

PROJECT EVALUATION

Final Evaluation of ADRA Leadership Development Program

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Acronyms

ADRA	Adventist Development and Relief Agency
AFRHS	Adolescent-Friendly Reproductive Health Services
HC	Health Center
IEC	Information, Education and Communication Materials
LDP	Leadership Development Program
MOH	Ministry of Health
MSH	Management Sciences for Health
OD	Operational District (Health)
WCA	Work Climate Assessment Survey
YFSRH	Youth Friendly Sexual Reproductive Health

Executive Summary

NEED TO IMPROVE HEALTH DELIVERY SYSTEMS

There is a need to improve health delivery systems in Cambodia and this is especially true for rural health services targeting youth reproductive health. A number of barriers prevent youth from accessing reproductive health services. Some of these barriers, identified by the youth themselves, include personal shyness, lack of confidentiality, low educational levels, illiteracy, poor relations with health center staff, and low prioritization by parents. There are therefore a number of leadership and management problems that need to be addressed in the administration of rural health facilities.

PROJECT OBJECTIVES

The ADRA Leadership Development Program: Youth Friendly Services - Cambodia project was designed to address these leadership challenges through:

- Building the capacity of health center teams, empowering them to take charge, helping to solve the access barriers and deal with attitudinal problems. The project assisted the health centers in the implementation of the Ministry of Health's (MOH) Youth Friendly Sexual Reproductive Health (YFSRH) service guidelines. This was done through the Leadership Development Program model or LDP approach.
- Empowering community youth and youth clubs to speak up for their health rights, human rights, and other issues that are important to them by building their leadership and advocacy skills.
- Decreasing the reproductive health risks of youth by strengthening National Youth Friendly Sexual Reproductive Health (YFSRH) services at the community level.

THE PURPOSE OF THE EVALUATION

The purpose of the final evaluation of the six month ADRA Leadership Development Program was to document the LDP pilot project process and outcomes. The conclusions and recommendations will be used to engage and advocate with the Ministry of Health, ADRA Cambodia, and other key stakeholders regarding the potential impact and usefulness of the LDP methodology for YSRH service and broader health system strengthening as a management tool. The evaluation also identifies

the strengths and challenges of the LDP tools and capacity building process.

**PRELIMINARY
RESULTS INDICATE
THAT THE PROJECT
HAS A MEASURE OF
SUCCESS**

Although the evaluation was conducted immediately upon completion of the project (leaving limited time to see the full scope of the project impacts) there is evidence to suggest that the project was successful in building capacity of health center management, empowering youth through youth groups, and there is a high possibility of its decreasing reproductive health risks.

Semi-structured interviews and focus group discussions were undertaken with the stakeholders and participants of the project at six of the health center sites (a total of thirteen were involved in the project).

**SUMMARY OF
RESULTS**

In summary the results of the evaluation indicate that:

- The LDP approach of combining training and coaching was relevant and was an effective approach to capacity building and the management in the health centers has improved to some extent as a result.
- The content of the LDP training was relevant to the recipients and addressed the knowledge gaps of the health center senior managers.
- The LDP tools were simple enough to be applied to the work situation faced by the health centers. It is not necessary to implement complicated and very detailed processes to management at this level.
- The application of the LDP tools and techniques through the coaching was an effective approach for solidifying the knowledge taught in the training workshops but more support and follow up coaching is needed in some health centers. Therefore a further process of defining capacity and knowledge gaps after the training and then tailoring specific coaching and follow up support is recommended.
- There was an increase in collaboration between stakeholders (health centers with the Operational District as well as in the community and youth).
- Applying the LDP techniques to establishing Youth

Reproductive Health Services (YRHS) was a very practical and useful approach.

- The youth groups were an effective strategy for disseminating reproductive health information to other youth. There was therefore increased awareness within communities as a result of the project.
- There is potential for reducing youth violence and aggression in the community due to the youth groups.
- Youth are more comfortable with seeking counseling for reproductive health at health centers.
- The Commune Leaders were very supportive of the project and also learnt about reproductive health.

**EXPANSION OF THE
LDP APPROACH**

It is concluded that the LDP approach is a more effective approach to capacity building than just training alone and there is an opportunity to expand this approach to other areas of rural health management, other locations in Cambodia and possibly to other sectors, such as primary education. The LDP approach, however, will need more resources and time to implement than other more traditional approaches. This needs to be considered when programming and designing projects based on this approach. The return on investment (i.e. improved health outcomes), however, should make it worth it in the long run.

Background to the Project

Youth in Cambodia comprise 34.9%¹ of the total population. The government of Cambodia recognizes the importance of taking action to provide youth with opportunities for improved mental, social and physical health to protect these youth. The Adolescent-Friendly Reproductive Health Services (AFRHS) national standard guidelines, created with input from ADRA Cambodia and other NGOs active in the youth sector, is a result of their initial efforts² in the overall formulation of a National Youth Policy. The Ministry of Health (MOH) is now beginning the process of incorporating AFRHS into the existing services at health facilities. This has had limited results, however, as leaders are faced with leadership and management challenges. There is a relatively low level of utilization of health services in the rural areas due to a perceived low level of quality of these services.

This is especially true for services needed by rural youth to both prevent and treat sexual reproductive health problems. Barriers to accessing these services identified by young people include personal shyness, lack of confidentiality, low educational levels, illiteracy, poor relations with health center staff, and low prioritization by parents (UNFPA). ADRA's leadership project was designed to address these leadership challenges by building the capacity of the health center team, empowering them to take charge, and helping them to solve the access barriers and dealing with attitudinal problems. The project utilized Management Sciences for Health's Leadership Development Program (LDP) approach for empowering and building the capacity of the health center team. The LDP is composed of a series of four training workshops, covering eight principles of leadership and management.

These series of workshops is comprised of 12 core sessions during which participants learn core leading and managing practices and concepts (See the LDP core sessions below). These were conducted with the fifty two health center (HC) staff over a six month period. The subsequent workshops progressed through the Scanning, Focusing, Aligning, and Inspiring skills. Each of the workshops had a specific outcomes linked to the national YFSRH service guidelines that were to be achieved before the next scheduled workshop.

LDP Workshop Core Sessions

Session	1	Program overview
Session	2	Leadership overview
Session	3	Scan
Session	4	Focus
Session	5	Focus 2
Session	6	Focus and Plan
Session	7	Align, Mobilize and Organize
Session	8	Align, Mobilize and Implement
Session	9	Inspire
Session	10	Inspire 2, Monitor and Evaluate
Session	11	Monitor and Evaluate
Session	12	Presentations

¹ CDHS 2005 p. 10. Young persons aged 10 to 24.

² MEDINEWS Volume 5, issue 2, February 2006

Each health center was facilitated to develop their own “Challenge Model” or mini project to address identified problems, and received training and coaching for the particular mini-project during the ADRA LDP (applying the leadership and management theory to practical, “on the job” situations). The Challenge Model was revisited and revised throughout the workshop process.

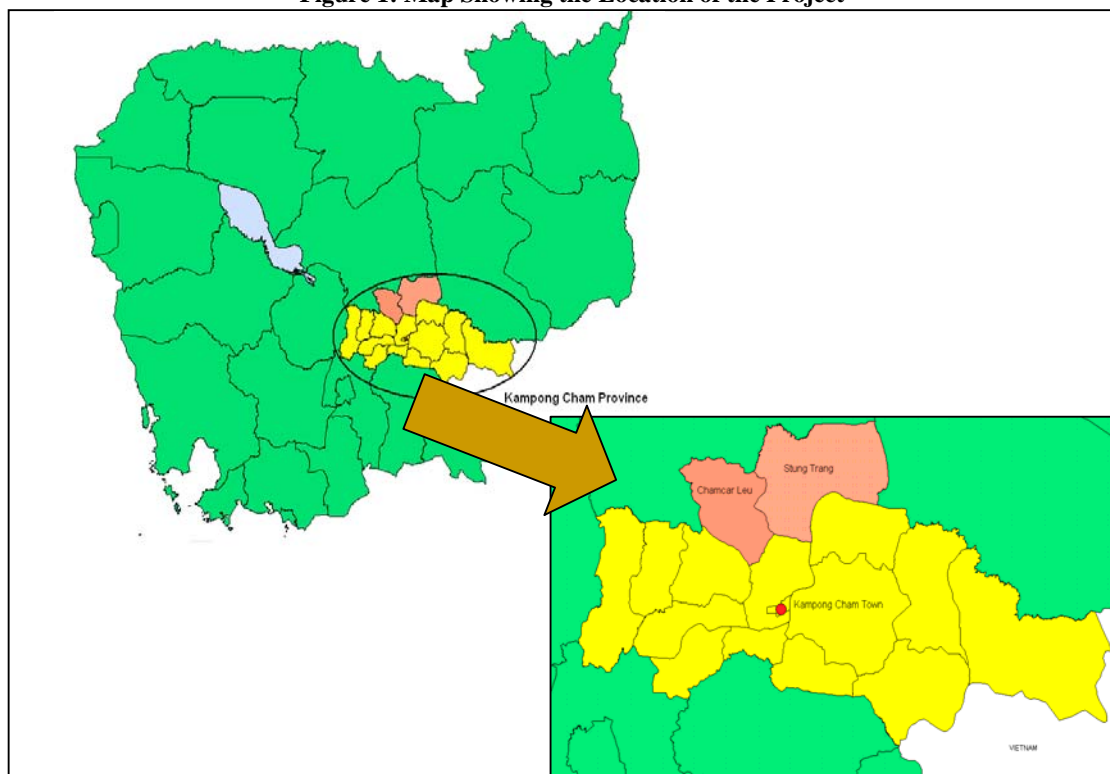
The ADRA Leadership project was the inception or foundation for a larger more intensive project on leadership and management development. See [Appendix 1](#) for the planned timeline for the intended larger project. It is expected that the LDP capacity building process will have two phases – foundation and action. The following processes were implemented during the project period.

- Alignment meetings with key senior level stakeholders.
- LDP workshops with health center staff and Youth Advocates.
- Follow-up of field team coaching meetings.
- Initiating action plans to address challenges.
- Dissemination of lessons learned.

The LDP training processes for both health facilities and youth was implemented under a six month timeline from an MSH/USAID grant. ADRA is currently in the process of seeking funding for an additional 18 months of programming to support additional community-based advocacy and health systems strengthening to capitalize on the foundation built with this project. This project was designed as a stand-alone project although further funding is being sought by ADRA to continue the work.

The ADRA Leadership project was a six month pilot project starting in January 2009 in the Chamkar Leu-Steung Trong Operational District of Kampong Cham Province. It attempted to build the management and leadership capacity and skills of fifty two health center staff from the thirteen health centers and twelve communes in this Operational Health District.

Figure 1: Map Showing the Location of the Project



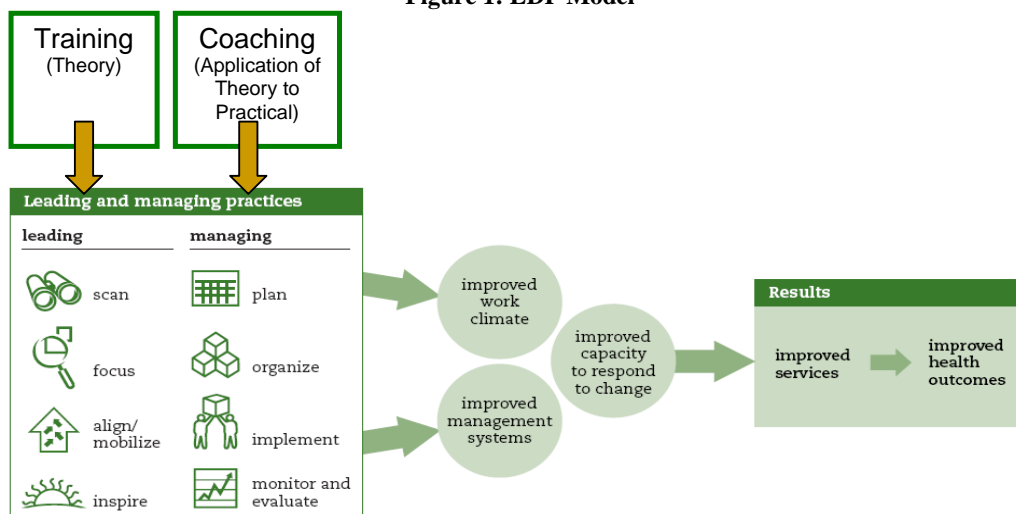
The **Goal** of the project was to use the Leadership Development Program (LDP) to strengthen reproductive health programs and systems in Cambodia. The Project **Objectives** were to:

- Strengthen the leadership and management skills of health service providers to implement the MOH Youth Friendly Sexual Reproductive Health (YFSRH) service guidelines. The approach to the LDP process is training participants in leadership and management concepts and applying these to real situations and problems in the health centers; and
- Empower community youth and youth clubs to speak up for their reproductive health rights and other issues that are important to them by building their leadership and advocacy skills.

The following initial outcomes were expected:

- Inspired leadership and sound management of clinics with Youth Friendly Service at 13 MoH health centers.
- Improved work environment, leadership management tools, systems, and HC staff roles.
- Increased understanding and commitment to the national YFSRH guidelines which will result in increased acceptance and access by young persons in the communities.
- Established district youth network to support youth advocacy activities and YFSRH service implementation.
- Awareness of the Leadership, Management and Sustainability Leadership Development Program approach at the Ministry of Health level.

Figure 1: LDP Model



Reference: Adapted from “Managers Who Lead, A Handbook for Improving Health Services”, MSH, 2005

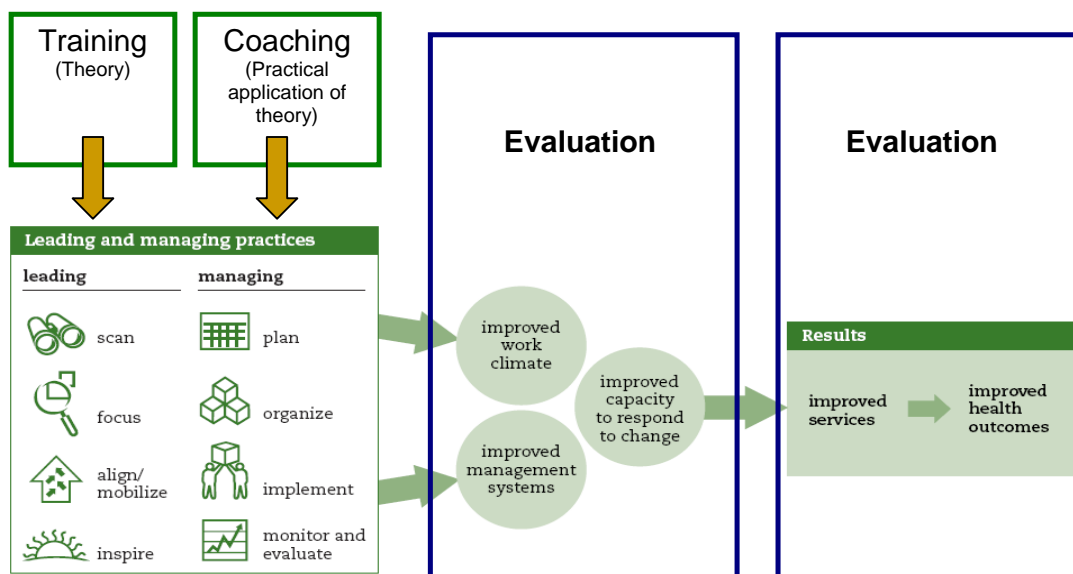
The reasoning behind the approach is that improved leadership and management practices of the health centers will result in improved work climate, management systems and processes, and increased capacity. This is an intermediate step which, in turn, improves health services and leads to improved health outcomes.

An important aspect of the LDP approach is the combination of introducing the concepts and techniques with practical application or coaching in the workplace thereafter. This differs from the more traditional approach of simply delivering one-time trainings. The combination of the training and the coaching allows a more in depth learning environment which gives greater success to obtaining the intermediate results (improved work climate, improved management systems, etc)

Approach and Methodology of the Evaluation

Given the LDP approach aims to develop management and leadership capacities (intermediate results) at the health center which in turn leads to improved health services and improved health outcomes (end results), the evaluation attempted to investigate these linkages further as well as any evidence that improvements in management and leadership capacities has occurred and if there was also an improvement in health services (or the potential of this occurring). Given that the time between the evaluation and the end of the project is small there may only be limited evidence of impacts to date, but there may be potential for these impacts to be realized. It is also too early to see if improved health outcomes were as a result of the project. This would need to be measured with a quantitative survey at least one year after the end of the project.

Figure 2: Approach to the Evaluation

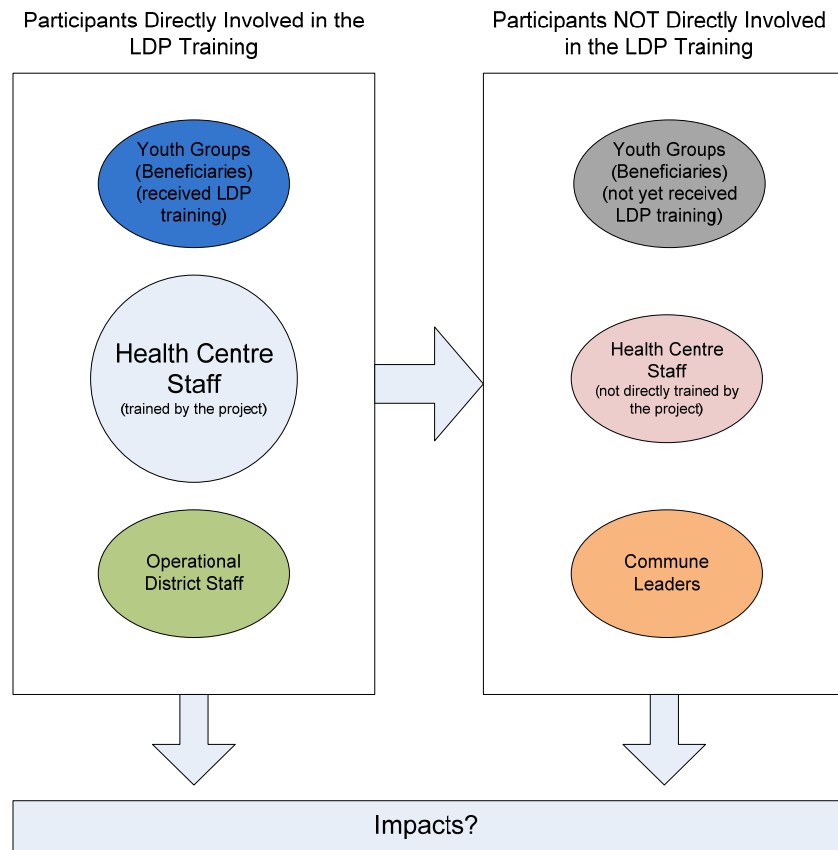


Reference: Adapted from "Managers Who Lead, A Handbook for Improving Health Services", MSH, 2005

The approach to conducting this evaluation was to undertake a qualitative assessment of the project. Quantitative data had been collected in a baseline assessment but no follow up impact survey or data had been collected for the purposes for the evaluation. The project was only just concluding at the time of the evaluation. The methodology was therefore to conduct semi-structured interviews and focus groups with participants and beneficiaries of the project.

The evaluation attempted to make a distinction between those participants who received direct support and benefits from the project and those who received indirect benefits. Figure 3 outlines this approach.

Figure 3: Approach to the Evaluation



The Evaluation attempted to assess the impacts the project had on the improved health center management and attempted to identify the flow of impacts into the community beyond the project activities (improved health outcomes, community mobilization, youth empowerment, etc). The next step was to identify the locations in which to undertake the assessment. There were thirteen health centers/locations that participated in the project. It was decided that six health centers would be used as the sites for conducting the qualitative data collection to be used for the project evaluation. This was mainly due to the limited time in which to undertake the evaluation as well as the feasibility of assessing a number of sites that can produce reasonable results and data (hence not all sites were assessed in the evaluation). It was estimated that a health center could be reasonably accessed and the staff and beneficiaries of the project adequately interviewed in one morning session (while health center staff do not normally work at the health center in the afternoon, a number of staff made themselves available for afternoon interviews.).

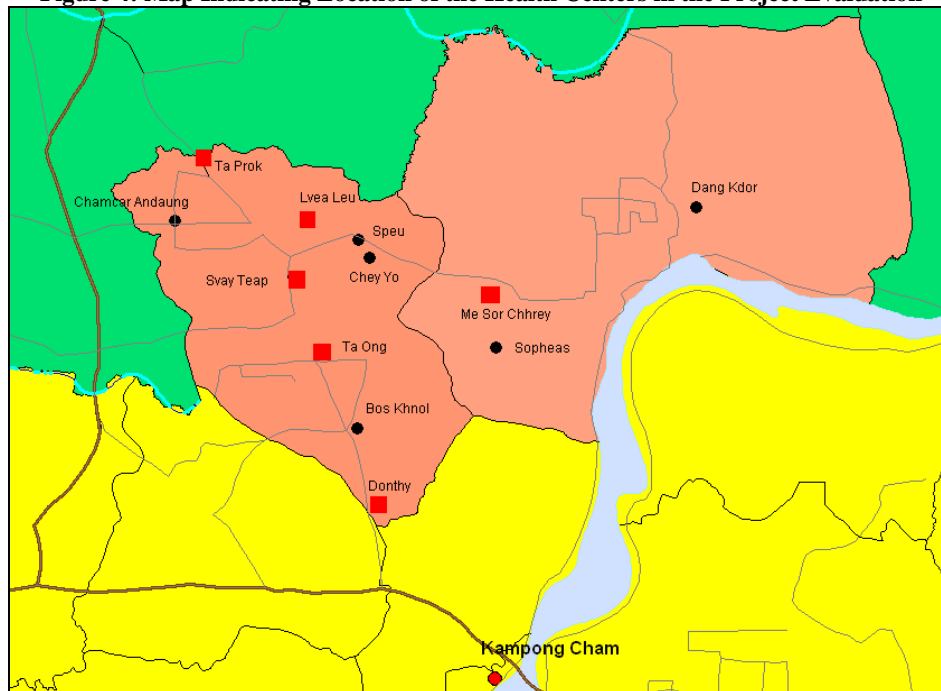
The selection of the health centers was based on the following basic criteria:

1. Selection of health centers that performed well under the project
2. Selection of health centers that did not perform so well under the project
3. Selection of health centers between these two points on the spectrum – a mid range.
4. A geographical distribution
5. Access criteria (not just include health centers that are located near main roads –but also include health centers that are located in rural areas).

The criteria for determining performance were based on a performance assessment conducted by project staff and the Operational District Health Officials. The performance criteria and results are presented in [Appendix 2](#) and [Appendix 3](#). They are based on the Health Center Action Plans and Challenge Model (quality and progress towards implementation). Based on this the health centers selected were:

1. Donty
2. Me Sor Chhrey
3. Lvea Leu
4. Ta Ong
5. Svay Teap
6. Ta Prok

Figure 4: Map Indicating Location of the Health Centers in the Project Evaluation



At each location the health center staff, youth representatives and commune authorities were interviewed. The Director and Vice Director of the Operational District (OD) were also interviewed for the purposes of the evaluation. The numbers and category of the project beneficiaries that were interviewed or participated in focus group discussions are outlined in Table 1 below.

Table 1: Participants Interviewed or in Focus Groups

					Age Range	
					13-22	14-26
	Health Center Staff (Trained)	Health Center Staff (Not Directly Trained)	Commune Officials	OD Staff	Youth (Not Trained)	Youth (Trained)
OD Staff				2		
Donty	1 HCC and 1 Midwife				7 Female, 4 Male	
Me Sor Chhrey	1 HCC and 1 Midwife	1				7 Female, 5 Male
Lvea Leu	1 HCC	1	1			2 Female, 5 Male
Ta Ong	1 HCC and 1 Midwife		1			7 Female, 7 Male
Svay Teap	1 HCC and 1 Midwife		1		11 Female	4 Female, 2 Male
Ta Prok	1 HCC and 1 Midwife		1			4 Female, 4 Male
Totals	11	2	4	2	18 Female, 4 Male	24 Female, 23 Male
HCC = Health Center Chief					42 Female, 27 Male	

The approach of this project was to apply the LDP to the important issue of youth reproductive health. The project evaluation also concentrated on the:

- Effectiveness of the training and coaching on the establishment of Youth Health Services at the health centers,
- Management of other health areas or general management of the health centers (applying these new techniques to other areas of health center management) as well as work climate improvements.
- Impact on youth with the formation of youth groups and the dissemination of information on Youth Reproductive Health.
- Interaction and management of the health centers at the OD level and with the commune authorities.

Results

Overall the project has contributed to achieving positive results and achieving a measure of success in reaching the objectives. An overview is provided against the main outcomes articulated in the project proposal followed by more detailed results and outcomes from the perspective of each project stakeholder in the next section.

In terms of health center management it was expected that there would be:

1. **Proposed:** Inspired leadership and sound management of clinics with Youth Friendly Service at 13 MOH health centers
Results: There is evidence to suggest that there is an improvement in the leadership and management of the health centers and the Operational District in relation to Youth Friendly Services. As a result of the project, staff morale and collaboration amongst the health center and OD staff has improved and youth are more confident in discussing reproductive health issues and seeking counseling and treatment at health centers. The representative sample included an evaluation of six health centers.
2. **Proposed:** Improved work environment, leadership management tools, systems, and health center staff roles.
Results: Health center staff reported improved work environment and allocation of roles and responsibilities as well as improved teamwork amongst colleagues. Also observed during the evaluation process was the use of the tools by health center management staff that were introduced in the LDP training. There is potential to further improve management through the application of the tools but further follow up and support (coaching) would be required to ensure that these tools are more effectively utilized.
3. **Proposed:** Increased understanding and commitment to the national YFSRH guidelines which will result in increased acceptance and access by young persons in the communities.
Results: The work of the health centers to advocate for YFSRH and the establishment of the youth groups for advocacy and dissemination of YFSRH information was successful in mobilizing youth. There was an increased acceptance of reproductive health issues among youth group members who in turn promoted better health practices with other youth in the community.

In terms of outcomes involving the youth there was to be:

1. **Proposed:** Established district youth network to support youth advocacy activities and YFSRH service implementation.
Results: The establishment of the youth groups was successful in achieving this objective (in the villages where they were established – two villages in each location). The participants in the youth groups were enthusiastic about disseminating the information and mobilizing other youth for the same purpose.
2. **Proposed:** Awareness of the Leadership Development Program approach at the Ministry of Health level.
Results: This was not specifically assessed during the evaluation period. The dissemination workshop however on the 29th June 2009 was an avenue for achieving this objective as will be the evaluation report. The MOH officials at the dissemination workshop expressed support for the LDP approach as did other stakeholders. Increased advocacy of the LDP approach to potential donors and other stakeholders would be beneficial in ensuring that this approach is more widely accepted and adopted.

Below is a more detailed description of the evaluation results from the perspective of the main stakeholder groups – Health Center Staff, Operational District Youth, and the Commune Authorities.

Health Centers

The feedback from the health center staff was very positive regarding the project and the concepts and techniques introduced. The LDP training combined theory and application of the theory to actual workplace challenges. This was seen as an effective approach since it allowed health center staff to directly apply the techniques and tools introduced by the project with support of the trainers. It would have been difficult to apply these techniques without the coaching and support since they had limited management and leadership skills prior to the project. For many it was the first time that they had been exposed and trained in these concepts.

The health centers were able to apply these techniques through the development of Youth Reproductive Health Services. This was a very practical approach in applying the concepts to an actual situation or problem within the health system. Part of the process of establishing the Youth Reproductive Health Services was to initiate youth groups for information dissemination and participation.

In establishing the youth groups the Health Center Chiefs have engaged with community stakeholders such as Village Leaders, Commune Leaders, parents, and primary school staff in order to establish these groups and motivate youth. They were able to mobilize stakeholders to become involved in disseminating youth reproductive health information and encouraging the participation of youth in the youth groups. It was stated by the health center staff that the project had contributed to community mobilization and improved collaboration among stakeholders through the establishment of youth groups.

It was also indicated that collaboration with the Operational District (OD) had improved. As a result of the project, there is a climate of joint problem solving rather than trying to apportion blame for poor results. The interaction between the OD staff and the health center staff in the training and coaching as well as the support provided by the OD staff to developing the health center mini projects and overall plans, engendered a collaborative relationship.

It was also indicated that management in the health centers had improved. This was reported by the staff that were not involved in the training but reported an improved work climate (more delegation of responsibilities, clearer roles and responsibilities of staff, improved team work environment, corrective feedback rather than apportioning blame for example). The use of simple and straightforward management tools and techniques (for example prioritizing using the Challenge Model, work plans, Work Climate Assessment Surveys) can also lead to improved management. These were primarily used for Youth Reproductive Health Services but it was indicated that the staff will use them for other areas of management in the health center. There is potential therefore for the level of management at the health centers to improve.

An example of the Challenge Model is presented in [Appendix 4](#). This was used to identify problems, prioritize them, identify resources and tasks required to address them and take

time-based actions. This tool was used for each health center. The Work Climate Surveys were undertaken periodically during the project (see [Appendix 5](#) for the survey forms and [Appendix 6](#) for the results). It should be noted that the results of the Work Climate Assessment (WCA) survey was based on internally generated answers (in the health centers). For the information to be reliable and accurate it would be best for these surveys to be conducted by the Operational District (currently the health centers are using them to measure their own success in improving the work climate – that is, they are not confidential surveys). They do have validity however in that the health center chiefs are aware of a positive work climate and the need to improve the team work of the health center staff. The results generally show an improvement in the work climate.

The health center staff indicated that they were not aware of the rights of youth relating to reproductive health and the importance of these issues to be treated in a special way. They became more supportive and caring for youth needs as a result of the project. Their approach in the past was to reprimand youth and they tended to be insensitive to their needs. They established the practice of providing counseling in private and which gives youth more confidence to seek counseling for reproductive health. As a result the services for Youth Reproductive Health had begun to improve. There was not sufficient patient data collected to confirm this to a great level of certainty but patient numbers in some health centers had shown increases in patients seeking services on youth reproductive health.

The project should increase the demand for Youth Reproductive Health Services. This demand will increase since the project was only working with two youth groups/villages for each health center location. Other villages were not involved in the project but there are indications that these villages want to set up youth groups and learn more about reproductive health. The health centers will therefore need to then apply the leadership and management techniques to effectively manage the increase in demand and patient numbers that are expected from the increased awareness of the reproductive health services now provided by the health centers.

It was also indicated by all the health center staff that there is a need for more follow up and support over a longer period of time. There will also be some health centers that need more support than others. All the health centers received a similar level of training and support. Some will need more capacity building and support to more firmly establish the LDP techniques and apply them to other areas of health center management.

Operational District Staff

The Operational District was involved in the project in terms of assisting in the facilitation of the training and working with the project staff in coaching the health center staff. As a result the assessment and observations of the OD staff interviewed was that the tools and techniques were relevant to the health center staff (it was pitched at the right level). All health center staff who received the training gave very positive feedback to the OD and were enthusiastic to be involved. Furthermore the training and coaching were useful for the OD staff. They had been trained in other projects or from the Ministry of Health in similar tools and techniques but were able to better understand their application through the coaching process of the Leadership Development Program. This process seemed to solidify the knowledge for them and they were able to apply it more effectively.

As a result of the project the OD staff worked closely with the health center (HC) staff in developing plans (the Challenge Model/mini-project) and finding solutions to problems through this process. As a result this formed better working relationships between the OD and health center staff. There was a sense of joint ownership of these plans. Further, the OD staff indicated that the relationship between the Operational District and the health centers was more collaborative than in the past (i.e. *“they come to us with solutions now, rather than just problems...”*). During the monthly meetings between all the health centers and the Operational District, problems and issues are approached in a way that is more constructive than before. Previously there was a blame factor from both sides but now it was reported that they work together more effectively.

It was indicated however that the training could have been more intensive and the follow up support could have been of a longer duration. More time was needed to ensure the benefits from the LDP process were firmly embedded and that follow up support can be tailored to where the need is greatest. It was also suggested that the training should be expanded to the referral hospital since a number of people access the hospital for reproductive health counseling and treatment. They are not aware of the services being offered at the health centers.

Youth

The establishment of youth groups was a direct result of the project. Their establishment was partly to demonstrate the application of the LDP tools and techniques but also to disseminate information of reproductive health information to youth. The feedback from the focus groups indicated that in most cases this was the first time in these communities that youth groups had been established or youth had been involved with youth groups. Youth representatives were selected from two villages per location (per health center) and were trained in the LDP process. Their feedback indicated that the LDP tools and techniques presented were very useful and important information for them. It inspired them into establishing the youth groups but also to apply the concepts to their personal lives. From the focus groups the youth indicated that they were more confident to speak out and get involved in community activities. This claim was also supported by the Commune officials (see next section).

It was observed through the focus group process that the youth groups provided a positive vehicle for youth to learn very important life skills (leadership and management), learn about reproductive health issues, engage with and support other youth, and engage with local authorities. This process of participation and building of confidence and self esteem is a positive outcome in society. It is the building of human social capital which is the building blocks of a strong and vibrant civil society.



This building of confidence has also occurred around the issue of youth reproductive health. The youth stated that they were more willing now to seek counseling from their local health center. Indeed all the youth interviewed indicated that they would seek advice on reproductive health from the health centers and encourage and support other youth to do the same. The health centers now provide confidential counseling services for youth. This was



the case for youth that had attended the training but for the youth who joined the youth groups subsequently (who did not attend the training) it was indicated that they too would seek counseling at the health center or seek medical advice and treatment. This would need to be more adequately measured over time to test this statement however (from the youth register in the health center that had been established under the project).

A common concern with all the youth in the focus groups was the high incidence of violence and aggression amongst youth in the community. This appeared to be caused by excessive alcohol consumption and sometimes drug abuse. This was also raised as a concern by the health center staff, the Operational District staff and the Commune officials. Although the project and its impacts are in the very early stages it was reported by the youth that this aggression was not as apparent as before and there is potential for this to be reduced significantly through the work of the youth groups – dissemination of information regarding health issues and leadership qualities (the project, through the training, gave them information about leadership as well as moral and ethical modes of behaviour) as well as the opportunity for youth to work together in youth groups and therefore building stronger social bonds.

The youth that did not attend the training but were encouraged to participate in the youth groups were also interested to learn more about reproductive health and learn from other youth about leadership and management. For the trained youth to effectively pass on the leadership and management techniques they learned in the workshops to their peers in the villages they would need support from the project, the health center or the local authorities to do so (to continue their work).

As with other stakeholders it was indicated by the youth that there is a need for more support to the youth groups to maintain their activities. Youth groups from two villages in each location were organized into youth groups. Up to seven villages in each location do not have youth groups established. There is demand for youth groups to be set up in these villages by the youth themselves as well as the Commune authorities.

The approach to dissemination for reproductive health information was mainly verbal through the youth groups, through presentations to the primary schools or through the advocacy of the Health Center Chief in the wider community. For the youth to more effectively disseminate this information it was suggested that more Information, Education

and Communication (IEC) materials should be given to the youth groups. They believed that they would be able to disseminate the messages more effectively if they had written materials (brochures, pamphlets, etc) officially endorsed and branded by the Ministry of Health, ADRA, donors etc. In many cases the youth were informing their peers verbally regarding the issues. In a high number of cases (reported around 50%) they were not able to convince their peers of the importance of reproductive health issues and to get involved in the youth group. Furthermore it was observed and indicated by the youth that female youth were more receptive to the information and were more likely to become involved in the youth groups to learn more about reproductive health compared to the male youth.

Commune Officials

The views and assessment of the local authorities were sought during this evaluation. The Health Center Chief and a representative of the Commune Council are members of the Health Center Management Committee. Commune representatives attended the LDP training but for one session only. It was for orientation purposes. They were not one of the target groups and so did not complete the entire course. From this orientation they observed some of the tools and techniques. They believed that the content of the training was very relevant and useful to their professional and personal lives.

The Commune representatives however stated that the set up of youth groups was a positive occurrence within the community and a major benefit from the project. In their opinions these groups had improved the behavior and attitude of the youth. They became less prone to violence and fighting amongst the youth involved in these groups but it was still not yet evident if this would be transferred to the wider community and youth in general as a result. They believed that there was significant potential for this to occur but it needed further support to sustain the activities of the youth groups. They also mentioned that the youth had become more confident and were able to participate more in Commune affairs.

Once again it was stated that there is a need to establish youth groups in other villages. In some cases the Commune and the health center can do this within existing resources but in other cases they may need resources or follow up support. The main response was that extra resources would be needed for this. The Commune Representatives also learnt about reproductive health issues and the importance of such. As a result they were more supportive of the project and its objectives. They became more engaged around this issue and were able to promote and support the activities of the health center within the community.

There were some instances where parents and other village leaders were not supportive of the youth participating in the youth groups because they saw no value in it and/or felt the subject matter (reproductive health) was too sensitive. This is an issue that needs to be addressed in future projects of this nature. One of the most important issues related the sustainability of the youth groups and their activities was that there is a need for continued support. There is a risk that youth will lose interest and motivation and thus behavior and attitudes in the community will not be as constructive as before. There were indications that funding is limited from the Communes and the health centers to support the youth groups financially (travel expenses, meeting expenses, printed materials, etc) but the LDP model encourages people to work within the existing resources. This approach (LDP) should be applied with Commune authorities.

Conclusions

General

In general the LDP approach is a more effective approach to capacity building than just training alone. The combination of training (theory) and coaching (application of the theory) is essential to achieving sustainable results in capacity building of management and leadership skills. The project approach was successful in building the capacity of health center management to a certain level (an improvement from the baseline) but more is required. It also appears that there is an improvement in Youth Reproductive Health Services supplied by the health centers.

The main constraint for the project however was that more time is needed to provide follow up coaching where it is needed and ensure that the tools and techniques are more “embedded” in the daily management practices of the health centers and the Operational District. The LDP approach has shown it is relevant to building capacity and should be expanded not only in this District but in other areas outside the scope of this project that require this type of capacity-building (Hospital level, and other Provinces, etc.). Strengths and challenges of the ADRA Cambodia LDP can be summarized as:

Strengths	Challenges
Training and Coaching – LDP approach (practical application of training) is an effective tool for capacity building.	This approach requires more resources and time to implement and time to see results
Using Youth Reproductive Health Services as a means to demonstrating the LDP approach	Increase in demand for Youth Reproductive Health Services as a result → strain on existing resources at health center level
The tools and techniques introduced were relevant and not complex (Challenge Model, work plans, Work Climate Assessment surveys, etc)	Need to sustain achievements so far and provide follow-up support to the participants who require it
The LDP approach can be expanded to other areas of health center management	A fairly new approach in Cambodia so will need time and resources to effectively advocate to government and donors on the effectiveness of the LDP approach.
The LDP approach can be expanded to other provinces in the health sector	
The LDP Approach can be tailored to other sectors such as education.	

It is important to note that the challenge of the LDP process is to show measurable results in a short amount time. It will take significantly more resources and time to implement and build capacity but the approach is much more intensive and can produce “richer” results. Donors and Government will need to commit to investing in this approach and be aware of the lessons and achievements of this approach from other countries (such as Nepal for example). It is also very important that a monitoring and evaluation framework be set up during project design. The performance indicators of success need to be carefully articulated before the project begins. They should be linked with the intended outcomes of the project (both intermediate and end results). Advocating to Donors and Governments of the success of the project in terms of development impacts and better health outcomes will require some measurable results.

Health Centers

As a result of the project it can be concluded that:

- The training and coaching approach has been very effective in this case. Training alone is not sufficient to impart skills and see them applied into daily routines and work practices.
- This being a pilot project has demonstrated the effectiveness of LDP but there are still capacity gaps among some of the participants and they require further support and training. There is a need for follow up coaching and support, however, to ensure the LDP approach is more firmly accepted and utilized in daily work practices.
- Some health centers will be able to sustain the techniques introduced during the LDP training while others will not. The project gave similar amounts of support to all participating health centers – further support to the health centers that require it will be needed.
- The collaboration between all stakeholders has improved → It is important that this be sustained so that the benefits of the project are sustained. There is a risk that over time the stakeholders will revert back to old practices and approaches. Therefore periodic follow up will be required to ensure that the motivation is still present. The OD Director and OD Vice-Director should be supported to follow up and maintain the momentum with the health centers.
- The use of youth groups as a means to disseminating information about reproductive health issues and the services supplied by the health centers was a very effective tool. This would need to be expanded to other villages within the District (the formation of youth groups) with the support from the health centers and the Commune Councils.

Operational District

- The relationship between the OD and the health centers has improved in a way that is more collaborative. The OD will need to continue working in this way to encourage improved performance of health center management. Any continuation of the project or the LDP process should focus on supporting existing management structures to in turn support the improved management of the health centers.

Youth

- A large amount of interest has been generated in the establishment and participation of youth groups by young people. There is considerable enthusiasm to start up and expand the youth groups to attain wider community development objectives as well (not just for disseminating reproductive health information). It is critical that this process continue and that the momentum be maintained. Supporting the youth groups through the Communes, health centers or schools would be one strategy. Health is a community issue so it does not necessarily have to be seen as the role entirely of the health center. Advocacy and information dissemination through the Commune Council and schools should also be encouraged. This would give greater depth to the development and continuation of the youth groups.
- The knowledge attained through the project and the vehicle in which to apply it (the youth groups) has given a level of empowerment to the youth who were involved with the project. The youth have been empowered to make decisions regarding reproductive health as well as being able to learn leadership, moral and ethical codes of behavior. The project tapped a resource and a large desire for youth to better their lives and develop their community. This needs to be supported and further encouraged.

- The establishment of the youth groups is a positive occurrence within the community. The youth groups encourage and support the development of human “social capital³”. Social capital is the enabling factor that allows people to participate and act together more effectively in the pursuit of shared objectives. It forms the basis of developing social norms and trust which enables people to work together and is the “glue” that binds individuals in a group or a community. Thus with these factors present individuals can act together and participate as groups within civil society for the collective good. The establishment of youth groups is an effective way to mobilize youth and other stakeholders and encourage and empower them to work together.
- Youth feel empowered when they have knowledge and are in a position to make choices about their own lives. They are encouraged to participate and contribute to the well-being of their community.
- There needs to be more time for these new concepts and knowledge to be more widely accepted by the community as a whole (especially parents) and the youth in general.
- There was a tendency for young women to be more interested in joining the youth groups than young men. Efforts should be made to engage with young men to promote better reproductive health practices and to participate with the youth groups. Positive role models need to be developed in the community to encourage young men to become involved.

Commune Authorities

- The Commune Authorities had limited exposure to the concepts and tools from the LDP training but they were able to identify the benefits of the project. To encourage further support and sustainability of the impacts of the project the Commune Officials should be more actively engaged in the training and capacity building. This would also allow closer relationships to be developed between the youth groups the health centers and other stakeholders in the District (schools for example).

³ Lehnig, P.B., 1998, “Towards a Multi-cultural Civil Society: The Role of Social Capital and Democratic Citizenship” in A., Bernard, H., Helmich and P.B., Lehnig (eds), Civil Society and International Development, North-South Centre Council of Europe/OECD Development Centre.

Recommendations

- The LDP approach should be utilized more extensively in developing capacity of health center management and possibly at the Referral Hospital level. This to be extended to other provinces where required or feasible.
- Any future project should involve Commune Council Representatives more actively in the training and coaching on leadership and management and reproductive health issues. Support from the Commune and Village Leaders is essential for the sustainability of the impacts of the project.
- Support existing structures → support the OD to provide follow up support to the health centers to continue the work.
- Youth who are involved with the project have become empowered with new information and knowledge. This needs to be sustained and further encouraged. They will need more positive creative opportunities to develop their leadership social skills. If the momentum slows or even stops in some locations this could have a detrimental impact on their attitude in general and create disillusionment. One of the main ways for sustaining this empowerment and continued personal growth would be to ensure that existing and established structures (such as the Commune Council and health center) are supported to in turn support youth participation.
- Such a project should have a longer duration (possibly twelve months or two years in the case of a province-wide project). This would allow for more targeted follow up and support once the original training and coaching has been undertaken. Periodic needs assessments can be carried out to determine the scope of the support and follow up with individual health centers.
- There needs to be coordination with other projects that have similar approaches or objectives. This is to reduce the possibility of duplication (for activities that occur in the same location) but also to be able to learn from these other similar projects (study tours for example). Similarly health centers from other provinces can learn from the successes of this project in Kampong Cham.
- Encourage the participation of young men to become involved in youth groups and become more aware of reproductive health through creating role models in the community (for example Health Center Chiefs and Commune Officials to be aware of the reluctance of young men to be involved and therefore actively engage with them to seek their participation).
- It is also very important that a monitoring and evaluation framework be set up during project design. The performance indicators of success need to be carefully articulated before the project begins (in a Logframe Approach for example). They should be linked with the intended outcomes of the project (both intermediate and end results) such as the improved management practices or increased numbers of youth seeking counselling for reproductive health. The results can then be used for advocacy purposes to the relevant ministries and donors to expand support for this approach.

Appendix I: LDP Timeline of Activities

		Key Group	January	February	March	April	May	June	
YFSRH for Health Centers	Phase one (foundation)	National Level Stakeholders: MOH,NRPH,PHD,MOWA, MOEYS, USAID, WHO, MEDICAM	Orientation Workshop at National Level (1 day)					National Dissemination Workshop (1 day)	
		District Level Stakeholders: MOH, NRPH, PHD, OD, HCC, USAID, HCC	YFSRH Alignment Workshop at District Level (2 day)	YFSRH Stakeholder meeting at District Level (1 day)		YFSRH Stakeholder meeting at District Level (1 day)		YFSRH Result Sharing Workshop (1 Day)	
		Local Participants (13 Health Centers, 52 staff)		LDP Workshop 1 (3 days) session 1-4	LDP Workshop 2 (3 days) session 5-7	LDP Workshop 3 (3 days) session 8-10	LDP Workshop 4 (3 days) session 11-12		
	Phase two (Action)	Participants Home Team (Health Center Team)		Field Team Meeting (Meet once or more to do assignments and work on leadership project)				Field Team Meeting (Review, evaluate, prepare results presentation)	Field Team Meeting (Select a new challenge to work on)
		Field Team Managers		Regular Coaching (Local health managers support the teams in implementing the tools of the LDP)					
					District Wide Sharing Meeting (Meeting to compare progress, practice leadership skills, and learn together)				

		Key Group	January	February	March	April	May	June
		Organizational Champion (PHD, OD)		Planning Meeting (2 days)	Coaching Visits (1 days)	Coaching Visits (1 days)	Coaching Visits (1 day)	
		Facilitator	Identification & Orientation	Meeting with team to encourage, monitor progress on leadership project, review team products, teach, and correct				Feedback on presentation of results
Youth Advocate LMS	Phase one (foundation)	District Level Stakeholders: MOWA, MOEYS, Parent's Council, Village Leaders, Commune Chiefs, OD Chiefs, HCMC, Youth Manager)				Youth Advocate Alignment Workshop at District Level (4 days)		
		Participants (208 youth)					LDP Youth Workshop 1 (Jamboc Hoas) (3 days) session 1-4	
	Phase two (Action)	Participant Home Team			Selection of 208 youth			Field Team Meeting (Meet once or more to do assignments and work on leadership project)
		Field Team Managers				Selection of youth manager		Regular Coaching (Local youth managers support the teams in implementing the tools of the LDP)

Appendix 2: Performance Criteria Checklists



Performance Checklist (Challenge Model)

Health Center.....

Duration of presentation.....

No	Description	0	1	2	3	4
1	Mission					
2	Vision					
3	Measurable Result					
4	Current Situation					
5	Root Cause					
6	Action Plan					
7	Presentation					
8	Initiation					
9	Alignment/Mobilize Stakeholder					
10	Duration of presentation					
Total						
Notes:						

Performance Checklist (Action Plan)

Health Center.....

Duration of presentation.....

No	Description	0	1	2	3	4
1	Alignment, Motivation and build up good relationship with local NGO, company, power person to support youth friendly health services					
2	Arrange privacy room for youth friendly health services					
3	Develop schedule for youth friendly health services					
4	Hang up and promote the youth right for using the HC service in community					
5	Develop register for youth client					
6	Develop register for referral					
7	Promote youth friendly services to youth and community					
8	Arrange the meeting with youth group at HC					
9	Align the stakeholder to get IEC materials					
10	HC staff provide services with quality and friendly					
12	Request for counselling training course					
Total						
Notes:						

Appendix 3: Performance Criteria for Selection

Sample Health Centers were selected for the Evaluation based on the following rankings.

Summary score of HC LDP

Implementation

11-Jun-09

No	HC	Assessor 1	Assessor 2	Assessor 3	Assessor 4	Total score	Average	Rank
1	Chamkar Andaung	29	22	26	31	108	27	10
2	Ta Ong	31	25	29.5	30.5	116	29	8
3	Mesor Chrey	35	30.5	29.5	33.5	128.5	32.125	2
4	Daun Thy	30.5	33	31.5	35	130	32.5	1
5	Bos Knol	32	29.5	29	32	122.5	30.625	3
6	Svay Teap	22	21	26.5	29	98.5	24.625	13
7	Ta Prok	21.5	26	28.5	27.5	103.5	25.875	11
8	Lvea Leu	27.5	28	25.5	35.5	116.5	29.125	7
9	Speu	32.5	26.5	28	34	121	30.25	5
10	Chey Yo	25	26	29	31	111	27.75	9
11	Sopheas	31.5	29	25.5	33.5	119.5	29.875	6
12	Taing Krang	22	25.5	28	27	102.5	25.625	12
13	Daun Kdar-Aumlou	28	31.5	29	33.5	122	30.5	4

Note:

OD
Director

SPY- APM

ADRA
Leadership
Project -
PM

OD Vice
Director

Appendix 4: Challenge Model (mini-Project)

Challenge Model HC Donthy

Mission

To strengthen Youth Reproductive Health Service at HC Donthy

Vision

Increasing number of youth accessing quality YFHS at Donthy Health center

- 8 Percent of youth among 2034 all clients who received services
 - 153 Number of youth counseled in YFHS
 - 42 Number of youth first clinic visit to the YFHS
 - 111 Number of youth follow-up visits to the YFHS
 - 0.09 Percent of youth referrals by Health center Donthy
- % of mystery clients reports satisfaction on the quality YFHS at Donthy HC

1. Don't have separate register for age 10-24
2. Youth are not involve in the improvement of YRH services at the HC
3. HC staffs and youth clients do not know about youth rights
4. HC staffs do not have proper attitude, friendly and non judgmental to the youth clients
5. HC do not have visible schedule, services and location on YFHS
6. Availability of information at the Youth counseling rooms (booklet, leaflets, posters, etc)
7. HC do not have separate counseling room for youth
8. No promotion of health center's youth reproductive health services in the community.
9. HC staffs has limited capacity in providing YFHS counselling

Obstacle/Root cause

1. Provide a separate register for the youth ages 10-24
2. youth are involved in the meetings at HC to discuss about quality YFHS
3. HC staff and youth clients knows and respect Youth rights
4. HC staffs are friendly and non judgmental to the youth clients
5. HC have visible schedule, services and location on YFHS
6. Youth counseling room furnished and have leaflets, posters and books on YRH information.
7. Arrange the HC room for providing youth reproductive health service.
8. Dissemination of YFHS through Commune Council, Village leaders, outreach- activities.
9. HC have a plan on staffs YFHS capacity building

Current Situation

- 8.56 Percent of youth among 1949 all clients who received services
 - 167 Number of youth counseled in YFHS
 - 44 Number of youth first clinic visit to the YFHS
 - 123 Number of youth follow-up visits to the YFHS
 - 0 Percent of youth referrals by Health Center Donthy
- % of mystery clients reports satisfaction on the quality YFHS at Donthy HC

Appendix 5: Work Climate Assessment Survey

Workgroup Climate Assessment - Part A

Please read each item below and indicate your selection by circling the appropriate number in both columns.

Workgroup Climate Assessment – Part A	How are things now in your workgroup?
I feel that in my workgroup.....	Please rate each item on a scale from 1 to 5 where:- 1 = Not at All 2 = To a Small Degree 3 = To a Moderate Degree 4 = To a Great Degree 5 = To a Very Great Degree
1. We feel our work is important	1 2 3 4 5
2. We strive to achieve successful outcomes	1 2 3 4 5
3. We pay attention to how well we are working together	1 2 3 4 5
4. We understand the relevance of the job of each member in our group	1 2 3 4 5
5. We have a plan which guides our activities	1 2 3 4 5
6. We understand each other's capabilities	1 2 3 4 5
7. We seek to understand the needs of our clients	1 2 3 4 5
8. We take pride in our work	1 2 3 4 5

After completing this part of the assessment, please move on to the section B found on the next page.

Workgroup Climate Assessment – Part B

This section is an assessment of your feelings about whether your workgroup is *known for quality work* and whether it is *productive*.

What does being *known for quality work* mean? It means that our workgroup:-

- is known for meeting our clients' needs
- receives positive feedback from our clients or supervisors

What is being productive mean? It means that our workgroup:-

- consistently meets our work objectives, such as monthly or annual objectives
- is recognized by others as a group that gets the job done

Please read each item and then decide how things are in your workgroup. Using the same scale as it Part A, indicate your selection by circling the appropriate number.

	<p>How are things now in your workgroup?</p> <p>Please rate each item on a scale from 1 to 5 where:</p> <p>1 = Not at All 2 = To a Small Degree 3 = To a Moderate Degree 4 = To a Great Degree 5 = To a Very Great Degree</p>
I feel that	
9. Our workgroup is known for quality work	1 2 3 4 5
10. Our workgroup is productive	1 2 3 4 5

Thank you for completing the assessment.

Appendix 6: Results of the WCA Survey

