Facing the challenges of functional rehabilitation under public management

Cambodia 2014-2017

Final external project evaluation

Handicap International

Facing the challenges of functional rehabilitation under public management

Pic.1: Portrait of father and daughter, a young woman living with paraplegia, Kampong Cham

Cambodia 2014-2017

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This evaluation was carried out by Judit van Geystelen and was facilitated by HI-Cambodia.

ACKNOWLEDGEMENTS

The realisation of this evaluation would not have been possible without the extensive participation of stakeholders, including beneficiaries.

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Special thanks go to PRC staff in Kampong Cham and the numerous project beneficiaries and their families who shared time and information most useful to gather in depth insight in various aspects of services demand and supply.

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TITLE PAGE

Program/Project Name	Facing the challenges of functional rehabilitation under public management, Cambodia
Project Location, Country	Kampong Cham, Cambodia
Main Partner Organisation	Persons with Disabilities Foundation (PWDF)
Project start & end dates, Phase of project	January 01, 2014 – December 31, 2017, 4 years
Evaluation Purpose	To review project achievements and make informed recommendations for the next phase of implementation
Evaluation Type	Final Project Evaluation
Commissioning organisation/ contact person	Handicap International (HI)– Cambodia Country Director Edith van Wijngaarden direction@hicambodia.org Program Manager Hiep Phan rehab.mgr@hicambodia.org
Names and organisations of the Evaluation Team members	Judit van Geystelen
Primary Methodology	Document review, individual interviews with stakeholders, focus group discussions with target groups, secondary analysis of quantitative data
Evaluation Start and End Dates	13/11/2017-22/12/2017
Recipient of Final Evaluation Report	HI-Cambodia
Date of final report submission	22/12/2017

LIST OF MAPS AND TABLES

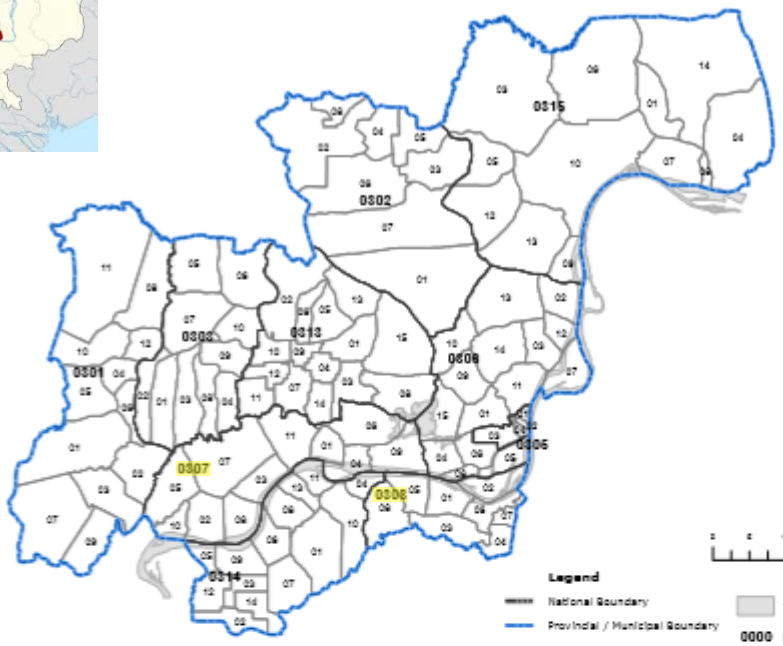
List of Abbreviations and Acronyms

AT	assistive technology, incl. assistive devices such as prosthetics, orthotics and mobility aids
CBR	community based rehabilitation
CDHS	Cambodia Demographic Health Survey
CHE	catastrophic health expenditure
CPA	complementary package of activities
CS	civil society
CTEV	congenital talipes equino varus (clubfoot)
DAC	Disability Action Council
DGD	Directorate General Development Cooperation and Humanitarian Aid
DO	District Office of Health
DPO	disabled persons organisations
DWPD	Department of Welfare for Persons living with Disabilities
e.g.	exempli gratia
EWR	Explosive war remittance
Fig.	figure
HC	health centre
HEF	Health Equity Fund
HI	Handicap International
IEC	information, education and communication
ICRC	International Committee of the Red Cross
incl.	including
INGO	international non-governmental organisations
M&E	monitoring and evaluation
MPA	minimum package of services
MoE	Ministry of Education
MoEF	Ministry of Economics and Finance
MoH	Ministry of Health
MoFA	Ministry of Foreign Affairs
MoSVY	Ministry of Social Affairs Veterans and Youth Rehabilitation
n	number
na	not available / not relevant
NGO	non-governmental organisation
OECD	Organisation for Economic Co-operation & Development
P&O	prosthetics and orthotics
phys	physical / physically
Pic.	picture

pop	population
PRC-KC	Physical rehabilitation centre of Kampong Cham
PSS	Personalised social support
PT	physiotherapy
PWDF	Persons With Disabilities Foundation
Rehabilitation Project	Facing the challenges of functional rehabilitation under public management, Cambodia - project
RGC	Royal Government of Cambodia
RMS	Rehabilitation management system
SDG	Sustainable Development Goals
SW	Social work
ToR	terms of reference
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDHR	United Nations Declaration of Human Rights
UPRC	universal physical rehabilitation coverage
VIC	Veterans International Cambodia
VIP	very important person
WHO	World Health Organisation
y	year

MAP OF PROJECT AREA

Kampong Cham province, Cambodia – administrative areas



Code of Province / Municipality, District, and Commune

03 KAMPONG CHAM

0301 Batheay
030101 Batheay
030102 Chear Ampov
030103 Chaeas
030104 Cheung Prey
030105 Ha Pring
030106 Phlau
030107 Sambour
030108 Sandaek
030109 Tang Krang
030110 Tang Krasang
030111 Trab
030112 Tumnob

0302 Chamkar Leu
030201 Bos Khnor
030202 Chamkar Andoung
030203 Chey Jou
030204 Lvea Leu
030205 Spueu
030206 Svay Teab
030207 Ta Ong
030208 Ta Prok

0303 Cheung Prey
030301 Khnor Dambang
030302 Kouk Roka
030303 Pdau Chum
030304 Prey Char
030305 Pring Chrum
030306 Sampong Chey
030307 Sdaeung Chey
030308 Soutip
030309 Stamar
030310 Trapeang Kor

0305 Krong Kampong Cham
030501 Sangkat Boeng Kok
030502 Sangkat Kampong Cham
030503 Sangkat Samsour Meas
030504 Sangkat Veal Vong

0306 Kampong Siem
030601 Ampil
030602 Hanchey
030603 Kien Chrey
030604 Kokor
030605 Koh Mitt
030606 Koh Roka
030607 Koh Samraong
030608 Koh Tontuem
030609 Krala
030610 Ou Svay
030611 Rolang
030612 Rumchek
030613 Srak
030614 Thean
030615 Vihear Thum

0307 Kang Meas
030701 Angkor Ban
030702 Kang Ta Noeng
030703 Khchau
030704 Peam Chi Kang
030705 Preaek Kpy
030706 Preaek Krabau
030707 Reay Pay
030708 Roka Ar
030709 Roka Kpy
030710 Sdau
030711 Sour Kong

0308 Kaoh Soutin
030801 Kampong Reab
030802 Kaoh Sotin
030803 Lve
030804 Moha Leaph
030805 Moha Khnhoung
030806 Peam Prathnuoh
030807 Pongro
030808 Preaek Ta Nong

0313 Prey Chhor
031301 Baray
031302 Boeng Nay
031303 Chrey Vien
031304 Khvet Thum
031305 Kor
031306 Knouch
031307 Lvea
031308 Mlen
031309 Prey Chhor
031310 Sour Saen
031311 Samraong
031312 Stegnas
031313 Thma Pun
031314 Tong Rong
031315 Trapeang Preah

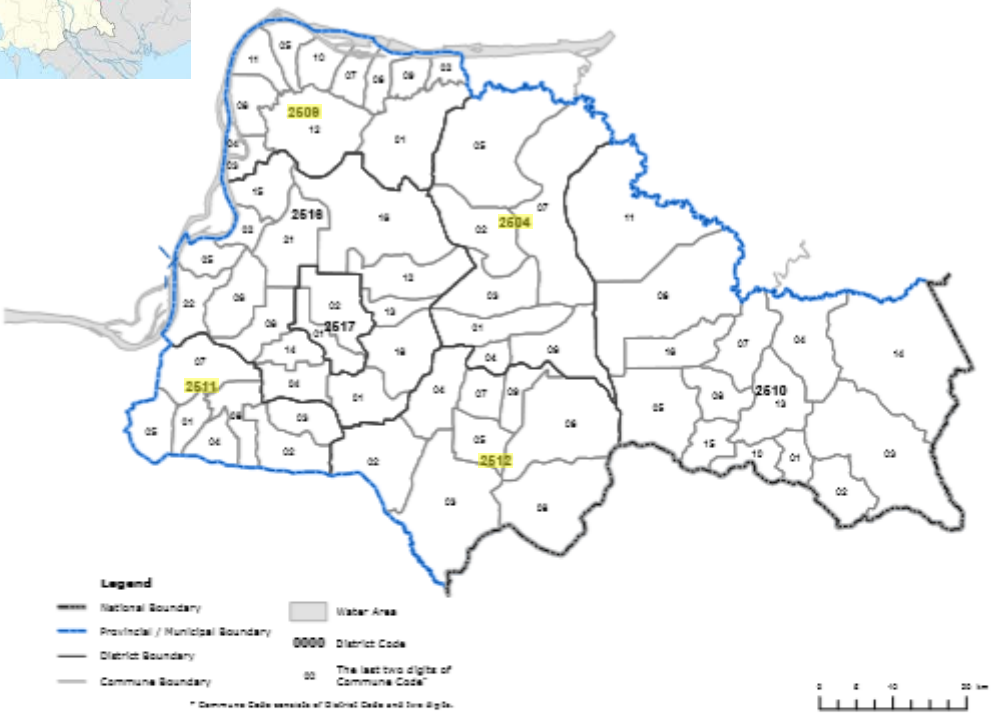
0314 Srei Santhor
031401 Baray
031402 Chi Bai
031403 Khnar Sa
031404 Kaoh Andaet
031405 Mean Chey
031406 Phteah Kandal
031407 Pram Yam
031409 Preaek Dambouk
031409 Preaek Pou
031410 Preaek Rumdeng
031411 Ruessei Srok
031412 Svay Pou
031413 Svay Khsach Phnum
031414 Tang Traiach

0315 Stueng Trang
031501 Areaks Thot
031503 Dang Kdar
031504 Khpob Ta Nguon
031505 Ha Ear Chrey
031506 Ou Mlu
031507 Peam Kaoh Snar
031508 Preah Andoung
031509 Preaek Bak
031510 Preak Kak
031512 Soukhaes
031513 Tuol Preah Khleang
031514 Tuol Sambuor

* Codes and boundaries are as of December 31, 2013.

Map 1: Rehabilitation Project area - Cambodia, Kampong Cham province

Tboeung Kmum province, Cambodia – administrative areas



Code of Province / Municipality, District, and Commune

25 TBOUNG KHMUM

2504 Dambae
250401 Chong Chaech
250402 Dambae
250403 Kouk Srok
250404 Naeng Teut
250405 Sala
250406 Tuek Chrov
250407 Trapeang Pring

2509 Krouch Chhmar
250901 Chhuk
250902 Chumnik
250903 Kampong Treas
250904 Kaoh Pir
250905 Krouch Chhmar
250906 Peus Muoy
250907 Peus Pir
250908 Prasek A chi
250909 Roka Khnor
250910 Svay Khleang
250911 Treas
250912 Tuol Snuol

2510 Memot
251001 Chan Mul
251002 Choam
251003 Choam Kravien
251004 Choam Ta Mau
251005 Dar
251006 Kampoan
251007 Memong
251008 Memot
251010 Rung
251011 Rumchek
251013 Thamung
251014 Tonlung
251015 Thlak
251016 Kokir

2511 Ou Reang Ov
251101 Ampil Ta Pok
251102 Chak
251103 Damril
251104 Kong Chey
251105 Mlan
251107 Preah Theat
251108 Tuol Sophi

2512 Ponhea Kraek
251202 Dountei
251203 Kak
251204 Kandaol Chrum
251205 Kaong Kang
251206 Kraek
251207 Popel
251208 Trapeang Phlong
251209 Veal Mlu

2516 Tboung Khmum
251601 Anhchaeum
251602 Boeng Pruol
251604 Chikor
251605 Chirou Ti Muoy
251606 Chirou Ti Pir
251609 Chob
251612 Kor
251613 Lngieng
251614 Nang Kiev
251615 Peam Chikeang
251616 Roka Po Pram
251619 Sralab
251621 Thma Pechr
251622 Tonle Bet

2517 Krong Suong
251701 Sangkat Suong
251702 Sangkat Vihear Luong

* Codes and boundaries are as of December 31, 2013.

Map 2: Rehabilitation Project area, Tboeung Kmum province, Cambodia

EXECUTIVE SUMMARY

This evaluation, concerned a final evaluation of the project "Facing the challenges of functional rehabilitation under public management, Cambodia", a project supported by HI and implemented in partnership with the Persons With Disabilities Foundation.

The objectives of the evaluation were: a) to make an informed assessment on the performance of the project so to provide sufficient information regarding the relevance, effectiveness, efficiency, quality, impact and sustainability of the project; and b) to provide, within the framework of the project continuation, practical recommendations.

The scope of the evaluation comprised a review of project achievements made, in the target area Kampong Cham, during the period 2014-2017. The target population comprised children and adults in need of physical rehabilitation, as well as their families and stakeholders involved in the project.

The "Facing the challenges of functional rehabilitation under public management, Cambodia project" achieved its goal.

It allowed persons in need, to receive comprehensive physical rehabilitation services in an effective and equitable way

and allowed children and adults living with disabilities to experience significant improvements in quality of life, from functional independence and enhanced social integration

The evaluation methodology followed directions as provided in the terms of reference. Consequently, methods comprised a desk and literature review, secondary analysis of quantitative data were relevant and additional primary qualitative data through in-depth discussions with direct and indirect project beneficiaries and stakeholders. Informants participated in semi-structured face-to-face interviews and focus group discussions. Most of the field phase took place at the project site in Kampong Cham and Tboeung Kmum provinces (formerly Kampong Cham province), additional meetings were held with stakeholders in Phnom Penh. A half day debriefing took place at the end of the field phase to discuss and explore primarily evaluation results and recommendations in depth. A draft report was submitted for commenting before finalisation. This report is the result of a final request to restructure the final report according to evaluation criteria.

A. RESULTS

The "Facing the challenges of functional rehabilitation under public management, Cambodia project" achieved its goal. It realised the provision of comprehensive physical rehabilitation services in children and adults with physical impairments in an effective and equitable way. It allowed persons living with disabilities to experience significant improvements in quality of life, from functional independence and enhanced social integration.

Collaboration for the implementation of comprehensive physical rehabilitation between HI and the public sector is considered a win-win for both parties

whereby experience from services implementation can guide the strengthening of an adequate sustainable services system

Relevance:

Relevance: Very high

The objectives of the project are consistent with the needs of beneficiaries, they are in line with partners' policies, country normative frameworks and global priorities.

Synergy: Potential demonstrated

Formal and informal partnerships were established to promote best achievement of project objectives. Synergies have been created between services providers and stakeholders, contributing to better outcomes for direct and indirect beneficiaries.

The overall project approach is in line with relevant international and national legal frameworks and goals. The Rehabilitation Project operates within a formal agreement of collaboration between HI and the Royal Government of Cambodia. HI-Cambodia works in close collaboration with a series of governmental and non-governmental stakeholders in the sector and is an acknowledged key actor in the field of physical rehabilitation

and cluster munitions, in the country. Partnerships create a synergy that benefit all parties involved. Collaboration between HI and the public sector for the implementation of comprehensive physical rehabilitation for persons with physical disabilities can be considered a win-win, whereby experience from services implementation can guide the strengthening of an adequate sustainable services system.

Over the last decades, Cambodia has gone through considerable socio-economic developments. These are reflected in changing needs for physical rehabilitation services and services at the physical rehabilitation centre in Kampong Cham have gone through a transition from primarily provision of lower limb prosthesis for landmine victims in the early post war era to the provision of comprehensive physical rehabilitation services. The physical rehabilitation centre in Kampong Cham now delivers prosthetics and orthotics as well as mobility devices, physiotherapy and social services for clients with a variety of physical rehabilitation needs. These may include musculo-skeletal and /or neurological health conditions, such as amputation following the explosion of explosive war remittance (EWR), road accidents or diabetes; infants with congenital talipes equino varus (clubfoot); or older persons with impairments related to old age (such as hemiplegia following stroke).

Data on needs for physical rehabilitation in the target population are limited, yet, it is generally agreed that this need is not covered in low and low-middle income countries and is linked to barriers at both, demand and supply side. The Physical Rehabilitation project addresses both, with innovative interventions, such as the Demonstration project to stimulate demand; and through the reinforcement of services to address quality of the supply side (e.g. introduction of the Personalised social support project and the Rehabilitation management system).

Fast and impressive socio-economic progresses translate in better health outcomes, yet, they also imply growing inequities and more particularly according to wealth and urban/rural divides. The public sector increasingly co-exists with a private sector and social and health sectors will have to ensure quality and equity in a services system characterised by a public / private mix. Number of social health protection schemes exist and the coverage of private and public health insurance plans expands. There is an increasing trend towards demanding services providers whether public or private to ensure a universal coverage of minimum packages of services with quality assurance, yet, this requires a new role for government institutions in regard to regularisation and M&E.

To promote sustainability of equitable, quality physical rehabilitation services for person(s) living with disability in Cambodia, HI may wish to invest to support the RGC in this transition.

Effectiveness:

Effectiveness: High

The project objectives are achieved, or are expected to be achieved (end of project December 2017). The relative importance of project activities has been taken into account and adjustments have been made to ensure reaching the project objectives effectively.

The project achieved the objectives as per project proposals and initial plans. Consequently, it can be considered that intervention methods were effective.

A considerable number of new clients were registered at the PRC during the project period what may be indicative of the positive outcomes of project interventions that aimed to lower barriers to access physical rehabilitation services (new clients represent 21% of total clients who visited the centre during the project period). Throughout the project period, the Physical rehabilitation centre of Kampong Cham provided an estimated* 6234 prosthesis, orthotics and mobility aids; 46961 physiotherapy sessions and well over 2000 specific acts of social assistance (such as follow-up sessions in the community) (*adjusted to cover the period November and December 2017).

The Physical Rehabilitation Centre of Kampong Cham fosters a holistic client centred multi-disciplinary approach. This is acknowledged to contribute to improved collaboration between different services sections, to promote cohesion amongst staff and to positively influence on patient care and satisfaction.

Social workers support clients with needs that cannot be addressed by the PRC to access external services, such as psychological care, vocational training or additional health care.

High patient satisfaction rates were reported in both, satisfaction surveys and interviews with PRC clients. Monitoring of intervention outcomes on functional autonomy and social participation showed substantial improvements and several clients reported a positive impact of physical rehabilitation services on self-esteem.

The project included piloting innovative interventions (demonstration project, personalised social support, results management system) that were effectively implemented. Learning processes were documented, shared and found useful in stakeholders.

The project developed a series of information, education and communication tools for training, advocacy and awareness raising. A request for pre-testing and simplification of materials was made and would be recommended.

The project operates with adequate resources in regard to financing, human resources, consumables and non-consumables. Project plans and budgeting were followed as agreed with relevant stakeholders (donors, project partners).

Overall management processes and procedures are in place and ensure effective operation towards reaching and documenting project outputs.

It was felt that the project could benefit from:

-additional technical assistance to leverage the quality of services provided; and

- a more effective, user-friendly administrative system (processes and procedures, including data management systems) that would allow to guide and withdraw information useful for M&E planning and implementation purposes with enhanced efficiency.

The considerable number of new clients registered at the PRC during the project period may be indicative of the positive outcomes of innovative project interventions that aimed to lower barriers to access physical rehabilitation services

Efficiency

Efficiency: Remains a challenge

The extent to which the outputs and/or desired effects have been achieved with the lowest possible use of resources / inputs could benefit further attention during the next phase of the project.

Overall, a concern for resources optimisation is shown in programme management and project implementation at various levels.

The project operates with sufficient resources in regard to financing, human resources, consumables and non-consumables. Use of the Rehabilitation Management System (RMS) to monitor PRC-KC management performance has helped to sensitise staff about the various aspects that influence on services delivery effectiveness and has led to considerable improvements in the quality of services provided by the centre and more particularly at the level of staff attitude and client satisfaction. However, it was noted that use of the tool has its limits. It was felt that: a) the tool may be too complicated for staff to use in an autonomous and participatory way; b) prioritising may be driven by availability of resources rather than improvements in programmatic outcomes; c) without external support, implementation efforts slow down. Consequently, the RMS tool may be most efficient as a tool in occasional evaluations or spot-checks to provide a basis of information for guiding discussions in planning or review processes.

Clients report high levels of satisfaction with positive impact of comprehensive physical rehabilitation services on autonomuous functioning, social participation and self esteem

Overall management processes and procedures are in place and ensure effective operation towards reaching and documenting project outputs. Yet, over the years, a multitude of adjustments and new tools have been introduced and the system has become burdensome. In addition, staff may not understand the added value with adverse effects on compliance.

It was felt that both, operational and organisational management aspects require more investment towards enhanced efficiency.

Impact

Impact: High

The project has shown the potential to create a highly positive impact, primary (gain of functioning) and secondary (gain of quality of life, participation in socio-economic activities and improved dignity and self-esteem amongst direct and indirect beneficiaries).

Monitoring of intervention outcomes on functional autonomy and social participation showed substantial improvements and several clients reported a positive secondary impact of physical rehabilitation services on self-esteem. Clients expressed to be pleased about accessibility and quality of services received at the centre, both in regard to infrastructure as well as attitude in staff.

Interventions in the area of Cluster munitions were implemented and ratification of the Conventions on Cluster Munitions is high on the political agenda. Yet, the latter will require more high level bilateral discussions between Cambodia and neighbouring countries Thailand and Vietnam.

Sustainability

Sustainability: Remains a challenge

The extent to which the benefits from the project will continue after termination of the external support in a way that is resilient to risks is influenced by current reforms ongoing in the health and social sectors and may be further addressed in the next phase of the project.

Cost recovery strategies are considered to promote sustainability of the Physical Rehabilitation Centre of Kampong Cham. Currently, they focus on the possibility to introduce user fees. Opportunities for alternatives were briefly explored, such as the possibility to introduce a basic package of services under universal coverage together with the provision of additional to be paid for services. The latter was found interesting in staff and stakeholders and feasibility of the latter may be subject of further investigation.

It was felt that although the project has been effective to reach the project objectives and consequently, effectiveness is to be considered high, operational and organisational aspects may require quality enhancement to ensure an efficient service that can serve as a model for hand-over or replication.

Enabling local authorities and health services providers to take up an active role in referral and follow-up is to be considered a best practice. Collaborations are valued and was felt that these could be further exploited in short, medium and long term approaches. For example, HI could invest more to translate its extensive field experience in supporting system strengthening efforts at the national level with for example: the inclusion of relevant training modules in national pre-service curricula for health staff.

Over the last decades, the country went through major socio-economic changes that translate in different needs for physical rehabilitation and demands for different approaches in services delivery.
It was felt that the extensive field experience of HI could be exploited further in supporting system strengthening efforts at the national level towards enhanced sustainability of quality physical rehabilitation services, in Cambodia

Collaboration with the public sector can be challenging, it requires strategic partnerships at different levels and across sectors with actors that evolve at different speed. It requires the uptake of a long term perspective that allows for flexibility and re-directing to integrate country level developments. The Physical Rehabilitation Centre of Kampong Cham works in partnership with the provincial branch of the Persons with Disabilities Foundation. Collaboration through this partnership is oriented towards project implementation, with exchanges to focus on information sharing rather than the building of local capacity to take over project activities. Significant results were achieved through this approach, yet, it was felt that more investment in a system strengthening approach with a broader network of cross sector stakeholders could favour sustainability of project interventions in a context of transition. Both, the health and social services sectors are currently under reform towards enhanced services system strengthening. It is acknowledged by both, parties that close collaboration is required to ensure persons with disabilities can access a continuum of care that addresses their complex needs.

Gender

Gender: Good

The project takes gender and disability aspects into account in design, planning and implementation and has a monitoring system in place that could alert and take action in case of in-equality.

Gender equity could be considered an intrinsic part of the project. No gender discrimination was reported and where gender differences were noted, they could not be linked to gender based discrimination.

Gender disaggregated data is recorded for all project components.

Child safeguarding

Child safeguarding: Good

Child safeguarding issues are considered and an associated policy is in place. Partners subject to a formal agreement of collaboration also have a child safe policy or principles in place.

A child safeguarding policy is in place and operational. Partners are requested to have a child safeguarding policy or principles in place.

B. RECOMMENDATIONS

The "Facing the challenges of functional rehabilitation under public management, Cambodia project" achieved its goal in an effective and equitable way. Recommendations mainly refer to fine-tuning and anticipating broader sector wide transitions to enhance sustainability rather than major programmatic issues.

Short term

At project level

- Continue the provision of comprehensive physical rehabilitation services through a multi-disciplinary client oriented approach, that comprises: prosthetics and orthotics, related physiotherapy, complementary social work and support services as per National Guidelines on the Provision of Physical Rehabilitation;
- Continue capacity building for the use of participatory monitoring and evaluation tools that sensitize about broader organisational management issues and show potential to improve quality of services and client satisfaction, e.g. Rehabilitation Management System;
- Enhance **efficiency** through:
    - The simplification and appropriateness of administrative processes and procedures;
    - Further optimization of resources;
    - Further investment in ensuring services are technically sound and least invasive for clients;
    - Enhanced opportunities for cost recovery.

At the level of handicap International

- Continue to provide technical expertise to facilitate the transition process from a physical rehabilitation service focusing on the provision of prosthesis for landmine victims to adequately respond to current and anticipated future physical rehabilitation needs
- Continue to provide ongoing managerial oversight and specific short-term technical expertise to ensure efficient quality services delivery and management and facilitate planning, implementation, monitoring and evaluation of the project
- Continue to allow for flexibility in activity implementation towards enhanced project effectiveness and priories project efficiency over indicators
- Adopt a system strengthening and capacity building approach and assess potential for the integration of project components in public administration, health and social sectors as well as private sector services providers

- Support the realisation of examples / models to illustrate best practices (e.g. adjustment of health centre facilities according to accessibility guidelines)
- Continue to try new and expand existing innovative pilots that have shown efficient if availability of resources allow
- Make available specific resources to implement a new approach to partnerships whereby partners are implementers rather than facilitators
- Open up to a broad variety of stakeholders and allow for flexibility so to enhance sustainable synergies resilient to contextual changes

Medium term

At the level of the Physical Rehabilitation Centre of Kampong Cham

Programme strategy:

- Adopt a balanced two pronged approach that exploits the additional resources from project implementation most effectively towards long term impact through:
    - a number of strategic short term activities with high potential for long term impact (models) that may require high investment of resources, to be implemented by project staff, during the project period; and
    - a services system strengthening approach by building capacity in local stakeholders towards formal partnerships for sustainable activity implementation
- Search for and support the realisation of inclusion opportunities in mainstream services and consider exclusive services a means of last resort
- Services:
    - Build on good practices; e.g. counter referral between the physical rehabilitation centre, provincial referral hospitals, health centres and village leaders
    - Expand use of phone messaging systems and IT for use in information, referral and follow-up services
    - Expand attractive target audience adjusted awareness raising materials
- Organisational / management:
    - Facilitate capacity building in public counterparts as part of system strengthening efforts
    - Strengthen information management and promote availability of comparative data useful to guide monitoring and evaluation of project implementation and progress

Long term

- Support the integration of quality physical rehabilitation services in services system strengthening efforts

  This could be through helping relevant Ministry counterparts to develop strategy notes that address the implementation of norms and standards for a minimum package of services; the development of a human resources development plan according to nationwide services delivery; and the development of a services implementation plan with relevant monitoring and evaluation framework. Subsequently, these strategic notes and their respective plans could be budgeted to provide a basis on which to discuss possibility for domestic funding earmarked for physical rehabilitation services with the Ministry of Economics and Finance.

1. INTRODUCTION

1.1 ORGANIZATIONAL BACKGROUND

HI is an independent and impartial international aid organisation working in situations of poverty and exclusion, conflict and disaster. Working alongside persons with disabilities and other vulnerable groups, the action and testimony of HI are focused on responding to their essential needs, improving their living conditions and promoting respect for their dignity and their fundamental rights. HI is currently implementing projects in more than 50 countries worldwide, including Cambodia.

1.2. PROJECT BACKGROUND

Cambodia remains one of the poorest countries in Asia and despite progresses being made towards achievement of the Sustainable Development Goals (SDG), growing inequalities are noted with steady increasing wealth and urban - rural divides. Around 90% of Cambodia's poor are estimated to live in rural areas (World Bank, 2014).

In terms of disability prevalence, data differs widely. The Cambodia Demographic and Health Survey (CDHS) (2014) estimates disability prevalence at 9.5% (10.4% women, 9.6% rural). In 2011, a study carried out by HI and the Ministry of Education estimated the prevalence of disability in children aged 2-9 years old at 10.06%. Global figures put the prevalence of disability at 15% (WHO 2011).

Over the last decades, the Royal Government of Cambodia has significantly invested in the reinforcement of legal frameworks to protect and promote the rights of person(s) living with disability, yet, services provision, including physical rehabilitation, remains mainly in the hands of non-governmental organisations (NGOs). The Ministry of Social Affairs, Veterans and Youth Rehabilitation is mandated to ensure the welfare of persons with disabilities and has a specific designated technical department, the Department of Welfare for Persons with Disabilities (DWPD). Other major public entities involved in physical rehabilitation are: the Persons with Disabilities Foundation (PWDF), a public administration institution under technical supervision of the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) and under financial supervision of the Ministry of Economic and Finance (MoEF) mandated to provide rehabilitation services for person(s) living with disability; and the Ministry of Health (MoH) assigned to ensure population health, manage the health services system and provide health care services, including medical rehabilitation and physiotherapy.

In the early nineties, during the post war period, physical rehabilitation centres were established by international organisations in collaboration with the Ministry of Social Affairs, Labour, Veterans Affairs and Youth Rehabilitation. Centres were established with an intention for hand-over to the public sector. In 2008, the Persons with Disabilities Foundation was established to facilitate the transition from international non-governmental organisation (INGO) to government management. However, limited capacity of PWDF to do so is highlighted in a 2016 report that estimated that another 5 to 10 years of support would be required for PWDF to achieve full managerial, technical and financial capacity to independently manage the PRC network across the country. Availability of physiotherapy services within the public health services delivery system remains weak.

The Kampong Cham Physical rehabilitation Centre, founded by HI, offers comprehensive physical rehabilitation services including prosthetics, orthotics and mobility aids (P&O), physiotherapy (PT) and social services (SW) in line with National Guidelines for the Management of Physical Rehabilitation Centres (MoSVY 2012). Services are provided mainly at the centre, with sporadic home visits for follow up of clients.

Socio-economic developments are reflected in changing needs for physical rehabilitation services. Consequently, PRC services have gone through a transition from primarily provision of lower limb prosthesis for landmine victims in the early post war era to the provision of comprehensive physical rehabilitation services. PRC now deliver prosthetic and orthotic as well as mobility devices, physiotherapy and social services for clients with a variety of physical rehabilitation needs. These may include musculo-skeletal and /or neurological health conditions, such as amputation following the explosion of explosive war remittance (EWR), road accidents or diabetes; infants with congenital talipes equino varus (clubfoot); or older persons with impairments related to old age (such as hemiplegia following stroke).

1.3 PROJECT SUMMARY INFORMATION

Through the "Facing the challenges of functional rehabilitation under public management project" HI supports the physical rehabilitation centre in Kampong Cham to provide comprehensive physical rehabilitation services.

This evaluation covers the period from 2014 to 2017, under funding from the Ministry of Foreign Affairs of Luxemburg (MoFA) and the Director General for Development Cooperation and Humanitarian Aid (DGD).

During this period, PRC-KC management progressed towards collaborative management with MosVY through PWDF. New approaches were tried and innovative management practices piloted, aiming at strengthening the quality of services and improving the viability of public physical rehabilitation centres. In addition, in order to support medium to long term sector funding, the project intended to enhance the consideration of rehabilitation on the political agenda and to advocate for a management framework adapted to the current institutional context. In this perspective, the project has supported: the building of a referral and counter referral framework with the health sector; mobilization of local authorities and village chiefs to play a key role in the provision of information and referral services to persons with physical rehabilitation needs; service users' involvement to promote access to services and improve the quality of service provision; improvements in existing management systems, in particular by using the Rehabilitation Management System tool (RMS) developed by HI and used in Southeast Asia to guide quality assurance processes; and the use of legitimacy acquired from rehabilitation support provided to landmine survivors, explosive remnants of war and cluster munitions survivors to reinforce advocacy for the ratification of the Convention on Cluster Munitions.

For more details, please refer to Annex 1: Rehabilitation Project, Donor proposals.

1.4 PROJECT OBJECTIVES, EXPECTED RESULTS AND INTENDED CHANGES FOR THE TARGET GROUP

Luxembourg MoFA Funding (2014-2017)

Overall objective:

The vulnerability of persons with disabilities in Cambodia is reduced as part of the national effort against poverty reduction and in accordance with the framework set by the National Plan of Action for Persons with Disabilities including Landmine survivors.

Specific Objective:

Persons with physical disabilities in Kampong Cham province receive quality rehabilitation and proposed innovations contribute to the sustainability of the sector and to the implementation of the commitments made by the Government under the framework for Victim Assistance Persons with Disabilities Rights.

Expected Result 1:

Persons with physical disabilities who can benefit from rehabilitation services are referred to Kampong Cham Physical Rehabilitation Centre) by health actors, local authorities and their peers.

Expected Result 2:

The viability of Kampong Cham rehabilitation centre is reinforced in the institutional framework adopted by MoSVY, to improve the quality of services and users involvement in service provision.

Expected Result 3:

The innovations introduced by HI in the management of Kampong Cham centre are capitalized and presented to rehabilitation stakeholders in the framework of the national sector dialogue, and contribute to advocacy for the ratification of the Convention on Cluster Munitions in accordance with the commitments taken through the Millennium Development Goal 9 adopted by the Government of Cambodia to reduce the risks created by unexploded ordnance of war and to promote economic growth in the affected areas.

DGD Funding (2017)

Specific objective:

By end of 2017, proposed innovations in the management and provision of rehabilitation services have long term benefits on persons with physical disabilities in Kampong Cham and Tboeung Kmum provinces and contribute to the sustainability of the sector within its long-term transition from international organizations to public management

Result 1:

2,200 people with disabilities (at least 35% female) receive rehabilitation services at Kampong Cham PRC, in line with the national Standard Working Procedures and within a strengthened management and quality framework

Result 2:

Kampong Cham PRC's innovations in terms of management and costing of rehabilitation services are shared with other PRCs and with PWDF

1.5 Activities implemented and outputs achieved

Activities implemented and outputs achieved followed the directions and projections of the original plan. Some minor changes were made during the course of the four year project. Where such changes occurred they were reasoned, driven by a search for enhanced effectiveness, agreed upon in advance by relevant stakeholders and accounted for in reporting.

The Physical Rehabilitation Centre of Kampong Cham (PRC-KC) provides a comprehensive package of physical rehabilitation services in line with the National Guidelines for Physical Rehabilitation, in Cambodia (MoSVY, 2012), including prosthetic and orthotic services, related physiotherapy services and complementary social work and other support services (transport, accommodation, food). Both, demand and supply sides are addressed with innovative interventions, such as the Demonstration project to stimulate demand; and through the reinforcement of PRC services to promote quality of the supply side form both, an operational and organisational perspective (e.g. introduction of the Personalised Social Support approach and the Rehabilitation Management System).

1.6 Details on the expected target group

In line with legal frameworks in place, the primary target group of the PRC-KC comprises persons in need of P&O services. Globally, the need for P&O services is estimated at 0.5% of a population (WHO, 2011). With the PRC-KC to cover the population of Kampong Cham and Tboeung Kmum provinces, estimated at 1.68milion (NIS, 2009), the primary target population can be estimated at 8500 persons.

Global estimates put the prevalence of disability at 15% (WHO, 2011). The proportion of person(s) living with disability who live with physical impairment is estimated at 19% (WHO, 2011). Disability prevalence increases by age, from an estimated 2.8% in children to 12.4% in the active population reaching 36.8% in the older population (WHO, 2011). Table 1: Estimated population living with physical impairments by age group in the target area, provides an indication of the project target population who may benefit from physical rehabilitation services[2].

Estimated population living with physical impairments, by age group, in the target area								
Age group /	<19y		19-54y		>54y		total	
Population*	n	*%*	n	%	n	%	n	%
Total	741641	*44.1*	758025	*45.1*	180326	*10.7*	1679992	*100.0*
Person(s) living with disability	20766	*1.2*	93995	*5.6*	66360	*4.0*	181121	*10.8*
Physical impairment	3738	*0.2*	17859	*9.9*	12608	*0.8*	34205	*2.0*

*(NIS 2009, WHO 2011)

Table 1: Estimated population living with physical impairments by age group in the target area

[2] General prevalence estimates have been used, age groups have been adjusted according to the local context with retirement age at 54years of age (RGC, 1994).

Project expected beneficiaries according to project plan

Direct beneficiaries

Children, youth, adults and older persons, men and women with physical impairments, including landmine and explosive remnants of war survivors who receive rehabilitation services (6600 persons during the project with an average estimated 2,200 persons per year and >35% women)

Users representatives, chosen among PRC clients to contribute to improve the quality of services at centre level as well as information and referral of persons with physical impairments in the pilot area (20 Health Centres)

Local authorities from the pilot area who are mobilized to facilitate information and referral within the community (20 communes)

Project staff involved in the provision of rehabilitation services and in the implementation of innovative management practices (30 employees)

Health staff from the pilot area and staff from the district referral hospital located in the Rehabilitation Project coverage area (approximately 70 people)

MoSVY personnel involved in rehabilitation and associated to the pilot actions implemented at PRC-KC to improve management practices and the viability of the centre (Disability Action Council (DAC), PWDF, DWPD) (a dozen people)

Actors from the rehabilitation sector who will be informed about the results achieved within the framework of innovative practices (a dozen representatives)

Cambodians informed about the risks induced by cluster munitions and who are mobilized to demand the ratification of the International Convention (approximately 10% of the population).

Clients with signs of psychological distress either targeted by activities at PRC-KC or referred to mental health services (50 persons in 2017)

Indirect beneficiaries

The families of people receiving physical rehabilitation services (n=23 100) - People with physical impairment who ultimately benefit from rehabilitation services of acceptable quality manageable by public authorities (n=150 000)

Inhabitants of cluster munitions affected areas who will ultimately benefit from the ratification of the Convention and the implementation of the related obligation

2. SCOPE OF THE EVALUATION

This evaluation, concerned an end-phase evaluation of the project "Facing the challenges of functional rehabilitation under public management" a project supported by HI and implemented in partnership with PWDF / MoSVY.

The evaluation was performed during the final stage of the project and was guided by the aim and objectives as stated in the Terms of Reference:

"… The evaluation … will play a key role in the process of ensuring the sustainability of the Kampong Cham Physical rehabilitation sector and of the sector in general. By analysing the actions implemented, their outcomes and measuring the gains reached over four years, it will help HI to make informed decisions about future approaches and the actions required to move towards greater autonomy of the PRC and greater sustainability.

- *To make an informed assessment on the performance of the project to provide the donors, HI and its partners with sufficient information regarding the relevance, effectiveness, efficiency, quality, impact and sustainability of the project as per Organisation for Economic Co-operation & Development (OECD) standards.*
- *To provide HI and its partners, within the framework of the project continuation, with practical recommendations. Strengths and weaknesses of the project's methodology and implementation process will be identified and analysed, with an objective to increase impact and sustainability in the next phase of the project …."*

The scope of the evaluation comprised a review of project achievements made during the period 2014-2017 of the "Facing the challenges of functional rehabilitation under public management, Cambodia project" (Rehabilitation Project) implemented in the target area in Kampong Cham. The target population comprised children and adults in need of physical rehabilitation, as well as their families and stakeholders involved in the project.

It assessed changes in the lives of persons with disabilities, captured strong practices and approaches; identified key triggers to success and defined sustainability aspects to be considered during implementation of the next phase.

The evaluation covered project implementation for the period 2014-2017 and concerns the provision of physical rehabilitation services in the target area with the implementation of innovative pilots to promote efficiency, such as the personalised social support project, the demonstration project and the use of the rehabilitation management system as well as awareness raising activities on the dangers of and advocacy and ratification of the convention on cluster munitions.

2.1 TARGET AUDIENCE OF THE EVALUATION

The final report of this evaluation will be shared with HI-Cambodia. Its findings and recommendations will be used to guide informed decision making for the next phase of the project. The final report is submitted in English.

3. Evaluation Methods and Limitations

The evaluation consisted of three phases. An initial desk review to guide the inception report; a field phase to allow for additional in depth primary and secondary data collection; and an analysis and reporting phase.

The intervention logic was used to guide answering the evaluation questions. Evaluation criteria follow OECD-DAC guidelines for project evaluations, namely: relevance, effectiveness, synergy, efficiency, impact and sustainability.

The evaluation methodology followed directions as provided in the terms of reference (ToR) (please refer to annex 2: Terms of Reference for further details). Consequently, methods comprised a desk and literature review, secondary analysis of quantitative data and in-depth discussions with direct and indirect project beneficiaries and stakeholders.

A field phase took place at the project site in Kampong Cham and Tboeung Kmum provinces (formerly Kampong Cham province), additional meetings were held with stakeholders in Phnom Penh. The evaluator met with direct and indirect project beneficiaries and stakeholders, including: children, youth and adults with disabilities, their families or care takers as well as other stakeholders, such as: 1) representatives of public and private stakeholders in the field of rehabilitation, including government institutions and (not) for profit private physical rehabilitation services providers; local authorities, partners, stakeholders and project staff who participated in HI-supported Rehabilitation Project activities between 2014-2017. Informants were invited for semi-structured face to face and group interviews (meetings, interviews, focus group discussions).

The initial meeting with HI project management staff allowed to adopt the inception report, finalise the list of stakeholders to be met during field phase and set a tentative evaluation schedule in a participatory way. A similar process was followed on site for the development of detailed field phase schedules in collaboration with PRC management staff. (Please refer to Annex 3: Evaluation schedule, for the final schedule followed for this evaluation).

A half day debriefing was held with HI project staff at the end of the field phase to discuss and explore primarily evaluation results and recommendations. A Power-point presentation guided the discussion. This allowed to illustrate findings, conclusions and recommendations with concrete examples to enhance understanding and promoted a participatory approach towards the formulation of recommendations for further project implementation. This report reflects on the debriefing discussions and provides a summary of results. A few examples are provided to enhance clarity.

A draft report was submitted for commenting and feedback integrated. This report is the result of a final request to restructure the final report according to evaluation criteria.

For more details on the evaluation methodology, please refer to Annex 4: Evaluation methodology, that provides additional information on methods used, tools used for data collection and analysis and key informant characteristics.

3.1 Limitations and facilitators in data collection and analysis, data quality or access to data sources.

Limitations

The initial desk review allowed to gather insight in different aspects of project design, implementation and evolution. It could be noted that monitoring tools gather information in accordance to the indicators as mentioned in the original log-frame. However, reports revealed some inconsistency in data. Consequently, monitoring and data management systems were given extra attention during the field visit.

Rehabilitation Project data management systems are multiple and cover both, continuous data collection from patient and services provision registration as well as specific data collected within the framework of particular project interventions. However, set up of data management systems and quality of data collected hindered in-depth complementary analysis and findings in this evaluation report are principally guided by secondary data from project documents, literature review and publicly accessible statistics as well as primary qualitative data collected during field phase. Triangulation was used to ensure validity of findings.

The evaluator had limited Khmer language skills and translation was required for meetings and discussions with key informants during field phase. An external translator / facilitator was hired following recommendations of

HI. The selected candidate had former work experience with HI and several stakeholders. This had the benefit of being able to function as a resources person, yet, also, implied possible biases, including: respondent and/or interpretation biases. The issue was discussed prior to hire whereby HI expressed itself in favour of the candidate. To limit biases different sources of data were considered to allow for triangulation and a number of interviews and meetings were held by the evaluator exclusively. No project staff was present during interviews, meetings or group discussions with informants.

Due to a tight schedule some meetings could not be held as planned and flexibility in time management as well as exploring alternative sources of information were required to ensure sufficient data could be collected for triangulation.

Due to unforeseen reasons and tight schedules neither the project manager nor the programme deputy coordinator could participate in the debriefing session.

Facilitators

Flexibility, patience and enthusiasm in project staff and stakeholders allowed to ensure sufficient data collection so to promote validity of qualitative findings.

4. ANALYSIS AND KEY FINDINGS

4.1 ANALYSIS

This chapter explores the data collected during the evaluation towards answering the evaluation questions. Evaluation questions and derived indicators against which to measure achievement were guided by the terms of reference (ToR). Indicators were agreed upon during the inception phase and used to develop the analytical framework linking indicators to themes. For more details, please refer to Box1: Evaluation questions and set indicators; as well as Annexe 4: Evaluation methodology for an overview of the analytical framework.

As per HI request findings are presented following the evaluation criteria as proposed under the ToR and the inception report, namely: relevance, effectiveness, synergy, efficiency, impact and sustainability, gender sensitivity and child safeguarding addressing the evaluation questions / derived indicators. Where findings overlap, information was repeated to ensure to follow the original structure. Definitions of the evaluation criteria follow OECD-DAC guidelines for project evaluations and were agreed during the inception phase. They are presented in Box 2: Definitions of evaluation criteria for the purpose of the Rehabilitation Project final external evaluation.

Box 1. Evaluation questions - indicators

Evaluation questions	*Indicators*

Relevance
 	
Is the PRC addressing the needs of the population?
 	
Is the current project approach relevant taking into consideration current policy reforms within and health sectors on a medium to long term?
 	
Including:
- Compare impairment classification of PRC clients and the types of services currently provided by the PRC with the target population. Identify any potential overlap with services offered within public health / services system, and define whether service packages provided at the PRC need to be reviewed
- Have the partnerships set up at the different levels of intervention proven to be successful? Did they foster dynamics in the implementation of the actions?
- Was the support provided to the PRC in line with what was needed? And have the shortcomings improved since?
	- PRC services correspond to estimated needs for physical rehabilitation (type, kind, quantity)
	  ○ PRC services are complementary to services provided within the public health / social services system (overlap, need for revised services packages)
	  ○ partnerships complement / strengthen activity implementation
	- project approach is in line with national legal frameworks, including health and social sector reform plans
	- activities and expected results are rational to attain the project objectives (needs assessment)

Synergy
- Have the partnerships with PWDF and MOH and with other stakeholders involved in the rehab sector proved to be coherent with the project's objectives, including but not limited to:
  ○ Have real synergies been created between health and rehab stakeholders? How could they be improved?
	- partnerships strengthen project achievements / outcomes (HI / PRC)
	  ○ effective (choice, kind, added value / synergy)
	  ▪ synergies exist between health and rehab stakeholders

○ What is the impact of enhanced links between health and rehabilitation stakeholders in terms of access to rehabilitation services for people with disabilities? - Is the Kampong Cham PRC effectively collaborating with local, provincial and national stakeholders? Is the intervention (technical working groups, participation to stakeholders meetings…) targeting all relevant stakeholders? Are there gaps? - What other partnerships could usefully have been set up?	▪ links between health and rehab stakeholders improve access to rehabilitation services for persons living with disabilities ▪ KC PRC collaborates effectively with relevant local, provincial and national stakeholders ○ documented ○ acknowledged by partners ○ sustainable
<u>Effectiveness</u> - To what extent did the proposed intervention method achieve the expected results and achieve value for money? - How is the quality of the Social Work, Physiotherapy and P&O services provided both at the centre and outreach services against relevant standards? Are the services provided comprehensive enough? Is the current model of care effective in addressing the rehabilitation needs of the target groups? - What is the effect of the social work unit in improving the holistic quality of interventions to support the clients' needs? Are people with psychological correctly identified and supported? How could this be improved? - Are the different disciplines working in a true inter-disciplinary model, or are services provided in the one location using a silo approach? What strategies are used/could be implemented to create a successful inter-disciplinary team? - Do clients receive all the appropriate equipment/adaptive devices required for their rehabilitation after discharge? - Are the monitoring mechanisms in place effective in measuring the effects of the intervention, and also in ensuring that the intervention is relevant to the Cambodian context? - Are there clear quality improvement plans in place for clinical services? - Are PRC services adapted for a logical handover to the PWDF? - Has the programme been able to adapt to unexpected developments? To what extent did any adjustments affect the achievement of expected outcomes? - What factors hindered or facilitated the achievement of objectives?	- level of achievement by result / objectively verifiable indicators (project prop. DGD, MOFA - READ 02) - PRC services provide quality services against relevant standards (national, HI) ○ social work ○ physiotherapy ○ P&O - PRC services comprehensively address rehabilitation needs ○ different disciplines work in a true inter-disciplinary model ▪ social work unit ensures a holistic approach to client needs ▪ clients with psychological or other needs that cannot be addressed at the PRC are identified and supported to access required services ▪ clients receive appropriate information and equipment/adaptive devices required for their rehabilitation at discharge - PRC provides satisfactory services at beneficiary level: ○ responds to needs within services scope ○ user friendly (accessibility, attitude) ○ improved functioning (ICF) - PRC has effective management systems in place (documented, implemented, effective, sustainable)

	○ normative framework (mandate, organisational structure), ○ resources (human, financial, material), ○ processes (procedures, information management, monitoring and evaluation (M&E)) ▪ monitoring mechanisms: effectively measure intervention outcomes, are context specific, feed quality improvement plans and their implementation - PRC services are adequate for handover to PWDF (operation, organisation) - need for project adjustments identified/made ○ reason (external, monitoring) ○ requirements (human resources, finance-funding, operationalization) ○ effect on the achievement of expected outcomes - challenges: what, why, lessons learned, action taken - good practices / case studies: what, why, recommendations
<u>Efficiency</u> - Have the resources been optimised? The evaluation will consider both the quantity and quality of the resources mobilised when dealing with this question. - Does the PRC allocate sufficient staff and resources and in an optimal fashion to provide quality services? - Does the PRC provide services at the most efficient and value for money cost? - Could the project outputs been achieved in a more efficient way?	- project action plan: used and up-to-date - budget spending: planned, revised, (un-)spent - resources optimisation considered in project interventions (quality, quantity, cost) - PRC services consider resources optimisation (quality, quantity, cost) ○ sufficient staff and resources used in an optimal way to provide quality services ○ costing mechanisms in place; cost effectiveness / benefit considered

<u>Capacity</u> - Are the technical capacities of the PRC staff optimal against international or national standards to be proposed by the consultant? Are mechanisms to allow continuous professional education effective? What is the level of autonomy of the PRC staff in managing their work? - What is the level of the organizational capacities (including management, communication as well as human resources, logistics and admin) of the PRC and is the team autonomous in their work? How could it be improved? Is the Rehabilitation Management System (RMS) effective in building the organizational capacities of the PRC? - Does the project provide sufficient capacity building opportunities for the PRC staff? Assess value for money of capacity building and potential for sustainability in a potential handover to the PWDF - How effective is the project in building the capacities of PWDF and of the rehabilitation sector in regards to long term sustainability? What factors have hindered or facilitated the capacity-building of institutional actors? What actions should be taken in priority in this domain (recommendations)? - What is the level of performance of the PRC and its level of production?	- technical capacities of PRC staff according to relevant international / national standards - mechanisms for continuous professional education in place, operational and effective - PRC staff is autonomous in managing work tasks - PRC team has sufficient organizational capacities (including management, communication, human resources, logistics and admin) to manage the PRC autonomously - the Rehabilitation Management System (RMS) has been effective to guide organizational development of the PRC towards an efficiently managed infrastructure - PRC staff capacity building opportunities are effective, efficient and with high potential for sustainability under PWDF - Capacity building efforts of PWDF and the rehabilitation sector are pro-active in regard to long term sustainability of KC PRC - factors that hindered / facilitated capacity-building of institutional actors, best practices, recommendations - performance level of PRC is adequate (quality, quantity)
<u>Impact</u> - Where there any positive or negative unexpected effects linked to the intervention? - To what extend the project contributed to improved socio-economic inclusion of the beneficiaries. - Did the programme enable the Cambodian population to learn more about cluster munitions? - What effects have advocacy actions related to the campaign to ban cluster munitions had? Did they impact the political agenda?	- positive/negative effects on persons living with disabilities, families, communities o functioning o awareness about cluster munitions (danger, accident prevention) - improved awareness on the importance to ban cluster munitions in national stakeholders - ban on cluster munitions integrated in policy agenda
<u>Sustainability</u> - What could be the criteria for defining the cost of physiotherapy, social work and prosthetic/orthotic services in consideration of cost recovery (taking into account the market, including private and public stakeholders)? - Are the current strategies (in terms of technical and management features) effective and relevant in supporting the sustainability of the PRC, including technical, financial, organizational sustainability? What could be additional ways forward? - Have the conditions for the technical and financial sustainability of rehabilitation services been put in place?	- feasibility of cost recovery of PRC services (considering market and public/private stakeholders) - sustainability strategies in place, operational and efficient for different project components (technical, financial, organizational) o responsibility taken by the services' governance bodies o stakeholders' capacities and competencies strengthened

- Have the strategies for ensuring the sustainability of rehabilitation services proved to be relevant and realistic? How involved and how much responsibility was taken by the services' governance bodies? What other forms of collaboration and governance could have been put in place with these bodies? At the end of the programme, can we consider that the stakeholders' capacities and competencies have been strengthened? - Should the outreach intervention be enhanced given the potential handover to the PWDF? - Has the intervention's learning processes been well managed and exploited? If so, how? - Is the intervention proving to be a good model within the sector? Are the innovative tools effectively disseminated? How could innovations be better disseminated? Are those innovation tools relevant to other stakeholders?	- feasibility of enhanced outreach services under PWDF - project implementation learning processes exploited to the full - innovative tools effectively disseminated and found relevant in stakeholders - PRC considered a good practice within the sector
<u>Gender</u> - Does the project respect equality between boys and girls, women and men? - Is data collected disaggregated according to gender? - Is there a significant gender difference between project beneficiaries?	- gender equity considered in all project components - gender disaggregated data available - gender difference in project beneficiaries
<u>Child Safeguarding</u> - Is a child safeguarding policy in place and is the policy implemented at partner level? - Are measures to safeguard children applied?	- appropriate child safeguarding policy in place - staff aware of child safeguarding policy - staff implement child safeguarding measures - partners have child safeguarding policy in place

Box1: Evaluation questions and set indicators

Box 2. Definitions of evaluation criteria for the purpose of the Rehabilitation Project final external evaluation

Relevance

The extent to which the objectives of the project are consistent with the needs of beneficiaries, in line with partners' policies, country normative frameworks and global priorities.

Effectiveness

The extent to which the project objectives were achieved, or are expected to be achieved, taking into account their relative importance and adaptability to risks and assumptions

Efficiency

The extent to which the outputs and/or desired effects have been achieved with the lowest possible use of resources / inputs (funds, expertise, time, administrative costs, etc.)

Impact

The positive and negative, primary and secondary long-term effects produced by the project, directly or indirectly, intended or unintended

Sustainability

The extent to which the benefits from the project continue after termination of the external support in a way that is resilient to risks

Synergy

The extent to which partnerships have proven coherent towards best achievement of project objectives

Gender sensitivity

The extent to which the project takes into account aspects of gender equality and prevention, identification, action, follow-up in case of in-equality.

Child safeguarding

The extent to which the project takes into account aspects of child safeguarding and prevention, identification, action, follow-up in case of risk/exposure.

Box 2: Definitions of evaluation criteria for the purpose of the Rehabilitation Project final external evaluation

4.2 KEY FINDINGS

This paragraph presents the findings based on data collected during the evaluation towards answering the evaluation questions. Findings are presented by theme and address the indicators set against which to measure project achievements and impacts towards the formulation of practical recommendations for further project implementation.

4.2.1 RELEVANCE / SYNERGY

Relevance: Very high

The objectives of the project are consistent with the needs of beneficiaries, they are in line with partners' policies, country normative frameworks and global priorities.

Synergy: Potential demonstrated

Formal and informal partnerships were established to promote best achievement of project objectives. Synergies have been created between services providers and stakeholders, contributing to better outcomes for direct and indirect beneficiaries.

PHYSICAL REHABILITATION PROJECT

Normative framework

The project approach is in line with relevant national and international legal frameworks and goals. Such as the Sustainable Development Goals (SDG) for which assistive technology (AT) can facilitate the achievement of each and most particularly SDG 3 and 10 related to health and well-being respectively, the Convention on Cluster Munitions (CCM), the Convention on the Rights of Persons with Disabilities (CRPD), the regional ICHEON strategy and Bali Declaration, the National Disability Strategic Plan (NDSP), the National Guidelines on Physical Rehabilitation (MoSVY 2012) and other relevant national and local Ministerial directives (MoH, MoSVY, PWDF, CMAA). Both, the health and social sectors are subject to reform. HI is well informed about current reform processes and is an active stakeholder here-in.

Partnerships

The Rehabilitation Project operates within a formal agreement of collaboration between HI and the Royal Government of Cambodia (RGC) through signed agreements with MoSVY and PWDF. In addition, HI – Cambodia works in close collaboration with a series of non-governmental stakeholders in the sector and is an acknowledged key actor in the field of physical rehabilitation and cluster munitions, in the country.

Collaboration with partner organisations (governmental and non-governmental) mainly consists of the sharing of information through reporting and participation in meetings, workshops, conferences, training and monitoring exercises.

Long standing collaboration between HI and the public sector, such as MoSVY, MoH, CMAA, has allowed HI to build a relationship of acknowledged expertise and thrust that helps to implement projects and to expand strategic partnerships with additional key players in the sector (e.g. Disability Action Council (DAC), PWDF). Collaboration between HI and the public sector for the implementation of comprehensive physical rehabilitation for persons with physical disabilities is valued in counterparts and can be considered a win-win for both, parties whereby experience from services implementation can guide policy development towards the strengthening of an adequate sustainable services system.

Limited availability of adequate resources (financial and human) and dependency that may put at risk own project achievement were identified as challenges to furthering operational collaboration. E.g. limited engagement of PWDF towards hiring / acknowledging qualified staff in appropriate civil servant status in a

framework of hand-over; or delay in delivery or low quality of materials and equipment processed through PWDF.

It was felt that HI could explore additional strategic partnerships to further opportunities for strengthening physical rehabilitation services and ratification of the Convention on Cluster Munitions. For example with the DWPD under MoSVY, responsible for development, implementation and M&E of appropriate legislative frameworks to guide adequate services delivery systems in the area of rehabilitation and assistive technologies; the Department of Preventive Medicine (DPM) and the Department of Hospital Services (DHS) of MoH - responsible for the development of normative frameworks and management of physiotherapy services within the health system and relevant Government bodies in Thailand and Vietnam in regard to the ratification of the Convention on Cluster Munitions so to promote tri-lateral ratification. The convention is currently signed by only one neighbouring country, Laos, neither Vietnam, nor Thailand have ratified the convention and the latter was claimed to use cluster munitions at the North Eastern border. This makes the situation unacceptable for Cambodia to further the process of ratification. However, CMAA reported the country is in favour of such ratification and would be pleased to facilitate a tri-lateral ratification.

PHYSICAL REHABILITATION CENTRE – KAMPONG CHAM

PRC-KC Services correspond to estimated needs

In line with legal frameworks in place, the primary target group of the PRC-KC comprises persons in need of P&O services. Globally, the need for P&O services is estimated at 0.5% of a population (WHO, 2011). With the PRC-KC to cover the population of Kampong Cham and Tboeung Kmum provinces, estimated at 1.68milion (NIS, 2009), the primary target population can be estimated at 8500 persons.

Global estimates put the prevalence of disability at 15% (WHO, 2011). The proportion of person(s) living with disability who live with physical impairment is estimated at 19% (WHO, 2011). Disability prevalence increases by age, from an estimated 2.8% in children to 12.4% in the active population reaching 36.8% in the older population (WHO, 2011). Table 1: Estimated population living with physical impairments by age group in the target area, provides an indication of the project target population who may benefit from physical rehabilitation services[3].

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Population*	N	*%*	n	%	n	%	n	%
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Physical impairment	3738	*0.2*	17859	*9.9*	12608	*0.8*	34205	*2.0*

*(NIS 2009, WHO 2011)

Table 1: Estimated population living with physical impairments by age group in the target area

It should be noted that, although, children represent the smallest group in number, their life time needs for physical rehabilitation exceed by far those of the older population group, even when taking ageing trends into consideration.

Over the last decades, Cambodia has gone through major socio-economic developments. These are increasingly reflected in changing needs for physical rehabilitation services and PRC services have gone through a transition of providing mainly lower limb prosthesis for landmine victims in the early post war era to the provision of prosthetic and orthotic assistive devices, physiotherapy and relevant social services to clients with a variety of physical rehabilitation needs following musculo-skeletal and /or neurological health conditions, such as: amputation following road accidents, congenital talipes equino varus (clubfoot) in young children; or impairments related to old age (such as hemiplegia following stroke).

[3] General prevalence estimates have been used, age groups have been adjusted according to the local context with retirement age at 54years of age (RGC, 1994).

Similar to other countries in the region, Cambodia knows a rapid increase in the number and proportion of older persons in the population. This translates in increases of the incidence and prevalence of ageing related impairments and will be reflected in rising demands and changing needs for assistive devices and physical rehabilitation. This taken into account and even children represent the smallest population group in need for rehabilitation services in number, their life time rehabilitation needs will remain higher than those required by the older population and outcomes more efficient, consequently, adequate rehabilitation services for children should not be overlooked.

Currently, no reliable data is available on the prevalence of health conditions that could benefit of physical rehabilitation services by kind in the target population. Data on type of impairment among clients at the PRC highlights the capacity of the PRC to deal with a broad variety of health conditions. Yet, this data does not allow to make projections on service needs, nor coverage. More in depth investigation in this area would require to improve quality of data to ensure validity (e.g. appropriate categorisation of pathology) and harmonising data bases, but would be worth considering.

It is generally agreed that the need for physical rehabilitation services is not covered in low and low-middle income countries and is linked to barriers at both, demand and supply side (WHO, 2017). The Physical Rehabilitation project addresses both, demand and supply sides with innovative interventions to address demand; and through the reinforcement of PRC services to address the supply side. Both, are explored more in depth in the following paragraphs.

PRC-KC Services package

HI works in close collaboration with the Persons with Disabilities' Foundation (PWDF) that is responsible for the provision of physical rehabilitation services under technical supervision of the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY). The PRC-KC provides prosthetic and orthotic (P&O) services, physiotherapy (PT) and social work (SW) as well as support services (such as: food, accommodation and transport) in line with the National Guidelines on Physical Rehabilitation (MoSVY, 2012).

Medical rehabilitation services are provided at the neighbouring provincial referral hospital that provides tertiary health care, including physiotherapy services for in and out patients. The hospital operates under the technical supervision of MoH.

Expansion of physiotherapy services under the MoH is proposed under the revised minimum package of activities (MPA) and complementary packages of activities (CPA). This does express an intention of the health sector to expand the availability of physiotherapy at different levels of health services delivery. Yet, inclusion of physiotherapy in MPA and CPA does not warrant its inclusion in health budgeting exercises, nor does it warrant the availability of qualified human resources or the delivery of quality services. Indeed, it was noted that even KC hospital has PT services with equipped PT room and related human resources, PT services tend to be weak with limited attendance of staff who reportedly may work as nurses to gain additional incentives and/or to work private (PT session at hospital was reported at 2.5USD and 7USD in the private sector).

Current legal frameworks leave space for interpretation and it was noted that the PRC-KC receives considerable numbers of hospital out patients who prefer to receive physiotherapy services at the PRC-KC that provides better quality services for free whereas physiotherapy services provided at the hospital are subject to user fees and reportedly informal out of pocket expenses.

Specific collaboration with the health sector may be required to ensure persons in need for physiotherapy can access adequate services through the health services system. While PRC-KC services may focus on PT related to the provision of P&O only, in line with current legal frameworks.

Furthermore, in line with international guidelines that highlight the need for quality prosthetic and orthotic services as well as other assistive devices in physical rehabilitation, it may be assumed that MoSVY will play a key role in making available a more comprehensive package of quality assistive devices in the future (WHO 2017, MoSVY 2017).

Both, the health and social services sectors are currently under reform towards enhanced services system strengthening. Both, parties provide complementary services and close collaboration is required to ensure person(s) living with disability can access a continuum of care that addresses their complex needs. Also the need to reinforce grass-root social work to further enhance the linking and bridging of complementary services across sectors is generally acknowledged, yet, still a challenge.

PRC-KC Partnerships

The PRC-KC works in partnership with the provincial branch of PWDF. Collaboration through this partnership is subject to a formal agreement between HI and PWDF. So far, collaboration has been oriented towards project implementation, with exchanges to focus on information sharing rather than the building of capacity for take over. Good results were achieved through this approach, yet, it was felt that more investment in a system strengthening approach could favour sustainability of project interventions at PRC-KC level and for the physical rehabilitation sector as a whole.

At centre based level, formal and informal partnerships with stakeholders promote a counter-referral system that creates a synergy between services providers towards a continuum of care for clients. The Demonstration project has considerably contributed to enabling local authorities and health services providers to take up an active role in referral and follow-up. This is to be considered a best practice. Yet, the use of incentives to cover communication and transport costs in referral network actors was noted to have an adverse effect on sustainability.

Collaboration with the public sector can be challenging, it requires strategic partnerships at different levels and across sectors with actors that evolve at different speed. It requires the uptake of a long term perspective that allows for flexibility and re-directing to integrate country level developments.

Since the late 80s, Cambodia has gone through considerable socio-economic developments and public sector reforms that influenced and continue to influence the need for physical rehabilitation and efficiency of public sector responses.

The Physical Rehabilitation project is implemented in collaboration with several actors of the public sector, such as health and social institutions and local public authorities. This is valued and it was felt that this could be further exploited.

HI could invest more to translate its extensive field experience in supporting system strengthening efforts at the national level. For example: through the integration of a module on disability in civil servant and health professional pre-service training; by advocating for the expansion of a grass-root professional social workforce (formally recognised training; integration of professional social workers at commune and district level); and by reinforcing the capacity of District and Provincial Offices of Social Affairs to monitor and advocate for adequate coverage of needs of persons living with physical impairments.

Fast and impressive socio-economic progresses translate in better health outcomes, yet, they also imply growing inequities and more particularly according to wealth and urban/rural divides. The public sector increasingly co-exists with a private sector and social and health sectors will have to ensure quality and equity in a services system characterised by a public / private mix. Number of social health protection schemes exist and the coverage of private and public health insurance plans expands. There is an increasing trend towards demanding services providers whether public or private to ensure a universal coverage of minimum packages of services with quality assurance, yet, this requires a new role for government institutions in regard to regularisation, M&E.

To promote sustainability of equitable, quality physical rehabilitation services for person(s) living with disability in Cambodia, HI may wish to invest to support the RGC in this transition.

HI GUIDANCE FOR PROJECT IMPLEMENTATION

HI provides financial, managerial and technical support for project implementation.

Project implementation has been according to initial plans and outputs are estimated to be achieved by the end of the project period. For more details, please refer to Annexe 2: Rehabilitation Project donor proposals. Consequently, following the definition of effectiveness as applied in this evaluation, the project could be rated as effective (please refer to Box2: Definitions of evaluation criteria for the purpose of the Rehabilitation Project final external evaluation).

It was felt that the project could have benefited from additional technical support in the areas of project efficiency and sustainability (please refer to Box2: Definitions of evaluation criteria for the purpose of the Rehabilitation Project final external evaluation and the next paragraphs for further details).

4.2.2 EFFECTIVENESS

Effectiveness: High

The project objectives are achieved, or are expected to be achieved (end of project December 2017). The relative importance of project activities has been taken into account and adjustments have been made to ensure reaching the project objectives effectively.

PHYSICAL REHABILITATION PROJECT ACHIEVEMENTS

The project achieved the objectives as per project proposals and initial plans. Consequently it can be considered that intervention methods were effective. (Please refer to Annexe 1: Rehabilitation Project donor proposals)

Table 2: Overview of project activities, provides an overview of major project interventions along the project period. It can be noted that implementation of interventions followed original project plans. Also, the following paragraphs explore project interventions in more detail.

PROJECT INTERVENTIONS

Referral mechanisms

The Demonstration component of the project was put in place to strengthen a counter referral mechanism based on identification, information and referral services provided by an enlarged cross sector network of local public and private not for profit stakeholders. Project activities included sensitisation and training of stakeholders and the provision of incentives to support communication and transport costs. Stakeholders included: representatives of local administrative authorities, health services providers and civil society (e.g. disabled persons organisations (DPO)) and focal point services users. The project experience was documented in a capitalisation report that includes lessons learned and recommendations (HI 2017). Results were shared amongst stakeholders through a national seminar. All parties expressed their satisfaction about and interest in the project.

Transport costs, severity of impairment and absence from home that requires to find alternatives for everyday tasks (such as: caring for children - siblings or old parents or work such as agriculture or farming) are identified as the major barriers to attend services at the PRC. Involvement of village leaders to motivate attendance was seen as considerable facilitator.

A considerable number of new clients were registered at the PRC during the Physical Rehabilitation project period (namely, 1554 new clients, representing 21% of the total number of clients who visited the PRC-KC during the Physical Rehabilitation project). This may be indicative of positive outcomes of the strengthened referral system that aimed to lower barriers to access physical rehabilitation services. Graph 1: Number of clients by referral source per year, illustrates referral sources of PRC-KC clients during the Physical Rehabilitation project.

The Demonstration project allowed to illustrate an interest in local stakeholders to take up an active role in identification, information and referral services. Some questions were raised about project efficiency and sustainability. It was felt that: 1) expansion could be considered over a short term period with the availability of financial resources; 2) efficiency and sustainability could be enhanced by using the key message from the pilot, namely that health centre (HC) staff and local authorities may wish to take up an active role in identification, information and referral of persons with physical impairments, to argue for the integration of a module on audience adjusted disability issues in pre-service training curricula of respective professions.

PRC-KC Services

In line with legal frameworks in place, PRC-KC provides a comprehensive package of physical rehabilitation services comprising prosthetics, orthotics, mobility devices and seating systems; physiotherapy and social assistance. Additional support services, include: food, accommodation and reimbursement of travel cost according to means. For details on services provided, please refer to Table 2: Overview of project activities that provides additional information on PRC-KC services by kind per year, and more particularly for the P&O and PT services and SW.

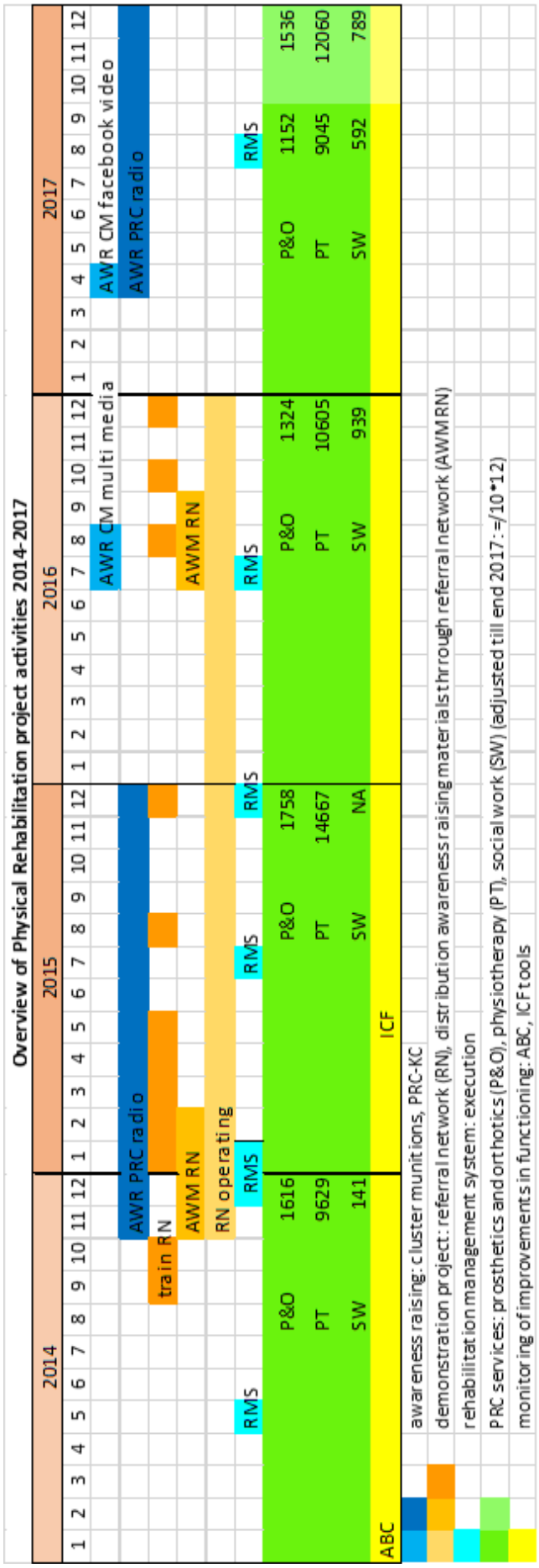

Table 2: Overview of project activities

The capacity of the PRC-KC to address a broad variety of physical rehabilitation needs could be noted through observation and reporting. A comprehensive approach is further reinforced through the development of counter referral mechanisms with complementary services, such as orthopaedic surgery at the hospital.

At the PRC-level a holistic client centred multi-disciplinary approach is adopted. This was noted to translate in an improved collaboration between different services sections, to promote cohesion amongst staff and to positively influence on patient care and satisfaction.

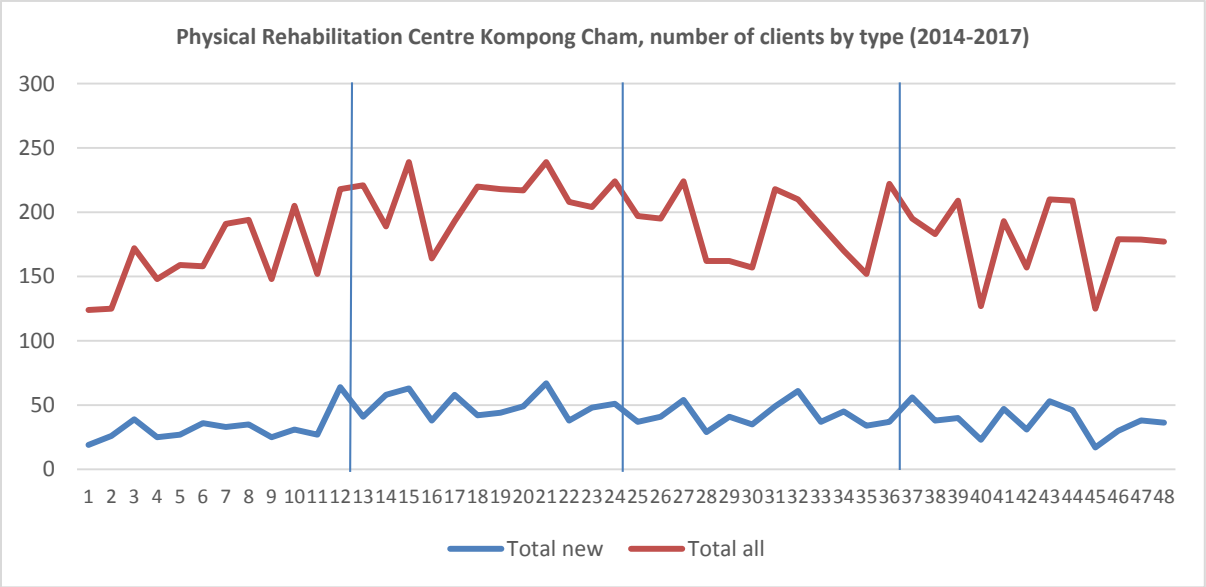

Fig. 1: Number of Physical Rehabilitation Centre clients by kind, over the project period 2014-2015[4]

Prosthetic and orthotic services (P&O)

P&O services offer a comprehensive variety of prosthetics, orthotics, mobility aids and seating systems. Assistive technology is produced following quality, low cost technologies that are generally used across physical rehabilitation centres nationwide.

Physiotherapy (PT)

PT is provided for all client who may benefit physiotherapy, including those who require P&O services. The mandate of PRC focuses on the latter group only, yet, current legal frameworks leave space for interpretation and the PRC receives an additional number of clients who prefer to receive physiotherapy services at the PRC that provides quality services for free. Whereas physiotherapy services provided elsewhere in town are subject to fees. E.g. physiotherapy in the private for profit sector or at the neighbouring referral hospital that applies user fees and reportedly is subject to informal out of pocket expenses.

Social work (SW)

Social workers provide information and referral services, basic individual and group counselling and facilitate awareness raising sessions. Volunteers, users of PRC services participate in referral services and orientation and awareness raising activities at the PRC. Clients with needs that cannot be addressed by the PRC are referred to access external services, such as for psychological care, vocational training or additional health care.

The Personalised Social Support (PSS) project made available additional means to provide a more holistic approach to client needs and allowed for improved social support at the grass root level with positive impact on functioning and quality of life. For example, clients' autonomy through guidance and resources to build accessible wash infrastructure made available under the PSS project was acknowledged by PRC clients to contribute to autonomy, dignity and quality of life, subsequently, considerably improving overall well-being.

Social workers try to ensure a holistic approach to client needs, yet, expressed concern about not having sufficient means to ensure the social assistance required in more complex cases, even during the PSS project. Complex cases were defined by social workers as those who need more than short term information, referral

[4] October-December 2017 adjusted (=/10*12)

and support services (such as guidance and materials to improve accessibility of infrastructure), namely, those who require specific case management with a personal approach and close monitoring and follow-up over a long period of time. Such cases may be linked to severe levels of disability or other factors that hinder the person with the impairment, their family or community to invest sufficiently in the realisation of an environment in which all can develop to one's full potential. Please refer to Case study 1: when clubfoot management requires more to be successful, the potential importance of social work in successful physical rehabilitation.

CASE STUDY: When clubfoot management requires more to be successful…
The potential importance of enhanced social work in successful physical rehabilitation.

"… My daughter was born with clubfoot.
First, she received plasters casts at the PRC,
then they referred her to Phnom Penh for free surgery,
but, the doctor could care for one foot only,
I had to go back to the PRC to get additional casting for the second foot…

I returned home, I had spent a lot of money to travel,
my husband had been alone to care for the other children and grandparents,
work at the farm was running behind…

So we decided to go back after harvesting,
yet, by that time, my daughter's feet had already turned inwards again.
The PRC referred us back for surgery in Phnom Penh,
But, I couldn't leave my family alone again…

We haven't been able do it…"

This case study shows that information, referral and quality physical rehabilitation services at the PRC and at referral services (here the hospital) may not be enough to ensure persons in need for physical rehabilitation receive the services they need. Cases like this require additional support that can be provided through enhanced grass-root social services.

Mother of a girl with clubfoot (7y) PRC-KC beneficiary, 2017

With an estimated 20% of person(s) living with disability to live with a severe level of impairment and severity identified as a main barrier to access services, it may be assumed that a considerable number of person(s) living with disability do not receive the services they need to enable them to participate in society to their full potential on equal base to others (WHO 2011, HI 2017). It highlights the substantial need for enhanced social

services at the local level. Table 3: Estimated needs for grass root social workers to assist families affected by severe physical impairments in the target area5 illustrates this potential unmet need.

Estimated social worker needs for persons with severe physical impairments, in the target area				
Age group / population	<19y	19-54y	>54y	total
Person(s) living with disability severe physical impairment	748	3572	2522	6841
Number social workers	37	179	126	342

Table 2: Estimated social worker needs for persons with severe physical impairments in the target area[6]

Technical quality

Services follow existing norms and standards in place. Yet, it was felt that services could benefit from extra technical support to further enhance quality of services. HI could play a considerable role, not only in the reinforcement of quality services delivery at PRC-KC level, but, also for the development of national norms and standards and consequently support sustainable quality services delivery.

The following paragraphs illustrate some examples for potential quality improvement of services:

Physiotherapy

Physiotherapy was found to be too invasive at times. For example in the case of torticollis in new-borns active stretching by the parents was proposed, while similar results could be obtained through gentle non-invasive techniques that motivate the baby to turn his/her head and allow for self-induced stretching, e.g. knowing a baby will search to look to a source of light, positioning the baby in a way that the source of light comes from opposite direction to the torticollis will invite the child to turn his head and stretch related muscles.

National treatment protocols may not be followed, for example in the case of congenital clubfoot. Protocols highlight the need for medical advice first so to differentiate positional and idiopathic deformity. Serial casting is done at the hospital and only when full positional correction has been achieved, cases are referred to physical rehabilitation services for bracing. Currently, new-borns as young as two days of age are subject to serial casting at the PRC. Not only is this not in line with national directives of care, also, there is no scientific evidence of an added value to start treatment before 28 days (Ilkar S, 2010).

Clients may receive too little explanation to know how to care (exercises, cast, device) when returning home. E.g. Parents may not be informed about the need to and how to take off a cast in case of danger signs in serial casting for clubfoot treatment (put in water, leave to soak, unroll the bandage, ... then return to the PRC).

Prosthetics and orthotics

P&O services do not always ensure proper fit and alignment. E.g. improper finishing with remaining sharp boarders; no height compensation to ensure proper bilateral height in unilateral AFO.

Social work

The referral network in social work is limited to a narrow network of services providers (number of services providers in the services directory for referrals equals seven), in addition, it was noted that some of these services providers may not be able to deal with the special needs of persons with moderate to severe physical impairments, yet, social workers do not provide support to services providers to develop capacity towards inclusiveness. This can be considered a missed opportunity.

Also, social workers are requested to identify clients with psychological distress for referral. An assessment tool was provided in this regard and the related questionnaire is now part of the standard social work procedure for clients. Yet, it was felt that the tool that includes several questions on suicide, goes beyond the depth of standard procedures and PRC-KC social worker expertise. It would be recommended to revise and adjust the tool to better respond to the general character of the target population.

[5] Social work needs are etimated on a 1/20 rate, an average case rate per social worker in complex case management (NASW, 2013).

Management processes

Overall management processes and procedures are in place and ensure effective operation towards reaching and documenting project outputs.

Mechanisms to address quality improvements are in place through staff meetings, M&E mechanisms and reporting with HI project/programme managers. Yet, no specific quality improvement plans for clinical and social services are in place. A P&O quality assessment was conducted by a partner services provider and followed with additional short course training for PRC-KC P&O staff. However, no follow-up has taken place.

A Data management (collection and analysis), patient recording systems, operational procedures and M&E mechanisms are in place. A considerable amount of information is gathered on activity implementation and services provision. Activity reports are written and graphs on activity implementation produced.

Over the years, a multitude of adjustments and new tools have been introduced and the system has become burdensome with adverse effects on efficiency. (Please refer to section 4.2.3 on efficiency for more details)

An M&E system is in place and although quantitative data management could be strengthened, qualitative reporting is done in a way that illustrates reflection on project implementation, drawing on lessons learned and building on best practices.

Overall, it was felt that the project could benefit from a more effective user friendly quality data-management system that would allow to withdraw information useful for M&E purposes toward guiding project planning and implementation with enhanced efficiency. (For more details, please refer to section 4.2.3 on efficiency).

IEC, awareness raising and advocacy

A series of information, education and communication (IEC)-tools for training, advocacy and awareness raising were developed and distributed through the project and more particularly in regard to training and sensitisation under the Demonstration and Cluster Munitions projects.

IEC activities are seen appreciated and effective to promote the involvement of local authorities and health sector managers in identification, information and referral services and helped to raise awareness on the importance of the Convention on Cluster Munitions.

It was felt that providing models/examples, such as infrastructural adjustments at HC are a welcome additional means to enhance direct and indirect awareness raising (e.g. accessible toilet, slope).

Involvement of national level stakeholders in field visits showed appreciated and effective to promote high level support in activity implementation and networking. Involvement of grass-root level HC staff in the facilitation of identification, information and referral services showed a positive effect on the interest and willingness of staff to take up a more active role in disability prevention and management.

Interventions in this area were appreciated and showed effective. Yet, they did not translate in the ratification of the Convention on Cluster Munitions nor in the standard integration of disability issues in local development plans with subsequent public budget allocation.

A demand for pre-testing of IEC materials was raised and it was felt that the project could benefit of standardised training materials and manuals so to guide and enhance sustainability of quality training and allow for distribution and sharing in external stakeholders.

It was noted that materials are often available in soft copy only, limiting accessibility of materials in all staff. The availability of hard copies was recommended to complement soft copies.

Planning and budgeting

Project plans and budgeting were followed according to the initial agreements. Some minor changes were made to enhance effectiveness of project implementation. E.g. Budget adjustment according to availability of additional funds (MoFA/WHO); purchases made to cover delay of quality products by PWDF.

For example: During the project period, quality of prosthetic foot bolts ordered through PWDF were found to be of insufficient quality. The problem was noted across PRCs purchasing through PWDF and bolts were re-called for replacement. An additional purchase was made to cover delay of replacements.

This flexibility in planning and budgeting allowed the PRC to continue to deliver high quality services and directly impacted on client satisfaction and project outcomes.

Were changes in planning and budgeting occurred, they were documented and agreed upon by partners and donors.

OVERALL

It was felt that although the project has been effective to reach the project objectives and consequently, effectiveness is to be considered high, operational and organisational aspects may require quality enhancement to ensure an efficient service that can serve as a model for hand-over or replication. Please refer to section 4.2.3 on project efficiency.

QUOTE 1: Comprehensive physical rehabilitation towards improved functioning, quality of life and well being

"… I was an **active** person supporting my wife, children and grand-children,
suddenly, I had become a **burden** to them…
I had come to a point where I was prepared to commit suicide.

Then, the **health centre** referred me to the **PRC-KC**,
during my stay there:

I **met other persons** with similar difficulties,
I **participated in group discussions** with the social worker,
I **did exercises** with the physiotherapist,
I **received** a foot orthosis from the orthopaedic technician, …
I learned to walk again and to better control my arm and hand,

it **changed my life**,
I can **participate in family life again …** I feel happy now!"

PRC-KC beneficiary with hemiplegia (M, 51y) 2017

4.2.2 EFFICIENCY / CAPACITY

Efficiency: Remains a challenge

The extent to which the outputs and/or desired effects have been achieved with the lowest possible use of resources / inputs could benefit further attention during the next phase of the project.

RESOURCES OPTIMISATION

Overall, a concern for resources optimisation is shown in programme management and project implementation at various levels. E.g. collaboration between HI and with partner services providers to bulk import orders; or shared use of vehicles. The allocation of resources is carefully considered and subject to prioritisation

processes. Also, a concern for contextual appropriateness is shown. E.g. choice for equipment and materials takes into account local production and availability aspects.

Monitoring exercises and analysis of data are used to identify potential for further resources optimisation. For example, assessment of the production realised by the P&O section allowed to identify the possibility to downsize staff. A change that since has been implemented and promotes more efficient use of human resources.

Yet, it was found that prioritisation processes may be driven by the availability of resources and opportunities rather than identified needs. This may limit efficiency of project investments. E.g. human resources development according to training offers rather than plans for continuing education; or ad hoc data collection systems rather than a review and adjustment of the data management system in place. Also, the HI team in PNH currently has no specific technical advisor to guide Rehabilitation Project implementation. It was felt that such position could add additional efficiency to project development, implementation and outcomes (for more details, please refer to the following paragraphs).

PRC MANAGEMENT

Resources management

The project operates with sufficient resources in regard to financing, human resources, consumables and non-consumables.

Financing

The PRC receives funds from both, PWDF and HI (MAElux, DGD (2017) and HI own funds). PWDF funds cover water, electricity and garbage collection fees and contribute to transport and food expenses as well as some materials and equipment. HI funds the remaining costs. Accounting takes part at both, the PRC centre and HI-PNH office. The project could count on reliable financial resources. Financial data is sufficient for administrative purposes.

Human resources

Human resources are according to the organisational structure. It was felt that a re-assessment of the organisational structure towards simplification and optimisation of work processes could optimise human resources. E.g. the social work section currently operates through two social workers and two half time volunteers for the provision of information, referral and follow-up services. It was noted that simplification of social work assessment forms (e.g. history, poverty, psychological well-being, ICF) and processes (e.g. information management or field visits to follow up on missed appointments) could be simplified to allow for human resources optimisation and improved efficiency.

The PRC currently employs 25 staff (7 civil servants, 18 HI) and receives support of two volunteers who receive an incentive by HI. Civil servant staff receive a top up on their salary by HI to reach an equivalent pay to HI staff. Staff wonder why Rehabilitation Project staff receive lower payments than other HI project staff, civil servant wonder why they do not receive the same benefits as HI PRC staff and volunteers wonder why they are not considered as staff after a given period of time. This was noted to lead to tensions between staff of different projects and within the Rehabilitation Project. Adjustment towards equal pay and benefits was requested.

Staff is trained and qualified to do their work tasks. Ortho-prosthesists and physiotherapists received formal professional training, other staff received on the job training and complementary short courses. Annual appraisals allow to identify needs for continuous education and staff are invited to participate in training and learning events. Yet, staff expressed the regret that training opportunities seem subject to offer rather than continuous education plans. One social worker and one volunteer expressed their interest to take up full time education and become professional social workers. This reflect a motivation that when translated into action may contribute to sustainability and services system strengthening. In addition, with volunteers to be PRC clients with physical impairment, this could contribute to the development of an inclusive workforce.

The use of volunteers to conduct a specific task over a given period of time is well accepted, yet, long term services delivery may not rely on volunteering because: 1) volunteers cannot be held accountable, nor responsible for the provision of services; and 2) volunteers are likely to wish to evolve towards the same work conditions as colleagues which when not considered will influence on motivation and quality of work. Volunteers at the PRC-KC expressed a frustration about the imbalance between their workload and benefits (compensation for transport and communication) and those of colleagues (salary, insurance, holidays, sick leave, extra incentives for New Year, etc.). Similar, participants in the Demonstration project reported to have

stopped activity implementation since the end of the project / payment of incentives. This highlights the potential to use volunteers as short term agents for change rather than to complement services delivery in the long term.

Materials and equipment

The project benefited sufficient, quality materials and equipment. Where possible local materials and equipment were used. A large store is available. Purchasing and orderings are ensured by the logistics officer. Sound purchasing procedures are in place.

Some delay and quality issues were noted in materials procured through PWDF. Similar problems were noted by other physical rehabilitation services providers and action taken, namely, bolts were recalled and replaced by new ones of improved quality.

Normative framework

The PRC management and operational procedures are in line with national legal frameworks and follow HI directives and standards. Budget spending is planned according to project implementation plans and revisions are made to enhance effectiveness of implementation. For example, additional bolts were bought to cover delay of replacement of low quality bolts by PWDF to avoid extensive waiting times amongst PRC-KC clients. Adjustments are documented in both, planning and budgeting exercises. Only minor changes were made.

Use of the Rehabilitation Management System (RMS) tool to monitor PRC management performance has helped to sensitise staff about the various aspects that influence on services delivery effectiveness and has led to remarkable improvements in the quality of services provided by the centre. For example, with the adoption of a warm and welcome attitude towards clients; the implementation of a multi-disciplinary client centred approach; and the importance to care for ones work-space (equipment maintenance and cleanliness).

On the other hand it was noted that use of the tool has its limits. a) It was felt that the tool is too complicated for staff to use in an autonomous and participatory way. It requires the capacity to ask the right questions, to gather good information, to analyse results towards the identification of problems, to define solutions, prioritise and translate recommendations into action. b) It was noted that prioritisation may be driven by availability of resources rather than improvements in programmatic outcomes. c) Without external support, implementation efforts slow down. For example, it could be noted that after the last RMS in August 2017, no more monthly staff meetings nor case study meetings took place.

Consequently, the RMS tool may be most efficient as a guiding tool, most useful in occasional evaluations or spot-checks to provide a basis of information for guiding discussions in planning or review processes.

Overall management processes and procedures are in place and ensure effective operation towards reaching and documenting project outputs. Yet, over the years, a multitude of adjustments and new tools have been introduced and the system has become burdensome with adverse effects on efficiency.

Staff may not understand the added value of tools, processes and procedures. This was noted to have a negative influence on compliance. For example, store management is rational for the store manager only who reports to "know" where store cards and items are located. Yet, there is no logic in store card order nor in physical item storage. This may hinder store management in case of absence of the store manager.

Information management

Communication channels

Communication channels for internal and external communication are defined and operational. Regular meetings and reporting mechanisms as well as individual contacts between staff of different levels allow to ensure a feedback and information sharing system. Yet, it was felt that too many reports and meetings are requested to be made and feedback and follow-up may be limited.

Data

Data is collected through patient and services delivery recording mechanisms, operational procedures (such as minutes of meetings, store management, accounting) and M&E mechanisms. This data helps to produce regular activity reports.

However, it was felt that the management of data could improve. It showed difficult to get a full picture of services received by a particular beneficiary as information is scattered across different database systems that are incompatible for cross data analysis in their current format. Also, current classifications on cause and kind of impairment are prone to misclassification and limit validity of data obtained. Together with limited validity of data related to compliance amongst staff to complete tools / feasibility for staff to manage data correctly (collection, entering, analysis, use) hinders possibilities for meaningful analysis. (Please refer to Annex 5: Debriefing presentation for an example: ICF – impact assessment).

Qualitative reporting is done in a way that illustrates reflection on project implementation, drawing on lessons learned and building on best practices.

It was felt that the project could benefit from a more effective user friendly administrative and quality data-management system that would allow to withdraw information useful for patient management, M&E and evidence based programming with enhanced efficiency.

Overall it was felt that although the project has shown effective to reach set objectives there is room for improvement in the area of operational and organisational efficiency and more particularly in regard to quality of clinical services and user-friendliness and usefulness of administrative procedures and processes.

Active engagement of PWDF remains limited as does direct investment of HI to strengthen the capacity of the institution for take over. It would be recommended to invest in enhanced PRC-KC efficiency and to explore a broader network of stakeholders relevant towards services system building so to promote sustainability of quality PRC services accessible to all. (Please refer to section 4.2.1: Relevance, synergy and the paragraph on partnerships for further details.)

4.2.4 IMPACT

Impact: High

The project has shown the potential to create a highly positive impact, primary (gain of functioning) and secondary (gain of quality of life, participation in socio-economic activities and improved dignity and self-esteem amongst direct and indirect beneficiaries).

Client satisfaction and impact

High client satisfaction rates were reported in both, satisfaction surveys and interviews with PRC clients. Monitoring of intervention outcomes on functional autonomy and social participation showed substantial improvements (47% functional improvement at 6months, using the HI ICF tool) and several clients reported a positive secondary impact of physical rehabilitation services on self-esteem. The latter was noted in clients who participated in specific activities implemented at the PRC with the social work unit, such as peer support, as well as amongst clients in general regardless of personalised social support received under the PSS project. Clients expressed to be pleased about accessibility and quality of services received at the centre, both in regard to infrastructure as well as attitude in staff.

Quote 1: Comprehensive physical rehabilitation towards improved functioning, quality of life and well-being; illustrates the impact physical rehabilitation services may have on both, physical functioning and psychological well-being.

Interventions in the area of Cluster munitions were implemented, a website was created and videos developed. Ratification of the Convention is high on the policy agenda for Cambodia, yet, more bilateral high level discussions with neighbouring countries Vietnam and Thailand are required to create a favourable context for tri-lateral ratification.

The major un-expected effect that could be identified would be the impact of administrative burden on staff motivation.

4.2.5 SUSTAINABILITY

Sustainability: Remains a challenge

The extent to which the benefits from the project will continue after termination of the external support in a way that is resilient to risks is influenced by current reforms ongoing in the health and social sectors and may be further addressed in the next phase of the project.

Cost recovery

Cost recovery strategies are considered to promote sustainability of the PRC. Currently they focus on the possibility to introduce user fees. A cost analysis was conducted to identify the cost of assistive devices and a poverty assessment tool has been piloted to assess its appropriateness towards the identification of user fees according to client capacity. Some reluctance was expressed by staff for its implementation considering: 1) clients may no longer come to the centre when informed that user fees are applied; and 2) the subjectivity and additional workload implied with poverty assessments.

Recent data published by the Ministry of Health report an increased risk for catastrophic health expenditure (CHE) and impoverishment due to health care payments in households with a member living with a disability (estimated at 7.5% and 3.83% respectively compared to 4.75% and 2.44% respectively in the general population) (MoH, 2017). Payment of PRC services is not considered a source for CHE, yet, when up and down-stream costs are included, physical rehabilitation treatment may represent a risk for CHE (HI, 2017).

In Cambodia, the mode of social health protection with largest coverage is founded on individual poverty assessments (e.g. Health Equity Fund (HEF), Identification of Poverty (IDP), various informal community based health insurance schemes) (HI, 2107). The national social security fund for veterans, employees and civil servants (NFV, NSSF and NSSFCS) and a growing number of private insurance providers start considering making available different types of health services coverage plans. It may be assumed that these schemes will increasingly include coverage of physical rehabilitation services. Some private insurance plans already do cover prosthetic and orthopaedic services provided by public or private services providers at a cost that allows the use of imported materials. Yet, coverage remains limited and alternatives may have to be sought to ensure equity in access to a minimum package of quality services for all.

The possibility to introduce a basic package of services under universal coverage together with the provision of additional to be paid for services was discussed and found of interest in PRC-KC staff and various stakeholders.

Operational and organisational readiness for hand-over

The Physical Rehabilitation Centre of Kampong Cham works in partnership with the provincial branch of the Persons with Disabilities Foundation (PWDF). Collaboration through this partnership is oriented towards project implementation, with exchanges to focus on information sharing rather than the building of local capacity to take over project activities. Significant results were achieved through this approach, yet, it was felt that more investment in a system strengthening approach with a broader network of cross sector stakeholders could favour sustainability of project interventions in a context of transition.

It was felt that although the project has been effective to reach the project objectives and consequently, effectiveness is to be considered high, operational and organisational aspects may require quality enhancement to ensure an efficient service that can serve as a model for hand-over or replication. Please refer to section 4.2.2 and 4.2.3 on project effectiveness and efficiency respectively.

Overall management processes and procedures are in place and ensure effective operation towards reaching and documenting project outputs. Yet, over the years, a multitude of adjustments and new tools have been introduced and the system has become burdensome with adverse effects on efficiency. It was felt that the project could benefit from a more effective user friendly quality data-management system that would allow to withdraw information useful for M&E purposes toward guiding project planning and implementation with enhanced efficiency. (For more details, please refer to section 4.2.3 on efficiency).

Service provided through the Demonstration and PSS projects were found to have considerable added value and could be considered for expansion if sufficient resources are available. Yet, efficiency and sustainability aspects could be further improved through the exploitation of positive results during the pilot period to feed a system strengthening approach. It would be recommended to translate positive experiences of project implementation and pilot activities to guide services system strengthening.

For example: through the integration of a module on disability in civil servant and health professional training curricula; by advocating for the expansion of a grass-root professional social workforce (formally recognised training, integration of professional social workers at commune level); by reinforcing the capacity of District and Provincial Offices of Social Affairs to monitor and advocate for the coverage of needs for grass-root social work related to physical impairment.

Feasibility for sustainable outreach

It may not be possible for the PRC-KC to cover regular outreach services throughout the target area and it would be recommended to assess potential for the integration of outreach services in locally available services with technical support of PRC-staff who could function as resources persons. Also the use of information technology to promote distance based sharing of information may be useful in this regard.

Piloting innovations and sharing lessons

The Rehabilitation Project focused on the provision of comprehensive physical rehabilitation services through the PRC-KC and included the piloting of innovative interventions such as the Demonstration project, the Personalised Social Support project and introduction of the Rehabilitation Management System. All three projects were implemented according to plan and outputs realised. Learning processes were documented in capitalisation reports and shared through national workshops with stakeholders. Stakeholders reported interest in the respective projects, yet, it was highlighted that although outputs are promising, additional fine-tuning would be required to demonstrate efficiency before to consider going to scale.

4.2.6 GENDER

Gender: Good

The project takes gender and disability aspects into account in design, planning and implementation and has a monitoring system in place that could alert and take action in case of in-equality.

Gender equity could be considered an intrinsic part of the project. The Rehabilitation Project has no specific gender equity measures in place, yet, no gender discrimination was reported and where gender differences were noted, they could not be linked to gender based discrimination.

Gender disaggregated data is recorded for all project components.

4.2.7 CHILD SAFEGUARDING

Child safeguarding: Good

Child safeguarding issues are considered and an associated policy is in place. Partners subject to a formal agreement of collaboration also have a child safe policy or principles in place.

A child safeguarding policy is in place and operational. Partners are requested to have a child safeguarding policy or principles in place.

Staff are aware of and implement child safeguarding measures. It could be noted that PRC staff value issues of child safeguarding and implement safeguarding measures in a natural.

5. Conclusions and Recommendations

5.1 Conclusions

The PRC-KC is an effective structure. Outputs have been achieved and considerable impacts made.

Quality comprehensive physical rehabilitation is a most effective means towards improved functioning and quality of life

Relevance: Very high

The objectives of the project are consistent with the needs of beneficiaries, they are in line with partners' policies, country normative frameworks and global priorities.

Effectiveness: High

The project objectives were achieved, or are expected to be achieved (end of project December 2017). The relative importance of project activities has been taken into account and adjustments have been made to ensure reaching the project objectives effectively.

Efficiency: Remains a challenge

The extent to which the outputs and/or desired effects have been achieved with the lowest possible use of resources / inputs could benefit further attention during the next phase of the project. It was felt that efficiency of services could be enhanced through further resources optimisation, enhanced monitoring of technical quality and simplification of processes and procedures.

Impact: High

The project has shown the potential to create a highly positive impact, primary (gain of functioning) and secondary (gain of quality of life, participation in socio-economic activities and improved dignity and self-esteem amongst direct and indirect beneficiaries).

Sustainability: Remains a challenge

The extent to which the benefits from the project will continue after termination of the external support in a way that is resilient to risks is influenced by current reforms ongoing in the health and social sectors and may be further addressed in the next phase of the project.

The project strategy has been oriented towards activity implementation. Capacity building was limited to delivery of specific tasks (both, clinical and managerial) rather than progressively shifting responsibilities and overall management to partners. More investment in the latter could promote sustainability of project interventions if conducted through a system strengthening approach.

Some sustainability aspects were considered since the early stages of the project, yet, the context in which the project operates has changed considerably. It was felt that in-depth, stakeholder assessment in this regard could help to map potential for hand-over of a number of activities in the mid-term, while to consider a system strengthening approach towards sustainability of equitable physical rehabilitation in the long term.

Synergy: Formal and informal partnerships were established to promote best achievement of project objectives. Synergies have been created between services providers and stakeholders, contributing to better outcomes for direct and indirect beneficiaries.

Gender: The project takes gender aspects into account in design, planning and implementation and has a monitoring system in place that could alert in case of in-equality. Project interventions are gender sensitive and no programmatic induced gender inequalities could be identified.

Child safeguarding: Child safeguarding issues are considered and an associated policy is in place. Partners subject to a formal agreement of collaboration also have a child safe policy or principles in place.

5.2 RECOMMENDATIONS

The "Facing the challenges of functional rehabilitation under public management, Cambodia project" achieved its goal in an effective and equitable way. Recommendations mainly refer to fine-tuning and anticipating broader sector wide transitions to enhance sustainability rather than major programmatic issues.

It would be recommended to balance implementation of short term interventions with high potential for quality results with capacity building towards sustainability of services.

Short term Recommendations

At Rehabilitation Project level

- Continue the provision of comprehensive physical rehabilitation services through a multi-disciplinary client oriented approach that comprises: P&O, related PT and complementary social and support services as per national guidelines on the provision of physical rehabilitation (MoSVY, 2012).
- Continue capacity building for the use of participatory M&E tools that sensitize about broader organizational management issues and show potential to improve quality of services and client satisfaction, e.g. Rehabilitation Management System.
- Enhance efficiency through:
    - The simplification and appropriateness of administrative processes and procedures.

      E.g.

      - ensure data collection is limited to information required to guide informed decisions for improving project efficiency and data management tools are user-friendly;

      -separate continuous data collection for monitoring purposes and specific data collection to build evidence towards recommendation formulation that requires a research approach with scientifically sound methodologies.
    - Further optimization of resources.
        - In regard to human resources: build on best practices to mobilise and strengthen existing (cross sector) resources rather than to expand PRC services beyond its mandate, e.g. the use of phone messaging and / or village chiefs to follow-up on missed appointments rather than having this service provided through outreach by PRC-KC social workers;
        - Finding qualified person(s) living with disability to participate in projects may not be easy, yet investment in their training may prove most effective to promote and showcase an inclusive workspace where persons living with and without disability work together on equal base;
        - In regard to P&O services: consider an expansion of the use of pre-fabricated and modular devices.
    - Further investment in ensuring services are technically sound and least invasive for clients.

      E.g.

      - respect national protocols on the treatment of congenital talipes equino varus (CTEV) (clubfoot) and ensure proper fit and alignment in P&O;
    - Enhance opportunities for cost recovery:
        - Continue to explore ways to promote cost-recovery.

      E.g.

      -such, as making available a donation box for clients who are willing to financially contribute;

      -expand services from a minimum package of free quality services with additional to be paid for services, potentially using more advanced technologies.

At the level of HI

- Continue to provide technical expertise to facilitate the transition process from a physical rehabilitation service focusing on the provision of prosthesis for landmine victims to adequately respond to current and anticipated future physical rehabilitation needs.
- Continue to provide ongoing managerial oversight and specific short-term technical expertise to ensure efficient quality services delivery and management and facilitate planning, implementation, M&E and implementation of the project.
- Continue to allow for flexibility in activity implementation towards enhanced project effectiveness and prioritise project efficiency over indicators.
- Adopt a system strengthening and capacity building approach and assess potential for the integration of project components in public administration, health and social sectors as well as private sector services providers.

  E.g.

  -build on experience from innovative pilot projects and PRC-KC services delivery to facilitate system strengthening;

  e.g.

  -facilitate the integration of relevant training modules in pre-service training of health, social and civil servant personnel;

  -support the process for P&O education to get accreditation of MoE;

  -support the development of a 1or2y professional social worker training with integrated module on disability issues towards a grass-root social workforce;

  -advocate for the expansion of a grass-root professional work force to conduct case management; at commune level for information and referral services and follow-up; and build capacity at district and provincial levels for M&E;

  -build a case on costing of effective services with scenarios to convince MoEF to integrate a package of UPRC.
- Support the realisation of examples / models to illustrate best practices (e.g. adjustment of HC facilities according to accessibility guidelines).
- Continue to try new and expand existing innovative pilots that have shown efficient if availability of resources allow.
- Make available specific resources to implement a new approach to partnerships whereby partners are implementers rather than facilitators.
- Open up to a broad variety of stakeholders and allow for flexibility so to enhance sustainable synergies resilient to contextual changes (CPTA, KhAPO).

Medium term Recommendations

At PRC level

Programme strategy:

- Adopt a balanced two pronged approach that exploits the additional resources from project implementation most effectively towards long term impact through:
  - a number of strategic short term activities with high potential for long term impact (models) that may require high investment of resources, to be implemented by project staff, during the project period; and
  - a services system strengthening approach by building capacity in local stakeholders towards formal partnerships for sustainable activity implementation.
- Search for and support the realisation of inclusion opportunities in mainstream services and consider exclusive services a means of last resort.

- Services:
    - Build on good practices;

    E.g.

    -counter referral between PRC-KC, provincial referral hospitals, health centres and village leaders.

    - Expand use of phone messaging systems and IT for use in information, referral and follow-up services;
    - Expand attractive and tested target audience adjusted awareness raising materials;

    E.g.

    -simple and colourful for children, more specific for health centre staff.
- Organisational / management:
    - Facilitate capacity building in public counterparts as part of system strengthening efforts;
    - Strengthen information management and promote availability of comparative data useful to guide M&E of project implementation and progress.

Long term Recommendations

- Support the integration of quality physical rehabilitation services in services system strengthening efforts,

E.g. the identification of a minimum package of services for universal coverage and the development of a nomenclature with norms and standards, certification, licencing and inspection; as well as costing towards helping the public sector to safeguard equitable, quality services for its population and for clients to be enabled to make informed decisions about choices in assistive technology and physical rehabilitation in a context of public-private services delivery models.

This could be through helping relevant Ministry counterparts to:

-develop a strategy note that would address the implementation of norms and standards for a minimum package of services;

-the development of a human resources development plan according to nationwide services delivery and

-the development of a services implementation plan with relevant M&E framework.

Subsequently, this strategic note and respective plans would be budgeted to discuss with MoEF the possibility for domestic funding earmarked for physical rehabilitation services.

ANNEXES

ANNEX 1: DONOR PROJECT PROPOSALS

To be obtained through HI-C office for consultation

ANNEX 2: TERMS OF REFERENCE

Available at HI-C office

ANNEX 3: EVALUATION SCHEDULE

Rehabilitation Project Final External Evaluation - 13 Nov to 22 Dec 2017

Date		Time	Work session
Friday	17-Nov	am pm	Introduction meeting HI team Initial meeting on project contents with key HI staff Clarification on administrative issues
Monday	20-Nov	am	Meeting with Deputy Programme Coordinator Meeting with Regional Technical Advisor
		pm	Meeting with WHO Meeting with ICRC
Tuesday	21-Nov	am	Leaving for Kampong Cham (KC) PRC Visit PRC
		pm	KC Meeting PRC key staff Finalisation of field phase planning
Wed.	22-Nov	am	KC PRC observational tour Focus group with PRC clients
		pm	KC Meeting with PWFD branch Meeting with DPO Meeting with PRC volunteers Meeting with PRC PT Meeting with PRC manager
Thurs.	23-Nov	am pm	Kong Meas Meeting with CCWC (CC) Meeting with HC Meeting with VHSG Meeting with SCI PRC client Meeting with referral user
Friday	24-Nov	am pm	KC Orang Oeuv Meeting with HC Meeting with referral user Meeting with CP PRC client Meeting with stroke PRC client
Monday	27-Nov	am	Meeting with Programme manager
		pm	Meeting with Programme coordinator
Tuesday	28-Nov	am	Data processing
		pm	Data processing
Wed.	29-Nov	am	KC Meeting with PRC Manager
		pm	Focus group discussion with PRC staff

Thurs.	30-Nov	am	KC Meeting with Logistics officer
		pm	KC Meeting with Data manager
Friday	1-Dec	am	KC Meeting with PHD Meeting with PRH
		pm	Orang Oeuv Meeting with OD
Monday	4-Dec	am	Meeting with DWPD
		pm	Meeting with VIC Meeting with PWDF
Tuesday	5-Dec	pm	Meeting with CMAA
Thurs.	7-Dec	pm	Meeting with Exceed
Monday	13-Dec	pm	Debriefing primary evaluation results
Monday	18-Dec		Draft report submission
Friday	22-Dec		Final report submission

Note: No appointments could be made with MoH and CPTA.

ANNEX 4 EVALUATION METHODOLOGY

The evaluation consisted of three phases. An initial desk review to guide the inception report; a field phase to allow for additional in depth primary and secondary data collection; and an analysis and reporting phase.

The intervention logic was used to guide answering the evaluation questions. Evaluation criteria follow OECD-DAC guidelines for project evaluations, namely: relevance, effectiveness, synergy, efficiency, impact and sustainability.

The evaluation methodology followed directions as provided in the terms of reference (ToR) (please refer to annex 2: Terms of Reference for further details). Consequently, methods comprised a desk and literature review, secondary analysis of quantitative data and in-depth discussions with direct and indirect project beneficiaries and stakeholders.

A field phase took place at the project site in Kampong Cham and Tboeung Kmum provinces (formerly Kampong Cham province), additional meetings were held with stakeholders in Phnom Penh. The evaluator met with direct and indirect project beneficiaries and stakeholders, including: children, youth and adults with disabilities, their families or care takers as well as other stakeholders, such as: 1) representatives of public and private stakeholders in the field of rehabilitation, including government institutions and (not) for profit private physical rehabilitation services providers; local authorities, partners, stakeholders and project staff who participated in HI-supported Rehabilitation Project activities between 2014-2017. Informants were invited for semi-structured face to face and group interviews (meetings, interviews, focus group discussions).

The initial meeting with HI project management staff allowed to adopt the inception report, finalise the list of stakeholders to be met during field phase and set a tentative evaluation schedule in a participatory way. A similar process was followed on site for the development of detailed field phase schedules in collaboration with PRC management staff. (Please refer to Annex 3: Evaluation schedule, for the final schedule followed for this evaluation).

A half day debriefing was held with HI project staff at the end of the field phase to discuss and explore primarily evaluation results and recommendations. A Power-point presentation guided the discussion. This allowed to illustrate findings, conclusions and recommendations with concrete examples to enhance understanding and promoted a participatory approach towards the formulation of recommendations for further project implementation. This report reflects on the debriefing discussions and provides a summary of results. A few examples are provided to enhance clarity.

A draft report was submitted for commenting and feedback integrated. This report is the result of a final request to restructure the final report according to evaluation criteria.

<u>Steps taken:</u>

Step 1.
Questions were translated into indicators.
Please refer to Box.1 Evaluation questions and indicators, integrated in the evaluation report.

Step 2.
Indicators were translated in an analytical framework, linking indicators to themes.
Please refer to Box. I Indicators by theme, integrated in this annex.

Step 3.
Data collection tools were developed to ensure adequate data, sufficient for triangulation so to promote validity of findings and appropriateness of recommendations.
Please refer to an outline of the tools as used to guide discussions, integrated in this annex 4.1: Guidelines for semi-structured interviews.

Step 4.
Data was collected from a variety of sources. High value was given to participation of stakeholders, key informants were invited to take part in face to face interviews, focus group discussions and meetings, e-mail and a comment box were made available for key informants to share additional information in a more / full confidential way. No e-mails were received within this framework, the comment box collected one confidential message.

Step 5.
Data was analysed by theme following the evaluation criteria as defined by OECD-DAC.

Step 6.
A debriefing was held to discuss primarily evaluation results in detail. Examples were discussed to illustrate findings, to highlight successes and to clarify limitations. Recommendations were explored in a participatory manner. Please refer to Annex 5: Debriefing presentation

Step 7.
Results of the debriefing guided the development of the draft report. Feedback was provided and taken into account.

Step 8.
This final draft report was submitted with the wish to best reply to the Terms of Reference and provide useful recommendations for project continuation.

Step 9.
Following the request of HI the final report was restructured to follow evaluation criteria rather than themes derived from the analytical framework.

Box I. Rehabilitation Project final external evaluation: Indicators by theme

Project HI

1. project approach is in line with national legal frameworks
2. project approach is in line with health and social sector reform plans
3. project action plan: used and up-to-date
4. budget spending: planned, revised, (un)spent
5. need for project adjustments identified/made
   - 5.1. reason (external, monitoring)
   - 5.2. requirements (HR, finance-funding, operationalization)
   - 5.3. effect on the achievement of expected outcomes
6. resources optimisation considered in project interventions (quality, quantity, cost)
7. project implementation learning processes exploited to the full
8. innovative tools effectively disseminated and found relevant in stakeholders

Partnership (formal / informal; HI)

9. partnerships strengthen project achievements / outcomes
10. synergies exist between HI, health and rehab stakeholders
11. PRC considered a good practice within the sector
12. improved awareness on the importance to ban cluster munitions in national stakeholders
13. ban on cluster munitions integrated in policy agenda

PRC services

Services kind

14. PRC services correspond to estimated needs for physical rehabilitation (type, kind, quantity)
15. PRC services are complementary to services provided within the public health / social services system (overlap, need for revised services packages)
16. PRC services comprehensively address (physical) rehabilitation needs
17. social work unit ensures a holistic approach to client needs
18. clients with psychological or other needs that cannot be addressed at the PRC are identified and supported to access required services
19. clients receive appropriate information, equipment/adaptive devices (AD), exercises required for their continuing rehabilitation at discharge

Services quality

20. PRC services provide quality services against relevant standards (national, HI)
    - 20.1. social work
    - 20.2. physiotherapy
    - 20.3. P&O
    - 20.4. Management
21. (Staff knows tools, understands added value, applies them, acknowledges feasibility, application is monitored, monitoring is analysed, findings are translated into recommendations and action for improvement)
22. PRC provides satisfactory services at beneficiary level:
    - 22.1. responds to needs within services scope
    - 22.2. user friendly (accessibility, attitude)
    - 22.3. improve functioning (ICF)
    - 22.4. improve self-esteem, dignity

PRC management

Budget

23. budget spending: planned, revised, (un)spent

Funding

24. feasibility of cost recovery of PRC services (considering market and public/private (not) for profit)

Human resources

25. technical capacities of PRC staff according to relevant international / national standards
26. PRC team has sufficient organizational capacities (including management, communication, HR, logistics and admin) to manage the PRC autonomously
27. mechanisms for continuous professional education in place, operational and effective

Processes and procedures

28. the Rehabilitation Management System (RMS) has been effective to guide organizational development of the PRC towards an efficiently managed infrastructure
29. different disciplines work in a true inter-disciplinary model
30. PRC services consider resources optimisation (quality, quantity, cost)
    - 30.1. facilities adequate (design, maintenance)
    - 30.2. sufficient staff, performance level of PRC staff is adequate (quality, quantity)
    - 30.3. sufficient operational (material/equipment/maintenance) resources used in an optimal way to provide quality services
    - 30.4. costing mechanisms in place; cost effectiveness / benefit considered
31. project action plan: used and up-to-date
32. need for project adjustments identified/made
    - 32.1. reason (external, monitoring)
    - 32.2. requirements (HR, finance-funding, operationalization)
    - 32.3. effect on the achievement of expected outcomes

Sustainability strategies

33. PRC services are adequate for handover to PWDF (operation / organisation)
    - 33.1. Effective
    - 33.2. Public institution status (finance, staff)
34. Capacity building efforts of PWDF and the rehabilitation sector are pro-active in regard to long term sustainability of KC PRC (incl. financial management through national budget - public / development partners)
35. challenges
36. good practices

Partnership (formal / informal PRC)

37. local partnerships strengthen PRC achievements (documented, acknowledged, sustainable)
38. synergies exist between health and rehab stakeholders and improve access to physical rehabilitation services for person(s) living with disability
39. factors that hindered / facilitated capacity-building of institutional actors, best practices, recommendations

Cluster munitions

40. awareness about cluster munitions (danger, accident prevention)
41. advocacy ratification Convention on Cluster Munitions

Gender

42. gender equity considered in all project components (gender equality in staff nominations, beneficiary services)

Child safeguarding

43. appropriate child safeguarding policy in place
44. staff aware of child safeguarding policy
45. staff implement child safeguarding measures
46. partners have child safeguarding policy in place

Box. I: Indicators by theme

4.1 DATA COLLECTION TOOLS USED TO GUIDE SEMI-STRUCTURED INTERVIEWS

1. List of participants

1.1 Participant Codes

Participant number: 1, 2, 3,
Location:
KC Kampong Cham (please specify district (D) and commune (C); or operational district (OD) and Health centre (HC) in "affiliation/comment")
PNH Phnom Penh
Type of interview:
FF face to face
FG focus group discussion

Informant:
b1 beneficiary 0-6y + guardian
b2 beneficiary 7-14y
b2g beneficiary 7-14y + guardian (if needed)
b3 beneficiary 15-18y
b3g beneficiary 15-18y + guardian (if needed)
b4 beneficiary >18y
b4g beneficiary >18y + guardian (if needed)
st PRC staff PRC
st HI staff HI
rnw referral network members (please specify kind in "affiliation/comment")
sh other stakeholder (please specify position and affiliation in "affiliation/comment")
part partner (PWDF)

Gender:
f female
m male

Example:

3rd informant, Kampong Cham, focus group discussion semi-structured face to face interview, 13y old, female

code	name, position	affiliation, comment
3 KC FG b2 f	*name*	*D Kroch Chhmar, C Chum Neak*

7th informant, Phnom Penh, semi-structured face to face interview, partner, male

code	name, position	affiliation, comment
7 PNH FF part m	*name, position*	

1.2 Participants list (n=)

Date: ……..

Name interviewer: …….

code	name, position	affiliation / comment

2. Fill instructions:

2.1 tick on the designated area
'……..' -> '…V… '

2.2 complete on the designated area
'……' -> '…write here…'

-Note:
If more space is required, please, continue your answer on the back of the page with reference to the number of the question.

2.3 circle the right answer when a choice is given

'yes/no' -> 'yes / no '

2.4 ask the informant to choose on a value line (Likert scale)

X……X…… V ……X
Not happy Happy Very happy
(1) (3) (5)

-Note:
Draw a line on an A4 page and use smileys to indicate the values (not happy, neutral, happy). Explain the informant that intermediate values are possible.
Rate on a scale of 1-5: 1 being not happy, 5 being very happy

3.a Introduction for face to face semi-structures interview:

-Start by greeting the informant and introduce yourself:
"My name is …… and I would like to ask you some questions about ……
(e.g. the services you received at the rehabilitation centre; or physical rehabilitation services in Cambodia within the framework of an external evaluation of the PRC project in KC by HI; or you and your disability).
It will take no longer then ……. minutes and all you tell me will remain between us (confidential)."

-Ask the informant consent for participation:
"Would you agree to participate in this interview?"
-If the answer is no, thank the informant for listening and his/her patience:
"Thank you for listening and apologies for disturbing"
-If the answer is yes, thank the informant and start the interview.

-Complete the participant list and use the corresponding code on the interview notes.

Note:
-Before to start asking questions inform the informant that he/she has the right to not answers a question or stop the interview at any time.
-Please hold the interview in a private space without being surrounded by curious witnesses.
-Respect the time schedule!
-Before taking and publishing pictures, ask the informant for consent on either issue.

At the end of the session, thank the informant for participation:

"I have finished my questions and would like to thank you for your collaboration. Your input is very valuable to formulate good recommendations to further improve the project and provide adequate physical rehabilitation services for persons with disabilities, in Cambodia!"

Questions for semi-structured interview with partner (PWDF)
Topics:

- Partner mandate
- Coordination mechanisms PR
- HI PRC-project
- Physical rehabilitation services, 15 y from now
- other

1-Stakeholders mandate
-Mandate
-Physical rehabilitation services
2-Coordination mechanisms PR
-Public / other services providers
-Efficiency
3-HI PRC-project
-collaboration contents
-added value
-what different to maximise cooperation potential
4-Physical rehabilitation services in Cambodia, 15y from now
-services system
-financing mechanisms
5-Other?

Probing will be used to ensure relevant evaluation questions are addressed.

Questions for semi-structured interviews with stakeholders directly involved
Topics:

- Stakeholder interventions in physical rehabilitation
- Relationship with other stakeholders/providers
- HI PRC-project
- 15 y from now
- other

1-Stakeholders interventions in regard to physical rehabilitation
-Mandate, services coverage
-Type, number of services
-Number beneficiaries
2-Relationship other services providers
-coordination mechanisms, public / other
-efficiency
3-HI PRC-project
-collaboration with HI PRC project, contents
-added value
-what different to maximise cooperation potential
4-Physical rehabilitation services in Cambodia, 15y from now

-services system
-financing mechanisms

5-Other?

Probing will be used to ensure relevant evaluation questions are addressed.

Questions for semi-structured interviews with CMAA

Topics:

- Mandate
- Legal framework development, cluster munitions
- HI collaboration
- Added value
- Other

1-Mandate
-role

2-Legal framework development

- Advocacy
- Legislation
- Implementation, awareness

3-HI collaboration

- contents

4-Added value
-added value of HI
-what different to maximise potential

5-Other?

Probing will be used to ensure relevant evaluation questions are addressed.

Questions for semi-structured interviews with beneficiaries / case studies

Topics:

- current situation (general)
- history impairment/disability
- history treatment, PRC involvement
- impact on everyday life
- most / least appreciated
- what to do different to further improve services (prevention, identification, information and referral (informed choice), services at PRC/other, follow-up)
- 10y from now? dreams, aspirations
- other?

Observation, verification of functioning (capacity / performance); appropriateness of information, assistive devices, exercises.

5-Other?

Probing will be used to ensure relevant evaluation questions are addressed.

Questions for semi-structured interviews with project staff HI

Topics:

- HI physical rehabilitation project
- Relationship with other physical rehabilitation providers
- Added value
- 10y from now
- other

1-HI physical rehabilitation project
- 1.1-key priorities for this evaluation
- 1.2-contents (ref., prod., doc. Incl. M&E), coverage/scale
- 1.3-type, number of services
- 1.4-number beneficiaries

2-Relationship other services providers
- -coordination mechanisms, public / other
- -efficiency

3-Added value
- -HI interventions / PRC
- -what different to maximise cooperation potential

4-Physical rehabilitation services in Cambodia, 10y from now
- -services system
- -financing mechanisms

5-Other?

Probing will be used to ensure relevant evaluation questions are addressed.

Questions for semi-structured interviews with PRC project staff

Topics:

- Interventions
- Relationship with other services
- Added value
- 10y from now
- Other

1-Interventions (admin, PT, P&O, SW, focal user volunteer)
- -role
- -type, number of services
- -number beneficiaries

2-Relationship other services
- -internal/external; information and referral, follow-up, collaboration
- -management tools

3-Added value
- -added value of PRC, PT, P&O, SW, identification & referral services
- -what different to maximise potential

4-10y from now
- -services system (PRC, PT, P&O, SW, identification & referral services)
- -financing mechanisms
- -self

5-Other?

Probing will be used to ensure relevant evaluation questions are addressed.

3.b Introduction for focus group:

-Start with greeting the informants and introduce yourself:
"My name is …….. and this is …….. and we I would like to ask you some questions about ……. (e.g. services at the PRC; or link with / role in the PRC project).
The discussion will not take longer than …… minutes) and all you tell us will remain between us (confidential)."

-Ask the consent of the informant for participation:
"Would you agree to participate in this interview?"
-If the answer is no, thank the informant for listening and for his/her patience:
"Thank you for listening and apologise for disturbing."
-If the answer is yes, thank the informant and prepare for the discussion.

-Complete the participants list and use the corresponding code on the interview notes.

Instructions for facilitators:
-Inform the group about the process of the discussion:
"During this discussion we will ask you some questions about a few topics, namely: ……. We would like you to talk about these topics together. We will be with you to help you through the discussion and we will take notes. Please feel free to say what you want. There are no right or wrong answers and all you say will remain between us (confidential)!"

-Start with a brief introduction of every-one:
"Let's start with a short introduction of each-other, please tell every-one your name and …
-for beneficiaries / guardians:
where you come from and … (e.g. what kind of services you receive(d) at the PRC)
-for stakeholders (referral network, PWDF branch, PRC staff):
your affiliation / position and …. (e.g. your link with / role in the PRC project)

-Clarify a few rules to make the discussion run smooth:
"To ensure the discussion runs smooth, I would like to ask you to:
- put your mobile phones on silent mode,
- to not cut off other participants who are speaking, and
- to follow the instructions of the facilitator.
-Do you have any other suggestions? "

-Thank the group members and introduce the topics:
*"*Thank you *for listening and accepting to participate, now let us present to you the discussion topics:"*
-…….

Note:
-the facilitator:
- can give examples, but, should not give the answers
- pays attention that every-one participates
- can probe, but, respects the answers of the group and does not try to influence
-note taking:
- preferably on a white board or papers on a wall so every-one can see
(use pictograms in low literate participants)
- all along the discussion, not only at the moment of decision taking
-respect the time schedule!
-Before taking and publishing pictures, ask the informant for consent on either issue.

Thank the group for participation at the end of the session:
"We now finished our discussion. I would like to thank you for your participation. Your input is very valuable to us to further improve the project and provide adequate physical rehabilitation services for persons with disabilities!"

Questions for focus group discussions with referral network members

Topics:

- Referral network interventions
- Relationship with other services providers
- Added value
- Physical rehabilitation in Cambodia 10y from now
- Other

1- Referral network interventions
    -mandate/role, services coverage
    -type, number of services
    -number beneficiaries
2-Relationship other services providers
    -coordination mechanisms, public / other
    -efficiency
3- Referral network
    -added value
    -what different to maximise cooperation potential
4-Physical rehabilitation services in Cambodia, 10y from now
    -services system (identification & referral services)
    -financing mechanisms
5-Other?

Questions for focus group discussions with PRC staff

Topics:

- Interventions
- Relationship with other services
- Added value
- 10y from now
- Other

1-Interventions (identification & referral, PT, P&O, SW)
    -quality, quantity
2-Relationship other services
    -internal/external; information and referral, follow-up, collaboration
    -management tools
3-Added value
    -added value of interventions
    -what different to maximise potential (by services, management)
4-10y from now
    -services system (PRC, PT, P&O, SW, identification & referral services)
    -financing mechanisms
    -own career
5-Other?

Probing will be used to ensure relevant evaluation questions are addressed.

Questions for focus group discussions with beneficiaries

Topics:

- PRC services
- Added value
- What different to make services even better
- Future

1- PRC services
    -kind, number of services at PRC
    -time spent at PRC, returns
    -referral services from/to
    -impact interventions daily life activities, dignity/self-esteem
2- Like most

-why / added value

3- What different to make services even better?

-attitude
-identification & referral
-waiting time, returns
-registration
-accommodation
-PT
-P&O
-SW
-referral
-expenses
-accessibility

4- 10y from now, dreams, aspirations

5-Other?

4.2 REFERENCES

This reference list refers to relevant documents referred to in this report other than those provided by HI in the framework of this evaluation.

Iltar S, et al (2010) *Treatment of clubfoot with the Ponseti Method: Should we begin casting in the new-born period or later?*, The Journal of foot and ankle surgery, Vol 49 pp426-431, US

MoH (2017) *Cambodia's performance compared globally*, Presentation at the National Health Account (2012-2016), Cambodia – Phnom Penh

NASW (2013) *Standards for Social Work Case Management*, National Association of Social Workers, US

RGC (1994) *On the common statute of civil servants NS-RKM-1094-006*, Translation certified by the Council of Jurists, Cambodia – Phnom Penh

WHO (2017) *Standards for prosthetics and orthotics*, World Health Organisation, Switzerland - Geneva

4.3 KEY INFORMANT CHARACTERISTICS

Date: …20nd…Nov…2017…..

code	name, position	affiliation / comment
1 PNH FF sh m	Philip Morgan, Physical rehabilitation	ICRC
1 PNH FF m	Chou Vivath, NCD Department	WHO

Date: …22nd…Nov…2017…..

code	name, position	affiliation / comment
1 KC FD st PRC m	Mr. DOUNG Chetha - PRC coordinator	PRC-KC
2 KC FD st PRC m	Mr. CHAMROEUN Sopha - head of PO unit	PRC-KC
3 KC FD st PRC m	Mr. SONG Sophea - head of social unit	PRC-KC
4 KC FD st PRC m	Mr. KHEM Phirum - Physiotherapist (representative head of PT unit)	PRC-KC
5 KC FD st PRC f	Mrs. KEM Soka - Logistic Assistant (representative of Administrative unit)	PRC-KC

Date: …22nd…Nov…2017…..

code	name, position	affiliation / comment
1 KC FD b4m	x, amputation TT	TK, TK, Chub, Slab Down
2 KC FD b4m	x, amputation TT	TK, MM, Memuth, Memuth Kandal
3 KC FD b4m	x, fracture LL	KC, PCh, Toul Prich, Toul Prich
4 KC FD b4m	x, amputation TT	KC, PCh, Sra Nge, Trapeang Thom
5 KC FD b4f	x, fracture UL	TK, MM, Kampourn, Sre Seam Thmey
6 KC FD b4f	x, stroke	KC, STr, Prek Kork, Prey
7 KC FD b1m	x, CP	KC, PCh, Kveth Thom, Ampil Thom
8 KC FD b4m	x, stroke	TK, OO, Chork, Pring
9 KC FD b4gf	x, stroke	KC, KgS, Kean Chrey, Kean Chrey
10 KC FD b1f	x, Clubfoot	TK, PnK, Krek, Chi Morn
11 KC FD b1m	x, CP	TK, TK, Sourng, Pon Reay

All of them are service users staying at the PRC. In the affiliation/comment their province, district, commune and village are recorded in order.
Note: TT: Trantibia, LL: Lower Limb, UL: Upper limb, CP: Cerebral Palsy, KC: Kampong Cham, TK: Tbong Khmum, MM: Memuth, PCh: Prey Chhor, STr: Stoeung Trang, OO: O Reang Ov, KgS: Kampong Siem, PnK: Pornheakrek

Date: …22nd…Nov…2017…..

code	name, position	affiliation / comment
1 KC FD st PRC f	Mom Ratha, PT	KC PRC
2 KC FD st PRC f	Koem Soka, Store Keeping Assistant	KC PRC
3 KC FD st PRC f	Sao Saroeun, SW	KC PRC
4 KC FD st PRC f	Chim Hean, BT	KC PRC

5 KC FD st PRC m	Chun Vanny, PO	KC PRC
6 KC FD st PRC m	Mith Bunthon, BT	KC PRC
7 KC FD st PRC m	Leap Vanno, PO	KC PRC
8 KC FD st PRC m	Thun Narom, Database assistant	KC PRC

Date: …22nd…Nov…2017…..

code	name, position	affiliation / comment
1 KC FF part m	Ek Pisey, Director of PWDF branch and Deputy Director of PoSVY	Director of the PWDF KC brand
2 KC FF DPO f	Eng Navi, Field officer	Staff of DPO Batheay work at Chamkar Leun district
3 KC FF vt PRC f	Sroen Kim Sreth, Focal Point Volunteer	KC PRC
4 KC FF vt PRC f	Kdoeb Chanthy, Focal Point Volunteer	KC PRC

Date: …23rd…Nov…2017…..

code	name, position	affiliation / comment
1 KC FF rnw m	Kong Samoeun, member of CC	KC, KMs, Sokong CC (replacing ccwc)
2 KC FF rnw f	Srorn Limsrouy, assistant to CC	KC, KMs, Sokong CC
3 KC FF rnw m	Srean Kunvuth, Head of HC	Reay Pay HC
4 KC FF rnw m	Pol Vath, VHSG	VHSG of Svay Village
5 KC FF b4f	x, SCI	KC, KMs, Sokung, Boeung Sang Ke
6 KC FF rnw	Leng Sokhom, referral focal point	KC, KMs, Sokong CC

Date: …24rd…Nov…2017…..

code	name, position	affiliation / comment
1 KC FF rnw m	Lav Suyhour, head of HC	KC, OO, Mean HC
2 KC FF b4 m	x, amputee TT	KC, OO, Mean, Thmor Samlieng
3 KC FF b2g m	x, CP	KC, OO, Prey Sroloa, Ampil Tapork
4 KC FF b4 f	x, Stroke	KC, OO, Chak, Chak

Date: …29th…Nov…2017…..

code	name, position	affiliation / comment
1 KC FF st PRC m	Srun Vimean, head of PT	KC PRC
2 KC FF st PRC m	Thun Narom, database assistant	KC PRC

Date: …30th…Nov…2017…..

code	name, position	affiliation / comment
1 KC FF st PRC m	Soeng Sophea, head of SW	KC PRC
2 KC FF st PRC f	Yun Mary, cook	KC PRC
3 KC FF st PRC f	Tieb Sokleat, cleaner	KC PRC
4 KC FF st PRC m	Chheang Kosal, guard	KC PRC

5 KC FF st PRC f	Koem Soka, store Keeping Assistance	KC PRC

Date: …1st…Dec…2017…..

Code	name, position	affiliation / comment
1 KC FF sh m	Seng Sopharun, Deputy director	KC PHD
2 KC FF sh m	Tan Hak Leang, Deputy director (responsible for NGOs)	KC PHD
3 KC FF sh m	Keo Chandara, Deputy director responsible for technical office	KC PHD
4 KC FF, sh m	Dr Phann Sovanndeth, deputy director	KC referral hospital
5 KC FF, rnw m	Dr Horn Chiheath, director of OD	OD OO
6	*CP-absent*	

Date: …4th…Dec…2017…..

Code	name, position	affiliation / comment
1 PNH FF sh m	Keo Rithy, Director VIC	VIC
2 PNH FF sh m	Men Meas, PRC manager	VIC / PWDF
3 PNP FF part m	Mom Sothara, Deputy director, responsible for PRC	PWDF central
4 PNH FF part m	Suy Sarith, Officer, Public Service and Social Pension Support chief of office	PWDF central
5 PNH FF, part m	Sor Makara, Staff, Public Service and Social Pension Support chief of office	PWDF central
6 PNH FF part m	Tiev Sam Ol, Public Service and Social Pension Support chief of office	PWDF central
7 PNH FF part m	Suy Sarith, Officer, Public Service and Social Pension Support chief of office	PWDF central
8 PNH FF part m	Sor Makara, Staff, Public Service and Social Pension Support chief of office	PWDF central
9 PNH FF part m	Yeap Malyno, Director DWPD	MoSVY-DWPD

Date: …5th…Dec…2017…..

Code	name, position	affiliation / comment
1 PNH FF part m	Mao Bunny, Director Assistant Victim Assistance	CMAA

Date: …7th…Dec…2017…..

Code	name, position	affiliation / comment
1 PNH FF sh m	Teap Odom, Director Exceed private clinic and President Khapo	Exceed, Khapo

ANNEX 5 DEBRIEFING PRESENTATION

Submitted independently

ANNEX 6 INCEPTION REPORT

Submitted independently