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IMPACT EVALUATION OF CAMBODIA'S IMPLEMENTATION OF THE SOCIAL ACCOUNTABILITY FRAMEWORK

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Abbreviations

| | |
|--------------|---|
| CAF | community accountability facilitator |
| CBO | community-based organization |
| CIP | commune investment program |
| CSC | community scorecard |
| CSO | civil society organization |
| DFGG | Demand for Good Governance Project |
| I4C | Information for Citizens |
| ISAF | Implementation of the Social Accountability Framework |
| JAAP | joint accountability action plan |
| NGO | nongovernmental organization |
| OLS | ordinary least squares |
| PECSA | Program to Enhance Capacity in Social Accountability |
| RCT | randomized controlled trial |
| RGC | Royal Government of Cambodia |
| ToC | theory of change |

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Disclaimer:

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Executive Summary

The Implementation of the Social Accountability Framework (ISAF) is a program of the Royal Government of Cambodia (RGC), jointly implemented with civil society organizations, that was designed to increase the government's capacity to implement social accountability approaches in 98 of Cambodia's 159 rural districts from 2016 to 2018. The social accountability approaches promoted by ISAF included the development of citizen-state feedback mechanisms to empower citizens to provide comments to service providers on the quality of critical public services in rural areas in Cambodia. These service providers included commune councils, which are directly elected bodies with small development budgets that provide basic administrative services. It was envisioned that, by mobilizing citizen demand and increasing government actors' understanding of social accountability, ISAF could improve the quality of basic services and, eventually, broader service delivery outcomes. ISAF was integrated into the RGC's annual local government planning and resource allocation processes so that it could harness synergies with ongoing decentralization reforms and establish sustainable social accountability processes.

ISAF integrates social accountability tools across three sets of service providers: health centers, primary schools, and the commune council. The program integrated social accountability approaches into local government through three main components: access to information and budget, citizen monitoring, and facilitation and capacity building. Under access to information and budget, the RGC published information related to service standards in simple information for citizen (I4C) packets pertaining to the three service providers, their budgets, and annual expenditures. These were disseminated primarily through village-level meetings attended by 551,913 villagers (396,487 women, 155,426 men.) ISAF also trained 16,644 government officials in the provision of I4C data and ISAF processes. Under citizen monitoring, villagers monitored the quality of services provided by 757 commune councils, 1,404 primary schools, and 605 health centers using citizen scorecards. Under facilitation and capacity building, ISAF mobilized 4,200 (2,605 women, 1,595 men) community accountability facilitators to disseminate information and facilitate the citizen scorecard process. The goal of this systematic approach was to increase transparency, responsiveness, and accountability in the provision of local services and emphasize citizen engagement in all aspects of programming. The total program investment from government and donors was nearly USD13 million.

The impact evaluation of ISAF was a multiyear randomized controlled trial (RCT) comprising baseline surveys administered in March and April of 2017 and endline surveys administered in April and May of 2019. The impact evaluation identifies the effect of ISAF interventions on villagers' demands for high-quality services from the commune administration, primary education providers, and basic health care providers, as well as their awareness of service standards. The impact evaluation also identifies the effect of ISAF interventions on the supply of high-quality education, health care, and commune services to villagers. The study sample consisted of 3,363 households in 168 communes across 42 districts in 15 provinces. Each of the 42 districts was assigned to the treatment or control group using matched-pair cluster randomization. The 21 treatment districts received ISAF interventions between April 2017 and December 2018. Areas where implementation was funded by the World Bank had 20 months of implementation, whereas other areas where implementation was funded by the U.S. Agency for International Development and the European Union had 13 to 16 months of implementation. The 21 control districts did not receive any ISAF interventions. Survey instruments included a household questionnaire and separate leader questionnaires targeting three groups of service providers (commune councils, primary schools, health centers) and village heads. The effects of ISAF are identified by comparing changes in outcomes of interest in treatment areas with changes in outcomes of interest in control areas. A summary of indicator results used in the report are included in appendix A, and a full set of results for all indicators from the five survey instruments is found in four spreadsheets published along with this report.

The impact evaluation is expected to inform funding and design decisions of national authorities, nongovernmental organizations, bilateral donors, and the World Bank related to future social accountability activities and the broader decentralization and deconcentration reform program. The results of the impact evaluation are specifically intended to inform the National Committee for Subnational Democratic Development Secretariat, which is the agency leading the reform program and coordinating with nongovernmental organizations who are implementing social accountability activities in Cambodia. By providing a rigorous assessment of a major national social accountability program, the impact evaluation is also of relevance for a global audience regarding lessons on implementing and evaluating such interventions.

Citizen Awareness of Rights to Services, Service Standards, and Budgets

ISAF increased awareness of village chiefs but had limited effects on citizen awareness of their rights vis-à-vis commune services. ISAF had no effect on whether villagers were aware of their right to attend meetings without an invitation or how much they knew about the responsibility of commune officials to be responsive to citizen concerns and to be transparent. As a result of ISAF, villagers were slightly more aware that commune officials must post information about meetings, budgets, fees, and other commune activities, but ISAF interventions had no effect on citizens' awareness of their rights to and standards for primary schools and basic health care. Village chiefs were 10 percentage points more aware of the commune budget in treatment than in control areas, which suggests that ISAF may have reinforced the role of the village chiefs as a conduit between the commune and citizens and may thereby increase awareness of the budget and other areas of commune functioning in the future.

The nature of the intervention or contextual factors could have attributed to the inability of ISAF to increase citizen awareness. Citizens' understanding of rights to basic services generally increased between baseline and endline, which suggests that other initiatives are increasing awareness of basic service standards. The inability of the ISAF interventions to significantly affect citizen awareness suggests that participation by villagers in ISAF activities designed to increase awareness was limited and/or that participating villagers failed to absorb specific information that those activities provided. For instance, only 50 (2.7%) respondents in treatment areas claimed to have participated in an ISAF event. Also, I4C data was shared with citizens approximately 1 year before the endline survey, so it is likely that retention of the information faded over time.

Levels of Citizen Engagement

While there was a slight increase in citizen engagement in the education and health sectors, **ISAF effects on citizen engagement with respect to the activities of the three service providers was overall not significant.** Across the treatment and control groups, there was a slight increase in citizen engagement between baseline and endline in the education and health care sectors and a decline in participation in commune administration activities. ISAF interventions did not cause more people to attend or speak at commune meetings or to engage more in commune investment program (CIP) development. ISAF had no effect on attendance at village-level meetings or frequency of village meetings and reduced the extent to which villagers discussed commune-, health care-, and education-related topics with other villagers. ISAF had no significant effect on villagers' engagement with schools or health care centers.

A critical barrier to citizen engagement at the commune level is lack of awareness of the rights of all citizens to attend commune meetings without an invitation. Despite ISAF awareness-raising regarding the rights of citizens to participate without an invitation, citizens thought that they needed to be invited to attend commune meetings. Although there was significant improvement from baseline to endline in the treatment and control groups, a large percentage of commune councilors and a significant percentage of village chiefs reported that citizens did not take part in commune meetings because "citizens cannot participate without an invitation." The lack of significant effect on citizen engagement in education and health potentially reflects a lack of linkages between ISAF and other community feedback mechanisms, and a lack of a tradition of participation overall.

The lack of impact of ISAF on citizen engagement may reflect an inability to affect awareness of citizen rights to participate in commune level governance. Although the design of the project was predicated on the assumption that citizen involvement in ISAF activities, such as community scorecards and interface meetings with service providers, would empower citizens to participate in other community activities, such as parent-teacher and village health committee meetings, the program did not directly facilitate such participation.

Service Delivery Quality and Outcomes

ISAF improved commune transparency, but had no effect on quality of registration services.¹ Although ISAF had no effect on the speed of registering birth, death or marriage events or the paying of informal payments, the quality of commune service provision was observed to be high in the treatment and control groups, with 55 percent of respondents receiving the registration certificate from their respective commune office in less than 1 day at endline from when they applied.² As a result of ISAF, communes in treatment areas were 28 percentage points more likely to post working hours, 16 percentage points more likely to list commune office staff, 16 percentage points more likely to list service fees, 26 percentage points more likely to display the CIP, 48 percentage points more likely to display the budget, 35 percentage points more likely to post information on the commune's expenditures for the services it provides, and 19 percentage points more likely to show the level of CIP expenditure for 2018.

ISAF had a mixed effect on quality of services provided in primary schools. ISAF interventions had no effect on teacher behavior and actually increased the probability of parents paying to enroll their children in primary school. ISAF interventions, however, increased transparency, with schools being 13 percentage points more likely to post budgets and improved some school facilities, with schools in treatment areas being 19 percentage points more likely to have hand-washing facilities in the classroom. ISAF had no effect on the access of enrolled children to textbooks, class size, or the probability that a school-age child was enrolled. The fact that parents' decisions on enrollment appear to be primarily related to economic constraints—which is not addressed in ISAF's key interventions—may explain the lack of an effect of ISAF on education outcomes. Furthermore, overall improvements in education services in control and treatment areas may indicate that other initiatives were more important drivers of improvement, such as efforts of the Ministry of Education, Youth, and Sport to promote access to textbooks and decrease the student-teacher ratio.

ISAF had some effect on quality of health center services. ISAF interventions had no effect on health center staffing levels, wait times, or payment of informal fees but reduced the incidence of payments for prescribed medicine by 25 percentage points. Health centers overall were more transparent as a result of ISAF, being 24 percentage points more likely to post their budgets. ISAF caused a 7 percentage point increase in the proportion of villagers who received a clear explanation of their condition, a 10 percentage point increase in the willingness of villagers to seek treatment at health centers, a 4 percentage point reduction in the proportion of villagers who experienced rude staff, and a 6 percentage point reduction in the proportion of villagers who perceived that they had to wait before treatment. ISAF had no effect on completeness of vaccinations.

Conclusions and Forward Look

Specific behaviors, processes, and service improvements that need to be influenced should be identified, including participatory opportunities in the education and health care sectors. The impacts of ISAF interventions are not detectable across a wide range of outcomes, including citizen awareness, citizen engagement, and service quality areas. ISAF interventions, however, increased dissemination of information by service providers and led to some modest improvements in school and health center services, including an increase in use of health centers. The limited effect of ISAF on other outcomes may be due to the complexity and broad coverage of the program, which may have diluted effects in a range of service areas. In addition, the presence of other service improvement investments in control and treatment areas may have overwhelmed the more limited impact of ISAF interventions.³

The results of the impact evaluation suggest the importance of using modern modalities for information dissemination and linking efforts to increase awareness of rights to specific services with efforts to increase awareness of basic legal rights. The impact evaluation suggests that dissemination of information using physical modes such as posters is not effective as hoped. Although citizens who have participated in ISAF events have highly rated in-person awareness-raising sessions, knowledge generated by these sessions have apparently not spilled over to others in the community who did not directly participate.

Future research may explore how to better understand how investments in citizen engagement can account for the existing power dynamics in society or how social accountability can guide improvements in basic services. Community power dynamics exist in terms of relationships between citizens, village chiefs, commune council members, and other local leaders. Future research may explore how to better understand how social accountability tools reconfigure such relationships within villages and between villagers and service providers and to understand the challenges and opportunities for marginalized populations regarding awareness-raising and engagement.

1.1 Introduction

The impact evaluation of the Implementation of the Social Accountability Framework (ISAF) was a multiyear randomized controlled trial (RCT) that measured changes outside of the immediate program context, especially whether ISAF increased citizens' awareness of and demand for critical rights and service standards in relation to the commune's administrative services, primary education, and basic health care (demand side). It also measured changes in the quality of education, health care, and commune services provided to villagers in rural Cambodia (supply side). Stakeholders on the demand side included citizens needing services, and those on the supply side included service providers responsible for supplying services. Local nongovernment organizations (NGOs) were included in the demand side because they mediate between citizens and the government and thus channel demand. Village chiefs were included in the demand side because they are ordinary citizens residing in villages as well as conduits between commune councils and villages.

The evaluation assessed the effect of the program in 42 districts in 15 provinces: 21 treatment districts and 21 control districts. The treatment districts received ISAF interventions from April 2017 to December 2018 and had no major variations in how activities were conducted aside from differences in the implementation period and use of different dissemination strategies. Two implementing partners finished earlier because of different donor arrangements, which are discussed further in section I.iv. Control districts did not receive any ISAF interventions during this period. The districts were jointly selected with the implementing partners; selection criteria are discussed in part II.

The analysis was structured on a series of evaluation questions based on the Theory of Change (ToC) laid out in the concept note for this impact evaluation (World Bank 2016). The four main questions were what the effect of ISAF interventions was on the quality of primary education, health care services, and services provided by local leaders and on the engagement of villagers in local governance

The impact evaluation drew on data from the baseline and endline surveys. The baseline survey was administered in March and April 2017, before ISAF intervention, and covered 1,682 male and 1,681 female villagers from 3,363 households. For local leaders, 168 primary school principals, 140 health center leaders, 168 commune council leaders, and 336 village chiefs were interviewed. The endline survey was administered in April and May 2019 and covered 1,544 male and 1,817 female villagers from 3,361 households. The goal was to interview the same households at baseline and endline, but 340 respondents could not be found at endline because they had moved in the interim.

The report is divided into four parts: Part I provides background information on ISAF and the country context and discusses the literature on social accountability. Part II details the research design and data collection methods. Part III outlines the results on the demand and supply sides. For the demand side, the results focused on changes in awareness and levels of citizen engagement. For the supply side, changes in the quality and outcomes are discussed according to service sector. Part IV offers conclusions related to the demand and supply sides and recommendations for future research.



1.1.1 Overview of ISAF

ISAF, a program of the Royal Government of Cambodia (RGC), was designed to increase the capacity of government actors to create opportunities for citizen engagement to inform and empower nonstate actors, including local NGOs and community-based organizations (CBOs). ISAF was integrated into the RGC's subnational government system so that it could harness synergies with ongoing governance reforms and initiatives. ISAF was implemented from 2016 to 2018 in 98 of Cambodia's 159 rural districts. The program covered all communes within each district, including all health centers and commune councils, but not all primary schools because there were too many for the implementing partners to cover. The total investment of the program for demand-side financing of NGOs and supply-side financing to government was nearly USD 13 million. It is the most systematic intervention to integrate social accountability tools into the local government system in the country.

Box 1: Social Accountability in Cambodia

The goal of encouraging social accountability in the Cambodian context was to increase transparency, responsiveness, and accountability in the provision of local services. Citizen engagement in all aspects of programming was emphasized. The Implementation of the Social Accountability Framework (ISAF) introduced tools to raise awareness of citizens, especially women and poor and other marginalized groups about their rights and responsibilities relative to public service delivery and access to budget and expenditure information. ISAF also promoted tools such as the community scorecard that channeled citizens' voices or demands to improve services. Furthermore, ISAF provided a platform for constructive engagement between citizens and government through systematic citizen monitoring of services, creating an evidence base to inform the government's reform efforts.

ISAF had three main subcomponents: access to information and budget, citizen monitoring, and facilitation and capacity building.¹

- > **Access to information about right to services, quality standards, and budget and expenditures:** Each of the relevant line ministries outlined, based on existing government policies, a set of core citizen rights to service delivery and minimum standards of quality services for primary education, primary health care, and local government and commune services. These data were compiled into an easy-to-access Information for Citizens (I4C) package, which the government designed, printed, and posted in accessible locations in villages and included simple, user-friendly posters with information on the annual budget and expenditures for each service provider, the previous years' service performance according to the specified standards, and other related information on the rights and responsibilities of service providers and service users. Community accountability facilitators (CAFs), who are independent volunteers, disseminated the I4C packages in village-level meetings. The implementing partners used other dissemination strategies discussed in section I.iv.ii. The objective was to enhance citizens' awareness of their rights and service standards so that they could be more informed and empowered to demand better-quality services and hold service providers accountable.

¹ Learning and monitoring was a fourth component but is not discussed here because it is not integral to the ToC.

- > **Citizen monitoring:** CAFs led discussions with villagers regarding their experiences with local services. This feedback was captured in a community scorecard (CSC), a tool that allowed villagers, as residents and users of services, to rank the performance of their commune council, primary school, and health center. The service guidelines that the RGC established and outlined in the I4C packages informed the rankings, although citizens were free to identify any aspect of service delivery they considered to be important and to rank the quality of service delivery according to those standards. Once priority service areas were identified and agreed upon, participants scored them on their relative strengths and weaknesses. CAFs also facilitated among service providers and helped them complete self-assessments based on service providers' understanding of how well their performance aligned with the government's guidelines on service provision. Service providers and users then came together to compare their scorecards and develop a list of common priorities for service improvement for each service provider. These priorities were captured in joint accountability action plans (JAAPs) that were publicly disseminated at commune and district-level events, including the district integration workshop, which is part of the annual district planning process that various line ministry and civil society representatives attend. The district integration workshop provided an opportunity to identify resources needed to address JAAP priorities. JAAPs informed decision-making about the local investments and actions that service providers, commune councils, and civil society actors take. In particular, the JAAPs informed the priorities of the annual commune investment program (CIP). In this way, the design of ISAF was intended to maximize the use of existing structures and mechanisms to promote change. The JAAPs also guided investment by community members and philanthropists and resource allocation by line ministries, such as deployment of staff and supplies.
- > **Facilitation and capacity building:** ISAF was designed to help state and nonstate actors assess and improve service delivery outcomes. The demand-side, nongovernmental implementing partners recruited CAFs to support all community-level ISAF activities, from dissemination of I4C information to implementation of CSCs, and preparation, dissemination, and follow-up on the JAAP. CAFs were community representatives who are supposed to ensure representative participation of vulnerable and marginalized groups (e.g., women, youth, ethnic minorities) during village meetings; they also prepared participants to assess local authorities and service providers, facilitate an inclusive environment in which government and nonstate actors can organize meetings, and manage tensions and conflicts that may arise.

1.1.2 Theory of Change

The ISAF ToC is depicted in figure 1, where each intended effect is labeled with a letter that corresponds to the discussion below. ISAF had short-, intermediate-, and long-term outcomes related to demand and supply.

Box 2: Concepts of Demand and Supply

The theory of change is organized around concepts of demand and supply. These terms are useful because they refer to the relevant stakeholders and imply the process that the Implementation of the Social Accountability Framework (ISAF) is intended to affect. Demand-side stakeholders include citizens, community accountability facilitators, and local nongovernmental organizations who require quality services; supply-side stakeholders are service providers. Through awareness-raising and monitoring, the goal of the ISAF was to increase informed demand for services and improve delivery of services to match demand. The idea is that shared understanding of service delivery needs and priorities by the demand and supply sides can induce and sustain service delivery reforms and improvements in service delivery quality and outcomes.

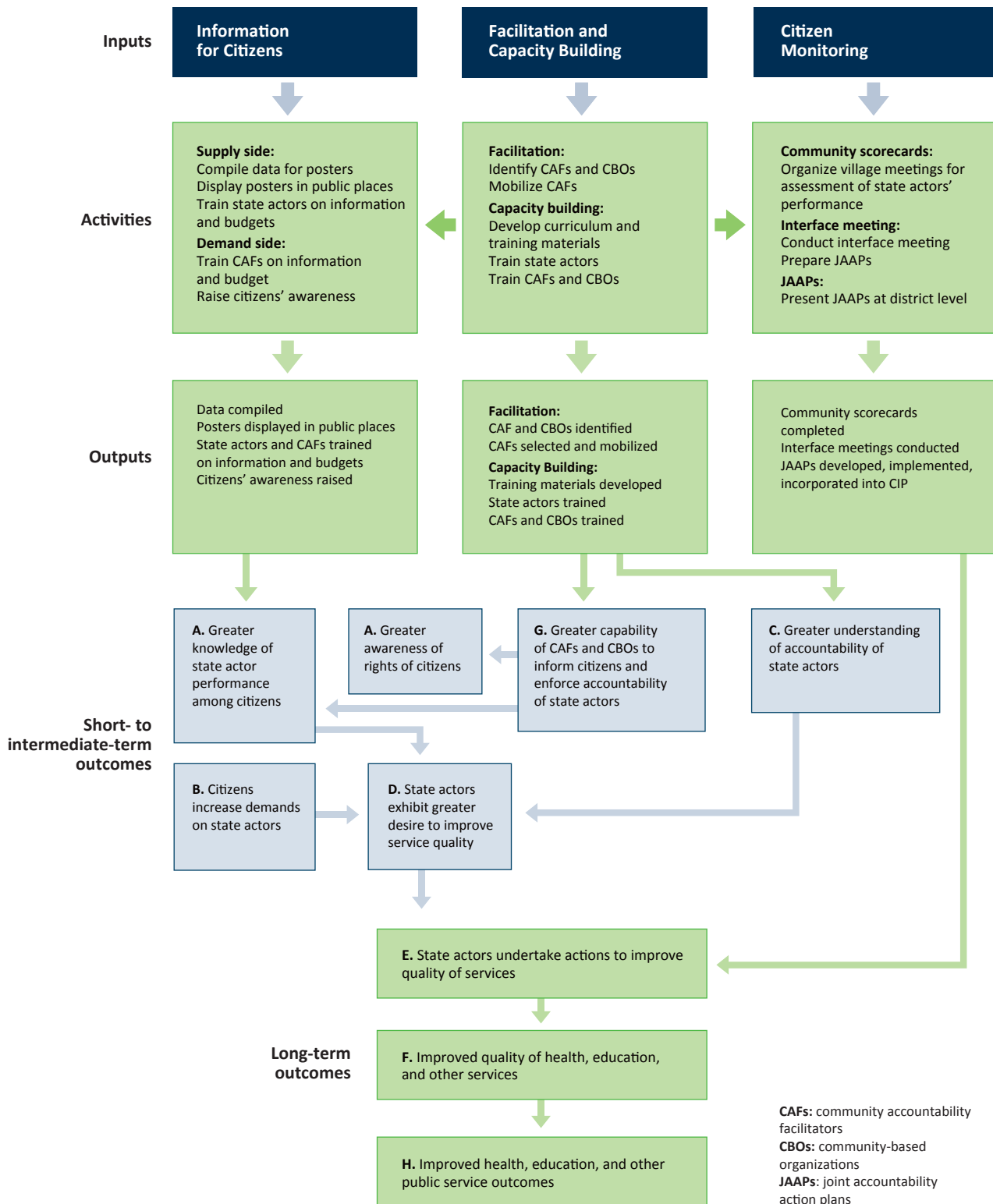


Figure 1: Theory of Change for Implementation of the Social Accountability Framework

For the demand side in the short term, the goal of ISAF was to increase the knowledge of citizens regarding services received from the commune, primary schools, and health centers (A). The I4C initiative provided information for citizens on their rights and quality standards in relation to services, knowledge related to performance of state actors, and the budget and expenditures of each service provider. The idea of service delivery as a public good to which citizens are entitled rather than a bequest by the government is built into I4C. Similarly, ISAF was designed to raise awareness of service providers regarding their responsibilities or minimum service standards that the RGC established, to improve their understanding of accountability and to encourage them to be responsive to citizens (C). It was assumed that, if citizens had greater knowledge and awareness of their rights and more trust in the government, as evidenced by greater understanding of accountability among government actors (C), they would be more likely to increase their demands on the service providers to improve services (B), leading to a positive cycle of reform. The expected increase in citizen demands was based on the assumption that a gain in knowledge would lead citizens to raise their voices and engage in village- and commune-level affairs. That is, it was hypothesized that a gain in knowledge would build confidence and empower citizens, mitigating the traditional power inequity between citizens and service providers in Cambodia.

Through tools such as CSCs and JAAPs, ISAF also increased understanding of accountability and the anticipated increase in citizen demand (B and C). CSCs were envisioned as a way to foster awareness and ownership. The process of identifying particular elements to score, informed by I4C, could theoretically help people gain deeper knowledge of services and existing performance and shift the focus from the idea of services belonging to the government to the concept of them belonging to the citizens. It was also hypothesized that the fact that scores were collectively assigned would propel citizens to increase their collective demands by creating a common focus and a set of priorities and would drive a process of identifying areas for improvement and actions to be taken. Collective scoring can also decrease risks associated with participation.

The JAAP, to which citizens and service providers contributed, was designed to align service providers and users on the priorities of service delivery. That is, the JAAP allowed both sets of actors to better understand each other's needs and challenges, leading to a more respectful working relationship and, theoretically, the ability to better negotiate priorities. The JAAP was intended to strengthen existing commune decision-making structures through priorities that villagers and service providers negotiated and the CSC informed. A better working relationship and deeper understanding of responsibility and needs were factors that were seen to create incentives for service providers to be more responsive (D). The role of intermediaries, such as CAFs and CBOs, was important in joining the two sides and fostering trust (G). Because CAFs and CBOs channel collective citizen demand, they were seen to be part of the demand side.

Providing the line ministries with data on service gaps that citizens identified over time and concrete recommendations was expected to lead to actions to improve the quality of services. The JAAP was intended to lead to improvements in the quality of education, health care, and commune services (F) and, over time, better outcomes in education, health care, and other services (H). The implementation cycle of ISAF coincided with the annual commune planning cycle so that the inputs from the JAAP could inform the local planning and budgeting process. Through the district integration workshop and other interactions with officials from other line ministries, the JAAP was intended to effect broad change in primary education and basic health care. This alignment was also designed to promote the representative function of the commune, the primary entity that coordinates between citizens and service providers and advocates for citizens' rights within the government.

1.2 Country Context

ISAF was designed to contribute to Cambodia's ongoing decentralization and deconcentration reforms by increasing the responsiveness of subnational authorities to citizens, a core and fundamental principle of the reform program. Cambodia initiated its decentralization policy in 2001 through the establishment of commune councils, representative bodies that citizens elect directly through the Commune/Sangkat Law and the Law on Commune Elections. Commune councils comprise five to 11 council members elected through a party list system. The Ministry of Interior appoints a commune clerk, a low-level civil servant to support the council, particularly in providing registration services. The government adopted the Strategic Framework for Decentralization and Deconcentration in 2005, followed by the Organic Law, which created district, municipal, and provincial councils, indirectly elected by commune councilors. Under the Organic Law, the RGC aimed to deconcentrate functions, as well as associated authority and resources, from the center to district, municipal, and provincial levels. These decentralization and deconcentration reforms were passed in part to allow the government to address shortfalls in service delivery and provide a mechanism to solicit feedback from citizens. Donors have supported decentralization and deconcentration extensively, partly to invest in more democratic processes (Andersen and Öjendal 2019).

The entrenched party network at the lowest level reproduces patron client relations, especially between citizens and local government officials. Because many party leaders have been operating in the commune since the fall of the Khmer Rouge, they have created personalized networks of power. An Asia Foundation (2014) survey of voters also showed that most citizens continue to define their relationship with elected officials as that of parent and child. These patronage networks serve two functions: providing a mechanism to extract rents from citizens to political patrons and engendering loyalty by distributing benefits—an important social safety net (Timberman and Bergthold 2014). Given this hierarchy, citizens have learned to resist through passive or informal means, but they hesitate to confront authorities publicly or through formal channels (Plummer and Tritt 2012).

Decentralization has been uneven, leading to inefficiencies and confusion about where responsibility for service delivery lies. The 10-year National Program for Subnational Democratic Development, 2010–2020, was the RGC's agenda for the comprehensive, in-depth governance reform process of the subnational administrations, which also affects other national institutions. The 10-year program was broken down into three 3-year implementation plans, which specified annual activities, budgets, and results. One of the core elements of the second and third implementation plans was the reassignment or transfer of functions and resources from central to subnational levels, but this has moved slowly.

Over time, the resources available to the communes have increased, underscoring their importance in the political structure of Cambodia. In 2019, the central government allocated an average annual amount of USD60,000 directly to these bodies for the implementation of community support services and local development projects selected through a process in which citizens can, in principle, participate. Forty percent of the budget is allocated for development purposes, with the remaining 60 percent funding administration and councilors' allowances. Every year, each commune finalizes a CIP based on the 5-year commune development plan, which includes feedback from villagers, including through inputs that the JAAP provides. According to Deputy Prime Minister and Minister of Interior Sar Kheng, the senior minister in charge of decentralization, the communes' budget will more than double in 2020. The exact budget allocation is based on a formula that includes population and poverty levels (NCDD 2017).

In 2013, under the first implementation plan, RGC endorsed the Strategic Plan on Social Accountability for Subnational Democratic Development, which acts as a road map for all relevant stakeholders in implementing social accountability under the National Program for Subnational Democratic Development. The strategic plan highlights the vision, objectives, expected outputs, and core principles of social accountability in Cambodia. The RGC's Secretariat of the National Committee for Subnational Democratic Development is responsible for implementing the overall decentralization and deconcentration reform program, including ISAF activities.

Since the 2000s, there has been a range of donor investments in establishing and promoting participatory processes that allow citizens to engage in and contribute to the development of the CIP, including civil society–led initiatives to support participatory processes at the commune level, including participatory planning and information sessions. In 2006, the World Bank implemented the Program to Enhance Capacity in Social Accountability (PECSA) in Cambodia to introduce and test social accountability approaches that had been successful in other Asian countries. The program first organized social accountability schools and training programs that were available to a range of government and nonstate actors. PECSA then provided small grants to allow nonstate actors to test various social accountability tools, including village forums to share access to information; tools to monitor service provision, such as the CSC and citizen report card; and programs that allowed state and nonstate actors to implement development projects jointly. The approaches implemented under PECSA were expanded under the World Bank–funded Demand for Good Governance Project (DFGG), which was implemented from 2007 to 2011.

1.3 Review of Social Accountability Literature

The research cited below used a range of methods, such as qualitative case studies and quantitative studies including RCTs and experimental designs. Qualitative studies can identify the dynamics of change that lead to successes or challenges and identify relevant factors or variables involved, but they cannot prove causality. RCTs can broadly indicate the direction of causality without explaining the dynamics that contributed to successes or challenges. This section includes a discussion of evidence from Cambodia before reporting on the findings on social accountability more widely.

1.3.1 Studies of Social Accountability in Cambodia

PECSA and DFGG initiatives suggested potential payoffs of investment in social accountability. Although no impact evaluations were conducted under DFGG and PECSA, monitoring and an independent assessment suggested that DFGG created stable citizen-state feedback mechanisms. These feedback mechanisms were linked to better relationships between state and nonstate actors reported in commune offices and health centers. The independent completion report that DFGG prepared and process audits that were conducted concluded that the social accountability methods helped recast the relationship between government officials and citizens from patron-client to service provider–user.² The evidence included greater responsiveness to service users; transparency about processes, including user fees and timings; and perceived closer access.

Despite these reconfigurations, service delivery was considered “government business,” and there were limits to citizens’ participation in these processes. Government officials at the lowest rung reinforced this perspective. Commune chiefs discouraged citizen participation in council meetings that were considered “government business.” Parents very rarely approached schoolteachers given the difference in their status (Vuković and Babović 2018). Attitudes such as these contribute to lack of demand for and participation in existing mechanisms such as the school support and parent-teacher committees. Similarly, health center directors maintained the perspective that citizens lack the technical knowledge needed to hold them accountable. Therefore, although avenues for participation have increased, participation remains formulaic. Furthermore, the more open the meeting, the less likely it is that people will participate freely (Plummer and Tritt 2012).

² Similarly, Öjendal and Sedara (2005) argue that the establishment of directly elected commune councils and opportunities for citizen engagement began to reshape the relationship between local authorities from one based on fear to one grounded in respect.

Eng et al. (2015) similarly emphasize the power dynamics that continue to prevent citizens from holding leaders to account. Citizens rely on local NGOs to implement social accountability projects, and consequently, when such organizations leave, the initiatives fall apart. For instance, Eng's (2015) case study on an NGO that worked with parents to mobilize parental monitoring of textbook delivery showed that the successes were short lived. The NGO, working with the central ministry, increased the supply of textbooks through a public expenditure tracking tool, but once the NGO left, the monitoring efforts stopped. The parents complained that the NGO stopped contacting them, and they were waiting for the NGO to organize more meetings. This case suggests that students and parents do not consider mobilization and monitoring as part of their responsibility or find themselves to be too exposed and therefore need an intermediary such as a nonstate actor to be the face of the effort and negotiate with the government. Aside from one-time elite-sponsored interventions, there are few existing structures to mediate citizen engagement at the village level (Vuković and Babović 2018; McBeth and Bottomley 2013; Eng et al. 2015).

According to Eng et al. (2015), having a government champion was critical in a success story involving the distribution of textbooks, which supports the discussion of patronage politics above. The Minister of Education, Youth, and Sport, appointed in 2013, had the reputation of being a reform-minded individual who encouraged the monitoring of problems in the delivery of textbooks. According to the implementors, there was little buy-in and participation by district- and provincial-level individuals, but because the minister took an interest, they cooperated with the local NGO while the project lasted (Eng et al. 2015; Kelsall et al. 2016).

Citizens' desires to maintain patronage-based relationships with local authorities may discourage participation in social accountability projects. In a project designed to improve waste management and sanitation, the intended beneficiaries were reluctant to participate in the project because waste management was seen to be the responsibility of the local contractor, and they worried that taking part in a project seen to tread on the purview of government might weaken their relationship with local authorities. The villagers engaged in social accountability activities partly because of the culture of social obligation to the NGO. That is, villagers usually complied with the NGO's invitation to attend meetings to fulfill a sense of social obligation, usually from someone with higher status or an educated NGO worker, but many in this case also wanted to preserve their relationships with the commune authorities (Eng et al. 2015).

Citizens may censor themselves by not raising concerns to service providers if it threatens their relationship with them or leads to conflict with high-status individuals. Vuković and Babović (2018) cite the phenomenon of auto-censoring in Cambodia, which may have prevented citizens from raising genuine concerns. Likewise, Eng et al.'s (2015) study cites the consequences of not censoring, such as a school blacklisting a student who took part in citizen monitoring efforts for school textbook delivery (Vuković and Babović 2018).

Social accountability initiatives may have the unintended effect of passing on responsibility for service delivery to nonstate actors. For instance, the responsibility for conservation of endangered natural resources, such as mangroves, which should be under the purview of government, fell to citizens because of their involvement in a social accountability initiative (Vuković and Babović 2018). In other instances, social accountability overloads local officials who do not have the means to respond to the service delivery needs of citizens. Creating mechanisms for feedback without delegating power may lead to a high level of frustration among service providers and disillusionment in citizens.

Finally, some of the challenges that PECSA and DFGG faced included difficulties in translating Western notions of accountability into Khmer. The term "accountability" is often translated as "kanakney-pheap," which literally translates from the root words in English "account" (kanakney) and "ability" (pheap) to mean "status" or "being." Put together, the term is understood as "status or being of accounts" and is most often considered by Cambodian civil servants to mean "financial accounting." Other interpretations are drawn from experiences, such as the Seila program, designed to introduce participatory processes at the village level, which emphasized government's compliance with policies rather than citizens holding government actors to account. (Pak et al. 2012). Öjendal and Lilja (2009) argue that notions of social accountability or the need for the government to obtain public legitimacy were antithetical to ideas of hierarchy in Cambodia and that accountability in Cambodia is traditionally defined as someone with low status being accountable to someone with high status.

1.3.2 Other Relevant Studies

Mechanisms that create citizen-to-state feedback channels allow citizens to hold representatives to account between electoral cycles (Peruzzotti and Smulovitz 2016), but for social accountability to succeed, there needs to be thoughtful consideration of the incentives and disincentives for behavior change by citizens and government actors. Fox (2014) emphasizes that leveraging incentives on each side is a necessary condition for change. For instance, greater access to information is not enough to engender change; providers need to face sanctions. Joshi (2013) emphasizes the need to question assumptions made in the ToC, such as the idea that fear of exposure of poor performance will lead to change or that failure of service delivery is based on motivational factors rather than resource constraint. As discussed above, public officials may be protected by patronage networks and may respond to social accountability approaches by reacting against citizens.

Studies of social accountability elsewhere have found that the use of CSCs has improved relationships between service users and providers. The use of the CSC in Andhra Pradesh India, did not necessarily improve services but contributed to charting a common path to improvements in education. The CSC improved the relationship between service providers and users by identifying shared concerns (Misra 2007). Similarly, in Madagascar, citizens assessed services using a tool that measured municipal staff performance, which led to improved communication channels, a precedent for partnership, and strategies to address staffing problems (Dufils 2010).

Other qualitative studies have highlighted positive effects. Gaventa and Barret (2010) created a comparative framework to analyze the effects of citizen engagement on service delivery in 100 cases. They identified service delivery effects in 30 cases in the health care and education sectors. For example, in Brazil, governance councils that emphasize participatory planning increased access to health care services. In Bangladesh, monitoring the efforts of parents of girls improved teacher behavior, including attendance.

RCTs measuring the effectiveness of social accountability approaches suggest that the results of social accountability initiatives involving information-awareness raising are mixed. An RCT examining the effect of awareness-raising on teacher performance in three states in India found that it improved teacher behavior (Pandey, Goyal, and Sundararaman 2009). In contrast, Banerjee et al. (2010) concluded that awareness-raising initiatives that shared information on education programs and gaps in child literacy through community discussions had no discernable effect on citizen engagement in schools in India or on improving educational outcomes; the knowledge gained did not influence the status hierarchy associated with service users and providers. Similarly, a study with an experimental design involving 26 matched villages in Kenya failed to show a link between an increase in shared knowledge and collective action. Parents who were provided with information on their children's educational performance acted no differently from parents who were not. The study concluded that incentives for action are linked to perceived responsibility, relationships with service providers and other community members, and a belief in the efficacy of their actions and not knowledge alone (Lieberman, Posner, and Tsai 2014).

Some randomized experiments have shown that demand-led monitoring interventions improve the quality of education. Lassibille et al.'s (2010) randomized experiment concluded that report cards led to greater improvements in the quality of education, drawing on indicators of teacher behavior, attendance, and test scores. Similarly, in a randomized experiment in Kenya, Duflo, Hanna, and Ryan (2010) found that greater accountability based on performance-based contracts and community monitoring had significant effects on student achievements.

A study that examined the combination of awareness-raising and monitoring initiatives led to greater accountability in, and use of, Ugandan primary health services. The intervention raised awareness of local actors of their rights to primary care and established a mechanism for community leaders to discuss concerns with service providers. The study showed effects in levels of citizen participation, use of health services, and health outcomes (Björkman Nyqvist, De Walque, and Svensson 2017; Björkman and Svensson 2009).

A recent study that reviewed RCTs concluded that citizen engagement led to some service delivery improvements but that local social dynamics, such as patronage relationships, shape long-term effects on empowerment. Although the study examined community-driven development, not social accountability approaches per se, it provides insight into citizen engagement, such that inclusion of marginalized voices alone does not lead to greater participation. Furthermore, citizen engagement in formal program processes may not necessarily lead to engagement outside of the program (Casey 2018).

The effects of citizen monitoring may vary according to sector. Citizen monitoring efforts in Indonesia had less effect on reducing corruption or improving road construction than the government's own internal audit process that was more effecting in stemming the misappropriation of funds by 8 percentage points. This study suggests a need for better understanding of the political economy of local communities and the incentive structure for citizens to hold their governments to account (Olken 2007). In contrast, another study that examined evidence from 25 impact evaluations found that citizen engagement had a limited effect on service delivery but that monitoring efforts could be harnessed to strengthen citizen feedback in small-scale infrastructure projects. The medium- to long-term spillover effect on inclusion and social cohesion could not be determined (White, Menon, and Waddington 2019).

1.4 Overview of ISAF Implementation Arrangements

1.4.1 Structure of ISAF

The National Committee for Subnational Democratic Development, housed at the Ministry of Interior, coordinated ISAF Phase I (2016–2018). ISAF's government partners also included the Ministry of Education, Youth, and Sport and Ministry of Health, given the focus on the service delivery of health and education. ISAF's nongovernmental demand-side implementors included Save the Children and World Vision, supported through the Japan Social Development Fund–financed, World Bank–administered Voice and Action Project; the Reproductive and Child Health Alliance, funded through the U.S. Agency for International Development; Care International, funded through the European Union; and Star Kampuchea, funded by Oxfam International. These projects are described in table 1.



Table 1: ISAF Implementation Partners

| Project | Funder | Objective | Geographic coverage |
|---|---|---|---|
| Voice and Action: Social Accountability for Improved Service Delivery Project | World Bank | Support the work of two ISAF implementing agencies (Save the Children and World Vision) during ISAF Phase I ^a | 659 primary schools, 334 health centers, and 446 communes in 48 districts in Kratie, Prey Veng, Pursat, Stung Treng and Thbong Khmum, Beanteay Meanchey, Kampong Chhnang, Kampong Thom, Preah Vihear, and Siem Reap provinces |
| Empowering Communities for Health Project | U.S. Agency for International Development | Strengthen community health system and improve priority health outcomes in selected areas of Cambodia.. | 338 health centers, 411 communes, 4,445 villages, and more than 4 million people in Siem Reap, Banteay Meanchey, Battambang, Pailin, Kampong Speu, and Pursat provinces |
| ISAF: Strengthening Social Accountability Capacities for Civil Society, Ethnic Minorities, Including Women, Youth, and Ethnic Minorities Project | European Union | Enhance performance, responsiveness, and accountability of local government and service providers (specifically communes, health centers, and primary schools) in selected districts by increasing access to local information, open budgets, and citizen-led monitoring, with specific focus on engagement of and effects on women, youth, and ethnic minorities | 70 communes, 242 primary schools, 58 health centers, and 65,165 participants in 20 districts in Ratanak Kiri, Mondul Kiri, Koh Kong, and Kampot |

^a As part of the national introduction of the Implementation of the Social Accountability Framework (ISAF), the Voice and Action Program is subjected to other institutional and governance arrangements of ISAF, and its districts and communes do not overlap with districts and communes in which other ISAF nongovernmental organizations implement programs.

1.4.2 Activities Under ISAF

Implementing partners trained CAFs in an extensive training program that was field-tested before implementation. The training curriculum included information on ISAF-related structures, social accountability tools, commune-level structures and budgets, and mediation and facilitation strategies. After the formal training, implementing partners provided mentoring and coaching that included pairing newer CAFs with more experienced CAFs or staff so that they could shadow them in the field. This was especially important because turnover was approximately 10 percent based on implementing partner reports. Implementing partners also led regular reflection sessions so that challenges and opportunities could be highlighted and outreach strategies revised.

ISAF implementing agencies reached 551,913 Cambodians (396,487 women, 155,426 men) with I4C activities, who learned about their rights to access commune registration services, primary education, and basic health care services. More women were reached than men because women are more likely to work in or near their homes and therefore easier to access than men, who often migrated for work. Although ISAF reached a critical and vulnerable population, women's functional literacy was much lower than men's, which created challenges for ISAF's awareness-raising initiatives. Most of the participants attended at least one I4C meeting; a smaller percentage may have attended follow-up sessions or been exposed to alternate I4C dissemination strategies. I4C outreach also involved 757 commune councils, 1,404 primary schools, and 605 health centers, which contributed to data on I4C. As an indirect consequence of participating, ISAF allowed service providers to gain access to information about each other. The I4C initiative mobilized 4,200 CAFs (2,605 women, 1,595 men), who were involved in disseminating information and facilitating the scorecard and 16,644 government officials (4,042 women, 12,602 men), including service providers at the commune, district, provincial, and national levels (NCDD 2018).

I4C dissemination involved peer-to-peer outreach; posters; interactive outreach such as drama shows performed by school children and information kiosks in village centers and marketplaces; and other media such as loudspeaker broadcasts, radio broadcasts, and radio shows (ADB 2017). In particular, Save the Children mounted loudspeakers on tractors, trailers, and tuk-tuks that reportedly had a prominent announcement effect. Some of these audio clips were translated into indigenous languages for broadcast in areas with high concentrations of Indigenous peoples. Outreach was on service standards, citizen rights, responsibilities of providers, and information related to service provider budgets and expenditures. Outreach frequently involved citizens and government officials. For instance, radio talk-show guest speakers were district ISAF focal points, service providers, local NGO staff, and CAFs (Save the Children 2017a, 2017b). Implementors from Reproductive and Child Health Alliance also used volunteers from the village health support group to disseminate I4C packages. In addition to the I4C poster, implementing agencies created innovative supplemental information such as a calendar of rights that was distributed to citizens and other service providers.

Based on monitoring reports from the implementing agencies, dissemination through peer-led sessions was the most effective. In such sessions, CAFs walked citizens through the categories of information contained in the posters. This in-person attention was critical for three reasons. First, citizens have the perception that data on budgets and information on services belong to the government. Having a peer, often someone from their own or a neighboring village, explain the information helped change this perception. Second, citizens perceive information regarding service providers to be highly technical. For this reason, citizens may be intimidated by and not directly engage with the material. This is especially reported for numeric data on posters, such as budgets and spending, a finding that a wide range of implementing agencies have confirmed. Third, peer-to-peer sessions were critical, given literacy challenges. Although the literacy rate in Cambodia is 81 percent, it varies greatly according to age and sex (UNESCO 2019). Functional literacy may be much lower, especially as it pertains to ability to understand information regarding rights and services. Based on feedback received from implementing agencies, the language used in development programs such as ISAF is often much more formal and technical than the everyday Khmer that citizens speak and thus benefits from explanations and discussions with peers. This is especially true of the Indigenous population, many of whom do not read or write Khmer. Beyond literacy, the power dynamics and societal attitudes embedded in national and local languages may limit participation of Indigenous groups. Anecdotal evidence from the implementing agencies indicated citizen demand for I4C information sessions and the inadequacy of one I4C session that many attended given the complexity of the information received (Care International 2017). Participants expressed the need for materials with visual aids, such as video animation.

The number of scores provided by villagers or number of villagers participating in the scorecard processes provided a measure of citizen engagement at the commune level. During ISAF Phase 1, citizens scored 757 local commune councils (46 percent of all councils), 605 health centers, and 1,404 primary schools (28 percent of all schools); 272,368 citizens (204,717 women, 67,651 men) were involved in the scoring process. In each location, citizens brainstormed important features of service delivery, which included service providers' perceived response, cleanliness, and timeliness. The average gathering included 33 people (World Vision International 2019). The Asian Development Bank–funded process audit suggested that the CAF facilitation of the CSC worked well, with villagers successfully brainstorming and coming up with their own indicators. The CAFs were also able to facilitate the service provider assessments (ADB 2017).

Subsequent to the scorecard process, service providers and representatives of the service users formulated the JAAP. Analysis that the National Committee for Subnational Democratic Development and World Vision conducted suggested that the service providers had greater input than citizens in the formulation of the JAAP overall. By 2018, providers suggested 45 percent of actions, and citizens suggested 20 percent, indicating ownership by service providers but also highlighting possible inequities in the process. Overall, citizens tended to target behavior improvement as a priority, whereas providers highlighted infrastructure—dynamics consistent with their respective roles. The analysis also highlighted how, over time, more JAAP items were incorporated into CIPs, from 2 percent to 7 percent of JAAP items. It is not clear whether the items were incorporated into the plan only if they were funded (World Vision International 2019). The Asian Development Bank–funded process audit suggested that CAFs successfully mediated the JAAPs, especially with support from implementing partner staff, and that the level of participation was high (ADB 2017).

Box 3: Understanding the Critical Aspects of Citizen Demand

When scoring the commune council, citizens highlighted the need for posting and disseminating information (66 percent of facilities) and respect for work hours. The condition of the commune hall (35 percent of facilities) and responsiveness to citizens were also common elements of scoring (48 percent of facilities).

Through the community scorecard (CSC), parents prioritized the need for sex-segregated toilets in 61 percent of schools. Hygiene and improvement in the environment were highlighted in 57 percent of schools. The most common items for the joint accountability action plan were attitudes of schoolteachers and infrastructure improvements.

Based on the analysis of CSCs, citizens emphasized the availability of staff during work hours (55 percent of health centers) and respect for work hours (51 percent of centers).

Source: World Vision International 2019.



2 METHODS

2.1 Introduction

ISAF impact evaluation uses an RCT design structured to provide rigorous, unbiased estimates of program effect. This provides for internal validity in the event of village-level attrition in the sample. The following sections provide details on the research design for the study. Section 2.2 describes procedures used to select the ISAF impact evaluation sample at the district and commune-level, section 2.3 outlines the procedure used to assign treatment, section 2.4 describes the survey instrument, section 2.5 describes the survey activities, section 2.6 discusses the methodology, section 2.7 discusses the accuracy and integrity of estimates, section 2.8 discusses the sample characteristics, and section 2.9 discusses alternative data sources.

2.2 Sample Selection

ISAF Phase I covered 98 rural districts in 18 provinces. Forty-two districts from 15 provinces were identified in conjunction with four civil society organization (CSO) partners to be included in the impact evaluation.

2.2.1 Selection Process

Based on budget availability and sample size requirement, on average, the study sampled four communes per sampled district. Given the large variation in the number of communes within a district (two to 18 communes per district), 168 communes were selected based on the following successive steps:

- All communes were sampled in districts that have fewer than three communes: Ou Reang (Mondul Kiri province), Preah Vihear (Preah Vihear province), Ta Veang (Ratanak Kiri province).
- The number of communes to be selected in other districts (162 communes in 39 districts) was determined based on a proportional sampling method. (Districts with many communes have more sampled communes than districts with few communes.)
- Once the number of communes to be sampled was known for each district, communes were selected using a simple random sampling methodology.

Two villages were randomly selected from each sampled commune, making the sample size 336 sampled villages. In each sampled village, five men and five women were randomly selected from the 10 randomly sampled households. The final sampled citizen population was 3,363 households. Regarding local leaders, at the village level, one village chief was sampled per sampled village or two village chiefs per sampled commune. At the commune level, commune chiefs, primary school principals, and commune health center directors were interviewed. If the sampled commune leaders were not available, their subordinates were interviewed. The study sample included 140 commune health centers; in some rural areas, one commune health center served two or three communes (table 2).

Table 2: Sample Size

| Strata | Rate | N | Selection method |
|---|----------------------|--------------|---|
| Province | -- | 15 | Purposive |
| District | | 42 | Purposive |
| Commune | 4/district (average) | 168 | Random proportional sampling among districts |
| • Commune council chief | 1/commune | 168 | Purposive (within commune council) |
| • Commune health center Director | 1/commune | 140 | Purposive (within commune health center) |
| • Primary school principal | 1/commune | 168 | Purposive (primary school covering selected villages) |
| • Village chief | 2/commune | 336 | Purposive/random (within selected villages) |
| Subtotal: individual local leader questionnaire Interviews | 5commune | 812 | |
| Village | 2/commune | 336 | Random (PPS village selection) |
| • Household: Male | 5/PSU | 1,682 | Random (EPI-Walk) |
| • Household: Female | 5/PSU | 1,681 | Random (EPI-Walk) |
| Subtotal: household Interviews | 10/village | 3,363 | |
| TOTAL INTERVIEWS | | 4,175 | |

2.2.2 Representativeness

Although the sampled communes, villages, and respondents were selected randomly, the provinces and districts were purposively sampled according to ISAF district prioritization, the rural focus of ISAF Phase I, and impact evaluation needs. It was therefore expected that the ISAF baseline sample would be unlikely to be representative of Cambodia in general or rural Cambodia specifically because the sample had a high concentration of mountainous districts and provinces. Nonetheless, it is a useful practice to situate sample statistics against national statistics. In the impact evaluation, demographic variables were compared with estimates obtained from the Census of Agriculture in Cambodia 2015 to evaluate the representativeness of the sample. A few national statistics were also acquired from the 2015 Cambodia Socio-Economic Survey, a national survey that documents aspects of the lives of Cambodian households other than agriculture that the National Institute of Statistics of the Ministry of Planning conducts. Together, the two national surveys help situate the sample of ISAF baseline survey (table 3).

Because some sampled provinces had a high concentration of ethnic minority communities, the sample has a higher proportion of ethnic minorities than the national average. Regarding gender distribution, the ISAF sample had more women than the national average. The sampled population also appeared to be more literate, although given that the literacy rate depends on the difficulty of the literacy test used, these differences could be attributed to the difference between this survey's literacy test and the Census of Agriculture of the Kingdom of Cambodia and CSEC literacy test. Finally, the sampled population had slightly lower levels of participation in the labor market.

Table 3: Comparison of Implementation of the Social Accountability Framework (ISAF) Sample with Representative Sample of Cambodian Population

| Variable | 2015 Census of Agriculture of the Kingdom of Cambodia and Cambodia Socio-Economic Survey % | ISAF Survey | P-value (chi-square test or t-test) |
|--|--|-------------|-------------------------------------|
| Household | | | |
| Male | 50 | 47 | <0.001 |
| Ethnicity | | | |
| Khmer | 95.3 | 90.0 | 0.008 |
| Cham | 1.2 | 2.9 | |
| Vietnamese | 0.4 | 0.2 | |
| Other | 3.1 | 6.8 | |
| Respondent | | | |
| Children younger than 5 registered for birth certificate | 74.7 | 74 | 0.59 |
| Adult literacy (aged 15 and older) | 76.8 | 81.9 | <0.001 |
| Labor force participation | 84.3 | 80.9 | <.001 |

2.3 Treatment Assignment

Each of the 42 districts was designated as a treatment or control area using matched-pair cluster randomization. The 42 districts contributed by respective NGOs had to satisfy the following eligibility criteria: had not received any ISAF interventions in 2015 and 2016, NGOs and the government had capacity to deliver ISAF interventions, and the government was willing to postpone ISAF interventions for 2 years if designated as a control area. Twenty-one districts were randomly selected to receive ISAF activities. The Mahalanobis distance was used to match-pair the 42 districts and was constructed based on the following variables extracted from the 2010 census: district population, proportion of communes with electricity, share of population in agriculture, number of communes in district, and a dummy variable for each province (appendix B).

The 21 treatment districts received ISAF interventions from April 2017 to December 2018, with some variation across the implementing agencies. The remaining districts were control areas and did not receive any ISAF interventions during this period. There were no design variations in the treatment arm, although the implementing agencies implemented the standard set of ISAF activities in slightly different ways. Communes in treatment districts received three interventions: I4C, citizen monitoring, and facilitation and capacity building (as outlined in the ToC section).



2.4 Survey Instruments

The baseline and endline surveys consisted of five survey instruments that ascertained information about villagers and village leaders as described below.

2.4.1 Household Questionnaire

Household questionnaires were administered to a sample of 10 households in each sample village. In each household, a male or female respondent was sampled; five male and five female household members were surveyed in each sampled village. Male and female enumerators administered questionnaires to the oldest working-age men and women, respectively, in the household.

The household questionnaire was designed to ascertain information on socioeconomic characteristics, use of health and education services, and knowledge of citizens of rights and service standards. The questionnaire did not assess citizens' experience with ISAF because it focused on identifying the effect of ISAF beyond specific program interventions. The sampling of an equal number of male and female respondents helped identify sex-based differences in outcomes of interest, such as participation in decision-making or awareness of rights and standards. Translation arrangements were made when interviews took place in areas with a high concentration of ethnic minorities not conversant in Khmer.

2.4.2 Leader Questionnaire

In each sample commune, individual local leader questionnaires were administered to four local leaders: the chief of the commune council or, in his or her absence, the deputy chief of the commune council; two village chiefs from the two random sampled villages in the sampled commune or, in his or her absence, a reserve village chief; the director of the commune health center or, in his or her absence, the deputy director of the commune health center; and the principal of the sampled primary school or, in his or her absence, the assistant principal.

The individual local leader questionnaires gathered information related to leaders' perceptions of local governance and service provision and constraints on villagers' participation in accountability mechanisms. There was some overlap in questions between the household questionnaires and individual local leader questionnaires (e.g., on perceived public service performance and perceived success or development needs), enabling local leaders' views to be juxtaposed with those of villagers. The chief of commune council questionnaire focused on commune-level concerns and the chief of commune council's knowledge of citizens' rights and service standards at the commune office. Village chiefs play a dual role as citizens and as state officials channeling the voices of citizens to the commune, serving on committees making decisions about local basic services. As such, the village chief questionnaire focused on village-level concerns such as citizen participation in village meetings, crime and dispute resolution, and social interactions. Given the village chiefs' dual role, in some instances, data from this questionnaire were used in discussion of demand-side results. The director of commune health center questionnaire focused on the director's knowledge of citizen rights and service standards at the commune health center. The director of primary school questionnaire focused on administrative information related to the school, such as the number of students, classrooms, and teachers and the director's knowledge of student rights and teaching standards. The individual local leader questionnaires also included observational data on service provider performance, especially related to improvements in facilities and overall transparency.

2.5 Survey Activity

2.5.1 Baseline Survey

The baseline survey was administered in 336 sample villages in March and April 2017, before the intervention, and covered 1,680 men and 1,680 women from 3,360 households. For local leaders, 168 primary school principals, 140 health center leaders, 168 commune council leaders, and 336 village chiefs were interviewed.

2.5.2 Endline Survey

The endline survey was administered in April and May 2019 and covered 1,544 men and 1,817 women from 3,361 households. It was intended to interview the same households at baseline and endline, but because of the movements of villagers, 340 respondents could not be found at endline. Using a replacement strategy, the survey firm added 338 new households for interview (see below). For local leaders, 168 primary school principals, 141 health center leaders, 168 commune council leaders, and 336 village chiefs were interviewed, preferably the same leader or location as at baseline.

If the same respondents could not be found, replacement strategies were implemented (figure 2). If the same household respondent was not available for the interview, the respondent was replaced with another member of the same sex and nearest in age to the listed respondent in the same household. If the family was no longer living in the same commune, the household was replaced by a household closest to the family that had moved. The replacement household was also selected such that its head was of the same sex as the missing respondent. If the local leader (commune councilor, health center director, primary school principal, or village chief) was no longer serving in the sample facility, the current leader was interviewed instead. If additional health centers had been built in target communes since baseline, the directors of these centers were added to the target sample and approached for local leader interviews.



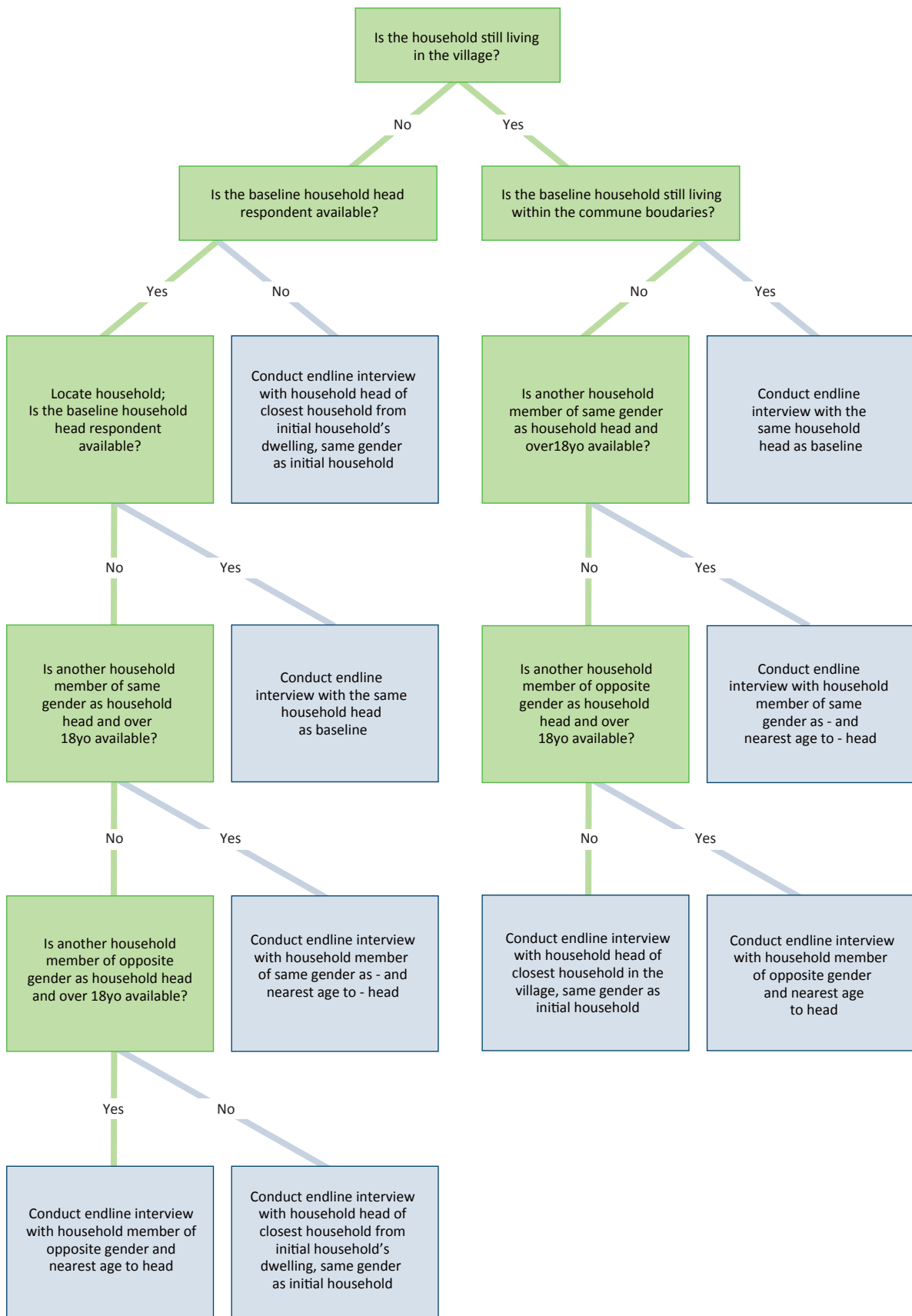


Figure 2: Sampling Strategy: Implementation of the Social Accountability Framework

2.6 Methodology

Data were provided on more than 800 indicators from household, primary school, health center, commune council, and village chief questionnaires to test the effect of ISAF on citizen knowledge and engagement and service provider quality and outcomes. Regressions were first run on the full set of indicators to identify overall ISAF effects. (Regression results for all indicators are provided in spreadsheets 1-3).

Key indicators were also analyzed based on a pre-analysis plan and are included in spreadsheet 1. Additional indicators were selected for further analyses and are discussed in Part III. These indicators were selected based on how well they mapped to the four main dimensions of the ToC: awareness-raising, level of citizen engagement, change in quality of services, and change in service delivery outcomes or specific behaviors and service improvements that ISAF sought to influence. Additional indicators that provided information on the wider political context, such as patronage relations and existing hierarchy, were also included to contextualize the impact evaluation results.

Approximately 100 indicators that correspond to the four overarching questions that guided the impact evaluation were used in this report. Indicators of awareness-raising measured change in knowledge of information contained in I4C. For instance, indicators included knowledge of service standards and information related to service provider budgets. The baseline and endline questionnaires did not contain questions on all 18 standards from the three I4C posters for each of the three services, e.g. commune services, primary schools, and health centers, so the results of a subset of indicators testing awareness of rights are discussed. Selected indicators also measured level of engagement in informal and formal meetings. Finally, indicators were selected based on service delivery standards that I4C promoted, such as behavior of service providers, payment of fees, and measures of responsiveness. Measures of outcomes include changes in citizen demand and changes in made in the supply of services at the district and provincial levels. Impact evaluation estimates of ISAF on these 100 indicators were assessed individually using t-tests or ordinary least squares (OLS) regression. The following sections describe the methodology of the study in detail.

2.6.1 Estimation of Difference Between Treatment and Control Groups

For background variables and key indicators at baseline, the following regression was run to examine whether the treatment and control areas were balanced (spreadsheet 4).

$$Y_{vi} = \alpha + \beta \cdot T_v + \varphi_p + \varepsilon_{vi} \quad (1)$$

in which Y_{vi} is the outcome of interest for household i in district v , T_v is the district treatment dummy, Y_{0vi} is the corresponding indicator from the baseline survey, φ_p is the matched-pair fixed effect, and ε_{vi} is the error term.

2.6.2 Estimation of Treatment Effect on Individual Indicators

For all indicators, the following OLS regression was used to estimate the treatment effect for each indicator.

$$Y_{vi} = \alpha + \beta \cdot T_v + \gamma Y_{0vi} + \varphi_p + \varepsilon_{vi} \quad (2)$$

in which Y_{vi} is the outcome of interest for household i in district v , T_v is the district treatment dummy, Y_{0vi} is the corresponding indicator from the baseline survey, φ_p is the matched-pair fixed effect, and ε_{vi} is the error term. When an indicator was constructed at the district level (such as for indicators constructed using information from primary school, health center, commune council, and village chief data) rather than the individual level, the outcome was Y_{tv} rather than Y_{tvi} .

Following Bruhn and McKenzie (2009), district-pair fixed effects were included to account for the use of pair-wise district matches in the allocation of treatment. Standard errors were clustered at the district-cluster level to account for correlation of residuals within district clusters caused by nonindependence of assignment of treatment status.

Although the method of RCTs was employed and implemented, there is a chance that the treatment and control districts were not well balanced before the intervention. To control for random variation in pretreatment characteristics, baseline survey data were included in the regression. The procedure represents analysis of covariance (ANCOVA). This specification calculated using the baseline survey data accounts for random variation between treatment and control areas more flexibly than the difference-in-difference estimator, which assumes that $\gamma=1$. In addition, McKenzie (2012) shows that it has better power properties than the difference-in-difference estimator, especially when autocorrelation for the outcomes of interest is low.

To preserve the integrity of the results, for the indicators at the household level, the benchmark analysis is limited to responses of the same person who participated in the baseline. Baseline and endline household data sets were merged based on variable of unique household identification, a unique number assigned to each household during the baseline which the survey firm assigned. For household-level indicators, the same baseline and endline results were examined for the same family. In addition, to matching the same person in the survey, there was a further attempt to verify the family by measuring the longitude and latitude to ensure that the household was less than 2.5 kilometers apart from the household's location at baseline. Factors, such as sex, ethnicity, religion, first language, and education level were also used to verify that the responder was the same person. According to these two criteria, the sample in the set of regression results defined as the main specification" does not involve households or individuals interviewed using the replacement strategy.

2.6.3 Robust Analyses

Specification 1 provided the basic specification used in the study. Robustness analyses were performed using two alternate specifications.

In the first alternate specification, the control-of-the-"same person" household-level indicators were removed from the analysis. According to the basic specification, analyses of household-level indicators included matched households between baseline and endline. According to specification 1, the replaced individuals, but not the replaced households, were included in the sample. Although the main specification provided a more-conservative perspective to the analyses, specification 1 increased the sample size and brought more statistical power to the analyses. Results for the robust specification 1 are included in spreadsheet 1.

In the second alternate specification, the control-of-baseline corresponding indicators. Therefore, for household-level indicators, control-of-the-"same person" and control-of-baseline corresponding indicators were removed; for district-level indicators, only control-of-baseline corresponding indicators were removed. These results are included in spreadsheet 2.

Because the results did not vary greatly from the benchmark and the robust specifications and the same-person constraints were especially relevant for indicators pertaining to awareness change, the results reported are based on the more conservative specification.

2.6.4 Analysis Based on Sex and Minority Status

Differences between female and male villagers were examined for some indicators, and the following OLS regression was implemented.

$$Y_{vi} = \alpha + \beta \cdot T_v + \gamma Y_{0vi} + \theta \cdot G_{vi} + \mu \cdot G_{vi} \cdot T_v + \delta \varphi_p + \varepsilon_{vi} \quad (3)$$

in which G_{vi} is the sex (dummy variable: male = 1, female = 0) of household respondent i in district v ; $G_{vi} \cdot T_v$ is the interaction terms of the sex and treatment dummy variables. The coefficient μ shows the difference between the treatment and control areas for the default sex (male in the current setting).

Similar to the main specification, the pair-wise districts method was considered, and standard errors were clustered at the district cluster level. The sample in the analyses does not include the individuals-under-replacement strategy. Because the service provider leaders were mainly male, only the questions from the household data set were analyzed in terms of differences according to sex.

The analysis also examined differences between Khmer and non-Khmer speakers. The sample included indigenous minority populations from the northeast of the country and members of the Cham population. There are multiple ways to measure the effect on ISAF of the minority population. We focused on a sample of non-Khmer speakers based on anecdotal evidence from implementing partners that language served as a barrier to participation. Similar to specification 2, an OLS regression was used to analyze effects on minorities.

$$Y_{vi} = \alpha + \beta \cdot T_v + \gamma Y_{0vi} + \theta \cdot K_{vi} + \mu \cdot G_{vi} \cdot T_v + \delta \varphi_p + \varepsilon_{vi} \quad (4)$$

The independent variables remained the same as in specification 2, except for K_{vi} , which is the minority status (dummy variable: non-Khmer = 1, Khmer = 0) of household respondent i in district v .

2.6.5 Estimation of Treatment Effect on Aggregated Indicators

For the key indicators in the pre-analysis plan, five aggregated indicators (school performance, health center performance, commune council performance, participation, voice) were analyzed and are presented in spreadsheet 1. The overall average treatment effect was estimated by combining the effects on each of the constituent indicators, which summarizes the effects for all constituent indicators that correspond to the same hypothesis.

First, all K indicators pertaining to a specific hypothesis were combined into a single dataset at the household level and standardized into z-scores with 0 mean and unit variance. If denoted by \mathbf{Y}_k , the vector of observations related to outcome k , and by Y_k^i , its elements, then:

$$\tilde{\mathbf{Y}}_k = \frac{\mathbf{Y}_k - \frac{1}{n} \sum_i Y_k^i}{\text{Var}(Y_k^i)} \quad (5)$$

Next, all regressions were estimated using these standardized indicators to obtain K standardized treatment effect $\tilde{\tau}_k$, where the regression equation is the same as equation (2), which in vector form, can be written as:

$$\tilde{Y}_k = X\beta + T\tilde{\tau}_k + \gamma\tilde{Y}_{0k} + \varepsilon_k \quad (6)$$

Last, the mean effect was computed for each hypothesis as the average of treatment effects for the constituent indicators. The P-value for the aggregated treatment effects was adjusted using wild bootstrapping.

Computing aggregate treatment effects allowed the results of estimates on individual indicators to be summarized and the general problem of multiplicity in hypothesis testing to be accounted for, although this approach has its limitations. First, it assumes that all constituent indicators are equally weighted and, accordingly, considers that all constituent indicators are equally important. Second, a hypothesis may be accepted even though only one of the constituent indicators is strongly affected. For both of these reasons, it is important to consider not only the aggregate treatment effects, but also the effects on the individual indicators.

2.6.6 Procedures for Addressing Missing Data

No imputation of missing data was performed, although checks were conducted to explore the correlation between treatment status and incidence of missing data. In the questionnaire design, some indicators had three options for responses: don't know, no, and yes. For outcome analyses of awareness and knowledge, in the case of respondents with "don't know" responses, interpretation for the response would simply be replaced as "no."

2.7 Accuracy and Integrity of Estimates

2.7.1 Compliance

Noncompliance with ISAF impact evaluation assignments has been limited. The implementing partners mistakenly designated three districts that were supposed to control areas as treatment areas (Banteay Meas and Dang Tong, in Kampot province; Bar Kaev, in Ratanak Kiri province). Estimates were derived using an assigned rather than actual treatment status. Although this approach preserves the randomized nature of treatment, it may underestimate the program effect, although given the few cases of noncompliance in the study, this had minimal effect on the analysis.

2.7.2 Idiosyncratic Imbalance

Matched-pair cluster randomization ensures the balance of treatment and control areas in expectation, although there is a nonzero probability that a particular outcome of randomization will result in treatment and control groups differing because of some underlying characteristics. The t-test was used on key underlying differences between the treatment and control groups, the results of which indicate that the two groups were well balanced.

2.7.3 Attrition

The attrition rate at the household level was approximately 9 percent, which was primarily caused by the -movement of villagers; 340 households from baseline could not be found at endline, although measured according to information on age, sex, and house location, the same respondent answered the endline and baseline surveys in only 65 percent of households. Nevertheless, the attrition rate in the treatment and control groups was not significantly different (table 4), so it is unlikely that attrition biased the results.

| Aspect | Household | Village chief | Commune council | Primary school | Health center |
|---|-----------|---------------|-----------------|----------------|---------------|
| | % | | | | |
| Households or service providers same as baseline | 90 | 100 | 100 | 95 | 94 |
| For the same households or service providers, responders same as baseline | 82 | 63 | 57 | 65 | 62 |

The same villages and commune councils were visited, although because of staffing changes, including the effectiveness of commune elections, only 63 percent of village chiefs and 57 percent of commune council leaders interviewed at endline were the same as at baseline. Nine of 159 health centers and nine of 132 primary schools could not be visited at endline.

2.7.4 Contamination

Social accountability approaches have been used in Cambodia since 2006, and there is fair mobility between the staff of local NGOs that were on the frontline of implementation. It is highly likely that some of the staff implementing under ISAF had been involved in some of the earlier projects, leading respondents to confuse ISAF initiatives with others. Furthermore, there are parallel efforts to increase accountability, especially the performance of service providers, such as health centers, through various donor and government funds. For example, the Health Equity and Quality Improvement Project, which the World Bank and other donors financed, provided performance grants to all health centers in the country for improving in certain performance areas, which could have shaped the quality of health care and other outcomes throughout the country (Nagpal 2019). Therefore, it is possible that implementation of a range of other activities aimed at the same outcomes measured in the study, particularly those focusing on service provider quality and outcomes, as well as the knowledge and experiences of earlier projects and associations with the staff of the implementing agencies, contaminated the findings reported under ISAF.

2.7.5 Spillover

Because ISAF is a national government program, it is possible that there are spillover effects, especially among service providers. For instance, service providers from the commune administrations, primary schools, and health centers meet with officials at the district level. It is possible that the line ministries, as well as the overall focus of decentralization reforms focusing on transparency and accountability, may have spilled over into neighboring communes. There is evidence that national ministry officials acted on information resulting from CSC and JAAP activities that identified service delivery gaps, but their response was nationwide rather than focused on the impact evaluation treatment areas. Furthermore, citizens have myriad social networks, and it possible that they were exposed to information shared through ISAF's awareness raising.

2.8 Sample Characteristics

2.8.1 Comparison of Household Characteristics of Treatment and Control Groups

It is important to ensure that there was little difference between the treatment and control groups at baseline, because any difference would have the potential to introduce variation in ISAF knowledge and participation outcomes. Table 5 compares some household variables that might influence ISAF knowledge and participation outcomes between the treatment and control groups. Household variables, including respondent sex, age, household head education level, and ethnicity, were all balanced. For some variables, including primary language and religion, there were slightly more individuals in the treatment group that belonged to the majority, and there were more respondents without an education in the treatment group.

| Table 5: Demographic Characteristics of Treatment and Control Group | | |
|---|-----------------------------|------------------|
| Variable | Treatment, (standard error) | Observations (n) |
| Sex | -0.006 (0.008) | 2,192 |
| Age | 0.283 (0.608) | 2,192 |
| Does responder work to generate any income? | 0.006 (0.013) | 2,192 |
| What type of work does responder do? | -0.013 (0.021) | 1,826 |
| Percentage of household heads without education | 0.001 (0.025) | 776 |
| Percentage of household heads with primary education as highest education | 0.017 (0.025) | 776 |
| Religion | -0.020 (0.018) | 2,192 |
| Native language: Khmer | -0.001 (0.006) | 2,192 |
| Ethnicity | -0.022 (0.018) | 2,192 |

2.8.2 Household Characteristics

Demographic Characteristics

There were a median of 4 and a mean of 4.5 household members in the 3,363 households from which data were collected. Households in the sample had slightly more female (53 percent) than male members (47 percent).

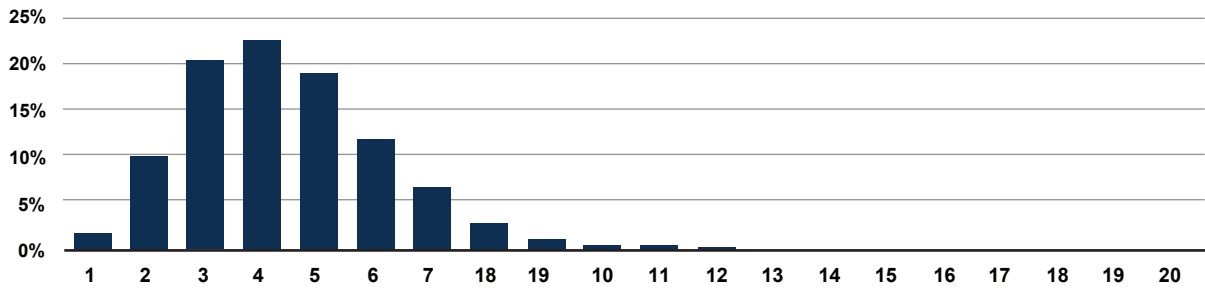


Figure 3: Number of Household Members

Forty-two percent of household members sampled in the baseline survey were younger than 20, 29 percent were aged 20 to 39, and 29 percent were aged 40 and older (figure 4).

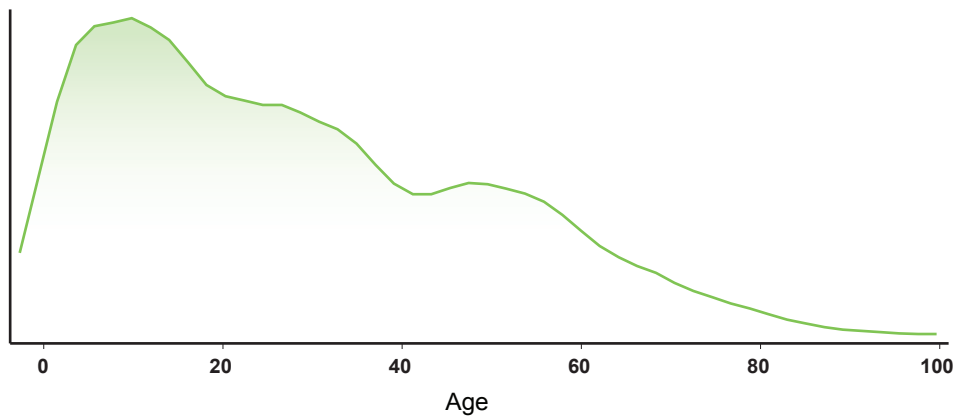


Figure 4: Age of Household Members

Ethnicity, Language, and Religion

Households in the sample overwhelmingly adhered to Buddhism (91 percent), spoke Khmer (96 percent), and identified with the Khmer ethnicity (90 percent), with Cham being the next most common language (3 percent, which corresponds to the proportion of Cham or Islamic households in the sample).

Livelihoods

A median of 2 members, half of household members, were actively involved in generation of income. Household heads frequently cited agricultural pursuits as the primary source of household income. Fifty-six percent of household heads reported that growing rice, orchard crops, or other crops provided the most income, and 31 percent cited that income from microenterprise, skilled labor, or civil servant salaries predominated (figures 5 and 6).

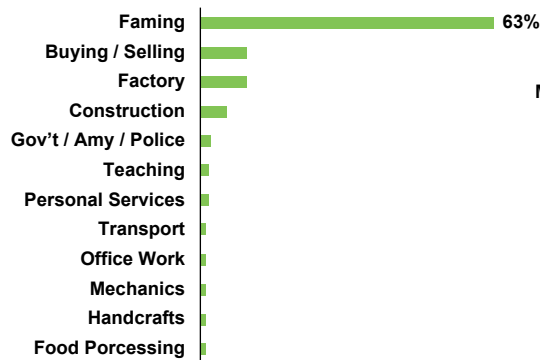


Figure 5: Type of Employment of Household Members

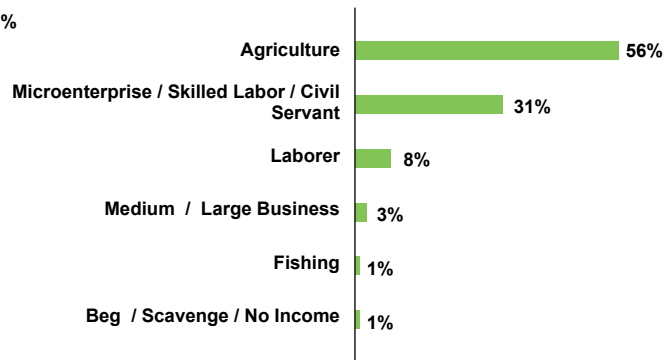


Figure 6: Main Source of Household Income

Educational Attainment

Twenty percent of sampled household respondents reported having received no formal education, 51 percent reported attending at least 1 year of primary school (grades 1 through 6), 19 percent reported attending at least 1 year of lower secondary school (grades 6 through 9); 8 percent reported attending at least 1 year of upper secondary school (grades 10 through 12), and 1 percent reported attending at least some university classes (figure 7). To obtain information on the functional literacy of respondents, four short questions were asked at the conclusion of the survey. Respondents were designated as literate if they answered all four questions correctly and semiliterate if they answered some questions correctly. Of the 3,361 respondents for whom data was collected, 54 percent answered all questions correctly, 28 percent answered some correctly, and 18 percent answered none correctly (figure 8).

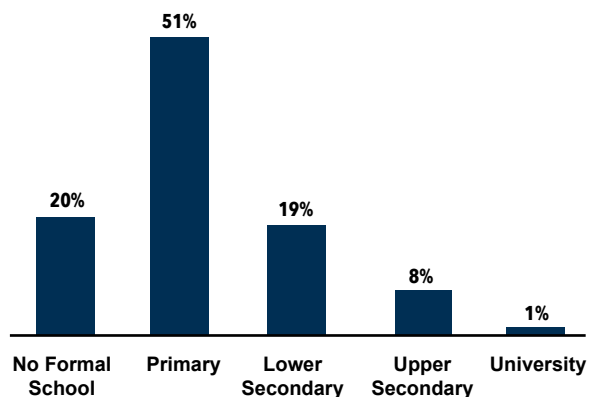


Figure 7: Household Respondents' Education

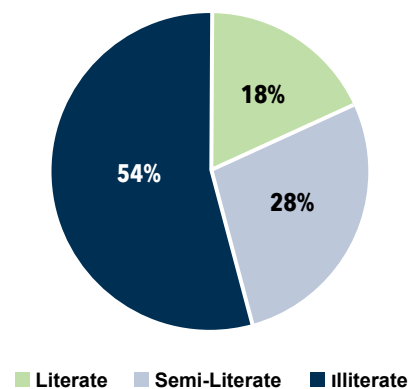


Figure 8: Household Respondents' Literacy

The nature of the sampling strategy used for the baseline survey enabled a comparison of educational attainment and literacy of male and female respondents. Male respondents generally reported higher levels of educational attainment than female respondents. Data that the literacy test at the end of the questionnaire generated suggested that female respondents were more likely to be illiterate than male respondents, with 65 percent of the 1,680 female respondents and 44 percent of the 1,681 male respondents unable to answer any of the four questions.

2.8.3 Comparison of Villagers and Local Leaders

Data that the baseline survey generated indicated that there were substantial differences in the characteristics of villagers and their local leaders. Whereas household respondents sampled in the baseline survey were relatively young and equally split between men and women, local leaders surveyed were mostly older men who had occupied their positions for several years. Whereas most household respondents and commune and village chiefs have not been educated beyond primary school level, commune health center directors and primary school principals have mostly attended at least lower secondary school. Sources of information differ substantially between villagers and local leaders, with the latter much more likely to use information and communications technologies—such as mobile phones, Facebook, and the Internet—to keep up to date on local and national events.

2.9 Data Sources

The next section draws on three data sources (the impact evaluation, monitoring data from implementing partners, and an analysis of the CSC and JAAP by World Vision) and secondary sectoral sources. During the endline survey, the enumerators also conducted a photo audit of the facilities, and the photographic data were used to verify the impact evaluation results. Monitoring data were used to contextualize impact evaluation findings within the ToC, but the impact evaluation focused on broader results rather than ISAF implementation, so there is not a detailed discussion of ISAF implementation strategies.



3

RESULTS

3.1 Introduction

This section of the report discusses the results of the ISAF impact evaluation based on the ToC described in part I. Section 3.2 discusses the demand-side results from citizens, and section 3.3 discusses the supply-side results from service providers. Results for citizen demand include citizen awareness of rights to services, service standards, and service provider budgets and levels of citizen engagement, which range from informal interactions with other community members to attendance at formal meetings. Results for the supply side include service providers' awareness of their responsibilities under existing service standards, changes in the quality of service delivery, and changes in service delivery outcomes. These results are organized according to service provider, namely communes, primary schools, and health centers. A discussion follows each results section to contextualize the results.

3.2 Demand-Side Results

3.2.1 Findings of Changes in Awareness of Rights to Services and Service Standards

Information for Citizens
Your Rights in the Commune

DID YOU KNOW? Your Commune Council will:

- BE ELECTED BY YOU EVERY 5 YEARS**
 - You can elect Commune Councilors every five years, to represent you
- LISTEN TO YOUR VIEWS**
 - Host annual village meetings to ask your opinions on how Commune funds should be spent
- INVITE YOU TO COUNCIL MEETINGS**
 - Councilors make decisions in Council meetings
 - Councilors must publicly announce and display meeting times, topics, and minutes on the notice board
 - You can attend Council meetings, speak, and ask questions about commune services and projects
- RESPOND TO YOUR CONCERNS AND INFORM YOU ABOUT DECISIONS**
 - You can contact your Councilors to help solve problems, respond to complaints, and answer questions about commune services and projects
 - Councilors will present and inform you about the Commune budget, plan, and proposed project activities at a public meeting
- ISSUE BIRTH, DEATH, AND MARRIAGE CERTIFICATES**
 - You can get birth, death, or marriage certificates from your Commune office within 3 working days, excluding holidays, if you bring the required documents
 - You are not expected to make any payment in addition to the official fees
 - Your Commune will provide you these services with dignity and respect
- POST INFORMATION**
 - Councilors will display publicly the Commune plan and budget, project information, working hours, list of services, and fees

JOIN IN ...and help improve your Commune

National Committee for Sub-National Democratic Development
Please contact your Commune Accountability Facilitators or Commune Chief for any certifications, questions, or more information.
Ministry of Interior
Nouveau Boulevard, Phnom Penh, Kingdom of Cambodia
Tel: 023 720 028 / 720 045 Email: info@nccdd.gov.kh Website: www.nccdd.gov.kh

Communes

Based on the indicators outlined in table 6, ISAF did not significantly increase villagers' awareness of their rights to access commune services. Villagers were not aware of their right to attend meetings and did not know about the main responsibilities of the commune—namely to be responsive to citizen concerns; to be transparent; and to share information on commune meetings, the budget, and the CIP. The rights that the I4C promotes are shown in Figure 9.

Figure 9: Commune Information for Citizens

Table 6: Awareness of Rights in Relation to the Commune

| Table 6: Awareness of Rights in Relation to the Commune | | | | | |
|---|--|---------------|---------------------|---------------------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
| Q4_1 | Are you aware of your commune's budget in 2018? | Village chief | 0.103** (0.044) | 0.142** (0.053) | 336 |
| Q2_15 | Do you know about your commune budget for 2018? | Household | -0.005 (0.007) | 0.218*** (0.057) | 2,192 |
| Q2_48a | Are you aware of your right to attend commune council meetings without invitation? | Household | 0.022 (0.017) | 0.227*** (0.024) | 2,192 |
| Q2_49a | Are you aware of your right to go to the commune office and look at documents such as the budget and the commune development plan (CDP)? | Household | 0.006 (0.017) | 0.203*** (0.026) | 2,192 |
| Q2_50a | Are you aware of your right to question the commune council on how budgeted funds were spent? | Household | 0.019 (0.021) | 0.265*** (0.018) | 2,192 |
| Q2_51a | Are you aware that the commune council has to display the date, time, and topics of meetings? | Household | -0.004 (0.023) | 0.123*** (0.016) | 2,192 |
| Q2_51b | Do you think that your commune council does so? | Household | 0.040* (0.023) | 0.170*** (0.032) | 913 |
| Q2_52a | Are you aware that the commune council has to display its commune investment program and budget? | Household | -0.002 (0.020) | 0.185*** (0.027) | 2,192 |
| Q2_52b | Do you think that your commune council does so? | Household | 0.033 (0.027) | 0.306*** (0.036) | 733 |
| Q7_2 | Have you seen the I4C posters in the commune? | Household | 0.084*** (0.019) | | 2,191 |

Note: Significant at ** 5 percent level; *** 1 percent level.

Citizens' knowledge of their rights related to the commune increased overall between baseline and endline. There was a 24 percent increase overall in the number of people who knew that the commune was responsible for publishing information related to commune meetings between the baseline and endline surveys and a 19 percent increase in people who realized that they could look at the commune development plan (CDP), the commune's five year plan for development priorities, and the commune's annual budget.

The regression results for indicators measuring whether villagers knew that the commune had to display the time, date, and topic of meetings and the commune budget and CIP were not significant or there were no differences between the treatment and control groups. In contrast, the regression results for the indicator that measured whether citizens knew that the commune published information on the date, time, and topic of the meeting was positive and significant at a 0.10 level. This suggests that, although villagers may not know of their rights to meeting-related information, they may be aware of the commune's practice of publishing this information. It also suggests that, if citizens were interested in this knowledge, they might know where to find it.

The impact evaluation results showed that village chiefs were 10 percentage points more aware of their commune budgets in treatment areas than in control areas (significant at the 0.05 level). In contrast, the indicator measuring citizen awareness of the commune budget was not significant or there was no difference between treatment and control group. When the regression results were further controlled for sex, women were 13 percentage points less likely than men to be aware of their right to ask councilors questions about the commune budget (significant at a 0.05 level). There was a disparity in knowledge between men and women even though far more women took part in ISAF activities than men, activities in which commune budget information was shared with participants.

Asked whether they had seen the I4C poster, villagers were 8 percentage points more likely to have seen it in treatment than control areas (significant at the 0.01 level). This again suggests that ISAF successfully supplied information and that villagers knew where to find the information if necessary.

Men were 6 percentage points more likely than women to be aware of the commune budget and 10 percentage points more likely to know about their right to go to the commune office to look at the budget and commune development plan documents (both significant at the 0.01 level) (table 7), although there were no differences in awareness between the treatment and control groups based on sex.



Table 7: Awareness of Rights in Relation to Commune According to Sex

| Indicator | Label | Respondent | Treatment | Baseline | Male | Interaction | Observations, n |
|-----------|---|------------|-----------|----------|----------|-------------|-----------------|
| Q2_15 | Do you know about your commune budget for 2018? | Household | 0.004 | 0.200*** | 0.058*** | -0.018 | 2,192 |
| | | | (0.013) | (0.057) | (0.018) | (0.028) | |
| Q2_48a | Are you aware of your right to attend commune council meetings without invitation? | Household | 0.043 | 0.223*** | 0.053 | -0.043 | 2,192 |
| | | | (0.027) | (0.024) | (0.033) | (0.047) | |
| Q2_49a | Are you aware of your right to go to the commune office and look at documents such as the budget and CDP? | Household | 0.001 | 0.188*** | 0.100*** | 0.008 | 2,192 |
| | | | (0.032) | (0.026) | (0.031) | (0.050) | |
| Q2_50a | Are you aware of your right to question the commune council on how the budget was spent? | Household | 0.066* | 0.257*** | 0.128*** | -0.096 | 2,192 |
| | | | (0.038) | (0.017) | (0.037) | (0.063) | |
| Q2_51a | Are you aware that the commune council has to display the date, time, and topic of meetings? | Household | -0.031 | 0.114*** | 0.015 | 0.055 | 2,192 |
| | | | (0.045) | (0.016) | (0.056) | (0.070) | |
| Q2_51b | Do you think that your commune council does so? | Household | 0.056 | 0.168*** | 0.008 | -0.026 | 913 |
| | | | (0.050) | (0.032) | (0.053) | (0.073) | |
| Q2_52a | Are you aware that the commune council has to display its commune investment program and budget? | Household | -0.025 | 0.173*** | 0.043 | 0.045 | 2,192 |
| | | | (0.042) | (0.025) | (0.051) | (0.067) | |
| Q2_52b | Do you think that your commune council does so? | Household | 0.067 | 0.311*** | 0.057 | -0.057 | 733 |
| | | | (0.049) | (0.036) | (0.056) | (0.074) | |
| Q7_2 | Have you seen the poster stating your rights in the commune? | Household | 0.067** | | -0.070* | 0.034 | 2,191 |
| | | | (0.032) | | (0.039) | (0.053) | |

Note: Significant at *10 percent level; ** 5 percent level; *** 1 percent level.

Being a non-Khmer speaker had a negative effect on awareness (table 8). For instance, non-Khmer speakers were 15 percentage points less likely to know about their right to attend commune council meetings without an invitation and 16 percentage points less likely to know that the commune must display meeting-related information (significant at the 0.01 level). Non-Khmer speakers were 8 percentage points less likely to know that the commune council has to display its commune investment program and budget (significant at the 0.10 level). Differences in other indicators, including awareness of rights to view commune development plan records and perceptions of whether the commune council publishes meeting, budget, and CIP-related information, were not significant.

Table 8: Awareness of the Non-Khmer-Speaking Minority Population of Rights Related to the Commune

| Indicator | Label | Respondent | Treatment | Baseline | Non-Khmer speakers | Interaction | Observations, n |
|-----------|---|------------|-----------|----------|--------------------|-------------|-----------------|
| | | | | | (standard error) | | |
| Q2_15 | Do you know about your commune budget for 2018? | Household | -0.005 | 0.218*** | -0.016* | -0.002 | 2,192 |
| | | | (0.007) | (0.057) | (0.010) | (0.011) | |
| Q2_48a | Are you aware of your right to attend commune council meetings without invitation? | Household | 0.021 | 0.227*** | -0.153*** | 0.032 | 2,192 |
| | | | (0.018) | (0.024) | (0.041) | (0.086) | |
| Q2_49a | Are you aware of your right to go to the commune office and look at documents such as budget and CDP? | Household | 0.008 | 0.204*** | 0.044 | -0.057 | 2,192 |
| | | | (0.018) | (0.026) | (0.104) | (0.094) | |
| Q2_50a | Are you aware of your right to question the commune council on how the budget was spent? | Household | 0.018 | 0.264*** | -0.114* | 0.024 | 2,192 |
| | | | (0.022) | (0.018) | (0.066) | (0.075) | |
| Q2_51a | Are you aware that the commune council has to display the date, time, and topic of meetings? | Household | -0.001 | 0.121*** | -0.161*** | -0.070 | 2,192 |
| | | | (0.024) | (0.016) | (0.038) | (0.056) | |
| Q2_51b | Do you think that your commune council does so? | Household | 0.038 | 0.171*** | -0.221 | 0.126 | 913 |
| | | | (0.023) | (0.032) | (0.196) | (0.226) | |
| Q2_52a | Are you aware that the commune council has to display its commune investment program and budget? | Household | 0.001 | 0.184*** | -0.083*** | -0.068 | 2,192 |
| | | | (0.020) | (0.027) | (0.027) | (0.049) | |
| Q2_52b | Do you think that your commune council does so? | Household | 0.033 | 0.306*** | 0.130 | -0.082 | 733 |
| | | | (0.027) | (0.036) | (0.230) | (0.259) | |

Note: Significant at *10 percent level; *** 1 percent level.



Figure 10: Primary School Information for Citizens

Primary Schools

Based on the measures of awareness, ISAF had no effect on citizens' awareness of their rights to primary education, but awareness of basic rights increased slightly overall (except for the use of corporal punishment) between baseline and endline. There was a 7 percent increase overall in the number of people who knew of the basic right to a free primary education and an 18 percent increase in people who knew the number of free textbooks to which a child is entitled.

Table 9 summarizes the results of the indicators that measured the level of awareness of the six rights to primary education included in the I4Cs (figure 10). The indicators measured awareness of the rights to free access to primary school, a certain number of textbooks allocated by the government per student, a certain number of teachers per class, and limits on use of corporal punishment. The differences were not significant. There were no significant gender differences for knowledge of the right to free primary education. The indicator that tested whether citizens were aware of the grades that were free was negative, suggesting that villagers in the household were 4 percentage points less likely than the control group to know of the grades covered in free primary education (significant at the 0.01 level).

| Table 9: Awareness of Rights to Primary Education | | | | | |
|---|--|------------|----------------------|---------------------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
| | | | (standard error) | | |
| Q4_47 | Awareness that primary school should be free | Household | 0.011 (0.007) | 0.153*** (0.023) | 2,192 |
| Q4_48 | Awareness of particular classes that should be free | Household | -0.043*** (0.015) | 0.213*** (0.021) | 1,823 |
| Q4_50 | Awareness that teachers cannot use corporal punishment on children in primary school | Household | -0.005 (0.012) | 0.096*** (0.024) | 2,192 |
| Q4_51 | Awareness of the number of free textbooks students in grade 3 should receive from the school | Household | -0.032 (0.028) | 0.270*** (0.027) | 2,192 |
| Project development objective_11 | Awareness that there should be 1 teacher per 35–42 students | Household | -0.022 (0.015) | 0.177*** (0.037) | 2,192 |

Note: Significant at *** 1 percent level.

Women were 10 percentage points more likely than men to be aware of the correct number of free textbooks their child should receive (significant at a 0.05 level) (table 10), but no difference was found between the treatment and control groups in mothers' awareness. Differences in the indicators measuring rights to education for the non-Khmer-speaking minority population were not significant.

| Table 10: Awareness of Rights to Primary Education According to Sex | | | | | | | |
|---|--|------------|-----------|----------|------------------|-------------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Male | Interaction | Observations, n |
| | | | | | (standard error) | | |
| Q4_47 | Awareness that primary school should be free | Household | 0.010 | 0.153*** | 0.004 | 0.001 | 2,192 |
| | | | (0.012) | (0.023) | (0.019) | (0.022) | |
| Q4_48 | Awareness of particular classes that should be free | Household | -0.042 | 0.216*** | 0.049 | -0.002 | 1,823 |
| | | | (0.031) | (0.020) | (0.035) | (0.055) | |
| Q4_50 | Awareness that teachers cannot use corporal punishment on children in primary school | Household | 0.000 | 0.104*** | -0.074 | -0.010 | 2,192 |
| | | | (0.022) | (0.023) | (0.028) | (0.037) | |
| Q4_51 | Awareness of the number of free textbooks students in grade 3 should receive from the school | Household | -0.009 | 0.261*** | -0.101** | -0.046 | 2,192 |
| | | | (0.048) | (0.027) | (0.047) | (0.062) | |
| Project development objective_11 | Awareness that there should be 1 teacher per 35–42 students | Household | -0.016 | 0.178*** | -0.014 | -0.012 | 2,192 |
| | | | (0.026) | (0.037) | (0.025) | (0.035) | |

Note: Significant at ** 5 percent level; *** 1 percent level.





Figure 11: Health Information for Citizens

Health Centers

Based on the impact evaluation measures, ISAF had no effect on villagers' awareness of their rights to health care. Table 11 shows the results of the three indicators that measured citizens' knowledge about their right to basic health care, including awareness of the correct number of staff, knowledge of whether staff were available at night, and whether citizens were informed of the fees for their treatment. The differences in these indicators were not statistically significant, although there was an overall increase in knowledge regarding these three indicators between baseline and endline, including a 9 percent increase in people who knew that a center must be open at night and a 97 percent increase in the number of people who knew the correct number of staff that should be available (although the total numbers remained low).

| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
|----------------------------------|---|------------|-------------------|---------------------|-----------------|
| | | | (Standard Error) | | |
| Project development objective_25 | Awareness of number of staff that should be working at health center | Household | -0.003 (0.009) | 0.104** (0.041) | 2,192 |
| Project development objective_26 | Awareness of number of staff that should be working at health center at night | Household | -0.003 (0.012) | 0.159*** (0.028) | 2,192 |
| Project development objective_28 | Awareness of treatment fee | Household | -0.046 (0.033) | 0.053 (0.043) | 515 |

Note: Significant at ** 5 percent level; *** 1 percent level.

Women were 7 percentage points more likely than men to be aware of the correct number of staff that should be working at a health center (significant at the 0.01 level) (table 12), but there was no difference in women's awareness between the treatment and control groups. Differences in indicators measuring rights to healthcare for the non-Khmer-speaking minority population were not significant.

| Table 12: Awareness of Rights to Health Care According to Sex | | | | | | | |
|---|--|------------|------------------|----------|-----------|-------------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Male | Interaction | Observations, n |
| | | | (Standard Error) | | | | |
| Project development objective_25 | Awareness of number of staff that should be working at health center | Household | -0.023 | 0.088** | -0.071*** | 0.039 | 2,192 |
| | | | (0.016) | (0.041) | (0.017) | (0.026) | |
| Project development objective_26 | Awareness regarding number of staff that should be working at health center at night | Household | -0.014 | 0.160*** | -0.020 | 0.024 | 2,192 |
| | | | (0.019) | (0.028) | (0.017) | (0.028) | |
| Project development objective_28 | Awareness of treatment fee | Household | -0.042 | 0.028 | -0.047 | 0.005 | 260 |
| | | | (0.076) | (0.085) | (0.091) | (0.131) | |

Note: Significant at ** 5 percent level; *** 1 percent level.

3.2.2 Discussion of Results on Awareness of Rights to Services and Service Standards

This section draws on other impact evaluation indicators, data from the implementing partner monitoring reports, and the literature and discusses the findings of ISAF on awareness. The people surveyed may not have attended an I4C dissemination session, the principal way that the information was disseminated. In addition, it may be difficult for people to recall specific information learned at an I4C event. It is more important for citizens to be aware of overall service standards.

Communes

There was an increase in the level of information regarding the commune in control and treatment areas. This could be an indication of other initiatives interacting with ISAF treatment effects.

Although ISAF did not directly increase citizen awareness of the budget, it may have reinforced the role of the village chief as a conduit between the commune and citizens. Villagers in treatment districts did not show greater knowledge of the commune budget than those in control districts, although the results suggest that ISAF may have increased awareness of the budget through the village chiefs. As discussed above, village chiefs in treatment areas were 10 percentage points more likely to have knowledge of the 2018 budget. When village chiefs were asked whether the commune shared the commune budget for 2018 with citizens, village chiefs in treatment areas were 10 percentage points more likely to report that the commune shared the budget with citizens (significant at the 0.01 level) (table 13).

| Table 13: Sharing of Budget with Citizens | | | | | |
|---|---|---------------|------------------|----------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
| | | | (standard error) | | |
| Q4_3 | Did the commune share the commune budget for the past year with citizens? | Village chief | 0.101*** | 0.228*** | 336 |
| | | | (0.036) | (0.054) | |

Note: Significant at *** 1 percent level.

When asked “How can you find out about your commune council budget and how it was spent?” 46 percent of citizens at baseline and 56 percent at endline mentioned the village chief (figure 12), suggesting that ISAF may increase awareness of the budget in future if village chiefs continue to share their knowledge with community members.

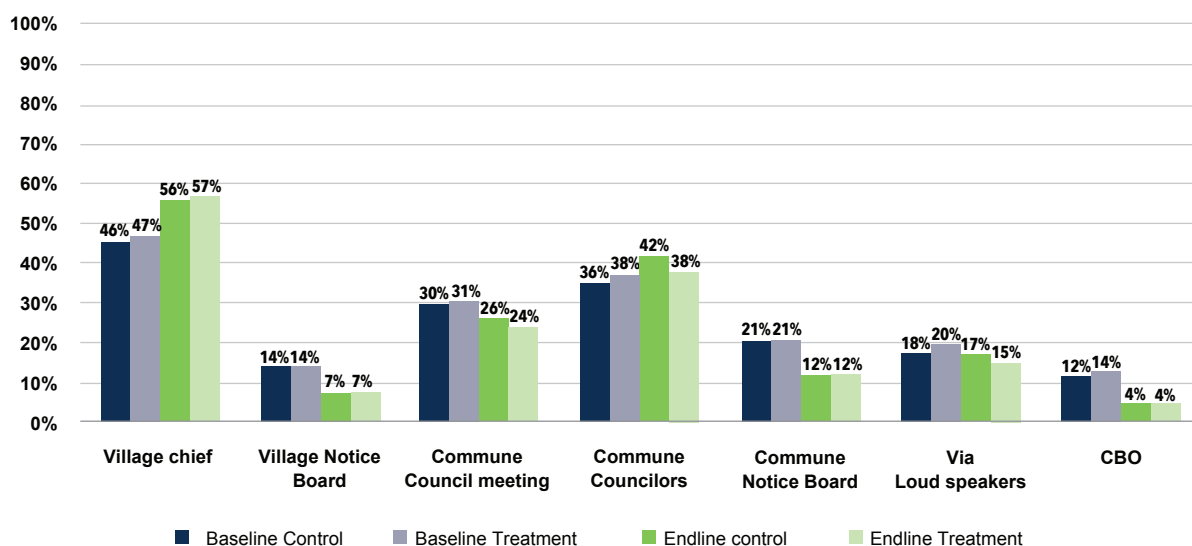


Figure 12: How to Find Out About Commune Budget (HHQ2_17)

Villagers may prefer to obtain information from individual authorities rather than at commune meetings or from notice boards. Villagers reported commune councilors as the second most common source of information (figure 12). The percentage of respondents overall selecting commune councilors as an information source rose slightly, from 37 percent at baseline to 39 percent at endline. The number of individuals citing commune- and village-level notice boards as a source of information (where I4C notices were probably posted) fell from baseline to endline, although it is not clear whether villagers’ perceptions of the reliability of the information posted changed, whether there was a problem of accessibility to the noticeboard, or whether they were accessing information differently. Villagers were not specifically asked about the I4C relating to the budget, so it is unclear whether their responses indicated awareness of the I4C or the budget more widely.

When villagers were asked which of the different types of information—village notice board, posters at public facilities, newspapers, magazines, radio, television, Internet, Facebook, or their mobile phone—they preferred, the impact evaluation survey confirmed television (53 percent), followed by mobile phones (44 percent). Only 5 percent of household respondents reported consulting posters at public facilities.

The endline survey with village chiefs confirmed that they played a role in sharing the budget with villagers (figure 13). Most village chiefs emphasized the presence of village-level mechanisms for sharing the budget with villagers. When asked how the commune had shared the budget in the past year, 65 percent of village chiefs at endline mentioned village meetings, and 58 percent said they did so through the village chief directly. The percentage of village chiefs who mentioned commune meetings as a source of information increased overall from 50 percent at baseline in the treatment group to 56 percent at endline. Finally, village chiefs reported a slight increase in use of commune notice boards overall, from 13 percent at baseline to 19 percent at endline.

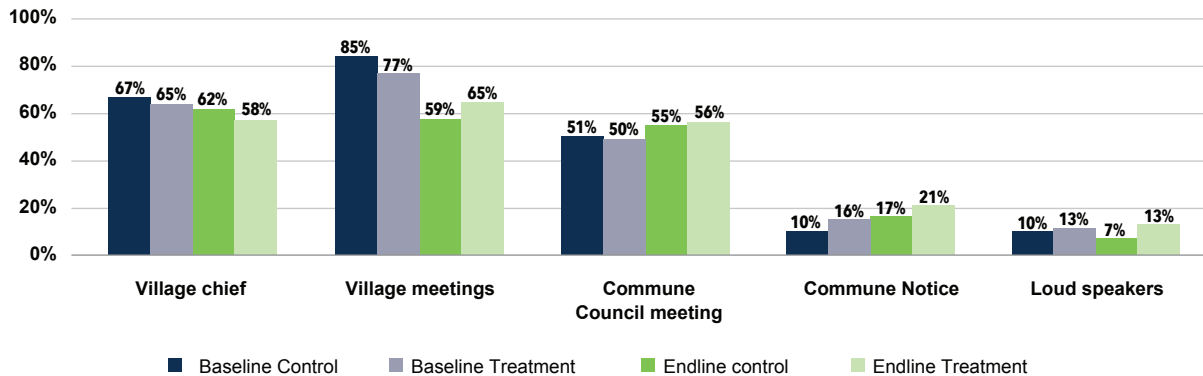


Figure 13: Ways of Commune Sharing Budget (VCQ4_4)

Nonstate actors, including CBOs, and personal contacts, such as friends and family, were not a common source of information on the budget. Overall, CBOs as a source of information declined from 13 percent at baseline to 4 percent at endline. Fourteen percent of villagers identified friends, and 13 percent identified family at baseline, both declining to 8 percent at endline. It is not clear who is considered a CBO, an ISAF implementing partner, an unregistered informal organization, or a volunteer. Villagers were not asked explicitly about the outreach function performed by CAFs so it is not clear how the quality of CAF facilitation or the design of I4C meetings shaped change in awareness.

Knowledge uptake and information dissemination capabilities of CAFs increased over time. Implementing partner reports suggest that CAFs and villagers struggled with understanding budgets initially, finding the technical nature of the information and its novelty intimidating. Implementing partners reported that CAFs gained greater comfort with budget and expenditure information over time but that they needed more mentoring to master the strategies necessary to pass this understanding on to villagers. Furthermore, because this was the first time that villagers had accessed such information, they would need time to develop a level of comfort and a baseline level of understanding. Implementing partners suggested that more time is needed to see results related to awareness change.

Primary Schools

Although differences in most impact evaluation indicators were not significant (table 9), there was a significant negative relationship between awareness of particular classes that are free and ISAF. The high level of knowledge at baseline may partly explain the negative coefficient of the indicator that measures knowledge of the right to a free primary education. At baseline, 87 percent knew that children were entitled to free primary education, suggesting that the variable of interest may have been saturated at endline for the treatment and control groups (Knutson 2017). The impact evaluation did not ask villagers how they knew about their right to primary education, so it is not possible to identify where the ToC breaks down. It could also be that more time is necessary for ISAF to increase citizen awareness regarding specific rights to education.

There was an increase in citizens' knowledge of the right to primary education, which could be an indication of other initiatives interacting with ISAF treatment effects.

Health Centers

ISAF's lack of effectiveness in raising awareness of health care services may be because citizen demand for health center services is low, with many people preferring private providers, including pharmacies. As such, people do not have much engagement with public health centers or awareness of how they operate. When asked where they sought treatment in the ISAF surveys, only 20 percent cited the public health clinic; 23 cited private hospitals, 17 percent private clinics, and 24 percent private pharmacies. Village chiefs confirmed in 30 percent of responses that one of the main reasons citizens do not go to health centers is that they prefer to go to pharmacies for a quick fix to their ailments, especially as pharmacies are quick to prescribe and dispense medicine (a finding that is consistent with the the baseline and endline surveys). More information is needed on how villagers learn about their rights to health care to better contextualize the results on change in awareness.

3.2.3 Results on Levels of Citizen Engagement

This section discusses levels of citizen engagement, focusing on engagement within the commune council as well as opportunities to engage with each of the other service providers. Results for citizen engagement at the commune level are disaggregated according to sex. The section also covers measures of citizen participation at the village level where relevant.

Communes

ISAF had no effect on citizen engagement at the commune level (table 14). It did not lead to more people attending and speaking at commune meetings. Two variables were used to measure citizen engagement in the CIP selection process: awareness of commune projects and participation in project selection. Differences were not significant for either variable. There was a slight decline in citizen participation in commune-level meetings from baseline to endline.

Impact evaluation results suggest that ISAF also had no effect on attendance at village-level meetings and informal forms of engagement at the village level, such as talking to other villagers. Treatment villages were not more likely to have village meetings, and villagers in treatment villages were 5 percentage points less likely to discuss commune-, health care-, or education-related issues with other villagers and slightly less likely to discuss commune issues with leaders (both significant at the 0.10 level). There was a slight overall decrease in villagers discussing service delivery (from 37 percent to 35 percent).

Table 14: Citizen Engagement in Commune Affairs

| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
|----------------------------------|---|---------------|----------------------|---------------------|-----------------|
| | | | (standard error) | | |
| Project development objective_41 | Attended commune council meeting in past year | Household | -0.013 (0.016) | 0.291*** (0.028) | 2,192 |
| Project development objective_43 | Aware of commune council projects | Household | -0.010 (0.020) | 0.164*** (0.032) | 2,192 |
| Project development objective_55 | Spoke at commune council meeting | Household | 0.001 (0.005) | 0.348*** (0.067) | 2,192 |
| Project development objective_45 | Talked about commune matters with leaders | Household | -0.032* (0.017) | 0.167*** (0.023) | 2,192 |
| Q2_20 | Participated in selection of commune council projects | Household | 0.007 (0.024) | 0.167*** (0.024) | 1,895 |
| Q4_13 | Number of village meetings organized | Village chief | 0.233 (0.308) | 0.235*** (0.059) | 336 |
| Q4_16 | Villagers shared thoughts or opinions during last month | Village chief | 0.000 (0.052) | 0.078 (0.064) | 304 |
| Q4_20 | Village planning meetings to inform commune development plan held in this village | Village chief | 0.059 (0.039) | 0.172** (0.080) | 334 |
| Q2_24 | Talked with villagers about commune, health care, or education during last month | Household | -0.053*** (0.017) | 0.162*** (0.028) | 2,192 |

Note: Significant at ** 5 percent level; *** 1 percent level.

The presence of CBOs did not have significant effects on whether villagers talked about commune, health care, or education-related matters with local leaders outside of public meetings. Only village chiefs were asked about CBOs, so the impact evaluation sample on CBOs is limited. Furthermore, it is not clear whether village chiefs were referring to implementing partners or informal local organizations when discussing CBOs.



Levels of Engagement According to Sex

Women were 12 percentage points more likely to participate in selection of CIP projects (significant at the 0.01 level). At baseline, men and women reported similar levels of participation (41 percent of men, 39 percent women), but at endline, 28 percent of men and 38 percent of women reported participating in project selection.

Women's participation in CIP project selection was not necessarily linked to awareness. For instance, men were more likely to know about the budget overall. At baseline, 4.5 percent of men and 0.7 percent of women reported knowing about the 2016 commune budget. At endline, 6.6 percent of men and 1.7 percent of women reported knowing about the commune budget. Men were 12 percentage points more likely to question commune council budget spending than women (significant at the 0.01 level).

| Table 15: Level of Engagement According to Sex | | | | | | | |
|--|---|------------|------------------|----------|-----------|-------------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Male | Interaction | Observations, n |
| | | | (standard error) | | | | |
| Q2_20 | Participated in selection of commune council projects | Household | 0.001 | 0.170*** | -0.115*** | 0.006 | 1,895 |
| | | | (0.029) | (0.024) | (0.025) | (0.038) | |
| Q2_24 | Talked with villagers about commune, health care, or education in last month | Household | -0.026 | 0.138*** | 0.150** | -0.056 | 2,192 |
| | | | (0.043) | (0.029) | (0.066) | (0.087) | |
| Q2_50b | Talked with commune council on how budget was spent | Household | -0.029 | 0.190*** | 0.115*** | -0.043 | 518 |
| | | | (0.029) | (0.051) | (0.040) | (0.050) | |
| Q3_73 | Ever put comments in suggestion box or talked with village health support group members | Household | -0.075* | 0.245*** | 0.004 | 0.068 | 894 |
| | | | (0.039) | (0.036) | (0.050) | (0.074) | |

Note: Significant at ** 5 percent level; *** 1 percent level.

The gender gap was evident when examining participation in informal village-level interactions (figure 14). Men were much more likely to talk with formal village and commune leaders, such as the village chief, commune chief, and councilors, although more women reached out to the village chief over time. At baseline, 41 percent of men and 29 percent of women reported that they spoke with the village chief. At endline, the gap was smaller because of lower reported levels of engagement with the village chief overall, with 27 percent of men and 23 percent of women reporting speaking to the village chief. The gap did not decrease much for commune officials or schoolteachers, although it decreased for health center workers between the endline and baseline surveys. At baseline, 27 percent of women and 20 percent of men indicated that they spoke to health care workers, but participation levels converged, at endline with only a 2–percentage point difference between men and women. It is not clear why the gender gap was reduced for contact with health care professions between the baseline and endline surveys. It may have been due to population characteristics or other intervening variables.

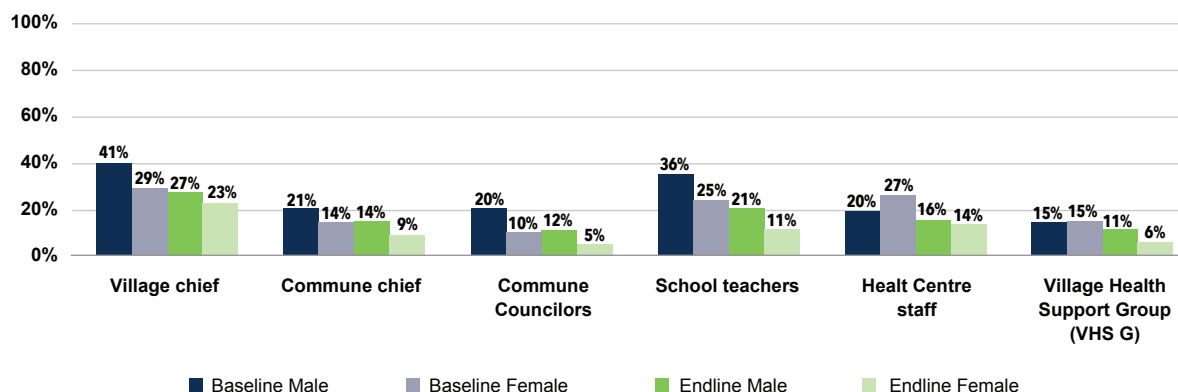


Figure 14: Households Reported Interaction with Local Leaders Outside of Public Meetings (HHQ2_22)

Men were 15 percentage points more likely to talk with other villagers about commune, health care, or education-related matters (significant at a 0.05 level). These figures were consistent at baseline and endline, suggesting that how men and women take part in the public sphere is linked to culturally determined gender roles.

Non-Khmer speakers in treatment areas were 28 percentage points less likely to participate in selection of commune council projects than the Khmer-speaking population (significant at the 0.01 level). Non-Khmer speakers were also 19 percentage points less likely to put comments in the suggestion box or talk with the village health support group (significant at a 0.10 level).

| Table 16: Levels of Engagement for Non-Khmer Speaking Minority | | | | | | | |
|--|--|------------|------------------|----------|-----------|-------------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Non-Khmer | Interaction | Observations, n |
| | | | (standard error) | | | | |
| Q2_20 | Participated in selection of commune council projects | Household | 0.012 | 0.166*** | 0.108 | -0.284*** | 1,895 |
| | | | (0.024) | (0.024) | (0.083) | (0.096) | |
| Q2_24 | Talked with villagers about commune, health care, or education in last month | Household | -0.056*** | 0.162*** | -0.012 | 0.075 | 2,192 |
| | | | (0.017) | (0.028) | (0.040) | (0.087) | |
| | | | (0.026) | (0.053) | (0.017) | | |
| Q3_73 | Ever put comments in suggestion box or talked with village health support group member | Household | -0.047** | 0.238*** | -0.191* | 0.141 | 894 |
| | | | (0.019) | (0.037) | (0.111) | (0.093) | |

Note: Significant at ** 5 percent level; *** 1 percent level.

Primary Schools

ISAF had no significant effect on villagers' engagement with schools (table 17). The impact evaluation measured citizen engagement with schools, examining attendance at parent-teacher meetings, one-on-one meetings with the teacher, and whether they commented in their child's record book. Overall, there was a slight (5 percent) increase in citizen engagement in schools between the endline and baseline surveys.

| Table 17: Engagement (Primary Schools) | | | | | |
|--|--|------------|------------------|----------|-----------------|
| Indicators | Label | Respondent | Treatment | Baseline | Observations, n |
| | | | (standard error) | | |
| Project development objective_15 | Parent met with child's teacher | Household | 0.017 | 0.344*** | 796 |
| | | | (0.029) | (0.039) | |
| Project development objective_51 | Attended parent-teacher meeting and discussed school matters | Household | -0.019 | 0.420*** | 796 |
| | | | (0.018) | (0.066) | |
| Project development objective_52 | Checked record book and left feedback | Household | -0.011 | 0.384*** | 796 |
| | | | (0.028) | (0.047) | |

Note: Significant at *** 1 percent level.

Health Centers

ISAF had no effect on citizen engagement with health centers. Because there are no existing mechanisms to engage with health centers, the impact evaluation used a proxy indicator, a related measure, such as engagement with village health support groups, a group of health center volunteers responsible for conducting outreach, or putting suggestions into the health center box (table 18). The impact evaluation results showed a significant negative relationship between ISAF and engaging with village health support group members in treatment villages (significant at a 0.05 level). There was a small increase in the percentage of citizens leaving suggestions or meeting with the village health support group between baseline and endline.

| Table 18: Engagement (Health Center) | | | | | |
|--------------------------------------|---|------------|------------------|----------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
| | | | (standard error) | | |
| Q3_73 | Ever put your comments in the suggestion box or talked with village health support group? | Household | -0.042** | 0.239*** | 894 |
| | | | (0.017) | (0.037) | |

Note: Significant at ** 5 percent level; *** 1 percent level.

3.2.4 Discussion of Results on Levels of Citizen Engagement

Communes

The dissolution of the main opposition party, the Cambodia National Rescue Party, may have contributed to low levels of citizen engagement. The impact evaluation did not directly study the effects of the ban, but between baseline and endline, the number of people participating at the commune level declined. In November 2017, when ISAF was in implementation, the Cambodian Supreme Court dissolved the opposition party, leading to the replacement of all elected Cambodia National Rescue Party members with ruling party members. Based on results that the Election Commission released, the Cambodia National Rescue Party won approximately 43 percent of commune seats (Radio Free Asia 2017). These critical political changes may have undermined the commune’s representative function and affected people’s willingness to engage in public meetings and to talk to local leaders.

Interviews with village chiefs indicated that there was an overall increase in the number of village meetings that focused on commune affairs. At baseline, 14 percent of village chiefs reported that the purpose of the previous meeting was to talk about commune matters, rising to 48 percent at endline. This increase may be linked to declining rates of participation at the commune level and may have strengthened the role of the village chiefs as intermediaries.

The survey results also suggest that one of the main reasons people did not take part in commune-level meetings was that they thought they had to be invited. Interviews with households, village chiefs, and councilors confirmed the perception of a need for an invitation to attend commune meetings. When villagers were asked in the impact evaluation survey for the “main reasons why they did not attend any meeting at the commune office in the past year,” 68 percent said that they were not invited (figure 15). The consistency of their responses over time suggests entrenched ideas about the need for an explicit invitation. This finding is consistent with the wider literature on citizen participation in Cambodia, which suggests that, even though commune councilors are directly elected, their representative function is not well understood, given the hierarchy between citizens and councilors and the sharp delineation between government and citizen affairs. More than one-quarter of individuals said that they were too busy to attend, suggesting that the relevance of participating may not be evident to villagers (Eng and Ear 2016; Öjendal and Sedara 2006).

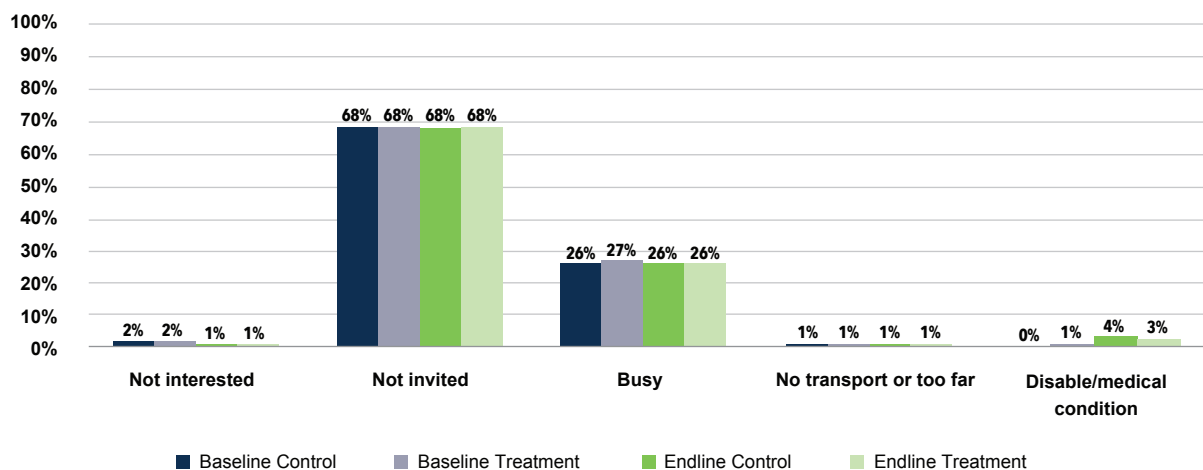


Figure 15: Reasons for Not Attending Meetings at Commune Office (HHQ2_26)

The village chiefs confirmed the finding that citizens thought they needed to be invited. They noted that the most common reason for citizens not participating was that they were not invited (83 percent overall at baseline, 74 percent at endline) (figure 16). There was no treatment effect on the village chiefs' responses over time. Village chiefs may overemphasize hierarchy because it may reinforce their position.

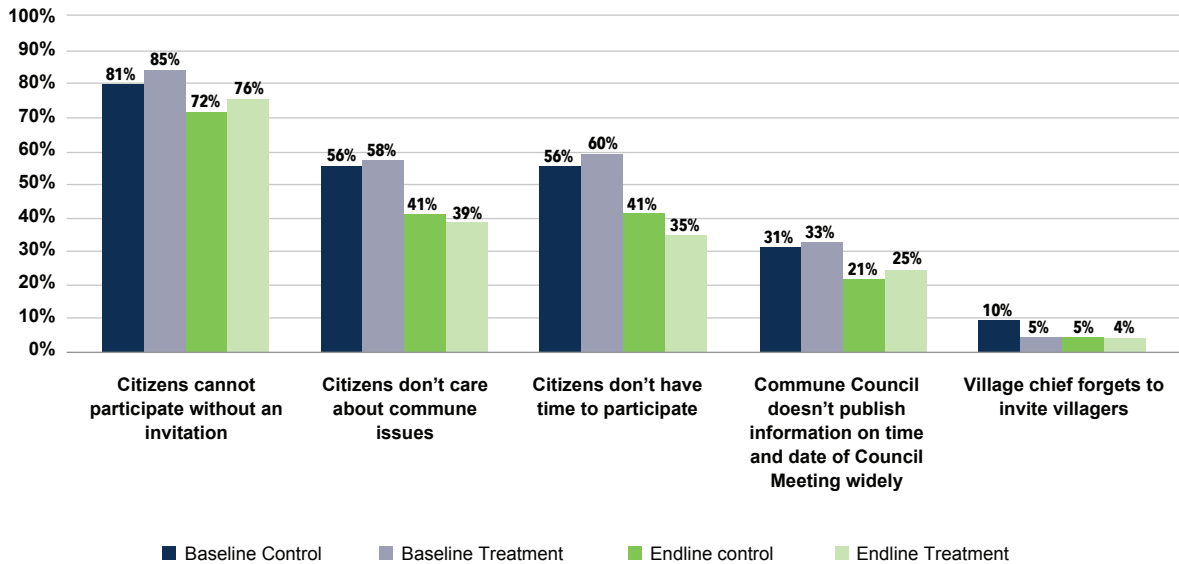


Figure 16: Reasons for Villagers Not Attending Commune Council Meetings

A significant number of commune councilors were unaware of villagers' rights to attend meetings without an invitation; 67 percent at baseline and 45 percent at endline overall reported that citizens did not take part because "citizens cannot participate without an invitation" (figure 17). Over time, commune councilors have gained understanding that citizens do not need an invitation, an understanding that needs to be explicitly addressed in programs promoting citizen engagement. There was no significant treatment effect. This finding may also explain ISAF's lack of discernable impact on citizen awareness regarding meetings. That is, although I4Cs emphasize the right to attend meetings, interactions with commune councilors may have contradicted the I4Cs and, in fact, discouraged attendance.

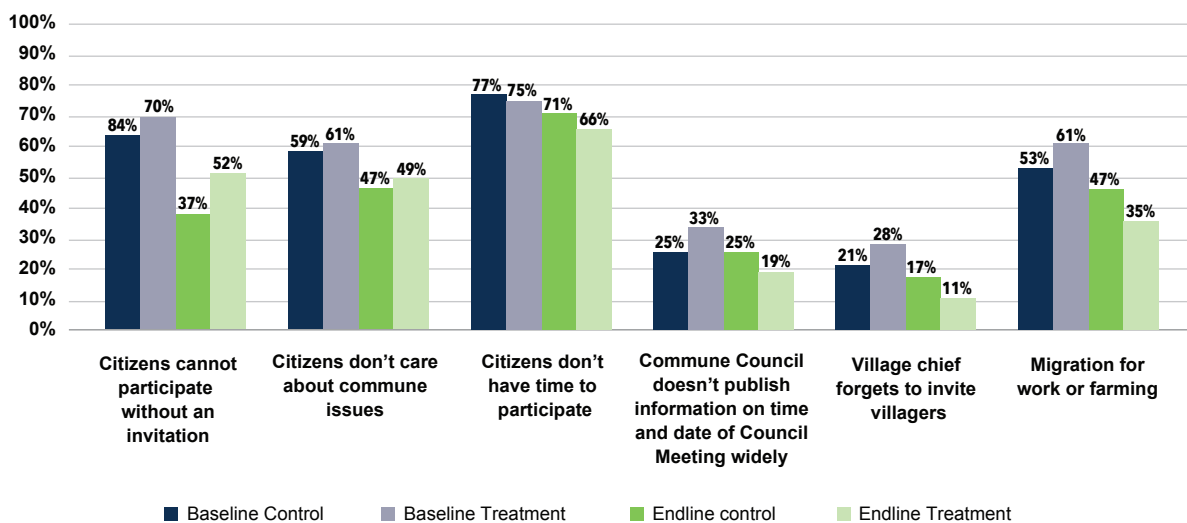


Figure 17: Reasons for Villagers Not Attending Commune Council Meetings

Based on implementing partner reports, CBOs and CAFs reported that they needed the permission of the commune chief (usually delivered through the village chief) to organize I4C awareness-raising sessions. The implication of this cultural practice is two-fold. First, it implies that participation is partly contingent on CBOs' and CAFs' relationships with commune councilors and village chiefs. It is not clear the extent to which such relationships shaped participation because it has not been systematically studied. Although the impact evaluation did not collect much data on CBOs, their presence in treatment areas did not contribute to greater citizen participation, suggesting that their role as mediators with the commune council cannot be assumed and needs to be studied further. Second, because even nonstate actors require the commune's permission to organize even though they have the approval of the central government, individual citizens may feel greater pressure to have an explicit invitation from the commune to attend their meetings.

The impact evaluation results also showed a significant positive link between having friends and family in government and attending a meeting at the commune office (consistent between baseline and endline). This suggests that hierarchy and patronage continue to influence access to and participation in commune-level meetings (table 19).

| Table 19: Effect of Having Family and Friends in Government on Commune Council Participation | | | | | | |
|--|-----------|---|------------|------------------|-----------|-----------------|
| Round | Indicator | Label | Respondent | Q2_45 | Treatment | Observations, n |
| | | | | (standard error) | | |
| Baseline | Q2_25 | In the past year have you attended a meeting at the commune office? | Household | 0.083*** | 0.005 | 3,363 |
| | | | | (0.011) | (0.013) | |
| Endline | Q2_25 | In the past year have you attended a meeting at the commune office? | Household | 0.051*** | -0.009 | 3,361 |
| | | | | (0.013) | (0.015) | |

Note: Significant at *** 1 percent level.

Lack of involvement in the commune selection process may also be linked to the commune council's historic investment in roads. Regardless of citizen participation, commune investments over the past 10 years have consistently prioritized road building based on perceived citizen needs and central government priorities. Councilors also report that they prioritize roads as the financing and procurement processes for infrastructure projects are simpler as compared to social service-related projects. When asked what projects their commune had implemented, 58 percent of citizens at baseline and 63 percent at endline reported roads. One possible explanation for the low levels of participation in project selection is that there is little variation in priorities for use of commune financing, so citizens do not see the point in participating because decisions have already been made, and there is little flexibility to implement different activities. When villagers were asked whether commune staff listened to their opinions, there were no discernable differences between the treatment and control groups. Furthermore, individuals in ISAF areas were slightly less likely as compared to control areas to talk about commune matters with leaders (significant at a 0.10 level) (table 20).

Table 20: Commune Responsiveness

| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
|----------------------------------|--|------------|--------------------|---------------------|-----------------|
| | | | (standard error) | | |
| Q2_36 | Did commune staff listen to your opinion to make their decision? | Household | 0.000 (0.000) | | 27 |
| Project development objective_45 | Did you talk about commune matters with leaders | Household | -0.032* (0.017) | 0.167*** (0.023) | 2,192 |

Note: Significant at * 10 percent level; *** 1 percent level.

Citizens may also have lacked interest in participation because the commune chief is the head of the JAAP committee. That is, citizens may have assumed that the chief would take part in their stead.

Primary Schools

ISAF had no discernable impact on citizen participation in formal school structures. To better understand this relationship, it is necessary to identify competing initiatives. Based on the ToC, the link between ISAF and participation in parent–teacher committees is tenuous. Although ISAF organized a significant amount of citizen monitoring activity conducted through CSCs for 1,404 schools in treatment districts, it did not explicitly advocate participation in school communities or meeting school officials. Other initiatives are focusing on promoting engagement of parents in school-level committees, but ISAF was focused on strengthening the commune’s role as a facilitator of basic service delivery and thus on commune-level structures. Additional review is necessary to identify mechanisms of participation.

Health Center

ISAF activities did not explicitly promote the use of village health support groups and comment boxes. As such, engagement with the village health support groups and use of comment boxes are proxy measures, and they may not be expected to show results. Participation in the many scorecard activities involving the 605 health centers included in ISAF may have reduced the need for citizen engagement with health centers in other ways. Additional review is necessary to explore additional opportunities for participation in the health sector.



3.3 Results on Service Delivery Quality and Outcomes

This section of the report discusses ISAF's effects on the quality and outcomes of service delivery under each service provider. First, awareness of service providers regarding their core responsibilities is discussed because the goal of ISAF was to increase their awareness. Second, the effect of impact evaluation results on quality of services and outcomes of each service provider is presented. Third, findings are discussed.

3.3.1 Communes

Communes' Awareness of Responsibilities

Ninety-eight percent of the 168 councilors surveyed claimed to be aware of their responsibilities and the rights of citizens. The majority were aware of their responsibility to issue birth, marriage, or death certificates promptly—a responsibility that was better understood over time (66 percent at baseline, 76 percent at endline). Thirty-eight percent at endline knew about the requirement for the commune to publicly display budgets and fees. Councilors in the treatment group were 14 percentage points more likely to report that they had a responsibility to be transparent or share information on the budget and user fees with citizens (significant at the 0.01 level) (table 21), suggesting that ISAF increased the commune's understanding of the need for transparency on the budget, although understanding of citizens' rights to attend meetings without invitation is low and varied little over time (10 percent at baseline, 12 percent at endline). Councilors' understanding of the need to inform citizens of commune council decisions increased from 10 percent at baseline to 29 percent at endline, but councilors' understanding regarding citizen rights to elect council members every 5 years decreased in treatment and control areas.

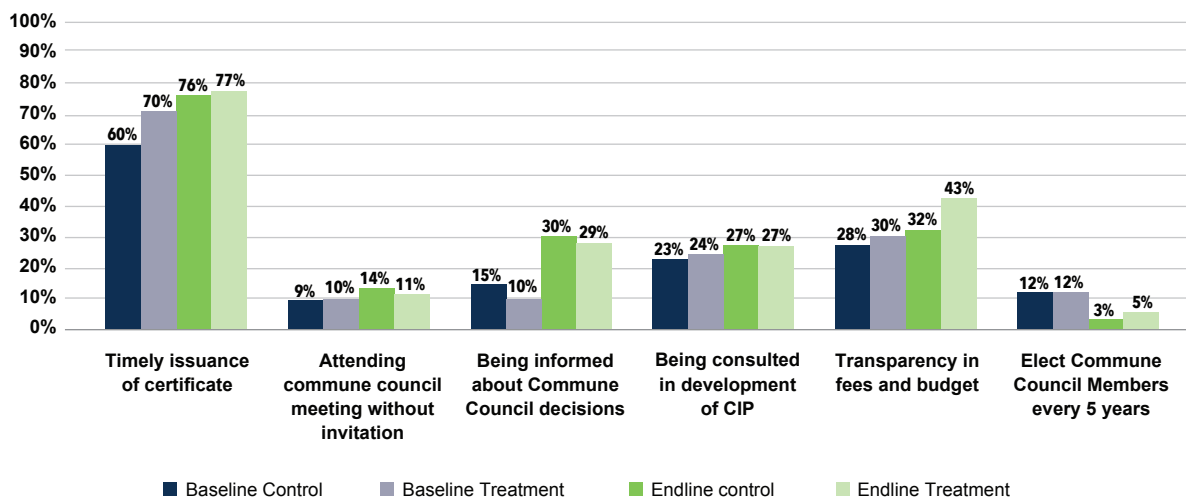


Figure 18: Commune Council Knowledge of Citizen (CCQ2_38)

| Table 21: Citizen's Rights | | | | | |
|----------------------------|---|-----------------|---------------------|------------------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
| | | | (standard error) | | |
| Q2_38_5 | Citizens' rights: Transparency in fees and budget | Commune council | 0.141*** (0.042) | 0.024 (0.090) | 163 |

Quality of Commune Services

The impact evaluation included two measures of commune quality: the experience of procuring registration documents and whether villagers had to pay “tea money” or an informal fee for this service. These measures provided an indication of how well commune councils fulfilled their core service delivery function of providing registration services.

Registration services

Most respondents who sought commune services had positive experiences with the commune’s provision of administrative services. The differences between the control and treatment groups were not significant because there was no variation between the two groups. The mean number of days required to obtain certificates for the treatment group was 4.7 at baseline (4.8 for the control group) and 4.9 at endline (4.5 for the control group). Fifty-five percent of those surveyed received the certificate in less than 1 day. Common reasons for delays included citizens did not bring documents (82 percent of responses at endline), citizens did not understand the required steps (70 percent of responses at endline), and lack of blank forms (43 percent of responses at endline) figure 20).

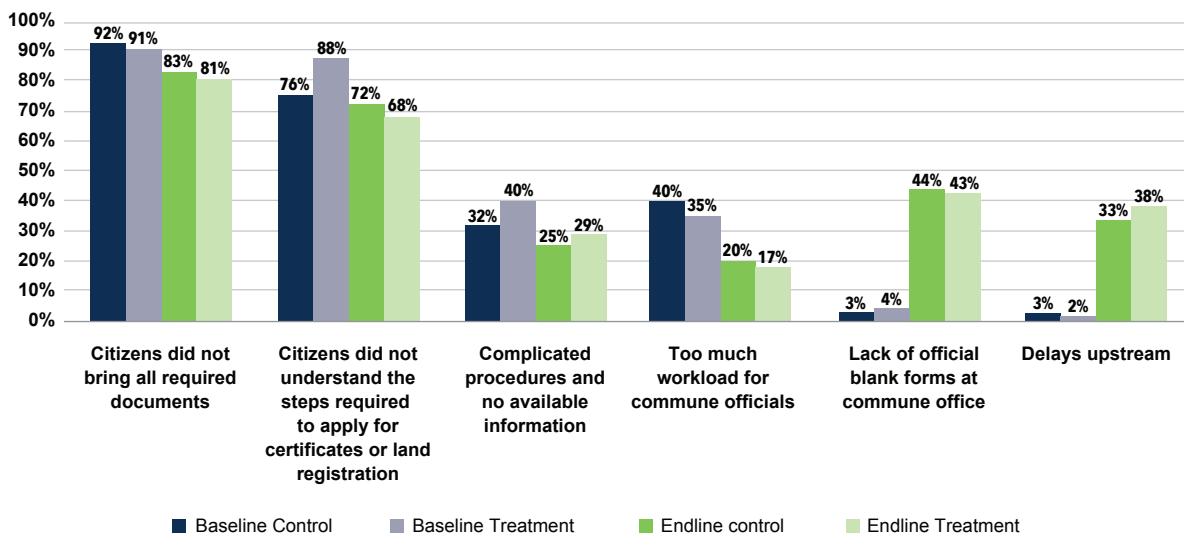


Figure 19: Reasons for Delaying in Issuing Certificates (CCQ1_15)

Payment of Tea Money

The effect of ISAF on the payment of “tea money” could not be determined because the sample size was too small. In 72 percent of responses at endline, individuals cited paying “tea money” to the commune for this certificate (51 individuals in control group, 67 in treatment group). The number of individuals paying “tea money” dropped in the treatment and control groups from baseline to endline (figure 20).

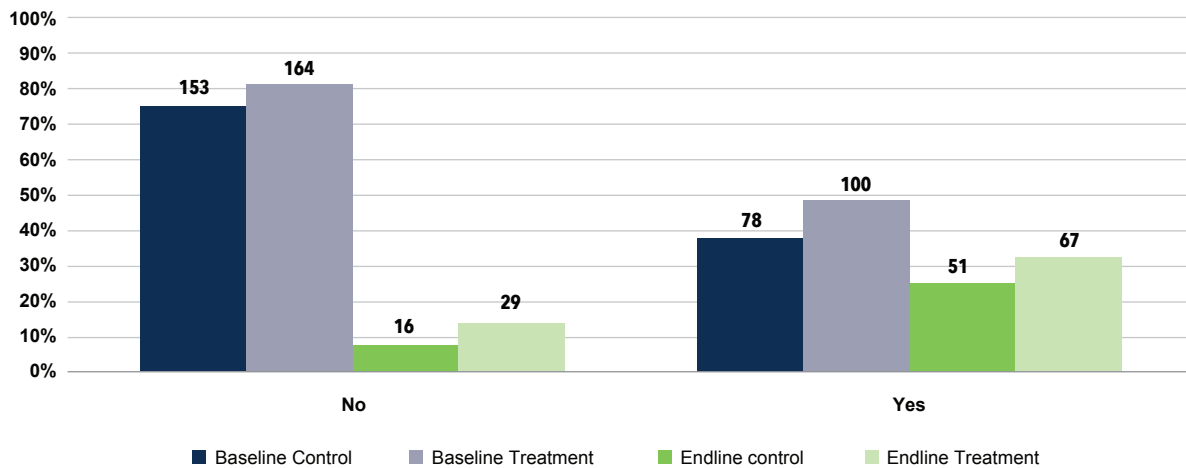


Figure 20: Number of Villagers Paying Tea Money for Certificate (HHQ2_7)

Outcomes for Commune Services

Outcome measures included whether citizens felt that the commune was responsive to their concerns and its transparency or willingness to supply information, because these are core indicators that measure how well the commune council functions as a representative body. As the lowest tier of government, the commune is responsible for sharing information and being a conduit between the national government and citizens. Ninety percent of citizens responded that the councilors were generally helpful and responsive, but there was little variation between baseline and endline, underscoring that ISAF had no effect.

ISAF changed commune-level procedures in making information available for citizens. The survey enumerators spot-checked the information published regarding the budget, working hours of the commune, contact information for commune councilors, fees and processing times, and scheduled meetings. Based on impact evaluation results, commune councilors in treatment areas were 28 percentage points more likely to post working hours, 16 percentage points more likely to list commune office staff, 15 percentage points more likely to list service fees, 26 percentage points more likely to display the CIP, 48 percentage points more likely to display the budget, 35 percentage points more likely to post information on how the budget was spent, and 19 percentage points more likely to show the level of CIP expenditures for 2018 than in control areas. A random review of photographs taken at baseline and endline that showed a 200 percent increase in the posting of budgets confirmed these significant positive differences.

| Table 22: Commune Transparency | | | | | |
|--------------------------------|---|-----------------|------------------|-----------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
| | | | (standard error) | | |
| Q1_1 | Commune council office hours posted | Commune council | 0.280*** | 0.302** | 168 |
| | | | (0.056) | (0.129) | |
| Q1_2 | Commune council phone numbers posted | Commune council | 0.097 | -0.023 | 168 |
| | | | (0.062) | (0.078) | |
| Q1_3 | Commune council staff list and contact information posted | Commune council | 0.162** | 0.088 | 168 |
| | | | (0.065) | (0.092) | |
| Q1_4 | Service fees for services and certificates posted | Commune council | 0.154** | 0.263*** | 168 |
| | | | (0.076) | (0.072) | |
| Q1_5 | Service processing time for services posted | Commune council | 0.095 | 0.035 | 168 |
| | | | (0.068) | (0.115) | |
| Q1_6 | Scheduled time for commune council meeting posted | Commune council | 0.098 | 0.050 | 168 |
| | | | (0.061) | (0.123) | |
| Q1_7 | Commune investment program posted | Commune council | 0.263*** | -0.134 | 168 |
| | | | (0.072) | (0.143) | |
| Q1_9 | Commune council budget posted | Commune council | 0.481*** | -0.305*** | 168 |
| | | | (0.065) | (0.103) | |
| Q1_9A | 2018 budget expenditure posted | Commune council | 0.353*** | -0.154 | 168 |
| | | | (0.071) | (0.101) | |
| Q1_10 | 2018 commune investment program posted | Commune council | 0.190*** | -0.244** | 168 |
| | | | (0.065) | (0.101) | |
| Q2_37 | Commune council meeting information posted | Household | -0.067 | 0.149 | 122 |
| | | | (0.074) | (0.093) | |
| Q2_39 | Perception that commune council councilors are generally helpful and responsive | Household | 0.018 | 0.168*** | 2,192 |
| | | | (0.011) | (0.028) | |

Note: Significant at * 10 percent level; *** 1 percent level.

3.3.2 Results on Quality and Outcomes of Commune Services

To contextualize communes' service delivery performance, the impact evaluation surveyed commune councilors on their greatest challenges, which included insufficient funds to meet citizen needs. Scholars cite how the focus on the commune and participatory planning has created a high level of expectation in citizens, but communes have limited ability to manage expectations, which may limit citizen engagement (Öjendal and Sedara 2011; Sreang et al. 2011). Budget shortfalls were reported in 47 percent of control communes and 35 percent of treatment groups at endline. The next most common challenge reported was lack of staff, reported in 27 percent of control areas and 38 percent of treatment areas at endline. Most councils have one clerk who assists with registration and councilors manage other businesses to supplement their income, so they lack manpower to perform their basic functions. Lack of material such as necessary forms and public awareness of the commune procedures were the fourth and fifth most common challenges reported (figure 21).

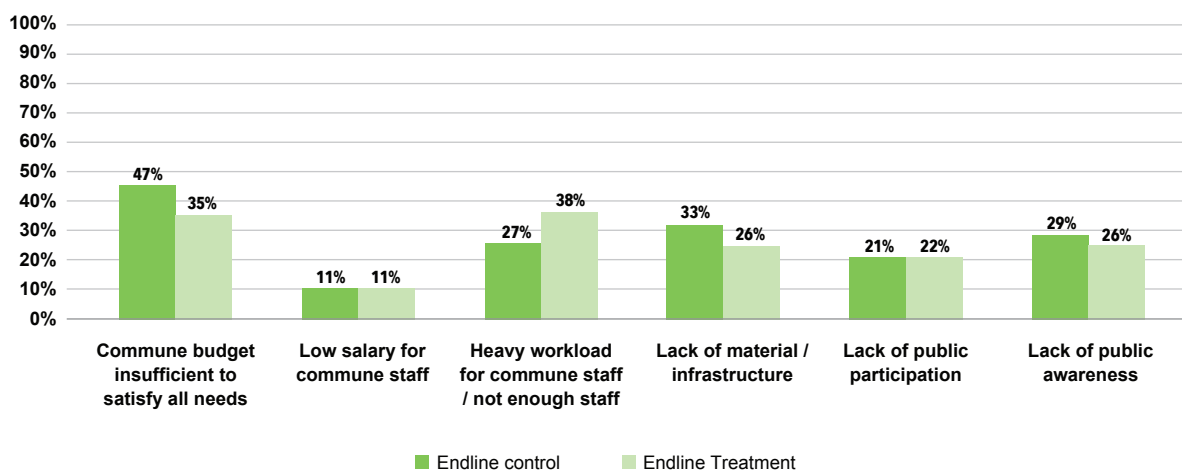


Figure 21: Challenges of Commune Council Chief (CCQ1_16)

Overall, registration services are working well given that half of the applicants were able to obtain their documents in less than 1 day. ISAF effects may be insignificant because registration has been in place in all treatment and control areas for longer than a decade and works relatively well.

Improvements in transparency were significant, suggesting that, because ISAF is a national program of the RGC, policies regarding transparency are being implemented and that the supply of information at the commune level is increasing.

3.3.3 Primary Education

Awareness of Rights of Children to Primary Education

Sixty-eight percent of school directors identified children's rights to a free primary education at baseline and 76.9 percent at endline (figure 22). School directors' understanding of other rights was more limited. Approximately 40 percent identified the right to free textbooks at endline (31 percent at baseline), and 33 percent indicated no informal payments for students at endline (17 percent at baseline). Other rights were less clear; 15 percent of teachers identified the right for boys and girls to have separate bathrooms at endline, and 19 percent identified the right to have one teacher for every classroom.

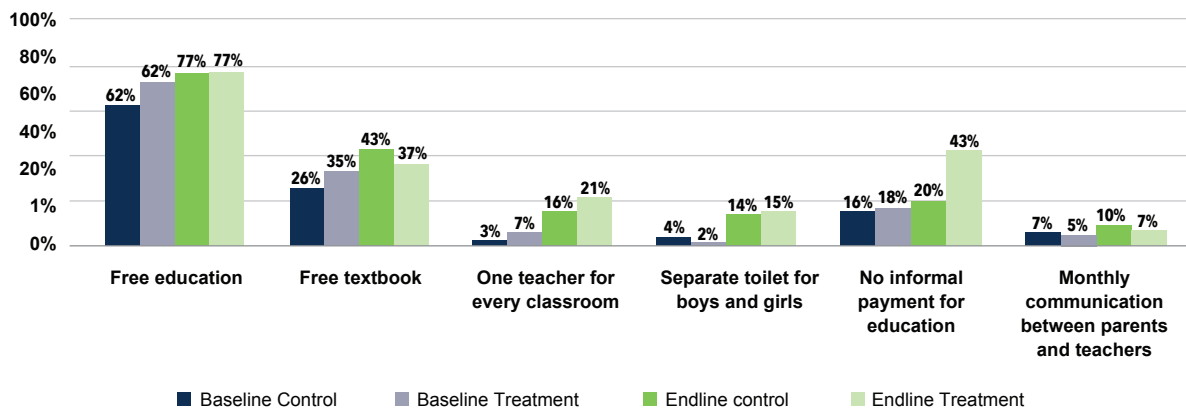


Figure 22: School Staff Understanding of Rights of Children to Primary School Education (PSQ2_37)

Quality of Primary Education

The impact evaluation included three measures of quality: behavior of teachers, payment of informal fees and transparency of school finances, and changes to facilities, such as school infrastructure improvements, which were service standards emphasized in the I4C.

Teacher Behavior

ISAF's effect on teacher behavior was not statistically significant. Teachers' behavior in the classroom was measured using two variables: drunkenness and absences. Based on the impact evaluation survey results, teachers' public drunkenness does not seem to be a problem, with 80 percent of households reporting that it was not a problem and 15 percent not knowing.

ISAF had no effect on teacher absences. Thirty-four percent of households reported absences, but there was no treatment effect. When school directors were asked about absences, 81 percent reported no unauthorized absences, with no discernable differences between treatment and control areas (table 23). This response may have been biased because it reflects on the director's performance and authority.

Table 23: PSQ1_36 - How Many Teachers Were Absent without Authorization?

| Number of Teachers Absent | Baseline | | | Endline | | |
|---------------------------|-----------|-----------|-----------|-----------|-----------|-----------|
| | Control | Treatment | Total | Control | Treatment | Total |
| 0 | 32 | 37 | 69 | 34 | 35 | 69 |
| 1 | 1 | 0 | 1 | 2 | 7 | 9 |
| 2 | 0 | 0 | 0 | 1 | 3 | 4 |
| 3 | 1 | 0 | 1 | 0 | 1 | 1 |
| 4 | 0 | 1 | 1 | 0 | 1 | 1 |
| 5 | 0 | 0 | 0 | 1 | 0 | 1 |
| >=6 | 1 | 1 | 2 | 0 | 0 | 0 |
| Total | 35 | 39 | 74 | 38 | 47 | 85 |

Informal Payments and Transparency

The impact evaluation showed that parents were more likely to pay for enrollment at their child's primary school in treatment areas (table 25) (significant at a 0.05 level). Based on the impact evaluation results, few parents in control or treatment areas reported paying for primary school enrollment. Ninety-eight percent of 1,537 parents did not pay for enrollment or provide any gifts or additional money to teachers. Five percent of parents left money in the record book for the teacher as a small gift, 53 percent of whom were asked to do so. When asked why this practice took place, 50 percent of school directors attributed it to teachers' poor attitudes and ethics; they saw it as an individual failure rather than a systemic problem (figure 23).

Table 24: Percentage of Responders Giving Money to Teachers

| Indicator | Label | Respondent | Baseline | | | Endline | | |
|-----------|---|------------|----------|-----------|-------|---------|-----------|-------|
| | | | Control | Treatment | Total | Control | Treatment | Total |
| | | | % | | | | | |
| Q4_19 | Gave additional money or gift to the teacher for enrollment | Household | 0.4 | 1.8 | 1.1 | 0.7 | 0.0 | 0.3 |
| Q4_22a | Gave money to teacher so child could attend school | Household | 1.2 | 0.6 | 0.9 | 0.3 | 0.2 | 0.3 |
| Q4_36 | Left money in record book for teacher | Household | 5.1 | 4.0 | 4.5 | 6.3 | 3.9 | 5.0 |

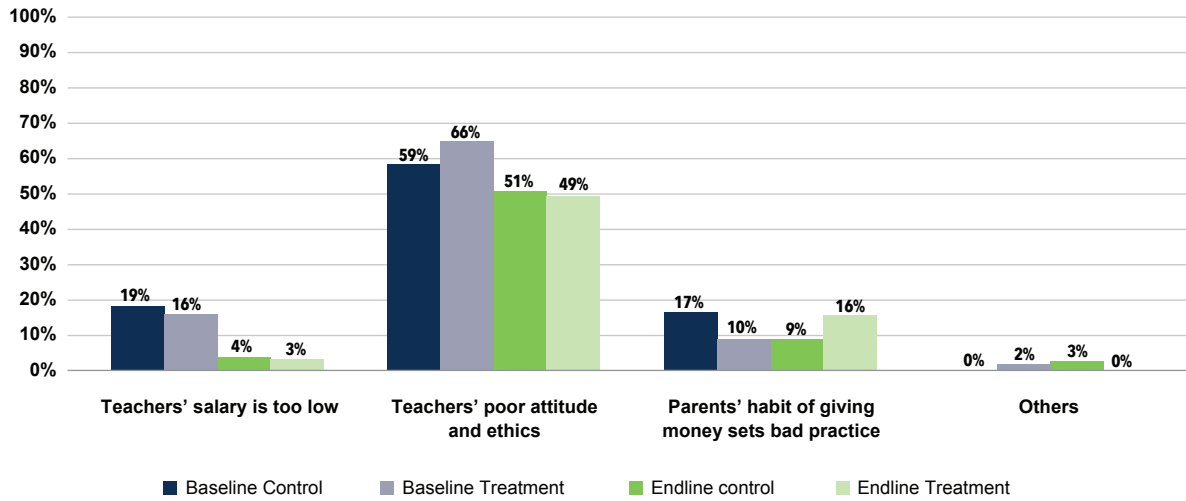


Figure 23: Reasons for Teachers Taking Money from Students (PSQ2_44C)

Transparency increased in primary schools in treatment areas. Primary schools in treatment areas were 13 percentage points more likely than those in control areas to post the school budget (table 25) (significant at the 0.05 level).

| Table 25: Payments and Transparency | | | | | |
|-------------------------------------|--|----------------|--------------------|------------------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
| Q4_17 | Paid for your child's enrollment in primary school this year | Household | 0.020** (0.009) | 0.068 (0.092) | 446 |
| Q1_27 | School posted school budget for 2017-18 | Primary school | 0.128** (0.055) | 0.103 (0.138) | 156 |

Note: Significant at ** 5 percent level.



Facilities

Results on improvements in school facilities were mixed (table 26). Based on independent observations by the enumerator, primary schools in treatment areas were 19 percentage points more likely to have hand-washing facilities for students in the classroom (although not necessarily in the bathrooms), differences that were statistically significant. Differences in whether there was a separate bathroom for boys and girls were not significant. The random photo audit showed a 23 percent increase in separate bathroom in treatment areas as compared to control areas.

| Indicator | Label | Respondent | Treatment (standard error) | Baseline | Observations, n |
|-----------|---|----------------|-------------------------------|--------------------|-----------------|
| Q1_11D | Hand-washing facilities for students available in classroom | Primary school | 0.193** (0.088) | 0.172* (0.094) | 149 |
| Q1_17 | Water available to wash hands in bathroom | Primary school | -0.115** (0.051) | 0.155** (0.065) | 141 |
| Q1_17A | Soap available in bathroom | Primary school | -0.133* (0.078) | 0.124 (0.080) | 141 |
| Q1_13 | Separate bathrooms available for boys and girls | Primary school | -0.009 (0.059) | 0.223** (0.091) | 145 |

Note: Significant at * 10 percent level; ** 5 percent level.

Primary Education Outcomes

Primary education outcome indicators included textbook delivery, class size, and enrollment. Textbook delivery and class size were identified as higher-level outcome measures because they require an input of resources and decision-making outside of the primary school level and, as such, would be considered wider changes in the supply of education. Changes in enrollment would signal changes in wider citizen demand, which would be an important measure of how social accountability approaches were shaping the choices and actions of citizens.

Textbook Delivery (Primary)

The treatment effect on receiving any textbooks was significant and negative (table 27). That is, children in treatment areas were 3 percentage points less likely to receive books (significant at the 0.05 percent level). Overall, 87 percent of parents reported receiving textbooks at baseline and 85 percent at endline, suggesting no major changes in distribution of textbooks. When asked whether parents had received any textbooks from the school, 85 percent of respondents in treatment areas reported yes at endline as compared to and 87 percent at baseline. Of respondents in treatment areas who reported that they received textbooks, 93 percent reported that the textbook was for their child alone and 5 percent reported that the children had to share the textbooks (the remainder did not know). Of individuals who received textbooks, 89 percent in treatment areas and 90 percent in control areas had received one to five textbooks for primary school at endline. Slightly but significantly fewer people paid for the textbooks in treatment areas than in control areas (significant at a 0.05 level).

Responses of school directors regarding whether there were enough textbooks was varied. Forty-eight percent said yes and 52 percent no, but the regression results were insignificant. When asked what percentage of students did not have textbooks, the results ranged from 11.5 percent to 12.8 percent for the control group and 10.9 percent to 15.3 percent for the treatment group.

Delivery of textbooks was not timely. Fifty-seven percent of parents did not know when books were received. At endline, 36 percent of respondents reported that books were received late, from November to March, as opposed to 23 percent at baseline. Books were meant to be distributed in October. Teachers reported a similar schedule of when students received textbooks.

Table 27: Availability of Textbooks

| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
|-----------|--|----------------|---------------------|---------------------|-----------------|
| | | | (standard error) | | |
| Q4_12a | Received any textbook from school during this school year? | Household | -0.036** (0.015) | 0.063** (0.029) | 876 |
| Q4_12b | Were these textbooks for the child only? | Household | -0.017 (0.012) | 0.171*** (0.046) | 703 |
| Q4_15 | Did you pay anything for child's textbook? | Household | -0.017** (0.007) | 0.028 (0.045) | 717 |
| Q2_23 | Were there adequate textbooks for all students? | Primary school | -0.069 (0.072) | 0.224** (0.096) | 159 |

Note: Significant at ** 5 percent level; *** 1 percent level.

Class Size

There were no significant variations in classroom size between the treatment and control areas. School directors and parents reported similar results. Mean classroom size was 34 for the control group and 32 for the treatment group (table 28).

Table 28: Average Number of Students Per Class

| Indicator | Respondent | Baseline | | | Endline | | |
|-----------|----------------|----------|-----------|-------|---------|-----------|-------|
| | | Control | Treatment | Total | Control | Treatment | Total |
| Q4_11 | Household | 35 | 35 | 35 | 34 | 32 | 33 |
| Q1_7A | Primary school | 37 | 36 | 36 | 36 | 35 | 35 |

Enrollment

ISAF's treatment effects on enrollment were mixed. For the 2017 school year when the endline was implemented, ISAF had a nonsignificant effect on enrollment. Children were slightly less likely (significant at the 0.10 level) to attend school in treatment areas than in control areas.

Table 29: Enrollment

| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
|-----------|---|------------|--------------------|---------------------|-----------------|
| | | | (standard error) | | |
| Q4_2 | Is your child formally enrolled for this school year? | Household | -0.021 (0.014) | 0.048** (0.022) | 2,136 |
| Q4_5 | Is your child attending school this school year? | Household | -0.015* (0.008) | 0.580*** (0.061) | 2,223 |

Note: Significant at * 10 percent level; ** 5 percent level; *** 1 percent level.

3.3.4 Discussion of Results on Primary School Quality and Outcomes

To contextualize the discussion on results, the impact evaluation asked primary school directors regarding the challenges they faced in their work. Surveyed primary school principals cited lack of infrastructure and equipment as the greatest challenges that they faced. Thirty-five percent of surveyed principals overall cited infrastructure, but that figure fell from 40 percent at baseline to 31 percent at endline, perhaps because of the RGC's investments in education.

The second most common challenge was parents' lack of understanding and engagement, which was cited in 30 percent of responses. This was a perspective that village chiefs shared, 33 percent of whom highlighted lack of infrastructure in schools as a problem, followed by parents' lack of understanding. This rose during ISAF's implementation, from 28 percent at baseline to 35 percent at endline. A related challenge was student absenteeism, which was also increasingly cited as a challenge, rising from 28 percent to 31 percent.

ISAF had no effect on quality of education as related to teacher behavior. Drunkenness was not reported as a problem, but 34 percent of households reported teacher absences, suggesting that it was a relatively common problem. It is unlikely that ISAF would have been able to make a difference in absences, which is an internal challenge for schools, especially given the power imbalance between schoolteachers and citizens reported widely in the literature. Although the Ministry of Education, Youth, and Sport is reforming these policies, institutional culture and practices may be slow to change.

ISAF contributed to transparency of budgets overall but had no effect on informal fees paid to teachers. Schools in treatment areas were more likely to post school budgets. Informal fees are a systemic problem. Estimates suggest that Cambodian families contribute as much to the education budget through informal fees and payments as the government contributes through formal financing (Eng et al. 2015).

ISAF had a mixed effect on textbooks, with slightly fewer people in treatment areas receiving books but being less likely to pay for them. It is unlikely that changes in citizen demand would have affected change in the supply of textbooks within the timeframe of the project. Textbooks in Cambodia have a complex supply chain whereby the number of textbooks needed each year is incorporated into the annual school development plan, produced at the school and approved by the school support committee and then submitted to the District Office of Education and Provincial Department of Education. The Department of Curriculum Development, a central agency, develops an annual budget for textbooks once it has received development plans from all provincial departments. Finally, the Publishing and Distribution House publishes and delivers textbooks to all schools. The negative effect is most likely associated with the central supply and distribution of textbooks.

ISAF had a small negative effect on enrollment (significant at the 0.01 level). It is not clear what factors shaped enrollment. Contributing to household income and lack of interest in attending school were given as the two most common reasons why children did not enroll. Approximately 23 percent of parents at baseline said that their children contributed to household income, falling to 16 percent at endline. Many parents said that their children did not want to enroll in school (36 percent at baseline, 26 percent at endline). The reported decision on whether to enroll or demand for education had little to do with the quality of education, such as presence of a teacher or facilities, or the cost of the school, and more with socioeconomic circumstances and parental attitudes toward education. Finally, ISAF had mixed effects on hygiene but did not lead to overall improvement in facilities.

National initiatives on education may have interacted with and mitigated the effects of ISAF. Based on a Global Partnership for Education Country Program Evaluation for Cambodia, support of education, especially primary school education, has been a strategic priority for the RGC, as set out in the education strategic plans that the Ministry of Education, Youth, and Sport produces, the latest covering from 2019 to 2023. Public funding for education grew by 273 percent between 2014 and 2019. During ISAF's implementation, the government constructed 500 community preschools, developed a national scholarship framework for primary education, awarded scholarships to 96,507 students in 2018, adopted a curriculum framework and syllabi for all subjects from grades 1 to 12, and introduced direct bank transfers for teachers' salaries. During this period, growth in the number of public primary school classrooms kept up with growth in primary student populations, and the pupil-to-classroom ratio remained 47:1 for 2014 to 2017. There was also a net increase of 177 public primary schools from 2014 to 2018. Textbooks that were revised for the newly developed syllabi were reported as having been disseminated to students (three books per student) between 2014 and 2018. Among the factors that positively contributed to changes in the education sector were the RGC's plan in 2014 to raise the salaries of civil servants, including teachers, as well as increased budget allocations from the Ministry of Economy and Finance and support of development partners (Universalia 2019).

3.3.5 Health Services

Awareness of Responsibilities

Ninety-five percent of health care staff reported knowing about their roles and responsibilities (figure 24). Health care staffs' awareness increased in treatment and control areas, suggesting that the knowledge gained was attributable to a wider health initiative. The number of staff reporting that staffing levels were correct for the health center (8–11) increased overall from 33 percent at baseline to 64 percent at endline. Similarly, the number of health center directors reporting that the health center was open for 24-hour emergency care increased from 28 percent at baseline to 60 percent at endline. The proportion of citizen reporting fees and budgets were publicly displayed decreased from 60 percent overall at baseline to 55 percent at endline. The lowest level of information was reported for number of meetings of the Health Center Management Committee.

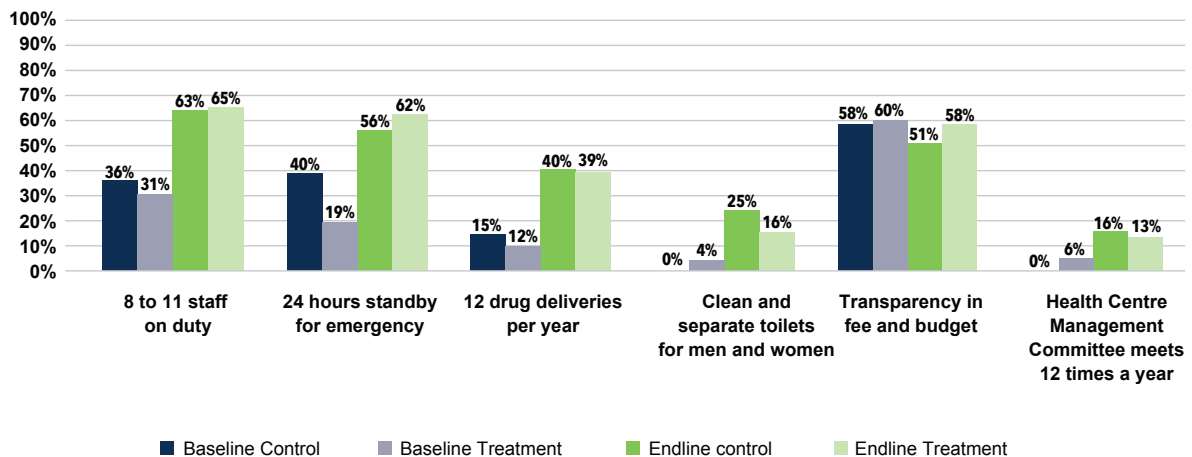


Figure 24: Knowledge of Health Center Standards (HCQ1_27)

Quality of Health Services³

Quality indicators were based on I4C service standards and pertained to availability of staff and wait times, fees, transparency, informal payments, and attitude of practitioners.

Staffing and Wait Times

There were no significant treatment effects on staffing levels and wait times. The variation between treatment and control areas at endline and baseline was small (table 30). Ninety-nine percent of households reported that the health center did not have more than eight staff members, which is stipulated in the health policy. It is not clear what knowledge base households were relying on because use of health centers was low. According to health center data, the mean number of staff available is 10. Health centers reported that two to four staff members were on call at night in 88 percent of centers.

| Indicator | Label | Respondent | Baseline | | | Endline | | |
|-----------|--|---------------|----------|-----------|-------|---------|-----------|-------|
| | | | Control | Treatment | Total | Control | Treatment | Total |
| Q3_49 | Average wait time to see a medical staff member for examination over past 12 months (in minutes) | Household | 9.9 | 12.5 | 11.3 | 13.5 | 13.5 | 13.5 |
| Q1_13a | Percentage of staff on call at this health center last night from 7 pm to 7 am | Health center | 98 | 99 | 99 | 98 | 100 | 99 |
| Q1_13b | Average number of health center staff on call last night | Health center | 2.5 | 2.4 | 2.4 | 2.3 | 2.6 | 2.5 |
| Q3_75 | Number of staff available | Household | 4.3 | 4.4 | 4.3 | 8.0 | 8.4 | 8.2 |
| Q3_77 | Percentage of medical staff available at night at the health center | Household | 82.4 | 76.8 | 79.3 | 84.9 | 84.6 | 84.7 |

Health center directors reported that 24-hour services were provided on weekdays in 99 percent of centers and on weekends in 98 percent. Eighty-five percent of households also reported that health centers had staff at night. There were no significant treatment effects. The availability of staff on holidays dropped to 88 percent on call overall. For 89 percent of centers, the person on call at night was reported to be a nurse, and for 74 percent it was a midwife. The health center director or deputy was on call in 19 percent of centers. The health center guidelines do not specify who should be on call.

³ The role of the health center is to provide a minimum package of services, especially to poor and vulnerable people. These include quality mother–child and reproductive health services, communicable disease control services, noncommunicable disease and other health problem services, health education, and outreach activities. For outreach, the Ministry of Health uses the Health Center Management Committee, village health support group, and village health volunteers to mobilize community members in all stages of primary health care activities and to strengthen links between communities and the health center. The Health Center Management Committee includes the commune chief or a responsible councilor and community representatives (MOH 2007).

Fees and Informal Payments

Although ISAF had no effect on the treatment fee or tea money (table 31), villagers seeking treatment in the health center were 25 percentage points less likely to pay for medicines as compared to the control areas (significant at the 0.05 level). The percentage of people who reported paying anything decreased overall from 53 percent at baseline to 43 percent at endline. The percentage paying for medicine also declined overall, from 18 percent at baseline to 13 percent at endline.

| Table 31: Payment and Transparency | | | | | |
|------------------------------------|--|---------------|---------------------|---------------------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
| | | | (standard error) | | |
| Q3_54 | Did you pay anything for this visit at the health center? | Household | -0.027 (0.042) | 0.256*** (0.053) | 260 |
| Q3_9 | Did you pay anything for this treatment? | Household | 0.079 (0.081) | 0.394** (0.169) | 89 |
| Q3_17 | Did you pay any tea money or thank you fee for this treatment? | Household | -0.732 (0.748) | 0.146 (0.237) | 89 |
| Q3_28 | Did you pay for antenatal care service for this pregnancy? | Household | -2.544 (4.453) | 11.534 (7.719) | 59 |
| Q3_14 | Did you pay for these medicines? | Household | -0.252** (0.122) | 0.147 (0.112) | 74 |
| Q3_20 | Health center budget posted | Health center | 0.242*** (0.056) | 0.056 (0.137) | 132 |

Note: Significant at ** 5 percent level; *** 1 percent level.

Health centers overall were transparent and were 24 percentage points more likely than control areas to post their budget (significant at the 0.01 level). The random review of photographs taken at baseline and endline, which showed a 100 percent increase in budgets posted at the health center between endline and baseline, supported this finding.

Attitude of Practitioners

Based on the impact evaluation findings, villagers seeking treatment at health centers in treatment areas were 7 percentage points more likely to receive an explanation of their condition and advice as compared to control areas on what to do to get better (significant at the 0.05 level).

| Table 32: Villager Experience at Health Centers | | | | | |
|---|--|------------|--------------------|------------------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
| | | | (standard error) | | |
| Q3_52 | Received explanation about conditions and told what to do to get better? | Household | 0.070** (0.033) | 0.053 (0.063) | 260 |

Note: Significant at ** 5 percent level.

Health Outcomes

Measures of health outcomes are based on access to care and vaccinations and would signal changes in citizen demand as well as improvements in a core function of the health center as a provider of preventive health care.

Access to Care

Based on the regression results (table 33), individuals in treatment areas were 10 percentage points more likely to seek care at the health center than those in control areas (significant at the 0.01 level). There was also some positive effects from the ISAF intervention that shaped villagers increased usage of health centers in treatment areas. Individuals in treatment areas were 5 percentage points less likely to experience rude staff and 6 percentage points less likely to wait long before treatment (significant at the 0.10 level), although they were 7 percentage points more likely to feel that health center quality was poor (significance level of 0.05) (table 31). The greater percentage of people who reported that quality was poor may have been linked to higher expectations and use of the health center, part of the ISAF ToC.

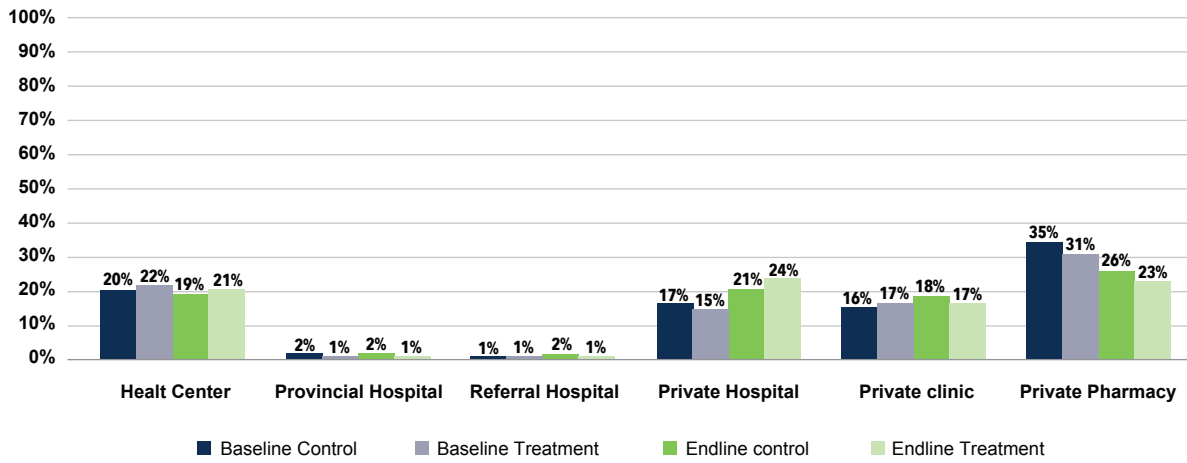


Figure 25: Where Villagers Sought Treatment (HHQ3_5)

Note: Based on whole sample and does not match the same person participating at baseline and endline for respondents at baseline and endline.

| Table 33: Health Center | | | | | |
|-------------------------|--|------------|------------------|----------|-----------------|
| Indicator | Label | Respondent | Treatment | Baseline | Observations, n |
| | | | (standard error) | | |
| Q3_5_1 | Place to seek treatment—health center | Household | 0.100*** | 0.271*** | 774 |
| | | | (0.031) | (0.038) | |
| | Reason for not going to health center for treatment | | | | |
| Q3_8_1 | Staff are rude | Household | -0.045* | -0.024 | 519 |
| | | | (0.025) | (0.015) | |
| Q3_8_2 | Poor quality | Household | 0.069** | 0.187*** | 519 |
| | | | (0.029) | (0.049) | |
| Q3_8_7 | Too long a wait time | Household | -0.083** | 0.165*** | 519 |
| | | | (0.039) | (0.053) | |

Note: Significant at * 10 percent level; ** 5 percent level; *** 1 percent level.

Vaccinations

There were no significant treatment effects related to vaccinations, given the overall high percentage of respondents (95 percent) who had a vaccination card. For children under 2, 83 percent of respondents reported that they had received a vaccination, a service that all but one health center offered. Eighty-eight percent of respondents reported receiving vaccinations from the health center, and another 10 percent reported receiving them from public outreach.

| Table 34: Household Questionnaire 3_35 - Has the Individual Ever Received Any Vaccination? | | | | | | |
|--|-----------|------------|------------|-----------|------------|------------|
| Response | Baseline | | | Endline | | |
| | Control | Treatment | Total | Control | Treatment | Total |
| | n | | | | | |
| Don't know | 0 | 0 | 0 | 6 | 8 | 14 |
| No | 9 | 12 | 21 | 5 | 11 | 16 |
| Yes | 67 | 102 | 169 | 67 | 83 | 150 |
| Total | 76 | 114 | 190 | 78 | 102 | 180 |

3.3.6 Discussion of Results on Health Service Delivery Quality and Outcomes

Based on interviews with health center staff conducted at endline, common challenges for doctors and nurses are presented in figure 26. The greatest challenge identified, accounting for 40 percent of overall responses, highlights lack of patient awareness and understanding (although this decreased significantly between baseline and endline). Approximately one-third of health center staff cited lack of medical staff, and 30 percent cited lack of infrastructure or equipment. Distance from the center was cited in 21 percent of responses. Another common challenge reported in treatment and control areas was that three people on average in each health center had a second job. For a health center with an average of 10 people, this is one-third of its staff. The need for a second job highlights problems with the central government compensation and incentive structure, especially compared with the private sector.

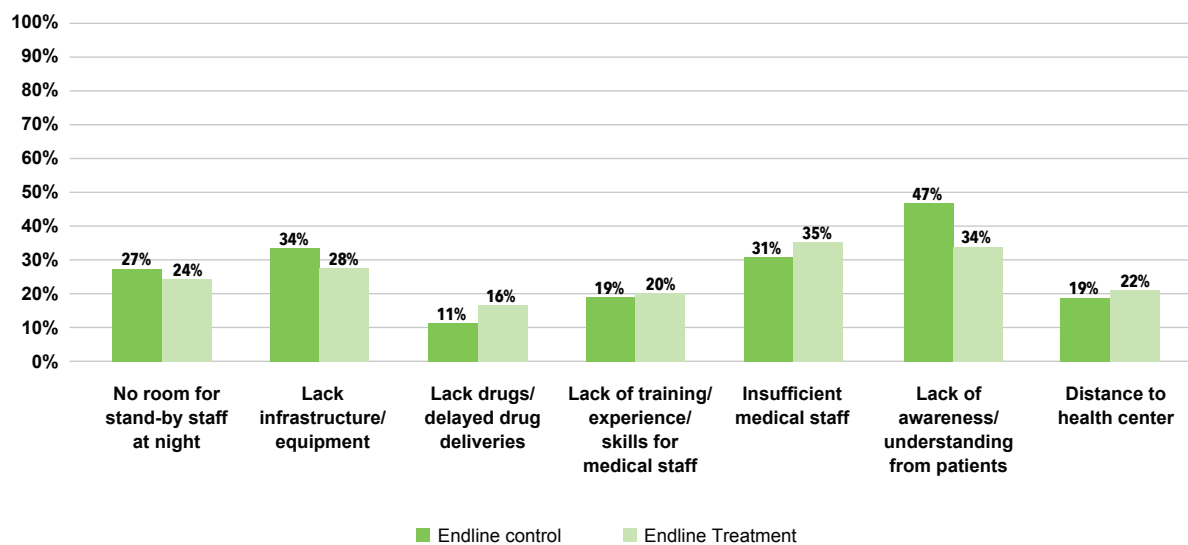


Figure 26: Challenges for Nurses and Doctors (HCQ1_44A)

Overall, ISAF had a positive effect on quality of care at health centers, measured according to user-reported satisfaction. Citizens in treatment areas reported gaining a more thorough explanation from health practitioners and were less likely to pay for medicines (results that were statistically significant) than those in control areas. Health centers in treatment districts were more transparent and more likely to post their budgets. People in treatment districts were 20 percentage points more likely to go to a health center than in control districts.



4

CONCLUSION

4.1 Summary of Results

Examining a wide range of citizen awareness, citizen engagement, and service quality areas, ISAF effects were not detectable in many of these areas. The main program effects were found in transparency in access to information and use of health centers, a health care outcome. There were some improvements in school facilities as well. This section summarizes the results of the ISAF impact evaluation and recommendations for future study. The results section is organized in two parts. The first section summarizes results for the demand side in two anticipated areas of change: awareness of rights to services and service standards and levels of citizen engagement. The second section summarizes results related to the three service providers: service provider awareness of their responsibilities; quality of services; and outcomes related to the commune's administration, primary education, and basic health services.

4.1.1 Awareness of Rights to Services and Service Standards

Impact Evaluation Results

ISAF had a very limited effect on awareness, with no statistically significant differences between the treatment and control groups. The indicators included villagers' rights to attend commune meetings without invitation; question the commune about the budget; and gain access to information regarding commune activities, including meetings, budgets, and the CIP. Village chiefs were 10 percentage points more aware of the budget in treatment than control areas (a difference significant). Meanwhile, the regression results for the indicator that measured whether citizens knew that the commune published information on the date, time, and topic of the meeting were positive and significant. Women and non-Khmer speakers were less aware. Women were significantly less likely than men to know about the budget, and non-Khmer speakers were significantly less likely to know of their right to attend commune meetings.

ISAF had no significant effects on citizen awareness of their rights to and standards for primary schools The impact evaluation measured citizens' awareness of the right to receive free primary education, to have one teacher allocated for 42 students, to receive three textbooks per school year, and not to be subject to corporal punishment.

The variables of awareness pertaining to health standards were not statistically significant and there were no differences between the treatment and control groups. The impact evaluation measured whether villagers were aware that each health center was supposed to have eight to 11 staff members, knew that health centers were supposed to have night staff, and were informed of the treatment fee.

Discussion

Although ISAF had no significant effect, overall citizen awareness of rights and service standards related to the commune, primary schools, and health centers increased between baseline and endline, underscoring an overall positive trend. This trend may also suggest the presence of other outreach initiatives that promoted awareness of basic service standards, such as free education for all, that may be interacting with ISAF's treatment effects.

ISAF increased awareness of village chiefs, an important intermediary for engagement between communes and villages, suggesting that, although ISAF did not directly raise citizen awareness of the budget, it may have reinforced the role of the village chief as a conduit between the commune and citizens and, as such, may increase awareness of the budget and other areas of commune functioning in the future.

The lack of perceptible differences in villagers' awareness of rights and standards could also be attributed to the limitations of the survey approach and contextual factors. Recalling specific detailed information on service provider rights and standards that were shared through the ISAF intervention through a household survey may be difficult because the villagers surveyed did not necessarily participate directly in ISAF activities, and such details may be difficult to remember or to relay widely in the village. Furthermore, participant knowledge tests that implementing agencies conduct at the end of ISAF's I4C events showed significant retention of standards and budget information. Such I4C events were concluded 1 year before the endline survey was conducted, suggesting that such knowledge is likely to have diminished over time. There may also be changes in how citizens access information that may have shaped outcomes. Citizen preference for private providers, such as pharmacies, could have limited demand for health center services. (Based on the impact evaluation surveys, only 20 percent cited going to a health center for their health needs.)

4.1.2 Levels of Citizen Engagement

Impact Evaluation Results

Impact evaluation measures of levels of civic engagement were not significant for formal or informal meetings or there were no differences between the treatment and control groups. Indicators of citizen engagement included participation in formal meetings at the commune and village levels and informally talking to villagers and service providers about commune, education, and health matters. Women were significantly less likely to participate in informal village conversations regarding commune services, education, or health, although the evidence suggests that women were significantly more likely than men to take part in project selection. Non-Khmer speakers were significantly less likely to question the commune on the budget. Impact evaluation results on levels of engagement with the school were not significant. For schools, the impact evaluation measured whether parents attended parent-teacher or one-on-one meetings and left any feedback in the record book. Impact evaluation results suggested that villagers in treatment areas were less likely to talk with health volunteers.

Discussion

Changes in the larger political environment may have shaped citizen engagement. Overall, there was a decline in citizen participation in commune- and village-level meetings and engagement with local leaders between baseline and endline. Furthermore, changes in citizen-state relationships take a long time to mature, and a small intervention, in a politically turbulent time, cannot be expected to show results for a few years after the program.

A critical barrier to citizen engagement at the commune level appeared to be lack of awareness of the right of all citizens to attend commune meetings without an invitation. Despite ISAF raising awareness of the rights of citizens to participate in commune meetings without an invitation, citizens felt that they needed to be invited, as did village chiefs and councilors. Based on the impact evaluation surveys, there was a decrease in this perception from 67 percent at baseline to 45 percent at endline, but a large percentage of commune councilors still reported that citizens did not take part in commune meetings because "citizens cannot participate without an invitation." This emphasis on an invitation from the commune, village chiefs, and citizens may be linked to significant developments in the political context of the program, in particular the commune council elections and dissolution of the main opposition party. The latter led to the replacement of nearly half of elected commune council members during the implementation period, which may have influenced ISAF treatment effects. This could have caused citizens to reduce their engagement with commune officials and village leaders and their participation in commune and village events and make more urgent the need for an "explicit invitation."

The result of lack of a significant effect on levels of citizen engagement in areas that the surveys covered needs to be considered alongside the fact that that ISAF did not explicitly promote such specific forms of engagement. Although the ToC assumed that engaging citizens in ISAF activities would empower them to participate more in other community activities and to speak up more often, the ISAF design did not explicitly encourage citizens to participate in activities such as parent-teacher, village health committee, or commune meetings. The focus of citizen engagement in ISAF was through the CSC and interface meetings with service providers. As such, the citizen engagement measures are indirect proxy measures of the empowerment that ISAF could bring about.

4.1.3 Service Delivery Quality and Outcomes

Impact Evaluation Results

Commune Services

The level of awareness of commune councilors regarding their responsibility to citizens varied greatly. Seventy-eight percent were aware that certificates issued by the commune must be issued within 3 days, but their understanding of the representative function was more limited. Commune councilors in treatment areas were 14 percentage points more likely to report that they had the responsibility to share information on user fees and the budget (results that were significant).

Most respondents who sought commune services reported positive experiences with the quality of the commune's provision of administrative services. The differences in these results were not significant because there was little difference between the control and treatment groups.

The greatest change in outcomes was in the supply of information and the commune's transparency (results that were significant). Given the small number of villagers sampled who attended commune meetings, the commune's policy to publish information on the commune's functioning was based on observations of the enumerators. Based on impact evaluation results, commune councilors in treatment areas were 28 percentage points more likely than those in control areas to post working hours, 16 percentage points more likely to list commune office staff, 16 percentage points more likely to list service fees, 26 percentage points more likely to display the CIP, 48 percentage points more likely to display the budget, 35 percentage points more likely to post information on how the budget was spent, and 19 points more likely to show the level of CIP expenditures for 2018. These results suggested that ISAF changed commune-level procedures in terms of making information available to citizens. Meanwhile, the indicator on whether communes in treatment areas were more responsive in issuing certificates was not significant or there were no differences between the treatment and control group.

Primary Schools

Although 77 percent of principals could identify children's rights to a free primary education at endline (compared with 68 percent at baseline), understanding of other rights was more limited. Approximately 40 percent identified the right to free textbooks (compared with 31 percent at baseline), whereas 33 percent recognized that they were not supposed to accept informal payments from students (compared with 17 at baseline). Other rights were more elusive; 15 percent of teachers identified the rights of male and female students to have separate toilets (3 percent at baseline) and 19 percent identified the right to have at least one teacher in every classroom (5 percent at baseline).

ISAF had mixed effects on the key quality and outcome indicators for primary schools. There were some improvements to facilities, such as washing facilities in the classroom, but there was no effect on teacher behavior. Primary schools in treatment areas were 13 percentage points more likely to post the school budget (differences that were significant). Parents were slightly but significantly more likely to pay for enrollment for their child's primary school in treatment areas. There was no treatment effect on school outcomes, measured according to class size and enrollment. The findings on textbook delivery were mixed; although people in treatment areas were slightly but significantly less likely to receive textbooks, they were also significantly less likely to pay for them, indicating some change in behavior.

Health Centers

Ninety-five percent of health center staff reported knowing about their roles and responsibilities. The knowledge gained increased in treatment and control areas, suggesting that it was because of a wider health initiative. The number of staff reporting the correct number of staff for the health center (8–11) increased from 33 percent to 64 percent overall. Similarly, the number of health center directors reporting that the health center was open for 24-hour emergency care increased from 28 percent to 60 percent. The lowest level of information was reported about the requirement that health centers have separate toilets for men and women.

Health center results were positive on several aspects. Quality was measured through indicators related to service standards promoted through I4C, including staffing and wait times, payment of informal fees, and attitudes of practitioners. There were no significant treatment effects on staffing levels or wait times. Although ISAF had no significant effects on payment of informal fees, based on impact evaluation estimates, villagers seeking treatment in health centers were 25 percentage points less likely to pay for medicines in treatment areas (differences that were significant). Health centers overall were more transparent, including 24 percentage points more likely to post their budget in treatment areas. Villagers seeking treatment at health centers in treatment areas were 7 percentage points more likely to receive an explanation of their condition and what they needed to do to get better.

There were also improvements in health outcomes, with respondents in treatment areas 10 percentage points more likely to seek care at the health center than in control areas (differences that were significant). Differences in vaccination rates were not significant.

4.1.4 Discussion

There was no discernable difference between treatment and control areas in quality of commune registration services because registration is working relatively well across the country. Because the commune's role as a service provider is limited to registration services, indicators of quality included only whether the commune provided a registration document in the required 3 days and whether they were able to curb payment of informal fees. The commune's ability to manage CIPs is linked to its role as a decision-making body and was beyond the scope of the impact evaluation. Fifty-five percent of those surveyed received the certificate in less than 1 day at endline. Common reasons for delays included citizens not bringing documents, citizens not understanding the required steps, and lack of blank forms. A mean of 4.7 days was required for the treatment group at baseline and 4.9 days at endline. ISAF's influence on reducing informal payments, or "tea money," was not clear given the small number of responses to this question.

ISAF had significant positive effects on commune transparency. This is a critical outcome, suggesting that ISAF increased the supply of information.

The lack of significant effects on quality and outcomes related to primary education may be linked to contextual factors. The Ministry of Education, Youth, and Sport has made significant efforts to increase access to textbooks and decrease the student-teacher ratio, which may have interacted with ISAF treatment effects. Furthermore, the two main factors that parents cited as contributing to decisions regarding enrollment (lack of interest and economic constraints) are not directly related to ISAF's key interventions.

ISAF had some effects on quality and outcomes of health center services. Villagers in treatment areas were more likely to seek care at health centers than those in control areas. The fact that individuals in treatment areas were less likely to experience rude staff and long waits before treatment could explain this greater use. There were no treatment effects related to vaccinations given the overall high percentage of respondents (92 percent overall at baseline, 95 percent at endline) who had a vaccination card.

4.2 Conclusions and Recommendations

ISAF should identify specific behaviors, processes, and service improvements that it seeks to influence, including participatory opportunities in the education and health care sectors. Examining a wide range of citizen awareness, citizen engagement, and service quality areas, ISAF effects are not detectable in many of these areas, although ISAF increased dissemination of information by service providers and led to modest improvements in school and health center services, including an increase in the use of health centers. The limited effects of ISAF on other outcomes may be due to the complexity and broad coverage of the program, which may have diluted effects on a range of service areas or the presence of other service improvement investments that overwhelmed ISAF interventions. Future research on ISAF and related interventions may focus on the efficacy of specific components of the program.

4.2.1 Awareness of Rights to Services and Standards

The results of the impact evaluation suggest the importance of using modern modalities for information dissemination and of connecting awareness of specific rights to services with a fundamental awareness of basic legal rights. The results of the impact evaluation suggest that dissemination of information using physical modes, such as posters, is not popular. Although citizens highly rated in-person awareness-raising sessions, these sessions have not necessarily resulted in a spill-over effect to non-ISAF participants. To that end, impact evaluation findings recommend an investigation of the evolution of village information flows. It is also important to probe citizens' awareness of basic rights, as well as the formal and informal ways they express those rights. A more fundamental awareness of basic legal rights could have a greater effect than knowledge retention of specific rights. The literature suggests that, although there has been a traditional hierarchy, over time and with establishment of a participatory mechanism, the relationship between citizens and government officials at the commune level has changed. Furthermore, the literature and anecdotal evidence suggest that social accountability tools have changed ideas of what constitutes a public good and of public rights.

4.2.2 Levels of Citizen Engagement

Future research may be conducted to better understand how social accountability tools reconfigure relationships within villages and between villagers and service providers through case studies in a representative sample of villages. Investments in citizen engagement must address existing social hierarchy. A case study approach will provide greater insight into the incentives for citizens to voice their demands and constraints on them doing so and for service providers to respond, including factors influencing their decision making. Such an approach would also allow exploration of how ISAF interacts with other development approaches and initiatives. In particular, it is necessary to understand the role of the village chief, who is emerging as an important conduit. Such a study could also examine additional opportunities for local participation.

A focused study on the capacity of CAFs to serve as facilitators will be important. One of the most important contributions of ISAF comes in the form of the 4,400 CAFs trained to mediate between service providers and citizens, as well as the emergence of CBOs that can continue to encourage engagement and mobilize citizen voice. However, questions of capacity were beyond the scope of the impact evaluation, and there needs to be a more thorough study of the capacity of CAFs to serve as facilitators, their incentives to continue in this role, how they fit within the existing village hierarchy, and how they link to existing support structures, such as CBOs. The capacity of CAFs to facilitate ISAF activities and links between CBOs and regional and national CSOs should also be investigated.

A systematic study of challenges and opportunities for marginalized populations regarding awareness raising and engagement is also critical. ISAF focused on the most marginalized, rural population. A comparison across income groups might provide additional information on how to better target awareness-raising strategies so they focus on the most vulnerable. Based on the impact evaluation results, there are different treatment effects on women in relation to their awareness of their rights and engagement in village affairs. Even though women reported lower levels of awareness than men on topics such as the budget, they were more likely to participate in CIP project selection. It is also important to study the challenges and constraints on awareness and engagement for other minority populations, including the Cham population, to better understand ISAF's effect on social inclusion and representation.

4.2.3 Service Delivery Quality and Outcomes

Examining relationships between monitoring data and impact evaluation data may lead to further conclusions on the effectiveness of specific ISAF interventions. The impact evaluation methodology tests ISAF's broader service delivery effect but not specific ISAF interventions. The latter were studied under an Asian Development Bank-funded process audit and reported on extensively by the implementing partners. The results of the impact evaluation in the health sector, supported by the findings of this audit, suggest that social accountability interventions have the potential to lead to service delivery changes.





5

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AND APPENDIX

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Appendix A: Summary of Regression Results for Reported Indicators

| Type | Group | Indicator | Treatment effect | Significance |
|------------|-----------|--|------------------|--------------|
| Awareness | Commune | Budget (village chief) | + | ** |
| | | Budget (household) | - | |
| | | Right to attend meeting | + | |
| | | Right to examine budget | + | |
| | | Commune council must display meeting information | - | |
| | | Commune council must display budget | - | |
| | | I4C poster | + | *** |
| | Education | Free primary school | + | |
| | | Correct grades for free education | - | *** |
| | | Appropriateness of corporal punishment | - | |
| | | Availability of free textbooks | - | |
| | | Appropriate teacher-student ratio in class-room | - | |
| | Health | Number of staff | - | |
| | | Available staff at night | - | |
| | | Treatment fee | - | |
| Engagement | Commune | Attended commune council meeting | - | |
| | | Participated in commune projects | - | |
| | | Spoke at commune council meeting | + | |
| | | Talked about commune matters with leaders | - | * |
| | | Participated in project selection | + | |
| | | Participated in village meeting | + | |
| | | Spoke during village meeting | | |
| | | Supported development infrastructure | + | |
| | | Talked about issues | - | * |
| | | Talked with villagers | - | *** |
| | Education | Participated in parent-teacher meeting | + | |
| | | Parents discussed school matters | - | |
| | | Examined record book and left feedback | - | |
| | Health | Placed feedback in suggestion box | - | ** |

| Type | Group | Indicator | Treatment effect | Significance |
|-------------------------------|-----------|---|------------------|--------------|
| Quality of services | Commune | Transparency of fees and budget | + | *** |
| | | Commune office working hours posted | + | *** |
| | | Commune office contact information posted | + | |
| | | Commune office staff information posted | + | ** |
| | | Service fees posted | + | ** |
| | | Service processing time posted | + | |
| | | Commune council meeting time posted | + | |
| | | Commune investment priorities posted | + | *** |
| | | Commune budget posted | + | *** |
| | | Commune investment information posted | + | *** |
| | | Commune meeting results made public | - | |
| | | Commune councilors being helpful | + | |
| | Education | Paid for enrollment | - | ** |
| | | Saw school budget | + | ** |
| | | Hand-washing facilities available | + | ** |
| | | Water available in bathroom | - | ** |
| | | Soap available in bathroom | - | * |
| | | Separate-sex bathrooms available | - | |
| | | Textbook received | - | ** |
| | | Access to personal textbooks | - | |
| | | Paid for textbook | + | ** |
| | | Adequate textbooks available | - | |
| | | Enrolled in school | - | |
| | | Attended school | - | * |
| | Health | Paid for visit at health center | + | |
| | | Paid for treatment | - | |
| | | Paid tea money for treatment | + | |
| | | Paid for antenatal care | + | |
| | | Paid for medicine | + | ** |
| | | Budget transparency | + | *** |
| | | Explanation about treatment | + | ** |
| | | Sought treatment at health center | + | *** |
| | | Staff attitude | + | * |
| Quality of health center | | - | ** | |
| Waiting time at health center | + | ** | | |

Note: Significant at * 10 percent level; ** 5 percent level; *** 1 percent level.

Appendix B: Details of Matched-Pair Randomization

| Geocode | Province | District | Nongovernmental organization | Pair | Treatment or control |
|---------|----------------|--------------------|--|------|----------------------|
| 1401 | Prey Veng | Ba Phnum | Save the Children | 1 | Treatment |
| 1405 | Prey Veng | Me Sang | Save the Children | 1 | Control |
| 1411 | Prey Veng | Por Reang | Save the Children | 2 | Control |
| 1412 | Prey Veng | Sithor Kandal | Save the Children | 2 | Treatment |
| 2509 | Tboung Khmum | Krouch Chhmar | Save the Children | 3 | Control |
| 2512 | Tboung Khmum | Ponhea Krack | Save the Children | 3 | Treatment |
| 1903 | Stoeung Treng | Siem Pang | Save the Children | 4 | Control |
| 1905 | Stoeung Treng | Thala Barivat | Save the Children | 4 | Treatment |
| 1005 | Kratie | Snuol | Save the Children | 5 | Treatment |
| 1502 | Pursat | Kandieng | Save the Children | 5 | Control |
| 0704 | Kampot | Chum Kiri | CARE | 6 | Control |
| 0705 | Kampot | Dang Tong | CARE | 6 | Treatment |
| 0701 | Kampot | Angkor Chey | CARE | 7 | Control |
| 0702 | Kampot | Banteay Meas | CARE | 7 | Treatment |
| 1603 | Ratanak Kiri | Bar Kaev | CARE | 8 | Treatment |
| 1607 | Ratanak Kiri | Ou Ya Dav | CARE | 8 | Control |
| 1606 | Ratanak Kiri | Ou Chum | CARE | 9 | Control |
| 1608 | Ratanak Kiri | Ta Veng | CARE | 9 | Treatment |
| 1103 | Mondul Kiri | Ou Reang | CARE | 10 | Treatment |
| 0903 | Kok Kong | Kaoh Kong | CARE | 10 | Control |
| 0405 | Kampong Chnang | Kampong Tralach | World Vision | 11 | Treatment |
| 0408 | Kampong Chnang | Tuek Phos | World Vision | 11 | Control |
| 1303 | Preah Vihear | Choam Ksant | World Vision | 12 | Treatment |
| 1308 | Preah Vihear | Preah Vihear | World Vision | 12 | Control |
| 0605 | Kampong thom | Prasat Sambour | World Vision | 13 | Control |
| 0606 | Kampong thom | Sandan | World Vision | 13 | Treatment |
| 0407 | Kampong Chnang | Sameakki Mean Chey | World Vision | 14 | Control |
| 0601 | Kampong thom | Baray | World Vision | 14 | Treatment |
| 0207 | Battambang | Ratanak Mondul | Reproductive and Child Health Alliance | 15 | Control |
| 0212 | Battambang | Kamreng | Reproductive and Child Health Alliance | 15 | Treatment |
| 1501 | Pursat | Bakan | Reproductive and Child Health Alliance | 16 | Treatment |

| | | | | | |
|------|--------------|---------------|--|----|-----------|
| 0211 | Battambang | Phnom Prek | Reproductive and Child Health Alliance | 16 | Control |
| 0503 | Kampong Speu | Kong Pisei | Reproductive and Child Health Alliance | 17 | Treatment |
| 0507 | Kampong Speu | Samraong Tong | Reproductive and Child Health Alliance | 17 | Control |
| 0501 | Kampong Speu | Boseth | Reproductive and Child Health Alliance | 18 | Treatment |
| 0506 | Kampong Speu | Phnom Sruoch | Reproductive and Child Health Alliance | 18 | Control |
| 0504 | Kampong Speu | Oral | Reproductive and Child Health Alliance | 19 | Treatment |
| 0508 | Kampong Speu | Thpong | Reproductive and Child Health Alliance | 19 | Control |
| 0307 | Kampong Cham | Kang Meas | Reproductive and Child Health Alliance | 20 | Control |
| 0505 | Kampong Speu | Oudong | Reproductive and Child Health Alliance | 20 | Treatment |
| 1504 | Pursat | Phnom Kravanh | Reproductive and Child Health Alliance | 25 | Control |
| 1506 | Pursat | Veal Veng | Reproductive and Child Health Alliance | 25 | Treatment |

1 Because the role of the commune as a service provider is limited to registration services, indicators of quality focus on whether the commune completed the registration process in the required 3 days and whether it was able to curb payment of informal fees. The commune's ability to manage commune investment programs is linked to its role as a decision-making body and was beyond the scope of the impact evaluation.

2 The mean number of days required for the treatment group was 4.7 days at baseline and 4.9 days at endline.

3 The ISAF program is wide-reaching in its scope, aiming to increase citizen engagement and the quality of service delivery in three large sectors that represent the most critical public services at the local level in Cambodia.



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