EVALUATION REPORT
APRIL 2018

EVALUATION OF THE CARD AND UNICEF CASH TRANSFER PILOT PROJECT FOR PREGNANT WOMEN AND CHILDREN IN CAMBODIA

Final Report – Volume I
September 2017 – March 2018
Cambodia
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The evaluation of the CARD and UNICEF Cash Transfer Pilot Project for Pregnant Women and Children in Cambodia was prepared by Ashish Mukherjee and Kriti Gupta on behalf of IPE Global Limited with contribution from Dr. Chey Tech, Dynamic Alliance Consulting (DAC) Group Co., Ltd, Cambodia. The evaluation was jointly commissioned by the Council for Agricultural and Rural Development and UNICEF Cambodia and managed by the evaluation management team comprising Erica Mattellone, Evaluation Specialist (UNICEF Cambodia); Phaloeuk Kong, M&E Officer (UNICEF Cambodia); Kimsong Chea, Social Policy Specialist (UNICEF Cambodia) and Sambo Pheakdey, Chief of Pension Department (Ministry of Economy and Finance), assisted by Cody Minnick, Evaluation Intern (UNICEF Cambodia) and Elizabeth Fisher, Evaluation Intern (UNICEF Cambodia).

It was supported by Reference Group members H.E. Sann Vathana, Deputy Secretary General (Council for Agricultural and Rural Development); Maki Kato, Chief of Social Inclusion and Governance (UNICEF Cambodia); Sophannha Chhour, Director of Social Welfare Department (Ministry of Social Affairs, Veterans, and Youth Rehabilitation); Betina Ramirez Lopez, Social Protection Technical Officer (International Labor Organization (ILO) Cambodia); Jillian Popkins, Chief of Social Policy (UNICEF China); Rim Nour, Consultant (UNICEF Regional Office for East Asia and the Pacific (EAPRO)) and Som Sophorn, Chief of Zone Office (UNICEF Siem Reap Zone Office). Further, the Regional Evaluation Adviser, Riccardo Polastro, (UNICEF EAPRO), and Evaluation Officer, Hiroaki Yagami (UNICEF EAPRO) provided guidance and oversight throughout.

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| **Title:** | EVALUATION REPORT FOR THE EVALUATION OF THE CARD AND UNICEF CASH TRANSFER PILOT PROJECT FOR PREGNANT WOMEN AND CHILDREN IN CAMBODIA |
| **Geographic Region of the Pilot:** | Prasat Bakong District, Siem Reap Province, Cambodia |
| **Timeline of the Evaluation:** | September 2017 – March 2018 |
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| **Name of the Organization Commissioning the Evaluation:** | The Council for Agricultural and Rural Development (CARD) and United Nations Children’s Fund (UNICEF) in Cambodia |
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We would like to thank UNICEF Cambodia for providing the opportunity to IPE Global Limited, in partnership with DAC Group Co. Limited, to conduct this evaluation. This evaluation would not have been possible without the guidance of the evaluation management team comprising of Erica Mattellone, Evaluation Specialist (UNICEF Cambodia), Phaloeuk Kong, M&E Officer (UNICEF Cambodia), Kimsong Chea, Social Policy Specialist (UNICEF Cambodia) and Sambo Pheakdey, Chief of Pension Department (Ministry of Economy and Finance). Their involvement throughout the evaluation life-cycle, along with the support provided while coordinating with different stakeholders, helped in effectively capturing in-depth insights. We would also like to thank Maki Kato, Chief of Social Inclusion and Governance (UNICEF Cambodia) for providing feedback at various points during the engagement life-cycle. This helped in enriching the evaluation. We would also like to acknowledge the support of Som Sophorn, Chief of Zone Office (UNICEF Siem Reap Zone Office).

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Most importantly, the evaluation team would like to thank the mothers and the people of Prasat Bakong district for their dedicated and spontaneous participation in the data collection process, including response to survey questions, participation in focus group discussions and key informant interviews, and overall hospitality to the enumerators.
EXECUTIVE SUMMARY

The Council for Agricultural and Rural Development (CARD) and the United Nations Children’s Fund (UNICEF) Cash Transfer Pilot Project for Pregnant Women and Children in Cambodia was designed in 2013, targeting pregnant women and children under-five living in poverty. The pilot, implemented in Prasat Bakong district in Siem Reap province, aimed to remove financial bottlenecks for poor families to access services and nutritious diets and to stimulate demand for basic health and nutrition services. It was implemented within the existing government structure (sub-national administrations), without the creation of any external implementation body, to test the viability of delivering cash transfers using government systems.

The target beneficiaries were provided cash transfers along with education sessions on topics of maternal health, child health and nutrition once every two months. Each eligible woman and child was entitled to receive a basic transfer of US$ 5\(^1\) per month unconditionally upon enrolment along with bonus transfers totalling to a maximum amount of US$ 90 per year. The bonus payment was linked to fulfilment of conditions related to health seeking behaviors, namely pre-natal check-ups, institutional delivery and post-natal check-ups, attending growth monitoring sessions, obtaining recommended vaccinations for children under five and attending health and nutrition education sessions.

During the project period, from May 2016 to November 2017, a total of 1,298 beneficiaries received the cash transfer, which included 59 pregnant women and 1,239 children. There was an average of 1.1 to 1.2 children per household participating in the pilot and the coverage was around half of the total poor households in the district.

Evaluation Purpose, Objectives and Intended Users: In September 2017, UNICEF Cambodia, on behalf of CARD, contracted IPE Global Limited in partnership with DAC Group Co. Ltd. to undertake an independent, formative and learning-oriented evaluation of the CARD-UNICEF cash transfer pilot project. The objective of the evaluation was to identify good practices and draw lessons from the cash transfer pilot project regarding overall relevance, effectiveness, efficiency, sustainability and equity of the design and implementation of the project. Impact as a criterion was excluded given that this evaluation was not an impact or summative evaluation as the project was on-going during the time of data collection. The evaluation was also aimed at informing the scale-up of this project and the design of the national cash transfer programme for countrywide roll-out led by the Royal Government of Cambodia (RGC) as planned under the National Social Protection Policy Framework 2016-2025. The primary users of the evaluation will be agencies and government bodies who are involved in the design and implementation of the national cash transfer programme.

Evaluation Methodology: A mixed methods approach was followed – combining quantitative and qualitative primary data collection (a beneficiary survey, key informant interviews and focus group discussions) along with secondary review of key project documents. An important methodological aspect of this evaluation was its participatory and learning-oriented nature, involving stakeholders in the design and development of the evaluation process, both at national (government ministries) and sub-national levels (district administrations, commune councils, village chiefs, Health Centres) along with implementing partners (CARD and UNICEF). The evaluation design incorporated a clear equity gender and human rights perspective.\(^2\) A purposive sampling was undertaken to select 23 villages in Prasat Bakong district, with representation from all eight communes. Random sampling of beneficiaries was undertaken to reduce bias on information obtained from within the target areas. A sample of 240 households was reached to gather information. Beneficiaries, husbands of beneficiaries, heads of households, and non-beneficiaries were interviewed at the household level. A total of 343 people were interviewed in survey interviews and KIIs at the national, district, commune

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1 US$ 1 is equal to approximately 4000 Riels.
2 The evaluation team was driven and guided by United Nations Evaluation Group’s (UNEG) ethical considerations and the evaluation guidelines.
and household level (52 males and 291 females) and 51 people were part of the focus group discussions (17 males and 34 females).

**Main Evaluation Findings and Conclusions:** The evaluation team arrived at findings and conclusions organised against the Organization for Economic Co-operation and Development’s Development Assistance Committee (OECD/DAC) criteria of relevance, effectiveness, efficiency and sustainability. In addition to these, equity, gender and human rights considerations were a key part of the evaluation. A summary of the findings and conclusions has been presented below.

**Relevance:** The CARD and UNICEF cash transfer pilot project was found to be relevant to Cambodia’s context with regard to the nutrition and health status of pregnant women and children under the age of five. Compliance of co-responsibilities was difficult to monitor, and no direct evidence was found to support their usefulness. The choice to receive cash rather than in-kind assistance was preferred by beneficiaries and implementers. The pilot relied on the Government’s identification of poor households’ programme (IDPoor) for targeting. Accordingly, one of the requirements for receiving cash transfer by the eligible beneficiaries was having an IDPoor card. Due to the limitations of the IDPoor system, the identification of beneficiaries under the cash transfer pilot suffered some gaps and led to the exclusion of the migratory population and other vulnerable groups who do not have access to IDPoor cards. Despite initial delays due to lack of documentation, the beneficiary enrolment mechanisms were smooth and regular.

Analysis of the survey data reveals that most beneficiaries used the cash transfer to purchase food, and the project induced health seeking behaviour and improved knowledge on nutrition. Implementation of the project without the creation of any external implementation body, but using existing government structures (district and commune administrations) was also successful with limitations in monitoring conditionalities and in complaint-handling mechanisms. It was observed that areas such as monitoring and evaluation and teaching participatory communication techniques to health workers providing education sessions could be strengthened. Beneficiaries appreciated the frequency of the cash transfers and felt that the cash transfer amount helped address their immediate needs. They, however, felt that the cash transfer amount was inadequate to address all their nutritional requirements.

**Effectiveness:** The beneficiaries and sub-national staff found the cash transfer project to be effective in increasing utilization of some health services, such as growth monitoring and consumption of more nutritious and diverse food. Most beneficiaries claimed to use the cash transfer money on food, especially cereals and fish. Improved knowledge on health and nutrition, sanitation and child care was reported. Regarding negative impacts, no evidence of cash usage on adverse items like alcohol or tobacco was found. A significant portion of the success of the cash transfer pilot could perhaps be attributed to the health and nutrition education sessions, which were appreciated by everyone. For these sessions to be more effective, respondents suggested use of more participatory methods, pictorial material and provision of refreshments. Having these sessions on the same day as the payment day was appreciated by the beneficiaries.

Greater effectiveness is needed in information dissemination through formal channels such as posters, pamphlets and campaigns. In some cases, the training of sub-national staff could not be easily understood, as it adopted limited participatory techniques. Another area for improvement, which can alter the effectiveness of the project, is timely delivery of the bonus transfers. During the pilot project, the majority of the bonus payments were done in a lump-sum during the last payment rather than being staggered across cycles. Evidence from other cash transfer programmes reveal that large payments that are not staggered are less likely to be used for daily nutrition expenses. Grievance redress processes and monitoring were two areas where effective implementation was deficient. There was no reporting of formal complaints being filed and only verbal complaints were stated. Similarly, detailed monitoring and results frameworks were not developed during the design of the project. A need to strengthen the management information systems and monitoring mechanisms was felt across stakeholders.
**Efficiency:** Use of the existing government structure instead of depending on externally-financed and expensive project staff helped improve cost-efficiency of the project. Timely delivery of basic payments to all beneficiaries was also one of the key successes of the cash transfer pilot. The use of an independent microfinance institution, AMK Microfinance, helped facilitate cash transfers in a seamless manner. The use of point of sale (POS) machines at the pay points, which require internet connectivity, increased the time taken to receive cash in some instances, thereby reducing efficiency of the process. Other challenges identified included infrastructural challenges like poor public transportation, lack of rural banking facilities, erratic internet connectivity and limited telecommunication networks. There was a lack of formal methods to raise awareness regarding the cash transfer project. Better designed case management, monitoring framework and management information systems were also sought by those involved in managing the pilot.

**Sustainability:** The pilot was useful for identifying gaps and bottlenecks and preparing a roadmap to tackle the shortcomings to have a better designed national cash transfer programme. Gaps identified in this pilot can be rectified and mostly require one-time expenses, which would be efficient in a larger project. The reliance on government structures added to its sustainability. However, there are constraints regarding commune administrations’ capacity to deliver the cash transfer, as well as IT and telecommunication infrastructure, which are critical for project sustainability. Other aspects, which should have been considered to enhance sustainability of gains include inflation, climate change and disaster resilience, and dietary shifts. Further, the stakeholder consultations revealed that coordination with various bodies, including government departments, such as Ministry of Planning (MoP), Ministry of Economy and Finance (MEF), Ministry of Health (MoH) and Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY); information system developers; local banks or other financial institutions, is imperative for successful and sustainable design and implementation of such projects.

**Equity, gender equality and human rights:** The cash transfer project mandated that mothers and female guardians be the bank account holders. Some initial bank accounts were opened in the name of the male head of household due to lack of clarity among the implementers. However, later on all accounts were opened in the name of the female guardian or mother. It was stated by almost all beneficiaries that women predominantly decided the use of the cash transfer money. The message that husbands also need to be equally involved was not observed among the respondents. It was noted that men rarely accompanied women to the health and education sessions and considered these lessons only for the women to help them take care of the house and children. No negative social effects were observed. Most non-beneficiaries understood and accepted the reason for their non-inclusion in the project and no resentment was expressed. The project was reported to be equitable with no instances of discrimination, with respect to access to cash transfers and opportunity of participation in health and education sessions amongst beneficiaries. Yet, exclusion of migratory populations and vulnerable groups such as orphans was seen.

**Lessons Learnt:** Preparedness is fundamental to ensure effective delivery of cash transfers such as confirming beneficiaries have all relevant documents and that telecommunication and banking networks are functional to minimise delays. It is further essential to establish and monitor coordination mechanisms with a number of bodies, including government departments, information system developers and financial institutions. Cash transfers also need to be supported with behavior change interventions to help meet project objectives and influence usage of cash. Moreover, ensuring regularity of cash transfers is a key requirement to build trust and for the cash to be used in the intended manner. In this regard, use of external payment agencies speed up the delivery of cash without leakages.

It was further learnt that compensation of staff for additional work including reimbursement of transport costs, especially if this is to become a full-scale project, can motivate staff to perform better. Further, supply side constraints need to be tackled along with demand side interventions such as ensuring presence of adequate staff at the health centers with essential equipment on a daily basis. Finally, the policy framework should be well defined and the policy processes and institutional contexts within
which cash transfer programmes are embedded, are critical factors that affect the likelihood of success or failure in the long-term.

Main Recommendations: The evaluation team, based on the findings, conclusions and lessons learnt, arrived at recommendations for the next phase of the cash transfer project. Inputs and feedback from stakeholders were sought at multiple stages and during several forums. The following recommendations are presented in order of priority based on the evaluators’ assessment and stakeholders’ opinions of the importance and timeliness of actions.

1. Reassess the size of cash transfer: A number of beneficiaries reported that the cash transfer amount is inadequate to meet their nutrition requirements. Accordingly, the size of transfer may be reassessed. In the longer run, benefit levels may need to be adjusted for inflation at periodic intervals.
   
   **Actors:** UNICEF, MEF, MoSVY
   **Timeline:** Design phase of the national programme

2. Trim co-responsibilities: The set of co-responsibilities for bonus payments must be reviewed and trimmed to ensure effective monitoring and cost-efficiency. It is recommended that conditions be limited only to attendance at health and nutrition education sessions.
   
   **Actors:** UNICEF, MoSVY, MOH
   **Timeline:** Design phase of the national programme

3. Create an inclusive targeting mechanism: The harmonized approach of using IDPoor may be continued; nevertheless, programme specific targeting mechanisms are required. This will help include all eligible vulnerable groups not covered under IDPoor, and enhance community engagement in selection of beneficiaries to reduce exclusion errors. Community-based targeting, in which the community collectively selects households they consider most in need of the transfers, may be an effective mechanism to identify migratory populations, orphans, etc.
   
   **Actors:** UNICEF, MoP, MoSVY
   **Timeline:** Design phase of the national programme

4. Adopt a phased approach to scale up: Considering human and fiscal capacity constraints, a phased approach is recommended for the roll-out of the national cash transfer programme. Identification of provinces/districts for scale-up can be based on poverty level; level of under-nutrition and utilization of health service; and infrastructure and human resource capability.
   
   **Actors:** UNICEF and implementing ministry
   **Timeline:** Design phase of the national programme

5. Establish a robust management information system (MIS) and develop appropriate monitoring and evaluation framework: A comprehensive and robust MIS, which captures the entire life-cycle of the beneficiary in the project is recommended. Physical forms should, in a phased manner, be replaced with information systems for registration, enrolment and payment, compliance with co-responsibility, case management and exit processes. A monitoring framework must be developed with clear indicators, frequency of updates, source of information, data validation methods, etc. Further, it is recommended to have a detailed evaluation plan outlining the timeline and objectives for baseline and periodic assessments to assess the impact of the cash transfers.
   
   **Actors:** UNICEF and implementing ministry
   **Timeline:** Design phase of the national programme

6. Roles and responsibilities of stakeholders along with capacity requirements: Roles and responsibilities of national and sub-national staff need to be re-assessed and re-assigned. Moreover, capacities need to be enhanced to improve cash transfer operations, particularly for commune council members, given the extent of their involvement in the project.
   
   **Actors:** MoH, UNICEF, implementing ministry, commune council members
   **Timeline:** Design phase of the national programme
7. **Undertake preparatory activities:** Awareness campaigns and camps for birth registration, provision of child vaccination card, etc. can be started before the start of the enrolment process. The registration point should be located reasonably close to the communities served, for which guidelines may be circulated to sub-national implementing actors.

**Actors:** MoI, MoH, implementing ministry  
**Timeline:** Pre-implementation phase of the national programme

8. **Design a grievance redress mechanism:** For national level roll-out of the cash transfer, a clear redress mechanism needs to be present that takes into account literacy levels of the beneficiaries.

**Actors:** UNICEF and implementing ministry  
**Timeline:** Design phase of the national programme
ABBREVIATIONS AND ACRONYMS

ANC  ante-natal check-up
AMK  AMK Microfinance Institution Plc
BCG  Bacillus Calmette–Guérin
BLT  Bantuan Langsung Tunai
CARD  Council for Agricultural and Rural Development
CBLS  community-based learning sessions
CBT  community-based targeting
CC  commune council
CCT  conditional cash transfer
CDHS  Cambodia Demographic and Health Survey
CSG  Child Support Grant
CSO  civil society organization
CT  cash transfer
CTR  cost-to-transfer ratios
DFID  Department for International Development
EAPRO  Regional Office for East Asia and the Pacific
FGD  focus group discussion
HACT  harmonized approach to cash transfer
HC  Health Centre
HEF  health equity fund
HEFI  health equity fund implementers
HEFO  health equity fund operators
IDPoor  identification of poor households programme
ILO  International Labour Organization
IP3  3-year Implementation Plan
IT  information technology
KII  key informant interview
MEF  Ministry of Economy and Finance
M&E  monitoring and evaluation
MIS  management information system
MoEYS  Ministry of Education, Youth and Sport
MoH  Ministry of Health
MoP  Ministry of Planning
MoSVY  Ministry of Social Affairs, Veteran and Youth Rehabilitation
MMR  Measles, Mumps, and Rubella
NCDD-S  National Committee for Sub-National Democratic Development Secretariat
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NGO  non-governmental organization
NSPPF  National Social Protection Policy Framework
NSPS  National Social Protection Strategy for the Poor and Vulnerable
OECD/DAC  Organisation for Economic Co-operation and Development / Development Assistance Committee
PIN  personal identification number
PMT  Proxy Means Test
PNC  prenatal care
POS  point of sale
PKH  Program Keluarga Harapan
RACHA  Reproductive and Child Health Alliance
RGC  Royal Government of Cambodia
SNDD  Sub-National Democratic Development
SPCU  Social Protection Coordination Unit
TCTR  total cost-transfer ratio
ToC  theory of change
ToR  terms of reference
UNDP  United Nations Development Programme
UNEG  United Nations Evaluations Group
UNICEF  United Nations Children’s Fund
US$  United States Dollar
VHSG  village health support group
WASH  water, sanitation and hygiene
WFP  World Food Programme
WHO  World Health Organization
The colors highlighting the provinces and project district have however been changed.
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1. INTRODUCTION

In September 2017, the United Nations Children’s Fund (UNICEF) Cambodia, on behalf of the Council for Agriculture and Rural Development (CARD), contracted IPE Global Limited in partnership with DAC Group Co. Ltd. to undertake an independent, formative and learning-oriented evaluation of the CARD-UNICEF Cash Transfer Pilot Project.

This evaluation was managed by an evaluation management team comprising UNICEF and Ministry of Economy and Finance (MEF) with technical support provided by a reference group consisting of members from CARD, Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY), UNICEF Cambodia, UNICEF China, UNICEF Regional Office for East Asia and the Pacific (EAPRO), UNICEF Siem Reap Zone Office, and International Labour Organization (ILO) Cambodia.

The evaluation focused on identifying good practices and lessons learnt from the CARD-UNICEF cash transfer pilot project regarding overall relevance, efficiency, effectiveness, sustainability and equity of the design and implementation of the project. This was with an aim to inform the design of the national cash transfer programme for nationwide roll-out led by the Royal Government of Cambodia (RGC). The terms of reference (ToR) for the evaluation are provided in Annex 1.

This report presents the findings from the evaluation and consists of seven sections. It is structured as follows: Section 1 is the introduction. Section 2 outlines the background and provides the context on the need for the cash transfer pilot. It also includes the objective of the evaluation detailing the fundamental information of the pilot including its national, economic and social contexts. Section 3 provides the evaluation purpose, objectives and scope along with information on limitations of the evaluation. Section 4 presents the evaluation approach and methodology, as well as an overview of the quantitative and qualitative methods applied, techniques used during data collection and processing, and the analytical framework along with details of key stakeholders. Section 5 details the findings from the study based on the key evaluation questions and are arranged under each of the OECD/DAC evaluation criteria, namely relevance, efficiency, effectiveness and sustainability. This is followed by findings from equity, gender and human rights considerations that have been included as additional criteria. Section 6 reflects the lessons learnt and conclusions based on the findings. These have been substantiated by evidence and provide insights into the objectives of the evaluation. Section 7 provides the recommendations that are feasible, relevant to the objective of the evaluation and actionable by specific entities.

2. BACKGROUND

Social protection emerged as a priority for the RGC with the endorsement of the National Social Protection Strategy (NSPS) 2011-2015 in December 2011. CARD, supported by UNICEF, designed a pilot cash transfer project in 2013, targeting pregnant women and children under the age of five living in poverty, with the aim to improve utilization of basic health and nutrition services and to improve their dietary intake for reduction of chronic malnutrition. The pilot was implemented in Prasat Bakong district in Siem Reap province. The first cash delivery started in May 2016 and the last was paid in November 2017.

In March 2017, a new national social protection policy framework was endorsed by the RGC. UNICEF played a key role in supporting CARD and Ministry of Economy and Finance (MEF) to formulate a new social protection policy framework, especially the social assistance chapter, within which cash transfers for pregnant women and children under the age of five was identified as a priority.
2.1. Context

Cambodia has experienced robust economic growth averaging more than 7 per cent since 2011.\(^1\) However, the 2015 poverty data shows that around 13.5 per cent of Cambodians are still living below the poverty line.\(^2\) Additional details of poverty estimates and intra-rural income inequality for Cambodia are provided in Annex 2. Furthermore, nutrition poses a challenge for current and future human development in the country. Stunting is an indication of chronic under-nutrition in children, particularly among children under five. While stunting in this age group (based on 2006 WHO Child Growth Standards) has seen a steady decline in Cambodia, it still remains high at 32 per cent as per 2014 data. It is inequitably distributed in rural and urban areas of Cambodia – 43 per cent in rural areas and 24 per cent in urban areas (see Figure 1). Conversely, wasting, a sign of acute malnutrition has marginally increased from 8 per cent to 10 per cent between 2005 and 2010.\(^3\)

Anaemia was found in 43 per cent of women and 53 per cent of children. Further, 17.8 per cent of the women had low concentrations of folic acid (<10 nmol/L). In children, the prevalence of iron, vitamin A, vitamin B12 or folic acid deficiency was less than 10 per cent.\(^4\)

The intervention province, Siem Reap, as per the 2014 Cambodia Demographic and Health Survey (CDHS) data, had 36 per cent of children under five who are stunted as compared to the national average (32 per cent). 10 per cent of children under the age of five experience wasting in the provinces (same as national average). According to the same data, under-five mortality in Siem Reap stands at 56 per 1,000 live births, whereas the national average for the same is 35 per 1,000 live births.

The health and nutrition indicators for the entirety of Cambodia, as well as for specific provinces are given in Annex 3. The selected provinces for profiling include the ones in which cash transfer projects have been undertaken by UNICEF, Save the Children and World Bank – Siem Reap, Pursat, Battambang and Banteay Meanchey. A snapshot of the identification of poor households programme (IDPoor) Data has also been provided in Annex 4 for the above-mentioned provinces.

The CDHS data on Cambodia has been disaggregated by gender and age for two key parameters – stunting and wasting (Annex 4). The baseline study conducted by Indochina Research Limited\(^5\) brought forward interesting insights about the health and nutrition situation in the intervention district, Prasat Bakong of Siem Reap province. It interviewed 268 respondents in the district, comprising poor women and children identified by IDPoor. The results indicated that 98 per cent of the households were enrolled in the Health Equity Fund (HEF)\(^6\). Despite this, only a few received compensation for transportation costs. Of the total households, 50 per cent had borrowed money to

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\(^1\) National Institute of Statistics (NIS) - Ministry of Planning, Royal Government of Cambodia.
\(^2\) UNDP Cambodia Country Profile http://www.kh.undp.org/content/cambodia/en/home/countryinfo.html
\(^3\) Cambodia Demographic and Health Survey (CDHS), 2014.
\(^6\) HEF is a funding mechanism that gives vulnerable populations access to health services. Identified poor patients receive reimbursement for transport and food costs and free care at government health facilities. Facilities are reimbursed monthly by the HEF scheme for foregone user fees. HEF is divided into 4 main group schemes – Group 1 consists of National Hospitals and Group 2 consists of Operation District Offices, whose funding source is the National Budget Prakas #809; Group 3 is MoH funded plus contracted HEF Implementers (HEFI) where funding is from non-pooled funding from at least one donor via MoH; while Group 4 is Other HEF’s, either HEFIs or HEF Operators (HEFO) where funding is not via MoH.
cover the cost of healthcare of children in the 24 months preceding the survey (September 2013 – September 2015). The average amount borrowed was US$ 218.02. Furthermore, 34 per cent of the total households had to borrow to cover the cost of delivery care in the same period.

2.2. Social protection in Cambodia

In Cambodia, social protection has gained renewed vigour since the release of NSPS in 2011, which has been continued in the National Social Protection Policy Framework (NSPPPF) for 2016-2025. Social assistance programmes in Cambodia include emergency responses, human development, social welfare and vocational training.

The cash transfer programmes being implemented in Cambodia include the following:

- Cash transfer for pregnant women and children (donor funded);
- Scholarships for primary school, lower secondary school and upper secondary school (Government funded); and
- Disability allowance programme for poor persons with disability (Government funded).

Cash transfers are increasingly being used by governments across the globe to help poor and vulnerable families break out of intergenerational poverty and food insecurity. Globally, it has been observed that even a small amount of cash made available to poor families on a predictable, regular basis allows families to invest in better health and education for children and nutritional outcomes for women. Descriptions and impacts of six conditional cash transfer programmes – the National Committee for Sub-National Democratic Development Secretariat (NCDD-S) World Bank Funded Cash Transfer Project in Cambodia, Save the Children’s Nourish Project in Cambodia, Shombhob Pilot Cash Transfer Project in Bangladesh, Pantawid in the Philippines, Prospera in Mexico and Programme Keluarga Harapan (PKH) in Indonesia are provided in Annex 5 along with two unconditional cash transfer programmes – Bantuan Langsung Tunai (BLT), Indonesia and South Africa Child Support Grant (CSG) to provide instances of success stories in cash transfer programmes.

When thinking of using cash transfer programmes for gender equity and empowerment, it is essential to consider that the decline in household income poverty rates do not necessarily translate into improved well-being of women and girls unless resources are shared equally within the household. Evidence of high malnutrition and anaemia among women and a high incidence of domestic violence indicate a need to improve the position of women and their access to resources.

IDPoor data is the main targeting tool used for several social protection programmes in Cambodia. IDPoor is compiled using two combined approaches: proxy means test and community-based targeting using participatory elements. It categorizes households as poor category 1 (very poor), poor category 2 (poor), or not poor. A village representative group is established to conduct interviews in different villages. Their local knowledge helps verify whether respondents accurately report their situation.

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and they are also able to assess any special circumstances during these interviews. The first draft list of poor households is publicly displayed in the village, giving people the opportunity to raise grievances. After the list is final, IDPoor identification cards, which include a family photograph, are issued per household to all poor households. The map in Figure 2 provides the percentage of poor households (level 1 and 2) by province.9

2.3. Cash transfer projects in Cambodia

Apart from the CARD-UNICEF pilot implemented in Prasat Bakong district, another project – the **NCDD-S World Bank Funded Cash Transfer Project** was piloted in Srey Snam (Siem Reap province) and Phnom Srok (Banteay Meanchey province) from February 2015 to May 2016. The project aimed to help increase the utilization of essential health services by pregnant women and children (0 to 5 years of age) and enhance the readiness of delivery mechanisms of the social protection system. The project consisted of three components: supporting the NSPS, undertaking conditional cash transfer, and strengthening social protection implementation systems. The project deployed externally-funded personnel and hired a non-governmental organization (NGO), Reproductive and Child Health Alliance (RACHA), to deliver community-based learning sessions (CBLS) to beneficiaries. NCDD-S acted as the implementing agency and provided national level management and leadership to support sub-national implementation. The social protection coordination unit (SPCU) of CARD oversaw policy coordination and coordination with other line ministries. AMK Microfinance was contracted to make the payments to beneficiaries.

To effectively enhance readiness of the social protection system, the programme was designed to develop and test effective systems and processes for beneficiary identification, enrolment, verification and payment, case management, and monitoring and evaluation. It also aimed to strengthen linkages with existing social services through increased coordination with the Ministry of Health’s (MoH) initiatives (such as Health Equity Funds that aim to promote equitable access to health services by the poor through reimbursements for treatment costs at health facilities).

**Save the Children’s ‘Nourish’ Programme** is another cash transfer initiative that is being implemented in Pursat, Battambang and Siem Reap provinces. The objective of the programme is to reduce preventable maternal and newborn deaths, apply key Government policies and improve the nutritional status and well-being of pregnant women and children under the age of two. The programme uses an integrated cross-sectoral approach, bringing together health; nutrition; water, sanitation and hygiene (WASH); and agriculture interventions.

The programme aims to create demand for the improved use of services, practices, and products. The project has set up a conditional cash transfer (CCT) initiative for poor, food-insecure households known as ‘first 1,000 days’, to incentivize the timely use of health and nutrition services. Under the initiative, eligible women can receive up to six payments to reach a total of US$ 65 over a period of 1,000 days. ‘First 1,000 days Village Fairs’ are also organized wherein various activities are undertaken, like making fish powder from small rice-field fish, building a hand washing device, and setting up a nutrient-rich micro-garden at home.

2.4. CARD and UNICEF cash transfer pilot project

CARD, supported by UNICEF, designed a cash transfer project in 2013, targeting pregnant women and children under the age of five living in poverty despite having the two aforementioned pilots already in place. UNICEF’s purpose for supporting the implementation of this project was based on the understanding that it was designed to be implemented through the existing government structure without deploying any other external human resources, unlike the other cash transfer pilots. This provided an opportunity to assess institutional capacity of the Government for implementing similar social protection projects in the country. The target population of this pilot was identical to the World

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Bank pilot. The project was implemented in Prasat Bakong district in Siem Reap province and distributed small monetary amounts to pregnant women and children under five, living in poverty, along with providing education sessions on health care and nutrition. During the project period (May 2016 to November 2017), a total of 1,298 beneficiaries\(^{10}\) which included 59 pregnant women and 1,239 children, received total cash transfers ranging from US$ 10\(^{11}\) to US$ 115 in the 18-month period, depending on when they were enrolled under the pilot and compliance to the co-responsibilities. A total amount of US$ 109,344 was disbursed to these beneficiaries over 9 payments during this period, with each payment delivery having an average duration of 9 days. The total cost of the cash transfer pilot is approximately US$ 189,589.

While CARD functioned as the implementing agency for the pilot, UNICEF provided financial assistance, supported in coordinating with relevant ministries, and provided technical support to CARD in designing, rolling-out and implementing the pilot, including training of commune council members on conducting the health and education sessions.

**Objectives of the cash transfer pilot**

The overall objective of implementing the cash transfer pilot was to assess the design and implementation of a cash transfer project aiming to encourage the use of basic health and nutrition services by poor pregnant women and children, as well as to lay the foundations for the development of institutional capacities for the implementation of social protection programmes in Cambodia.

The specific objectives of the pilot are defined at three levels:

A. **At the household level**: To increase utilization of basic health and nutrition services by poor pregnant women and young children.

B. **At the institutional level**: (i) To test institutional capacity of central and local authorities for implementation and coordination of social protection programmes and to oversee community-level supply-side services, in line with the legislative framework for Sub-National Democratic Development (SNDD) and the current 3-year Implementation Plan (IP3); (ii) To identify good practices and challenges in implementing such projects through the existing government structure without the creation of any external implementation body, but using existing government structures.

C. **At the operational level**: (i) To develop the overall design of the operations cycle and test the effectiveness of the proposed mechanisms for beneficiary enrolment, case management, community participation, benefit payments, and monitoring and evaluation; (ii) To test the linkages with complementary supply-side activities such as learning sessions, Health Centre services and possibly later, other related social protection services.

**Theory of change for the cash transfer**

The conceptual framework for child nutrition *(see Figure 3)* identifies household food security, care, and a healthy environment as the underlying determinants that influence the immediate determinants of children’s nutritional intake and health status.\(^ {12}\) The combination and interaction of these two immediate determinants define the child’s nutritional status (outcome). Household food security in this model is defined by the availability of household resources to consume sufficient food for all members in the household, either by food production, cash income or food received as gifts.\(^ {13}\)

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\(^{10}\) According to the Aide Memoire for CCT, shared by UNICEF, 829 IDPoor families were targeted as a part of the cash transfer project. Prasat Bakong has 594 IDPoor 1 families and 1,053 IDPoor 2 families according to Round 9 IDPoor data collected in 2015. Commune-wide data from the same source is presented in Annex 6.

\(^{11}\) US$ 1 is equal to approximately 4000 RIELs.


\(^{13}\) In a broader context, the UN framework of food security embodies four dimensions: (1) physical availability of food, (2) economic and physical access to food, (3) food utilization, and (4) stability of the other three dimensions over time (FAO, 2008).
Care in this context refers to caregiver’s behaviours that affect all aspects of child development including psychosocial care, feeding practices, breastfeeding, food preparation, hygiene, health-seeking behaviour and healthcare. The care for children is determined by caregiver\(^{14}\) control over resources and autonomy, mental and physical status (i.e., level of stress, maternal nutritional status), knowledge (including literacy and educational attainment), preferences and beliefs. The third underlying determinant is the health environment, which depends on the child’s access to safe water and sanitation facilities, health care and shelter.\(^ {15}\)

**Figure 3.** Conceptual framework of the determinants that affect child nutritional status

The framework also considers several moderators and mediators of the relationship between cash transfers and child nutrition. For example, the child’s dietary intake is mediated by the caregiver’s feeding practices and feeding styles. The health status of a child is mediated by the health-seeking behaviour of the caregiver. Household food security is moderated by the availability and price level of food and by external shocks. Women’s empowerment (as women’s decision-making or women’s control over resources) is influenced by the underlying societal values and in turn mediates the caregiver autonomy and control over resources and care for mothers and children.

In this framework, there are three main pathways through which cash transfers, by making additional financial resources available in a household, may impact the underlying determinants of child nutrition: resources for 1) food security; 2) health; and 3) care. (see Figure 3).

\(^{14}\) In line with Engle et al.’s (1997) terminology, the term ‘caregiver’ is used rather than ‘mother’. In most instances, it will be the mother of the child who is the primary caregiver, but also fathers and other females in the households provide care.

\(^{15}\) Smith, Lisa C., and Haddad, Lawrence James, ‘The importance of women’s status for child nutrition in developing countries,’ International Food Policy Research Institute, 2002.
No theory of change (ToC) had been prepared by UNICEF or other stakeholders for the cash transfer pilot. Nevertheless, based on the conceptual framework for child nutrition, a review of secondary literature and the understanding gained during interactions with CARD and UNICEF, a theory of change has been developed by the evaluation team (see Figure 4).

Cash increases income, thereby allowing the households to purchase better quality food, leading to increased food security, and diet quantity, quality and diversity. The availability of cash to women may directly increase their control over resources, economic empowerment and decision-making power. The conditionality of health check-ups may increase overall use of health services, depending on contextual factors such as quality and distance of health services. The condition to receive nutrition education may change household preferences to nutrient-rich food, and improve feeding and caregiving practices through an increase in women’s knowledge and awareness. Each of these effects have multiple assumptions underpinning the expected chain from actions to outcomes. The one overarching assumption is that the mechanics of the cash transfer work smoothly, such as that the right amount of cash is disbursed in a timely manner to the eligible beneficiaries with no leakage or transaction costs, beneficiaries and implementing staff are correctly informed about the pilot; and beneficiaries have all required documents for enrolling in the pilot.  

**Programme design**

The cash transfer pilot was designed to provide periodic cash (a regular and predictable amount of US$ 5 per month provided every two months) to beneficiary households to incentivize adequate health and nutrition practices with bonus payments rewarding compliance with co-responsibilities. Given that there is the IDPoor programme in the country that provides information on poor households and can be used for targeting various poverty reduction interventions, the pilot was designed to reach out to the poorest and most vulnerable population first, as directed by UNICEF principles.

**Eligibility criteria:** The target population for the pilot project was the one that met all three criteria:

a. Households identified as IDPoor 1 or IDPoor 2;

b. Households located in the district selected to implement the cash transfer pilot: Prasat Bakong district of Siem Reap province; and

c. Household included a pregnant woman and/or children aged 0-5 years.

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16 Adapted from Figure1. Mechanisms by which CCT programmes might affect nutritional status.
Enrolment criteria: Eligible household members needed to meet the following conditions to be enrolled or registered in the cash transfer project.

- For pregnant women to have at least one essential pre-natal check-up (before the 14th week of gestation) at a Health Centre with confirmation stated in the mother health book17; and
- For young children to have a birth certificate or at least a child health yellow book18 for confirmation.

Transfer and amount: Transfers consisted of two types – basic transfers and bonus transfers. Basic transfers were paid unconditionally upon enrolment, while bonus transfers were paid conditionally upon the compliance with co-responsibilities. Details of transfer amounts and co-responsibilities are given in Annex 7.

Co-responsibilities: Co-responsibilities are the set of conditions for enrolled members to receive bonus payment(s). These conditions were in accordance with the safe motherhood standards as defined by the Ministry of Health, and aimed to increase health care utilization among pregnant women and children and to enhance their knowledge on health and nutrition.

Household receivers: The eligible households had to assign a member of the household who would act as ‘the receiver of the cash’ – this by rule was to be a female member of the household. This was intended to maximize investments on human capital and to strengthen the bargaining power and autonomy of women within the family group. It was expected that this would increase their financial literacy and access to financial tools, such as ATM cards and formal savings accounts.

Payment frequency: Payment to household receivers was to be made once every two months, after verifying compliance of co-responsibilities for bonus payment. CARD generated the payroll list which was forwarded to the payment agency (AMK Microfinance), who was then responsible to disburse cash to household receivers.

Exit rules: After enrolment, households continued to be part of the cash transfer pilot if they met the eligibility criteria for the duration of the implementation phase. Households exited from the cash transfer pilot project in the following cases:

a) The household no longer has a pregnant woman or child under the age of five. If this happens for the regular process of children surpassing the age of eligibility, the last payment will correspond to the month of the child’s fifth birthday. Exits from the project following miscarriage or the death of the eligible pregnant woman or child will be treated as follows:

- Miscarriage: a bonus for institutional delivery is considered but basic transfers are stopped;
- Voluntary abortions: village health support group/Health Centre (VHSG/HC) staff is responsible for the provision of information to the cash transfer pilot for basic transfers to stop;
- Still birth: institutional delivery payment, but no regular payments for child;
- Death of the child (0-60 months): one more monthly transfer after reported death of the child; and
- Death of the woman: a) if the woman is mother of a child 0-5 years of age: the family designates a new adult beneficiary with the commune council for the child to continue to be enrolled in the project; b) pregnant women with no beneficiary children enrolled in the cash transfer pilot: one more monthly payment to the family of the beneficiary.

17 A handbook provided at the Health Center for recording information for the entire period between pregnancy and early childhood and is updated by the health service provider during check-ups.

18 A yellow color book provided at the Health Center in which the child’s history of vaccinations and weight is recorded by the health service provider.
b) Household relocates to an area where the cash transfer pilot is not operating (exit due to administrative reasons): no payments will be made after relocation is confirmed;

c) Household decides to stop participation (voluntary exit – to be confirmed by the commune council (CC)): payments will stop after confirmation of voluntary exit;

d) Household provided false information (exit due to fraud): payments will stop after fraud is confirmed; and

e) All households will exit at the end of the cash transfer pilot.

**Implementation of the pilot**

While the design of the cash transfer pilot began in 2013, the field mission to initiate implementation of the pilot in Prasat Bakong took place in December 2014. Thereafter, preparatory activities such as training of implementing staff, identification and registration of beneficiaries, finalization of the payment agency, etc. were carried out. The opening of bank accounts for the beneficiaries started in July 2015 and the first payment was delivered in May 2016, which included retroactive payments from November 2015. A total of nine education sessions were carried out over a period from May 2016 to October 2017. The last payment for the pilot was disbursed in October 2017. The various implementation steps undertaken during the project life-cycle are presented in Annex 8.

The operating cycle contains the dynamic sequence of processes for the implementation of the project. Six processes were defined (see Figure 5), some of which were performed simultaneously:

1. Targeting;
2. Enrolment;
3. Verification of compliance with co-responsibilities;
4. Processing payroll and payments; and
5. Case management (updates, grievances).

The education sessions began with the second distribution of cash and were conducted jointly by commune and Health Centre staff once every two months. The sessions focussed on ante-natal and post-natal care; delivery; proper breastfeeding; complementary feeding; water, sanitation and hygiene; common diseases and care of sick children and birth registration.

**The role of key stakeholders:** CARD, MEF, MoH, Ministry of Planning (MoP), AMK, UNICEF and beneficiaries were the key stakeholders of the project. UNICEF provided the funding as well as the technical support for the project, whereas CARD, through the district administrations and commune councils, was the implementing agency. A stakeholder analysis and the implementation structure have been provided in Annex 9.

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19 Cambodia Cash Transfer Pilot Project Operation Manual.
3. EVALUATION PURPOSE, OBJECTIVES AND SCOPE

3.1. Purpose and use of evaluation findings

The purpose of the evaluation is in line with the terms of reference (Annex 1). It included identifying good practices and drawing lessons from the Council for Agricultural and Rural Development - United Nations Children's Fund (CARD-UNICEF) Cash Transfer Pilot project regarding overall relevance, efficiency, effectiveness, sustainability and equity of the design and implementation of the project from 2013-2017. This was with an aim to inform the design and nation-wide implementation of the national cash transfer programme for children and pregnant women as envisioned in the National Social Protection Policy Framework (NSPPF) 2016-2025. The evaluation assessed the design and implementation mechanism of the project along with the institutional capacity at the national and sub-national levels, identifying key gaps and bottlenecks. This was done keeping in mind that the pilot was implemented through the existing government structure without creation of any external implementation body. Understanding the use of the cash transfer money by beneficiaries was another important objective of the evaluation. The formative evaluation began during the final distribution of the cash transfer amount. This allowed the evaluation to examine not only an on-going project, but also to identify key programmatic challenges and gaps as well as good practices and lessons learnt. Further, there was a need to identify and assess its effectiveness, as well as women’s preferences and satisfaction with the project. The evaluation also compared the pilot with similar cash transfer projects in similar social and economic contexts. The evaluation was conducted from September 2017 to March 2018.

The primary users of the evaluation will be agencies and government bodies who are involved in design and implementation of the national cash transfer programme. This would include the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY), Ministry of Economy and Finance (MEF) (General Department of Financial Industry and General Department of Budget), CARD, and UNICEF. Secondary users include other agencies involved in cash transfer programming in Cambodia, civil society organizations, development partners, and UNICEF’s Regional Office for East Asia and the Pacific (EAPRO) among others.

The findings will also help UNICEF strengthen its advocacy around the efficacy of cash transfer for health and nutrition outcomes. Further, the Government, NGOs and other stakeholders will also benefit from the evaluation and use the findings for designing any other future cash transfer interventions, as indicated in the NSPPF 2016-2025.

3.2. Objectives

The objectives of the evaluation included the following:

- Analyse the extent to which the cash transfer project was appropriately designed, effectively implemented, and efficiently assessed in terms of its cost-effectiveness;
- Understand how the money provided was used by the beneficiaries, assess their satisfaction with regard to the size of transfer, account for their perceptions and opinions of the requirements, assess the implementation and the suitability of the co-responsibilities;
- Assess whether the cash transfer has led to changes in health seeking behaviour, care during pregnancy and care of children of age 0-5 years;
- Seek to measure the capacity of the Royal Government of Cambodia (RGC) to deliver the project and assess the institutional capacity at national and sub-national levels for management and implementation of the CARD-UNICEF cash transfer pilot;
- Identify specific lessons and challenges regarding management and implementation capacity at the national and sub-national levels along with any training needs;
- Identify key gaps and bottlenecks in relation to the cash transfer pilot project life-cycle; and
• Assess the strengths and weaknesses of the cash transfer pilot versus other cash transfer interventions in Cambodia, as well as similar successful cash transfer programmes, both conditional and unconditional in similar social and economic contexts.

3.3. Scope

As per the terms of reference for the study and discussions with the evaluation management team, the evaluation not only sought to examine the cash delivery from May 2016 to November 2017, but also looked at the inception phase, thus covering the project design and targeting from 2013 to 2016. The project area was Prasat Bakong district in Siem Reap province, covering 1,298 recipients of the cash transfer.

This is not an impact evaluation and no comparison with baseline indicators has been attempted. The evaluation is based on the Organisation for Economic Co-operation and Development’s Development Assistance Committee (OECD/DAC) criteria; however, impact as a criterion has been excluded given the formative nature of the evaluation. The design of this evaluation and its approach is not quasi-experimental in nature and no attempt was made to create a counterfactual. A few non-beneficiaries were interviewed to understand the reason for their non-inclusion in the project and their opinion on the same. A comparison with other cash transfer projects, especially the World Bank cash transfer project and Save the Children’s Nourish programme was undertaken through secondary data review and high-level stakeholder interactions. Primary data collection at household level was not undertaken in any other project intervention area other than for the UNICEF-CARD cash transfer pilot project.

4. EVALUATION APPROACH AND METHODOLOGY

4.1. Approach

The evaluation of the Council on Agriculture and Rural Development (CARD) and UNICEF Cash Transfer Pilot Project for Pregnant Women and Children in Cambodia was formative in nature. The evaluation adopted a mixed-methods approach to assess the suitability of the design; efficiency of the delivery of the conditional cash transfer project, in relation to the overall project objectives; and to obtain beneficiary feedback. The study design combined quantitative and qualitative techniques to understand adequacy of the transfer level, beneficiary satisfaction and utilization of the cash transfer. The evaluation sought to inform the design of a national cash transfer project by examining the design and delivery of the pilot, the quality of its implementation and the organizational context, personnel, structures and procedures. The study was not intended to be a comparative evaluation of the pilot against conditional cash transfer projects of similar type. It, however, attempted a desk review of some of the successful cash transfer projects, both conditional and unconditional, so as to derive lessons and insights to recommend improvements in the design and implementation for scalability of this cash transfer pilot.

Further, a participatory approach was adopted to improve accuracy and relevance of responses by allowing experiences of beneficiaries to be heard as well as to ascertain unintended positive and negative experiences and outcomes. The approach was also learning-oriented and centred on identification of good practices, lessons and recommendations. Additionally, the participatory process helped identify the implementation partners who played an important role in the cash transfer pilot. The specific roles and functions which can be decentralized to the sub-national level were also identified. Moreover, the effectiveness and adequacy of technical support from CARD and UNICEF to the sub-national administrations, along with the guidance provided by the national level stakeholders (quality of training, coaching, forms/formats, etc.) were carefully taken into account. The guidance and support by the district team were also further assessed for efficiency.

Given the timing of the evaluation and its objectives, it has adopted a formative approach, identifying and assessing the project effectiveness, and women’s preferences and satisfaction with
Evaluation of the CARD and UNICEF Cash Transfer Pilot Project for Pregnant Women and Children in Cambodia

the project to date. The role of formative evaluation such as this one, is to develop and refine intervention content before implementing it fully, allowing for feedback to be incorporated during a project cycle or during scale-up of pilot projects. The project aims to inform design of a national cash transfer programme as envisaged in the NSPPF, rather than to identify impacts on the beneficiaries. However, during the evaluation, an attempt to evaluate the effect of the project on beneficiaries’ knowledge, attitude and practices was undertaken.

4.2. Methodology

The evaluation is informed by the OECD/DAC criteria of relevance, efficiency, effectiveness and sustainability. Equity, gender equality and human rights considerations have been additionally included as UNICEF priority areas. Impact as a criterion has been excluded given that this evaluation is not an impact or summative evaluation as the project was on-going during the time of data collection and is a pilot project having a limited number of beneficiaries.

A reference list of key evaluation questions was provided in the terms of reference for the evaluation, which were enhanced and edited in the technical proposal submitted by the evaluation team. Further refinement and finalization of the key evaluation questions was undertaken during the inception mission – through multiple interactions with the evaluation management team and key stakeholders. Insights and recommendations on the inception report from the reference group discussions were also suitably incorporated in the final set of key evaluation questions. The overarching evaluation questions included the following:

- Appropriateness and effectiveness of selection and targeting of beneficiaries, financial management system, monitoring, information dissemination, and grievance redress mechanisms;
- Adequacy of the size and regularity of the cash transfer and usage of the cash by beneficiaries;
- Effectiveness of the complementary community-based education sessions including increased use of health services and change in knowledge, attitudes and practices;
- Cost effectiveness of the pilot;
- Sustainability of the project without creation of any external implementation body, but using existing government structures and existing implementation capacity of the Government;
- Equity of project design and delivery including issues of gender and human rights; and
- Comparison with other cash transfer projects (both conditional and unconditional) in the region and successful global examples of cash transfer projects.

The detailed evaluation matrix with the specific evaluation questions are given in Annex 10. The key evaluation questions for this project have been presented in the findings section.

A two-pronged methodology was adopted for the evaluation. A secondary information review was done to build an understanding of the CARD-UNICEF cash transfer pilot. This was followed by primary information collection from service providers, beneficiaries, government counterparts, donors and other stakeholders. The primary information was collected through quantitative and qualitative data collection methods, such as surveys, key informant interviews (KII), focus group discussions (FGDs), etc. The sample for the evaluation covered all the 8 communes and ensured that a diverse set of stakeholders involved in the project were met during the data collection process so that the perspective of all the stakeholders is triangulated, analysed and reflected in the evaluation, thereby ensuring equity. The evaluation tools were finalised in consultation with UNICEF and other stakeholders. They were also assessed based on respondent type, nature of information to be gathered from each respondent, and data triangulation requirements.
The evaluation started with the inception phase in September 2017. During this phase, the evaluation team collected data and information from various sources including UNICEF, Ministry of Economy and Finance (MEF), Ministry of Health (MoH), Ministry of Planning (MoP), Save the Children, district office and commune council. The list of documents reviewed during the evaluation is given in Annex 1. Further, a scoping visit to Prasat Bakong district from 7-15 September 2017 was undertaken. The list of people met during the visit is attached as Annex 2. During the visit, evaluation questions were also piloted with the beneficiaries based on a zero draft that was prepared in advance. Based on insights from the scoping visit, the team developed evaluation tools (Annex 3).

The next phase of the assignment comprised data collection activities, which were conducted in October 2017. This included training the enumerators and piloting of data collection tools in Boeung Chum, Koun Sat and Ta Ei villages in Trapeang Thom commune. Based on the observations during the pilot and the subsequent discussions with the team members and UNICEF, the tools were modified and finalized. Thereafter, the evaluation team conducted in-depth interviews with key stakeholders at the national level (Annex 3 provides key stakeholder list, data collection method and broad category of questions). In addition, the team collected details on the costs and expenses incurred for implementation of the cash transfer pilot.

The data collection for the evaluation was completed in early November 2017 and a debriefing and validation workshop was undertaken on 14 November 2017. The key findings from the desk study, interviews, focus group discussions and surveys were presented and discussed. The observations, comments and insights from the workshop were used in the final analysis and report writing. The sampling methodology, data collection methods and data analysis methodology are described below.

### Sampling and data collection methods

Owing to the qualitative nature of this evaluation, which has an emphasis on project outcomes rather than impact, a **purposive and convenience sampling approach** was used to identify sample villages from all eight communes. **Random sampling** was undertaken to identify specific beneficiaries within sampled villages. The list of beneficiaries was obtained from CARD and the survey team randomly selected the requisite number of beneficiaries for each sampled village. Thereafter, the team met the village chief to reach out to the sampled beneficiary households. Some 'non-beneficiaries' i.e., individuals who were not a part of the pilot were interviewed only from a perspective of understanding the reason for their exclusion and their opinion of the pilot. The team ensured that the selected villages and households were suitably represented in terms of the different groups, such as pregnant women, mothers of children, non-beneficiaries, husbands and marginalized populations. This was done, for example, by visiting floating villages and other hard to reach areas. The final sample for the field work is given below.

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Data Collection Tool</th>
<th>Total Nos.</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commune council members</td>
<td>Focus Group Discussions</td>
<td>8</td>
<td>17 7</td>
</tr>
<tr>
<td>Beneficiary households</td>
<td>Focus Group Discussions</td>
<td>4</td>
<td>0 27</td>
</tr>
<tr>
<td>Commune focal persons</td>
<td>Key Informant Interviews</td>
<td>8</td>
<td>1 7</td>
</tr>
<tr>
<td>Village chief</td>
<td>Key Informant Interviews</td>
<td>23</td>
<td>11 12</td>
</tr>
<tr>
<td>Beneficiaries – Pregnant women/mothers/caregivers</td>
<td>Survey Interview</td>
<td>240</td>
<td>0 240</td>
</tr>
<tr>
<td>Non-beneficiaries</td>
<td>Key Informant Interviews</td>
<td>23</td>
<td>0 23</td>
</tr>
</tbody>
</table>
Data analysis

Quantitative data were analysed using descriptive statistics. Qualitative data were evaluated using an iterative analytical process for thematic identification and triangulation based on the feedback from multiple stakeholders. The data collected focused on both the implementers (including local authorities, service providers and implementing partners) as well as the affected populations themselves.

Cost-effectiveness analysis has been informed by the Department for International Development (DFID) guidance on measuring and maximizing value for money in social transfer projects. The evaluation team has also compared the costs and benefits of other cash transfer projects. Some of the critical cost-effectiveness drivers are given in Annex 14.

4.3. Increasing reliability and validity of data collection and analysis

In order to increase the reliability and validity of our evaluation methods, the following methods were used during preparation of data collection tools, field work and data analysis:

- Having a variety of item types (multiple-choice, open-ended, quantitative and qualitative) in questionnaires, presenting and accounting for multiple response types and ensuring objective answers;
- Triangulation of data by cross verification of main findings from two or more sources and through interaction with beneficiaries in two format types, survey interviews and FGDs;
- Validating findings from multiple stakeholders;
- Well-documented audit trail of materials and processes; and
- Making references to quantitative aspects wherever possible.

4.4. Risks, limitations and mitigation measures

Certain risks and limitations associated with the evaluation were identified; however, due mitigation measures were taken to overcome these, as mentioned below:

<table>
<thead>
<tr>
<th>Limitation</th>
<th>Measures Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language barriers</td>
<td>To overcome the language barrier, the national partner identified local staff to carry out the data collection activities. All field researchers were well versed in the local language.</td>
</tr>
<tr>
<td>Gender sensitivity of the topics</td>
<td>All enumerators were briefed on United Nations Evaluation Group (UNEG) Code of Conduct for Evaluation in the UN system and UNEG Handbook on Integrating Human Rights and Gender Equality in Evaluation. This ensured that the data collection process was gender sensitive and inclusive.</td>
</tr>
</tbody>
</table>

Evaluation of the CARD and UNICEF Cash Transfer Pilot Project for Pregnant Women and Children in Cambodia

<table>
<thead>
<tr>
<th>Limitation</th>
<th>Measures Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported behaviour change</td>
<td>For any evaluation related to behaviour change, it is difficult to assess whether the respondents actually follow the behaviour they claim to follow. Therefore, responses are assessed based on the respondents reporting to practice a certain behaviour and triangulated with responses of other stakeholders who are able to observe these behaviours.</td>
</tr>
<tr>
<td>Recall bias</td>
<td>Since disbursements of payments have been made over a period of time, it is possible that the respondents may have had a recall bias while answering questions during the survey or interview. These were mitigated by triangulating data with appropriate sources throughout the report and not relying on survey findings entirely on their own.</td>
</tr>
<tr>
<td>Attribution of results</td>
<td>It may be noted that NGOs/civil society organizations (CSOs) may also be implementing projects that can influence the outcomes of interest. It would therefore be difficult to attribute any changes solely to the pilot under this study. Although attempts will be made to map the different stakeholders working in the pilot areas; however, an in-depth analysis of their impact is out of the scope of this evaluation.</td>
</tr>
<tr>
<td>Data availability</td>
<td>Limited secondary data was available for the cash transfer pilot. Measures were taken to use all available secondary literature and data and collection of primary data from various stakeholders.</td>
</tr>
<tr>
<td>Sampling and data collection</td>
<td>As this is not a quasi-experimental study, non-beneficiaries were not sampled nor was any other district part of the sample, where the cash transfer pilot was not implemented. However, a few non-beneficiaries were interviewed to understand their opinion.</td>
</tr>
</tbody>
</table>

4.5. Equity, gender equality and human rights

In line with the UNEG Handbook on Integrating Human Rights and Gender Equality in Evaluation, as well as the UNICEF Handbook on How to Design and Conduct Equity-Focused Evaluations, the evaluation integrated equity, gender equality and human rights considerations in the conduct of the evaluation. In particular:

- The evaluation criteria and questions sought information on whether equity, gender equality and human rights issues were integrated into the design, planning and implementation of the project;
- The evaluation followed a participatory and consultative approach throughout the engagement life-cycle. Consultations held ensured that the evaluation could capture insights from all the key stakeholders involved in the project;
- For data collection, a gender balanced (2 women and 3 men) team was deployed;
- Other than beneficiaries and implementing agents, interviews with husbands, non-beneficiaries and heads of household were also conducted to ensure equity and get an insight on the opinion of the community regarding gender equality;
- The sample for the evaluation covered all the eight communes to ensure equity; and
- After purposely selecting villages, random sampling of beneficiaries was undertaken to ensure equity.

The evaluation ensured that a diverse set of stakeholders involved in the project were interviewed during the data collection in order to ensure that the perspective of all the stakeholders is triangulated, analysed and reflected in the evaluation, thereby ensuring equity.
4.6. Ethics and United Nations evaluation guidelines

The evaluation was driven and guided by the UNICEF and UNEG ethical guidelines. The design of the evaluation incorporated a clear human rights, equity and gender perspective. The team paid close attention to the fact that the aforementioned dimensions were integrated into the interventions, such as inclusion of girls, women and excluded communities, and the effects of the cash transfer pilot on such groups. This is also explicitly reflected in the evaluation tools and the methodology used.

To ensure impartiality, the evaluation team took into account the views of all stakeholders without prioritizing some over others. The team adhered to UNEG norms and standards, namely credibility, utility, independence, impartiality, ethics, transparency, human rights and gender equality. Furthermore, UNEG ethical considerations were respected, particularly in regard to inclusion of the views of community members. The team ensured that sensitive information derived from the FGDs, KIs and surveys were secured with utmost confidentiality. All interactions with stakeholders were done with prior consent. Further, the ethical review was performed by the UNICEF Evaluation and Research Committee. The four obligations for participants are further elaborated in Annex 15.

The team ensured that the methods applied in the evaluation of the CARD-UNICEF cash transfer pilot project caused no physical or psychological harm to the participants. The team strictly followed the obligation of evaluations: independence, impartiality, credibility, no conflict of interest, honesty and integrity, and accountability. The evaluators also observed the obligations towards the participants including respect for dignity and diversity, rights, confidentiality, and avoidance of harm. The obligations were met through trainings of field enumerators in these aspects and appropriate design of the sampling methodology. There was no conflict of interest of enumerators and evaluators.

After the data was collected and analysed, the evaluation team verified that there was accuracy, completeness and reliability reflected in the presentations and reports, as per the UNEG guidelines on the evaluation process and product. Further, transparency in accessibility of the data collected, presentations and reports have been taken into sincere consideration.

5. EVALUATION FINDINGS AND ANALYSIS

The team visited all eight communes, covering 23 villages and observed two cash distribution sessions. During the community visits, the team interviewed beneficiaries, husbands, heads of household, non-beneficiaries, sub-national staff and implementing partners. The team also visited Health Centres to interact with their staff. In addition, the team held discussions with senior project staff and with representatives from various ministries. The main findings from these interactions, as well as field observations and desk reviews are given below.

5.1. Relevance

The section on relevance provides an understanding of the extent to which the cash transfer project was suited to the priorities and needs of pregnant women and children under the age of five, the community, the Council on Agricultural and Rural Development (CARD), UNICEF and various government ministries in Cambodia.

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Relevance

<table>
<thead>
<tr>
<th>Key evaluation parameter</th>
<th>Key findings</th>
</tr>
</thead>
</table>
| Relevance of using conditional cash transfer | • Compliance of co-responsibilities was difficult to monitor, and no direct evidence was found to support their usefulness. Verifying compliance of growth monitoring was also a challenge as several beneficiaries did not bring the child health yellow book to the pay day. Further, there were also cases where the Health Centre staff did not record the growth monitoring results in the yellow book.  
• Cash transfer as opposed to in-kind transfer was the preference across all sets of stakeholders. |
| Appropriateness of targeting and enrolment mechanisms | • Targeting and use of IDPoor as a basis of identification of beneficiaries was appropriate despite the inherent limitation of the IDPoor process.  
• The migratory population was excluded as they did not have IDPoor cards and special mechanisms to include vulnerable groups such as orphans were not present.  
• A mechanism to use the IDPoor questionnaire for identification of those who did not have IDPoor card was considered but no clear evidence of how often it was used was found.  
• Beneficiaries reported that no participatory process was adopted for finalising the criteria of beneficiary selection.  
• The enrolment process was smooth; however, at the onset of the enrolment process, several beneficiaries did not have the required documents which posed a challenge and led to delays.  
• Payroll processing and payments were done in a timely manner with no reported leakages. |
| Requirement of externally-funded posts for project implementation | • Even without the creation of any external implementation body, but using existing government structures (district and commune administrations), the cash transfer pilot was successful in delivering the cash transfers to the target groups with limitation in monitoring conditionalities and in complain handing mechanism. Though there were delays initially in making the bonus payments due to issues in verifying compliance of co-responsibilities, these were later resolved.  
• There is a requirement of hiring skilled external resources on short-term basis for one-time activities such as training of trainers and development of a detailed monitoring framework. |
| Adequacy of size and regularity of the cash transfer amount | • Basic payments were insufficient to address entire nutrition deficiency and health expenses. The amount did help supplement the income of beneficiaries to buy better and more food, and in some cases to repay debt. |

According to UNICEF’s 2013 report on Improving Child Nutrition, nutritional status is influenced by three broad factors: food, health and care. Nutritional status is optimal when children have access to affordable, diverse, nutrient-rich food; appropriate maternal and child-care practices; adequate health services; and a healthy environment including safe water, sanitation and good hygiene practices. These factors directly influence nutrient intake and the presence of disease. The cash transfer pilot attempted to address all these factors by incorporating co-responsibilities related to use of health services and through behaviour change communication sessions concurrent with cash transfers.

The timeliness of the project was appropriate given RGC’s commitment to social protection as per the NSPS and the intention to roll out a national cash transfer project for pregnant women and children. The project aligned with RGC’s intention of having targeted projects without creation of any external implementation body, but using existing government structures at the sub-national level.
(district and commune administrations). The project aimed at understanding and building human resource capacity of the sub-national Government and identifying any gaps which need strengthening. A majority of commune council members considered the project to be relevant and successful. Some members however felt that the project was not as successful due to change in focal persons as a result of the elections:

\[\text{In this commune the project is not as successful because focal person resigned due to elections. I am not sure that the new focal point can undertake education sessions and do the required duties. -- Former commune focal person}\]

According to the RGC – UNICEF Country Programme Action Plan 2016-2018, financial burden is a critical barrier to use of public health services, with the majority of un-vaccinated children from the poorest wealth quintile, and poor pregnant women less likely to complete the full package of maternal care. Consequently, the project’s fit in the context and the requirement of the country to break from the intergenerational poverty trap. With other similar projects also being undertaken in Cambodia, including the National Committee for Sub-National Democratic Development Secretariat (NCDD-S) World Bank Funded Cash Transfer Project and Save the Children’s ‘Nourish’ programme, the projects will be able to learn from one another and conclude with the best way forward to roll out the national cash transfer project. Though the UNICEF-CARD cash transfer pilot was congruent to the other cash transfer projects in terms of its location and design, it had key elements which distinguished it, such as implementing the pilot using only the existing government structures. It also did not overlap with any other intervention; thus, duplication of effort was not witnessed.

**Targeting**

IDPoor is used as the principal targeting mechanism by the Government and various international donors and NGOs in Cambodia. It is instituted and led by the Ministry of Planning (MoP) and updated every three years. In the IDPoor system, photo identity cards are provided to households identified as very poor (IDPoor 1) or poor (IDPoor 2) based on an asset scoring system. The target population for the pilot project was households identified as IDPoor 1 or 2 located in Prasat Bakong district having a pregnant woman and/or child(ren) aged 0-5 years. This was in line with UNICEF’s policy of targeting the poorest and most excluded first.

The targeting criterion was well understood by beneficiaries and project staff alike. Almost 100 per cent of the commune focal points correctly described the process and said that the targeting mechanism is appropriate and effective. The majority of the village chiefs interviewed were aware that the IDPoor criterion is used for targeting beneficiaries; however, their knowledge of the specificities of the targeting methods was less than commune council members. Some key issues regarding IDPoor based targeting emerged, with several respondents, including beneficiaries, commune council members, and village chiefs, mentioning that the migratory population has been excluded as they do not have IDPoor cards. Village chiefs also expressed an opinion that other vulnerable groups such as orphans should be included. Further, the challenge of using IDPoor as a targeting tool is its low frequency of update.

\[\text{Some of villagers are very poor, but they do not have IDPoor cards because they migrated or have a big house – however the fact may be that a member of the household is sick. This wasn't taken into consideration. – FGD with commune council members}\]

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23 Based on interactions with commune council members during KIIs.
24 Based on interaction with Save the Children, World Bank and UNICEF Cambodia.
25 Based on interactions during key informant interviews with commune focal points and village chiefs.
Some cases of poor households having no IDPoor card were reported to have been included in the cash transfer pilot. However, no mechanisms have been outlined to make the process transparent and equitable. A mechanism to use the IDPoor questionnaire for identification of those who do not have an IDPoor card was considered. The assessment and decisions were similar to the IDPoor process, except it should only be assessed by the village chief and approved by the commune council. However, no clear evidence of how often this was used was found.26

At the national level, all stakeholders were aware of the issues in targeting and how vulnerable sections are being excluded as they do not have IDPoor cards.27 It was recognised that a pilot to improve IDPoor implementation is being initiated in selected districts; however, this is a time-consuming exercise and until IDPoor’s update mechanisms change, additional mechanisms for identifying beneficiaries is needed.

Choice of the type of cash transfer

Cash transfers empower families and help reduce the chasm between rich and poor, thereby reducing the potential for exclusion and conflict. There is increasing evidence that more equal societies develop more rapidly and growing inequality works against development.28 Based on the evidence reviewed in many countries, 30 per cent of people would be below the poverty line, but with cash transfers programmes, the number falls below 10 per cent. In most of these, impacts can be attained at less than 2 per cent of the GDP through a targeted programme, implemented in a phased scale-up approach.29

The choice to use a mix of unconditional and conditional cash transfers in the Cambodian context had varied viewpoints. KIIs with UNICEF and CARD presented the view that conditionalities are difficult and costly to monitor and do not have any direct evidence to support their usefulness. Some commune council members during FGDs believed that while the conditions are difficult to monitor, they are still important to increase health service use and encourage better practices. It is pertinent to mention here that commune council members do not have any experience with unconditional cash transfers and therefore cannot provide inputs which are comparative in nature. In UNICEF’s assistance to governments to develop new social protection programmes or reform existing ones, UNICEF does not actively promote the use of conditionality in its technical assistance, in light of human rights and operational concerns and insufficient evidence of the added value of conditionality. UNICEF’s application of this approach is however context-specific, taking into consideration national priorities, political economy, and the social and economic vulnerabilities of children and their families.30

Several commune focal points mentioned during KIIs that beneficiaries do not bring the child health yellow book to the pay day, which makes verification of growth monitoring co-responsibilities extremely difficult. They also reported cases when the Health Centre staff did not record the growth monitoring results in the yellow book. They specified that this data can be collected at the Health Centre and shared with the commune council members for bonus payment. Moreover, conditions such as institutional delivery and child immunization already have a high use in Cambodia (see Box 1).

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26 Based on interactions with CARD and discussions made during the validation workshop.
27 Based on interactions with UNICEF, CARD, MoP and MEF.
Box 1. Health service utilization in Cambodia (CDHS 2014)

<table>
<thead>
<tr>
<th>Health service utilization in Cambodia</th>
</tr>
</thead>
<tbody>
<tr>
<td>• More than four in five births – 83 per cent in the five years before the survey were delivered in a health facility.</td>
</tr>
<tr>
<td>• Two-thirds of children (65 per cent) aged 12-23 months were fully vaccinated by age 12 months.</td>
</tr>
<tr>
<td>• Nearly all children had received the Bacillus Calmette–Guérin (BCG) vaccination and the first two doses of tetravalent/pentavalent vaccine or polio vaccine (89 per cent to 96 per cent), and 70 per cent had been vaccinated against measles.</td>
</tr>
<tr>
<td>• When looking at the proportion of children who received vaccines at any time before the survey (not necessarily before age 12 months), the percentages are higher, with 73 per cent fully vaccinated.</td>
</tr>
</tbody>
</table>

Including an element of conditionality (in terms of health and education service use) can, but does not necessarily, lead to greater impacts in these areas; clear communication about the importance of using services is an element of conditionality clearly associated with greater service use.\(^\text{31}\) Most commune focal points, village chiefs and district officials during KIIs had the view that conditions on attendance of health and education sessions should continue to be in place. During the validation workshop, CARD presented a point of view that if individuals not having IDPoor cards are included in the cash transfer project, then they will not have access to the Health Equity Fund (HEF) benefits and may not be able to comply with the conditions. Most individuals who are poor and not included in IDPoor are migratory populations who are most vulnerable. Imposing health service use conditions may lead to penalizing this most vulnerable group.

*We request there to be fewer conditions for bonus payment. Sometimes beneficiaries attended two education or growth monitoring sessions but not the third due to urgent issues. In such cases, bonus payment should also be provided.* – Commune focal point, during validation workshop

Evidence from UNICEF Evaluations 2010-2014 report also helps in reiterating the evidence for cash transfers with rather limited conditions. According to the evaluation, households exhibit highly rational decision-making, each of the types of spending choices improves household welfare in some way. This evaluation also concludes that unconditional cash grants generate the broadest range of benefits and offer maximum flexibility and respect for beneficiary views, in line with a rights-based approach to programming. With the UNICEF-CARD cash transfer project, UNICEF sought to understand the positives as well as challenges of having a mixed/hybrid cash transfer project having elements of both conditionality as well as un-conditionality. Further, several stakeholders were involved along with UNICEF in finalising the project design. Therefore, a mixed model rather than an unconditional cash transfer project was deemed suitable for the pilot.

Further, given that HEF covers the costs for a range of health check-ups and treatment, cash transfer as opposed to in-kind transfer was the preference across all sets of stakeholders, for improving nutrition status. During the household survey, 61 per cent of beneficiaries said that they preferred cash transfers to any other alternatives and 11 per cent said they would prefer free food. The remaining said that they preferred food vouchers, free medical care, study material for their child, etc. Beneficiaries expressed that the cash transfer amount helped them address their most immediate needs, such as food, medical expenses and debt repayment.

\(^\text{31}\) Overseas Development Institute, ‘Understanding the impact of cash transfers: the evidence,’ July 2016.
Enrolment

Enrolment of beneficiaries was done in two ways – mass enrolment at communes and on-demand registration. Most respondents (85 per cent) were enrolled in mass enrolments at the communes. Of those enrolled under ‘admission on demand’, the most common reason was that the respondent was not present on registration day (see Figure 6). Further, 20 per cent of those who enrolled under admission on demand reported that their name was not on the IDPoor list. Mass enrolment proved to be an efficient way of enrolment by minimizing costs and allowing for easy dissemination of information.

The enrolment process was deemed smooth by stakeholders; however, several beneficiaries during FGDs reported that no participatory process was used for finalizing the criteria of beneficiary selection. KIIIs of village chiefs led to a majority viewpoint that the enrolment process was clear to them and they faced no challenges. The selection criteria were also explained during orientation sessions and village chiefs were asked to interview and select beneficiaries accordingly. Based on the criteria, they sent the list of eligible beneficiaries to the commune focal point. For the process of enrolment, the final list of beneficiaries was shared with the village chief or posted in the commune hall. KIIIs with beneficiaries, village chiefs, as well as non-beneficiaries indicated that specific cases of wrong inclusion were not found. However, during a focus group with commune council members, it was mentioned that friends of the village chief are able to get IDPoor cards even though they are not really poor.

Around 98 per cent of respondents had reportedly participated in the enrolment orientation session. 79 per cent of respondents said the orientation session helped them receive information in an open manner. Most respondents came to know about the cash transfer project from the village chief/VHSG or commune council. Almost all the respondents were aware of the selection criteria for the project.

Some commune focal points reported during KIIIs that at the onset of the enrolment process, several beneficiaries did not have the required documents (birth certificate, pink/yellow book), which posed a challenge and led to delays. Commune council members and village chiefs, however, guided and facilitated the beneficiaries to obtain the required documents. During FGDs with commune council members, a few reported that an increase in birth registrations was witnessed and attributed it to the cash transfer programme. It is obligatory for parents to register their child’s birth within 30 days of delivery. Birth registration establishes formal proof of a child’s name, age and establishes the child’s lawful existence and provides the foundation for safeguarding the child against exploitation and abuse. Thus, an increase in birth registration is an important unintended outcome of the project.

Assessment of need for externally-funded posts in the project

As mentioned earlier, no external implementation body was created for rolling out the pilot. Existing government structures (district and commune administrations) were used to test the possibility of implementing similar projects. This is in line with UNICEF’s key principle to provide support to nationally owned and led systems.32

The commune focal points unanimously said that the cash transfer pilot was successful in delivering the cash transfers to the target groups in a timely manner and improving nutrition behaviours of the target group. Most village chiefs also agreed; however, a village chief from Trapeang Thom commune

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commented that the success of the pilot cannot be judged given that bonus payments had not been given.33 Neither the village chiefs nor the commune council members stated that additional external resources are required for targeting and enrolment mechanisms.

While the UNICEF pilot did not use any external human resources for project implementation, the World Bank cash transfer pilot hired key consultants at project management and district levels (see Box 2). It also used an external agency (Reproductive and Child Health Alliance (RACHA)) for conducting the health and education sessions. Discussions with the district focal point and district advisor of Srey Snam district brought forth that the recall of the content of these sessions was very high. While knowledge was imparted in the education sessions under both projects, changing behaviours is far more complex, and requires changing norms and mindsets of not only the pregnant women or mothers, but also of the community as a whole. Addressing individual behaviours, which are shaped by social, cultural, economic and political contexts, requires interactive approaches and mixed communication channels to encourage and sustain positive and appropriate behaviours.34

Box 2. Use of external resources in the World Bank supported cash transfer pilot

A total of 10 consultants were hired by the project of which two consultants (an international consultant and a local MIS consultant) were hired for a short-term period. Three local consultants were recruited for supporting project component one run by CARD, including a senior specialist for social protection policy, junior technical assistant for data management and junior technical assistant for social protection research. There were three local consultants hired to support NCDDS, including National Project Management Adviser, National Finance Adviser and National M&E Officer. Two district advisers were deployed to support district administrations. – World Bank Representative

The World Bank pilot, however, had high operational costs, which can be attributed due to the hiring of external resources, which according to respondents, was expensive and not replicable for a national cash transfer project. Similarly, the cost of having communication sessions carried out by NGOs is very high. Given this, externally-funded resources for implementation of the project are not required. However, short time resources may be hired for one-time activities, such as training of trainers, and developing a monitoring framework. NGOs can partner with the Health Centre staff to teach effective mechanisms for bringing about behaviour change in beneficiaries.

Adequacy of cash transfer amount and regularity of payment

The transfer of cash under the pilot took place once every two months. Basic transfers were US$ 535 per month per woman and per child. Bonus payments were made upon completion of co-responsibilities with a total maximum benefit per year per child of US$ 90.

Most beneficiaries during FGDs expressed concern that the amount of basic payments was insufficient to address the entire nutrition deficiency and health expenses (bonus payments were largely not received until the time of data collection, due to complexity of monitoring and verification of the conditions). However, the beneficiaries felt that the basic transfer amount did help supplement incomes to buy better and more food, and in some cases to repay debt.

Receiving cash transfer is good because we receive US$ 10 every two-month which is better than every month get only US$ 5 which is a small amount. The money is helpful for intermediate needs even though it is only US$ 10. – Beneficiary FGD

As expected, evidence suggests that larger transfers generally produce bigger improvements in consumption. This gives rise to the potential need to re-assess benefit levels since improving nutritional status is a key objective of the pilot and the benefits are not only needed to incentivize

33 Bonus payment was given in the ninth payment. Primary data was collected before this.
35 US$ 1 is equal to approximately 4000 Riels.
service utilization but also to increase household consumption. Basic payment is the amount that households receive on a regular basis, which they can count on as a regular form of income to help supplement their wages. In UNICEF’s 2012 report, *Estimation of Rates of Return of Social Protection Instruments in Cambodia: a Case for Non-Contributory Social Transfers*, the effect of household consumption on under-five malnutrition was estimated. The findings suggest that a 10 per cent increase in household consumption per capita is related with a 0.4 percentage point lower probability of being underweight. However, the link between household consumption and underweight status is not significant for poor households.

### 5.2. Effectiveness

The section on effectiveness discusses the extent to which the cash transfer projects attained its objectives, including increase in utilization of basic health services and improved nutritional intake; the design of the implementation mechanisms; institutional capacity of central and local authorities; and the linkages of various supply side activities.

<table>
<thead>
<tr>
<th>Key evaluation parameter</th>
<th>Key findings</th>
</tr>
</thead>
</table>
| **Usage of cash transfer amount and utilization of health and nutrition services** | • Beneficiaries used the cash to buy food, especially cereals and fish.  
  • 80 per cent of the beneficiaries responded that the cash transfer money helped address their food need with 36 per cent stating that food was the only item for which the cash transfer amount was utilised.  
  • An increase in utilization of health services especially growth monitoring for children and pre- and post-natal check-ups for pregnant women was seen.  
  • No evidence of cash usage on adverse items such as alcohol was found, except that a few respondents reported having purchased cakes. |
| **Change in the knowledge, attitudes and practices of women** | • Beneficiaries have increased knowledge and better practices related to hand washing, drinking boiled water and utilization of health services.  
  • To change attitudes and practices, a change in norms is required; therefore, not including other family members in the purview of the health and education sessions was seen as a gap. |
| **Effectiveness of information dissemination mechanism, trainings and community-based education sessions** | • Inter-personal communication by functionaries was the predominant form of awareness generation activity. No mass media approaches were used nor was there an information, education and communication strategy prepared as a part of the pilot.  
  • Official training sessions for village chiefs were missing. Commune council members expressed a need for having the guidelines in a form that is specific to the roles and responsibilities of a functionary so that they don’t need to go through the full document.  
  • Health Centre staff appreciated the training on conducting health and nutrition education session and found them to be useful.  
  • The health and nutrition education sessions were appreciated by everyone; however, for better understanding of the content, more participatory methods, pictorial material and provision of refreshments were suggested. |
| **Efficacy of payment mechanism and cash withdrawal patterns** | • Timely delivery of the bonus payments helped improve effectiveness of the cash transfer.  
  • During the initial months of enrolment, there was confusion as to who should be the designated household receiver and some bank accounts were opened in the name of male members and heads of household.  
  • Internet connectivity is required for the POS machine to work, so there were some complaints that the wait time was over two hours given poor network availability. |
**Key evaluation parameter** | **Key findings**
--- | ---
**Availability and effectiveness of monitoring and grievance redress mechanisms** | • Grievance redress processes and monitoring were two areas where effective implementation was deficient.  
• There was no reporting of formal complaints being filed and only verbal complaints were stated.  
• A comprehensive monitoring framework with clear indicators was not prepared for the pilot project. Most reporting mechanisms were manual and no clear data verification or validation methods were found.

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**Usage of cash**

As per responses received from various stakeholders, the majority of the respondents said that the usage of the cash transfer amount was in line with project objectives. The beneficiary survey showed that beneficiaries used the cash to buy food, especially cereals and fish. Most beneficiaries said that rice is important for their daily diet and the cash transfer amount helped them buy rice for their families. The survey also demonstrated that 80 per cent of the beneficiaries used the cash transfer money to help address their food needs, with 36 per cent stating that food was the only item for which the cash transfer amount was utilised. 16 per cent of the beneficiaries said that the cash transfer amount was only used on the medical needs of the family. Spending on non-food items and non-medical needs included spending on clothing and shoes and debt repayment; however, these numbers were limited.

Overall, 98 per cent of the beneficiaries felt that the cash transfer amount had helped address the immediate needs of their family (see Figure 7). This is in line with UNICEF findings in their 2015 study on cash transfers and child nutrition. According to the study, there is strong evidence that cash transfer programmes have a positive effect on resources for food security. The study continues to suggest that households use the transfer to buy larger quantities of and higher quality (i.e., more nutritious and diverse) food, and in many cases, household food security indicators improve. Additional findings from the beneficiary survey are provided in Box 3 below.

![Figure 7. Analysis of usage of cash by beneficiaries](image)

| Exclusively addressed medical needs | 16% |
| Exclusively addressed food need | 36% |
| Addressed food need | 80% |
| Cash transfer addressed immediate needs | 98% |

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36 FGDs with commune council members, key informant interviews with villages chiefs, survey of beneficiaries, head of household/husband survey.

Box 3. Survey findings on usage of cash by beneficiaries

<table>
<thead>
<tr>
<th>Survey findings on usage of cash by beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>57 respondents (out of a total of 240) stated that the cash transfer amount resulted in increase of their household expenditure. For these respondents, the findings are:</td>
</tr>
<tr>
<td>• 53 (93 per cent) stated that at least some part of their expenditure increased on food.</td>
</tr>
<tr>
<td>• 22 (39 per cent) stated that their expenditure increased only on food.</td>
</tr>
<tr>
<td>• 19 (33 per cent) stated that some part of their expenditure increased on clothing and shoes.</td>
</tr>
<tr>
<td>• 12 (21 per cent) stated that some part of their expenditure increased on medical expenses.</td>
</tr>
<tr>
<td>• 10 (18 per cent) stated that some part of their expenditure increased on debt repayment.</td>
</tr>
<tr>
<td>Other items on which very few respondents stated that their expenditure increased included livestock, firewood, savings, transport and school fees.</td>
</tr>
</tbody>
</table>

Outcome analysis – improved nutrition, utilization of health services

I. Nutrition intake

With regard to influencing improved nutrition intake and outcomes, several village chiefs and commune council members stated that there has been improvement in quantity and quality of food by beneficiaries. Most beneficiaries corroborated this and mentioned that the improvement is for the whole family, especially in the consumption of rice. Beneficiaries also reported during the survey that they spent the cash transfer money mostly on cereals and fish. During beneficiary FGDs, most claimed that they used the cash transfer to buy meat, vegetables and eggs, and practice dietary diversity in cooking food since they have the required knowledge that they received from the education sessions. Beneficiaries also have better knowledge of exclusive breastfeeding practices as a result of the cash transfer. 93 per cent of beneficiaries correctly answered that the baby should be exclusively breastfed until six months. 99 per cent of beneficiaries claimed to have breastfed their baby and 100 per cent of beneficiaries answered that mother’s milk is the first drink/food which should be given to a new-born baby.

II. Utilisation of health services (growth monitoring, pre-natal check-up utilization, institutional delivery, post-natal check-up and immunization)

In case of health services, the overall utilization has been high. All Health Centre staff interviewed reported an increase in utilization of health services, especially growth monitoring for children and pre- and post-natal check-ups for pregnant women.

Growth monitoring

A downward trend is seen in growth monitoring utilization for all children combined in the Health Centre data; however, an upward trend is seen in growth monitoring utilization for IDPoor children (Figures H and I, Annex 16). Conditionality on growth monitoring possibly led to this increase. However, the yellow book as a tool to verify growth monitoring had its challenges. There were instances where the health staff did not record the child’s weight in a yellow book. Close collaboration with operational district and provincial health department can help motivate Health Centre staff to record child weight in the yellow book as well as provide counselling to parents and caregivers. It, however, needs follow-up and support for implementation.

However, for treatment of Severely Acutely Malnourished (SAM) children, no standard treatment protocol was reported by Health Centre staff during KII's. They mentioned that they recommend the mother to breastfeed more and provided Oralite and multi-vitamins to malnourished beneficiaries.
Pre-natal check-up utilization

In order to receive bonus payment for completion of pre-natal check-ups, the pregnant beneficiary must have had at least four pre-natal visits – one visit in each trimester and a fourth visit at term. Secondary data\(^{38}\) shows that pre-natal check-up utilization is generally high in Prasat Bakong. According to data collected from all four Health Centres in Prasat Bakong, comparing the period before and after the start of the cash transfer project, there is an upward trend in utilization of pre-natal check, both for total pregnant women undergoing pre-natal check-ups and for IDPoor women undergoing the same (Figure A and B, Annex 16). The slope of the trend line is steeper for IDPoor women, thus showing that a greater increase in utilization by this segment of the population. Commune-wide data on total number of pregnant women who came for pre-natal check-ups in Prasat Bakong is given in Figure C, Annex 16, which shows an upward trend for two of the communes and horizontal trend for the remaining two.

Institutional delivery and post-natal check-up

Further, institutional delivery rates are also very high with 99 per cent of respondents in the beneficiary survey claiming to have given birth at a health facility. On average, a total of 14 deliveries took place every month across the four Health Centres in Prasat Bakong district. No clear trend in utilization of institutional deliveries is seen in the Health Centre data (Figure D, Annex 16). It would be pertinent to mention here that the rate of institutional delivery is already as high as 83 per cent in Cambodia.\(^{40}\)

Post-natal check-up utilization has a clear upward trend in the months following the cash transfer project. However, as compared to the pre-natal check-ups, this number is still very small (Figures E and F, Annex 16). According to the World Bank NCDD-S pilot project process evaluation, a key reason for missing out on the second pre-natal check-up is constraints on visiting the Health Centre after delivery. Commune-wide post-natal check-up data is given in Figure G, Annex 16.

Immunization

Immunization utilization is high, with 99 per cent of respondents claiming that their baby has been immunized. 92 per cent of beneficiaries had their baby immunized at the local Health Centre while others visited the provincial or district hospital (see Figure 8). Few instances of Health Centre staff providing immunization services at home were reported. Knowledge and practices around consumption of IFA tablets and iodized salt were also good (see Figure 9).\(^{40}\)

No clear trends in vaccination were seen, possibly because immunization rates are already high in Prasat Bakong (see Table 2).

These findings are triangulated by UNICEF’s 2015 study on cash transfers and child nutrition\(^{41}\) in which the evidence in general points to positive impacts. Cash transfer programmes increased preventive health care visits and antenatal care-seeking in most cases. There were also positive

| Table 2. Vaccination details of Prasat Bakong Health Centres\(^{39}\) |
|-----------------|-----|
| BCG             | 98% |
| DPT-HepB-Hib 1  | 93% |
| DPT-HepB-Hib 2  | 94% |
| DPT-HepB-Hib 3  | 92% |
| Hepatitis B     | 94% |
| Polio 1         | 93% |
| Polio 2         | 94% |
| Polio 3         | 91% |
| Measles         | 51% |

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\(^{38}\) Cambodia Demographic Health Survey, 2014.

\(^{39}\) Indochina Research Ltd Cambodia, CCT Maternal Health Baseline.

\(^{40}\) During the validation workshop, Save the children shared a finding that in the Cambodian context, use of iodized salt as an indicator may not be appropriate given that the salt is not appropriately iodized.

\(^{41}\) United Nations Children’s Fund, ‘Cash Transfers and Child Nutrition: What We Know and What We Need to Know,’ 2015.
effects on better hygiene and on the probability of using improved sanitation or water sources. Commune focal persons noted that the beneficiaries now wear cleaner clothes and are more concerned with their hygiene and the hygiene of their children.

58 per cent of beneficiaries reported borrowing money to cover the cost of healthcare for themselves or their children since receiving the cash transfer. Average amount of money borrowed was around US$ 70. This may imply that the cash transfer amount was insufficient to cover medical costs not included under HEF. It was also learnt that earlier beneficiaries were less willing to visit Health Centres due to fear of wages being lost. Now with increased awareness and income supplementation by cash transfer money, they are willing to lose a day’s wage to take their child to the Health Centre.42

Yes, there is an increase, before they never come to Health Centre for monitoring growth. They come more and more now as we teach them during the health and education sessions. – Health Centre staff

Knowledge, attitudes and practices

The beneficiary survey indicates that the pregnant women and mothers have increased knowledge and better practices related to hand washing, drinking boiled water and utilization of health services. However, some beneficiaries mentioned during FGDs that they felt that there would be more significant improvement if the beneficiaries were provided pictorial material that they could take home. This would help them remember the lessons. This was corroborated by several commune council members during KIIs.

The health and nutrition education session are very useful since the beneficiaries are illiterate and have limited knowledge. – Commune focal person

95 per cent of the respondents reported receiving information regarding health and nutrition from healthcare providers rather than from family members or traditional healers. 45 per cent of the respondents correctly responded that complementary feeding should start at the age of 6 months.

42 This points to the fact that an integrated systems approach is required to respond to the multiple and interrelated dimensions of child vulnerability to exclusion and poverty. Although individual programmes can achieve important positive impacts, a more integrated system can produce multiplier effects greater than the individual interventions.
81 per cent of the respondents knew about anaemia, of these 91 per cent knew at least one measure to prevent anaemia (see Figure 10).

Findings from the CARD and UNICEF commissioned Indochina Research Ltd., Cambodia to undertake a CCT Maternal Health Baseline survey also brought to fore interesting insights. The survey was carried out in two districts, Prasat Bakong (intervention district) and Pouk (comparison district). Some key results from the baseline assessment are given in Annex 17. It may be noted that the studies have a different purpose and sampling methodology and results are not directly comparable. The survey conducted as a part of this evaluation was not an end-line survey.

At the preliminary findings validation workshop, several points were raised regarding the importance of inducing behaviour change and not simply imparting knowledge. It must also be considered that to change attitudes and practices, a change in norms is required. It, therefore, might be useful to consider including other family members in the purview of the health and education sessions.

Information dissemination

During interactions with beneficiaries during the survey and FGDs, good understanding of the rationale and purpose of the project was seen. 99 per cent of respondents of the beneficiary survey claimed to be aware of the selection criteria being used to select beneficiary households. The majority also knew that the focus was on health and nutrition and were also clear about their entitlements in terms of the basic and bonus payments. Awareness regarding the project was high even among non-beneficiaries even though no formal mechanisms of information dissemination apart from village meetings were conducted. Most non-beneficiaries interviewed, knew about the selection criteria, payment frequency and conditions.

During FGDs with beneficiaries, some of them raised the point that they were not very clear on when payments for the co-responsibilities would be made. Mechanisms to improve communications and formal complaint mechanism remained limited. This is corroborated by UNICEF’s 2016 document on Cash transfer pilot for maternal and child health and nutrition, which states that strong communication strategy is critical for smooth and successful implementation of cash transfer projects.

Training of project implementing agents (focal persons, commune focal persons, and Health Centre staff)

As discussed, the pilot was implemented using the Government’s existing human resources and that these functionaries did not have any experience of managing cash transfers, training was a very important facet of this project. Training for the skills required to conduct education sessions and the extent of monitoring of co-responsibilities that was required were especially important. Trainings, including induction and refresher training, were provided to commune council members at the district level. Additionally, the Health Centre staff and commune focal persons received trainings regarding the specific modules which had to be taught during the health and education sessions held every two months. Nine trainings were conducted as a part of the cash transfer project between May 2016 and October 2017. The participants included district focal persons, commune focal persons, and Health Centre staff. The initial training was held at the province level in Siem Reap in May 2016 during which
training was imparted on the implementation and operational guidelines. The other trainings were health education trainings held at the Prasat Bakong district hall on topics such as maternal healthcare; child health and nutrition; child vaccination and growth monitoring; and hand washing and sanitation. A detailed list of trainings is given in Annex 18.

The majority of the village chiefs reported having received orientation from the commune council regarding targeting and enrolment of beneficiaries. They, however, mentioned not having received any formal training or any project documents. The information dissemination from commune council members to village chiefs was not monitored and a formal mechanism of information dissemination was not established. As village chiefs work at the ground level and are most able to disseminate information to the beneficiaries and community, it is vital that they are provided complete information regarding the project.

All Health Centre staff during KIIs confirmed that they received the lesson-plans and training related to the sessions a few days before they had to conduct the health and nutrition education sessions. They deemed these trainings to be useful in delivering the sessions to the beneficiaries. However, they also reported that they had not received any other training or presentation about the overall project.

While the commune focal person(s) were provided training on beneficiary selection, report writing, cash payment, maternal health and nutrition, etc.; they initially found the job tough as it required understanding the guidelines and formats, convincing the beneficiaries, etc. However, they were able to get their queries resolved with support from district staff and the intention to help the poor motivated them to do the tasks. The beneficiaries during FGDs also validated that the commune council members helped them understand the cash transfer project. The commune council members expressed the need for receiving separate guidelines that is specific only to their roles and responsibilities. The majority of the materials, such as flip charts and lesson plans, were reportedly given only to the Health Centre staff to facilitate health and education sessions and not to the commune council members who at times conducted the education sessions.

Health and nutrition education sessions

The health and nutrition education sessions were appreciated by implementers and beneficiaries alike. During KIIs, several commune council members stated that they witnessed better hygiene practices, an increase in growing of vegetable gardens and consumption of more diverse food as a result of the education sessions. Most village chiefs said that the education sessions are useful for beneficiaries as they raised awareness regarding maternal and child health. Some village chiefs and commune council members claimed that the beneficiaries visit the Health Centre for ante-natal check-ups (ANC), post-natal check-ups, growth monitoring and vaccination of their children more often:

Earlier villagers would not get their children vaccinated thinking that it would make their child ill. Now things have changed and beneficiaries get their children vaccinated. – Village chief

This view was confirmed from the beneficiary survey findings, which showed that 69 per cent of beneficiaries responded that they had attended six to eight health and nutrition education sessions, while 28 per cent claimed to have attended three to six sessions. 69 per cent of the beneficiaries agreed and 21 per cent strongly agreed that the health and nutrition sessions were useful (see Figure 11).

43 As per stakeholder discussions with CARD and KIIs with commune council members.
Many commune focal points had observations regarding the education sessions, which included having bigger and more pictorial descriptions, having more modules on childcare and provision of material for mothers to take home to help them remember better. It was also mentioned by a few focal points that elderly caregivers participating in the education sessions find difficulty in understanding the messages being conveyed. It was recommended that material could be developed to be disseminated to the whole village rather than only to the beneficiaries. Some of the Health Centre staff stated that only about 50 per cent of participants were able to recall what was conveyed during the previous session. One particular commune council suggested during an FGD that it would be better to get an external trainer as people often do not listen to local authority:

*Beneficiaries do not listen to information given by commune council members or local authority. It is better to get a trained professional from outside.* – Commune council member

Several respondents, Health Centre staff and commune council members noted that education sessions are often very noisy, and the beneficiaries are often distracted by looking after their children, leading to limited understanding of the sessions. They felt that these sessions could be improved if refreshments were provided and if they were not scheduled on Mondays, given the increased load at the Health Centres, which are closed on Sundays.

As a consequence of these sessions, an increase in growth monitoring of children was reported by a staff at two Health Centres. One Health Centre worker reported that non-beneficiaries also brought children for growth monitoring when they saw other mothers taking their children. Further, providing additional support to beneficiaries for visiting the Health Centres for ante-natal and post-natal check-ups, such as reimbursement of transportation costs, was suggested.

**Payment process**

AMK Microfinance was responsible for delivering the cash to the designated household receiver. Cash was provided at specified pay points once every two months and account holders needed to present their ATM card and pin code (password) in order to receive the payments. They also had the option to withdraw cash either at an ATM/bank branch or from an AMK mobile cash transfer agent. Both beneficiaries and the administrative staff stated that the payment process was smooth and easy and is a great success of the project. Some grievances regarding lost ATM cards and
beneficiaries forgetting the ATM pin were reported, but these were effectively resolved by AMK staff. Payment through a third party was successful and no leakages were reported.\textsuperscript{44} In recent years, mobile payment platforms have grown rapidly in Cambodia and may be explored though there could be challenges in implementing the same, considering low mobile usage\textsuperscript{45} among rural women and limited financial literacy of beneficiaries. Also, cash payment days worked well as opportunities to gather the target audience and provide health and nutrition education sessions.

It was reported by CARD and AMK Microfinance that during the initial few months of enrolment there was some confusion as to who should be the designated household receiver and some bank accounts were opened in the name of male members and head of households. This was later resolved.

**Withdrawal of funds**

Nine payments were completed over an 18-month period. On average, only 5 per cent of the beneficiaries did not withdraw the cash amount on the cash distribution day (see Table 3). As per our stakeholder discussion with AMK, the main reason for non-withdrawal on payment date was because the beneficiary could not attend payday due to other engagements. It is not clear whether the beneficiary intended to save the money or could not come due to some exigency. One specific issue that several beneficiaries and commune council members mentioned was that if a beneficiary is unable to collect payment on the distribution day, they need to go to an AMK office to receive the cash transfer amount. This proves to be difficult for the beneficiaries given that the bank branch is often far from their home and with limited financial literacy, beneficiaries are reluctant to visit the bank to withdraw money. National level consultations with AMK provided the information that cash amounts, which are not paid to beneficiaries during one delivery, can be carried forward to the next delivery. It was mentioned during the interaction with AMK that this is currently not a part of the contract signed with CARD; however, it can be explored in the future. The cash received in these bank accounts was only from the cash transfer pilot and none of the bank accounts received funds from any other source.\textsuperscript{46}

<table>
<thead>
<tr>
<th>Session</th>
<th>Date</th>
<th>No. of Payments</th>
<th>No. who did not withdraw</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>May 23-27, 2016</td>
<td>1147</td>
<td>118</td>
</tr>
<tr>
<td>2nd</td>
<td>Aug 03-11, 2016</td>
<td>950</td>
<td>44</td>
</tr>
<tr>
<td>3rd</td>
<td>Oct 05-14, 2016</td>
<td>731</td>
<td>20</td>
</tr>
<tr>
<td>4th (1)</td>
<td>Oct-26, 2016</td>
<td>25</td>
<td>1</td>
</tr>
<tr>
<td>4th (2)</td>
<td>Dec 04-15, 2016</td>
<td>716</td>
<td>23</td>
</tr>
<tr>
<td>5th</td>
<td>Feb 07-16, 2017</td>
<td>718</td>
<td>62</td>
</tr>
<tr>
<td>6th</td>
<td>Apr 04-12, 2017</td>
<td>1004</td>
<td>66</td>
</tr>
<tr>
<td>7th</td>
<td>June 13-21, 2017</td>
<td>729</td>
<td>20</td>
</tr>
<tr>
<td>8th</td>
<td>Aug 08-16, 2017</td>
<td>688</td>
<td>32</td>
</tr>
<tr>
<td>9th</td>
<td>10-19 Oct, 2017</td>
<td>686</td>
<td>5</td>
</tr>
</tbody>
</table>

\textsuperscript{44} Based on interactions with district administrations, commune council members and beneficiaries.

\textsuperscript{45} While mobile penetration has increased significantly over the years.

\textsuperscript{46} Based on responses by AMK Microfinance during national consultation.
Most beneficiaries were satisfied with the payment process and did not find it time consuming (see Figure 12). In the household survey, 94 per cent of the respondents strongly agreed and another 2 per cent agreed that opening a bank account\(^{47}\) and the process for receiving money was clear and simple. Beneficiaries suggested having one pay point in each village (current list of pay points per commune are given in Table 4 below). If the pilot is to be scaled up, it is likely that different payment methods may be needed. While in Prasat Bakong district the payments were smooth. In remote areas with limited internet connectivity, offline mechanisms will also need to be explored. No problem or grievance was reported from the beneficiaries or commune council members regarding the payment process by AMK.

Table 4. Details of pay points per village

<table>
<thead>
<tr>
<th>Commune name</th>
<th>Avg. distance from villages</th>
<th>Number of pay points</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bakong</td>
<td>2 to 6 km</td>
<td>1</td>
<td>Bakong Commune Hall</td>
</tr>
<tr>
<td>Balangk</td>
<td>1 to 1.5 km</td>
<td>3</td>
<td>Balangk Commune Hall, Kroper primary school, Vice village chief's house</td>
</tr>
<tr>
<td>Kg Phlok</td>
<td>1 to 4 km</td>
<td>1</td>
<td>Kampong Phlok pagoda</td>
</tr>
<tr>
<td>Kantrang</td>
<td>1 to 4 km</td>
<td>1</td>
<td>Kor Ki pagoda</td>
</tr>
<tr>
<td>Kondaek</td>
<td>1 to 4 km</td>
<td>2</td>
<td>Sala Chhortean Spean Kha Ek and Sala Chhortean. Khun Mok</td>
</tr>
<tr>
<td>Meanchey</td>
<td>1 to 2 km</td>
<td>1</td>
<td>Sala Domnak Doun Num</td>
</tr>
<tr>
<td>Rolous</td>
<td>2 to 5 km</td>
<td>2</td>
<td>Rolous Commune Hall and Sala Chhortean Chombok</td>
</tr>
<tr>
<td>Trapaina Thom</td>
<td>1 to 5 km</td>
<td>2</td>
<td>Tropaing Thom Commune Hall and Sala Damnak Roka Kombot</td>
</tr>
</tbody>
</table>

Source: AMK Microfinance

\(^{47}\) The bank accounts were regular accounts, opened as per the guidelines of the National Bank of Cambodia and can be used for various banking transactions. No payments were required for opening the accounts or for the ATM card. As a special provision for the project by AMK, no minimum balance is required to be maintained.
Basic payments were disbursed on a timely basis – every two months as per the design of the pilot. This was corroborated by AMK Microfinance, CARD, commune council members and beneficiaries. This is commendable given that only internal human resources were used for payroll creation. The beneficiaries were therefore able to rely on receiving a basic payment of US$ 10 every two months. Regular payment of cash transfers to help smooth consumption from predictable and reliable cash transfers is critical to address issues of under nutrition.\textsuperscript{48} Most beneficiaries, however, reported that they had not received bonus payments even after compliance with co-responsibilities. On consulting with CARD, it was shared that there was a delay in payment due to administrative reasons. They further stated that during the 6\textsuperscript{th} payment, bonus payment for only attendance of the health and education nutrition sessions was made. During the 9\textsuperscript{th} payment delivery, payment for completion of all co-responsibilities was undertaken.

\textbf{Case management}

For the pilot project, case management related to updates, appeals and complaints was outlined in the operational manual. It also stated that all complaints must be answered in writing and should be answered in at least three months. However, no clear and formal grievance redress mechanism was reported by any respondent. During the stakeholder discussion, CARD mentioned that the complaint form was given to the commune focal point; however, no one used it. Instances of informal methods, such as verbal complaints and resolutions were provided. Commune members claimed that while a grievance redress mechanism is present, the beneficiaries never complained. This is at odds with the findings since beneficiaries do have complaints such as non-payment of bonus amount.

\textbf{Monitoring}

For the pilot project, a detailed monitoring framework with specific indicators was not developed. Several commune focal points and district staff said that details of payment to beneficiaries are noted and listed by the commune focal person and thereafter sent to the district office. All Health Centre staff claimed that centres did not maintain any specific records for the cash transfer project, but routine manual records are maintained, and some computerised reports are prepared. No defined monitoring plan was found for verifying the efficacy of reports received from the commune level. Field visits were conducted by CARD staff to observe training and payment sessions; however, there was no documented monitoring plan as such, nor were any reports prepared as a result of these field visits.\textsuperscript{49}

Commune focal points collect data on co-responsibility compliance, such as ante-natal care, post-natal care, institutional delivery and vaccination from the Health Centre. This is often time consuming and requires checking multiple log-books.\textsuperscript{50} Growth monitoring verification is done by reviewing the child’s yellow health card during payment day. This too is problematic since mothers often forgot to bring the card.

Various types of forms are currently in place to collect data in the current pilot project in Prasat Bakong. However, there is a big question on how many forms are actually being filled and if they are being filled, whether the information is entered on the online MIS and at what frequency. Further, the existing information system in place for data collection and reporting appears to be weak without an all-inclusive MIS system.

\textsuperscript{48} Based on consultation with UNICEF.
\textsuperscript{49} Based on discussion with CARD at the national level.
\textsuperscript{50} Stated by commune focal points during key informant interviews and during the validation workshop.
5.3. Efficiency

The section on efficiency shows the qualitative and quantitative outputs in relation to the inputs in terms of cost, time and resource utilization.

<table>
<thead>
<tr>
<th>Efficiency</th>
<th>Key findings</th>
</tr>
</thead>
</table>
| **Efficiency of the implementation process in the project cycle – key achievements and gaps** | • The implementation of the cash transfer project in the absence of creation of any external implementation body, but using existing government structures was cost-efficient and well-functioning.  
• The choice to use an independent microfinance institution allowed payments to be made in a timely manner without any leakages.  
• No formal mechanism to document and disseminate lessons learnt and best practices was present. |
| **Coordination between implementation agents and UNICEF** | • Efficient coordination between UNICEF and CARD was reported and decisions on any actions/measures were taken unanimously between the two agencies.  
• A harmonized approach to cash transfer was followed wherein CARD communicated directly with AMK and the district administrations. |
| **Infrastructural challenges and gaps** | • Infrastructural challenges such as poor public transportation, lack of rural banking facilities, erratic internet connectivity and limited telecommunication networks need to be tackled. |
| **Cost-efficiency of the project** | • Comparing cost-efficiency was constrained due to a lack of cost data for pilot cash transfer. The project's cost-efficiency cannot be compared to long-term, large-scale cash transfer projects. |

**Efficiency of implementation process**

Overall, the implementation of the project without the use of external resources was streamlined and met the objectives of the project. In order to understand the efficiency of the implementation process, multiple key informant interviews, in-depth interviews and focus group discussions with national level stakeholders, sub-national staff and implementation partners were performed. The findings based on primary data collection at the national and sub-national level are as follows:

**Coordination**

- Interviews with sub-national administrative staff showed that there was clear demarcation of roles and responsibilities and no overlap of work was seen.
- A common forum where stakeholders from each administrative unit and level participate, which meets on a regular basis for improved coordination, is not present.
- Cooperation with organizations providing complementary services, such as growth monitoring projects, is absent. Save the Children’s programme has growth monitoring being undertaken at the village level on specific days, which provides easy access for beneficiaries.
- Coordination between UNICEF, CARD and the district level functionaries was smooth. This was expressed by stakeholders at all three levels.

**Training**

- As reported by them, orientation sessions are provided to sub-national staff. This was corroborated by CARD.
- Trainings, including refresher training, were provided to commune council members. A cascading model was applied wherein commune councils formally communicated the information to village chiefs. Village chiefs, however, maintained that no formal mechanism of information dissemination was present.
Trainings, once every two months, for preparation on the health and education sessions were conducted in a timely and effective manner. The Health Centre staff appreciated these and found them useful.

The commune council members stated that the trainings were often complex and limited written material was provided. Giving concise documents relevant to the functioning of each administrative unit may be more beneficial than providing only operational guidelines.

Due to elections and changes in administrative members, several commune council members stated that materials and gains from training are lost.

**Targeting**

- No cases of inclusion error were reported during primary data collection. This was corroborated by beneficiaries, non-beneficiaries and the village chiefs. A few commune council members stated that village chiefs got their relatives enrolled as IDPoor; however, no examples of such cases were found.
- Mechanisms to include vulnerable communities with no IDPoor such as migrant population, orphans were not a part of the project design.
- The guidelines were followed and individuals having IDPoor 1 or 2 were included in the project without discrimination as reported by the project beneficiaries, non-beneficiaries and heads of households.
- No instance of corruption was reported in targeting of beneficiaries by any stakeholder interviewed.
- Coordination with other government ministries in developing targeting approaches was lacking. For example, MoSVY has developed a targeting mechanism for their persons with disability project, which may be examined for insights.

**Awareness generation**

- For a pilot project, only word-of-mouth techniques to raise awareness worked and high awareness regarding the project was seen even among non-beneficiaries. Formal mechanisms of awareness generation, such as mass media campaigns were not included. All beneficiaries reported having heard about the pilot from the village chief, commune council member or member of the community.

**Dissemination of information**

- Each set of stakeholders were aware of the challenges in targeting, data reporting etc. being faced.
- A process of documentation and dissemination of lessons learnt and best practices was missing, though minutes from the meetings between CARD and UNICEF were found.

**Roles and responsibilities of implementing staff and key institutions**

One of the measures of efficiency of a project is how well the planned activities have been implemented by the functionaries, given the capacities and trainings imparted to them. The roles and responsibilities of the staff involved in the project; and gaps in training and processes identified during the evaluation are provided below:

- An information flow mechanism from the district to the village level with accountability mechanisms built-in was missing. It was the duty of the commune council members to brief the village chiefs, based on the trainings they received. However, officials from CARD stated that no formal mechanism was defined for the same. Further, no feedback was taken from village chiefs nor was any report taken from the commune council members regarding the same.
- Inputs from other related ministries and key functionaries during the design phase of the project were found to be limited.
• IT capacity, both in terms of infrastructure and human resource capability was limited. Several commune council members stated during FGDs that they wish to learn how to use email, data management, sharing files, etc. as a part of their capacity building activities.

• Verbal complaints were reported by some commune focal points and beneficiaries; however, no responsibility was assigned to get the complaint form filled and follow due process.

Detailed information on recommended roles and responsibilities as well as ways to address capacity gaps at each level is provided in the section on recommendations.

**Coordination between UNICEF and implementing agencies**

Efficient coordination between UNICEF and CARD was reported during stakeholder discussions with both. Decisions on any actions or measures were taken unanimously between the two agencies. UNICEF’s harmonized approach to cash transfer (HACT) was followed wherein CARD communicated directly with AMK and the district administrations. CARD then reported back to UNICEF on financial and technical issues related to the pilot, following which UNICEF processed financial requests, disbursement, assurance and settlement/reporting procedures. For communication with the district and commune, CARD communicated using written and stamped letters and also via telegram and phone communication. miscommunication was reported during the early stage of the pilot by CARD as telephonic communication between CARD staff and district administrations was used upon the pilot roll-out, i.e., some activities were implemented without official letters of communication from CARD. However, following discussions between UNICEF and CARD, it was agreed that all communication with district administrations would be taken through official letters for documentation.

Financial reporting was also as per HACT with the district reporting to CARD who in turn reported to UNICEF on each distribution, monitoring and training. Other reporting mechanisms included email communication between UNICEF and CARD. In addition to technical reports (which were in hard and soft copy with signature and stamp), CARD also provided financial reports to UNICEF.

**Infrastructural challenges**

Some infrastructural challenges were witnessed during the data collection process. Banking penetration in rural areas is limited in Cambodia. Low presence of bank branches and ATMs at the village and commune level in rural areas makes it difficult for the rural population to access banking services. Further, the beneficiaries often do not have access to phones and internet connectivity in rural areas which poses a challenge. IT infrastructure was also found to be lacking at the commune and village levels. Given this situation, alternative technology-dependent mechanisms for payment, as well as monitoring, may not be feasible. However, given the fact that the mobile banking system is expanding rapidly in Cambodia, it could be tested out in some areas where beneficiary access to mobile phones is high. Connectivity of villages to neighbouring districts is also a challenge in some areas, particularly for floating villages. For example, Meanchey Health Centre reported difficulty with access to the Health Centre particularly for Kompung Phluk, a floating village.

**Cost effectiveness analysis**

Cost-effectiveness analysis measures the cost of achieving intended programme outcomes and impacts, and can compare the costs of alternative ways of producing the same or similar benefits.

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51 Based on interactions with UNICEF.
52 Based on secondary data sources such as minutes of the meeting between CARD and UNICEF.
Since it is not possible to measures outcomes and impacts given the short duration of implementation of the cash transfer pilot, we have attempted to analyse the cost-efficiency.

Literature reviews suggest that cash transfers are effective in achieving a range of development objectives and that reservations with respect to creating dependency or enabling misuse of funds by recipients are unwarranted. The academic literature on cash transfer programmes uses the ‘total cost-transfer ratio’ (TCTR) to measure cost-efficiency\(^{53}\), i.e., the ratio of total programme cost to value of transfers. As per the available data for the cash transfer pilot the TCTR works out to 1.73.\(^{54}\)

<table>
<thead>
<tr>
<th>Programme</th>
<th>Year of operation</th>
<th>No. of direct recipients</th>
<th>Total cost (US$) per direct recipient (incl. transfer costs)</th>
<th>Admin cost per recipient (US$)</th>
<th>Admin cost as % of total cost</th>
<th>Total cost-transfer ratio (TCTR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana LEAP, 2010</td>
<td>3</td>
<td>26,079</td>
<td>132</td>
<td>69</td>
<td>53%</td>
<td>2.11</td>
</tr>
<tr>
<td>Kenya CT-OVC, 2008/09</td>
<td>3</td>
<td>15,000</td>
<td>331</td>
<td>83</td>
<td>25%</td>
<td>1.34</td>
</tr>
<tr>
<td>Bangladesh CLP, 2011</td>
<td>8</td>
<td>17,485</td>
<td>940</td>
<td>347</td>
<td>37%</td>
<td>1.59</td>
</tr>
<tr>
<td>Zambia Child Grant, 2011</td>
<td>2</td>
<td>32,643</td>
<td>251</td>
<td>111</td>
<td>44%</td>
<td>1.79</td>
</tr>
<tr>
<td>CARD – UNICEF Cash Transfer Pilot, 2017</td>
<td>1</td>
<td>1,298</td>
<td>148</td>
<td>62</td>
<td>42%</td>
<td>1.73</td>
</tr>
</tbody>
</table>

Total cost-transfer ratio (TCTR) is the ratio of total programme costs to the value of transfers.

Source: LEAP = Livelihoods Empowerment Against Poverty Programme, Ghana (White, 2011); CT-OVC = Cash Transfers for Orphans and Vulnerable Children, Kenya (OPM, 2010); CLP = Chars Livelihood Programme, Bangladesh (White, 2012) – includes complementary support.

The table above shows total cost per direct recipient, administration cost and percentage of administration cost for some of the cash transfer programmes at initial year implementation, the cost-efficiency of the pilot cannot be compared to the other cash transfer programmes due to various limitations. Care needs to be taken to interpret the comparison since the programmes are not directly comparable (see Box 4).

**Box 4. Parameters for consideration when comparing cost-efficiency**

Comparing cost-efficiency against international benchmarks is critical to judging value for money. But great care must be taken to interpret these benchmarks in light of:
- Problems of comparability between different methods of measuring cost: are we comparing like with like?
- Different contexts with different challenges for delivery (e.g. conflict, geography, Government’s capacity);
- Different programme objectives and designs;
- Difference between pilots and national programmes;
- Difference between different points on the programme cycle – because costs are generally much higher in the early years;
- Are costs too low in relation to total amounts transferred, and likely to reduce performance and cost-effectiveness?

Evidence shows that cost-efficiency improves as programmes evolve from small pilots to expand programme coverage. The TCTR for Mexico’s PROGRESA fell sharply from 2.34 in year 1 to 1.05 in year 4, mainly due to the rapid increase in transfer volumes. The ex-ante TCTR for the Nigerian Child Development Grant declined from 2.04 in year 2 (the first year of transfers) to 1.49 in year 5. Kenya’s

\(^{53}\) The most significant driver of cost-efficiency is the scale at which the programme is implemented. A larger coverage of beneficiaries spreads the fixed costs over a wider pool thereby driving down per household costs. It is common for the cost-to-transfer ratios (CTRs) of pilot interventions to be relatively large as there are no economies of scale.

\(^{54}\) Total project cost/ value of transfers = US$ 189,589/US$ 109,344 =1.73. Cost breakdown is given in Annex 19.
Hunger Safety Net Programme followed a similar pattern. Likewise, administrative costs during the start-up of Progresa/Oportunidades in Mexico in 1997-2000 showed a similar evolution, in that set-up and roll-out costs gradually gave way to operational costs as the programme grew, falling from 71 per cent to 15 per cent of administrative costs between years 1 and 4.

The analysis is inevitably limited to administrative costs, ignoring private and social costs to beneficiaries, or adverse incentive, broader economic and political costs. Low cost-efficiency does not necessarily mean low cost-effectiveness, and vice versa. A higher administrative cost may be necessary to improve social outcomes. The cost-efficiency analysis faces significant data deficiencies, including a lack of information on Government’s overhead costs.

5.4. Sustainability

The section on sustainability assesses whether the benefits of the cash transfer project are likely to continue after the entire transfer amount has been given.

<table>
<thead>
<tr>
<th>Key evaluation parameter</th>
<th>Key findings</th>
</tr>
</thead>
</table>
| Capacity gaps, bottlenecks and sustainability without creation of any external implementation body, but using existing government structures | • The gaps identified in this pilot can be rectified and mostly require one-time expenses, which would be efficient in a larger project.  
• The use of only internal human resources added to its sustainability. |
| Considerations for roll out of national cash transfer project | • Considerations of inflation, climate change and disaster resilience and dietary shifts in the design of a large-scale cash transfer project would also be key in ensuring sustainability of gains. |

Capacity gaps and bottlenecks

The cash transfer pilot project was well designed and implemented. It was largely able to reach its objectives in a relatively smooth manner. The gaps which have been identified in the sections above can be easily rectified and most of them require a one-time expense, which would be cost effective in a larger-scale project. This includes investing resources in creating a mechanism to include non-IDPoor beneficiaries; developing monitoring frameworks and MIS systems; having training of trainers for processes such as conducting education sessions, monitoring activities and communication; and developing an automated grievance redress system.

The use of only internal human resources in successfully implementing the project is another positive sign of the financial sustainability of the project. However, some capacity gaps for the sub-national administrative levels which have been identified in previous sections can be overcome with proper training and guidance, and are not a hindrance to the potential scalability of the project.

The overall roles at each administrative level are well-defined in the operational manual. These roles are appropriate considering the governance structure, with the national level being responsible for design of the project and monitoring of the intervention areas; and communes being key implementation agents with support from villages. However, decentralisation and decision-making capacity of sub-national units is limited.

55 The administrative costs may be high (low cost-efficiency) but impacts may be much higher leading to high cost effectiveness. Similarly, there may be high cost-efficiency but impacts may be low (low cost effectiveness).

56 White, Philip, Hodges, Anthony and Greenslade, Matthew, 'Guidance on measuring and maximising value for money in social transfer programmes - second edition,' Department for International Development, April 2013.
Roll out of a national cash transfer project

During national-level consultations and the preliminary findings workshop, views on roll-out of the national level project were shared. Most stakeholders were of the opinion that, considering human and financial capacity constraints, a phased scale-up over a few years would be more suitable than scaling-up nationally all at once. In using a phased approach, stakeholders were divided on the main parameters for selection of districts for roll-out of the project. Some were of the opinion that areas of high poverty with poorest nutrition indicators should be targeted, which is in line with UNICEF policy of targeting the poorest and most excluded first. Others were of the view that, to begin with, areas of better infrastructure and administrative capacity should be targeted, while improving capacities in other districts for the next phase. It should be noted here that areas having superior infrastructure and administrative capacities, will, probabilistically, have better indicators due to superior service delivery. Therefore, the impacts observed are expected to be less.

Sustainability of gains

To ensure sustainability of gains made by the project as well as continued relevance of the project in coming years, the following need to be kept in consideration while designing the national project:

- **Climate change and variability:** A high percentage of the rural population in Cambodia is dependent on agriculture. Climate changes are likely to have the greatest impact in many low resource regions’ agriculture output, which lowers incomes and resilience, and subsequently reduces access to sufficient nutrient-dense foods.\(^{57}\) This must be taken into consideration to ensure sustainability of gains made in the longer term.

- **High and volatile food prices:** The poorest communities and especially female-headed households, feel the consequences of increased food prices most strongly. Increase in food costs forces people to reduce the quantity and nutrient quality of food consumed, particularly affecting those who are in need of nutrient-dense foods like young children and pregnant and lactating women.\(^{58}\) The cash transfer amount should be flexible and adaptive to inflation rates.

- **Dietary shifts:** Diet changes include an increase in the consumption of vegetable oils, sugar-sweetened beverages, ultra-processed and fast and street foods. Several beneficiaries commented that they used the money from the cash transfers to buy ‘cake’ – which is a packaged and processed sweet, seen as a treat by children. Adequate knowledge needs to be given to beneficiaries informing them of the ill effects of such food items.


5.5. Equity, gender equality and human rights

The section on equity and gender presents how equitable the cash transfer project was to different social groups, especially focusing on vulnerable groups.

<table>
<thead>
<tr>
<th>Equity, gender equality and human rights</th>
<th>Key findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equitability of the project to different social groups and gender</strong></td>
<td>The cash transfer project had mothers and female guardians as account holders. Some initial accounts were opened in the male head of household’s name due to lack of clarity among the implementers. It was observed that men rarely accompanied women to the health and education sessions and considered these lessons only for the women to help them take care of the house and children. Most men did not consider this to be their responsibility.</td>
</tr>
<tr>
<td><strong>Negative effects felt by any social groups</strong></td>
<td>No negative social effects were observed. Most non-beneficiaries understood and accepted the reason for their non-inclusion in the project and no resentment was expressed. Beneficiaries rather claimed that a positive social change is seen as a result of the cash transfer project.</td>
</tr>
<tr>
<td><strong>Equity and human rights considerations</strong></td>
<td>The project was reported to be equitable with no instances of discrimination, with respect to access to cash transfers and opportunity of participation in health and education sessions amongst beneficiaries. Exclusion of migratory populations and vulnerable groups such as orphans was seen.</td>
</tr>
</tbody>
</table>

**Gender equality**

Cambodian women represent 51 per cent of the country’s population, yet their ability to participate as equal partners in social, political, and economic life is severely constrained. Fewer girls attend and complete school and gender-based violence remains a serious problem. Around 32 per cent of partnered Cambodian women experience emotional abuse by an intimate partner in their lifetime, while 21 per cent face physical and/or sexual violence and 8 per cent experienced physical and/or sexual violence in the past 12 months.59 Women in Cambodia are important economic actors, often responsible for the production and marketing of products. Nonetheless, they are historically underrepresented in decision-making and leadership capacities.60

The main gender inequalities typically involve girls’ comparatively lower level of achievement in education and are evident in women’s lack of access to income-generating opportunities, control of household assets and the high incidence of gender-based violence against women. Evidence suggests that as a result of cash transfer projects, women have means to spend money on items which positively influence household health and nutrition status. They also are able to participate more in the spending decisions of the household and may also have effects on improving the balance in intra-household dynamics. The country programme of World Food Programme (WFP) that encourages female heads of households to take control over food and cash resources, showed that on average, 94 per cent of women played a decisive role in the use of WFP cash and food rations. This overall translates into status improvement of women in the community.61

The 2009 UNICEF analysis of the situation of children and women in Cambodia identified some of the causes preventing children in the country from enjoying their rights and explained why key duty-bearers are not always able to fulfil their obligations. These mainly comprised of economic and institutional constraints that impede the state from ensuring the provision of services for all children,

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59 Cambodia Ministry of Women’s Affairs, ‘National Survey on Women’s Health and Life Experiences,’ 2015.
60 Asia Foundation, ‘The Role of Women in Cambodia,’ 2013.
like inadequate number of Health Centres and schools and ineffective social welfare services. It further states that Cambodian children’s right to health clearly depends on the economic level of their families since health care is essentially unaffordable for a large proportion of the population.

The cash transfer pilot project was targeted at women and young children. In order to ensure that women have access to the cash transfer amount, as a part of the project design, pregnant women or mothers or female legal guardians were the preference to be the cash transfer account holders. Some accounts were initially opened in the names of head of the household due to lack of clarity in project directives. This was however clarified and around 91 per cent of the account holders are women.

It is important that women are not seen as powerless victims or passive recipients of assistance, but as rights holders who can play an active role in advocating with duty bearers. Therefore, including beneficiaries and communities in the project design is a critical aspect which was missing in the pilot project.

All respondents said that the mother or female guardian had a say in the use of the cash transfer money. Most of the women mentioned that the cash transfer had a positive impact and felt more confident to make better decisions around nutrition and health care of their children. They also mentioned that they had control over the cash and took the decision to spend the same.

*My wife makes decision on spending the cash transfer money. But if I want to buy the machine of boat then I need to discuss with my wife.* – Husband of beneficiary

Literature has also expressed concerns for cash transfer projects focused on women – projects must be careful in ensuring that the notion of women alone being responsible for rearing children and attending to the health and education upbringing of the children is not promoted. It was observed that men rarely accompanied women to the health and education sessions as they considered these lessons only for the women. Most men did not consider raising children to be their responsibility.

*I want there to be more education sessions in order for my wife to learn more on how to take care of children’s health and make better and more nutritious food.* – Husband of beneficiary

The mother remains the primary caregiver. Responsibility towards ensuring healthcare and proper diet seems to not rest with both parents.

**Equity and human rights**

The project was reported to be equitable with no instances of discrimination with respect to access to cash transfers and opportunity of participation in health and education sessions amongst all beneficiaries. However, as was mentioned in the sections above, exclusion of migratory populations and vulnerable groups such as orphans was observed. This was due to these populations not having an IDPoor card, which is a pre-requisite for registering as a beneficiary in this programme. No negative social effects were observed such as crime or social rivalry. Most non-beneficiaries understood and accepted the reason for their non-inclusion in the project and no resentment was expressed.

*I do not wish to be a part of the cash transfer project because there are many ID poor people and widows who have more children in this village and are needier.* – Non-beneficiary

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According to UNICEF’s *Operational Guidelines on Promoting Gender Equality through UNICEF-Supported Programming in Child Protection*, boys and girls without parental care find themselves at a higher risk of discrimination, inadequate care, abuse and exploitation, and their well-being is often insufficiently monitored. This reaffirms the need to include orphans within the purview of the cash transfer project.

During focus group discussions, some of the beneficiaries claimed that a positive social change is seen as a result of the cash transfer project with a reduction in domestic violence, greater confidence to participate in community activities and more respect from neighbours and the community.

No significant differences were seen across communes in project efficiency and effectiveness. The project achieved the same level of success in different places. Floating villages have a problem of access; however, beneficiaries were grateful for the cash transfer project. They claimed that the cash transfer and education sessions were very useful even if they had to travel some distance to receive the money and education sessions. They would however prefer if the cash pay points were nearer and internet connectivity was not an issue.

### 6. EVALUATION CONCLUSIONS AND LESSONS LEARNT

Cambodia’s largely stagnant nutrition status of children under the age of five indicates the need for complementary interventions. This need seems to be have been addressed (albeit in a limited geography) to some extent by which this Council on Agricultural and Rural Development (CARD) and UNICEF’s cash transfer pilot project. The cash transfer pilot in Prasat Bakong district has been a relevant and effective intervention to improve nutrition and health seeking behaviours. The pilot has been successfully implemented using only existing government staff and was able to deliver cash transfers to pregnant women and children in a timely and efficient manner. The health and nutrition education sessions had an overall positive effect on the knowledge, attitude and practices of women, and the cash transfer amount allowed them to follow the learnings provided in these sessions. The conclusions from the evaluation have been categorized under the evaluation criteria as given below:

#### Relevance

The project was in line with the Royal Government of Cambodia’s objectives for social protection and synergized with other similar cash transfer projects, which are working in different geographies and have varied designs. The project followed UNICEF’s country programme 2016-2018 and helped prioritize children’s rights and equity in social sector policies, plans, budgets and public discussions to improve all children’s access to quality social services. The targeting mechanism was somewhat relevant as it was able to capture the intended target audience; however, exclusion of vulnerable populations such as orphans and migratory populations was witnessed and remains a challenge. Negligible evidence of inclusion error was witnessed, thereby making the case that the Government should focus on exclusion errors instead. The enrolment process was smooth and appropriate given the low literacy level of the population. Methods to ensure that beneficiaries have all the required documents before the enrolment process to avoid delays remains unexplored.

The project was successful in using internal sub-national administrative staff for implementation of basic project activities. However, external staff is required on a short-term basis for developing a monitoring and evaluation framework and training of trainers for conducting health and nutrition education sessions. Further, strong capacity is needed at the national level with adequate human resources and management structure. A decentralised structure for cash transfer delivery works well but successful implementation largely depends on quality/commitment of commune focal persons.

The national level scale-up should consider trimming the co-responsibilities, keeping the ones related to health and education sessions and reducing ones which focus on institutional delivery and
vaccination. Since payment days were designed to coincide with health and nutrition education sessions, monitoring of attendance is also relatively easy. Cash transfer as opposed to in-kind transfer is the better option, given access to markets, beneficiary preference and administrative systems. Usage of cash was relevant to project objectives with most mothers spending the money on food and medicines and occasionally on clothes and debt repayment.64

### KEY LESSONS LEARNT

- **Preparedness is fundamental to ensure effective delivery of cash transfers:** Several preparatory activities can and should be done in advance, ensuring beneficiaries have all relevant documents and that telecommunication and banking networks are functional to ensure minimum delays in the payment process.

- **It is essential to establish proper coordination mechanisms:** In order to successfully design and operate a cash transfer project, coordination with a number of bodies, including government departments, information system developers and local banks or other financial institutions is imperative. These relationships need to be defined at an early stage and monitored throughout the project.

- **Cash transfers cannot be undertaken without behavior change interventions:** The health and nutrition education sessions are valued almost as much as cash transfers. Such behaviour change sessions must be a key aspect of cash transfer projects and a part of co-responsibilities to help meet project objectives and influence usage of cash. These findings are corroborated by UNICEF’s report – The Imperative of Improving Child Nutrition and the Case for Cash Transfers in Cambodia, which states that nutrition education can contribute to improved child nutritional status by improving health-related behaviors, whether hand-washing, breastfeeding, or choices about fuel use, drinking water, or sanitation. Also, Bhutta et al. (2008) find that education on complementary feeding improves height for age scores by 0.25, and supplements increase height for age by 0.41.

### Effectiveness

The cash transfer was largely effective in terms of its how the cash was used by the beneficiaries, with most of them stating that they spent it on food. The cash addressed the food need of the majority of beneficiaries and medical needs of some beneficiaries. The size of the cash transfer is seemingly inadequate to address all the nutrition and health needs of the beneficiaries. Despite effectiveness of education sessions in imparting information, effectiveness on changing mind-sets and norms is not clear. The source of information for beneficiaries regarding health and nutrition was largely noticed to be health care workers thereby validating the importance of having a platform for beneficiaries to gather information and ask questions. Some areas of improvement must be accounted for in order to change behaviour in addition to imparting information. These have been further unpacked in the section on recommendations.

A clear trend in increase in utilization of health services was not witnessed; however, some evidence of an increase in usage of health service in the district was found. Greater growth monitoring among IDPoor households was confirmed by both quantitative and qualitative data. Improved knowledge of beneficiaries on issues of hygiene and nutrition practices was reported. Better knowledge of breastfeeding practices was clearly visible, showing the effectiveness of the nutrition and health education sessions in this regard. Training of sub-national staff has scope for improvement, such as

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64 Cash transfers until the time of data collection mostly comprised of only basic payments – this must be taken into consideration while reviewing the findings and conclusions regarding adequacy of cash transfers.
making them more participative in nature. Training of Health Centre staff conducted once every two months on performing health and nutrition education sessions was successful and effective.

Use of an external agency, AMK Microfinance, was one of the key reasons for timely payment without any leakages in the payment. Information dissemination and training were relatively effective given that this was a pilot. Case management and monitoring were less effective and has scope for significant improvements.

**KEY LESSONS LEARNT**

- **Ensuring regularity of cash transfers is a key requirement to achieve intended outcomes**: Consistency of cash transfer is essential to build trust and for the cash to be used in the intended manner. Lump-sum payments at distant intervals do not work as well, presumably because they do not achieve the consumption smoothing that smaller, more predictable and regular payments do. Irregular payments also hamper the ability to support significant changes in behaviors, especially routine food consumption.

- **Use of external payment agencies can be effective in cash transfer delivery**: Cash transfers through external payment agencies sped up the delivery of cash without any leakages. Distribution through pay points avoided time delays and allowed beneficiaries to access funds through a familiar system, without discrimination.

- **Monitoring mechanisms need to be in place to track project performance**: Identifying parameters and tracking co-responsibilities, health service utilization, nutritional outcomes and key performance indicators is essential for proper monitoring and evaluation of the project.

**Efficiency**

The project was run in a smooth manner and was fairly efficient with few constraints and challenges. The administrative staff admirably undertook the implementation of targeting, enrolment and payment processes. Challenges were mainly seen in the areas of management information systems and data dissemination, monitoring and verification, and case management. The roles and responsibilities of each sub-national administrative position were clearly demarcated with no overlaps; however, there is further need for capacity building and training. Infrastructural challenges, such as internet connectivity in remote areas, access to floating villages and lack of proper IT infrastructure for better monitoring at sub-district levels, need to be examined before scale-up of the project.

The project was timely in relation to needs of social groups and relatively efficient in its overall design and implementation. The project is congruent to other similar projects with no geographical overlap. Coordination between different administrative levels was evident; however, participation of NGOs and other agencies providing complementary services was not part of the design.

Regarding cost-efficiency, overall implementation of the pilot was done in an economical manner, without using any external human resources. Service fees paid for transfer of cash to beneficiaries was as per prevailing rates for other cash transfer programmes.

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65 Consumption smoothing is the economic concept that is derived from an individual’s desire to have a stable path of consumption over a specific duration of time. It defines the ways in which people try to optimize their standard of living by ensuring a proper balance of spending and saving during the different phases of their life. Individuals desire to translate their consumption from periods of high income to periods of low income to obtain more stability and predictability.
KEY LESSONS LEARNT

➢ Compensation of staff for additional work may be required: Project implementation, reporting tools and additional demand increased workload for the participating facilities, which had varying levels of capacity to handle this work. Facility staff may need to be compensated for these additional demands including reimbursement of transport costs, especially if this is to become a full-scale project.

➢ Cost-efficiency can be achieved in the longer run due to economies of scale: Start-up costs for cash transfer projects can be expected to be high, covering formative research and advocacy, development of new management information systems to track beneficiaries on an individual level, engagement of additional staff for short term consultations and data collection, and logistics. If such a project is implemented at a larger scale, economies of scale would enter and reduce cost per beneficiary.

➢ Supply side constraints need to be tackled along with demand side interventions: For successful fulfillment of co-responsibilities and adoption of behavior change messages, it is necessary that adequate staff is present at the Health Centers with essential equipment on a daily basis. Availability of food items and dietary patterns similarly must be taken into account when providing nutrition education.

Sustainability

The gaps identified in terms of project design and implementation are rectifiable at no great cost, thereby improving the sustainability of the project. The effective and efficient use of only internal human resources in project implementation is a great success and adds to the long-term sustainability of the project. No serious challenges, constraints in the time or overall capacity of implementation staff is foreseen for a scale-up.

Overall, with some investment in increasing human resource capabilities and infrastructure (particularly information technology (IT) and telecom), this project has potential as a full-fledged national level project.

KEY LESSONS LEARNT

➢ Adequate budget should be allocated towards management costs: Appropriate resources must be allocated within project budgets for management, administrative systems, information systems, supervision and monitoring and evaluation. Large scale projects that try to cut management costs in an effort to maximize transfers to beneficiaries raise their susceptibility to mismanagement. Inadequate provision for monitoring and cross-checking increases likelihood of diversion of funds away from transfers to eligible beneficiaries, thereby undermining the objective of maximizing these transfers and dampening the sustainability of the project.

➢ Policy framework should be well defined: The policy processes and institutional contexts within which cash transfer programmes are embedded, are critical factors that affect their likelihood of success or failure in the long run.

Equity, gender equality and human rights

Project implementation was in line with the project design and women were the predominant holders of the cash transfer accounts. The involvement of men in the cash transfer project was not a part of the project design. Improving the knowledge and practices of husbands was, therefore, not directly
witnessed. The project was successful in having the same level of success across communes. No reports of problems from Health Centres or commune councils were reported.

**KEY LESSONS LEARNT**

- **Greater involvement of husbands is required:** In the next phase of the project, husbands of beneficiaries should also be encouraged to be a part of the health and nutrition education sessions. It should be reinforced that it is the duty of both parents to ensure the well-being of their child, and it is not only the mother’s responsibility.
- **Women should be the account holder to receive the cash transfer:** The account holders should continue to be women in subsequent cash transfer projects as well. The project showed that women primarily made the decision regarding usage of the cash transfer amount, which is in line with the cash transfer objectives.

7. **RECOMMENDATIONS**

The recommendations were developed based on the findings from the data collection and document review. Inputs and feedback from stakeholders were sought at multiple stages and, during several forums (presentations, workshops, one-to-one interactions and iterative reviews of reports). Responses from the key informant interviews (KII), focus group discussions (FGDs) and surveys were appropriately used, and the key gaps and challenges which were found in the pilot project informed the section on recommendations. Further, review of other cash transfer programmes in Cambodia and other countries guided the recommendations presented below. The following recommendations are presented in order of priority based on evaluator's assessment and stakeholders' opinions of the importance and timelines of actions considering the conclusions presented in the previous section.

1. **Reassess the size of cash transfer** *(Actors: UNICEF, MEF, MoSVY; Timeline: Design phase of the national programme)*

   Considering a number of beneficiaries stated that the cash transfer amount is inadequate to meet their nutrition requirements, the size of cash transfer may be re-assessed. In the longer run, benefit levels may need to be adjusted for inflation at periodic intervals.

2. **Trim co-responsibilities** *(Actors: UNICEF, MoSVY, MoH; Timeline: Design phase of the national cash transfer programme)*

   The mixed payment design (both unconditional and conditional) may be continued for future CT programmes. However, the conditions should be simple and comprehensible as well as easy for beneficiaries to understand and for service providers to deliver. Indicators/behaviours with high compliance should not be considered, for example institutional delivery. In addition to this, the unconditional design elements should also continue to be included, as these have demonstrated to generate the broadest range of benefits and offer maximum flexibility and respect for beneficiary views. This is also in line with the rights-based approach to developing cash transfer programmes.

   It is recommended that co-responsibilities be limited to attendance at health and nutrition education sessions. This is easy to monitor as these coincide with payment days and have negligible opportunity costs in terms of wages lost and transport costs. Growth monitoring too has witnessed a significant increase for IDPoor populations. However, given that the numbers participating in growth monitoring still remain low, bonus transfer based on this co-responsibility should also continue. Further, it may be considered that growth monitoring takes place during the pay days since monitoring of the condition would be easier and better compliance can be ensured. Nevertheless,
in case any conditions were to be imposed, the mechanisms to monitor them should be cost-effective and easy to implement.

Supply-side availability of health services will also need careful consideration, given that the cash transfer project will lead to an increase in utilisation of specific health services. It needs to be assured that appropriate Health Centres staff is available to perform the required services.

3. **Create an inclusive targeting mechanism** *(Actors: UNICEF, MoP, MoSVY; Timeline: Design phase of the national programme)*

The current method of targeting using IDPoor functions is more effective as a way of excluding better-off households than reaching the poorest groups. The harmonized approach of using IDPoor may be continued; however, programme specific targeting mechanisms are required to ensure inclusion of all eligible vulnerable groups not covered under IDPoor.

- IDPoor based targeting should be complemented with other mechanisms to be effective. A post-IDPoor process which is used alongside IDPoor based targeting such as community-based targeting (CBT)\(^{66}\) can be used. Combining IDPoor targeting with CBT could be the most practical way of maximizing community participation and local ownership whilst simultaneously minimizing inclusion and exclusion errors. This is reinforced by Coady et al.\(^{67}\) which highlights that targeting effectiveness is strongly associated with the use of multiple targeting instruments rather than the use of any one instrument.

- Evidence also suggests that the Proxy Means Test (PMT) approach can result in accurate targeting. While IDPoor is a PMT based approach, the update takes place every three years, which is not adequate in Cambodia’s context. Therefore, having a separate PMT mechanism may also be considered. The frequency of targeting rounds for this PMT mechanism may be annual.

A harmonized method for targeting the poorest of the poor would need to find the right combination among CBT, welfare estimations and categorical selection based on IDPoor.

4. **Adopt a phased approach to scale up** *(Actors: UNICEF and implementing ministry; Timeline: Design phase of the national programme)*

For the roll-out of the national level cash transfer project, a phased approach is recommended. To identify the areas for scaling-up, the following three key parameters may be considered:

- Level of poverty;
- Level of under-nutrition and utilization of health services in the region; and
- Infrastructure and human resource capability available in the region.

Some possible indicators, which can be assessed to identify districts for a phased approach, have been provided in **Annex 20**. Based on the combination of the indicators, districts may be selected for phased scaling-up.

The process evaluation of the World Bank-supported cash transfer pilot in Cambodia also recommends a phased approach for scaling-up. First, a short pilot phase to test the effectiveness of the proposed institutional and operational mechanisms and focus on improved utilization of public services like health and nutrition; second, a potential provincial implementation (scale-up phase) to test the impact on improving the nutritional status of children and women; and third, a potential

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\(^{66}\) In CBT, the community collectively selects households they consider most in need of the transfers. This method may be an effective mechanism to identify migratory populations, orphans etc.

nation-wide implementation (expansion phase) with focus on poverty reduction and human capital development.

5. Establish a robust management information system (MIS) and develop an appropriate monitoring and evaluation (M&E) framework (Actors: UNICEF and implementing ministry; Timeline: Design phase of the national programme)

A comprehensive robust MIS system which captures the entire life-cycle of the beneficiary in the project is recommended. Registration, enrolment and payment, compliance with co-responsibility, case management and exit processes all involve the collection, storage and regular reference to information about project beneficiaries.

- Currently several physical forms are used to capture this information. During scale-up, project MISs supporting the automated execution of the following functions: eligibility assessment, entitlement calculation and payroll production, payments reconciliation, complaints tracking, and production of analytical programme performance reports are recommended.

- Linking project MIS systems with other projects’ MIS can enable different schemes across the Government to share information reducing duplicity of efforts.

- Financial management systems which ensures timely and accurate payment of beneficiaries using payrolls prepared by the MIS, timely disbursement of funds for time-sensitive operations such as training and registration exercises, and accurate accounting for programme resources are also recommended.

Further, monitoring is a vital element of a programme to track progress and implementation quality. It can also provide valuable data to uncover whether price changes are affecting the impact of the cash transfer, payments are reaching the targeted beneficiaries, how cash is being used and the effect of cash transfers on health service utilization and improved diets. Moreover, monitoring implementation and outcomes helps to generate timely lessons for improving impact and communication to the public and policy makers.68

- Clear indicators must be identified along with the frequency of update, source of information, method to check data validity and aggregation techniques. While identifying indicators, it is important to understand what it is that is being measured, who will use the resultant information and what is expected to be done with this knowledge. Some relevant monitoring areas, indicators and sources are presented in the Annex 21.

- There should be alignment with UNICEF’s country plan69 to provide training and technical assistance to the Ministry of Planning (MoP), Ministry of Economy and Finance (MEF) and social ministries for results-based planning and M&E.

- Further, it would be beneficial to have a detailed evaluation plan outlining the timeline and objectives for baseline and periodic assessments to assess the impact of the cash transfers.

6. Roles and responsibilities of stakeholders along with capacity requirements (Actors: MoH, UNICEF, implementing ministry, commune council members; Timeline: Design phase of the national programme)

Roles and responsibilities of national and sub-national staff need to be re-assessed and re-assigned. Greater involvement of health, nutrition, and finance departments should be seen

during scale-up of the project. The following are recommendations of roles and responsibilities of the functionaries involved in implementing the cash transfer programme:

<table>
<thead>
<tr>
<th>Position/ Level</th>
<th>Current roles and responsibility</th>
<th>Recommended additional roles and responsibilities</th>
</tr>
</thead>
</table>
| National level (CARD) | • Implementation agency responsible for design, planning, roll-out, capacity building, monitoring and overall management | • Develop a social and behaviour change package for the roll out of the national level cash transfer  
• Establish social audit mechanisms. If resources permit, commission periodic validation/verification of data, on sample basis, through independent agency |
| District office | • Data collection and monitoring  
• Monitoring of commune council activities  
• Case management  
• Coordination with sectorial structures involved in social protection | • Plan and disseminate lessons learnt and good practices through appropriate channels  
• Guide sub-district staff for awareness raising activities |
| Commune council and commune committee for women and children | • Raise awareness about the cash transfer pilot among community members  
• Enrol beneficiaries  
• Compile and receive complaints  
• Ensure primary data collection of lists of compliance from Health Centres  
• Support education sessions through co-facilitation of sessions and monitor attendance  
• Promote birth registration  
• Monitor availability of preventive health services at Health Centre  
• Disseminate information regarding the pilot to village chiefs | |
| Village chief and village health support groups (VHSGs) | • Help implement education sessions alongside commune focal points  
• Promote awareness regarding the project  
• Facilitate identification and enrolment of beneficiaries  
• Provide feedback regarding beneficiary satisfaction | • Undertake a first screening of potential project beneficiaries |
| Health Centre staff | • Undertake education sessions | • Raise awareness regarding the project  
• Verification of co-responsibilities, if any |
| Payment agency | • Make payments to beneficiaries at agreed distribution points  
• Provide reconciliation report to CARD | • Conduct financial literacy sessions during pay day |
Along with recommendations on the changes in roles and responsibilities, additional recommendations on staffing requirements are given in table 7.

<table>
<thead>
<tr>
<th>Position/ Level</th>
<th>Current roles and responsibility</th>
<th>Recommended additional roles and responsibilities</th>
</tr>
</thead>
</table>
| Development partners and NGOs | - | • Conduct training of trainers on effective behaviour change  
| | | • Support in development of an effective monitoring framework with specific monitoring indicators  
| | | • Support in monitoring implementation of the project, wherever possible |

**Table 7. Recommendations on staffing and capacity building requirements**

<table>
<thead>
<tr>
<th>Position/ Level</th>
<th>Staffing and implementation mechanisms</th>
<th>Capacity building requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>National level (CARD)</td>
<td>• A small but dedicated implementation team that may be initially supported through external technical assistance for design, development and roll-out. Thereafter monitors service providers, supervises payment process and eases any difficulties within the Government system is important for the smooth transfer of payments</td>
<td>• Training and skills are required in areas of programme management, data analysis, routine capacity building, maintaining MIS and M&amp;E</td>
</tr>
</tbody>
</table>
| District office | • A dedicated grievance redress officer may be required at the district level  
| | • Coordination with ministries/departments/institutions such as MoSVY to collaborate on preparation of cash management and monitoring plans may be considered | • Capacity building on programme monitoring, data collection and data analysis  
| | | • Trainings to strengthen case management. Mechanisms may be undertaken using external resources; it must, however, be ensured that elections do not hinder the process and proper orientation is undertaken  
| | | • Capacity building to develop material to raise awareness about the project and also health and nutrition education materials |
| Commune council and commune committee for women and children | • Formal mechanisms to raise awareness about the project are required. This may include having campaigns, distributing pamphlets and organizing participatory activities, such as plays. Additional training on communication and message delivery may be considered | • Training on pre-implementation phase activities, such as, organizing birth registration camps, identifying pay points, conducting meetings with village chiefs to disseminate information etc.  
| | | • Training on what services at the Health Centres need to be monitored and ways to monitor the same  
| | | • Ensure knowledge transfer and adequate training for new council members (particularly after elections)  
| | | • Better IT training and infrastructure is needed such that primary data on compliance of co-responsibilities, attendance of education sessions can be electronically compiled and stored rather than being done manually |
### Position/Level | Staffing and Implementation Mechanisms | Capacity Building Requirements
--- | --- | ---
Village chief and VHSG  | • Become first point of contact for providing clarifications and receiving complaints from beneficiaries. Training on communication and message delivery may be considered  • Provide a FAQ booklet to enable them to answer beneficiaries’ questions effectively | • Training on formal mechanisms to raise awareness about the project is required. Capacity and material development on conducting mass media campaigns, preparing pamphlets and organizing participatory activities such as plays may be done
Health Centre staff  | • Detailed orientation on the project objectives, guidelines is needed  • Staff should record growth monitoring data in log books | • Training on ways to change behaviour and not just impart knowledge. Ways to use props and pictorial material along with participatory methods should be taught
Payment agency  | • Identify offline mechanisms for making payments at pay points with no or poor internet connectivity. An offline or manual system that can be linked for online update may be incorporated |  
Development partners and NGOs  | • No NGOs or other partners were involved in implementation of the cash transfer pilot; however, giving them the role of promoting behaviour change and monitoring may be considered |  

7. **Undertake preparatory activities** *(Actors: MoI, MoH, implementing ministry; Timeline: Pre-implementation phase of the national programme)*

Certain activities can be initiated to ensure preparedness so that the cash transfer can be rolled out smoothly and without delays. The following actions may be taken:

- Awareness campaigns and camps for birth registration, provision of yellow book etc. can be started before the start of the enrolment process thereby leading to greater efficiency in the processes; and
- The registration points should be located at a reasonable distance from the communities served, with consideration for programme budgets. If registration points require people to travel long distances, this would have time and cost implications on beneficiaries. Many people, particularly the more vulnerable, may be unable to register. Therefore, guidelines can be developed for the sub-national implementing authorities for identification of registration points.

8. **Design a grievance redress mechanism** *(Actors: UNICEF, implementing ministry; Timeline: Design phase of the national programme)*

For national level roll-out of the cash transfer, a clear redress mechanism needs to be present. A clear process flow and system for grievance resolution with specific point of contacts at each level, from village to district and even the national level, is required. The grievance redress system having the following features should be considered:

- There is an assigned focal point or grievance redress officer who manages the system. There may be different focal points for different levels to whom people can appeal if they are unhappy with the decision made at their level;
- The provision and process of the grievance redress mechanism is well publicized;
• A complaints form is available and on submission of the form, a receipt is provided to complainant;
• Information about the complaint and its resolution is documented, possibly in a management information system (MIS). The information should be accessible by relevant stakeholders with appropriate data privacy being maintained;
• There is a committee-based hearing process, which is open to the public, for certain categories of complaints, such as enrolment issues at community level, etc.; and
• Complaints are addressed within a specific timeline, generally around two weeks.

Grievance redress mechanism should consider that people have limited literacy and thus provide customer service assistants across most of its centres to help people fill in the formal complaints forms. An example of the grievance redress mechanism that was proposed for Bangladesh’s income support programme is provided in Annex 22.