Report of evaluation

„Partnership for Improvement and Prevention in NCDs/Mental Health (PIP-MH), Cambodia"

(2022_EKHA186)

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Content

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Heinz Henghuber
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Front Picture:
Example of developed IEC material as used in awareness raising activities (Ou Reang Ov District)
Photo: Courtesy of Christine Baggio/LC

List of Acronyms

CCM	Collaborative Care Model
CCAMH	Centre of Child and Adolescent Mental Health
CPA	Complementary Package of Activities
CPD	Continuing Professional Development
DALY	Disability Adjusted Life Years
DGD	Directorate-general for Development Cooperation and Humanitarian Aid
DMHSA	Department of Mental Health and Substance Abuse
EKFS	Else-Kröner-Fresenius Stiftung
GBV	Gender Based Violence
GDP	Gross Domestic Product
HC	Health Center
IEC	Information Education and Communication
KAP	Knowledge Attitudes and Practice
LC	Louvain Coopération
MD	Medical Doctor
M&E	Monitoring & Evaluation
MOSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MOH	Ministry of Health
MPA	Minimum Package of Activities
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
PCF	Patient Care Facilitator
PIP-MH	Partnership for Improvement and Prevention in Mental Health
PTSD	Post-Traumatic Stress Disorder
RH	Referral Hospital
SDG	Sustainable Development Goal
SOP	Standard Operating Procedures
TPO	Transcultural Psychosocial Organization
TWG	Technical Working Group
UHC	Universal Health Coverage
UW	University of Washington
VCD	Village Community Development
VHSG	Village Health Support Groups
WHO	World Health Organization

1 Executive Summary

The Else-Kröner-Fresenius Stiftung (EKFS) and the Belgian Directorate-general for Development Cooperation and Humanitarian Aid support the Belgian NGO Louvain Coopération (LC) for the program *Partnership for Improvement and Prevention in NCD/ Mental Health in Cambodia*. The budget is 880.371 € of which 655.381 € budget is by the Belgian DGD for five years and 225.000 € funding contributed by the EKFS for 36 months. The current evaluation is a mid-term evaluation. The program is implemented in rural areas in Chamkar Leu and in Ou Reang Ov districts with a target population of about 100.000.

Cambodia has about 16.9 million inhabitants and is ranked 146th out of 191 countries in the human development index. Life expectancy at birth is at 71 years, 73 years for female and 69.2 years for male. Mental health is crucial to personal, community and socio-economic development. People with severe mental disorders die 10 to 20 years earlier than the general population. Mental health conditions comprise a major component of morbidity and the common conditions include post-traumatic stress disorder, depression, and anxiety disorders. The WHO estimated in 2017, 10.7% of the Cambodian population suffered from some form of mental illness. The most common mental disorders were depression (3.4%), anxiety (3.2%) and schizophrenia (0.3%). For women higher rates are reported than for men. The World Bank reports a suicide mortality rate at 4.9 per 100.000 for Cambodia. The prevalence of substance misuse disorders has been estimated as over 2%. Moreover, the failure to adequately address Cambodians' mental health needs has significant adverse consequences for the population's overall health, including increased risks of heart disease, diabetes, HIV/AIDS, and tuberculosis. Stigma in the family and in the community is one of the main barriers to access health services. Existing mental health facilities are rather concentrated in major urban centres, namely in Phnom Penh and Siem Reap, even though 74% of Cambodians live in rural communities. Most rural patients seeking mental health services must travel long distances to receive treatment, which typically entails out-of-pocket transportation costs. This implies the need to move mental health services closer to the patients at primary care level, which is fostered within the project. From the government, mental health services have been developed and vertically integrated in public health system through a minimum package of activities (MPA) for health centres and complementary package of activities (CPA) for referral hospitals. Still, there remains a significant **treatment gap**, between the number of people with mental disorders who need care and those who receive care. As well there is a significant **prevention gap**, the gap in the coverage of interventions focused on targeting mental health risk factors. While there is an increase in the geographic coverage of mental health services, the quality of services remains low and there is a **quality gap**, the mismatch between the quality of care that should be delivered for people with mental disorders and the quality of care that is delivered. **In summary, Cambodia is still relevant as intervention country. The needs and the identified gaps in mental health are relevant to be supported by the EKFS and the Belgian DGD. LC is aware of the specific barriers for mental health and the chosen project components are programmatically relevant to address them.** The project contributes to SDG 3 on good health and well-being particularly to sub goal 3.4 on premature mortality of NCDs (including mental health), to 3.5 on prevention and treatment of substance abuse, on 3.8 on universal health coverage and to 3.c which includes the capacity building of the health work force. Indirectly it also contributes to SDG 1 on poverty.

The overall objective of the project is to improve availability, accessibility, and quality of mental health services in the two target districts and the general prevention on NCDs, considering the differentiated impact on children, adolescents, men, and women.

LC follows the approach to implement via a broad range of local NGOs, universities, and government partners. This methodology raises pro and contra arguments, but in the case of LC overweighing advantages can be recognised. The project activities include implementation of a collaborative care model for mental health; implementation of health technology initiatives including a patient tracking system; capacity building of partners; medical and non-medical training, coaching in the areas of diagnosis, treatment, referrals, counselling and psychoeducation; development and dissemination of related knowledge management products; capacity building of people in the communities, public education and awareness of prevention of non-communicable diseases and mental health issues. **In summary, effectiveness appears on track to be implemented as planned at midterm.** Almost all indicators will be achieved or surpassed, particularly those indicators which can be directly influenced by LC and partners will be exceeded. **Results of activities and achievements/outputs have accelerated in 2023 over 2022.** The LC approach to use a variety of partners supports effectiveness and adds flexibility with implementation.

Out of the three building blocks (treatment and care, capacity building and research) the project focusses on capacity building with a broad range of persons benefitting. Treatment and care are predominantly performed through the government health staff in nine health centres and two district referral hospitals. The social workers and patient care facilitators employed by LC and the implementing partners improve the care and prevention. They increase availability and access to mental health care. Research or creating evidence for influencing future policies and strategies, is integrated by accompanying studies or surveys, such as the KAP survey completed in 2023. The interviewed district hospital directors and vice directors were very satisfied with the cooperation with LC and its partners. The target population is about 100.000 persons. Some of the patients would have gotten care without the project, but probably at a lower quality. Other cases will have been only detected and referred to care by the project's screening activities and the awareness raising in the communities. In general, the patients with care will gain more life quality through an improved status of health and well-being. Due to the nature of mental illnesses, vulnerable groups can benefit likely more from the project. This includes women, children, pregnant and lactating mothers, parents and caretakers, people with disabilities, migrant families, elderly, and victims of domestic violence. The collaborative care model (CCM) developed by the University of Washington is built around the ideas of task shifting, linking the community with the health centers or hospitals and multidisciplinary care while using a so-called patient care facilitator as the connecting person. The CCM was initiated with diabetes patients and will be extended to pregnant women and mothers with post-partum depression soon and eventually cancer patients later. The level of impact of the project will also depend on how policies and strategies can be influenced and how established proven solutions can be scaled up in the country such as the CCM to be used and scaled up outside the project or social work to be integrated in the Complementary Package of Activities for referral hospitals. **Regarding sustainability** the capacity built up with health care staff at provincial and district level and in the communities will remain at least for some time. It should enable partner organizations and their staff to run the project independently when LC would phase out. LC expects that the partners will be able to mobilize the financial resources and replicate the intervention strategy or model in other provinces in Cambodia. If this is realistic, could not be clarified in detail. It

can be expected the gained evidence-based information, practices and learnt from the project (e.g. the CCM experience, the KAP survey) can be used for adapting policies and strategies for clinical improvement, health systems development and information sharing mechanisms. Some social workers and patient care facilitators will need external funding. Expansion of services and capacity building, refresher trainings and other will all likely depend on external funding. Otherwise, future capacity building activities would be strongly reduced. Treatment and care happen within the government health system already and should be sustainable at a certain level. For added or enhanced social work future funding is unclear. The project contributes to increased acceptance of mental health issues, both among family members and professionals. Village health support groups can build up knowledge and can foster their role for the longer run. In a nutshell, **the impact of the project is reasonable as it serves neglected target populations in need**. Contributing to impact is the holistic approach and the broad range of activities. The target areas are rather small though and further scale up to other districts is not foreseen. When some of the identified milestones (e.g. the CCM, integration in CPA and MPA) can be achieved, the impact will be considerably higher. The predominant focus on capacity building creates longer lasting benefits. The level of impact of the project is also affected by the lack of political coordination within the mental health sector.

The cost allocation for personnel including travel (50,9%) is within reasonable thresholds, particularly as it includes also administrative cost. However, the project activities contain also large personnel expenses at partner level. The cost for the office and equipment (together 5,3%) are comparably small. As per info given, no direct overhead is charged additionally by LC or its partners apart from the personnel and running cost needed to perform the activities planned. The National Mental Health Strategy mentions that for every US$1 invested in scaled-up treatment for depression and anxiety, there would be a $4 return in better health and productivity. The salaries paid by LC and partners are within Cambodian standards. Using specialized and in their domain highly competent partners, such as TPO for community mental health work, rather strengthens cost efficiency if no significant overhead cost is charged on. There was no overlap of activities between the different partners observed. Instead, there are rather complementary synergies. **In summary the project is cost efficient given the cost/output (benefit) relationship** at about average of other evaluated EKFS funded projects. Positive are the high share of funds spent in Cambodia (90%) and that no significant separate overhead cost is charged.

The project is coherent with present national Cambodian policies and strategies, as well as with the Belgian cooperation policy. The project pays attention to include vulnerable groups more affected by mental health disorders. The gender perspective is considered and integrated.

The Finance & Administration Manager in Phnom Penh briefly explained the accounting's set-up and procedures. There is one bank book and two petty cash books in the system. All receipts and supporting documents are scanned and stored in the system. Three selected random samples of receipts out of the general ledger were quickly available as scan in the system and correct with supporting documents. There is one bank account for all projects and every transaction has a project code and a separate code for the corresponding funding.

There is a financial policy and a purchasing policy in place. **In summary, the accounting systems and procedures follow professional standards. There was no indication for any gaps.**

Some "lessons learnt "can be found on page 20, 25 and 27. Recommendations are summarized on page 29.

2 Background

2.1 Introduction

The Else-Kröner-Fresenius Stiftung (EKFS) and the Belgian Directorate-general for Development Cooperation and Humanitarian Aid (DGD) support the Belgian NGO Louvain Coopération (LC) for the program *Partnership for Improvement and Prevention in Mental Health (PIP-MH)* in Cambodia. It must be noted, that the DGD project part is called *Partnership for Improvement and Prevention in NCDs (PIP-NCD)* and has a slightly broader scope of diseases. The budget is 880.371, - € of which 655.381, - € budget is by the Belgian DGD for five years and 225.000, - € funding contributed by the EKFS for 36 months. The current evaluation is a mid-term evaluation.

The program of Louvain Coopération is located in rural areas in Chamkar Leu district/ Kampong Cham province in Chamkar Leu Referral Hospital and five health centers and in Ou Reang Ov district/ Tbong Khmum province in Ou Reang Ov Referral Hospital and four health centers. Louvain Coopération has been working in the field of mental health in Cambodia since 2004. LC is part of Uni4Coop, a cooperation of four Belgian NGOs linked with universities. However, this specific program is solely managed by Louvain Coopération.

Provincial map of Cambodia with project intervention districts

Source : https://www.worldatlas.com/maps/cambodia

2.2 Methodology

Evaluation background
The Else-Kröner Foundation does routine "short" evaluations for all their projects. The evaluation reports are written for a donor perspective. As Louvain Cooperation has planned an evaluation as well, covering more the perspective of the evaluated organisation, additional questions were added to the terms of reference to cover both evaluations' needs. To do both evaluations at the same time, added significant cost efficiency. In 2019 the predecessor project was evaluated in depth with an extensive field data gathering exercise. The present evaluation was not set up to repeat the field exercise, but -amongst other points- follows up on findings and recommendations from the former evaluation.

Data collection and analysis
A mix of quantitative and qualitative approaches was employed. Regarding qualitative methods a desk review of the main project documents and other information (e.g., studies, journal articles, policies and strategies, external reports) was performed. A mid-term project report to the donors was not available at the time of the evaluation. Therefore the "effectiveness" section includes the mid-term status of outputs and indicators provided by LC. Semi-structured, individual or group interviews were performed with six staff of Louvain Cooperation (including two patient care facilitators) as well as six interviews (a total of ten persons) with key informants from the Ministry of Health and the health facilities. Additionally, two persons from WHO could be met for interview. Furthermore, 25 mainly directly implementing partners of the project were interviewed with semi-structured questions in a total of 14 interviews. In addition, one patient could be interviewed.

For the quantitative analysis, data from the reports and presentations provided, were used. To assess the bookkeeping, the evaluator interviewed the responsible Finance persons and checked the filing in the Phnom Penh office. The Finance responsible persons briefly explained the system and main procedures. Random sample checks of receipts were performed. To evaluate cost efficiency mainly the (last adapted) budget was used for analysis.

Limitations/restrictions
The evaluation did not include an extensive field study as the one of 2019. From the main stakeholders and partners, only the Department of Mental Health and Substance Abuse at the Ministry of Health could not be interviewed due to re-scheduling of the appointment. By virtue of the nature of Mental Health and the relatively short time in the health facilities, only one patient (who gave consent) could be interviewed.

3 Analysis

3.1 Relevance

Cambodia has about 16.9 million inhabitants (estimate 2023) and is ranked 146th out of 191 countries in the human development index.[1] Life expectancy at birth is at 71 years (2023 est.), 73 years for female and 69.2 years for male. [2]
The countries' current health expenditure is 7.5% of GDP (2020). Around 40% of the population have social health protection coverage[3] and approximately 62%[4] of Cambodia's total health expenditure is out-of-pocket, which is the second-highest percentage in Southeast Asia.[5] The physician density is 19 per 100.000 population (2014)[6] and there are only 97 psychiatrists and 33 psychiatric nurses in Cambodia (2022).[7]A further 296 medical doctors and 627 nurses have been trained on mental health and substance abuse.

The WHO defines mental health "as a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well, and work well, and contribute to their community. It is an integral component of health and well-being that underpins individual and collective abilities to make decisions, build relationships and shape the world people live in."

Mental health is a basic human right. And it is crucial to personal, community and socio-economic development. Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm. People with severe mental disorders die 10 to 20 years earlier than the general population.[8]Mental health conditions comprise a major component of morbidity and the common conditions include post-traumatic stress disorder, depression, and anxiety disorders.[9]

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes that underlie mental and behavioral functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational, or other important areas of functioning.[10]

Cambodia has not conducted a national mental health survey yet. Epidemiological data from limited studies consistently shows high rates of anxiety, depression, and post-traumatic stress disorder (PTSD) in Cambodia. A cross-sectional study in 2019 showed rates of depression as

[1] UNDP, Human Development Report 2021/2022
[2] CIA World factbook accessed on 11th Jan 2024
[3] Ministry of Health, Primary Health Care Booster Implementation Framework, June 2023
[4] WHO Cambodia, Country Cooperation Strategy 2016–2020, 2016
[5] Viroj Tangcharoensathien et al., Health FinancingReJbmns in Southeast Asia: Challenges in Achieving Universal Coverage, 377 LANCET 863, 865 (2011).
[6] Statistics taken from CIA World Factbook, as they are more current.
[7] Department of mental health and substance abuse, Mental Health Strategic Plan 2023-2032, December 2023
[8] WHO, https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response, accessed 12th Jan 2024
[9] Department of Planning and Health Information, Health Strategic Plan 2016-2020, May 2026
[10] WHO, 2022

high as 16.7%, anxiety as 27.4% and PTSD 7.6%.[11] Whereas the WHO estimated slightly lower numbers in 2017, 10.7% of the Cambodian population suffered from some form of mental illness. The most common mental disorders were depression (3.4%), anxiety (3.2%) and schizophrenia (0.3%).[12]

For women higher rates are reported than for men. Women who were in debt, widowed or divorced and had low levels of education were the most likely to report symptoms. In addition, two thirds of women who experienced intimate partner violence reported adverse physical or mental health consequences. Only half of them had ever sought health care for their injuries. Furthermore, a survey on stigma and discrimination among people living with HIV in Cambodia reported that in the preceding 12 months, approximately 20 percent of respondents had been diagnosed with a mental health condition (e.g. anxiety, depression, insomnia).[13]

The World Bank reports a suicide mortality rate at 4.9 per 100.000 for Cambodia.[14] The prevalence of substance misuse disorders has been estimated as over 2%, with the main drugs used in Cambodia being amphetamine type stimulants, cannabis, heroin, and opium.[15] Moreover, the failure to adequately address Cambodians' mental health needs can have significant adverse consequences for the population's overall health, including increased risks of heart disease, diabetes, HIV/AIDS, and tuberculosis.[16]

Mental health is determined by a complex interplay of individual, family and community and structural factors. For instance, the recent Covid-19 pandemic has jeopardized many jobs, causing immense socioeconomic and emotional stress.

The vicious cycle between poverty and mental ill-health exacerbates mental health conditions and people living with mental health conditions are the subject of deep-rooted stigma and discrimination.[17] Stigma in the family and in the community is a main barrier to access health services. All these factors highlight connectedness of the importance of social interventions needed to accompany the pure health interventions.

Mental health in Cambodia faces significant challenges, with high rates of mental health disorders and a lack of adequate services. The country's traumatic history, including the long-lasting effects of genocide and war, still contributes to the complex trauma that affects the mental well-being of the population.[18] Traditional and religious healers play an important role in the country's healthcare system provided by a mix of non-government and private services. NGOs are generally trusted by the population, and they are permitted an active role by the government if they remain apolitical. Several interview partners reported a rather shrinking than growing role of civil society though.

[11] Seponski, D. M., Lahar, C. J., Khann, S., Kao, S., & Schunert, T. (2019). Four decades following the Khmer rouge: sociodemographic factors impacting depression, anxiety, and PTSD in Cambodia. Journal of Mental Health, 28(2), 175-180.
[12] World Health Statistics 2017: monitoring health for the SDGs, sustainable development goals. WHO; 2017.
[13] The People Living with HIV Stigma Index 2.0 Cambodia: Research Report. NAA, CPN+; 2019.
[14] Suicide mortality rate (per 100,000 population) | Data. World Bank; 2019.
[15] Devaney ML, Reid G, Baldwin S. Prevalence of illicit drug use in Asia and the Pacific. Drug Alcohol Rev. 2007;26(1):97–102. https://doi. org/10.1080/09595230601037034.
[16] McLaughlin D &Wickeri E (2012) Special Report: Mental Health and Human Rights in Cambodia, Fordham International Law Journal, L Volume 35, Issue 4 2017
[17] Parry, S.J., Ean, N., Sinclair, S.P. et al. Development of mental healthcare in Cambodia: barriers and opportunities. Int J Ment Health Syst 14, 53 (2020). https://doi.org/10.1186/s13033-020-00385-4
[18] Parry SJ, Wilkinson E. Mental health services in Cambodia: an overview. BJPsych Int. 2020 May;17(2):29-31. doi: 10.1192/bji.2019.24. Epub 2019 Nov 13. PMID: 32558820; PMCID: PMC7283113.

Few mental health facilities are concentrated in major urban centres, namely in Phnom Penh and Siem Reap, even though the majority of Cambodians live in rural communities, an estimated 74,4% as of 2023.[19] Most rural patients seeking mental health services must travel long distances to receive treatment, which typically entails additional transportation costs. The differences are pronounced in the health indicators between urban and rural areas, which experience greater poverty. According to the KAP survey performed in 2023[20] people residing in the target areas face poverty. Even covering the transport expenses to seek mental health services at a hospital becomes a significant burden for them. 52% of all people asked in the KAP survey cited lack of financial resources as the primary barrier to accessing mental health services. The second most mentioned barrier was lack of knowledge about mental illness, with 49% of respondents reporting this.[21] As a result, most individuals must rely on health centres for their medical treatment, with the district-level hospital being the farthest they can reach, and many cannot reach hospitals at the provincial level due to the lack of means. This implies the need to move mental health services closer to the patients at primary care level, which is fostered within the project. There is an ID poor card and a disability identification card for persons with disabilities as well. Most poor patients can get care for free apart from registration fees.

The lack of mental health services is evident, with only a low percentage of health centres and referral hospitals offering mental health services, and a limited number of psychiatric in-patient units and trained mental health professionals are available for the entire country. Availability of service for mental health differs considerably over the sources and timing of reports, as in the past years, attention and corresponding focus for mental health has obviously increased. The mental health component of the national health strategy has been increasingly expanded and integrated into the public health system across the country. In December 2023 significant progress was made with the publication of a National Mental Health Strategy.[22]
Mental health services have been developed and vertically integrated in public health system through a minimum package of activities (MPA) for health centres[23] and complementary package of activities (CPA) for referral hospitals.[24] According to the national mental health strategy 99 out of 131 hospitals at the secondary level are available for mental health services (CPA). 356 out of 1.305 health centres at the first level of care offer mental health services (MPA)[25], whereas the general quality of care is not known. The provision of mental health and substance abuse services is aligned with the WHO-mhGAP intervention guide, which is integrated into MPA and CPA.[26]The WHO at present works with the Department of Mental Health on a guideline for substance abuse.

[19] CIA World Factbook
[20] Phnom Penh Consulting Research Institute Co. Ltd, Knowledge, Attitude, and Practice (KAP) Survey Mental Health & Non-Communicable Diseases Ou Reang Ov and Chamkar Leu Operational Districts, March 2023
[21] Idem KAP survey
[22] Department of mental health and substance abuse, Mental Health Strategic Plan 2023-2032, December 2023
[23] Ministry of Health Cambodia, Guidelines on Minimum Package of Activities, 2018
[24] Ministry of Health Cambodia, Guidelines on Complementary Package of Activities for Referral Hospital Development, June 2014
[25] Department of mental health and substance abuse, Mental Health Strategic Plan 2023-2032, December 2023
[26] WHO, mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings Version 2.0

Still, there remains a significant **treatment gap**, between the number of people with mental disorders who need care and those who receive care. As well there is a significant **prevention gap**, the gap in the coverage of interventions focused on targeting mental health risk factors. While there is an increase in the geographic coverage of mental health services, the quality of services remains low and there is a **quality gap**, the mismatch between the quality of care that should be delivered for people with mental disorders and the quality of care that is delivered.[27] The quality of mental health care provided is often low, adequate follow-up is lacking and referrals between services are deficient. An over-reliance on medication and a very low mental health literacy, such as the ability to recognize mental health problems are general quality gaps. The further development of mental healthcare is hindered by barriers such as inadequate access to psychotropic medications, the absence of mental health legislation, and the shortage of public health trained mental health leaders.[28] In addition, the lack of research on Cambodia's mental health systems and services is a significant barrier to the development of evidence-based mental health policies and practice. Moreover, there has been no reliable study on comorbidity of mental illness and NCD.

Programmatic relevance: Barriers to mental health in Cambodia – does the program address them?

A few studies (e.g., Sarah Parry et al.)[29] outline the barriers to mental health in Cambodia in detail. How does the project of LC address them:

- **Lack of collaboration between professional disciplines**

The project addresses the collaboration between professional disciplines. The funded partner University of Washington has piloted a collaborative care model, which is about to be expanded and has a reasonable chance to be scaled up in the country in the future.

- **Few collaborations between NGOs, government services, institutions, and departments. Little coordination which offers a patchwork of services to target populations.**

LC's general implementation approach is to work through partners including NGOs, government services and institutions. LC is very open for coordination. However, coordination beyond its direct partners remains a major challenge as the adequate forums for mental health are lacking.

- **No integrated system of referral between services**

Referral forms exist. LC funded partners trained Village Health Support Groups to refer the identified potential Mental Health patients in the covered districts. For instance, patients in need of palliative care are referred to the NGO *Douleurs sans Frontières* (DSF). Within the target areas of LC, it can be stated the system of referrals is improved.

- **Western models of mental healthcare imported without cultural adaptation are often**

[27] Cited for LMIC, but valid for Cambodia in Parry, S.J., Ean, N., Sinclair, S.P. et al. Development of mental healthcare in Cambodia: barriers and opportunities. Int J Ment Health Syst 14, 53 (2020). https://doi.org/10.1186/s13033-020-00385-4
[28] Parry, S.J., Ean, N., Sinclair, S.P. et al. Development of mental healthcare in Cambodia: barriers and opportunities. Int J Ment Health Syst 14, 53 (2020). https://doi.org/10.1186/s13033-020-00385-4
[29] Parry, S.J., Ean, N., Sinclair, S.P. et al. Development of mental healthcare in Cambodia: barriers and opportunities. Int J Ment Health Syst 14, 53 (2020). https://doi.org/10.1186/s13033-020-00385-4

less effective.

Cultural adaptation of all project activities and approaches is given according to the interviewed partners and health professionals. CCAMH for instance adapted the WHO guidelines on epilepsy and behavior problems for children to local customs and into Khmer language. The full training packages are translated to Khmer.

- **Services concentrated in urban areas inappropriate for rural context.**

The LC project covers exclusively the needier rural areas.

- **Incomplete implementation of mental health policy**

Within its relatively small target area the project aims for a rather complete implementation in the covered districts.

- **Stigma and discrimination against people with mental disorders**
- **Lack of awareness and understanding of mental health amongst leaders and the general population** (both was confirmed by the KAP survey in 2023)[30]

Awareness raising and information, education, and communication (IEC) in the communities by the project as well as capacity building for the staff of the health facilities aim on reducing stigma and discrimination. The interviews point to a tangible reduction of stigma in the covered districts due to the implemented activities.

- **Attrition of mental health professionals**

There is a high turnover of medical staff in the system due to regular new postings within the government system. To mitigate the risk, in the project at least a slightly larger number of health staff is trained than immediately needed.

- **Lack of professionalism and ethical framework in mental healthcare.**

Capacity building for the staff of the health facilities and the volunteer in the project aims to address this issue.

In summary, Cambodia is still relevant as intervention country. The needs and the identified gaps in mental health are relevant to be supported by the EKFS and the Belgian DGD. LC is aware of the barriers for mental health and the chosen project components are programmatically relevant to address them.

The project contributes to SDG 3 on good health and well-being particularly to sub goal 3.4 on premature mortality of NCDs (including mental health), to 3.5 on prevention and treatment of substance abuse (incl. drugs and alcohol), on 3.8 on universal health coverage and to 3.c which include the capacity building of the health work force. Indirectly it also contributes to SDG 1 on poverty.

[30] Phnom Penh Consulting Research Institute Co. Ltd, Knowledge, Attitude, and Practice (KAP) Survey Mental Health & Non-Communicable Diseases Ou Reang Ov and Chamkar Leu Operational Districts, March 2023

3.2 Effectiveness

The project is in **mid-term** execution. At the time of evaluation there was no interim mid-term report for EKFS or DGD available. Two progress reports by LC for the authorities for 2022 and for 2023 were shared.

The objective of the project is to provide appropriate clinical and non-clinical psychological health services that are culturally appropriate and take prevalent attitudes on health into account.

The project includes the following activities:

- Introduction and implementation of a collaborative care model for the mental health of children and adolescents and integration in the psychosocial services.
- Implementation of health technology initiatives, including a patient tracking system.
- Strengthening the partners' capacities, particularly their administrative systems and management skills.
- Medical and non-medical training, coaching, and consulting staff in the areas of diagnosis, treatment, referrals, and advice for mental health.
- Development and dissemination of related knowledge management products with the project.
- Strengthening the capacities of people in the communities' resources to provide, promote public education and awareness of prevention, non-communicable diseases, mental health, disabilities, de-stigmatization, domestic violence, and early childhood development.
- In addition, the project strives to change mindsets and beliefs and influence behaviours of the population in the target areas, through information, education, and communication campaigns.

LC follows the approach to implement via a broad range of partners. This methodology raises pro and contra arguments, but in the case of LC advantages overweighing can be recognised. It is a lot easier to recruit and engage specialist expertise such as the University of Washington (UW), a leading research institution on social work practice and community engagement for the collaborative care model; the Transcultural Psychosocial Organization (TPO) for community-based work and the Caritas Centre of Child and Adolescent Mental Health (CCAMH) for child and adolescent health. It allows to start much faster with implementation activities, and it will be also easier to exit any activities in case, e.g. with the end of the contract. Disadvantages include another layer of reporting and a certain dependency on external reporting of the partners. This plays out for instance while monitoring progress based on the status of indicators, which in majority must be delivered by the partners. Furthermore, the coordination is rather external than internal, which adds some complexity to coordination, although there was no indication of problems in this regard. A potential disadvantage of adding supplementary overhead structures, reducing cost-efficiency appears has not materialized based on the info received.

In detail, LC implements with the following partners:

- The **Department** of **Preventive Medicine Department** (DPM) of Ministry of Health will do capacity building for health centre staff and village health volunteers on NCD

communication. The original idea to develop a mobile app for NCDs was cancelled due to a new World Bank e-health project overlapping and covering the original need.[31] The DPM also provides technical inputs and advice on the development of Information, Education and Communication (IEC) materials on NCDs.

- With the **Department of Mental Health and Substance Abuse** (DMHSA) of Ministry of Health several options have been discussed ranging from the continuation of a pilot community mental health project to supporting the DMHSA's monitoring, evaluation, coordination, and training responsibilities. Up to February 2024, no decision has been made on the content and scope of the collaboration.

The DPM and the DMHSA of the Ministry of Health are the two main government counterparts within the project.

- The NGO **Transcultural Psycho - social Organization** (TPO) implements capacity building social workers, village health support group and health professionals regarding NCDS and mental health of adults. TPO has permanent staff in the project locations. TPO is the leading civil society organization specialized in prevention, treatment, training, coaching, research and advocacy on mental health and psychosocial support in Cambodia.
- The **Centre for Child Adolescent Mental Health - CARITAS** (CCAMH), a public private partnership between the Ministry of Health (MoH) and Caritas Cambodia, an international NGO implements capacity building regarding mental health for children and adolescents. CARITAS (CCAMH) implements capacity building regarding mental health for children and adolescents.
- The **University of Washington** (UW) is a technical advisor for the collaborative care model (CCM) for both LC and its partners. The two patient care facilitators as integral part of the CCM are LC staff. The CCM was developed by UW and implemented with the partners and government counterparts.
- **The NGO Social Services Cambodia** (SSC) performed capacity building of Community Social Workers (CSWs) in several districts. The contract finished. They trained community social workers to work as focal points at the district level in close collaboration with the Commune Council for Women and Children (CCWC), who are continuing contacts in the communities.
- The NGO **Douleurs Sans Frontières** (DSF) does capacity building for palliative care[32] addressed to social workers, village health support group and health professionals as well as implementing a referral procedure and tool. They also accompany the identified patients in need and their care givers.
- The NGO **Humanity & Inclusion** (HI) on capacity building for social workers, village health support group and health professionals regarding people with disabilities to support the cross-referral system for disabled people to receive mental health and rehabilitation services.
- **Saint Paul Institute** has sent four students to do their internship in the target areas of the project in Chamkar Leu and Tboung Kmum provinces, for the period of 3 months.

[31] The change of activity will be requested with the donors for authorization.

[32] Palliative care is specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness. It also can help one cope with side effects from medical treatments. The availability of palliative care does not depend on whether a condition can be cured.

Furthermore, under a collaboration agreement between the Kampong Cham provincial hospital, the Université Catholique de Louvain (UCL) and LC, three medical students from UCL could undergo their internship in this provincial hospital (December 2022 to March 2023). Some other collaborations with Belgian universities for research in the field of NCDs and mental health are in discussion.

Table: Objectives and indicators - Status versus Plan (as from the statistics provided)

Overall Objective (project target)	
The availability, accessibility, and quality of mental health services in Chamkar Leu and Ou Reang Ov operational districts and the general prevention on NCDs, are improved, considering the differentiated impact on children, adolescents, men, and women.	
Indicators Overall Objective	**MIDTERM Status/Comment Evaluation**
• 60% of women and men treated for depression and/or General Anxiety Disorders report reduced symptoms and improve their functioning and well-being. (Baseline to be defined in year 1). • Comprehensive/integrated mental health services for children and adolescents are available in 2 referral hospitals (RH) and 9 health centres (HC) cumulative. (Baseline: no mental health service is integrated into RH and HC yet). • 40% of new cases (sex disaggregated) are self-referred to mental health services. (Baseline: to be determined in Y1, through collection of sex disaggregated data).	In 2023, TPO conducted a pre survey with 100 clients and a post survey with 59 clients. There is no report on the result of pre and post-test survey yet at this stage. The report will be made available in 2025 when completing the survey among 300 clients. 2 RHs and 2 HCs were selected to be model health centres for the integration of child and adolescent mental health. 5 staff were sent to India to learn about the first 1.000-day care program and Mobile application to apply the relevant practices in their health facilities. Base line data (for 2022 and 2023 cumulative: 441 new cases (329 women) were self-referred to MH services. In 2023 these were already 51% of new patients, in 2022 still 20%**.**
Outcome (sub target) 1: The technical knowledge among service providers and the referral system in an integrated mental health care approach is improved at community, health centres and district referral hospitals.	
Indicator – Output	**MIDTERM Status/Comment Evaluation**
1.1. Number of appropriate personnel in Primary Health Care receiving training in integrated Collaborative Care, capable of screening, referring, diagnosing, and treating clients with psychosocial and other disabilities following the guidelines. (Baseline: to be identified in Y1 through the CCM readiness assessment).	The implementation of Collaborative Care Model (CCM) in Chamkar Leu district hospital was launched in July 2023. The sub-quality improvement team consisting of 15 members was set up and two Patients Care Facilitators were recruited. They all received training and technical support from LC partners. **On track.**
1.2 40 cases (sex disaggregated) referred from health centres to district referral hospitals (Baseline: 8 cases are referred from HCs to RHs).	In 2022 and 2023, 35 cases (16 women) were referred from HCs to RHs. 10 more cases were referred from Chamkar Leu and Ou Reang Ov to CCAMH outreach clinical service in 2023. **This indicator will be exceeded by the end of the project.**
1.3 200 new cases (disaggregated by sex) of patient with mental health problems and/or psychosocial and/or other disabilities accessing	In total, 40 cases (28 women) were referred by Village Health support Groups to HCs. **At present it is not clear, if this indicator will be reached.**

OPD have been referred by VHSG, VCD or other volunteers. (Baseline: 49 cases referred by VHSGs).	
Outcome (sub target) 2: Partners organisations dedicated to people with mental disorders and psychosocial disabilities are strengthened and empowered on digitalization and gender sensitised.	
Indicator – Output	**Status/Comment Evaluation**
2.1 Number of health technologies developed and fully implemented, including a patients' tracking system for the integrated CCM and tele-health delivery tools. (Baseline: A pilot tele-mental health program was introduced in 2020 by CCAMH).	The patient tracking system was developed by LC's implementing partners. The system was developed to record patient profiles, people screened, people who received psychotherapy, referral, and follow-up. The tele-health delivery equipment was installed in 2020. A few technical meetings were organised via zoom or other online platforms. **On track.**
2.2 One digital platform containing: M&E tools, guidelines, clinical training curriculum/sessions, and strategies on behavioural change is established and managed by the partners. (Baseline: 0)	TPO has agreed to set up a digital sharing platform integrated into its website. The set-up of this sharing platform will start in **Feb 2024.**
Outcome (sub target) 3: Community based services to promote and prevent NCDs with gender lenses are strengthened.	
Indicator – Output	**Status/Comment Evaluation**
3.1 14 awareness raising sessions / campaigns, matching the needs of specific groups (children, adolescents, women, men, elderly, displaced persons, disabled persons), in prevention of mental health issues are conducted by a community-based services team cumulative. (Baseline: 5 campaigns per year).	TPO conducted 25 campaigns in communities. 847 people (679 women) attended. In addition, CCAMH also conducted monthly campaigns in 18 villages. Eight meetings were organised per village per year. 2997 people (1622 women) attended. **This indicator will be largely exceeded.**
3.2 Increase and improve percentage of community members' knowledge, attitudes and practices on mental health and mental health care (by gender and age). (Baseline: to be determined on Y1 by the Knowledge Attitudes and Practices (KAP) survey).	The KAP survey in 2023, reported the following data (baseline): (1) % of people with good knowledge (64%) (2) % of people with negative attitudes (48%) (3) % of people with positive/good practices and behaviour (66%) The project plans to conduct the endline survey **before the end of the project** to measure the change of KAP among the target beneficiaries.
3.3. Three new Information Education and Communication (IEC) materials developed with gender lenses for NCD burden prevention are evaluated, improved, and disseminated, and one digital application system is established and effectively functioning. (Baseline: 0).	In 2023, CCAMH designed 5 types of leaflets on the first 1.000 days of life, prevention of childhood disability and promotion of infant health, cerebral palsy, understanding feeding challenges and strategies to help). CCAMH also developed 2 newsletters on psychosis and somatoform disorder. Publication is planned in Q1 of 2024. **The indicator is already exceeded.**
Outcome (sub target) 4:	

More evidence-based information for policy advocacy through regular research and action-research on clinic and community-based services is produced to assist the process of clinical improvement, health systems development and information.	
Indicator – Output	**Status/Comment Evaluation**
4.1. Five knowledge management products with gender analysis (including studies, assessments, tools, systemisation of experiences, action research) developed and produced with local partners and first line population -cumulative- (Baseline: 0).	Three knowledge management products have been completed: (1) CCM Readiness assessment was carried out in 2022 and 2023 (2) The KAP survey (Baseline) was completed in 2023. (3) The "Intergenerational Transmission of Trauma among Cambodian Migrant Households" field study was carried by PhD Thesis student. The report will be completed in 2024. **On track.**
4.2. Four knowledge dissemination products (including policy briefs, conference presentations, videos,) developed for advocacy, based on outputs from previous and new programmes (studies, assessments and action-research addressing factors influencing gender disparities/barriers) and according to the target audiences -cumulative-. (Baseline: 0).	(1) Presentation of the paper on the study related to the "Impact of psychosocial challenges at home on primary school children performance: the case of Cambodia" was presented during the ACEID online conference in 2023 by LC partner. T (2) The result of the CM readiness assessment was presented to partners (TPO, CCAMH, Kampong Cham health professionals and leaders. (2023) (3) The KAP survey report was shared with local partners (TPO, CCAMH, UW-DSW, DSF) (4) -The results of KAP survey were presented during the World Mental Health Day in Oct 2023 (5) The LC Health Programme Manager made a presentation about the Contribution of social workers in promoting children mental health, during a meeting of the Association of Professional Social Workers of Cambodia in 2023. **On track.**
4.3 Number of occasions for exchanges / meetings (18 meetings) in which knowledge management outputs and lessons learnt are discussed and co-built with policy makers and health stakeholders -cumulative-. (Baseline: 6 meetings per year).	The validation of a screening tool for expansion of mental health services in Cambodia was carried out by LC partners in June 2020. The final report on this study and the instrument for screening and diagnosing depression and anxiety disorder was shared with CCAMH, the Department of Preventive Medicine and the Department of Mental Health and Substance Abuse in 2023. The result of the KAP survey was presented during Kampong Cham Provincial Technical Working Group meeting in Dec 2023. (see also above for other exchange meetings)

It needs to be noted, that more capacity building results (in terms of output) are not integrated in the log frame (e.g., number of health workers trained on x). Hence the log frame does not give a full picture of achievements/outputs.

The Knowledge, Attitudes and Practices (KAP) survey performed in 2023 was very valuable to obtain reliable and relevant data in the target areas of Chamkar Leu and Ou Reang Ov regarding NCDs and Mental Health. The survey results informed the development of intervention strategies for improving health promotion and for increased availability and access to NCD and mental health care services.[33]

Six girls, victims of physical and / or sexual violence received psychological and material support from CCWC and TPO during 2023.
In 2023, two new Self-Help Groups were established in Chamkar Leu and in Ou Reang Ov.

Challenges and other achievements

The Covid-19 epidemic had a strong influence on mental health care, particularly of the community health parts and social work, but also creating anxiety and depression. It affected personal connectedness, safety, freedom of movement, and livelihoods. However, it influenced more the preceding project and to a much lesser effect the current phase. According to the interviewed health professionals and social workers, the epidemic is at present no challenge.

Most partners reported to have Standard Operating Procedures (SOPs) in place. TPO for instance has guidelines for coaching, for home visits, for care givers and for counselling.

In summary, **effectiveness appears on track at midterm to be implemented as planned.** Almost all indicators will be achieved or surpassed, particularly those indicators, which can be directly influenced by LC and partners will be exceeded. Others, such as referrals from Village Health Support Groups are -amongst other factors- depending on the prevalence of mental health cases in the communities. Results of activities and achievements have accelerated in 2023 over 2022. The LC approach to use a variety of partners supports effectiveness and adds flexibility with implementation.

Table: Lessons learnt Part 1

Lessons learnt
A major finding of the KAP survey indicates the presence of gender disparities in mental health. It is evident that females are more susceptible to mental illnesses compared to males. Consequently, there is a greater demand for mental health services among females, which needs to be considered for the project activities.

[33] Phnom Penh Consulting Research Institute Co. Ltd, Knowledge, Attitude, and Practice (KAP) Survey Mental Health & Non-Communicable Diseases Ou Reang Ov and Chamkar Leu Operational Districts, March 2023

Lessons learnt
It is very difficult for the NGOs and to the MoH to fill staff positions in the province. This is particularly valid for psychiatrists, but also for social workers including the patient care facilitators (which were filled by Master students). There is a strong reluctance to leave Phnom Penh for the rural areas for a variety of reasons, e.g., longer-term career and income possibilities.
There is still reluctance and hesitance to link social work practice and mental health amongst some of the authorities despite its obvious synergies and needs for universal health coverage. The Ministry of Social Affairs, Veterans and Youth Rehabilitation is responsible for the social services on national level within the Operational Departments at provincial levels. The Department of Mental Health and Substance Abuse is responsible for Mental Health in the Ministry of Health.
There is only one social worker in each of the two referral hospitals covered by the project. The dilemma is, If the one person gets sick, there is no coverage to perform the activities. This did not happen so far. The social workers also complained to be alone for organising, preparing, and performing the community awareness events. Otherwise, there is no budget and no immediate need for a second person. Occasional support with the community events may be an option.
The provision of services and the corresponding allowed resources in the district referral hospitals are defined by the categories in the Complementary Package of Activities for Referral Hospitals (CPA1, CPA2, CPA3). Adding mental health patients by enhanced community work and implemented referral system will not result in increased corresponding resources. The only option to increase resources is, that the referral hospital reaches the criteria to be allowed to move from CPA1 to CPA2 or CPA2 to CPA3. The hospital in Ou Reang Ov may be able to move to CPA2 in the near future for instance.
All interviewed health centre and hospital staff confirmed occasional stockouts of psychotropic and other drugs. Only cheaper first-generation drugs are available and second-generation drugs were not available, also not in the list of essential medicine of the Ministry of health. Often, they must use revolving funds from user fee schemes to buy in the private pharmacies to cover the shortages.

3.3 Sustainable Impact

The overall objective of the project is to improve availability, accessibility, and quality of mental health services in Chamkar Leu and Ou Reang Ov operational districts and the general prevention on NCDs, considering the differentiated impact on children, adolescents, men, and women.

Out of the three building blocks (**treatment and care, capacity building and research**) the project focusses on capacity building with a broad range of persons benefitting. Treatment and care are mainly performed through government health staff in nine health centers and two district referral hospitals. The social workers employed by LC and the implementing partners improve the care and prevention. They increase availability and access to mental health care.

Research or creating evidence for influencing future policies and strategies, is performed by accompanying studies as by the University of Washington team) or surveys, such as the KAP survey in 2023.[34]

The program is in process to improve the management of the public health system at district and provincial levels, where the implementation of a more patient-driven approach contributes to better-quality mental health services. The interviewed district hospital directors and vice directors were very satisfied with the cooperation with LC and its partners. The approach of integrated mental health at the community level can equip key community members together with non-specialist health workers with the skills and competencies to provide culturally appropriate care and referrals. This includes such details as training children, who cannot go to school, on engaging activities and later for vocational training (CCAMH). Additionally, people with mental health problems and their caregivers will be empowered to advocate for themselves and for each other.

Beneficiaries

The project improves access to the higher quality of NCD and mental health services through promotion, prevention, treatment, and care in the target areas. The target population are 20,972 families or roughly 100.000[35] (51% are women) who live in 112 villages. They benefit from the project by improved access to mental health care and prevention and directly from awareness raising activities. About 4,725 adults and 2,125 children and adolescent with mental health problems were expected to benefit from improved treatment and psychosocial support in the project application (new and existing patients). For 2022 and 2023 1.323 new mental health cases are reported in the targeted health centres.

Some of these patients would have gotten care without the project, but probably at a lower quality. Many cases will have been only detected and referred to care by the project's screening activities and the awareness raising in the communities (441 new cases self-referred so far, plus 35 referred from HC to RH). Children with potential mental disorders for instance often come to the outreach activities but would not be accompanied to the health centres without the project. The number of new cases and referrals has accelerated in 2023 over 2022. In general, the patients with care will gain more life quality through improved health and well-being status.

Due to the nature of mental illnesses, vulnerable groups are more affected by mental health illnesses, which then likely more benefit more from the project. This includes women, children, pregnant and lactating mothers, parents and caretakers, people with disabilities, migrant families, elderly, and victims of domestic violence. It is likely the project contributed to the target areas to National outcome and impact indicators such as percentage of people with depression or schizophrenia receiving treatment, percentage of children or elderly receiving treatment.[36]

From the capacity building a few hundred pregnant & lactating mothers will benefit from awareness raising activities on preventing disabilities, balanced diet during pregnancy early childhood and positive parenting and non-violent communication. Several thousand parents

[34] Phnom Penh Consulting Research Institute Co. Ltd, Knowledge, Attitude, and Practice (KAP) Survey Mental Health & Non-Communicable Diseases Ou Reang Ov and Chamkar Leu Operational Districts, March 2023
[35] Number taken from the project application. This is roughly 0,6% of the Cambodian population.
[36] Department of mental health and substance abuse, Mental Health Strategic Plan 2023-2032, December 2023

and caretakers can benefit from knowledge and experiences exchange about positive parenting, the care of children with disabilities, palliative care, impact of stigma, discrimination, and domestic violence (TPO in 2023 alone: 2.997 clients).

More than 40 primary medical staff, several hundred volunteers and Commune Committees for Women and Children (CCWC), commune social workers, public social workers and outreach staff benefitted from technical training and coaching support by the various implementing partners. Exact cumulative numbers for the persons benefitting from capacity building activities are not summarized, but likely exceed numbers expected in the beginning.

The collaborative care model (CCM)

The collaborative care model by the University of Washington is built around the ideas of task shifting, linking the community with the health centers or hospitals and multidisciplinary care while using– a so-called patient care facilitator (PCF)- as the connecting person. This PCF can screen the patients based on a questionnaire using questions from the General Anxiety Disorder (GAD 7)[37] scale or the Patient Health Questionnaire (PHQ 9) for scoring the patient. When a patient exceeds the threshold score, the patient can receive direct psychological support from PCFs or can be referred to the consulting psychiatrist or medical doctor. This process allows to screen large groups of people and can identify more hidden cases. It saves time for the treating specialist, due to the task shifting. It was tested to use a nurse for screening instead of a patient care facilitator, but it did not work as good. Nurses do not have sufficient time availability and lack some of the psychological skills and trainings to carry out the PCF function.

The CCM also has a suicide prevention dimension, while identifying and referring potential persons earlier.
Other district hospitals and the provincial health director expressed the wish for scaling up the patient care facilitators to other referral hospitals. A patient tracking system is an essential feature of the system. It was adjusted to the local Cambodian context and should facilitate the integration of mental health, including children and adolescent mental health, into the existing health services. A patient satisfaction survey is in process too. A dedicated quality improvement team was created at the Chamkar Leu Referral Hospital in autumn 2023.

The CCM was initiated with Diabetes patients. Depression is a common co-morbidity in patients with type 2 diabetes mellitus. The prevalence of depression is two to three times higher in people with diabetes mellitus than in the general population. Most cases remain under-diagnosed outside the project. The CCM will now be expanded to pregnant women and mothers with post-partum depression. Depression is the most common psychiatric disorder during pregnancy and post-partum. Despite being a common and pervasive mental health problem, maternal depression often goes undetected. Later the CCM model could be also adapted for cancer patients and families of children living with developmental disabilities or epilepsy.

[37] The Patient Health Questionnaire—9 (PHQ-9) and the Generalized Anxiety Disorder Questionnaire– 7 (GAD-7) are short screening instruments used for detection of depression and anxiety symptoms in various settings, including general and mental health care as well as the general population. They are promoted by the WHO and are also accepted in Cambodia.

The National Mental Health Strategic Plan 2023-2032lists the development of tools for integrative collaborative care model for mental illness as strategic intervention. It lists guidelines for collaborative care of mental health with HIV, TB, diabetes, cancer, maternal and child health, child and adolescent health, and health for the elderly. Hence, the CCM model has a reasonable chance to become broader model for the overall country.

The level of impact of the project will much depend on how policies and strategies can be influenced and how established proven solutions can be scaled up in the country:

Table: Critical milestones depending on external decisions, but can be influenced by LC advocacy and support (the list is not exhaustive)

Milestones	**Possibility**
The Department of Social Work of the Royal University of Phnom Phen aims to get medical social work integrated in the complementary package of activities (CPA) for referral hospitals. This would include integrated social work for mental health becomes country standard as well. There is hesitance in some part of the MoH to combine social work and mental health, as for instance different Ministries are involved and responsibilities become blurred.	The possibility to achieve this, is very high.
The CCM model by the University of Washington has potential to become a standard approach for mental health for Cambodia. As laid out in the National strategy it can be easily adjusted as tools for mental health of HIV, TB, diabetes, cancer patients, and for mental health on maternal and child health, child and adolescent health, and health for the elderly. It will require advocacy on all levels by various partners to achieve this.	The possibility to achieve this is good.
The integration of children and adolescents' mental health in the Minimum Package of Activities (MPA) and in the Complementary Package of Activities (CPA) is still limited. Clinical treatment and counselling for children and adolescents could be more integrated into these policies.	The possibility to achieve this, is very high.
The patient tracking system**,** established in Chamkar Leu RH is an essential feature of the CCM system. It could be a model to be scaled up to other provinces.	The possibility is good.

Risks

Out of the identified risks in the project application the lack of collaboration between NGOs, government services, institutions and departments remain imminent. The DMHSA is reluctant to take on the lead in coordinating mental health actors.
The low interest of health staff participating in outreach activities is still a substantial risk as it strongly depends on paying allowances or incentives.
The lack of participation in community groups and participation of the population almost not materialised. Still, the community sessions are mainly frequented by elder people and

predominantly women. The younger generation is rather absent.
A potential lack of professionalism and ethics in mental health care could be mitigated by interaction of the respective partners and new MoH policies.

Programmatic (technical) sustainability

The capacity built up with health care staff at provincial and district level and in the communities will remain at least for some time. The capacity building enables some system strengthening, with enhanced skills, resources, and abilities that allow partner organizations and their staff to run the project independently when LC would phase out. LC expects that the partners will be able to mobilize the financial resources and replicate the intervention strategy or model in other provinces in Cambodia. If this is realistic, could not be evaluated further. It can be further expected the gained evidence-based information, practices and lessons learnt from the project (e.g. the proven CCM model, the KAP survey) can be used for adapting policies and strategies for clinical improvement, health systems development and information sharing mechanisms.

Financial sustainability after project end

Positions added such as the Patient Care Facilitators or the TPO social workers, will need other sources of funds to continue. Either the government is ready to fund these positions or external funds are still needed. Expansion of services and capacity building, refresher trainings and other will all likely depend on future external funding. Otherwise, the capacity building activities would need to be strongly reduced. The treatment and care happen largely within the government health system already and should be sustainable at a certain level. For added or enhanced social work future funding is still unclear.

Social sustainability

The project contributes to increased acceptance of mental health issues, both among family members and professionals. Empowering mental health service users contributes to tangible physical, psychological, and societal benefits. These may include enhanced self-esteem, a greater sense of connectedness to local social groups and a meaningful engagement in society. Village Health Support Groups can build up knowledge and can foster their role for the longer run. The improved collaboration within the covered health services will likely remain for some time.

In a nutshell, **the impact of the project is reasonable as it serves neglected target populations in need.** Contributing to impact is the holistic approach and the broad range of activities. The target areas are rather small though and further scale up to other districts is not foreseen. When some of the identified milestones (e.g. the CCM, integration in CPA and MPA) can be achieved, the impact will be considerably higher.
The predominant focus on capacity building creates longer lasting benefits. The level of impact of the project is affected negatively by the lack of political coordination within the mental health sector.

Table: Lessons learnt Part 2

Lessons learnt
Civil Society is an essential factor in social work, community health and mental health. Several interviewees reported the space for Civil Society organizations is rather shrinking

Lessons learnt
than growing. Changes in the stakeholder landscape of mental health bring new opportunities, but bring also risks and even threats to the longer-term project prevail.
Cross-referral of patients toward adequate mental health and rehabilitation services from the communities, but also within the health system remain a key for success, particularly for the impact perspective.
Collaboration and Coordination remain a crucial success factor for expanding the quantity and quality of mental health care. There are coordination meetings for health in general with main MoH partners and there are meetings for NCD treatment and prevention. Both may discuss issues on mental health on occasion. Hence, being present in all those meetings can become inefficient if no mental health topics are discussed. Specific coordination meetings and technical work groups for mental health are still lacking due to missing coordination from the DMHSA.
CCAMH reports good results with parent support groups. Parents of children with mental health issues meet regularly to support each other and share experiences and information. This fosters the support and reduces the stigma, both for children and family. In the target area there are six parent support groups. Three villages build one group. PHQ 9 questionnaires are used with the parents.

3.4 Efficiency

The evaluation of allocation efficiency[38] is based on the provided current budgets of the DGD and the EKFS funded parts together. For production efficiency[39] the comments are based on notes, findings and observations during the visit and desk study.

Allocation efficiency

The cost allocation for personnel including travel (50,9%) is within reasonable thresholds, particularly as it includes also administrative cost. However, the project activities contain also large personnel expenses at partner level. 43,8% are spent on direct project activities (mainly through partners). The cost for the office and equipment (together 5,3%) are comparably small. As per info given, no direct overhead is charged additionally by LC or its partners apart from the personnel and running cost needed to perform the activities planned.

Production efficiency

According to costing studies in South Asia and sub-Saharan Africa, the cost of scaling up delivery of an integrated package for epilepsy, depression, bipolar disorder, schizophrenia, and heavy alcohol use has been calculated at US$ 3–4 per capita. The return on that investment is estimated at 500–1.000 healthy years of life for every million dollars spent.[40]The National Mental Health Strategy 2023-2032 mentions that for every US$1 invested in scaled-up treatment for depression and anxiety, there would be a $4 return in better health and

[38] Allocation efficiency: The project's use or allocation of resources is appropriate regarding achieving the project's objectives.
[39] Production efficiency: The project's use of resources is appropriate regarding the outputs achieved.
[40] Chisholm D, Saxena S. Cost effectiveness of strategies to combat neuropsychiatric conditions in sub-Saharan Africa and Southeast Asia: mathematical modelling study. BMJ. 2012;344:e609.

productivity.[41] From this general programmatic perspective, investment in mental health in general appears as very cost effective.

The salaries paid by LC and partners are within Cambodian standards. Using specialized and in their domain highly competent partners, such as TPO for community mental health work or the Univ. of Washington for its academic excellence in social work rather strengthens cost efficiency, as long as no significant overhead cost is charged on. There was no overlap of activities between the different partners observed. Instead, there were rather complementary synergies.
LC has a purchasing policy in place mitigating the risk of overly expensive purchases. In addition, the evaluation could cover both donors, with little extra cost.

Table: Aggregated budget incl. relative share[42]

Category	Funded by EKFS (3 years)	Funded by DGD (5 years)	Total budget as per Jan. 2024	%age of total
Human Ressources LC (incl. travel)	37.307,68			
Human Ressources TPO (incl. travel)	41.013,50			
Human Ressources CCAMH (incl. travel)	15.272,16			
SUB TOTAL Human Ressouces	**93.593,34**	**349.590,02**	**443.183,36**	**50,9%**
KAP survey	11.827,62		11.827,62	
Collaboration of other orgs	62.508,25		62.508,25	
CCAMH project cost	20.558,19		20.558,19	
TPO project cost	20.333,79		20.333,79	
Training and coaching	2.462,07		2.462,07	
SUB TOTAL Project Activities	**117.689,92**	**263.619,19**	**381.309,11**	**43,8%**
			-	
Equipment, furniture and Machinery	6.219,99	5.430,08	11.650,07	1,3%
Other cost incl. Office	7.496,75	27.498,89	34.995,64	4,0%
TOTAL	**225.000,00**	**646.138,18**	**871.138,18**	**100,0%**

Table: Share of budget by organization (as of budget shared in Jan. 2024)

Allocation	%age of budget
Louvain Cooperation HQ Belgium	8%
Louvain Cooperation Cambodia	45%
Partner TPO	22%
Partner CCAMH- Cambodia	10%
All other partners	15%
TOTAL	100%

[41] Department of mental health and substance abuse, Mental Health Strategic Plan 2023-2032, December 2023, page 11
[42] The budget has changed a few times. This total was given during the evaluation in Jan. 2024.

Positive about 90% of the budget are spent in Cambodia. The University of Washington contribution contains some international parts. As mental health covers so many other aspects of society and health care (e.g., sexual violence, domestic violence, migration, children, substance abuse) synergies are materialized due to the project activity mix, which contributes to an improved cost/benefit ratio.

In summary the project is cost efficient given the cost/output (benefit) relationship at about average of other evaluated EKFS funded projects. Positive are the high share of funds spent in Cambodia (90%) and that no significant separate overhead cost is charged.

Table: Lessons learnt Part 3

Lessons learnt
Without payments of per diem, transport allowance and other incentives, volunteer work and outreach work of health staff in the communities, as well as capacity building will not happen. The various partners appear as little coordinated in paying uniform or standard rates and even compete non-intentionally.

3.5 Coherence

Coherence

The last **WHO** Cambodia **country cooperation strategy** document (2016) mentions NCD and Universal Health Coverage as strategic priorities but has very little mention of mental health.

To increase coverage and access to primary and complementary mental health services, including substance treatment services; and promote awareness about mental health risks is an objective of the Health Strategic Plan 2016-2020. The mental health and NCD programs have the fastest growth in expenses; in 2020 four times the estimated costs for 2016. This can be interpreted, that the authorities have more recognized the importance of mental health. The project is fully coherent with this focus and corresponding strategies.
Since December 2023 the new **Mental Health Strategic Plan 2023-2032** is published, a major progress for mental health in Cambodia. The Strategic Plan has four main strategic objectives:

1. Ensure Resilient System and Governance for Sustainable Mental Health Development.
2. Ensure Comprehensive Mental Health Service through Reforming from Promotion to Prevention, Care, Treatment, and Rehabilitation.
3. Ensure Mental Health Services Provision in Compliance with Best Practice to Maximize Outcomes for the Patients.
4. Enable People with Mental Health Conditions to receive Universal Health Coverage for Mental Health.[43]

LC's activities are fully in line with these main objectives and the overall Mental Health Strategic Plan. The CCM Model-piloted and tested by LC and the University of Washington-, fits the intention to develop tools for integrative collaborative care model for mental illness. It lists guidelines for collaborative care of mental health with HIV, TB, diabetes, cancer, maternal and child health, child and adolescent health, and health for the elderly. Diabetes

[43] Department of mental health and substance abuse, Mental Health Strategic Plan 2023-2032, December 2023

and maternal and child health will be covered by the project. The CCM model could be easily adjusted to cover each other individual guideline. The project fits also the National Multisectoral Action Plan for the prevention and control of NCDs 2018 to 2027[44]and the Primary Health Care Booster Implementation Framework.[45]

In a nutshell, the project is fully coherent with national Cambodian policies and strategies.

Belgium's development co-operation policy is set out in the 2013 Law on Development Co-operation. In addition to tackling fragility, other policy priorities include a stronger focus on social protection, private sector development, climate change, digital for development and human rights-based approaches. The Partnership for improvement and prevention of Mental Health in Cambodia is coherent with this policy.

Gender and ethnic groups

As laid out are women more affected by mental disorders than men in Cambodia. The program takes this largely into account. There is an emphasis on educating pregnant and lactating women for early detection and prevention, particularly with the next steps of the CMM model. The awareness sessions in the villages are more frequented by women, as the men are out for income gaining activities. There is gender parity observed with the persons employed by LC and with its partners. No discrimination of ethnic groups was mentioned by the interviewees directly asked about it.

In summary, the project pays attention to include vulnerable groups more affected by mental health disorders. The gender perspective is considered and integrated.

3.6 Accounting

The Finance & Administration Manager in Phnom Penh briefly explained the accounting's set-up and procedures.

LC uses *WinBooks*, a standard Accounting/Finance package for the bookkeeping. The books are in Euro, the invoices and salaries are in Cambodian Riel and US Dollar. US Dollar are a fully accepted second currency in Cambodia. There is one bank book and two petty cash books in the system. All receipts and supporting documents are scanned and stored in the system. Three selected random samples of receipts out of the general ledger were quickly available as scan in the system and found correct with supporting documents. The original receipts are stored in Phnom Penh. Headquarter in Belgium has access to all scanned documents via the cloud.

There is one bank account for all project and every transaction has a project code and a separate code for the corresponding funding. Transfers are usually made about quarterly from Belgium in Euro to USD after transfer request. Hence, the project will have exchange gains or losses regarding the Euro based funding.

There is a financial policy and a purchasing policy in place. For purchases less than 500 US$ no quotation is needed, from 500 US$ to 2.000 US$ two quotes are required and above three

[44] Ministry of Health, National multisectoral action plan for the prevention and control of non-communicable diseases 2018-2022, June 2018
[45] Ministry of Health, Primary Health Care Booster Implementation Framework, June 2023

quotes. The purchases are signed by the Finance Manager and the Country Director based on the amounts. Payments are signed by two signatories above 1.000 US $ and four persons have signature right.

The budget is mainly monitored by the Finance and Admin Manager. It is tracked outside of the system in MS Excel. There were some changes to the budget (amongst other things the Euro amounts will be affected by exchange variances). LC is annually audited on headquarter level in Belgium.

In summary, the accounting systems and procedures follow professional standards. There was no indication for any gaps in the Accounting.

3.7 Recommendations and its corresponding Findings and Observations

Table: Recommendations and its corresponding findings and observations

Findings, observations, issues	Recommendations
In Chamkar Leu referral hospital the staff and the patient care facilitators mentioned the lack of a separate (not shared) room for counselling. In general, a lack of confidentiality was observed for the patients, mainly in Chamkar Leu referral hospital.	It is recommended to investigate possibilities for having separate rooms for counselling in both hospitals. In general, confidentiality for the patients should be monitored and refreshed within the trainings to hospital, HC staff and social workers. *(must have priority)*
DSF mentioned the need to continue referrals of patients in need for palliative care and the risk of fading corresponding awareness.	The functioning of the referral processes within the two district hospitals needs to be monitored on a continuous basis. Refresher trainings or coaching on the job for health care staff should be considered if number of referrals drop or stop. *(good to have priority)*
Many milestones will directly affect impact and sustainability results of the project (e.g., adding social work to the Complementary Package of Activities, getting the Collaborative care model by UW scaled up to become the country standard). They depend on advocacy efforts -amongst other points- to be achieved.	LC does advocacy by circumstance and staff attends many meetings. It should be decided if and how far advocacy should be a defined (written, more formalised) activity and strategy. Concrete Advocacy objectives (such as for instance social work added to the CPA or further acceptance and scale up -outside LC- of the CCM or similar models) could be set. A formal strategy may drive the activities in a more structured way. *(good to have priority)*
The project has funding up to 2026. The longer-term strategy is yet not defined. A clear idea of handover or exit (if in 2026 or later) in case is not defined.	A written "exit" or "handover" or "what/if" strategy should be defined. This can be part of an overall longer-term strategy and does not have to be a separate paper. It does not need to set fixed times but should lay out what is needed in terms of results and activities to hand over or end the project, who could be potential

Findings, observations, issues	Recommendations
	handover partners and how can be sustainability, particularly financial sustainability be fostered. *(should have priority)*
The mental health care landscape in Cambodia is scattered. Overall collaboration between NGOs, donors, UN, and authorities (e.g. DMHSA) for mental health care in particular is insufficient and bears substantial potential for improving the mental health care system. LC is fully prepared to coordinate and collaborate but depends largely on official bodies for coordinating the sector and getting involved.	LC – as an important, but not agenda-setting strong actor- has two pathways to improve collaboration and coordination within the mental health care. a) The low fruit: Meet and collaborate with other international (e.g., Johanniter, DSF) and local NGOs including LC's implementing partners to share who does what/where, to advertise own results[46], to discuss standards on allowances and incentives to be agreed, to share barriers and obstacles, to learn from potential "best practices" and to advocate for specific topics. b) More difficult: Continue the dialogue with the authorities (particularly with DMHSA) to show the preparedness for support in coordinating and collaborating in the sector. Apparently the DMHSA plans to set up a Technical Working Group (TWG) to operationalise the National new Mental Health Strategic Plan. It would be good to get invited to this TWG. c) In the scattered landscape of health and social work, not all meetings are pertinent for Mental Health. LC has limited coordination resources and has to make choices. The attendance of <u>general</u> health meetings could be shared amongst partners. *(must have priority)*
Monitoring and measuring the success and contribution of capacity building activities could be enhanced.	It is recommended to think about "before and after" knowledge tests in major trainings to health staff and social workers to measure the gained knowledge. This will help monitoring the impact of activities and can support advertising on the successes. *(good to have priority)*
At present, LC will rather stay in the chosen districts and deepen the ongoing activities – such as expanding the CCM model to pregnant women,	The decision to stay in the present target districts is not challenged by the evaluation. Deepening the activities in the pilot area while for instance expanding the CCM model to other

[46] For instance, WHO was not very aware what LC is doing in mental health in detail.

Findings, observations, issues	**Recommendations**
post-partum mothers and potentially other groups. The alternative is expanding into other districts with more geographic coverage and increased patient flow…if the budget allows this.	diseases and develop the corresponding tools (e.g., HIV, TB, and cancer) or more refresher trainings or adding a counselling room are reasonable next steps. This should be accompanied by documenting the results of the pilots to share the experiences and to scale up successful ideas.
Payments of per diem, transport allowance and other incentives are essential for volunteer work and outreach work of health staff in the communities, as well as capacity building. The various partners are little coordinated in paying uniform or standard rates and even compete non-intentionally.	It is recommended to agree and standardise allowances and incentives across the various implementing directly funded partners. It would be good to aim for uniform rates with other implementing NGOs as well. *(good to have priority)*

4 ANNEX

Schedule of Field Mission

Date/Day	Activity	Remarks
Sun, 21st Jan 2024	Flight from Berlin to Phom Penh via Vienna and Bangkok	Departure in the afternoon
Mon, 22nd Jan 2024	Arrival in Phnom Penh in the evening	
Tue, 23rd Jan 2024	Online meeting with Univ. of Washington team from 9:00-10:00, meeting and exchange with LC team from 10:00-12:00, meeting the department of social work from 14:00-15:00	Departure to Kampong Cham and arrival 18.30h (3 hours' drive) and stay in Kampong Cham province
Wed, 24th Jan 2024	Visit Ou Reang Ov hospital to see consultation, counselling, visit a village campaign organised by TPO, interviews with TPO and govt. staff	
Thu, 25th Jan 2024	Visit Chamkar Leu (consultation, screening), interviews with staff, meeting QI sub-team, visit Chamkar Andoung HC, one home visit with TPO & nurse	Return back to Phnom Penh late afternoon (3 hours drive)
Fri, 26thJan 2024	Meeting TPO team from 9:00-11:00, online interview SSC from 14h to 14.30h, meeting and interview DSF team from 15:30-16.00, 16:30 meeting Director of Preventive Medicine Department/MoH	
Sat, 27th Jan 2024	Meeting Finance and Accounting, notes taking, report writing,	
Sun, 28th Jan 2024	Notes taking, report writing, preparing debrief	
Mon, 29th Jan 2024	Meeting CCAMH team from 8:30-10:00 Meeting Humanity and Inclusion from 11:00-12:30, further interviews, debriefing with LC team	
Tue, 30th Jan 2024	Meeting WHO from 8:30-9:30, meeting Johanniter International from 10:00-11:30, flight out to Bangkok in the early afternoon	Flight from Phom Penh to Berlin via Bangkok and Munich
Wed, 31st Jan 2024	Arrival home at 10.30 am	

List of contacts (Interviews, group discussions)

Name	Organisation & Function	Date
Dr. Thann Khem	Uni4Coop Cambodia, Health Programme Manager	Exchange on several days
Philippe Devaud	Uni4Coop Cambodia, Country Director	Exchange on 23rd Jan and 29th Jan 2024
Christine Baggio	Louvain Coopération, Business Officer	Exchange on several days
Phal Oudamsambath	Vice Head of Dept., Department of Social Work, Royal Univ. of Phnom Penh	Interview 23rd Jan 2024
Ung Kimkanika	Head of Dept., Department of Social Work, Royal Univ. of Phnom Penh	
Dr. Lesley E. Steinman	Research Scientist, school of Public Health, University of Washington/Seattle	Online talk and Q&A, 23rd Jan 2024
Dr. Tracy W. Harachi	Prof. in School of Social Work, University of Washington/Seattle	
Dr. James P. LoGerfo	Prof. in Department of Global Health in the Schools of Medicine, University of Washington/Seattle	
Dr. Heng An	District Hospital Ou Reang Ov, Hospital Director	Courtesy visit, 24th Jan 2024
Dr. Yean Seang Hong	District Hospital Ou Reang Ov, Deputy Hospital Director, Mental Health Responsible	Interview, 24th Jan 2024
Dr. Han Chinheat	Ou Reang Ov, Operations District Director	Interview, 24th Jan 2024
Heng Kanha	TPO, Social worker in Ou Reang Ov	Interview, 24th Jan 2024
Seang Leap	TPO, Project Coordinator, Psychologist	Interview, 24th Jan 2024
Nhan Chanthon	Vice Chief Commune Council, Women's Council Ou Reang Ov	Interview, 24th Jan 2024
Kea Raksmey	Louvain Coopération, Patient Care Facilitator Chamkar Leu	Interview, 25th Jan 2024
Korn Saren	Louvain Coopération, Patient Care Facilitator Chamkar Leu	Interview, 25th Jan 2024
Noun Bopha	TPO, Social Worker Chamkar Leu	Interview, 25th Jan 2024
Kok Sithanit	Louvain Coopération, Health Technical assistant	Interview, 25th Jan 2024
Bun Thea	Andoung Health Center, Mental Health Counsellor, Nurse	Interview, 25th Jan 2024
Dr. Heng Dane	Referral Hospital Chamkar Leu, Deputy Director	Group Interview, 25th Jan 2024
Im Souchoeun	Referral Hospital Chamkar Leu, Counselor	
Khim Kosal	Referral Hospital Chamkar Leu, Counselor	
Loeung Rathstheary	Referral Hospital Chamkar Leu, Counselor	
Hok Leanghuo	Referral Hospital Chamkar Leu, Counselor	
Dr. Chhim Sotheara	TPO, Executive Director	Group Interview, 26th Jan 2024
Dr. Ang Sody	TPO, Senior Psychiatrist	
Taing Sopheap	TPO, Deputy Director	
Seang Leap	TPO, Project Coordinator, Psychologist	

Name	Organisation & Function	Date
Khaylay Heang	Former Social Services Cambodia, now advisor on Mental Health and other programs, now Lecturer National Inst. Of Social Affairs	Online interview 26th Jan 2024
Claire Robaye	Douleurs Sans Frontières, Country Director	Interview, 26th Jan 2024
Prak Kanika	Douleurs Sans Frontières, Medical Coordinator	
Pierre Migne	Douleurs Sans Frontières, Administrative Coordinator	
Dr. Kol Hero	Ministry of Health, Director of the Preventive Medicine Department	Interview, 26th Jan 2024
Dr. Muy Senghorn	Ministry of Health, Deputy Director of the Preventive Medicine Department	
Kuntha Lim	Louvain Coopération, Finance & Admin. Manager	Interview, 27th Jan 2024
Sok Dearozet	Caritas-Center for Child and Adolescent Mental Health, Program Manager	Interview, 29th Jan 2024
Dr. Jegannathan Bhoomikumar,	Caritas-Center for Child and Adolescent Mental Health, Program Director	Interview, 29th Jan 2024
Peng Iyamato	Caritas-Center for Child and Adolescent Mental Health, Community Health Nurse	Interview, 29th Jan 2024
Bora Khorn	Humanity & Inclusion, SHARE Project Manager	Interview, 29th Jan 2024
Dr. Nargiza Khodljaeva	WHO Cambodia, Technical Team lead	Interview/exchange, 30th Jan 2024
Dr. Yel Daravuth	WHO Cambodia, Technical Advisor	
Anette Müller	Johanniter International, Regional Lead Southeast Asia	Interview/exchange, 30th Jan 2024
Connie Pomposa	Johanniter International, Regional Funding Coordinator	
Huon Borany	Johanniter International, Country Manager	
Kov Soriya	Johanniter International, Program Manager	

Main documents as basis for the evaluation

1) Louvain Coopération, Project Application to EKFS, *Partnership for Improvement and Prevention in Mental Health – Cambodia*
2) Louvain Coopération, Fiche Projet, DGD 2022-2026 – Health Cambodia, *Partnership for Improvement and Prevention in NCDs (PIP-NCD)*
3) McLaughlin D &Wickeri E (2012) Special Report: Mental Health and Human Rights in Cambodia, Fordham International Law Journal, L Volume 35, Issue 4 2017
4) Seponski, D. M., Lahar, C. J., Khann, S., Kao, S., & Schunert, T. (2019). Four decades following the Khmer rouge: sociodemographic factors impacting depression, anxiety, and PTSD in Cambodia. Journal of Mental Health, 28(2), 175-180.
5) Parry, S.J., Ean, N., Sinclair, S.P. *et al.* Development of mental healthcare in Cambodia: barriers and opportunities. *Int J Ment Health Syst* **14**, 53 (2020). https://doi.org/10.1186/s13033-020-00385-4
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7) World Health Organization, Addressing violence against women in Cambodia: The health system response,2015. https://apps.who.int/iris/bitstream/handle/10665/201705/WHO_RHR_15.25_eng.pdf?sequence=1.
8) Parry SJ, Wilkinson E. Mental health services in Cambodia: an overview. BJPsych Int. 2020 May;17(2):29-31. doi: 10.1192/bji.2019.24. Epub 2019 Nov 13. PMID: 32558820; PMCID: PMC7283113.
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10) Maddock, A., Ean, N., Campbell, A. *et al.* Mental health service accessibility, development and research priority setting in Cambodia - a post-conflict nation. *BMC Health Serv Res* **23**, 183 (2023). https://doi.org/10.1186/s12913-023-09187-z
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12) WHO Cambodia, Country Cooperation Strategy 2016–2020, 2016
13) WHO, World mental health report, Transforming mental health for all, 2022.
14) Chisholm D, Saxena S. Cost effectiveness of strategies to combat neuropsychiatric conditions in sub-Saharan Africa and Southeast Asia: mathematical modelling study. BMJ. 2012;344:e609.
15) Ministry of Health, *National multisectoral action plan for the prevention and control of non-communicable diseases 2018-2022*, June 2018
16) Department of Planning and Health Information, *Health Strategic Plan 2016-2020,* May 2026
17) Royal University of Phnom Penh's (RUPP) Department of Social Work and the University of Washington's (UW) Schools of Medicine, Public Health, and Social Work, PIP-NCD Program: *Assessment of the Chamkar Leu Operational District in Kampong Cham and capacity to improve access to and quality of mental health care using a Collaborative Care Model,* 28 Feb 2023
18) Phnom Penh Consulting Research Institute Co. Ltd, *Knowledge, Attitude, and Practice (KAP) Survey Mental Health & Non-Communicable Diseases Ou Reang Ov and Chamkar Leu Operational Districts,* March 2023
19) Department of mental health and substance abuse, *Mental Health Strategic Plan 2023-2032*, December 2023
20) Ministry of Health, *Primary Health Care Booster Implementation Framework,* June 2023
21) WHO, mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings Version 2.0
22) Ministry of Health Cambodia, Guidelines on Minimum Package of Activities, 2018
23) Ministry of Health Cambodia, Guidelines on Complementary Package of Activities for Referral Hospital Development, June 2014

24) Louvain Coopération, Summary report on projects' achievements for 2022 to the Ministry of Foreign Affairs and International Cooperation and the Ministry of Economy and Finance, 28 Feb 2023
25) Louvain Coopération, Summary report on projects' achievements for 2023 to the Ministry of Foreign Affairs and International Cooperation and the Ministry of Economy and Finance, 15 Feb 2024
26) Department of Mental Health and Substance Abuse, MoH, Mental Health and Substance Abuse Services in Cambodia, Power point Presentation

One Patient interview

Patient testimony

One woman of 58 years interviewed (with consent) at Ou Reang OV hospital. She comes to the hospital for four months. She lives about three kilometres from the hospital and comes by motorcycle. She came mainly to the hospital as the medication (high blood pressure, sleeping pills, headache), but also for counselling with the nurse as she has symptoms of anxiety and depression. She was referred by the village chief, who was trained by the social worker (TPO) on the selection criteria.

She was very happy with the nurse because she was listening to her problems. She feels better because of the counselling. The medicine she got for free (as per the poor fund). Before she had to buy the medication at the pharmacy. She only had to pay 6.000 riel (1,5 US$) for registration.

Images from the project visit (photos by Christine Baggio and H. Henghuber)

Awareness raising in the village by TPO social worker in Ou Reang Ov District

Patient Health Care Facilitators in Chamkar Leu district hospital

Signing for Mental Health Department in Chamkar Leu district hospital

Example of developed IEC material as used in awareness raising activities (picture by Christine Baggio/LC)

District Referral Hospital in Chamkar Leu

Terms of Reference of the mid-term evaluation of the project

Partnership for Improvement and Prevention
in Non-Communicable Diseases (PIP-NCD) 2022 – 2026

The project to be evaluated is the project *Partnership for Improvement and Prevention in Non-Communicable Diseases (PIP-NCD) 2022 - 2026*, funded by the DGD and EKFS. The project's intended outcome is **to improve the availability, accessibility, and quality of mental health services in two Cambodian districts, together with the general prevention of NCDs, taking into account the differentiated impact on men and women**. It is implemented by Louvain Cooperation through partnerships and collaborations with a broad range of civil society organisations, central and local government institutions, and universities. A project fiche, describing the main features and the status of implementation of the project as of November 2023 is attached to these ToRs.

The evaluation form for the project is based on the GIZ evaluation sheet, which is also used for the BMZ / EKFS clinic partnership projects. It addresses the topics **(a) relevance, (b) effectiveness, (c) sustainable impact, (d) efficiency, (e) particularities and (f) accounting**. In addition, the evaluation will formulate **(g) key findings and recommendations** to guide and improve the implementation of the activities until the end of the project and to tackle the issues that have been identified.

Each thematic complex is subdivided into several sub-questions, the answers of which will form a report in the range of 20 to 30 pages will be submitted to the board of trustees of EKFS and to Louvain Cooperation. Before being finalised, a draft version of this report will be submitted to Louvain Cooperation for its review and comments.

Evaluation form for the project

(a) **Relevance (Does the project do the right thing?)**

Development policy reference:

- Have national and / or local health strategies or policies been adequately considered in project planning?
- Is there a plausible explanation of how the project contributes to the development of the partners, institutions, and the target region(s) through its technical and regional orientation?
- Does the project contribute to the achievement of SDG3 (Ensuring a healthy life for all people of all ages and promoting their well-being)?

Target group references:

- Does the project address a relevant problem of the local population?
- Does the project ensure that vulnerable groups benefit from the project activities?

Participatory Planning:

- Has the needs of local and German partners been identified together and has the project been planned and designed jointly?
- Have local key actors been involved in the planning of the project?

Rights and Ethical guidelines:

- Are gender aspects (in terms of Do-No-Harm) taken into account in project planning?
- Is project implementation ethically and politically justifiable?

(b) ***Effectiveness (Can the goals of the project be realistically achieved?)***

Traceability and impact logic:

- Is the project planning and implementation promising in view of the described needs / problem analysis?
- Is there a clear link between the activities and the objective of the project? Do the activities appear suitable to achieve the project objective?
- Does the project follow comprehensible impact logic? Are activities and project goals as well as indicators assigned to each other in a meaningful way?
- Are the project goals realistically achievable with the existing staff and expertise?

Measurability and feasibility:

- Are there initial values for the indicators to be measured (baseline)?
- Are suitable measuring instruments chosen to collect data?
- Do the named target values appear realistically achievable?

(c) ***Sustainable impact (Are the positive effects of the project likely to be sustainable?)***

Strengthening local structures:

- Will local structures be strengthened in the longer term through their involvement in the project and through cooperation?

Capacity development:

- Does the project contribute to capacity development at the human and institutional level in the partner country?
- Does the project contribute to the optimization of processes?

(d) ***Efficiency (Are the objectives of the project achieved economically?)***

- Do the resources used appear proportionate to the planned services and intended effects? (For example, is the budget well thought out, are finances planned realistically, is the number of budgeted trips appropriate?)

(e) ***Particularities***

Are there other positive unique selling points of the application that confirm the eligibility? Special features may include, but are not limited to:

- Does the project contain promising innovations?
- Is there already a well thought out monitoring concept?
- Does the applicant have a positive experience with similar projects?
- Does the applicant have regional experience / experience in low or low - income countries?
  middle income?
- Are the learning outcomes and improvements that the project aspires to be potentially in one?
- larger context transferable (up-scaling)?
- Is the local partner particularly interesting and promising?
- Are questions dealt with that are of particular relevance to German development cooperation?
- Are gender aspects, vulnerable groups and inclusion particularly taken into account?
- Is the project following a multi-sector approach?
- Is a triangular cooperation implemented in the project?

(f) ***Accounting***

- What is your impression of accounting and local financial management?

(g) **Findings and recommendations**

- What are the main findings in terms of strengths and weaknesses of the project?
- What are the actions that should be envisaged and / or taken in order to address the issues faced by the project and to improve its performance?
