Author's Name**:** Robert Horvath
Descriptive Title: Report of the WVF Sponsored Program in Cambodia (VI/C)
Project / Activity Number: 442-0112-A-00-6513-00
Sponsoring USAID Office or Contract Number: HRN-C-00-95-0004-00
Contractor Name: Robert Horvath
Date of Publication: 6-14-98
Indication: none

REPORT OF THE WVF SPONSORED PROGRAM IN CAMBODIA (VI/C)

Robert Horvath

January 24 - February 7, 1998

The evaluation report was conducted under the auspices of the United States Agency for International Development. The evaluation was conducted by the Displaced Children and Orphans Fund and War Victims Fund Contract (HRN-C-00-95-0004-00). The opinions expressed are those of the author and do not necessarily reflect the views of the U.S. Agency for International Development or TvT Associates**.**

Additional information or copies of this report can be obtained by contacting:

Displaced Children and Orphan Fund & War Victims Fund
1601 N. Kent St., Suite 1104
Arlington, VA 22209
(703) 516-9166

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EXECUTIVE SUMMARY

The following contains major findings and recommendations from the author's recent trip to Cambodia. The major purpose of the trip was to participate in an internal evaluation being conducted by Veterans International/Cambodia (VI/C), a program of the Vietnam Veterans of America Foundation. The primary evaluator of the program was Ms. Sue Eitel. The author participated on behalf of the War Victims Fund. See attached report for full findings and recommendations for this objective.

In addition to the VI/C evaluation, the author also attempted to:

1. Gain a greater understanding of the CBR efforts being put forth in Cambodia by the American Red Cross (ARC) and others;

2. Gain a greater understanding of the newly formed Disability Action Council (DAC) as well as ascertain the current status of the DAC's proposal for funding;

3. Review VI/C's "prosthetic plus" activities to ascertain there effectiveness and applicability to other WVF country programs; and

4. Begin discussions with appropriate people regarding a potential WVF foot initiative.

The report will be laid out using these four objectives as a guide.

CBR and the American Red Cross

ARC has been active in the prosthetic sector in Cambodia for numerous years, supported both internally as well as through both USAID/Cambodia and the War Victims Fund. ARC recently received a one year $600,000 grant from USAID/Cambodia in support of several new initiatives, including community based rehabilitation.

The current ARC program is a triad consisting of:

1. Orthopaedic workshop in Kompong Speu - Operating costs of the workshop are funded by a 3 year commitment from USAID. The workshop produces about 50 polypro prostheses a month. In January, 1998, the workshop began producing orthoses. The current goal of ARC is to eventually transfer responsibility of the workshop to the Cambodian Red Cross (CRC). However, ARC has discovered that the CRC is a fairly immature organization and hence is not able to develop a definite time frame for transfer. See the attached VI/C evaluation report for a more detailed description of the ARC program.

2. Community Based Rehabilitation (CBR) - CBR is a new facet of the ARC program funded by USAID. To date, CBR has not been used in Cambodia. In very simplistic terms, ARC proposes to train and employ CBR supervisors who will oversee local CBR workers. These workers will be volunteers and will travel to patient's homes to provide rehabilitation services. In a strict definition, therefore, the program is not community-based, but rather rehabilitation work at a community or family level. This is similar to other "CBR" programs around the world.

Beyond simply providing CBR services, ARC has proposed to "nationalize" their CBR approach through the National Committee for Disabled Persons (NCDP). The NCDP is a membership organization active in advocacy and policy change for, and run by, persons with disabilities. The NCDP was formed in 1994 as a result of a Ministry and NGO workshop. The NCDP contains four components or offices: a) income generation - this includes running a small craft shop and restaurant; b) resource center - providing access to and a repository of materials on disabled persons; c) information and referral services (IRS) - providing counseling, job skill training, resume preparation, as well as a database of clients and potential employers; d) training - mostly in entrepreneurial skills. ARC has proposed that the CBR program will be placed under the training section at the NCDP.

The promotion of CBR, or rather community work with the disabled is one of the

recommendations of the "national plan on the disabled", a working document called *A National Strategy for MSALVA and NGO's of the Rehabilitation Sector on Disability Issues and the Rehabilitation and Integration of Disabled People in Cambodia - A Summary Report.* In 1995, due to poor coordination, a national task force, chaired by the government ministry in charge of rehabilitation, the Ministry of Social Affairs, Labor and Veterans Affairs (MSALVA) and attended by all NGOs in the sector, was set up to develop more effective strategies for organizations working in the area of rehabilitation. After over nine months of work, the task force made its recommendations in the above titled document. This document has been adopted by MSALVA as its working national plan.

The formation of an organizing body, now called the Disability Action Council (DAC) was also a recommendation of the task force. While DAC will be discussed in detail further in this report, it is important to note that under the DAC Secretariat, there are four subcommittees; one of which is responsible for community-based work with disabled persons (CWD). It is under this subcommittee that the formation of a national plan on CBR should have been formulated. The ARC program was not developed in cooperation with this subcommittee nor does it appear that the recommendations of the task force, as outlined in the national plan, were taken into consideration in the development of this plan. The project proposal submitted to and funded by USAID/Cambodia notes that DAC, its subcommittee and VI/C were consulted on the development of the ARC program. In fact, all persons queried on the subcommittee as well as at the DAC executive level were unaware of the ARC proposal. Similarly, key persons at VI/C, including the rehabilitation support services director, were also unaware of the proposed program. The ARC proposal has proposed close collaboration with VI/C as CBR activities will overlap the current VI/C catchment area in Kandal province.

When questioned, ARC notes that the development of the CBR program was a direct result of USAID current policy to NOT fund any activities directly associated with or for the government of Cambodia. Evidently, USAID approached ARC (and VI/C) with an unsolicited proposal request. These organizations were selected as they were 1) the only current USAID grantees in the rehabilitation field and; 2) as current grantees only grant modifications would have to be made to commit funds to this sector. While a national CBR program would normally be developed in conjunction with DAC and Ministry of Social Affairs, Labor, and Veterans Affairs (MSALVA), this was not possible under the current funding climate of USAID.

ARC's country director appeared genuinely surprised that the person tasked by ARC to develop the program, Mr. Billy Barnaat, did not closely collaborate with others in the field. Surprisingly, Mr. Barnaat is the chair of the CWD subcommittee within the DAC.

Recommendations

It is recommended that ARC review its proposed approach to CBR to ensure that it is collaborative, cooperative and within the guidelines set forth in the national plan.

To this end, USAID/Cambodia is encouraged to facilitate a meeting with the major players (VI, ARC, DAC, etc.) in the area of CBR, and whom are slated to be collaborators under the ARC program, to ensure an appropriate program is promulgated.

THE DISABILITY ACTION COUNCIL (DAC)

As noted earlier, the DAC was an outcome of the 1996 task force. Among its recommendations was the urging of the establishment of a body "...to monitor and implement the approved recommendations of the MSALVA Task Force on Disability Issues." The DAC was established as this body. The current organizational body of the DAC and it's committees and subcommittes is outlined in Appendix 2.

The precursor to the DAC, the MSALVA Task Force, was a body consisting of representatives of most all NGOs, IOs, an MSALVA officials involved in the provision of services to persons with disabilities. The Task Force met for over nine months to a) assess the current situation of the sector; b) generate guiding principles of the group; c) analyze all information and identify major issues; d) prioritize these issues; and e) develop recommendations and action plans to address each of the major issues. The Task Force consisted of five sub-committees which met regularly. Once a month a representative of the each sub-committee, plus representatives of the four largest NGOs, the director of the Cambodian Disabled People's Organization (CDPO), several resource persons and MSALVA representatives, met to review the progress of each group and bring up topics for discussion. The five sub-committee were: 1) children with disabilities; 2) community based work with disabled persons (CWD); 3) prosthetics and orthotics; 4) blindness and visual impairments; and 5) vocational and skills training. In the nine months, the body was able to achieve all objectives but the development of appropriate action plans for each subsector.

The outcome of the Task Force, the national strategy document, contains 135 recommendations as well as sub-committee sector analysis and some preliminary action planning. This document is accepted by MSALVA as a "working document" and stands as the national plan for person with disabilities.

As indicated in Appendix 2, the DAC consists mainly of an Executive Board. That board, by mandate, is elected for three years and consists of 3 representatives from MSALVA, 3 representatives who are persons with disabilities (currently 1 member from CDPO and 2 from National Center of Disabled People, NCDP), 3 representatives from NGOs (currently Jesuit Rescue Service (JRS), Handicap International (HI) and ?). The DAC meets on an every other month basis.

It is proposed that the DAC be supported by a Permanent Secretariat, consisting of an Executive Director, advisors and supporting committees as well as sector-based sub-committees. The secretariat level is currently unfunded and operates on the basis of seconded personnel and small amounts of private and NGO funding. In the absence of and executive director, the secretariat formed a steering committee. This committee consists of the country director's of VI/C, HI,

Action on Disability and Development (ADD) and Cambodian School of Prosthetic and Orthotic (CSPO). They are volunteers. The committee has been attempting to guide the sub-committees as well as make decisions on hiring administrative personnel, support staff, etc. It has been proposed that this steering committee remain in support of the secretariat. This committee was appointed, however, and some organizations feel that their continued presence does not follow the elected mandate of the DAC.

Helen Pitt, who has been an advisor to MSALVA for a number of years, has been instrumental in getting the DAC up and running and currently sits in an advisors role. While a dynamic and proactive planner and implementor, Ms. Pitt has stepped on some NGO toes and therefore is not liked or respected universally. This is mentioned because this author feels that as such, Ms. Pitt would not make an appropriate executive director of the permanent secretariat, should such a nomination be put forth. Ms. Pitt is in Cambodia unfunded and has been participating "out of her own pocket." She is recently began her own NGO in Australia and has committed to only 4 6-week periods in Cambodia. The first of these periods ends on February 14th and Ms. Pitt will be returning to Australia.

Also assisting the secretariat at this time is Ms. Joelle Cashera, who has been seconded from HI/Belgium. Under the DAC proposed program plan, Ms. Cashera will become a funded Technical Support Worker (TSW) assisting the executive director. Currently, Ms. Cashera's function is as a facilitator ensuring that the technical sub-committees continue to move forward in the development of their respective action plans. Ms. Cashera has been with the DAC for only two months.

During this trip, considerable time was spent meeting with persons associated with the DAC. Persons and groups met include: Helen Pitt, Joelle Cashera, Larrie Warren (VI/C), Som Sombo (HI), Peter Poetsma (ICRC), Claude Ung and Jo Nagel (VI/C), USAID/Cambodia, and Glen Dixon (ARC). Interestingly, while certainly the theme of the DAC is one of coordination, the different parties met had at times differing ideas/understandings of how the DAC will operate. The author's best understanding is this: the technical sub-committees, consisting of NGOs, IOS and others are directly tasked with planning for the implementation of the task force recommendations. Currently they are preparing action plans for their respective sectors. These action plans will then flow upward through the Secretariat and to the Council for discussion and voting, as necessary. The information will then flow back down to the implementors. The Council and managing Secretariat will monitor and coordinate activities as implemented at the technical level. This is an arduous task and requires the support and cooperation of the implementing agents as well. As you can see from the discussion under the ARC, however, the NGOs/IOs continue to have their own vested interests and the DAC has no legal authority in which to "force" organizations to participate and cooperate. Furthermore, some organizations are uncomfortable with the DAC's charter which notes that it can "implement" as well as coordinate. While those associated with the DAC say that this was included "just in case", others feel that it is contradictory to the DAC's main role as coordinator and facilitator and expressed concern that specific organizations (Cambodia Trust and Handicap International were consistently mentioned)

may use the DAC to promulgate their own agenda .

That said, the DAC is a direct outcome of the Task Force and its participating NGO/IO members. There was a consensus to formulate the DAC and even its staucheset critics foresee an important role for the DAC to play. The DAC is in an immature state and as has not developed consistent credibility. It is the only player in town and potentially may play a very important role in Cambodia.

In meetings with USAID, the author discussed with the Mission the overall concept of the DAC and also queried the Mission as to why it did not seriously consider funding the organization's project proposal under its current humanitarian program. While the Mission is aware of the DAC it has not followed its actions or course with any regularity. The same could be said about not tracking the P&O sector as a whole. Understandably, last year the Mission made a decision to withdrawal from direct support to the P&O sector. However, the July, 1997 "coup d'état" resulted in the US removing all direct support/funding to the government. As a result, the Mission was forced to review its current strategy and consequently direct P&O support was put back on the table. The current VI/C and ARC grants are the outcome. DAC was not seriously considered, thought the Mission noted it merited consideration, due to the close relationship with the government, which the Mission was prohibited from supporting.

The War Victims Fund also received a copy of unsolicited proposal from the DAC. The proposed program was for support of the Secretariat for three years. The proposal has also been sent to others including the European Community (EC). An interesting aside is that in order to submit to the EC, the proposal was "massaged" and put forth by HI. This again fostered the "HI-agenda" criticism.

I have received a revised budget for this proposal. It is attached as Appendix 3. The revisions reduce the solicited amount from the original $539,210 to $500,210. Corresponding yearly changes are: Year 1 - from $263,700 to $230,700; Year 2 - from $191,810 to $177,310; and Year 3 - from $83,700 to $92,200. The increase for Year 3 includes $5,000 for an evaluation and $3,00 for "miscellaneous" expenses.

Recommendations

- The DAC program proposal should be given serious consideration for either full or partial funding by the WVF. Due to the immature nature of the organization, as well as the tenuous nature of the current government (with elections to be held in July), however, even if full funding were available, incremental commitments may be a more appropriate route to follow. However, more specific programming indicators, targets and benchmarks must be developed and submitted. This is absent in the current proposal. Other items which need to be addressed include:

    1. The proposal notes that the DAC will be "Cambodianized" within three

years. It is extremely doubtful that this is a reasonable time frame. Rather than write what perhaps they feel a donor wants to hear, the DAC should develop a realistic and credible scheme for nationalizing the DAC. This may include a gradual reduction of direct expatriate staff while still maintaining NGO representation/advisors, etc.

2. The proposal should clearly state what role each level within the DAC will play (i.e. the council, secretariat, sub-committees, etc.) and how information/decisions will flow and be promulgated.

3. The proposal should clearly state what specific outcomes/ends will result from the organization. These accomplishments should be noted as specific targets with corresponding benchmarks. At the heart of this accomplishments approach should be programmatic indicators which will clearly and accurately measure movement and progress towards the targets. It may be necessary to offer guidance/assistance in the development of these performance measurement tools. An alternative approach would be to develop and include a results framework.

4. The proposal should clearly indicate how the DAC will "coordinate" the work and activities of organizations within the rehabilitation sector in Cambodia and what authority it has been/will be given by MSALVA. To this end, DAC may consider securing written commitments (time and resource) from organizations willing to participate/involve/coordinate with the DAC.

5. The proposal should include an implementation/activity timeline.

6. Budget items:

   A. USAID funds cannot be used to purchase used equipment. The budget calls for the purchase of a used sedan.

   B. $36,000 is budgeted for use of MSALVA premises, electricity and water. At the very least, the $24,000 budgeted for use of premises should be negotiated as an in-kind contribution of the government.

   C. $6,000 is budgeted for secondments from the government. Can these staff positions be negotiated as a government contribution?

   D. Salaries for support staff such as secretary, driver and cleaner appear high compared to local government salaries. While not "high" by Western standards, they may be difficult to maintain when donor funding as been reduced. Does DAC have policies

and procedures as they pertain to staff, travel, equipment, etc.? If not, these should be developed and in place before funding is provided.

- Will/can USAID/Cambodia assume management responsibility for this activity? How long will/can this commitment last?

VI/CAMBODIA'S "PROSTHETICS PLUS" ACTIVITIES

While a bit unclear as to what question was being asked when requested to look at VI/C's prosthetic plus activities, I have divided this into a number of subactivities. They will be discussed or deferred to below.

Outreach/Physiotherapy

Extremely detailed discussions of these activities are included in the internal review report written by Sue Eitel. Additionally, outlines of activities and recommendations are included in Appendix 1. See these documents for more information.

Wheelchair/Crutches

VI/C continues to make the modified Hotchkiss wheelchair. It is noted to be the best in Cambodia and VI/C sells to other organizations; including ICRC in HCMC, Vietnam. It would make a lot of sense to have at least one person from VNAH/HCMC come to VI/C to view their wheelchair making facility. It seems silly that ICRC/HCMC is purchasing from Cambodia when chairs are being made locally. That is, of course, unless the local chair are inferior.

Currently, the wheelchair department only makes wheelchairs. They are no longer producing small items for sale or treadle pumps for a local NGO. The molds for the pumps are still being maintained in case further orders are needed, but this is not in the near future. Staffing in the department is lean, but they are able to keep up with demand.

The expatriate CPO, Jo Nagels, is currently working on a polypropelene inner wheel for the wheelchair. While this doesn't appear to have direct applications for countries like Cambodia where there is a well development bicycle manufacturing sector and, hence, inexpensive parts, it may have appropriate applications in countries like Mozambique and Angola.

Crutches are still obtained for free from ICRC/Phnom Penh. An interesting side note is that ICRC indicates that although the recycling aspect of polypropelene was/is an important selling point of the technology, at least in Cambodia (and Vietnam) it is cheaper to purchase polypropelene pellets from Vietnam and have them trucked into Cambodia then it is to recycle polypro already in the country!

Income Generation and Skills Training

These activities are discussed in detail in Ms. Eitel's report.

Briefly summarized, however, while the activities may have some merit, they are currently totally VI (i.e. the expat manger) driven, managed and run. Moreover, the market for the goods produced is limited at best. The outcome of the evaluation is that VI/C does not promulgate these activities in other areas of the country at this time.

VI/C was also planning to add an economic/social rehabilitation component to their current inventory of activities. However, as substantial solidification and foundation building still needs to take place under their outreach approach, it was recommended that these activities do not take place at this time.

Patient Tracking, Follow-up, and End User Surveys

VI/C does not conduct follow up of any of the amputees receiving services through their centers nor do they conduct end user surveys. Only orthotic/polio patients are seen outside of the center.

VI/C does maintain several databases which will be solidified into one. If needed, the information contained in the database would allow for adequate tracking of patients as well as device/service quality control/assurance. However, as noted above, the information is not currently used for these purposes.

The ICRC database developed last year and distributed amongst the P&O service delivery organizations is not being used. One reason is that some of the fields are either not appropriate/applicable, redundant, missing, etc. to specific organizations. Another reason is that the database was developed in using Lotus software which organizations are not familiar or comfortable with. There is some discussion that a comprehensive, appropriate database will be developed in collaboration with all organizations, but nothing definite is on paper. For the time being, each organization appears to have developed and is using its own database.

War Victims Fund Foot Initiative

Discussions were held with several technicians including Jo Nagels, VI/C and Peter Poetsma, ICRC/Phnom Penh as well as with Theo Verhoeff, ICRC/Geneva, regarding the WVF Foot Initiative. Everyone I spoke to applauded the effort and spoke of how sorely it is needed.

Ideas put forth by Lloyd Feinberg on small workshops, an initiative manager, etc. were thought to have a lot of merit and were supported.

Some suggestions, in no special order, from persons spoken to:

- Do not make the process competitive. Organizations already compete on most other issues/processes and this initiative should be brought forth in a collaborative/cooperative spirit.

- It is encouraged to have representative experts from both the private and public sectors.

- Bringing together "experts" is strongly suggested prior to initiating/pursuing any substantial R&D efforts. A lot of "reinventing the wheel" will be avoided if major players/experts hash out technical issues/successes/failures before sitting down to the drawing board.

- Make sure adequate and appropriate field trials are apart of the process. Interior trials (i.e. mechanical testing, etc.) play a very small role in the eventual success or failure of componentry developed and used in developing countries.

- Some componentry is applicable under certain climates, conditions and countries but may not be in others. Could this be the same for the foot? This needs to be adequately explored before a "world-wide" effort/initiative is put forth.

Recommendations

The WVF should move forward with this initiative. Perhaps the June International ISPO conference in Amsterdam would be an appropriate place to announce the initiative, gather support, and begin preliminary planning with a number of the experts who will be present.

APPENDICES

I. TRIP ITENERARY

Saturday, January 24	Arrive Phnom Penh Meeting with Larrie Warren, Director VI/C to clarify schedule
Sunday, January 25	Team Preparation
Monday, January 26	Meeting/briefing with VI/C and USAID/Cambodia

	Team departs for Prey Veng Province - afternoon visit to provincial rehab center and discussions with staff evening - meeting with Ruth Etherington, VI/C
Tuesday, January 27	am - Outreach with rehab workers pm - visit to provincial hospital and discussions with staff evening - meeting with Ruth Etherington, VI/C
Wednesday, January 28	am - discussions with center staff; depart for Phnom Penh pm - Kien Klaeng tour; discussions with senior staff at KK evening - meeting with Helen Pitt, DAC
Thursday, January 29	am - outreach with KK rehab workers pm - outreach; discussions with patients and rehab workers evening - meeting with Peter Poetsma, ICRC; Jo Nagels, VI
Friday, January 30	am - flight to Prey Vihear Province; meeting with site manager, Bud Gibbons pm - visit to sewing center and silk farm; meetings with staff
Saturday, January 31	am - visit prosthetics clinic and hospital; meetings with staff pm - flight back to Phnom Penh
Sunday, February 1	am - free pm - first week debrief with Larrie Warren
Monday, February 2	am - meetings with - ICRC Component factory and Peter Poetsma - HI polio program and PRES program pm - meetings with - AmCross, Glenn Dixon, Director - Claudie Ung, VI/C dinner - Larrie Warren, VI/C
Tuesday, February 3	all day - at Kien Klaeng Rehab Center dinner - Theo Verhoeff, ICRC/Geneva, Peter Poetsma, ICRC/Phnom Penh, Jo Nagels, VI/C
Wednesday, February 4	am - meeting with Larrie Warren lunch - meeting with Joelle H., DAC pm - meeting with Som Sambo, HI/PRES

Thursday, February 5	am - work on draft report pm - presentation of findings to VI/C
Friday, February 6	am - presentation of findings to USAID/Cambodia pm - meetings with USAID/Cambodia re. R4 as well as Laos
Saturday, February 7	am - work on trip report pm - Return to Bangkok

II. PERSONS/AGENCIES CONTACTED

American Red Cross (ARC): *PO Box 535, Phnom Penh; Tel: 855-23-362-105; Fax: 855-23-362-970*

- Mr. Glenn Dixon, Head of Delegation/Project Coordinator
- Mr. Claude Tardif, Orthotist

Disability Action Council (DAC): *28 Street 184, Chey Chum Nas Quarter, Khan Daun Penh, Phnom Penh; Tel: 855-23-215-341; Fax: 855-23-216-270*

- Ms. Helen Pitt, Senior Advisor
- Ms. Joelle, Technical Support Advisor (Secondment from HI)

Handicap International (HI):

- Ms. Mari Christine, Director of Readaptation Unit
- Mr. Som Sambo, Director of PRES Programme
- Mr. Marc Bonnet, Programme Director
- Mr. Henri, Physiotherapist

International Committee of the Red Cross (ICRC)/Cambodia: *788 Monivong Blvd.; Tel: 855-23-368-023; Fax: 855-23-364-058*

- Mr. Peter Poetsma, CPO, Head of Prosthetic Programme,

International Committee of the Red Cross (ICRC)/Geneva: *19 Avenue de la Paix, CH- 1202 Geneva; Tel: 022-734-2357; Fax: 022-733-2057*

- Mr. Theo Verhoeff - Coordinator Special Fund for the Disabled

US Agency for International Development (USAID)/Cambodia: *c/o American Embassy, Phnom Penh, Cambodia; Tel: 855-23-217635; Fax: 855-23-217638*

- Ms. Enrica Aquino, Grants Manager
- Ms. Louis Bradshaw, Health Program Manager
- Mr. Carey Gordon, Contracts Officer

Veterans International/Cambodia (VI/C): *17 Street 178, PO Box 467, Phnom Penh; Tel: 855-23-427-204; Fax: 855-23-428-963*

A. Senior Staff

- Mr. Larrie Warren, Country Director
- Mr. Jo Nagels, Director of Rehabilitation
- Ms. Claudie Ung, Director of Rehabilitation Support Services

B. Kien Khleang Rehabilitation Center

- Mr. Hing Channarith, Administration Manager

- Mr. Ee Samron, Supervisor, Rehabilitation Support Services
- Mr. Kim Samon, Rehabilitation Worker
- Mr. Ah Naut, Rehabilitation Worker
- Numerous others including: Physiotherapists, CPOs, technicians and service recipients

C. Prey Veng

- Ms. Ruth Etherington, Physiotherapist
- Mr. Keith Etherington, Program Coordinator, Christian Outreach
- Mr. Sareth, Program/Site Manager
- Mr. Hour, Supervisor of Rehabilitation Unit
- Mr. Doen, Rehabilitation Worker
- Numerous others including: screener, physiotherapist, prosthetic technicians, as well as several physicians at the local hospital and service recipients

D. Prey Vihear

- Mr. Bud Gibbons, Site Manager
- Numerous others including: program recipients and hospital staff

III. VI/C FINDINGS AND RECOMMENDATIONS

VETERANS INTERNATIONAL EVALUATION
January 24 - February 6, 1998
Debriefing Document

Rationale for the Evaluation
** Normally to be made at the end of the grant period 1995-97.*
** Former evaluation in October 1995 focused on management/finance and production of mobility aids. These areas have greatly improved and no need to make the same eval.*
** VI felt that it would be useful to evaluate the RSS (rehab support services) sector and focus on effectiveness of the RSS actions in the geographic areas where VI is currently working.*
** The evaluation is meant to be a "friendly" evaluation in that it will provide VI/C with feedback about this sector that will help in future planning and programming. At the minimum, the recommendations will highlight areas that deserve attention or further discussion.*

VOCABULARY

	Prey Veng	***Kheang Khlang***	***Prey Vihar***
RSS (Rehabilitation Support Services)	*has screener, physio, rehab worker and outreach. RSS term not used here.*	*RSS is a very broad term used frequently; it is an area, a team, a service and a unit.*	*there is no physio, no rehab worker, screening and outreach are made by the technician.* *RSS term is not used.*

Recommendations:
Abandon the term of RSS and stay with specific sector titles (screener, physio, etc).
Continue with RSS term, clearly define it and apply it in a standard manner within VI/C.

	Prey Veng	***Kheang Khlang***	***Prey Vihar***
TREATMENTS ***vs.*** *are* ***CONSULTATIONS***	*they are used synonomously*	** 1 consultation is screener.* ** 1 consultation is evaluation.* *(every pt has at least two consultations in the center)* ** consultation is less than 2x seen per month in center.* ** treatment is more than 3x seen per month in center and all sessions counted.* ** outreach depends on the service that's provided.*	*consultations/ treatments not counted nor documented*

Recommendations:
Define and standardize the use of these terms. Modify statistics forms to reflect this.

OUTREACH: *service <u>outside the center</u>. Need to define who does it, where, what and when? (follow-up, recruitment, transport, awareness campaign, in-home treatments only)*
FOLLOW-UP: *actions taken <u>after initial service is provided</u>; these actions may occur in the center or outside of the center. What is "appropriate follow-up"?*
TRACKING: *Unclear and may mean "method to find" target individuals*

Recommendations:
Clarify the terms of outreach and follow-up.
These actions should be clearly found in statistics (will be addressed later).

SCREENER

Actions of Screener	***Prey Veng***	***Kheang Khlang***	***Prey Vihar***
staff	*1 fixed (same since the beginning)*	*1 fixed (started with two and one quit); two rehab workers can replace if sick.*	*doesn't exist; made by the technician*
triage	*yes*	*yes*	*yes*
writes in central registration book (all patients)	*yes*	*yes*	*yes*
fills small patient card	*yes*	*yes*	*yes*
fills amputee form	*yes (type A)*	*yes (type B, and now new type C)*	*no form*
fills measurement card (amputees)	*no*	*no*	*yes*
fills non-amputee form	*no (sends to physio or rehab worker with form A)*	*yes fills history form B and sends to rehab worker for evaluation and to fill form C/D and see with physio for some parts of these forms.*	*no form and no treatment for non-amputees except w/c or crutches.*
organizes patient sleeping in center	*yes (encourage only patient to stay)*	*no (sends to dormitory section; allows one additional person to stay)*	*woman asst. (Pao Sim) does this; no limit.*
enters information into database	*yes (database A)*	*yes (database B)*	*no computer no database*
last one to see does	*yes; money given*	*yes; same as in Prey*	*Pao Sim*

patient before	*for first return trip.*	*Veng, but also start*	*this; pays*
departure and provides money for transport	*Money given for round-trip with repairs. If seen in outreach, may bring back to the center.*	*to send mini-bus or arrange boat to pick-up the amputees (and other disabled) and also bring them home.*	*for round-trip for first treatment; no payment for repairs.*

Screener-related Recommendations:

Check to see all information recorded in central book is the same; if not the same, then try to work toward standardization.

Review amputee forms and discuss why VI/C is using different forms in each site; if no reason, then recommend development of one standard form.

Review forms for patient history, physical therapy evaluation, muscle and ROM forms. Are all of these necessary? Possible to have a simple standard?

Review database information from Prey Veng and Kheang Khlang. Select important common elements from each and develop standard database for VI/C. Recommend database to include date of entry and departure from center and also outreach information.

Clarify VI/C policy regarding payment for transport.

Recommend VI/C to consider long-term implications of providing a "taxi service" for the disabled. This may lead to an unwanted dependency and set a precedent that may be difficult to justify or follow.

HOSPITAL/SURGICAL SERVICES

Services	***Prey Veng***	***Kheang Khlang***	***Prey Vihar***
Type of Surgery	*Provincial Hospital Orthopaedic, club foot, tendon length-ening, equinus correction*	*Khanta Bopha Childrens Orthopaedic ages 0-13. Similar to Prey Veng*	*Provincial Hospital amputations with no skin flap; guillotine style*
Cost	*Currently charges VI 50,000 reil for each surgery ($15 USD). Plan to increase*	*Free*	*Free? (VI pays nothing)*
Agreement	*verbal only*	*verbal?*	*no real contact*
Referral	*VI refers cases from patients seen in center (PV or KK).*	*Makes own ortho surgeries plus will receive referrals from VI.*	*VI does not refer patients to this hospital; takes PP for service.*
VI Support	*1 rehab worker visits patient daily; provides meals and provides medicines if needed.*	*1 rehab worker visits patient once per week; gives money for food; helps to find attendant to stay if needed.*	*Pao Sim gives two meals per day; offers vitamins. Only for amputees.*
Physio Services	*two Khmer physio staff work in hospital*	*approx 5 Khmer physio staff work in hospital*	*there is no physio service here*

Recommendations:

** As there is no physio service in Prey Vihar hospital VI should provide training to help prepare the amputee for a prostheses (good positioning, some strengthening, bandaging massage to strengthen the scar area). This training can be given to Pao Sim, hospital staff, Bud or NGO's working in the area.*

** Develop written agreements; helps ensure continuity of services provided.*

** Although surgery may offer more treatment options, VI should use prudence in referral and consider the patient's function after surgery. Aesthetics should be secondary.*

** The physio service in Prey Veng Hospital and the rehab services offered by VI in Prey Veng Center need attention in order to avoid competition or duplication. It appears the*

VI Center (free food and treatment) is the attractive option.
** If possible, VI could investigate the types of amputation surgeries made in Cambodia and facilitate a training for the Prey Vihar surgeons regarding amputation techniques. See with ICRC or other hospitals for potential training options.*

PHYSIOTHERAPISTS

Services	***Prey Veng***	***Kheang Khlang***	***Prey Vihar***
staff	*1 general physio* *(since 3 weeks)*	*1 head of section (mid-'96)* *1 general physio (mid-'97)* *1 gait trainer (Jan '97)*	*no physio*
outreach	*not yet and not in job descriptn*	*head of section goes from time to time; discussion of patient when rw returns from outreach*	*no physio*
treatment schedule	*daily in the center; no specific time for individual cases.*	*same as in Prey Veng; outpatients have priority*	*no physio*
treatment	*massage is common; little training and much doing FOR the pt.*	*as in Prey Veng; very little creativity or problem solving seen.*	*stockinette cut in strips and circular wrap around stump.*
relation with rehab worker	*currently receiving practical training from rehab worker; equal relation*	*feel a division between the two sections; salary differences, skill levels and attitude of superiority*	*NA*
relation with techs	*limited as the physio is new*	*gait trainer has direct contact; others not clear relations.*	*NA*
documentation	*write in patient chart only when there is a change; daily record sheet?*	*as in Prey Veng, for sure there is daily record sheet*	*NA*
training	*three years in PT school; on the job training in Prey Veng given by rehab worker Polio training by HI/VI*	*three years PT school; on the job training given by head physio in KK. Polio training?*	*NA*

Recommendations:
**Develop point system scale for salaries (determined by diploma, experience, skill level, attitude with the disabled, chart writing, etc) instead of only on title of position.*
** Stimulate physio for problem solving and creative treatment plans.*
** Review documentation in patient chart -- ideal to have record in chart of total treatments received, not just when a change is seen.*

REHABILITATION WORKERS

Services	***Prey Veng***	***Kheang Khlang***	***Prey Vihar***
staff	*1 rehab coordinator -out* *1 rehab worker (1) -out* *1 rehab worker (2)* *(new since '96)*	*1 RSS supervisor* *1 rehab worker (1) -out* *1 rehab worker (2) - out* *1 gait trainer* *1 w/c and exercise trainer*	*no rehab worker*
actions in the center	*patient evaluation and independent treatment (not rehab worker 2)*	*partial patient eval for non-amputees and write in book; instructions from physio for treatment to give*	*NA*
actions outside the center	*SEE OUTREACH*	*SEE OUTREACH*	*NA*
relations with physio	*seem equal (see physio section for additional details)*	*apparent division*	*NA*
relations with techs	*informal and as needed; worked with KK techs for braces every 2 weeks*	*gait trainer works with techs, Bhopa hospital with techs*	*NA*
documen-tation	*write in chart for all outreach visits and write when there are changes for inpatient*	*write for all outreach visits; physio writes for inpatient?*	*none*

Recommendations:
**Develop point system scale for salaries (determined by diploma, experience, skill level, attitude with the disabled, etc) instead of only on title of position.*

OUTREACH

Description	***Prey Veng***	***Kheang Khlang***	***Prey Vihar***
staff	*2 rehab workers* *2 MSALVA staff in Svay Rieng*	*2 rehab workers* *2 techs for Bhopa Hospital*	*1 technician* *Pao Sim*
working	*1 rehab worker*	*1 rehab worker*	*Pao Sim and*
team	*(driver if with car)*	*and driver*	*tech together*
location	*9 of 11 districts in Prey Veng province;* *Prey Veng Hospital* *Svey Rieng province*	*7 of 11 districts in Kandal Province* *Bhopa Hospital*	*5 of 7 districts in Prey Vihar*
schedule	*daily to community* *daily to hospital* *1x/3months to SR*	*MTThF to community only in dry season* *Wed to Bhopa hospital*	
transport	*1 project vehicle* *1 motorcycle*	*1 project vehicle*	*1 motorcycle* *local convoys*
target group	*children and polio*	*children and polio*	*amputees*
actions	*check condition of patient and device, is patient wearing the device/any problems, review exercises, referral, awareness of social situation and answer questions. May transport patients back to workshop.*		
prosthetic			*repair and mine awareness (MAG video)*
expatriate supervision	*upon request (stopped end '96)*	*upon request (stopped end '96)*	*none*
referral	*write "outreach" in upper left corner of patient chart page*	*discussion from physio to rehab worker*	*made only by area not by individual*

documentation	*write in patient chart each time patient visited; write in outreach book*	*write in patient chart each visit; write in daily worksheet write in outreach book?*	*no documentation*
statistics	*outreach actions are not included in monthly stats at any VI/C site*		

OUTREACH OBSERVATIONS:

** The method of referral for initiating outreach is not well defined. Verbal instruction given to rehab worker in KK, and "outreach" written in corner of chart for PVeng.*

** Not clear exactly how many total patients have been identified to be followed outside of the center and how many of those have actually been seen by outreach.*

** The "ideal" frequency for patient follow-up is not followed by outreach as there is not enough time; there is no assurance a patient will be seen in the suggested time frame.*

** There is a general sense that there are too many patients to follow. There is no objective calculation of the number of patients selected for outreach and the specific time period they need to be followed, balanced against the number of patients able to be seen by the outreach worker and the number of outreach workers.*

** There is no data collection from outreach regarding number of treatments given.*

** Planning for outreach is often dictated by the district selected for visit; mainly are visited on a rotation basis and not specifically dictated by number of patients (KK).*

** "Appropriate follow-up" is a term used in project documents, but this needs to be clearly defined and respected.*

** Primarily children and persons receiving orthotic braces receive visits outside the center. Amputees and those with wheelchairs are not scheduled for any visit by outreach.*

** The time spent for outreach actions could be more effectively used; there is little justification for outreach workers to be giving massage, ROM or strengthening exercises.*

** The family is often passive during the outreach worker visit. They are rarely told what the rehab potential is for their child.*

** Appropriate actions taken for problems with brace were inconsistent (PV referred to center for adjustment, KK advised to "get used to it").*

** Reporting in the chart was inconsistent; content of what is written is of questionable*

value, reporting methods differ between PV and KK (SOAP notes), documentation of visit is inconsistent (one KK chart forgotten, no record of visits made to many patients).

** De-briefing meetings after outreach are held in KK, but do not seem to hold any practical value. There is little accountability for knowing what is actually happening with the patients once they have returned home.*

** Once patients are asked to come to the workshop, there is no follow-up to see if they actually came or not.*

OUTREACH RECOMMENDATIONS:

** Develop clear system to identify those needing outreach and the target date for visit.*

** Implement method to check if/when these individuals received a visit.*

** Modify statistics forms to include section about outreach activities (how many total patients to be followed by outreach, how many treatments were given, how many new cases referred for outreach, etc.)*

** Identify workload of rehab workers in relation to number of patients to be seen by outreach; increase rehab worker staff and transportation as indicated by results.*

** All patients receiving a service from the VI/C center should receive target date for follow-up. Can be once per year (or other) for accountability information, planning, direction for other assistance programs, human service.*

** Review methods of reporting for outreach -- not only in the patient chart, but also when returning to the center and how this information is used.*

** Provide additional supervision and training of rehab workers for outreach.*

** Consider rehab workers to work in pairs and not individually.*

** Consolidate current outreach actions and clarify system of work prior to investing in expanding the outreach team to include one social worker. The referral to other organizations is a good idea (and already included in outreach worker job description), but basic follow-up care for the physical aspect of the patient is not yet at a high level.*

** Identify who will participate on outreach (physio, technician, rehab worker) and their role.*

MISCELLANEOUS TOPICS

REPORT WRITING

Situation:

Report writing seems dictated by donor request; narrative reports are generally not written and it is up to the individual staff member to write reports. VI/C institutional memory is primarily by word of mouth and scattered information found in a wide variety of documents. Statistical outputs have been addressed, but project description and developments are not recorded in a systematic way.

Recommendations:

Each site to prepare a monthly report to include: general situation (security/politics), staffing, physical therapy activities, device sector activities, dormitory updates, outreach actions, visitors or special events in the month, main problems encountered, objectives for the coming month.

The Director should read these reports and prepare general "main event summary" each month. This summary should be circulated to all sites, USAID and Washington DC office. Reports serve as a record of what has happened in the Program, helps identify short term direction, facilitates complete information sharing and clear communication.

MOBILE TEAM

Situation:

In general, the mobile team refers to actions previously taken in the Northeast and in Prey Vihar. The mobile team had previously included approximately 6-8 techs and 1-2 rehab workers. The team in Prey Vihar is one technician and one social assistant (Pao Sim).

This evaluation team was unable to assess the skills or actions of the outreach from Prey Vihar and thus cannot comment on actions made or effectiveness of service. Pre-prosthetic care does not seem to apply at this site.

From mid-1997, the responsibility of the mobile team shifted to Kheang Khlang Center. The approach has shifted from local treatment with Jaipur technology to transport of amputees (and other disabled) to and from Kheang Khlang for treatment.

There have been two amputee collection trips made to Kratie, one collection trip is planned for Steung Treng at the end of February, and trips have already started in 5 districts of Kandal province. This action is not described in current project proposal.

Recommendations:

Discontinue reference to Prey Vihar as Mobile Team and label it as a satellite workshop. Do not begin polypropelene technology in Prey Vihar (not adapted and logistically hard).

Provide support for tech and social service person through training, tech supervision.
Review policy for current actions regarding amputee (and other disabled) transport to KK center; be aware of developing unwanted dependency on this service.
Justify use of polypropelene in far Northeast, re-consider satellite workshop with continuation of Jaipur technology in these areas.

COORDINATION/MANAGEMENT

Situation:
There are two areas of coordination and management: expatriate and national staff.
In Prey Veng, the expat will leave in late May; Hour (rehab worker) is moving into the role of "rehab coordinator" which places him in between the new physio and the new CPO that will arrive in Prey Veng. Sareth is manager of the PV center and works well with current actions.
In KK, Mr. Hing is admin director and Ee Sarom is RSS supervisor. The role of technical supervisor and overall direction of the center is still held by Jo.

For expat staff, the organigramme is not followed in practice. Larrie serves as director and each expatriate appears to report directly to him (some with copies to Jo). There is no apparent coordination between projects and a toleration of actions in KK. This program seems to be led by individual initiatives rather than one cohesive plan.
With Claudie and Jo positioned to play a role in Vietnam, the communication within the program may suffer.

Recommendations:
Ideally, the Director would have the background to identify rehab directions that are suited to the beneficiaries' needs, VI/C's philosophy, and capacity of the VI/C centers and staff to undertake specific actions. At this time, the director is pulled by various persuasive arguments and may need objective advice from a non-sector specific player.
An expatriate coordinator could be beneficial in consolidating VI/C's program.

SEWING AND SILK PROJECTS

Situation:
One expatrtiate developing two vocational training projects that are similar to sheltered workshops. One is a sewing project while the other is silk production and weaving.
There are also interships provided (2 months) for working in Phnom Penh. At this time, the project is completely dependent on expat in-put for contacts, training, salaries, direction and general organization and management.

Recommendations:

Do not expand these actions to other areas in Cambodia until after the current questions of sustainability (financial and institutional) have been adequately addressed. VI should focus on bringing physical rehab activities to a consistent standard prior to investing additional time and resources in areas that are outside of this sector.

The expat needs to identify a local counterpart and involve this person in all aspects of the project.

BRACE PRESCRIPTION

Situation:
Some basic treatment given regarding strengthening and then brace is ordered. Unclear if this is meant to be an "interim" brace with further muscle development expected or if this is the full rehab potential of the patient and no further progression is expected. If mixing these, then patietns and families develop unclear expectations of what the future will be regarding their physical abilities.

Recommendation:
Need to develop clear policy of when to give a brace, explain to the patient and family for what purpose, and then follow with appropriate information for expectations and follow-up needed.