REDUCING STUNTING IN CHILDREN UNDER FIVE YEARS OF AGE: A COMPREHENSIVE EVALUATION OF UNICEF’S STRATEGIES AND PROGRAMME PERFORMANCE

CAMBODIA COUNTRY CASE STUDY
REDUCING STUNTING IN CHILDREN UNDER FIVE YEARS OF AGE: A COMPREHENSIVE EVALUATION OF UNICEF’S STRATEGIES AND PROGRAMME PERFORMANCE

CAMBODIA COUNTRY CASE STUDY
Reducing Stunting in Children Under Five Years of Age:
A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance –
Cambodia Country Case Study

United Nations Children’s Fund
Three United Nations Plaza
New York, New York 10017

April 2017

The purpose of publishing evaluation reports produced by the UNICEF Evaluation Office is to
fulfil a corporate commitment to transparency through the publication of all completed
evaluations. The reports are designed to stimulate a free exchange of ideas among those
interested in the topic and to assure those supporting the work of UNICEF that it rigorously
examines its strategies, results, and overall effectiveness.

This report for Cambodia constitutes part of a global evaluation titled “Reducing Stunting in
Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and
Programme Performance” which includes six country case studies. The Cambodia case study
report was prepared by a team of independent consultants, namely Rachel Kagel and Anna
Tarrant from ICF. Senior Evaluation Officer, EO led and managed the overall evaluation
process in close collaboration with the UNICEF Cambodia Country Office where Arnaud Laillou
and Erica Mattellone were the lead counterparts. Abdoulaye Seye, Evaluation Specialist in the
EO, supported the management of the evaluation including inputs to quality assurance.

The contents of the report do not necessarily reflect the policies or views of UNICEF. The views
expressed in this report are those of the evaluators. The text has not been edited to official
publication standards and UNICEF accepts no responsibility for error. The designations in this
publication do not imply an opinion on the legal status of any country or territory, or of its
authorities, or the delimitation of frontiers.

The copyright for this report is held by the United Nations Children’s Fund. Permission is
required to reprint/reproduce/photocopy or in any other way cite or quote from this report in
written form. UNICEF has a formal permission policy that requires a written request to be
submitted. For non-commercial uses, the permission will normally be granted free of charge.
Please write to the Evaluation Office at the address below to initiate a permission request.

For further information, please contact:

Evaluation Office
United Nations Children’s Fund
Three United Nations Plaza
New York, New York 10017
evalhelp@unicef.org
ACKNOWLEDGEMENTS

This case study report is the result of the commitment, efforts and contribution of a large number of individuals and institutions. The Evaluation Office and the team wishes to thank all individuals who gave freely of their time for this evaluation, including staff from UNICEF, Government of Cambodia, UN agencies and the many International and National NGOs. We thank, Arnaud Laillou, Erica Mattellone and Natascha Paddison in the CO for facilitating management support and reviewing draft reports. We are grateful to the members of the national reference group for the Cambodia evaluation namely, H.E. Sok Silo, H.E. Prak Sophonneary, Pom Chreay, Chun Sophat, Than Sreymach, Etienne Poirot and Andrew Hill for their contributions to the evaluation.

Most importantly, we would like to thank all the children, women, members of various committees and community groups and local leaders who shared their experiences and contributed important insights to this evaluation. Thanks to Celeste Lebowitz, Evaluation Office for formatting the final report.
# Table of Contents

**ACKNOWLEDGEMENTS** .......................................................................................................................... ii  
**ACRONYMS** ........................................................................................................................................ vi  
**EXECUTIVE SUMMARY** ....................................................................................................................... 1  
  
  - Background ......................................................................................................................................... 1  
  - Case Study and Approach ...................................................................................................................... 1  
  - Key Conclusions ................................................................................................................................. 2  
  - Recommendations ............................................................................................................................. 3  

1. **Introduction** ........................................................................................................................................ 5  
   
   - About This Report .............................................................................................................................. 5  
   - Global Context ................................................................................................................................... 5  
   - UNICEF’s Focus on Stunting .............................................................................................................. 6  
   - Need to Assess UNICEF’s Strategies and Performance ........................................................................ 7  

2. **Global Evaluation Methodology** ........................................................................................................... 7  
   
   - Methodological Approach ................................................................................................................ 7  
   - Evaluation Components ...................................................................................................................... 8  
   - Country Selection ............................................................................................................................... 9  

3. **Cambodia Case Study Methodology** .................................................................................................... 9  
   
   - Data Sources .................................................................................................................................... 10  
     - Document Review .......................................................................................................................... 10  
     - Secondary Quantitative Data .......................................................................................................... 10  
     - Key Informant Interviews ................................................................................................................ 10  
     - Country Office and External Stakeholder Survey ............................................................................. 11  
   - Data Analysis ..................................................................................................................................... 11  
   - Case Study Limitations ...................................................................................................................... 11  

4. **UNICEF Cambodia Programme Overview** .......................................................................................... 12  
   
   - Overview of Stunting in Cambodia ..................................................................................................... 12  
     - Background and Recent Trends ......................................................................................................... 12  
     - Government Strategies ...................................................................................................................... 14  
   - UNICEF Cambodia Country Programme ............................................................................................ 14  
   - UNICEF Cambodia Approach to Stunting .......................................................................................... 15  
     - 2011–2015 Approach to Stunting Reduction .................................................................................... 15  
     - 2016–2018 Approach to Stunting Reduction .................................................................................... 17  

5. **Evaluation Findings** ............................................................................................................................ 18  
   
   - Relevance, appropriateness, adequacy, and coherence of strategies and plans ............................... 18  
     - Relevance to Country Context and Needs ........................................................................................ 18  
     - Alignment with National Strategies ................................................................................................. 21  
     - Alignment with Regional Strategies ................................................................................................. 22  
     - Alignment with Global Strategies .................................................................................................... 23  
     - Conclusion ....................................................................................................................................... 24  
   - Effectiveness of the country programme in addressing stunting ....................................................... 24  

Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance  
Cambodia Country Case Study
Changes in Performance of Stunting Indicators ................................................................. 25
Achievements Towards Addressing Strategic Plan Outputs .......................................... 25
Conclusion..................................................................................................................... 30
5.3 Efficiency of management and operations................................................................. 31
Utilization of available resources to achieve programme outputs .............................. 31
Conclusion..................................................................................................................... 33
5.4 Sustainability and scale-up ....................................................................................... 33
Sustainability ............................................................................................................... 33
Scale-Up ....................................................................................................................... 35
Conclusion..................................................................................................................... 35
5.5 Leadership and leveraging partnerships ..................................................................... 35
Types of Partnerships and Leadership Activities ......................................................... 36
Successes ....................................................................................................................... 36
Challenges ..................................................................................................................... 36
Conclusion..................................................................................................................... 37
5.6 Equity and reach of disadvantaged children .............................................................. 38
Approach to Reaching Vulnerable Populations ............................................................ 38
Successes ....................................................................................................................... 40
Challenges ..................................................................................................................... 40
Conclusion..................................................................................................................... 40
5.7 Knowledge/data generation, management, and use ..................................................... 40
Knowledge and Data Generation Activities ................................................................. 41
Successes ....................................................................................................................... 42
Challenges ..................................................................................................................... 43
Gaps in Knowledge and Data ....................................................................................... 43
Conclusion..................................................................................................................... 43
6. Recommendations ..................................................................................................... 44
ANNEXES ....................................................................................................................... 45
Annex 1 ............................................................................................................................ 45
    Global Evaluation Methodology ................................................................................ 45
Annex 2 ............................................................................................................................ 49
    Cambodia Evaluation Reference Group ................................................................. 49
Annex 3 ............................................................................................................................ 51
    Documents Reviewed ................................................................................................ 51
Annex 4 ............................................................................................................................ 53
    Key Informant Interview Respondents ..................................................................... 53
Annex 5 ............................................................................................................................ 55
    UNICEF Cambodia’s Plan to Reduce Stunting 2011-2015 ...................................... 55
Annex 6 ............................................................................................................................ 68
    UNICEF Cambodia’s Plan to Reduce Stunting 2016-2018 ...................................... 68
Annex 7 ............................................................................................................................ 75
Evidence Matrix of Key Contextual Factors Related to Stunting in Cambodia.................. 75

Annex 8 .................................................................................................................................................. 87

Assessment of UNICEF Cambodia’s Approach to Stunting Reduction Using UNICEF’s Simplified Schematic Linking Conditions to Interventions for Improving Child and Maternal Nutrition .................................................................................................................... 87

Annex 9 .................................................................................................................................................. 95

Evidence Matrix of the Effectiveness of Stunting-Related Components of the 2011–2015 Country Programme................................................................................................................................. 95
# ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>C4D</td>
<td>Communication for Development</td>
</tr>
<tr>
<td>CARD</td>
<td>Council for Agricultural and Rural Development</td>
</tr>
<tr>
<td>CDB</td>
<td>Commune Data Base</td>
</tr>
<tr>
<td>CHAI</td>
<td>Clinton Health Access Initiative</td>
</tr>
<tr>
<td>CLTS</td>
<td>Community-Led Total Sanitation</td>
</tr>
<tr>
<td>CO</td>
<td>Country Office</td>
</tr>
<tr>
<td>COMBI</td>
<td>Communication for Behavioural Impact</td>
</tr>
<tr>
<td>CPAP</td>
<td>County Programme Action Plan</td>
</tr>
<tr>
<td>CPD</td>
<td>Country Programme Document</td>
</tr>
<tr>
<td>CSES</td>
<td>Cambodia Socio-Economic Survey</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
</tr>
<tr>
<td>CSPKK</td>
<td>Community of Salt Producers of Kampot and Kep</td>
</tr>
<tr>
<td>CSR</td>
<td>Corporate Social Responsibility</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>EAPRO</td>
<td>East Asia and Pacific Regional Office</td>
</tr>
<tr>
<td>ECCD</td>
<td>Early Childhood Care and Development</td>
</tr>
<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
</tr>
<tr>
<td>EO</td>
<td>Evaluation Office</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organization of the United Nations</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>GIZ</td>
<td>Deutsche Gesellschaft für Internationale Zusammenarbeit</td>
</tr>
<tr>
<td>GRET</td>
<td>Groupe de Recherche et d’Echanges Technologiques</td>
</tr>
<tr>
<td>GTZ</td>
<td>German Technical Cooperation</td>
</tr>
<tr>
<td>HKI</td>
<td>Helen Keller International</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HSSP2</td>
<td>The Second Health Sector Support Project</td>
</tr>
<tr>
<td>IECD</td>
<td>Integrated Early Childhood Development</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labour Organization</td>
</tr>
<tr>
<td>IRD</td>
<td>Institut de Recherche pour le Développement</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>IUGR</td>
<td>Intrauterine Growth Restriction</td>
</tr>
<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
</tr>
<tr>
<td>KII</td>
<td>Key Informant Interview</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
</tr>
<tr>
<td>MNCHN</td>
<td>Maternal, Newborn Child Health and Nutrition</td>
</tr>
<tr>
<td>MNP</td>
<td>Micronutrient Powder</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOP</td>
<td>Ministry of Planning</td>
</tr>
<tr>
<td>MRD</td>
<td>Ministry of Rural Development</td>
</tr>
<tr>
<td>MTR</td>
<td>Midterm Review</td>
</tr>
<tr>
<td>MUAC</td>
<td>Mid-Upper Arm Circumference</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental Organisation</td>
</tr>
<tr>
<td>NSDP</td>
<td>National Strategic Development Plan</td>
</tr>
<tr>
<td>PAC</td>
<td>Policy, Advocacy and Communication</td>
</tr>
<tr>
<td>PBA</td>
<td>Programme-Based Approach</td>
</tr>
<tr>
<td>RACHA</td>
<td>Reproductive and Child Health Alliance</td>
</tr>
<tr>
<td>RAR</td>
<td>Regional Analysis Report</td>
</tr>
<tr>
<td>REACH</td>
<td>Renewed Efforts Against Child Hunger and Undernutrition</td>
</tr>
<tr>
<td>RGC</td>
<td>Royal Government of Cambodia</td>
</tr>
<tr>
<td>RHAC</td>
<td>Reproductive Health Association of Cambodia</td>
</tr>
<tr>
<td>ROMP</td>
<td>Regional Office Operations and Management Plan</td>
</tr>
<tr>
<td>RUTF</td>
<td>Ready-To-Use Therapeutic Food</td>
</tr>
<tr>
<td>RWSSH</td>
<td>Rural Water Supply, Sanitation and Hygiene</td>
</tr>
<tr>
<td>SAM</td>
<td>Severe Acute Malnutrition</td>
</tr>
<tr>
<td>SP</td>
<td>Strategic Plan</td>
</tr>
<tr>
<td>SUN</td>
<td>Scaling Up Nutrition</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>UNDAP</td>
<td>United Nations Development Assistance Plan</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
</tbody>
</table>

Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance
Cambodia Country Case Study
USAID  U.S. Agency for International Development
WASH  Water, Sanitation and Hygiene
WFP  United Nations World Food Programme
WHA  World Health Assembly
WHO  World Health Organization
WSP  Water Safety Plan
WSP  World Bank Water and Sanitation Programme
EXECUTIVE SUMMARY

Background

Approximately 156 million of the world’s children under the age of 5 are stunted, with an estimated 80% of these children concentrated in only 14 countries. Stunting jeopardizes child survival and development by contributing to child mortality, morbidity, and disability, including impaired or non-optimal physical growth and cognitive development. In recent years, the global nutrition community has increased its focus on stunting. Developments in science have supported the causal relationship between stunting and short-term childhood development, as well as with long-term intergenerational effects on families. These relationships highlight the critical importance of nutrition during the first 1,000 days between a woman’s pregnancy and her child’s 2nd birthday, a period associated with risks of irreversible effects. In addition, research has provided evidence identifying effective, cost-efficient, and scalable interventions to address stunting. Concurrently, the international community working to reduce stunting has recognized lessons learned and models to support multi-sectoral approaches to improvements in nutrition.

Case Study and Approach

Given the global commitments, the United Nations Children’s Fund (UNICEF) contracted with ICF to conduct an evaluation of UNICEF stunting reduction efforts. The evaluation is the first formal, global attempt to assess UNICEF’s global strategies and country programme performance in reducing stunting among children under 5. The evaluation consists of three related studies: a desk review of documents from 24 globally representative countries, in-depth case studies of UNICEF’s stunting reduction efforts and activities in six countries (which is the focus of this report), and a global synthesis of UNICEF efforts.

Country selection took into account the range of country contexts where stunting is widely prevalent, giving attention to development settings and to contexts affected by fragility and humanitarian emergencies. Cambodia has seen a decline in stunting of over 25 percentage points over the last 20 years but still has a high burden—the most recent figures show a stunting prevalence of 32%. The country was selected for a case study to explore the situation of a high stunting burden coupled with high severe acute malnutrition rates but low resources available to address stunting within UNICEF.

The case study addresses three UNICEF objectives:

1. Assess the **relevance, appropriateness, and coherence** of UNICEF’s country strategies and plans to address stunting in young children.

2. Assess the **effectiveness, efficiency, and sustainability** of UNICEF’s country programmes in addressing stunting in young children, with particular attention to less-reached, disadvantaged, and vulnerable groups, and draw lessons on **equitable** progress in reducing stunting in various programme contexts.
3. Assess UNICEF’s leadership, guidance, and technical support, as well as the adequacy of UNICEF staffing and institutional capacity to respond to the lead role the organization is expected to play at the field level in contributing to the sustainable and equitable reduction of stunting.

**Key Conclusions**

**Conclusion 1:** The 2016–2018 country program is a strong move towards adopting a more integrated, intentional, and effective approach to stunting.

UNICEF Cambodia’s country programs have operated from 2011 to 2015 and then from 2016 to 2018. Stunting was not a focus of the 2011–2015 program, but Cambodia’s newer approach to stunting consists of a more intentionally integrated approach to stunting reduction through the intentional convergence of health, Water, Sanitation and Hygiene (WASH), and nutrition-specific programming in the Northeast. Severe stunting is more prevalent in the Northeast, and fewer health and nutrition services are available there. This approach is aligned to the desired outputs of the global Strategic Plan (SP), adapted to the country context and responsive to thorough situation analyses as well as government plans and priorities.

Gaps in the new current country programme related to migrant labour, gender, linkages to agriculture, and disaggregated nutrition data were relatively minor.

**Conclusion 2:** Results in the area of national capacity to provide access to nutrition interventions have not been realised. Challenges in creating behaviour change also remain.

Successes were strongest in strengthening political commitment rather than capacity building or supporting service delivery, which is logical—political commitment and national capacity to legislate, plan, and budget are necessary first steps to provide access to nutrition interventions or provide support for caregivers and communities to improve nutrition and care practices.

Further, wasting has been highly prevalent in Cambodia over the last decade, and much nutrition funding and attention has understandably been given to treating severe acute malnutrition rather than stunting. Building national capacity and supporting multisectoral stunting interventions are the next steps that UNICEF Cambodia is taking. Cultural practices around breastfeeding have been a significant challenge in advancing nutrition interventions.

**Conclusion 3:** UNICEF Cambodia has been effective in generating political commitment through data and knowledge generation, but commitment needs to be better translated into program actions.

UNICEF’s success in strengthening political commitment is largely owed to substantial knowledge and data generation, including the use of an economic argument presented in *The Imperative of Improving Child Nutrition and the Case for Cash Transfers in Cambodia*. UNICEF has been prolific in generating evidence for nutrition in the form of peer-reviewed articles. While this is a clear success, much of the more academic knowledge that UNICEF generates could benefit from being synthesised and transformed for different audiences.
Leadership and leveraging partnerships to reduce stunting are also among UNICEF Cambodia’s strongest comparative advantages. Three factors have driven its ability to leverage partnerships: a high degree of technical expertise that is trusted by government and non-government partners, generation and use of high-quality data, and the “naming and shaming” process of not having been on track to achieve Millennium Development Goal (MDG) 1, which seeks to eradicate extreme poverty and hunger. UNICEF has been successful at convening partners to work on stunting but could play a stronger role in improving coordination mechanisms and capacity for stunting prevention among other United Nations (UN) agencies that do not have nutrition-specific expertise, development partners that are also working on stunting, and subnational actors.

**Conclusion 4: The current vision for scale-up of stunting prevention activities could be better articulated.**

UNICEF Cambodia has considered sustainability and scale-up when designing and implementing their country programmes, namely through individual and institutional capacity building of multiple national structures. Scale-up has focused on balancing upstream policy work with maintaining and learning from its on-the-ground presence. UNICEF’s work in the Northeast targets populations more at risk for severe stunting, however, it is not clear if or how lessons generated from this work will apply to populations across the country who are vulnerable to moderate stunting. Further, better subnational data on moderate stunting is needed to be confident that those most vulnerable to stunting overall have been identified.

**Conclusion 5: The level of funding available for stunting prevention is inadequate.**

As Cambodia transitions to middle-income status, UNICEF Cambodia faces a dwindling resource base and must target resources towards the most effective interventions and reaching the most vulnerable populations. More resources are needed to reach all children in Cambodia vulnerable to stunting.

**Recommendations**

1. Invest in capacity building with external stakeholders and partners around the concept and operationalization of stunting as a multi-sectoral issue, especially at the subnational level. Internally, continue to build staff capacity in the areas of policy and advocacy work for stunting and to refine the approach to integrating health, WASH, and nutrition and working with other sectors, including social protection.

2. Allocate financial resources to create action-oriented briefs for all relevant research published in academic journals. These briefs should be translated into Khmer so that Royal Government of Cambodia (RGC) counterparts can use them.

3. Further, in the context of limited resources, it is important to clarify the strategy and vision for scaling up integrated nutrition, health and WASH interventions in the Northeast that target populations most vulnerable to severe stunting to wider populations that are vulnerable to moderate stunting. Given the level of resources available, the ultimate goal may not be scale-up, but rather to generate general lessons on delivering multi-sectoral interventions.
4. The UN family exercises a high degree of influence in policy and advocacy efforts, and it could benefit from developing plans and procedures for conducting joint advocacy efforts to translate what each organization has learned into concrete ideas for government stakeholders.

5. Infant and Young Child Feeding (IYCF) campaigns should leverage the expertise of Communication for Development (C4D) and nutrition staff to move from traditional communication and media campaigns to a focus on behaviour change for stunting interventions—the provision in the current country programme to reinforce these messages through health workers is a step in the right direction. Central to this is the ability to mobilize adequate funding.
1. Introduction

1.1 About This Report

This country report was developed to provide evidence of UNICEF Cambodia’s accountability, effectiveness, and organizational learning and to advance its work to reduce stunting among young children in Cambodia. The report includes six major chapters that discuss the results of the Cambodia case study component of the Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance. The first chapter provides an overview of the problem of child stunting and the scope and approach of the case study. The second chapter provides an overview of the global evaluation methodology, while the third chapter discusses the Cambodia case study methodology. UNICEF Cambodia’s approaches to the problem of stunting are presented in chapter 4. The fifth chapter presents the findings of the case study evaluation. Chapter 5.1 discusses evaluation findings related to the relevance, appropriateness, adequacy, and coherence of UNICEF Cambodia’s strategies and plans to reduce child stunting. Chapter 5.2 presents the effectiveness of country programs to address stunting with respect to upstream work, capacity development, nutrition-specific and nutrition-sensitive interventions, and addressing stunting in emergency situations. The efficiency of management and program operations are presented in Chapter 5.3. Sustainability and the scale-up of promising strategies are presented in Chapter 5.4, while Chapter 5.5 presents an assessment of UNICEF’s leadership and collaboration with partners as they relate to stunting reduction. Chapter 5.6 describes equity issues related to child stunting and UNICEF’s work, and Chapter 5.7 summarizes the evaluation findings related to programme knowledge use, data generation, and knowledge dissemination. Finally, Chapter 6 presents recommendations for UNICEF Cambodia’s future work in child stunting reduction.

1.2 Global Context

Approximately 156 million of the world’s children under the age of 5 are stunted.\(^1\) Stunting, or low height for age, results from chronic undernutrition, frequent infections, and other conditions that reduce absorption of important nutrients. Stunting is most likely to occur within the first 1,000 days, the period from conception through the child’s first two years of life.\(^2\) Stunting is associated with suboptimal mental and physical development, having long-term impact on

---


intellectual functioning, school performance, future earnings, risk of obesity, and risk of chronic diseases. These effects are often irreversible, even with improvements in nutrition after age 2.

In 2008, *The Lancet* published an important series on maternal and child undernutrition that concluded that more than a third of child deaths and 11% of the total disease burden worldwide were due to maternal and child undernutrition. The series characterized nutrition as a desperately neglected aspect of maternal and child health and played a key role in garnering the attention of the global development community to nutrition, especially to the first 1,000 days, the critical period of vulnerability from pregnancy to a child’s second birthday. The series quantified the prevalence and consequences of stunting specifically, bringing much-needed attention to the link between chronic undernutrition and development.

The Scaling Up Nutrition (SUN) movement was launched soon thereafter to address *The Lancet’s* characterization of the international architecture to deal with undernutrition as “fragmented and dysfunctional.” Several UN agencies joined together in 2008 to form the Renewed Efforts Against Child Hunger and undernutrition (REACH) to assist governments of countries with a high burden of child and maternal undernutrition in accelerating the scale-up of food and nutrition actions. The World Health Assembly (WHA) endorsed stunting as a key indicator for monitoring maternal, infant, and young child nutrition in 2012.

### 1.3 UNICEF’s Focus on Stunting

With a greater focus on and understanding of the long-term consequences of chronic undernutrition, UNICEF and other international actors shifted their emphasis from efforts to reduce the prevalence of underweight to the prevention of stunting among children. UNICEF prioritized stunting reduction in its SP 2014–2017. The SP 2014–2017 includes Outcome 4: Nutrition: “improved and equitable use of nutrition support and improved nutrition and care priorities,” and the corresponding six output statements (Exhibit 1). Impact Indicator 4a measures the “number of children under 5 years who are moderately and severely stunted” and aligns with the WHA Global Nutrition Target 2025 for stunting, which calls for a 40% reduction in the number of children under 5 who are stunted. These commitments require UNICEF to work in an integrated manner across sections including nutrition, health, WASH, early childhood development, education, and social protection to reduce stunting. Concurrently, UNICEF has increased its funding and investment in nutrition, health, WASH, education, and social protection. In 2015, UNICEF developed its Approach to Scaling Up Nutrition, which more clearly

---


---

Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance Cambodia Country Case Study
articulates “malnutrition’s multifactorial aetiology” and the importance of coordination across sectors to achieve optimal and sustainable impact towards the reduction of stunting. Although this document has not been formally adopted by UNICEF’s Executive Board, it serves as an important resource for country offices (COs).

Exhibit 1. Nutrition Outputs in the UNICEF Strategic Plan 2014–2017

### Outcome Area 4: Nutrition

| Enhanced support for children, caregivers, and communities for improved nutrition and care practices | Increased national capacity to provide access to nutrition interventions | Strengthened political commitment, accountability, and national capacity to legislate, plan, and budget for scaling up nutrition interventions | Increased country capacity and delivery of services to ensure protection of the nutritional status of girls, boys, and women from the effects of humanitarian situations | Increased capacity of governments and partners, as duty-bearers, to identify and respond to key human rights and gender equality dimensions of nutrition | Enhanced global and regional capacity to accelerate progress in child nutrition |

1.4 Need to Assess UNICEF’s Strategies and Performance

Given these global commitments, UNICEF’s Evaluation Office (EO) commissioned a corporate-level external evaluation of UNICEF efforts to reduce stunting, produce concrete policy and programmatic evidence, and inform future global strategies and country programmes. The purpose of the comprehensive evaluation is to provide evidence to enhance UNICEF’s accountability, effectiveness, and organizational learning and advance its work to reduce stunting among young children. The evaluation is the first formal, global attempt to assess UNICEF’s global strategies and country programme performance in reducing stunting among children under 5. The evaluation was independently managed by the UNICEF Evaluation Office.

2. Global Evaluation Methodology

2.1 Methodological Approach

The evaluation uses a theory-based approach that examines UNICEF efforts to reduce stunting through nutrition-specific and nutrition-sensitive action (see Evaluation Framework in Exhibit 2). The evaluation explores the relevance, appropriateness, and coherence of UNICEF’s global strategic plans; global and regional support; country programmes and plans; the effectiveness, efficiency, and sustainability of country programmes; and UNICEF’s leadership, guidance, and technical support at all levels. The evaluation also considers the extent to which UNICEF engages across sectors to reduce stunting, both internally and externally. The full evaluation methodology is presented in Annex 1.
2.2 Evaluation Components

The global evaluation consists of three components: a desk review of 24 countries,\(^9\) case studies in 6 countries,\(^10\) and a global synthesis. Each evaluation component is described in Exhibit 3 below.

### Desk review of 24 countries

The desk review is used to assess UNICEF’s work at the country level and will include a mix of countries from all UNICEF regions and various contexts where stunting has decreased significantly and where it has remained stagnant. The desk review evaluates the translation of global strategies to country strategies and action plans and will investigate if relevant outputs from the Strategic Plan are aligned with country plans and priorities are being sustainably achieved.

### Case studies of 6 countries

The case studies provide a more detailed analysis of country programmes and provide greater depth in interpreting the evaluation questions. In particular, the country case studies will allow for a better understanding of subnational situations, strategies, and programmes; operations across organizational levels (subnational, national, regional, global); and relationships with other stakeholders in stunting reduction.

### Global synthesis

The synthesis of global findings builds on evidence from the desk review and country case studies to identify outputs being achieved from a global perspective and to provide a comprehensive picture of UNICEF leadership efforts to shape the agenda and drive sustainable results for stunting reduction at a global level.

---

\(^9\) Desk review countries considered were Bangladesh, Bolivia, Burundi, Cambodia, Ecuador, Egypt, Ethiopia, Ghana, Guatemala, Haiti, India, Indonesia, Kenya, Madagascar, Mali, Mozambique, Myanmar, Nepal, Niger, Nigeria, Pakistan, Rwanda, Somalia, Sudan, Tajikistan, Timor Leste, Turkmenistan, Uganda, Vietnam, and Yemen.

\(^10\) Case study countries considered were Cambodia, Haiti, India, Mozambique, Rwanda, and Niger.
The global evaluation uses a mix of qualitative and quantitative data and analytical methods to assess UNICEF’s strategies and programme performance for the period 2010–2015. Data was aggregated and triangulated to track common themes, trends, and patterns across key evaluation questions. Both qualitative and quantitative data were utilized, but the qualitative data received more weight in the interpretation of findings.

2.3 Country Selection

Desk review countries were selected to provide a comprehensive picture of UNICEF programming globally while prioritizing countries with a high stunting burden. The evaluation team primarily considered current stunting prevalence and change in stunting prevalence but also considered variations in geographic region; WASH indicators; UNICEF programmatic approaches; and UNICEF funding for nutrition programming, poverty, gender equality, emergencies, and political situations.

Case study countries were selected to explore successful and less successful programs in varying contexts. Although they are intended to represent diverse program implementation circumstances and outcomes, the selected case study countries are not intended to represent all UNICEF stunting reduction programs globally. One case study was conducted in each region with the exception of the Middle East and North Africa regions, where no case studies were conducted, and the East and Southern Africa regions, where two case studies were conducted. Consideration was also given to country office staff capacity and willingness to participate in a case study.

Cambodia was selected as the case study country for the East Asia and Pacific region because it has one of the highest stunting rates in the region. It also represents an opportunity to explore a substantial decline in stunting prevalence coupled with relatively high rates of severe acute malnutrition. UNICEF Cambodia also had few resources dedicated to addressing stunting during the evaluation period, providing an opportunity to explore how UNICEF addressed stunting in a resource-scarce setting.

3. Cambodia Case Study Methodology

This case study examines UNICEF Cambodia’s efforts to address stunting at the national and subnational levels. It considers the extent to which the country programme and related plans support the effective implementation of programme actions at the national and subnational levels, and the alignment and achievement of outputs to improve nutrition.

This report provides an overview of stunting among children under 5 in Cambodia and findings from the case study in seven areas:

1. Relevance, appropriateness, adequacy, and coherence of strategies and plans
2. Effectiveness of the country programme in addressing stunting
3. Efficiency of management and operations
4. Sustainability and scale-up
5. Leadership and leveraging partnerships
6. Equity and reach of disadvantaged children
7. Knowledge/data generation, management, and use

The design of this case study was reviewed by an Evaluation Reference Group. A list of reference group members is included as Annex 2.

This report provides conclusions and recommendations for strengthening UNICEF Cambodia’s approach to reducing stunting. This report may also be useful to other UNICEF country offices interested in adopting parts of UNICEF Cambodia’s approach.

3.1 Data Sources

The Cambodia case study relied on four data sources:

- Document review of UNICEF-provided documents
- Secondary quantitative data
- Key informant interviews (KIIs) with UNICEF Cambodia staff and relevant external stakeholders
- CO and external stakeholder survey data

Document Review

The qualitative assessment was informed by documents gathered by the UNICEF EO, Regional Office, and Cambodia CO, as well as publicly available documents extracted from UNICEF Web sites. Documents for the case studies included UNICEF Country Programme Documents (CPDs), annual reports, United Nations Development Assistance Frameworks (UNDAFs), United Nations Development Assistance Plans (UNDAPs), and Midterm Reviews (MTRs) for the years 2010–2015. In addition, the evaluation team reviewed Regional Office Operations and Management Plans (ROMPs), Regional Analysis Reports (RARs), and global strategic documents related to stunting reduction. A complete list of documents reviewed for the Cambodia case study is included in Annex 3.

Secondary Quantitative Data

The Cambodia Demographic & Health Surveys (DHS) conducted in 2010 and 2014 serve as the primary source of secondary quantitative data. DHS are nationally (but not provincially) representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition. Additional data sources such as the UNICEF Joint Monitoring Program and the Food and Agriculture Organization of the United Nations’ (FAO’s) Food Security Statistics were used to inform global and national measures and trends related to stunting reduction efforts. As a proxy for resources, UNICEF shared funding information related to overall and nutrition-related programming for Cambodia’s CO.

Key Informant Interviews

Thirty-nine KIIs were conducted by two ICF evaluation team members primarily during a one-week site visit in June 2016. The evaluation team worked with the Cambodia Evaluation Reference Group to identify key informants, who included UNICEF Cambodia technical staff.
and leaders, national and subnational policymakers and programme coordinators, donors, other UN agencies, and nongovernmental organisation (NGO) partners. A full list of KII respondents is included in Annex 4.

Interviews were primarily conducted in Phnom Penh, but the team also visited Kratie in the Northeast. Kratie was selected for a field visit because UNICEF’s zone office for the Northeast is located there—the Northeast is a focus of the current country programme. Further, Kratie was selected because of its proximity to Phnom Penh, making a visit more feasible.

Country Office and External Stakeholder Survey

To supplement data collected through document review, KII, and secondary data, ICF developed two Web-based survey instruments. Survey questions included a mix of predetermined and open-ended responses across the evaluation subjects. The first Web-based survey was sent to the UNICEF COs in all evaluation countries. A second survey was administered to external stakeholders identified by CO staff.

3.2 Data Analysis

The evaluation team used thematic analysis to systematically review and sort data according to a framework informed by the programme logic and research questions. As issues, patterns, and themes were identified during the review, the evaluation team expanded the framework to incorporate them into the analysis. Interpretation of the data proceeded along with development of the thematic framework and included the identification of associations among, and explanations for, observed phenomena.

The evaluation team used triangulation to provide confirmation of patterns or findings and the identification of important discrepancies across sources of information:

- Triangulation was used to reconcile findings across the multiple sources of data.
- For the interviews and surveys, triangulation was used to identify agreement and discrepancies in responses within and across the individuals’ roles.
- Qualitative and quantitative data collected were triangulated to respond to evaluation questions.

Additional information related to the coding and analysis of the KII and documents is provided in the Evaluation Methodology (Annex 1).

3.3 Case Study Limitations

The evaluation has made best efforts to triangulate information to follow the agreed-upon evaluation framework and respond to evaluation questions. However, in some cases information was not available to assess some questions. Case studies were limited to a one-week period in the country and thus primarily focused on the national-level programme. Furthermore, key informants responded to each evaluation subject according to their knowledge and experience with UNICEF in that specific area. Therefore, the depth of information collected in the KII varies
across evaluation subjects and respondents. The evaluation team triangulated data from other sources to address these limitations of the qualitative data.

Despite these constraints and limitations, the evaluation team addresses the evaluation questions and provides the most accurate findings and recommendations from them as possible.

The time period for this evaluation is 2010–2015, which mostly coincides with Cambodia’s 2011–2015 country programme. However, stunting was not a focus of this programme, which is a limitation. As the evaluation is formative and forward-looking, the evaluation also considers UNICEF Cambodia’s current country programme (2016–2018), in all areas except for effectiveness—as it is too early to evaluate the effectiveness of the new programme.

4. UNICEF Cambodia Programme Overview

4.1 Overview of Stunting in Cambodia

Background and Recent Trends

In recent years, Cambodia has experienced significant economic and human development and officially reached middle-income status in July 2016. Marked improvements in nutrition have followed economic growth, with a 25 percentage point drop in stunting over the last 20 years (see Exhibit 4). However, stunting prevalence remains high—the most recent figures show a stunting prevalence of 32%.¹¹ Large economic disparities exist in nutritional status, with children from the poorest families more than twice as likely to be stunted as children from the wealthiest families.¹² Stunting is more prevalent among children whose mother did not attend


school, who live in rural areas, and who fall within the lowest wealth quintile. Relatedly, improvements in stunting have not been shared equally across the country, with stark disparities between urban and remote rural areas in the Northeast (see Exhibit 5). Cambodia is likely to remain a least developed country for the foreseeable future.


---


14 As noted above, DHS studies are limited by sample size to be representative at the provincial level. The evaluation reference group felt that these statistics may not be completely accurate.
Child mortality in Cambodia remains among the highest in Asia, predominately due to high neonatal mortality caused by pneumonia and diarrhoea. Malnutrition is considered the underlying cause of 45% of child deaths and 20% of maternal deaths and creates an economic loss of 1-2% of the gross domestic product (GDP) annually, more than 40% of which is estimated to be attributable to stunting. More than 50% of children under 5 are anaemic; 10% are wasted, including 2% severely wasted; and 24% are underweight. In 2015, only about 5% of severely acute malnourished children were referred for treatment.

**Government Strategies**

Within the past 4-5 years, the RGC has taken action to address the nutritional status of children under-5 through the instalment of a nutrition coordination body and development of the National Strategy for Food Security and Nutrition 2014–2018 and Fast Track Road Map for Improving Nutrition 2014–2020. Cambodia joined the SUN movement in 2015, furthering this commitment. The Council for Agricultural and Rural Development (CARD) reports directly to the Prime Minister and is a key government stakeholder in the coordination and implementation of nutrition-specific and nutrition-sensitive interventions.

**4.2 UNICEF Cambodia Country Programme**

UNICEF began its work in Cambodia in 1952 and opened its first country office in 1973 at the height of the country’s civil war. At the time, the organization’s key mandate was to provide humanitarian relief to children affected by conflict. Today, UNICEF works in Cambodia to promote and protect the rights of children in partnership with the government, civil society, NGOs, development partners, and the communities themselves. While operating nationwide, UNICEF focuses on provinces with the highest disparities and worst child development indicators to ensure an equitable approach towards improving the lives of women and children.

UNICEF’s country-specific strategies are organized in three- to five-year country programmes that have usually been evaluated during an MTR process. Cambodia’s recent country programmes were developed for 2011–2015 and 2016–2018. The overall goal of the 2011–

---


Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance

Cambodia Country Case Study
2015 country programme was to “advance the realization of children’s rights by contributing to accelerated progress towards achievement of the Cambodian MDGs, with equity.”23 The impact statement for the 2016–2018 country programme was that “all children, especially the most disadvantaged, enjoy their rights to survival, care, protection, and development.” The Ministry of Planning of the RGC assumes overall coordination of the UNICEF country programme.24

4.3 UNICEF Cambodia Approach to Stunting

Because the period for this evaluation is 2010–2015, this report primarily focuses on the 2011–2015 country programme, both as originally planned and as revised following the MTR. Annex 5 of this report presents the stunting-related components of the country programme for 2011–2015 as described in written materials. Annex 6 presents the same for the 2016–2018 country programme. These written materials are triangulated with KII data and survey data and are summarized below.

2011–2015 Approach to Stunting Reduction

UNICEF Cambodia did not explicitly devote its work/resources toward stunting reduction during this period. However, the country programme did include a number of nutrition-specific and nutrition-sensitive components relevant for addressing stunting.

Strengthened political commitment and national capacity to legislate, plan, and budget for scaling up nutrition interventions

Upstream work is key to ensuring that the national development agendas prominently feature stunting. Relevant actions for upstream work outlined in global guidance documents include advocacy, support for the development of national policies, and guidance development on how to implement, monitor, and evaluate nutrition programmes.

UNICEF Cambodia planned to contribute to an “enhanced policy environment” and participate in “policy development advocacy and resource leveraging” related to the Maternal, Newborn Child Health and Nutrition (MNCHN) Programme, but it is not stated which policies this applies to and whether they were stunting-related. UNICEF stakeholders reported that supporting the development of the National Strategy for Food Security and Nutrition 2014–2018 and Fast Track Road Map for Improving Nutrition 2014–2020 was a key component of their plan,25,26 as was advocating for Cambodia joining the SUN movement. In WASH, UNICEF planned to continue to support the rollout of the Rural Water Supply, Sanitation and Hygiene (RWSSH) strategy.

24 Ibid.
The MNCHN programme planned to continue close collaboration with the Ministry of Health (MOH), the Ministry of Planning (MoP), and CARD. The WASH program primarily partnered with the Ministry of Rural Development (MRD).

**Increased national capacity to provide access to nutrition interventions**

Relevant actions for capacity building usually include training of national governments and partners on leadership, programme implementation and management, and provision of technical guidance and training to strengthen human resources for nutrition.

As a partner of the Second Health Sector Support Programme (2008–2013), UNICEF planned to support improved sector strategic and operational planning, community participation, and the deconcentration and decentralization process in the health sector. Again, it is not clear whether this is stunting-related. The MNCHN programme also planned to support vaccine delivery through ensuring sustainability of the national immunization program.

**Enhanced support for children, caregivers, and communities for improved nutrition and care practices**

Addressing stunting requires a multisectoral approach, which includes delivery of nutrition-specific and nutrition-sensitive interventions. Nutrition-specific interventions address the immediate causes of undernutrition, such as inadequate dietary intake, and some of the underlying causes, including feeding practices and access to food. Nutrition-sensitive interventions can address some of the underlying and basic causes of malnutrition by incorporating nutrition goals and actions from a wide range of sectors.

**Support of Nutrition-Specific Service Delivery Approaches**

UNICEF Cambodia’s nutrition-specific service delivery approaches were:

1. Promotion of IYCF (including complementary feeding and breastfeeding)
2. Preventing anaemia and other micronutrient deficiencies

Systematizing and supporting the treatment of severe acute malnutrition was a significant part of the country plan. While the evaluation notes that this is not a stunting prevention activity, it is a necessary and important nutrition activity, discussed further in the following chapter.

**Support of Nutrition-Sensitive Service Delivery Approaches**

UNICEF Cambodia’s nutrition-sensitive service delivery approaches were:

1. Increasing antenatal, new-born and child health services, including community care of mothers and new-borns, strengthening pneumonia case management, and expanding diarrheal treatment with zinc
2. Promoting hygiene behaviours and increasing access to safe water, sanitation, and hygiene using a community-led total sanitation approach
3. A cash transfer pilot program

Communication for development was also included as a cross-cutting issue used to achieve all programme results and to support improvements in nutrition.
2016–2018 Approach to Stunting Reduction

The 2016–2018 country programme shifted to a more intentionally integrated approach to stunting reduction. Nutrition, health, and WASH were combined into one output related to integrated early childhood development (IECD) rather than being separated into three components as they were in the 2011–2015 programme. The newly formed IECD programme combines health, nutrition, WASH, and C4D into one integrated section. Further, the 2016–2018 approach includes the intentional convergence of health, WASH, and nutrition-specific programming in the Northeast and the capital of Phnom Penh.

Strengthened political commitment and national capacity to legislate, plan and budget for scaling up nutrition interventions

The IECD Program planned to support the government in the development of a new Health SP and a national Newborn Action Plan, but again, it is not clear the degree to which this was envisioned to include nutrition. The Social Inclusion and Governance Programme planned to support CARD and the Ministry of Economy and Finance to develop a costed national social protection strategy.

Increased national capacity to provide access to nutrition interventions

UNICEF Cambodia’s approach to building capacity included a number of elements:

- Support the operationalization of the government’s early childhood care and development (ECCD) National Action Plan 2014–2018
- Provide technical assistance for the development of new multisectoral national guidelines for better nutrition, along with national and subnational action plans for their implementation
- Support capacity development of service providers—including community workers—in the six priority districts, with a focus on improving the nutritional status of children under 5, pregnant and lactating women, and adolescent girls
- Develop the national immunization supply chain improvement plan, along with standard operating procedures, guidelines, and other supporting tools required for implementation and monitoring
- Support the implementation of the costed Rural Water Supply, Sanitation and Hygiene National Action Plan (2015–2018) through implementation of a WASH early childhood development package, notably specifically calling out ending the practice of open defecation
- Support the government to undertake a feasibility study for developing a cash transfer programme and supporting CARD to establish functional monitoring and evaluation (M&E) for the social protection system

Support of Nutrition-Specific Service Delivery Approaches

UNICEF Cambodia’s nutrition-specific service delivery approaches were:

- IYCF counselling services at targeted health facilities
- Increasing coverage of deworming and calcium and iron folate supplementation for pregnant women
• Promoting the use of iodized salt
• Strengthening the skills of community health workers to undertake regular screening of children for acute malnutrition
• Promoting social marketing systems for micronutrient supplementation
• Developing innovative local food supplements to increase the quality of complementary feeding
• Providing nutrition-related communication and education resources and initiatives for commune and village development committee members, teachers, religious leaders, parents and caregivers

Again, there was a significant component focusing on treating severe acute malnutrition.

Support of Nutrition-Sensitive Service Delivery Approaches

UNICEF Cambodia’s nutrition-sensitive service delivery approaches were:

• A range of WASH services primarily implemented using community-led total sanitation (CLTS), focused in the Northeast
• Quality antenatal, delivery and postnatal services to pregnant women and their new-borns
• Nutrition-sensitive care practices (interactive caregiving, creation of child-safe environments, timely and correct health care seeking behaviours, stimulation/early learning practices, proper treatment and storage of drinking water, hand-washing practices, consistent use of toilets, enrolling children in early learning, and birth registration) communication and education resources

5. Evaluation Findings

5.1 Relevance, appropriateness, adequacy, and coherence of strategies and plans

This chapter explores the evaluation question: How relevant, appropriate, adequate, and coherent are UNICEF’s country programme strategies and actions to reduce stunting?

Relevance to Country Context and Needs

UNICEF Cambodia conducted a situational analysis in 2009 to inform the country programme,27 updated in 2013.28 In addition to the overall national situation analysis, UNICEF Cambodia invested in a situational analysis of climate change, an analysis of the situation of children and families in urban settings, and individual provincial situational analyses by zone offices. A formal situation analysis was not conducted for the current country programme, but important

contextual factors were noted in the summary of the situation of children and women in the Country Programme Document.

UNICEF Cambodia has recently developed a theory of change for WASH and nutrition, seen in Exhibit 6, which describes five pathways for reaching its vision of children growing to meet their full potential. Though not specific to stunting, the five pathways serve as important guiding principles for focusing on resources, understanding among pregnant and lactating women, access to WASH and nutrition services, recognition of community leaders, and technology solutions.

Exhibit 6. UNICEF Cambodia Joint WASH and Nutrition Theory of Change

The evaluation finds that the 2016–2018 approach to stunting reduction that is guided by this theory of change is more responsive and relevant to the context of the country than was the previous approach. In Annex 7, the evaluation team presents key contextual factors and presents evidence of whether they were adequately addressed by UNICEF Cambodia’s approaches to stunting reduction. The newer country programme successfully addressed contextual factors such as stagnant progress in most nutrition indicators, high national wasting prevalence, incorporating nutrition into emergency preparedness and response, building on improvements seen in sanitation, addressing cultural practices around IYCF, pregnancy and birth weight, and increasing vulnerable populations’ access to nutrition and WASH services/interventions in the Northeast and in urban areas.

There was only one nutrition-specific contextual factor that the current country programme did not adequately address:

The evaluation finds that the 2016–2018 approach to stunting reduction that is guided by this theory of change is more responsive and relevant to the context of the country than was the previous approach. In Annex 7, the evaluation team presents key contextual factors and presents evidence of whether they were adequately addressed by UNICEF Cambodia’s approaches to stunting reduction. The newer country programme successfully addressed contextual factors such as stagnant progress in most nutrition indicators, high national wasting prevalence, incorporating nutrition into emergency preparedness and response, building on improvements seen in sanitation, addressing cultural practices around IYCF, pregnancy and birth weight, and increasing vulnerable populations’ access to nutrition and WASH services/interventions in the Northeast and in urban areas.

There was only one nutrition-specific contextual factor that the current country programme did not adequately address:

---


Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance Cambodia Country Case Study
• **The effect of women’s participation in industry and other migrant labour on breastfeeding and caretaking practices:** Breastmilk substitutes were identified as a key nutrition challenge in urban areas (breastfeeding including in rural areas remained unchanged between DHS 2010 and DHS 2015). While the country program included provisions for promoting breastfeeding, it did not address the issue of the increase in women’s participation in industry and other migratory labour. While only about 10% of women work in industry, there is a growing segment of young mothers who are not present to breastfeed and do not have access to infrastructure for breastmilk storage. The issue of migrant labour is also important to how programmes are targeted—when mothers are not the primary caretakers of children, stakeholders felt that programmes should be targeting grandparents and in some cases older siblings. UNICEF’s approach did not address this root cause or help promote workable alternatives for working mothers such as maternity protection in the workplace. Labour issues do not fall directly into UNICEF’s mandate but are included here because stakeholders felt they were an important gap in programming.

The key nutrition-sensitive contextual factors that the country programme did not adequately address were:

- **Gender:** While gender is mentioned as a cross-cutting issue in the 2011–2015 approach and the country office has done an extensive study on inequalities in nutrition among Cambodian women, the evaluation did not find evidence of a clear strategy to address gender issues within stunting reduction approaches. Stakeholders felt that many nutrition initiatives targeting women did not address the responsibilities of men in the raising of their children.

- **Linkages to agriculture:** Evidence that food consumption is inadequate in Cambodia is well documented and was particularly important during the food crisis of 2008. There are provisions in UNICEF’s approaches to support linkages with agriculture, namely supporting the National Strategy for Food Security and Nutrition 2014–2018, which includes WASH and nutrition considerations. However, efforts to work more closely with agriculture-focused UN organizations such as FAO through SUN and national systems have not progressed beyond writing concept papers. Further, a lack of focus on linkages to agriculture may be because the National Nutrition Strategy, to which UNICEF aligns its nutrition work, focuses primarily on actions that the Ministry of Health can take rather than the full spectrum of causes of undernutrition.

Two other contextual factors specific to disaggregated nutrition-related data were also not adequately addressed because they are not well understood. These were:

---


• Stunting prevalence in the <6 months of age category worsened from 10% to 16% from 2010 to 2014, while all other age categories saw improvements, and wasting rates for this same age group also improved. The evaluation team notes that UNICEF is working with the Ministry of Health to address low mid-upper arm circumferences (MUACs) of mothers in the Northeast, but that funding is extremely limited to include concrete components.

• The 2014 Annual Report noted that in case management of severe and acute malnutrition, gender-disaggregated data showed that boys arrive at hospital in a more severe state than girls, calling for further investigation into the causes.

Alignment with National Strategies

The RGC’s approach to nutrition is primarily outlined in the National Strategic Development Plan (NSDP) and the Cambodia MDGs. The RGC included nutrition as a key policy priority and action in the NSDP 2009–2013 in four areas:

1. Improving Agricultural Productivity and Diversification
2. Fisheries Reform
3. Creation of Social Safety Nets
4. Enhancing Health Services

UNICEF’s mandate most directly falls within the third and fourth areas (social safety nets and health services), and these were included in components of UNICEF’s country programme as explored in the previous chapter. But again, UNICEF Cambodia’s linkages with agriculture, an approach recommended in UNICEF’s Approach to Scaling Up Nutrition, could have been stronger.

The NSDP 2014–2018 significantly increased the general prioritization of nutrition by the Cambodian government and specifically reflects a much broader understanding of chronic malnutrition and stunting. The government redefined the poverty line using a reference food basket and an allowance for access to clean water, for the first time in any developing country, demonstrating this broader understanding. Further, stunting prevalence was included as one of only two goal indicators for health, setting an ambitious target of 25% for 2018. It recognized that stunting had only slightly reduced from 2005 to 2010 and identified three causes: insufficient calorie intake, inadequate IYCF practices, and poor sanitation conditions.

35 Ibid.
36 Ibid.
37 Ibid.
Accordingly, UNICEF Cambodia also increased its focus on nutrition in its 2016–2018 country programme. Undernutrition receives its own section in the programme rationale, with a specific mention of stunting rates and stunting distribution. The country programme broadly addresses the three causes identified in the NSDP through a new integrated early childhood survival, care, and development strategy.

The evaluation team concluded that UNICEF Cambodia’s country programme was mostly aligned with national strategies. However, UNICEF Cambodia does not include stunting as an impact indicator in its 2016–2018 country programme, which it could have considered given that the NSDP includes it as an indicator and UNICEF is seen as a key actor in implementing this plan.

**Alignment with Regional Strategies**

The East Asia and Pacific Regional Office (EAPRO) has published a Strategic Approach to Nutrition Programming for the region to “guide UNICEF country offices in the EAP region in accelerating progress in reducing child undernutrition and preventing overnutrition; and to serve as an advocacy and technical resource for national governments about why nutrition is important for human, economic and social development, what needs to be done based on current context, and how to do it.” The regional approach is designed to complement UNICEF’s global approach but adds overnutrition and long-term and intergenerational consequences, and discusses the complex relationship of malnutrition as a cause and consequence of underlying issues.

The regional approach identified seven packages of nutrition interventions, five of which are relevant to Cambodia:

1. Core package for maternal and child undernutrition
2. Package for nutrition in emergencies
3. Package for water and sanitation
4. Package to address child wasting
5. A food security package

A sixth package for teenage pregnancy might also be warranted, as Cambodia is on the threshold of the rate necessitating intervention and teen pregnancy rates are increasing. While UNICEF Cambodia includes components of each of these five packages in its current country programme, the major gaps are similar to the gaps described above regarding the country context. These include, among others, promoting linkages to agriculture, breastfeeding counselling in the context of HIV, prevention and treatment of malaria, pregnancy spacing,


maternity protection in the workplace, and interventions to reduce tobacco consumption and indoor air pollution.

The evaluation team notes that the major point of misalignment between the regional and Cambodia strategy is that the regional strategy outlines several stages that eventually lead to implementing all of the interventions on a national scale in countries like Cambodia, where stunting, maternal undernutrition, and anaemia rates are above critical thresholds. The range of interventions included in the regional strategy’s packages is intentionally designed to be all-encompassing. While this is a strength and should result in the most impact, it does not take resource availability into account and is simply not possible given the level of funding UNICEF Cambodia has access to for nutrition. Almost all of the bottlenecks listed for scaling up health system nutrition interventions apply to Cambodia—how or where to begin addressing these is not clear. Scalability is explored further in the “Sustainability and Scale-Up” chapter.

Alignment with Global Strategies

The 2011–2015 country programme was generally aligned to UNICEF’s 2006–2015 Health and Nutrition Strategy in that it included joint health and nutrition actions, and it was aligned with the WASH Strategy 2006–2015. It was also aligned to the Midterm Strategic Plan 2006–2013 in that it prioritized young child survival and development, particularly through addressing severe acute malnutrition (SAM), to achieve MDG 1, which seeks to eradicate extreme poverty and hunger.

UNICEF Cambodia’s 2016–2018 country programme reflects global strategies outlined in the Strategic Plan 2014–2017 and the Approach to Scaling Up Nutrition in the following ways:

- The Strategic Plan 2014–2017 is a move towards adopting an integrated approach to reduce stunting. Cambodia’s more recent country programme also moves toward a more integrated approach through the creation of a new IECD Program which combines health, nutrition, WASH, and C4D into one integrated section. Further, the 2016–2018 Plan includes the intentional convergence of health, WASH, and nutrition-specific programming in the Northeast.
- The Approach to Scaling Up Nutrition links 10 conditions to interventions for addressing childhood stunting and wasting. Cambodia’s situation analysis showed nine of these 10 conditions (see Annex 8). Its country programme included at least one suggested intervention for each condition.
- The global theory of change for nutrition that is included in the Strategic Plan 2014-2017 is generally reflected in UNICEF Cambodia’s WASH and Nutrition Theory of Change.

Overall, UNICEF Cambodia stakeholders reported that they balance global guidance and strategies with the evidence gathered in situational analyses to create programmes that are tailored to the unique situation of Cambodia. For example, UNICEF nutrition staff do not feel that WHO SAM guidelines are appropriate for Cambodia and were instead working to create a new, locally produced ready-to-use therapeutic food (RUTF) using fish protein. Their efforts are supported through real-time evaluation to identify what is working and what is not and change course accordingly.
Conclusion

UNICEF Cambodia has made concerted efforts to move towards more integrated approaches to stunting reduction, in line with the country context and regional and global strategies and thinking. The regional strategy’s approach to nutrition is relevant to Cambodia’s context and is an important advocacy and technical resource; however, the evaluation was not able to specify how it has influenced programming in Cambodia. Its application to Cambodia does make clear that the multisectoral burden of undernutrition in Cambodia is pronounced compared to many of its neighbours, as so many of the packages are relevant.

The country programs balance the focus on national policies with the provision of support to build capacity and provide key nutrition services. Advocacy for national policies focuses primarily on strategies and actions that MOH, CARD, MRD, and MoP can take. The scope of nutrition-related capacity building as well as support of service delivery significantly increased from the former to the current country programme, including support for multiple nutrition-specific interventions (notably, IYCF counselling rather than promotion through campaigns, specifically targeting deworming, calcium and iron folate supplementation for pregnant women, promoting the use of iodized salt, promoting social marketing systems for micronutrient supplementation, and producing local food supplements). The balance between nutrition-specific and nutrition-sensitive interventions is appropriate for the context.

Gaps in the new current country programme related to migrant labour, gender, linkages to agriculture, and disaggregated nutrition data were relatively minor.

5.2 Effectiveness of the country programme in addressing stunting

This chapter starts with an analysis of Cambodia’s progress in reducing stunting in under 5 children and related indicators. The analysis of effectiveness focuses on four main Strategic Plan output areas that are relevant for Cambodia: 1) strengthened political commitment, accountability, and national capacity to legislate, plan and budget for scaling up nutrition interventions, 2) increased national capacity to provide access to nutrition interventions, 3) enhanced support for children, caregivers, and communities for improved nutrition and care practices, and 4) increased country capacity and delivery of services to ensure protection of the nutritional status of girls, boys and women from the effects of humanitarian situations. As per the evaluation framework, the analysis considers both nutrition specific and nutrition sensitive interventions included within the Cambodia programme, and in view of the scope of the evaluation the analysis, focuses on the 2011-15 country programme.
Changes in Performance of Stunting Indicators

National stunting prevalence decreased by 8.5% from 2010 to 2014, which is a significant decline of over 2 percentage points annually.\textsuperscript{40, 41} Annex 9 presents specific indicators that were included in UNICEF Cambodia’s results matrices. Annex 8 presented the specific figures for UNICEF’s global stunting indicators. To summarize, progress was seen in the following indicators:

- Appropriate complementary feeding, which showed improvement but fell slightly short of the target
- The quality of complementary foods and the practice of complementary feeding
- Frequency of antenatal care (ANC) consultations
- Percent of rural households practicing open defecation, the target for which was met, but UNICEF raised concerns about quality of data for this indicator
- Percent of rural households treating drinking water, the target for which was also met, but UNICEF again raised concerns about quality of data for this indicator
- Percent of rural households with access to improved sanitation, which showed improvement
- Calorie deficits
- Prevalence of diarrhoea and pneumonia
- Coverage of antenatal care and skilled birth attendance

The only stunting-related indicators which did not show progress were exclusive breastfeeding by children 0-6 months, and children aged 18-23 months not breastfeeding at all. The issue of breastfeeding and IYCF is explored below.

Achievements Towards Addressing Strategic Plan Outputs

This section provides an analysis of UNICEF Cambodia’s 2011–2015 programme towards the four relevant outputs of UNICEF’s Strategic Plan mentioned above. Additional evidence is presented in Annex 9, organized by country programme component.

Strengthened political commitment and national capacity to legislate, plan, and budget for scaling up nutrition interventions

UNICEF Cambodia contributed to strengthening political commitment and national capacity to legislate and plan for scaling up nutrition interventions. UNICEF’s actions to garner attention to and strengthen political commitment to malnutrition led to several Ministries passing key pieces of legislation and developed action plans for nutrition-specific interventions (treating acute malnutrition) and nutrition-sensitive interventions (primary health care, immunizations, and...
Further, the establishment of coordination mechanisms for nutrition was in progress during the evaluation period and will be vital moving forward. These successes are explored in further detail in the following paragraphs. One area for further improvement is in national capacity to budget for scaling up nutrition, which is limited substantially by the overall funds available for nutrition but is improving.

UNICEF’s publication of *The Economic Consequences of Malnutrition in Cambodia*, which was developed in partnership with CARD and the United Nations World Food Programme (WFP) and updated with 2014 DHS data, is considered pivotal by stakeholders. They felt that an economic argument was key to garnering political commitment at higher levels and by those outside of the health system which had historically been more responsible for nutrition.

UNICEF was also a key player in advocating for the National Strategy for Food Security and Nutrition 2014–2018 and Fast Track Road Map for Improving Nutrition 2014–2020. Towards the end of the evaluation period in 2015, Cambodia officially joined the SUN movement, a strong signal of the political commitment to nutrition for which UNICEF advocated. UNICEF serves as the lead UN agency for SUN, which is discussed further in the “Leadership and Leveraging Partnerships” chapter. Even more recently, in May 2016, the Deputy Prime Minister requested a budget line item for nutrition, signalling that advocacy efforts may be paying off in the future.

The following paragraphs summarize evidence of effectiveness in building national capacity to legislate and plan for scaling up nutrition interventions.

**Coordination for Nutrition:** UNICEF played a key role in bringing attention to Cambodia’s malnutrition situation by developing the National Seminar on Nutrition in 2011, in partnership with WFP, FAO, and the World Health Organization (WHO), which resulted in government commitment to SUN, the instalment of a coordination body, and the development of an operational plan. Multi-stakeholder platforms within CARD are explored in the “Leadership and Leveraging Partnerships” chapter, but these were also key successes of increasing the capacity for coordination. UNICEF also collaborated with CARD to develop their first annual report, which captures progress from the first multisectoral partnership involving various government ministries, UN agencies, NGOs, and the private sector on improving maternal and infant nutrition and serves as a baseline for assessing this integrated approach. UNICEF supported the development of this report within the SUN movement.

**Health Sector Strengthening:** Notably, in 2012, UNICEF’s advocacy resulted in a more than 60% increase of The Second Health Sector Support Project (HSSP2) resources allotted to outreach and other primary health care activities for the poorest and most remote areas. The 2012 Annual Report stated that UNICEF played a key role in making malnutrition visible, presumably within the HSSP2.

**Acute Malnutrition:** UNICEF successfully advocated for MOH to include acute malnutrition in national policy, guidelines and curricula in 2011 (currently under revision again to be more locally sensitive). They also successfully advocated for the inclusion of RUTF on the list of essential drugs.

**Micronutrients:** UNICEF successfully advocated for and provided financial support for the inclusion of a micronutrient module (including haemoglobin disorder and parasites) in the DHS.
Through this study, Vitamin A deficiency was not found to be highly prevalent and thus not necessary to legislate, plan, or budget for.

**Immunizations:** The government approved US $1.5 million via UNICEF for vaccine procurement in 2013. UNICEF successfully supported MOH in advocating for an additional $700,000 to meet a funding gap and ensure universal coverage. The government maintained this allocation of $2.2 million in the following years. UNICEF argues that while vaccines are largely funded by Gavi, including a national budget for vaccine procurement improves the sustainability of immunization programmes.

**WASH:** UNICEF noted in 2012 that despite the presence of the RWSSH strategy, the sector did not have a comprehensive, government-led national programme. UNICEF outlined a number of steps to address this, and the first-ever Rural Water Supply Sanitation and Hygiene National Action Plan (2015–2018) was expected to be finalised and endorsed in January 2016.

**Social Protection:** UNICEF published a white paper, *The Imperative of Improving Child Nutrition and the Case for Cash Transfers in Cambodia*, in 2011. The country programme built upon this thinking by piloting a cash transfer program with an explicit goal of improving nutrition to further the case made in the white paper.

There were challenges in translating the cash transfer pilot into a scalable program, as stakeholders reported that donors were not interested in funding it and government did not have enough available resources. However, UNICEF persisted, and a national policy is reportedly being developed for rollout of the program by 2025.

While a number of successes were achieved, one area for further improvement is in national capacity to budget for scaling up nutrition, which is limited substantially by the overall funds available for nutrition but is improving.

**Increased national capacity to provide access to nutrition interventions**

This section analyses the effectiveness of UNICEF Cambodia’s Country Programme in enhancing national capacity in general and for nutrition-specific and nutrition-sensitive interventions. UNICEF Cambodia’s 2011–2015 approach did not include a significant capacity building component and as a result was not very effective in increasing national capacity to provide access to nutrition interventions. This may be related to the budgeting issue mentioned previously—in other words, while key political figures are committed to improving nutrition on paper, it was more challenging to translate this commitment into funded, actionable nutrition interventions. UNICEF helped to steer the resources that were available towards treating and preventing severe acute malnutrition, explored later in this section. Given the high prevalence of wasting and the overall goals of the country programme, this is understandable, but more work is needed to build national capacity around prevention of chronic malnutrition rather than acute. In retrospect, there were two other key areas where UNICEF should have increased national capacity around enforcement: breastmilk substitutes and iodized salt.

---

42 Wieringa, F. T., Dahl, M., Chamnan, C., Poirot, E., Kuong, K., Sophonneary, P., et al. (2016). The high prevalence of anemia in Cambodian children and women cannot be satisfactorily explained by nutritional deficiencies or hemoglobin disorders. *Nutrients*, 8(6); 348.
Breastmilk Substitutes: The major challenge to strengthening political commitment to promote exclusive breastfeeding was in the enforcement of Sub-Decree 133, which prohibits the promotion of breastmilk substitutes but is weakly enforced. Evidence suggests and stakeholders confirmed that national capacity to enforce this decree is extremely weak and an area where UNICEF and partners should contribute.

Iodized Salt: UNICEF’s support of the national salt iodization program after 2011 was limited—it had previously supported the establishment of a legal mandate and the scale-up of the government-run programme, which was complete by 2011. However, iodized salt usage among households with children aged 6-23 months fell dramatically from 2011 to 2014—this was identified through a UNICEF-supported national survey in 2014 using regular resources and related peer-reviewed articles showing that the drastic decreases in the prevalence of iodized salt were due to limited enforcement of legislation. As a result, UNICEF resumed working with the Ministry of Planning on salt iodization in 2016 using a different model. This underscores the importance of building capacity for monitoring even after advocacy activities have been successfully completed.

Enhanced support for children, caregivers, and communities for improved nutrition and care practices

UNICEF Cambodia’s approach to providing support for caregivers and communities to improve nutrition and care practices primarily consisted of three components: (1) rolling out mass media campaigns on breastfeeding and complementary feeding, (2) improving micronutrient deficiencies through improving micronutrient powder (MNP) coverage, developing local supplements, and investing in research on anaemia, and (3) WASH activities implemented using a CLTS approach. While the WASH activities did result in key behaviour changes such as elimination of open defecation, the mass media campaigns were less successful in creating behaviour change. While both WASH and breastfeeding/complementary feeding interventions invested in the identification of barriers (through a bottleneck analysis and midline evaluation, respectively), the results of the WASH analysis were more conclusive and somewhat less complicated. Cultural practices around breastfeeding and complementary feeding remain a substantial challenge to more effectively reducing stunting. These components are explored further in the subsequent paragraphs.

IYCF: As was planned, two mass media campaigns around breastfeeding and complementary feeding mass media campaigns were carried out to improve exclusive breastfeeding rates and appropriate complementary feeding. A midline evaluation of this campaign was conducted in 2013 and showed that while messages were well recalled, behaviour change was constrained by availability of ingredients, lack of time and money, and poor taste. It is not clear if or how these constraints were addressed. Stakeholders felt that cultural practices, particularly around the ingredients and methods used to make Bor Bor (rice porridge), were an ongoing challenge. These constraints were being further explored at the time of this evaluation. The 2012 Annual


Report acknowledged that the lack of a government-led community-based program was a barrier to scale-up of breastfeeding and complementary feeding interventions. Further, the relationship between these two campaigns and between a related animal source protein campaign is unclear—a singular, cohesive and integrated campaign may have been more effective. Stakeholders also expressed concerns that campaigns may not have reached intended populations. Stakeholders reported that most people received messages through interpersonal communications through village health support groups or health centre staff rather than mass media campaigns, and these may be more effective communication channels. However, there was disagreement among UNICEF staff regarding the effectiveness of interpersonal communication used in specific strategies from 2012-2015. Further, there was a lack of resources to properly implement communication campaigns: There was not enough money to engage an external ad agency, design campaigns backed by market research, target rural areas, and develop a robust campaign, which would have been preferred by country staff.

**Micronutrient Deficiencies:** Together with Helen Keller International, UNICEF collaborated throughout the evaluation period to improve coverage of micronutrient powder. Some 24 million sachets of micronutrient powders and food supplements were distributed to children aged 6 to 24 months in 2014.

In 2014, UNICEF partnered with the *Institut de Recherche pour le Développement* (IRD) to develop “Fish Snack”—a locally produced, fish protein–based specialized nutritious food. The Fish Snack team paid special attention to Cambodian context, where snacking culture is highly prevalent—snacks make up 6% to 7% of total household expenditures. The team adjusted the formula to meet Cambodian taste preferences. Fish Snack is intentionally designed to treat severe wasting but also has the potential to contribute to the prevention of stunting.

It had generally been assumed that, in Cambodia, the majority of anaemia is associated with insufficient iron intake. A mass media campaign promoting iron folate supplementation was present in 2012. However, UNICEF invested in research demonstrating that while approximately 40% of women of reproductive age in Cambodia are anaemic, less than 10% experience iron deficiency. Thus, factors other than iron deficiency must play an important role in the pathogenesis of anaemia in Cambodia.

**WASH:** CLTS was central to UNICEF’s approach and was one of the most effective components of the WASH programme as it relates to stunting. During the evaluation period, more than 400 villages were reached with improved sanitation, and 147 of those villages were

---


certified open-defecation–free. UNICEF was successful in revising guidelines around CLTS, and UNICEF began coupling CLTS with supply-side sanitation marketing and mass media to accelerate change in 2013. It also invested in identifying important bottlenecks to further CLTS, such as poorer households opting for no toilet over building a basic dry pit facility. Linkages with schools for WASH implementation were also strong.

There is limited evidence of strengthening partnerships with the health sector or training health centre staff around hygiene and sanitation, which was an objective of the country programme. Stakeholders who were health care workers did not conceptualize hygiene and sanitation as part of their contribution to reduce stunting. This implies that UNICEF’s approach here may not have been effective.

**Social Protection:** As previously mentioned, the cash transfer pilot program was implemented to generate evidence for effective scale-up, which is planned to be rolled out by 2025.

**Increased country capacity and delivery of services to ensure protection of the nutritional status of girls, boys, and women from the effects of humanitarian situations**

Cambodia, with much of the rest of the world, experienced a food price crisis beginning in 2008 that is thought to have contributed to very high rates of wasting. Understandably, this resulted in UNICEF directing much of its resources towards treating severe acute malnutrition rather than stunting. There is evidence of success in several areas around systematizing the treatment process for SAM. UNICEF supported the treatment of 5,546 children from 2011 to 2014 and an additional 4,776 in 2015, representing an increase of over 30% from to 2015. UNICEF supported mass screening campaigns, helped develop a Web-based monitoring system for SAM, and had successes around reducing dropout rates and improving adherence to follow-up. Stakeholders felt that UNICEF was playing a key role of ensuring that children with SAM were not only identified but also treated. Overall, it is clear that UNICEF was instrumental in increasing the number of children with SAM who were successfully treated, but there is limited evidence that this process was fully systematized across the country, particularly for outpatient care at health centres.

The evaluation team found that, as a result of the strong focus on SAM, some stakeholders conceptualize all nutrition interventions, including stunting prevention, as encompassing only SAM—many stakeholders mentioned only SAM identification and treatment when asked about stunting reduction efforts, which suggests the need to create further awareness regarding malnutrition prevention.

**Conclusion**

UNICEF Cambodia experienced successes in each of the four key outputs of the Strategic Plan.

It was successful in strengthening political commitment through substantial knowledge and data generation, including the use of an economic argument presented in *The Imperative of Improving Child Nutrition and the Case for Cash Transfers in Cambodia*. They supported the development of stunting-related legislation, action plans, and budgets with several Ministries. However, challenges related to overall national resource allocation for nutrition-related sectors were persistent.
It was less effective at increasing national capacity to provide access to nutrition interventions, which may be related to resource allocation in that transforming political commitment into funded interventions has been a challenge. Capacity building is particularly needed for government partners around the multisectoral nature of stunting and technical assistance for how to enforce mandates around breastmilk substitutes and iodized salt.

UNICEF Cambodia was nominally successful at enhancing support for improved nutrition care and practices. Key behaviour changes such as elimination of open defecation were seen for WASH, but IYCF campaigns were less successful in creating behaviour change. Cultural practices around breastfeeding and complementary feeding remain a substantial challenge to more effectively reducing stunting.

In emergency response, UNICEF Cambodia focused heavily on systematizing treatment for SAM. The evaluation team found that as a result of the strong focus on SAM, some stakeholders conceptualize all nutrition interventions, including stunting prevention, as encompassing only SAM.

These findings align with a sequential conception of the strategic plan outputs—it makes sense that successes were strongest in strengthening political commitment rather than the other two outputs, because the evaluation is looking at one period of time—political commitment and national capacity to legislate, plan, and budget are necessary first steps to provide access to nutrition interventions or provide support for caregivers and communities to improve nutrition and care practices. Improvements in the second and third outputs should be expected in the coming years.

While the effectiveness of the 2016–2018 country programme is not considered in this chapter, the evaluation notes that the approaches included in the new country programme resolve some of these key challenges and gaps by addressing each of the SP outputs in a less fragmented way through the integrated approach to WASH, health, and nutrition in the Northeast.

5.3 Efficiency of management and operations

This chapter addresses the evaluation question: Are UNICEF’s management and operations approaches and resources adequate and efficiently utilized for its stunting reduction strategies and programmes?

Utilization of available resources to achieve programme outputs

Staff

The UNICEF Cambodia CO has two nutritionists on staff, one national nutrition officer, and one international nutrition specialist. Nutrition staff felt that their main need was a statistician to support data collection and prompt analysis. The evaluation team noted that many UNICEF Cambodia staff members, not just nutrition staff, feel they are stretched thin because the country programme covers a wide range of issues affecting children. Some stakeholders felt that it would be better to select a few issues that fall specifically into UNICEF’s niche and dedicate more resources to addressing them. However, they did not necessarily agree on what that niche was.
The regional strategy recommends that all UNICEF country programme team members have a minimum level of nutrition fluency and that lead technical staff on nutrition should have adequate skills to enable them to exercise the high-level political advocacy and technical leadership required. The evaluation team found that lead technical staff in Cambodia have more than adequate skills but likely need additional staff to be able to efficiently practice high-level political advocacy, particularly at subnational levels.

Staff capacity is a challenge for working on stunting in two additional ways:

- Staff report needing training in advocacy and policy work as UNICEF moves away from direct service delivery.
- Staff also report struggling with integrated approaches. While almost everyone reported that the decentralized structure of UNICEF globally was positive, respondents also indicated that it would be helpful if staff at headquarters and in regional offices were working together in an integrated, multisectoral manner, to serve as a model for CO staff. EAPRO has limited resources and staff to provide technical assistance on integrated models. Internal stakeholders felt that they could benefit from support from EAPRO by sharing evidence from other countries using integrated models. And indeed, EAPRO does promote cross-country learning that may serve as a forum for multisectorality: for example, they convened all the deputy representatives in the region to discuss how to translate UNICEF global guidance into action. Internal stakeholders also felt that EAPRO’s support of their WASH and nutrition theory of change and the guidebook on WASH and nutrition integration were important.

**Funding**

The overall UNICEF funds for Cambodia modestly declined from $20.6 million in 2012 to $19.4 million in 2015. Similarly, nutrition funds also decreased from $1.3 million in 2012 to about $830,000 in 2015, accounting for 6.5% and 4.3% of the total funds respectively. The 2013 Annual Report noted a number of actions being carried out to meet the recommendations of the MTR to increase efficiency in the face of decreasing funding, including the development of national staff management and leadership, a move toward integrated programming, closure of two of the five zone offices, and abolishment of 57 posts. The evaluation could not determine whether these changes specifically relate to stunting. As explored further in the “Sustainability and Scale-Up” chapter, the intention of these changes is not clear—the Annual Report states that the changes were made to save money, but stakeholders reported that they were made to reach vulnerable populations, generate lessons for scale-up, and/or reach populations to work where results were most attainable. Efficiency could be improved if the intention was clarified and staff focused resources accordingly.

Stakeholders also felt that financial resources were structured in a manner that does not promote multisectoral work but encourages silos. In practice, integrated working groups often feel or appear inefficient at the beginning but over time become more effective and efficient as individual staff become more versed in the language of other technical areas and joint programming. The integrated IECD section is likely to be an example of this efficiency in the near future.
Organizational Policies

Last, there are two organizational policies that stakeholders described as problematic. First, UN procurement requirements would make increasing the production of Fish Snack with the current producer impossible, as the requirements would be too strenuous for it even with technical assistance. Second, long-term funding from UNICEF to partners is often unclear, as it can only be guaranteed in two- to three-month periods. However, stakeholders noted that they understood why these policies are in place.

COs have far more financial and human resources as a feature of the decentralized nature of UNICEF and a high degree of control over the way resources are used, so EAPRO’s ability to provide support is limited. It primarily provides what is needed when requested rather than proactively interacting with country offices. This structure has worked well for addressing stunting in Cambodia because there is a high degree of expertise present in the CO. However, the evaluation team identifies integration as an important area for cross-country learning. EAPRO acknowledges in its 2015 Annual Report that it is important to model how sectors can converge to achieve broader, integrated outcomes in headquarters and regional offices, but that this is an ongoing challenge. Country staff felt that the regional office leads cross-country and bottom-up learning efforts around integrated nutrition programming as much as possible given its funding.

Conclusion

UNICEF Cambodia has developed solutions to support the efficient implementation of programme actions in the face of decreasing funding. Integrating WASH and nutrition programming is one of these solutions. Integration could benefit from training in specific areas and filling in gaps in expertise as well as further support from EAPRO around cross-country learning.

5.4 Sustainability and scale-up

This chapter answers the evaluation question: Is there evidence that UNICEF’s strategies and programmes to reduce stunting are likely to be sustained or scaled up?

Sustainability

UNICEF Cambodia primarily addressed the sustainability of stunting reduction efforts by building the capacity of government to own nutrition-specific and nutrition-sensitive interventions. UNICEF also prioritized working within existing structures of the health system (village health workers, community volunteers).

UNICEF Cambodia’s approach to capacity building has changed significantly in the last decade. Before 2010, UNICEF was funding government salaries as a form of capacity building. In 2010 it began providing staff directly to CARD, and it now focuses on institutional and individual capacity building, primarily through advocacy, knowledge generation and dissemination, and direct training/technical assistance for government staff which is conducted in various fora but primarily in the Technical Working Group on WASH and Nutrition. The evaluation team found
that institutional capacity building was conducted not only with MOH, but also with MRD. For example, during the evaluation period, UNICEF heavily supported the government’s development of SAM guidelines and the National Nutrition Strategy. They also supported costing the National Nutrition Strategy as a way to generate increased understanding of how much progress will actually cost. Looking at the longer term, they have supported the development of a Master’s of Nutrition program to improve in-service training and availability of nutrition expertise in the country.

There are four notable challenges to sustainability:

- **Funding:** As previously mentioned, Cambodia is transitioning to middle-income status and is no longer able to mobilize sufficient donor funding to build sustainable programs—funding is difficult to obtain and unpredictable. Government resources are also not adequate to meet the need—one stakeholder explained that while government has prioritized nutrition on paper, its commitment has not been backed up with funding. While the exercise of costing the National Nutrition Strategy may have improved understanding of the cost of interventions, the strategy is still largely unfunded. Stakeholders identified corporate social responsibility (CSR) initiatives with local companies as a possible alternative funding source, but as yet, they have been unable to mobilize interest. The SUN business network was identified as one possible way to mobilize this support, but challenges are noted in the structuring of the private sector, which is not well organized. Further, WFP (not UNICEF) is the lead UN agency for the business network.

- **Subnational Capacity:** So far, capacity-building efforts seem to focus mostly on government staff at national level, but internal stakeholders identified subnational leadership as a barrier. A possible explanation for this lack of capacity is that UNICEF’s staffing strategy at the subnational level has changed fairly drastically with each new country programme. The 2006–2010 country programme embedded UNICEF staff within seven provincial government offices. The 2011–2015 country programme moved those staff to five new zone offices, partly in order to decrease reliance on UNICEF staff and build capacity of government staff, and the current country programme concentrated these staff into three zone offices. Further exploration of the effect of these changes on the sustainability of subnational government capacity is needed. Cambodia is still implementing decentralization efforts in which communes, the lowest level of democratic representation, exercise control over some significant resources. These bodies may be a mechanism for addressing stunting at the local level.

- **Programming:** In addition, the shifts in zone offices coincided with shifts in programming priorities at the subnational level, e.g., supporting the Northeast rather than other provinces. Stakeholders from partner organizations reported that it can be challenging to sustain the effects of their programs when funding is granted only for short periods of time. Defining clear exit strategies with partners at the outset of programs may help resolve this challenge.

- **Partners:** Stakeholders reported that UNICEF has not been able to impart the importance of sustainability on its NGO partners. This is likely tied to competition for funding among NGOs and a focus on on-the-ground implementation rather than long-term sustainability.
Scale-Up

UNICEF Cambodia has been successful in operating at scale in much of its programming, particularly in SAM treatment and other health interventions. Stakeholders report that the focus on the Northeast has potential to generate lessons for scale-up. The real-time monitoring system should also enhance capability to scale up. UNICEF also supports government in working at scale. UNICEF supported a budgeting exercise, the Fast Track Road Map for Improving Nutrition 2014–2020 to identify cost-effective interventions that can be implemented at significant scale to reduce the national burden of malnutrition, mainly financed by domestic sources, by 2020.50

However, there are two notable challenges to scale-up:

- **Funding:** Internal and external stakeholders all agreed that funding would be the most significant challenge to scaling up interventions to address stunting, exacerbated by climate emergencies and potential civil unrest from upcoming elections.
- **Intentionality:** Both country programmes state that they are nationwide in character but mention that having a UNICEF presence on the ground is “a feature considered to add value to UNICEF cooperation.” However, their presence on the ground could be clarified as it relates to scale-up, specifically how models that are designed to reach the most vulnerable populations in the Northeast can be scaled and/or used to show strong evidence to government on the effectiveness of interventions.

Conclusion

UNICEF Cambodia has considered sustainability and scale-up when designing and implementing its country programmes, namely through individual and institutional capacity building of multiple national structures. Scale-up has focused on balancing upstream policy work with maintaining and learning from their on-the-ground presence. Long-term funding predictability and the overall level of funding are the primary challenges to both sustainability and scale-up. The intention of UNICEF’s presence in the Northeast is not explicit in regards to scale-up, but convergent health, WASH, and nutrition programming within the Northeast and led by the Kratie zone office seems to show significant promise for generating lessons and models for scale-up.

5.5 Leadership and leveraging partnerships

This chapter assesses the evaluation question: Is UNICEF effective in leading and leveraging partnerships to reduce stunting? Below, an overview of the types of partnerships and leadership activities that UNICEF conducts is presented, followed by successes and challenges experienced during the evaluation period.

Types of Partnerships and Leadership Activities

UNICEF Cambodia is an integral part of several nutrition-related working groups:

- Lead UN agency for the UN Network within SUN
- Co-facilitator with the U.S. Agency for International Development (USAID) of the Technical Working Group on Social Protection and Food Security and Nutrition within CARD
- Participant in the WASH/Nutrition Integration Group within CARD
- National Nutrition Working Group under MOH
- Working Group on Health and WASH hosted by CARD

UNICEF Cambodia has excelled at facilitating and furthering national partnerships to advance the nutrition agenda—many stakeholders identified this as its comparative advantage. Though relatively recent, the SUN movement has reportedly made it easier for UNICEF staff to gain entrée to government counterparts, specifically through annual meetings in which a report is presented to SUN. It also provides learning opportunities for stakeholders—for example, UNICEF supported CARD to join the SUN meeting in October 2016 in Milan, Italy.

Successes

UNICEF’s leadership is particularly effective in convening development partners to work together to support government initiatives. For example, UNICEF worked with the World Bank Water and Sanitation Programme to support MRD in drafting the Rural WASH National Action Plan (2016–2018), which will form the basis for the sector’s work planning, budgeting, and resource mobilization. UNICEF is also frequently called upon directly by the government for advice—one stakeholder described this relationship as “private advisors.” While other organizations and individuals may have the ability to advise publicly through formal forums, UNICEF is called upon directly for its technical expertise. As an example, CARD has asked UNICEF specifically to help with the MTR of the National Strategy for Food Security and Nutrition.

External stakeholders felt that UNICEF is also particularly successful at leveraging partnerships by generating and using high-quality data. For example, UNICEF Cambodia’s study on breastfeeding practices using secondary DHS data informed WHO’s strategy to focus on breastfeeding in urban areas where the decline is most prominent.

Evidence that Cambodia was not on track to reach its target related to MDG 1 was released in 2010. This proved very effective at increasing attention to nutrition. As conversations take place around the post-2015 agenda and Cambodia’s agenda for the Sustainable Development Goals (SDGs), there are likely opportunities for UNICEF to provide leadership around including stunting as a priority.

Challenges

There are a few challenges in improving UNICEF’s leadership and leveraging of partnerships:

- As previously mentioned, there are opportunities for UNICEF to lead other UN agencies on nutrition. This is understandably difficult for three reasons:
Other UN organizations in Cambodia have very little funding—there is a joint UN plan that has not been realised because no funding is available.

There is overlap in mandates among UNICEF and other UN agencies. The main point of overlap is with WFP, stemming from issue around who is responsible for moderate acute malnutrition.

Most other agencies do not have nutrition expertise or advocates.

That said, partnerships among UN agencies still represent an important opportunity to work multisectorally. They are more likely to be successful when roles and responsibilities are clearly defined—a stakeholder reported that FAO and UNICEF were currently working on a proposal together because they have clear niches. Stakeholders also felt that partnerships like these help mobilize funding.

- There are opportunities for increased partnership with other development partners as well. USAID and UNICEF are now both working on stunting in a multisectoral manner (USAID through the Nourish Project). They do meet on occasion and participate in many of the same working groups, but a more explicit attempt to participate in bilateral learning may be beneficial. Stunting reduction efforts would likely benefit from joint advocacy efforts, translating what each organization has learned into concrete ideas for government stakeholders.

- Other development partners, particularly Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), are also working on stunting and stakeholders indicated that there are opportunities for collaboration within their voucher program on Fish Snack.

- Government officials and NGOs at the subnational level could greatly benefit from additional capacity-building exercises around nutrition, which is rightly included as a component of the new country programme. However, this capacity building should specifically address stunting, which is not clear from the country programme document.

A stakeholder explained that exercising leadership with NGOs is easy—they will work on nutrition if they are funded to do so. But multiple stakeholders reported that NGOs’ nutrition work is not always the highest quality: They mostly focus on monitoring and screening for acute malnutrition, as their capacity to work multisectorally on stunting is extremely limited. This is also true of many local government agencies, particularly around data usage for designing interventions. An external stakeholder indicated that civil society organisations (CSOs) and NGOs are not yet well coordinated but that coordination is a work in progress, which may represent an important opportunity and role for UNICEF.

**Conclusion**

Leadership and leveraging partnerships to reduce stunting are among UNICEF Cambodia’s strongest comparative advantages. Three factors have driven its ability to leverage partnerships: a high degree of technical expertise that is trusted by government and non-government partners, generation and use of high-quality data, and the “naming and shaming” process of not having been on track to achieve MDG 1. UNICEF has been successful at convening partners to work on stunting but could play a stronger role in improving coordination mechanisms and capacity for stunting prevention among other UN agencies that do not have
nutrition-specific expertise, development partners that are also working on stunting, and subnational actors.

5.6 Equity and reach of disadvantaged children

In its mission statement, UNICEF states that it is committed to ensuring special protection for the most disadvantaged children—victims of war, disasters, extreme poverty, and all forms of violence and exploitation, and those with disabilities. Considerations of equity are particularly important in Cambodia, as many stakeholders felt that Cambodia’s classification as a middle-income country masks stark inequality. This chapter identifies the disadvantaged groups in Cambodia and assesses the evaluation question: Are UNICEF’s strategies and programmes to reduce stunting equitable and effective in reaching disadvantaged children, including children with disabilities?

Approach to Reaching Vulnerable Populations

The 2016–2018 country programme’s approach to reaching disadvantaged children who are most vulnerable to stunting is to focus health, WASH, and nutrition interventions on children living in the Northeast provinces. This decision was made using data from DHS, the Oxford Multidimensional Poverty Index and UNICEF EQUIST showing that severe stunting is most prevalent in the Northeast, combined with the knowledge that fewer government and NGO services are available there. Given financial and data constraints, this is an appropriate strategy. However, there are other disadvantaged children vulnerable to moderate stunting that may not be reached. Data are clear around several of these groups:

- **Children from the poorest households:** In 2010, children living in the poorest households experienced much higher stunting levels (51%) than among children in the richest households (23%). While this remained true in 2014, the poorest wealth quintile saw the largest reduction in stunting prevalence between 2010 and 2014 (see Exhibit 7). This may be an indicator that the food crisis in 2008 was primarily affecting stunting prevalence among the poorest.
• **Rural children**: In general, data show that children living in rural areas are worse off than their urban counterparts. Stunting prevalence for urban children was 27.5 percent in 2010, compared to 42.2 percent for rural children. These disparities persisted into 2014 but to a slightly lesser extent: 23.7 percent in urban areas, 33.8 percent in rural areas. However, stakeholders noted that data on urban children likely mask significant inequality seen in urban areas and thus may not be very meaningful.

Data are less clear regarding other populations that stakeholders identified as vulnerable, including ethnic minorities, landless populations, populations most affected by drought and climate change, children from less educated families, and children of migrant caregivers. Cambodia does not collect data on ethnic minorities, and stakeholders noted that data at the household level or even below provincial level are not available, so no conclusions about children of migrant workers, landless populations, or populations most affected by drought and climate change can be made using data.

UNICEF contributed to two studies on inequalities in women’s nutrition and children’s nutrition using the last four DHS studies. They found that socioeconomic characteristics (place of residence, wealth status, education level, and age) were major contributing factors for women being underweight. For children, wealth status was the main factor associated with undernutrition. Thus, targeting the poorest households is an appropriate strategy. But complicating this issue is that there is only one measure of vulnerability below provincial level—the government classification known as IDPoor households. However, this measure does not

---

51 Data come from DHS 2005, 2010, and 2014. Model is adapted from Bredenkamp et al. (2014).
take debt into account, so there is no way to verify whether the provinces UNICEF has selected has the most vulnerable households.

**Successes**

- External stakeholders felt that UNICEF’s approach to equity was strong and a high priority. Stakeholders noted successes in the areas of policy support, evidence generation, and support for activities in specific vulnerable provinces.
- As noted previously, both country programmes included provisions for the creation of a child- and gender-sensitive social welfare system and cash transfer program.
- Certain activities were conducted with specific vulnerable populations, such as a mass screening campaign conducted in August 2015 in three provinces where the prevalence of SAM was above 5%. As a result, an additional 480 highly vulnerable children received treatment through outpatient or inpatient care.
- The 2016–2018 approach explicitly states that UNICEF will include provisions for nutrition during emergencies in its nutrition and health programming in Outcome 1 and Outcome 3. These provisions mainly consist of increasing the number of health centres able to treat SAM and increasing capacity at community level to identify SAM.

**Challenges**

- As explained above, the Northeast does not have a monopoly on high stunting prevalence, and thus UNICEF is not reaching pockets of high burden located elsewhere in the country. However, this approach is warranted given the level of funding.
- According to stakeholders, there is internal debate within UNICEF Cambodia on whether stunting programmes should be targeted only at vulnerable households or at all women of reproductive age and children.
- External stakeholders agreed that the additional costs associated with addressing the stunting-related needs of vulnerable children were not likely to be borne by government at national or subnational levels.

**Conclusion**

Evidence is clear that stunting disproportionately affects children who are poorer and who live in rural areas, but that there are pockets of other vulnerable children, such as those in urban areas. UNICEF Cambodia’s current strategies and programs are designed to reach disadvantaged children who live in the Northeast, where severe stunting is most prevalent and where fewer services are available. Better subnational data on moderate stunting is needed to be confident that those most vulnerable to stunting overall have been identified.

**5.7 Knowledge/data generation, management, and use**

This chapter explores the evaluation question: Does UNICEF generate and utilize knowledge and data sufficiently and appropriately to realize its stunting reduction strategies and programmes? Below, we present an overview of knowledge and data generation activities that UNICEF Cambodia conducted, followed by a summary of successes, including an assessment
of how effective these activities have been and challenges around knowledge and data generation.

**Knowledge and Data Generation Activities**

During the evaluation period, UNICEF was successful at conducting the following knowledge and data generation activities:

**Data Generation**

- The addition of a micronutrient module to the DHS in 2014, which should generate increased evidence of micronutrient deficiencies that are highly associated with the economic burden of malnutrition.
- Evidence around the social marketability of Fish Snack and the importance of producing specialized nutritious foods locally.
- The hiring by C4D section of an external NGO to conduct participatory research on 17–18 family practices to identify five on which to focus their new C4D strategy. Research will identify nutrition bottlenecks and have a caregiver component that should address stunting reduction efforts.

**Knowledge Generation**

- Advocating for increased attention to the issue of nutrition and stunting by supporting *The Economic Consequences of Malnutrition in Cambodia* and developing a related peer-reviewed article.\(^{54}\) The costs are primarily driven by mortality, health care costs, lower productivity and income deficits, and labour output.
- A study on breastfeeding practices using secondary DHS data that found that the use of breastmilk substitutes was substantially increasing, especially among the urban poor.\(^{55}\) The authors recommended assessment of existing practices at community and health facility levels, and the identification of bottlenecks, such as maternity leave.
- A study finding that the high prevalence of anaemia in women and children in Cambodia is not driven by micronutrient deficiency or haemoglobin disorders, and thus interventions should be expanded to include zinc and folic acid as well as effective anti-hookworm measures.\(^{56}\)
- The previously mentioned studies on nutritional inequalities among women and children.\(^{57,58}\) The papers concluded that policies should target the most vulnerable

---


\(^{56}\) Wieringa, F. T., Dahl, M., Chamnan, C., Poirrot, E., Kuong, K., Sophonneary, P., et al. (2016). The high prevalence of anaemia in Cambodian children and women cannot be satisfactorily explained by nutritional deficiencies or hemoglobin disorders. *Nutrients, 8*(6), 348.


women and children and support integrated interventions in the health, social, and agriculture sectors. The paper also identified several actionable items, such as the production of micronutrient-rich foods in the agriculture and agri-food sectors. While this is an accomplishment in terms of knowledge generation, it may be helpful to expound on how policies accomplish this.

- The previously mentioned article exploring the issue of iodized salt that recommends that the government reinforce quality inspection to reduce the quantity of salt not meeting the national requirement,\(^{59, 60}\) as well as an article on urinary iodine concentration among mothers and children in Cambodia.\(^{61}\)
- Multiple other peer-reviewed papers including guidelines on screening for acute malnutrition,\(^{62, 63}\) an exploration of vitamin D deficiency,\(^{64}\) micronutrient retention in different rice cooking methods,\(^{65}\) and a case study on the quality of iron fortification of fish and soy sauce.\(^{66}\)
- The development of a real-time monitoring system consisting of a longitudinal study in the Northeast.

**Successes**

Publication of multiple peer-reviewed articles on nutrition is a clear success. Stakeholders felt that UNICEF Cambodia was playing a very prominent role in knowledge generation within the nutrition sector in Cambodia, particularly updating SAM guidelines, development of Fish Snack, and research on anaemia.

It has also been successful in generating data that are used by other partners. Government partners reported relying on DHS in the past but now look to UNICEF to support research and data generation—they indicated that they are very receptive to UNICEF’s information. A stakeholder indicated that UNICEF’s cash transfer program helped the Nourish Project develop its 1,000 Days Conditional Cash Transfer initiative specifically set up for stunting prevention,

---

60 Laillou, A., Mam, B., Oeurn, S., & Chea, C. Cambodia’s IDD program jeopardized by poorly iodized salt.
and, as previously mentioned, WHO based its breastfeeding strategy on the breastfeeding study conducted by UNICEF.

**Challenges**

**Dissemination**

There exists some tension between UNICEF’s role as a rigorous researcher and its role as an implementer and strategy developer. Research produced by UNICEF is extremely rigorous and well-respected, as evidenced by the 15 papers published in peer-reviewed journals. However, the ability of other stakeholders to translate this research into actionable direction without the help of UNICEF is limited, in part because, according to stakeholders, the number of English-speaking staff within key government agencies is not adequate to do so. Further, academic articles are primarily shared with stakeholders through direct email. These stakeholders may or may not have the time and capacity to read and apply the research findings to their work.

**Government Response**

External stakeholders were mixed on the extent to which they felt the government was receptive on taking action in response to knowledge generated by UNICEF—some felt that it was not as receptive as other countries’ governments to outside pressure, and all felt that although there has been a big step forward in commitment, there was still room for improvement.

**Gaps in Knowledge and Data**

There are several key gaps in knowledge and data that require further research:

- Stunting is often misunderstood even by experienced health workers. Because stunting is not a treatable condition, height for age is not measured in health centres as part of growth monitoring, in spite of strong advocacy from UNICEF and others. This means that there is no system in place for monitoring stunting.
- DHS data show that there was a sharp increase from 2010 to 2014 in stunting prevalence for children less than 6 months of age (from 10.4% to 16.1%). Severe stunting for this age group also increased. Stunting prevalence for all other age categories decreased during this same time period, as did wasting prevalence. This may have implications for focusing on pregnancy, but more data on intrauterine growth restriction (IUGR) and birth weight are needed.
- UNICEF nutrition staff reported that they also experienced gaps in knowledge and skills in the areas of statistics, anthropology of ethnic minorities in Cambodia, waste management, and WASH strategies that are specific to the first 1,000 days.

**Conclusion**

UNICEF plays a pivotal role in generating and disseminating knowledge and data to realise its own stunting reduction programmes—this knowledge and data is also used by partners to realise their nutrition programmes. While the publication of many peer-reviewed articles on nutrition is a clear success, much of the more academic knowledge that UNICEF generates could benefit from being synthesised and transformed for different audiences. Key gaps in knowledge and data include the lack of a monitoring system for tracking stunting nationally and
lack of evidence around WASH for the first 1,000 days, specific stunting-related needs of ethnic minorities, and the issue of IUGR and birth weight.

6. Recommendations

1. The 2016–2018 country programme is a strong move towards adopting a more integrated, intentional, and effective approach to stunting. However, partly because wasting has been so prevalent in Cambodia over the last decade, much nutrition funding and attention has understandably been given to treating severe acute malnutrition rather than stunting. This has resulted in the conflating of all nutrition interventions with SAM treatment. Further capacity building with external stakeholders and partners around the concept of stunting as a multisectoral issue and how to operationalise interventions to prevent stunting are needed, especially at the subnational level. Internally, UNICEF Cambodia should continue to build staff capacity in the areas of policy and advocacy work for stunting and to refine the approach to integrating health, WASH, and nutrition and working with other sectors, including social protection through the cash transfer pilot.

2. As Cambodia transitions to middle-income status, UNICEF Cambodia faces a dwindling resource base and must target resources towards the most effective interventions and reaching the most vulnerable populations. UNICEF has been prolific in generating evidence and peer-reviewed articles, but it should better translate these into program actions. The evaluation recommends allocating financial resources to create action-oriented briefs for all relevant research published in academic journals. These briefs should be translated into Khmer so that RGC counterparts can use them.

3. Further, in the context of limited resources, it is important to clarify the strategy and vision for scaling up integrated nutrition, health, and WASH interventions in the Northeast that target populations most vulnerable to severe stunting to wider populations that are vulnerable to moderate stunting. Given the level of resources available, the ultimate goal may not be scale-up, but rather the generation of general lessons.

4. The UN family exercises a high degree of influence in policy and advocacy efforts, and it could benefit from developing plans and procedures for conducting joint advocacy efforts to translate what each organization has learned into concrete ideas for government stakeholders.

5. IYCF campaigns should leverage the expertise of C4D and nutrition staff to move from traditional communication and media campaigns to a focus on behaviour change for stunting interventions—the provision in the new country programme to reinforce these messages through health workers is a step in the right direction. Central to this is the ability to mobilize adequate funding.
ANNEXES

Annex 1

Global Evaluation Methodology
Detailed Evaluation Methodology

Quantitative methods

Purpose

The quantitative parts of the evaluation identified the trends and differences in stunting rates and inequities during the study period (2010-2015) across geographic, social, political, demographic, and environmental factors. It analysed correlations among stunting trends and other observed characteristics as informed by the data and the qualitative analysis.

Data Sources

Secondary Data

The trend analysis relies primarily on the Demographic Health Survey (DHS) and the Multiple Indicator Cluster Survey (MICS) and will be supplemented by other data provided by UNICEF (HQ and country), country-level data (such as country nutrition surveys and routine information system data), and other sources of publicly available information (e.g., academic data and studies) that is relevant to the particular level of analysis, especially where disaggregated data (e.g., subnational) may be required. Secondary data will be used to as part of the triangulation process to validate findings contribute to exploration of the appropriateness of UNICEF’s country programmes and global and regional strategies.  

Data Management and Analysis

The primary method of quantitative analysis will be descriptive. For secondary data analysis, the focus will include changes in stunting burden and prevalence over the course of the evaluation (2010-2015). Descriptive analyses will include measures of central tendency (mean, median) and spread (standard deviation, range) for continuous variables and frequencies for categorical variables.

Correlations between stunting and identified variables will also be explored at the global, regional, and country levels. If correlations and/or previous qualitative findings suggest that further exploration may be meaningful, additional quantitative analyses, such as t-tests, ANOVA, or regression analysis may be utilized if an appropriate methodology can be determined and the appropriate data (i.e., variables, data size, and data quality) are available. Further categorization will be identified as a result of the initial examination of the data and the qualitative evaluation and may vary by country.

All quantitative analysis will be conducted using Stata software.

Qualitative methods

Purpose

The qualitative assessment will be used to validate and elucidate contextual factors for differences in trends that will be identified and triangulated by the quantitative analysis. The findings will be used to formulate evidence-based recommendations for improving UNICEF’s

67 For fragile settings (both natural and man-made) FEWs and other surveillance sentinel data may be important in assessing responsiveness to early warning systems and may be potential data sources for this evaluation.
Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance

Cambodia Country Case Study

accountability for its performance and results and to guide effective action towards sustainable stunting reduction in the coming years.

**Data Sources**

**Document Review**

The qualitative assessment was informed by documents provided by UNICEF and will include policy, strategy, and evaluation reports at all levels (country, regional, global). Country documents for the evaluation of Cambodia included UNICEF Country Programme Documents (CPD), annual reports, national County Programme Action Plans (CPAP), and Mid-Term Evaluations (MTRs) for the years 2010-2015. In addition, the evaluation team reviewed Regional Office Operations and Management Plans (ROMPs) and Regional Analysis Reports (RARs), and global strategic documents related to stunting reduction. Publicly available documents for review have been extracted from UNICEF web-sites. The ICF evaluation team has been working with the EO, ROs, and COs to collect additional documents for review.

**Key Informant Interviews**

Key Informant Interviews (KIIs) were conducted at the global, regional and country levels. Key staff from HQ, ROs, and selected COs were interviewed during the inception phase to ascertain regional and country programme highlights. The evaluation team conducted KIIs with UNICEF Regional Nutrition Advisors during the inception phase. Findings from the interviews informed the inception report and will be utilized during the desk review to better target document and data collection and to better inform and target the questions being asked in case study countries.

During the implementation phase, interviews were conducted at the country level with UNICEF-Cambodia staff including local-level personnel involved in managing and supporting UNICEF programmes, representatives and/or deputies, and programme managers and advisors at various levels. National policy makers and programme coordinators (including subnational staff) were also interviewed. Additional KIIs were conducted with external experts and stakeholders, and staff of other UN agencies and organizations that contribute to and partner in relevant sectors at the global and national levels.

**Data Management and Analysis**

Qualitative analysis is an iterative process. Through coding and text retrieval, data moves from abstract (thick description) to drawing concrete conclusions and developing targeted recommendations. This method adopts the emic perspective in which participants relate personal narratives. Through individual stories, evaluators identify patterns of meaning that evolve into targeted and specific insights and recommendations.

The interviewers responsible for the KIIs and the individuals identified to review the collected documentation were designated as coders. If more than one interviewer was present during a KII, the individual tasked to take notes was designated as the primary coder and the interviewer acted as a secondary coder, to review and refine the primary coder’s results. For each of the KIIIs, the case study interviewer or notetaker typed up the notes and used the recordings to corroborate the notes. All notes were coded using qualitative data analysis. The seven
Evaluation Areas were used as the “deductive” or *a priori* codes. Multiple codes were applied to the same text excerpt from the notes if the segment conveyed multiple concepts that should be captured. Similarly, as documents were reviewed, codes were mapped onto information that addressed an aspect of the seven identified evaluation questions.

During coding, the evaluation team employed a rating-scale rubric of measures corresponding to select indicators to score elements of the document, including the DAC criteria of relevance, effectiveness, efficiency, and sustainability as applicable, and cross-cutting areas of leadership, equity, and knowledge management and use.

The evaluation team noted any emerging themes from the documents and KII’s. These themes were aggregated conceptually and transformed into “inductive” codes. For example, ICF may develop a new code if careful readings of the notes point to discussions across multiple participants about standardization of cross-collaboration across programme areas being important to implementation. Subcodes were developed and linked to these main deductive and inductive codes to capture different nuances of the central themes. Based on the notes and conversations with each of the coders, the task lead drafted definitions and exclusion/inclusion criteria for each code.

Data analysis proceeded in two steps. First, coders constructed focused queries in the qualitative data management software ATLAS.ti, to retrieve specific text segments. To accomplish this task, team members developed lists of questions that speak to different components of the evaluation questions. Examples include:

- What are the activities that the Cambodia Country Office identify as key to reducing stunting?
- What national priorities inform the Cambodia Country Programme?

These team-generated questions were transformed into queries readable by the data management software. Team members read the various outputs, notating themes or patterns that develop. They also developed new questions that arose from the data and transformed them into new queries. Team members involved in the queries met regularly to share findings and discuss analysis strategies. The cycle of question creation, output, theme notation, and team analysis discussion was repeated until the study’s research questions are satisfactorily answered. In addition, the team used other analytic tools to examine inductive themes (e.g., exploring which codes tend to co-occur) and whether any patterns emerge through these networks. For example, by looking at the data points where evaluation areas intersect, themes may emerge. Thus, for the report, findings may be obtained by combining retrieved segments from the deductive inquiries with the patterns that arise through the inductive networks.
Annex 2

Cambodia Evaluation Reference Group
The members of the National Reference Group for the Cambodia Evaluation included the following persons:

- H.E. Sok Silo
- H.E. Prak Sophonneary
- Pom Chreay
- Arnaud Laillou
- Chun Sophat
- Than Sreymach
- Etienne Poirot
- Andrew Hill
Annex 3

Documents Reviewed
The following documents were reviewed as part of this case study:

UNICEF Cambodia Country Programme Document 2016–2018
UNICEF Cambodia Country Programme Action Plan 2016–2018
UNICEF Cambodia Annual Report 2010
UNICEF Cambodia Annual Report 2012
UNICEF Cambodia Annual Report 2013
UNICEF Cambodia Annual Report 2014
UNICEF Cambodia Annual Report 2015

An Analysis of the Situation of Women and Children in Cambodia 2009
A Damage Assessment Report: The Economic Consequences Of Malnutrition In Cambodia
Breastfeeding Trends in Cambodia, and the Increased Use of Breast-Milk Substitute—Why Is It a Danger?
The High Prevalence of Anemia in Cambodian Children and Women Cannot Be Satisfactorily Explained by Nutritional Deficiencies or Hemoglobin Disorders
Low Urinary Iodine Concentration among Mothers and Children in Cambodia
The Economic Burden of Malnutrition in Pregnant Women and Children under 5 Years of Age in Cambodia
Inequalities in Nutrition between Cambodian Women over the Last 15 Years (2000–2014)
Persistent Inequalities in Child Undernutrition in Cambodia from 2000 Until Today
The Imperative of Improving Child Nutrition in Cambodia and the Case for Cash Transfers in Cambodia
Strategy Brief: National Strategy For Food Security And Nutrition 2014–2018
Annex 4

Key Informant Interview Respondents
The evaluation expresses our thanks to all of the key informant interview respondents who participated in the evaluation:

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arnaud Laillou</td>
<td>Mao Sokchea</td>
</tr>
<tr>
<td>Sam Oeurn Un</td>
<td>Mao Sophalla</td>
</tr>
<tr>
<td>Sam Treglown</td>
<td>Pech Seima</td>
</tr>
<tr>
<td>Etienne Poitot</td>
<td>Sek Saravy</td>
</tr>
<tr>
<td>Debora Comini</td>
<td>Natascha Paddison</td>
</tr>
<tr>
<td>Ismail Kamil</td>
<td>Frank Weiringa</td>
</tr>
<tr>
<td>Maki Kato</td>
<td>James Rarick</td>
</tr>
<tr>
<td>Keo Sovannary</td>
<td>Jean Luc Lambert</td>
</tr>
<tr>
<td>Rachel McCarthy</td>
<td>Hou Kroeun</td>
</tr>
<tr>
<td>Path Heang</td>
<td>Kao Vibol</td>
</tr>
<tr>
<td>Pharim Khlev</td>
<td>Chon Dan</td>
</tr>
<tr>
<td>Iman Morooka</td>
<td>Nai Muth</td>
</tr>
<tr>
<td>Savy Bou</td>
<td>Pheng Sameth</td>
</tr>
<tr>
<td>Borath Mam</td>
<td>Heng Sokha</td>
</tr>
<tr>
<td>H.E. Prak Sophonneary</td>
<td>Mony Kunthea</td>
</tr>
<tr>
<td>H.E. Sok Silo</td>
<td>Wolfgang Weber</td>
</tr>
<tr>
<td>Inna Sacci</td>
<td>Sophea Nonh</td>
</tr>
<tr>
<td>Andrew Hill</td>
<td>Leng Punlok</td>
</tr>
<tr>
<td>Annie Nut</td>
<td>Vanny Kong</td>
</tr>
<tr>
<td>Navy Kieng</td>
<td>Erica Mattellone</td>
</tr>
</tbody>
</table>
Annex 5

UNICEF Cambodia’s Plan to Reduce Stunting 2011-2015
**Approach to Defining the Plan to Reduce Stunting**

As noted in the body of this report, UNICEF Cambodia did not have a specific strategy or approach to stunting during the period of this evaluation. This annex is the evaluation team’s documentation of components outlined in three documents that, whether intentionally or unintentionally, could have impacted stunting outcomes. The Country Programme Document and related Country Programme Action Plan (CPAP) 2011-2015 serve as the foundational documents with indicators taken from the Summary Results Matrix. The last programme component from the CPAP is supplemented with information from the Country Programme Management Plan and Integrated Budget 2011 – 2015, which also provides budget figures.
Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance – Cambodia Country Case Study
Programme Component 1: Maternal, Newborn Child Health and Nutrition (MNCHN)

Total Budget: $24,500

The MNCHN Programme will contribute to the Second Health Sector Support Programme, supporting capacities at national and sub-national levels to achieve MDGs 1, 4, 5 and 6 through an enhanced policy environment; increased coverage of an integrated package of services, including HIV-related services; and improved practices by individuals, families and communities. While seeking nation-wide expansion of high-impact MNCHN and HIV interventions through policy development advocacy and resource leveraging, the programme will adopt an equity-focused approach in accelerating progress towards the MDGs. This will be achieved through improving availability of data on the most vulnerable and underserved populations, strengthening the capacity of national partners for disparity analysis and expanding programmatic approaches and operational strategies aimed at reducing inequities, especially those caused by poverty and remoteness. This will include support to pilots on cash transfers linked to maternal health and nutrition, on the contracting of health volunteers to improve quality and sustainability of community-based programmes, and on a follow-up system for children born to HIV-positive women.

The programme results are derived from two related UNDAF programme outcomes: “Improved national and sub-national equitable coverage with quality reproductive, maternal, newborn and child health and nutrition services” and “Strengthened health sector response to HIV”. They are as follows:

1.1 Improved national and sub-national capacity to increase availability, accessibility and utilization of quality maternal, newborn and child health services. To address the high burden of maternal and newborn deaths, this component will support improvements in coverage and quality of antenatal, delivery and postpartum care at the facility level and the roll out of community care of mothers and newborns. Programme approaches especially those concerned with maternal health will involve men and promote women’s empowerment. Major child survival activities will focus on ensuring sustainability of the national immunization programme, supporting the introduction of

<table>
<thead>
<tr>
<th>Key Progress Indicators, Baselines and Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 1.1.1 % pregnant women with two or more ANC consultations (Baseline: 82.1; Target: 90)</td>
</tr>
<tr>
<td>• 1.1.2 % postpartum women and newborns attended by trained provider in the first 72 hours after delivery (Baseline: TBD; Target: 15 pp increase)</td>
</tr>
<tr>
<td>• 1.1.3 # ODs with more than 80% immunization coverage for DPT-HepB-Hib3 and Measles (Baseline: 61; Target: 77)</td>
</tr>
<tr>
<td>• 1.1.4 % HCs that implement appropriate management of diarrhea and pneumonia in children (Baseline: TBD; Target: 90)</td>
</tr>
</tbody>
</table>
new vaccines, strengthening pneumonia case management and expanding diarrhoeal
treatment with zinc. Quality improvement in the area of MNCHN will be addressed
through standardizing relevant methods and tools and through strengthening support
systems for supervisors and clinical coaches at the national and sub-national levels.

1.2 Increased national and sub-national capacity to expand coverage of evidence-
based nutrition interventions to prevent and treat malnutrition in women of
reproductive age and children under-five. This component will promote optimal infant
and young child feeding practices, emphasizing adequate complementary feeding while
continuing to support breastfeeding promotion. A national system for management of
acute malnutrition will be established. Prevention of anaemia and other micronutrient
deficiencies in children and women will be addressed through multiple micronutrient
supplementation and fortification. Monitoring and evaluation in the area of food security
and nutrition will be strengthened through the establishment of a national management

**Key Progress Indicators, Baselines and Targets**

- 1.2.1 % children < 6 mo who are exclusively breastfed (Baseline: 66; Target: 70)
- 1.2.2 % children < 2 yrs who receive appropriate complementary feeding
  (Baseline: TBD; Target: 10 pp increase)
- 1.2.3 % HCs that implement in-home multi-micronutrient fortification to children 6-
  24 months of age (Baseline: 1; Target: 50)
- 1.2.4 # RHs that implement appropriate management of acute malnutrition with
  complication (Baseline: 0; Target: 24)
- 1.2.5 % HCs able to screen, refer and manage for acute malnutrition (Baseline: 0;
  Target: 50)

Communication for development will be a cross-cutting strategy used to achieve all
programme results and to support improvements in health, nutrition and HIV-related practices at
the individual and family levels, as well as in care-seeking during pregnancy, childbirth and early
childhood. Capacity building for strategic communication planning along with support to
implementation, monitoring and evaluation of comprehensive communication plans and
community-based programmes tackling select priority practices will represent the focus of
UNICEF support. In this work, UNICEF will also support strengthening of inter-personal
communication and counselling skills of health workers.

The MNCHN programme will continue close collaboration with the Ministry of Health (MoH) and
its structures for sustainable achievement of MNCH, nutrition and HIV/AIDS results as outlined
in related national and sector strategies and plans of actions. As a partner of the Second Health
Sector Support Programme (2008-2013), UNICEF will support improved sector strategic and
operational planning, community participation, as well as the deconcentration and
decentralization process in the health sector and emergency preparedness and response.

Along with MoH, collaboration with the Ministry of Planning (MoP) and the Council for
Agricultural and Rural Development (CARD) will be advanced to improve availability of health-
and nutrition-related information and analysis as well as quality of inter-sectoral planning and
coordination in the areas of nutrition and social protection. UNICEF will closely work with the Food and Agriculture Organization of the United Nations (FAO), German Technical Cooperation (GTZ), International Labour Organization (ILO), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Educational, Scientific and Cultural Organization (UNESCO), United Nations Population Fund (UNFPA), World Bank, World Food Programme (WFP), World Health Organization (WHO), as well as non-UN partners – among others, Clinton Health Access Initiative (CHAI), Groupe de Recherche et d’Echanges Technologiques (GRET), Helen Keller International (HKI), MAGNA Children at Risks, Reproductive and Child Health Alliance (RACHA), Reproductive Health Association of Cambodia (RHAC), University Research Company, United States Centre for Disease Control and Prevention – and bilateral donors – Australian Agency for International Development (AusAID) and the United States Agency for International Development (USAID) – to support innovations, strengthen the evidence base for programmes and advocacy activities for health, nutrition and HIV and AIDS.

Programme Component 2: Water, Sanitation and Hygiene (WASH)

Total Budget: $12,500

The **WASH Programme** will support the Rural Water, Sanitation and Hygiene (RWSSH) Sector to achieve MDG 7c with emphasis on the un-reached among rural communities. It will seek to leverage resources, particularly those of the Government, to scale up decentralized approaches to WASH improvement, towards ensuring that more women, men, children, and young people enjoy safe water, sanitation and hygiene conditions.

It aims to achieve the following results, which directly link to UNDAF outputs: (1) communities practice key hygiene behaviours; (2) communities, schools and health centres have access to sustainable technologies for safe water, sanitation and hygiene and (3) the Ministry of Rural Development (MRD) and concerned sub-national agencies are able to lead, coordinate, facilitate, monitor and evaluate the RWSSH and arsenic mitigation national strategy.

The first two result areas will focus on communities in a number of select, remote communes where sanitation coverage is below the national average and/or extensively affected by arsenic contamination. Support will be provided in a linked and mutually reinforcing way to national leadership for increased performance and effectiveness of the sector. The purpose is to produce evidence showing that WASH services are vital for health, education, economic development and gender equality and to advocate for requisite national policy and resources for improved access to safe water, sanitation and hygiene education. It will also demonstrate cost-effective approaches and technologies that can be expanded towards achieving universal coverage, with particular attention to the marginalized communities.
• **Communities practice key hygiene behaviours.** UNICEF will provide technical assistance to develop, implement and evaluate interventions that motivate and facilitate improved hygiene practices among men, women and children. The focus will be on large-scale improvement of three key hygiene practices: hand washing with soap at critical times, using latrines and drinking safe water. It will promote coordinated efforts among various actors involved in sanitation and hygiene promotion, integration of hygiene into health and basic education services, and engagement of the private sector to ensure products and services are available and affordable. Partnership with the health sector will be strengthened to integrate promotion of the key behaviours into health programmes and training of health centre staff. Partnership with the education sector will build on the results and lessons learned of the School and Community WASH initiative promoted by MRD and MoEYS since 2009. Implementation of the tested and innovative CLTS approach will be improved with special attention to gender and equity, children and youth participation, community monitoring and the roles of commune authorities. It will seek to develop stronger links to sanitation marketing, particularly for the promotion of access to environmentally appropriate technology.

<table>
<thead>
<tr>
<th>Key Progress Indicators, Baselines and Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2.1.1 % HH, primary schools and HCs with designated place for hand washing where water and soap are present (Baseline and Target not provided)</td>
</tr>
<tr>
<td>• 2.1.2 % rural HH practicing open defecation (Baseline: 69; Target: 50)</td>
</tr>
<tr>
<td>• 2.1.3 % rural HH that always treat drinking water (Baseline: 57; Target: 75)</td>
</tr>
</tbody>
</table>

• **Access to sustainable technologies for safe water, sanitation and hygiene.** The programme will promote community-based water quality monitoring and response to ensure water is safe (from biological, arsenic or other contamination) for consumption from the water source to point of use at households. It will be based on the Water Safety Plan (WSP) approach, which involves comprehensive risk management and mitigation, such as renovation and maintenance of facilities, household water treatment and safe storage, and sanitation improvement. Selected communes will be supported to ensure schools and health centres serving the most vulnerable communities in remote, disaster-prone and seasonally flooded areas have safe water supplies, toilets and hand-washing facilities. In line with the national RWSSH strategy, the programme will promote a demand responsive approach while ensuring that the poorest households can participate and benefit. This component will include promotion of the role of the private sector, including sanitation marketing to ensure that water, sanitation and hygiene products are available and affordable to the poorest, building on recent initiatives supported by NGO partners in three provinces.
• **Strengthening sector leadership.** Together with partners, particularly the Asian Development Bank (ADB), WHO, World Bank Water and Sanitation Programme (WSP) and other members of the Technical Working Group-RWSSH, UNICEF will support MRD to strengthen its focus on policy; to secure sustainable, cost-effective and inclusive implementation of the national strategy; and to engage in partnerships that aim to galvanize political, financial and technical commitments to the sector. Strengthening private sector participation will focus on development of business and technical skills of village- and commune-based artisans, masons, mechanics and local companies to supply cost-effective services that respond to community demand, especially in underserved areas.

<table>
<thead>
<tr>
<th>Key Progress Indicators, Baselines and Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2.2.1 % HH with access to improved source of drinking water (Baseline: 40.5; Target: 50)</td>
</tr>
<tr>
<td>• 2.2.2 % rural HH with access to improved sanitation (Baseline: 23.24; Target: 53)</td>
</tr>
<tr>
<td>• 2.2.3 % primary schools with access to improved source of drinking water and improved sanitation (Baseline: 65.2 and 77.6; Target: 100)</td>
</tr>
<tr>
<td>• 2.2.4 % HCs with access to improved source of drinking water and improved sanitation (Baseline: TBD; Target: TBD)</td>
</tr>
</tbody>
</table>

Improvement of the sector monitoring system will be pursued to promote streamlined reporting requirements and increased community engagement to provide a reliable, local source of information on use of and access to WASH facilities. Support for emergency preparedness will focus on strengthening the capacity of communities and of the Provincial Departments of Rural Development in preparedness and response to natural and other disasters.

Programme coordination will be assured through the TWG RWSSH, led by the Ministry of Rural Development. Other major partners include MoH, MoEYS and local and international NGOs.
Programme Component 6: Policy, Advocacy and Communication (PAC)

Total Budget: $10,500

The PAC Programme will contribute to enhanced capacities for collection, access, and utilisation of disaggregated information at national and sub-national levels to develop and monitor policies and plans that are responsive to the needs of children and most vulnerable groups. The programme will contribute to strengthened national systems of analysis and planning across sectors, leading notably to the creation of a comprehensive package of social protection measures for the poorest families and children. This will also be the locus for attention to significant cross-sectoral issues, such as C4D, gender and adolescence, with attention to an equity agenda in achieving the CMDGs.

In partnership with the Government, UN agencies, development partners, civil society organizations and communities, PAC will provide capacity development on key areas from data collection through to policy advice, namely for:

- strengthening national systems for collection, analysis and dissemination of child-relevant data and monitoring and evaluation systems, with a focus on equity analysis and outcomes;
- strengthening the national knowledge management function for children, which keeps track of the situation of children and the attainment of children’s rights, for well-informed decisionmaking;
- strengthening national capacity for research to include participatory approaches to research in order to facilitate the contribution of rights-holders to the decision-making process;
- supporting the development of a child- and gender-sensitive approach to social budget analysis and monitoring of social investments with a focus on pro-child, pro-poor and pro-equity investments;
- supporting dialogue on strategic and programmatic choices for designing, implementing and resourcing child-sensitive social protection programmes and packages; and
- supporting analysis of laws and policies to assess their impact on children’s well-being.

PAC programme results focus on:

- **Strengthened national institutional capacity including resources and technical knowledge to develop, roll out and coordinate a cross-sectoral social protection strategy, inclusive of social welfare services.** PAC will provide technical assistance and strengthening of the national social protection system and its coordination mechanisms through support to policy formulation and programme design, the expansion of the analytical capacity of the Government in securing adequate
investments into basic social services and social protection, and analysis of the child poverty impact of social investments. This is expected to contribute to more adequate resourcing of child-related interventions and their translation into better child development outcomes.

**Key Progress Indicators, Baselines and Targets**

- The national social protection strategy is operational and includes packages addressing critical vulnerabilities affecting children (Baseline: N; Target: Y)

PAC support to C4D is reflected in the results statements and indicators of other programme components.

Programme coordination will be assured through the TWG Planning and Poverty Reduction, led by the Ministry of Planning, and the interim TWG on Safety Nets and Social Protection. PAC will work in partnership with a number of implementing and coordinating partners, including the Ministry of Planning/National Institute of Statistics (MoP/NIS), CNCC, the Supreme National Economic Council, MEF and the Council for Agricultural and Rural Development.

**Management Plan Components:**

**Use of Regular Resources/Other Resources:** Across the country programme, regular resources will be used for advocacy, core capacity development, assurance of critical UNICEF staff functions and for strengthening sector partnerships, including contributions to pooled funding mechanisms. Other resources will allow for expanded capacity development, operational research and extended staff deployment. The present policy of funding a core of staff in each section – Chief, one national officer and one admin or programme assistant – from regular resources will thus be maintained with a similar formula applying for zone offices.

**Interagency Cooperation:** For some time now, the UN system in Cambodia has been involved in an ongoing common premises initiative. The UN house design has been developed by a contracted architect and was used to seek proposals from interested developers to potentially construct a purpose built office building to be rented by participating UN agencies. Though supportive of ongoing UN coherence activities, UNICEF has opted out of the current initiative on grounds of cost, as have UNFPA and UNAIDS. The TTCP has also indicated that it cannot formally endorse the project due to the anticipated higher rental rates, which are unsustainable for most participating agencies. In establishing proposed new zone offices, UNICEF proposes to co-locate with other agencies to the maximum extent possible. Steps are underway for participating agencies (UNICEF, UNDP and UNFPA) to become fully HACT compliant by the end of 2010. Our new, expanded sub-national presence supported by the new zone offices will facilitate efforts to carry out field monitoring and other required assurance activities in order to insure that funds transferred to implementing partners are being used for their intended purposes.
Proposed Changes in the Office Structure:

- In recognition of the importance of Water, Sanitation and Hygiene and Local Governance as distinct “sectors” within the government’s development architecture, these become distinct programmes; during 2006-2010 they were combined in the Seth Koma programme.

- UNICEF support to the fight against HIV and AIDS has focused on prevention of mother-to-child transmission and paediatric treatment, through public health services, and children affected and primary prevention among young people, through child protection services. These elements will be integrated, respectively, into the Maternal, Newborn and Child Health and Nutrition programme and Child Protection programme. In order to assure coherence of HIV & AIDS programming, an HIV & AIDS Adviser at the L4 level will also be assigned to the Programme Coordination, Monitoring and Field Support Section (see below).

- To enhance UNICEF’s role in knowledge management and policy and behaviour change, a new Policy, Advocacy and Communication programme is proposed. Communication for development will be a major part of this programme and will be separate from communication for external relations.

- Recognizing that human capacities of Cambodians have significantly increased over the past years and in order to provide for enhanced career paths for nationals, there will be at least one post at NO-C level in each programme section. Sections have reviewed the current mix of national and international posts with a view to determining which international posts would most appropriately be nationalized, while maintaining a due balance between national and international positions.

- Gender, adolescence and emergency preparedness & response cut across all programmes and will continue to be covered through the assignment of focal point responsibilities.

- New office locations: The focus-province approach adopted in the previous country programme, covering six of Cambodia’s 24 provinces, was successful in garnering field experience and conducting pilots that have positively impacted national policy. However, an internal analysis found that higher levels of vulnerability were mostly found in provinces other than those selected. Moreover, pockets of acute poverty, vulnerability and disparity occur throughout the country at levels below that of the province, and further analysis found many instances where the benefits of UNICEF support have been limited to these focus provinces. The historical presence of UNICEF programme staff in provincial government offices has also led to a degree of capacity substitution.

- Reflecting the nationwide character of the country programme but maintaining a UNICEF presence on the ground, a feature much valued by both government and development partners, it is proposed to relocate staff functions presently assigned in six focus provinces to five zone offices to manage sub-national programme cooperation, following through on the strategic shift from focus provinces to local coverage for all of Cambodia. Bearing in mind the need to provide duty stations that are more family friendly, as well as to ensure adequate connectivity with the country office, these will be located in major cities with adequate infrastructure: Kampong Cham (for north eastern provinces), Siem
Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance Cambodia Country Case Study

For cost-efficiency, the Phnom Penh zone office will be co-located with the country office but as a distinct entity. In Kampong Cham and Siem Reap, we are exploring co-location with WFP. Other UN agencies have or plan to establish field presence in Battambang and Preah Sihanouk, and we shall explore cost-sharing arrangements with them, as appropriate.

- Each zone office will be headed by a Chief, Field Office, provisionally graded at NO-C. The Chief, Field Office will also act as a capacity development specialist. Professional staff (NO-B) posted to the zone offices will be assigned sectoral functions and have appropriate qualifications and experience. The required mix of staff for zone offices is proposed based on programme sections’ analysis of programming imperatives for particular provinces. Staffing of zone offices is not intended to be uniform. Since all work at sub-national level is conducted in Khmer, zone office staff will be nationals, except for one international UNV per zone office fulfilling a knowledge management function, linked to the PAC programme; WFP is making similar appointments in its sub-offices. All staff in the zone office will report, directly or indirectly, to the Chief, Field Office. E-PAS will facilitate input to performance appraisal of appropriate sector staff in the country office.

- **Funding and Leveraging Strategy:** In the new cycle the challenge will be to move to a new resource mobilization paradigm. As already indicated, UNICEF will maximize its engagement in multi-stakeholder programme-based approaches (PBAs4). The first priority will thus be to advocate practically, through the mobilization and use of good evidence, increased resource allocations to programmes for children both from the government’s own budget and from pooled funding sources: budget support, trust funds, etc... Where PBAs exist, therefore, we shall not be seeking other resources (OR) to fund programme activities, with a percentage of such OR also funding UNICEF operational capacity. We shall need rather to persuade partners to make additional provisions to their contributions to PBAs, so that UNICEF retains the level of technical and field staff needed to provide the normative, monitoring and capacity development services that partners recognize as a strength that UNICEF brings to enhanced aid effectiveness mechanisms. We have broached this shift with a number of partners, but the move from intellectual understanding to actual changed practice represents a real, if very necessary, risk that we have to assume.

At present, indications are that ODA commitments to Cambodia will remain at current levels in the short term totaling around US$ 900 million per year. However, the impending withdrawal of donors such as DFID in 2011, and the cascading effect this may have in the donor community, leaves some uncertainty whether these levels are sustainable in the next 3-5 years and beyond; there are also concerns among some donors over overcrowding, fragmentation, better value for investment elsewhere and issues of governance and accountability. This will pose serious challenges to UNICEF and the broader UNDAF, and reiterates the need to reinvigorate partnership strategy, adopt sustainable funding modalities and implement a UN wide advocacy effort. UNICEF Cambodia has revised its existing resource mobilisation strategy to reflect the new country programme priorities and changing funding environment and modalities. It
is expected that the UNICEF Executive Board will approve the aggregate indicative budget of US$ 32,530,000 in RR, subject to the availability of funds, and US$ 75,000,000 in OR for 2011-2015 (a 25 percent reduction from the previous cycle). The strategy combines:

- Optimal programming of current OR and planned income in 2010, to ensure basic funding for the first year 2011 (possibly partly for 2012) of the country programme. Current analysis and projections of funds under negotiation show that an amount of US$ 10.5 million OR could be 4 In keeping with the new terminology of Vision, and that of aid effectiveness, PBAs in this CPMP refer to programme-based approaches, not programme budget allotments. 13 available at the start of the country programme, though with highly unequal spread across programmes.

- Maximizing use of thematic funds – exploring potential of opening country thematic windows

- Pursuing and building upon existing relationships with National Committees (which represented 27 per cent of OR income in the previous cycle)

- Pursuing and building upon existing relationships with bilateral and intergovernmental partners such as Sida, AusAID, EU, USAID, JICA, World Bank, ADB, recognizing that these will require distinct, though coordinated, approaches to leverage and funding

- Seeking synergies through joint programming with UN agencies

- Exploring new partnerships, mostly as leverage, with emerging donors: Korea, China, India, wealthier ASEAN member states

As effective and innovative programmes are the best fundraising tools, the office will emphasize evidence-based management through its expanded field presence, increased technical competencies, results-based monitoring and reporting and more flexible UNICEF internal processes. Resource mobilization will be coordinated by the Representative and contribution management by the Programme Coordination, Monitoring and Field Support Section under the overall supervision of the Deputy Representative.
Annex 6

UNICEF Cambodia’s Plan to Reduce Stunting 2016-2018
Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance – Cambodia Country Case Study

<table>
<thead>
<tr>
<th>Country Programme Outputs</th>
<th>Country Programme Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. By 2018, all children had access to nutrition-specific services at all levels in an enabling environment, particularly in six target provinces.</td>
<td>1. By 2018, strengthened capacities of administrators in six target provinces in monitoring, planning, coordinating, implementing and monitoring actions that promote ECD.</td>
</tr>
<tr>
<td>1.2. By 2018, increased capacities of service providers to promote access to nutrition-specific services at all levels in an enabling environment, particularly in six target provinces.</td>
<td>2.1. By 2018, strengthened government capacity for policy development, planning and financing of quality education.</td>
</tr>
<tr>
<td>1.3. By 2018, increased government and non-government capacities to provide access to inclusive basic education, particularly amongst indigenous minorities and children with disabilities including in emergencies.</td>
<td>3.1. By 2018, strengthened government capacity for national government and five provincial authorities to formulate and implement the institutional and legal framework and cost plan for the scaling up of child protection and response interventions, including deinstitutionalization and reintegration services.</td>
</tr>
<tr>
<td>1.4. By 2018, increased capacities of service providers to promote access to nutrition-specific services in all levels in an enabling environment, particularly in six target provinces.</td>
<td>4.1. By 2018, increased capacities of four social sector ministries to formulate, execute and monitor programmes with a focus on equity.</td>
</tr>
<tr>
<td>1.5. By 2018, strengthened commitment and capacity of government to provide more children and their families, particularly in six target provinces, with increased access to quality WASH facilities/services.</td>
<td>5.1. UNICEF staff and partners are provided with guidance, tools and resources for effective communications, advocacy and partnerships.</td>
</tr>
<tr>
<td>1.6. By 2018, strengthened commitment and capacity of government to provide more children under 5 with increased access to inclusive quality early childhood education, particularly among children with disabilities, indigenous minority children, and those living in six target provinces.</td>
<td>5.2. UNICEF staff and partners are provided with guidance, tools and resources for effective communications, advocacy and partnerships.</td>
</tr>
</tbody>
</table>

---

All children, especially the most disadvantaged, progressively enjoy their rights to survival, care, protection and development.
Integrated Early Childhood Survival, Care and Development Programme (IECD)

Total Budget: $25,300,000

Outcome: By 2018, infants, children 0-5 years old and pregnant women in target provinces have improved and more equitable use of integrated early childhood survival, care and development interventions and practices, including in emergencies.

Outcome Indicators:
1. Skilled attendance at birth
2. Percentage of children under-5 with birth certificates
3. ECE enrolment of 5-year-olds
4. Percentage of children aged 0-59 months wasted, treated for severe acute malnutrition
5. Exclusive breastfeeding rate among children 0-5 months old
6. Percentage of rural households in target provinces with access to improved sanitation facility
7. Percentage of households where place for washing hands was observed
8. Percentage of primary schools with latrines/water

The programme will support the operationalization of the Government’s early childhood care and development (ECCD) National Action Plan 2014–2018 by demonstrating the physical, social and cognitive development benefits, along with cost-effectiveness, of providing an integrated approach to health, nutrition, water, sanitation and hygiene, child protection, care and stimulation.

A ‘whole district’ approach will be used as the geographic scale of reference, with a focus on provinces with considerably lower outcomes in key women and child development indicators. These are primarily the north-east provinces of Mondulkiri, Ratanakiri, Kratie, Stung Treng and Preah Vihear as well as Phnom Penh Capital. UNICEF will prioritize technical and financial support to the selected districts, where monitoring systems will be developed in the targeted communities in order to generate evidence of the impact of investment in the integrated approach on behaviours, practices and outcomes for children.

Based on upcoming evaluations, during the first half of the Country Programme UNICEF will promote the functional transfer of community preschools to communes and the gradual phase out of direct financial support to commune councils, in favour of a broader and measurable IECD approach.

The programme is operationalized through six Outputs.

Output 2: By 2018, strengthened capacities of communities, caregivers and families to practice timely and appropriate birth registration, complementary feeding, hygiene and health seeking behaviours for children under the age of 5, especially in six target provinces.

Output Indicators:
1.2.1: Number of targeted (65) communes with communication and parenting education initiatives that promote resilience, care, survival, protection and development of infants and children
1.2.2 Number of villages in target districts that are triggered with Community-Led Total Sanitation

1.2.3 Number of villages in target districts reached through household water treatment and safe storage education sessions

1.2.4 Percentage of targeted (26) health facilities with infant and young child feeding counselling services

To support caregivers and families to adopt practices and behaviours that contribute to the safe and healthy development of children, UNICEF will collaborate with the ECCD National Committee and other key stakeholders to develop a comprehensive set of communication and education resources and initiatives for commune and village development committee members, teachers, religious leaders, parents and caregivers. The communication and education resources will promote key practices for full child development, including interactive caregiving, creating child-safe environments, timely and correct health care seeking behaviours, improved infant and young child feeding and child care, stimulation/early learning (ECD) practices, proper treatment and storage of drinking water, hand-washing practices, consistent use of toilets, enrolling children in early learning, and birth registration.

The key care practice information will be incorporated into existing guidelines and training packages. UNICEF will support the community-wide use and monitoring of resources in the six target districts, and promote reinforcement through partnerships with radio and television programmes.

**Output 3: By 2018, increased capacities of service providers to promote access to nutrition specific services at all levels in an enabling environment, particularly in six target provinces.**

Output Indicators:

1.3.1 Percentage of health facilities providing nutrition-specific services (severe acute malnutrition (SAM))

1.3.2 Number of new policies in Nutrition adopted and implemented for SAM, micronutrient powders, fortification, budgeting

With malnutrition being the underlying cause of almost half (45 per cent) of all under-five deaths in the country, UNICEF will support actions to overcome the major enabling environment barriers, as well as access to quality nutrition services bottlenecks. This will include the provision of technical assistance for the development of new multi-sectoral national guidelines for better nutrition, along with national and sub-national level action plans for their implementation. Direct capacity development of service providers – including community workers – will be supported in the six priority districts, with a focus on improving the nutritional status of children under-5 years of age, pregnant and lactating women, and adolescent girls.

Specific actions to improve child nutrition will include increasing coverage of deworming, calcium and iron folate supplementation for pregnant women, promoting the use of iodized salt, strengthening the skills of community health workers to undertake regular screening of children for acute malnutrition, along with treatment when necessary, and promoting social marketing systems for micronutrient supplementation. UNICEF will work with the private sector to improve
salt iodization and develop innovative local food supplements to increase the quality of complementary feeding and the treatment of children with severe acute malnutrition. Improving screening processes, out-patient treatment at health facility level, and the availability of local food supplements are interventions which will lay the groundwork for any emergency preparedness and response planning UNICEF may need for nutrition.

**Output 4:** By 2018, increased capacities of service providers to promote access by more newborns, children and women to quality primary health services, focusing on neonatal and maternal health and immunization, especially in six target provinces.

1.4.1 Percentage of health centres in selected IECD districts conducting at least 80% of planned outreach

1.4.2 Percentage of health centres in selected IECD districts with <5% out of stock of essential medicines and commodities

1.4.3 Percentage of health facilities in selected IECD districts with at least two midwives trained in ANC, delivery, PNC and EENC

1.4.4 Percentage of Operational Districts with at least two cold chain/EPI officers trained on newly developed standard operating procedures

1.4.5 Percentage of health facilities in selected IECD districts with stock out of finger-prick HIV test kits

In collaboration with other development partners, technical assistance will be provided to the Government for the development of a new Health Strategic Plan and a national Newborn Action Plan. UNICEF will advocate for emphasizing an equity approach in both plans, prioritizing the lower performing districts and vulnerable communities.

Development of the national immunization supply chain improvement plan, along with standard operating procedures, guidelines and other supporting tools, will be supported, along with assistance for implementation and monitoring. The innovative technology-based monitoring system for the operation and maintenance of the cold chain central systems will be scaled up. In the six priority IECD districts, UNICEF will provide technical financial and, where necessary, material support to ensure that all health facilities provide quality antenatal, delivery and postnatal services to pregnant women and their newborns. This will be done through outreach services, routine immunization services for children 0-23 months and women, including through outreach to hard-to-reach villages, quality health care services and follow up for sick children, and HIV treatment and care services for pregnant women, children and adolescents. UNICEF will support an inter-sectoral longitudinal study on the impact of IECD on the survival and development of children.

**Output 5:** By 2018, strengthened commitment and capacity of government to provide more children and their families, particularly in the six target provinces, with increased access to quality WASH facilities/services.

**Output Indicators:**

1.5.1 Number of provincial RWSSH WG established, meeting at least once per year
1.5.2 Percentage of preschools in target areas implementing minimum WASH package
1.5.3 Percentage of households in target rural areas that have access to improved water supply
1.5.4 Percentage of health care facilities in the target areas implementing minimum WASH standards, including waste management

To overcome disparities between urban and rural populations in terms of access to improved water and sanitation, UNICEF will support the implementation of the costed Rural Water Supply, Sanitation and Hygiene National Action Plan (2015–2018) through implementation of a WASH early childhood development package. Direct support for improved and equitable access to and use of WASH will focus on addressing the WASH needs of children under 5 years old and pregnant women at the household and community level in the six priority districts. This will be done through ending the practice of open defecation, improving hygiene practices, particularly those related to the safe management of infant and young child faeces, and ensuring the provision of WASH services in health care facilities, primary schools and preschools. UNICEF will work to strengthen the existing Health Management Information System (HMIS) and EMIS to better capture and monitor the status of WASH in health care facilities and schools. It will work to strengthen analysis of other national datasets such as the Commune Data Base (CDB), Cambodia Socio-Economic Survey (CSES) and CDHS, to track WASH progress and highlight equity issues.

Using the disaster risk reduction approach, which aims to reduce the potential loss of health status, livelihoods, assets and services at community level related to the impact of natural disasters, UNICEF will provide technical support to build the capacities of government and local council members to analyse risks and vulnerabilities to disasters and develop WASH-specific preparedness plans, focusing on villages affected by arsenic or recurrent emergencies.

**Social Inclusion and Governance Programme**

**Total Budget: $5,200,000**

*Outcome: By 2018, child rights and equity are increasingly prioritized in social sector national and sub-national policies, budget allocation, social protection systems and public discussion.*

Outcome Indicators:

4.1 Proportion of social sector (health, education, social welfare, rural development) recurrent budget allocation in total recurrent budget

4.2 Proportion of budget allocation for social protection programmes targeting the most vulnerable as percentage of total national recurrent budget

4.3 Percentage increase in disadvantaged children benefiting from social protection programmes

To support the Government to implement the national D&D approach to improving access and quality of social services for all children in Cambodia, particularly those most vulnerable, the Social Inclusion and Governance programme will focus on overcoming the enabling environment barriers and capacity constraints to equitable and efficient financing, management
and monitoring of equity-based services at central and sub-national levels, in support of the three areas of government reform: Public Finance Reform, Decentralization and Deconcentration reform; and Public Administration Reform. Support will be prioritized in developing the costed national social protection strategy and ensuring its emphasis on the most vulnerable and disadvantaged children and families. To further promote social inclusion, the programme will continue to coordinate UNICEF’s efforts to enhance access to services by children with disabilities, in support of the National Disability Strategic Plan.

The programme is operationalized through five Outputs.

**Output 2: By 2018, strengthened national social protection system to address the needs of the most vulnerable children and families and to enhance resilience against shocks.**

Output Indicators:

4.2.1 New costed National Social Protection Strategy addressing child vulnerability in place

4.2.2 National M&E system for social protection programmes with data disaggregation and budgetary information in place

4.2.3 Cash transfer pilot targeting pregnant women and children implemented and evaluated.

With financial barriers a key bottleneck for utilization of social services, and a large number of uncoordinated social assistance programmes operating in Cambodia, in collaboration with development partners, UNICEF will support the Council for Agricultural and Rural Development (CARD) and MEF to develop a costed national social protection strategy, which is child-centred and focuses on the poorest and most vulnerable families and individuals. UNICEF will advocate for its implementation using public budget allocation. Towards operationalization of the strategy, UNICEF will support the Government to undertake a feasibility study for developing a cash transfer programme specifically targeting vulnerable children, developing operational guidelines and manuals for its implementation, and developing capacity of staff who will manage the programme.

Additional technical support will be provided to support CARD to establish functional monitoring and evaluation (M&E) for the social protection system, including dynamic databases. UNICEF will collaborate with the Ministry of Planning and CARD to conduct an assessment of the design of “ID-Poor” (the social protection targeting tool) towards strengthening its child sensitiveness, and to promote a focus on multi-dimensional child poverty, ensuring the inclusion of children and adults with disabilities. This will include facilitation of South-South cooperation and strengthening coordination and harmonized support for social protection through the Technical Working Group on Social Protection/Food Security/Nutrition.
Annex 7

Evidence Matrix of Key Contextual Factors Related to Stunting in Cambodia

Contextual factors come from either the background section of the 2011–2015 Country Programme Document or in the 2009 Analysis of the Situation of Women and Children in Cambodia. Contextual factors that were identified by stakeholders or the evaluation team rather than in one of these two documents are noted with an asterisk.
## 2011–2015 Country Programme

<table>
<thead>
<tr>
<th>Contextual Factor</th>
<th>How Factor Is Addressed in the Stunting Reduction Plan</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL CONTEXTUAL FACTORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Cambodia was transitioning to middle-income status, and donor interest is</td>
<td>Stakeholders indicated that funding was a major consideration in the design of relevant and appropriate country programme strategies and that the country programme generally focused on upstream policy strategies rather than direct implementation. The MNCHN programme aimed to “support capacities at national and sub-national levels through an enhanced policy environment.” The country programme document does not specifically state which policy environments or strategies it aimed to enhance, but stakeholders in general spoke of increasing budget items for nutrition and increasing the capacity of government staff to address nutrition. Further, the Funding and Leveraging Strategy detailed the general plan to maximize engagement in multi-stakeholder programme-based approaches (PBAs) by providing normative, monitoring, and capacity development services rather than funding programme activities where PBAs exist.</td>
<td></td>
</tr>
<tr>
<td>shifting to neighbouring countries, meaning that there is an increasingly smaller pool of resources available.*</td>
<td></td>
<td>Addressed</td>
</tr>
<tr>
<td>2. Cambodia is highly vulnerable to climate change, and floods, droughts, and</td>
<td>Some degree of disagreement existed around this contextual factor. While the Situation Analysis noted that Cambodia was highly vulnerable to climate change, floods, droughts and storms, the Management Plan noted that: “While the Country is relatively exempt of major natural disasters, except for potentially severe annual floods, it is recognized that climate change and other factors can lead to repeated small to medium scale emergencies becoming more frequent, and which could lead to the need for the UNICEF to respond.” The country programme document does not specify how it will incorporate stunting or nutrition into emergency planning and response. It does mention emergencies within the WASH programme within Programme Component 2.2 and 2.3.</td>
<td></td>
</tr>
<tr>
<td>storms are frequent.</td>
<td></td>
<td>Somewhat Addressed</td>
</tr>
<tr>
<td>Contextual Factor</td>
<td>How Factor Is Addressed in the Stunting Reduction Plan</td>
<td>Rating</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>3. Women had low levels of participation in positions of authority and in the decision-making process, including control of household assets.</td>
<td>While gender was mentioned as a cross-cutting issue in the plan, there are no further details included on how gender would be incorporated into nutrition. Stakeholders felt that many nutrition initiatives targeting women did not address the responsibilities of men in the raising of their children, nor did they address the issue of control of household assets, which may affect nutrition if, for example, women do not have power to buy nutritious foods.</td>
<td>Not Addressed</td>
</tr>
</tbody>
</table>

**CONTEXTUAL FACTORS RELATED TO NUTRITION**

<table>
<thead>
<tr>
<th>Contextual Factor</th>
<th>How Factor Is Addressed in the Stunting Reduction Plan</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. 8.9% of children in 2008 were wasted. Wasting among the general population essentially showed no improvement from 2005 to 2008.</td>
<td>Programme Components 1.1 and 1.2 address wasting through health and nutrition interventions (vaccines, pneumonia case management, diarrheal treatment, micronutrient supplementation and fortification, treatment of SAM with complication, and establishment of a national management information system). Stakeholders indicated that supplying RUTF was also an important part of the plan to address wasting. Other parts of Programme Component 1.1 may also have been designed to address wasting, such as ANC consultations -made nutrition-sensitive through the inclusion of breastfeeding counselling. There is some evidence that these interventions were nutrition-sensitive (explored in the “Effectiveness” chapter), but making these connections more explicit in the Plan would have increased the relevance of this programming.</td>
<td>Addressed</td>
</tr>
</tbody>
</table>

68 An Analysis of the Situation of Women and Children in Cambodia 2009.
<table>
<thead>
<tr>
<th>Contextual Factor</th>
<th>How Factor Is Addressed in the Stunting Reduction Plan</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Some population groups and areas had recorded significant increases in wasting, particularly poor urban children, where wasting prevalence increased from 9.6% in 2005 to 15.9% in 2008, likely due to soaring food prices. These rates exceeded the threshold of the 15% threshold for a humanitarian emergency and called for emergency response in urban areas.</td>
<td>While the Plan to Reduce Stunting addressed high wasting rates through the above, it is not clear how they planned to address disparities in wasting rates. Further, the Plan did very little to address the underlying cause – the price of food. It rather focused on treatment. This may be understandable given UNICEF’s mandate and historical focus on health-centred approaches. Food access, and more specifically linkages to agriculture, are explored further in contextual factor 7.</td>
<td>Not Addressed</td>
</tr>
<tr>
<td>6. The exclusive breastfeeding rate was one of the highest in Asia at 66 percent, but 44 percent of children were still not exclusively breastfed. Further, Cambodia had recently seen a significant rise in economic development drawing on low-skilled labour by women, such as garment factories.</td>
<td>Programme Component 1.2 indicates that breastfeeding will be promoted, and exclusive breastfeeding is included as an indicator. The Plan does not offer further details on how UNICEF planned to support breastfeeding promotion, though stakeholders’ impression was that this was primarily envisioned as a media campaign. However, external stakeholders indicated that breastmilk substitutes were identified as a major nutrition challenge because of the increase in women’s factory labour—mothers who work in factories are not present to breastfeed and do not have access to infrastructure for breastmilk storage. The Plan did not address this root cause or help promote workable alternatives for working mothers such as maternity protection in the workplace. Further, the issue of factory work is important to how programmes are targeted—when mothers are not the primary caretakers of children, stakeholders felt that programmes should be targeting grandparents and in some cases older siblings. A stakeholder at the subnational level explained that caregivers are often siblings as young as 6 or 7 years old. There is no written evidence that the Plan took these dynamics into account, nor did stakeholders feel the approach was adequate.</td>
<td>Somewhat Addressed</td>
</tr>
</tbody>
</table>
The low intake of energy and nutrient-rich complementary food had been identified as a major driver of undernutrition. Only about 1/3 of children were fed the recommended four or more food groups. Again, the plan in Programme Component 1.2 does include provisions for promoting IYCF practices as well as treating deficiencies through multiple micronutrient supplementation and fortification, but it does not include further details on how this will be accomplished. Stakeholders indicated that C4D activities would be a major component of promoting optimal IYCF practices. It is not clear whether UNICEF intended to include IYCF in its plan to strengthen the counselling skills of health workers, which would have strengthened the relevance of the Stunting Plan. Certainly, stakeholders now feel that IYCF counselling may not be of the highest quality nationwide, but there is no evidence that this was the case in 2010. Either way, there are two other major gaps in the adequacy of the Plan to address complementary food:

1. There was no provision in the plan to support salt iodization, likely due to the fact that iodized salt consumption had increased significantly from 2000 to 2008 as a result of the adoption of a legal mandate and the formation of the Community of Salt Producers of Kampot and Kep (CSPKK). While iodized salt usage in total was over 70 percent, 30 percent of people were still not using iodized salt, and the Plan should have included provisions for sustainability.

2. There were only weak provisions in the country programme to support linkages with agriculture, namely listing several agriculture-focused organizations with whom UNICEF would partner “to improve the quality of inter-sectoral planning and coordination in the areas of nutrition and social protection.” There are no further details provided, and stakeholders also emphasized that they would like to see stronger partnerships between UNICEF and agriculture-focused organizations, specifically the UN agencies WFP and FAO. A lack of focus on linkages to agriculture may be because the National Nutrition Strategy, to which UNICEF aligns its nutrition work, focuses primarily on actions that the MOH can take rather than the full spectrum of causes of undernutrition.
**Contextual Factor** | **How Factor Is Addressed in the Stunting Reduction Plan** | **Rating**
---|---|---
8. The national prevalence of vitamin A deficiency among children was unknown but was assumed to be a public health problem, given that infant and under-5 mortality rates were high. | UNICEF addressed the issue of vitamin A deficiency through in-home micronutrient fortification (Programme Component 1.2). | Addressed |
9. While significantly higher malnutrition rates were reported among the poor, children of wealthier households were also found to suffer from malnutrition. | The fact that wealthier households were also found to suffer from malnutrition is an indicator that care practices, not only the ability to purchase food, are drivers of stunting. Thus, UNICEF Cambodia included interventions on IYCF (Programme Component 1.2) and WASH (Programme Component 2). | Addressed |

**CONTEXTUAL FACTORS RELATED TO NUTRITION-SENSITIVE SECTORS**

10. Rural access to an improved source of drinking water was 41% and improved sanitation 23%. 8.4 million people practiced open defecation because they do not have a safe way to dispose of their excreta. Many of these people are not aware of the health risks of their unhygienic practices, particularly to infants and children. | In recognition of the importance of WASH and local governance as distinct “sectors” within the government’s development architecture, WASH became a distinct programme; during 2006-2010 they were combined in the Seth Koma programme. UNICEF’s Plan to Reduce Stunting included several intensive WASH interventions that focus primarily on infrastructure, technologies, and supporting the government’s WASH strategy (Programme Component 2.1, 2.2, and 2.3). The Plan is less clear about increasing awareness of the health risks of unhygienic practices but does include components that may have been intended to address this aspect. These include using a CLTS approach, training health centre staff, developing stronger links to sanitation marketing, and promoting a demand-responsive approach. However, there are no output indicators related to public awareness, and C4D is not included in the WASH programme as it is for MNCHN. | Somewhat Addressed |

---

69 An Analysis of the Situation of Women and Children in Cambodia 2009 pg. 59

Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance – Cambodia Country Case Study
<table>
<thead>
<tr>
<th>Contextual Factor</th>
<th>How Factor Is Addressed in the Stunting Reduction Plan</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Maternal and neonatal mortality remained high due to the fact that 57 percent of pregnant women had anaemia, skilled birth attendance was low, and detrimental family practices such as reliance on traditional birth attendants were practiced.</td>
<td>Maternal and neonatal mortality generally receives adequate attention in the Plan (Programme Component 1.1), including skilled birth attendance (coverage and quality of delivery care at the facility level). Preventing anaemia is included in Programme Component 1.2, but neither anaemia nor skilled birth attendance receives a specific indicator. The issue of traditional birth attendants was not addressed in the Country Programme.</td>
<td>Somewhat Addressed</td>
</tr>
<tr>
<td>12. A large percentage of the population was subjected to pervasive economic vulnerability, and many households were forced to adopt extreme coping mechanisms such as pulling children out of school to work or beg.</td>
<td>Stakeholders reported that a cash transfer pilot program was planned as one way to address this inequity and improve the nutritional status of the most economically vulnerable children. This component is mentioned in various sources in Programme Components 1 and 6.3.</td>
<td>Addressed</td>
</tr>
<tr>
<td>13. Family planning, including the prevention of unwanted pregnancies, was noted as key to improving women’s health and nutrition in Cambodia. Only 40% of the total need for family planning was being met.</td>
<td>The Plan does not include any specific provisions for creating linkages to family planning. While it mentions UNFPA as a partner within the MNCHN Programme Component, there is no explicit connection made between nutrition and reproductive health issues. Internal stakeholders also did not mention family planning or reproductive health. This is likely because family planning is not part of UNICEF’s mandate but is nonetheless an important component of stunting reduction.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**CONTEXTUAL FACTORS RELATED TO EQUITY**

<table>
<thead>
<tr>
<th>Contextual Factor</th>
<th>How Factor Is Addressed in the Stunting Reduction Plan</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Government commitment to improving the situation of children with disabilities had increased as the numbers of casualties from mines has decreased considerably.</td>
<td>While not a component that would have reduced stunting, this represents a missed opportunity for UNICEF to support government in addressing the needs (namely cognitive impairment) of children who are already stunted.</td>
<td>N/A</td>
</tr>
<tr>
<td>Contextual Factor</td>
<td>How Factor Is Addressed in the Stunting Reduction Plan</td>
<td>Rating</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>15. Though Cambodia had recently experienced robust economic growth, about 80% of the population was concentrated in rural areas and were unable to benefit from robust economic growth and resulting opportunities.</td>
<td>The 2011–2015 country programme strategy to target vulnerable groups moved from the previous strategy of covering six of Cambodia’s 24 provinces to addressing the plight of vulnerable children on a nationwide basis. This was done because there were pockets of vulnerability and poverty in other provinces and to eliminate the substitution of government staff capacity with UNICEF staff in provinces where there had been a long-standing relationship.</td>
<td>Addressed</td>
</tr>
<tr>
<td>16. Though HIV prevalence has surpassed the MDG target to reach 0.7%, nearly 2% of all children under 18 years of age were HIV-infected, and less than half were reached with support to ensure their access to essential basic services.</td>
<td>The Plan does not include any specific provisions for providing nutrition services to adolescent girls, pregnant women, or children living with HIV. Doing so may have better addressed the needs of this highly vulnerable population, part of UNICEF’s mandate.</td>
<td>Not Addressed</td>
</tr>
</tbody>
</table>
## 2016–2018 Country Programme

<table>
<thead>
<tr>
<th>Contextual Factor</th>
<th>How Factor is Addressed in the Plan to Reduce Stunting</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL CONTEXTUAL FACTORS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. The UN’s World Risk Report in 2014 ranked Cambodia the ninth most at-risk</td>
<td>The CPD specifically states that UNICEF will include provisions for nutrition during emergencies in their nutrition and</td>
<td>Addressed</td>
</tr>
<tr>
<td>country in the world to disasters.</td>
<td>health programming in Outcome 1 and Outcome 3.</td>
<td></td>
</tr>
<tr>
<td><strong>CONTEXTUAL FACTORS RELATED TO THE NUTRITION SECTOR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. While wasting prevalence was still high compared to neighbouring countries,</td>
<td>Overall, both the 2011–2015 and 2016–2018 country programmes strongly address treatment of severe acute malnutrition.</td>
<td>Somewhat</td>
</tr>
<tr>
<td>by 2014 it no longer constituted an emergency and was much lower than stunting</td>
<td>However, this attention came somewhat at the expense of interventions to prevent severe and moderate acute malnutrition</td>
<td>Addressed</td>
</tr>
<tr>
<td>rates.</td>
<td>and stunting, which were not a focus of the Country Programme and also not a donor priority according to stakeholders.</td>
<td></td>
</tr>
<tr>
<td>19. Progress in most nutrition indicators was stagnant during the last country</td>
<td>The 2016–2018 Plan drastically increased UNICEF Cambodia’s attention to the multisectoral nature of nutrition, most notably</td>
<td>Somewhat</td>
</tr>
<tr>
<td>programme, partially explained by stagnant trends in some determinants of nutrition, including diarrhoea prevalence, improper complementary feeding and breastfeeding, limited treatment of severe acute malnutrition, and inadequate WASH practices. Malnutrition was considered the underlying cause of 45% of all child deaths in Cambodia.</td>
<td>through the intentional convergence of health, WASH, and nutrition-specific programming planned for the Northeast. It increases the degree of sensitivity to nutrition within each of these sectors. For example, Output 1.3 explicitly outlines that health care service providers will focus on improving the nutritional status of children under 5 years of age, pregnant and lactating women, and adolescent girls. The Plan also addresses these stagnant trends by increasing the focus on a life-cycle approach, explicitly including adolescent girls in nutrition programming.</td>
<td>Addressed</td>
</tr>
</tbody>
</table>

The country office was reorganized to promote this integrated work, putting health, nutrition, WASH, and C4D under a newly created IECD Program. This shift was also responsive to a recommendation from the Midterm Review to prioritize support to the ECCD policy developed in 2010. This policy includes interventions in health.
<table>
<thead>
<tr>
<th>Contextual Factor</th>
<th>How Factor is Addressed in the Plan to Reduce Stunting</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>nutrition, and hygiene, as well as cognitive, social, physical, and emotional development.</td>
<td>The multisectoral approach is still being refined, which is understandable. Efforts to work multisectorally are relatively new, and there is no identifiable model for doing so. Stakeholders reported that evidence around multisectorality is limited, especially as it applies to Cambodia. The Plan also retains the challenge of creating linkages with agriculture, so the breadth of multisectorality is limited in this respect. Further, while staff understand the importance of an integrated approach, they reportedly struggle to find time to devote time to meetings that are outside of their direct job responsibilities, such as meetings for the task force of the IECD. And lastly, as previously mentioned, funding for working multisectorally is not always available. Finally, while it is important for UNICEF to work multisectorally, building the capacity of government to work multisectorally is equally important. Addressing these issues would increase the relevance of the IECD approach.</td>
<td></td>
</tr>
<tr>
<td>One stakeholder felt that the integration of WASH and nutrition was a major contribution from UNICEF, and that it should work to also integrate education and agriculture, while another felt that the integration of WASH and nutrition was the most important area to which UNICEF could contribute but perhaps had not yet done so.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. The percent of children ages 6-23 months who live in households using iodized salt fell from 84% in 2010 to 69% in 2014.  
UNICEF resumed its support of the salt iodization programme in the new Plan in Outcome 1.3.  
Addressed
<table>
<thead>
<tr>
<th>Contextual Factor</th>
<th>How Factor is Addressed in the Plan to Reduce Stunting</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. Stunting prevalence in the &lt;6 months of age category worsened from 10% to 16% between 2010 and 2014, while all other age categories saw improvements, and wasting rates for this same age group also improved.</td>
<td>The cause of this is unclear but may be related to intrauterine growth restriction. The Plan does not recognize or include provisions for investigating the causes, but UNICEF staff believe this is related to pregnant women with low MUAC. No funds have been allocated by MOH to address this.</td>
<td>Somewhat Addressed</td>
</tr>
<tr>
<td>22. The 2014 Annual Report noted that in case management of severe and acute malnutrition, gender-disaggregated data showed that boys arrive at hospital in a more severe state than girls, calling for further investigation into the causes.</td>
<td>The country programme does not clearly outline if or how the causes of this will be investigated.</td>
<td>Not Addressed</td>
</tr>
</tbody>
</table>

**CONTEXTUAL FACTORS RELATED TO NUTRITION-SENSITIVE SECTORS**

<table>
<thead>
<tr>
<th>Contextual Factor</th>
<th>How Factor is Addressed in the Plan to Reduce Stunting</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>23. Marked improvements in sanitation have been seen in sanitation over the last four years—percent of population using an improved, not shared facility improved by about 13 percentage points, and open defecation decreased by about 12 percent.</td>
<td>The new Plan is less detailed around WASH interventions because it is integrated into the IECD programme rather than a separate programme component. However, the Plan builds on the successes seen in WASH by continuing similar strategies, namely supporting the implementation of the costed RWSSH National Action Plan. It increases the likelihood of addressing stunting by specifically “addressing the WASH needs of children under 5 years old and pregnant women at the household and community level,” and it more efficiently uses limited WASH resources by focusing on the six priority districts. UNICEF Cambodia staff indicated that awareness of WASH’s contribution to stunting was no longer the problem; concerns have evolved to behaviour change—the Plan does not clearly address this issue. Stakeholders echoed this concern, indicating that behaviour change communication versus awareness raising was an area to which UNICEF could contribute to address stunting.</td>
<td>Addressed</td>
</tr>
<tr>
<td>Contextual Factor</td>
<td>How Factor is Addressed in the Plan to Reduce Stunting</td>
<td>Rating</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>CONTEXTUAL FACTORS RELATED TO EQUITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. A child living in the less populated and predominantly rural Northeastern provinces is more likely to be deprived in relation to education, health, and living standards than a child living elsewhere in the country. Ethnic minorities are prevalent in the Northeast, and there are fewer social services provided by government or NGOs. Most children in urban settings are living in slums and are particularly vulnerable to malnutrition, diarrhoea, and acute infections due to the lack of hygiene and sanitation.</td>
<td>The 2016–2018 country programme focuses on the urban poor in Phnom Penh and the Northeast provinces, where children experience the lowest child development indicators. It decreased the number of zone offices from five to three to “ensure that specific programme interventions directly focus on the most vulnerable children and are complemented by and contribute to broader national policy and strategies.”</td>
<td>Addressed</td>
</tr>
</tbody>
</table>
Annex 8

Assessment of UNICEF Cambodia’s Approach to Stunting Reduction Using UNICEF’s Simplified Schematic Linking Conditions to Interventions for Improving Child and Maternal Nutrition
## Addressing Childhood Stunting and Wasting

### If Situation Analysis Shows These Conditions:

#### Food

- Inadequate quality of complementary foods
  - Micronutrient supplementation
  - Nutrition education and counselling
  - Fortified and supplemental/specialized foods (including iodized salt)
- Chronic or significant seasonal food shortages
  - Fortified and supplemental/specialized foods
  - Social protection programmes
  - Community management of acute malnutrition programmes
  - Nutrition surveillance system
  - Promotion of linkages with agriculture

#### Care

- Inadequate breastfeeding
  - Breastfeeding counseling and support through community- and facility-based contacts
  - Intensive capacity development for health and nutrition workers
  - Early childhood development interventions, nurturing family care practices and responsive feeding
  - Baby Friendly Hospital Initiative
  - Control of the marketing of breast milk substitutes
  - Maternity protection in the workplace
  - Education and behaviour change communication
  - Early childhood development interventions, nurturing family care practices and responsive feeding
  - Multiple micronutrient powders for home fortification of complementary foods
- Poor hygiene and sanitation
  - Intensive WASH interventions (behaviour change and communication and supplies for hand washing with soap at critical times, safe disposal of faeces; open-defecation free communities; construction, management and use of latrines/toilets; access to adequate, safe water)
  - Improved safety of complementary foods

#### Health

- High prevalence of diarrhoea and pneumonia
  - Oral rehydration solution and zinc supplementation
  - WASH interventions
  - Vitamin A supplementation
  - Nutrition counselling for the adequate care of sick children
  - Treatment of SAM
<table>
<thead>
<tr>
<th>IF SITUATION ANALYSIS SHOWS THESE CONDITIONS:</th>
<th>THEN CONSIDER THESE INTERVENTIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH (cont.)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>High prevalence of HIV/AIDS</strong></td>
<td>• As part of community management of acute malnutrition programmes, provider-initiated HIV testing and counselling</td>
</tr>
<tr>
<td></td>
<td>• National guideline development for infant feeding in the context of HIV</td>
</tr>
<tr>
<td></td>
<td>• Voluntary, confidential testing and treatment and infant feeding counselling for pregnant women</td>
</tr>
<tr>
<td></td>
<td>• Nutritional support</td>
</tr>
<tr>
<td><strong>High prevalence of malaria</strong></td>
<td>• Intermittent preventative treatment and promotion of insecticide-treated bed nets for pregnant women (in high-malaria areas)</td>
</tr>
<tr>
<td></td>
<td>• Insecticide-treated bed nets for children &lt;24 months (in high-malaria areas)</td>
</tr>
<tr>
<td></td>
<td>• Behaviour change and communication</td>
</tr>
<tr>
<td></td>
<td>• Nutrition counselling for the adequate care of sick children</td>
</tr>
<tr>
<td><strong>High prevalence of parasitic infections</strong></td>
<td>• Deworming for pregnant women</td>
</tr>
<tr>
<td></td>
<td>• Deworming for children 6–59 months</td>
</tr>
<tr>
<td></td>
<td>• WASH interventions</td>
</tr>
<tr>
<td></td>
<td>• Nutritional support</td>
</tr>
<tr>
<td><strong>Insufficient coverage of antenatal care or skilled birth attendant</strong></td>
<td>• Health interventions (promotion of healthy practices and appropriate use of health services during the continuum of care)</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>FOOD</td>
<td></td>
</tr>
</tbody>
</table>
| Inadequate quality of complementary foods | Yes. Only 36.9% of children 6-23 months receive the WHO standard of four or more food groups each day. 70 | • Micronutrient supplementation  
• Nutrition education and counselling | • Fortified and supplemental/specialized foods (including iodized salt) | Children 6–23 months receive the WHO standard of four or more food groups each day increased to 47.6% | Yes |
| Chronic or significant seasonal food shortages | Yes. FAO Food Security Statistics showed a deficit of 119 kilocalories per day in 2010, higher than the average for lower- to middle-income | • Fortified and supplemental/specialized foods  
• Social protection programmes  
• Community management of acute malnutrition programmes | • Nutrition surveillance system  
• Promotion of linkages with agriculture | 108 kilocalories per day | Yes |

---

70 DHS 2010
Reducing Stunting in Children Under Five Years of Age: A Comprehensive Evaluation of UNICEF’s Strategies and Programme Performance
Cambodia Country Case Study

<table>
<thead>
<tr>
<th>Inadequate breastfeeding</th>
<th>Breastfeeding counselling and support through community- and facility-based contacts</th>
<th>Early childhood development interventions, nurturing family care practices, and responsive feeding</th>
<th>Exclusive breastfeeding decreased to 65%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes. 73.5% of children under 6 months were exclusively breastfed in 2010, and 49.6% of children ages 18–23 months were not breastfeeding at all. However, 96.3% of children born in the last two years had ever been breastfed.</td>
<td>Intensive capacity development for health and nutrition workers</td>
<td>Baby Friendly Hospital Initiative</td>
<td>Percent of children ages 18–23 months not breastfeeding at all increased to 60.3%</td>
</tr>
<tr>
<td>Inadequate complementary feeding</td>
<td>Education and behaviour change communication</td>
<td>Early childhood development interventions, nurturing family care practices, and responsive feeding</td>
<td>IYCF practices increased to 30.4%</td>
</tr>
<tr>
<td>Yes. Only 24% of children 6–23 months were fed, according to all three IYCF practices.</td>
<td>Multiple micronutrient powders for home fortification of complementary foods</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Poor hygiene and sanitation</td>
<td>Intensive WASH interventions (behaviour change and communication)</td>
<td>None</td>
<td>Percent of people using an improved facility</td>
</tr>
<tr>
<td>Yes. 35.4% of people were using an improved, not</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>
shared facility, and 55.3% were practicing open defecation.\textsuperscript{71} and supplies for hand washing with soap at critical times, safe disposal of faeces; open-defecation–free communities; construction, management and use of latrines/toilets; access to adequate, safe water)
- Improved safety of complementary foods

| HEALTH |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| High prevalence of diarrhoea and pneumonia | Yes. Diarrheal rates were estimated at 14.9% and acute respiratory infections (ARIs) at 6.4%.\textsuperscript{72} | WASH interventions  
- Treatment of SAM  
- Zinc supplementation | Vitamin A supplementation  
- Nutrition counselling for the adequate care of sick children  
- Oral rehydration solution | Diarrheal rates had decreased to 12.8%.  
ARI had decreased to 5.5% | Yes |
| High prevalence of HIV/AIDS | No (0.7%) |  |  |  |  |

\textsuperscript{71} DHS 2010, 2014
\textsuperscript{72} DHS 2010, 2014—ARI is used as a proxy for pneumonia.
| High prevalence of malaria | Somewhat. The Situational Analysis noted that malaria remains a serious public health problem with over 60,000 cases recorded in 2005. Malaria was the third leading cause of outpatient visits and the fourth leading cause of inpatient visits for this age group. | None: Malaria prevention and treatment does not directly fall within UNICEF’s mandate, and this was not a key component of its programme. | • Intermittent preventative treatment and promotion of insecticide-treated bed nets for pregnant women (in high-malaria areas)  
• Insecticide-treated bed nets for children <24 months (in high-malaria areas)  
• Behaviour change and communication  
• Nutrition counselling for the adequate care of sick children |

| High prevalence of parasitic infections | Not measured in DHS 2010 or included in Situational Analysis | • WASH interventions  
• Deworming for pregnant women  
• Deworming for children 6–59 months  
• Nutritional support | 18.5% of women and 10.4% of children had parasitic infections.  
Unable to assess, however, the inclusion of this data in the 2014 DHS is an improvement. |

| Insufficient coverage of antenatal care or skilled birth attendant⁷³ | Yes. Only 59.4% of women attended four or more ANC visits in 2010. 71% of | • Health interventions (promotion of healthy practices and appropriate use of health services)  
• None | ANC visits increased to 75.6%.  
Yes |

⁷³ DHS 2010
| births were attended by a skilled attendant. | during the continuum of care) | Skilled birth attendance increased to 95.3%. |
Annex 9

Evidence Matrix of the Effectiveness of Stunting-Related Components of the 2011–2015 Country Programme
<table>
<thead>
<tr>
<th>Component of Plan to Reduce Stunting</th>
<th>Evidence of Effectiveness of Component</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NUTRITION-SPECIFIC COMPONENTS</strong></td>
<td></td>
</tr>
<tr>
<td>Maternal, Newborn and Child Health Programme</td>
<td></td>
</tr>
<tr>
<td>1.2: Increased national and subnational capacity to expand coverage of evidence-based nutrition interventions to prevent and treat malnutrition in women of reproductive age and children under 5.</td>
<td>a. UNICEF supported a mass media campaign for breastfeeding in 2012 which led to increased coverage.(^7). This campaign was scaled up in 2015. UNICEF published a paper, <em>Breastfeeding Trends in Cambodia, and the Increased Use of Breast-Milk Substitute—Why Is It a Danger?</em> and advocated for a ban on the marketing of breastmilk substitutes in developing the National Nutrition Strategy. Complementary feeding was also promoted through a nationwide mass media campaign (including TV/radio spots, posters, and leaflets) with community activities targeting 42,000 women and children in 10 provinces in 2012.(^7) The 2012 Annual Report stated that UNICEF played a key role in changing cultural practices around complementary feeding, though no further evidence is given and it is not clear which cultural practices were changed. This campaign was evaluated in 2013 and showed that while messages were well recalled, behaviour change was constrained by availability of ingredients, lack of time and money, and poor taste. The campaign continued in 2014, reaching 20,000 caregivers at village level and 13,000 caregivers at hospitals. The 2015 DHS showed evidence of effectiveness the number of children receiving three infant and young child feeding practices, but it is not clear if or how the constraints identified in the midline evaluation were addressed. Stakeholders felt that cultural practices, particularly around the ingredients and methods used to make <em>Bor Bor</em> (rice porridge), were an ongoing challenge.</td>
</tr>
<tr>
<td>a. Promote optimal infant and young child feeding practices, emphasizing adequate complementary feeding while continuing to support breastfeeding promotion.</td>
<td>a. Promote optimal infant and young child feeding practices, emphasizing adequate complementary feeding while continuing to support breastfeeding promotion.</td>
</tr>
<tr>
<td>b. Establish a national system for management of acute malnutrition.</td>
<td>b. Establish a national system for management of acute malnutrition.</td>
</tr>
<tr>
<td>c. Address the prevention of anaemia and other micronutrient deficiencies in children and women through multiple micronutrient supplementation and fortification.</td>
<td>c. Address the prevention of anaemia and other micronutrient deficiencies in children and women through multiple micronutrient supplementation and fortification.</td>
</tr>
<tr>
<td>d. Establish a national management information system for strengthening monitoring and evaluation in the area of food security and nutrition.</td>
<td>d. Establish a national management information system for strengthening monitoring and evaluation in the area of food security and nutrition.</td>
</tr>
</tbody>
</table>

\(^7\)Annual Report 2012.
Indicator 1.1.1: Percent of pregnant women with two or more ANC consultations (Baseline: 82.1; Target: 90)

Indicator 1.2.2: Percent children <2 yrs who receive appropriate complementary feeding (Baseline: TBD; Target: 10 pp increase)

Indicator 1.2.3: Percent of health centres that implement in-home multi-micronutrient fortification to children 6-24 months of age (Baseline: 1; Target: 50)

Indicator 1.2.4: Number of referral hospitals that implement appropriate management of acute malnutrition with complication (Baseline: 0; Target: 24)

Indicator 1.2.5: Percent of health centres able to screen, refer, and manage for acute malnutrition (Baseline: 0; Target: 50)

The 2012 Annual Report acknowledged that the lack of a government-led, community-based program was a barrier to scale-up of both of these interventions. Further, it is unclear what the relationship is between the breastfeeding, complementary feeding, and animal source蛋白 campaigns—a more cohesive and integrated campaign may have been more effective.

b. The plan is not specific about what a successful system for management of acute malnutrition looks like, but there is evidence of success in several areas around systematising the treatment process for SAM. UNICEF helped MOH include acute malnutrition in national policy, guidelines, and curricula in 2011 and successfully advocated for the inclusion of RUTF on the list of essential drugs. UNICEF supported the treatment of 5,546 children from 2011 to 2014 and an additional 4,776 in 2015, representing an increase of over 30% from 2014 to 2015. It participated in mass screening campaigns and helped develop a Web-based monitoring system for SAM, and it has successes around reducing dropout rates and adherence to followup. Stakeholders felt that UNICEF was playing a key role of ensuring that children with SAM were not only identified but also treated.

Perhaps unintentionally, treatment of acute malnutrition was also addressed through the Local Governance for Child Rights Programme, in that communes organized and covered transport costs to health facilities for treatment, as outlined in the 2012 Annual Report. UNICEF also supported food allowances for caretakers.

Overall, it is clear that UNICEF was instrumental in increasing the number of children with SAM who were successfully treated, but there is limited evidence that this process was fully systematised across the country. In addition, there is evidence that as a result of the strong focus on SAM, some stakeholders conceptualise all nutrition interventions as SAM interventions—many stakeholders mentioned only SAM identification and treatment when asked about stunting reduction efforts.
c. It had generally been assumed that, in Cambodia, the majority of anaemia is associated with insufficient iron intake. A mass media campaign promoting iron folate supplementation was present in 2012. However, UNICEF invested in research demonstrating that while approximately 40% of women of reproductive age in Cambodia are anaemic, less than 10% experience iron deficiency. Thus, factors other than iron deficiency must play an important role in the pathogenesis of anaemia in Cambodia.

In 2014, UNICEF partnered with Dr. Frank Wieringa to develop “Fish Snack” – a locally produced, fish-protein–based specialized nutritious food. The Fish Snack team paid special attention to Cambodian context, where snacking culture is highly prevalent—snacks make up 6% to 7% of total household expenditures. The team adjusted the formula to meet Cambodian taste preferences. Fish Snack is intentionally designed to address stunting and be socially marketable.

Vitamin A deficiency was included in a national micronutrient survey and was not found to be highly prevalent.

Together with Helen Keller International, UNICEF collaborated throughout the evaluation period to improve coverage of micronutrient powder, which reached 80% in 2012–2013. Some 24 million sachets of micronutrient powders and food supplements were distributed to children aged 6 to 24 months in 2014.

---

76 Annual Report 2012.
78 DHS 2014
79 Wieringa, F. T., Dahl, M., Channan, C., Poirot, E., Kuong, K., Sophonneary, P., et al. (2016). The high prevalence of anemia in Cambodian children and women cannot be satisfactorily explained by nutritional deficiencies or hemoglobin disorders. *Nutrients*, 8(6); 348.
80 Annual Report 2013
81 Annual Report 2014
As mentioned previously, UNICEF’s support of the national salt iodization program after 2011 was extremely limited because a legal mandate was in place and the programme had been scaled up. Iodized salt usage among households with children 6-23 months fell between 2010 and 2014. UNICEF resumed working with the Ministry of Planning on salt iodization in 2016.

Indicator 1.1.1: Cambodia DHS indicates a baseline of 84.5 in 2011 and an improvement to 92.3. This baseline figure differs from what was included in the Plan, but likely represents a success.

Indicator 1.1.2: The exact indicator is not given, but DHS indicates that 24.0% of children aged 6-23 months were fed with three or more IYCF practices in 2010, falling short of the target of 30.4%.

The evaluation does not have access to the data sources indicated for the three other indicators for this Programme Component.

Use C4D as a cross-cutting strategy to achieve all programme results and to support improvements in nutrition practices at the individual and family levels, as well as in care-seeking during pregnancy, childbirth, and early childhood.

Nutrition, sanitation, and birth registration were the three flagship components of the C4D programme beginning in 2013. Successes included the Communication for Behavioural Impact (COMBI) approach, which was used, yielded results, and has been successful in improving health/nutrition-related practices. No further information about these practices was provided, but MOH has adopted this approach and continued to apply it to other subjects including care-seeking for pneumonia and new-borns. Other successes include national media campaigns promoting breastfeeding, iron folate supplementation, antenatal care, and appropriate care seeking for diarrhoea.

However, there were major challenges reported by stakeholders. The behaviour change communication campaigns (namely IYCF) implemented during the 2011–2014 country programme may not have been effective at reaching the intended populations as many people do not watch live TV, but instead watch Korean and Thai dramas on DVD. Most people report receiving messages through interpersonal communications through village health support groups or health centre staff rather than mass media campaigns, and these may be more effective communication channels. Further, there was a lack of resources to properly implement
<table>
<thead>
<tr>
<th>Continue close collaboration with the Ministry of Health (MoH) and its structures for sustainable achievement of nutrition results as outlined in related national and sector strategies and plans of actions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF and MOH worked closely on several items related to stunting, such as vaccine procurement in 2012/2013, including therapeutic food in their essential drugs list, and the 2014 MOH National Nutrition Report.</td>
</tr>
<tr>
<td>Notably, in 2012, UNICEF’s advocacy resulted in a more than 60% increase of HSSP2 resources allotted to outreach and other primary health care activities for the poorest and most remote areas. The 2012 Annual Report stated that UNICEF played a key role in making malnutrition visible, presumably within the HSSP2.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advance collaboration with MoP and CARD to improve availability of nutrition-related information and analysis as well as quality of intersectoral planning and coordination in the areas of nutrition and social protection.</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNICEF has been highly effective at generally increasing the government’s attention to stunting, most notably through publication of <em>The Economic Consequences of Malnutrition in Cambodia</em>, which was developed in partnership with CARD and WFP. More recently, in May 2016, the Deputy Prime Minister requested a budget line item for nutrition, signalling that advocacy efforts may be paying off in the future.</td>
</tr>
<tr>
<td>UNICEF also collaborated with CARD to develop their first annual report, which captures progress from the first multisectoral partnership involving various government ministries, UN agencies, NGOs, and the private sector on improving maternal and infant nutrition and serves as a baseline for assessing this integrated approach. UNICEF supported the development of this report within the SUN movement.</td>
</tr>
<tr>
<td>Regarding MoP, as mentioned previously, UNICEF largely was not supporting its iodized salt programme during this period, which may have contributed to its decline in effectiveness. However, UNICEF did publish research that argued that the drastic decreases in the prevalence of iodized salt were due to limited enforcement of legislation. This article’s publication seemed to have the desired effect, as UNICEF and MoP did resume collaboration on the salt programme in 2016. However, this</td>
</tr>
</tbody>
</table>

---

82 Low Urinary Iodine Concentration among Mothers and Children in Cambodia
Closely work with partners (including FAO, GTZ, UNFPA, WFP, and USAID) to support innovations and strengthen the evidence base for programmes and advocacy activities for nutrition.

UNICEF played a key role in bringing attention to Cambodia's malnutrition situation by developing the National Seminar on Nutrition in 2011, in partnership with WFP, FAO, and WHO, which resulted in government commitment to SUN, the instalment of a coordination body, and the development of an operational plan. The degree to which stunting was included over other components of malnutrition is unclear.

<table>
<thead>
<tr>
<th>NUTRITION-SENSITIVE COMPONENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal, Newborn and Child Health Programme</td>
</tr>
</tbody>
</table>

1.1: Improved national and subnational capacity to increase availability, accessibility, and utilization of quality maternal, new-born, and child health services.

Key Components:

- a. Support improvements in coverage and quality of antenatal, delivery and postpartum care at the facility level
- b. Support the rollout of community care of mothers and new-borns
- c. Ensure sustainability of the national immunization programme
- d. Support the introduction of new vaccines
- e. Strengthen pneumonia case management
- f. Expand diarrhoeal treatment with zinc

| Indicator 1.1.3: Number of health operational districts with more than 80% immunization coverage for DPT-HepB-Hib3 and Measles (Baseline: 61; Target: 77) |

a. UNICEF efforts to improve knowledge and access to services for children and pregnant women through training on Integrated Management of Childhood Illness services. Though not explicitly stated, this approach includes nutrition-related services. As mentioned previously, it is not possible to assess the effectiveness of antenatal, delivery, and postpartum care on stunting, since there is no evidence that nutrition components were included in these services.

b. Again, several successes were noted around the rollout of community care of mothers and new-borns (14 lowest-performing operational districts were supported in 2012 and 10 in 2013/2014, MOH outreach guidelines on essential maternal, new-born and child health interventions include community care), but there is no evidence of whether nutrition components were successfully integrated into this programme.

c. The government approved US $1.5 million via UNICEF for vaccine procurement in 2013, and UNICEF successfully supported MOH in advocating for an additional $700,000 to meet a funding gap and ensure universal coverage. The government maintained this allocation of $2.2 million in the following years. UNICEF argues that while vaccines are largely funded by Gavi, including a national budget for vaccine procurement improves the sustainability of immunization programmes.
Indicator 1.1.4: Percent of health centres that implement appropriate management of diarrhoea and pneumonia in children (Baseline: TBD; Target: 90)

d. In 2015, Cambodia was validated with the elimination of maternal and neonatal tetanus, and the polio vaccine was introduced into the national routine immunization programme.

e. Through the period, UNICEF focused on specific operational districts to improve pneumonia case management through a communication strategic plan and a home care and appropriate care-seeking programme. In 2013, MOH adopted the COMBI approach for pneumonia as well.

f. This component is not addressed in Annual Reports.

Indicators: The evaluation does not have access to the data sources indicated.

WASH Programme

2.1: Communities practice key hygiene behaviours (handwashing with soap at critical times, using toilet, and drinking safe water).

a. Strengthen partnership with the health sector to integrate promotion of the key behaviours into health programmes and training of health centre staff.

b. Improve implementation of the tested and innovative CLTS approach with special attention

CLTS was central to UNICEF’s approach and was one of the most effective components of the WASH programme as it relates to stunting. During the evaluation period, more than 400 villages were reached with improved sanitation, and 147 of those villages were certified open-defecation-free. UNICEF was successful in revising guidelines around CLTS, and UNICEF began coupling CLTS with supply-side sanitation marketing and mass media to accelerate change in 2013. It also invested in identifying important bottlenecks to further CLTS, such as poorer households opting for no toilet over building a basic dry pit facility.

83 WASH was a major component of the Country Programme, and UNICEF sought to address all of these subcomponents at the beginning of the Country Programme. Beginning in 2013, they narrowed their focus to be on:

1. Community-led approaches, but working much more closely with sanitation marketing and supply-side initiatives to ensure sustainable and affordable technology options.

2. Evidence-based advocacy for clearer policy direction towards mitigation of arsenic and better regulation of arsenic removal technologies and drilling in affected areas.

3. Development of a sectoral monitoring and information management system.

The first component is most related to stunting and is evaluated here.
to gender and equity, children and youth participation, community monitoring, and the roles of commune authorities.

c. Develop stronger links to sanitation marketing, particularly for the promotion of access to environmentally appropriate technology.

*Indicator 2.1.2: Percent rural households practicing open defecation. (Baseline: 69; Target: 50)*

*Indicator 2.1.3: Percent of rural households that always treat drinking water (Baseline: 57; Target: 75)*

2.2: Communities, schools and health centres have access to sustainable technologies for safe water, sanitation, and hygiene.


b. Support selected communes to ensure schools and health centres serving the most vulnerable communities in remote, disaster-prone and seasonally flooded areas have safe water supplies, toilets, and hand-washing facilities.

c. Promote a demand-responsive approach while ensuring that the poorest households can participate and benefit.

d. Promote the role of the private sector, including sanitation marketing.

*Indicator 2.2.1: Percent of households with access to improved source of drinking water (Baseline: 40.5; Target: 50)*

There is limited evidence of strengthening partnership with the health sector or training health centre staff around hygiene and sanitation, though linkages with schools were strong. Though certainly not a comprehensive study of health care workers, stakeholders who were health care workers did not conceptualize hygiene and sanitation as part of their contribution to reduce stunting.

*Indicators 2.1.2 and 2.1.3: UNICEF reported that both of these targets were met in their 2015 Annual Report but raised questions around data quality. DHS data are somewhat different but also show evidence of improvement.*

*Indicator 2.2.1: The evaluation does not have access to the data sources indicated.*

*Indicator 2.2.2: The evaluation does not have access to the data sources indicated, but DHS data shows an improvement of 35% to 48%.*

*Indicator 2.2.4: The evaluation does not have access to the data sources indicated.*
2.3: Ministry of Rural Development (MRD) and concerned subnational government agencies lead, coordinate, facilitate, monitor, and evaluate the RWSSH strategy.

a. Support MRD to strengthen its focus on policy; to secure sustainable, cost-effective and inclusive implementation of the national strategy; and to engage in partnerships that aim to galvanize political, financial, and technical commitments to the sector.

b. Strengthen private sector participation, focusing on development of business and technical skills of village- and commune-based artisans, masons, mechanics, and local companies to supply cost-effective services that respond to community demand, especially in underserved areas.

Indicator 2.3.1: Percent investment (RGC and provinces) for implementation of the RWSSH.

a. UNICEF noted in 2012 that despite the presence of the RWSSH strategy, the sector did not have a comprehensive, government-led national programme. UNICEF outlined a number of steps to address this, and the first-ever RWSSH National Action Plan (2015–2018) was expected to be finalised and endorsed in January 2016.

b. Private sector participation primarily focused on addressing arsenic contamination and does not appear to have been effective at utilizing village- and commune-based artisans.

Indicator 2.3.1: The evaluation does not have access to the data sources indicated.

For emergency preparedness, strengthen the capacity of communities and of the Provincial Departments of Rural Development in preparedness and response to natural and other disasters.

Severe flooding occurred in 2011, 2012 and 2013—UNICEF provided direct support to the most vulnerable populations during these emergencies, for example, by distributing WASH relief supplies and chlorinating wells. But it also built capacity of government to respond to future emergencies in the short term, for example, by procuring 2,700 cartons of biscuits that were prepositioned at provincial hospitals to facilitate quick response during emergencies, and in the long term by supporting the
<table>
<thead>
<tr>
<th></th>
<th>National Committee for Subnational Democratic Development and 13 provinces in the formulation of guidelines for emergency preparedness and response plans.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6. Policy, Advocacy and Communication (PAC)</strong></td>
<td><strong>6.3: Strengthen national institutional capacity including resources and technical knowledge to develop, roll out and coordinate a cross-sectoral social protection strategy, inclusive of social welfare services.</strong></td>
</tr>
<tr>
<td></td>
<td>UNICEF published a white paper, <em>The Imperative of Improving Child Nutrition and the Case for Cash Transfers in Cambodia</em>, in 2011. The country programme built upon this thinking by piloting a cash transfer program with an explicit goal of improving nutrition to further the case made in the white paper.</td>
</tr>
<tr>
<td></td>
<td>There were challenges in translating the cash transfer pilot into a scalable program, as stakeholders reported that donors were not interested in funding it and government did not have enough available resources. However, UNICEF persisted, and a national policy is reportedly being developed for rollout of the program by 2025.</td>
</tr>
<tr>
<td>a.</td>
<td>Provide technical assistance and strengthening of the national social protection system and its coordination mechanisms through support to policy formulation and programme design, the expansion of the analytical capacity of the government in securing adequate investments into basic social services and social protection, and analysis of the child poverty impact of social investments.</td>
</tr>
<tr>
<td>b.</td>
<td>Contribute to more adequate resourcing of child-related interventions and their translation into better child development outcomes.</td>
</tr>
</tbody>
</table>