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A STRATEGIC ASSESSMENT OF THREE INTEGRATED HEALTH PROJECTS IN CAMBODIA

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A STRATEGIC ASSESSMENT OF THREE INTEGRATED HEALTH PROJECTS IN CAMBODIA:

Reproductive and Child Health Alliance (RACHA)
under Cooperative Agreement number 493-A-00-04-00005-00

Reproductive Health Association of Cambodia (RHAC)
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University Research Co., LLC (URC)
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ACRONYMS

ADB	Asian Development Bank
AI	Avian influenza
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
AOP	Annual operational plan
ART	Antiretroviral therapy
AVSC	Association for Voluntary Surgical Contraception
BASICS	Basic Support for Institutionalizing Child Survival
C-DOTS	Community Directly Observed Treatment, Short Course
CA	Cooperating agency
CBD	Community-based distribution
CBHIF	Community-based health insurance fund
CDHS	Cambodia Demographic and Health Survey
CENAT	Center for Tuberculosis and Leprosy Control
COPE	Client-Oriented, Provider-Efficient
CPA	Complementary Package of Activities
DfID	Department for International Development (U.K.)
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment, Short Course (for TB)
DPHI	Department of Planning and Health Information
EC	European Community
EOC	Emergency obstetric care
EPI	Expanded Program for Immunization
FP	Family planning
GDP	Gross domestic product
GFATM	Global Fund to Fights AIDS, Tuberculosis and Malaria
GTZ	German Technical Cooperation Agency
HC	Health center
HEF	Health equity fund
HIS	Health information system
HIV	Human immunodeficiency virus
HSP	Health strategic plan
HSSC	Health Systems Strengthening in Cambodia (URC project)
HSSP	Health Sector Support Project (ADB/WB/DfID project)
IEC	Information, education, and communication
IMCI	Integrated Management of Childhood Illness
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LMIS	Logistics management information system
LSS	Lifesaving skills
M&E	Monitoring and evaluation
MCH	Maternal and child health
MDG	Millennium Development Goal
MoH	Ministry of Health
MPA	Minimum Package of Activities
NCHADS	National Center for HIV/AIDS, Dermatology, and STD
NGO	Nongovernmental organization
NSDP	National Strategic Development Plan

OD	Operational district
OI	Opportunistic infection
OPHE	Office of Public Health and Education
PAC	Post-abortion care
PBCI	Provider behavior change intervention
PHD	Provincial Health Department/Director
PHR	Partners for Health Reform
PMTCT	Prevention of mother-to-child transmission
PPM	Public-Private Mix
QAO	Quality Assurance Office
QI	Quality improvement
RACHA	Reproductive and Child Health Alliance
RCH	Reproductive and child health
RGoC	Royal Government of Cambodia
RH	Reproductive health
RHAC	Reproductive Health Association of Cambodia
RTI	Reproductive tract infection
SEATS	Service Expansion and Technical Support Project
SO	Strategic Objective
SOW	Scope of work
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SWAp	Sectorwide approach
SWiM	Sectorwide management
TA	Technical assistance
TB	Tuberculosis
TBA	Traditional birth attendant
TWG	Technical Working Group
UK	United Kingdom
UN	United Nations
URC	University Research Corporation
USAID	United States Agency for International Development
VCCT	Voluntary confidential counseling and testing
VHSG	Village Health Support Group
VSC	Voluntary surgical contraception
WHO	World Health Organization
WB	World Bank

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EXECUTIVE SUMMARY

This strategic assessment reviews the project activities and achievements of three USAID-funded organizations in Cambodia: the Reproductive Health Association of Cambodia (RHAC), the Reproductive and Child Health Association (RACHA), and the University Research Co., LLC (URC). The assessment reviews the accomplishments of the three groups toward achieving their objectives and in the context of the forthcoming Ministry of Health (MoH) National Strategic Plan for Health 2008-2015. Conclusions and recommendations are made for each organization as well as for the overall program strategy and objectives.

The assessment is based on a review of documents, interviews with various stakeholders in the health sector (MoH officials at the central, provincial, district, and health facility levels; community volunteers; and other community residents), and interviews with the three organizations' management and field-based staff. The assessment team made field visits to see activities on the ground, both to validate perceptions gained from document reviews and interviews, and to gather more information on activities and insights from service providers and recipients. In total, the team visited five provinces, 13 operational districts (ODs), or health administrative districts; nine referral hospitals (district and provincial level); 24 health centers (HCs); and nine rural communities.

RHAC and RACHA are national nongovernmental organizations (NGOs) developed under USAID sponsorship; URC is a private Washington-based firm that has a USAID agreement to implement the Health Systems Strengthening in Cambodia (HSSC) Project. All three organizations support integrated health activities, focusing on the USAID priorities to address HIV/AIDS, maternal/child/reproductive health, infectious illnesses (specifically tuberculosis, malaria, and dengue), and health system strengthening. The RHAC and RACHA program activities have expanded in size and scope since their last evaluation four years ago. Currently, RHAC works in 11 provinces and 26 ODs, RACHA in seven provinces and 13 ODs, and HSSC/URC in six provinces and 21 ODs. Although the organizations may work in the same provinces and ODs, their actual work responsibilities do not overlap.

The three organizations have some similar objectives and working methods. They all support activities designed to strengthen the technical content, management, availability, quality, and utilization of government health services. Their activities and strategies include strengthening provincial and district management capacity by providing funding for training, on-the-job support for operational planning following MoH requirements, and monitoring results against objectives. All provide training as well as financial and on-the-job support for improving provider skills, service management, and supervision, especially in hospitals and HCs. In addition to supporting government health services, all three organizations have pilot-tested service delivery initiatives with the objective of introducing new technologies and methods that increase community-based access to and delivery of essential services. All address financing issues that are barriers to service access and implement health equity funds (HEFs) or community-based insurance funds. RHAC and RACHA also work with community volunteers (either government- or organization-identified) to promote community education, community-based interventions, and appropriate utilization of health services.

Each organization also has unique strengths and program features. RHAC is a private reproductive health service provider, operating clinics primarily in urban and peri-urban areas with a community network of its own volunteers. RACHA exclusively supports the MoH programs and has a strong community-based program presence. URC brings strong international technical expertise in quality assessment and improvement.

Overall, findings for each organization are extremely positive. The organizations are meeting their objectives and providing quality interventions that have resulted in increased availability and access to health services and that are clearly linked to an improvement in health indicators (maternal mortality ratios being the glaring exception). The expansion and success of HEFs, community-based treatment for tuberculosis, and improved immunization coverage can be directly attributed to these organizations. RHAC is credited with providing a large percentage of national reproductive and HIV testing services. RACHA has pioneered strategies for developing linkages between the community and HCs, mobilizing the community health volunteer force, and increasing demand for government health services, including using microcredit mechanisms to support community-based health insurance. The MoH has adopted URC-supported capacity assessment tools for provincial and OD managers and hospital quality assessments for nationwide implementation.

Conclusions about the overall contribution of RHAC, RACHA, and URC and their impact on MoH programs and USAID objectives include the following:

- Investment in developing and partnering with local organizations has produced highly effective local NGOs that are achieving significant results.
- RHAC, RACHA, and URC have played critical roles in improved delivery and utilization of health services. The government's delivery of health services is being strengthened, and there is evidence of better quality services and increased coverage.
- Activities to strengthen community-government service linkages, including community-based services and implementation of third-party payment mechanisms for communities and for the poor, are strengthening a civil society role in demanding government health services, as well as taking responsibility for supporting them.
- RHAC, RACHA, and URC efforts to link payment mechanisms such as equity funds to quality standards for health services are resulting in increased utilization, increased demand for services, and increased client demand for quality. This has led to improved facility quality and more client-oriented behavior on the part of service providers.

As the team reviewed its findings in the context of objectives outlined in the forthcoming second national health strategic plan (HSP2) for 2008 to 2015, several areas that need to be addressed are apparent:

- All three organizations currently use a similar approach for supporting provincial and OD management in planning, strategic assessments of data, and managing services. The approach is dependent on technical assistance (TA) and funding support without a clear design for shifting future responsibility and accountability to MoH managers. In addition, major weaknesses in the government management system, which, to a large extent, stem from the central MoH environment and policies, are offset by the inputs of external (uncoordinated) funds, TA, and equipment and supplies, possibly resulting in less urgency among stakeholders – including the MoH – to find solutions for the system weaknesses.
- What is described as planning together at the local level is, in fact, a compilation of many separate plans and strategies into one document rather than one integrated plan for an OD or provincial health department to achieve specific strategic objectives.
- Increasing dependence on volunteers for providing community-based services and supporting MoH services requires review to ensure that long-term expectations for the volunteers are realistic and that appropriate support is provided.
- There are significant issues external to these projects that constitute barriers to achieving their objectives. These issues, well known among the health stakeholders, relate to governance and

management policies and environment at the central level; a lack of strong stewardship for health by the MoH; and weak leadership with regard to ethics and standards from the side of national health professionals.

Based on the above observations and conclusions, the assessment team proposes the following general recommendations for future USAID programming:

1. Continue supporting public, private, and civil society programs outside of the joint donor funding baskets, such as the sectorwide "SWAp" and "SWiM" baskets, while coordinating to support the MoH's HSP2. This complementary approach is necessary both for achieving results and to enhance the implementation of the HSP.
2. Recognizing the significant internal disparities in health status, use disaggregated data in planning the next phase of support. Encourage use of these data at all levels of planning for the MoH and donor community to strengthen the focus on planning for poor underserved populations and those subgroups at highest risk within the generally poor and underserved communities the USAID-funded programs already serve.
3. Enhance current capacity building and sector reform activities to improve government management, transparency, and accountability, and further strengthen linkages between incentives and salaries to improve staff motivation and performance.
4. Develop a strategy to increase community ownership and responsibility for volunteers and their activities and reinforce the importance of linkages between communities and local HCs.
5. Recognizing the significant role played by the private sector in service delivery, develop an approach and strategy for improving public-private collaboration to fulfill unmet service needs and to ensure the quality of both public and private sector services.
6. Explore support for strengthening private sector professionalism and standards to address a rapidly expanding and increasingly utilized, but as yet unregulated and unmonitored, private sector.
7. Ensure that USAID, its partners, and other donors actively use the available data on systemwide drug supply problems in regular discussions with senior decisionmakers and policy leaders as part of the ongoing national health plan and health sector support strategy dialogue.
8. Give high priority to institutionalization and development of full MoH ownership over the process of the quality improvement system for hospitals.
9. Strengthen strategies to increase the national-level profile of large NGOs such as RHAC and RACHA as advocates and role models for improved health services. This can be supported by limiting the field-level implementation activities of international organizations to those that cannot be carried out by local NGOs.

Additional recommendations specific to each organization are provided in section III of this report.

I. BACKGROUND

INTRODUCTION AND OBJECTIVES

Over the past five years, the United States Agency for International Development (USAID) has invested significant resources in three integrated health projects in Cambodia: the Reproductive Health Association of Cambodia (RHAC), the Reproductive and Child Health Alliance (RACHA), and the Health Systems Strengthening in Cambodia Project through the University Research Co., LLC (HSSC/URC). RHAC and RACHA are local nongovernmental organizations (NGOs), and URC is a U.S.-based cooperating agency (CA) for USAID. USAID/Cambodia commissioned the assessment of activities of these three partner organizations, all of whose current agreements will end in 2008, in preparation for planning the next phase of support, to cover 2008 to 2012.

The current health priority for USAID, as defined in USAID/Cambodia's Strategic Objective (SO) 9, is "Improved Health Services in HIV/AIDS and Infectious Diseases as well as Maternal, Child, and Reproductive Health," to be achieved by (a) addressing causal factors at the community level that contribute to high maternal, child, and infant mortality; (b) preventing and mitigating the impacts of infectious diseases of major importance, including tuberculosis (TB), HIV/AIDS, malaria, avian influenza (AI), and dengue fever; and (c) strengthening the health system at various levels.

Each of the three organizations assessed has unique activities to address the SO9 objectives, as well as some approaches that are similar.

Within different geographic areas, all three organizations provide support to provincial and operational district (OD[1]) management teams and to government-managed hospitals and health centers (HCs). They help to fill gaps related to service provision by supplementing funding or supply needs and also provide technical support for strengthening skills and capacity. Specific activities include (a) funding per diem and other expenses for training relevant to management and service provision (and for government supervision of some specific activities where government funding is not available); (b) procuring and repairing facility-level equipment; (c) procuring items to fill supply gaps at the facility level; and (d) refurbishing and renovating buildings needed for specific services. All three organizations provide supplementary funding and technical support for meetings at the provincial and district levels for development of annual operational plans (AOPs). All three are working with aspects of health equity funds (HEFs) and have strategies to improve the quality of health services at government-managed health facilities.

In addition to the common activities described in the previous paragraph, RHAC and RACHA support community linkages with HCs and build community-based capacity to improve service availability and utilization. RHAC operates private not-for-profit clinics with an outreach network of health posts and volunteers that provide reproductive health (RH) services, including recently added HIV/AIDS services. RACHA strengthens the government-created community volunteer capacities and has specific community development activities including microeconomic development and microcredit pilot project funding strategies for community-based health insurance. HSSC/URC works at the central-level Ministry of Health (MoH) to influence national policies related to health financing, service quality, and management practice assessments, and is piloting public-private partnerships to improve TB case detection and treatment.

[1] An OD is a geographic area that reflects the health sector administrative area. ODs do not necessarily correspond to administrative districts for civil government.

These USAID-supported projects are active across many of Cambodia's 24 provinces and 77 ODs, with RHAC working in 11 provinces and 26 ODs, RACHA in seven provinces and 13 ODs, and URC in six provinces and 21 ODs. Although the projects are jointly present in several provinces, there is only geographic overlap in three or four ODs.

Objectives

The objectives of this report are to:

- Provide a final strategic assessment of each of the mentioned USAID-supported organizations
- Identify lessons learned in project design and implementation
- Make recommendations with regard to successful interventions for continuation or replication, better practices, and significant products and tools of the above projects for possible dissemination and replication
- Provide recommendations for the strategic directions and future design of USAID's health assistance in Cambodia, addressing key factors such as institutional and financial sustainability, systems strengthening, increased sector accountability, and improved donor harmonization and coordination

Statement of work

The assessments of the three projects specifically address the major outcomes, achievements, constraints, and gaps, identifying information relevant to the following issues:

- The design of the overall program and the individual projects (e.g., did they correctly identify the problems and constraints and approaches to addressing the key issues?)
- How and why plans for accomplishing planned outcomes changed during the life of the projects
- Project progress to date in relation to planned results and performance indicators provided in the Results Framework and the projects' Performance Monitoring Plans identifying:
    - Planned result targets that were not met or exceeded and why
    - Constraints to achieving results
    - Gaps in planning that might have increased the likelihood of being unable to achieve a result or target
    - Specific project management policies, structure, or practices that contributed to either success or failure of intervention implementation
- Unexpected project outcomes and how they contributed to the overall Results Framework
- Outstanding issues and important gaps that have not been addressed by the projects that require attention and should be considered for future USAID investment

In addition, the assessment team was asked to comment on the overall role of the three organizations in improving the health system and the health of the population, and their role in coordination and/or support for the government and other NGOs and CAs.

This report is meant to provide guidance for the final year of project implementation and to inform the upcoming design of a new USAID/Cambodia integrated health program for the next phase, which supports the MoH's second health strategic plan (HSP2) for 2008 to 2015 and improves the alignment and coordination of USAID activities in the health sector with other donor initiatives.

COUNTRY CONTEXT

After almost total destruction from war and genocidal policies during the 1970s, there remained an estimated 50 of the nation's original 600 medical doctors and essentially no health system or service infrastructures in Cambodia (MoH 1997). In the subsequent 15 years, the country continued to experience civil war and internal political instability. During that time, emergency aid, including infrastructure and system development, was provided on a limited scale. For the past 10 years, Cambodia has been relatively stable politically and has achieved enormous economic strides at the national level. Annual gross domestic product (GDP) is estimated to be increasing at 9 to 10 percent for 2006-2007 (IMF 2007), and gross national income is estimated at US$480 (World Bank 2007a). Along with these gains, however, over one-third of the population continues to live in extreme poverty.

During the 1990s, donors supported health sector reform, ensuring that each province had a technical advisor (supported by various donors) and building capacity in the MoH in health sector planning and health information systems (HIS). Progress in developing the physical infrastructure, as well as service and policy capacity within the MoH, has been documented. The MoH Guidelines for Operational Districts (MoH 1997b) describe a Minimum Package of Activities (MPA) for HCs and a Complementary Package of Activities (CPA) for hospitals. CPA services have been redefined to describe three packages of services, with CPA3 describing the highest-level hospital services. The MoH estimated that at the end of 2006 about 85% of the Health Coverage Plan infrastructure was in place, with 30% of district hospitals offering basic surgical services (MoH 2007c). A Health Financing Charter (1996) introduced guidelines and regulations for user fees in the public sector that allows utilization of 99% of the collected fees by the facility (39% for operating costs and 60% for staff incentives). User fees are estimated to have contributed 13% of HC revenues and 22% of hospital revenues in 2004 (MoH 2007c). HEFs, designed to cover expenses for low-income clients exempted from user fees, were introduced in 2000 and are estimated to cover almost half of all health ODs. A 2006 study[2] showed that HEFs significantly increase utilization of facilities and successfully target the poor (MoH 2007c). Community-based health insurance funds (CBHIFs) are also being pilot-tested in the country, with guidelines adopted by the MoH in 2006. Finally, the 2003-2007 HSP has been generally acknowledged by technical evaluators and donors as a sound basis for planning health sector activities and support, and the 2008-2015 HSP2 is currently under development.

Over the past 10 years, the MoH has initiated a number of innovative strategies for fast-tracking progress in delivery of health services and improving the health status of the population, such as public-private partnerships that include contracting with NGOs for the management of government services at the OD level (currently implemented in 11 of 77 ODs), and contracting or pay-for-performance agreements at the facility level, with both approaches documented to effectively improve health service delivery and quality (Conseil Santé Final Evaluation of Contracting, 2007). In addition to the innovations initiated by the MoH, private sector health services have expanded, with a majority of the private providers estimated to also be MoH employees. Utilization of both outpatient and inpatient government services improved considerably from 2003 to 2007, although overall utilization levels of government services remain low. The public sector is estimated to provide only 22% of health care services (MoH 2007c, World Bank 2007b).

Overview of the current health situation in Cambodia

Despite generally acknowledged poor quality of health services in both the public and private sectors, over the past 10 years there have been dramatic improvements in most health indicators in Cambodia. This is attributable to many factors, including improved health infrastructure and expanded coverage for

[2] Financial Access to Health Services for the Poor in Cambodia, Phase 1, 2006.

preventive services, improvements in the economic status of the population, and significant amounts of bilateral and NGO donor funding and technical support to the health sector.

As noted in a recent review of progress in achieving the objectives of the HSP and Health Sector Support Project (HSSP),[3] "Physical access to health facilities able to provide full complement HC care (full MPA) and referral hospital care (CPA2 and 3) is improving. Utilization of essential health services (immunization, pregnancy, etc.) is on the increase. About 1 million poor people have effective coverage from equity funds. Out-of-pocket costs per disease episode have fallen in rural areas by 30%, and health costs-related borrowing and asset sales have been falling" (World Bank 2007b).

Table 1: Changes in Key Health Indicators in Cambodia, Overall and for Urban and Rural Populations

	2000 DHS	2005 DHS	2005 DHS	
			Urban	Rural
Infant mortality rate per 1,000 live births (4-year period prior to survey)	99	66	65	92
< 5 mortality rate per 1,000 live births	124.4	83	76	111
Percent of children 12-23m fully immunized	39.9	66.6	69.4	66.2
Percent of children stunted (height for age <-2 SD)	44.6	37.3	30.5	38.3
Percent of children wasted (weight for height)	15.0	7.3	8.3	7.1
Percent of children underweight (weight for age)	45.2	35.6	34.7	35.7
Total fertility rate	4.0	3.5	2.8	3.5
Percent of currently married women using modern method of contraception	na	27.2	30.6	26.5
Percent of women receiving antenatal care at least once during pregnancy	37.7	69.3	79.2	67.7
Maternal mortality per 100,000 live births	437	472	na	na
Percent of births attended by skilled health personnel	31.8	43.4	70.1	39.4
Percent of births in health facility	9.9	21.5	50.1	16.9
HIV/AIDS prevalence, adults 15-49 (%)	2.6 [4]	0.6	1.3	0.5

na: information not available

Source: CDHS 2000, 2005

As shown in table 1, between 2000 and 2005 there were significant improvements in child health (decreased mortality and malnutrition rates), with utilization of immunization and prenatal services increasing and fertility rates dropping. Although these improvements are impressive, large disparities exist between urban and rural populations, and maternal mortality remains one key area with no measured improvements.

Challenges to increasing service uptake, to improving quality, and to expanding access to essential services

Despite much improvement in the health status of the population, including improvements in both rural and urban areas and among the poorest rural areas, low-income people continue to have the most serious health indicators (DHS 2005), and, overall, Cambodia's health indicators are among the worst in the region. "… Still, about 3 million of poor population lack protection mechanisms against catastrophic

[3] A World Bank/Asian Development Bank/U.K. Department for International Development-funded initiative
[4] Estimate based on National Center for HIV/AIDS, Dermatology, and STD sentinel surveillance data, 2002.

health expenditures… More than 50% of HCs have not reached full MPA[5] capacity and not all ODs have a CPA[6] 2 or 3 level referral hospital" (World Bank 2007b).

Numerous evaluations and assessments of the health sector in Cambodia have consistently identified the same challenges for increasing service uptake in the public sector, for improving the quality of health care, and for expanding access to essential services (MoH 2007c, World Bank 2007b). These include the following:

- Poor capacity, including:
  - Insufficient numbers and levels of skill among health personnel
  - Poor basic-level training for doctors
  - Insufficient numbers of trained secondary midwives and insufficient skill level of primary midwives to impact the maternal mortality ratio (Chhuong, C. 2006)
  - Poor attitudes of service providers toward patients
  - Inadequate management capacity and government systems that are not supportive of good management practices, particularly with regard to the management of financial and human resources
- Inadequate resources within the public sector:
  - Total health expenditures are generally assessed as adequate, but two-thirds of these expenditures are disproportionately financed out of pocket, contributing to impoverishment and inappropriate or non-use of health services.
- Fragmentation and lack of donor coordination among donors adding to the problems of effectively addressing the above challenges

In addition to insufficient numbers and levels of skill among doctors and midwives, the existing personnel are disproportionately located in urban areas. Within the public sector, many practical, as well as system, factors hinder the rational assignment of needed staff to rural areas. The low salary level is provided as one of the reasons staff cannot be compelled to take assignments (e.g., in rural areas) they do not want. Many health service providers prefer assignments in urban areas, where they have more scope for private practice or other means for supplementing their incomes and where the community infrastructure is better developed. It was noted during the field visits for this assessment that despite a shortage of secondary midwives, particularly in rural areas, 66 secondary midwives are officially assigned to the Battambang Referral Hospital, and a secondary midwife is in charge of the continuing education records in Pursat Provincial Health Department (PHD). Several HCs adjacent to hospitals had secondary midwives assigned, though they reported they do no deliveries because most clients bypass the HC to deliver at the hospital.

The private sector is largely unregulated with services of questionable quality. A large proportion of government health service providers also have private practices, which has been identified as a factor impeding the development of quality public sector services (Conseil Santé 2007).

Health expenditures in Cambodia are high, reaching more than 10% of the GDP, although most expenditures are out-of-pocket payments for services. Donor expenditures have been rising (US$140 million in 2006, or one-half to two-thirds the level of the public expenditure for health). The government expenditure for health has increased to a planned 13% of the national budget for 2007 (MoH 2007c),

[5] Minimum Package of Activities (for health centers)
[6] Complementary Package of Activities (of increased levels of sophistication, for hospitals)

representing an increase from US$2.10 per capita in 2000 to US$5.70 per capita.[7] The majority of public sector spending does not reach below the provincial level, with an estimated 18% of the gross health budget (36% after intergovernmental transfers) reaching the district hospital and HC levels (MoH 2007c).

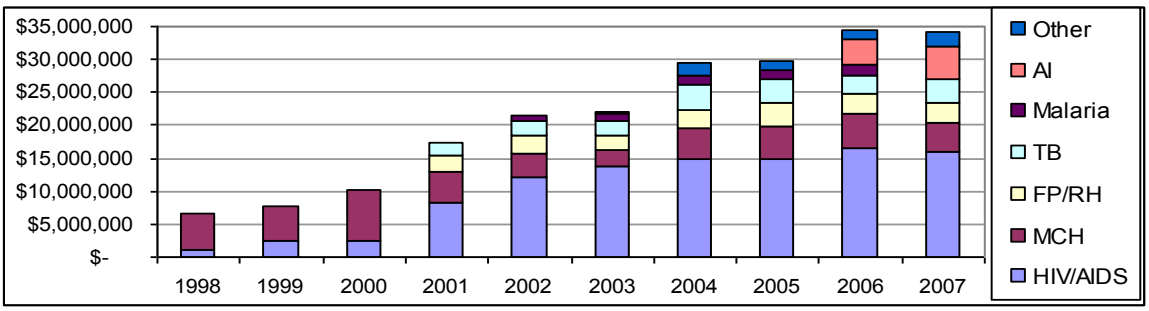
USAID ASSISTANCE TO DATE

In order to respond to the health sector situation noted above, between 1998 and 2007 USAID/ Cambodia's health program underwent two evolutions. From 1998 to 2002, USAID/Cambodia managed its health programs through a combination of SO2, "Improved Reproductive and Child Health," and Special Objective 2, "Reduced Transmission of Sexually Transmitted Infections (STIs)/HIV among High-Risk Populations." After being designated an HIV/AIDS "rapid scale-up" country in 2001, HIV/AIDS funding levels began to increase significantly (from US$1 million in 1998 to almost US$16 million in 2007).

In October 2002, an Interim Health Strategy (2002-2005) integrated HIV/AIDS with reproductive and child health under the new SO9. In addition to better representing the changing balance in funding, this new SO took on a more family health-oriented approach with greater focus on access, capacity building, behavior change, quality, and systems. In 2006, USAID/Cambodia adopted its first full-fledged country strategy, essentially continuing the Interim Health Strategy approach but dividing once again into the technical areas of HIV/AIDS, infectious diseases, and maternal and child health (MCH), with health system support a crosscutting area. This new program-oriented SO structure aligns better and provides for more efficient management within USAID/Cambodia's organizational and staffing structure. However, integrated programs carried out by groups like URC, RACHA, and RHAC continue to report across the organizational structure. This latest strategy aims to move away from pilot-type projects and to expand programs nationally, where possible, moving beyond humanitarian relief to address more long-term development concerns (figure 1).

Expanding and shifting budget priorities have had a major impact on the focus of USAID's work in Cambodia. While MCH budget levels have remained relatively stable over time, they have significantly decreased as a percentage of the overall health portfolio, from more than 50% in 1998 to 13% in 2007. Even if the RH and family planning (FP) budgets that help fund URC, RACHA, and RHAC programs are included, the percentage only increases to 22% in 2007. Conversely, HIV/AIDS funding now represents approximately 30% of USAID's annual funding to URC and RACHA and 40% to RHAC. This shift in funding clearly places HIV/AIDS budget and programmatic pressures on the USAID/Cambodia strategy in health, a funding trend that is expected to continue for the foreseeable future.

Figure 1: USAID/Cambodia Health Sector Budget Trend (1998-2007) (US$)

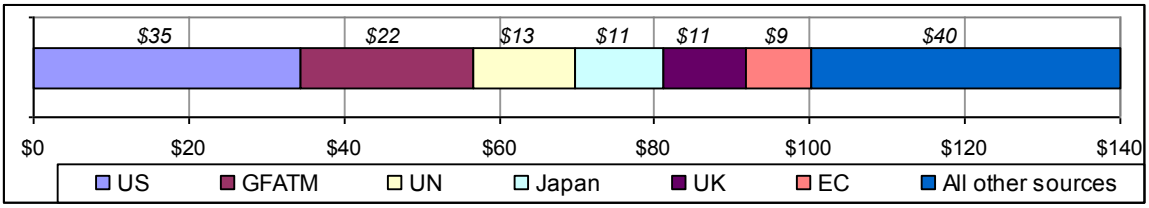


Source: USAID/Cambodia/OPHE

[7] Only 32% of this budget has actually been mandated, and an estimated 22% of the budget was expended during the first six months of 2007 (2007c).

In 2006, USAID accounted for approximately 10 percent of the estimated US$570 million in donor assistance provided to Cambodia each year for all sectors, ranking third behind Japan and the Asian Development Bank (ADB) for overall donor assistance. USAID continues, however, to be the largest donor in the health sector.[8] Within a crowded field of donors and partners, USAID/Cambodia's niche is especially pronounced – and sometimes controversial – in its focus on HIV/AIDS, RH, and child survival, and on avoiding direct funding to the government, instead relying almost exclusively on local and international NGOs and firms (such as URC) to implement programs. Funding support to these partners is provided under an annual Strategic Objective Agreement with the Royal Government of Cambodia (RGoC), with no direct funding to the government.

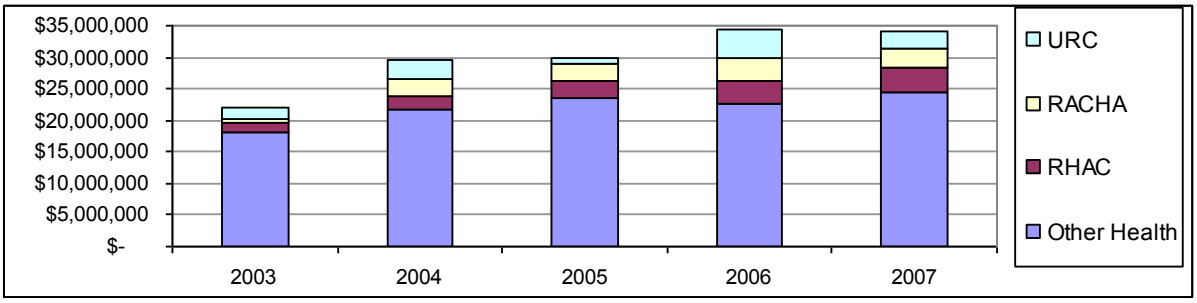
Figure 2: Health Sector Assistance to Cambodia by All Donors (2006) (US$ millions)



Source: Australian Cambodia Engagement Strategy to the Health Sector (2007-2013)

Under the current development approach, URC, RACHA, and RHAC are funded as a complementary – though not integrated – package of activities aimed at fostering high-quality private service provision and outreach (RHAC), building linkages between the community and public sector health services (RACHA), and supporting and strengthening the national health system (URC). In 2007, funding to these three organizations accounted for approximately 28% of USAID/Cambodia's overall health sector portfolio.

Figure 3: Trend in USAID/Cambodia Funding to URC, RACHA, and RHAC (2003-2007) (US$)

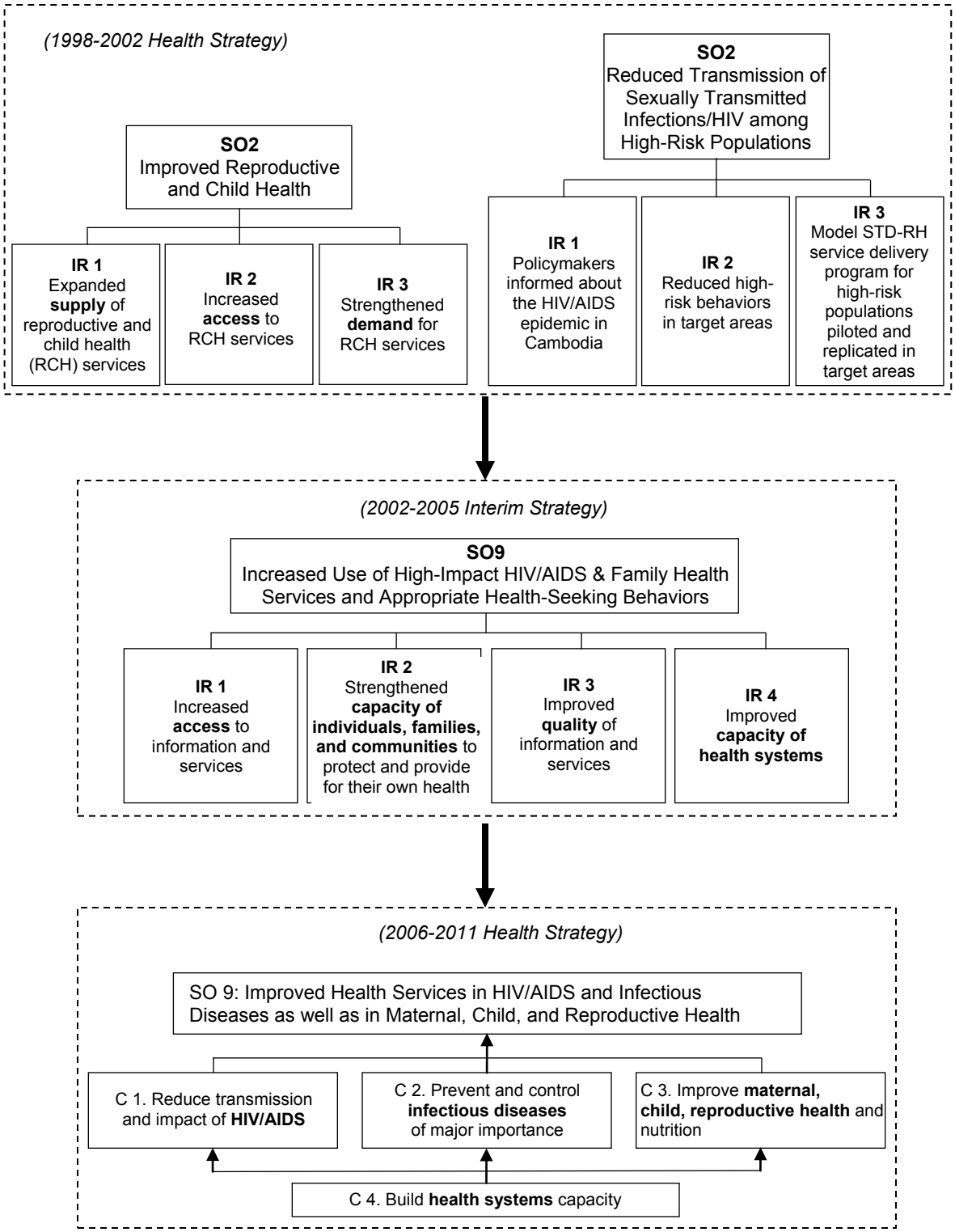


Source: USAID/Cambodia/OPHE

Until recently, in addition to national-level activities, USAID/Cambodia's health sector work was focused in eight priority provinces and 16 priority ODs. Therefore, the bulk of these organizations' activities have been in these geographic areas (Banteay Meanchey, Battambang, Koh Kong, Kratie, Pursat, Siem Reap, and Phnom Penh). USAID/Cambodia is currently phasing out this approach, however, in an effort to ensure that programs are reaching the neediest and most at risk.

[8] Source: Cambodia Aid Effectiveness Report 2007

Figure 4: USAID/Cambodia's Evolving Strategic Framework (1998-2007)



II. METHODOLOGY

This strategic assessment was carried out in Cambodia from November 12 to December 7, 2007. Upon arrival of the assessment team, there were discussions with USAID/Cambodia to clarify the practicality of the original scope of work (SOW) (appendix A), given the time frame and three-person team. USAID agreed that the final evaluation referred to in the SOW would be structured as a strategic assessment of each program that would review progress in achieving goals and objectives, relevance, and responsiveness to recommendations from the previous evaluations and relevance to the national health strategy. The overall findings and recommendations are provided in the context of the MoH's forthcoming HSP2 for 2008 to 2015.

Information for the assessments comes from a review of documents, key informant interviews, and field visits to health service sites and with managers at the provincial and OD levels. Appendix B provides details on the assessment team schedule.

Review of documents

Documents reviewed included relevant documents from the MoH, the RGoC, USAID/Cambodia, and other stakeholders, as well as project documents from the three organizations being assessed. Appendix C lists all documents reviewed.

Key informant interviews

The team met with key informants among program and management personnel from each of the three organizations, as well as other relevant stakeholders, during the first week in country. Appendix D lists all persons interviewed. During these meetings, the team sought information on:

- Perceptions of the three organizations and how their work impacts on the overall objectives of the MoH health strategy; the degree of collaboration and integration among the three as well as with the MoH; and feedback on accomplishments and issues where their work has not been in line or coordinated well with the MoH or others carrying out similar activities
- Specific areas of collaboration with stakeholders
- Perceptions of the future strategy for the health sector and how these organizations and/or USAID/Cambodia support can most effectively contribute to strengthening the MoH as a steward for health and ensure that services are available and used by the population

Field visits

The objective of the field visits was to validate and expand information from the reviewed documents and from interviews in Phnom Penh.

The assessment team traveled to five provinces where the three organizations have activities. In the provinces, the team divided into three groups, with each visiting different locations. MoH managers from the provinces and ODs visited were interviewed about the activities and coordination of the organizations being assessed that worked within in their province or OD. Structured outlines were used to guide the discussions. Occasionally, the three organizations, or sometimes, two, had activities in the same OD at one time or another. But most often, each worked in separate ODs.

Provincial and district-level hospitals, as well as HCs, were visited. Around half of the HCs visited were selected by the organization being assessed, and the other half were randomly selected by assessment team members from among those logistically feasible to reach, given time constraints. Communities served by HCs were also visited. A structured checklist was used to guide the assessments in each HC and community. Items assessed in the facilities included overall cleanliness, infection control supplies,

availability of equipment and supplies, health information records, records for user fee and equity fund transactions, presence of guidelines and protocols, and staff management and meeting information, with the objective of ensuring that the three team members used similar information when forming their impressions about the functioning of the facilities. The checklist also included questions about the role and activities of the NGO/URC groups being assessed, and the local staffs' perceptions of their contributions, as well as questions about the HCs' links to and support for the community volunteers. In the community, discussions were held primarily with community volunteers who provide Community Directly Observed Treatment, Short Course (C-DOTS) activities for TB; support community-level activities (e.g., immunization and vitamin A supplementation) provided by HC staff; encourage appropriate utilization of facilities; and/or engage in community health promotion and interventions. Discussions were also held with community members who participate in equity funds or CBHIFs.

In total, five provinces, nine hospitals (district- and provincial-level), 24 HCs, and nine rural communities were visited. Appendix D provides a list of sites visited.

Preliminary findings and recommendations were reviewed with USAID/Cambodia's Office of Public Health and Education (OPHE) and with the three organizations. Input from these sessions was incorporated into this report where appropriate.

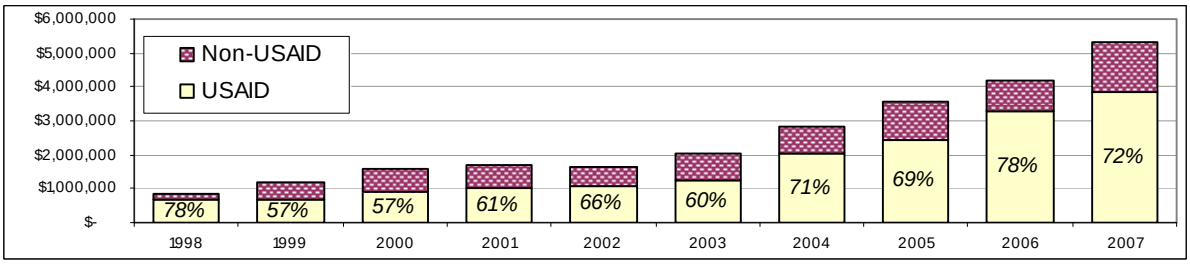
III. FINDINGS

REPRODUCTIVE HEALTH ASSOCIATION OF CAMBODIA (RHAC)

Background and overview

Initially funded through USAID's Service Expansion and Technical Support (SEATS) Project, RHAC was founded as an NGO in April 1996 by staff working on USAID's Family Health and Birth Spacing Project, managed through Family Planning International. In 1997, RHAC took over the bulk of the project and also became an associate member of the International Planned Parenthood Federation (IPPF). At this point, RHAC had approximately 40 staff, one clinic in Phnom Penh offering primarily RH services and a small community-based distribution (CBD) system for contraceptives. By 1999, RHAC was operating four clinics (two in Phnom Penh and one each in Battambang and Sihanoukville), had 346 volunteer members providing outreach, and nascent programs in both youth RH and HIV/AIDS prevention. That year it became a direct recipient of USAID/Cambodia funding through a bilateral cooperative agreement. USAID remains RHAC's main donor today, accounting for more than 70% of external support.

Figure 5: RHAC Budget History – USAID and Non-USAID Sources (1998-2007) (US$)



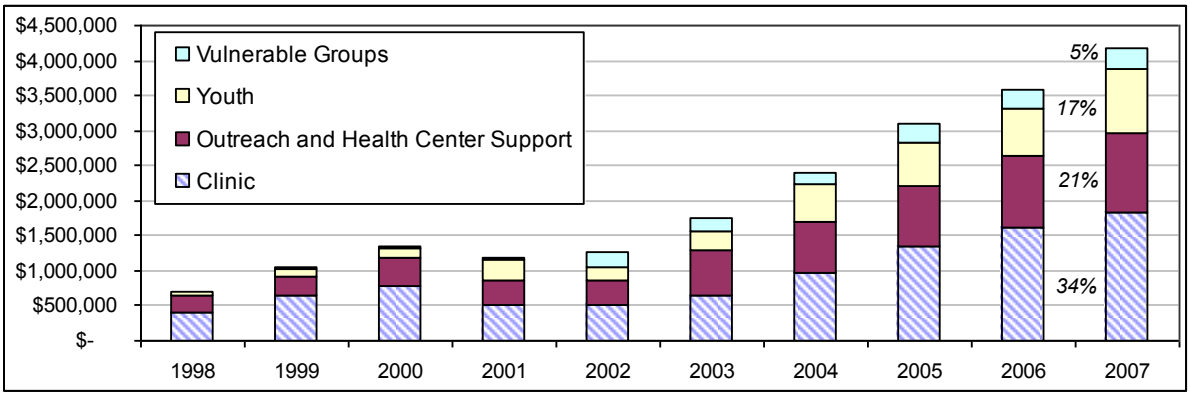
Source: RHAC M&E data

The sixfold budget scale-up between 1998 and 2007 has been significant not only in dollar terms. First, it allowed RHAC to grow from a small organization in 1998 with staff managing one RH clinic and a small outreach program to an organization with more than 500 staff working in 11 provinces and 26 ODs. Currently RHAC provides services through eight clinics, eight health posts, and an outreach program with nearly 20,000 volunteers and peer educators recruited, trained, and supervised by RHAC. Through these programs, RHAC reaches approximately 250,000 clients each year. In addition, RHAC supports government health services, referring or mobilizing nearly 500,000 clients to receive public sector services such as deliveries and community-level immunization and vitamin A campaigns. RHAC has a focus on quality assurance in both its private and public sector work. Second, RHAC has generated and tested health service development models and technical interventions – in both the public and private sectors – some of which were then scaled up and/or adopted by partners and the government. Third, and perhaps most importantly, the scale-up has fostered and developed RHAC itself as an indigenous NGO – perhaps the largest in Cambodia – with high technical and management capacity and a focus on quality programming and service delivery, achieving important results and international recognition.

Since the previous evaluation in 2003, RHAC has expanded its core programs and now operates in seven programmatic areas: clinical services, outreach and HC support, youth health, HIV/AIDS for vulnerable groups, training, contracting for health services, and health care financing. All programs are supported by crosscutting strategies for monitoring and evaluation (M&E); information-education-communication (IEC); market research; and finance, inventory, and administration practices. Within this programmatic expansion, there has been a significant trend of steady increase in youth-centered programs, which now

account for 20% of staff and which RHAC sees as critical to the future. Clinical services, while expanding significantly over the years and currently taking up 40% of staff, have decreased from about half of RHAC's total budget in the early years to about 34% of the budget in 2007. Outreach activities, which accounted for 30% of the budget in 1998, have seen a dramatic scale-up in terms of activities (now in 10 provinces and 20 ODs) and sheer numbers of clients reached (more than 500,000 in 2007), and now account for just over 20% of both staff and the budget. In addition, tapping into its significant growth and economies of scale, RHAC has demonstrated its commitment to improving internal systems and financial management by halving general and administrative operational costs from approximately 30% of the budget in 2001 to 15% in 2006.

Figure 6: RHAC Programmatic Funding (1998-2007) (US$)

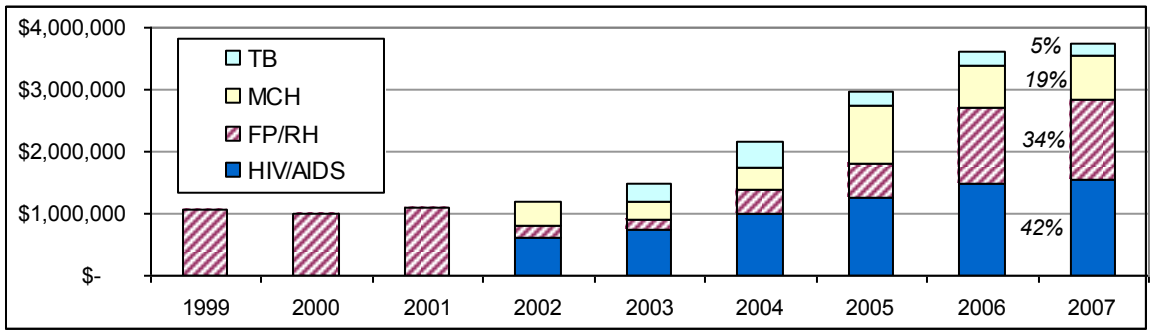


Source: RHAC M&E data

Findings

Funding and scope of work: Perhaps the most significant change in RHAC's program and evolution over the years has been the influx of HIV/AIDS resources. This is not, of course, exclusive to RHAC but demonstrates how donors' shifting budget priorities impact an organization. From 1999, when RHAC first became a direct recipient of USAID funding, through 2001, all of RHAC's USAID funding was for FP/RH. Following Cambodia's designation as a rapid scale-up country for HIV/AIDS, funding for HIV/AIDS surged from 2002 to 2004 to make up half of RHAC's budget from USAID. In 2007, that percentage leveled out to just over 40% of RHAC's USAID funding. This percentage jumps to over 60%, however, if Round 2 and Round 5 funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), RHAC's other main funder, are included. AIDS has thus become a driving force of RHAC's total funding. RHAC's shift from an RH focus to a broader mandate represents an evolution that brings with it unique benefits but which must be reviewed in terms of RHAC's current and potential role in USAID's portfolio, as well as in the Cambodian health care system in general.

Figure 7: USAID Funding to RHAC by Budget Earmark (1998-2007) (US$)



Source: USAID/Cambodia/OPHE data

An important point to note here is that across its many areas of work and accomplishments, RHAC has been able to not only minimize the potential "narrowness" of HIV/AIDS resources by taking an integrated approach, but has used these extra resources as a springboard for scaling up its work. This does not come without a cost, however, and RHAC as an organization is being stretched exceedingly thin, potentially threatening its comparative advantage: the quality of its work. The possible removal of the word "reproductive" from RHAC's name epitomizes this evolution.

Achievements in health service coverage: In terms of programming and service delivery, RHAC's focus on quality earned it IPPF's award for Highest Quality of Care in 2005, and its clinics and health posts continue to score high on quality and other monitoring tools and assessments. Emanating from these quality standards and coupled with a strategic vision, RHAC continues to be a major contributor to Cambodia's improved health indicators. In terms of outreach and service delivery, RHAC now supports 25% of the national C-DOTS coverage; provides services for 25% of all voluntary confidential HIV counseling and testing (VCCT) and prevention of mother-to-child HIV transmission (PMTCT) clients; and provides 65% of all treatments of sexually transmitted infections (STIs). RHAC played a significant role in increasing vitamin A coverage from 18% to over 80%, through collaboration and coordination with the MoH, and continues to distribute approximately one-quarter of national FP commodities. RHAC reports reaching more than 500,000 clients in 2007, after adding FP to the range of services offered by government-supported Village Health Support Group (VHSG) volunteers, which include health and nutrition education, antenatal care (ANC), counseling on breastfeeding, promoting oral rehydration salts for diarrhea, counseling for prevention and help-seeking for STIs, C-DOTS, counseling for HIV/AIDS prevention, and VCCT. RHAC's achievements in its coverage areas include the following:

- Full immunization rates for children have increased to 83%.
- Contraceptive couple-years of protection have increased steadily over the years to more than 40,000 (despite government policies that limit community distribution of injectable contraceptives and have probably contributed to an observed reduction in injectable use).
- Contraceptive prevalence rates of 38.6% for all methods and 29.5% for modern methods surpass the national averages (but miss the ambitious Millennium Development Goal [MDG]-oriented national target).
- Deliveries by trained personnel in public facilities have risen to an impressive 75%.
- TB clients served by DOTS Watchers (C-DOTS) have increased from 48 in 2004 to 1,500 in 2007.

Support to government health services: In 2003, RHAC made a strategic policy shift to focus its outreach work on stronger collaboration with, and referrals to, government health services, and in 2007 more than 22,000 clients were referred to government HCs through the RHAC-supported volunteer/clinic staff partnership. This transition in its outreach work from a primarily passive education model to one with more of a focus on demand creation and getting people to use services (mostly public, but also RHAC clinics and private facilities where appropriate) represents a logical and important progression in programming. Part of the challenge lies in ensuring that referred clients will receive quality services at a reasonable cost. From field visits, it was apparent that service utilization has increased in many areas and HCs are more active (e.g., open, staffed, and equipped) than they had been a few years earlier. Also, health centers supported by equity funds were indeed found to be serving poor clients. In addition, RHAC's creative and important voucher program, whereby it will only subsidize public health clinic births that have benefited from a full package of ANC, delivery, and postnatal care services (rather than just delivery), is helping address systemic public health incentive and quality issues.

During field visits, it was noted that there was great diversity among the visited facilities in equipment and staffing, as well as in the availability of drugs and supplies. Numerous field comments mentioned the obvious potential negative repercussions for clients referred to a clinic that was either closed, unstaffed, unfriendly, or ill-equipped. In this regard, it is unclear if RHAC is fully utilizing USAID's and other donor partners' comparative advantages to minimize these quality problems and maximize programmatic impact.

In 2006, RHAC entered into a subcontract with URC to manage an HEF in Sihanoukville. RHAC is responsible for ensuring that the costs related to accessing government health services are paid through the fund for eligible poor community members. The HEF contributes to the user-fee funding base of HCs and hospitals that can be used to augment staff salaries and to cover running costs when the budget is inadequate. Equity funds have improved utilization of and access to government health services.

RHAC provided services: As an example, and in stark contrast to government clinics, RHAC's service rates are impressive. In Battambang, for instance, in 2007 one RHAC clinic provided 30% of all VCCT, 26% of all PMTCT, and 48% of all services for reproductive tract infections (RTIs), although there were 16 government clinics offering VCCT, nine offering PMTCT, and 18 offering RTI services. On the HIV/AIDS front, with a heightened need for confidentiality, RHAC has made significant progress, with the National Center for HIV/AIDS, Dermatology, and STD (NCHADS) now viewing them more as a contributing partner than as competition.

Role in the health sector: Technically, RHAC has been providing valuable real-world programmatic input and guidance on interventions and program models with some of its key approaches (e.g., C-DOTS, vitamin A, outreach for youth, etc.) being adopted by national programs and others. Building on its critical role in HIV testing in Cambodia, RHAC has been actively – though as yet unsuccessfully – lobbying NCHADS to allow RHAC clinics to provide antiretroviral treatment (ART). Here, RHAC plays an important part in the national discussion but could clearly play an even stronger role if it were granted approval to provide ART services. Thus RHAC continues to play a critical and recognized role in service delivery and outreach. However, in its role in the broader policy arena and national agenda-setting, RHAC has been noticeably weaker and does not command a national voice commensurate with its significant inputs into the health system, although it has increased its efforts and visibility.

Appendix F.1 provides additional information on RHAC programs geographic coverage by OD as of November 2007; appendix F.2 provides information on lessons learned, challenges, and constraints experienced; and appendix F.3 provides additional information on RHAC program coverage from 1998 to 2007.

Issues and conclusions

Lessons learned: Perhaps one of RHAC's most significant lessons learned is that simply providing good services is not enough – it takes years of advocacy and trust building in the community to improve service use and coverage. In that regard, RHAC's combination of a high-quality service delivery model coupled with massive outreach activities is unique and appropriate in the Cambodian context. Consequently, while RHAC's 510 staff and horizontal organization provide the framework for achieving these ends, and while there has been some delegation of responsibility and authority to middle management, it is likely that greater senior-level capacity and staff are still needed to bolster the organization's current heavy dependence on the three-person senior management team. Furthermore, in order to maintain and improve RHAC's comparative advantage, staff capacity should be monitored and enhanced, particularly at the provincial level. Finally, for cost-effectiveness as well as continued input of new ideas and practices, existing technical assistance (TA) external to RHAC needs to be identified and used when appropriate.

Funding: The dichotomy between reaching the poor (notably absent in RHAC's Mission Statement) and achieving sustainability is a difficult one. Here, the overriding issue facing RHAC is its dependency on USAID and other donors, as well as on 20,000 volunteers and peer educators. USAID funding can be a double-edged sword (for example, the Mexico City Policy effectively ended IPPF funding to RHAC, resulting in the organization not meeting its 40% cost-share requirement for the past four years). RHAC's focus also appears to have been on expanding the program through USAID support rather than looking for more funding sources, though it has found some complementary funds in GFATM. RHAC's exploration of clinic privatization and selling services (i.e., laboratory, training, etc.) is needed but will be a slow process.

Comparative advantages: In terms of programming, and in a bottom-up policy development environment that is notably weak in regulation and social protection, mid-sized yet highly effective projects like RHAC continue to be needed. RHAC's many contributions to health improvements and indicators demonstrate this fact. As noted earlier, RHAC services significantly contribute to PHD-reported service provision statistics. While this is a major achievement, it is also a red flag raising questions about the degree to which RHAC is substituting for or replacing government services, which seems to be a commonly held perception. Cambodia is rife with fragmented projects vying for resources and attention, and RHAC needs to better position itself as a support and complement to public and private services, rather than as a substitute or replacement. This is particularly critical if RHAC service delivery continues to be dependent on funding from a single donor.

Looking at service delivery, quality, and cost, it is clear that achieving equity in Cambodia will require a continued strong focus on the public sector. However, recognizing current trends in health-seeking behavior coupled with continued financial, geographic, and service management barriers to public sector access, attention to improving private sector services and programs is also warranted. While utilization rates of services provided through the private sector are largely unknown, it is clear that Cambodians – rich and poor alike – spend a great deal out of pocket in this unregulated and uncontrolled sector. With its highly used and successful private not-for-profit clinics and health posts, RHAC is in a unique position to influence the quality and development of the private sector while improving public-private complementarities through outreach and other activities. Transitioning RHAC's capacity to a resource-starved public sector or using it as a model for management or programming has had limited success thus far.

With its institutionalized focus on quality, RHAC is a unique and introspective organization, generally aware of its strengths and weaknesses. In Cambodia's evolving public and private health care system, there is a continued need for the services and model that RHAC provides.

Recommendations

1. *Reduce RHAC's dependency on USAID:* As noted in the 2003 evaluation report for RHAC, there is still a need to recruit a resource development officer as well as to develop and implement a donor recruitment strategy to enable RHAC to have a group of significant and regular donors in the long term.
2. *Increase financial sustainability:* In addition to donor diversification, RHAC should explore privatization of urban clinics, sales, and possibly franchising to subsidize health posts and outreach work.
3. *Apply the RHAC model to public clinics:* Though a resource-poor public system will not be able to apply RHAC's full model to its clinics, RHAC should investigate means through which more effective sharing of best practices and cost-effective tools and quality management practices with the public sector can be instituted. The RHAC experience with public-private contracting under HSSP might provide some examples of how the RHAC experience can be used to effectively improve public sector services.
4. *Enhance community ownership of VHSG volunteers:* For this extremely important group, shift the onus of ownership from top-down RHAC/donor (where it currently sits) to the bottom-up villages and communes.
5. *Adopt transition and phase-out strategies:* Where appropriate, to avoid substituting for or competing with government services, develop and enact plans with clear handover or exit strategies for all or part of service delivery and/or outreach work.
6. *Support PHD and OD planning:* Foster demand-driven planning from local government stakeholders. Remain close to government service delivery but avoid being a substitute.
7. *Demand creation:* Continue the trend away from passive education to focusing on improving appropriate utilization of health services. Work with partners to ensure services will be available and of good quality.
8. *Improve RHAC's national voice:* RHAC should expand work with the MoH (and other relevant ministries and partners) centrally and seek to be a more vocal private sector NGO voice in the national and international health arena.
9. *Enhance MoH safe delivery program:* Negotiate with the MoH to coordinate, combine, and/or augment their delivery incentive program with RHAC's voucher package.
10. *Explore private sector modeling:* Keeping in mind that public and private practitioners are often the same people, assess and explore with the MoH Private Sector group and, perhaps under a professional association, the development of a pilot private sector quality service/management model, focusing specifically on providers and sites where the poor are known to access services.
11. *ART:* Continue advocating with NCHADS to support ART at RHAC clinics. Examples from international experience with public-private agreements for ART might provide evidence to support the advocacy.
12. *Avoid overextending:* Reassess the portfolio of activities and seriously explore transferring some services under RHAC's clinic and outreach programs that are not depending on RHAC models, and that others are already providing, to other groups or NGOs. Explore and address the benefits and pitfalls of this apparent shift away from RHAC's core FP/RH activities, including re-emphasizing this programmatic area as appropriate.
13. *Increase numbers and capacity of senior staff:* With RHAC's staff of 510 and horizontal organization, greater senior-level capacity and staff are needed to bolster the current heavy dependence on a three-person senior management team.

14. *Improve internal staff capacity:* In order to maintain and improve RHAC's comparative advantage, staff capacity should be monitored and enhanced, particularly in the provinces. For cost-effectiveness as well as continued input of new ideas and practices, ensure that existing TA external to RHAC is identified and used when appropriate.

REPRODUCTIVE AND CHILD HEALTH ALLIANCE (RACHA)

Background and overview

In 1996, as a means to implement its reproductive and child health strategy in support of the MoH, USAID/Cambodia formed a partnership of three Global Health Bureau projects – Basic Support for Institutionalizing Child Survival (BASICS I), the Association for Voluntary Surgical Contraception (AVSC), and SEATS – to create a local implementing organization, the Reproductive and Child Health Alliance (RACHA). With AVSC (now called EngenderHealth) initially providing overall technical and managerial support, the RACHA team collaborated with the MoH to design and implement a package of maternal and child health activities focused on support of MoH priorities in three provinces.

In 2003, responding to a USAID evaluation recommendation, RACHA became an independent registered local NGO and signed a US$13.5 million, 4.5-year cooperative agreement with USAID/Cambodia in 2004. RACHA reorganized under the new agreement, and the former resident expatriate technical advisors were replaced with local technical staff. Through USAID, RACHA receives about US$3 million annually, compared with an average of US$2 million annually in the five years prior to the cooperative agreement. Although RACHA has secured funds from other sources, USAID still provides nearly 90% of its funding. Over 40% of the annual budget is used for program costs, which RACHA has progressively increased while decreasing operational costs, despite a substantial expansion of its staff and geographic reach under the USAID agreement.

RACHA works almost exclusively in support of MoH priorities and programs. Unlike RHAC, RACHA has no service facilities of its own, nor does it deliver health services, but works only through the MoH's service network and its community links. RACHA results reported are those achieved by the MoH service system in the geographic areas that it supports. RACHA's stated strategic focus is to promote health-seeking behavior, to increase the availability and appropriate use of services, especially at the community level, and to help translate MoH technical policy and program priorities into quality, effective intervention programs in the field. Since 2004, under its USAID cooperative agreement, RACHA has expanded its program coverage areas from four to seven PHDs, from seven to 13 ODs**,** and from 94 to 164 HCs, covering 2,329 villages in 259 communes and serving a population RACHA estimates at more than 2 million. During this period, RACHA staff numbers have increased by 50%, to 164. With its expansion, RACHA shifted many Phnom Penh staff to the field and now has provincial coordinators and teams of five to 25 people located in each PHD and in key ODs where it has programs (with office space provided in the PHD/OD offices). RACHA staff regularly participate with PHD and OD managers in the preparation of AOPs, in monthly and quarterly reviews of progress against the AOP, and in provincial and OD technical committees. They regularly travel to HCs and communities – often jointly with OD and HC staff – to provide technical and managerial support.

During its current USAID agreement period, RACHA has expanded its core maternal, newborn, and child health and FP program activities to include HIV/AIDS and other infectious diseases (primarily TB and malaria). This has been, in part, a response to recommendations from the 2002 program evaluation by USAID and also a response to changing program and funding priorities of both the MoH and USAID. In summary, since its previous evaluation and certification as a local NGO in 2003, RACHA has: 1) expanded its staff, geographic, and program areas; 2) added new interventions and piloted others; 3) collaborated with new technical partners; and 4) closely aligned its results to USAID's SOs.

RACHA's specific goals are to:

- Increase access, availability, and quality for maternal and newborn care services
- Improve and expand child health services
- Improve and expand FP and limiting services
- Improve and expand infectious disease services – particularly C-DOTS and community malaria programs
- Improve and expand HIV/AIDS-related services

In addition, RACHA's crosscutting approaches to support the specific objectives aim to a) develop the capacity of the MoH to improve and expand health system capacity and the quality of its services; b) improve the national logistics system and inventory data base for essential drugs and birth spacing commodities, as well as computer capability; c) strengthen the capacity of communities to provide and use health information and appropriate services; d) strengthen monitoring, evaluation, and operational research capacity to improve the health system and influence policy and program decisions; and e) provide technical support to RACHA units in communication strategies and behavior change.

Findings

Building MoH technical and service capacity:

- MCH/FP: Since becoming a local NGO with direct USAID funding, RACHA has expanded its contribution to MoH technical and managerial capacity building in its core areas of MCH and FP, especially at the OD and HC levels but also nationwide. For example, to address current gaps in midwifery/nursing skills, RACHA has continued to support training in lifesaving skills (LSS) (which it designed for midwives and nurses, with almost one-third of all midwives in Cambodia having received this training) and an emergency obstetric care (EOC) course for doctors and midwives in selected referral hospitals. In response to recommendations from its 2002 evaluation, RACHA initiated the EOC training, the more recent introduction of training for active management of third stage labor and post-abortion care (PAC), and clean birth kits to address maternal mortality and other obstetric risks. Almost 2,000 doctors, midwives, and nurses have now been trained in the RACHA-developed neonatal resuscitation program, which, along with newborn kits, are technical interventions for newborn care that RACHA introduced and continues to support in referral hospitals, ODs and HCs. With TA from its former partner, EngenderHealth, RACHA trained a corps of trainers in insertion of intrauterine devices (IUDs) and voluntary surgical contraception (VSC), who in turn have trained many MoH providers and significantly expanded public birth spacing and limiting services.

- HIV/AIDS and other infectious diseases: RACHA has played a major role in developing the community-based treatment of TB, or C-DOTS, through the community volunteer network, which it now supports in 1,500 villages in 10 ODs. Similarly, in 117 villages of nine ODs in areas considered high risk for malaria, RACHA trains and supports community volunteers in education and referral of suspected malaria cases. RACHA support for AIDS has focused on strengthening STI services, promoting condom use, and supporting training and facility renovation at four VCCT and four PMTCT service sites.

Strengthening management capacity: RACHA continues to focus on building OD and HC management capacity through use of its Client-Oriented, Provider-Efficient (COPE) tool, developed to improve HC management, and through its Self-Improvement System, introduced to improve HC staff use of MoH service delivery protocols. RACHA has emphasized the importance of the MoH's health information system, investing considerable resources in orienting and training health staff in its use at the facility

level. In most HCs visited by team members, the senior staff showed familiarity with the key health indicators in their areas and capably discussed the annual data summaries posted on wall charts (supported by RACHA) in each HC.

RACHA introduced a computerized drug logistics management information system (LMIS), developed and maintained to help the MoH manage drugs and contraceptive commodities; the system is installed at the MoH central drug stores and all PHDs and ODs, where all HC and hospital data are entered. The LMIS – and the national and OD drug inventory databases derived from it – enables each OD/PHD to quickly identify needs, place medicine orders, and detect stock-outs, and has produced a large cadre of computer-trained staff. During team visits to OD offices, OD staff demonstrated how the computerized system functions, noting how easily stock-outs and chronic drug shortages can be pinpointed. In many cases, both HC and OD staff mentioned the usefulness of the system in identifying logistics problems, but also the challenge they face in addressing the unresolved chronic drug supply problems that seriously affect delivery of services and which primarily originate in the MoH's central drug procurement and management system.

Support to infrastructure and capacity for MoH services: Most of the OD and HC staff have received several of the technical/management training programs supported by RACHA (or other partners), and RACHA supplementary funding for selected field support and training activities is clearly a critical element in OD and HC functioning. The physical evidence of RACHA support is apparent in many HCs: renovated training or postpartum recovery rooms, solar panels/battery systems for electricity, water systems, and the computerized drug logistics management system at OD, PHD, and national levels, all designed to improve functioning of the facilities. Although RACHA's support has resulted in improved infrastructure and equipment at HCs, the management, maintenance, and repair of infrastructure, and equipment and availability of supplies continue to be problems. Many of the HCs visited by the assessment team were not always clean, orderly, fully staffed, or equipped to respond to client needs.

Community outreach/community-based services: From interviews with HC and OD staff, and from reviews of patient registers and HIS summaries, it appears that client numbers have been increasing substantially in most RACHA-supported facilities that were visited (although very few had patients waiting at the time of assessment team visits). Most of the interviewed OD and HC staff identified RACHA's support for community outreach and community-based services as a major contributing factor to the increased HC service uptake. To raise awareness and understanding about health and service needs and educate and mobilize communities for appropriate utilization of services, RACHA has trained, motivated, and nurtured community volunteers, focusing on government-selected VHSG volunteers (normally two per village) but also other groups of volunteers such as traditional birth attendants (TBAs), nuns, temple grannies, and village drug sellers. Equally important, RACHA has emphasized building mutually beneficial links between the HC staff and the community volunteers, reinforced, for example, by its strategic funding of per diem for HC staff to deliver weekly TB drugs and other supplies to the volunteers, to provide technical support and gather community service data, and to continue joint training of community members. In every HC visited, a wall chart (prepared with RACHA assistance) mapping the location, with photos, of all community volunteers, is prominently displayed, showing and recognizing the role of the volunteers in HC services.

Closely linked to community outreach is RACHA's successful effort to build community capability to address health needs close to home. Many HC and OD staff who were interviewed mentioned that with RACHA training and support, VHSG volunteers have been the source for identifying the majority of new TB patients, and that they now treat 60% to 90% of TB patients at their homes through C-DOTS. RACHA currently supports C-DOTS volunteers in 1,500 villages in 10 ODs. The volunteers are also recognized as key mobilizers for community vitamin A distribution and immunization services provided by HC staff, an important component of RACHA's child health program support. Volunteers are seen as a

major factor in the documented increase in coverage of these services, and assessment team members observed the volunteer-HC staff collaboration during several immunization sessions in the field. Community volunteers also sell contraceptives and promote awareness and use of home treatments for diarrhea, where appropriate, and for symptoms/illnesses that require families to seek help, such as acute respiratory infections and severe diarrhea. They also provide community-level education and awareness about HIV/AIDS and the benefits of breastfeeding and FP. In addition, RACHA-supported volunteers promote awareness of the benefits and availability of MoH services and refer clients for ANC, delivery by skilled providers, diagnosis for suspected TB, and other services.

Better practices, products, and tools for dissemination/replication: As an NGO, RACHA has been able to initiate – both on its own and in collaboration with external TA – many important advances on a small scale that have later become part of policy and programs and which might not normally have gained momentum in the government system. RACHA's integration with the MoH service network and its strong MoH relationships at all levels constitute a valued platform for introducing new approaches and for collaboration with other technical groups. Some of the outstanding examples mentioned earlier are RACHA's advocacy and development of LSS and EOC training courses (now part of a nationwide program under which almost one-third of all midwives have received training) and introduction of IUD and VSC services. RACHA is currently supporting pilot initiatives with promise for effective impact that include testing of community-based use of misoprostol (with the ACCESS project) and PAC (with Pathfinder), both of which have potential for addressing major causes of maternal mortality and other RH problems. In addition, RACHA is facilitating, in partnership with the International Life Sciences Institute and the USAID-funded A2Z project, a pilot commercial introduction of iron-fortified fish sauce (a universal condiment in Cambodia), and, in collaboration with the USAID-funded BASICS II project, is supporting a pilot test for community treatment of pneumonia, and potentially diarrhea, in remote areas.

Health financing mechanisms: In 2000, RACHA created a microcredit fund in a small number of rural communities to provide modest loans – primarily to women from poor families – to support small-scale income-generating activities. The interest revenues derived from the loans are pooled as a fund for improving HC facilities and staff incentives and to ensure access to services by low-income families. The 2002 evaluation team questioned RACHA's involvement in the microcredit fund, considering it to be an activity outside of the NGO's core program areas and recommending it be turned over to another agency. RACHA contested this point, emphasizing that the microcredit fund is one part of its goals of building sustainable community capability and empowerment, generating resources that address the health service constraints on the poor, and reinforcing the HCs' links to the communities. RACHA has modestly expanded the microcredit fund to 211 villages, but the substantial interest revenues generated up to 2007 total almost US$500,000 for a revolving capital fund. In several HCs visited by team members where the microcredit fund is in operation, HC staff noted the importance of fund contributions for HC support.

In 2006, RACHA began piloting in several villages of Pursat Province a CBHIF, a currently small but promising model that serves non-poor community members. The insurance fund creates a dependable source of prepaid family financing for health care at MoH facilities, particularly when coupled with RACHA's parallel financing approach using interest from its microcredit funds to pay the service fees for poor clients who hold a health equity pre-identification card. These measures help communities avoid the need for emergency fund-raising for health care (averting the indebtedness often incurred to secure services); stimulate more regular service use; and contribute to RACHA's goal of community self-sufficiency. One result of these health insurance (and equity) funds is that members place demands on providers and facilities (especially at HCs) to be available at all hours and responsive to their needs, contributing to observed changes in provider behavior. Insured clients who were interviewed during this assessment mentioned that HC staff are now usually available when needed and give more attentive service. They indicated that their CHIF membership gives them a sense of empowerment and felt HC

providers were more receptive and attentive when they showed their insurance cards. A recent RACHA-organized assessment of the Pursat insurance fund confirmed many similar insights on the functioning of the system and client perceptions.

Besides insuring community clients, the CBHIF is viewed by RACHA as an instrument to increase appropriate utilization and demand for care at public facilities, especially at HCs. The fund is also a mechanism to augment user-fee revenues for facilities, providing additional funds to supplement staff salaries, which, in turn, motivates providers to be present 24 hours and improve the reception and attentiveness provided to clients. Staff at facilities visited for this assessment reported that the insurance-generated income has also been used to improve the facility appearance, maintain the cleanliness of the HC and surroundings, contract professional staff and cleaning services, and to purchase out-of-stock drugs and supplies at peak demand times. With the increased demand for services, some of the HCs reported that they are experiencing space limitations, especially postpartum recovery areas for women who delivered at the facility.

The health insurance and equity funds are also placing new demands on HC staff to carefully record, organize, and document income and expenses that must be submitted for payment. RACHA has played a key role in setting up the system and in managing/monitoring the use of the funds (similar to groups supporting the equity fund). This could become a major management challenge if the programs are expanded. The health insurance fund and microcredit program, which are still at a pilot level in scale, are models that may provide useful lessons, though significant impact can only be achieved if they are implemented on a large scale. These, and other such initiatives, are part of a crowded field of new financing mechanisms evolving in the absence to date of a clear government regulatory framework.

Improving governance/responsiveness/empowerment: In numerous ways, USAID support for RACHA and other partners' efforts have unintentionally impacted, or reinforced in unexpected ways, the government's planned decentralization and deconcentration measures, modifying the traditional top-down policy development and program implementation. RACHA is pilot-testing technical interventions, service delivery strategies, and financial and management approaches that produce tools and evidence that clearly influence central policy and program decisions, a bottom-up approach that is valued and intrinsically modifies normal decisionmaking patterns.

Appendix G.1 provides information on lessons learned by RACHA; appendices G.2 and G.3 provide additional information on RACHA activities.

Issues and conclusions

Scope of RACHA activities: From reviews of annual reports and work plans, discussions with key informants, and field visits, it is clear that RACHA is involved in an extremely wide array of activities – technical, managerial, and financial – at every level, from the central ministry to PHDs, ODs, hospitals, HCs, and communities. This is not surprising, given RACHA's own view of its role in serving the country's health needs; its confidence in its core capabilities and experience; its readiness to support whatever program needs the MoH identifies; and its responsiveness to USAID priorities as they evolve, as well as to requests from other technical and donor groups who wish to draw on its technical and organizational strengths for joint activities. The 2002 evaluation team found RACHA's agenda to be very broad and not clearly focused and recommended several activities that might be shifted to other agencies. At the same time, the team recommended a number of new activities to be incorporated into RACHA's programs. RACHA complied, reducing some activities, retaining others, but it also incorporated all of the recommended new activities. These have addressed important gaps in the MoH health programs but have also expanded RACHA's program agenda. There will ultimately come a point at which limitations in RACHA staff, financial resources, and capable collaborating partners will compel the organization to review the broad focus of its program.

There are perceptions among some stakeholders that NGOs such as RACHA are replacing or substituting for government staff rather than strengthening the government health system. Although, MoH staff who were interviewed at all levels universally praised the work of RACHA in supporting MoH programs and service utilization, the current system relies substantially on RACHA staff motivating MoH managers and HC staff and providing incentives (usually through per diems for training or community-level activities) where the government budget is not sufficient. RACHA is also providing funding and technical support to MoH staff for planning and strengthening government technical and management capacity. RACHA's support has clearly been effective and valued, but no clear strategy or benchmarks for changing or shifting out of this role are present.

Other issues relevant to health system strengthening and sustainability that need to be addressed have been identified. These include the following:

- RACHA plays a key role in VHSG volunteers training, motivation, and incentives, and in maintaining links to MoH services. If RACHA were to shift out of an area, it is uncertain if the important support and building of community-HC linkages would continue in its current successful manner.
- The expansion of health equity and community insurance funds, as well as referrals from the community, has increased demand for quality services and created a need for expanded service space and improved provider behavior, which have not yet occurred uniformly. Despite substantial technical training/management support, many facilities in RACHA support areas still do not meet desired standards.
- RACHA has been preparing a quality assessment protocol for HCs (in areas where community health insurance or micro-credit programs are operating) that is independent of the highly regarded HC and other facility assessment protocols designed for the MoH by URC. It would be useful for RACHA to coordinate with URC (and with RHAC) to gain a uniform approach to quality assessment.
- Planning is needed to ensure that facilities and ODs can manage the increased financial accounting and accountability demands of community health insurance and equity funds that will emerge under HSP2. In the early pilot insurance funds, RACHA has played a major role in preparing participating health facilities, marketing the insurance and monitoring and ensuring accountability. Can this be replicated on a large scale? The implementation of HSP2 and the follow on Health Sector Support Project for 2008-2015 (HSSP2) will add further demands in this area.

Strengthening civil society: Supporting new or existing NGOs strengthens emerging civil society, providing models for technical excellence, client/community orientation, and services to assist the poor and complement public services. RACHA and other partner NGOs have also attracted and developed many talented, motivated professionals who are gaining invaluable skills and experience that will equip them to influence future health policy and program decisions. The RACHA approach and experience in working at the community level has played an influential role in developing civil society, strengthening its demand for and utilization of quality government health services, and mobilizing community-level support for government outreach activities as well as other community-level health services. This experience could be expanded into one that focuses not only on civil society support for government health services, but also one that increasingly addresses civil society's role in community development and problem solving, which can impact on the overall health and welfare of the community.

Community approaches: RACHA and RHAC have independently strengthened community outreach and built networks of trained, motivated community volunteers who have clearly been major factors in the success of their respective programs. RACHA's approach is based on building the capability of the government-chosen VHSG volunteers (and other community resources) whose activities extend and support MoH programs. RHAC, on the other hand, selects and trains its own private volunteers who provide services and referrals to the RHAC service system but have also taken on responsibilities for referrals to MoH services. Neither RACHA nor RHAC staff appeared sufficiently informed of the other's approach to provide assessment team members with a comprehensive comparison of the similarities/differences, strengths, and achievements of the two approaches. Both NGOs have rich, productive experiences with community volunteers and community outreach, and sharing experiences and lessons learned would benefit both programs.

Recommendations

1. *Improve targeting to reach the most vulnerable members of society:* RACHA should look at the potential to expand or shift its activities to other geographic areas with high concentrations of poverty and high mortality/low service coverage. Most of the areas where RACHA is engaged have substantial poor populations, but some of the areas also have numerous other donors/NGOs. RACHA can use its extensive experience to formulate a strategy to ensure a focus on the most vulnerable in collaboration with the MoH and PHD/OD management teams.

2. *Develop a strategic approach for phased withdrawal:* Before shifting geographic locations, RACHA should develop a strategic approach for phased withdrawal, gradually reducing ongoing support while monitoring potential impact or faltering of capacity. Having moved into ODs previously supported by other NGOs who departed and encountered sharply declining performance after their phase-out, RACHA has drawn some lessons from this experience that should help them develop approaches to avoid similar problems as they consider shifting to other geographic locations.

3. *Continue to identify and pilot-test new interventions:* RACHA has successfully introduced a number of important program interventions and approaches that have been adopted by the MoH. In collaboration with appropriate partners, RACHA should continue to identify and pilot-test new interventions in community and HC settings, providing an evidence base and demonstrating impact on key problems that can lead to MoH adoption and policy change. RACHA's extensive network of field staff and strong collaborative relations at the central MoH, PHD, OD, and community levels, along with further complementary partnering with respected technical resource groups, will enhance RACHA's credibility and impact when presenting findings from piloted activities.

4. *Expand community health care financing:* RACHA should further develop, expand, and document the effectiveness and impact of CBHIFs and microenterprise programs to cover health care for poor and moderate income groups. They should also ensure that an assessment formula for preparation and readiness of facilities is in place before allowing the flow of CBHIFs and other funds to the services providers. (The quality assessment tool should be consistent with those under development by URC). Also, as HSP2 and HSSP2 lead to clearer policy and regulatory guidelines, RACHA should use its experience in this area to influence MoH policy decisions and adapt its health financing approaches to conform once these become operational.

5. *Improve cross-fertilization of approaches and lessons across USAID-funded projects:* RACHA should regularly communicate and coordinate with RHAC and HSSC/URC and others to share experiences, lessons learned, and tools and technologies to cross-strengthen their programs and the effectiveness of their support to the MoH. There should be regular meetings among these organizations outside of the routine MoH, PHD, and OD planning and technical committees where they commonly interact. RACHA and its other USAID-supported partners each have strong

capabilities that are complementary if marshaled appropriately. The USAID Mission can play a key role in facilitating coordination and communication among the partners.

6. *Strengthen its community development role:* RACHA should consider how its current community-level expertise can be used to strengthen the role of civil society in community development.

HEALTH SYSTEMS STRENGTHENING IN CAMBODIA/UNIVERSITY RESEARCH CO., LLC (HSSC/URC)

Background and overview

The HSSC/URC project began in November 2002 and has had activities to improve quality, equity, and utilization of health services at all levels of the government health system. Activities have focused on 1) improving the quality of hospital and HC services; 2) strengthening capacity for managing, planning, supervising, and providing services at PHD, OD, and facility levels; 3) improving equity through health care financing mechanisms; and 4) strengthening aspects of services for specific infectious illnesses (TB, HIV/AIDS, AI).

The government counterpart for the HSSC/URC project is the Director of the Department of Planning and Health Information (DPHI) in the MoH. The project also works closely with the MoH Quality Assurance Office (QAO) under the Hospital Services Department and with a variety of technical working groups (TWGs) at the national level. The project has worked in seven (currently six) provinces and across 22 (currently 21) ODs. Appendix H.1 provides a timeline for project geographic locations, staffing, and budget.

HSSC/URC has conducted numerous situation analyses since the start of the project to understand the health system and community issues related to service utilization in order to inform project decisions.

Quality: A main focus has been developing a quality improvement (QI) system for hospitals and HCs. The system process includes a) orientating facility staff to QI; b) teaching facilities to use the QI program tool to conduct self-assessments of their status; c) providing TA to facilities on how to use assessment results in planning for improvement; and d) facilitating annual assessments by external persons that provide an overall score with benchmarks for eligibility for equity funds. The HSSC/URC coordinated closely with the Director of the DPHI, with the QAO, and with the QI TWG while developing the tools and methods for QI. The QI Level 1 tool assesses infrastructure, equipment and supplies, and health information record systems. A Level 2 QI tool is currently under development. This will measure the quality of service by checking for adherence to standards in practice. A QI tool for HCs that have HEFs is currently being field tested.

HSSC/URC also developed a provider behavior change intervention (PBCI) in collaboration with the MoH Center for Health Promotion and is working at a few sites to pilot test approaches for improving referrals from the community to facilities. HSSC/URC provides funds, editorial assistance, and contributions to the organization *Ponleu sokhapheap*, which produces a bilingual English/Khmer health news magazine, *The Messenger.* The monthly magazine shares current health information and is distributed to MoH managers and facilities, with a reported circulation of around 30,000 health staff.

Management: The HSSC/URC provides technical and financial support for training and on-the-job counterparts working with PHD and OD managers in developing AOPs, subsequent review of the AOPs, and quarterly review of PHD- and OD-level HIS and other data against plans. HSSC/URC has focused on training and improving supportive supervision for Integrated Management of Childhood Illness (IMCI) and TB, using checklists based on national and World Health Organization (WHO) guidelines to assess

adherence to standards in practice. HSSC/URC is also working with the MoH to revise the IMCI checklist. A capacity development assessment tool for PHD and OD management was developed with the DPHI and has been implemented at the national level.

Equity: HSSC/URC has worked at the national level to develop guidelines for HEFs, developing policies that link them with quality of services. The project subcontracts management of equity funds through NGOs. A database has been developed to provide information on HEF participants.

Strengthening services: HSSC/URC has worked with the Center for Tuberculosis and Leprosy Control (CENAT), the government TB agency, to introduce new strategies for public-private partnerships in TB diagnosis and treatment. The Public-Private Mix (PPM) initiative supports private sector referral of suspect TB cases to the nearest HC for diagnosis and, if needed, treatment. A process for introducing TB treatment through the private sector (PPM2) has been initiated with assessments of private laboratory diagnostic capacity carried out and initial meetings with CENAT held. In 2004, HSSC/URC was asked to continue the HIV-TB cross-referral work of a recently completed USAID funded project (PHR+). HSSC/URC has participated extensively in the development of guidelines for the expanded TB activities, such as C-DOTS, PPM, and diagnostic procedures for TB-HIV co-infections, and has identified areas within the TB program where its expertise can support improved case finding and treatment and improve availability and utilization of information for monitoring and evaluating program activities.

HSSC/URC has supported NCHADS' expansion of HIV/AIDS services, managing and financially supporting expansion of PMTCT and VCCT sites and ART and opportunistic infection (OI) services. Activities have included refurbishing buildings and providing equipment and supplies as well as funding training in adherence to government guidelines and supporting travel costs of people living with HIV/AIDS who receive ART and OI services from sites supported by HSSC/URC.

At the request of USAID, URC supported national-level health service preparations for managing potential cases of AI. Activities included developing four isolation wards (with the sites identified by the MoH) across the country, developing protocols and guidelines, providing training, and refurbishing sites to meet infection control standards. As a result of this process, the need to upgrade national standards for management of infectious waste was identified and is being followed up with the MoH.

HSSC/URC participates in various TWGs at the central level and has identified the need for national-level guidelines to support an MoH strategy for programs being carried out within the MoH system by numerous partners using different strategies. C-DOTS and HEFs are two examples where an MoH policy need was identified and the policy subsequently developed.

Other activities:

- Attempts have been made to establish a system for maintaining an up-to-date MoH Web site, working with the DPHI and a local information technology group. A desktop computer and printer were provided to the Department of International Cooperation of the MoH so that it can take over the responsibilities of the MoH Web site from DPHI. The process is reported to have become bogged down due to MoH issues with making the documents of interest generally available through the Internet.
- HSSC/URC has also developed a versatile Project Data System, which not only serves its own project data needs but has also been provided to the MoH/DPHI for analysis of HIS and HEF data and to CENAT for TB-related data.

Appendix H.2 provides an annual timeline for key activities; appendix H.3 lists the tools and guidelines developed or heavily influenced by the HSSP/URC project.

Findings

Quality improvement: The Level 1 QI Tool and a provincial and district management capacity development assessment tool have been endorsed by the MoH for scale-up countrywide. These three tools measure aspects of compliance with MoH regulations and guidelines and provide a way to compare facilities, PHDs, and ODs. Interviews of PHD and OD managers revealed that the tools were well liked, because "now we know what we are supposed to do." URC has documented improvements in practices and the management and work environment at the PHD and OD levels using these tools. The QI results for different hospital services have shown impact on overall QI for specific services of interest such as pediatric care and maternal health. HSSC/URC has been asked to develop a tool for assessing the quality of VCCT services, which fall under the management of NCHADS rather than the Hospital Services Department. To date, the QI Level 1 tool has been used in eight referral hospitals and a self- assessment has been conducted in several additional hospitals (three of which were visited by the assessment team) in preparation for QI and introduction of an HEF. The QI process has begun in 19 HCs where HEFs are in place.

Linking the QI tool with equity funds is acknowledged at all levels as an effective incentive for achieving improvements under the QI system. In addition to improved service conditions, there is evidence that the QI tool supports facility managers in following MoH guidelines, including using MoH-mandated hospital disciplinary committees, which several of the facilities had not formed prior to the QI process. Hospital directors indirectly noted the supportive role of these committees in decreasing the external pressures that otherwise fall on one individual when trying to make changes, allowing them to practice good management, including removing staff from facilities for not following rules. Several examples were mentioned of facility management enforcing discipline through now-functioning hospital disciplinary committees. Although few in number, these examples indicate an advance from common management practices that do not effectively address staff discipline problems.

Staff from both ODs in Pursat Province spoke very strongly in favor of the PBCI that was used for their facility staff and the impact it had on their perceptions and behavior. This intervention is not being used as extensively as it should be, due to issues with cost and the MoH Center for Health Promotion. It was unclear why the issue cannot be resolved.

The German Technical Cooperation Agency (GTZ) was instrumental in the inception of the QAO within the MoH and has a technical advisor in the QAO. During interviews with GTZ, there was some dissatisfaction with the process that resulted in the MoH adopting the QI tool for national usage. Reservations were expressed that URC moved forward with insufficient MoH input in the development of the tool and process. This perception was not shared by the MoH. The QAO and DPHI both acknowledge the role of HSSC/URC in providing technical expertise in QI; however, they assert full ownership over the tool. The Mongol Borei Referral Hospital director provided an extensive explanation about the role he played in ensuring that the tool was appropriate for the Cambodia context and how URC accepted his input on this. During discussions at facilities that have recently started the QI process, staff explained that "this is the MoH system so we must comply." This ownership by the MoH is a strong, positive outcome of the HSSP/URC process.

The only complaint about QI content and process from hospital staff using this tool was that it unfairly penalizes them when facilities do not meet standards because of problems with supplies and lack of budget from the central MoH. Hospital managers and URC staff noted that the facilities, not infrequently, use part of the equity fund/user fee funds that should go toward salary supplements to procure or repair items for the facility so that they can maintain standards. This decreases the level of incentives available for facilities that meet QI standards.

Equity funds: These were universally praised in acknowledgement of their role in increasing utilization of health services and for being a catalyst for improved quality of services. Currently, there are subcontracts with four NGOs in 14 ODs in six provinces for monitoring and implementing equity funds. Monitors were present in three of the hospitals visited for the assessment and were able to show records and discuss how the system works. As of September 2007, around 733,489 HEF clients had been precertified as eligible for HEFs, with 83,759 clients (pre- and post-certified) HEF client visits having occurred during the previous 12 months. A total of 107,347 HEF visits were recorded from the start though June 2007. The equity fund database shows higher utilization rates in populations with an HEF: 60% of users are female, 35% of users are women of reproductive age, and 17% are children below 5 years of age. HSSC/URC has been an advocate of expanding HEFs and linking payment with quality. HSSP, which sits within a project coordination unit in the MoH that manages ADB, World Bank (WB), and U.K. Department for International Development (DfID) basket funds, has just signed an agreement for URC to manage WB/MoH-provided equity funds for 10 additional ODs.

Planning, management, and data utilization: HSSC/URC described how it works with PHD and OD managers to help them follow MoH planning requirements, providing training and on-the-job assistance in developing plans, conducting quarterly reviews of activities and results against plans, and improving the quality and types of data available for planning. In addition to TA, per diems are paid for participants to attend meetings and workshops. When asked why PHDs and ODs that have received management support for years still need TA, funding was one issue, but there was also an observation by PHD, OD, and URC staff that the MoH keeps changing the reporting requirements and that the PHD and OD managers often do not understand what is required for the new report.

HSSC/URC has documented improved practices attributed to the supportive post-training follow-up supervision funded by HSSC/URC and carried out by PHD and OD staff for IMCI and TB using checklists. The MoH, however, has no budget to support this type of special follow-up.

Although multiple organizations sometimes worked in the same PHD and OD, there did not appear to be overlap among organizations for the training and planning activities that are supported, since during joint planning sessions with the PHD and OD the various organizations share information about planned trainings and working areas where supervision is supported. Although there did not appear to be overlap or duplication in activities, there were also no identified links between activities that lend themselves to linkages within the same OD, such as the Belgian Technical Corporation pay-for-performance contracts in Soutnikum OD and the HSSC/URC OD management strengthening activities for the same OD. There was no identified strategic plan for an OD or PHD where training and supervision were planned in view of achieving a specific objective (e.g., decreased maternal mortality). There was also no identified strategic plan for developing capacity and monitoring progress in strengthening management capacity at PHD, OD, or facility levels.

Tuberculosis: HSSC/URC identified problems that contribute to low case-detection rates and inadequate treatment for TB and introduced new strategies through CENAT to address these issues. Recognizing that the private sector is the first line of treatment for most sick clients in Cambodia, the PPM initiative provides an official link between the MoH and the private sector through monthly collection of data by the district health office. HSSC/URC also identified areas where guidelines were needed to formalize the various TB diagnostic and treatment strategies being implemented in different ways by different organizations and was instrumental in developing the MoH policy guidelines for these areas. Exposure of CENAT program leaders to international meetings where they learn more about internationally supported ideas that are new to Cambodia is likely to increase the willingness of the department to try new strategies for addressing TB, including working with the private sector.

Other infectious illnesses: At the request of the MoH and USAID, HSSC/URC provided infrastructure and training support to scale up HIV/AIDS and AI activities. URC noted that implementation of these activities provided side benefits of improving credibility with NCHADS, which allowed them to advocate for the value of focusing on QI for HIV/AIDS services and to integrate this into the facility QI process (rather than only being implemented through the vertical program). The need to improve national-level management of infectious waste was identified when building capacity to respond to AI.

The activities of HSSC/URC support the HSP and USAID's SO9. Appendix H.4 outlines HSSC/URC activities relevant to SO9, and appendix H.5 provides URC-identified lessons learned.

Issues and conclusions

Quality improvement: The QI process and tool, including linking reimbursement to quality, have a high probability of being successful in improving sustainable quality within MoH-managed facilities. The development of tools for QI and management assessment has been a highly effective approach for achieving MoH endorsement for measuring quality and capacity and for ultimate use of the findings in planning and allocating resources. From discussions with MoH managers, it appears that a key factor in gaining MoH acceptance of the QI strategy is their belief that they can implement the strategy because the tools – and what they measure – are practical to use. NCHAD'S acceptance that the QI process should include elements for VCCT is a small step toward integrating vertical HIV/AIDS program services into an overall health systems framework at the service level.

Technical expertise: The level of technical expertise of HSSC/URC staff and short-term consultants has contributed to effective policy-level inputs including:

- Identifying a need and then effectively working with the MoH to identify best practices to incorporate into MoH policies governing activities carried by multiple NGOs. TB service linkages with the private sector and communities (PPM and C-DOTS), linkages between TB and HIV/AIDS, and HEFs are key areas that are now coming under MoH policies as a result of HSSC/URC project support. HSSC/URC has identified other unmet needs for MoH policies to coordinate implementation practices (or lack of practices), including general infection control at service delivery points and management of infectious waste.
- Improving the availability and utilization of data critical for assessing and further developing new strategies, such as HEF client and service utilization information, and databases with information for assessing TB and HIV/AIDS service linkages.
- Introducing new strategies to address emerging and/or newly identified problems (e.g., low TB case detection rates, QI process, linking TB and HIV, linking HEF and quality).
- Improving the MoH Web page was identified in a recent assessment (Riggs-Perla 2007) as an activity that is no longer cost-effective due to prolonged delays at the MoH. The site and means for the MoH Department of International Affairs to move forward now exists if the MoH is willing. The lack of updated material on the Web site was notable during preparations for this assessment.

Strengthening capacity: The current strategy for supporting PHD and OD managers in planning, reviewing data, and developing AOPs has resulted in improved quality of government planning documents, and MoH staff believe that the managers' capacity is stronger. This support process, however, is carried out by multiple partners, and there was no strategy identified for developing central MoH capacity to support their own managers at different levels. Frequently changing MoH reporting requirements without sufficiently updating the training of provincial managers by the central MoH has created a management problem for which there is no apparent strategy for resolution.

There remains a need to identify best practices related to building MoH management capacity so that MoH managers can function effectively without external support. Best practices need to be shared among those providing TA, and URC needs to advocate for a uniform MoH policy that incorporates the best practices to be used by all groups working to strengthen PHD and OD capacity. The MoH should be encouraged to periodically assess the effectiveness of the capacity building TA to identify problems that contribute to an OD not being able to manage and plan effectively after many years of capacity building TA.

The current strategy to fill gaps by funding per diems for training and follow-up supervision after training (e.g., IMCI), while useful in supporting a minimum standard in service delivery, does not seem to address the need to improve OD, PHD, and central MoH systems for effective and supportive supervision to reinforce the adherence in practice to standards learned through training.

Focus of work: Although there are advantages to HSSC/URC implementing pilot field activities and having an implementation presence at the OD level, there are also disadvantages. Opportunities to strengthen local NGOs in some of these activities and to raise their profile as contributors to improved health services and improved MoH systems are being missed. Some of the activities that HSSC/URC is involved with are important and seem to be implemented effectively, but they are not unique to the HSSC/URC body of expertise. Other competent organizations could assume these activities (e.g., support to CENAT and NCHADS activities and working on village-to-facility referral systems) should there be a desire to focus more on overall health system strengthening.

Recommendations

1. *Support institutionalization of QI for hospitals:* HSSC/URC should focus on ensuring that the MoH has the institutional capacity to support a functional and routine nationwide QI system for hospitals.
    - It is critical to develop a strategic plan for implementing the QI strategy with the QAO and to identify the resources needed to strengthen the QAO office so the QI system is institutionalized. HSSC/URC can be responsible for the components of this strategic plan, which should be clearly endorsed by all stakeholders.
    - Ensure that HSSC/URC support for implementing QI nationwide is carried out through the MoH, and that all levels (central, PHD, OD) are officially delegated responsibility, as per MoH lines of authority, in order to support institutionalization and responsibility for this process within the MoH.
    - Efforts should be made to facilitate MoH resolution of the issues that are limiting utilization of the PBCI.
2. *Develop Level 2 QI tool:* URC should continue to work with the QAO and QI TWG to complete and gain policy-level support for institutionalization of the QI Level 2 tool.
3. *Support HC QI process:* HSSC/URC should continue to roll out QI in HCs, linking this with HEF, while strengthening MoH ownership and responsibility for this process at all levels.
4. *Increase transparency of central MoH system problems:* Central MoH system problems that are affecting services should be documented during the QI assessments. A process for transparently and routinely quantifying the extent to which the central-level MoH is unable to provide commodities or funds that are central-level MoH responsibilities is needed to provide objective evidence of problems and to advocate for needed changes in central resources and/or management practices. If PHDs and

ODs divert other resources to fill these gaps (e.g., using their user-fee salary supplements to fill gaps), this should be documented as well.

5. *Discontinue village-level activities:* HSSC/URC should address referral issues within the context of QI between facilities and facilitate NGOs working at the village level to address the referral needs from that level. HSSC/URC should not implement activities that could feasibly be carried out (through subcontract if necessary) by local NGOs.

6. *Continue efforts to link health financing and quality as policy:* HSSC/URC TA to the RGoC and MoH to improve the health financing mechanisms and their practical application, including linking payment to quality of services, should continue.

7. *Explore institutionalization of HEF management:* The feasibility of beginning development of private sector capacity to effectively implement the various third-party payment mechanisms should be explored.

8. *Institutionalize the HEF database:* The HEF database developed by HSSC/URC should be supported and an institutional setting for maintaining and updating the database strengthened. The appropriate government staff (DPHI?) should be mentored to use the information for further analysis and planning as well as reporting.

9. *Use evidence-based capacity building strategies:* Best practices in developing managerial and planning capacity at the PHD and OD levels, as well as an assessment of the quality of the skills developed, should be undertaken in collaboration with the DPHI. Similar to the process for developing the PHD/OD management capacity assessment tools, MoH endorsement of a strategy to achieve a management capacity that can function within the MoH system without constant external TA should be advocated. HSSC/URC is in a strong position to provide TA and to assist the MoH in monitoring partner NGOs who aim to develop PHD and OD management capacity.

10. *Maintain focus on policy-level activities:* Support for HIV/AIDS, AI, and TB should focus on policy issues with regard to standards and guidelines and QI-related aspects for service delivery.

11. *Continued technical support to The Messenger:* National ownership of this publication and editorial board capacity to identify key issues should be strengthened. Information of appropriate technical depth should be targeted to the right people.

    - Ways to promote the sale of *The Messenger* in the private sector and ensure that there are always sections that are considered relevant to the private sector should be explored.

12. *Increase the national-level profile for HSSC/URC:* Greater effort should be made to develop a national-level profile for HSSC/URC, including spending more time at the central MoH and strengthening the collaborative ties within the QAO and with collaborating organizations (e.g., GTZ). This effort may result in stronger influence at the central level and among donor/partner organizations as the collaborative working pattern becomes better defined.

IV. GENERAL CONCLUSIONS AND LESSONS LEARNED FOR USAID PROGRAMMING

1. Investment in working through local organizational capacity has produced highly effective local NGOs that are achieving significant results.
2. RHAC, RACHA, and URC:
   - Have played a critical role in improved delivery and utilization of health services. The government health service delivery is being strengthened, and there is evidence of better quality services and increased coverage.
   - Have identified new strategies and pilot-tested interventions and developed models for providing quality health services through the private sector and public-private partnerships (C-DOTS, PPM). Pilot interventions have been integrated into the health system.
   - Technical expertise within these organizations and demonstrations of successful implementation of activities have influenced national policy, programs, and approaches.
3. It was noteworthy that when pressed about why PHDs and ODs still need and desire an NGO presence (other than funding), various managers, particularly at implementation levels, alluded to the following issues:
   - The periodic presence of NGO staff decreases external pressures and strengthens managers who might want to support adherence to rules and regulations but who cannot always withstand outside influences, particularly in decisions related to staff discipline and accountability.
   - The managers noted that the NGOs often identify and facilitate the introduction of accepted and proven interventions that the central MoH may not perceive as important. The NGOs bring needed resources and technical input to produce the evidence base from pilot activities.
   - The NGOs are helping government facilities achieve increases in reportable targets by strengthening the utilization of services.
4. The current strategy being used by all three organizations for developing capacity (e.g., filling funding gaps, improving provider technical skills, and providing technical input for planning, strategic assessments of data, and managing services) does not have a clear design for shifting responsibility and accountability to the MoH managers.
   - A concern expressed by many stakeholders that the current strategies for "building capacity" are, in fact, resulting in NGOs substituting for government staff and weakening MoH managers appears to have some merit.
   - Major weaknesses in the government management system are not being effectively addressed. These include the system's ability to manage funds and staff, provide an adequate supply of medicines, and ensure maintenance and repair of infrastructure and equipment. It was noteworthy that at several of the new (less than two years old) WB-funded HCs visited, the incinerator and water systems were already not functioning.
   - The planning support provided by the NGOs to an OD or PHD does not focus on strategic objectives. The end result of current practices is that the AOP is a compilation of many plans and strategies into one document rather than a single, integrated plan for an OD or PHD focused on achieving specific strategic objectives.

- The current direct channeling of funds by RHAC, RACHA, and URC to support OD and PHD activities (e.g., per diems, funds for training, meetings) does not support the authority or credibility of OD/PHD managers and, in fact, may undermine their credibility.

5. Systems for community-government service linkages are being developed.
   - Demand for improved service quality and availability has been generated by community education and funding mechanisms such as equity funds and CBHIF.
   - Capacity is being built in the community for community-level services provided either by NGO or government-supported volunteers.
   - Volunteers and other community members are effectively encouraging appropriate utilization of the formal health sector, particularly for TB, immunization, and MCH.

6. Increasing dependence on community volunteers for provision of services and supporting MoH services seems to be taking place without a long-term strategy to address the sustainability of the community service networks and shift ownership to the community.

7. Linking payment mechanisms, such as equity funds, to quality of health services is resulting in increased utilization, increased demand for services, and increased demand for quality (e.g., there are reports of users complaining when they don't get services they think they should receive). This is also resulting in improved facility-level quality and improved staff attitudes.
   - There is a need for forward planning along with strategies for increasing demand and service utilization. There were a few field visit sites where increased utilization was creating problems due to lack of space for the increased numbers of deliveries and postpartum recovery.
   - Increased demand for financing management/accountability at facility levels can be anticipated as an expanded number of financing mechanisms are introduced.

8. There is a perception among some members of the international community that USAID and USAID-funded projects work outside the MoH structure and are unsupportive of the overall national strategic plan. Some comments indicated a lack of understanding of what and how USAID-supported groups work with the MoH, as well as a lack of awareness of the size and scope of RHAC and RACHA versus other smaller NGOs.

9. Comparative advantages and areas of expertise among the three organizations do not seem to be fully shared or used. Although they coordinate activities at joint meetings and share information, they do not routinely discuss strategies and the effectiveness of these strategies for activities they have in common (e.g., building OD capacity for planning). There is an undercurrent of competitive rather than synergistic work.

10. There are key MoH issues external to the projects that impact on their work. These are well known among the health stakeholders but need to be mentioned as they are the context in which the USAID-funded projects are working.
    - Chronic stock-outs of essential medicines (e.g., STI medicines)
    - Shortages and poor allocation of trained staff; lack of living wages and budgets to fund government objectives
    - Conflict of interest from dual public/private practice and services by employees
    - Poor quality of basic training for doctors, nurses, and midwives
    - Lack of accepted professional ethical standards that Cambodian health professionals promote among themselves

- Insufficient coordination among other donors/stakeholders who influence program inputs

COMMENTS ABOUT THE OVERALL DESIGN OF THE PROGRAM AND THE PROJECTS

1. USAID program priorities, and the balance between dual priorities, were unclear:
    - Is the priority to target the most vulnerable, least-served populations, or to achieve overall improvements in the population's health? The 2005 Cambodia Demographic and Health Survey (CDHS) indicates that while overall health statistics are improving, disparities among subgroups in the population are increasing.
    - Is the priority to ensure access to and utilization of services regardless of government capacity or to ensure sustainability of services? Assuming it is both, how should balance be achieved when gaps are constantly being filled to ensure service availability (which may be impeding progress in making improvements needed to strengthen government systems)?
2. None of the assessed projects were developed with clear points at which they are deemed successful, nor were there exit strategies that indicate a future date when external project support for some activities will no longer be needed.
    - Numerous informant comments indicated a perception that credibility was lost previously when NGOs withdrew as their projects were completed (e.g., CARE). The withdrawal was perceived by communities and the government as precipitous and not well planned. Other USAID-funded NGOs were asked by the MoH and by USAID to replace those NGOs whose projects had completed.
    - The current design does not facilitate best use of the unique skills each organization brings to different sectors, such as international technical expertise, clinical and training expertise, community development, policy and strategic design, and private sector service provision. There are missed opportunities for sharing both TA and results among partner organizations on best practices, lessons learned, and implementation tools developed.
3. The impact of USAID system issues, such as last-minute workloads (e.g., reports, implementing activities for AI) and partner implementers being asked midway through project agreements to contribute to new USAID priorities (e.g., expand geographic working area; help roll out the PEPFAR program), all of which may impact on effective implementation of ongoing programs and work plans, is an issue that needs to be explicitly acknowledged. There may not be a good solution to these issues, but they do impact on a long-term strategy and focus for these projects.

V. RECOMMENDATIONS

USAID has indicated a desire to frame the next HSP in light of the donor community commitment to increased harmonization and alignment with national priorities, and specifically with the HSP2 and HSSP2 (2008-2015).

CONTEXT FOR RECOMMENDATIONS: STRATEGIC PLANNING FOR 2008-2015 (HSSP2 AND HSP2)[9]

Although there has been progress in public sector reform and decentralization (CRDB February 2007), there remain many hurdles in policy implementation, transparency, and accountability. Donors and the MoH have been consulting on strategies for increased harmonization and alignment in the health sector toward more efficient and effective health services, given continued government and donor constraints for full integration of aid, planning, and implementation of desired systems for the health sector.

The National Strategic Development Plan 2006-2010 (NSDP) sets the main priorities for Cambodian strategic development, while the Cambodian MDGs set the indicators and targets to achieve by 2015. The NSDP specifically calls for expansion of pro-poor health financing and improved service delivery through additional investment and expansion using lessons from contracting to delivery of basic health services. It also calls for increased involvement of the private sector in delivery of basic health services.

HSP2, currently being drafted to cover the 2008-2015 period, draws from lessons learned in the first HSP, as well as from events related to the NSDP.

Issues of concern raised by donors and RGoC related to the health sector

Midterm reviews as well as meetings and assessments in preparation for drafting the HSP2 have consistently identified the same issues contributing to successes and those contributing to inefficiencies and impeding progress in the health sector. These include:

Successes:

- General agreement that contracting models at the OD level are successful
- General agreement that equity funds have strengthened utilization of services and improved coverage of the health needs of the poor
- Appreciation that the MoH and RGoC are focused on results and that this is supported by their acceptance of MDGs

Problems:

- Lack of harmonization of HSP objectives with the actual budget for implementation
- Weak donor coordination and harmonization
- Weak organizational capacity at all levels within the MoH. Problems in capacity building identified from the past include the absence of a guiding framework, lack of an enabling institutional environment, insufficient emphasis on coaching and mentoring, inadequate funding flows, and a lack of clarity regarding capacity gaps. Insufficient incentives within the government system were also identified.
- An overall lack of professional standards, quality of basic training, and a system for monitoring these

[9] Information in this section is drawn from the HSP midterm evaluation, WB notes on HSSP and SWAp, and notes from donor consultative meetings related to donor harmonization and alignment.

Issues/recommendations:

- WB noted the value of donors and the MoH negotiating memoranda of understanding that focus on pragmatic steps for how existing strategies (such as HSP2) can be supported more effectively.
- One coordinated approach for OD or PHD level services, so that inputs and technical support are coordinated and with more participation from the government in needs assessments, should be supported. This has been discussed in terms of scaling up service delivery, pooling funds, and harmonizing management systems.
    - Access to high-quality essential health services (MPA and CPA standards), potentially using block grants or contracting mechanisms that link pay to performance and based on a harmonized plan for an OD or PHD, should be improved.
    - Contracting mechanisms between government bodies, such as a PHD contracting with an OD or the central MOH contracting with a PHD (referred to as contracting-in), has been suggested as a means for achieving results and supporting one coordinated approach.
- The stewardship role of the MoH needs to be strengthened to improve integration of the private sector.
    - There is a need to increase knowledge about, and linkages with, the private sector, both to know the amounts and quality of services the public is receiving, and to use the private sector potential for improving service availability and quality where the government cannot meet the needs.
- A focus on equity issues – including support for equity funds – and linking these with improved quality of health services is advocated.
- A focus on improving professional standards and quality is advocated, including working with training institutions, licensing and regulation of practitioners, and strengthening the effectiveness of professional associations to improve professional standards and quality.
- Organizational and management reform in the MoH to respond effectively to change and development challenges should be advanced. One option is to "establish an Institutional Capacity Development and Technical Cooperation Facility … to provide a framework for strengthening the MoH and the key agencies to perform policy development, regulatory and enforcement, monitoring and oversight, technical leadership and quality assurance and other key government roles in the health sector."
    - Existing processes and structures for policy and coordination should be strengthened, with specific support to the Health TWG as the central government vehicle to lead in the implementation of the action.
- Support to NGOs and civil society organizations to complement government activities and increase demand-side initiatives should be continued.

ISSUES AND RECOMMENDATIONS

1. Continue supporting complementary public, private, and civil society programs outside of the SWAp/SwIM funding baskets. Other donors urge USAID to contribute their funds to the HSP2 and other sector funding mechanisms. USAID is fully involved in the HSP2 and HSSP2 development discussions, is providing highly regarded TA to the processes, and will continue to be a strong supporter of donor harmonization and alignment with RGoC goals. However, given current financial accountability conditions, the moment for USAID contributions into joint health sector funding mechanisms has not yet arrived.

2. Most health indicators have shown a marked improvement over the past five years, but gaps between rural/urban and low-income/high-income groups persist and are growing. To bridge these gaps and address them more equitably requires a closer analysis of problem.

   Recommendation: Use disaggregated data in planning the next phase of support:

   - National government and donor-level strategies should give emphasis to the gaps and inequities in health indicators. A review and discussion of provincial-level MDG indicators could focus central government attention on these disparities.
   - Technical assistance to the MoH in using disaggregated data for decisionmaking, incorporating this analysis into setting Ministry priorities, should be provided.
     - At the OD/PHD level, planning should focus on disaggregated data to identify and ensure that the least-serviced/highest-risk groups are targeted among the populations served and given priority in operational plans. Setting program priorities based on these priorities in operational plans should be encouraged.
   - Secondary data analysis (DHS 2005) should be carried out to identify geographic areas/populations of greatest need, which, if addressed successfully, could have a substantial impact on overall national indicators.

3. A major national goal and universal priority of all donors is to strengthen human capacity in the government health system. There are two interrelated aspects of capacity building that need to be addressed: (a) building capacity through targeted training and mentoring on one hand, which has attracted the most support to date; and (b) the system interventions and cultural issues that limit or prevent MoH staff from fully using their demonstrated capabilities.

   Recommendation: Revise current support systems to strengthen government management accountability and performance:

   - As national policies evolve to establish the development of merit pay approaches, support changes at the program operational level in the mechanism for salary supplementation to a pay-for-performance system.
     - Link pay-for-performance to completion of planned activities: management initiating required meetings; field supervision; monitoring services after training.
     - Link pay-for-performance to management teams' developing AOPs meeting minimum standards and targeted to program outcomes. This could be introduced on a pilot basis in a select promising OD/PHD as a goal-oriented operational plan followed by a performance-based system to reward achieved outcomes (e.g., key service coverage, reduced mortality/morbidity).
     - If feasible, the above mechanisms could be introduced through support for contracting-in at the OD or PHD level, using experienced NGOs to monitor the contracts.
   - Plans for supporting OD/PHD-level capacity building that include a package of training, on-the-job support, and a timeline anticipated to achieve expected capacity should be developed.
   - If funding supplements for MoH management and services continue to be channeled through NGO-implemented projects, the NGOs should prepare consolidated budgets for management/ operations support (per diems for training, meetings, supervision) and channel funds into the OD or PHD budget. NGOs should monitor achievement of planned results, shifting responsibility for appropriate use of the budget to the government staff, who will gain pragmatic financial management experience and better control while monitoring systems are still in place to reinforce implementation of good practices.

4. RACHA and RHAC have demonstrated the important impact that can be achieved by building community outreach and community resources based on training and regular support for a network of community volunteers. These are seen by the MoH as an important extension of government services. Volunteers' service and motivation are highly dependent on the types of support provided jointly by the NGOs, local government health staff, and their communities. The long-term sustainability of services dependent on volunteers is therefore a topic that should be considered carefully at a time when support for their role is at a peak.

   Recommendation: Develop a strategy to increase community ownership and responsibility for volunteers and to reinforce the importance of local HC teams' continued support for and collaboration with the community volunteers, who contribute substantially to achieving national objectives.

   - Assess the existing community support resources – VHSGs, commune councils, and HC management committees (of which volunteers are members) and other NGO-initiated volunteer systems (such as the RHAC community volunteers and peer educators. Pragmatically assess (with the community) the realistic work expectations for volunteers related to the benefits (tangible and perceived) they receive, and the kinds of approaches the NGOs have used to build and maintain volunteer skills and motivation. Based on the assessments, develop a strategy to sustain the role and important contributions of community volunteers.

5. Utilization of private sector potential should be improved. The rapid economic expansion has stimulated use of the burgeoning private health care sector, with potential for cooperation.

   Recommendation: Seek improved public-private sector cooperation to address key areas of health service need.

   - Address the lack of skilled birth attendants in rural and remote areas through private sector incentives (combined with the current government effort to recruit midwives from remote or difficult areas). Such an initiative should avoid creating incentives for public sector midwives in remote areas to do private practice, except as part of an overall strategy.
   - Continue supporting the role of local NGOs in service provision at the community level:
     - Pilot testing of technical strategies at the community level through local NGOs to address problems and develop locally relevant "evidence for decisionmaking."
     - Use the NGOs' high standards of quality service and client orientation as a model to influence other private providers.
     - Strengthen community demand and effective civil society strategies to strengthen government fulfillment of its responsibility to ensure the availability of quality health services.

6. Private sector health care is rapidly expanding without an effective monitoring or licensing/regulatory framework. There are no nationally advocated basic service quality and ethical standards among health professionals.

   Recommendation: Support strengthening of private sector professionalism and standards.

   - Support and provide TA to local health professional organizations to develop standards of ethics and standards for services.
   - Through linkages with private sector providers, introduce a professional stamp of approval that certifies and identifies those meeting or adopting standards.

- The potential exists to institutionalize national research capacity through the private sector to test emerging or new interventions and approaches in health and to assess and evaluate the impact of those in operation (e.g., pilots potentially carried out through RACHA and RHAC).

7. Irregularities in the national procurement and distribution of medicines and key medical supplies continue to disrupt the availability of drugs at all public service facilities. This problem is particularly highlighted as donor and government efforts are achieving results in increasing service utilization and on assessing and improving the quality of public services. The drug supply has remained an issue somewhat impervious to quick solution. However, with the development of such important tools as the drug logistics information system, which produces the national, provincial, and OD drug inventory databases, along with the application of facility quality assessment tools on a national scale, there is continual monitoring of the dimensions and impact of the drug supply problem.

   Recommendation: USAID, its partners, and other donors should actively use the available data on drug supply problems in regular discussions with senior decisionmakers and policy leaders as part of the ongoing national health plan and health sector support strategy dialogue.

   - In support of the above, and of general transparency, the stakeholders should use their influence to encourage the MoH to maintain an updated Web page with information that is helpful and relevant to parties working in the health sector (or external to Cambodia) who might be able to use the information in support of a stronger health system and better program planning for Cambodia.

8. Perceived lack of cooperation from USAID and USAID-supported programs. In some segments of the international community, there is a perception that USAID funds NGOs and other groups directly, which creates a parallel system not integrated into the MoH. Although there is respect for USAID's health team, there is clearly a lack of awareness in some quarters of what USAID is supporting and how the Mission operates.

   Recommendation: The Mission should assess the level of importance of this issue and take appropriate steps to improve perceptions and relationships where needed.

Recommendations of importance, but outside of USAID's current program purview:

Recommendation: Look at potential mechanisms to strengthen preservice training for doctors.

- An area of critical need has been flagged for potential USAID support – the possibility of linking a U.S. medical school with the national medical school in Phnom Penh to collaborate in assessing the current situation and proposing improvements in the quality of basic medical training. This is probably a longer-term, resource-intensive undertaking, with potential political overtones, but is a challenge that continues to affect Cambodian health care.

APPENDICES

APPENDIX A TERMS OF REFERENCE

SCOPE OF WORK
(Revised GH Tech/Mission: 11-04-07)

Cambodia Strategic Assessment of USAID funded health programs implemented by:

Reproductive and Child Health Alliance (RACHA) under Cooperative Agreement number 493-a-00-04-00005-00
Reproductive Association of Cambodia (RHAC) under Cooperative Agreement number 442-A-00-99-00033-00
University Research Co., LLC (URC) under Cooperative Agreement number 442-A-00-02-00214-00

Identification of the Tasks:

The USAID/Cambodia Office of Public Health & Education (OPHE) requests technical assistance from the Global Health Technical Assistance Project (GH Tech) to evaluate three major integrated health projects focusing on reducing the leading causes of maternal, child and neonatal mortality; improving the reproductive health services; reducing the burden of and mitigating the impacts of infectious diseases of major importance, including HIV/AIDS, Tuberculosis and malaria; and strengthening health system in Cambodia;

The Mission is requesting that the evaluation be completed on an accelerated basis, by December 2007, in order that we can proceed to the subsequent redesign of our health sector programs this fiscal year.

Purpose/Objectives/Key Evaluation Questions

Purpose: Conduct a final evaluation of the three major integrated health projects implemented by RHAC, RACHA and URC, while assessing current program integration.

Key Evaluation Questions

1. Evaluate the major outcomes, achievements, constraints and gaps of the USAID/Cambodia projects implemented by RHAC from (April 1999 – September 2008), RACHA (February 2004 – September 2008), and URC (October 2002 – September 2008), at various levels.

a) Were, in retrospect, the design of both the overall program and the individual projects sound, e.g. did they correctly identify the problems and constraints and approaches to addressing these?
b) How have plans for accomplishing planned outcomes changed during the life of the projects? Why?
c) What has been the projects' progress to date in relation to planned results and performance indicators (provided in the Results Framework and the projects' Performance Monitoring Plans)?
d) What planned result targets were not met or exceeded? Why?
e) What have been the largest constraints to achieving results?
f) Were there gaps in planning that might have increased the likelihood of being unable to achieve a result or target?
g) Were there specific project management policies, structure or practices that contributed to either success or failure of intervention implementation?

h) What were the unexpected project outcomes and how have they contributed to the overall Results Framework?
i) What are the outstanding issues and important gaps that have not been addressed by the projects that require attention and should be considered for future USAID investment?

2. Identify lessons learnt, successful interventions for continuation or replication, better practices, significant products and tools of the above projects for possible dissemination and replication.

a) What if any lessons have been learned regarding the overall design of the program and projects?
b) What project activities or accomplishments have led to implementation best practices? Describe those best practices.
c) What interventions have the best likelihood of sustainable replication?
d) Which lessons learned or best practices have already been successfully replicated by other donor projects/programs or by the Government of Cambodia?
e) What key products or tools have been developed by the projects?
f) What are the key initiatives, activities and approaches that warrant continued/additional USAID investment in the future?
g) What are other promising, potentially sustainable service delivery models or approaches, not currently addressed by the projects that should be considered for future USAID investment?

Evaluation Objective
Based on the findings, formulate recommendations for the strategic directions and future design of USAID's health assistance in Cambodia addressing such key factors as: institutional and financial sustainability, systems strengthening, increased sector accountability and improved donor harmonization and coordination.

III. Methodology

Review relevant national documents including RGC/MOH policies, guidelines, strategic documents, relevant program reviews and evaluations, national surveys; annual operational plans of national programs, provincial and operational districts, reports etc.
Review project documents; proposals, implementation plans, monitoring and evaluation plans, progress reports, review/evaluation reports, training curricula etc.

The team will conduct a 2-3 day team planning meeting (TPM) upon arrival in Cambodia and before starting the in-country portion of the evaluation. The TPM will review and clarify any questions on the evaluation SOW, draft an initial work plan, develop a data collection plan, finalize the evaluation questions, develop the evaluation report table of contents, clarify team members' roles, and assign drafting responsibilities for the evaluation report. The TPM outcomes will be shared with USAID/Cambodia and the health team will participate in sections of the TPM.

Field operations observations.
Literature reviews in relevant areas.
Interview key informants including USAID Mission management/staff and key Ministry of Health partners (MOH, National programs, Provincial offices, District health teams); key health partners (MOH, DfID, WHO, WB, GTZ, UNICEF, JICA); and relevant NGO partners.

Total timeframe for the Evaluation is estimated to be approximately 4 weeks.

APPENDIX B ACTIVITY TIMELINE/SCHEDULE

November 11	Team arrives in country
November 12	Team-building meeting and clarification of terms of reference and schedule with USAID
November 13-16	Meetings with various stakeholders and organizations in Phnom Penh
November 17	Review of documents and notes
November 18-19	Travel to Siem Riep Province, meetings and site visits in various ODs in Siem Riep Province
November 20	Meetings and site visits in Banteay Meanchey PHD and ODs
November 21	Meetings and site visits in Battambang PHD and ODs, return to Phnom Penh
November 22-25	Review of documents and information from interviews and site visits, begin drafting sections of report
November 26-27	Meetings with URC, RACHA, and RHAC by team member assigned to the group for further discussions
November 28-29	Travel to Pursat Province (2 team members) and Sihanoukville (1 team member) for meetings and site visits.
November 30-December 7	Further discussions with key informants, drafting report, preparation of draft findings for USAID, finalization of draft report
December 4	Presentation and discussion of draft findings with OPHE and Mission Director at USAID
December 6	Joint debriefing with RACHA and URC
December 7	Debriefing with RHAC

APPENDIX C DOCUMENTS REVIEWED

The Australia-Cambodia Engagement Strategy to the Health Sector (2007-2013). Draft for Submission to RGoC, July 31, 2007.

Cambodia's Sector-Wide Management in Health. Preliminary Findings and Recommendations (Phase 1) (Draft). Mid-term evaluation of the Health Sector Strategic Plan 2006/7.

Chhuong C., Sherratt D. R., White P., 'Comprehensive Midwifery Review: Draft Final Report,' Ministry Of Health Kingdom of Cambodia, September 2006.

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APPENDIX D PERSONS CONTACTED

USAID

Erin Soto	Mission Director
Kate Crawford	Director, Office of Public Health (OPH)
Jonathan Ross	Deputy Director OPH
Chantha Chak	Infectious Diseases Team Leader (TL) OPH
Sopheanarith Sek	OPHE
Hen Sokun Charya	Team Leader for Family Health

University Research Corporation

Tapley Jordanwood	Health Financing Program Manager
Tan Chanthy	Quality Improvement (QI)/Reproductive Health Technical Officer
Frances Daily	Technical Advisor
Seak Kunrath	Tuberculosis Technical Officer
Huong Vuthy	QI/Hospital Program Manager
Or Vathanak	HIV Technical Officer
Peng Vanny	Deputy Country Director HSSC/URC
Michael Bernhart	Country Director

RACHA

Chan Theary	Director
Lim Navy	Capacity Building TL
Mam Soehenda	Health Communication TL
Ngeth Lavan	Financial Operations
Chuon Satharida	Financial Operations
Eam Mony	Safe Motherhood TL
Kov Buntor	Logistics Management/Information System
Nou SoVann	Infectious Diseases
Chan Ketsana	Child Health Monitoring and Evaluation
Sun Nasy	Deputy Executive Director
Khieu Serey Vuthua	Birth Spacing-HIV TL
Neou VongSa	Information Technology TL

RHAC

Ouk Vong Vathiny	Executive Director
Var Chivorn	Associate Executive Director
Ping Chutema	Director of Clinical Services
Eng Veng Eang	Program Coordinator, Outreach and Health Center Support
Hou Hem Munnary	Youth Health Program Coordinator
Mak Muninth	Program Officer, HIV for Vulnerable Groups
Lay Houy	Program Officer

(plus RHAC HQ and field staff)

Ministry of Health Phnom Penh

H.E. Nuth Sokhom	Minister of Health
H.I. Tep Lun	Director General of Health
H.E. Ouk Mona	Secretary of State for Health
Dr. Chea Sokhim	Deputy Director of International Cooperation
Dr. Vy Sophoat	Deputy Director of International Cooperation
Mr. Heng Si Leng	Cabinet
LoVeasna Kiry	Director, Department of Planning
H.E. Eng Huot	Secretary of State
Mao Tan Eang	Director, National Center for TB and Leprosy Control (CENET)
Chon Sinoun	Chief of Quality Assurance Office
Voeurng Vireak	Vice-chief of Quality Assurance Office, Hospital Services Dept.
Sok Po	Deputy Director of Hospital Services Department
Dr. Tung Rathavy	National Reproductive Health Program Manager, Dep. Director, National Maternal and Child Health Center.

Other Consultants and Technical Advisors

Mary Dunbar	Resident Advisor A2Z, Academy for Educational Development
Judith Moore	Resident Advisor ACCESS Program, JHPIEGO
Prateek Gupta	Monitoring and Evaluation Advisor, BASICS
Meas Pheng	Child Health Specialist, BASICS
Chris Jones	Country Director, PSI
Claes Ortendahl	Consultant to development of National Strategic Plan for Health
John Grundy	Technical Advisor GAVI and WHO, Australian International Health Institute
Maurits van Pelt	MoPo/Tsyo Patient Information Center Executive Director and independent consultant to WHO and URC for health financing

JICA

Tatuo Sugiyama	Project Leader CENAT/JICA National TB Control Project
Mari Nagai	Expert, Community Health, Project for Improving Maternal and Child Health Services in Rural Areas in Cambodia
Sato Shoko	Project formulation Advisor (Health Sector)

WHO and UNICEF

Nikias Danielsson	Child and Adolescent Health, WHO
La-ong Tok	Technical Officer for Nutrition, UNICEF
Paul Weelen	Health System Development Advisor, WHO
Benjaim Lane	Equity Fund Manager, WHO

The World Bank

Ly Nareth	Operations Officer for Health Program
Toomas Palu	Lead Health Specialist
Anne Erpelding	Program Coordinator, Support to the Health Sector Reform, **GTZ**
Dirk Horemans	Project Co-Director, Belgium Technical Cooperation (**BTC**)

Siem Riep

Dy bunchhem	PHD Director Siem Riep
Ith Sakhoeun	Deputy Director Siem Riep OD
Iv Lyda	Pharmacy OD Siem Riep
Katu Daly	Pharmacy OD Siem Riep
Ney Phalen	Director OD Soutnikum
Thong Ramy	MCH Chief, Siem Riep PHD
Mak San Oeun	OD Director, Angkor Chum
Phat Sophy	Micro-Credit Focal Point, Angkor Chum OD
Un Many	Chief of Drug Unit, Angkor Chum OD
Huot Savun	TB Program Officer, Angkor Chum OD
Khan Sakhan	STD/HIV Program Officer, Angkor Chum OD
Rim Rik	EPI Officer, Angkor Chum OD
Bou Kim Ea	Director Kralanh OD
Pich Hathu	Asst. Program Coordinator URC Siem Riep
Peou Hun	Siam Riep Provincial Coordinator, URC
Thach Lykhan	RACHA Provincial Coordinator

Banteay Meanchey

Chhum Vannarith	PHD Deputy Director, Banteay Meanchey
Roeun Sothy	HIV Program Officer, Banteay Meanchey PHD
Chea Yuthearith	Chief of Technical Office, Banteay Meanchey PHD
Kim Samoeun	TB Program Officer, Banteay Meanchey PHD
Din Cheam	Chief of Admin Office, Banteay Meanchey PHD
Yuk Sovuth	MCH Officer, Banteay Meanchey PHD
Hou Sereywitchouk	Director, Mongolborei Referral Hospital
Soeung Sophornmony	Director Ochrov RH
Cheam Samorn	Director Preash Net Preas OD Banteay Meanchey
KhunnaVut	Provincial Coordinator, RACHA
Aok Sothiry	Director Thmar Puok OD
Leang Lenin	Director O'Chroy OD
Chou Chanvoan	EPI Officer
Soeung Sopheap	TB/HIS Officer, O'Chroy OD

Battambang Province

Nhek Bunchhup	PHD Director Battambang
Chan Daveoung	Chief of Technical Office, Battambang PHD
Som Hun	Provincial Coordinator Battambang, URC
Oum Vanna	Director Moung Russey OD
Sok Sokun	Assistant Provincial Coordinator, RACHA Battambang

Pursat Province

Klem Sokun	PHD Director Pursat
Ky Kien Hong	Chief Provincial Hospital Pursat
Chan Sokha	Vice-director/Chief of Surgery Provincial Hospital Pursat
Sieng Kim Seng	OD Chief Pursat OD
Pol Sarem	In-charge PHD continuing education

Chhun Pholly	Provincial Coordinator Pursat PHD, URC
Sarng Phal Bon	Director Bakan District Hospital
Koy Dy	RACHA Provincial Coordinator

Sihanoukville

Mean Malongvy	RHAC Clinic Manager and staff
Suon Bophea	Sihanoukville Referral Hospital, Health Equity Fund, Hospital Staff
Khem Sarong	Sihanoukville Provincial Health Department Director
Sechou Sethychot	Vice-Director Sihanoukville PHD

Phnom Penh

Neth Sovirak	Director Municipal Hospital
Long Ky	Vice Director Municipal Hospital
Hing Sothea	Vice Director Municipal Hospital
Son Sida	Monitoring Officer for HEF, Urban Sector Group
Kong Kunthea	Project Manager, Equity Funds Urban Sector Group

APPENDIX E SITES VISITED

Siem Riep Province

Siem Riep PHD

Siem Riep OD

- Bakong Pharmacy (PPM), Kantraing Health Center, Kandek Health Center, RHAC Clinic, RHAC Health Post

Angkor Chum OD

- Reul Health Center, Samrong Yea Health Center, Kok Russey Village—2 village support group volunteers, C-DOTS patient, Puok Health Center

Soutnikum OD

- Soutnikum RH, Soutnikum Health Center

Kralanh OD

- Sranal Health Center, Prey Chrouk Health Center, Chra Neang Village–village health support volunteer, Krawlean Hospital (in-depth visit), Chunlasday Health Center

Banteay Meanchey Province

Banteay Meanchey PHD

Mongolborei OD

- Mongolborei Referral Hospital, Makak Health Center, Kabal Spean Village—vitamin A/immunization session: volunteer and HC staff

O Chrov OD

- Nimitt Health Center, O Chrov Referral Hospital, Poipet 1, Sophy Health Center

Preah Net Preah OD

- Chup Vary Clinic, Preah Net Preah Health Center

Thmar Puok OD

- Phkoam Health Center, Village—VSG volunteer, Svay Chek Health Center, Yeang Vien Village-VSG volunteer

Battambang Province

Battambang PHD

Battambang OD

- Battambang RH (hospital assessment report being given), Svay Por HC (beside Referral Hospital), RHAC Clinic Battambang

Mong Russei OD

- Mong Russey Referral Hospital, Mong Russey Health Center next to Referral Hospital, Prey Svay Health Center, Russey Kraing Health Center, Chrey Health Center, Robas Mongkul Health Center, Chong Samnay Village—volunteer post vitamin-A/immunization session

Pursat Province

Pursat PHD

Sampeov Meas OD

- Sampeov Meas Referral Hospital, Chhoukmeas Health Center, Tbeng Chrum Village—VHSG who is also CBHIF member. Met poverty card holder, Tah Sas Health Center, Tah Sas village-

met with CBHIF Member, Sdok Tum Village—VHGG who is also CBHIF member. Met two other CBHIF members.

Bakan OD

- Bakan District Hospital

Sihanoukville

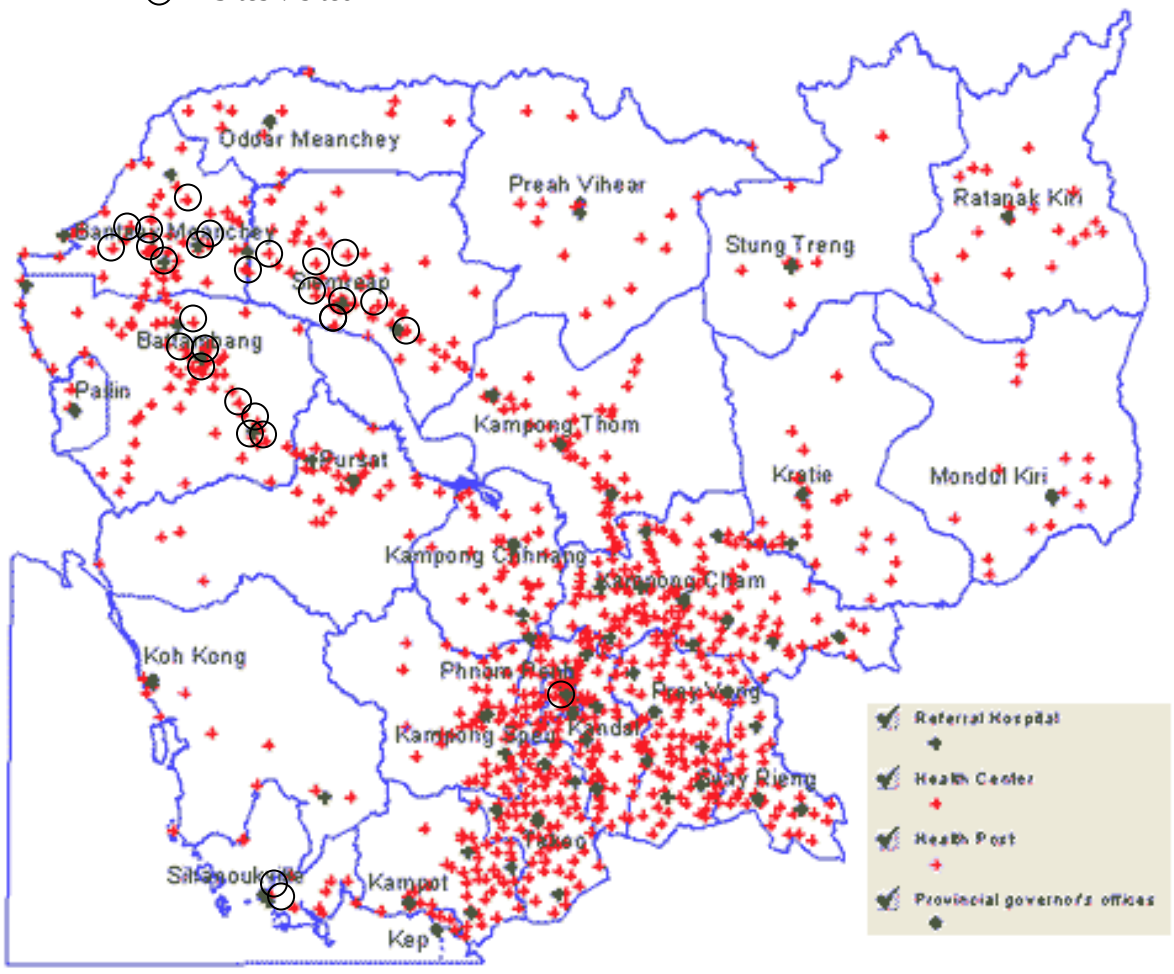
- RHAC Clinic, Sihanoukville Referral Hospital, Sihanoukville PHD

Phnom Penh

- Municipal Referral Hospital

Map of Sites Visited

◯ = Sites visited



APPENDIX F ADDITIONAL INFORMATION ON RHAC

APPENDIX F.1 RHAC Programs Geographic Coverage by Operational District (OD) November 2007

1. Battambang	**1. Battambang**	• Clinic • Youth health program • Community-based FP and health education • Support outreach services of health center • Vitamin A distribution • Mother and newborn health • Community DOTS (TB) • Childhood illnesses treatment • Health information system strengthening	Activities from second bullets onward will move to new OD in 2008
	2. Sangke	• Youth health program • Community-based FP and health education • Support outreach services of health center • Vitamin A distribution • Mother and newborn health • Community DOTS • Childhood illnesses treatment • PMTCT • Public-private mix for TB • Health information system strengthening	
	3. Thmor Korl	• Youth health program • Community-based FP and health education • Support outreach services of health center • Vitamin A distribution • Mother and newborn health • Community DOTS • Childhood illnesses treatment • Health information system strengthening	
2. Kampong Speu	**4. Kampong Speu**	• Clinic • Youth health program • Community-based FP and health education • Community DOTS • Community movie	Expand mother and newborn health and HIS strengthening activities in 2008
	5. Kong Pisey	• Community-based FP and health education • Support outreach services of health center • Vitamin A distribution • Community DOTS	
3. Kampong Cham	**6. Tbong Khmum-Kroch Chmar**	• Health post • Youth health program • Workplace-based program • Support outreach services of health center • Vitamin A distribution • Community DOTS	
	7. Kampong Cham-	• Clinic	

	Kampong Siem	• Youth health program	
	8. Cheung Prey	• Health post	
4. Mondulkiry	**9. Senmonorom**	• Youth health program • HIV for vulnerable group program	
5. Phnom Penh	**10. Cheung**	• Health post (1 health post) • Workplace-based program • HIV for vulnerable group program • Community-based FP and health education • Support outreach services of health center • Vitamin A distribution	
	11. Tbong	• Health post (2 health posts) • Youth health program • Health post (2 health posts) • Workplace-based program • HIV for vulnerable group program • Community-based FP and health education • Vitamin A distribution • Support outreach services of health center	
	12. Lech	• Health post (2 health posts) • Youth health program • Workplace-based program • HIV for vulnerable group program • Community-based FP and health education • Support outreach services of health center • Vitamin A distribution • Community DOTS	
	13. Kandal	• Clinic (2 clinics) • Workplace-based program • HIV for vulnerable group program	
6. Prey Veng	**14. Preah Sdach**	• Community movie • Contracting health service (HSSP)	
7. Pailin Municipal	**15. Pailin**	• Youth health program • Support health center outreach • Mother and newborn health	Expand Vitamin A distribution and HIS strengthening activities in '08
8. Svay Rieng	**16. Chiphou**	• HIV for vulnerable group program • Community-based FP and health education • Home-based care • Community movie	
	17. Romeas Hek	• Community-based FP and health education • Community movie	
	18. Svay Rieng	• Youth health program • HIV for vulnerable group program	
9. Siem Reap	**19. Siem Reap**	• Clinic • Youth health program • HIV for vulnerable group program (construction worker, young entertainer, MSM) • Pediatric AIDS treatment and OVC (sub-grant)	
	20. Angkor Chum	• Health post • Youth health program	

Provinces	Operational Districts	Program/Activities	Remark
10. Sihanoukville	**21. Sihanoukville**	• Clinic • Youth health program • Workplace-based program • HIV for vulnerable group program (young entertainer, fishermen) • Community-based FP and health education • Support outreach services of health center • Vitamin A distribution • Mother and newborn health • Health information system strengthening	Expand childhood illnesses treatment activities in 2008
11. Takeo	**22. Bati**	• Youth health program • Community-based FP and health education • Support outreach services of health center • Vitamin A distribution • Mother and newborn health • Community DOTS • Health information system strengthening	
	23. Prey Kabas	• Community-based FP and health education • Support outreach services of health center • Vitamin A distribution • Community DOTS • Mother and newborn health • Health information system strengthening	
	24. Daunkeo	• Clinic • Youth health program • Community-based FP and health education • Support outreach services of health center • Vitamin A distribution • Community DOTS • Community movie • Health information system strengthening	Expand mother and newborn health in 2008
	25. Kirivong	• Community-based FP and health education	
	26. Ang Roka	• Community-based FP and health education • Community movie	
• Sites visited by assessment team			

APPENDIX F.2 RHAC Lessons Learned, Challenges, and Constraints

(Submitted by RHAC)

1. Lessons Learned

1.1. Promote condom use through peer education approaches

IDSWs Peer Educators said that condom use was an important behavior change topic and that they found the role-play activities on condom use very helpful. Before being trained as a RHAC Peer Educator, these IDSWs would "sometimes use condoms and sometimes not." Now they know that sex without condoms is high-risk and that they should use condoms all the time. IDSWs Peer Educators believed that their peers are more likely to carry condoms at all times because of knowledge they gained through RHAC program activities and that carrying and using condoms was no longer disapproved of by others.

1.2. RHAC's community-based FP program

From resentment to acceptance and appreciation: RHAC has been implementing a community-based family planning program (known as HDT program) through its volunteers in the rural community, with contraceptive supplies from RHAC. The HDT workers were viewed by some health center staff as the competitors. Since late 2002, RHAC has started discussions with relevant provincial health departments to streamline the HDT program in the government health center outreach program. The decision was that all the HDT workers would purchase contraceptives from relevant health centers and the HDTs would report their achievements to the health centers. The health center staff are happy with this decision, since their health centers could increase income through the sale of contraceptives to the HDT, and the combination of HDT's achievements with those of the HC's make the HC's achievements look much better. However, there is still a constraint in organizing effective supply of contraceptives from HC to the HDT.

2. Challenges and Constraints

2.1. The existing health information's reporting format (HC1) does not include some information required by the Operational Plan; thus, RHAC needs to spend additional time to collect additional information.

2.2. Some approaches proved to be effective and approved by the national program and provincial level, but some ODs were resistant to accept the new approach and need more time than expected to be convinced (e.g. BTB OD on maternal and newborn project and C-DOTS).

2.3. Some of the RHAC's proposed plan could be implemented in one OD but not in other ODs; for example, the training on birth preparedness was done by HC staff in Pailin and Prey Kabas, but it was not approved to do the same at BTB and SHV.

2.4. RHAC's plan to provide birth preparedness training to VHSG through health center trainers could not be attained because the National Reproductive Health Program allows only the PHD and OD conduct the training in collaboration with the national program. This approach is in reality slower than the planned cascade training to be conducted by health centers, because there is limited number of trainers at the National, PHD, and OD levels. RHAC is now addressing this training

issue by incorporating birth preparedness training in bi-monthly VHSG meetings at health centers, instead of organizing formal training sessions.

2.5. The plan to expand Community DOTS for TB to all health centers of Battambang OD was delayed because RHAC did not agree with the OD's request for funding support for volunteers who are DOT observers.

2.6. Some achievements on maternal and newborn health are lower than the target due to the lengthy discussions involved in reaching agreement on the process of implementation before RHAC can start the activities. One OD (OD Battambang) is still discussing these approaches, especially the payment issues. Thus it could not start as yet. Only the training has been conducted.

2.7. IPPF has been funding a number of projects to RHAC, e.g. a clinic in Kampong Cham and a home-based care project in SHV, and promised to extend its support to other RHAC programs in 2006. From January 2006, IPPF suspended its support to RHAC due to RHAC's agreeing to implement USAID's Mexico City policies. The suspension lead to the reduction of level of effort for a number of activities, but from April onwards, all the suspended activities were implemented following the approval from USAID to fill the funding gap. The reduced support from IPPF may affect the planned USAID cost share requirement.

2.8. Permission to conduct youth program activities has yet to be granted by the Ministry of Education, Youth, and Sports for all seven of the targeted high schools in Phnom Penh. As a result, the school sites planned for Phnom Penh have been dropped during this reporting period. Due to this current impasse with the MoEYS, some provincial education departments have also barred project staff from working with high school students and teachers.

2.9. Several managers and owners of karaoke clubs and massage parlors refuse to cooperate with the HIV/AIDS for Vulnerable Groups project staff on HIV prevention and peer education activities, primarily because their establishments are illegal under Cambodian law. The government is currently cracking down on sex trafficking organizations, which often pose as entertainment establishments. This has forced the closure of some entertainment establishments covered by RHAC's program, leading to an overall drop in the number of project sites where RHAC conducts activities.

APPENDIX F.3 RHAC Program Coverage (1998 - 2007)

Year			1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Staff	**Total Staff**	**Total**	**50**	**64**	**72**	**82**	**125**	**163**	**250**	**353**	**439**	**510**
		HQ only	16	18	22	26	34	37	51	71	74	86
	Peer Educators	**Total**	**53**	**350**	**500**	**751**	**1,381**	**1,677**	**2,308**	**3,364**	**3,613**	**5,125**
		Youth	53	350	500	751	1,046	1,142	1,192	1,822	1,885	2,841
		Vulnerable Groups					140	215	376	496	596	1,158
		Workplace Based					195	320	740	1,046	1,132	1,126
	VHSG		**365**	**462**	**468**	**517**	**565**	**563**	**1,267**	**1,733**	**2,344**	**5,485**
	Community Support Groups (CSG)								420	2,128	5,994	7,721
Health Facilities	**RHAC Clinics**	**Total**	**4**	**5**	**5**	**9**	**9**	**10**	**13**	**14**	**15**	**16**
		Clinics	4	5	5	6	6	7	7	7	7	8
		Health Posts	0	0	0	3	3	3	6	7	8	8
		Laboratories (come with clinics and Health post)										
	MoH Health Center supported by Outeach and Health Support Program	Number of MoH Health Centers received financial and teachnical support from RHAC to conduct outreach services.						13	129	145	156	162
		Number of MoH Health Centers where RHAC support health education in community				206	206	206	222	222	219	226
Program areas	**Youth Health Program**	No. Villages	0	52	72	88	89	105	379	535	543	1,130
		No. Schools	1	9	14	16	16	17	27	40	41	39
	Outeach & HC Support Program	No. OD suppor Community Base Family Planning	18	18	18	18	18	18	18	18	16	16
		No. of OD supports Comminity Health Education	18	18	18	18	18	18	18	19	18	19
		No. OD Supports Outreach Services to HC						1	9	10	12	13
		No. OD supports Vitamin A Distribution and deworming							1	4	7	13
		No. OD support C-DOTS							2	6	7	10

		No. OD support Maternal and Newborn Health									1	6
		No. OD supports Child illness and treatment										3
		No. OD supports PPM for TB										1
		No. OD supports HIS strengthening										7
		No. OD supports Community Movie									6	6
	Pediatric AIDS care and OVC (Angkor Hospital for Children)											1
	Health Care Financing	No. OD Health Equity Fund									2	2
	No. OD support Contracting Services with MoH								1	1	1	1
	Vulnerable Group Program	No. of Entertainment Establishment					46	46	61	86	126	165
		No. of Fishing ports						56	69	69	69	69
		No. of Construction Companies							11	11	13	12
	Workplace Based	No. of Factories	5	5	5	5	6	6	16	22	28	29
Coverage	**Population covered**											5,030,586
	Provinces covered		6	7	7	7	7	7	8	8	10	11
	ODs covered		16	18	18	18	18	19	20	21	25	26

APPENDIX G ADDITIONAL INFORMATION ON RACHA

APPENDIX G.1 RACHA Lessons Learned

(Submitted by RACHA)

RACHA Lessons Learned

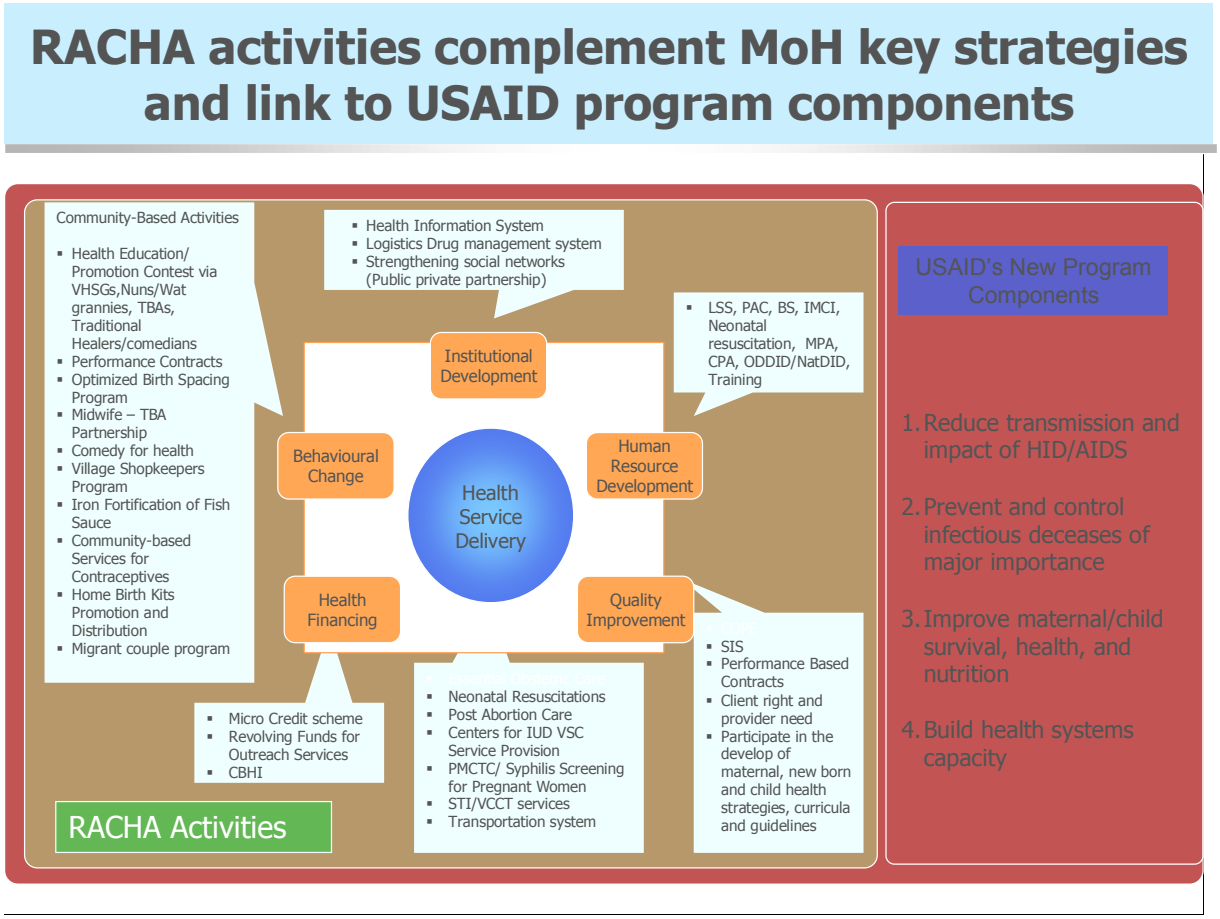
The implementation process of RACHA interventions and programs is designed to ensure all types of long-term sustainability. RACHA's fruitful years of endeavor in improving the reproductive and child health of Cambodians has imparted important lessons and has highlighted best practices that would advance its ongoing operation to a much greater heights.

LESSONS LEARNED	BEST PRACTICES
• RACHA's partnership with the MoH creates a synergy that enhances RACHA's ability to carry out its programs in line with national policy and donor's strategic framework. However, to work on three shifts to make the HC open for 24 hours (in order to increase access and utilization rate), RACHA was impelled to initiate the change. • The implementation of RACHA programs in some geographical areas was found not to be promising due to limited collaboration from the MoH counterparts and the presence of other NGOs working in similar programs. RACHA may gradually phase out from these areas and move to other underserved areas with good collaboration and support the local counterparts. • After the localization, RACHA has piloted the CBHI and Iron Fortification Fish Sauce projects, which were successful and relevant to the need of the community. Scaling up of these projects is foreseen to bring benefit to more beneficiaries. • It is important that the existing program of CBHI, Micro Credit, Equity fund, and Community Network has participation by the government in terms of manpower and cost-sharing. The support of local government is also needed. However, proper timing must be observed to ensure that the program will not be used by some government officials as a tool in furthering their political agenda. • Capacity building and leadership enhancement activities are deemed important, using not only the funds from USAID but also those from other donors and sponsors. • The greatest resources lie at the community level. The local human resources such as Village Health Support Groups, nuns and Watt grannies, village shopkeepers, traditional healers, and local comedians are very versatile and effective conduits in delivering culturally and linguistically appropriate community health advocacy at the grassroots level. • Investing in existing community resources to empower the general population to participate in health and health-related activities as well as strengthening the network system at all levels have positive effect in reinforcing the foundation of RACHA's broad-based health programs. • RACHA has observed that it has provided training to the HC staff that overlaps with the activities of other NGOs. The staff received the theoretical knowledge away from their workstation. RACHA has now shifted to "on site" training, which focuses on the enhancement of practical skills without leaving the post.	**Political Sustainability** • Complementing and supplementing the health programs to make RACHA's thrust relevant and responsive to national health policy and protocol • Strengthening Health Information System on operational planning, monitoring and evaluation at OD and HC levels **Institutional Sustainability** • Continuous staff development and leadership training • Workforce commitment and work ethics • Synergistic collaboration with NGOs and other agencies • Strengthening the network system at all levels • Continuous enhancement of both the demand and supply side of health care. • Mainstreaming TBAs and traditional healers into the health education programs. **Social and Cultural Sustainability** • Mobilization of local human resources/ local talents/ volunteers and strengthening community network in promoting health advocacy at the community level. • Promoting community service and stewardship

LESSONS LEARNED	BEST PRACTICES
• Working with national programs like COPE, LSS, and LDMS outside its area of coverage was found to be difficult to monitor and uses up much of RACHA's financial and human resources. It has downsized these programs and established collaboration with other stakeholders and counterparts by providing technical skills. • Due to the absence of functioning health infrastructure and the peoples' traditional health-seeking behaviors, TBAs have to be trained and linked to skilled health providers. Referral system from HC to RH has to be established. The capacity of midwives in managing EmOC at RH has to be enhanced. Volunteers/TBAs, as with midwives at HCs, will need to be trained in managing basic community postpartum hemorrhage with Misoprostol. These are important in strengthening the supply side. • There are ways to generate resources locally through Credit for Quality Improvement (CQI) scheme and CBHI, which could reduce out-of-pocket payment for health and widened access of the poor and vulnerable people to health care. As of now, the microcredit project complements and supplements the CBHI project; however, RACHA is optimistic that once CBHI is stabilized, corresponding adjustment in the premium rates will be made. This is based on the assumptions that the living conditions of villagers will improve and both the supply and demand sides will get better. • The microcredit scheme is very significant. The credit interest which came from the community is being plowed back to the community for its welfare. It goes a long way in paying for the transportation cost of crossing the river by sick villagers and in helping the floating Health Center. It covers the cost of pulling the HC up in times of flood and pulling it down when the water is at normal level, a situation peculiar to the Cambodian rural setting. • The equity fund is also vital to the sustainability of CBHI, since it only accredits Referral Hospitals with an existing equity fund program to ensure quality service to its clients. The availability of drugs, equipment, and supplies at the health facilities is another issue that has to be addressed by the Ministry of Health in order to give quality service not only to the CBHI members but also to the whole community.	**Financial Sustainability** • Strengthening the innovative trilogy of Credit for Quality Improvement, Equity Fund, and CBHI to general funds locally. • Geographical expansion of CBHI project • Prudent use of donated and locally generated funds • Transparency and fiscal control **Technical Sustainability** • Provide opportunity for Both and RACHA staff to attend local and international training/ refresher training and workshops • Mobilize human resource counterparts to train their peers while RACHA has facilitative role • Promote local internship and build capacity of young professionals who are potential human resources in the future

Source: RACHA

APPENDIX G.2 RACHA Activities



APPENDIX G.3 Summary of RACHA's Current Activities

RACHA Activity Title	Technical Assistance	Description	RACHA	Non–RACHA	Total
Supporting IR 1: Supply					
Birth Spacing	Service Delivery	Accredited centers of excellence for intrauterine devices (IUDs)	3 ODs	5 ODs	8 ODs
		Access improvement pilot study for voluntary surgical contraception (VSC)	4 ODs	5 ODs	9 ODs
	Training	Training sites: minilaparotomy in Pursat, VSC in Siem Reap	2 hospitals		
HC Health Contests	Service Delivery/ Quality Improvement	Competition between health center caseload and quality of services	3 ODs		3 ODs
HC Performance Contracts	Service Delivery	Awards scheme tied to health center delivery of services	4 ODs	2 ODs	6 ODs
Health Information System (HIS)	Information Systems	Support development and management of national HIS, program decision-making, and planning	9 ODs		9 ODs
Logistics	Logistics	Central management and LMIS support	72 ODs		72 ODs
		Logistics at health center and districts	9 ODs	6 ODs	15 ODs
Quality Improvement	Quality Improvement	Introduce COPE and self-improvement system	4 ODs	14 ODs	18 ODs
Bopha Thmey Center	Service Delivery	Operate drop-in center and STD clinic for indirect sex workers	1 center		1 center
Safe Motherhood	Service Delivery	Life-saving skills (LSS) training, antenatal care (ANC)/delivery/post-delivery	4 ODs	6 ODs	10 ODs
		Clinical training for midwives unqualified for LSS	4 ODs	2 ODs	6 ODs
		Continuing education program for midwives	4 ODs	2 ODs	6 ODs
	Training	Establish and support two LSS training sites	2 hospitals		2 hospitals
		Refurbish maternity unit and train midwives	8 hospitals		8 hospitals
In-service Training	Training	Birth spacing (refresher/counseling), syphilis counseling	3 ODs	8 ODs	11 ODs
Supporting IR 2: Demand					
Feedback Committees	Demand	Group education and doorstep interpersonal communication on health centers' range of services	3 ODs		3 ODs
Village-Level Health Contests	Demand	Competition between village residents on health knowledge	3 ODs		3 ODs
Health Education	Demand	Training in health promotion for all community-level volunteers	3 ODs		3 ODs
		Training in health education for outreach: RH, child health, and HIV	4 ODs		4 ODs
IEC	BCC	Design and provision of IEC materials	4 ODs	5 ODs	9 ODs
Nuns and Wat Grannies	Demand	Group education and interpersonal communication on acute respiratory infection (ARI), breastfeeding, birth spacing, and control of diarrheal disease (CDD)	3 ODs		3 ODs
Shopkeepers/Community-Based Services	Demand	Training shopkeepers in birth spacing promotion	3 ODs		3 ODs
Shopkeepers/CDD	Demand	Training shopkeepers in CDD/ORS promotion	3 ODs		3 ODs
Microcredit	Demand	25 percent interest on small loans directed to health promotion	3 ODs		3 ODs
Village-Level Performance Contracts	Demand	Award scheme tied to village health indicators	3 ODs		3 ODs

RACHA Activity Title	Technical Assistance	Description	RACHA	Non–RACHA	Total
Supporting IR 3: Access					
Community-Based Services	Awareness	Promoting health center (clinic and outreach) and retail birth spacing services	3 ODs		3 ODs
Feedback Committees	CBD	Stock-holding and distribution of temporary family planning methods	3 ODs		3 ODs
	Logistics	Support health centers' logistics for outreach (EPI, ANC)	3 ODs		3 ODs
Home Birth Kits	CBD	Sale of home birth kits through feedback committees, midwives, and traditional birth attendants (TBAs)	3 ODs		3 ODs
TBAs	Service Delivery	Training and linking TBAs with midwives	4 ODs	2 ODs	6 ODs

APPENDIX H ADDITIONAL INFORMATION ON URC

APPENDIX H.1 URC Timeline for Program Development

	FY 2003	2004	2005	2006	FY 2007	FY2008	Total
Funding US$							
USAID-HSSC (expenditures)	$1,046,221	$2,421,968	$2,851,845	$2,424,239	$3,749,718		$12,493,991
PHRplus funds		Amount not available	Amount not available		(includes AI funds)		
USAID-HSSC (budgeted)						$2,596,950	$15,090,941
/HSSP (budgeted)						$ 667,653	$ 667,653
USAID Malaria (budgeted)						$1,072,227	$1,072,227
Staffing							
Full-time total	11	17	15	21	22	23	36
Full-time field only	6	7	11	11	10	10	
Short-term consultants	Inter- 5, Local 2	Inter- 8, Local 15	Inter- 6, Local 7	Inter- 4, Local 2	Inter- 5, Local 2	-	14
Coverage**							
Provinces	7	7	7	7	6*	6	
ODs	16	17	22	22	21	21	
Facilities	205 HCs	239 HCs	281 HCs, 5 RHs	230 HCs, 12 RHs	230 HCs, 11 RHs	230 HCs, 10 RHs	
Population	n/a	3,348,013	4,500,000	7,690,644	7,645,763	5,194,285	

* Support to Koh Kong PHD was discontinued because other organizations were working extensively in the province

** Coverage is the total population and facilities that are reached by activities supported by HSSC/URC (e.g., the total population of the ODs where URC supports activities). This does not mean that HSSC/URC actually works with each HC or community indicated

APPENDIX H.2 URC Timeline for Specific Program Interventions

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY2008
Service						
IMCI training and follow-up (FU)		8 HCs	52 HCs	FU for 28 HCs	FU for 17 HCs	FU for 17 HCs
VC / VCT				31 sites	31 sites	FU 31 sites
PMTCT				9 sites	9 sites	FU 9 sites
OI/ART				2 sites	2 sites	FU 2 sites
C-DOTS				1 OD	1 OD	Handed over
PPM			1 OD	5 OD	8 OD	8 OD
Avian Influenza					4 RH site	4 RH site
Health system strengthening (HSS) activities						
Provincial level	7 PHD	6 PHD	6 PHD	6 PHD	6 PHD	
PHD/OD management checklist			6 PHD & 18 OD	6 PHD & 18 OD	5 PHD & 18 OD	
Health Equity Fund (HEF)*		5 RH, 11 OD	5 RH, 11 OD	8 RH, 14 OD	8 RH, 14 OD	10 RH, 14 OD
HEF HC		4 HC, 3 OD	4 HC, 3 OD	5 HC, 4 OD	18 HC, 7 OD	19 HC in 7 OD
Provider Behavior Change			32 HCs, 1 RH	69 HCs, 4 RH	53 HCs, 4 RH	
Quality improvement						
Level 1 tool	Baseline information for tool development		Conduct Baseline	Re-assess RHs	Level 1 tool adopted as national policy Reassess RHs	
Level 2 tool					Under development	
HC level tool					Baseline carried out 16 HC	

* HEF activities in some HC or the RH in the ODs
RH Referral Hospital

APPENDIX H.3 Documents Developed for National/Policy Level

TB National Strategic Plan TB Control 2006-2010 (approved)
National Strategic Plan TB laboratory 2007-2010 (approved)
National Guidelines C-DOTS (approved)
National Guidelines TB PPM Strategy (approved)
National Guidelines (SOP) TB/HIV (not approved yet)

AI Infection control guidelines for severe respiratory infections (under process for approval)
Guidelines for setting up and managing isolation ward (adopted, follows WHO standard)

HEF "National Equity Fund Implementation & Monitoring Framework" (final document reflects USAID-HSSC model)

Other strategic documents and planning

- National Strategic Plan for 2008-2015 (URC supported consultant who provided TA to planning department)
- National Workplan for TB 2006 and 2007
- National Workplan for HIV/AIDS 2006, 2007, and 2008
- National Strategic Plan for PMTCT for NMCH
- Served on the Executive Steering Committee for the Health Equity Fund Forum in January 2006 giving four key presentations
- Lead Facilitator of National "Common Core Indicators" for HEFs now in use nationwide

Other Health system strengthening tools

- PBCI training curriculum and guideline (approved and in use countrywide)
- Terms of Reference of Provincial Technical Working Group for Health (approved and used countrywide)
- Development and adoption of a database to track and analyze "Common Core Indicators" for HEFs
- TB supervision checklist, job aid, and guideline (under process for getting approval from CENAT)
- Training curriculum PPM, TB/HIV, TB Management (used for country-wide training)
- Supervisors' training curriculum "Facilitative Supervision" (used for countrywide training)
- Curriculum for training of trainers on using information for planning at local level (used for countrywide training)
- RH Facility Assessment Tool Level 1 (adopted by QI Office and Prakas for assessment of all hospitals in 2007)
- PHD and OD Management Assessment (adopted and disseminated for countrywide use)
- HC assessment tool (aligned with QA, GTZ, RACHA, tool has not been approved yet)
- Referral system assessment tool (tested in eight ODs, not yet approved)
- Simulation Exercise Checklists for AI (using PPE control on AI)
- Working with Department of Preventive Medicine to update Integrated Supervision Checklist
- Provincial and OD AOP development and AOP review in six provinces from 2004-07

HIS TB Database for national TB program
AI NGO mapping (URC sub-grant to MEDECAM and it was completed)

APPENDIX H.4 URC Activities Related to SO9 Objectives

Reduce transmission and impact HIV/AIDS; HIV/AIDS prevention, care/treatment

- Assist government in scaling up services: infrastructure refurbishment, procure equipment, funding for training
- Gained agreement from NCHADS that VCCT items can be a part of QIP assessment

Prevention and control of infectious diseases: TB, Avian Influenza (AI), Dengue

- Many activities to improve TB case-finding and treatment completion
    i. PPM for case referral integrated into OD
    ii. Protocols and Guidelines (C-DOTS, PPM, HIV, and TB)
    iii. Pilot activities for improving linkages between HIV and TB diagnostic testing (Still not fully developed, but policy developed)
- AI units in four hospitals
    i. Training on infection control
    ii. Guidelines for prevention of respiratory infection transmission
    iii. QIP quality of infrastructure and systems for facility-based infection control

Improve MCH and neonatal health

- Support training per diem for related topics
- Support per diem for field follow-up after IMCI training for OD and PHD staff, training in using IMCI supervision checklist
- QIP quality of infrastructure and systems for facility-based services

Build HS capacity (quality, sustainability, government linkages)

- Link HEF with facility quality
- Facility-level QIP tools for infrastructure and systems
- Provider behavior change (Pursat)
- Management assessment tools for PHD and OD
- Training and support to PHD and OD in preparation of AOPs-use of data and strategic planning
- Improve HIS and use of data

APPENDIX H.5 URC Lessons Learned

(Submitted by URC)

Key lessons learned and best practices from hospital assessment program

Strong Points:

- The hospital assessment tool uses a horizontal and comprehensive approach to analyze problems to deal with a dysfunctional facility rather than using a vertical approach.
- The assessment tool is designed to use with frequent intervals, this can allow someone to monitor the progress of a health facility over a period of time.
- The assessment can be used for benchmarking between referral hospitals as well as within each hospital. This means that hospitals can share and learn about their good results and best practices each others.
- The assessment is linked with a Health Equity Fund (HEF). Minimum score requirement and improvement of score overtime is the condition for a facility to receive and/or continue to receive HEF. Part of HEF can be use for an increase of financial income for an individual health provider which in turn to motivate them to improve their work performance.
- The assessor team is external, consisting of local professionals, and mixed between MoH and NGOs. This is to ensure the accuracy and reliability of the assessment results.
- The assessment tool is designed based on the CPA (complementary package of activity) guideline and other MoH guidelines. The assessment aimed to measure compliance with these guidelines. This will allow MoH to assess their policies/guidelines, gaps, and how to close the gaps.
- The assessment tool starts with very basic input that should be in place in order to provide good quality service. When these basic things are improved and are in place, the higher levels of assessment tool (raising the bar) will then be needed to focus more on patient safety and quality of patient care and continue to do so until the international accreditation standard is met.

Weak points:

- Length of the assessment may be too long. It takes almost 15 person-days for a medium size hospital.
- The tool does not measure technical quality of patient care.
- The tool does not measure all services in the hospital, especially the specialty such as eyes, ENT, dentistry, etc.
- Lack of control over resources at central level. Some problems occurred at facility are due to central MoH level such as shortage of supplies/drugs, inappropriate and delayed release of the government budget, lack of human resources, etc.
- Low staff salary and low staff motivation. Low-salary staff have to poach patients, use government work time to do private practice or other business, steal public drugs/supplies, or focus on activities that can generate more individual income such as training, workshops, vertical programs, etc.

Best practices:

- Self-assessment and self improvement activities conducted by a health facility by using the hospital assessment tool are very useful for them to identify the gaps/problems and try to solve those problems. This can be done with very little resources, such as an outside TA for a two-day orientation to the tool.
- Findings from self-assessment as well as external assessment can be used as the basis for development of a joint annual action plan with PHD/OD and NGOs active in areas, in order to jointly set target and activities to deal with these findings. This will increase manpower and financial aid to improve the facility performance.

For more information, please visit
http://www.ghtechproject.com/resources/

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