Focus group discussions** were originally planned at health facility level, in order to triangulate staff perceptions with quantitative variables. For logistical reasons, however, semi-structured interviews with staff members were carried out. Instead, group discussions were held to assess target group-related results with representatives of disabled people's organisations in each project province in order to cover the whole range of involved organisations.

- **Field visits** have been carried out in the project provinces Kampot and Kampong Thom in order to (a) obtain an overview of the achieved outputs and outcomes and (b) increase the understanding of change processes. Field visits are not a method in themselves but will include semi-structured interviews, focus group discussions and the retrieval of additional secondary data. Field visits were useful mainly to assess results at the organisational level (e.g. provincial health departments, operational districts, NGOs, commune associations).

For most intervention areas and evaluation dimensions, a mix of the above-mentioned methods was applied (except for focus group discussions which were exclusively used with DPO members, i.e. in output D (vulnerable groups). Interview data (and for output 4, focus group data) was continuously cross-checked with information from project and/or sector documents in order to validate the information or discover incongruencies (triangulation of methods). In all intervention areas, different stakeholders were interviewed in order to cover and compare different perspectives (e.g. for questions related to quality improvement at health facility level: sub-national health managers, representatives of health facilities, representatives of commune associations, DOPs = triangulation

of data). Throughout the report, sources (literature, specific project or partner documents) and interviewed stakeholders (see the codes in the list of acronyms) are extensively quoted. The quotations make it possible to keep track of method and data triangulation on specific evaluation dimensions. Please also refer to the evaluation matrix in Annex 2, which provides a full overview of all relevant documents, monitoring/secondary data and interviews used for the assessment of each evaluation dimension.

The evaluation team held short internal meetings on a daily basis (for the recapitulation of collected information, discussion of findings and conclusions and, towards the second week of the field phase, discussion of the assessments of the evaluation dimensions). Each assessment is the result of thorough discussions and reflects consensus achieved by both evaluators (researcher triangulation). The project was involved through constant bilateral exchange with key staff, both in Phnom Penh (open door principle during working time in the project office) and, more intensively, during the site visits, which were accompanied by GIZ staff (opportunities for informal interviews and evening sessions). Further intermediary meetings were held with the officer responsible for the contract (*Auftragsverantwortlicher,* AV). On the last day, a debriefing with the project and further GDC staff was held to present and discuss preliminary findings, conclusions and recommendations.

Data was analysed based on the evaluation guide for the central project evaluations, which provides broad sets of specific evaluation questions for each evaluation dimension assessed in this report (see the columns ‘Evaluation dimension’ and ‘Analysis questions’ of the evaluation matrix, Annex 2). Key aspects were further operationalised as indicators (see column ‘Evaluation indicators’ in Annex 2; please also refer to the description of the evaluation basis in chapter 4.2).

4.3 Evaluation process

The evaluation process comprised an inception phase (final draft of the Inception Report on 7 November 2017), a field phase (20 November to 1 December 2017) and a reporting phase (deadline for the final version of the evaluation report: 19 January 2017). The stakeholders of the evaluation coincide with the project stakeholders. Potential users of evaluation findings and recommendations are particularly those stakeholders that will be closely involved in the discussion and decision-making processes for the follow-on module planned from 2019 onwards. Besides the project staff, key stakeholders are the representatives of the Ministry of Health, the Ministry of Economy and Finance and the National Social Security Fund.

During the inception mission the project director consulted the national counterparts for additional or more specific evaluation questions, but no questions were added beyond the standards guidelines. During the field phase, the project director and the evaluation team agreed on limiting the briefing/debriefing cycle to GIZ health sector staff and the German Embassy, to avoid overburdening of the counterparts with subsequent missions and concentrate on stakeholder participation during the upcoming planning process. In order to assure transparency, evaluation results will be shared with the counterparts in writing.

5 Assessment of the project's results (OECD/DAC criteria)

5.1 Relevance

Fit into the relevant strategic reference frameworks

At the national level, the current overarching strategic framework for the Cambodian health sector is outlined in the **Third Health Strategic Plan (HSP) 2016-2020** launched by the Ministry of Health in March 2016. The plan expresses the commitment of the Royal Government of Cambodia to move steadily and incrementally towards the attainment of universal health coverage by 2030, led by the overarching health policy goal to 'improve health outcomes and increase financial risk protection across the population' (MoH 2016a: 5). The objectives and intervention areas of SHPP directly contribute to the three of seven strategic objectives of the HSP (MoH 2016a: 64f):

- Intervention area 1 – health system financing → HSP - strategic objective 2: 'There will be stable and sustained health financing of healthcare services with increased financial risk protection when accessing healthcare services'
- Intervention area 2 – health service delivery → HSP - strategic objective 1: 'The population will have access to comprehensive, safe and effective quality health services at public and private health facilities'
- Intervention area 3 – Governance → HSP - strategic objective 7: 'Strong health institutional capacity at all levels including leadership and management competency (…) and local accountability in health'
- Intervention area 4 – vulnerable groups responds to one of the five working principles of the HSP (Equity) → 'Removing social-cultural, geographical, financial and bureaucratic barriers in access to and utilisation of quality health services, especially by poor and vulnerable people, including persons with disability (…) and elderly'.

SHPP is also closely aligned to the **current sector programme H-EQIP** and its overall development objective 'to improve access to quality health services for targeted population groups with protection against impoverishment due to the cost of health services' (MoH 2016c: 24) with contributions to the H-EQIP concentrating on the implementation of continuous quality improvement processes and improved performance of health service providers in quality assessments.

For each intervention area of SHPP, several more specific national policies, strategies and programmes serve as reference points:

- In the intervention area of health system financing, SHPP technical support at the time of the evaluation is well-aligned with National Social Protection Policy Framework (NSPPF) in the sense that it is oriented towards developing the institutional and organisational capacities required for the steering of the NSPPF reform process and the operationalisation of social protection system components. Beyond the current alignment, it must be noted that SHPP has also provided significant technical support during the formulation of the NSPPF, in particular through a USAID co-financing agreement for the placement of a CIM expert in the Ministry of Economy and Finance, and the NSPPF is considered a technically appropriate framework by international development partners (INT-DP).

  Despite the strong strategic alignment of SHPP interventions at the time of the evaluation, it must be pointed out that the original design of SHPP was not formulated under the NSPPF (formally approved

in March 2017). In the absence of a single payer system, the original design of SHPP focused strongly on the validation and scaling-up of particular community-based health insurance schemes that would effectively include the project's target groups (i.e. near poor, informal sector, vulnerable groups). The insurance schemes were built upon existing operational structures (NGOs acting as operators of the Health Equity Fund) which were not continued under the new policy framework. Therefore, the focus of the technical assistance shifted from the scaling-up of voluntary social health protection schemes in the project provinces to policy advice and institutional capacity development at the national level.

- With regard to health service delivery, the National Strategy for Quality and Safety in Health (MoH 2017b) is a generic document that roughly defines key principles and intervention areas for the sector development, whereas the Quality Improvement Master Plan 2017-2022 (MoH 2017c) sets out a roadmap towards the implementation of a coherent accreditation system. All objectives, indicators and interventions of SHPP are aligned to one of the 20 sub-strategic areas of the QIMP (No. 2.3 'establishing reliable assessment processes', No. 2.5 'promoting organisational development of health facilities', No. 2.6 'establishing healthcare accreditation, among others). Beyond the current alignment, SHPP has assisted the Royal Government of Cambodia at an early stage of the present programme term in formulating a National Strategy Quality and Safety in Health (MoH 2017b) and the new QIMP.

Figure 2: Group Photo of the Dissemination Workshop for the National Policy on Quality and Safety in Health

- In the intervention area of health system governance, the objective of increasing the transparency and accountability of health services through better client feedback mechanisms and increased citizen participation in planning processes is also aligned with the current QIMP (see strategic area No. 1 'empowerment of the consumers' with the sub-strategic areas No. 1.1 'promotion of patient's rights', No. 1.2 'disseminating information on quality and safety and 1.3 'improving client satisfaction'). SHPP support is further based on the principles outlined in the Community Participation Policy for Health (see MoH 2008b) that defines, for example, the role and functions of the village health support groups (VHSG) and Health Center Management Committees (HCMC). Furthermore, SHPP strategy in regard to health sector governance directly connects to the decentralisation and deconcentration process in Cambodia.

  The SHPP strategy for the inclusion of vulnerable groups is mandated by several of the previously mentioned policy and strategy documents which consider the inclusion of vulnerable groups as a cross-cutting or even as a priority issue (e.g. MoH 2016a: 37ff; MoH2016c: 1; MoH 2017b: 2). The rights of specific vulnerable groups, such as people with disablities and older people, are considered (although unsufficiently implemented) in legal and strategic frameworks, such as the National Disability Strategic Plan 2014-2018 (MoH 2013b) or the National Health Care Policy and Strategy for Older People (MoH 2016b).

In total, all dimensions of SHPP are designed to contribute to the implementation of **national policies and strategies**. Furthermore, the project has made significant contributions to policy and strategy formulation, particularly in the fields of health financing and health service delivery.

The SHPP concept is also in line with **international standards**, particularly with the concept of universal health coverage – promoted by the World Health Organization (WHO) since 2008 – which aims to achieve health coverage in three dimensions: including services that people need, coverage of all people living in a country (including vulnerable groups of any kind) and financial protection of individuals or families in case of illness. In the above-mentioned policies and strategies, the Cambodian Government has adopted this concept and SHPP supports the implementation. The support to community participation in the intervention area of health governance follows the principles of the Declaration of Alma Ata, which formally recognised that people have the 'right and duty to participate individually and collectively in the planning and implementation of their health care' (Rifkin & Kangare 2002: 37) with the government being responsible for the facilitation of participatory processes (GIZ-SHPP 2016d: 1f).

The SHPP objectives are also consistently linked to the health-related SDGs, particularly to SDG 3.8 'achieve universal health coverage, including risk protection and access to quality essential health care services (…)'. Through longer result chains, improved service access and service quality also contribute to health status targets such as SDG 3.1 (reduction of maternal mortality), SDG 3.2 (reduction of neonatal and under-5 mortality) and SDG 3.4 (reduction of mortality from non-communicable diseases). Though Cambodia has not yet formalised its national SDGs, health-related targets have already been integrated into the current Health Strategic Plan 2016-2020 (see MoH 2016a: 66f), including indicators for the national adoption of the above-mentioned targets.

From both a sector and a regional/country perspective, the project corresponds with the relevant **concepts and strategies of German development cooperation**, i.e. of BMZ as commissioning party. The German Development Policy in the Health Sector of 2009 promotes health as a 'basic human right', with universal accessibility and quality as two of four key elements (BMZ 2009: 7). Relevant levels of action highlighted by the Sector Strategy that are reflected in the SHPP strategy are (a) the health system development through multilevel approaches intervening both at policy and service delivery level, (b) the support for solidarity-based health financing and SHP. BMZ's New Asia Strategy names improving health and living conditions in cities as two out of seven priority issues for German development cooperation in the region (see BMZ 2015a). In absence of a current BMZ country strategy for Cambodia, the design of SHPP has been guided by a sector strategy, i.e. the Strategy Paper for the Priority Area Health – Social Protection for the Poor and Vulnerable, 2014-2018 (see GDC 2014b), updated by the new programme framework (Part A) of 2015 (GDC 2015a). The module objective ('poor and vulnerable groups have more equitable access to health services of appropriate quality') is an expression of the human right to health and the project design responds to most of the strategic areas outlined in the relevant BMZ strategy (e.g. overcome discriminatory practices, overcome stigmatisation of ill people, strengthen patients' rights, support participatory planning and decision making (see BMZ 2009a).

In summary, the project fits into the relevant strategic reference frameworks at all levels (national policies and strategies, international standards, strategies of German development cooperation). The overall score is slightly affected by the fact that the initial support to the voluntary community-based health insurance schemes has rendered obsolete the above-mentioned policy shift towards the NSPPF (**rating: 37 of 40 points**).

Suitability to match problems/needs of the target groups

According to the project offer, the groups targeted by SHPP are poor and vulnerable populations in the provinces Kampong Thom, Kampot and Kep. The core problem underlying the module objective (i.e. insufficient access to health services of adequate quality; see GIZ-SHPP 2015a: 5) as well as the assumed causes (e.g. financial barriers due to the lack of social protection, absence of quality enhancement mechanisms) are clearly

evidence-based. Out-of-pocket payments for health services in Cambodia accounted for 67% of the Total Health Expenditure in 2015 (MoH 2016a: 141). Per year, approximately 5% of the households face catastrophic health expenditures (defined as out-of-pocket payments exceeding 40% of household capacity-to-pay, see MoH 2016a 53). Several sector studies confirm low levels of service quality at all levels of the health system. Though limited evidence exists regarding the situation of specific vulnerable groups, it is known that out-of-pocket payments are 5 times above average for people with disabilities, 3 to 5 times above average for older people and up to 16 times above average for people with chronic diseases.

The project strategy considers feasible interventions for all of the above-mentioned dimensions. The support of inclusive social health protection mechanisms aims to eliminate the financial barrier for basic health services. The broad range of systemic interventions in the area of health service quality enhancement includes interventions that address quality improvement processes at facility level and the client-provider-relationship. Local populations are directly addressed at grassroots level (e.g. training on clients' rights and providers' duties, feedback to health care providers) and thus empowered to express and advocate their needs. With regard to the availability of inclusive social protection mechanisms, the policy shift of the NSPPF unfortunately resulted in a backlash which affected the ability of SHPP to directly reach the target groups during the project period. Despite the redirection of efforts towards policy advice at the national level, the long-term objectives of SHPP – and thus its suitability to match the needs of the target groups – remain unchanged.

The leave no one behind principle is inherent in the concept of universal health coverage. Its expression in the SHPP strategy is the focus on near poor, informal sector and specific vulnerable groups (disabled and older people), each facing different risks of exclusion from basic health services. Beyond the mainstreaming of the LNOB principle, the design of SHPP puts a strong emphasis on the empowerment of vulnerable groups (i.e. on their self-representation and advocacy for specific needs, see GDC 2015a).

Different perspectives, needs and concerns of women and men played an important role in the intervention area of health financing where equal access to the previous CBHI schemes was supported and monitored through gender-disaggregated data. After the termination of the CBHI schemes, gender mainstreaming has become less present in the project strategy. Currently, gender mainstreaming within SHPP is still more explicit in the intervention output areas of citizen participation and vulnerable groups where the gender balance in public committees and female participation in capacity development measures are promoted and monitored.

In summary, the strategy is generally suitable to match the core problems/needs of the target groups although the support for the upscaling of CBHI schemes had to be abandoned and, thus, the related direct benefits for the target groups will not be achieved during the current project term. The strong focus on vulnerable groups contributes to the positive assessment (**rating: 25 out of 30 points**).

Adaptation of the design to the module objective

Beyond the generic problem analysis in the project offer, the core problem, its causes and negative impacts are further analysed and supported with evidence in specific documents at the level of each intervention area. Results hypotheses that connect the project outputs with the intended goal are plausible, although the changes in the framework conditions compromised the original design of the intervention area of health system financing and the related dimension of the module objective.

Whereas each intervention area of SHPP III individually contributes to a specific dimension of the module objective (lowering the financial barrier, improving service quality, enhancing the responsiveness of health system management to the needs of target groups), the intervention areas are also closely interlinked, e.g. regarding the role of quality improvement processes for (incentive) payment mechanisms, the feedback of client satisfaction surveys into quality improvement processes or the mainstreaming of the needs of vulnerable populations into all intervention areas of SHPP.

Throughout the four intervention areas, the project applies a consistent multi-level approach, supporting the Ministry of Health in designing national policies to implement the ambitious reform agenda enshrined in the NSPPF and in H-EQIP and in initiating the implementation of these policies through the sub-national administrations, i.e. the provincial health departments and operational districts This enables health care facilities to develop their individual quality improvement plans, thus reducing costs, increasing the quality and utilisation of health care, and increasing client satisfaction.

All in all, the project design fully responds to the module objective (**rating: 20 out of 20 points**).

Adaptability to changes in the framework conditions

As already explained, SHPP had to adapt to a major policy shift defined by the approval of the NSPPF and the transition to the H-EQIP which mainly affected the strategic orientation of the intervention area of health system financing. According to the stakeholder interviews, SHPP has been at the same time strategically focused and responsive to urgent partner needs while shifting its support to the operationalisation of the NSPPF and the related capacity development (INT-P, INT-DP, INT-G). Consensus also exists regarding the appropriateness of the decision to abandon the support of the CBHI schemes since they had become unsustainable since the implementing NGOs ceased to function as operators of the Health Equity Fund.

The new sector development programme H-EQIP is mostly compatible with the original SHPP design, though technical adjustments were required regarding the quality assessments supported in the intervention area of health service delivery. H-EQIP is introducing a quality enhancement mechanism which includes periodic quality assessments linked to performance grants as incentive payments. SHPP support of continuous quality improvement processes at provider level is still valid according to the original design, but slightly adjusted in order to support the H-EQIP readiness of the involved stakeholders (i.e. prioritizing H-EQIP quality indicators instead of other quality assurance standards as originally specified in the relevant output indicators, see GDC 2016a and 2017a). Again, stakeholder interviews confirm that SHPP has appropriately adapted to its environment (INT-G, INT-S).

Although the project has adapted well to changes in the framework conditions, an earlier adjustment of the formal goal system (i.e. the results model and results matrix) would have been desirable. The above-mentioned changes affect the goal system substantially (e.g. module objective indicator 1 and two output indicators becoming obsolete). Strictly speaking, even the module objective would require a reformulation since intended direct effects on service access of target groups will no longer be achieved during the present project term (through CBHI schemes), although they are still addressed on the long run (through the support to the NSPPF operationalisation). This means that the project has operated for an entire year and had to be evaluated under a partly obsolete goal framework; a proposal for adjustments of the results matrix has been recently submitted with the progress report of November 2017 (see GDC 2017a).

Since the latter is rather a formal observation, the overall rating is based predominantly on the positive assessment of the appropriateness of the underlying strategic decisions (**rating: 9 out of 10 points**).

Criterion	Assessment dimension	Score
Relevance	The project fits into the relevant strategic reference frameworks	*37 out of 40 points*
	Suitability of the strategy to match core problems/needs of the target groups	*25 out of 30 points*
	The design of the project is adequately adapted to the chosen goal.	*20 out of 20 points*
	The conceptual design of the project was adapted in line with requirements and re-adapted where applicable.	*9 out of 10 points*
Overall rating relevance		*91 out of 100 points*

5.2 Effectiveness

Degree of goal attainment

Goal attainment is assessed according to the partly adjusted indicators and assessment criteria for the outcome level (see chapter 4.2). In this section, the assessment focuses on the current goal attainment indicator status and the forecast of the attainability of indicators until the end of the current term whereas the relevant project contributions will be assessed in the subsequent section.

- *Indicator 1: Social health protection schemes in 10 out of 81 districts cover both poor and vulnerable groups (baseline value 2014: 2 out of 81 districts)*

The integrated CBHI schemes supported by SHPP were based on the assumption of (transaction) cost sharing. It was set up to cooperate with NGOs that acted as operators of the Health Equity Fund and already had an operational structure in place to manage the social protection scheme for the poor population with IDPoor cards. Complementary voluntary health insurance for target groups without IDPoor card (e.g. near poor, informal sector workers, vulnerable groups) could build upon the existing operational structures, thus keeping their transaction costs to a minimum and offering health insurance for an affordable premium.

At the beginning of the current project term, when this assumption was still valid, the CBHI scheme in Kampong Thom continued to increase its coverage up to 22,000 members of the voluntary health insurance and expanded to all three operational districts of Kampong Thom by August 2015 (baseline 2014: 2 operational districts, see GIZ 2017b and 2017d). However, NGOs ceased be operators of the Health Equity Fund with the start of H-EQIP in 2016 and thus lost their ability to offer supplementary CBHI to the near poor and their ability to positively discriminate in favor of older persons and persons with disabilities amongst IDPoor cardholders. Therefore, the CBHI could not be rolled out to other districts nor maintain its operation in the districts already covered.

In summary, **indicator 1 has not been achieved.** Since it has become obsolete under the new policy framework, it is complemented by additional success criteria adjusted to the current methodological approach of the project's health financing area.

- *Additional success criterion for the health financing dimension: increased ability of the Ministry of Health to use costing data to inform payment rates of the National Social Security Fund and the Health Equity Fund (Milestone until the 12/2017: SHPP supported costing studies covering 6 of 25 provinces)*

Instead of directly benefiting target groups at provincial level, SHPP now intervenes at national level in order to advise on the operationalisation of the NSPPF. The development of the single payer system under the National Social Security Fund and the development of the required institutional and organisational capacities are long-term challenges that exceed the scope of the current programme term; goal attainment must therefore be measured against the above-mentioned intermediate criterion (costing data analysis capacity).

One critical capacity to be developed is the ability of the Ministry of Health to generate data about the costs of health services and use the data to establish adequate payment rates for health insurance. Until the end of 2017, SHPP has assisted the Ministry of Health to develop a costing methodology which was successfully piloted in Kampong Thom and Kampot. The National Institute of Public Health (NIPH) is to be contracted by the National Social Security Fund to extend the costing study to more provinces and national hospitals using the same methodology. Since this line of action was not part of the original methodological approach, no formally agreed target values exist, but an internally established milestone of covering 6 out of 25 provinces until the end of the current project term appears achievable (see GIZ-SHPP 2017e, INT-P). At the same time, the Ministry of Health and the National Social Security Fund are receiving advice regarding the relationship between operating costs per health service used and user fees charged and will gradually build the capacity to calculate appropriate payment rates under the NSPPF. However, there is a long way to go from initial snapshot studies and the facilitation of sample service fee calculations to the establishment of institutional capacities and a routine costing system. Challenges to be addressed over time include technical bottlenecks, such as low data quality due to weak record keeping capacities at the level of sub-national administrations and health facilities, but also politically sensitive processes, for example when it comes to seek the right balance between supply-side funding through budgetary allocations and demand-side funding through fees for service. In conclusion, the ability of the Ministry of Health to use costing data and inform payment rates of the National Social Security Fund and the Ministry of Economy and Finance **(= complementary success criterion for indicator 1) will be partly developed** during the project term whereas the development and utilisation of a routine costing system have to be supported far beyond the current phase.

- *Indicator 2: The utilisation rate for outpatient consultation in public health services increases on average to 0.66 per capita of the population per annum in Kampong Thom, Kampot and Kep provinces. (baseline 2014: 0.42 per capita)*

This indicator is calculated quarterly based on the Health Management Information System (HMIS, see GIZ-SHPP 2017f) of the Ministry of Health. The calculation considers only the new cases of out-patient departments of the health centres in each province divided by the total population of the province (see GIZ-SHPP 2017g). Despite the termination of the CBHI support, the indicator remains valid, since utilisation rates are also influenced by the perceived service quality, patient satisfaction and responsiveness to the needs of specific target groups. However, up to now the potential influence of the project outputs has been temporarily, but massively, overlaid by the above-mentioned transition to the new sector programme H-EQIP which led to a temporary disruption of Health Equity Fund services to the eligible beneficiaries and subsequently to a strong decline of outpatient service utilisation rates. In numbers, the utilisation for the three project provinces fell from 0.42 (baseline 2014) to 0.33 (third quarter 2016). Since then, they have recovered and oscillated between 0.50 (first quarter 2017) and 0.45 (second quarter 2017) to a current value of 0.49 (third quarter 2017, see the monitoring data GIZ-SHPP 2017f).

Compared to the fairly constant national average (without net increase of out-patient service utilisation rates since 2010, see MoH 2017e), the project provinces show a slightly positive trend (+0.07 between 2014 and the third quarter of 2017), albeit starting from a significantly lower level (baseline 2014 in the project provinces: 0.42 compared to a national average of 0.59 in the same year). Nevertheless, the increase in utilisation is significantly smaller than expected, which may be attributed to several factors: (a) the still prolonged consequences of the above-mentioned temporary backlash in utilisation rates, (b) the abolition of the CBHI schemes which had already demonstrated their ability to enhance utilisation rates (see the results of operational research in GIZ-SHPP 2017b) and (c) the probably overambitious target value of 0.66 which – in absolute numbers – would presume an increase of out-patient consultations of more than 50%. In conclusion, the indicator will probably show a **positive tendency** until the end of the current project term, but **not achieve the intended target value**.

Although some of the project interventions (e.g. regarding service quality improvement at health facility level) benefit the entire target population, the needs of selected sub-groups (e.g. disabled people) receive particular attention. Therefore, a disaggregated analysis of group-specific utilisation rates might be more appropriate to visualise specific project outcomes that are disguised by aggregated population-based indicators. Since this data is not routinely collected, it is not available for the present evaluation, but could be generated by the project for the indicator measurement at the end of the project term.

- *Indicator 3: A new national framework document for quality improvement in the health sector was adopted by the Ministry of Health.*

Through its engagement in the national Quality Improvement Working Group, SHPP has supported updates to the National Policy for Quality and Safety in Health, which provides the guiding framework for all efforts related to patient safety, quality assurance and improvement in health care and services, as well as to the accompanying Quality Improvement Master Plan (QIMP), which guides implementation, monitoring and evaluation of the revised policy. The Ministry of Health adopted the revised strategy and the QIMP in August 2017 (**Indicator 3: achieved**, see section 'Additional positive results' for further outcomes in the field of health service delivery that are not covered by Indicator 3).

Since the module objective refers to the actual access for the target groups to quality health service, indicator 3 is complemented by the assessment of **contributions to quality improvement in the intervention provinces**. Methodologically, the assessment tools used by SHPP have been aligned with the Quality Enhancement Monitoring Tool (QEMT) that is used for quality assessment, scoring and the calculation of incentive payments under H-EQIP. Though the QEMT has not yet been rolled out nationwide and will not be implemented in the project provinces before 2018, the tool is already used for self-assessments and stakeholders interviewed in Kampot and Kampong Thom agree that SHPP has significantly contributed to the QEMT readiness of health administrations and facilities in the project provinces (INT-S, INT-H).

Since the QEMT has not been formally applied in the project provinces, it is not yet possible to compare changes in health facility performance in the project provinces to other provinces or to a national average. Prior to the start of H-EQIP, baseline assessments in the project provinces were carried in early 2015 using the Level 2 Assessments and only 4 out of 116 health facilities passed the threshold scoring value of 60% at that time (percentage value = number of indicators fulfilled as share of the total number of indicators of the Level 2 Assessment). Master's degree students from the National Institute for Public Health carried out re-assessments during the last quarter 2017. However, the results were not available for the present evaluation, so the outcome of quality improvement processes cannot yet be measured in quantitative terms. The evaluation has to rely on the interviews conducted during field visits with health facility staff in Kampot and Kampong Thom (INT-H) which provide examples of tangible quality improvements (e.g. in the areas of client treatment, infection control, access for disabled people). The general impression is that feedback loops on the basis of Plan-Do-Check-Act

cycle management are established and actively promoted by the interviewed health facility staff (INT-H). Despite the lack of quantitative evidence regarding actual service quality improvement, the evaluation concludes that health facilities are using the project support and implementing quality improvement processes (i.e. the **hypothesis connecting indicator 3 to the module objective can be sustained**).

Figure 3: Client feedback during a public forum

- *Indicator 4: The number of hospitals obtaining a minimum of 85% for each criterion in the Client Satisfaction Survey (CSS) for male and female patients increases from 0 to 3.*

The Client Satisfaction Survey (CSS) is a national tool adopted by the Ministry of Health in 2010 with Likert-Scales for 22 criteria to measure the level of client satisfaction in hospitals. Based on the result of the latest CSS (2nd quarter of 2017), the three hospitals in Kampong Thom achieved an average of 79% satisfaction while the hospital in Kampot received an average of 83% (see GIZ-SHPP 2017f). So far, none of the three hospitals gained 85% satisfaction for each criterion in the CSS, although in all three hospitals some service-related items consistently scored above 90%, such as privacy, confidentiality, communication with the health staff, instructions for the use of medicines, having an opportunity to ask questions to health staff. Although the target has not been (and will probably not be) formally met, the average scores of all health facilities are relatively close to the target of 85% which – from the point of view of the evaluation team – should be considered as an approximation rather than a strict threshold, which means that **indicator 4 is already partially achieved** and is **mostly achievable during the project term.** This evaluation is also supported by the interviews held with hospital staff, members of the Health Center Management Committees (HCMC) and health managers (provincial health departments and operational districts) regarding patient feedback in public forums and HCMC sessions. In 11 interviews that explicitly addressed issues regarding client orientation and responsiveness to clients' feedback, all interviewees could provide examples of positive results (INT-H, INT-S).

Summarising the attainment of the indicators and complementary assessment criteria, one indicator has already been achieved (indicator 3), two indicators were mostly (indicator 4) or partially (indicator 2) achievable during the project term whereas one original indicator (see indicator 1 in the area of health financing) has not been achieved and has become obsolete. Complementary success criteria are used for the new project strategy in health financing and show positive developments at the level of intermediate results (institutional capacity development). All in all, the degree of **goal attainment is rated with 30 out of 40 points**.

Contribution of project interventions to goal attainment

- *Contribution of the intervention area of health system financing to the module objective (to indicator 1 and its complementary success criterion)*

Since the CBHI schemes (see the results model in Annex 5, box A3, as a precondition for achieving indicator 1 of the module objective M1) have become obsolete under the National Social Protection Policy Framework, no further analyses are carried out in this chapter. In the future, there will be only a limited role for the NGOs, as the Health Equity Fund will be operated by a new Payment Certification Agency and later on be transferred to

the future single payer entity (probably the National Social Security Fund). Therefore, there is hardly any potential to transfer capacities developed under the CBHI schemes to a future single payer mechanism (see results model, relation A6/M1 and A-1).

On the other hand, the new policy framework offers the possibility of extending social health protection nationwide with differentiated mechanisms for different target groups, but under a unified single payer mechanism. According to stakeholders within the Ministry of Health and the Ministry of Economy and Finance, SHPP has provided valuable technical assistance during the conceptualisation of the NSPPF (INT-G, see results model, A-4). The policy support, however, has been much broader and comprised further advice regarding the implementation of the legal and institutional set-up for the upcoming reform. The project has advised on the formulation of a sub-decree (to be approved in early 2018) for the formation of the National Social Protection Council (NSPC) which has the mandate to drive the reform efforts over the next decade. In cooperation with the Sector Initiative Social Protection (PN 2017.2045.7), it has assisted the Ministry of Economy and Finance in formulating a draft social protection law (to be consolidated by the NSPC once established. According to key stakeholders, the project played a fundamental role in the relevant processes, regarding the facilitation of stakeholder dialogues and the provision of technical expertise (INT-G, INT-P, INT-DP).

SHPP has also contributed to the capacity development of key counterparts as required for the operationalisation of the NSPPF (see results matrix, A-2). Since the policy framework emerged during the current project term, SHPP had to flexibly adjust to urgent capacity development needs resulting from the operationalisation of the NSPPF and advise counterparts on identifying and strategically addressing capacity gaps. Staff members of the Ministry of Economy and Finance confirm that SHPP significantly contributed to the learning curve of the responsible departments regarding social health protection, thus enhancing the Ministry's capacity to lead political processes in the field (INT-G). The National Social Security Fund as the presumed single payer has also received a broad range of advisory services and CD support which has been highly valued by interviewed staff members (e.g. in the areas of process automation, provider contracts, claims management, exposure to international networks; INT-G). The National Social Security Fund, however, still faces huge capacity gaps and there is a serious risk that capacity development may not keep up with the extension of the mandate (INT-P, INT-DP, INT-G). Officials of the National Social Security Fund themselves admit that the organisation is currently overloaded and a mid- to long-term strategy for organisational development is still pending (INT-G).

All in all, SHPP has contributed to the current progress towards the development of institutional settings and partner capacities although not yet to the extension of specific social protection schemes for its target groups (see results matrix, A-6/M1). Since the NSPPF is still emerging, the actual outcome for the target groups (as originally measured by indicator 1) cannot yet be assessed during the current project term, but the (intermediate) project outputs provide a reasonable basis for further progress towards the rollout of social protection for differentiated target groups (including the near poor and vulnerable).

- *Contribution of the intervention area of health service delivery to the module objective (to indicator 2, indicator 3 and indicator 4).*

Regarding the contribution of the project to the achievement of indicator 3 (the adoption of a national framework document for quality improvement in the health care sector), an international consultant funded by SHPP directly advised the Quality Improvement Working Group of the Ministry of Health on the review and revision of the National Policy for Quality and Safety in Health and the QIMP (see GIZ-SHPP 2017e). Through the direct involvement in the finalisation of the two documents, the project contribution to the indicator achievement is

evident and does not depend on intermediate results hypothesis. It must be noted, however, that the scope of the project by far exceeds the indicator (see section ‘Additional positive results’).

Regarding the contribution to quality improvement processes at health facility level (i.e. to the access to quality health services as stated by the module objective, related to indicator 3), SHPP has supported health managers of the provincial health departments and the operational districts as well as health care providers through different types of training sessions and technical assistance (e.g. the application of quality assessment tools, quality management approaches, infection prevention control, nursing protocols). At the time of the evaluation, quality improvement working groups are established at the level of the operational districts in the project provinces. According to the interviews held during the evaluation, basic capacities to undertake supportive quality assessments are in place and quality improvement plans have been developed and followed-up in hospitals and health centres (INT-P, INT-S, INT-H, see results model, B-2). Internal progress reports (see GIZ-SHPP 2017e) and interview results sustain the hypothesis that these quality improvement processes supported by SHPP have contributed to gradually improving several dimensions of health service quality as outlined in the previous section (see results model, B-3/B-4).

In conclusion, it is plausible that the project is contributing to service quality improvement (additional success criterion under indicator 3) and thus indirectly to utilisation rates (indicator 2) and client satisfaction (indicator 4), although the latter correlations cannot be analysed due to the presence of confounding variables (indicator 2) or lack of comparative data (indicator 4, see previous section).

- *Contribution of the intervention area of health system governance (output: citizen participation) to the module objective (indicator 2 and indicator 4).*

At the provincial level, SHPP has supported community participation in the health system by focusing on the functioning of the Health Center Management Committee (HCMCs) of the 116 health facilities in the project provinces, raising awareness of client rights and provider rights and duties and promoting citizen participation in planning processes. Some interventions aiming to strengthen the HCMCs were (a) training courses for HCMC members on how to run effective meetings (HCMCs of 52 health facilities, 162 trained members), (b) workshops on annual operational planning (for 131 health facilities) (c) supporting provincial health departments in the coaching for 9 selected (poor performing) HCMCs. Whereas many HCMCs were not functional in the past (see GIZ-SHPP 2016f), approximately 90% of the HCMCs were conducting meetings at least once per quarter at the time of the evaluation (see GDC 2017a: 169). Representatives of the commune associations (associations of municipal district commune/Sangkat Councils (AMDSCS) of Kampot and Kampong Thom and interviewees at health facility level confirm that meetings are better structured than in the past (INT-S, INT-H). Roles and functions have become clearer, particularly regarding the leading role of the chief of commune, though a leadership vacuum arises occasionally following political changes (approximately 50% of commune council members were newly elected in July 2017 with further fluctuation due to the ban on the Cambodian National Rescue Party in October/November 2017).

The project monitoring shows that by September 2017, 75% of the health facilities in the project provinces follow up on the results of patient feedback (see results model, C-2) during HCMC meetings in order to inform their planning cycles (baseline August 2015: 53%, see GIZ-SHPP 2017f). The monitoring also shows a higher degree of citizen participation in planning processes of the health facilities (see results model, C-1) for dimensions such as attendance of citizens, active participation, issues raised and accepted (see GIZ-SHPP 2017f). Some interviewees (INT-P) comment that the quality of participation is not yet satisfactory (e.g. reluctance to speak out in discussions, see also GDC 2017a: 189). In order to raise public awareness of client rights and provider rights and duties, local NGOs were conceptually and financially supported to conduct awareness raising sessions, reaching more than 10,000 people in 279 villages in Kampong Thom and Kampot.

Figure 4: Awareness raising workshop for client's rights and provider rights and duties

In conclusion, the contribution of SHPP to an enhanced degree of public participation and feedback of the client perspective in planning and quality improvement cycles (see results model, relation C-2 – B3/B-4) is observable. It is plausible that this will have a positive effect on client satisfaction (indicator 4) and, therefore, also on utilisation rates (indicator 2; see results model, relation M4-M2). Regarding the quantitative assessment of the correlations, however, the same restrictions apply as for the intervention area of health service delivery.

- *Contribution of the intervention area health system governance (output: vulnerable groups) to the module objective (indicator 2 and indicator 4).*

The intervention area contributes to the module objective both through targeted interventions for selected target groups (e.g. supporting disabled people organisations/DPOs) and through the mainstreaming of the topic in the other intervention areas of the project. Until the time of the evaluation, SHPP has provided technical and financial support to six DPOs and one older people's organisation in the project provinces that carried out training measures for their members to increase awareness of health-related topics (e.g. hygiene, nutrition, healthy lifestyles). Based on a quality checklist (see GIZ-SHPP 2017e), 93% of nearly 130 training sessions were conducted in accordance with quality criteria (e.g. clearly stated objectives, availability of training materials, quality of the organisation) and reached more than 2,200 disabled people (approximately 1,000 women) and 295 older people (205 women, see GIZ-SHPP 2017f). A baseline KAP survey about the target group's knowledge of health issues and diseases, health service access, health-related rights etc. was carried out in 2016 (see GIZ-SHPP 2016g), but an endline is not yet available at the time of the evaluation, so that training effects cannot be assessed. The same is the case for target group-differentiated utilisation rates for out-patient services (see indicator 2) which should be positively influenced by an enhanced awareness of the target group.

The DPOs themselves have also received capacity building support facilitated by SHPP and carried out by their national representative body, the Cambodian Disabled People Organization (CDPO). Members of four DPOs have participated in group discussions during the evaluation and reported an increased intensity and effectiveness of their advocacy work (see results model, D-1). As a consequence of the outlined capacity development and awareness raising measures (as confirmed by INT-N, INT-H, FGD), the degree of participation of DPO or older people's organisation members in operational planning meetings of health centres has increased from 70% in 2016 to 76% in 2017 (see GIZ-SHPP 2017f; see results model, D-2) and become more active and visible according not only to target group representatives but also to other members of the Health Center Management Committee (INT-S, INT-H). Again, correlations with the results of client feedback surveys (see results model, relation D-2 / C-2) cannot be established due to the lack of target group-differentiated data

but interviewed DPO members provide examples of service improvements (e.g. increased awareness of rights to free treatment, decrease in discriminatory attitudes of health staff, improvements regarding the physical access to health centres; see results mode, relation D2- / B-3, B-4). They also state that they feel empowered to demand the services they need and express themselves in their community (FGD).

All changes reported for the module objective and its indicators (see the previous section) are directly (indicator 2) or plausibly (new success criterion for indicator 1, indicator 3, indicator 4) influenced by project interventions. At the output level, the degree of goal attainment is higher than at the level of the module objective and most results hypotheses can be sustained (except for those related to the obsolete original version of indicator 1). **The contribution of the project interventions to goal attainment is rated with 27 of 30 points**.

Figure 5: Barrier-free health centre in Kampot

Additional positive results

The direct results of the intervention area of health system financing are mostly covered by the statements in the two previous sections. By contrast, the scope of the **intervention area of health service delivery** significantly exceeds the contribution to the above-mentioned strategic documents and quality improvement processes at sub-national level.

The long-term objective of this area is to establish a national accreditation system (see results model, B-5). In May 2015, SHPP assisted the formulation of a roadmap for establishing health care accreditation which links accreditation with internal quality improvement, licensing, registration, complaints management and performance-based payment (see GIZ-SHPP 2016a: 75). The implementation was delayed due to the lack of legal basis and limited resources at the responsible Quality Assurance Office (QAO). A Law on Regulation for Health Practitioners (also advised by SHPP, see GDC 2017a: 165) was approved in November 2016 and includes the obligation to register with professional councils and undergo regular licensing processes, thus paving the way for continuous education of health professionals. The development of a complementary Law on Regulation of Health Care Facilities and Health Care Services, Pharmacy, Medical Aids and Supporting Services is taking longer than expected but should be finalised in early 2018 (see GIZ-SHPP 2017h: 2). Between late 2015 and late 2017, SHPP has facilitated the technical aspects of a taskforce for the revision of the Minimum Package of Activities for Health Centers (MPA) which includes a screening tool for the early detection of disabilities in newborns and children, developed by the project Improving Maternal and Newborn Care/Muskoka (PN 2014.2473.8). The MPA provide comprehensive guidance on the essential services to be provided by a health centre and will serve as a reference for accreditation as well as for resource allocation.

In 2017, SHPP supported the drafting of the organogram of the QAO and advocated a staff increase, resulting in an actual enhancement from 4 to 11 staff members. Thus, the QAO should be enabled to manage the workload associated with H-EQIP implementation. SHPP contributions to the set-up of the assessment processes within H-EQIP were (a) advice for the development and testing of the quality enhancement monitoring tool (QEMT), (b) the development of training curricula on QEMT for assessors at sub-national level, (c) support to the QAO in conducting the training (see GIZ-SHPP 2017h). The rollout of quality assessments has started, but does not yet include the three project provinces. Thus, the support to the QAO and the facilitation of quality improvement processes at sub-national level are not yet producing the intended synergies. Nevertheless, monitoring data of the QAO demonstrates that the assessments and performance payments may enhance service quality even without parallel support to the implementation of quality improvement processes at health facility level. Although health facilities generally achieved low scores during a first assessment round, they performed significantly better in the first re-assessment (average for 29 referral hospitals: 27% in the first round, 42% in

the second round; average for 453 health centres: 45% in the first round, 66% in the second round, see MoH 2017f).

Regarding the mainstreaming of health services for vulnerable groups, relevant additional results of SHPP were (a) the revision and drafting of the standard operating procedures for the Package of Essential Non-communicable Diseases including diabetes and hypertension; (b) the drafting of national physical therapy standards and (c) relevant pilot activities at the level of operational district and/or health facilities (although subsequent recommendations have not yet been adopted by the Ministry of Health, see GIZ 2017h). When integrated in the health service delivery on a larger scale, these contributions may improve health services (see results model, B-3, B-4) for the various vulnerable target groups.

Additional results of the area of health system governance beyond the scope of the goal attainment indicators are observed regarding the contribution of SHPP to the decentralisation and deconcentration (D&D) process in Cambodia (see results model, C/D-3). SHPP closely cooperates with the Decentralisation and Administrative Reform Project (DAR, PN 2015.2094.9), providing technical assistance to the sub-technical working group on D&D. Current milestones, such as the annual action plan for 2017 for health sector D&D, cannot be primarily attributed to the SHPP contribution, but consultations were facilitated by the project. A sub-decree on the functional transfer in the health sector has been drafted with project support, but still requires further revision before SHPP advice on the technical aspects of the transfer of functions can take place (GIZ-SHPP 2017a: 11). In the meanwhile, SHPP is supporting capacity development at sub-national level (e.g. quality improvement mechanisms at the level of provincial health departments, operational districts and health facilities, functional Health Center Management Committees) that increases the preparedness to respond to future requirements of the D&D process.

An additional result of the intervention area vulnerable groups is the strengthening of the Cambodian Disabled People's Organization (CDPO) as the umbrella organisation for approximately 70 local DPOs (thus enhancing the relevant output in the project provinces – see results model D-1 – on a national scale). The presence of a development advisor and national disability health specialist enabled the CDPO to carry out capacity development for DPOs and facilitate the DPO training activities outlined in the previous section. At the national and international level, the CDPO could intensify its activities on advocacy (e.g. participation in consultations for the National Disability Strategic Plan 2014-2018) and public awareness raising (e.g. organisation of a national Disability and Health Forum in late 2016, participation in international events). However, CDPO is still fully dependent on donor funding for the continuation of its activities (INT-N, FG-D).

Project-related negative results

There is no direct evidence for project-related negative results. However, some interviewed stakeholders mention the risk that the sudden rupture of the CBHI schemes in the intervention area of health system financing could compromise the target group's attitudes towards (voluntary) health insurance (INT-P, INT-G). During the period of CBHI implementation, operational research demonstrated that the rationale of pre-paid social health insurance was well understood and accepted by the target groups (see GIZ 2017b). Later on, the policy shift increased the transaction costs of the implementing NGOs, led to much higher premiums and then to the termination of CBHI schemes. The forced termination of their insurance contracts may have negatively affected the image of social health insurance, particularly among target groups that have never used the insurance for the payment of health services (i.e. have never experienced the benefit of being insured).

All in all, SHPP broadly contributes to systemic multi-level reform processes which significantly exceeds the dimensions measured by official goal attainment indicators, whereas (potential) project-related negative results are limited to a very specific aspect (**rating with 28 out of 30 points**).

Criterion	Assessment dimension	Score
Effectiveness	The project achieves the goal on time in accordance with the TC measures' goal indicators agreed upon in the contract.	*30 out of 40 points*
	The services implemented by the project successfully contribute to the achievement of the goal agreed upon in the contract.	*27 out of 30 points*
	The occurrence of additional (not formally agreed) positive results has been monitored and additional opportunities for further positive results have been seized. No project-related negative results have occurred – and if any negative results occurred the project responded adequately.	*28 out of 30 points*
Overall rating effectiveness		*85 out of 100 points*

5.3 Impact

Occurrence of superordinate long-term results and contribution of the project

The overarching development goals to which SHPP contributes are defined by the programme goal of German development cooperation ('The poor and vulnerable population of Cambodia is healthier and faces less financial burden by using quality health care services'). In this section, the current status of the programme goal indicators and a forecast of expected developments are addressed. Contributions of SHPP are discussed in the subsequent section:

- *Goal dimension: Financial burden related to illness and/or the utilisation of health services (Programme indicator: incidence of catastrophic health expenditure; baseline value 2014: 4,9%, target value 2018: 4,4%, source: Cambodian Socio-Economic Survey (CSES))*

The indicator is derived from further statistical analysis of the Cambodian Socio-Economic Survey (CSES) which is conducted every five years (last surveys: 2004, 2009 and 2014). Therefore, no statistical data is available that would allow for quantitative analysis of changes towards this programme goal indicator. Other sources are also time-delayed and use different operationalisations (e.g. regarding the share of out-of-pocket spending in relation to the capacity-to-pay), so that the lack of current data cannot be compensated for.

Despite differences in methodology and operationalisation, several sector studies (e.g. Flores, Men et al. 2013; GIZ 2014b, Chhun et al. 2015) have confirmed a long-term trend towards the reduction of catastrophic health expenditure which is likely to continue. On the one hand, the trend is supported by the rapid economic growth. Though rising incomes are strongly correlated with increases in out-of-pocket payments, those have not grown at the same rate and indices of catastrophic health expenditure have decreased over time. According to the study Out-of-Pocket and Catastrophic Expenditure on Health in Cambodia from 2014, secondary analyses of the CSES provide evidence that social health protection mechanisms (such as the Health Equity Fund and the CBHI schemes) have played a role in protecting vulnerable groups from catastrophic health expenditure, but

they also state ‘that the formulation of survey questions in the CSES (…) did not allow them to produce as much evidence regarding the impact of social health protection mechanisms as we might hope for (GIZ 2014b: 3). Differently, a study by Flores et al. (2013) indicates a significant impact of the coverage of the Health Equity Fund on the reduction of out-of-pocket payment by 35%. In general, study results indicate that residents of operational districts with Health Equity Funds had lower out-of-pocket payment rates for health care and were less likely to suffer catastrophic health expenditures or to become indebted due to illness, but patterns vary for different population groups such as rural vs. urban population, income quintiles or age groups so that aggregated numbers have to be analysed and interpreted carefully. For future impact studies, this means that analyses should pay close attention to the effects of specific mechanisms for specific target groups in order to produce valid results.

All in all, and despite the lack of current data, it can be assumed that the programme indicator will be achieved, and that extension of social health protection is contributing to the expected positive change. Since the methodological approach of SHPP has switched from the support to a specific social health protection scheme towards the policy field and a more overarching approach towards system CD, it is not possible to determine the specific contribution at the impact level. However, it is a plausible assumption that intended mid-term outcomes of the project advice (e.g. adequate costing and suitable health provider payment rates, increased capacity of the National Social Security Fund to manage protection schemes, implementation of a scheme for the informal sector) would significantly contribute to the performance, effectiveness and coverage of social health protection in Cambodia – and thus to the associated impact regarding the reduction of out-of-pocket payments and catastrophic health expenditure.

- *Goal dimension: Utilisation of health services (Indicator: utilisation rates for out-patient health services of members/beneficiaries of social health protection, target value 2018: 1.0 contacts per person per year)*

The indicator is a compound indicator consisting of the analyses of utilisation figures of beneficiaries of the Health Equity Fund, members of the CBHI schemes and beneficiaries of voucher programmes supported by the KfW Development Bank. The temporary disruption of the Health Equity Fund had negative short-term effects which obliterate the assumed long-term trend. In numbers, beneficiaries of social health protection mechanisms have had 0.53 contacts per person per year in the current year compared to 0.57 during the same period in 2016. Nevertheless, according to the interviews held during the evaluation, the impact hypothesis remains intact, and the indicator value is expected to rise again as the operations of the Health Equity Fund have normalised (INT-P, INT-G).

The contribution of SHPP largely coincides with the outcome measured by module objective Indicator 2 (utilisation rate for outpatient consultation in public health services) which in turn is the combined result of the project outcomes in regard to social protection, service quality improvement and increased needs orientation of planning processes. The analysis shows positive tendencies and indications for plausible SHPP contributions to the utilisation rates (see chapter 5.2 for details), but is based on assumptions rather than on current evidence.

- *Goal dimension: Health service quality (Indicator: number of health facilities offering services according to national quality standards, baseline value 2014: 0, target value 2018: 25%, current value: 0)*

The indicator is based on the national Level 2 assessments and the achievement of a certain threshold value (60% of the maximum score). In the last national Level 2 assessments during 2014, no health facility had surpassed the threshold yet (and only four out of 116 in the Level 2 baseline assessments carried out in the project province in 2015). Since then, no further assessment round has been carried out and no data is available for the original goal attainment indicator. SHPP has conducted Level 2 assessments in its target provinces during the third quarter of 2017, but results were not yet available at the time of the evaluation. As outlined in the

Effectiveness chapter (section 'Additional positive results'), the recently established regular Quality Enhancement Monitoring under H-EQIP is currently rolled out in three phases until the end of 2018. Data provided by the Quality Assurance Office of the Ministry of Health shows a rapid increase of quality scores between baseline assessments and first re-assessments of more than 500 health facilities in the first batch (see MoH 2017f).

The significant contributions of SHPP to quality improvement at facility level have already been analysed in the Effectiveness chapter, both regarding the service quality improvement at health facility in the project provinces and the policy advice and capacity development for a national accreditation system. So far, results are limited to the output and outcome (with their respective outcome indicators yet to be validated). The extent to which SHPP may contribute to more systemic (broad) impact will depend on the future functionality of and interaction between the elements of the future accreditation system (accreditation, licensing, continuous quality improvement), which is still under construction.

- *Goal dimension: Quality of diagnoses and treatment (Indicator: number of screenings and (early) treatments for diabetes and hypertension, baseline value 2014: 2.11 new diabetic patients and 14.41 hypertensive patients per 1,000 screened adults, target value 2018: 5 new diabetic patients and 20 new hypertensive patients detected per 1,000 screened adults)*

There is a slight increase in this indicator compared to the baseline (2.92 new diabetic patients 14.63 hypertensive patients per 1,000 screened adults) due to a slowly rising awareness of the relevance of non-communicable diseases, both at policy and health facility level. The target value, however, will not be achieved due to the still limited engagement of the Cambodian Government and international donors (except the WHO, see GDC 2017a: 16 and 26). Disease patterns according to data of the Health Management Information System of the Ministry of Health leave no doubt that the rising prevalence of diabetes (41,958 registered new cases in 2016 compared to 24,301 in 2014) and hypertension (219,737 new cases in 2016 compared to 157,542 in 2014, see MoH 2017e) poses a huge challenge to the health system. Therefore, sooner or later, a more comprehensive response must be developed.

SHPP is contributing to the NCD response through continuous advocacy and awareness raising which has resulted in a need for a more pronounced NCD focus in the National Policy for Quality and Safety in Health (see MoH 2017b: 6). Also supported by SHPP, the new MPA guidelines include the integrated management of specific prevention, care and treatment of NCDs, including diabetes and hypertension. Due to SHPP's focus on vulnerable groups (particularly disabled and older people), the MPA guidelines also cover screening tools for the early detection of disabilities in newborns and children, physiotherapy and rehabilitation services and enabling infrastructure design of health centres (see GIZ-SHPP 2017h). Since the MPA is intended to be a reference for resource allocations and an upcoming accreditation system, it may have a relevant impact on a better NCD response in the future. The above-mentioned national HMIS data regarding the current screening quality, however, cannot be plausibly related to SHPP interventions.

- *Goal dimension: Health situation of the target population (Indicator: maternal and neonatal mortality rates, baseline value 2014: MMR 170 per 100,000 live births and NMR 25 per 1,000 live births, target value 2018: MMR 150 per 100,000 live births and NMR 20 per 1,000 live births)*

The national indicator for maternal and neonatal mortality is only surveyed every four years in Cambodia and was not available at the time of the evaluation. Expected positive trends may be slightly enhanced by an increasing coverage of social health protection and the upscaling of mechanisms that foster health service quality enhancement. However, other German development projects (particularly the Muskoka TC measure) and other international development partners (e.g. USAID) are intervening in areas more specifically related to maternal health, and thus also contributing more specifically to a reduction of maternal and neonatal mortality rates (see GIZS-SHPP 2017a, USAID 2016).

The programme goals of German development cooperation are closely aligned with strategic objectives of the Cambodian Government and coincide with objectives and indicators of the national Health Strategic Plan and the underlying Health Development Goals (see MoH 2016a, e.g. Strategic Outcome 3: Quality-assured health services; Strategic Outcome 9: Minimised catastrophic and impoverishing health spending; Health Development Goal-Indicator 1.3/1.4: reduced maternal and neonatal mortality rates). Therefore, no additional indicators are required to analyse the contribution of SHPP to the Cambodian Government's development goals.

All in all, evidence for intended changes of impact variables is relatively weak. For two indicators (incidence of catastrophic health expenditure and the number of health facilities offering services according to national standards), future results in line with the intended changes are plausibly assumed. For three indicators, positive but slower than expected trends are assumed based on available data (quality of NCD screening) or stakeholder estimations (care-seeking behaviour of beneficiaries of social health protection, maternal and neonatal mortality rates). The occurrence of superordinate long-term results is **rated with 30 of 40 points**. Relevant contributions of SHPP can be plausibly assumed (though not measured) to a varying extent for most indicators (**rating of the contributions with 25 of 30 points**).

Additional positive results and project-related negative results

Due to the complexity of the strategic approach, the goals and indicators formulated in the results matrix are quite selective and a broad range of additional results (partly anticipated in the narrative of the strategic approach and partly by using windows of opportunity) has been achieved. They are mostly related to the institutional development for social health protection and health service accreditation, the operationalisation of specific system elements and the capacity development of key stakeholders. Most of these additional results, however, are direct outcomes and have already been analysed in chapter 5.2) although they have partly occurred at a high system level. Therefore, no further additional results are reported in this section.

Contributions to cross-cutting issues, too, are incorporated in the intervention strategy and therefore closely related to the module or programme goal attainment indicators: Contributions to the reduction of catastrophic out-of-pocket expenditure for the poor and other vulnerable groups are at the heart of SHPP and, at the same time, make an immediate contribution to poverty reduction (marker AO-1). Although the originally direct effects through CBHI schemes and the financial pooling of contributory and non-contributory schemes could not be scaled up or sustained, ongoing support at the system level may have an equally significant effect in the long run.

SHPP has significant direct effects on participatory development and good governance (marker PD/GG1) which is the main focus of the intervention area health system governance. Whereas already observable effects are analysed in chapter 5.2, wider impact at the system level may be achieved by providing a showcase for the decentralisation and deconcentration process in the health sector. At the beginning of 2017, the MoH decided to proceed with a transfer of health governance functions to the sub-national structures of three provinces – including the project province Kampot. SHPP is involved in discussions with the National Committee on Decentralization and Deconcentration (NCDD) and providing technical inputs; however, its influence on the overall dynamics of the decentralisation and deconcentration (D&D) process is quite limited. As outlined in the Effectiveness chapter, the project contribution lies in the capacity development at sub-national level which increases stakeholders' D&D-readiness". The upcoming functional transfer will require close monitoring and documentation, not only in order to verify the above-mentioned results hypothesis, but also to ensure that the showcase can serve as a learning experience for the nationwide health sector D&D. Since the second quarter of 2017, however, the process has lost momentum when the political focus shifted towards the local government elections and has not yet recovered. Since further elections (senate and general) are imminent, it is probable that the process will not advance before mid-2018.

Effects on the Gender Equity (marker GG-1) are monitored at activity level, focusing on female participation in training, awareness raising measures and public forums in the intervention area of health system governance (outputs citizen participation and vulnerable groups). Monitoring results show that the proportion of female participants in local-level events comes close to a 50% average. However, there is no evidence for more systemic effects. The previously supported CBHI schemes encouraged female participation but the termination of the schemes renders the impact question obsolete.

During the evaluation, no indications of project-related negative results at the impact level have been observed. Although no formal risk monitoring was established, regular progress monitoring in each intervention area has identified, discussed and followed up relevant risks (e.g. political risks regarding the continuity of current political momentum, the appropriateness of governmental resource allocation, structural stakeholder interest conflicts, binding constraints at health facility level such as low skill levels of health workers). At this level, risks are mostly outside the scope of the project, particularly risks related to overarching political momentum for health system reform processes (e.g. the slow-down of the decentralisation and deconcentration process) or to the power equilibrium in the institutional landscape (e.g. accountability challenges resulting from a Payment Certification Agency subordinate to the Ministry of Health; INT-P, INT-DP). Although a minor player, SHPP advocates for functional and technical considerations in the relevant policy discussions.

New risks have emerged from the recent political situation in Cambodia and the narrowing radius of operation for the opposition. The space for NGOs which operate in the political sphere and/or focus on politically controversial subjects has shrunk over the past six months. So far, implementing partners of SHPP have not been affected, since NGOs providing social services or promoting (uncontroversial) basic human rights have not been hindered in carrying out their activities (INT-P).

Summarising the above-mentioned relevant contributions to poverty reduction, participatory development and good governance, the less significant effects on gender equity, the adequate risk monitoring and response and the absence of project-related negative results, this dimension is **rated with 27 out of 30 points**.

Criterion	Assessment dimension	Score
Impact	The announced superordinate long-term results have occurred or are foreseen (should be plausibly explained).	*30 out of 40 points*
	The project contributed to the intended superordinate long-term results.	*25 out of 30 points*
	The occurrence of additional (not formally agreed) positive results has been monitored and additional opportunities for further positive results have been seized. No project-related negative results have occurred – and if any negative results occurred the project responded adequately.	*27 out of 30 points*
Overall rating impact		*82 out of 100 points*

5.4 Efficiency

Appropriate resources with regard to the outputs achieved (production efficiency)

The efficiency analysis in the context of the GIZ project evaluations is based on an Excel tool which captures (retrospectively, at the time of the evaluation) all project-related costs and estimates how they are distributed among cost categories (e.g. for personnel, consultancies, financing instruments, partner contributions) and among the different outputs in order to gain an understanding of the cost intensity of each output (follow-the-money approach). To identify deviations from the original planning, operational plans have been contrasted to the actual implementation process. Regarding the efficiency of the organisational set-up of the project, the steering structure has been revised. Analytical questions have been discussed with the officer responsible for the contract and key staff in order to identify inefficiencies and potential regarding the relationship between costs and achieved results.

The total contract value of the German contribution for the whole duration of the project (09/2015 to 12/2018) is 8,732,280 euros, approved in two tranches by BMZ in October 2015 and February 2016 and including a co-financing agreement (700,000 euros) with the US Agency for International Development (USAID) in the intervention area of health financing (agreed in April 2016, see GIZ-SHPP 2016a).

Interventions in the area of health system financing are implemented by two international and four national long-term advisors. Additionally, two Integrated Experts are placed at the Ministry of Economy and Finance and the National Social Security Fund and a Development Advisor at the Social Health Protection Agency, the national umbrella organisation of NGOs engaged in social health protection. NGOs in this area were supported through local subsidies until the termination of their function as operators of the Health Equity Fund. A **deviation of the use of instruments and resources** from the original planning has occurred due to the policy shift in the intervention area of health system financing where subsidy contracts with local NGOs for the implementation of CBHI schemes were not continued and resources were reallocated within the same intervention area

to financing agreements, short-term consultancies and HCD measures directed to key stakeholders for the implementation of the NSPPF (particularly the Ministry of Health, the National Social Security Fund and the National Social Protection Council). The development advisor at the Social Health Protection Agency is not yet reassigned and does currently not contribute to goal attainment. Regarding the **maximum principle** (i.e. the optimal relation between cost and output), the decision to withdraw from NGO support and focus on system development was compelling and caused by an external factor. It should therefore not compromise the efficiency assessment. Since the new intervention strategy entails totally different outputs (although still under the same objective), there is no basis for an assessment of the maximum principle and further considerations mainly refer to cost effectiveness (see the next section).

Advisory services in the intervention area of health service delivery have been provided by three long-term national advisors assigned to different departments and technical committees of the Ministry of Health, five technical advisors at provincial level and a development advisor at Kampot Provincial Referral Hospital (who resigned in January 2017 and has not yet been replaced). Short-term consultants combined with local subsidies were used for specific technical matters, training and workshops on different aspects of quality and safety in health care. The interventions are implemented as planned. There are no major **deviations of the use of instruments and resources**, except some technical adjustments due to external changes (e.g. the adaptation to QEMT standards for the quality of service delivery). When narrowly focusing on the results matrix, only a limited share of the activities (and resources) in the intervention area are directed towards the output-objective indicators (i.e. service quality improvement in (a) health centres and (b) hospitals in the project provinces). A significant share of the resources has been applied in policy-level support (e.g. QAO advice, Law on Regulation of Health Care Facilities, Law on Regulation of Health Care Practitioners, Revision of the Minimum Package of Activities for Health Centers, advice for a technical working group on public-private partnership) which does not directly contribute to the (short-term) module objective since the intended target groups do not directly benefit. At first sight, this seems to compromise the **maximum principle;** all activities, however, are following the dynamics of the recent sector reforms and may significantly enhance the cost-outcome relationship in the long term. The **potential alternative** of focusing more strongly on the project provinces (e.g. intensifying direct support to quality improvement processes at health facility level) could have apparently increased the cost-output relationship but at the expense of a much more integrated health-system-strengthening perspective. Therefore, the evaluation concludes that resources have been applied efficiently and in a pertinent manner.

The intervention area of health system governance is managed by a common national team leader for the outputs citizen participation and vulnerable groups and further five and two national advisors in Phnom Penh and the project offices, respectively, and a development advisor at in the Cambodian Disabled People Organization. Local subsidy agreements were particularly used for CD measures for involved organisations (such as disabled people organisations and older people's organisations) and the implementation of awareness raising activities by local NGOs. The activities have been carried out as planned, with no major **deviations of the use of instruments and resources**, and outputs at provincial level have been achieved (i.e. thresholds achieved for patient mechanisms in place, extent of citizen and vulnerable group participation in health sector planning processes, quality of awareness raising measures of DPOs and OPAs). Regarding the **maximum principle**, the most evident **alternative** would have been to approach vulnerable groups as a mainstreaming issue only, thus saving costs for specific interventions in the self-representative structures of disabled and older people. On the one hand, the methodology would still have been strategically consistent but on the other hand, the output barely absorbed 15% of the overall cost of the project. At the same time, the Disabled People Organization demonstrated a capacity to turn minor financial subsidies into a very significant outreach (see chapter 5.2) so that it is considered highly efficient by the related stakeholders (INT-P, INT-N). Therefore, the evaluation concludes for this intervention area that resources have been applied efficiently and in a pertinent manner.

According to the cost analysis (see the results of GIZ's Tool for the Efficiency Assessment, cockpit screenshot in Annex 6), nearly half of the contract value (47%) is dedicated to the health system financing-related output A. Approximately a quarter of the resources (26%) is allocated to output B (health service delivery). Output C

(citizen participation) absorbs 12% and output D (vulnerable groups) 15% of the overall budget. Since the different intervention areas and outputs are closely linked to each other, many team members are not exclusively working for only one of them. Taking into account the individual distribution of working time among the outputs and the specific costs of the different personnel instruments, nearly 70% of personnel resources are dedicated to the health financing output, slightly above or below 10% to each other output.

The **allocation of resources** to the different outputs is very much in line with their relevance to the attainment of the module objective. The operationalisation of the NSPPF is the more complex reform process, faces more significant institutional challenges and potential conflicts of interest and is, at the same time, the key factor for the removal of the financial barrier to health service access. Regarding the distribution of resources among the remaining outputs, the set-up of a future accreditation system could potentially absorb far more project support. However, since health services and quality enhancement processes are administered by sub-national administrations and governance challenges become more evident under the ongoing D&D reform, the synergy between the intervention areas health service delivery and health system governance is obvious. From this perspective, it has been pertinent to equally distribute resources among the areas.

From a conceptual point of view, the linkages between the outputs are convincing (e.g. establishing the link between social health protection, performance-based payment and assurance of service quality, the linkage between quality improvement and cost reduction, the feedback of the client's perspective into quality improvement processes, the mainstreaming of vulnerable groups' issues into the other outputs). They are relevant for the allocation efficiency since they generate synergies which are the precondition for aggregated outcomes that exceed the linear results changes of single intervention areas (e.g. increase of out-patient utilisation rates which is a combined effect of all four intervention areas).

Altogether, the evaluation concludes that the cost-output relation within the component has mainly been positive and that the distribution among the intervention areas was pertinent regarding the relative weight of their contribution to the attainment of the module objective. In comparison with potential alternatives, the evaluation team concludes that the actual utilisation of resources has been more efficient. Therefore, the production efficiency is **rated with 66 out of 70 points**.

Appropriate use of resources with regard to TC measures' objective/outcome (allocation efficiency)

Again, discussions were held regarding the implications of the strategic shift in health system financing. As mentioned above, the project did well in following the flow of the political and institutional changes in the subsector. But another question is, if – according to the maximum principle – the initial approach of strongly supporting the upscaling of the CBHI scheme offered the most appropriate relationship between cost and potential outcome (i.e. increasing social health protection coverage for near poor, informal sector and other vulnerable groups). On the one hand, a policy framework was lacking before 2016 and no specific social health protection approach was endorsed by the government, so that there is a consensus that it was technically a valid approach to support and learn from pilot experiences even though unconnected to a government policy. On the other hand, there are divergent opinions on (a) the cost-effectiveness relationship of the CBHI despite its positive outcome, (b) the scalability of the approach and (c) an inherent risk of economic unsustainability. It is difficult to assess whether the problematic aspects of the CBHI schemes, which have become visible under the present institutional framework, were foreseeable earlier. Whereas some officials of the Ministry of Health consider that CBHI was never a scalable option (INT-G), even the NSPPF document approved in March 2017 still stated that 'community-based health insurance schemes (…) could be a trend for the future development of social health insurance of the informal sector' (RGC 2017a: 27). Since SHPP simultaneously provided policy advice and supports the outreach of the Health Equity Fund to vulnerable groups, no other opportunities were missed that could have enhanced the cost effectiveness in the intervention area of health system financing, but

with today's knowledge, the same outcome could have been achieved with fewer resources. In the other intervention areas, no alternative resource allocation options have been identified during the evaluation that would have maximised the project outcome.

Scaling-up options are generally taken into consideration, although not every intervention area bears the same scaling-up potential. Each area intervenes simultaneously at sub-national and national level so that local experiences are connected to and inform national policies. In health service delivery, SHPP has already contributed to the rollout of quality standards and assessment methodology which will be applied nationwide (and intends to initiate similar processes for other elements of an accreditation system). Regarding health system governance, too, the instruments and mechanisms for client feedback and public participation are based on approved tools and existing structures. In that area, however, the challenge is not t the design of tools and mechanisms, but the process consulting in order to sensitise stakeholders, change behavioural patterns and the way how stakeholders relate to each other. Thus, the systematisation of the interventions can provide useful lessons for similar processes outside the sphere of the project, but not in the sense of scalable packages which would further enhance the cost effectiveness. In this direction, the slow progress of the decentralisation and deconcentration process is an additional obstacle.

In the case of SHPP, synergies with other development partners and projects and the leveraging of resources are an important contributing factor to the project's allocation efficiency. In general, according to all interviewed members, the Health Partner Group in Cambodia functions effectively and generates an active dialogue through bimonthly meetings (an interesting indicator for the good communication among development partners is the harmonisation of daily subsistence allowances for partners participating in workshops, training and travel). Cooperation is intense, and synergies are exploited to a satisfactory extent. From the perspective of SHPP, the most relevant are: (a) the co-financing of USAID which has enabled SHPP to strongly engage in policy advice and capacity development for the Ministry of Economy and Finance and the National Social Security Fund and further cooperation with bilateral USAID projects involved in quality improvement initiatives and conceptual work on social health financing, (b) the alignment of interventions in health service delivery with the H-EQIP and its multi-donor trust fund which assures the scalability of SHPP interventions in that area, (c) the integration of the national desk for the international Providing for Health (P4H) initiative in SHPP, providing additional expertise for intergovernmental and multi-sectoral cooperation in regard to health financing and (d) coordination with the Japanese International Cooperation Agency in advising the Ministry of Health on the development of an social health protection scheme for the informal sector under the NSPPF.

Coordination between the two technical and two financial cooperation measures of the German health sector programme is ensured through regular focal area health meetings. The two TC measures (SHPP and the Muskoka project) in particular cooperate closely on several matters, such as the development of the disability screening tools for newborns and children and the revision of MPA guidelines (see chapter 5.2, section 'Additional positive results'). In cooperation with the TC project Support to the Identification of Poor (IDPoor) Households (PN 2015.2093.1), SHPP has contributed to the establishment of a national reference system which is now used by both financial cooperation projects in the health sector in order to better identify poor target groups.

Though the allocation efficiency is adversely affected by termination of the CBHI schemes, other criteria are positively assessed: the consideration of scaling-up options (although not equally pronounced in each area) and synergies with other development partners (including coordination with German financial development cooperation). Overall, the allocation efficiency is rated with **25 out of 30 points**.

Criterion	Assessment dimension	Score
Efficiency	The project's use of resources is appropriate with regard to the outputs achieved. [Production efficiency: Resources/services in accordance with BMZ]	*65 out of 70 points*
	The project's use of resources is appropriate with regard to achieving the TC measures' goal (outcome). [Allocation efficiency: Resources/services in accordance with BMZ]	*25 out of 30 points*
Overall rating efficiency		*90 ou tof 100 points*

5.5 Sustainability

Extent to which results are anchored in the partner structures

From a conceptual point of view, the project is consistently focusing on the development of partner capacities at all levels (individual, organisational, networks and policy field) in order **to ensure that intended medium and long-term effects can be achieved by the partners themselves**. All three intervention areas follow multi-level approaches that consistently combine policy advice and process consulting at the system level with organisational development measures for key stakeholders and a wide range of human capacity development interventions. According to the initial CD strategy (see GIZ 2014c), interventions at the different levels are closely related to each other in order to ensure that the partner system (instead of isolated system components only) is strengthened. Occasional deviations from this principle occurred due to changes in the framework conditions and the need to follow the flow of developments in the partner system (e.g. intensified CD measures for the National Social Security Fund not yet oriented by an organisational CD strategy, support to the Quality Assurance Office for the H-EQIP implementation in parallel to the regional quality improvement support of provinces not yet covered by the rollout of H-EQIP assessment tools).

The degree to which **advisory elements, approaches, methods and concepts of the project are already anchored/institutionalised in the partner system** varies among the intervention areas.

- In the intervention area of health system financing, the initial development path of scaling up CBHI schemes, including voluntary health insurance for near poor and the informal sector, was abandoned. The potential for integrating specific elements and/or lessons learnt from these schemes into the operationalisation of the NFPPS is rather limited, notably since the sudden rupture took place without a transition phase that would have allowed the participating NGOs to adjust to the new policy framework and explore possibilities to make use of the acquired institutional and organisational capacities. Now, on the contrary, involved NGOs may even cease to function. Regarding the operationalisation of the NSPPF, on the other hand, it is too early to forecast the integration of project outputs into the partner

structures since the process in still in an early phase and relevant milestones for the system strengthening (e.g. governance structure and institutional set-up of the upcoming system, insurance scheme for the informal sector under the NSPPF, cost monitoring and costing capacities, etc.) are still pending.

- In the intervention area of health service delivery, the national strategy, the QIMP and the H-EQIP provide a positive context both for further development of the intended national accreditation system and the dissemination of quality improvement processes at health facility level. Current system development is consistently based on the existing strategic framework (i.e. project advisory elements have been institutionalised and is followed). Capacity development measures at national level (support to the Quality Assurance Office and the Quality Enhancement Working Group), sub-national administrations (e.g. quality improvement working groups at provincial/district level) and health facilities (e.g. implementation of quality improvement processes) are fully aligned with H-EQIP methodologies and therefore well-anchored in the partner system.
- In the intervention area of health system governance, citizen participation is supported within existing structures and mechanisms (such as Health Center Management Committees, village health support groups, public forums, networks of disabled people organisations) which have absorbed the capacity development support and strengthened participatory mechanisms to a reasonable degree (see also chapter 5.2).

Due to the combined effect of increases in the total national budget (from USD 3,400 million in 2014 to USD 5,000 million in 2017) and slight increase of the percentage of the total budget dedicated to the health sector (from 7.2% in 2014 to 8.4% in 2017), the health budget has grown significantly during the last few years (from USD 243 million in 2014 to USD 423 million in 2017). The Cambodian Government is increasingly taking over financial responsibility for previously donor-financed and donor-driven programmes. For example, more than 70% of the project cost of H-EQIP's of health service delivery component (54 of USD 74 million) and nearly 60% of the operation and expansion of the Health Equity Fund (40 of USD 70 million) is directly financed by the Cambodian Government. Unlike the predecessor project, which was managed by a particular project management unit, H-EQIP is run through the existing organisational structure of the Ministry of Health. Regarding the set-up of the NSPPF, the Cambodian Government is also in the driving seat in relation to the definition of the development path and future financing. All in all, **financial resources are available to a growing extent**. Nevertheless, **bottlenecks do exist regarding personnel and organisational capacities at different levels**. The present overload of the National Social Security Fund as designated single payer under the NSPPF has already been mentioned (see chapter 5.2). The Quality Assurance Office, despite its recent upgrade, is reported to face limited staff capacities and limited staff availability for the management of the current quality enhancement processes under H-EQIP; the ubiquitous shortage of adequately qualified health professionals still poses a challenge to the sustainability of CD measures at all administrative levels (including provincial health departments and operational districts) and the level of health facilities. In the intervention area of health system governance, the Health Center Management Committees face challenges regarding the fluctuation of political leaders (commune chiefs as chairs of the Committees) since the system capacities for introducing new commune chiefs to their health-related functions (e.g. coaching provided by the commune associations) are fairly limited. NGOs involved in awareness raising campaigns fully depend on external funding. Disabled people organisations supported in the intervention area for vulnerable groups are based on participation and self-help mechanisms, but also depend on external resources for any significant project activity. The national umbrella organisation CDPO, too, relies on mostly project-based and therefore unstable external funding.

Summarizing the strong conceptual orientation towards sustainable capacity development, the high degree of absorption of project outputs and advisory elements in the partner structures and the mixed picture regarding the availability of financial, organisational and personnel capacities in the partner system, the evaluation dimension is **rated with 33 out of 40 points.**

Forecast of durability of project results

The forecast of durability of project results is closely related to the analyses in the previous section. General factors that increase the probability of sustainable systems strengthening are the increasing readiness of the Cambodian Government to invest in the health sector, the active leadership of the government in designing and operationalizing the ongoing health system reforms and an adequate understanding of the potential and limitations of technical assistance that has improved over time.

Regarding the sustainability of specific outputs and outcomes, the evaluation judgement is based on the current assumptions of stakeholders rather than on empirical evidence since essential system components are still to be developed under the ongoing reforms. This is also the case for health system financing (i.e. the operationalisation of the NSPPF) and for health service delivery (i.e. the establishment of accreditation and licensing mechanisms that are not yet in place).

Certainly, the abolition of the CBHI lowers the sustainability rating due to the significant effort invested in an insurance model which finally did not coincide with the development path chosen by the partners. On the other hand, investing in the implementation of an overarching strategic framework instead of a target group-specific, not yet strategically integrated model offers a far better chance to achieve sustainable results on the longer run. From the evaluators' point of view, SHPP is adequately focusing key capacities in the partner system which are prerequisites for the successful implementation and sustainable functioning of the upcoming single payer system (e.g. costing capacities, organisational development of the National Social Security Fund). Nevertheless, other critical sustainability factors are beyond the scope of SHPP. For example, the intended integration of the Payment Certification Agency under the umbrella of the Ministry of Health would not offer the same degree of accountability within the system as the creation of an independent body. Although SHPP is trying to raise awareness of the need of an independent certification function, the relevant political and technical decisions are taken outside the scope of the project (INT-P).

In the intervention area of health service delivery, the evaluation judgement in this section focuses on the forecast of durability of the already achieved results regarding the implementation of quality improvement processes at health facility level. On the one hand, all health facility representatives and several other stakeholders emphasise infrastructural limitations and the shortage of qualified health professionals as binding constraints that impede the achievement of high quality scores. On the other hand, quality assessments and incentive payments under H-EQIP have a proven effect on service quality (see chapter 5.2) and there is no reason to suspect that health facilities would not be able to maintain improvements implemented on their own account. It is unclear, however, if the same facilities will keep improving in future assessment rounds of H-EQIP or if improvements will be constrained to early quick wins (INT-P, INT-S). Sub-national administrations and health facilities in the project provinces should have a comparative advantage since they have received additional coaching during operational planning and quality improvement processes. But again, there is no evidence to sustain or reject the assumption that the combination of H-EQIP incentives and previous project support will add up to more sustainable quality improvements than in other provinces where H-EQIP was implemented without prior technical assistance.

In the intervention area of health system governance, enhanced citizen participation in health-related planning processes could be maintained if there is (1) a continued presence of leadership for the dialogue spaces (i.e. Health Center Management Committees and public forums) and (2) a sufficient quality of vertical communication and support from provincial health departments and operational districts down to the communal level. Since both factors strongly depend on attitudes of involved stakeholders, project results would most probably persist in some communes and regress in others. The sustainability of the results of public awareness raising campaigns would require ex-post KAP studies and cannot be assessed during an intermediate evaluation. Cer-

tainly, sustainability would be limited to the durability of campaign results, since the responsible NGOs exclusively rely on external funding and will not continue campaigning beyond the end of their respective financing contracts.

The situation is similar for the intervention area vulnerable groups. Disabled people organisations will probably benefit from their enhanced visibility, high commitment of their leaders and low staff fluctuation (i.e. longer-lasting effects of HCD measures), but do not have resources for the perpetuation of project activities such as the organisations of training and other public events. The project has supported disabled people organisations in developing proposal writing capacity and facilitated the formulation of specific project proposals. At the time evaluation, it is not yet possible to assess the outcome of this support though there is one example of a disabled people organisation that has successfully applied for funding (FG-D).

Taking into account the abolition of the CBHI schemes and related capacities, the well-focused interventions but still uncertain outlook regarding the sustainability of the upcoming single payer system, the relatively positive outlook regarding the durability of health service quality improvements and the mixed picture of sustainability potential and challenges in the intervention area of health system governance, the forecasted durability of project results is **rated with 24 out of 40 points**.

Balance of the social, economic and environmental dimension of sustainability

Depending on the specific health topic, there are many interdepencies between health and environmental issues (e.g. health impacts of environmental factors, environmental impacts of health facilities), but the intervention areas of SHPP are not related to environmental issues, neither with regard to the intended changes nor with regard to potential environmental side-effects. Consequently the project offer has no markers for environmental and resource protection, climate mitigation or adaptation to climate change.

The project outcome as formulated by the module objective belongs to the social dimension of sustainabilty and contributes to fundamental social rights (human right to health). The social and economic dimensions of sustainability are closely intertwined, both at the target group level (i.e. economical determinants for access to health services, economic impact of health expenditures or inability to work) and at the level of health system development (e.g. implications of financing mechanisms for all other health system building blocks).

In social health protection, social and economic sustainability are two sides of the same coin, since access to health services – as a fundamental social right – is assured through the removal of economic barriers to health service access and coverage of the risk of catastrophic health expenditure. The project focuses on the health financing issues and conditions for economic sustainability (e.g. costing capacities, payer provider split), and the orientation towards the inclusion of vulnerable populations is well-balanced and constitutive for the project design.

The economic dimension is also relevant at the interface between health financing mechanisms and health service delivery. Health facilities react to economic stimuli, so all SHPP interventions are based on the awareness of the incentives created by health financing mechanisms. In the context of H-EQIP, for example, fixed grants to health facilitites are complemented by performance-related payments bound to the scores achieved in quality assessments. Thus, economic mechanisms are used in order to engage health professionals in quality improvement process.

The adequate balance of the social and the economic dimension of sustainability is **rated with 30 out of 30 points**.

Criterion	Assessment dimension	Score
Sustainability	Prerequisites for ensuring the long-term success of the project: Results are anchored in (partner) structures.	*33 out of 40 points*
	Forecast of durability: Results of the project are permanent, stable and have long-term resilience.	*24 out of 30 points*
	Are the results of the project environmentally, socially and economically balanced?	*30 out of 30 points*
Overall rating sustainability		*87 out of 100 points*

5.6 Long-term results of predecessor

The original design of SHPP III was very closely based on the conceptual approach of the predecessor TC measure Social Health Protection Project II (PN 2009.2171.8) which covered the same intervention areas that are now continued in SHPP III. In health financing, the predecessor strategy focused on reducing the financial barriers by supporting the community-based health insurance schemes in Kampot and Kampont Thom. In health service delivery, it emphasised improving clinical practices, professional development and a supportive environment for quality improvement processes. In health system governance, it focused on enhancing local governance and community monitoring of health services. The inclusion of vulnerable groups was already a mainstreaming task, but is not yet addressed as an output on its own (see GIZ-SHPP 2014a: 8ff).

With regard to the intervention area of health system financing, it has been outlined throughout this report that the social health protection schemes supported by SHPP in the project provinces have not been continued; the reasons that contributed to their termination have been explained. Consequently, the support to the Social Health Protection Agency, initiated during the predecessor project, is also ending. Thus, the project output – which was still crucial for the design of SHPP III – has not been sustainable. At first sight, the overall sustainablity of the predecessor also seems to be compromised since three of five indicators for the module objective depended entirely or partly on the existence of the supported schemes in Kampong Thom and Kampot (out-patient service utilisation rates of beneficiaries, proportion of skilled birth attendance covered by social health protection, proportion of women and men covered by social health protection). Long-term results are mostly limited to the learning experiences that informed the policy advice at national level (e.g. with regard to the applied provider payment mechanisms) and do not include a transfer of the technical capacities acquired by the NGOs due to the abrupt termination of their role as health equity fund operators. To put this critical assessment into perspective, it must be considered that the predecessor programme experimented with social protection schemes long before a national policy was under way. While maintaining that the integrated social health protection scheme promoted by the project ‘could easily be upscaled’ and used as a model for the development of the policy framework (GIZ-SHPP 2014a: 30), the final evaluation of SHPP also stated the risk that ‘some achievements may not be durable (but) they are adequate transitory solutions (…) towards the establishment of sustainable systems’ (see GIZ-SHPP 2014a: 16).

In the other intervention areas, however, relevant contributions to health system strengthening persist and are brought to the next level by SHPP III. With regard to health service delivery, the predecessor had reached its objective of increasing the percentage of public hospitals and hospitals recognised by the Ministry of Health as institutions implementing national quality standards (reaching 86% at the end of the project term) by supporting the rollout of Level 1 assessments. Despite the indicator achievement, there was broad consensus that service delivery is still sub-standard. Therefore, SHPP III built on SHPP II experience and developed it further. The focus shifted to the Level 2 assessments and subsequently to supporting the quality enhancement monitoring through H-EQIP, both with more sophisticated sets of standards. Alhough at the time of the evaluation, there are no means to assess the impact and sustainability of results achieved by SHPP II at health facility level, it is very plausible that the project has contributed to shaping the ongoing reform process. External quality assessment of health facilities – still incipient at the beginning of the predecessor project – are now established principles and pave the way towards the future development of an accreditation system. The previous version of the Quality Improvement Master Plan that outlines the roadmap towards a comprehensive system was formulated under SHPP II and served as a reference for the updated, now authoritative version of the QIMP.

In the intervention area of health system governance, SHPP had already initiated the work on sensitizing stakeholders at all level for the benefits of citizen participation in health planning processes, the strengthening of the Health Center Management Committees and village health support groups and their role in feedback mechanisms and the promotion of client rights. It was an achievement of SHPP II that the principle of considering patients' views and rights for quality improvement was already well-accepted (although not yet effectively implemented) at the end of the project term, i.e. at the beginning of SHPP III (see GIZ-SHPP 2014a: 31). Though formulated at the beginning of SHPP III, it was also a merit of SHPP II that a strategic objective in this regard was integrated in the Health Strategic Plan 2016-2020 (Encourage active participation of communities and sub-national level administration to strengthen local accountabilitiy in health", see MoH 2016a: 105). At present, SHPP III is building upon and further enhancing the same strategic approach already valid under SHPP II, which means that long-term results at target group level coincide with the current results of SHPP III (see chapter 5.2 and 5.3).

In conclusion, the overall assessment of the mid- and long-term results of the predecessor is still positive. Despite the unsustainability of the supported social protection scheme, results achieved in the intervention areas of health service delivery and health system governance persist, have been a solid basis for the design of SHPP III and have helped to motivate and to inform the current reform processes.

6 Overall rating

Relevance: All dimensions of SHPP contribute to the implementation of national policies and strategies. The concept is also in line with international standards, particularly regarding its orientation towards universal health coverage. The objectives are consistently relevant to the health-related SDG, particularly SDG 3.8 regarding universal health coverage. The project corresponds with the relevant concepts and strategies of German development cooperation (i.e. of BMZ) from both a sector and a regional/country perspective. The strategy is mostly suitable to match the core problems/needs of the target groups, although the support to the upscaling of CBHI schemes had to be abandoned. The related direct benefits for the target groups will therefore not be achieved during the current project term. The leave no one behind principle is inherent in the concept of universal health coverage. Despite the strategic shift in health financing, the project design fully responds to the module objective which is also due to the positively assessed adaptability of the project to changes in the framework conditions. Altogether, relevance is rated with 91 out of 100 points (Level 2 – successful).

Effectiveness: Goal attainment at the time of the evaluation is medium. One original indicator (regarding the extension of social protection in the project provinces) has not been achieved and has become obsolete. One indicator has already been achieved (formulation of a national strategy on quality improvement), two indicators are mostly achievable (regarding the improvement of client satisfaction levels at health facilities) or partially achievable (regarding the increase of out-patient utilisation rates) during the project. The project pursues a complex strategic approach (multi-level, cooperation with many stakeholders, broad range of complementary activities) and has therefore achieved a broad range of outcomes related to the national reform processes in the field of social health protection and accreditation which exceed the scope of the formally agreed goal attainment indicators. The sudden rupture of the CBHI schemes in the intervention area of health system financing bears a certain risk of compromising the target group's attitudes towards (voluntary) health insurance. Altogether, effectiveness is rated with 85 out of 100 points (Level 2 – successful).

Impact: Evidence for intended changes at impact level (indicators for the programme goal) is relatively weak. For two indicators (incidence of catastrophic health expenditure and the number of health facilities offering services according to national standards), future results in line with the intended changes are plausibly assumed. For three indicators, positive but slower than expected trends are assumed based on available data (quality of NCD screening) or stakeholder estimations (care-seeking behaviour of beneficiaries of social health protection, maternal and neonatal mortality rates). Relevant contributions of SHPP can be plausibly assumed (although not measured) to a varying extent for most indicators. Altogether, impact is rated with 82 out of 100 points (Level 2 – successful).

Efficiency: The stakeholder landscapes are very diverse and resource allocation is widespread among many partners in order to address interrelated stakeholders at all system levels. So far, the project management has been up to the challenges of avoiding a dilution of efforts and fostering and resource allocations (present and planned) are well-distributed. No suggestions have been identified how another resource allocation could have maximised outputs (production efficiency). The linkages between the different outputs are convincing (e.g. establishing the link between social health protection, performance-based payment and assurance of service quality, feedback of the client's perspective into quality improvement processes, mainstreaming of vulnerable groups' issues into the other outputs). Resources are adequately distributed among the intervention areas and reflect the relative weight of their contribution to the attainment of the module objective. Effort and resources invested in the upscaling of a social health protection approach that become unsustainable lowers the score for the allocation efficiency. Cooperation with other international development partners as well as with other German development measures is intense and synergies are exploited to a satisfactory extent. Altogether, efficiency is rated with 90 out of 100 points (Level 2 – successful).

Sustainability: The degree to which advisory elements of the project are already anchored in the partner system varies among the intervention areas. In health financing, the CBHI schemes have not been sustainable; regarding the operationalisation of the NSPPF, on the other hand, it is too early to forecast the integration of project outputs into the partner structures since the process in still in an early phase. In the intervention area of health service delivery, the national strategy, the QIMP and the H-EQIP provide a positive context for further development of the intended national accreditation system. In the intervention area of health system governance, citizen participation is supported within existing structures and mechanisms which have absorbed the CD support and strengthened participatory mechanisms to a reasonable degree. Due to a mixed outlook regarding the forecast of durability of project outcomes, sustainability is rated with 84 out of 100 points.

Criterion	Score	Rating
Relevance	*91 points*	*Level 2 – successful*
Effectiveness	*85 points*	*Level 2 – successful*
Impact	*82 points*	*Level 2 – successful*
Efficiency	*90 points*	*Level 2 – successful*
Sustainability	*87 points*	*Level 2 – successful*
Overall score and rating for all criteria	*87 points*	*Level 2 – successful*

100-point scale (score)	6-level scale (rating)
92-100	Level 1 = very successful
81-91	Level 2 = successful
67-80	Level 3 = rather successful
50-66	Level 4 = rather unsatisfactory
30-49	Level 5 = unsatisfactory
0-29	Level 6 = very unsatisfactory

7 Conclusions

Analysis of selected hypotheses

The results model (see figure 1 in chapter 3.2) converges in the following key hypotheses:

(1) A broad range of capacity development measures of SHPP enable partner organisations (MoH, MEF, NSSF / output level) to operationalise and gradually implement the National Social Protection Policy Framework (outcome level)

(2) Support to strategy formulation at national level and local support to the health administrations and health facilities regarding the implementation of continuous quality improvement processes (output level) leads to better service quality at health facilities (outcome level).

(3) Increased citizen participation and a more effective representation of vulnerable groups in joint and planning processes linked to health facilities and the institutionalisation of patient feedback mechanisms (output level) lead to a higher patient satisfaction (outcome level). Patient feedback also informs

the quality improvement processes and thus contributes to better service quality (see above, outcome level)

(4) The lower financial barrier for the use of health services, better service quality and higher patient satisfaction (outcome level) lead to an increased utilisation of public health services (aggregated outcome / impact level, depending on the scope).

(5) Higher utilisation rates of health services of improved quality (aggregated outcome) improve the health situation of the target groups (impact level).

As explained in chapter 5.3 ‘Impact’, changes in the health situation of the target groups are currently not measurable for the target groups, so the various hypotheses (5) can neither be confirmed nor refuted. Contributions of the project to the intended changes at the outcome level are summarised in the following table (for further detail, see chapters 5.2 and 5.3):

No.	Intended outcomes and evidences for contributions	Sources	Strengths of contribution	Correspondence with ToC
(1) ***A-4***	**Operationalisation and implementation of the National Social Protection Policy Framework**	Monthly RBM reporting		gradually attainable
M-1, A-3	CBHI schemes have become obsolete and are no longer considered under the NSPFF	Monitoring reports	(obsolete)	refuted
A-2	Costing studies piloted in project provinces and further extension initiated (intended system capacity: capacity to calculate appropriate payment rates)	Monthly RBM reporting, interviews	high	plausible
A-2	Specific contributions to operationalisation of the framework, e.g. advice for the sub-decree for the formation of the NSPC and formulation of the social protection law.	Monthly RBM reporting, interviews	High	confirmed
(2) ***B-3, B-4***	**Improved quality of health services**			partially attained
B-2	Quality Improvement Working Groups active at the level of sub-national health administrations; interviewees confirm increased readiness for the upcoming quality assessments under H-EQIP (e.g. assessment capacity)	Monitoring reports, interviews	moderate	plausible
B-2	Quality improvement processes (e.g. plan-do-check-act cycles) being established, although not yet fully institutionalised at health facility level	Monitoring reports, interviews	moderate	plausible
External	Adverse incentives (e.g. conflicts of interests of doctors serving as public and private providers at the same time) and infrastructural constraints	Literature, interviews	High (negative)	refuted
(3) ***C-4, M-4***	**Increased patient satisfaction**			partially attained
C-1	Positive statements of hospital staff, HCMC members and health managers (sub-national administrations) regarding more active patient feedback in public forums and HCMC sessions	Interviews	high	plausible
C-1	Improved planning capacities of HCMCs	Interviews	moderate	plausible
D-2	Ability of disabled people and elder people to express themselves in public forums through self-representative organisations has increased	Interviews	moderate	confirmed
(4) ***M-2, I-3***	**Increased utilisation rates of health services**			not yet attained
M-1	Intended contribution of the CBHI did not take place due to the shrinkage of these schemes and the strategic shift towards capacity development at national level	Monitoring reports; interviews	(obsolete)	refuted
External	Temporary disruption of the Health Equity Fund services during the initial phase of H-EQIP	HMIS; project reporting	high (negative)	refuted
B3/4, M-4	Aggregated results regarding changes in health service quality and patient satisfaction (see above)	see above (2) and (3)	low	supporting and refuting evidence

Factors of success or failure

Factors of success or failure include different aspects that range from external factors beyond the project's immediate range of responsibility (e.g. changes in the political and institutional environment) and aspects related to the quality of implementation and to management aspects such as the overall management set-up and the quality of cooperation management.

The most important external factors that have influenced the project success are:

- **Positive:** Constant economic growth has led to a significant increase of health spending by the Royal Government of Cambodia. The positive economic and budgetary situation has been an important catalyst for the country's path towards improving health service quality and introducing mechanisms for financial risk protection.
- **Positive:** The approval of the National Social Protection Policy Framework is an important milestone towards the implementation of a comprehensive system of complementary social assistance and insurance elements. Since the formulation of the framework, it has become easier to ensure that technical support for institutional/organisational capacity development and design of protection schemes can be targeted in line with the partner's (stated) objectives.
- **Both positive and negative:** The Health Equity and Quality Improvement Project – which replaced the previous Health Sector Programme at the beginning of the project term – is very much compatible with the goal system of SHPP. Through the alignment with and integration into H-EQIP processes, the scope of project results in the field of health service quality is enhanced. At the same time, however, the new organisational set-up of the Health Equity Fund rendered the CBHI schemes and their respective project results in the field of health financing obsolete.
- **Negative:** In the field of health service delivery in particular, the project still faces external binding constraints that affect the effectiveness and sustainability of quality improvement processes at health facility level and are not (significantly) targeted by current project interventions. They include the availability of qualified health professionals, infrastructural limitations and adverse interests of health professionals serving in public facilities and as private providers at the same time.

Whereas the above-mentioned factors are mostly beyond the scope of the project, the following factors are related to the quality of implementation and/or management aspects:

- **Positive:** Despite the major policy defined by the approval of the NSPPF and the transition to the H-EQIP, SHPP has managed to conceptually align with the strategic orientation of the partner. Possibly, an earlier adaptation of the formal results framework to the new framework conditions could have facilitated the process of responding to urgent partner needs, on the one hand, and maintaining a clear strategic focus, on the other hand.
- **Both positive and negative:** To some degree, the elimination of the CBHI schemes compromised the goal attainment at target group level since project efforts were redirected from local target group interventions to national reform processes with possibly more substantial, but also rather long-term results. However, the shift was appropriate under the given framework conditions and ensures the project's integration into key national reform processes.
- **Positive:** The resource allocation among the different outputs has been very much in line with their relative importance for the attainment of the module objective. Several clear linkages between the different outputs (e.g. support to financing schemes related to quality improvement processes, integration of patient feedback into quality improvement processes) enhance the overall effectiveness and efficiency of the project.
- **Mostly positive:** The project applies a multi-level approach that links policy support and institutional capacity development at national level with local support to quality improvement and governance pro-

cesses. Though conceptually consistent, operational alignment has not been fully achieved, e.g. regarding the late rollout of H-EQIP quality monitoring in the project provinces. On the other hand, the team-set up combined a thematic structure (financing, service delivery and governance) and the intervention levels (national level, local level) in a pertinent manner.

- **Both positive and negative:** Overall, the alignment of the project's goal system with the strategic orientation of the partners has been convincing despite challenging changes to the framework conditions. However, the cooperation management (CW factors: strategy and steering) has been somewhat fragmented, relying on a bilateral strategy and steering process with stakeholders of each intervention area instead of more integrated steering processes of the overall project. Despite the above-mentioned linkages, the integration and interrelation of the wide range of interventions in the different areas could have been strengthened through more integrated planning processes.

8 Key recommendations

The current SHPP III has been shaped by long-awaited sector reform processes that have been initiated fairly recently: the third Health Sector Strategic Plan (2016-2020), finally published in July 2017, the National Social Protection Policy Framework, approved in March 2017, and a reform process regarding health service delivery based on the National Strategy on Quality and Safety in Health, the Quality Improvement Master Plan (both adopted in August 2017) and the sector programme H-EQIP (regarding the alignment with sector policies and strategies, see chapter 5.1).

Building on the experiences and results of a predecessor project (see chapter 5.6) which also informed the design of the above-mentioned policies and strategies, SHPP has provided significant technical assistance to the operationalisation and implementation of the ongoing sector reforms (see chapter 5.2 and 5.3 for the achieved results), but many of the achieved results are milestones for complex health system development processes which -n the longer run will culminate in the establishment of an integrated single-payer social health protection system with differentiated but harmonised mechanism for different target groups and a system for the regulation and accreditation of health service providers (see p. 29f). Both reform processes will require further technical assistance from international development partners and SHPP should maintain its presence in their respective intervention areas. The same applies to the intervention area of health system governance where the project has supported the readiness for the upcoming functional changes under the decentralisation and deconcentration process (see p. 34), but once the transfer of powers becomes effective, further technical assistance should be available to accompany the counterparts in addressing eventual capacity gaps. Furthermore, health governance issues are strongly intertwined with quality improvement in health service delivery (see p. 42). In conclusion, based on the findings of the evaluation, the overall structure of SHPP could be maintained in a follow-on project in order to provide continued advice in the above-mentioned three key sector reforms.

Within the different intervention areas, the following specific recommendations can be drawn from the evaluation findings:

Findings: In the intervention area of health system financing, the institutional set-up of the future single payer system and the payer-provider split are not yet fully established and must therefore be developed over the coming years. Stakeholder interests are not always congruent in regard to pending decisions, for example regarding the set-up of the upcoming Payment Certification Agency (p. 30 and p. 39).

- *Recommendation:* Building on international experience, SHPP can play an important role in identifying and promoting suitable options for the institutional set-up of the social protection system and the right equilibrium between different financing mechanisms. The project is well-positioned to continue facilitating stakeholder discussions and providing technical advice to the Ministry of Economy and Finance, the Ministry of Health, the National Social Security Fund and the National Social Protection Council. In particular, SHPP should continue advocating for adequate accountability functions within the system (i.e. for the independence of the upcoming Payment Certification Agency). The recommendation applies both to the remaining time of the current project term and to a possible follow-on project.

Findings: In the original design of the current project, the CBHI schemes were the chosen model to include vulnerable target groups not yet covered by the Health Equity Fund. Since the CBHI will not become part of the future system, relevant project target groups (near poor and informal sector) are currently not covered by a specific social protection scheme (see p. 26).

- *Recommendation:* SHPP has to advocate for a suitable social health protection mechanism under the National Social Protection Policy Framework which addresses informal sector and near poor target groups. At the time of the evaluation, such a model is being developed in cooperation with the Japanese International Cooperation Agency (see p. 30). The project should (a) assist the Ministry of Health to assure, that the specific target groups of SHPP (i.e. near poor, informal sector and other vulnerable groups) receive coverage under the new social health protection framework as soon as possible. Until the end of the current project term, a suitable model should be ready for implementation. During a follow-on-project, SHPP should support the implementation process throughout of a respective insurance scheme.

Findings: Key stakeholders of the up-coming social health protection system, particularly the Ministry of Economy and Finance, have shown a considerable learning curve (see p. 30), but they still face significant capacity gaps. The National Social Security Fund as designated single payer entity may be overburdened by its hugely extended mandate (see p. 30).

- *Recommendation:* During the remaining time of the current project term, the National Social Security Fund should be assisted in further structuring its capacity needs for the management of its rapidly growing portfolio and in developing a mid- to long-term strategy for the enhancement of its organisational and human capacities. The follow-on project should then assist the implementation of CD measures in order to assure that the designated single payer entity develops the required capacity for further conceptualizing, implementing and managing its growing portfolio of social health protection schemes and appropriately addressing the needs of differentiated target groups

Findings: A reliable costing of health service and the calculation of adequate provider payment rates is a precondition for the shift from present supply-side funding of public providers to a demand-side funding with accredited public and private providers. So far, no routine system is in place and project progress is limited to the validation of a costing methodology and carrying out pilot costing studies (p. 27).

- The results of the pilot costing study should be analysed together with the Ministry of Health and the National Social Security Fund. They should be complemented with capacity development measures and coaching for the calculation of adequate payment rates until the end of the current project term. The institutionalisation of costing capacities, however, is a far more comprehensive task (see p. 27), which should therefore be a focus of the follow-on project of SHPP.

Findings: The shortage of adequately qualified health professionals is ubiquitous in Cambodia and particularly pronounced in regard to health financing and social health protection (see p. 45).

- The methodological approach of a follow-on project: SHPP should therefore consider facilitating the facilitation of human capacity development in the institutional landscape of the health sector (e.g. integrating health economics in the Master's in Public Health at the NIPH).

Findings: In the intervention area of health service delivery, future technical assistance will take place under the umbrella of the QIMP and the H-EQIP. In the current project term, the quality assessments mechanism of H-EQIP was not yet rolled out to project provinces so that synergies between national level support to the Quality Assurance Office of the Ministry of Health and support to quality improvement processes at sub-national level were not yet exploited (see p. 33).

- During the remaining time of the current project term, SHPP should systematise its experiences with support to quality improvement processes at sub-national and health facility level (process documentation, showcases, success factors, obstacles, lessons learnt etc.) to develop a strategy for capitalizing on the results and experiences in the project provinces and supporting the dissemination of Continuous Quality Improvement mechanisms nation-wide under H-EQIP.

Findings: External quality assessment of health facilities – still incipient at the beginning of the predecessor project – are now established principles and pave the way towards the future development of an accreditation system. The implementation, however, is still incipient (see p. 33)

- Regarding the roadmap towards the implementation of a comprehensive system for regulation and accreditation, SHPP should emphasise policy advice on still missing system components (see p. 29) and, during the remaining time of the current project term, preselect potential priority areas for the technical support beyond 2018, e.g. regarding (a) contributions to the intended set-up of an accreditation body and accreditation standards/procedures and (b) potential solutions for the continuous professional education for the licensing of health professionals. Support to their respective implementation processes should be considered for the follow-on project.

Findings: Although present in the methodological approach of SHPP, thematic areas, in the opinion of several interviewees, have not yet taken off sufficiently and should be given greater emphasis by SHPP in the future. In particular, this is the case for the support of the NCD response and the dissemination of special health services that meet the needs of particular vulnerable groups such as older and disabled people (see p. 37).

- During the appraisal mission for the follow-on measure, it is important to emphasise the importance of the NCD response and the dissemination of special health services for particular vulnerable groups. If a consensus on pertinent measures can be achieved, an NCD-related output and module objective indicator should be considered in order to assure that the topic is prioritised appropriately.

Findings: Citizen participation in health system governance has been strengthened since the beginning of SHPP and existing mechanisms, such as the Health Center Management Committees, are operating more effectively. However, sustainability of the developed capacities is not yet assured. Despite a higher degree of citizen participation, the quality of participation remains limited (see p. 32).

- To ensure the sustainability of citizen participation and the upscaling of project experiences in the D&D process, awareness raising measure are still required beyond the current term, i.e. as part of a follow-on project. A follow-on project should also develop a stronger focus on health literacy and address sustainability issues (e.g. the coaching capacities of the commune associations).

Findings: Also in the area of citizen participation, the self-representation of vulnerable groups has been significantly enhanced by SHPP III, but the capacity of the disabled people organisations to continue advocacy, awareness raising and training activities on their own account is still limited (see p. 34).

- Therefore, SHPP should further support the consolidation of self-representative organisations beyond the end of the current project term. Regardless of the sustainability risks, SHPP should further capitalise on the disabled people organisations' demonstrated capacity to turn minor financial subsidies into a significant outreach. Further support to the organisational development of the disabled people organisations could also address the strengthening of their networking at provincial level (as there is no link between the national Cambodian Disabled People Organization and local organisations).

Annex

Annex 1: Evaluation matrix

Evaluation dimension	***Analysis questions***	***Evaluation indicators***	***Project documents***	***Literature and external documents***	***Secondary data***	***Primary data***	***Results***
The project fits into the relevant strategic reference frameworks.	• Which framework conditions or guidelines exist for the project? • To what extent does the project contribute to the implementation of the underlying strategies (if available, especially the strategies of the partner countries)? • To what extent does the TC measure fit into the programme and the BMZ country strategy (if adequate)? • How was the country's implementation and accountability for Agenda 2030 set up and what support needs were defined? • Sectors etc. Is there a prioritisation of the objectives of Agenda 2030 within a country context? To which SDGs does the project contribute? To what extent is the contribution of the intervention to the national/global SDGs reflected in the theory of change? • Cross-sectoral change strategies, etc. Where has work been carried out on a supra-sectoral basis and where have such approaches been used to reinforce results/avoid negative results? • To what extent are the interactions (synergies/trade-offs) of the intervention with other sectors reflected in conception and theory of change – also regarding the sustainability dimensions (environmental, economic and social)?	*(1) The methodological approach is consistent with the strategic orientation of GDC:* *- Health Sector Strategy* *- Strategy Paper Health for Cambodia* *- Regional Strategy for Asia* *(2) The methodological approach is consistent with international standards and agreements* *- Agenda 2030 principles* *- SDGs* *- UHC* *(3) The programme interventions and objectives are related to policy/strategy frameworks of the Cambodian partner* *- HSSP and H-EQIP* *- National Social Protection Policy Framework* *(4) National Policy for Quality and Safety in Health* *- Health Care Policy for Older People* *- Community Participation Policy*	*Angebot an das BMZ (2015)* *Gemeinsamer Programmvorschlag zum EZ-Programm Soziale Absicherung im Krankheitsfall (2015)* *Grant Agreement between BMZ and USAID for support to SHPP (2016)*	*Health Sector Strategic Plan 2008-2015* *Health Strategic Plan 2016-2020* *National Social Protection Policy Framework 2016-2025* *National Policy for Quality and Safety in Health* *Master Plan for Quality Improvement in Health 2015-2020* *Master Plan for Quality Improvement in Health 2017-2022* *Health Equity Fund, Operational Manual* *Community Participation Policy for Health* *National Strategic Plan for the Prevention and Control of NCDs* *National Disability Strategy* *National Health Care Policy and Strategy for Older People* *BMZ-Sektorkonzept Gesundheit in der deutschen Entwicklungspolitik (2009)* *Die neue Asienpolitik des BMZ (2015)* *BMZ-Strategie: Ge-*	'---	*INT-P* *INT-D* *INT-DP* *INT-G*	HSP committed to UHC (quote o.5). Specific to SHPP: *- IA 1 → SO2* *- IA 2 → SO1* *- IA 3 → SO7* *- IA 4 → General Working Principle* *Close alignment with H-EQIP → directly supporting QEMT, all IA aligned with some specific H-EQIP component* *SHPP contributed to NSPPF → all current effort directed towards NSPPF operationalisation (auch = Fokus USAID KoFi)* *Original design not under NSPPF and not relevant anymore* *SHPP supported NSGSH and QIMP; both aligned with H-EQIP and orienting further SHPP interventions* *SHPP in HSG component working towards several strategies (for DP, OP, NCD); also anchored in QIMP* *Orientation towards UHC as promoted by WHO and SDG 3.8* *Indirect relation with other health-related SDG (3.1, 3.2, 3.4), both in general and with the Cambodian SDG (not yet formalised, but health-related SDGs identical with HSD).* *Contribution to the human right to health according to BMZ 2009, in particular through the VG component* *Alignment to Sector Strategy (e.g. ML approach, solidarity-based HF,*

				sundheit und Menschenrechte (2009) *Chapeau Papier zur gemeinsamen europäischen Strategie 2014-2018 zur EZ mit Kambodscha* *GDC Strategy Paper for the Priority Area Health 2014-2018*			*HSD CD)* *Mandated by Asia Strategy: Health as dimension of living conditions in cities.* *Well-designed contribution to GDC programme and GDC health sector strategy for Cambodia*
Suitability of the strategy? the conception? to match core problems/needs of the target groups	• To what extent was the concept designed to reach particularly disadvantaged groups (LNOB principle)? Which prerequisites were addressed for the concept and used as a basis? • How are the different perspectives, needs and concerns of women and men represented in the change process and how are the objectives represented (Safeguard & Gender)? • To what extent is the chosen TC measures' goal geared to the core problems/needs of the target group?	*(1) The core problem addressed by SHPP is directly derivable from current sector analyses:* *- Cambodian Demographic Health Survey 2014* *- Socio-Economic Survey 2014* *- Health System Review 2015* *(2) 'Near poor', elderly persons and disabled persons are directly targeted by specific interventions* *(3) Gender-specific needs are considered in (a) supported social protection schemes and (b) health care quality standards.*	*Angebot an das BMZ (2015)* *Gemeinsamer Programmvorschlag zum EZ-Programm Soziale Absicherung im Krankheitsfall (2015)*	*ADB 2014* *Annear 2014 and Annear et al 2015* *Chhun et al. 2015* *GIZ 2014b* *Health Sector Strategic Plan 2008-2015* *NIS 2015, NIS et al. 2015* *Rifkin & Kangare 2002*	'---	*INT-P* *INT-D* *INT-DP* *INT-G*	*Core problem and assumed clearly evidence-based.* *OOP = 67% of THE (MoH 2016a: 141). OOP 5 times above average for PDA, 3 to 5 times above average for OP, 16 times above average for people with NCD.* *5% of HH/year facing CHE (OOP > 40% HH capacity-to-pay, see MoH 2016a 53).* *Low levels of service quality at all system levels.* *SHPP offering feasible interventions for all above-mentioned dimensions, oriented towards (a) eliminating the financial barrier to basic health services (b) interventions addressing QI processes at facility level (c) improving client-providerrelationship (d) local public participation (e) strengthening self-representation of PDA* *Abolition of iHSP / CBHI → no direct target group benefit during current phase.* *But: long-term goal and target-group focus unchanged* *LNOB: prominent in methodological approach; VG component and focus on near poor* *LNOB implicit in UHC → Mainstreaming of LNOB in other intervention areas.* *Gender mainstreaming addressed, but not as prominent: (a) CBHI pilots with interventions to assure equal access, (b) gender balance in events and training sessions of HSG component,*

							equal representation in HCMC and others.
The design of the project is adequately adapted to the chosen goal.	• Results logic as a basis for monitoring and evaluability (theory of change) ○ Are the hypotheses plausible? ○ Are the risks presented plausibly? • Is the strategic reference framework well anchored in the concept? • To what extent does the strategic orientation of the project address changes in its framework conditions. • How is/was the complexity of the framework conditions and guidelines handled? How is/was any possible overloading dealt with and strategically focused?	*(1) The results logic obeys current quality criteria of GIZ* *(2) The potential effectiveness of key interventions is based on previous evidence and/or validated through monitoring or operational research during implementation* *(3) Key stakeholders of each intervention area confirm that interventions were strategically focused*	*Angebot an das BMZ (2015)* *Gemeinsamer Programmvorschlag zum EZ-Programm Soziale Absicherung im Krankheitsfall (2015)* *Grant Agreement between BMZ and USAID for support to SHPP (2016)*	*'---*	*'---*	*INT-P* *INT-D*	*Core problem, causes and negative impacts well analysed and supported by evidence* *Consistent logic/hypotheses activities → outputs → outcome* *Intervention areas closely linked to each other* *Contributions to overarching strategies are methodologically sound* *Consistent multi-level approach, linking national government and SNA as well as SNA and health facilities.*
The conceptual design of the project was adapted to changes in line with requirements and re-adapted where applicable.	• What changes have occurred? • How were the changes dealt with?	*(1) Project interventions have been adapted to the strategic orientation of H-EQIP and NHPPF*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall*	*'---*	*'---*	*INT-P* *INT-D* *INT-G* *INT-S*	*Changing policy framework in 2016/17: NSPPF, H-EQIP → major consequences for health system financing → CBHI, iHSP became obsolete due to abolition of the HEFO operators.* *SHP now focusing policy and strategy formulation and operationalisation of the NSPPF (appropriate shift, CBHI unsustainable)* *H-EQIP mostly compatible with original SHPP design, though, but adjustment in QEMT procedures → SHPP shifted towards QEMT support at national level and H-EQIP readiness in provinces (project provinces not yet covered by H-EQIP)* *All stakeholders confirming that strategic shifts were pertinent.* *Attention: Project formulation doesn't fully fit any more (→ now system strengthening rather than direct target-group benefits)* *Obsolete CBHI indicators not formally substituted until 12-2017*
Evaluation dimension	***Analysis questions***	***Evaluation indicators***	***Project documents***	***Literature and external documents***	***Secondary data***	***Primary data***	***Results***
The project achieves the goal on time in accordance with the TC measures' goal indicators agreed upon in the contract.	• To what extent has the agreed TC measures' goal already been achieved at the time of evaluation, measured against the goal indicators? • To what extent is it foreseeable that unachieved goals will be achieved during the current project term?	*Present degree of goal attainment and anticipated degree of goal attainment byl the end of the project term for the following indicators:*					
		<u>Indicator 1:</u> *Social health protection schemes in 10 of 81 districts*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im*	*'---*	*SHPP Online Results Monitor*	*INT-P* *INT-S*	*Current value: SHP schemes operating in 2 districts (target: 3, baseline: 10)*

		cover both poor and vulnerable groups *And additional success criteria:* *(a) increased ability of the MoH to use costing data to inform NSSF and HEF payment rates, (b) social health protection scheme for covering the informal sector under the NSPPF is ready for endorsement*	*Krankheitsfall* *GIZ-SHPP 2017b (Evaluation of the integrated Social Health Protection Scheme)* *GIZ-SHPP 2017d (CBHI-Analysis)* *Monthly RBM reporting for HF component*			*INT-N*	*CBHI operating on the basis of transaction cost sharing with HEF until H-EQIP and NSPPF* *Functioning successfully until mid-2016 → 22.000 in Kampong Thom voluntarily insured, expansion to all KT-OD* *Operations ceased with start of H-EQIP → without HEFOs no ability to offer supplementary CBHI to the near poor* *Additional success criterion:* *Until the late 2017 costing methodology piloted in Kampong Thom and Kampot.* *NIPH contracted by NSSF to extend costing study to more provinces (target value 12/2018: 6 out of 25 provinces)* *SHPP supporting MoH and NSSF regarding relation: operating costs per health service consumed and user fees charged* *Gradually improving capacity to calculate appropriate payment rates (on-going and long-term)* *Bottlenecks: weak record keeping capacities at SNA and HF level; balance between supply-side demand-politically sensitive*
		<u>Indicator 2:</u> *The utilisation rate for outpatient consultation in public health services increases on average to 0.66 per capita of the population per annum in Kampot, Kampong Thom and Kep provinces*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall* *GIZ-SHPP 2017b (Evaluation of the integrated Social Health Protection Scheme)*	*'---*	*MoH - Health Management Information System* *SHPP Online Results Monitor*	*INT-P* *INT-G*	*Potential project results temporarily, but massively overlaid by temporary disruption of HEF services → strong decline of OPD utilisation rates* *OPD utilisation 2014 for SHPP provinces* *Third quarter 2016: 0.33* *First quarter 2017: 0.50* *Second quarter 2017: 0.45* *Third quarter 2017: 0.49* *National average fairly constant (without net increase of OPD utilisation rates since 2010, see MoH 2017e)* *Slightly positive trend in Project provinces: +0.07, baseline 0,42)* *But: increase much smaller than*

							expected *Factors:* *(a) temporary backlash of utilisation rates at H-EQIP start, (b) abolition of CBHI (c) overambitious target value*
		<u>Indicator 3:</u> *(1) A new national framework document for quality improvement in the health care sector was adopted by the MoH.* *to be complemented with compliance indicator:* *(2) The percentage of health centres that reach the minimum score in evaluations of quality of care processes increases from 0 to 60% in the intervention operational departments*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall* *GIZ-SHPP 2017h (Annual reports of the HSD component)*	*National Policy for Quality and Safety in Health* *Master Plan for Quality Improvement in Health 2015-2020* *Master Plan for Quality Improvement in Health 2017-2022*	*SHPP Online Results Monitor*	*INT-P* *INT-DP* *INT-G* *INT-S* *INT-H*	*SHPP support to QIWG → formulating NPQSH and updating QIMP* *QIMP guiding implementation, monitoring and evaluation of the revised policy.* *Both adopted in August 2017* *At sub-national level, SHPP supporting QEMT readiness -→ PHD/OD/HF in Kampong Thom and Kampot confirming readiness for assessments.* *QEMT not yet rolled out to project provinces → no comparable results yet regarding HSD performance.* *Baseline according to Level 2 exams currently updated by NIPH master students, but data not yet available at 12/2017* *HF staff providing qualitative information → examples for tangible quality improvements (e.g. in the areas of client treatment, infection control, access for disabled people).* *General impression that PDCA cycles are being established*
		<u>Indicator 4:</u> *The number of hospitals obtaining a minimum score of 85% for each criterion in the client satisfaction survey for male and female patients increases from 0 to 3.*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall* *GIZ-SHPP 2016f (Review of HSG results)*	*'---*	*SHPP Online Results Monitor (results from CSS surveys)*	*INT-P* *INT-G* *INT-S* *INT-H* *FG-D*	*Current average values: Kampong Thom 79% of satisfaction, Kampot 83%. No hospital gained 85% for each CSS criterion* *But: Some service-related items consistently scored above 90%: privacy, confidentiality, communication with the health staff, instructions for the use of medicines having a chance to ask questions to health staff.* *Average scores of all health facilities are relatively close to the target of 85%* *Positive statements of hospital staff, HCMC members and health managers (PHD and OD) regard-*

							ing patient feedback in public forums and HCMC sessions.
The services implemented by the project successfully contribute to the achievement of the goal agreed upon in the contract.	• What concrete contribution does the project make to the achievement of the agreed TC measures' goal, measured against the goal indicators? • Which factors in the implementation contribute successfully to the achievement of the project objectives? • What other/alternative reasons contributed to the fact that the objective was achieved or not achieved? • Are core, support and management processes designed in such a way that they contribute to the achievement of the objective? To what extent have risks (see also Safeguards & Gender) and assumptions of the theory of change been addressed in the implementation and steering of the project?	*See above → the criterion refers to the determination of the net effect which is already considered in the remarks for column 6 (Evaluation strategy)* *Further guiding questions are rather descriptive (identification of causal mechanisms) than evaluative (i.e. no further indicators are required).*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall* *GIZ-SHPP 2014e (Briefing Notes HSG component)* *GIZ-SHPP 2016d (Process report Citizen Participation interventions)* *GIZ-SHPP 2016f (Review of HSG results)* *GIZ-SHPP 2016g (KAP-Survey for Disabled People)* *GIZ-SHPP 2017b (Evaluation of the integrated Social Health Protection Scheme)* *GIZ-SHPP 2017h (Annual reports of the HSD component)*	*GIZ-SHPP 2016c (Policy Brief on D&D)*	'---	*INT-P* *INT-D* *INT-DP* *INT-G* *INT-S* *INT-H* *INT-N* *FG-D*	*SHPP assistance valuable for conceptualisation of the NSPPF (INT-G).* *Advice for sub-decree, approved in early 2018 → conformation of the NSPC* *Continuous advice to NSPC* *Together with SISS, assistance to MEF in formulating a draft social protection law* *According to stakeholders, key elements of the institutional set-up for NSPPF will be in place before 12/2018.* *With JICA: focus on how to extend SHP coverage to the informal sector (scheme design)* *Minor role in other schemes* *Contributions to CD of key counterparts for implementation of NSPPF (MEF, MoH, NFPPF) → flexible adjustment to urgent needs, supporting identification of capacity gaps* *But: still huge capacity gaps in NSSF → overburdened with extended mandate, no CD strategy* *International consultant financed by SHPP advised QIWG → NSQSH and QIMP = direct outputs of SHPP* *At sub-national level: SHPP supported PHD and OD health managers and HF staff through coaching and training (e.g. QI assessment, QM, infection prevention control, nursing protocols).* *QIWGs working at OD level → assessment capacity in place and QI plans follow-up.* *HSG:* *(a) Training courses for HCMC members (HCMCs of 52 health facilities, 162 trained members), (b) workshops on annual operational planning (for 131 health facilities) (c) supporting PHD coaching for 9*

							selected (poor performing) HCMCs. *90% of the HCMCs conducting meetings once per quarter INT confirming that meetings are better structured than in the past* *INT confirming that roles and functions have become clearer (e.g. leading role CC)* *Leadership challenges: due to political changes (elections and dissolution of the opposition party)* *75% of HF follow-up on the results of CSS in HCMC-meetings (baseline 15: 53%)* *Better citizen participation: (attendance, active participation, issues raised and accepted), but: can be further enhanced (e.g. reluctance to speak out in discussions)* *Subsidies to local NGOs for awareness raising sessions → more than 10,000 attendees in 279 villages* *Vulnerable groups:* *Technical and financial support to six DPOs and one OPA for target group training → 93% of nearly 130 training sessions in accordance with agreed quality criteria* *Scope: 2,200 DP (ca. 1,000 women) and 295 older people (205 women).* *No data available regarding training outcome (no KAP endline).* *Organisational CD measures for DPOs, DA in CDPO → improved advocacy, VG in 76% of HCMC (baseline 70%)* *INT/FG-evidence that HF awareness for DP needs has improved (e.g. increased awareness of rights for free treatment, decrease of discriminatory attitudes of health staff, improvements regarding the physical access to health centres).*
The occurrence of additional/ not for-	• Refers to Option A, Sustainability (determination of interactions in effectiveness and impact):	*The project periodically monitors framework conditions, risks and unintended effects based*	*Gemeinsame Berichterstattung zum EZ-Pro-*	'---	'---	*INT-P* *INT-D*	*HSD:* *Law on Regulation for Health Practitioners advised by SHPP*

mally agreed positive results and unintended negative results was assessed and adequately addressed where required.	• To what extent were risks of unintended results assessed as observation fields by the monitoring system (e.g. compass)? • To what extent have the project's benefits produced results that were unintended? • Which positive or negative unintended results (economic, social, ecological) does the project produce? Is there any identifiable tension between the ecological, economic and social dimensions? • How were negative unintended results and interactions counteracted and synergies exploited? What measures were taken?	*on defined processes/tools/instruments* *The rationale of management decisions based on the identification of external changes/risks and/or unintended results is documented and conducive towards the project goal.*	*gramm Soziale Absicherung im Krankheitsfall* *GIZ-SHPP 2014e (Briefing Notes HSG component)* *GIZ-SHPP 2016d (Process report Citizen Participation interventions)* *GIZ-SHPP 2016f (Review of HSG results)* *GIZ-SHPP 2017h (Annual reports of the HSD component)*			*INT-DP* *INT-G* *INT-S* *INT-H* *INT-N* *FG-D*	*approved in November 2016 → basis for regular licensing processes* *Ongoing: Law on Regulation of Health Care Facilities and Health Care Services* *Revision of the MP, including the screening tool for the early detection of disabilities in newborns and children (together with Muskoka) → reference for accreditation and resource allocation.* *Support to QAO to manage H-EQIP implementation → advice for the development and testing of QEMT, development of QEMT-curricula, support to QAO in conducting the training sessions.* *QEMT rollout started, but not yet including project provinces.* *QEMT outcome: health facilities generally achieved low scores during a first assessment round but performed significantly better in the first re-assessment (average for 29 referral hospitals: 27% → 42%; for 453 health centres: 45% → 66%.* *HSG/VG:* *Revision EPN-SOP on NCD, including diabetes and hypertension* *Drafting of national physical therapy standards* *Pilot activities for both at OD/HF level* *CDPO strengthened (with development advisor) → better training capacity, advocacy capacity, networking capacity, but: dependence on external funding* *Contributions to D&D (together with DAR), supporting sub-technical working group on D&D → Milestone: annual action plan for 2017 for health sector D&D* *Sub-decree on the functional transfer drafted with project support (further revision ongoing)* *SNA-CD (e.g. QI mechanisms at the level of PHD, ODs and health facilities, functional HCMCs) →*

							preparedness to respond to future requirements of the D&D process. *Negative results: Risk that the sudden rupture of the CBHI schemes could compromise the target group's attitudes towards (voluntary) health insurance*
Evaluation dimension	***Analysis questions***	***Evaluation indicators***	***Project Documents***	***Literature and external documents***	***Secondary data***	***Primary data***	***Results***
The announced superordinate long-term results have occurred or are foreseen (should be plausibly explained).	• To which superordinate long-term results should the project contribute (cf. module and programme proposal, if no individual measure; indicators, identifiers, narrative)? • To what extent will the project contribute to the implementation of the partner country's national strategy for implementing Agenda 2030/to the SDGs? • Which dimensions of sustainability (economic, ecological, social) does the project affect at impact level? Were there positive synergies on the three levels? • 'Leave No One Behind': To what extent have targeted marginalised groups (such as women, children, young people, the elderly, people with disabilities, indigenous peoples, refugees, IDPs and migrants, people living with HIV/AIDS and the poorest of the poor) been reached and is there evidence of the results achieved at target group level?	*See nationwide indicators for the programme objective:* *(1) incidence of catastrophic health expenditure* *(2) utilisation rates of health services among beneficiaries of health protection mechanism* *(3) Maternal and neonatal mortality rates among poor and vulnerable population groups* *(4) number of health facilities providing services according to national quality standards* *(5) number of screenings and (early) treatments for diabetes and hypertension*	*(1) to (4) Offer to BMZ* *(1) to (4) Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall*	*(1) to (4) Health Strategic Plan 2016-2020* *(1) to (4) Health Equity Fund, Operational Manual* *(1) Flores, Men et al. 2013* *(1) Chhun et al. 2015* *(1) GIZ 2014b*	*(1) to (4) SHPP Online Results Monitor* *(1) Socio-Economic Survey 2014 (and previous surveys)* *(1) MoH - Health Management Information System Data* *(2) Data provided by HEF* *(3) Demographic Health Survey Data* *(4) Results of Level-1 and Level 2 Exams (SHPP Results Monitor)* *(4) Quality enhancement monitoring results provided by the QAO* *(5) MoH - Health Management Information System Data*	*INT-P* *INT-D* *INT-DP* *INT-G* *INT-S*	*(1)* *Studies confirming long-term trend towards the reduction of CHE. External factor: economic growth, rising income, rising (absolute) OOP.* *Also, evidence that SHP contributes to lower OOP, while OOP is a main contributor to poverty (Attention: target-group specific dynamics that should be investigated in detail in endline-operational-research).* *Strategic shift in HF = shift towards system CD = more difficult to determine the specific project contribution at the impact level.* *Plausible assumption that intended mid-term (e.g. adequate costing and suitable health provider payment rates, NSSF-CD) would contribute to a higher SHP coverage, thus reducing CHE* *(2)* *Temporary disruption of the HEF overlaying assumed long-term trend.* *0.53 contacts per person per year (2017) compared to 0.57 (2016), but: INT suggest that impact hypothesis remains intact, value is expected to rise again as HEF normalisation.* *SHPP contribution: same as module objective Indicator 2* *(3)* *Level 2-assessments 2014: no health facility surpassed 60%-threshold* *Level 2-assessments 2017 finished, but not yet published. QEMT (as alternative source for*
The project contributed to the intended superordinate long-term results.	• To what extent is it plausible that the results of the project on the output and outcome levels (project goal) contribute to the superordinate results? (contribution-analysis approach) • What are the alternative explanations/reasons for the results observed? (e.g. the activities of other stakeholders) • To what extent do changes in the framework conditions influence superordinate long-term results? • To what extent is the effectiveness of the development measures positively or negatively influenced by other policy areas, strategies or interests (German ministries, bilateral and multilateral development partners)? What are the consequences of the project? • To what extent has the project made an active and systematic contribution to widespread impact? (4 dimensions: relevance, quality, quantity, sustainability; scaling-up approaches: vertical, horizontal, functional	*See above → the criterion refers to the determination of (potential) net contributions which is already considered in the remarks for column 6 (Evaluation strategy)* *Further guiding questions are rather descriptive (identification of causal mechanisms) than evaluative (i.e. no further indicators are required).*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall* *GIZ-SHPP 2014e (Briefing Notes HSG component)* *GIZ-SHPP 2016d (Process report Citizen Participation interventions)* *GIZ-SHPP 2016f (Review of HSG results)* *GIZ-SHPP 2016g (KAP-Survey for Disabled People)* *GIZ-SHPP 2017b (Evaluation of the integrated Social Health*	*Health Strategic Plan 2016-2020*	*'---*	*INT-P* *INT-D* *INT-DP* *INT-G* *INT-S*	

	or combined)? If not, could there have been potential? Why was the potential not exploited? • Referring to the three dimensions of sustainability (economic, ecological, social): How was it ensured that synergies were exploited in the three dimensions? What measures were taken? (-> discussion of interactions in the sense of trade-offs below for unintended results)		*Protection Scheme)* *GIZ-SHPP 2017h (Annual reports of the HSD component)*				*comparisons) not yet rolled out to project provinces.* *SHPP contribution to QI at facility level: see MO indicator 3* *(4)* *2017: 2.92 new diabetic patients 14.63 hypertensive patients per 1,000 screened adults* *2014: 2.11 / 14.41* *Disease patterns: 41,958 registered new cases in 2016 compared to 24,301 in 2014 for diabetes and (219,737 new cases in 2016 compared to 157,542 in 2014 for hypertension* *Slowly rising awareness of the relevance of NCDs, but target value will not be achieved* *Half-hearted response by RGC and DP (except WHO)* *SHPP contribution to NCD-response:* *advocacy and awareness raising → NCD focus in the NPQSH, MPA guidelines include NCDs and related aspects.* *(5)* *No current data (every 4 months only DHS)* *Expected positive trends, possibly enhanced by increasing SHP coverage QE. SHPP contribution less relevant than other projects and DPs*
Unintended superordinate long-term (positive or negative) results have occurred.	• Which unintended positive and/or negative results/changes at the level of superordinate results can be observed in the wider sectoral and regional environment of the development measure (e.g. cross-cutting issues, interactions between the three sustainability dimensions)? • To what extent is the (positive or negative) contribution of the project plausible? • What are the alternative explanations/reasons for the results observed? (e.g. the activities of other stakeholders)	*(though unintended effects may add value to the project, absence of unintended results has no implications for the evaluation judgement; therefore, no indicator is required).*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall*	'---	'---	*INT-P* *INT-D* *INT-DP* *INT-G* *INT-S*	*Additional results beyond indicators: mostly identical with respective section under effectiveness → respective results occurred at a high system level.* *Cross-cutting issues:* *Poverty reduction: reduction of CHE and OOP for the poor and other VG at the heart of SHPP* *But: Effects rather indirect since strategic shift to system's development instead of CBHI upscaling* *PD/GG: main focus of the intervention area HSG; possibly wider*
No project-related negative results have been observed – and the	• Have negative results occurred? • To what extent were the risks of negative, unintended, superordinate results identified and assessed in the monitoring system? To	*Potential project-related negative results are considered in the risk monitoring (see also the*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im*	'---	'---	*INT-P* *INT-D*	

project responded adequately if any negative results were determined at any time.	what extent were these negative results in the sense of (negative) interactions or trade-offs in the ecological, economic and social dimensions already known during the conception of the project and reflected (e.g. in the module or programme proposal)? • Was there a corresponding risk assessment in the TC-measures' proposal? How was the ability to influence these risks originally assessed? • To what extent have the project's services caused negative (unintended) results (economic, social, ecological)? Is there any identifiable tension between the ecological, economic and social dimensions? ○ Economically: Impairment of competitiveness, employability, etc. ○ Socially: How should the impact be assessed in terms of distributive results, non-discrimination and universal access to social services and social security systems? To what extent can particularly disadvantaged population groups benefit from the results or have negative results for particularly disadvantaged population groups been created? ○ Ecologically: What are the positive or negative environmental impacts of the project? • What measures have been taken by the project to counteract the risks/negative interactions? • To what extent have the framework conditions for the negative results played a role? How did the project react to this?	*respective indicator at the Effectiveness level)* *The rationale of management decisions based on the identification of potential unintended results is documented and conducive towards the overarching development goal*	*Krankheitsfall*			*INT-DP* *INT-G* *INT-S*	*impact in D&D context (if the process takes off → Kampot = pilot area of D&D)* *SHPP involved in NCDD-S* *Main contribution at present: increasing D&D-readiness in project provinces* *GG: focusing on female participation in training sessions, awareness raising measures and public forums in HSG component* *Female participants in local level events close to 50%; but no evidence for more systemic effects.* *CBHI encouraged gender-balanced coverage (now obsolete)* *No indications of project-related negative results at impact level* *Relevant risks were regularly identified and discussed; risks mostly outside the scope of the project, but considered appropriately*
Evaluation dimension	***Analysis questions***	***Evaluation indicators***	***Project Documents***	***Literature and external documents***	***Secondary data***	***Primary data***	***Results***
The project's use of resources is appropriate with regard to the outputs achieved. [Production efficiency: Resources/Services in accordance with BMZ]	• To what extent are there deviations between the identified costs and the projected costs? What are the reasons for the identified deviation(s)?2) • To what extent could the outputs have been maximised with the same amount of resources and under the same framework conditions and with the same or better quality (maximum principle)?3) • To what extent could outputs have been maximised by reallocating resources between the outputs?3) • Were the output/resource ratio and alternatives carefully considered during the design and implementation process – and if so, how? • For interim evaluations based on the analysis to date: To what extent are further planned expenditures meaningfully distributed among the targeted outputs?	*The core criteria for the efficiency evaluation are scenario-based instead of measurement based (i.e. relying on counterfactual assumptions regarding alternative resource allocations, instruments uses and methodological approaches for the maximisation of outputs and outcomes).* *Therefore, we recommend abstaining from formulating indicators (which are associated with actual measurement) and rely on the guiding questions which are sufficiently evaluative ('to what extent …')*	*Offer to BMZ (2015) (and change offers)* *Grant Agreement between BMZ and USAID for support to SHPP (2016)* *SHPP Implementation Agreement* *SHPP Instrument Concept* *Current Cost-Obligo-Sheet* *Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im*	'---	'---	*Efficiency Tool filled out and discussed together with:* *INT-P*	*See Efficiency Tool for all financial and further data related to Efficiency* *See the Efficiency Tool and BE for all data related to applied staff and instruments* *Use of instruments and resources is in line with the provisions of the offer.* *Deviations due to adjustment of HF component → CBHI support shifted towards policy advice and CD interventions → DA at SHPA not yet reassigned.* *No basis for the assessment of the maximum-principle in HF com-*

			Krankheitsfall *GIZ-SHPP 2014b (Stakeholder Analyses)* *(see Effectiveness criterion for process and result related sources)*				*ponent (complete turnover of outputs)* *Other components implemented as planned, some technical adjustments due to external changes (e.g. QEMT standards).* *Widespread stakeholder landscape, but well-balanced and distributed interventions.* *No indications for dilution of efforts* *Strong linkages between interventions.*
The project's use of resources is appropriate with regard to achieving the TC-measures' goal (outcome). [Allocation efficiency: Resources/Services in accordance with BMZ]	• To what extent could the outcome have been maximised with the same amount of resources and the same or better quality (maximum principle)?4) • Were the outcome-resources ratio and alternatives carefully considered during the conception and implementation process – and if so, how? Were any scaling-up options considered? 4) • To what extent was more impact achieved through synergies and/or leverage of more resources, with the help of other bilateral and multilateral donors and organisations (e.g. Kofi, MSPs)? If so, was the relationship between costs and results appropriate?5)		*Angebot an das BMZ (2015)* *Grant Agreement between BMZ and USAID for support to SHPP (2016)* *Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall* *Current Cost-Obligo-Sheet* *(see Effectiveness criterion for process and result related sources)*	'---	'---	*Efficiency Tool filled out and discussed together with:* *INT-P*	*See Efficiency Tool for all financial and further data related to Efficiency* *See the Efficiency Tool and BE for all data related to applied staff and instruments* *Convincing linkages between components (e.g. between SHP, performance-based payment and QI; between QI and cost reduction, feedback of the client's perspective into QI, mainstreaming of VG needs).* *INT sustaining that that resources are adequately distributed and reflect the relative weight of components* *CBHI from the beginning not economically self-sustaining* *CBHI technically valid, but not very cost-effective* *INT Divergent opinions: (a) on cost-effectiveness, (b) on scalability and (c) on sustainability risks.* *No missed opportunities thanks to multi-level and multi-stakeholder approach* *Scaling-up options taken into consideration (not the same potential in every IA)* *HSD: Support to nationwide rollout of QEMT* *HSG: CS based on approved, national tools (CSS), Public participation based on existing structures (HCMC, public forums)*

							But: In HSG rather learning experiences than scalable packages *Very positive: Synergies with other DPs (well-functioning Health Partners Group)* *Synergies:* *co-financing of USAID → policy advice and CD for MEF and NSSF,* *alignment of HSD-interventions with H-EQIP* *integration of P4H desk* *coordination with JICA in advising the MoH with regard to the development of an SHP scheme for the informal sector under the NSPPF* *Regular meetings of GDC focal area health meetings.* *Coordination and cooperation with Muskoka: disability screening tools for newborns, MPA* *IDPoor-Project: Establishment of a national reference system now used by all GDC projects*
Evaluation dimension	***Analysis questions***	***Evaluation indicators***	***Project Documents***	***Literature and external documents***	***Secondary data***	***Primary data***	***Results***
Prerequisite for ensuring the long-term success of the project: results are anchored in (partner) structures	• What has the project done to ensure that the intended effect can be achieved in the medium to long term by the partners themselves (working aid review)? • Which advisory contents, approaches, methods and concepts of the project are anchored/institutionalised in the (partner) system? • To what extent are they continuously used and/or further developed by the target group and/or implementing partners? • To what extent are (organisational, personnel, financial, economic) resources and capacities in the partner country (longer-term) available to ensure the continuation of the results achieved (e.g. multi-stakeholder partnerships (MSPs)? • To what extent are national structures and accountability mechanisms in place to support the results achieved (e.g. for the implementation and review of Agenda 2030)? ○ What is the project's exit strategy? ○ How are lessons learnt prepared and documented?	*(1) Supported health financing tools are routinely applied by the partners* *(2) Lessons Learnt from SHPP supported protection schemes are integrated in the operationalisation of the NFPPS* *(3) MoH engagement in the area of quality and safety is consistently based on SHPP supported framework document* *(4) Mechanisms for citizen participation and assurance of target group specific needs-orientation are adopted at policy level and as routine processes by the respective partners (e.g. health facilities, local administrations)*	*(1) to (4) Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall* *(1) to (4) GIZ-SHPP 2014c (CD Strategy)* *(1) GIZ 2017d (CBHI-Analysis)* *(1) Monthly RBM reporting for HF component* *(2) Monthly RBM reporting for the HF component* *(3) GIZ-SHPP 2017h (Annual reports of the HSD component)* *(4) GIZ-SHPP 2016f (HSG Results Reporting)*	*National Social Protection Policy Framework 2016-2025* *National Policy for Quality and Safety in Health* *Master Plan for Quality Improvement in Health 2017-2022* *National Health Care Policy and Strategy for Older People*	*'---*	*INT-P* *INT-D* *INT-DP* *INT-G* *INT-S* *INT-H* *INT-N* *FG-D*	*Consistent CD at all levels (individual, organisational, networks and policy field)* *Clear orientation towards partner capacities* *Well-arranged combination of policy advice and process consulting at the system level with OD measures HCD interventions.* *Clear results logic connecting CD levels; exceptions due to changes of the framework conditions and the need to follow the flow* *HF:* *CBHI abandoned → too abrupt to allow for uptake of operational lessons learnt* *For NSPPF: Too early to forecast the integration of project outputs, many milestones till pending (which doesn't mean: late)*

							HSD: *Strategy and QIMP positive context further national accreditation system and dissemination of QI.* *Current system development is consistently based on the existing strategic framework* *QI related CD at national level (support to the QAO and QEWG), SNA (e.g. QIWGs at provincial/district level) and health facilities (e.g. implementation of QI processes) aligned with H-EQIP and therefore well-anchored.* *HSG:* *SHPP supporting existing structures → CD support absorbed, participatory mechanisms strengthened* *RGC taking over more financial responsibility (70% of H-EQIP's HSD; nearly 60% of HEF operation)* *No PMU for H-EQIP → implementation through MoH structure* *MEF leading NSPPF* *Bottlenecks: personal and organisational capacities* *NSSF overburdened with extended mandate* *QAO understaffed for H-EQIP implementation* *Shortage of qualified (!) health professionals* *Fluctuation of political leaders at commune level (community chiefs) → lacking capacities for introducing new CCs* *NGOs depending on external funding, DPOs depending on external funding.*
Are the results of the project ecologically, socially and economically balanced?	• Evaluation of the outcome results with regard to interactions between the environmental, social and economic dimensions of sustainability • Which positive or negative intended and unintended results (economic, social, ecological) does the project produce? (Assign intended and unintended results from the	*The evaluative judgement will be based on a qualitative analysis of potentially relevant sustainability dimensions and the respective interrelations and possible trade-offs.* *Since the analysis focuses in-*	*Angebot an das BMZ (2015)* *Gemeinsamer Programmvorschlag zum EZ-Programm Soziale Absicherung im Krankheitsfall (2015)*	*Health Strategic Plan 2016-2020*	'---	*INT-P* *INT-D*	*Potential linkages with the environmental dimension do not apply for SHPP (UR-0)* *Social / Economical: Closely intertwined* *Target group level: economical determinants for the access to*

	effectiveness evaluation to the three sustainability dimensions) • Is there any identifiable tension between the ecological, economic and social dimensions? ○ *Economically*: Impairment of competitiveness, employability, etc. ○ Socially: How should the impact be assessed in terms of distributive results, non-discrimination and universal access to social services and social security systems? To what extent can particularly disadvantaged population groups benefit from the results or have negative results for particularly disadvantaged population groups been created? ○ *Ecologically*: What are the positive or negative environmental impacts of the project? • If negative interactions have been avoided and synergies exploited, how was this ensured? What measures were taken?	*terdependencies rather than individual, pre-defined variables, we recommend abstaining from formulating indicators and rely on the guiding questions only.*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall* *results presentations by SHPP*				*health services, economic impact due to health expenditures or inability to work* *HS-level: implications of financing mechanisms for all other health system building blocks.* *SHP: removal of economic barriers for health service, coverage of CHE risk* *Focus on health financing issues and conditions for economic sustainability (e.g. costing capacities, payer provider split)* *At the same time, focus on LNOB* *HF/HSD: Facilities react to economic stimuli, which are fostered by SHPP* *H-EQIP: Incentive payments for QI*
<u>Forecast of durability</u>: Results of the project are permanent, stable and long-term resilient	• To what extent are the results of the project durable, stable and resilient in the longer-term under the given conditions? • What risks and potential are emerging for the long-term protection of the results and how likely are these factors to occur? ○ (Example: Adaptability of target groups and institutions regarding economic dynamism & climate change; particularly disadvantaged groups are able to represent themselves in the long term and their individual countries have the capacity for their participation; changes in behaviour, attitudes and awareness among target groups and institutions that support the sustainability of the project's results, etc.? ○ What has the project done to reduce these risks and exploit potential?	*The core criteria for the sustainability evaluation are assumption-based instead of measurement based* *Therefore, we recommend abstaining from formulating indicators (which are associated with actual measurement) and rely on the guiding questions only.*	*Gemeinsame Berichterstattung zum EZ-Programm Soziale Absicherung im Krankheitsfall*	'---	'---	*INT-P* *INT-D* *INT-DP* *INT-G* *INT-S* *INT-H* *INT-N* *FG-D*	*General factors:* *Increasing readiness of the RGC to invest* *Active leadership of the RGC in designing and operationalizing the on-going health system reforms* *Adequate understanding of potential and limitations of TA* *Sustainability of specific outputs:* *CBHI obsolete (unsustainable, despite significant efforts)* *NSPPF appropriate framework for long-term results and sustainability* *Well-oriented focus towards CD which increases prospects for sustainabilty (e.g. costing capacities, NSSF organisational development)* *Some critical sustainability factors beyond the scope of SHPP: positioning of the PCA* *HSD: INT in QI emphasise infrastructural limitations and staff shortage* *But: Incentive payments under H-EQIP are effective → results*

							achieved by HF on their own, hence it is possible to sustain *Unclear, if improvements at HF are just quick wins* *So far: HF in project provinces cannot be compared to others (Synergy between SHPP-HF and H-EQIP not yet proven)* *HSG: Sustainabilty factors for CP (1) continued leadership for. HCMCs and public forums, (2) quality of vertical communication and support* *No data to assess sustainability of the results of public awareness raising campaigns (sustainability would be limited to the durability of campaign results, since NGOs rely on external funding)* *VG: Enhanced visibility of DPOs probably stable (low staff fluctuation → longer-lasting effects of HCD)* *But: no resources for project activities, training sessions etc.*

Annex 2: List of resources

Standard documents: offer and relevant additional documents

BMZ (2014a): Auftragserteilung mit Auflagen - TZ-Folgemaßnahme ‘Soziale Absicherung im Krankheitsfall’, PN 2013.2137.1 vom 31.08.2014.

BMZ (2016a): Auftragserteilung mit Auflagen - TZ-Maßnahme ‘Soziale Absicherung im Krankheitsfall’, PN 2013.2137.1 vom 03.02.2016.

BMZ (2016b): Auftragserteilung mit Auflagen - TZ-Maßnahme ‘Soziale Absicherung im Krankheitsfall’, PN 2013.2137.1 vom 12.05.2016.

BMZ (2017a): Auftragserteilung mit Auflagen - TZ-Maßnahme ‘Soziale Absicherung im Krankheitsfall’, PN 2013.2137.1 vom 31.03.2017.

German Development Cooperation (GDC 2014a): Implementation Agreement, Social Health Protection Programme, Technical Cooperation (09/2015 – 12/2018).

German Development Cooperation (GDC 2015a): Gemeinsamer Programmvorschlag zum EZ-Programm Soziale Absicherung im Krankheitsfall vom 27.11.2015.

GIZ-SHPP (2015a): Angebot für die Durchführung einer TZ-Folgemaßnahme – Soziale Absicherung im Krankheitsfall, PN 2013.2137.1 vom 26.05.2014.

GIZ-SHPP (2015b): Instrumentenkonzept – Soziale Absicherung im Krankheitsfall, PN 2013.2137.1.

GIZ-SHPP (2016a): Grant Agreement between GIZ and USAID for Support to the Social Health Protection Project in Cambodia, 29 April 2016.

GIZ-SHPP (2016b): Änderungsangebot mit Kombifinanzierung, TZ-Maßnahme ‘Soziale Absicherung im Krankheitsfall’, PN 2013.2137.1 vom 02.05.2016.

GIZ-SHPP (2017a): Einfaches Änderungsangebot, TZ-Maßnahme ‘Soziale Absicherung im Krankheitsfall’, PN 2013.2137.1 vom 15.02.2017.

Standard documents: reporting and evaluations

BMZ (2016c): Kambodscha - Entwicklungspolitischer Jahresbericht 2016.

BMZ (2017b): Rückmeldungen auf die Rückfragen des BMZ vom 18.05.2017 zur Berichterstattung des Programmes Soziale Absicherung im Krankheitsfall für das Berichtsjahr 2016.

GIZ (2014a): Project Evaluation Report, TC measure ‘Social Health Protection’, PN 2009.2171.8, 17.12.2014 (main report & summary report).

German Development Cooperation (GDC 2016a): Gemeinsame Berichterstattung (BE) zum EZ-Programm Soziale Absicherung im Krankheitsfall vom 06.12.2016.

German Development Cooperation (GDC 2017a): Gemeinsame Berichterstattung (BE) zum EZ-Programm Soziale Absicherung im Krankheitsfall vom 30.11.2017.

Standard documents: quality-in-line and Capacity Works

GIZ-SHPP (2014a): Draft-Gender Analysis for GIZ- Social Health Protection Project. Author: Anna Berezovskaja, Phnom Penh, November 2013.

GIZ-SHPP (2014b): Stakeholder Maps of the SHPP (Several Power Point Presentations of the project and of individual intervention areas).

GIZ-SHPP (2014c): Capacity Development Strategy, SHP, 14.12.2014.

GIZ-SHPP (2014d): Steering Structure, SHP.

GIZ-SHPP (2017e): RBM documents at component level (different Documents and Excel Matrixes)

GIZ-SHPP (2017f): RBM documents at project level (different Excel Matrixes and web-based Results Monitoring)

GIZ-SHPP (2017g): Definition of Indicator Management for SHP (internal project document).

Additional project documents

GIZ-SHPP (2014e): Briefing notes, Results and Processes of the Accountability Mechanism, Health System Governance Component, Social Health Protection Project.

GIZ-SHPP (2016c): Decentralization in Cambodia's health sector, draft 29 December 2016.

GIZ-SHPP (2016d): Approach and processes of citizen participation in health service delivery.

GIZ-SHPP (2016e): Quality Checklist für Disabled People Organizations.

GIZ-SHPP (2016f): Review HSG intended change over 09/2015 to 03/2016.

GIZ-SHPP (2016g): Baseline Survey – Knowledge Attitude Practice of Persons with Disabilities.

GIZ-SHPP (2017b): Working Paper – Attracting Poor People to public health facilities to access free health care: an assessment of the Integrated Social Health Protection Scheme. Phnom Penh: GIZ, June 2017.

GIZ-SHPP (2017c): Health Service Delivery: Support Quality Improvement of Healthcare Services through Health Equity and Quality Improvement Project (H-EQIP) Implementation, Factsheet.

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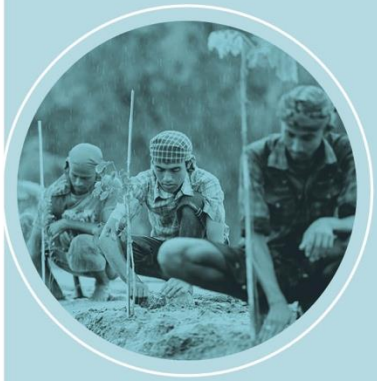

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