



The European Union's Aid for Policies and Actions
on Reproductive and Sexual Health and Rights
in Developing Countries programme
For Cambodia



Rural Cambodian Youth Sexual Reproductive
Health Project (August 2006 - July 2009)

Final Evaluation

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30th July 2009
Phnom Penh, Cambodia



This project is being funded by
The European Union



A Project implemented by
ADRA and RACHA

Rural Cambodian Youth Sexual Reproductive Health Project

Final Evaluation

August 1, 2006 to July 31, 2009

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The European Union is made up of 27 Member States who have decided to gradually link together their know-how, resources and destinies. Together, during a period of enlargement of 50 years, they have built a zone of stability, democracy and sustainable development whilst maintaining cultural diversity, tolerance and individual freedoms. The European Union is committed to sharing its achievements and its values with countries and peoples beyond its borders.

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1. EXECUTIVE SUMMARY

The project has its overall objective that Young people have disease-free, fulfilled sexual and reproductive health and its specific objective to enable young people to experience informed, responsible, and coercion-free sexual reproductive health in an environment where they receive needed support from policy makers, social gatekeepers and health service delivery systems.

To fulfil the specific objective, the project has its three strategies: **1)** Ensuring that quality Youth-Friendly Sexual Reproductive Health (SRH) services and referral systems are available and utilized at each level of service delivery, **2)** Increasing knowledge and awareness of youth SRH & Rights, and empowering youth to make health SRH choices through practicing Life Skills (LS) based on their awareness of potential dangers, risks and understanding of protective factors and **3)** Improving support for Youth Sexual Reproductive Health (YSRH) programs by community advocacy efforts and research aimed at influencing Youth Reproductive Health (YRH) policy and practice.

The goal and objectives of the project evaluation

The evaluation goal and objectives are to assess the overall project success and accountability, drawing lessons for future actions. The overall project success is understood as quality and quantity achievements of project indicators and goals. The accountability is referring to the project overall implementation as described and dictated by proposal, grant agreement with donors, reports to donors and the Modified Implementation Plan (MIP). Lessons for future actions are best practices, lessons learnt, sustainability and policy recommendation to the relevant authorities.

The evaluator summarized these as measuring 1) the project effectiveness along with its objectives to measure the progress, 2) the change and the effectiveness of the project implementation, 3) the project strengths and limitations and 4) to develop recommendation based on these.

The methods

Three main methods were used: **1)** Literature review, **2)** the qualitative survey design using in-depth interview, focus group discussion and observation methods to collect data from project officers and staff, field implementer as well as beneficiary and **3)** the two consultative workshops that organized consecutively among the project implementers in the field and stakeholders at the national level.

The achievements

The project achieved almost 100% of its target providers and beneficiaries directly or indirectly as planned including:

- 28 Core Training Team (CTT) members trained to provide further training to School Based Training Team (SBTT) and Community Based Training Team (CBTT)
- 161 public Health Care Providers (HCP) and 161 private HCP trained in providing Youth Friendly Health Service (YFHS)
- 326 formal professionals and 474 lay counsellors received counselling training while 163.3% formal professional and 74.44% lay counsellors could provide skilful counselling.
- 41 YFHS and Youth Resource Rooms (YRR) were supported in renovated or new building, equipment and materials necessary for functioning service.
- 203 school teachers were trained and all of them did provide further Reproductive Health (RH) education to their students.
- 850 schools Peer Educators (PE) and 2003 community Peer Educator Leaders (PEL) were selected and trained and 80% among them did actively provide peer education to their school friends.

- 38 schools and 454 communities had youth clubs established but youth clubs only 28 schools were active and functioned regularly as planned.
- 156 school-wide activities and 577 community awareness and youth day activities were conducted by PEs during the national holidays or international event such as World AIDS Day, International Children's Day, or Khmer New Year. In addition, 400 regular radio broadcasts were aired in both provinces.
- 38 schools had youth corners and resource libraries established and all were active and functioned regularly as planned.
- 156 Community Youth Advocates (CYA) were trained and 80% of them did demonstrate active advocacy roles.
- 324 Health Centre Management Committee (HCMC) members were trained on health financing scheme strengthening, YSRH advocacy, basic monitoring and evaluation / data collection, and project feedback using Client Oriented Provider Efficient (COPE).
- 970 Village Health Support Group (VHSG) members were trained on YSRH basic concepts and introduction to the project. Then, 712 VHSG did show active involvement and commitment to their roles and responsibilities.
- Several types of IEC materials were developed and distributed including: 37,500 writing books with health messages, 19,004 story books on Reproductive Health, 622,560 of 8 types of leaflets, 23,936 T-shirts, 3,860 caps, 60 billboards, 5,581 bags, 21,201 of six types of posters and 870 of two types of flipcharts.
- 39 Project Monitoring and Advisory Committees (PMAC) at 39 Health Centres (HCs) were established and trained.
- 500 Religious Leaders and Traditional Birth Attendants (TBA) from 45 village religious structures were trained on YSRH concepts.
- 37 community youth-watch programs in 37 villages were created and community stakeholder committee trained to report regularly to relevant local authorities or project management inappropriate when problematic issues are identified in their community such as youth with sexual reproductive health problems and especially where there was a violation of youth's right, rape, forced migration or trafficking.
- Three researches on 1) YSRH including socio-cultural factors and their impact on access to health information and services, 2) a comparative study on the effectiveness of differing strategies in YSRH education operated in Preah Vihear (PVH) and Kompong Thom (KPT) provinces and 3) a comparison of the effectiveness of health system support regarding YFHS between RACHA's target areas (the "Health Services Contracting District") in PVH and (a non-contracting area) in KPT Province were conducted and there findings were disseminated.
- Two papers exploring policy issues and/or recommendations concerning the drafting process of a national YFHS Policy Guideline were developed and distributed
- 171,000 youth in both sexes, aged 10-24 years old received RH information directly through school education, peer education, youth resource room or school library and youth friendly health service.
- 331,000 community members received RH information indirectly from the school and community awareness campaign activities

The effectiveness

The project did make significant effect in comparing the survey finding between base line to end line:

- RH knowledge increases from 50% to 59%
- HIV/AIDS/STI knowledge increase from 73% to 77%
- Positive RH increases from 65% to 74%
- Positive RH attitudes, beliefs and values increases from 44% to 48%
- Decreased risky social influences causing unhealthy YRH behaviours from 49% to 41%

Conclusion

The project received approval and highly support from all related government agencies. It was designed and implemented based on the national reproductive health strategy, policy and program as contributing to fill the gap of the national response to youth reproductive health issues in Cambodia and it was strongly managed by two organizations that have had a long and strong experience managing several projects successfully in Cambodia. More importantly it was implemented based on clear policy and guidelines with consistent and regular planning, monitoring and evaluation and project report writing on a monthly, quarterly and annually basis.

The project life based on the proposal was three years, but based on a phasing plan more than 50% of the project coverage sites had activity implementation less than three years and even a few project sites were less than a year due to the limited human resource mainly of the project officers and staffs.

The project, in general achieved successfully almost 100% of its activities planned and reached almost all targets set in the project.

Most of the target groups, providers and beneficiaries (171,000 young women and men aged of 10-24 years old and 331,000 community members in three operational districts) were reached.

The project provided opportunity for provincial government authorities down to local authorities to own and be fully involved in the project implementation although not at the project design and management level.

The project did provide a positive enabling environment to change community and society norms from negative thinking towards positive thinking to accept their children, their community learning, discussing, and talking openly on reproductive health.

The project was designed with no clear exit strategy that makes it difficult to be ready to hand over to local authorities to ensure the project sustainability. It is believed that all project activities that are not stand alone and are not requiring daily operational cost will be sustained.

The result of this project evaluation could be used as a reference and contributing document to advocate for political commitment to open the doors for youth to gain full access to RH context, to help the Ministry of Education, Youth and Sport (MoEYS), Ministry of Health (MoH) and Ministry of Women's Affairs (MoWA) to develop a strategy, policy and program as well as to allocate resources and build infrastructure on RH delivery for youth in their respective mandates.

The Challenges

The total project staff were not sufficient to implement in all project areas at one time, thus, the project target area was divided into three intervention phases. Each intervention phases lasted around 9-12 months before moving to the next phase intervention area. The follow up and the continuing activities on the old phase target area then depend fully upon volunteers and CTT/CBTT commitment.

The recruitment process of providers such as PEs, religious leaders, private providers etc, designed by the project, consumed a lot of time and so delayed the provision of support or services to the beneficiaries. The recruitment processes were fully community participatory involving community leaders and structures. The process, though cumbersome, built community ownership, acceptance and support for the field activities.

It is a challenge to have training activities with 100% participation of target beneficiaries, especially the private health care providers. They don't see the benefit of coming to the training activities when the project does not provide any incentives whatsoever. However, those who participated were genuinely

interested in learning about Youth sexual reproductive health challenges and participated in addressing them.

PE attrition during project life, cost the project time and resources to recruit and train replacements. PEs are community youth volunteers who have a passion to help their fellow youth. However, the economy pressure was the reason most of the time why youth volunteers need to leave the project. The reality is that these youth volunteers (PEs) had been equipped with knowledge and skills needed, to protect their Sexual reproductive health rights. The recruitment and training of new PEs may be interpreted as project loss, but gain in terms of quality youth leaders trained and ready to become agents of change wherever they go.

The Project provided a variety of books mainly limited to Youth sexual reproductive health information in school libraries. Some people addressed this as project limitation, expecting the project to supply a much larger variety of books on general information for the school libraries which was beyond the project mandate.

There was a challenge to establish Youth Friendly Health Services at Health Centres Trea and Chamna Leu of Kampong Thom province. Trea Health Centre has no physical structures but existed in the Ministry of Health register. The Project's limited resources could not provide physical structures for only youth friendly services. Chamna Leu Health Centre had only two staff and could not participate in the establishment of Youth Friendly Services.

There is a limitation to describe the outcome of the overall project while the project activities were not implemented at the same phase for example, some sites received full proposed activities within three years period while some exposed to the project few months before it ended.

Recommendations

ADRA, RACHA, MoH, MoWA and MoEYS could be in the right position to use the findings from this project evaluation to advocate for further resource mobilization from other sources for at least two more years or integrate some project interventions into other on-going projects where funding is available.

To better insure the project sustainability, government partners, as project owners, should be involved at all levels since the project design, implementation, management and MEL with clear exit strategy.

Further evaluation should focus on cost efficiency and cost effectiveness of using peer educators while it keeps moving out and requires resource for training continuously.

The project should be flexible on reprogramming related to human resources, financial resources and equipment or materials based on the progress reports from monitoring in which the project could be improved.

New measures or mechanisms to encourage students to use the library during school time, on the weekend and to update resource books should be considered.

There should be a standard for project implementation in terms of policy and guideline or SOP

The Lessons Learned

With strong support from the government partners at the national level down to the grass roots level, it does facilitate the project implementation to run smoothly as in achieving all the activities planned and successfully as in achieving all the objectives set in the project.

Using the existing human resources, systems and services available locally and being owned by the local authority does speed up the project implementation with low cost and to ensure the project sustainability.

Initiating multi-sectoral participation and commitment through community networking does have strong influence to break the community silence on RH into accepting RH discussion openly.

Peer education programs do provide a quick effective way to increase youth knowledge both in school and in the community during a short period of time; however without integrating into any existing system or services, sustainability is a question for a long period of time.

The Project did create a supportive community network to encourage and motivate youth to use their rights, responsibilities and improved confidence to make decisions to access RH knowledge and services, and monitoring of risky factors at the community level.

ACKNOWLEDGEMENTS

First of all I wish to express my great thanks to Mark Schwisow, country director of ADRA Cambodia; Ann Marie Stickle, associate director of ADRA Cambodia, Mr Leonard Uisetiawan, advisor to RCYSRH project who provided all management and administrative support to facilitate this evaluation successfully.

In particular, my great appreciation and thanks to Mr Moth Sokhon, project manager, Kim Srey Mom, assistant project manager, Mr Chan Vuthy, project monitoring and evaluation for learning officer in Kampong Thom, Dr Chou Ponina, project team leader in Preah Vihear and Mr Om Chhen, assistant to consultant on field data collection who were very active to facilitate the field work and to provide all necessary documents to develop this evaluation paper.

My sincerely thanks and appreciations go to large number of local partners, field implementers and beneficiary who participated in in-depth interview, focus group discussion and consultative meetings and have made available documents and other information leading to evidence-based paper.

Finally, I am grateful for the financial support provided document by the EC through ADRA for the development of this important evaluation.

Acronyms and Abbreviations

ADRA	Adventist Development and Relief Agency	PAS	Provincial AIDS Secretariat
AFSRH	Adolescent-Friendly Reproductive and Sexual Health Services	PE	Peer Educator
AIDS	Acquired Immune Deficiency Syndrome	PED	Provincial Education Department
BCC	Behaviour Change Communication	PEL	Peer Educator Leader
BSOD	Baray-Santuk Operational Health District	PHD	Provincial Health Department
CBTT	Community Based Training Team	PLA	Participatory Learning through Action
CC	Commune Council	PMAC	Project Monitoring and Advisory Committee
COPE	Client Oriented Provider Efficient	PMTCT	Prevention of Mother to Child Transmission
CTT	Core Training Team	PP	Phnom Penh
CYA	Community Youth Advocate	PVH	Preah Vihear Province
CYWP	Community Youth Watch Programme	PVHOD	Preah Vihear Operational Health District
EC	European Commission	PWA	Provincial Women's Affairs Department
HC	Health Centre	Q&A	Question and Answer
HCMC	Health Centre Management Committee	RACHA	Reproductive and Child Health Alliance
HCP	Health Care Provider	RCYSRH	Rural Cambodian Youth Sexual Reproductive Health Project
HCW	Health Care Worker	RHAC	Reproductive Health Association of Cambodia
HIV	Human Immuno-Deficiency Virus	RHPWG	Reproductive Health Programs Working Group
ICPD	International Cooperation for Population Development	RH	Reproductive Health
IEC	Information Education Communication	SBTT	School Based Training Team
JBH	Jomboc Hoas "Flying Tree" (Adventure Learning Center)	SRH	Sexual Reproductive Health
KAP	Knowledge, Attitudes and Practice	SOD	Stoung Operational Health District
KPT	Kompong Thom Province	SOP	Standard Operating Procedure
LS	Life Skills	SRH	Sexual Reproductive Health
MDG	Millennial Development Goal	STD	Sexually Transmitted Disease
MEDiCAM	Consortium of <i>MEDical</i> NGOs working in health in <i>CAMBodia</i>	STI	Sexually Transmitted Infection
MEL	Monitoring and Evaluation for Learning	TBA	Traditional Birth Attendants
MIP	Modified Implementation Plan	UN	United Nations
MoEYS	Ministry of Education, Youth and Sport	VCT	Voluntary Counselling and Testing
MoH	Ministry of Health	VHSG	Village Health Support Group
MoWA	Ministry of Women's Affairs	YAC	Youth Advisory Committee
NAA	National AIDS Authority	YFHS	Youth Friendly Health Service
NGO	Non-Governmental Organization	YFS	Youth Friendly Service
OD	Operational District	YRH	Youth Reproductive Health
		YSRH	Youth Sexual Reproductive Health
		SBTT	School Based Training Team

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2. Introduction

1. About the project

The RCYSRH is an acronym of “Rural Cambodian Youth Sexual Reproductive Health Project”. It is an integrated community based initiative project aiming to build the capacity of local and national stakeholders to meet sexual reproductive health needs of 171,000 rural young people (youth aged 10-24) and over 502,000 population at three operational districts in two provinces, Kampong Thom and Preah Vihear.

The RCYSRH was a three-year project funded by EC with total amount of £1.65 millions, to meet two out of three principal objectives of the programme as set out in Regulation n° 1567/2003 of the European Parliament and of the European Council on "Aid for policies and actions on reproductive and sexual health and rights in developing countries". The two objectives are:

- First to secure the right of women, men and adolescents to good reproductive and sexual health and
- Secondly, to enable women, men and adolescents to have access to a comprehensive range of safe and reliable reproductive and sexual health care services and products by ensuring that young people’s rights are respected by the policies, policy makers and social “gatekeepers”. This advocacy with the duty bearers to make youth friendly SRH information and services available to meet the unique needs of the young people and helping them understand their own SRH needs by building their capacity to demand their rights, the proposed activity will help to secure the rights of the young people, men and women alike as outlined in the first principal objective. Similarly, by working with both public and private services providers to expand the availability of youth-friendly sexual and reproductive health services, the action will help the young people to make more informed and safe SRH choices.

The objective of the project is also in line with recommendations made by ICPD declaration to consider the rights of men and women be informed, have access services, include sexual health for enhancement of life and personal relations, enable attainment of the highest standard of sexual and reproductive health, promote mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents and to enable them to deal in a positive and responsible way with their sexuality.

Similarly, using the gender sensitive approach that takes into account the unique needs of men and women and by helping them understand their respective roles, the project objective will also help meet the need identified by the UN Development Goals report for Cambodia 2001 which recommends that “in order to reach the MDG related to Gender Equality and to Empower women and minimize gender disparities in the policy and decision making process at all levels, there is an urgent need to have active participation of NGO’s in the implementation of programmes for women’s empowerment, especially for greater access to quality health care including reproductive health.” The project objective also helps achieve the MDGs goals set for Cambodia such as reduce extreme poverty, improve health (and reduce child mortality) reduce HIV/AIDS, and improve reproductive health.

1.1. The project overall objective

The project had its overall objective that Young people have disease free among youth people, fulfilled sexual and reproductive health

The project had its specific objective to enable young people to experience informed, responsible, and coercion-free sexual reproductive health in an environment where they receive needed support from policy makers, social gatekeepers and health service delivery systems.

1.2. The project objectives

To fulfil the specific objective, the project had three specific strategies:

1. Ensuring that quality of Youth-Friendly SRH services and referral systems are available and utilized at each level of service delivery,
2. Increasing knowledge and awareness of youth SRH & Rights, and empowering youth to make SRH choices through practicing Life Skills (LS) based on their awareness of potential dangers, risks and understanding of protective factors and
3. Improving support for YSRH programs by community advocacy efforts and research aimed at influencing YRH policy and practice.

1.3. The project results

To achieve the project strategies, three results were adopted:

1. Youth-friendly community health services strengthened (Institutional youth friendly health service)
2. Increased community knowledge and awareness of YSRH issues (Facility strengthening, building of community advocacy networks, peer education), and
3. Local and national rural youth Reproductive Health policy and response strengthened (National YSRH policy advocacy and promotion).

1.4. The project activities

In order to achieve its overall and specific objectives, there were several activities designed based on strategy and result

Strategy 1: Ensuring that quality of Youth-Friendly SRH services and referral systems were available and utilized at each level of service delivery,

Activities 1: Established and strengthened "Youth-Friendly Community Health Services"

This component focused on improving access to sexual and reproductive health services that were geared towards meeting the needs of young people. It was established and strengthened at the health centre. This service was expected to increase youth access to health services, make youth aware of the services, and to ensure that these services were "youth-friendly" and providing appropriate care.

Target 39 health centres and three referral hospitals have "Youth-Friendly Community Health Services" established and strengthened.

Activities 2: Conduct training to core training team (CTT)

Based on the project plan, there were various trainings, educational sessions and skills development workshops aimed at building capacity for partners at each level of the project; from village youth to District and Provincial Government staff. The trainings were started in the following training frame work.

Totally there were three *Core Training Teams* established consisting of ADRA and RACHA trainers as well as representatives from District and Provincial levels of the project's three primary government partners; MoEYS, MoH, and MoWA.

These *Core Training Teams* (CTT) received "Training of Trainers" (TOT) training by RHAC and PATH in youth sexual and reproductive health and rights issues, peer-education modalities and the establishment of "youth-friendly" health services.

The trainers then were divided into:

- In-School CTT: focusing on training of teachers and staff in the formal education system and
- Out-of-School CTT who further trained community-level youth advocates, government health system staff and private sector health service providers.

Target **28** members of CTT were trained, **13** in Kampong Thom, **15** in Preah Vihear

Activities 3: Train Key private and government health service providers in YSRH service delivery and other support groups

- Health Centre staff at both the referral hospitals and health centres received YFHS training, with the aim of improving the quality and appropriateness of care provided to youth through the government health system.

As target **156** health centre staff and **15** referral hospital HCW received training using a curriculum based on the "youth-friendly" health services training modules developed.

- Health Centre staff were given training in advanced therapeutic counselling skills, and expected to serve as professional YSRH counsellors as well as clinical care providers. Peer educators were trained in specific peer counselling techniques, and taught how to use their natural ability to communicate with friends as a means of BCC. Religious leaders and community youth advocates also learn basic counselling techniques, and were able to respond and interact with youth in an appropriate way

As target **300** formal professional counsellors and **360** lay counsellors were trained.

As target 50% of trained formal professionals and lay counsellors could perform appropriate counselling skills.

- Private sector health service providers in the target areas (clinics, pharmacies, informal 'drug sellers' or other avenues of care or commodities) were identified and offered training in YFHS.

As target **160** private sector health service providers, **40** registered and **120** unregistered health service providers in the target areas were identified and offered training in YFHS. Among those trained 80% were active in providing youth friendly service.

Activities 4: Established "youth resource rooms" in referral hospitals and health centres that provided YSRH information and a confidential learning /counselling environment

Target 39 health centres and 3 referral hospitals had youth resource rooms established and functioned. 16 rooms were renovated with materials and books supplied and the others were supplied with only the materials and books.

Activities 5: Provided capital improvements

- Support provided to government health facilities and the youth resource rooms to develop infrastructure, facility improvements, and selected materials and equipment as needed for effective Youth Friendly service delivery.

As target some selected materials and equipment as needed for effective YFS delivery and YRR were equipped and supplied.

- Develop IEC materials including posters and flyers which were available to youth accessing their facilities.

As target some selected IEC materials as needed for effective YFS delivery and YRR were developed, printed and supplied.

Activities 6: Establish sustained referral linkages of public-private YFS providers.

- Training government and private service providers in YRH referral system strengthening.

As target, 39 health centres, 3 referral hospitals and 81 private clinics would be trained in YRH referral system strengthening.

Strategy 2: Increasing knowledge and awareness of youth SRH & Rights, and empowering youth to make health SRH choices through practicing Life Skills (LS) based on their awareness of potential dangers, risks and understanding of protective factors.

1. The In-school component would implement the following key activities:

Activities 1: Conduct training to:

- **School teachers**

To provide RH knowledge to youth in-school, school teachers and school administrators (grade 7 to 11) were selected and trained in YSRH issues and taught how to effectively teach and incorporate SRH into the school curriculum.

Some trained teachers and administrators were chosen to receive advanced training in PE / Life-Skills to become "School-Based Training Teams" that was responsible to select, train and supervise the Peer Educators in their schools and to conduct extra-curricular Life-skills and YSRH classes as scheduled. They would function as Peer Educator Mentors, meeting with Peer Educator "Youth Club" groups on a monthly basis, collecting PE reports, and being available to assist and advise the Peer Educators as needed.

As target **200** teachers and school administrators would be trained and 38 out of 200 would be selected as SBTT.

- **School Peer Educator Leader (PEL):**

Two peer educators per class (grades 7-11) in 38 schools would be nominated by their classmates and selected based upon their reputation, leadership abilities and ability to role model. They would receive training in YSRH concepts, practical Life Skills and in basic BCC techniques.

As target, a total of **850** peer educators would be trained by the project.

Activities 2: organize education session on RH

After being trained, teachers were requested to organize educational plan to their students based on school program and RH curriculum developed by the project.

As target **150** trained teachers conducted RH educational session to students.

Activities 3: organize peer education session

After being trained, school PEs were requested to organize peer session among their friends in class or in school.

As target **10** formal sessions were organized by each PE per month.

Activities 4: Establish School Youth Club:

Peer Educators within each school were responsible for organizing themselves into a "Youth Club" once a month to discuss YSRH issues, to have Q&A sessions, to share experiences, to discuss lessons-learn, and to submit monthly "peer contact" reports, to plan awareness events, and in-school educational activities with their peers under support from peer educator mentors and school administrators.

As target **38** school youth clubs would be established and 28 out of 38 would be active and functioning well.

Activities 5: Conduct School-wide Awareness Activities:

Peer Educators would plan and lead out in Awareness Activities during school programs planned to celebrate national holidays or international awareness days such as World AIDS Day, International Children's Day, or Khmer New Year. Youth Clubs would also use these awareness events as opportunities to display and distribute YSRH-related IEC materials. Efforts would be made to link the school Youth Clubs with the community-based Youth Clubs, coordinating social activities such as sports competitions or drama presentations.

As target **130** schools would conduct school-wide awareness activities

Activities 6: Establish Youth Corners and Resource Libraries:

Each school would be supported to develop a "Youth Corner" located in a classroom or library which was easily accessible to all youth and provides a safe environment conducive to peer-to-peer discussions about sexual health.

As target **38** schools would be supported to establish youth library

2. The out-of-School component would implement the following key activities:

Activities 1: Conduct training

○ **Community Youth Advocate (CYA)**

Two Community Youth Advocates would be chosen from each commune and trained in YSRH concepts, PE and Life-skills education and would function as CBTT "training assistants" for training workshops held in their communes.

A target **188** CYA were trained.

○ **Health Centre Management Committee (HCMC)**

HCMC members would receive 2 days of training on health financing scheme strengthening, YSRH advocacy, basic MEL/data collection, and project feedback using COPE.

As target **615** HCMC were trained and **188** out of 615 demonstrated active advocacy role.

○ **Peer Education Leaders (PEL)**

"Peer Educator Leaders" (3-5 per village based on population) would be nominated by their peers and selected to undergo training with an initial 4 day training session by the CBTTs in YSRH and PE concepts. 1000 PEL's (1 male and 1 female per village) would then be selected for advanced leadership, advanced life-skills and concepts of BCC and community mobilizations.

- As target **2000** PEL would be trained in YSRH and PE concepts
- As target 42 PEL representatives would attend PMAC meeting at the HC on quarterly basis
- **1000** PEL would be trained in advanced leadership, advanced life-skills and concepts of BCC and community mobilization and
- At least 1200 trained PEL would report their activities regularly on monthly basis.

○ **Village Health Support Group members (VHSG)**

VHSG members (1-2 / village) would be trained (x 2 days) in YSRH basic concepts and introduction to the project.

As target **1000** VHSG would be trained in YSRH basic concepts and at least 600 trained VHSG reported their activities regularly.

○ **Gate keepers (religious leaders and traditional birth attendants)**

Religious leaders (mostly Wat Grannies and Ajah) at 45 village religious structures (mostly Wats, some mosques) would be taught YSRH concepts and basic lay counselling skills.

As target **500** religious leaders would be trained in YSRH basic concepts and basic lay counselling skills.

Activities 2: Conduct community awareness activities:

- Organize drama performance
- Organize World AIDS Day, International Children's Day,
- Regular broadcast through mass media/public Media such as radio programs

As target

- 500 community awareness activities would be organized
- 3 WAD would be organized in 3 ODs.
- 3 International Children's Day would be organized in 2 ODs.
- 3 Water Festival would be organized.
- 400 radio program would be broadcasted

Activities 3: Create youth club

Peer Educator Leaders within villages would be responsible for organizing Peer Educators into a "Youth Club." This informal association of PE's would be expected to meet together once a month during the village "youth day" to discuss YSRH issues and plan village awareness events and educational activities with their peers.

As target 500 youth clubs with **monthly** meeting would be organized.

Strategy 3: Improving support for YSRH programs by community advocacy efforts and research aimed at influencing YRH policy and practice.

Activities 1: Establish, train and function community youth advocate (CYA)

One male and one female CYA would be participated in advocacy training and in effective communication and networking for advocacy.

As target **158** CYA would be trained.

Activities 2: Establish and function Youth Advisory Committee (YAC)

YAC would be established to provide project critical feedback and management support. This committee would be given ample opportunities to meet and provide critical planning and review of the program's progress and future direction.

As target a YAC would be established and 21 quarterly meetings would be organized.

Activities 3: Establish and function Project Monitoring and Advisory Committee (PMAC).

An important part of gathering data and community feedback the PMAC would be established that would meet quarterly at each health centre. The PMAC consisted of HCMC members, CYA's and youth PEL representatives, the committee would receive training and support from the project MEL officer, who would attend all quarterly meetings.

As target a PMAC would be established and 31 quarterly meetings would be organized.

Activities 4: Conduct sensitization workshops

To gain comprehensive project support, key policy makers at national and provincial levels such as Health Centre Management committees, Commune council leaders, and other key local players would be sensitized.

As target:

- 500 religious leaders and traditional birth attendants (TBA) would be trained
- 35 HC catchments' areas demonstrated greater sensitizations after workshop organized for community leaders and gate keepers.

Activities 5: organize advocacy campaign through media

The project officers and staff were sent to participate in any media activities organized by television and radio stations at the national and provincial level.

Activities 6: participate in national forum on youth policy development

As contribution to the national response on RH, the project would provide opportunity to project officers and staff to participate in national forum to learn and share lesson-learn from this project to influence any development made at the national level for youth reproductive health such as strategy, policy, guideline, curriculum etc.

As target project officers and staff would participate in:

- Support national efforts at defining a National Adolescent Reproductive Health Policy.
- Participate regularly in the policy development working group
- Attend national and regional YSRH workshops and participated as needed in supporting the development of policies and would advocate for policies and practices that promote YSRH & Rights.
- Initiate opportunistic meetings with key government leaders across relevant ministries to promote and advocate in support of improved policy.

Activities 7: Establish Community Youth-Watch Program

An innovative initiative that encouraged community members to take responsibility for the activities and social environment in their villages to promote attitudes of non-tolerance and facilitate community action against inappropriate activities or environments in the community that encourage or enable high-risk sexual behaviour (such as the practice of showing pornographic videos in public coffee shops frequented by young people, under-age alcohol use, drug abuse and the existence of community youth gangs). The Youth Watch program would also identify situations and activities that were illegal or in violation of youth's rights and report it to authorities or to project staff, VHSG members or CYAs.

A targeted 8 CYWP would be established and functioning through integration with the Child Friendly Village project (child friendly village committees) in Kampong Thom, and newly created in Preah Vihear, regularly meeting on a monthly basis.

Activities 8: Establish supporting networks and coalitions.

The project would strengthen partnerships with national and local government as well as NGOs such as, the National AIDS Authority (NAA), MoH, Provincial AIDS Secretariat (PAS), PHD, etc through coordinating networks.

Activities 9: Conduct and use research data for advocacy

The project would design and implement a series of research initiatives that would be undertaken over the life of the project, with the aim of gathering information and data which would contribute to a more thorough understanding of YSRH issues in Cambodia.

- Conduct research activities: there were several research subjects planned as following:
 - A series of community and school-based knowledge, attitudes and practice (KAP) and participatory learning through action (PLA) qualitative studies on YSRH including socio-

- cultural factors and their impact on access to health information and services, antecedents to risky sexual behaviours and key motivating factors for practicing safe sexual health.
 - Operational research on key-localized risky behaviours, social factors and migration preparedness.
 - A comparative study on the effectiveness of differing implementation strategies in YSRH education as demonstrated by the MoE / WE "Life-Skills for HIV / AIDS Education" project in Preah Vihear Province and similar ADRA / RACHA interventions in Kompong Thom Province.
 - A comparison of the effectiveness of health system support / intervention regarding YSRH youth-friendly services between RACHA's target areas (the "Health Services Contracting District") in Preah Vihear Province as compared with (a non-contracting area) Kampong Thom Province.
 - Papers exploring policy issues and/or recommendations concerning the drafting process of a national YFHS Policy Guideline.
- All research findings were planned to have it disseminated through workshop organized for policy makers at national and provincial level.

As target one MIP workshop, one mid-term evaluation workshop and one final evaluation workshop would be conducted.

1.5. The project methods

1.5.1. The design

- The partnership
- The capacity building
- The evidence based and participatory planning
- The use of existing system and services
- The sustainability concept
- The feedback through monitoring and evaluation

1.5.2. The tools

- Curriculum was used as tool for capacity building through training, consisting of 33 different topics divided into three chapters:
 - **Chapter one:** with nine topics on YSRH concept
 - 1) RH and Adolescence Sexual Reproductive Rights,
 - 2) Youth/Adolescent Development,
 - 3) Problem and concern which related RH-YSRH
 - 4) Fertility and Pregnancy,
 - 5) Birth Spacing
 - 6) Drug abuse
 - 7) STI/HIV/AIDS
 - 8) Nutrition
 - 9) Domestic violence
 - **Chapter two:** with six topics on YSRH-Life Skill
 - 10) Life skills
 - 11) Morals and values
 - 12) Behaviour change,
 - 13) Gender and RH,
 - 14) Men's involvement for Birth Spacing and RH
 - 15) Peer education

- **Chapter three:** with six topics on Youth Friendly Service
 - 16) RH & SRH Strategy for year 2006-2010
 - 17) Youth friendly service
 - 18) Killing words
 - 19) Key capacity for health providers
 - 20) Counselling skill for health providers
 - 21) Key messages

- And twelve more topics as integrated topics
 - 22) Communication skills,
 - 23) Facilitation skills,
 - 24) Migration,
 - 25) Trafficking,
 - 26) Advocacy,
 - 27) Referral system,
 - 28) Role and responsibility,
 - 29) Use fee scheme
 - 30) Collection of data relevant YSRH
 - 31) Monitoring and evaluation
 - 32) Feedback information
 - 33) COPE methodology

- IEC materials were used as tools to support the training and service activity such as peer education, counselling, youth resource room etc. There was variety of IEC material developed and disseminated:
 - Leaflets
 - Posters
 - Flipcharts
 - Billboards
 - Story books
 - Video spots and stories
 - Radio stories etc

- Supplies and equipments were used to support service infrastructure and function.
- Monitoring systems and reporting format were used to collect data and produce project reports.

1.6. The project management

ADRA was the lead overall project management to facilitate the overall project implementation by ADRA itself in Kampong Thom and by RACHA in Preah Vihear under a sub-agreement to implement assigned project activities.

Below the overall management by ADRA, the inter-agencies management established to monitor the progress of project implementation, to solve problem if any and to make decisions on project management.

At the individual organization, the project management team established to play the same role and responsibility as the inter-agency management team above but focusing only the project sites covered by the agency, for instance, Kampong Thom by ADRA management team and Preah Vihear by RACHA management team.

Most of the projects initiatives, training tools, IEC materials were developed in partnership with both implementing agencies (ADRA and RACHA) and the representatives from line provincial departments as implementing partners.

The provincial health, education, youth and sport and women affair departments, the district health, education, youth and sport and women affair offices and the local authority played as close implementing partners to carry out a significant planning, training, follow-up and monitoring roles.

Overall, the project was managed by the project management team consisting of representative from both ADRA and RACHA who played the role on project coordination.

The project management and implement team was:

- Project Manager/ Provincial Team Leader
- Project Advisor
- Assistant Project Manager/Provincial Program Clerk
- Monitoring and Evaluation for Learning (MEL) Officer
- YSRH Community Training/Youth Friendly Service Training Specialists
- Mass Media Specialist
- Community Mobilization Officer/YSRH Assistants and field support
- Adventure Learning Trainers
- Administrative and Logistics Support Staff

1.7. The project monitoring and evaluation

A project MEL officer was assigned to be responsible for planning, collecting, managing and reporting on project data and vital information.

- **Monitoring:** Project monitoring was aimed at gathering data and information in all phases of project implementation through the system set and the reporting format developed based on set indicators. The reporting format that was developed by the project was:
 - Monitoring training report,
 - Monitoring supervision report,
 - Monitoring visit reports by trainers, teachers or project staff,
 - CYA monthly reports,
 - Meeting minutes from bi-monthly YAC,
 - Meeting minutes from quarterly PMAC,
 - Quantitative data record formats from the government Health Information System.
- **Financial:** Accurate and transparent accounting of all project funds was kept according to Generally Accepted Accounting Principles. Financial monitoring was done through regular financial reports produced by the project accounting officers as required by the project management. Complete financial statements were prepared on a monthly, quarterly and annual basis.
- **Evaluation:** The project hired external consultants to conduct the baseline, mid-term and end of project evaluations:
 - A baseline evaluation used both quantitative and qualitative methods in cross-sectional design aiming at obtaining baseline data to be used in measuring program progress over the implementation timeline and to identify "priority areas" upon which to focus project activities.
 - A mid-term formative evaluation used quantitative survey for monitoring of situational changes within the project target areas. These results were used to determine progress towards stated objectives and to recommend strategies for realignment through changes to methodologies and/or implementation strategies.
 - An end of project cumulative evaluation will use both qualitative and quantitative methodologies and involved all stakeholders in a thorough review of the program to obtain a comprehensive understanding of the total project, its inputs, activities, outputs and impact, and examined the effectiveness and efficiency of the program strategy and focus on the quantifiable outputs, expected results/outcomes and ascertain whether the program has achieved its stated objectives. The evaluation provides a full report with recommendations on program improvements or strategy changes as well as notations on areas that can be replicated, scaled up or published.

2. About the implementing agencies

2.1. ADRA

ADRA is an acronym from its full term as The Adventist Development and Relief Agency. It is a private voluntary organization, founded since 1956 by the Seventh-day Adventist Church, to provide relief and development assistance to all people regardless of ethnicity, gender, religion or political affiliation. So far, ADRA is operating its mandate in more than 120 countries around the world.

In Cambodia, ADRA has been in action since 1988 and was registered as an international NGO, ADRA Cambodia, in 1991. So far, ADRA has its program coverage areas in six provinces (Preah Vihear, Siem Reap, Kampong Thom, Pursat, Kampong Cham and Phnom Penh) to serve the poor and at risk population.

ADRA Cambodia has its core value to live and work with Compassion, Integrity & Respect in all we do.

ADRA Cambodia has its mission to reflect God's character of love through development activities that alleviate poverty and empower people to realize an improved quality of life.

ADRA Cambodia has its mandate working on health, food security and water and sanitation.

- Health Focuses: Tobacco or health, Maternal child health, Reproductive health including Youth RH, HIV and AIDS, Hygiene and Sanitation, family health through women's literacy
- Water and Sanitation Focus: Agriculture and Household water supply, Latrines, Drinking water supply and quality
- Food security Focus: Agriculture, Income Generation, Literacy and Life-skills, Microfinance

ADRA has key strategies and methodologies to achieve its mandate:

- Technical excellence within ADRA and in community
- Promotion of sustainable learning and change processes
- Promotion of Core Values through the development process
- Usage of REFLECT Methodology (<http://www.reflect-action.org/>), Participatory Extension Approaches, Leadership Development and Adventure learning and other methods.

For “The Rural Cambodian Youth Sexual Reproductive Health Project”, in general, ADRA plays a leading role to be responsible for the whole project implementation but particularly in the target project sites of Baray-Santuk and Stoung OD's in Kampong Thom province where they have long working experience.

2.2. RACHA

RACHA is abbreviated from its full term as Reproductive and Child Health Alliance. It is a Cambodia based Non-Governmental Organization founded in 2003 which focuses on community health programming that improves the quality and utilization of local public health service provision. Its creation was a consequence of a partnership formed by USAID/Cambodia of three Global Health Bureau projects, SEATS, BASICS and Engender Health (previously known as AVSC) which ran from 1996 to 2003.

So far, RACHA has its program coverage areas in 2,329 villages, in 259 communes, in 164 health centres, in 16 operational districts and serving an estimated population of more than 2 millions. The core activities in maternal, newborn and child health and family planning have extended to include HIV/AIDS and infectious diseases (primarily tuberculosis and malaria).

RACHA has its vision to be a leading and dynamic NGO which advances the health of the Cambodian people through sustainable, relevant, and responsive community-based health programs.

RACHA has three key approaches: to increase coverage and access to local public health services, to improve the quality of these services, and to positively influence the health seeking behaviour and health-related practices of rural communities to utilize public services and protect their health.

RACHA has its 2008-2012 strategic plan for 2008-2012 that is to improve the lives of individuals in Cambodia by focusing on priority areas that help to make reproductive, newborn and child health, infectious diseases, HIV/AIDS and related services:

- Safe
- Available
- Accessible
- Sustainable

For “The Rural Cambodian Youth Sexual Reproductive Health Project”, RACHA is an autonomous sub-grantee of the project, responsible for the Preah Vihear operational district in Preah Vihear province where they have long experience working in public health issues there.

2.3. Definition of terms

To carry out this evaluation, it is first important to clearly define what we mean by:

- **Youth:** refers to male and female adolescents and young adults aged 10-24 years old
- **Youth friendly service:** refers to a counselling services provided to youth at the public service located at the health centres or referral hospitals
- **Youth resource room:** refers to a room located at the health centre or referral hospital with stock a large collection of YSRH educational materials, including books, pamphlets, magazines and brochures. There is a librarian for counselling
- **Quality of service for youth:** refers to cleanliness, friendliness, and information given by health care provider regarding counselling skill.
- **Peer education leader:** is a community youth who is nominated by their peers and selected to undergo training with their role to educate their community peers and friends
- **VHSG:** Village Health Support Groups which are represented by one or two VHSG members in each village who meet regularly at the health centre to report on health issues within their village and to assist the Health Centre staff with village mobilization on immunization days or other outreach activities.
- **Youth club:** is an informal association of PE's will be expected to meet together once a month to discuss YSRH issues and plan awareness events and educational activities with their peers.
- **Community youth advocate:** refers to one male and one female selected from each commune, with the female CYA a member of the commune office of Women's Affairs. The male CYA is chosen from the Commune Council, or the HCMC. CYA's function as community-level advocates for Youth's rights, promoting their access to SRH information and services.
- **Project monitoring and advisory committee:** Consisting of HCMC members, CYA's and youth PEL representatives, the committee received training and support from the project MEL officer, who attend all quarterly meetings.

3. Methodology

3.1. The evaluation goal and objectives

The evaluation goal and objectives are to assess the overall project success and accountability, drawing lessons for future actions. The overall project success is understood as quality and quantity achievements of project indicators and goals. The accountability is referring to the project overall implementation as described and dictated by proposal, grant agreement with donors, reports to donors and the Modified

Implementation Plan (MIP). Lessons for future actions are best practices, lessons learnt, sustainability and policy recommendation to the relevant authorities.

The evaluator summarized these as measuring 1) the project effectiveness along with its objectives to measure the progress, 2) the change and the effectiveness of the project implementation, 3) the project strengths and limitations and 4) to develop recommendation based on these.

3.2. The evaluation methods

This project evaluation was carried out from 1 to 30 July, 2009 and used three main methods:

1. The first method used was the literature review. Reviewed literature included:
 - The project proposal document
 - The baseline report
 - The mid-term evaluation report
 - The final survey report in quantitative design
 - The project progress report and
 - Other papers related to the project implementation such information on policy, strategy, guideline, curriculum that linking to youth and reproductive health.
 - Furthermore, the project documents and notes were inspected.
2. The second method used was the qualitative survey design using in-depth interview, focus group discussion and observation methods to collect data from project officers and staff, field implementers as well as beneficiaries.
3. The third method used was the two consultative workshops organized consecutively among the project implementers and stakeholders to gather more insights on the findings and to gain more comments, suggestions and recommendation on the preliminary finding and for future project design.
 - 3.1. The feedback workshop organized in Kampong Thom on 22 July, 2009 among the field implementers and providers to gather feedback from them on the first draft evaluation report presented by the consultant.
 - 3.2. The national final dissemination workshop on results of the Rural Cambodian Youth Sexual Reproductive Health project organized in Phnom Penh on 27 July, 2009 among all stakeholders from donors, governments and NGOs which gain feedback from them on the second draft evaluation report presented by the consultant.

3. Results

After three years of implementation, the project produced results as following:

3.1. Relevance

Based on Cambodian Demographic Health Survey 2005, Cambodia has a high rate of adolescents, specifically youth less than 25 years old which represents 60% of the total population while 36% are adolescents aged 10-24 years old. In addition the findings from the 2005 survey did show that youth have limited knowledge on sexual reproductive health in particularly HIV/AIDS. In addition, when they get drunk, unwanted pregnancy easily happens due to the high incidence of non-condom use. Women are identified as a more vulnerable group due to naturally having less power to negotiate with their sexual partners in addition to limited skills in protecting themselves from disease.

Various research documents have suggested that the young people in Cambodia have low knowledge of reproductive health and issues especially in areas such as birth spacing where the knowledge was found to be even lower for the adolescent age group than for the population as a whole. Issues about sexuality and bodily changes were also not recognized satisfactorily by the young people. Many fundamental issues such as the time of the menstrual cycle when a woman is likely to become pregnant are not very widely recognized but are rather distorted by traditional beliefs hold that a woman is most fertile at the time of her menstrual period. Other misconceptions are that engaging in sexual activity mid-cycle is considered a time when the uterus is “closed” and a woman is least likely to become pregnant.¹ Many cultural issues make adolescents vulnerable to SRH problems in Cambodia. Local norms require adolescent girls to uphold the virtue and honour of their family by taking care of their reputation and maintaining not only their actual virginity but also their imputed sexual reputation. While this acts as a protective factor the much practised adage “men are gold, women are cloth,” suggests that when soiled through their actions men can easily be cleaned but women can never be completely cleaned. Therefore:

- This project did directly align with the needs of the young people in the targeted areas who try to understand the biological changes they are experiencing and become more curious in terms of their sexual and reproductive health. The project action did help them find answers and involve them in making healthy decisions that will safeguard their lives.
- The project did also help those vulnerable young people who are either already facing high risk situations or are in the process of being exposed to a high risk condition to have the knowledge and the skill to negotiate a position of safety and protect themselves.
- The project did directly address the unique challenges and risks facing rural youth through empowering them 1) to adopt responsible safe decision making and behaviour before they face risky situations, 2) to encourage behaviour change as well as improve negotiation skills if they are already facing vulnerable situations and 3) to connect with quality referral and RH/LS counselling/care services when needed.
- The project did take into account the unique needs of adolescents between 10-14 years, adolescents between 15-19 years and young people between 20-24 years of age as well as the distinctive requirements of married and unmarried youth.
- Indigenous existing community and government structures were empowered to equip youth individually and collectively with knowledge of protective LS tools in personal decision making, sexuality and relationships, negotiation skills, unwanted pregnancy STI and HIV/AIDS

¹ Adolescent Reproductive Health in Cambodia Status, Policies, Programs, and Issues, Graham Fordham, PhD, January 2003, POLICY Project

prevention, gender and domestic/sexual violence and other issues. Additionally, actions did establish supportive community youth environments bringing coordinated appropriate national policy to effect at local government and civil societal levels. Specific emphasis was targeted at empowering individuals and communities in responding to the acute RH risks at home and those faced during rural to urban and rural to rural migration.

- The project did directly benefit 171,000 young women and men from the ages of 10-24 and indirectly strengthen the family and community social support systems through an additional 331,000 persons in the three MoH Operational Districts – Baray-Santuk, Stoung, and Preah Vihear making up a total of 10 administrative districts in the Kampong Thom and Preah Vihear Provinces. This project did as well contribute to the health and well-being of young people throughout Cambodia through positive contributions to the development and implementation of National Youth and Health Services Policy.

Cambodia at present has no multi-sectoral policy on youth and their SRH and well-being. The lack of clear policy and political will has resulted in scarce resource allocation for addressing rural SRH issues. The Cambodian reproductive health context also suggests that many Cambodian policymakers deny the existence of sexual activity among young people, leading them to consider that reproductive health training activities are inappropriate for young people prior to marriage. Thus:

- The emphasis on YSRH did build the capacity of its health delivery system in reproductive health (RH), the political commitment, resource allocation and ability of service providers and infrastructure of the health facilities to cater to the unique needs of the young people is alarmingly lacking – especially for the 85% of Cambodian young people in rural areas. The SRH issues are primarily addressed within policies regarding MCH, population/birth spacing, gender equity and equality (MoWA) and AIDS, but these fail to emphasize the magnitude and identify the unique nature of youth services as a priority.

3.2. Effectiveness

3.2.1. The project management

3.2.1.1. The project management team

As planned, the overall project management team was established by ADRA as the executive agency followed by setting establishment of an inter-agency management team or inter-agency coordinating team consisting of representatives from ADRA and RACHA as implementing agencies. The inter-agency coordinating team, known as the Project Coordination Committee, was made up of project managers, project advisors, MEL officers and associate/deputy directors from both organizations, met regularly on bi-monthly basis with some ad-hoc meetings as needed to ensure the project implementation, project monitoring and evaluation and solution for project improvement.

At the project sites, there were two management teams created, in ADRA project site, there was Project Management Committee set to support project on funding management. In RACHA, the YSRH project management was integrated into routine RACHA Technical and Management Team meeting on monthly basis.

3.2.1.2. The project staff

The officers and staffs to manage and implement the project were recruited and achieved as project planned with time consuming on its recruitment process.

Totally, there were 37 managers, advisors, officers, and support staff working in this project. Among those 37, 26 individuals worked for ADRA in Kampong Thom and Phnom Penh (Phnom Penh) that was more than RACHA (11) because ADRA was responsible for overall management, monitoring and evaluation for the donor, had additional school based programming implemented activities in 70% of the project area while RACHA had about 30% based on the 500 targeted villages.

It was acknowledged by both ADRA and RACHA during the proposal design that the project officers and staff were not proportionate to the scope of project coverage to implement in all locations at one time. Therefore, the decision was made by the management team to divide the project into three implementing phases during the initial Modified Implementation Plan session.

Table 1: The comparative project officers and staff between two organizations

No	Project officers and staff			
	ADRA		RACHA	
	Position	#	Position	#
01	PP: Country/Associate director (1) 20%, (1) 5%	0.25	PP: Executive Director (10%)	0.10
02	KPT: SRH Technical Advisor (85%)	0.85	PP: RH Specialist 60%	0.60
03	PVH: Provincial program advisor (10%)	0.10	PP: Community Mobilization Officer (20%)	0.20
04	KPT: Project Manager	1	PP: Capacity Building Team Leader (10%)	0.10
05	KPT: Project Assistant Manager	1	PP: Monitoring and Evaluation Officer (20%)	0.20
06	KPT: YSRH Community Training Specialist	1	PVH: Provincial Team Leader	1
07	KPT: Youth Friendly Training Specialists(2)	2	PVH: Provincial Program Clerk	1
08			PVH: YSRH Training Assistants (2)	2
09	Mass Media Specialist KPT(1), PP(2) 20%	1.40	PVH: YSRH Field Support (3)	3
10	KPT: Community Mobilization Officers (8)	8	PP: Media Specialist	1
11	Monitoring & Evaluations Officer KPT(1), PP(1) 15%	1.15	PP: Finance & Administrative Director (20%)	0.20
12	PP: Health Programs Coordinator (25%)	0.25	PP: Logistics and Procurement Officer (10%)	0.10
13	PVH: Adventure Learning Trainers (4) 75%	3	PP: Administrative Program Assistant (10%)	0.10
14	PP: Finance Director (14%)	0.14	PP: Accountant	1
15	PP: Human Resource Man./Govt. Liaison/IEC Resource (2) 15%	0.30	PP: Financial Coordinator (10%)	0.10
16	PP: IT Managerial Assistant (15%)	0.15	PP: Cashier (10%)	0.10
17	Accountants/ Finance Assistants KPT(1) 100%, PP(5) 20%	2	PP: Driver (40%)	0.40
18	Administrative Assistants KPT(1) 60%, PP(1) 10%	0.70		
19	PP: Logistics/ Procurement Officer (15%)	0.15		
20	PP: Driver/ Messenger (15%)	0.15		
21	KPT:Cleaner/ Watchman (2) 100%, (3) 60%, (1) 75%	2		
	Total	25.59		11.20
	Grand total		36.79	

3.2.1.3. The project phases

As planned the project life was three years beginning August 2006 until July 2009. Based on previous successful experiences in phasing project activities, during the proposal design both ADRA and RACHA agreed to divide the project into multiple implementing phases. In each phase, complementary project interventions would be targeted by staff and partners with partners following up for sustainability while staff moved to the next phase area. These phases were determined during the initial Modified

Implementation Planning session into three target areas with an intense training period of six to eight months for each. The first phase was twice as long as the other two as it involved development of training curriculums and materials, capacity building for the training teams which included revisions and modifications after initial sessions.

- Phase 1: covered 4 HC in stung, 5 HC in Baray-Santuk and 3 HC in Tbeng Mean Chey
- Phase 2: covered 3 HC in stung, 8 HC in Baray-Santuk and 4 HC in Tbeng Mean Chey
- Phase 3: covered 3 HC in stung, 6 HC in Baray-Santuk and 3 HC in Tbeng Mean Chey

Therefore all project sites could not be implemented at the same time due to no choice situation on increasing project human resource.

Table 2: The phases of project implementation by sites

N ⁰	Phase	Number of health centres			Total
		Kampong Thom		Preah Vihear	
		Baray-Santuk	Stoung	Tbeng Meanchey	
01	Phase I	5	4	3	12
02	Phase II	8	3	4	15
03	Phase III	6	3	3	12
Total		19	10	10	39

3.2.1.4. The project sites

The project implementation did cover to all target geographic locations as planned. It did reach:

- 3 ODs (2 ODs in Kampong Thom province and one OD in Preah Vihear province),
- 39 HCs (29 HCs in Kampong Thom province and 10 HCs in Preah Vihear province and
- 3 referrals hospital (1 in Baray Santuk OD, 1 in Stoung OD and 1 in Tbeng Mean Chey OD)
- 500 villages (350 villages in Kampong Thom province and 150 villages in Preah Vihear province).

Anyway, there is one HC (Chamna Leu) in Stoung where the full package of planned project activities could not be implemented, the youth friendly service, due to the shortage of HC staff (only 2 available out of 4).

Table 3: The distribution of project sites

N ⁰	Phase	Provinces			Total
		Kampong Thom		Preah Vihear	
		Baray-Santuk OD	Stoung OD	Tbeng Meanchey OD	
01	RHs	01	01	01	03
02	HCS	19	10	10	39
03	Villages	212	138	150	500

3.2.1.5. The target beneficiaries

The project achieved almost 100% of its target providers and beneficiaries directly or indirectly as planned that divided into:

- 2,850 PEs (2000 out of school – 850 in school)
- 1000 VHSGs
- 815 CYAs, teachers and religious leaders
- 171,000 youth in both sexes, age 10-24 years old
- 331,000 community members

3.2.1.6. The project monitoring and evaluation

There was an officer in charge of overall project monitoring and evaluation with systems set and reporting format developed. The monitoring reports were completed regularly on a monthly, quarterly and annually basis as well as the report writing and dissemination.

The project evaluation was done as planned from base line evaluation to mid-term evaluation and final evaluation.

Therefore the project could clearly capture all the progress of project implementation and its results were used to improve the program implementation that influenced to the achievement of project objectives.

3.2.2. The project achievements

3.2.2.1. Under objective1: Ensuring that quality Youth-Friendly SRH services and referral systems are available and utilized at each level of service delivery,

a. Establish "Youth-Friendly Health Services" (YFHS)

Totally, 41 out of 42 selected government health facilities (39 HC and 3 RH) received support consisting of either the renovation and or the improvement of the counselling room within their health facility, and including basic equipment needs and materials for YFHS operation. Therefore there was an achievement of 97.6% against the target. The reason that it could not be achieved up to 100% as plan was due to one HC named Trea where its physical building is not available yet.

Table 4: The achievement of YFHS established by the project

N ^o	Activity	# planned	# observed	Achievement
01	YFHS	42	41	97.6%

b. Conduct training

b.1. Core training team (CTT)

The project achieved **140%** comparing to the plan while a total of 28 core training team members (13 in Kampong Thom and 15 in Preah Vihear) trained in YFHS and YSRH promotion concepts. In addition to core training subjects, the CTT received refresher trainings in pre-migration (trafficking/migration). The members of CTT did reflect the distribution of multi-participation and ownership by the government agencies as planned such as the representatives from health, women's affairs and education at the provincial and district level.

There was a notice of the difference of CTT members in Preah Vihear where the project coverage was smaller than Kampong Thom but the number of CTT members was more than Kampong Thom. The reason was CTT members in Preah Vihear had double roles to monitor the CBTT and to provide training to community providers while the CTT members in Kampong Thom played only a supervision role.

The reasons behind the over number of CTT trained were, firstly the CTT members from government partners were not full time for the project, therefore they usually had busy schedule to implement their core work, secondly the number of CTT members planned did not fit the scope of further training and supervision to Community and School Based Training Teams (CBTT/SBTT).

Table 5: The achievement of CTT members trained by the project

N ^o	Target providers	# planned	# observed	Achievement
01	CTTs	20	28	140%

b.2. Public Health Care Providers

All health centres under the project coverage received support to open a counselling room to provide youth friendly health services with necessary material equipped. As result, a total of **148** health care providers at the HCs and **13** HCPs at the referral hospital were trained to run the "youth-friendly health services". As noticed, the number of HCP in referral hospital planned to be trained (15) could not be reached due to their busy time during the training conducted.

After training, nearly all of them did demonstrate their skilful practices with quality of care improvement.

Table 6: The achievement of public HCPs trained by the project

N⁰	Provider	# planned	# observed	Achievement
01	HC providers	156	148	94.8%
02	Referral hospital HCW	15	13	86.6%
	Total	171	161	94.15%

The health care providers who have the role to provide youth counselling admitted that they feel that their knowledge on counselling is still limited to provide the best counselling to youth.

b.3. Private Health Care Providers

A total of **161** private health care providers were trained in selected components of YFHS and met on monthly basis. Among 161 trained, 37 were in Preah Vihear and 124 were in Kampong Thom and they were divided into 50 registered and 111 unregistered private HCPs.

Table 7: The achievement of private HCPs trained by the project

N⁰	Private provider	# planned	# observed	Achievement
01	Registered providers	40	50	125%
02	Unregistered providers	120	111	92.5%
	Total	160	161	100.6%

After receiving training, 120 private health care providers showed their progress activities through regular reports. As finding from the mid-term survey, it indicated that there was an increasing percentage of youth consulting with private HCP from 12.72% in the baseline to 34.87% in the mid-term.

Table 8: The achievement of private HCPs being active in YFHS

N⁰	Activity	# planned	# observed	Achievement
01	Show progress activity	120	120	100%

To establish sustained referral linkages of public-private youth friendly service providers, 160 private health care providers were trained in YFHS referral system as plan.

Table 9: The achievement of private HCPs trained by the project on referral system

N0	Target provider	# planned	# observed	Achievement
01	Private HCPs	160	160	100%

The project did provide them the referral slips that they could use for referred case and the record book for youth that they consulted with.

During the in-depth interview with them, they said that they were very happy to be exposed to the training that provided them a lot of opportunity to learn more about RH that they could use to help youth around their community. They claimed that they ever had youth consulted and referred but sometime they forgot to make the record and use the referral slip.

b.4. Counsellors

As planned in strengthening the YFHS, the youth counselling on RH is the most important part of the YFHS function. Therefore counselling training was provided to both professional and lay counsellors.

As result, a total of 326 of formal professional and 474 lay counsellors were trained in counselling skill.

Table 10: The achievement of counsellors trained by the project

N⁰	Providers	# planned	# observed	Achievement
01	Formal professionals	300	326	100.9%
02	Lay counsellors	360	474	132%
	Total	660	800	121%

After training, 245 formal professional and 134 lay counsellors showed appropriate counselling skill in their practices.

Table 11: The achievement of capable counsellors shown by the project

N⁰	Providers	# planned	# observed	Achievement
01	Formal professionals	150	245	163.3%
02	Lay counsellors	180	134	74.44%
	Total	330	243	73.63%

c. Youth resource rooms

As planned, the project did achieve to have 41 youth resource rooms opening its door to all community members especially youth. Based on the project plan, support could be provided for renovating 16 existing building of youth resource room while the others, support could be provided as only equipment, material and RH resource books. Anyway, in practical situation, only 5 out of 16 youth resource rooms were renovated while the other 11 were new build youth resource rooms. The reason, the project decided to have youth resource room build because there was no physical building for renovation.

Figure 1: The difference between new build and renovated youth resource rooms



The new build youth resource room



The renovated youth resource room

Table 12: The achievements of youth resource rooms supported by the project

N ⁰	Youth resource room	# planned	# observed	Achievement
01	Renovation	16	5	
02	New building	0	11	
03	Only material and books	25	25	
	Total	41	41	100%

In Preah Vihear, there is one youth resource room located at the Kulen HC that construction could not be completed while 80% of its plan was completed. After receiving written permission from the PHD, the construction was started up to 80% of its plan due to an order by MOH to stop construction and destroy what was done to date after approval was given because the World Bank was going to construct a new model HC and this YRR was deemed by someone to be in the way. RACHA has been negotiating with the PHD to either leave the YRR building or provide a YRR in the new building if this was torn down.

Figure 2: The youth resource room in Kulen HC that could not be completed on time



There was a difference noticed regarding the youth resources room between Preah Vihear and Kampong Thom sites:

- In Kampong Thom site, there is a counselling room inside the youth resource room when in Preah Vihear there is not.

Figure 3: The counselling room within the youth resource room



By the project plan the youth resource room was designed with the counselling room aiming at providing counselling to youth especially on the weekend when the health centre is closed.

The usefulness of having a counselling room inside the YRR in KPT is to facilitate the counselling sessions to be done when the HC is closed on the weekend.

In PVH, based on their contracting plan the HC is opened 24 hours therefore there is no need to have a counselling room in the YRR

- In the Kampong Thom site, the youth resource rooms stand detached from the health centre when in Preah Vihear, they are attached to the health centre. The

reason behind this difference was due to the decision of the provincial health department. For example, it was not allowed to build in attachment to the health centre building in Kampong Thom because there is plan to expend more services in the health centre such as post natal care etc.

Figure 4: The different designs of youth resource rooms



It stands alone from the health centre in KPT site



It stands attached to health centre in PVH site

- In Kampong Thom, the books in the youth resource room could not be borrowed because the number of book is still limited and they want to encourage youth to be familiar with the resource room and youth friendly service, while in Preah Vihear, the book could be borrowed for no more than 5 days to only youth who live nearby.
- As the project planned, there are two librarians (one female youth and one male youth) working in the YRR. Anyway in Kampong Thom site, one librarian is youth and another is health centre staff when in Preah Vihear site both are youth hired by the project. The Preah Vihear model faces a sustainability problem when the project ends due to no more payment to them when the Kampong Thom model could ensure its sustainable functioning but in some limited time and days.

In a meeting with the youth librarian at the youth resource room in Preah Vihear site, both of them said that without support from the project they will look for a job related to what they learn and have experience with this project to support their living standard.

In a meeting with the chief of the health centre on the youth resource room, they pointed out to RACHA for mobilize other resource to keep this youth resource room opened because it is a real important for the new generation on RH. Some chiefs of HC committed to use their HC staff to keep the doors opened for half days or use HC income to pay one librarian instead of two.

d. Provide capital improvements

The project did provide some supplies and essential equipment etc as following:

- For youth friendly service such as: file cabinet, folding chair, table, standing curtain, shelf tray, magazine stand etc to ensure that the youth counselling room is in friendly environment ensuring privacy and confidentiality.
- For youth resource room such as: television, DVD player, amplifier for Karaoke, microphone, super bass, generator, folding chair, table, folding chair, book shelf, etc to ensure lively environment to attract youth and to make youth enjoyed during their time spent in the resource room.

There was a difference noticed between ADRA and RACHA support to youth resource rooms in term of equipment and materials. RACHA provided more variety of equipment including entertainment equipment such as a television, DVD player, Karaoke amplifier etc than the ADRA site. For example: in four youth resource rooms planned in Preah Vihear site, there were karaoke sets supplied to each resource room while in Kampong Thom sites among 12 youth resource rooms, there were only 3 television sets and DVD players supplied, therefore it was used as mobile video show instead of making it fixed in the resource room. After the project ended, this television and DVD player will be handed over to youth resource rooms where its operation is qualified and satisfied as project plan.

Figure 5: The differences in material and equipment supplied to youth resource rooms



There is no karaoke set in KPT



There is a karaoke set in PVH

3.2.2.2. Under objectives 2: Increasing knowledge and awareness of youth SRH & Rights, and empowering youth to make health SRH choices through practicing Life Skills (LS) based on their awareness of potential dangers, risks and understanding of protective factors.

a. The In-school component

a.1. Conduct training

The trainings were conducted as planned with the training curriculum utilized and upgraded four times during utilization after feedback from teachers.

a.1.1. School based training team (SBTT)

As result a total of **203** teachers and school administrators (grades 7 to 11) were trained in YSRH issues and taught how to effectively teach and incorporate SRH into the school curriculum and to train school PE. Therefore the project did achieve 102% thus exceeding the target.

Table 13: The achievement of in-school teachers trained by the project

N ⁰	Target providers	# planned	# observed	Achievement
01	In-school teachers	200	203	102%

After being trained, the project did achieve 100% as 38 school teachers were selected as SBTT to provide further training to school peer educator.

Table 14: The achievement of selecting SBTTs by the project

N ⁰	Target providers	# planned	# observed	Achievement
01	SBTTs	38	38	100%

a.1.2. School peer educators

A total of **850** peer educators trained in 38 selected schools on YSRH concepts, practical Life Skills and in basic BCC techniques by the school teachers. Therefore the project did achieve 100% of it targets.

Figure 6: Training conducted for school peer educators in KPT



Table 15: The achievement of school PEs trained by the project

N ⁰	Target providers	# planned	# observed	Achievement
01	School peer educators	850	850	100%

a.2. School education session on RH

As planned all 200 trained teachers were expected to demonstrate their training skill to make plan for education of their students based on available time with little motivation from the project. It was observed that all of trained teachers (203) could make it successfully. Therefore achievement was 102%.

Table 16: The achievement of RH education by trained school teachers

N ⁰	Activity	# planned	# observed	Achievement
01	RH education to students by trained teachers	200	203	102%

a.3. Peer education session

Based on the project report about **80%** of the school PEs trained played their role as agents of change within their respective schools by providing information to their fellow students about sexual reproductive issues.

In Focus Group Discussions during the evaluation, they claimed that their friends were very interested in RH information, they felt very proud to be PEs and they learn a lot about RH. They said female students paid more attention to participate in the peer education session than male students. Entertainment performance such as drama and video was the best interest to integrate RH knowledge among school youth.

School students who were not PEs said they knew the PEs and they were very interested. They confirmed that there is increasing general interest among students to hear and participate in YSRH related programs. They said more schools youths were involved in the school wide drama awareness campaigns, including impromptu comedy teams, performing role plays and skits promoting specific sexual RH and social awareness issues, YSRH songs competitions, etc.

a.4. School Youth Clubs (SYC)

All school PEs were experience to organize youth club continuously but not regularly on monthly basis as project plan due to several factors:

- The school holidays or vacation
- The national and international holidays
- The preparations for school exam

Anyway, as result, 28 school youth clubs were active and functioned regularly as planned.

Table 17: The achievement of school youth club established and organized by peers

N ⁰	Activity	# planned	# observed	Achievement
01	Establish school youth club	38	38	100%
02	Active and functioning youth clubs	28	28	100%

The school PEs said that “The youth clubs are an invaluable chance for me to refresh and increase my knowledge on RH and to share my experience with others”. If the project will end “We feel that we will lose the club, the network, and the support. We will have no activity planned and we would not need to write the report anymore”.

Asking about the sustainability, the school PEs said, “The RH knowledge is with us forever. Supposed that we could not organize school activities anymore due to the project ended, but at least we could educate our family members, our friends and our neighbours”.

Figure 7: Youth club activities organized by school PEs



B. Conduct school-wide awareness activities

There were several activities organized by peer educators during the national holidays or international event such as World AIDS Day, International Children's Day, or Khmer New Year. Among total 130 activities planned, 156 were implemented; therefore the project achieved 120%.

Table 18: The achievement of school-wide awareness activities

N ⁰	Activity	# planned	# observed	Achievement
01	School awareness activities	130	156	120%

Figure 8: School awareness activities organized by school PEs



a.5. Establish youth corners and resource libraries

All 38 schools where libraries are available in large or small rooms, were supported by the project on librarian training, library equipment and the educational resources. Furthermore, some library supplies such as booklets, health magazines, leaflets, posters etc were made available by the project to ensure the daily functioning of the school library.

Table 19: The achievement of school library support

N ⁰	Activity	# planned	# observed	Achievement
01	School libraries	38	38	100%

When asking students about library during a focus group discussion, all of them claimed that they know about the library, they prefer to use library and they all had experience to library. But they did not have

enough time to go frequently to the library because of their busy school time in the public class and the private class. Some of them said they had free time on the weekend while the library was closed. Some students requested more variety and updated books in the library.

b. The out-school component

b.1. Conduct training

b.1.1. Community Youth Advocates (CYA)

There were 156 CYA trained by the project, therefore it achieved 82.97% against 188 CYA as target.

Table 20: The achievement of CYAs trained by the project

N ⁰	Providers	# planned	# observed	Achievement
01	CYAs	188	156	82.97%

After training, only 150 CYA, coming from the local Commune Council or other key stakeholder, demonstrated an active advocacy role though less than the expected CYA target. Therefore participation was only 79.78% of the intended number.

Table 21: The achievement of CYA demonstrating an active advocacy role

N ⁰	Activity	# planned	# observed	Achievement
01	CYAs demonstrated advocacy role	188	150	79.78%

b.1.2. Health Centre Management Committee (HCMC)

A total of 324 HCMC members were trained on health financing scheme strengthening, YSRH advocacy, basic MEL / data collection, and service feedback using COPE as planned. The training to HCMC members was not fully achieved as planned due to perceived financial constraints during the implementation of project phase III.

Based on the original plan 615 HCMC members were supposed to be trained but this number was over estimated at the time of the preparation of the proposal (15 persons per HC x 41 HC = 615) in comparison to the 390 actual HCMC members within the community.

Table 22: The achievement of HCMCs trained by the project

N ⁰	Target providers	# planned	# observed	Achievement
01	HCMC members	390	324	83.07%

b.1.3. Peer educator leader (PEL)

A total of 2,003 Peer Education Leaders were trained on YSRH and PE concepts. Then half of them (1,000) received further training in advanced leadership, advanced life-skills and concepts of BCC and community mobilization as planned.

Table 23: The achievement of PELs trained by the project

N ⁰	Provider	# planned	# observed	Achievement
01	PELs trained	2,000	2,003	100.15%

As representative in PMAC, 77 PEL representatives (42 planned) was trained in project monitoring and evaluation and participated regularly in quarterly meeting.

In addition to the basic training, 1,748 PELs received refresher training to update new SRH information as well as to discuss approaches to facilitate the peer sessions.

Table 24: The achievement of PELs refreshed by the project

N ⁰	Activity	# planned	# observed	Achievement
01	PELs receiving refresher training	2,000	1,748	87.4%

Among PELs trained, based on report, 1,228 were very active in providing peer education, participated in youth club and community awareness activities. Therefore, it was achieved over the target.

Table 25: The achievement of PELs providing peer education

N ⁰	Activity	# planned	# observed	Achievement
01	PELs providing peer education	1,200	1228	102%

As part of project motivation, active and committed PELs were selected to attend learning sessions at Jombok Hoas (JBH) Adventure Learning Centre aiming at building youth courage and confidence to be a leader. As result, 1,115 PELs participated against 1,000 PELs planned.

Table 26: The achievement of PELs attending JBH Adventure Learning Centre

N ⁰	Activity	# planned	# observed	Achievement
01	PELs attending JBH centre	1,000	1,115	112%

b.1.4 Village Health Support Group (VHSG)

Under project plan, a total of 970 Village Health Support Group members were trained on YSRH basic concepts and introduction to the project. Out of this number, KPT achieved 708, over the target (700) while PVH achieved 262 which is under the target (300).

Table 27: The achievement of VHSGs trained by the project

N ⁰	Target providers	# planned	# observed	Achievement
01	VHSGs	1,000	970	97%

As result, after training, 712 VHSG did show active involvement and commitment to the project based on their roles and responsibilities.

Table 28: The achievement of active VHSGs involved in project implementation

N ⁰	Activity	# planned	# observed	Achievement
01	Active involvement of VHSGs	600	712	119%

b.2. Community awareness activities: The project did provide several methods to organize community awareness activities such as: the drama performance, the video show, the campaign during national and international day etc.

- Both Preah Vihear and Kampong Thom provinces, a total of **577** drama performances and mobile video shows in schools and communities were organized in strategic project coverage areas. Some villages and schools received more than one drama performance and or video shows. Performances were also held during national and international awareness days.
- In both provinces, the World AIDS Day and the International Children's Day were organized regularly once a year as planned in every OD.
- For water festival, only Kampong Thom was feasible for this particular event. As result, two out of three events planned were achieved.
- The Candle Light Memorial Day (a national awareness of victims of HIV/AIDS) event was originally was not in the project plans, but it was organized regularly on yearly basis due to the requests from the local authority. Therefore two Candle Light Memorial events were organized.

Figure 9: A World AIDS Day campaign in community and school organized by the project



- A total of **404** times of regular radio broadcasting were done in both provinces:
 - In Preah Vihear site, the pre-record radio was developed in RACHA studio in Phnom Penh and broadcasted through radio station in Preah Vihear regularly on Friday and Sunday from 11 – 12 a.m.
 - In Kampong Thom site, the pre-record radio program was developed at the provincial project office and broadcasted or during radio live program with experts in every Monday and Friday through two radio channels in the afternoon program.

Figure 10: A drama performance organized in community and school



Table 29: The achievement of community awareness activities organized by the project

N ⁰	Activities	# planned	# observed	Achievement
01	World AIDS Day	3	3	100%
02	Child Rights Day	3	3	100%
03	Water Festival	3	2	66.66%
04	Candle Light Memorial Day	3	3	100%
05	Drama performance and mobile video show	524	577	110%
06	Radio broadcasting	400	404	101%

b.3. Youth club

All PELs within villages did organize Peer Educators group meeting into a "Youth Club" continuously but not regularly on monthly basis. Totally, 454 youth clubs were created that achieved 90.8% as target. In addition, about 80% of youth clubs met regularly on monthly basis.

Table 30: The achievement of youth clubs creation

N ⁰	Activities	# planned	# observed	Achievement
01	Created youth clubs	500	454	90.8%

Figure 11: Community youth club activities organized by PEL**b.4. IEC material**

There were varieties of IEC materials developed and educational materials bought and supplied to the project sites to support the project activity implementation. As planned, several IEC materials were developed as agreed by the joint IEC team from RACHA and ADRA.

- Writing books with messages 37,500
- Story books on RH 19,004
- 8 types of leaflets 622,560
- T-shirts 23,936; caps 3,860; bags 5,581

- Billboards 60
- 6 types of Posters 21,201
- 2 types of flipcharts 870

It was noticed that a few of the IEC materials produced by ADRA and RACHA were not used by the other organization thus not the entire target area. For example, a billboard developed by RACHA was put only in PVH but it was not put in KPT and vice versa. The decision to allow differences was sometimes because of preferences in pre-testing of IEC materials in the different target areas.

Figure 12: The difference between billboards used in KPT and PVH



One of the billboards used in PVHs



The one type of billboard used in KPT

3.2.2.3. Under objectives 3: Improving support for YSRH programs by community advocacy efforts and research aimed at influencing YRH policy and practice.

a. Advocacy workshop

a.1. Project monitoring and advisory committee (PMAC)

Totally, 39 Project Monitoring and Advisory Committees at 39 HCs were established and trained. As their role and responsibility, they met on a quarterly basis to monitor the project implementation, to discuss and provide recommendations on problem with the activity report submitted to the project MEL. As a result, PMAC achieved 100% of its plan to have 13 quarterly meeting.

Table 31: The achievement of PMACs established and trained by the project

N ⁰	Activity	# planned	# observed	Achievement
01	Created and function PMACs	39	39	100%

a.2. Conduct sensitizing workshop

The project did organize several sensitizing workshops for a total of 500 Religious Leaders and TBAs from 45 village religious structures on YSRH concepts and basic lay counselling as planned.

Table 32: The achievement of religious leaders sensitized by the project

N ⁰	Target providers	# planned	# observed	Achievement
01	Religious leaders and Traditional Birth Attendants	500	500	100%

b. Media sensitization

Beside the local authority sensitized, the sensitization through media was used by the project on following activities:

- The project representatives and PELs participated in a television (Apsara station) talk show on RH on the Valentine’s Day event.
- The project staff participated in a discussion on “Youth and the Menstrual Cycle” aired at radio 103 MHZ.
- The project staff participated in FM-103 of TV3 station in Phnom Penh as a guest speaker in Really Program that was on air FM-103 MHz every Sunday and supported by BBC-World Service Trust with young hosts. The objective of Really Program is to urge youth groups aged 15-23 years old to openly raise their health problems related to sexual reproductive health issues, drug abuse, gambling migration and trafficking.

c. National policy workshops

The project did provide for high level project representatives to participate in the national forum on RH, for example the regular participation in the TWG of the national reproductive health program.

ADRA Cambodia always participates and contributes in the development of AOP (Annual Operational Plan) that is a yearly planning conducted by Ministry of Health at the provincial level, with the participation of local and international NGOs. This has taken place in both provinces.

The project officers and staff participated in the MoEYS launched, a National Youth Policy Consultation to draft the Cambodian Youth Policy.

As member of the Child Survival Technical Working Group and Reproductive Health Technical Working Group, ADRA Cambodia participated regularly in the drafting of country policy/guidelines, advocating changes in the government strategies and provided technical input to the government agencies. A section of current National Standard Guidelines for Adolescent-Friendly Reproductive and Sexual Health Services was written by Reproductive Health Technical Working Group allowing the projects technical staff to strengthen good partnership with the government agencies.

The Project sent representatives to participate in the formulation of National Adolescent Friendly Sexual Reproductive Health guidelines in 2008. ADRA, RHAC, CARE, MEDICAM, KHANA and WHO were given assignment to develop the chapter of community participation and collaboration. This guideline focuses on improving Adolescent Sexual Reproductive Health, including AFSRH services at all levels of the health care delivery system starting from family and the community. It recognizes the importance of family and community protective systems for youth and seeks to collaborate with family and other relevant social structures in the detection of youth with sexual reproductive health problems, referral to the AFRSH and appropriate authorities and follow up support and social awareness on Adolescent Sexual Reproductive Health issues.

d. Community Youth-Watch Program (CYWP)

The project did support to have community youth-watch program established, trained and to support its function to have meeting on monthly basis as stated in the project design.

As result, 37 community youth-watch programs in 37 villages organized meetings regularly with regular reports to local authority or to project management on some inappropriate or negative activities that they met in their communities. For example under-age alcohol use, drug abuse, community youth gangs etc.

Table 33: The achievement of CYWPs created by project and functioning

N⁰	Activity	# planned	# observed	Achievement
01	CYWP	8	37	462%

Met with the members of the community youth-watch program, they highly appreciated the project in believing that the project had influence to the reduction of the negative and illegal activities in the community. They gave examples of youth gang, alcohol use by youth during the community event etc.

e. Networks and coalitions

The project did receive strong support from the national authority based on official support letter from the National AIDS Authority (NAA), the Ministry of Health (MoH), the Ministry of Women Affair (MoWA), Ministry of Education, Youth and Sport (MoEYS).

The project did provide local authority specially, the provincial AIDS secretariat (PAS), provincial health department, provincial education, youth and sport department, provincial women affair department to have full authority to make request on project implementation under technical and financial support from the project officers and staff.

The project management participated in the regular provincial technical working group for health to keep them updated on the progress of project implementation, to share resource mobilization with other partners related to the project and to get feedback, comments and recommendation to improve the project. The project representatives participated in provincial AIDS network organized by the provincial health department in order to share the HIV/AIDS information from different HIV/AIDS partners working in the provincial level as well as forum to do resource mobilization and coordination for better coverage, for example the organization of World AIDS Day, the Candle Light Memorial Day etc.

The project did provide snack support, as partnership contribution, to two provincial TWG networks, the provincial AIDS network and the Provincial health TWG.

f. Research and data use

The project did commit to conduct five researches as planned.

- A series of community and school-based KAP and PLA qualitative studies on YSRH including socio-cultural factors and their impact on access to health information and services, antecedents to risky sexual behaviours and key motivating factors for practicing safe sexual health.
- Operational research on key-localized risky behaviours, social factors and migration preparedness.
- A comparative study on the effectiveness of differing implementation strategies in YSRH education as demonstrated by the MoE / WE "Life-Skills for HIV / AIDS Education" project in Preah Vihear Province and similar ADRA / RACHA interventions in Kompong Thom Province.
- A comparison of the effectiveness of health system support / intervention regarding YSRH youth-friendly services between RACHA's target areas (the "Health Services Contracting District") in Preah Vihear Province as compared with (a non-contracting area) Kampong Thom Province.
- Papers exploring policy issues and/ or recommendations concerning the drafting process of a national YFHS Policy Guideline.

The finding report from all of these research papers were supported to have it publicized and disseminated during disseminating meetings with key policy makers at the national and provincial level especially among the project officers and staff. As result three dissemination workshop were organized:

1. Conduct MIP workshop
2. Conduct dissemination workshop for mid-tem evaluation
3. Conduct dissemination workshop for final evaluation

3.3. Efficiency

Due to the non-stand alone project with aligning and integrating into the existing system of health care services delivery, public school system as well as the existing community structure, the project did

achieve efficiently almost all activities as plan as the project budget did spend only to direct field operational cost for example per-diem or travel instead of salary or overhead cost.

With strong support from the government partners at the national down to the provincial level, the district, the commune and the village level, it does facilitate the project implementation smoothly as achieving all the activities planned and successfully as achieving all the objectives set in the project.

Using the existing human resources, systems and services available locally and being ownership by the local authority, it did speed up the project implementation in low cost with an assurance of the project sustainability.

With the participation of peer educators, village health volunteers etc to the project implementation, it did show highly productivity with low cost because salary is excluded.

Using and integrating this project into the existing organization as ADRA and RACHA that have its officers and staff networks in the project implementation areas, did make a lot of cost saving especially spent on management and administration.

3.4. Impact

The following indicators were set to measure the specific objectives of the project:

- % of youth's knowledge on SRH
- % of youth's knowledge on HIV/AIDS/STI
- % of youth's belief and value on RH, HIV/AIDS and STI
- % of health seeking behaviour among youth and
- % of supportive social influences towards healthy YRH behaviours

As planned, the final quantitative survey in combining with qualitative survey was conducted to get information to make a judgment on effectiveness of the three-year project implementation.

3.4.1. The finding by individual question

3.4.1.1. % of youth's knowledge on SRH

a. When asking the same question “A women has never had sex before, when she has sex for the first time can she get pregnant?”, the finding shown that the knowledge on RH among the youth who could provide the right answer to this questions increased from 57.5% in the baseline to 70.8% in the mid-term and to 81.6% in the final survey.

Table 34: The comparison of SRH knowledge on question “A women has never had sex before, when she has sex for the first time can she get pregnant?” between baseline, mid-term and final surveys

Answer	Baseline	Mid-term	Final
Yes	57.5	70.8	81.6
No	20.5	21.3	10.3
Don't know	21.7	7.9	8.1

b. Based on the question “A girl has not yet had her menstrual period. If she had sex, can she get pregnant?”, the survey result show that 80% of the respondents gave the right answer increased from 67.8% at the baseline and 78.7% at the mid-term survey. The most interesting one was the sample who did not know the answer dropped from 20% at the baseline to 10% at the final survey.

Table 35: The comparison of SRH knowledge on question “A girl has not yet had her menstrual period. If she had sex, can she get pregnant?” between baseline, mid-term and final surveys

Answer	Baseline	Mid-term	Final
Yes	12.3	12.1	9.6
No	67.8	78.7	80.3
Don't know	20.0	9.2	10.1

c. Referring to the question “Is it possible for a girl to get pregnant if the boy withdraws before ejaculation??”, there was a slightly increasing percentage between baseline (59.2%) and end line (61.4%). There was a noticeably high percentage of respondents who could not answer this question. The proportion of wrong answers provided was also high.

Table 36: The comparison of SRH knowledge on question “Is it possible for a girl to get pregnant if the boy withdraws before ejaculation?” between baseline, mid-term and final surveys

Answer	Baseline	Mid-term	Final
Yes	15.4	23.7	18.4
No	59.2	55.0	61.4
Don't know	25.4	21.3	20.21

d. When asking “How long do you think it is best for a woman to wait after giving birth again?”, there was a slightly increasing percentage between baseline (46.5%) and end line (54.6%). The proportion of thinking about one to two years was high and pretty similar across the line (33.1% baseline, 30.3% mid-term, and 32.2% end line).

Table 37: The comparison of SRH knowledge on question “How long do you think it is best for a woman to wait after giving birth again?” between baseline, mid-term and final surveys

Answer	Baseline	Mid-term	Final
< 1 year	0.4	1.3	
1-2 years	33.1	30.3	32.2
3-5 years	46.5	53.1	54.6
>5 years	10.5	10.1	6.4
Does not matter	0.2	0.2	0.4
Don't know	9.2	5.0	6.4

e. For the question “Do you know until what age is best for a woman to wait until she first get pregnant?” 20-24 years old was the answer that gained highest proportion than the other age groups and there was slightly increasing percentage between baseline (58.3%) and end line (67.1%). There was a high proportion of answers to the age group from 25-30 years old.

Table 38: The comparison of SRH knowledge on question “Do you know until what age is best for a woman to wait until she first get pregnant?” between baseline, mid-term and final surveys

Answer	Baseline	Mid-term	Final
15-19 year	14.7	12.1	7.2
20-24 years	58.3	67.2	67.1
25-30 years	16.7	15.4	20.4
31-35 years	0.9	0.7	0.4
> 35	0.2	4.4	0.4
Don't know	9.2		4.4

3.4.1.2. % of youth's knowledge on HIV/AIDS/STI

To assess the knowledge on HIV/AIDS/STI several questions were asked to youth.

a. There was no change in level of knowledge on ever heard illness called HIV/AIDS among the sample across the line. It is a mature stage of hearing the disease called AIDS everywhere in the country therefore the proportion of providing "yes" answer was high since the baseline.

Table 39: The comparison of HIV/AIDS/STI knowledge on question “Have you heard illness called HIV/AIDS?” between baseline, mid-term and final surveys

Answer	Baseline	Mid-term	Final
Yes	96.71	96.5	97.4
No	3.29	3.5	2.6

b. Nearly all interviewees agreed that a person could get infected through sexual intercourse and there was a small increase of percentage between the baseline (88.8%) and the end line (94.1%).

Table 40: The comparison of HIV/AIDS/STI knowledge on question “Do you know of any infection a person can get through sexual intercourse?” between baseline, mid-term and final surveys

Answer	Baseline	Mid-term	Final
Yes	88.8	94.5	94.1
No	11.2	5.5	5.9

c. Sexual intercourse was believed as a mode of HIV transmission that significantly increased from 43.5% in the baseline to 93.4% in the end line. Regarding avoiding HIV transmission, of the sample population, total respondents identifying ‘abstinence’ increased from 19.3% to 25%, ‘be faithful’ increased from 19% to 21.8% and ‘condom use’ increased from 79.9% to 86.9%. Responses for identify avoid sharing needles also increased from 20.9% to 35.1%.

3.4.1.3. % of youth's belief and value

a. Assessing on the perception of the youth values on having sexual partners during the rest of their adolescent years, the results found that the respondents who decided not to have any partner dropped from

36% in the baseline to 22% in the end line, and to have one partner increased from 53% in the baseline to 73% in the end line. It was very interesting that nobody claimed to have more than one partner.

Table 41: The comparison of perception on youth value between baseline, mid-term and final surveys

Answer	Baseline	Final
Have no partner	36	22
Only one partner	53	73
Don't know	11	5

3.4.1.4. % of health seeking behaviour among youth

To measure the change regarding the RH seeking behaviour, several questions were asked to respondents.

a. On question “Where did you (STI infected person) seek advice or treatment?” There was a slight increase of positive behaviour to seek proper STI service such as health centre, referral hospital etc, from 75.6% in the baseline to 79.5% in the end line. The proportion of choosing inappropriate STI service was still high.

Table 42: The comparison of STI seeking behaviour between baseline, mid-term and final surveys

Answer	Baseline	Mid-term	Final
Proper place	75.6	65	79.5
Not proper place	19.2	33	16.1
Don't know	5.3	2	4.4

b. On question “Where did you go to receive health service at the last time? the answer of

- Using nowhere dropped from 20.1% in the baseline to 0.7% in the end line
- Using the health centre and referral hospital was not different between the baseline and the end line
- Using private clinic and pharmacy was still popular among the sample and increased in proportion in the end line comparing to the baseline.

Table 43: The comparison of health seeking behaviour between baseline, end line surveys

Answer	Baseline	End line
No where	20.1%	0.7%
Health centre	42.4%	36.6%
Referral hospital	12.5%	7.2%
Private clinic	9.9%	18.6%
Pharmacy	1.6%	16.7%

3.4.1.5. % of sexual behaviour and practice among youth

To measure the change regarding the sexual behaviour and practice several questions were used:

- In the last 6 month, do you think that any of your friends have had sex with a commercial sex worker?

There was a decline in percentage of sample who thought that any of their friends have had sex with commercial sex worker from 17% in the baseline to 6% in the end line.

Table 44: The comparison of practice with sex worker among the sample between baseline and end line surveys

Answer	Baseline (%)	Final (%)
Yes	17	6
No	61	80
Don't know	22	14

- In your group what activities are regularly practices?

There is a significant decline of negative picture practiced by the respondents. The proportion dropped from 23.02% to 15.4% on activity of going out at night, 17.76% to 3.5% on alcohol use and 5.7% to 1.8% on gambling. There was no change regarding drug use.

Table 45: The comparison of negative picture behaved and practiced among the sample between baseline and end line surveys

Answer	Baseline (%)	Final (%)
Going out at night	23.02	15.4
Alcohol use	17.76	3.5
Drug use	2	2
Gambling	5.7	1.8

- Have you ever had boyfriend/girlfriend?

There was no change regarding behaviour and practice on having boyfriend or girlfriend in the baseline and end line.

Table 46: The comparison of practice on having boyfriend or girlfriend among the sample between baseline and end line surveys

Answer	Baseline (%)	Final (%)
Yes	23	20.2
No	77	79.8

3.4.1.6. % of supportive social influences towards healthy YRH behaviours

As the same as the other above measurements, there were several questions introduced to identify the change of supportive social influence towards healthy YRH behaviours

To measure the change regarding the sexual behaviour and practice several questions were used:

- In the last 6 month, do you think that any of your friends have had sex with a commercial sex worker?

There was a decline in % of sample who thought that any of their friends have had sex with a commercial sex worker from 17% in the baseline to 6% in the end line – see Table 44.

- 96.6% did confirm that there was no any pressure from their friends for them to have sexual intercourse
- 93% said that there was no pressure in their family. Only 3.1% received pressure on dropping out of school early that decreased from 9% in the baseline.
- About one third of the respondents said that they had family problems such as domestic violence (22.8% against 40% in the baseline), low income (8.6% against 29.4% in the baseline), alcohol abuse (2.4% against 16% in the baseline) and gambling (1.3% against 2.8% at the baseline).

3.4.2. The finding by combining questions

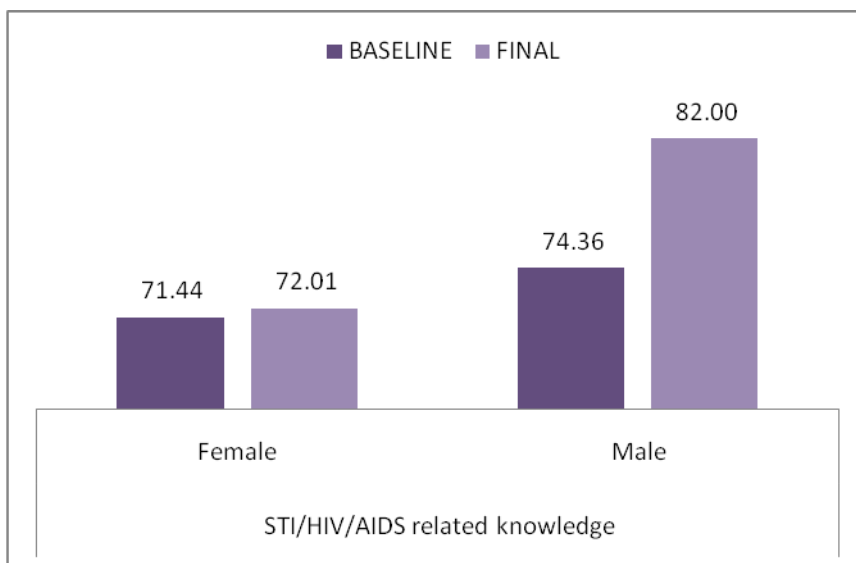
In order to measure the overall effect from the activity achievements to the objective level of the project, the individual questions in the survey questionnaires were combined to four components as stated in the objectives. The results are as follows:

3.4.2.1. The percentage of RH and HIV/AIDS/STI knowledge.

Comparing with the baseline finding, there was a slight difference of HIV/AIDS/STI knowledge between the baseline and the end line. Overall the percentage of HIV/AIDS/STI knowledge was slightly increased from 73% in the baseline to 77% in the end line.

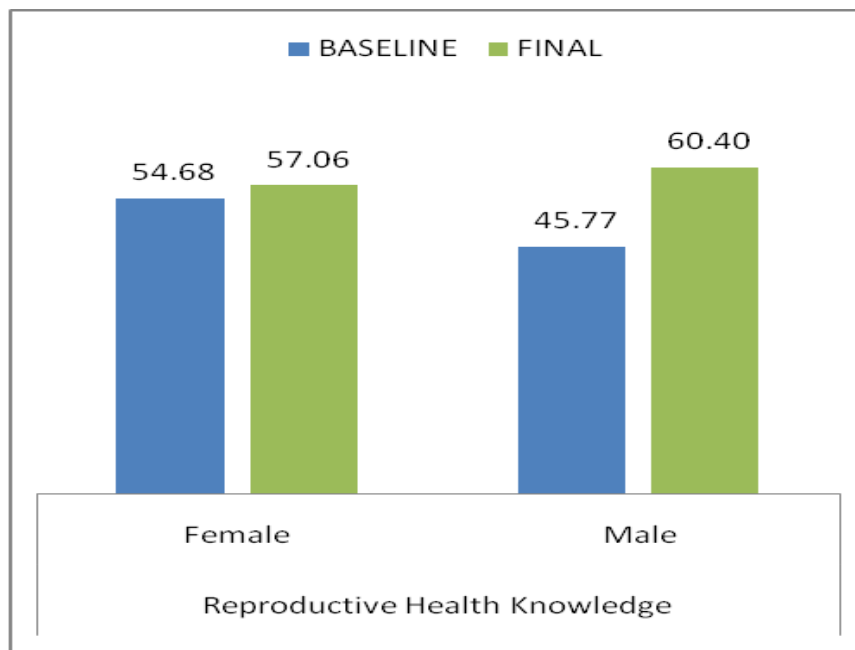
When stratified by sex, there is no difference between baseline and end line among females (71.44% versus 72.01%) while there is small increase from 74.36% at the baseline to 82% at the end line among male group.

Figure 13: The comparison of level of HIV/AIDS/STI knowledge between baseline and end line by sex



It is nearly the same concerning the RH knowledge among the sample when stratified by sex. There is no difference between baseline and end line among females (54.68% versus 57.06%) while there is small increase from 45.77% at the baseline to 60.40% at the end line among male group.

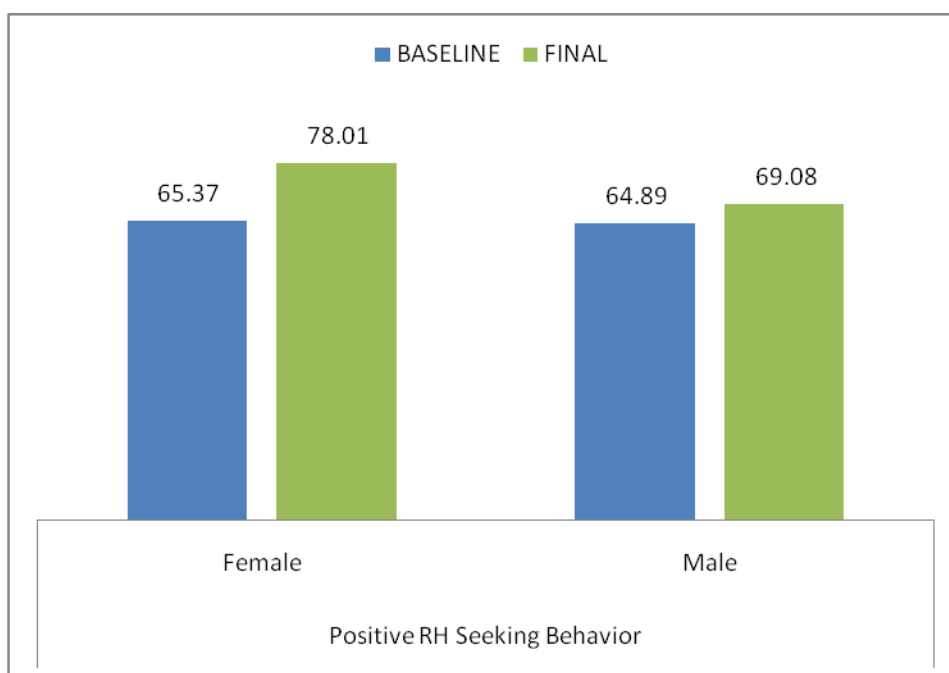
Figure 14: The comparison of level of RH knowledge between baseline and end line by sex



3.4.2.2. The percentage of RH seeking behaviour

Looking at the positive behaviour change on RH seeking behaviour to the appropriate services, it was seen as increasing change from 65% in the baseline to 74% in the end line and the change is seen among females (from 65.37% versus 78.01%).

Figure 15: The comparison of practice on RH seeking behaviour between baseline and end line by sex

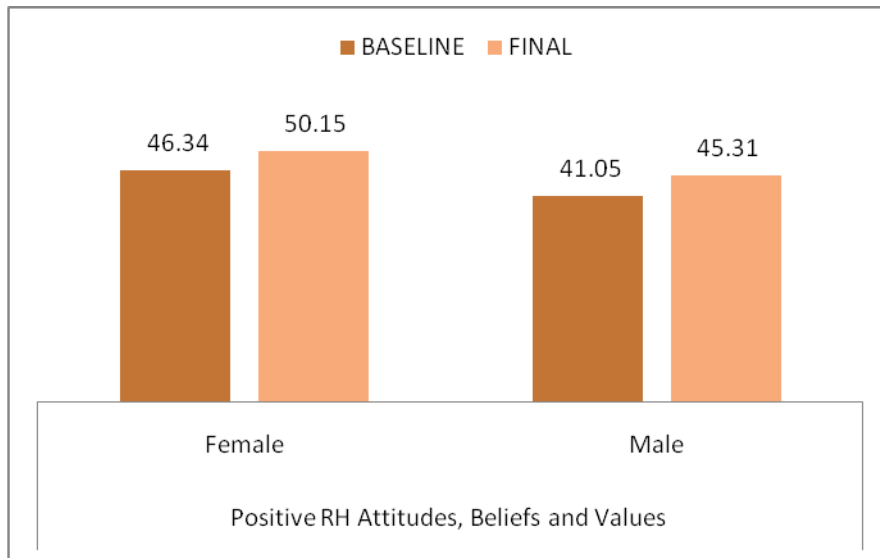


The notice from the health centre and referral hospital, there was an increasing number of youth using the service but the cases were still small in number. It did show the positive change while it was compared to no cases coming before the project started.

3.4.2.3. The percentage of RH attitudes, Beliefs and Values

Regarding the positive attitudes, beliefs and values of community youth as well as gatekeepers, the survey, overall showed the increasing percentage change from 44% in the baseline to 48% in the end line.

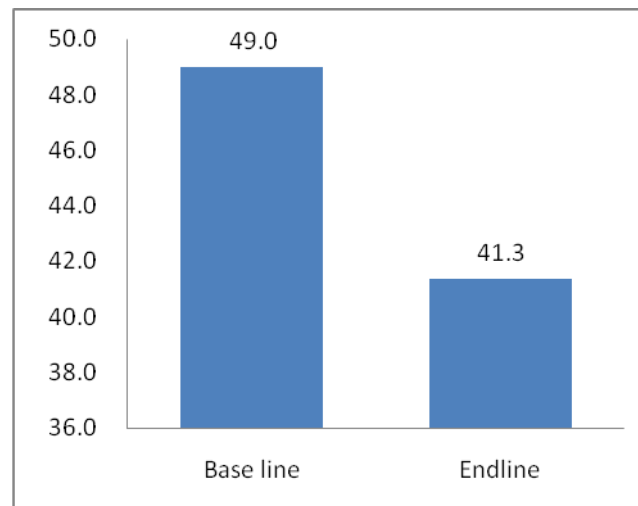
Figure 16: The comparison of level of attitude, belief and values on RH between baseline and end line by sex



3.4.2.4. The percentage of social influences towards unhealthy YRH behaviours

For social influences towards unhealthy YRH behaviour, the survey did clearly inform the difference between the baseline (49%) and the end line (41%)

Figure 17: The comparison of level of social influences towards unhealthy YSRH behaviour between baseline and end line surveys



3.4.3. The change of quality of public health facility and providers

Based on the mid-term evaluation using mystery client interview methods, the quality of care at the YFS was assessed by mystery clients through:

- Cleanliness
- Friendliness and
- Information given of health provider regarding counselling skills.

As a result on:

- Cleanliness:
 - 79.8% accepted that the outside of the HC was clean and 89.3% accepted the inside of the HC was clean
- Friendliness which includes: knowledge, closeness, quality, communication, respect, politeness, and confidentiality.
 - 58.3% of mystery clients were satisfied regarding knowledge of the HCP
 - 69% reported satisfaction with quality of care of HCP
 - 60.7% reported satisfaction with communication of care of HCP
 - 57.1% reported satisfaction with the confidentiality of HCP
- Counselling skills
 - 96.4% reported that HCP used simple language
 - 92.9% reported satisfaction and understanding of what HCP told them
 - 94% said they had enough time to raise their issues
 - 89.3% said they had chance to ask questions or clarification
 - 56%-60% said they were satisfied with the process of doing counselling from the HCP.

In comparing to the end line survey, there was a significant increase of quality of health care service in HCs as well as in the referral hospital based on cleanliness, friendliness and counselling skills.

Regarding the friendliness:

- The satisfaction with knowledge of HCP moved up from 58.3% at the mid-term to 82.9% at the final survey.
- The satisfaction with quality of care of HCP moved up from 69% at the mid-term to 90.6% at the final survey.
- The satisfaction with communication of HCP moved up from 60.7% at the mid-term to 86.6% at the final survey.
- The satisfaction with confidentiality of HCP moved up from 57.1% at the mid-term to 65.4% at the final survey.

3.4.4. The change of community to support YSRH projects

In an interview with a school principle as school peer mentor, he strongly confirmed that the project did benefit a lot of teachers and students not only the RH knowledge, but the variety of issues related to RH such as human rights, gender etc and it did increase a lot of teacher and students' knowledge. He showed his regret to learn that the project was ended.

Religious leaders said “In our generation at this age, we knew nothing about reproductive health, it was a taboo, we were not allowed to learn, to discuss, to speak up or to share the knowledge, skills and experience on RH. With this project, our community members, even some at the project started, did complain or disagree to have their children involved, now totally accepted and valued the project as the most important for their children to cope with the serious reproductive health problem in the 21st century as HIV/AIDS.

Peer educators said “We could value ourselves and we could get it from our friend even our parents now sometime asking us about RH”. We always enjoyed working with this project, because it is fun, helpful, and proud.

Community youth reported that we had a lot of chance now to learn what were secret before. We also learn that we had a variety of means to access to RH information and services. Our parents also changed,

they disagreed to have us accessing to RH knowledge before but now they always encourage us to join RH education session.

Parents of community youth claimed that we live in the 21st century while we open the door to the free world that youth could access to all good or bad information through all kinds of communication channels. Therefore youth could adopt bad practice behaviour based on what they learn for example, there were few cases in our community that youth came back from work in Phnom Penh with disease called HIV/AIDS and unwanted pregnancy. This project should be highly valued because it equipped youth RH knowledge and life skill since they was young (10 years old) to adopt safe practice behaviour when they reach reproductive age. We support to have this project forever in our community for young generation.

Some parents said: “It was difficult for us to talk with our children about RH, even we know that it is important”. Therefore the project could help parents and community to break these difficult barriers.

All providers and beneficiaries provided the same impression on the effect of the project to increase RH, HIV/AIDS and STI knowledge and awareness and to reduce negative picture of their community.

3.5. Sustainability

Even though this project life is definitely ended as its schedule, the project activities are not all ended completely. Due to the willingness from all partners involved in this project both public and NGOs, they agreed to try all effort to keep at least some even not all project activities continued. As evidence:

- The project, in fact, owned by the public sectors as department of health, department of education and women affair and local authority, therefore even the project is ended that is referred to end the funding support, all the project activities that do not need funding will sustain for ever but for some activities that need funding, the public sectors from health, education, youth and sport and women affair do show their commitment to mobilize the resource from national and international budget to keep those activities within their mandate continued. In addition, the NGOs directly involved also show their interest to integrate some activities in this project to other existing projects.
- The knowledge, skill and experience gain from this project by providers in all levels are still there for the beneficiary
- The youth resource room and the school library are still there to serve school students and community youth as reproductive health resource centres. Some health centre providers and school principles confirm their commitment to ensure the library and resource room regularly opened with updated resource books.

3.6. Coherence

This YSRH project directly helped to meet two out of three principle objectives of this program as set out in regulation number 1567/2003 of the European Parliament and of the council on "Aid for policies and action on reproductive and sexual health and right in developing countries. The two objectives are first to secure the right of women, men and adolescents to good reproductive and sexual and secondly, to enable men, women and adolescents to have access to a comprehensive range of safe and reliable reproductive and sexual health care services and products by ensuring that young people's right are respected by the policies, policy makers and social gatekeepers.

The objective of the project is also in line with recommendation made by ICPD declaration to consider to right of women, men be informed, have access services, including sexual health for enhancement of life and personal relations, enable attainment of the highest standard of sexual and reproductive health , promote mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents and to enable them to deal in positive and responsible way with their sexuality.

Accordingly, the project has taken into consideration the recommendations made by "Round Table on Adolescent Sexual and Reproductive Health" (as part of the ICPD+5) for future action to equip adults to better help adolescents, expand national policies and implement rights, increase and sustain youth participation.

The project did also help meet the need identified by the UN Development Goal report for Cambodia 2001 which recommends that "in order to help reach the MDG related to Gender Equality and to Empower women and minimize gender disparities in the policy and decision making process at all levels, there is an urgent need to have active participation of NGOs in the implementation of programmes for women's empowerment, especially for greater access to quality health care including reproductive health.

The project objective also helps achieve the MDGs goals set for Cambodia such as reduce extreme poverty, improve health (and reduce child mortality) reduce HIV/AIDS and improve reproductive health.

The project did support the National AIDS Authority to implement strategy one of the National Strategic Plan for Comprehensive and Multi-Sectoral Response to HIV/AIDS II (2006-2010) to scale up the effective prevention program through increasing scientific knowledge on HIV/AIDS/STI and condom promotion as well as integrating into reproductive health program.

The project did support the strategic plan and operational plan for HIV 2008-2012 of the Ministry of Education, Youth and Sport to promote HIV/AIDS through life skill curriculum in school and out of school youth in the rural areas.

The project did support Ministry of Women Affair to implement the Strategic Plan on Women, the Girl Child and HIV/AIDS in Cambodia 2007-2010 focusing on providing accessibility to sexual and reproductive health information and service to women and girl including empowering women right and gender.

3.7. EC value added

During the project implementation, the project did communicate regularly with the EC office to Cambodia and the regional EC office in Bangkok for keeping them informed about the progress of the project implementation and to request advice or approval on the project modification and change. In fact, it is very helpful to always get response from the EC Cambodia and Bangkok as requested.

4. Visibility

Upon signing of the RCYSRH memorandum of understanding with the Ministry of Health, a Press Release was issued following the EC Visibility protocol. From the start of the project at the Kompong Thom and Preah Vihear sites, stickers and signs were posted for EC visibility. The project management had been briefed on the visibility requirements, and worked to ensure that all protocols and guidelines were used for both general activities as well as during production of IEC materials. An IEC materials development communication flowchart was developed and followed for communication between RACHA and ADRA staff and then the ADRA Public Relations Officer communicated with the EC Delegation about visibility on IEC materials in general as well as on specific significant items. All printed items use the EC format and visibility standards for production including activity and research reports. A representative from the EC delegation also was present at the evaluation and research dissemination workshop at the national level.

5. Overall assessment

The YSRH project is the contributing part to the national YSRH program of the government of Cambodia. It received strong support and commitment from all level of public institutions, health, education women affair and the local authority and civil society partners to implement it successfully.

The project could be considered as a pilot project to provide first ever opportunity to rural youth in Cambodia to access to sexual reproductive health.

From the evaluation finding, the YSRH project is concluded as the successful project due to some significant evidences as following:

- All activities planned were implemented
- Most all target were achieved some even exceeded the target
- It did provide a positive impact when some changes in behaviour and practice were noticed
- The findings from this evaluation could be used among national partners to use as national model to further develop the national policy and guidelines for nationwide scale-up and could be used by other NGOs in other areas.
- It did show some, but not all, sustainability such as the training curriculum is used by other projects, the school youth library and the community youth resource room keep functioning, the peer educators still continue to spread sexual health information to their peer and community member etc.
- It initiated multi-sectoral participation and commitment through community networking leading to strong influence to break the community silence on RH into accepting RH discussion openly.
- With strong policy and community support, it created a positive enabling environment for youth to meet, to learn, to understand and to educate each other the scientific information on RH and its related subjects.
- The Peer education program does provide quick effects on increasing youth knowledge both in school and in community in the short period of time, but without integrating into any existing system or services; the sustainability is a question for a long period of time.
- All providers and beneficiaries in all levels do welcome the project, are interested and consider the project as important to their community and particularly youth.
- All providers and beneficiaries agree consistently that the project does reduce the negative picture in their community such as violence, gang, drug use, rape, alcohol etc
- The Project did provide knowledge, skills and experience to project providers as officers, staff, activists and volunteers from the provincial down to the grass roots level that is sustained with them to provide further services to youth even though project is ended
- The Project did create supportive community networks to encourage and motivate youth to use their rights, responsibilities and confidence to make decisions to access to RH knowledge and services, monitoring and watching network.
- The Project did change the resisting of the concept on educating RH to youth to become fully supporting concept to advocate for YSRH

Figure 18: The logic model of the project achievement and success

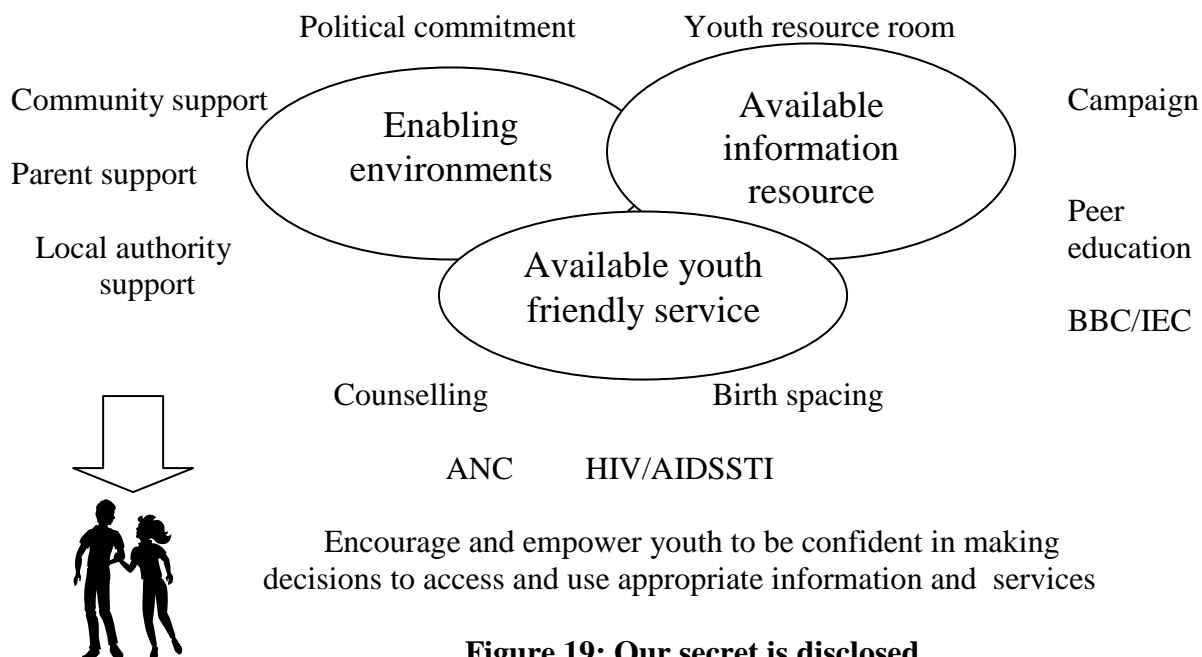


Figure 19: Our secret is disclosed



The project does create community enabling environment for us to have chance to access RH information, to youth friendly service leading us to be confident in making decision on our health and safe RH.

6. Conclusions and Recommendations

6.1. Conclusions

6.1.1. The strengths

The project received approval and high support from all government agencies that have their mandate related directly to the project. For example, the project did receive supporting letters from the National AIDS Authority, the Ministry of Women's Affairs (MoWA), the Ministry of Education, Youth and Sport (MoYES), the local authorities (governor office, Provincial Health Department (PHD), Women's Affairs Department (WAD), Education, Youth and Sport Department (EYSD), Provincial AIDS Secretariat (PAS) down to the district, commune and village level). Additionally, the MoU was signed between ADRA and the Ministry of Health (MoH).

The project was designed and implemented based on the national reproductive health strategy, policy and program. It did contribute to fill the gap of the national response to reproductive health issues in Cambodia, especially on youth aged 10-24 years old. Most of the project activities were integrated into existing system and services that lead to project sustainability

The project was strongly managed by two organizations that have had long and strong experience managing several projects successfully in Cambodia.

The project had a limited number of staff, covered two provinces with highly complex intervention activities, and only had three years project life. In less than three years, the project has covered all its project target area, achieved more than 50% of targeted goals, addressed surmountable issues related to implementation complexities and integrated measures for community project ownership and sustainability. Therefore, it did have effect to the project achievement at the objectives level.

The project was implemented based on clear policy and guideline with consistent and regular planning development on monthly, quarterly and annually basis with monitoring and evaluation system set, reporting format developed and regular project report writing on monthly, quarterly and yearly basis.

Some project components, for example the community youth program, looked like a pilot project to test a model that has not been available yet in Cambodia with clearly design to have a baseline, a mid-term and final term evaluation.

Project did provide many opportunities to rural youth to be encouraged, empowered and supported to accessed to RH information and services

The project, in general achieved successfully almost 100% of its activities planned and reached almost all targets set in the project. Looking at the project outcome, it was noticed that there was a different percentage of increasing knowledge, increasing positive RH seeking behaviour, increasing positive attitude, beliefs and value and increasing positive community. But the change in some components was not significant due to the time of the project implementation was not quite enough to observe such intended change.

Most of the target groups, providers and beneficiaries (171,000 young women and men aged of 10-24 years old and 331,000 community members in three operational districts) were reached. Most of them expressed their support of the project to community especially to rural youth. In addition, all of them claimed the project life was too short.

The project provided opportunity for provincial down to local authority to own and be fully involved in project implementation even though it was not at the project design and management level.

The project did not involve government partners at the national levels except the participation of the project officers in the national technical working group, the national policy development etc to update and share project information.

Regarding the age of youth to be targeted by the project, all target providers and beneficiary, in principle accepted while there was few people met expressing uncomfortable to talk with youth aged 10-15 to learn RH while their bodies were not ready yet to reproductive stage, especially among male youth. Anyway, most of them said it is too late to inform youth after they practice high-risk behaviour because it is hard to change the individual behaviour therefore to inform them in advanced stage is seen useful for them to adopt safe RH behaviour when they start their sexual activities.

All target groups under the project coverage expressed their support and highly appreciated the project with request to have it continued. They all felt very sorry to learn that the project was ended and they all agreed that the project life was too short.

The project did provide a positive enabling environment to change community and society norms from negative thinking toward positive thinking to accept their children, their community learning, discussing, and taking openly on reproductive health.

Regarding the financial expenses, the project could achieve almost 100% of its budget planned covering to all activities implementation. A budget modification was approved during year two including increases for renovation and construction of community youth resource rooms. Amounts over and under the revised budget are shown in the year three report still to be audited.

Except the project officers, staff and implementing partners at the provincial level, the grass roots implementers did not know that project is ended. Therefore, they were not ready yet to cope with the situation after the project ended.

The project was originally designed with no clear exit strategy on commitment from the government partners that made it difficult to be ready to hand over to local authorities to ensure project sustainability. It was originally planned to have a workshop in project quarter 4 to address this issue but this event did not happen and various aspects of “hand-over” were worked out during the activities of project year 3. In some cases this happened a bit late and some project partners were not adequately informed leaving uncertainties for some staff and community partners regarding the expectations for the future.

The project did provide knowledge, skills and experience on RH and its related issues to different levels of project staff and implementers as well as beneficiaries. This knowledge, skills and experience stay with them to continue the job voluntarily or with other projects.

After the project ends, not all project activities will be sustained. It is believed that all project activities that do not stand alone and do not required daily operational cost will be sustained.

The project was designed in a complex manner including consuming a lot of time on selecting and recruiting the government services providers that caused activities implemented to be delayed.

Regarding one to two days as time on counselling training, it was hard to judge that the counsellor could perform quality counselling to youth when based on other experience the standard of basic counselling training would probably require at least 5-days.

The result of this project evaluation could be used as reference and contributing document to advocate political commitment to open the door for youth to gain full access to RH context, to help MoEYS, MoH

and MoWA to develop strategies, policies, programs, allocate resources and build infrastructure on RH delivery for youth in their respective mandate.

Overall, the project did the following:

1. Achieve almost all activities planned in the project

Table 47: A summary of the project achievements

N ^o	Activity	# targeted	# observed	Achievement
<i>Objective 1: Ensuring that quality of Youth-Friendly SRH services and referral systems are available and utilized at each level of service delivery,</i>				
01	Establish YFHS	42	41	97.6%
02	Train CTT	20	28	140%
03	Train public HCP	171	161	94.15%
04	Train private HCP	160	161	107.5%
05	Train private HCP on referral system	160	160	100%
06	Private HCP submit regular report	120	120	100%
07	Train counsellor	660	689	104.39%
08	Counsellors provide skilful counselling	330	243	73.63%
09	Establish YRR	41	41	100%
<i>Objective 2: Increasing knowledge and awareness of youth SRH & Rights, and empowering youth to make health SRH choices</i>				
2.1. In-school youth				
10	Train school teachers	200	203	102%
11	Organize SBTT	38	38	100%
12	Train school PE	850	850	100%
13	Educate student by trained teacher	200	203	102%
14	Establish school youth club	38	38	100
15	Organize school awareness activities	130	156	120
16	Establish youth corners and resource libraries	38	38	100%
2.2. Out of school youth				
17	Establish and train CYA	188	156	82.97%
18	CYA demonstrate active advocacy role	188	150	79.78%
19	Train HCMC (initial estimates on HCMC size too high – target # not in proposal)	390	324	83.07%
20	Train PEL	2000	2003	100.15%

21	Organize refresher training to PEL	2000	1748	87.4%
22	PEL demonstrate active role	1200	1791	149%
23	Organize JBH activities	1000	1115	112%
24	Train VHSG	1000	970	97%
25	VHSG demonstrate active role	600	614	102%
26	Community awareness			
	1. World AIDS Day	3	3	100%
	2. Child' Right Day	3	3	100%
	3. Water festival	3	2	66.6%
	4. Candle Light Memorial Day	3	3	100%
	5. Drama performance and Video show	524	577	110%
	6. Radio program and broadcasting	400	404	101%
27	Establish youth club	500	454	90.8%

Objective 3: Improving support for YSRH programs by community advocacy efforts and research aimed at influencing YRH policy and practice.

28	Train CYA	158	156	98.73%
29	Establish PMAC at HC	39	39	100%
30	Sensitize religious leader	500	500	100%
31	Establish CYWP	8	37	463%
32	Support networks and coalitions	2	2	100%
33	Conduct research	6	4	66.66%
34	Disseminate research finding	3	3	100%

2. Make significant effect to

- Increasing RH and HIV/AIDS/STI knowledge
- Increase positive RH seeking behaviour
- Increase positive RH attitudes, beliefs and values
- Increase supportive social influences towards healthy YRH behaviours
- Increase quality of care

Table 48: A summary of the project effectiveness

N ^o	Objective	Baseline	End line
01	Increasing RH knowledge	50%	59%
02	Increasing HIV/AIDS/STI knowledge	73%	77%
03	Increase positive RH seeking behaviour	65%	74%
04	Increase positive RH attitudes, beliefs and values	44%	48%
05	Decrease in risky social influences leading to unhealthy YRH behaviours	49%	41%

6.1.2. The limitations

The limited number of project management staff at the main Kompong Thom office, seemed to be disproportionate with the project coverage plan. The project target area was divided into three intervention phases according to the length of time needed to train and support initial project activities within one phase area. Each intervention phase lasted around 9-12 months before moving to the next phase intervention area. The follow up of continuing activities in the prior phase target area then depended heavily upon volunteer CTT/CBTT commitment.

The recruitment process of providers such as PEs, religious leaders, private providers etc, designed by the project, consumed a lot of times and so delayed the provision of support or services to the beneficiaries. The recruitment processes were fully community participation involving community leaders and structures. The process though cumbersome, built community ownership, acceptance and support to its field activities.

It is a challenge to have training activities with 100% participation of target beneficiaries, especially the private health care providers. They don't see much benefit in coming to the training activities when the project does not provide any financial incentives. However, those who participated were genuinely interested in learning about Youth sexual reproductive health challenges and participated in addressing them.

PE attrition during the project life cost project time and resources to recruit and train replacements. PEs are community youth volunteers who have a passion to help their fellow youth. However, the economy pressures where the reason why youth volunteers needed to leave their volunteer work with the project. The reality is that these youth volunteers (PE) have been equipped with knowledge and skills needed to protect their Sexual reproductive health rights. The recruitment and training of new PEs may be interpreted as a project loss, but it is a gain in terms of quality youth leaders trained and ready to become agents of change wherever they go.

The Project provided a limited variety of books limited to Youth sexual reproductive health information in school libraries. Some people had addressed this as a project limitation, expecting the project to supply a larger variety of book on general information for the school libraries which is beyond the project mandate.

There was a challenge to establish Youth Friendly Health Services at Health Centres Trea and Chamna Leu of Kampong Thom province. Trea health centre has no physical structures but existed in the Ministry of Health registrations. Project limited resources can't provide physical structures for only youth friendly services. Chamna Leu health centre has only two staff and could not participate in the establishment of Youth Friendly Services.

There is a limitation to evaluate the outcome of the overall project because the impact of project activities in phase three are not as clear as the earlier phases as training was completed too recently.

6.2. Recommendations

Both ADRA and RACHA could be in the right position to use the findings from this project evaluation to advocate for further resource mobilization from other sources to continue at least for two more years. If it is a case, time is enough for the project to generate a concrete evidence base to answer clearly to the project objectives and it could be used as evidenced base to advocate for scaling up.

The MoH, MoWA and MoEYS at the national level and health department, education, youth and sport department and women's affairs department at the provincial level, should use the findings from this evaluation report to advocate for internal and external resource to sustain some key interventions relevant to their mandate. For example "Youth friendly service" for MoH; "School based program" for MoEYS and "Community based program" for MoWA.

For another option, ADRA, RACHA and government partner should integrate some project interventions into other on-going projects where funding is available. For instance, ADRA could integrate it into on-going Child Friendly Village project, RACHA could integrate it into saving for change project etc.

To better insure the project sustainability in the next project, government partners, as project owners, should be involved at all levels from the project design stage, to project implementation, project management and to project monitoring and evaluation with a clear exit strategy.

Further evaluation should be focused on cost efficiency and cost effectiveness of using peer educator while it keeps moving out and requires resource for training continuously. Learning from this project evaluation, if the school library, youth resource rooms and librarians are well equipped and updated it seems to be enough to provide RH information to youth. Therefore, two options recommended to be tested in the future project:

- Option one: the project site with peer educator
- Option two: the project site without peer educator

The school principals should look at new measures or mechanisms to encourage student to use the library during school time, the librarian book should be updated and if it is possible the library should be opened on the weekend.

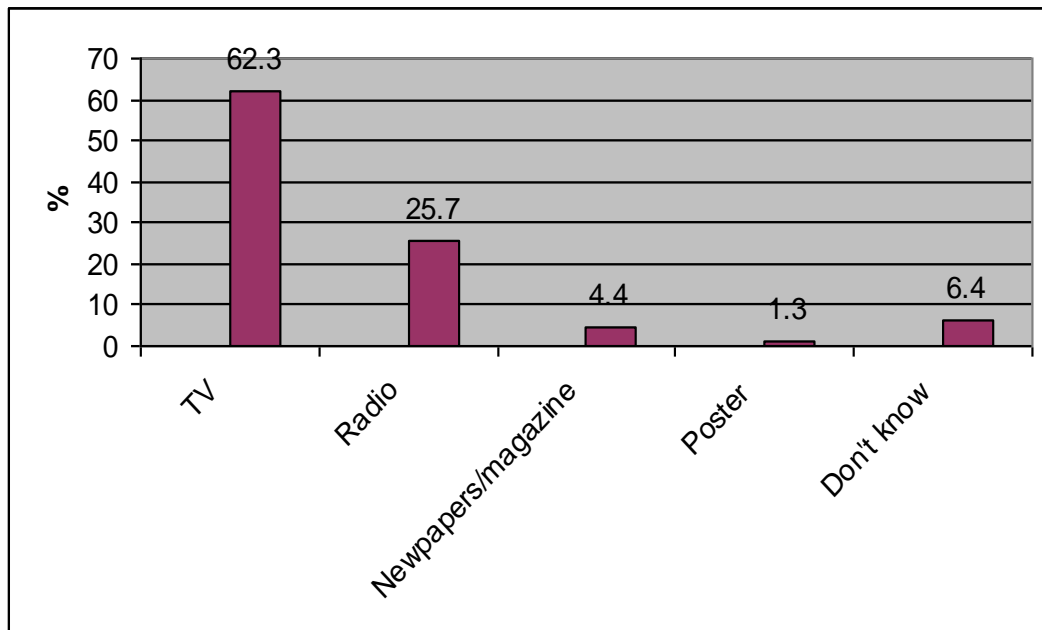
There should be a standard for project implementation that would make sense on project monitoring and evaluation for example:

- The standard policy on project management
- The guideline or SOP on project implementation etc

In general, the target population did gain the knowledge, adopted positive attitude and practiced safe behaviour but there is still some misunderstanding on specific knowledge that leads to adopt negative attitude and inappropriate practice (pharmacy is still popular among target group for seeking treatment), therefore the limitation on knowledge, attitude, behaviour and practice found through this evaluation should be used or further in-depth investigations to improve the next project on training curriculum, the IEC material, the methods of campaign etc.

BCC through media is still the most popular channel among community population to access to information therefore media production and broadcasting is the most effective way to raise RH awareness among community people.

Figure 20: The distribution of sources of information preferred by the sample



7. Annexes of the report

7.1. Reference

- 1)** The Rural Cambodian Youth Sexual Reproductive Health Project Proposal funded by EuropeAid/120804/C/G under Programme of Aid for Policies and Actions on Reproductive and Sexual Health and Rights in Developing Countries in 2006.
- 2)** The annual work plan of the RCYSRH project in 2007
- 3)** The annual work plan of the RCYSRH project in 2008
- 4)** The annual work plan of the RCYSRH project in 2009
- 5)** The quarterly RCYSRH project report in 2006
- 6)** The annual RCYSRH project report in 2007
- 7)** The annual RCYSRH project report in 2008
- 8)** The annual RCYSRH project report in 2009
- 9)** A Baseline Evaluation Report “Assessing Reproductive & Sexual Health Knowledge, Attitudes & Behaviour of Rural Youth in Preah Vihear and Kompong Thom Provinces, Kingdom of Cambodia, Stephen Nyirady, RN, MA, MSA, April 30, 2007 ADRA, Cambodia.
- 10)** “Comparative study on youth friendly health services in operational districts with contracting and non-contracting health centres in Kampong Thom and Preah Vihear provinces of Cambodia”, Jan 2009, CORD Cambodia.
- 11)** A Mid-term Evaluation Report “Assessing Reproductive & Sexual Health Knowledge, Attitudes & Behaviour of Rural Youth in Preah Vihear and Kompong Thom Provinces, Kingdom of Cambodia, August 2008, Chan Vuthy, ADRA Cambodia.
- 12)** “Health Facilities Survey Report”, Feb 5, 2008, Chan Vuthy, ADRA Cambodia
- 13)** “Community and school-based KAP and PLA qualitative studies on YSRH including socio-cultural factors and their impact on access to health information and services, antecedents to risky sexual behaviours and key motivating factors for practicing safe sexual health, and on key-localized risky behaviours, social factors and migration preparedness” Apr 2009, Loma Linda University
- 14)** A comparative study on the effectiveness of differing implementation strategies in YSRH education as demonstrated by the MoE / WE "Life-Skills for HIV / AIDS Education" project in Preah Vihear Province and similar interventions in Kompong Thom Province, Apr 2009, Loma Linda University
- 15)** “Mystery Client Survey Report”, Feb 12 to Mar 11, 2009, Chan Vuthy, ADRA Cambodia

7.2. Appendix

Appendix 1: Field visit to Kampong Thom Province

7 July, 2009	Travel to Kampong Thom
8 July, 2009	
Time	Activities
8:00 -9:30	Visit school library and focus group with peer in school
9:30-11:00	Visit health centre and interview member of health centre management team
11:00-12:00	Focus group with VHSG
12:00-13:00	Lunch break
13:00-14:00	Focus group with youth advisory committee
14:00-15:30	Focus group with community youth advocate
15:30-17:00	Focus group with peer out of school
16:30-17:30	
End of the day	
9 July, 2009	
Time	Activities
8:00 -9:30	Interview with 2 religious leaders
9:30-11:00	Interview with 2 private providers
11:00-12:30	Interview with member of community youth watch program
12:30-13:30	Lunch break
13:30-15:30	Meet with project manager
15:30-17:00	Meet with project monitoring officer
End of the day	
10 July,2009	Travel back to Phnom Penh

Appendix 2: Field visit to Preah Vihear Province

11 July, 2009	Travel to Preah Vihear province
12 July, 2009	
Time	Activities
8:00 -9:30	Interview with 2 religious leaders
9:30-11:00	Interview with 2 private providers
11:00-12:00	Focus group with VHSG
12:00-13:00	Lunch break
13:00-14:00	Focus group with youth advisory committee
14:00-15:30	Focus group with community youth advocate
15:30-17:00	Focus group with peer out of school
End of the day	
13 July, 2009	
Time	Activities
8:00 -9:30	Visit school library and focus group with peer in school
9:30-11:00	Visit health centre and interview member of health centre management team
11:00-12:30	Interview with member of community youth watch program
12:30-13:30	Lunch break
13:30-15:30	Meet with project manager
15:30-17:00	Meet with project monitoring officer
End of the day	
14 July,2009	Travel back to Phnom Penh

Appendix 3: The unstructured questionnaire for peer educators

1. Do you know about the “Rural Cambodian Youth Sexual Reproductive Health Project? What is the project for?
2. Why do you interested to be a peer educator? Why you are selected as peer educator?
3. What is your role and responsibility?
4. What do you get from the project? Do you feel that you have enough knowledge from the project to work as peer? Are you satisfied with the project?
5. Do your friends welcome your job? What is your difficulty as being peer?
6. Do you think that it is right to have youth like you to learn RH? what about the age of 10 -13 to learn RH?
7. Do you have any problem with your parents about your job as peer?
8. Do you think that you, your friend and community benefit from this project? Could you give me an example?
9. Do your friends who expose to this project apply safe reproductive behaviour or change their high-risk behaviour? How to know that?
10. Now do your friends talk or discuss openly about reproductive health?
11. Do your friends or anybody ever come to discuss with you about RH?
12. Do you have any experience to support your friend who have RH problem? Could you describe?
13. What do you see as the strength and weaknesses of the project?
14. If the project ended by the end of this year? Do you still play a role as peer educator? if yes or no could you give us reason?
15. . What is your recommendation to this project?

Appendix 4: The unstructured questionnaire for Public Health Care Providers

1. Do you know about the “Rural Cambodian Youth Sexual Reproductive Health Project? What is the project for?
2. What is your role and responsibility? What do you get from the project? Training, equipment, material to YFHS and YRR? Do you feel that you have enough knowledge to work for this project? Are you satisfied with the project?
3. What is your difficulty as providing youth friendly service?
4. So far, do you ever receive youth clients to use YFHS? What is their common problem?
5. Do you think that youth benefit from this project? Could you give me an example?
6. What do you see as difference between pre and post project?
7. Do you see the increasing number of youth using your service? Do you see the increasing number of youth using YRR?
8. What do you see as the strength and weaknesses of the project?
9. If the project ended by the end of this year? Do YFHS still function? Does youth resource room still function? if yes or no could you provide reason?
10. What is your recommendation to this project?

Appendix 5: The unstructured questionnaire for the Health Centre Management Committee

1. Do you know about the “Rural Cambodian Youth Sexual Reproductive Health Project?
2. What is the project for?
3. What is your role and responsibility in this project?
4. What do you get from the project?
5. What is the benefit that you get from this project?
6. Are you satisfied with the project?
7. What do you see as difference between pre and post project?
8. Do you think that your community benefits from this project? Could you give me an example?
9. Do you have any difficulty to work in this project or you see as barrier to this project?
10. What do you see as the strength and weaknesses of the project?
11. If the project ended by the end of this year? Do you still play a role as what you have been so far?
12. In order to improve this project, what is your comments, suggestions and recommendation to the next project?

Appendix 6: The unstructured questionnaire for Private Health Care Providers

1. Do you know about the “Rural Cambodian Youth Sexual Reproductive Health Project?”
2. What is the project for?
3. What is your role and responsibility in this project?
4. What do you get from the project?
5. What is the benefit that you get from this project?
6. Are you satisfied and confident to work with the project?
7. What do you see as difference between pre and post project?
8. Do you think that your community benefits from this project? Could you give me an example?
9. Do you ever refer youth to any services? could I see the refer slip and the record book?
10. What do you see as the strength and weaknesses of the project?
11. If the project ended by the end of this year? Do you still play a role as what you have been so far?
12. In order to improve this project, what are your comments, suggestions and recommendation to the next project?

Appendix 7: The unstructured questionnaire for the Project Manager

1. How long have you been in the project?
2. Could you brief me a little bit about the project?
3. Could you brief me about the project management?
4. Could you brief me about the project implementation?
5. Could you brief me about the project monitoring and evaluation?
6. What do you see as strength and weakness of the project?
7. What do you see as the achievements of the project?
8. What do you see as the success of this project?
9. What is about the project partnership?
10. What is about the project coordination?
11. What is about the financial management?
12. What do you think about the sustainability issue? What do you see as difference between pre and post project? What is your recommendation to this project?

Appendix 8: The unstructured questionnaire for Community Youth Advocates

1. Do you know about the “Rural Cambodian Youth Sexual Reproductive Health Project?”
2. What is the project for?
3. What do you get from the project?
4. Do you feel that you have enough knowledge from the project to work as peer?
5. When have you been in this project?
6. What do you do in this project?
7. What is your difficulty as being youth advocate?
8. What is the benefit that you get from this project?
9. Are you satisfied with the project?
10. What do you see as difference between pre and post project?
11. Do you think that your friends benefit from this project? Could you give me an example?
12. What do you see as the strength and weaknesses of the project?
13. If the project ended by the end of this year? Do you still play a role as RH provider? What do want to recommend to the next project?

Appendix 9: The unstructured questionnaire for the Community Youth Watch Program

1. What is the community youth watch program? Could you brief me a little bit?
2. What is your role in this program?
3. What do you get from this project?
4. What is the main achievement so far in this project?
5. What is the strength and weakness of the project?
6. What do you see as best practice from this project?
7. What do you think about the sustainability issue?
8. Do you think that the project gain support from all stakeholders in different level?
9. What do you see as difference between pre and post project?
10. If the project ended by the end of this year? Do you still play a role as RH provider? What do want to recommend to the next project?

Appendix 10: The unstructured questionnaire for Religious Leaders

1. Do you know about the “Rural Cambodian Youth Sexual Reproductive Health Project?”
2. What is the project for?
3. What is your role and responsibility in this project?
4. What do you get from the project?
5. Do you feel that you have enough knowledge, skill and experience to work as RL in this project?
14. What is your main difficulty as working in this project?
15. Why you participate and support that project?
16. What is the benefit that you get from this project?
17. Are you satisfied with the project?
18. What is the main achievement so far in this project?
19. What is the strength and weakness of the project?
20. What do you see as lesson learns from this project?
21. What do you think about the sustainability issue?
22. Do you think that it is good to have youth aged 10-15 leaning RH? Do you think that it is too young for 10-15 years old?
23. What do you see as difference between pre and post project?
24. If the project ended by the end of this year? Do you still play a role as advocator for YSRH? if yes or no, could you provide reason?
25. What is your recommendation to this project?

Appendix 11: The unstructured questionnaire for the Project MEL Officer

1. What is your role and responsibility in this project?
2. What is the system and data collecting format that you use for monitoring?
3. What is method used for evaluation?
4. What kind of training provided?
5. How is the report developed and disseminated?
6. What is the strength and weakness of the project MEL?
7. What is the strength and weakness of this whole project?
8. What was research topic conducted in this project?
9. How is the research finding disseminated?
10. Based on your judgment how is about the project achievements?
11. Based on your judgments how is about the project effectiveness?
12. Are you satisfied with the project?
13. What do you see as lesson learns from this project?
14. What do you think about the sustainability issue?
15. Do you think that the project gain support from all stakeholders in different level?
16. What do you see as difference between pre and post project?
17. What is your recommendation to this project?