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CONTRACTING AND SIMILAR EXPERIENCES IN HEALTH IN CAMBODIA

ការចុះកិច្ចសន្យា និងបទពិសោធន៍ស្រដៀងគ្នាក្នុងវិស័យសុខាភិបាលនៅកម្ពុជា

A SYNTHESIS REPORT

របាយការណ៍ សំយោគ

ដោយ លោក ពីត ហ្វិនស្ត្រា
ទីប្រឹក្សាឯករាជ្យម្នាក់
សម្រាប់ មេឌីកាំ

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For Medicam

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បទពិសោធន៍តាមរយៈការចុះកិច្ចសន្យា និង បទពិសោធន៍ស្រដៀងគ្នាផ្សេងៗទៀត ក្នុងការ ផ្តល់សេវាសុខាភិបាលនៅក្នុងប្រទេសកម្ពុជា

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អង្គការ មេឌីខាំ

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Pieter Feenstra

DISCLAIMER

The views expressed in this document are an independent review of contracting and similar NGO experiences in the health sector in Cambodia and are not necessarily the views of anyone organization.

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ចោយការណ៍សង្ខេប

ការសិក្សានេះត្រូវបានធ្វើឡើងក្នុងកំឡុងខែ វិ ច្ឆិកា ដល់ ខែធ្នូ ឆ្នាំ ២០០១ សំរាប់ ក្រុមការងារ របស់អង្គការមេឌីខាំ ដែលផ្តោតការគិត ក្នុងកំណែ ទំរង់វិស័យសុខាភិបាល ។ គោលបំណងនៃការសិក្សានេះគឺធ្វើការសំយោគ ទៅលើបទពិសោធន៍ចំបងៗ របស់អង្គការមិនមែនរដ្ឋាភិបាល ដែលចុះ កិច្ចសន្យាក្នុងការផ្តល់សេវាសុខាភិបាល និង អង្គការមួយចំនួនទៀតដែលមានគំរោងកម្មវិធី មានបទពិសោធន៍ប្រហាក់ប្រហែលគ្នានៅក្នុងប្រទេស កម្ពុជា ដើម្បីកត់ត្រាទុក នូ វ អ្វីដែលជាទស្សនៈល្អ ដែលអាច ផ្តល់ជាគំនិតសំខាន់ៗសំរាប់ អង្គការ មិនមែនរដ្ឋាភិបាល អាចរកបានជាធនធាន ទៅដល់ សមាជិកក្រុមការងាររបស់អង្គការមេឌីខាំ ដែលផ្តោតការគិត ទៅលើកំណែទំរង់សុខាភិបាល ដែលក្រុមនេះនឹងអាចចូលរួមប្រជុំក្នុងក្រុម ពិគ្រោះយោបល់ក្នុងការអភិវឌ្ឍន៍ទំរង់ក្របខ័ណ្ឌ គ្រប់គ្រងទូ លំទូលាយគ្របវិសយ័ (Sector Wide Management)របស់រាជ្យរដ្ឋាភិបាល ។

វត្ថុបំណងលំអិត:

១) ការត្រួតពិនិត្យមើលឡើងវិញ នូវរាល់ឯកសារទាំងឡាយ ដែលទាក់ ទង ទៅនឹង អង្គការមិនមែនរដ្ឋាភិបាលណា ដែលចុះកិច្ចសន្យា ផ្តល់សេវា សុខាភិបាល និង បទពិសោធន៍ក្នុងការផ្តល់សេវាសុខាភិបាលស្រដៀងគ្នាផ្សេងទៀត ។

២) ដើម្បីគូស នូវ ចំណុចសំខាន់ ដែលមាន្នៅក្នុងបទពិសោធន៍ទាំងនោះ

៣) ដើម្បីនាំផ្លូវក្នុងការវិភាគ អោយបាន ម៉ត់ចត់ ក្នុងការអនុវត្តន៍ នូវគំនិតផ្តួចផ្តើម ផែនការកំណែទំរង់ សុខាភិបាល ដែលក្នុងនោះ អង្គការក្រៅ រដ្ឋាភិបាលដែលជាអ្នក បាន និងកំពុង អនុវត្តទៅតាមផ្នែកដូចខាងក្រោម:

- និយតកម្មសុខាភិបាល រួមបញ្ចូល សេវាសុខាភិបាលចំរុះ សាធារណៈ និងឯកជន
- ការអនុវត្តន៍ ហិរញ្ញប្បទានសុខាភិបាល, និង ការគ្រប់គ្រង
- បញ្ហាធនធានមនុស្ស /បុគ្គលិក
- ឥរិយាបទក្នុងការស្វែងរកសេវាសុខាភិបាល និង តំរូវការរបស់សហគមន៍

រចាយការណ៍សំយោគនេះគឺត្រូវបានសំរេចធ្វើទៅលើអង្គការមិនមែនរដ្ឋាភិបាលទាំង បួន ដែលកំពុងអនុវត្តន៍ ជំហ៊ានសាកល្បងនៃការចុះកិច្ចសន្យា ក្នុងគំរោង ផ្តល់សេវាសុខាភិបាលមូលដ្ឋាន រួមមានអង្គការដូចតទៅ : ១) អង្គការសមាគមន៍វេជ្ជបណ្ឌិតអាស៊ី ២) អង្គការសង្គ្រោះកុមារបារាំង, ៣) អង្គការសង្គ្រោះកុមារអូស្ត្រាលី, ៤) អង្គការបណ្តាញសុខភាពអន្តរៈជាតិ ។ ម្យ៉ាងទៀតឯកសារនេះ ក៏បានសិក្សាផងដែរទៅ លើគំរោង កម្មវិធី ផ្សេងៗដែលមាន បទពិសោធន៍ ប្រហែលគ្នា ជាមួយគំរោងអនុវត្តកិច្ចសន្យា ក្នុងនោះរួមមាន អង្គការ កាកបាទក្រហមស្វ៊ីស និង, អង្គការគ្រួពេទ្យគ្មានព្រំដែន ជាដើម ។

ជាចុងក្រោយនេះ អង្គការ **ការីតាស** ដែលជាអង្គការមិនមែនរដ្ឋាភិបាលមួយ ដែលដើរតាមវិធី បូរាណ ក្នុងការផ្តល់សេវាសុខាភិបាល ប៉ុន្តែ គោលបំណង ប្រហាក់ប្រហែលគ្នា ក៏ត្រូវបានបញ្ចូលទៅក្នុងការរំលឹកឡើងវិញនេះដែរ ដើម្បីអោយ ទទួលបាន នូវបទពិសោធន៍ ផ្សេងៗ គ្នា យ៉ាងទូលំទូលាយ ។

ចំពោះវិធីសាស្ត្រ ក្នុងការធ្វើរបាយការណ៍សំយោគនេះ គឺយើងប្រមូលឯកសារដែលពាក់ព័ន្ធទាំងអស់ មកពិនិត្យរួមគ្នា រួចហើយធ្វើការពិគ្រោះ ដល់កន្លែង ជាមួយ សាមីអង្គការដែលពាក់ព័ន្ធទាំងអស់ ។ នៅក្នុងខណៈនៃការពិភាក្សានោះ គឺត្រូវបានកត់សំគាល់ឃើញថា មានពីរផ្នែកសំខាន់គឺ ការត្រួតពិនិត្យ/វាយតំលៃ និង និរន្តភាព ដែលត្រូវបានយកចិត្តទុកដាក់ជាបញ្ហាអទិភាព ដោយអង្គការពាក់ព័ន្ធ ។ ហេតុដូច្នេះហើយ បញ្ហាសំខាន់ ទាំងនេះ គឺត្រូវបានដាក់បញ្ចូលក្នុងការសំយោគនេះ ។

នៅក្នុងខណៈដែលកំពុងធ្វើការពិនិត្យមើលឡើងវិញនេះ គឺយើងរកឃើញនូវ មធ្យោបាយមួយចំនួនទៀតដែលអង្គការមិនមែនរដ្ឋាភិបាល ជ្រើសរើសដើម្បីសំរេចគោលបំណងរបស់គេ ។ ដោយមានការយល់ឃើញនូវមធ្យោបាយផ្សេងៗគ្នា និង អាស្រ័យទៅតាមកាលៈទេសៈ ជាក់ស្តែងនៅនឹងកន្លែងផងនោះ ជាហេតុផលមួយសំខាន់ សំរាប់អង្គការមិនមែនរដ្ឋាភិបាលយកមធ្យោបាយទាំងនោះមកធ្វើការអនុវត្តន៍ ។

ក្រៅអំពី មធ្យោបាយ និងវិធីសាស្ត្រផ្សេងៗដែលអង្គការក្រៅរដ្ឋាភិបាល ជ្រើសរើស មកអនុវត្ត បានយ៉ាងល្អប្រសើរ ក្នុងការលើកស្ទួយសេវា សុខាភិបាល ដូចជាលទ្ធផល ការកើនឡើងចំនួនអ្នកប្រើប្រាស់សេវា , លើកកំពស់ គុណភាពក្នុងការព្យាបាល ហើយ បង្កើននូវភាពអាចទទួលយក បាន សំរាប់ អ្នកក្រីក្រ ។

វិធីសាស្ត្រនានា ដែលបានអនុវត្តដោយអង្គការមិនមែនរដ្ឋាភិបាល ដែលបានចាត់ទុក ថាការអនុវត្តន៍បានជោគជ័យនោះ គឺ:

និយតកម្មសុខាភិបាលផ្សេងៗ (Health Regulations)

- ការគាំទ្ររបស់សហគមន៍ នៅមូលដ្ឋានផ្តល់សេវាសុខាភិបាល: សកម្មភាពរបស់សហគមន៍ បានចូលរួមក្នុងរយៈពេលវែងក្នុង សុខាភិបាល ស្រុក , កិច្ចអនុវត្តន៍ ក្រោមការគ្រប់គ្រង ដូចគ្នា គឺបានផ្តល់នូវលទ្ធផលផលសំរេចជោគជ័យ។ បុគ្គលិកថ្នាក់ស្រុកប្រតិបត្តិ មិនមានជំនឿ ជឿជាក់ និងទំនុកចិត្តខ្លួនឯងចំពោះការដឹកនាំ នៅពេលមានការផ្លាស់ប្តូរការគ្រប់គ្រងរបស់អង្គការមិនរដ្ឋាភិបាល ។

- គោលការណ៍គ្រប់គ្រង និង បទបញ្ជាផ្ទៃក្នុងការជុំវិញអោយប្រតិបត្តិ នូវគោលការណ៍ គ្រប់គ្រង ផ្ទៃក្នុងទាំងនោះ (ឧទាហរណ៍ : ការកាត់ ប្រាក់ប្សេវត្ស លើកទឹកចិត្ត ឬ ការបណ្តេញ បុគ្គលិក ចេញជាដើម) ដែលជាចមន្ទុចមួយក្នុងការបង្កើតឡើងនូវ តំរូវការអោយបុគ្គលិក មាន ការតាំងចិត្តចំពោះការងាររបស់គេ ។
- ហាមឃាត់ ការផ្តល់សេវាឯកជន ដោយបុគ្គលិកសុខាភិបាលរបស់រាជ្យរដ្ឋាភិបាល នៅតំបន់ ដែលមានសេវាឯកជន ច្រើន។ ការហាមឃាត់ ការផ្តល់សេវាឯកជន នៅតំបន់ដែលមានសេវាឯកជនច្រើន លទ្ធផលបានបង្ហាញថា មានការ កើនឡើង នូវការប្រើប្រាស់សេវា សុខាភិបាល សាធារណៈ ។

ហិរញ្ញប្បទានសុខាភិបាល~ ការងារគ្រប់គ្រង (Health Financing/Management)

- បង្កើតអោយមានជា ហិរញ្ញប្បទានសុខាភិបាល ដោយរួមបញ្ចូល យន្តការ ដើម្បី ឧបត្ថម្ភតំលៃសេវា (cost-recovery) តាមរយៈការ កំនត់តំលៃចំពោះអ្នកប្រើប្រាស់សេវា :

  ការចាប់ផ្តើមដាក់បញ្ចូលនូវតំលៃសំរាប់អ្នកប្រើប្រាស់ សេវា គឺជាមធ្យោបាយដ៏មាន ប្រសិទ្ធិភាព ក្នុងការបង្កើនការ លើកទឹកចិត្តដល់បុគ្គលិក ទន្ទឹមគ្នានឹងបង្កើតអោយមាន នូវគំនិតធ្វើជាម្ចាស់ ក្នុងចំណោម បុគ្គលិកសុខាភិបាល។ គោលការណ៍នេះត្រូវបានទទួលយកដោយប្រជាជន ដោយសារការបង្កើន នូវតំលាភាព និង កាត់បន្ថយ នូវការបង់ ប្រាក់ក្រោមតុ (មិនផ្លូវការ) ។
- ផ្តល់នូវការលើកទឹកចិត្ត ដល់ បុគ្គលិកសុខាភិបាលរបស់រាជ្យរដ្ឋាភិបាល ប្រហាក់ប្រហែលនឹងប្រាក់ប្សេវត្ស ដែល អាចរស់បាន (living wages) :

  ការផ្តល់ប្រាក់លើកទឹកចិត្ត តាមប្រាក់ប្សេវត្ស ដែលអាចរស់បាន គួរតែត្រូវប្រគល់ជូន ដើម្បីជៀសវាង ជំលោះដណ្តើម ផលប្រយោជន៍ (conflict of interest).
- ផ្តល់នូវការលើកទឹកចិត្ត ដោយផ្អែកលើ លទ្ធផលសំដែងចេញ (performance based incentive):

ផ្តល់នូវការលើកទឹកចិត្ត ដោយផ្អែកលើ លទ្ធផលសំដែងចេញ ទៅដល់បុគ្គលិកសុខាភិបាល ជំរុញអោយពួកគេ ស្វែង រកដំណោះ ស្រាយដោយផ្អែកប្រឌិតនៅនឹងកន្លែងដែលអាចទទួលយកបាន

និងផ្តល់លទ្ធផលធ្វើអោយប្រសើរឡើងនូវការប្រើប្រាស់សេវាថែទាំសុខភាព ។

- វិមជ្ឈការ នៃការធ្វើការសំរេចចិត្ត ទៅដល់ មូលដ្ឋានសុខាភិបាល :

ការអនុវត្តវិមជ្ឈការពេញលេញ ដោយផ្តោតលើ ថ្នាក់មូលដ្ឋានសុខាភិបាល កន្លងមកបានទទួលជោគជ័យ ។ ទោះជា យ៉ាងនេះក៏ដោយ ក៏តំរូវអោយមានការទទួលខុសត្រូវ ខ្ពស់ និងការតាមឃ្លាំមើលពីខាងក្រៅផងដែរ ។

ប្រព័ន្ធធ្វើការតាមដាន និង វាយតំលៃ (Monitoring and Evaluation System)

- ប្រព័ន្ធធ្វើការតាមដាន មួយដែលរៀបចំ បានល្អ និងមានប្រសិទ្ធិភាពដើម្បីអាចធ្វើការផ្តល់ប្រាក់លើក ទឹកចិត្តអោយ បានត្រឹមត្រូវ: ប្រព័ន្ធដែលរៀបចំយ៉ាងល្អមួយសំរាប់ ធ្វើការតាមដាន ដើម្បីត្រួតពិនិត្យលទ្ធផល របស់ មូលដ្ឋានសុខាភិបាល

  គឺមានសារៈសំខាន់ណាស់ ។ ការផ្តល់ប្រាក់ឧបត្ថម្ភដើម្បីលើកទឹកចិត្ត គួរត្រូវ ពឹងផ្អែកទៅលើ លទ្ធផលទាំងនោះ ។

ការណែនាំបុគ្គលិក

- ធ្វើការជ្រើសរើសបុគ្គលិកដែលមានគុណភាពសំរាប់មណ្ឌលសុខភាពទាំងឡាយ :

ការដាក់អោយមានជាគ្រូពេទ្យមធ្យម ដែលមានគុណភាពខ្ពស់នៅតាមមណ្ឌលសុខភាព បានធ្វើអោយប្រសើរឡើងនូវ គុណភាពសេវាដែលបានផ្តល់ ។

- ធ្វើការសហការណ៏យ៉ាងជិតស្និត ជាមួយបុគ្គលិកនៅការិយាល័យស្រុកប្រតិបត្តិ :

ទោះបីជា ការកសាងសមត្ថភាព របស់ ការិយាល័យស្រុកប្រតិបត្តិ គឺជាកិច្ចការមួយលំបាកក្នុងការសំរេច ហើយវា អាស្រ័យយ៉ាងខ្លាំងទៅលើការស្មគ្រ័ ចិត្ត និងការព្យាយាមរបស់បុគ្គលិកក្នុងការបំពេញការងារដើម្បីធ្វើអោយប្រសើរឡើងនូវប្រព័ន្ធសុខាភិបាលស្រុកក៏ ដោយក៏ការបង្កើតអោយមានជាបរិយាកាស អំណោយផលដល់ បុគ្គលិក នៅ ការិយាល័យស្រុកប្រតិបត្តិ បានបង្កើននូវការតស៊ូព្យាយាមរបស់ពួកគេ ។

ការិយាបទក្នុងការស្វែងរកសេវាសុខាភិបាល តំរូវការរបស់សហគមន៏

- ការវិនិយោគ នូវពេលវេលា និង ធនធានហិរញ្ញវត្ថុក្នុងការចូលរួមរបស់សហគមន៏:

ការចំណាយពេលវេលានិង ធនធានហិរញ្ញវត្ថុគ្រប់គ្រាន់ សំរាប់ធ្វើការបណ្តុះបណ្តាល និងសកម្មភាពតាមដានបន្ត ដល់ភ្នាក់ងារសុខភាពរបស់សហគមន៏ បានផ្តល់លទ្ធផលជាការចូលរួមយ៉ាងសកម្មពីសហគមន៏ និងការគាំទ្រ ដ៏ល្អ ប្រសើរ ។

វិធីសាស្ត្រប្រកបដោយជោគជ័យទាំងនេះ គឺជាមេរៀនបទពិសោធន៏ ដែលគួរតែត្រូវបានលើកយកមកគិតពិចារណា ក្នុងការរៀបចំអន្តរាគមន៏កំនែទំរង់វិស័យសុខាភិបាលក្នុងពេលអនាគត ។ ស្ថាប័ន ឬ អង្គការដែលពាក់ព័ន្ធទាំងឡាយ បានកំណត់យកទិសដៅសំរាប់អនាគតដូចតទៅ:

- អង្គការក្រៅរដ្ឋាភិបាល និងអង្គភាពសំរបសំរួលគំរោង (MoH/ADB) សំណើរអោយបន្តយុទ្ធសាស្ត្រ កិច្ចសន្យាផ្តាច់ (Contracting Out) ក្នុងទ្រង់ទ្រាយធំ ដោយមានការកែសំរួលមួយចំនួន ។
- ក្រសួងសុខាភិបាល-អង្គការសុខភាពពិភពលោក គាំទ្រ យុទ្ធសាស្ត្របង្កើនសន្ទុះសេវាសុខាភិបាល និងតួនាទីទៅអនាគត សំរាប់កិច្ចសន្យា ម៉ៅការ (Contracting)មានកំនត់ ។
- មន្ទីរសុខាភិបាលខេត្ត -យកចិត្តទុកដាក់ ថាទោះបី ជាយុទ្ធសាស្ត្រណាមួយក៏ដោយដែលនឹងត្រូវជ្រើសរើសយក ប្រាក់ ប្រៃវត្សន៏សំរាប់គ្រប់មូលដ្ឋានសុខាភិបាលទាំងអស់ គួរតែត្រូវ កំណត់ដែលអាចរស់បាន (living wage) ។ តាមវិធីនេះ មន្ទីរសុខាភិបាលខេត្តអាចធ្វើការត្រួតពិនិត្យ និង តាមដាន មូលដ្ឋានសុខាភិបាលស្រុកបានល្អប្រសើរ ។
- ការផ្លាស់ប្តូរដ៏ចំបងដែលបានកំណត់រកឃើញ គឺអង្គការដែលមានថវិការច្រើនមានលទ្ធភាពបត់បែនក្នុងការ ជ្រើស រើសដើម្បីចំណាយនោះគឺ ភ្នាក់ងារផ្តល់ជំនួយ ពហុភាគី និង ទ្វេភាគី (Multilateral and Bilateral donors)

តទៅនេះគឺជាការវិភាគចេញពីបទពិសោធន៏ របស់អង្គការក្រៅរដ្ឋាភិបាល, លក្ខខណ្ឌចំបងមួយចំនួន ត្រូវបាន កំណត់រកឃើញ ដែលនឹងត្រូវបំពេញ ដើម្បីការអនុវត្តន៏ អោយបានជោគជ័យ នូវកិច្ចសន្យាម៉ៅការផ្នែកសុខាភិបាល រឹត គំរោងស្រដៀងគ្នា ។

- ធ្វើវិមជ្ឈការ នៃការសំរេចចិត្ត
- មានការទទួលខុសត្រូវ របស់ភាគីទាំងអស់ (មន្ទីរសុខាភិបាលខេត្ត, ការិយាល័យស្រុកប្រតិបត្តិ, អ្នកម៉ៅការ, និង មូលដ្ឋានសុខាភិបាល) រួមបញ្ចូលទាំង ភាពអាចរកបាន នៃថវិការ ។
- ធ្វើអោយមានប្រព័ន្ធតាមដានដ៏មានប្រសិទ្ធិភាព ដល់គ្រប់ភាគីទាំងអស់ រួមបញ្ចូលទាំងការប្រតិបត្តិផង ។
- ធ្វើកិច្ចសន្យាដោយផ្អែកលើលទ្ធផលសំដែងចេញ (performance based contracts) សំរាប់មូលដ្ឋានសុខាភិបាល មន្ទីរសុខាភិបាលខេត្ត, ការិយាល័យស្រុកប្រតិបត្តិ ដោយយកការផ្តល់ការលើកទឹកចិត្តជាប្រាក់ប្រៀវត្សដែលអាច រស់បាន ជាមូលដ្ឋាន ។
- សកម្មភាព នៅតែមានបន្ត ។
- ការផ្តល់ជាជំនួយបច្ចេកទេស ទៅដល់ទាំង មន្ទីរសុខាភិបាលខេត្ត, ការិយាល័យស្រុកប្រតិបត្តិ និង មូលដ្ឋានសុខាភិបាល រួមបញ្ចូលទាំងទំនាក់ទំនងជាមួយសកម្មភាពដែលត្រូវការ ។
- អនុវត្តន៏ ការបង់តំលៃ ចំពោះអ្នកប្រើប្រាស់ សេវា នៅតាម មូលដ្ឋានសុខាភិបាល ។

Summary

This study was conducted for the Health Sector Reform (HSR) think-tank of Medicam in November - December 2001. The purpose of this study was to synthesise the NGOs main experiences regarding contracting and similar projects in health in Cambodia, so that an inventory of what is important for the NGOs point of view can be available as a resource to the HSR think-tank members who would attend Sector Wide Management Consultative Group meetings.

Specific objectives were:

1) To review the literature of the contracting NGOs or similar experiences
2) To draw the main lines of these experiences
3) To conduct a critical analysis of the implementation of the HSR initiative, in which NGOs have been implementers, along the following fields:
   - Health Regulations, including Public/Private Mix;
   - Health Financing/Management;
   - Human Resource Issues;
   - Health Seeking Behavior/Community Needs.

It was decided to include all four NGOs currently implementing the contracting pilots of the Basic Health Services Project in the synthesis viz. i) The Association of Medical Doctors of Asia (AMDA); ii) Save the Children France - Enfants et Développement (SCF/EED); iii) Save the Children Australia (SCA) and; iv) HealthNet International (HNI). Furthermore, experiences similar to contracting supported by the Swiss Red Cross (SRC) and Medecins sans Frontieres (MSF) were also included. Finally Caritas, an NGO following a more traditional approach though with similar objectives, was included in the review process in order to broaden the variety of experiences.

The methodology followed for this synthesis involved reviewing relevant documents and consultations with different stakeholders. During these discussions it was observed that two more fields were considered as high priority issues by the stakeholders, viz. monitoring & evaluation systems and sustainability. These fields were therefore included in the analysis.

During the review it appeared that several approaches were followed by the NGOs in order to reach their objectives. Besides different perceptions of the NGOs, local circumstances were often a major reason for the application of certain methods.

Despite the different approaches all NGOs were very successful in improvement of health service delivery, resulting in increased utilization, improved quality of care and increased access for the poor.

Approaches applied by the NGOs, regarded as successful were:

Health Regulations:

- *Continuity in supporting health facilities.*
  Continuity of activities over a longer period of time in the same district, operating under the same management has proven its success. High turn over rate of NGO management did not bring the necessary trust and confidence for district staff.
- *Internal management rules and enforcement.*
  Enforcement of internal management rules (e.g. by cutting incentives or firing staff) is necessary to create the required commitment.

- *Prohibiting private practice by public health workers in areas with abundant private practice.*
  In areas with abundant private practice a ban has proven to result in increased utilization of public health services.

Health Financing/Management:

- *Establishment of a Health Financing Scheme, including mechanisms for cost-recovery through user fees.*
  Introduction of user fees is an efficient way to increase staff incentives, while creating a sense of ownership among the health staff. It has been accepted by the population as it increased transparency and reduced under the table fees.
- *Provision of incentives to public health staff, similar to living wages.*
  Living wage incentive payments should preferably be awarded to avoid conflict of interests.
- *Provision of incentives on the basis of performance.*
  Performance based incentives stimulated health staff to find their own local acceptable innovative solutions and resulted in further improvement of utilization of health services.
- *Decentralization of decision-making to health facility level.*
  Full decentralization focused at health facility level has been successful. However, it needs strong, accountable and external monitoring.

Monitoring and Evaluation Systems

- *A well-designed, effective monitoring system in order to be able to correctly award incentive payments.*
  A well-designed monitoring system to check output at health facilities is extremely important. Incentive payments should be dependent on these results.

Human Resource Issues:

- *Recruiting qualified staff at health centers.*
  Posting higher qualified Medical Assistants at health centers did improve the quality of service delivery.
- *Close cooperation with staff from the Operational District Office.*
  Although building capacity of the ODO was difficult to achieve and heavily depend on the willingness and commitment of people to work to improve the district health system, establishing an enabling environment for the ODO did increase their commitment.

Health Seeking Behaviour/Community Needs:

- *Investing time and financial resources in community involvement.*
  Spending sufficient time and financial resources for training and follow-up activities to community health workers did result in active community involvement and good support.

These successful approaches are important lessons learnt and should preferably be taken into account in the design of future health sector reform interventions. The different stakeholders identified the following future directions:

- NGOs and the Project Coordination Unit (MoH/ADB) preferred a continuation of the contracting out strategy on a larger scale, with some modifications.

- MoH/WHO supported the Boosting Strategy and also a future role for limited contracting.
- The Provincial Health Departments (PHD) emphasized that whatever strategy will be chosen the salaries for all district health facilities should be set at "living wage". In this way the PHD's can better monitor/control the district health facilities.
- The major change agents identified are the multilateral and bilateral donors, who have a lot of manoeuvring space to spend their large sums of money.

Following from the analysis of the experiences of the NGOs the following pre-conditions were identified, which need to be fulfilled for successful implementation of a health contracting or similar project.

- Decentralization of decision making.
- Accountability of all actors (PHD, ODO, contractor, health facilities), including access to budget.
- Effective monitoring system for all actors in place, including enforcement.
- Performance based contracts for health facilities, OD's and PHD's on the basis of living wage incentive payments.
- Continuity of activities.
- The provision of TA at both PHD, ODO and health facility level, including demand related activities.
- User Fees at health facilities.

LIST OF ABBREVIATIONS

ADB	Asian Development Bank
ADD	Accelerated District Development
AMDA	The Association of Medical Doctors of Asia
BS	Birth Spacing
CI	Contracting-In
CO	Contracting -Out
CPA	Complementary Package of Activities
CDRI	Cambodian Development Research Institute
DMT	District Management Team
EPI	Expanded Program of Immunization
FBC	Feedback Committee
HC	Health Center
HC-CMC	Health Center Co-management Committee
HCSC	Health Center Support Committee
HFS	Hospital Financing Scheme
HIS	Health Information System
HNI	HealthNet International
HSR	Health Sector Reform
IPD	In Patient Days
MoEF	Ministry of Economic and Finance
MoH	Ministry of Health
MPA	Minimum Package of Activities
MSF	Medicins Sans Frontieres
OD	Operational District
ODO	Operational District Office
OPD	Out Patient Department
PAP	Priority Action Program
PCU	Project Coordination Unit
PHD	Provincial Health Department
RACHA	Reproductive and Child Health Alliance
SCA	Save the Children Australia
SCF/EED	Save the Children France-Enfants et Développement
SRC	Swiss Red Cross
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
VHV	Village Health Volunteer
WHO	World Health Organization

Chapter I: Background

Since 1996 the Ministry of Health (MoH) of Cambodia is implementing health sector reforms, which includes a process of organizational, financial and human resource reforms to ensure that the population has access to affordable, quality health services.

A major component of these health sector reform projects is the implementation of the Health Coverage Plan (1996), designed to rationalize the allocation of health services delivery. This plans foresees covering the entire population by means of a network of health centers and referral hospitals grouped into 71 operational districts with a population of 100,000-200,000. These districts have been developed on a demographic and geographical basis rather than the existing, impractical, administrative districts. While each referral hospital in the operational district (OD) serves an average population of 135,000, each health center is designed to serve an approximate 10,000 people. As per June 2001 748 health centers and 67 referral hospitals have been newly constructed or renovated, which is respectively 82% and 94% of the planned total.

Under the Health Coverage Plan each health center will be equipped to provide the Minimum Package of Activities (MPA), while referral hospitals are to provide the Complementary Package of Activities (CPA). While the vast majority of the health centers currently offer the MPA only 30% of the referral hospitals offer basic surgical services, which is part of the CPA.

In addition to the Health Coverage Plan that provided for the organizational reforms in the health sector, the Health Financing Charter (1996) opened the door for innovative financial reforms such as charging reasonable user fees[1], contracting and similar initiatives.

[1] As of September 2000, 143 health facilities (128 health centers, 14 referral hospitals and one laboratory for quality control of drugs) have MoH approved user-fees schemes (Wilkinson et al. 2000).

Chapter II: Methodology

2.1 Objectives of the Review

Since the release of the Health Financing Charter various innovative experiences with contracting individual and district health facilities under various management arrangements have been carried out. These experiences have yielded a variety of very useful insights in the process of improving the health status of the Cambodian population. The objective of this review is to provide a synthesis of several of these innovative contracting and similar experiences. It analyses the approaches and methods used by the different international contracting NGOs in order to increase access to quality public health services and making them affordable for the poor. The most successful approaches will be analysed, however the review will also elaborate on the problems encountered. It has to be noted that since the focus of the review is on the process of managing the health services it will not include a comprehensive quantitative analysis of these contracting experiences.

For this synthesis the following international NGOs with extensive contracting or similar experiences were reviewed:

- Swiss Red Cross (SRC)
- Medecins sans Frontieres (MSF)
- HealthNet International (HNI)
- The Association of Medical Doctors of Asia (AMDA)
- Save the Children France - Enfants et Développement (SCF/EED)
- Save the Children Australia (SCA)
- Caritas 023 210 757

The following fields were considered of key importance with regard to contracting and similar experiences. Along the lines of these fields a critical analysis has been undertaken. These fields include:

- Health Regulations, including Public/Private Mix
- Health Financing/Management
- Monitoring & Evaluation Systems
- Human Resource Issues
- Health Seeking Behavior/Community Needs
- Sustainability

2.2 Study Approach

The study approach is designed in order to provide the greatest opportunity for all stakeholders involved to actively participate in the review process. The process followed included discussions with all program managers at the projects sites. These discussions were aimed to get a detailed picture of the NGO's experiences so far with a particular focus on the key fields mentioned before. Discussions were also held with the directors of the Provincial Health Department in Takeo and Siem Reap. Their opinion of the ongoing contracting and similar experiences was addressed together with their desired future role. Furthermore, key persons of the health sector reform project were contacted. At this level discussions were focused on the NGO's contributions to improve the health status, the major successes and bottlenecks of different forms of contracting and the possible strategies for future interventions in the health sector. Finally, in order to be able to identify the major change agents in the health sector reform

process discussions were held with representatives of a major funding organization (ADB) and an independent research institute viz. the Cambodian Development Research Institute (CDRI), which is an influential institution with regard to directing future government policy in the social sector. For all discussions semi-structured interviews were conducted. This technique has the possibility to make comparisons, while it also allows for reporting stand-alone innovative approaches implemented by the NGOs.

In addition to these discussions, a review was conducted of relevant literature on contracting and similar experiences in health. This included both internal documents of the NGOs under review as well as background literature to place these experiences within the overall context of the ongoing health sector reforms.

The next chapter (Chapter III) places all the NGOs under review in their specific context. This is followed by Chapter IV that presents an overview of the perceived priority issues of the different NGOs and the basic starting approaches taken to address these. Chapter V conducts a critical analysis of the NGO's approaches of the key fields, while Chapter VI discusses the experiences of the PHD's regarding the contracting and similar experiences. Chapter VII elaborates on the desired future directions as expressed by the different stakeholders. This is followed by Chapter VIII that attempts to identify the change agents, responsible for future developments of the health sector reforms. Chapter VIIII addresses issues for NGOs to be considered for future health contracting. Finally, Chapter X presents the main conclusions of the review.

Chapter III: Context of the Different Contracting Schemes

3.1 Objectives and Contracting Management Arrangements

The contracting NGOs have different objectives, and, as stated before, operate under various management arrangements. In order to clearly understand the working environment of the NGOs under review this section provides an overview of these different objectives and management arrangements.

3.1.1 CONTRACTING-IN AND OUT PILOT PROJECTS

HNI (Pereang OD, Prey Veng), AMDA (Ang-Roka OD, Takeo), SCF/EED (Kirivong OD, Takeo) and SCA (Chung Prey OD and Memot OD, Kampong Cham) currently implement the Contracting-In (CI) and Contracting-Out (CO) pilot projects, funded by a government loan. For these two models of contracting, contracts have been signed with set output indicators. Its objectives are to achieve health system development and service coverage within OD's with certain quality indicators. CI was designed in order to provide the contractor with full *management* responsibility. Important features of this model are:

- *Contractor receives funds to provide technical support to the OD, has management responsibility of the district, but limited administrative authority over MoH staff working in the OD.*
- *Running costs for health services, supply of medical equipment, drugs and staff salaries are the responsibility of the MoH.*
- *Contractor should follow the Health Coverage Plan, the MoH technical protocols and collect and process the data required for the Health Information System (HIS).*
- *District public health staff remain MoH employees. The contractor does not have the authority to hire, fire and replace staff.*
- *Contractor receives a budget supplement of US$0,25 per capita for improvement of district health services. This supplement can be spent according to the contractors' own preference.*

Contrary to CI, the contractors implementing CO were given full responsibility over the district. Key components of this model are:

- *Contractor has full responsibility of district management and funds for running costs, medical equipment, drugs, staff salaries and staffing. However, the contractor should follow the Health Coverage Plan, the MoH technical protocols and collect and process the data required for the HIS.*
- *District public health staff are directly employed by, and paid by, the contractor.*
- *Supply of medical equipment is the responsibility of the MoH.*

Included in these contracting pilot projects are control districts. These control districts remain under the normal MoH management system, with the District Management Team (DMT) responsible for the delivery of the health services. Similar to the CI districts, the control districts receive a budget supplement of US$0,25 per capita. However, in contrary to the CI districts the DMT of the control districts have to submit a proposal before this budget supplement is granted. This proposal has to be approved by the PHD before the money is released.

The CI, CO and control districts are monitored by the Project Coordination Unit (PCU) of the MoH/ADB. This unit has been specially established to monitor and supervise the implementation of the projects on behalf of the MoH. In contrary to other government authorities PCU members are paid decent salaries by the ADB.

	Contracting Out	Contracting In	Hospital Financing Scheme	New Deal	Caritas
Objectives	To achieve health system development and service coverage within OD's with certain quality indicators	To achieve health system development and service coverage within OD's with certain quality indicators	Develop an alternative Hospital Financing Scheme, resulting in a more efficient and more affordable high quality health service, covering a larger part of the target population	Build a health system and give access to quality care to the population of Sotnikum OD and be a catalyst for changes in the national health policy	To provide quality care and access to the poor at 7 health centers in Siem Reap OD.
Funding Source	Government Loan	Government Loan + MoH (salaries, drugs and running costs)	MoH (salaries, drugs and running costs) + NGO funds	MoH (salaries, drugs and running costs) + NGO funds UNICEF	MoH (salaries, drugs and running costs) + NGO funds
Scope of Funds[2]	Full budget set by the Contractor	Government budget Chapter 10 (salaries) and 11 (drugs and running costs) + US$ 0.25 per capita/annum	Government budget Chapter 10 (salaries) and 11(drugs and running costs) + NGO contribution	Government budget Chapter 10 (salaries) and 11 (drugs and running costs) + NGO contribution UNICEF	Government budget Chapter 10 (salaries) and 11 (drugs and running costs) + NGO contribution
Management Arrangements	Contractor Determines	Contractor Determines	Hospital Management Committee	DMT / PHD determine. Approved by Steering Committee	DMT / PHD determine.

Table 1. Initial objectives, financial and management arrangements of each NGO

3.1.2 HOSPITAL FINANCING SCHEME

The Hospital Financing Scheme (HFS) at Takeo Referral Hospital, implemented by the MoH/Swiss Red Cross also operates within the Health Coverage Plan of the MoH. Its objective is to develop an alternative Hospital Financing Scheme, resulting in a more efficient and more affordable high quality health service, covering a larger part of the target population. Similar to CI, running costs for health services, supply of medical equipment, drugs and staff salaries are the responsibility of the MoH. However, the HFS does not operate through a government loan. Funding of the HFS is through central MoH funds with additional NGO contribution. The NGO has a supporting advisory and catalyst role rather than management responsibility.

3.1.3 NEW DEAL

The objectives of the New Deal implemented by MoH/MSF/UNICEF in Sotnikum OD, Siem Reap are to build a health system and give access to quality care to the population of the OD. These objectives strongly resemble the objectives of the CI and CO pilot projects. The third objective added during project implementation was to be a catalyst for changes in the national health policy. Building upon the experiences of the HFS, the New Deal conducts an advisory and catalyst role without management responsibility in the OD. Funding of the New Deal is

[2] At some districts (part of the) funds for running costs, originally disbursed through chapter 11, currently arrives through new methods of public budget disbursement viz. Accelerated District Development (ADD) and Priority Action Program (PAP). See #5.1.1 for more details.

through central MoH funds with additional NGO and UNICEF contribution. Running costs for health services, supply of medical equipment, drugs and staff salaries are the responsibility of the MoH.

3.1.4 CARITAS

Caritas aim is to provide quality care and access for the poor to seven health centers in Siem Reap OD, with a strong focus on community involvement. Funds for the project is through regular MoH channels, supplemented by resources from the NGO. Caritas does not have management responsibility and follows the existing government channels.

A summary of the different objectives, financial and management arrangements of each NGO at the start of the projects is presented in table 1.

3.2 Basic characteristics for each project

In addition to the differences in budgetary and management arrangements, the basic characteristics of the projects vary considerably between the NGOs. These include, amongst others, the implementation period, population size, accessibility and the area of intervention (district hospital versus referral hospital(s) with several health centers). Table 2 presents an overview of these basic characteristics.

Type of Project	New Deal	Hospital Financing Scheme	CO	CO	CI	CI	CI	"Traditional" NGO Support
Implementing Agency	MoH / MSF / Unicef	MoH / SRC	AMDA	SCA	SCF/EED	SCA	HNI	Caritas
Province	Siem Reap	Takeo	Takeo	Kampong Cham	Takeo	Kampong Cham	Prey Veng	Siem Reap
District	Sotnikum	Takeo	Ang-Roka	Memot	Kirivong	Cheung Prey	Pereang	Siem Reap
Start of Project	jan-00	sep-97	may-99	may-99	apr-99	apr-99	apr-99	1995
Project Time	3 years (extension?)	3 years (+ 1 extension)	4 years	4 years	4 years	4 years	4 years	> 7 years
End of Project	dec-02	may-01*	dec-02	dec-02	dec-02	dec-02	dec-02	> dec 2002
Population in catchment area	210.000	711.000 (whole province)	125.000	110.000	225.000	165.000	180.000	63.000
Accessibility	moderate	good	good	poor	poor	good	poor	poor
No of HC's	12**	0	9	8	20	13	15	7
No of hospitals	1	1	1	1	2	1	2	-
No of hospital beds	120	210	47	70	117	100	91	-

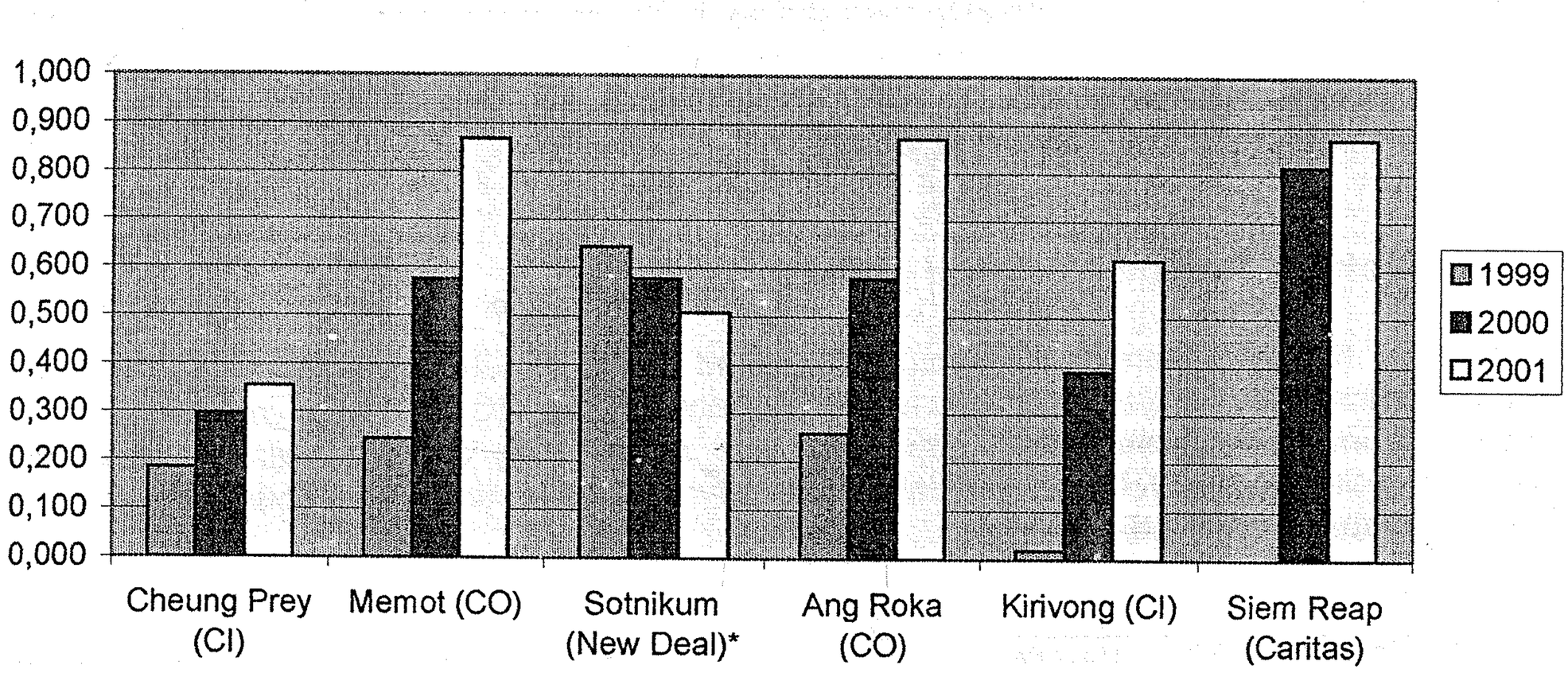
Table 2. Basic characteristics of each NGO

** Since May 2001 SRC stopped funding the project and currently only subsidizes the equity fund.*
*** While the district contains 17 health centers, 12 are currently in the New Deal.*

Due to the large differences in budget, management arrangements and project characteristics, comparisons between the NGO's experiences are extremely difficult. This should be taken in mind when analysing the different approaches of the NGOs.

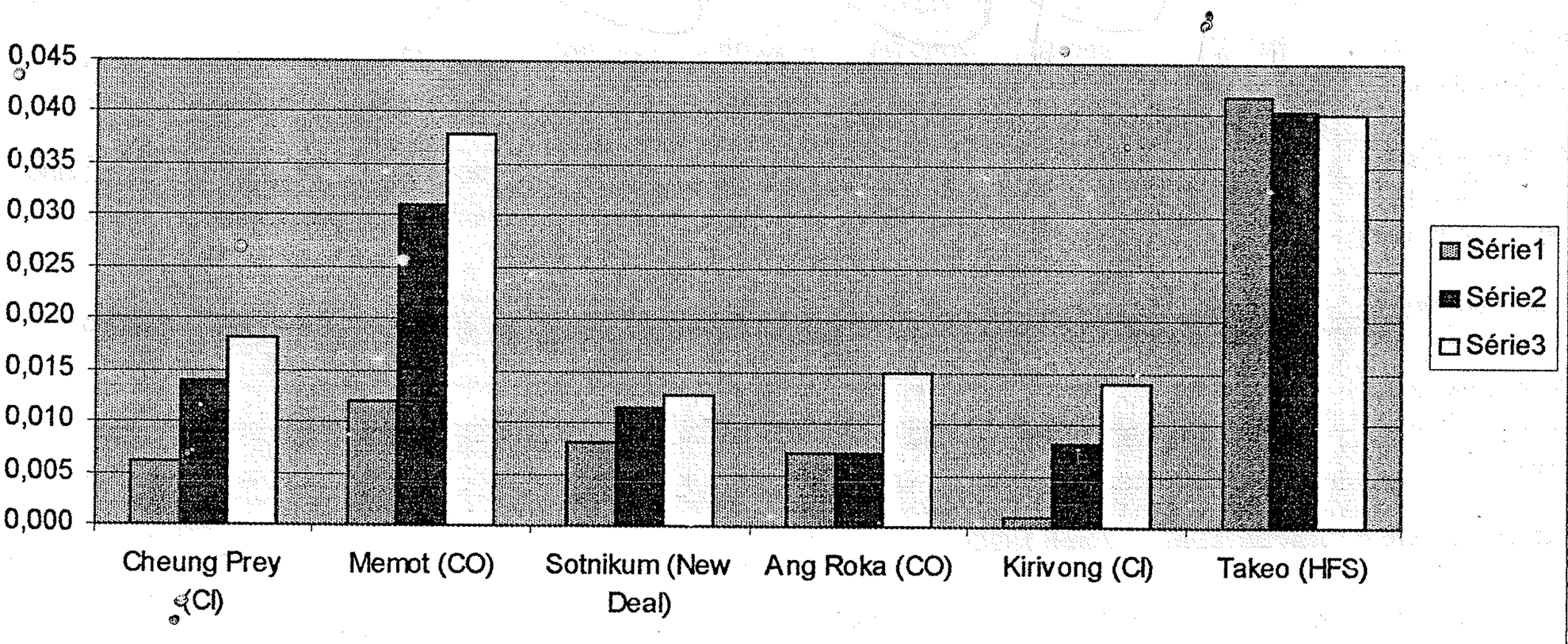
As discussed before, the main purpose of this synthesis is not to conduct a quantitative analysis of the achievements of the NGOs so far[3]. Instead, the methods and approaches used by the NGOs are analysed. However, in order to give an indication of the progress made by the NGOs figure 1 presents the no. of OPD and IPD consultancies per inhabitant/year. Although the figure shows merely two indicators of the achievements of 1999 and 2001, it gives a clear indication of the tremendous progress made by all projects in a relatively short time period.

Figure 1: OPD consultations per inhabitant/year of the different projects reviewed



* New Deal: 1999: 2 Health Centers; 2000: 7 Health Centers; 2001: 12 Health Centers

Figure 2: Hospitalisations per habitant/year of the different projects reviewed (exclusive TB patients)



The next chapter presents an overview of the rationale of the starting approaches of each NGO.

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[3] An independent mid-term evaluation on of four contractors has been carried out in July/August 2001, funded by the ADB and presented at a workshop in October 2001. These contracting experiences showed marked improvements with significant higher utilization of public health facilities, improved access for the poor and reduced out-of-pocket expenditures. However, this evaluation focused exclusively on output indicators and did not evaluate any process issues.

Chapter IV: Rationale of the specific starting approaches of each NGO

4.1 HealthNet International

After an inception period the project started in December 1999 with an Incentive, Quality Assurance and Cost-Recovery Scheme.

The first pillar of this plan involved paying government health workers, in addition to their own government salary, monthly incentives in the range of US$70 – US$180. These incentives were provided on top of the regular government salaries and awarded to health center, hospital as well as to staff from the OD office (ODO). The concept behind was that only with right financial incentives health workers would improve their performance. To receive this incentive each health worker was requested to sign a contract with HNI in which individual targets were set. Payments were based on a basic contract amount of 55%, a punctuality bonus of 15% and a 30% bonus based on achievements of the set targets. Targets were related to revenue collection and expected output (OPD, BS attendance etc.), while the contract also included an article stipulating that the government health worker would not practice privately. This to avoid "poaching" of patients from the public facility to the private practice.

The second pillar of the scheme was focused on the improvement of quality of care. This was of paramount importance and continuous efforts were invested in on-the-job training, supervision and formal training courses. An expat medical doctor was recruited to address the quality at the hospital.

The third pillar was aimed to recover part of the incentive payments by charging user fees for public health services. This was also considered as necessary since large amounts of the MoH contributions under chapter 11 through the Provincial Health Department were not forthcoming. From the beginning user fees were not fixed and were allowed to float after consultation with the communities and according to the prevailing prices in the private sector. Despite an income from user fees of US$26,000 in the year 2000 the project budget fall short. This was addressed after interference of HNI's headquarters that provided the project with an average annual financial contribution of approximately US$20,000.

After one year, when gradually more health facilities entered the scheme, the incentive scheme based on individual contracts became unmanageable and impractical. In addition, available funds were insufficient to maintain the present scheme. It was then decided to further decentralize the responsibilities of the managers at the health facilities. For this process subcontracts were signed with the chiefs of the health centers and directors of the hospitals. Under this subcontract the income from user fees remained at the health facilities. The subcontractors received an additional 80% in cash from HNI on top of the income from user fees. In addition, US$0,1 per capita for preventive services was awarded to each health center, based on the achievement of certain agreed targets, while the hospital received an additional 1400 Riel (US$0,35) per in-patient day for tuberculosis (TB) patients. This decentralization process gave the subcontractor a lot of freedom. He could assign the revenues of the health facility at his own preference and was also able to recruit temporary non-MoH staff on his own initiative, although this process was thoroughly scrutinized, and needed approval, from the NGO.

Between February and July 2001 all health 15 health centers and 2 hospitals in the district signed subcontracts. A subcontract was also given to the ODO. Under this contract 15% of the total revenues of the health facilities added with 10% of the bonus paid to health centers for preventive services was awarded to the ODO. To receive this amount the ODO was required to perform successfully with consolidated bookkeeping practices and monitoring the health facilities.

Hence, the major reason behind the incentive, quality assurance and cost-recovery approach was to provide health workers with adequate incentives, while at the same time making a clear distinction between workers in the public and the private sectors. The scheme relied heavily on decentralization of decision making with a strong monitoring and supporting role of the NGO.

4.2 Hospital Financing Scheme

The Hospital Financing Scheme at Takeo hospital is based on user fees, staff incentives and rational management with the belief that the quality of services will subsequently improve, leading toward better utilization of the hospital by the population[4]. User fees were implemented in order to reduce informal payments. It was anticipated that this would result in decreasing out-of-pocket payments, while securing hospital income. It was stressed that this increase of funding through user fees should not substitute but rather complement the government funding. The goal is to establish a financial system in which government funding and revenue from user fees represent a sustainable income for the hospital, with a complete stop of external donor funds within three years. The management of funds in the hospital should also become more efficient, transparent and systematic. Furthermore, coverage should be increased, especially for the rural poor who should have access to the health services. Finally, it was considered as very important that close cooperation with the governmental health policy makers (MoH) and health administrators (MoH and PHD) were maintained during both the development and the implementation of the HFS.

To start with in September 1997 a global contract was signed for three years and later extended for one year. This contract was signed by (representatives of) the following authorities: MoH, PHD, directors of the hospital, provincial administrative authorities, the Swiss Red Cross and the newly established Takeo Referral Hospital Management Committee. The global contract clearly defined the advisory and catalyst role of the supporting NGO SRC. Furthermore, the global contract specified the commitment of the MoH to timely distribute the allocated budget. The MoH also guaranteed to regularly and timely provide drugs and consumable medical equipment from the CMS according to real needs. The PHD committed itself to facilitate administrative procedures and human resource issues, in particular for the reduction of staff during restructuring. Furthermore, they guaranteed a swift mobilization of the total budget received from the MoH.

The Takeo Referral Hospital Management Committee has been set up during the development of the pilot scheme in order to provide a crucial role in leadership and decisive action. Committee members consist of elected representatives of hospital staff from all departments together with representatives from the PHD, the Provincial Governors' office and representatives from the community.

After signing the global contract, individual contracts between the Hospital Management Committee and all hospital staff were established. These contracts were based on quality of work and adherence to the rules laid down by the Management Committee. Internal financial and management decisions were decentralized and placed in the hospital in order to use the resources rationally and to stimulate an increased flow of financial resources. Performance related bonuses were introduced to link the income of the hospital with output indicators, while strictly prohibiting: i) the collection of informal fees; ii) misappropriation of material, money and drugs and; iii) "poaching" of patients from the public to the private sector. The maximum bonus payments ranged from US$75 for primary nurses to US$250 for the head of wards and hospital director. Furthermore, an exemption scheme has been set up in order to increase hospital access of the poor.

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[4] Due to the presence of SRC since 1986 the technical competence was considered as relatively high. Therefore, improvement of quality was not considered as an objective or strategy in the HFS.

4.3 New Deal

Although since 1997 a health system in Siem Reap Province was in place, including a policy, infrastructure, budgets, supplies, modes of functioning and training to support this, it became apparent that despite all these good efforts and support, none of the OD's were really functioning. Many brand new facilities remained almost empty and very few patients were hospitalised in government hospitals. Of the many causes two seemed of paramount importance: 1) staff motivation 2) mismatch between health care offered and the population's demand for care.

With this context in mind, MSF and MoH wanted to explore whether the public sector was able to compete effectively with the private sector and to make it acceptable for the population by implementing on the ground the national health policy. This was the basis for the experiment Sotnikum New Deal.

The New Deal built heavily on the experiences of the HFS in Takeo hospital. Similar to the HFS, providing staff a better income, while strict adhering to internal regulations was a key entry point. This new working environment was the cornerstone to improve patient confidence in the health facility and to improve quality of care. In addition, additional inputs like, training, technical assistance (TA), supervision, etc. were also expected to improve the quality of care. Transparent increased official user fees in exchange for better services were introduced, since it was assumed that increased official user fees would actually decrease the real cash payments, resulting in cheaper health care for the population. Negotiation was also considered as an important principle in particular since one of the objectives of the New Deal was related to be a catalyst for changes in the health system.

It was decided to start the New Deal for the hospital in December 1999, while the deals for the ODO and health centers were still being negotiated. Although basic principles were agreed upon, it was thought that operational details would best be established while already implementing the scheme. In order to anticipate on these expected adjustments, MSF opted for short term contracting of 3 months.

To create a platform for discussions and create a broad basis of ownership an external Steering Committee has been set up including representatives of MoH (national, provincial and district level), several government administrations (MoEF, provincial governor, district governor), and representatives of UNICEF, WHO and MSF. Meetings are open to staff of the ODO, hospital, health center and other interested to acknowledge the important role of the implementing actors in the reform process. The Steering Committee is responsible for decisions on patient fees, bonus systems and external budget support. These decisions are formalized in a 'global contract' between all actors.

The Steering Committee takes the role of managing the health system consisting of short-term contracts between individual health facilities and the Steering Committee. These contracts are related to quantitative and qualitative indicators and include certain internal management regulations, of which respect for opening timings is considered of paramount importance. In order to achieve more accountability for each health facility with regard to the use of resources and the results obtained, another, more decentralized, level of management has been introduced. Each public health facility and the ODO obtain a certain degree of autonomy in managing internal affairs. This includes the establishment of individual contracts of each health facility with their own staff members. It should be noted that this decentralized form of management has to operate within the boundaries of the global contract.

Similar to the approach of the HFS, the approach of the New Deal is focused on increased staff salaries, improving quality of care and the introduction of transparent and increased user fees. In addition, to create a platform for discussions among all stakeholders the Steering Committee has been established with far reaching authority over the district.

4.4 Association of Medical Doctors of Asia

The strategic management approach form AMDA is to firm up the prerequisites to sound institutional foundation strengthening. These entailed basic system development in the first year and human resource development in the second year coupled with participatory decision making for systems and service improvement.

Although CO districts have through the contractual arrangements a high degree of independency, AMDA put lots of efforts in building effective partnership with all different government levels within Takeo Province. Relations were built with the PHD, the provincial and district governments, and local government authorities including commune chiefs and village chiefs. In addition, working relationships were established with other government agencies in the district. This was done through the District Management Committee, composed of representatives of education, rural development, women's affairs, health sector and the local governments. Furthermore, the project started to work closely together with local and international NGOs already working in the OD. Finally, AMDA also tried to work together with private health providers in the district, in particular traditional birth attendants (TBA's).

Through this capacity building process the health care system in the OD was expected to develop in an effective, efficient, equitable and sustainable way. Major attention was also put towards support at community level through provision of information, health promotion and health education. In addition to empowerment of ODO personnel and communities, developing local capacity for health care financing, cost-effectiveness and providing quality care, were also part of AMDA's strategies.

AMDA's strategic approach on capacity building included a major emphasis towards human resource development. It was acknowledged that the development and cooperation of local district staff was the most important reason for the results achieved so far. An important measure taken with regard to staff development was the creation of additional positions at the health centers. Increased numbers of female staff and relative high-qualified medical assistants were employed in all 9 health centers. At the same time the numbers of ODO and hospital staff were reduced. AMDA recruited the majority of professional health staff from within the district. However, in order to anticipate on increased activities few government health workers were recruited from other OD's and Phnom Penh. Another measure taken was the increase of salary for all positions. This was linked with the prohibition of private clinical practice within the OD for those who agreed to work full time with the project.

For the community participation component AMDA recruited 8 village health workers who received a fixed salary. These consisted of six retired government health staff workers, one TBA and one student. They were based in remote villages of the district and equipped with basic medical supplies.

For the final year AMDA aimed to further increase the prerequisites for sustainability. This includes transferring more administrative functions to the ODO, mobilizing more internal and community-generated resources for service delivery, including a health financing scheme, and fostering more community participation in health care.

4.5 Save the Children France - Enfants et Développement

The initial implementing approach of SCF/EED was the establishment and strict enforcement of internal management regulations together with a major focus on outreach activities as no proper facilities, neither health centers nor hospitals, were existing in Kirivong OD.

With regard to salaries, SCF/EED provided small supplements from the budget supplement for all district health staff consisting of US$25 for health center staff and US$33 for hospital staff. In order to receive this, working timings were adapted and should be adhered to. While for health

center staff working timings represented around 108 hours a month (60%), hospital staff were expected to work 185 hours (100%). Although SCF/EED acknowledged that salary supplements were limited, the available budget was insufficient to allow for further increases.

All staff had a fixed schedule of their working timings and clear roles and responsibilities were defined and signed by each individual public health staff working in the OD. Discipline rules of the MoH were applied and enforced, including salary supplement cuts when ignoring these rules. These rules were related to absence at work and the non-respect of certain protocols (e.g. drugs protocols, reports, hygiene). It has to be noted that all rules are applicable only for unacceptable behaviours and do not relate to quality performance. Major emphasis has been put towards respecting the outreach schedule, since preventive services, including EPI, ANC and BS were given the highest priority. Each village is visited once a month on a date announced one month in advance.

To improve quality care at the health facilities other measures were put in place. These included, amongst others, the availability of the national protocols in each health facility, training of staff with respect to these protocols, a tight supervision schedule, and the recruitment of an expat medical doctor in charge of quality improvement at the referral hospitals.

Annual work plans for all staff aimed towards improvement of the services have been established. In these plans no targets have been fixed in order to diminish the temptation to fake the results. Instead the plan focused on operational matters. As an example, for outreach activities the plan includes: i) respect of the scheduled dates; ii) the availability of equipment, budget and supplies and; iii) information of the visit passed to the village chiefs and communities.

In October 2001, SCF/EED has embarked on establishing community based structures and user fee scheme. To allow for effective and efficient participation it was opted to collaborate with the pagodas and their associated volunteers. These volunteers and their related networks allow for appropriately targeting the most vulnerable and effectively disseminating correct information to the majority of the population. The Health Center Management and Feedback Committees are, therefore, comprised of pagoda volunteers (see also #5.5.1.1).

The ODO and the NGO are totally integrated in Kirivong and together they constitute the management team of Kirivong OD with the contractor having the final authority as stated in the contract.

4.6 Save the Children Australia

SCA is the contractor for both a CI and CO district. From the start different bottlenecks within the health sector were tackled. First of all strong management and leadership arrangements were put in place, including a set of working rules and regulations. Although formal authority was with the NGO, cooperation and strengthening of ODO staff was of significant importance in both the CI and the CO districts. In both districts NGO staff worked for ongoing operational activities together with a counterpart from the ODO.

Importance was also given to monitoring carried out by an independent team, employed by the NGO. The objective of the team is to supervise the performance of the health facilities and to provide feedback to the management. The management analyses the findings of the monitoring team and addresses the quality issues at the health facilities by sending the training team. This team consist of two medical doctors and two midwife trainers with different fields of competence.

In addition, the NGO also put lots of efforts to establish effective community based structures. Village Health Volunteers and TBA's were trained in creating awareness of health facilities and

other health promotion activities. Furthermore, TBA's were trained in order to refer all complicated deliveries to health centers.

In the CO district of Memot staff were paid "living" salaries in the range of US$80 and US$200. These were significantly higher than the staff salaries paid in Cheung Prey CI district. Since incentives for CI districts had to be provided through the budget supplement these were with US$18 – US$30, on top of the regular government salaries, significantly lower[5].

4.7 Caritas

Outside the spotlights Caritas is since 1995 supporting 7 health centers in Siem Reap Province. This is only slightly more than a quarter of the 27 health centers in the whole OD. From the start Caritas implemented user fees and awarded bonus payments to staff in the health centers. The health staff receive a maximum bonus payment of US$30, based on performance in curative and preventive care. The health center chief receives an additional US$5. Health centers staff who also run a TB clinic or HIV/AIDS programme (2 health centers each) receive an additional maximum bonus payment of US$10, depending on the achievement of targets. Furthermore, staff at the health center running a nutrition programme receive an additional US$8. In addition to these performance related payments, the staff also distribute 49% of the user fees among staff as incentive payments, which is according to the MoH guidelines.

Outside the health sector, Caritas also supports a credit scheme, a home gardening project and a small-scale water supply project. These projects are carried out in the same district and therefore a strong basis is laid for community involvement. Of the twelve local staff, 4 work with the HIV/AIDS programme, 4 are involved with community work (home gardening, micro credit and rural drinking water supply), while the remaining 4 staff work with the health centers. Out of these last 4 staff members, one medical assistant and one secondary midwife are responsible for health center supervision activities, while the other 2 staff members work for the nutrition programme.

In contrary to the approach of HNI, exemptions for the poor are granted at health center level. This is considered as necessary, since the people in the area are extremely poor. Furthermore, Caritas does not support the ODO, since RACHA already supports the district office. Supervision is done by Caritas, while the ODO work according to their own schedule. Only in cases of difficulties Caritas will seek assistance of the ODO.

Table 3 provides a brief summary of the main starting approaches of all NGOs under review.

ict / ect	Sotnikum / New Deal	Takeo / HFS	Ang-Roka / CO	Memot / CO	Kirivong / CI	Cheung Prey / CI	Pereang / CI	Siem Reap / Caritas
Key g ches	- Incentive payments; - User Fees; - Rational management	- Incentive payments; - User Fees; - Rational management	- Incentive Payments; - Institutional strengthening; - Human resource development	- Incentive payments; - Institutional strengthening; - Human resource Development; - Community Involvement	- Limited incentive payments; - Rational management, (with strict enforcement)	- Limited Incentive payments; - Institutional strengthening; - Community involvement	- Incentive payments; - User fees; - Quality assurance	- Incentive payments; - User fees; - Community involvement

Table 3. NGOs key starting approaches

[5] Since the 4th quarter of 2001 incentive payments increased to US$40 - US$100, due to additional allocation of the contracting budget to incentive payments.

Chapter V: Analysis of the NGO approaches regarding key fields

After having presented the context and the main starting approaches of each NGO under review this chapter provides a more detailed analysis of the approaches followed by the NGOs, regarding the following key fields:

- Health Regulations, including Public/Private Mix
- Health Financing/Management
- Monitoring & Evaluation Systems
- Human Resource Issues (Allocation & Development)
- Health Seeking Behavior/Community Needs
- Sustainability

5.1 Health Regulations

5.1.1 OVERVIEW OF GOVERNMENT REGULATIONS IN HEALTH

The MoH is the responsible body for regulating the health sector on national level. National guidelines and protocols have been developed in order to ensure that ongoing developments within the health sector follow a similar pattern in all districts. In order to be able to coordinate this whole process, major responsibilities of managing the OD's, including staff management, training and monitoring have been delegated to the different PHD's. At operational district level the ODO is responsible for financial reporting and submitting HIS data to the PHD. Furthermore, it is the ODO's responsibility to manage the health facilities in the district and to distribute material and financial resources to the health facilities.

Besides the regulator role, the government is also the financing agent. Budget, whether loans or own sources, comes from the MoEF and is then channelled to the health facilities, using various intermediate levels. Government salaries are disbursed through chapter 10, while the budget for running costs comes through chapter 11. These funds follow the traditional route from MoEF – MoH – PHD – OD – health facilities. The PHD often provides the allocated budget for chapter 11 in kind.

The new budgetary systems viz. Accelerated District Development (ADD) and Priority Action Program (PAP) follow different routes. ADD is channelled to the MoH from where it is disbursed directly to the OD, thus bypassing the PHD. PAP is a more advanced method of budget disbursement reform based on post-audit instead of the former pre-audit method. This budget is released from the MoEF to the provincial treasury, from where it is channelled to the PHD, OD and health facilities.

Of the districts under review **Siem Reap** and **Cheung Prey** are currently PAP Provinces, while **Kirivong** OD is an ADD district. Although these new methods do not affect the total allocated amount, it is anticipated that through ADD and PAP a greater share of the allocated budget will arrive at district level in a timely manner.

As explained before, **CO** works within a different framework. The major difference is that the contractors become the financing agents. The contractors' budget arrives directly from the MoH/ADB, while the MoH remains the regulator, defining the borders within the contracting process takes place. Hence, the set up of the CO was far more straightforward containing the contractors' full responsibility (management, budget and staff) over the district.

5.1.2 OVERVIEW OF RULES AND REGULATIONS SET BY THE NGOS AT DISTRICT LEVEL

Either through input of own resources (HFS, New Deal and Caritas) or through contractual stipulations (CI and CO) the NGOs exerted influence over the day-to-day operation at the health facilities. As a first step, all NGOs set up clear rules and responsibilities for each health worker. The major components consisted of: i) job description, including respect for working hours; ii) no charging of informal fees; iii) no misappropriation of money, drugs and material; iv) no 'poaching' of patients i.e. diversion of patients from the public to the private sector. In all districts these rules were stipulated in agreements/contracts between the contractor and the individual public health workers and subject to reduction of incentive payments.

With regard to working hours (component i) different approaches were followed by the NGOs. Health center staff working for **SCF/EED**, Kirivong and **SCA**, Cheung Prey were expected to work in the health centers only during morning time[6], leaving them the opportunity to work in their private practice during the remainder of the day. In contrary, the staff working with the other NGOs had to work the full day in the health facility, while most of the districts under review currently have a 24-hours schedule in place. Furthermore, regarding the fourth component **AMDA** and **HNI** went one step further by including a non-private practice agreement for all public health workers.

5.1.3 Analysis of NGO's experiences regarding government budgetary regulations

The three **CI** districts depending on the budget and material disbursement through the PHD faced with enormous difficulties in receiving this budget. In particular the budget for running cost (Chapter 11) was extremely limited, e.g. Kirivong district received only 7% of the allocated budget in 2000. Drugs from CMS also fall short and consumer goods and medical equipment were overpriced, of doubtful quality or did not arrive at all. To quote an example, shelves were sent from the PHD to Kirivong district costing US$1000, while the market price was below US$150. Furthermore, in Cheung Prey only 19 different drug items arrived while 96 items were ordered according to the CMS system (first quarter 2001). A last striking example are the refrigerators that were sent to all referral hospitals of CI districts for storage of vaccine, blood and reagent. When the refrigerators were delivered they had large warnings affixed to them reading, "Not to be used for vaccines, reagents or blood".

Major equipment, like surgery equipment came through MoH/ADB and had to be delivered to both the CI and CO districts. Although the quality of this equipment was reasonable, it did often arrive late. While surgery equipment for referral hospitals were planned for the end of 2000, the first materials arrived only in November 2001[7]. Since this is only at the end of the third year of the four years project it severely hampered the service provision and the ability to raise revenues through user fees.

In **Sotnikum**, the **Takeo hospital** and **Siem Reap** OD the commitment from the PHD was initially higher. The budget of Chapter 11 normally arrived in Sotnikum, while Takeo hospital received 60% of the allocated budget for running costs[8]. Part of this higher commitment can be attributed to the involvement of the PHD's in designing and executing the "global contract". In particular at the New Deal, where the PHD chairs the Steering Committee and major decisions have to be approved by this committee, the role of the PHD is important. However, signals from the HFS in Takeo hospital showed that it is not sufficient to only provide the PHD with more influence. In Takeo hospital, the budget disbursement significantly reduced to only 30% after the Swiss Red Cross stopped their major funding. It seems that when there is no effective control mechanism in place to supervise the PHD old practices are continued even when a higher stake in managing the provinces' health services is assigned to them.

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[6] Hospital staff in these districts had a 24-hours working schedule.
[7] In Ang Roka district no surgery equipment has arrived so far.
[8] Since Caritas does not support the ODO, data regarding budget disbursement to Siem Reap OD was not readily available.

With regard to the new methods of budget disbursements, reports from the field showed mixed results. While for the first 4 months budget from PAP did not arrive at all in **Sotnikum,** the situation has improved dramatically. Currently the larger share of funds does arrive and are sufficient to pay for the running costs. At **Siem Reap** OD, it appeared that PAP disbursement is still not satisfactory. This may be caused by the fact that in particular health centers and the ODO's face difficulties in making proposals according to the acceptable format. The PHD director also stated that he still does not know how to access all budget lines, and that the shift to this whole new method is fairly complicated. In **Cheung Prey** the PAP system currently does not work at all. While the OD receive a high proportion of its allocation, the PAP system in its current form precludes expenditure of this money. The ADD district **Kirivong** does currently receive an approximate 50% of the allocated budget. Although this is much more than the previous disbursed 7% through the former system it is still unsatisfactory.

5.1.4 Analysis of NGO's experiences regarding enforcement of rules and non-private practice agreements

In order to enforce the internal rules set by the NGOs different strategies were followed. It appeared that the **HFS** and **SCF/EED** were most strict in enforcing these rules. The HFS in Takeo had four persons dismissed in the last two years due to accepting of under the table fees, while SCF/EED dismissed two persons because of corruptive activities[9]. Although not having dismissed staff the other NGOs, with the exception of SCA in Cheung Prey, did use reduction of incentives as a tool to enforce contractual obligations.

Not respecting the opening hours was a major reason to cut incentive payments. Strict enforcement of this rule was applied by **SCF/EED** in Kirivong. **AMDA** punished staff that did not respect the time schedule by cutting 1 leave day. In **Pereang** no punitive action was taken for not respecting opening hours, since incentive payments are currently fully based on performance. Therefore, it up to the health center chief to punish latecomers. In **Sotnikum** a similar approach was followed. The health center chief could reduce the share of the income from user fees to staff members who did not respect the opening timings.

The non-private practice agreement formulated by **AMDA** and **HNI** was an innovation in Cambodia. The far majority of public health staff had their own private business, which they were asked to stop when the NGO came in. To effectively implement this agreement was therefore not an easy task. At AMDA it came to a strike of health staff, and only through interference of the PCU the problem was settled. It is interesting to note that although the non-private practice agreement remained unchanged all staff workers continued to work for the NGO. It appeared that when the staff was used to the new working environment they accepted the new rules. The ADB survey pointed out that this ban on private practice is probably a major reason for the significant reduction of out-of-pocket expenditures in Ang Roka and Pereang OD's (ADB Presentation on the Evaluation of Contracting, 2001). However, it should be emphasized that this rule was only made possible through the provision of living wages for health staff.

After approximately one year of implementation the strict enforcement of this rule was relaxed in both districts. In **Pereang** the reason was the awarding of subcontracts, which gave the subcontractor more responsibility in managing his own staff. However, it is estimated that private practice by public health staff is still very rare in this district. This is probably due to the performance-based contracts, which relate income from health staff directly with output (see #5.2.5). In **Ang Roka**, however, it was stated that after the period of strict control the majority of staff returned to work at their private practice. Especially when family members run the practice during daytime it proofed to be extremely difficult to enforce the non-private practice agreement

[9] Although working in a CI environment, SCF/EED was able to dismiss these staff through intervention of the PCU of MoH/ADB.

in this district. For this reason AMDA now turn a blind eye towards public health staff with a private practice.

With the exception of **Memot**, Kampong Cham (CO) and the Caritas supported health centers in **Siem Reap** a large number of health staff in all other districts under review also have their private practice[10]. It would be interesting to investigate in more detail the effect of the ban of private practice on the out-of-pocket expenditures of the population. In particular it would be interesting to find out whether the approach of both AMDA and HNI are replicable in other Cambodian districts.

5.2 Health Financing/Management

5.2.1 OVERVIEW OF USER FEES AND AFFORDABILITY

With the Health Financing Charter the foundation was laid for charging user fees at health facility level. Of the projects under review, the **HFS, New Deal, Pereang** and **Caritas** have several years of experience with charging user fees. The rationale for these NGOs to introduce user fees were fourfold and included:

- Supplement Staff Incentives.
- Transparency, by setting official fees, thereby effectively eliminating under the table fees. This was supposed to result in a reduction of out-of-pocket expenditures.
- Improvement of Statistics.
- Sustainability.

A definite advantage of user fees was the increase of staff incentives. Since the **HFS** the **New Deal** and **Caritas** have no management responsibility over the district the MoH guidelines were followed for allocating these. According to MoH guidelines 50% of the revenues from user fees are to cover running costs of the health facility, while 49% can be used as additional income for staff. The remaining 1% is reserved for the provincial treasury. At the **New Deal** the 49% received from user fees for incentives payments were doubled by MSF/Unicef, resulting in a total of 98% of the income through user fees allocated for incentive payments. In Pereang the subcontracting system indicated that a total of 180% (all user fees + an additional 80% provided by **HNI**) of the money generated from user fees were allocated for incentive payments and running costs. It was the sole responsibility of the subcontractor to divide this money between these two components and to design a fair system for distribution of the incentives.

At the start of the projects charging informal fees were the rule rather than the exception. Charging formal, transparent user fees was seen as an important intervention in order to reduce these under the table fees. Transparency significantly improved by setting clear-cut prices and introduction of single payments at one counter. Patients were aware how much they had to pay for a specific service, while health staff were bound to charge only the approved fees. Control mechanism from community structures and the NGO ensured reporting of defaulters and sanctioning. It is difficult to state to what extent informal payments have been stopped, but it is clear that in particular in districts with user fees a significant reduction of informal payments took place.

The third major positive effect of user fees reflects to a significant improvement of the reliability of statistics at health facilities. Since the receipting process is directly linked to patient

[10] Since many of the staff working in Memot were recruited from outside the district and because the area is unsafe for travel, not many public health staff have their own private practice. At the Caritas supported health centers no specific reasons were mentioned, but it might be a combination of extreme poverty and the recent unsafe situation in this area that private practices are still not widespread.

registration, inflation of patient numbers was significantly reduced[11]. The user fees therefore act as an inadvertent audit tool by identifying any inaccuracies found in the registration and/or admission process.

A fourth reason to start user fees was to increase the potential for sustainability. When revenues through user fees increase, the facility has an increased budget for staff incentives and running costs. This does increase the chances to continue the services at the same level of activity in case the NGO stop their financial contribution.

However, apart from the anticipated positive effects of introducing user fees, a major concern was the affordability of the health services for the poor. To tackle this issue, different methods have been applied, while some are still in the design stage. In **Pereang** fee levels at health centers were set consisting of around 75% of the current prices of the private services. These prices were set after conducting a survey, including questions about the ability to pay for the poorest people of the district. Since the survey showed that the poorest were able to pay these nominal fees no exemption scheme was put in place. In the health centers in **Sotnikum** and **Siem Reap** exemptions to the poor were granted as it was stated that people were often so poor that they could not even afford minimal fees. The staff at the health centers made the final decision on granting these exemptions. Furthermore, as an incentive, community health workers and their direct relatives were provided with free care at the health facilities in Siem Reap.

Although an issue at health center level, at referral hospitals the affordability issue is of even greater importance. Since prices for the second level of care are generally higher, the poor often have difficulties to pay for the services. For this reason the NGOs with health financing schemes have established exemption schemes and developed them into equity funds. The **Takeo hospital**, which offers the highest level of care of the NGOs under review, was first confronted with the issue of access for the poor. It was then decided to establish an exemption scheme. However, this did not work well, since health staff were reluctant to award exemptions, due to the obvious reason that the incentive payments for staff are related to the revenue from user fees. In order to tackle this problem an equity fund has been set up, whereby the loss of income from exempted patients is recovered through an established fund. The most advanced equity fund exists in **Sotnikum**. In this district poor patients are initially screened by the hospital staff and referred to an independent local NGO, responsible for granting free care to patients. The NGO has developed several criteria for awarding free care. Depending on the score, the patient can be granted full, partly or no exemption. In **Pereang** and **Takeo hospital** the hospital staff do the initial screening, while the final decision of granting free care is with the NGO (Pereang) or the health financing committee (Takeo).

While four NGOs introduced user fees, the other four districts decided to introduce user fees in later stages of the project. In the CI districts of **Cheung Prey** and **Kirivong**, the reason for not introducing user fee systems from the start was that at least a basic level of system building, including capacity building of the ODO and quality delivery in health facilities should be in place before fees could be asked from the patients. At the **CO** districts incentive payments for staff from the contractors' budget were sufficient to pay for living wages and therefore the NGOs felt that there was no immediate need to develop a user fee system.

However all the four projects without an initial user fee system recently started implementing a health financing system as per contract requirements. While setting up the system lessons have been learnt from the other NGOs. One lesson learnt is that at hospital level an exemption scheme has adverse effects on hospital revenues. For this reason, an equity fund is a far better alternative. New approaches are also being piloted, of which a system of identification of the

[11] In non-contracting districts without strong management and/or user fees, patient numbers were often inflated. This was done in order to acquire more drugs or to show that the health facilities did perform satisfactory.

poor through identity cards is an innovative method. **SCF/EED, AMDA** and **SCA** will identify the poor through community members and provide them with identity cards for free health care at the public health facilities. The piloted system of SCA is most advanced since it will also include a scaling system for patients who don't necessarily be extremely poor, but might not be able to afford high bills. These planned systems of the three NGOs has the potential for a better identification of the poor since the people living in the communities have a better notion of the poorest in their villages. However, developing and updating these cards requires a lot of financial and human resource input. Furthermore, the introduction of this system heavily depends on the commitment of village leaders, including the relation between these leaders and the poor households. Finally, it has to be investigated in which respect these cards might stigmatise and as a result deterring the poor to access the health facilities.

Another innovative approach with regard to user fees is **AMDA's** concept to collect all user fees of the final year of the project. The full amount will, according to a certain formula, be distributed after the project to the health facilities and the ODO. This method has been initiated in order to create a buffer of money for incentive payments after the contractor leaves. However, this concept is in an initial stage and has so far not been finalized.

5.2.2 Analysis of NGO's experiences with user fees and affordability

Shortly after introduction of user fees, the utilization of the public health facilities increased rapidly. Staff became more motivated and the general perception of the population was also positive. People perceive that paying for services is related to improvement of quality. Furthermore, the certainty to find the facility open during the advertised opening hours also significantly contributed to the increased utilization.

For the NGO who recently introduced user fees, responses varied. **AMDA** stated that after the first month of user fees 7 health centers and the hospital experienced a decrease of patient numbers, while the remaining 2 health centers sustained similar level of activities. It was stated, however, that the major reason for decreased utilization was not the affordability of the fees but the fact that before the fee scheme was initialised many family members accompanied the sick patients and also requested medicines. Although not being sick, they were also recorded as OPD patients. Furthermore, it also has to be taken into account that before starting the user fee scheme, AMDA worked already for over 3 years in the district and the level of activities were already very high.

SCF/EED reported different trends at the first months of the user fee scheme. While the best running health centers showed a slight decrease in utilization, the hospital and health centers performing below average reported an increase in activities. The hospital, which already had a high degree of utilization further improved due to better behavior of staff. Since policy of SCF/EED is to provide the full income from user fees to staff incentives, staff at the hospital reacted promptly. At health center level it was stated that the low performing health centers were now more motivated to make use of the community structures set up by SCF/EED. This approach raised awareness of the population and consequently the utilization at these health centers increased.

With respect to experiences of affordability it was observed that exemption schemes at hospital level do not work well due to conflict of interest. However, despite this constraint it was observed that the exemptions schemes in the health centers of **Sotnikum** and **Siem Reap** did work satisfactory. This might be due to the relative low amounts charged at the health centers. Exempting a few patients do therefore not have a major impact on staff salaries. Furthermore, the health center is less hierarchic than a hospital and the staff often works more as a team. This might also have an impact in the relative successful application of simple exemption schemes in health centers.

With regard to equity funds at the hospital the NGOs were faced with three major issues viz. identification of the poor, sustainability and promotion. The first issue has been addressed above and shows that currently hospital staff do the first screening, while a separate committee (HFS), the contracting NGO (HNI), or an independent local NGO (CFDS in Sotnikum) make the final decisions on granting exemptions. This screening process is changed at the new schemes introduced by SCF/EED, AMDA and SCA.

Sustainability appeared to be a great concern for health facilities with an equity fund in place. The Swiss Red Cross currently financially supports the equity fund of the **HFS in Takeo**, while MSF and the British Embassy provide funds for the referral hospitals in respectively **Sotnikum** and **Pereang** districts. It is likely that within a few months the SRC and British Embassy will stop their funding. In Takeo no new funding agency has been found to date in order to continue financing the equity fund. In Pereang, the contractor might support the equity fund. This is feasible only since the current level of service provision does not include advanced services like surgery. When this service is in place, the funds necessary for the equity fund are expected to increase rapidly, beyond the capacity of the contractors' budget. In Sotnikum it is also not clear how to receive further funds to support the equity funds.

RACHA has developed a more sustainable method, where loans are provided to villagers for rural development schemes. The interests of these loans are collected at community level and (part) of these are spent to the poor community members for free access to public health facilities.

Promotion of the equity fund is also an important issue to be considered. It appeared that in all three hospitals with the equity funds in place, awareness of the fund was extremely low. A survey carried out in the catchment area of **Takeo hospital** revealed that many of the poor did not access the hospital due to the perceived high prices. Recently a start was made to address this issue by launching promotion campaigns with the purpose to raise awareness of the equity fund among the poor. In **Sotnikum** district a similar campaign has been initiated.

5.2.3 OVERVIEW OF INCENTIVE PAYMENTS

The provision of incentives by the NGO has been an approach applied by all NGOs. The NGOs consider this as the most important necessary condition for effectively running district health services. However, due to budgetary differences, the level of incentives varied considerably between the NGOs (table 4).

Project	**Average range incentive payments for public health staff (US$)**
HFS, Takeo	75 - 250
Caritas, Siem Reap	50 - 60
HNI, Pereang	70 - 180[12]
AMDA, Ang Roka	77 - 160
New Deal, Sotnikum	50 - 130[13]
SCA, Memot	80 - 200
SCA, Cheung Prey	18 - 30[14]
SCF/EED, Kirivong	25 – 33[15]

[12] After the scheme changed to fully performance based incentives health center staff earned slightly more, while hospital staff experienced a reduction of their income.
[13] Due to the performance based system incentive payments are currently in the range from US$80 - US$200.
[14] These increased to US$40 - US$100 from the 4th quarter of 2001.
[15] From the fourth quarter 2001, these increased to $40 - $80 due to introduction of user fee scheme at all facilities.

Table 4. Average range of incentive payments for public health staff

The table shows that the **CO** projects, the **HFS, the New Deal, Caritas** and the CI project in **Pereang** were able to pay living wages to the public health workers. These NGOs were of the strong opinion that a fair income for staff is the basis for providing quality services. Funding of these incentives were directly through the contractors' budget (CO), provided through external assistance from the NGO (HFS, New Deal and Caritas) or a combination of these (Pereang). The HFS, New Deal, Pereang and Caritas also allocated part of the income generated through user fees for incentive payments[16].

The remaining two **CI** projects did not put external money in the project. Their principle was not to supplement the lack of funds from the PHD with their own resources. Since these two contractors also opted for a late start of the health-financing scheme, income from user fees was also not available. As a result the incentive payments to staff had to come through the budget supplement (US$0.25 per capita) and was consequently much lower[17]. To supplement these low incentives, private practice was not prohibited and, as indicated before, health centers were only open during morning time.

5.2.4 Analysis of NGO's experiences with incentive payments

All NGOs stressed the importance of providing incentive payments to public health staff. Due to the very low government salaries, provision of incentives was regarded as a very successful and necessary condition in order to increase utilization and improve the quality of care at public health facilities. The NGO experiences also showed that, if feasible, staff should be paid incentives equal to a living wage in order to eliminate under the table fees and avoid poaching of patients from the public to the private sector. It appeared that in **Cheung Prey** district with low incentive payments and no user fees, informal fees continued (Cuturilo, 2001). The ADB survey reported that in this district most hospital patients were charged informal fees, while an approximate 1/3 of patients at the health centers ended up with paying fees. Similar observations were done at the sub-referral hospital in **Kirivong**.

A factor of concern were the significant differences of incentive payments provided by NGOs within a single province. Both Takeo and Kampong Cham Province have pilot projects were huge varieties of incentive payments are provided. As expected some of the staff in the CI district were jealous and requested to be transferred to CO districts were attractive incentives were paid[18]. This was also a critical issue observed by the PHD director of Takeo (see #7.2).

5.2.5 Overview of performance based incentives

Off all projects under review the **HFS, New Deal, HNI, Caritas and SCA** (Cheung Prey) have performance based incentive systems in place. While the HFS and the New Deal have partly performance based incentives, HNI and Caritas have established incentive schemes that are fully depending on output. The HFS and New Deal have fixed components of awarding incentives, which are awarded when internal rules are adhered. At Caritas and HNI no fixed payments are provided but depending on output indicators incentives are awarded. In Cheung

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Note. Regular government salaries in the range of US$10-15 were provided on top of these incentives. These government salaries were, however, not provided in the CO districts Ang Roka and Memot.

[16] The remaining districts recently introduced user fees and presently also generate additional income for incentive payments.

[17] The additional incentives payments paid later by SCA in Cheung Prey came from outside the budget supplement but, in contrary to HNI, within the contracting budget.

[18] However, as stated by the OD director Cheung Prey, this seemed not to occur on a large scale. Persons who had a relation with the area (land, family, private practice etc.) did not want to move to Memot District.

Prey incentives provision are based on service quality, service performance and, recently on ethical practices. In practice, however this system has limited impact since incentives have up to now fully been awarded to all public health staff.

Another major difference is that incentive provision at hospitals at the **HFS** and **New Deal** are awarded to each health worker on an individual basis, while in Pereang the incentives are provided to the subcontractor (hospital director) who has the full authority to disburse the amount among the hospital staff.

At the **HFS** the criteria for awarding the individual incentives to hospital staff are as follows:
- Individual maximum incentive depending on position and qualification. Public health staff range US$75 - US$250
- Multiplied by 'punctuality' factor (determining 70% of incentive)
- Multiplied by 'quality of performance' factor (determining 30% of incentive; awarded according to evaluation)
- Multiplied by 'global hospital activity' factor (total income received / total income expected that month)

The **New Deal** hospital initially followed a similar approach, with the major difference of setting the maximum monthly bonus level initially at US$50 - US$130, which is significantly lower than at the HFS in Takeo. However, the New Deal developed its system and since May 2001, a newly established Health Financing Committee became responsible for awarding the incentive payments in the hospital, while the former Hospital Management Committee remained responsible for hospital management. The criteria for bonus payments also changed. The most important change was that for the hospital the fixed part of the subsidy was spilt into a fixed and variable part. Furthermore, the 49% of the user fees were doubled by the NGO, while the individual maximum incentives for hospital staff were reduced. This new method increased the variable (or performance related) part, while reducing the fixed part of the incentive payments. As indicated before, this resulted in a significant increase of incentive payments to an average of US$80 - US$200.

It was recognized by the **New Deal** that the health centers have a less hierarchical organization than a hospital. The health centers have limited staff, work already as a team and regard the achievements as a team operation. Therefore, in health centers bonuses were not awarded on the basis of individual evaluations by a committee, but were awarded to the health center as a whole. The monthly maximum bonus the health centers received consisted approximately of US$250[19]. This was split in:
- US$130 - US$150 for fixed bonus payments (with the health center chief receiving US$10 more than the rest of the staff members).
- Doubling the 49% revenues from user fees (approx. between US$50 - US$120)
- 5,000 Riel per referral to the hospital (approx. US$5 - US$10)

At **Caritas** a maximum bonus of US$30 was awarded to each staff member, with an additional US$5 for the chief. This bonus was proportionally reduced if the targets set for preventive and curative care were not achieved. Most of these targets were consistent with the national guidelines, while some were set at a higher level[20]. In addition to this bonus the health facilities with a TB clinic could receive an additional US$10 per staff member if monthly targets for recruiting new TB patients were achieved. Furthermore, one of the Caritas supported health centers ran a large nutrition program and reaching the target set for this program would result in an additional US$8 for each health staff. Finally, 49% of the income through user fees was divided among staff as incentive payments.

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[19] With an average of 5 staff, this resulted in an average of US$50 per health worker.
[20] For example targets related to OPD patients were based on 1 consultancy per inhabitant/year.

In **Pereang** the health facilities (hospital and health centers) receive 80% on top of the revenues from user fees from the NGO. Furthermore, US$0,1 per capita/year was awarded for preventive services according to agreed targets. It is up to the subcontractor to allocate these resources for running costs and staff incentives. Punitive actions are imposed for mismanagement, irrational drug prescription, inconsistencies and misconduct.

5.2.6 ANALYSIS OF NGO'S EXPERIENCES WITH PERFORMANCE-BASED INCENTIVES

5.2.6.1 REFERRAL HOSPITALS

At the **HFS** a major problem with the effective implementation of performance based incentives was that the Hospital Management Committee largely consisted of hospital employees. The reason for this set up was twofold. Firstly, hospital workers are best informed about staff performance. Secondly, this system was thought to be sustainable after the NGO leaves. However, the major difficulty with this system is that it appeared difficult for the committee to sanction their own staff. In particular the bonus related to quality assessment was often subject for debate. Quality aspects were difficult to measure and for this reason easy to contest. In practice bonus payments were largely related to attendance, while the bonus on quality was in most cases fully granted.

At the **New Deal** a similar set up was followed with similar problems. After 1 year experience with the awarding of performance-related bonus it was stated that this system in the hospital was a relative failure (Van Damme et al. 2001). Reason for the difficulties with the performance related incentives was the role of the hospital director. When the majority of committee members agreed on awarding certain bonus payments the hospital director sometimes changed the committee's agreement. As the director, he was entitled to do this.

However, since October 2001 it was agreed that instead of the Hospital Management Committee, the newly created Hospital Financing Committee would be responsible for awarding the performance based incentives. In this new committee the hospital director was not a member. This new approach was set up in order to achieve a fairer distribution of the incentive payments. This diffusion of authority by setting up this committee worked better for some time and bonuses were awarded more on observed performance, including cuts for non-attendance. However, during the Steering Committee in November 2001, the hospital director stated that it was difficult for him to run his hospital without having a stake in awarding the performance based incentives. It was therefore decided that the decision of the Hospital Financing Committee needed the approval of the hospital director. This decision might undermine the positive changes that recently occurred.

In **Pereang** hospital the performance related bonus distribution was also problematic. The problems started after the changes from individual contracts with partly fixed payments to fully performance based incentives. The reason was that the fees generated at the hospital were not sufficient to provide for living wages for all staff members. The major reasons for the limited income from user fees were:

- The hospital had no surgical equipment for which higher fees could be charged.
- User fees were set low.
- The services provided at the hospital were not very attractive to patients since it did not provide for a significant higher level of care than the health centers (competition between the hospital and health centers did indeed exist).
- Too many staff for the numbers of patients; the already small amounts of user fees were divided among many staff members, resulting in a small portion of the cake for each health staff.
- Unwillingness of the hospital director to dismiss his staff in order to increase efficiency.
- Contrary to the health centers, the hospital lacked the promotion systems through community involvement.

Due to the low incentives for hospital staff, some staff members returned to their private practice in order to 'fill the financial gap' between the old scheme, when the hospital staff earned living wages, and the relative new subcontract arrangement.

5.2.6.2 HEALTH CENTERS

Contrary to the hospitals, the performance based incentives worked very well at the health centers. This was expressed by adhering to a 24-hours schedule and better behavior of staff. Together with innovative approaches applied by health staff (see #5.4.3), these leaded towards dramatically increases in utilization rates. While the national average is 0.29 OPD visits per capita/year the health centers supported by MSF, HNI and CARITAS realized averages of >0.5 visits per year.

However, in **Pereang** an area of concern is the correct treatment at the health centers. It appeared that patients arriving at the health center with a minor illness often stay unnecessary for 1 day for which higher fees are charged. Furthermore, unnecessary injections and IV-Fluids are still provided on a large scale. This issue is difficult to address since patients' often request for injections, IV-Fluid and longer treatment, while health center staff are eager to provide these since it increases the total amounts from user fees. To complicate matters further, the public health staff also strongly belief in the provision of injectable medicines and admission of patients, which makes it difficult to change these practices. Although HNI does take action by cutting incentive payments this does not prevent health centers to continue these habits. Very strict enforcement by cancellation of the contract on the basis of incorrect treatment practices was however not considered as the solution, since it was stated by the HNI consultant that it is better to have the unwanted practices carried out in a transparent way in the health facilities, rather than "invisible" at the patients' home under dubious conditions. If all these practices become visible at the first place, necessary regulatory measures, including quality improvement, can be tackled. This approach, where the public health facility partly conducts unnecessary and incorrect practices as are abundant in the private sector, is controversial and open for debate.

One apparent problem, which appeared with the performance based incentives awarded at the **New Deal** health centers, was that no criteria for preventive care were included. This is expected to result in a strong emphasis on curative care in health facilities. Although statistics for preventive care appeared to be satisfactory, the project manager of MSF stated that these are likely to be inflated.

5.3 Monitoring and Evaluation Systems

Instead of the traditional NGO approach of support and training, the NGOs under review presently perform as purchaser of health services. Since they are also held strictly accountable the NGOs are much concerned with the return on its investment. Therefore, monitoring and supervision systems have been developed including not only quality aspects, but also a clearly check for results. NGOs with performance based incentives systems in place have additional requirements regarding monitoring and evaluation and will be analysed first.

5.3.1 OVERVIEW OF MONITORING SYSTEMS OF NGOS

According to the project managers, one pre-condition to successfully implement a performance based incentive system is a well-designed, effective monitoring system with a clear check of output indicators. This is regarded as an absolute necessity in order to make a fair judgement regarding granting or reducing incentive payments.

The monitoring and supervision systems in place for evaluating the performance of staff are different for all NGOs. The **HNI** monitoring checklist was designed for the specific requirements of the project and included both quality indicators, as well as output indicators to measure

performance for curative and preventive care. In addition, spot-checks and sample surveys formed an integral part of the monitoring checklist. Spot-checks were included for four main reasons:

- To identify 'ghost' patients[21].
- To investigate whether the patients received the correct treatment[22].
- To check the prices charged.
- To assess patients' satisfaction.

Sample surveys were conducted in order to ensure that health education, for which there is no incentive, to the communities was provided. The monitoring team consisted of HNI staff coupled with staff from the ODO, while for monitoring the hospitals also senior staff of the former district hospital were part of the monitoring team.

In **Takeo Hospital** and **Sotnikum** OD the elected Hospital Management Committees are responsible for monitoring the performance and quality of hospital staff and awarding the individual bonus payments. However, as discussed before, since October 2001 a separate Health Financing Committee became responsible for monitoring and awarding the bonus to individual staff in the hospital of Sotnikum OD.

In contrary to the hospital the incentive payments at the health centers in **Sotnikum** were awarded on the basis of attendance and not on quality indicators. For monitoring the variable part of the 98% from the user fees, MSF staff always checked the income from user fees and occasionally carried out spot checks. Although registering 'ghost' patients is not lucrative when less than 100% of the user fees are allocated for staff incentives, the spot check were deemed necessary in order to check the treatment practices, prices charged and patients' satisfaction.

Quality monitoring at the health centers in **Sotnikum** was also conducted on regular basis, although incentive payments were not affected by these visits. These monitoring visits were done by two staff members of MSF. They work separately from the supervision team of the ODO staff.

In order to improve the monitoring system at the health centers and hospital in **Sotnikum**, plans are developed to establish two additional committees. One will be responsible for service quality, while the second team will be a management audit team responsible for reporting misconduct (overcharging, not respecting opening hours, patients' satisfaction etc.). The quality improvement team will consist of representatives from the ODO, health facilities and NGO, while the audit team includes one representative of the PHD and two from the NGO. The audit team will report their evaluation findings to the Steering Committee, who will make the final decision of the total financial incentive payments provided to the health facilities and ODO. When the total amount is decided, the Hospital Financing Committee, will remain responsible for distributing the performance related bonus to each individual staff member.

In comparison with the systems mentioned above, the monitoring system of **Caritas** in order to award the performance based incentives is simpler and more straightforward. As indicated before, it is based on performance indicators related to curative and preventive care with a major emphasis on preventive care. Occasionally spot checks were conducted to identify "ghost" patients[23], and more importantly, for checking overcharging, treatment practices and to report patients' satisfaction.

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[21] Since health centers receive more than 100% (180%) of the paid user fees, it is lucrative for the health centers to register additional so-called 'ghost' patients in the source books.

[22] Questions related to treatment were included in order to identify patients that ended up with unnecessary treatment and, consequently, higher bills.

[23] Registration of "ghost" patients could be beneficial to reach the targets, however this potential increase of incentive payments would be countered by the fact that the health staff had to pay for the registration of this "ghost" patient. Therefore, contrary to the HNI approach the benefits for registration "ghost" patiens was very limited.

Apart from monitoring the performance **Caritas** has two staff members (a medical assistant and a secondary midwife) responsible for quality monitoring. The checklist used was designed by Caritas, but was not very comprehensive for good quality monitoring. Similar to Sotnikum, the results of the quality monitoring did not affect the incentive payments. The staff supervisors from Caritas conducted their supervision visits independent from the ODO and even independent from each other. It was stated that it was difficult to supervise the health facilities together with the ODO, since the ODO only visited the remote health facilities once every three months on an irregular basis. Besides the infrequent visits the public health staff also questioned the usefulness of the supervision team of the ODO.

At **SCF/EED** the supervision system initially included two levels of supervision, conducted separately by SCF/EED staff and ODO supervisors in charge of health center activities (EPI, MCH, pharmacy and equipment), focusing on quality aspects and using an internally developed checklist. In case of misbehaviours incentive payments could be affected by these visits.

This approach changed late 2001, when a new manager became responsible for the implementation of the project and the user fee scheme was launched in all health facilities in the district. Since that time a new approach with regard to supervision of health facilities was followed, including more involvement of the ODO and new supervision tools.

SCA took the opportunity to exploit the economies of scale by establishing one monitoring and supervision team for two districts. The purpose of the team was to support the health staff at all levels to improve their performance in caring the people in their district. The checklist designed by SCA also evaluated staff performance and quality, where 70% of the total score was assigned to quality, whereas the remaining 30% was assigned to output indicators[24]. A separate training team was established to improve the skills at the health facilities. This team used the results of the monitoring team in order to work on the reported shortcoming. The team provided not only on-the-job training, but also joint training courses for staff in case scores for particular subjects were lower than expected. Staff from both districts could participate in these training courses. In contrary, to the NGOs with performance-based contracts, SCA did not reduce incentives on the basis of the results of the monitoring and supervision teams.

5.3.2 Analysis of NGO's experiences with monitoring and supervision

The monitoring system developed for **Pereang** appeared to be very fruitful. After a few months of piloting, the staff at the health facilities understood the system, resulting in a reduction of overcharging and an almost elimination of registration of "ghost" patients. Since improving quality of care through on-the-job training goes along with the more auditing role of identifying mismanagement and misconduct, health center staff appreciated the constructive way of monitoring. The ODO is more involved and since they have been assigned clear tasks and responsibilities they certainly are more committed to their work.

The monitoring system for awarding incentive payments of **New Deal** and **Caritas** health centers also worked well. In particular the evaluation form of Caritas was clear and comprehensive. The form was well understood by staff and efforts were made to reach the criteria resulting in higher commitment and improvements of health service delivery.

In conclusion it can be stated that the monitoring systems at health centers for awarding performance-based incentives appear to be very successful. However, at hospitals the establishment of effective systems turned out to be far more problematic. In particular the fact that hospital staff members decide on incentive payment of their own staff heavily relies on commitment, capability and, most important, willingness of fair judgement.

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[24] This was changed in a later stage when equal percentages were assigned to quality and performance indicators.

Besides the monitoring of performance indicators, the effectiveness of monitoring and supervision systems in order to improve the quality of care is not yet clear. While most NGOs invested lots of efforts to improve the quality of care at health centers and hospitals the impact has not yet been fully demonstrated. Although the ADB evaluation reported marked improvements of quality indicators at both hospitals and health centers, these indicators were mainly based on record keeping practices and availability of equipment and staff (ADB Presentation on the Evaluation of Contracting, 2001). It would be extremely interesting to assess the differences of quality of care of the health facilities under review and health facilities without NGO support.

The MoH also has its own monitoring mechanisms in place. The ODO is responsible for monitoring quality and performance at the health facilities by using the Integrated Supervision Checklist. However, it appeared that this system is not very effective due to low commitment of ODO staff and a rather cumbersome checklist. This was addressed by the NGOs by designing their own checklist in order to monitor the health facilities in a more effective way, depending on the specific management arrangements in the district. At provincial level the PHD has also been assigned with monitoring responsibilities. However, similar to the monitoring role of the ODO, the monitoring role of the PHD is currently not very effective. Findings are seldom discussed with the NGOs and follow-up activities are lacking. For the contracting NGOs the PCU complemented the PHD monitoring responsibilities. Although the NGOs generally appreciated the achievements of the PCU, it was stated by some NGOs that their effectiveness was limited since the PCU worked through the existing PHD monitoring system, which was considered as inadequate. Furthermore, feedback of the findings of the PCU to the NGO's could be improved. However, despite the mentioned shortcomings of the PCU monitoring functions, it was generally stated that the PCU was far more involved and committed with monitoring the contracting projects in comparison with the PHD's.

5.4 Human Resource Management and Development

5.4.1 ALLOCATION OF HUMAN RESOURCES

The NGOs under review reported that human resource management has been a critical issue in order to deliver quality services at district level. Concerns were expressed with regard to low commitment of ODO staff, the current unbalanced staff allocation i.e. understaffing in remote districts, while overstaffing at the provincial hospitals, and the very low quality of staff in even basic skills. Furthermore, it was stated by all NGOs that the numbers of secondary midwifes were extremely low, adversely affecting the mother and child health services offered at the health facilities and during outreach activities.

At the start of the project **Takeo hospital** was severely overstaffed. In order to be able to successfully implement the HFS, 55 (28%) staff members had to be transferred. For carrying out this operation the commitment of the PHD to facilitate this restructuring process was an absolute requirement. This was stipulated in the global contract, and resulted in a positive contribution of the PHD.

In the CO district Ang Roka human resource management was the first priority of the NGO. An important measure taken was to increase the staff numbers to 6 staff at each health center. These were all headed by a medical assistant instead of the common secondary or even primary nurses. Medical assistants have a substantial higher education standard and gain more respect of the population and from their own staff. The project manager of **AMDA** stated that this measure significantly contributed towards quality improvement at the health centers, which was also confirmed by the ADB evaluation results (ADB Presentation on the Evaluation of Contracting, 2001).

In CI districts, the NGOs had to work with existing staff, which appeared to be inadequate in both quantity and quality aspects. Although transferring of staff was possible, the mangers found it cumbersome to enforce this transfer. Hiring and firing needed the approval of PHD and was even more difficult to realize. In order to partly overcome the staffing problems, the NGOs working in CI districts recruited some temporary staff members. However, the budget was not sufficient to recruit the required numbers of qualified staff as deemed necessary.

In **Pereang** OD the chief of the health facility in the role of subcontractor is currently responsible for staff management and may, after screening by the NGO, recruit additional non-MoH staff. In practice most health centers recruited 1 or 2 additional staff members, mostly qualified retired health staff or staff without medical training for non-medical tasks (cleaner, guard etc.). Although firing existing MoH staff was not possible the subcontractor may or may not include staff members in the incentive scheme.

In **New Deal** and **Caritas** supported health centers, the NGO did not have any authority over staff numbers. Although at New Deal it was advised to increase the number of nurses at the hospital, the hospital management became very reluctant to this proposal.

Limited staff was also an issue when NGOs started 24 hours service. Shortage of staff seemed to be most problematic in **Kirivong** where the average numbers of staff per health center was with 3.7 the lowest of all areas. It was stated that this is certainly not sufficient to offer 24 hours service. In this respect it is interested to note that AMDA who recently started 24 hours service feel that even with 6 staff members per health center a 24 hours schedule is difficult to implement.

5.4.2 OVERVIEW OF HUMAN RESOURCE DEVELOPMENT

When the NGOs started working in the district, organizational structures to efficiently manage the district health facilities were virtually non-existent. To set up these structures, which included, amongst others, establishing district management teams and regular meetings with health center and hospital staff, was considered of major importance by all NGOs. Due to these efforts all districts have now the structures in place that are necessary for managing the district. With these structures in place a start could be made with further improvements of the capacity at the ODO, health centers and referral hospitals. Different concepts were used by the NGOs in order to build this capacity. It appeared that negotiation, training and creating an environment of accountability and transparency were regarded as the most important components to built capacity.

SCA started with a focus on training of district health staff. For these activities SCA had different training teams in place in order to improve the skills of staff in the hospital and the health centers. In addition to public health staff, formal training sessions were also organized to improve the skills of community health workers and TBA's. Building capacity with the ODO was also regarded as a priority. The SCA approach was to strengthen the existing ODO by coupling staff members from SCA with ODO staff for all daily operational management activities. This counterpart system was aimed to transfer knowledge and skills in an effective way.

For the capacity building process **HNI** focused on creating an environment of accountability and transparency. This was realized by providing all district health staff, including the ODO, with a subcontract. The responsibilities were stipulated in a contract between the contractor and the subcontractors. For the ODO these responsibilities were related to organizational management and monitoring & supervision activities, for which they received 15% of the total income from

user fees at the health facilities[25]. Similar to the SCA approach, staff from the ODO was coupled with HNI staff during these monitoring and supervision visits. However, in contrary to the other NGOs, HNI's main focus with regard to the development of human resources were the health centers and not the ODO.

Probably the NGOs that put most efforts in the capacity building process of the ODO were **AMDA**, the **HFS** and the **New Deal**. All these NGOs put a major emphasis on negotiation. AMDA's approach was that through this process of negotiation the sense of ownership and the level of commitment of the ODO staff would increase, resulting in better management of the health services in the district. Increased responsibilities were given to the local district management, while for major issues a committee was set up with all relevant stakeholders involved, i.e. representatives of the ODO, hospital, and health center staff. Major changes had to have the approval from the majority of this committee, through a voting process. For example, the setting of user fees was done by the committee, without interference of AMDA. Although as being the contractor AMDA could, if deemed necessary, overrule the decision in practice this was so far not necessary.

The **HFS** and **New Deal** also put major emphasis on the process of negotiation, and extended this approach by including representatives of MoH (national, provincial and district level) and several government administrations (MoEF, provincial governor, district governor). The Steering Committee at the New Deal is probably Cambodia's most far-reaching experiment with involving all relevant stakeholders in the decision making process of a single OD. Development of human resources of the ODO in Sotnikum comprised of major technical assistance inputs of the Steering Committee together with financial inputs. The technical assistance was related to management and supervision activities, while financial input was through external subsidy of MSF and the provision of "indirect" user fees, i.e. 5% of the user fees of the health facilities were provided to the ODO in exchange for access to the government budget, supplies and coordination and quality supervision. However, regarding supervision activities it appeared that staff from the ODO did not work together with MSF staff.

In addition to NGO's activities to develop the human resources, the **PHD** as the responsible authority for staff development in the province also provided training courses focusing on national guidelines, protocols and MPA/CPA modules. However, the efficiency and effectiveness of these courses were not always appreciated by the NGOs. Training courses were often announced no longer than 1 day in advance and often attended by management staff for which the course was not intended[26]. Finally, the usefulness and quality of these courses was also debated by the NGOs. Therefore, it was suggested by the NGOs to better coordinate training courses for public health staff, organized at provincial level, with the ongoing operational activities in the field.

5.4.3 Analysis of NGO's experiences with human resource development

The NGOs put a lot of efforts in training and support, however its impact is difficult to assess. Certainly skills of the district health workers improved but since it is difficult to change habits, it appeared to be a slow process. Reasons mentioned were numerous and included: reluctance to change, low level of even basic skills, divergence with self-interest, poor commitment to establish good relations with the patients etc.

The counterpart system from **SCA** seemed to work well in particular because it kept the original structure of the ODO in place. Decision making by the ODO was also encouraged and gradually more responsibilities beyond reporting and distributing resources were assigned to the ODO.

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[25] This approach appeared to have operational difficulties since the income from ODO staff was directly related with the income generation through user fees at health facilities. ODO staff were therefore reluctant to report misconduct at the health facilities. To address this issue a change of the incentive concept for ODO staff is in preparation.
[26] ODO directors attended courses meant for EPI staff etc.

One initiative from the ODO of Cheung Prey was to set up a health post within the catchment area of one health center. Since the catchment area of this health center was too large and, moreover, difficult to access many people were restricted in accessing the public health facility.

In **Pereang** the focus on transfer of responsibilities to health facilities also lead towards innovative solutions initiated by the staff of the health facilities. Health staff from the hospital and health centers were inventive with creating their own referral system, whereby the hospital pays the health center a small amount of money for each referred patient. In addition, health center staff actively recruited staff, in particular retired public health workers, who are well known and respected by the communities. Furthermore, TBA's received a financial contribution from the health centers by referring patients for deliveries and community representatives of the Health Center Support Committee received incentives from some health centers for each referred patient with a referral letter.

The experience of **Sotnikum** with regard to the Steering Committee is that although the large majority of staff working in the health facilities showed increased dedication to work, the commitment of key-actors is lagging. This low commitment was expressed by great difficulties to access the government budget, to establish transparency in its management, to recruit qualified nurses, to reorganize the hospital and to develop team-work[27] (Van Damme et al. 2001). Different reasons were mentioned for this lack of commitment of which conflict with self-interest is probably the most important one. Managers of the province, district and hospital are now operating in the spotlights and more accountable for their actions. It is therefore reasonable to assume that the pre-New Deal was more lucrative for them. It can thus be stated that, the New Deal has succeeded to create right incentives mechanisms for all the staff but the managers (Van Damme et al. 2001). As discussed earlier, the other NGOs had similar experiences with low commitment of higher officials. While for lower qualified staff the appearance of the NGO with its support brought financial benefits, higher qualified staff often saw a reduction of their incomes.

5.5 Health Seeking Behavior/Community Needs

5.5.1 Overview of Community Involvement, Outreach and Referral Systems

5.5.1.1 Community Involvement

Most of the health centers in the districts under review are relatively new and awareness among the population of the health centers and its services provided is still relatively low. Furthermore, the health seeking behavior pattern of the population is focused on injectable medicines and coloured tablets, which are not, or only in limited quantities available in health centers. For these reasons, added with the fact that public health facilities are often not very close to the homes of people, the far majority of people in rural areas use the private sector as the first level of care. Besides private practitioners communities also still strongly belief in traditional healers. An area of concern with regard to services delivered by private practitioners and traditional healers are the frequent use of inferior medicines and the harmful practices conducted by these workers, who often lack a medical background. In contrary, staff at public health facilities are better qualified and fees are significantly lower. Therefore, in order to promote the public health facilities and change the current health seeking behavior pattern of the villagers, active involvement of the communities is seen as an important factor. Since the health centers are meant for the people in the villages their active involvement will lead towards a sense of ownership, further improving the utilization and quality of the public health facilities.

All projects under review have active participation of communities at village level, however the CI and CO pilot projects did not all follow the proposed guidelines for community participation

[27] The previous problems related to access of government budget have been largely addressed, since budget from PAP is currently forthcoming.

consisting of the two-layer structure with Health Center Co-Management Committees (HC-CMC's) and Feedback Committees (FBC's). Feedback Committees were generally established and appreciated[28], while HC-CMC were often not in place, not very effective, or conducted different roles than originally planned. It was felt by some project teams that two different layers at community level was a bit overdone and would result in decreased effectiveness.

Noteworthy are **SCA** and **Caritas** who invested many resources towards the establishment of effective community-based structures.

SCA has set up Health Center Support Committees (HCSC)[29] and Feedback Committees in Memot and Cheung Prey. The FBC members consist of two elected village members, one men and one woman. These are referred to by SCA as Village Health Volunteers (VHV's). The HCSC consist of different respected persons like, village and commune chiefs, schoolteachers, representatives of women affairs etc. The main role of the VHV's is to provide information from the villages to the HCSC, who forward this information to the public health centers during their monthly meetings. This information includes a wide variety of topics like: outbreak of diseases in the village, report of villagers about the health center (behavior of staff, respect of opening timings, availability of medicines etc.), and information on outreach activities. SCA also provided training to HCSC members and VHV's. The committees were supposed to work independently from the health centers and were therefore not paid any incentives. In addition to these committee members, SCA also trained TBA's in the villages, who were selected and classified according to their skills for training. As an incentive for their time invested both VHV's and TBA's were awarded with free health care at the health facilities after the Health Financing Scheme was established.

SCA also took the opportunity to establish sub-projects related to supplementary feeding and malnutrition. Due to this additional capacity, revenues increased to further develop the community structures in the district.

Caritas also put lots of efforts in community participation, with similar roles and responsibilities for the committee members. With regard to community participation it has been a definite advantage that Caritas has been active in the same district for over 6 years, since it takes time to establish trust and good relationships with the communities. Furthermore, Caritas implemented other community related programs in the same district focused on credit schemes and home gardening. Since, health promotion was integrated in these programs increased awareness and involvement of the communities in health was observed.

Similar to SCA, **AMDA** also trained TBA's, however this training focused on referrals of complicated cases to the health centers rather than intensive training courses for safe deliveries. Intensive training of TBA's contain the risk that the training results in too much confidence of TBA's, who will then not refer complicated cases. This training can therefore become counterproductive. Besides promoting referrals AMDA also worked with TBA's in order to request and convince them to send pregnant women to the health centers for antenatal care.

SCF/EED recently started to work with pagoda committees in order to increase awareness about the health center activities, including its newly established user fee scheme. Since pagoda committees have a lot of respect among the population, active participation of the pagodas associated volunteers are expected to increase the trust among the population in public health activities.

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[28] Members of these committees are referred to as Feedback Committee Members. However, various names were used for these community health workers like: Village Health Volunteers, Community Representatives and Village Health Workers.

[29] These are the equivalent of Health Center Co-Management Committees.

5.5.1.2 OUTREACH ACTIVITIES

While **Caritas** and **HNI** awarded incentive payments based on output indicators for preventive services, the other NGOs also had mechanisms in place to ensure that outreach activities were getting the required priority.

SCF/EED's major focus was on outreach activities, since preventive services contribute the most towards reduction of main health indicators, like child and maternal morbidity and mortality. This focus on outreach was expressed by strict adherence to the outreach schedule, emphasis on the complete and right equipment, ensuring that the outreach day is reported to the village chief and the active follow-up to ensure that the village chief did disseminate this information to the villagers.

The other NGOs also stressed the importance of outreach activities. **MSF** was the only NGO, where no criteria for outreach activities were included in the performance based contracts with the health centers. However, as indicated earlier, since this project has not been evaluated it is not clear whether this resulted in the expected focus on curative services with a relative neglect on preventive services.

5.5.1.3 REFERRAL SYSTEMS WITHIN THE PUBLIC HEALTH SECTOR

Referral systems have been put in place by some NGOs, including ambulance services in Memot, Sotnikum and Kirivong district. In addition, the Caritas supported health centers in Siem Reap OD also have permanent ambulance service available, while in Pereang arrangements have been made with local taxi drivers for referral of emergency patients to Phnom Penh.

In order to attract patients local arrangements initiated by staff of the referral hospital of **Pereang** have been set up, including small payments from the hospital to the health center for each correct referral. In **Sotnikum** OD, MSF tries to encourage referrals from the health centers to the hospital by providing 5,000 Riel for each referred patient to the referral hospital. The Takeo hospital also intends to strengthen the referral system through the provision of incentives for correct referrals and improvement of communication with the health centers through radio transmission.

5.5.2 ANALYSIS OF NGO'S EXPERIENCES WITH COMMUNITY INVOLVEMENT, OUTREACH AND REFERRAL SYSTEMS

5.5.2.1 COMMUNITY INVOLVEMENT

It seemed that NGOs who invested time and financial resources in setting up viable community structures also reported a positive impact of these community mechanisms. Structures set up by **SCA** and **Caritas** and the efforts invested in training activities for the committees did result in more involvement of the population at health center level. Furthermore, although still in an initial phase, **SCF/EED** already reported increased health center activities due to the pagoda structures.

The most significant contributions of community structures are probably the increased awareness of the population about the health center building, the opening timings, their roles with regard to setting user fees, problem solving, passing information of the dates for outreach activities etc. A possible next step could be to further improve consumer health and health seeking behavior.

5.5.2.2 OUTREACH

While attention for community participation differed between NGOs, all NGOs acknowledged the importance of preventive services during outreach. Successes for outreach indicators were significant and clearly expressed by the ADB survey results (ADB Presentation on the Evaluation of Contracting, 2001).

One issue with respect to outreach activities is the supply of curative care during outreach sessions. It appeared that apart from MSF in Sotnikum OD all NGOs occasionally conduct outreach consultations in remote villages. Although this is not in line with MoH policy it was felt that in remote areas there was an urgent need for villagers to receive common medicines. The danger, however, is that if applied on a large scale the health center utilization might decrease. Furthermore, consultations during outreach are often chaotic and proper examination is often lacking. **AMDA** tried to address this problem by recruiting a few retired health workers who provide curative and preventive care in remote villages at a permanent place. Furthermore, in **Siem Reap** and **Cheung Prey** OD's, separate health posts were set up in order to provide curative care to the most remote villagers. However, despite these initiatives it was felt by the NGOs that in remote areas curative care during outreach is still necessary in order to avoid that whole villages completely lack access to public health care. A final note on curative outreach consultations is that even in areas with user fees the consultations during outreach appeared to be free of cost. This probably contributed to the chaotic supply of medicines and the lack of proper examination.

5.5.2.3 REFERRAL SYSTEMS

However, despite good initiatives, the numbers of referrals from health centers to referral hospitals are still generally low. Major problems exist with accessibility; roads are often in bad condition and during floods often not accessible at all. Furthermore, health centers are sometimes reluctant to refer patients (Pereang) and, even more frequently patients do not want or cannot afford to travel long distances.

Referrals from referral hospitals to provincial/national hospitals cause even more problems. In **Siem Reap** and **Sotnikum** OD it was stated that the Provincial Hospital was not accessible for the poor since exorbitant fees were charged. Patients from Siem Reap town even travel to the referral hospital in Sotnikum for treatment, as it was observed as cheaper and of better quality. Furthermore, in **Pereang** persons who were referred to government hospitals in Phnom Penh could end up with paying US$100 before getting admitted. Although these issues were brought up many times to higher government officials so far no action has been taken to address these.

5.6 Sustainability

5.6.1 OVERVIEW OF NGO'S TECHNICAL, MANAGERIAL AND FINANCIAL SUSTAINABILITY COMPONENTS

A key issue for all projects is sustainability. Although the contract specifications for the contracting projects did not include indicators for sustainability, NGOs are generally used to work to hand over responsibilities to local actors. Most of the NGOs therefore have in-built strategies in order to increase the potential for sustainability. These in-built strategies used by the NGOs vary tremendously and also focus on different levels viz. ODO, hospital and health center. Some of these in-built sustainability strategies used by the NGOs are:

Caritas: Since Caritas does not have a limited contract period the potential for sustainability has so far not been addressed. However, the fact that Caritas is working for over 6 years with the same health centers in the same district with the same project management and with a major emphasis of continuity of the approaches strongly contributes to commitment and trust of the health center staff. The experiences of income generation through user fees and the performance based incentives added to the potential for sustainability. In addition, a lot of freedom is given to the health centers to manage the health centers in their own way. It was estimated that when the NGO stops the financial contribution a few health centers might sustain their current performance, while others will continue to operate on a lower level.

AMDA: In Ang Roka most efforts were invested with regard to managerial sustainability at ODO level. Major responsibilities have been transferred from the NGO to the ODO. However, since salaries have been set at living wages and user fees were only recently introduced, financial sustainability has still a long way to go. One measure to address the income gap of district health staff, is to collect the income from user fees at AMDA office and distribute these to the health facilities after the projects ends (see #5.2.1). However, as indicated before the district management committee has not approved this proposal yet. A major reason was that staff from the health facilities did not trust the ODO to release the money after the project. This process of joint decision-making by public health staff is perhaps a stronger in-built managerial sustainability measure than the collection and distribution of user fees, which will have only a short-term effect.

SCA, Memot: In Memot the main in-built elements with regard to managerial and technical sustainability consist of capacity building elements of the ODO together with training health staff and a strong focus on community participation. Similar to AMDA high incentive payments are awarded to district health staff, which implicates that there is a great concern for financial sustainability. This concern is even stronger in Memot since many of the staff members have been recruited from outside the district. It is feared that most of the staff will return to their former places if the staff salaries will decrease to "normal" government standards. To erode the sustainability prospects even further, district health staff in CO projects have all taken four-years leave from the civil service. This one-time leave permission from the civil service comes to an end for most of the recruited public health staff. The health staff is therefore not only expected, but probably also required to return to their former positions if they want to remain public health workers.

SCF/EED and SCA, Cheung Prey: Salary incentives in these districts are set lower and health center staff have the possibility to work in their private practice in the afternoons/evenings. Although this could implicate that public health workers are less dependent on their financial incentives, sustainability in these districts was also a major point of concern. The ODO Director of Cheung Prey stressed that the whole system might collapse when no alternatives are available when the NGO leaves. He emphasized that most patients visit the health facilities during the morning hours. Therefore, without the strong presence of a supervision system and additional payments, the public health staff workers might devote much more time to private business than they currently do. Furthermore, he stressed that the managerial capacities at OD level are not yet at the level to take over all responsibilities from the NGO.

New Deal: At Sotnikum District concerns about sustainability were also expressed. Financial, managerial and in particular technical sustainability are not expected to be achieved in the near future. Although the New Deal put a major focus on technical sustainability through the input of a relative large number of expatriates, it appeared that this did not achieve the desired results. Although the technical capacity of nurses did improve the performance of other hospital staff remained below expectation.

The Steering Committee with its large input of technical assistance on national level seemed to have achieved its objectives of: i) getting commitment from the stakeholders; ii) monitoring the progress; iii) establishing a platform for sharing information and; iv) creating a sense of ownership of the project. However, this approach seems neither sustainable nor replicable due to the limited amount of time of the higher officials and the relative high costs involved.

HNI: It is doubtful whether the recently started active involvement of ODO staff will be continued at the same level when HNI pulls out. A higher degree of sustainability is expected at health center level since these operate as more or less independent bodies. However, since salaries are still for a large part dependent of the NGOs' financial assistance it is not expected that the health centers will maintain the same level of activity. Furthermore, it is feared that without a strong external monitoring system the public health facilities will act as the place where private

practice methods will be applied. Therefore, while conditions for managerial sustainability at health center level are promising, financial sustainability and in particular technical sustainability are areas of great concern.

HFS: The Takeo hospital is a major test case with regard to sustainability. Since May 2001 the SRC stopped the external technical assistance and financial input[30] and handed over all major responsibilities to the Hospital Management Committee. After 6 months "standing on their own feet" it appeared that financial sustainability at the hospital is eroding. Over the last 4 months only an average of 75% of the maximum incentive payments could be awarded. Although part of the reason for "lowering the ceiling" of maximum incentive payments is the missing of funds from the SRC, a major part of the current problems are related to a further reduction of funds from the PHD. It appeared that after the strong external "pressure" from the SRC, the PHD "relaxed" its commitments, which made the process for HFS to "stand on their own feet" very difficult. Due to the smaller amounts for incentive payments, the whole performance based incentives scheme is difficult to maintain. It was stated by the hospital director that it is very difficult to justify further reduction of payments based on performance when the total amounts received are merely 75% of the previous amounts. It was observed that, due to this reduction of incentive payments staff were less motivated and some did not respect the opening hours any longer. The director also stated that staff members will devote more time to their private practice if this situation is prolonged over a longer period. In order to tackle this situation it was not considered effective to stress the PHD to adhere to the "global contract". Instead, the hospital tries to focus on increased utilization of the hospital. An additional operating theatre is under construction and more emphasis is put towards setting up a referral system and promoting the hospital services in remote villages. In addition, the establishment of user fees are reconsidered and set in a way that is expected to bring the highest return. This included increase of fees for well-running services like surgery, while prices for paediatrics services were decreased due to its relative low utilization.

5.6.2 Analysis of NGO's experiences with technical, managerial and financial sustainability

In conclusion it can be stated that the NGOs have so far not achieved technical, managerial and financial sustainability.

Technical Sustainability: NGOs expressed their disappointment in the achievements on technical level. Although all NGOs have devoted much time towards training, supervision and other activities in order to increase the quality of care, staff quality remains low. It appeared to be extremely difficult to transfer practical knowledge to the public health staff workers, particularly because basic skills are very limited. Skills have certainly improved, but the level of improvements were below expectations.

Managerial Sustainability: Sustainability at managerial level is presently also still inadequate. Due to various reasons like understaffing, low skills and limited commitment, the NGOs do not expect that the ODO's are currently capable to run the district with the same level of output. The ODO director of Cheung Prey expressed the same concern. Managerial capacities at health center level seems more promising, however support remains necessary in particular in the PAP districts in order to assist the health centers in getting access to the PAP budget.

Financial Sustainability: Financial Sustainability is however the greatest concern since without financial sustainability, technical and managerial sustainability are also difficult, if not impossible, to reach. None of the NGOs expected that the health facilities are capable to sustain the current level of income through user fees and government budget alone. NGOs

[30] Although a relative small amount of US$1000 is still contributed by the SRC to support the equity fund.

therefore expressed their concern that all efforts invested in setting up the whole system might erode, or at best sustain at a level of an approximate 2/3 of current performance.

Much of the successfulness of the contracting districts therefore depend on the political sustainability i.e. the will and commitment of higher level authorities to continue supporting the systems and favour its development until district health facilities, ODO's and PHD's feel confident to sustain their performance without external support.

Chapter VI: Experiences of PHD's regarding contracting and similar experiences

Besides the implementing agencies, the opinions of the different PHD's, responsible for managing all OD's in the district were also addressed. It was considered as important to assess the opinions and experiences of the PHD directors with regard to contracting and similar experiences in order to be able to analyse possible future strategies regarding health sector developments.

Although the PHD's were involved in the design stages of the contracting component of the Basic Health Services Project they apparently mainly took it as another experiment without giving it much priority. Commitment further decreased when it appeared that the contracting districts were actually challenging the capabilities of the PHD's. At CO districts the PHD did not have the resources to exert control. Probably this was the reason that the relations with the NGOs implementing CO were considered as neutral. However, at the CI districts the PHD had the final authority over staff and, in addition, controlled the disbursements of financial and material resources, including drugs. It was observed that the PHD's used this influence in a counterproductive rather than supportive way.

The PHD director of Takeo stated that he gave priority to the Takeo hospital above the CI project in Kirivong. He indicated that a good running provincial hospital is an absolute must, and for this reason he contributed most resources towards this project. The fact that a global contract was signed at the start of the project, which included the active participation of the PHD certainly contributed to this initial higher involvement. This involvement was expressed by an active participation of the PHD regarding staff reduction requirements at the provincial hospital. According to the PHD director another reason for not closely cooperating with the CI district was that the management style of the contractor was not in line with Cambodian culture. Since the PHD had more influence over Bati control district, many efforts were invested to develop the health services in this district. In particular he mentioned his direct involvement of staff management, including the replacement of the hospital director and ODO chief. Since this process was only completed in July 2000 he felt extremely proud of the ADB survey results achieved in Bati. It was stressed that these results were achieved in only a 1-year period and did not significantly differ from the results of the CI and CO projects. He therefore suggested that all districts should receive a budget supplement of US$0.25 per capita. However, the PHD director did acknowledge the success of the contracting experiences and suggested that it could be continued. It was his suggestion to have Cambodian contractors managing a few operational districts according to the CI formula as to ensure that the PHD could exert influence over staff management. He stated that limited contracting would be very useful, since the PHD does currently not have the capacity to affectively run all operational districts. In this regard he mentioned that the health facilities in Donkeo district were still running on very low level, since the PHD focused their activities at the Takeo Hospital[31]. With regard to boosting the PHD director of Takeo stated that he did not know the details, but stressed again that if implemented, Cambodian contractors should be involved. Finally, he pointed out that whatever system would be implemented it should have a similar budget for staff incentives, since the current wide range of staff incentives negatively affect staff motivation. In addition, these discrepancies in incentives made his job to allocate staff in an efficient way very difficult.

Contrary to the rather gloomy experiences of the Takeo PHD with contracting, the PHD of Siem Reap was proud to have 9 NGOs working in his district to develop the health services. Despite these large numbers he felt that the PHD had strict control over the health activities and

[31] However, as indicated earlier, financial disbursement from the PHD to the Takeo Provincial Hospital significantly decreased. It was stated by the PHD that this was mainly due to the budget of MoEF/MoH, which was not being disbursed to provincial level.

stressed that all NGOs had to follow the guidelines set by the MoH. He appreciated the working relations with the New Deal and Caritas. He indicated that the Steering Committee set up at the New Deal was valuable, in particular because participants from the MoEF were present to explain how to get access to the PAP budget. He pointed out that receiving and distributing the available PAP budget was one of his priorities. In order to increase the access to this budget he actively follows up the proposals submitted by the OD's, which are often not in line with the required format. This lack of capacity at OD level was also observed in other activities, like health center supervision. He quoted the example of Siem Reap OD, having 27 health centers, which makes it difficult to supervise by the ODO on a monthly basis. Furthermore, the PHD director stressed that a flexible, pro-active attitude of the PHD was necessary and therefore, if considered useful, new developments were approved and implemented. In this respect he allowed having emergency admissions in the most remote areas of the Caritas supported health centers, although this was against the opinion of the Provincial Health Advisor. Furthermore, he approved the TB clinics at the Caritas supported health facilities and also approved the construction of health posts in remote areas. Similar to the PHD director in Takeo, the PHD director mentioned that the capacity at his department was limited. Health staff worked as accountants, for which they did not have the required skills. For this reason he appreciated the NGO input, which significantly contributed to the rapid developments in the public health sector in the province.

The discussions with the PHD directors revealed that the capacity at the PHD to manage all OD's in the provinces is currently inadequate. Therefore, it is recommended to further strengthen the capacity at the PHD. This capacity building process should of course match the future role that the PHD will perform. Furthermore, the experiences of the PHD directors showed that their commitment towards the CI and CO experiences have been neutral for the CO, while counterproductive for the CI districts. In Siem Reap where the PHD director retained control over all the OD's, the working relations with NGOs was far more constructive. This might indicate that a clear stake for the PHD is important and does create a sense of ownership. This preliminary conclusion should be taken with caution since it is based on only a few experiences. It might also be just the level of goodwill of the higher authorities that makes the difference. However, it is evident that in order to increase the commitment at PHD level a clear stake should be assigned to them. This stake should preferably include clearly defined roles and responsibilities.

Chapter VII: Desired future directions as expressed by the different stakeholders

7.1 NGOs under Review

The contracting NGOs pointed out that the current CI system is not workable and need to be revised considerably. All three NGOs currently implementing the CI approach stated that they will not continue to work under the current rules and regulations of CI. The ADB evaluation also pointed towards major flaws in the present design of the CI approach. Specific flaws included: i) The contractor has management responsibility of health workers, but these are not employed or paid by the contractor; ii) Contractor management budget relying solely on MoH and; iii) Expectation that contractors between two levels of MoH civil service could wield effective management authority. These flaws were a major reason why the CO projects were more successful in service delivery in comparison with CI (ADB Presentation on the Evaluation of Contracting, 2001).

The CO approach was much more promising. The NGOs stated that the CO approach was very successful and should be implemented on a larger scale. The relative large freedom for the contractors to manage the district, including staff and financial management resulted in a rapid increase of utilization of health services. Furthermore, the CO approach had the support of the staff working in the district who were willing to work under stricter rules and regulations in exchange for living wages. However, some adjustments are recommended by the NGOs to improve the efficiency of the CO approach. Suggested adjustments included the provision of funds for medical equipment procurement by the contractor (instead of relying on the MoH) and an improved system of purchasing drugs.

MSF did not want to enter into contracting and followed an approach more related to the existing MoH structures. Although not as spectacular as CO, results have been dramatic without much distortion of the current MoH system. The major disappointment was related to the pace of developing the technical capacity of the health facilities. In particular the low commitment of high qualified staff was disappointing, despite the provision of good incentives. However, despite this constraint achievements have been tremendous and continuation of the New Deal was desired.

The long-term experiences of Caritas in building relationships with the health center staff following a more traditional NGO approach were considered as successful by the project manager. She expressed that this approach should also be prolonged alongside the possible new strategies of developing the Cambodian public health sector.

The HFS expressed their concerns about the future, since the approved regular funds from the government were decreasing. For this reason, it was heavily emphasized that all funds from the government, allocated for the Provincial Hospital should be disbursed in time in order to continue the provision of high quality services.

7.2 Provincial Health Departments

PHD's were in general not very pleased with the CI and CO experiences. They lost control over the district and felt challenged by the contractors due to the relative success of the contracting experiences. A higher stake for the PHD's was desired, which will probably result in a higher commitment as the experience in Siem Reap showed. However, the PHD's were aware of their limitations to manage all districts and therefore requested to have technical assistance from outside. Furthermore, they expressed their concern over the different salary levels of public health staff, which makes it difficult for them to manage the human resources in the provinces in

an effective way. Concerns with regard to communication with foreign district managers were also expressed, although these concerns were limited to the CI districts.

Despite these concerns, PHD directors seemed to welcome future changes in the health sector. These future strategies should prioritise an increase of salary levels of public health staff throughout the province. Furthermore, if the future strategy would heavily depend on contracting it was preferred to have local NGOs responsible for the contracts. The Boosting Strategy was also considered as a viable option, but only when the precondition of increased salaries for public health staff was met.

7.3 Central Ministry of Health / World Health Organization

Apart form the contracting strategy, the MoH in cooperation with the WHO, have developed another strategy to improve the public health services in Cambodia. The approach is referred to as the Boosting Strategy. This strategy is proposed to operate within the public sector and is aimed to develop a viable public health sector that provides quality health services at a reasonable cost and to improve the health and well-being of the people of Cambodia, especially the poor. The Boosting Strategy was developed since it was observed that four key obstacles were responsible for the low quality and utilization of public health services. These are: i) Insufficient funds for running costs and salaries; ii) Lack of sufficiently trained and motivated staff; iii) lack of accountability for financial and staff management, and; iv) poor consumer knowledge of appropriate health care seeking practices.

The Boosting Strategy is expected to address these obstacles by means of the introduction of contractual relationships within the public health sector. Three main annual contracts are envisaged viz.

1) The MoH will contract with the PHD for an achievement of improved district health services. As a financer and purchaser of PHD services, the MoH will monitor the PHD performance and take necessary actions to ensure successful implementation of the contract.
2) The PHD will subcontract with each OD, for achievement of the specific milestones and targets agreed to in the contract with the MoH. As a purchaser of OD services, the PHD will monitor the performance of each OD.
3) Each OD will sign performance based contracts with all health facilities (referral hospital and health centers) included in the Boosting Strategy. The PHD will assist OD's in developing performance based contracts and will need to approve individual contracts between OD and health facilities. The OD will monitor the performance of the health facilities.

In addition to these contractual relationships, three core conditions are proposed that should be met for success to be achieved. These core conditions are: 1) Adequate human and financial resources are available at the service delivery level to achieve the desired outcomes. 2) Human and financial resources are managed in an effective and transparent manner. Managers and workers are held accountable for performance through contractual agreements. 3) Demand-side initiatives are in place.

Similar to the NGO's experiences reviewed so far, the Boosting Strategy also stressed the need for increased salaries of public health staff. With the current plans of public sector developments it is anticipated that within a five years period the fixed salaries of staff working in the public sector staff will increase to an average US$48. This amount will consist of a US$36 basic payment supplemented with allowances of US$12. In addition, special allowances for night duty, outreach activities, working in remote areas and abolishment of private practice will be awarded on top of these. Finally, part of the income from user fees will be allocated to staff

salaries. It is expected that these average monthly payments for public health staff will commit the health staff to work and deliver quality care in the public health sector.

It was stated by the Team Leader of the Health Sector Reform project that although the Boosting Strategy will involve higher risks in comparison with contracting, it is far more acceptable for the government, since the system works within the existing public health sector system. The Boosting Strategy has clear commitment to support its implementation within the Royal Government of Cambodia as expressed by the Council of Ministers and the Ministry of Economics and Finance[32]. The Team Leader of the Health Sector Reform regarded this commitment for the Boosting Strategy as a key advantage. With regard to contracting, the Team Leader expressed his concerns about the fact that contractors do currently not have any responsibilities with regard to capacity building and an appropriate exit strategy. It was stated that if these two issues were addressed, contracting could co-exist with the Boosting Strategy. In provinces with poor health indicators and low capacity of the ODO's a form of contracting, preferably CO with capacity building and sustainability elements, could be implemented. In provinces with enough capacity, strong leadership and goodwill the Boosting Strategy was recommended.

Several NGOs expressed their concern about the Boosting Strategy. They stated that since the whole system operates within the current government authorities, one cannot speak of a *contracting systems* but rather of *agreements*. Since agreements depend on the goodwill of people major improvements are not expected through this strategy. Unless a clear accountable system, together with an independent effective monitoring body with enforcement capacities is in place, major improvements in health service delivery through the Boosting Strategy are not expected. Besides the NGOs, the OD director of Cheung Prey also expected difficulties when implementing the Boosting Strategy. He stated that this system is similar to the existing CI project with additional salary supplements. This means that for developing the district health services one still has to rely on the goodwill of higher government authorities. It was therefore feared that the Boosting Strategy would fail since it would face similar problems as the current CI approach even without the inputs of external management.

7.4 Project Coordination Unit

The CI and CO pilot projects were initiated since it was expected that the delivery of quality health services could better and more efficiently be carried out by private providers who were held strictly accountable for their performance. Although at the start most of the stakeholders expected improved service delivery, major doubts were expressed regarding the cost-effectiveness of the system. These doubts were removed after the ADB survey, which proofed that contracting health services resulted in a significant reduction of out-of-pocket expenditures and was therefore indeed cost-effective (ADB Presentation on the Evaluation of Contracting, 2001).

The PCU, involved in close monitoring of the contracting projects, observed that although all contractors applied different methods, they were all successful in achieving marked improvements in service delivery. For this reason the PCU strongly beliefs in contracting as the way forward. The PCU also recognized the difficulties with the CI system and therefore strongly recommends the CO model. The liaison officer of the PCU stated that ideally the whole country should be contracted out. It was specifically recommended to combine the CO strategy with a ban of private practice of public health staff in order to avoid conflict of interest. This ban was considered important, since it was observed from the monitoring visits that "poaching" of patients did still take place in districts without an effective ban of private practice, eventually resulting in higher out-of-pocket expenditures by the population.

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[32] Commitment to the Boosting Strategy of higher government officials might also be partly related to the fact that the Boosting Strategy will be implemented through grants instead of loans.

The desired future CO districts could work with the existing ODO as counterpart. By working alongside the contractor the capacity of the people within the ODO would be improved in an effective way, since only the people who are willing and committed to learn will profit from the contractors' presence. It was stated that forcing people to learn through pre-imposed capacity building elements would never bring any results.

The role of the PHD in this process of full contracting is crucial in particular with regard to monitoring the implementation of the contracts. Furthermore, the PHD's have an important role to play in quality improvement and technical supervision.

The PCU did not express much confidence in the Boosting Strategy since in this system the contracts remain in one system i.e. the government system. It was feared that since government staff are supposed to monitor government staff the Boosting Strategy will lack a comprehensive accountability system, including mechanisms to take action against not performing of (high ranking) government officials.

7.5 Pre-conditions which need to be fulfilled for successful implementation of a health contracting or similar project

After having presented the experiences and desired future directions of all stakeholders the following seven points have been identified as pre-conditions which should be met for future health interventions to become successful.

1) Decentralization of decision making.
2) Accountability of all actors (PHD, ODO, contractor, health facilities), including access to budget.
3) Effective monitoring system for all actors in place, including enforcement.
4) Performance based contracts for health facilities, OD's and PHD's on the basis of living wage incentive payments.
5) Continuity of activities.
6) The provision of TA at both PHD, ODO and health facility level, including demand related activities.
7) User Fees at health facilities.

1) Decentralization of decision making is necessary as situations are different from one province to another, one district to another and also varies within districts. More autonomy has proven to increase effective and efficient health sector development.
Clear boundaries should be established for each actor (PHD, OD, NGO/contractor, health facilities). Within these general boundaries a fair degree of autonomy should be given to each actor, to anticipate on local circumstances and to give each actor opportunities to develop innovative approaches and creating a sense of ownership.

The following issues should be more decentralized: purchasing of drugs, purchasing medical equipment, allocation and recruiting staff, budget distribution at health center level (more flexibility in the 50%-49%-1% rule), flexibility for OD's to allow for emergency admissions and TB clinics at remote health centers etc.

2) Strict accountability mechanisms should go along with the increased flexibility of each actor. Comprehensive and clear ToR's should be developed for PHD's and OD's in order to clearly identify their roles, responsibilities and expected achievements. Targets should explicitly be included in the contracts and these should be realistic. Commitment of financial disbursement should be part of the responsibilities of the PHD's and OD's.

3) Effective monitoring systems should be in place to control the quality and performance of the public health facilities, OD's and PHD's. Monitoring should preferably be done by independent, external actors. The team responsible for monitoring should consist of highly qualified persons and should preferably awarded with decent salaries. The responsibilities of the monitoring teams should include sanctions if not performing or when mismanagement or misconduct is observed. These sanctions should preferably include the right to dismiss (higher) government officials who do not perform. This is particularly relevant with relation to financial disbursement issues, since access to budget is a necessary but not sufficient condition for successful future health (contracting) implementation.

4) Performance based contracts for health facilities, OD's and PHD's. Contracts for all these actors should be established and related to performance. When performing at or above the expected standard this should result in living wage payments. Providing living wage incentives is a necessary but not sufficient precondition for successful future health (contracting) implementation.

5) Continuity of activities over a longer period (minimal 5 years) with consistent policy has proven to be successful. This also implicates that the contractors' input should consist of an intervention rather than another pilot project.

6) Technical Assistance at health facility, OD and PHD level, since the current capacity of all actors is still insufficient to run the district without assistance. TA could consist of:

TA health facility level:	-) Improve quality of care. Improve basic technical skills of staff. -) Assist health facilities with involvement of communities. This assistance should be specific for the local context.
TA OD level:	-) Assist OD's with the development of performance based incentives for each health facility. -) Assist OD's to develop their managerial skills (accountancy, reporting, drug management etc.)
TA PHD level:	-) Assist PHD's to develop their managerial skills (accountancy etc.)
TA Monitoring:	-) Depending on the composition of the (external) monitoring teams, additional TA input should be addressed.

7) User Fees at health facilities, preferably with schemes to provide free care to the poorest. Through user fees staff become more motivated since incentives are related to patients' numbers. In addition, people perceive that paying for services is related to improvement of quality.

Chapter VIII: Change Agents

The discussions as presented in the previous section showed a wide variety of desired future directions in order to improve utilization and quality of care for the Cambodian people. In order to anticipate on the future directions it is necessary to identify the change agents, responsible for the health sector reforms.

Discussions with various stakeholders at policy level of the health sector reforms in Cambodia revealed that the major change agents are the large multilateral and bilateral donors. These institutions possess the financial resources and the power to design and implement health sector reforms in Cambodia according to their priorities. The influence of the large donors has recently been expressed by the ADB, World Bank and DFID who decided to provide a five-year package US$92 million of loans and grants to the Cambodian Government in order to support the public health services in Cambodia. During the process of designing an effective strategy, the lessons learnt from the contracting and similar experiences are currently being considered. In addition, the opinions of the main stakeholders from the different government levels, in particular central MoH and PHD are heard. However, it goes without saying that despite this consultation process the large donors have the final decision power on how the loan will be spent.

The role of WHO in this change process can be described as a neutral broker. Together with the MoH they have designed the Boosting Strategy and, through the provision of technical advice, were successful to convince the MoH of the effectiveness of this strategy. Although the MoH fully supports the Boosting Strategy, the ministry is still heavily dependent on donor funds. For this reason the large donors have a lot of scope to manoeuvre to invest the money according to their own observations.

The influence of the Provincial Governor as a change agent appears to be limited. Although they have to approve the final proposed strategy they are not heavily involved in the design process of the health sector reforms. When it appears that the Provincial Governor does not approve a certain strategy, efforts initiated from the MoH will try to convince the Governor to finally agree.

Besides the apparent limited role of the Provincial Governor as a change agent in the overall health sector reform process, it also appeared that their role in managing the health sector on provincial level is focused on administrative, financial and staff issues, with very limited technical inputs. The PHD director of Siem Reap stated that for most technical issues that need approval from higher government authorities the Central MoH is consulted directly. The Provincial Government is regarded as an administrative body, which only needs to be informed. Approval from the Provincial Government Department was, however, recently required with regard to the location of additional health posts in Siem Reap OD. The PHD director stated that in case the Provincial Governor would not have approved this request, he would inform the MoH at central level to help solving the issue.

Although the large donors have been identified as the main change agents for health sector reform at policy level further research is necessary to identify the mechanisms for change that take place within Cambodian civil society. These involve not only legal but also political, cultural and interpersonal relationships.

Chapter IX: Considerations for future health contracting by NGOs

The whole concept of contracting health services and the provision of performance based incentives is new for the NGOs under review. It significantly deviates from the traditional approach, where NGOs main role consisted of supporting the existing public health system through training and support of health staff. This shift in focus from the belief in human goodwill and investing in people, towards having management responsibility, and even financial and staff responsibility, has been a major transformation process. This transformation process was not without its difficulties, since a newly adopted working style was necessary in order to achieve the objectives. This style was not always in line with the traditional one. For example, the NGOs had to: i) establish and enforce internal rules; ii) sanction staff who were not performing according to the required standards; iii) complain to higher government authorities regarding the non-commitment of contractual agreements etc.

This radical change of approach, with the NGO working through a loan directed them more towards performing as a private enterprise. This is certainly a big change that needs to be taken into account before stepping into similar projects. It was stated by various project managers of NGOs that a clear vision with regard to contracting health services was lacking at the NGO headquarters. For this reason different expectations existed between the headquarters and the implementers in the field. It is suggested that, in order to avoid different expectations in future, a clear vision could be developed before NGOs start with project implementation.

Chapter X: Conclusions

The findings of the synthesis identify a tremendous variety of approaches used by the NGOs under review. The synthesis also showed that despite the different approaches followed, all NGOs were highly successful in improving the district health services, resulting in dramatic increases in utilization, improved access for the poor and improved quality of care. Therefore, not one single approach can be defined as "The Model" for future intervention. While one approach might work in one district, it might fail in another. To quote one example, while in Pereang and Ang Roka a prohibition of private practice was regarded as high priority, in other districts this was not an issue since relative few private practices were present (Memot and Siem Reap).

Even within a single district similar approaches might have various levels of success. While, in some more developed areas, promotion strategies focusing on competition between public and private sector have been effective, in more remote areas people still have to be convinced of the usefulness of allopathic health services, since they still merely belief in traditional and spiritual healers.

Decentralization of decision-making is therefore the key towards success in health sector development.

Although the synthesis concludes that the approaches regarding improvements of the public health sector heavily depends on local circumstances, more common findings and conclusions of the NGO's experiences are also identified. Some of these that could be considered for future health interventions are:

Health Regulations:

- Full responsibility over the district (CO) is more successful than merely management responsibility (CI). No control over staff management and budget appeared to severely hamper progress in CI districts.
- Operating entirely within the current government system (New Deal and Caritas) did bring results. However, it is very much dependent on the commitment and goodwill of higher government staff.
- A clear stake for the PHD with regard to CO and CI is missing.
- Continuity of activities over a longer period of time in the same district, operating under the same management has proven its success. High turn over rate of NGO management does not bring the necessary trust and confidence for district staff.
- Enforcement of internal management rules (e.g. by cutting incentives or firing staff) is necessary to create the required commitment.
- In areas with abundant private practice a ban has proven to result in increased utilization of public health services.

Health Financing/Management:

- Incentive payments are regarded as the single most important necessary condition to improve service delivery in the public health sector.
- Living wage incentive payments should preferably be awarded to avoid conflict of interests.
- Performance based incentives stimulate health staff to find their own local acceptable innovative solutions and result in further improvement of utilization of health services. At health center level this system works very well. At hospitals the performance based incentives appear to be far more problematic.

- The current wide variety of incentive payments within a single province makes it difficult for the PHD to manage his staff.
- Introduction of user fees is an efficient way to increase staff incentives, while creating a sense of ownership among the health staff. It is acceptable for the population as it increases transparency and reduces under the table fees.
- Equity funds to provide free hospital care for the poor are better options than exemption schemes. The operation of an equity fund by an independent local NGO has been successful.
- Sustainability of equity funds is a major concern. It is strongly suggested that the government also contribute, part of, these funds.
- In very poor districts granting free care to people in health centers is necessary. While the current system of granting exemptions by the health center staff seems not to deter access of the poor, the system at health center level can be improved. Systems with identity cards to identify the poor, or credit schemes implemented at village level might be better alternatives.
- Full decentralization focused at health facility level is successful. However, it needs strong, accountable and external monitoring.

Monitoring and Evaluation Systems:

- A well-designed monitoring system to check output at health facilities is extremely important. Incentive payments should be dependent on these results.
- Relating quality indicators to incentive provisions is problematic, in particular at hospital level.
- Monitoring by ODO using the integrated checklist is currently not very effective. The monitoring activities of the PHD do also not bring the desired results.

Human Resource Management and Development:

- Despite relative high incentive payments, commitment of public health staff remains low. This is in particular true for higher hospital staff and ODO staff.
- Low basic skills of staff is a major concern.
- Training courses provided by the PHD do often not match the requirements at OD level. Coordination needs to be improved.
- Capacity building is related to NGO work. Even when no contractual obligations towards capacity building are made, NGOs will actively involve local partners.
- Building capacity of ODO is difficult to achieve. It depends more on the willingness and commitment of people to work to improve the district health system.
- Posting higher qualified Medical Assistants at health centers does improve the quality of service delivery.

Health Seeking Behavior/Community Needs:

- All NGOs have established structures in order to enhance communities' capacity in heath. Most activities of communities are related to the provision of information to villagers and feedback from the communities to the health centers.
- Members of the Health Center Co-Management Committees have a supporting rather than co-management role.
- Spending sufficient time and financial resources for training and follow-up activities to community health workers, does result in active community involvement and good support.
- Provision of curative care during outreach is justified in remote areas. However, it is suggested to ask fees for these services, in order to avoid disorder and improper examination of patients. Prices charged should be at least similar but preferably a bit above the current health center fees.

Sustainability:

- Although all NGOs have some mechanisms in place to increase the potential for technical, managerial and financial sustainability, none of the current projects seems currently sustainable.

With regard to future directions the management experiences of the NGOs revealed their preferences for CO above CI. NGOs implementing CI experienced large difficulties since they did not have full responsibility over the district. In particular they lacked control over staff and budget. The other NGOs without any management control over the district could achieve results through extensive negotiation processes with government authorities at all levels. These NGOs, however, also felt that more responsibility would have lead towards better results. One note of caution is that NGOs who opt for future contracting should be aware of the change of role from advice and support towards becoming a purchaser of health services, working with a loan.

The desired future directions of the NGOs regarding contracting out of health services were in line with the preferred strategy of the PCU, the responsible monitoring body of the CI and CO projects.

The MoH and WHO are supporting the Boosting Strategy, whereby the MoH, PHD's and OD's are held accountable through contractual arrangements. However, they regarded limited contracting also as a feasible option, whereby due consideration should be given towards capacity building and sustainability components.

Although the number of experiences was limited, it appeared that the PHD directors were most concerned about the current low salaries of health staff. They stated that irrespective the future strategy the salaries should be set at a living wage level in order to be able to properly manage the public health sector in the provinces. Furthermore, PHD's tend to be more committed towards NGOs if the PHD retain full management control over the districts. Finally, the PHD's mentioned that their current capacity is insufficient to manage the whole district without support.

From this synthesis it was observed that the main change agents, responsible for directing the future of the health sector reforms are the large multilateral and bilateral donors. Since Cambodia is still heavily dependent on external financial assistance the directions suggested by the large donors are instrumental for the future developments of Cambodia's health sector. However, the change processes that take place within Cambodian civil society have not been fully addressed and require further research. A thorough understanding of the complex political, cultural and interpersonal relationships in Cambodia is necessary in order to identify the change processes in the health sector at the civil society level.

Annex 2: List of People Met

MoH Officials

Dr. Dy Bun Chhem	Provincial Health Director Siem Reap
Dr. Oum Sokhon	Provincial Health Director Takeo
Mr. Heung Thol	Operational District Director, Cheung Prey
Health Center Chiefs of Siem Reap OD	
Health Center Chiefs of Sotnikum OD	

Project Managers/Coordinators

Ms. Bernadette Glisse	Caritas
Ms. Misha Coleman	SCA
Mr. Kenichi Bamba	AMDA
Dr. Fred Griffiths	HNI
Dr. Prudence Hamade	MSF H/B
Dr. Bart Jacobs	SCF/F-EED
Dr. Hem Sareth	Director (Takeo Hospital)
Dr Chham Samnang	SCA OD Chief counterpart

Medicam's Health Sector Reform Think Tank Members

Mr. Marc Vandenberghe	Director (HNI)
Mr. Laurent Ponta	Director (SCF/F-EED)
Ms. Misha Coleman	Deputy Country Program Manager-Projects (SCA)
Mr. Chukmel Santepheap	Liaison Delegate (Swiss Red Cross)
Dr. Wim van Damme	Medical Coordinator (MSF H/B)
Mr. Jean-François Frys	Executive Director (Medicam)

Other Stakeholders involved in Health Sector Reform

Dr. Henk Bekedam	Team Leader of Health Sector Reform Project (WHO)
Mr. Ross Naylor	Team Leader Basic Health Services Project n°2 (ADB)
Mr. Sao Chhorn	Technical Liaison Officer (PCU, MoH/ADB)
Mr. Joe Martin	Health Budget Advisor (WHO)
Ms. Eva Mysliwiec	Director (CDRI)
Ms. Ann Robins	Program Director (SCF-UK)
Mr. Sok Sovanarith	Executive Director's Assistant (Medicam)
Dr. Sabiena Feenstra	Medical Advisor (HNI)
Dr. Robert Soeters	Consultant Health Economics (HNI)
Dr. Iv Ek Navapol	Health Center Officer (AMDA)
Dr. Maria Corazon Lucia Teoxon	Former Project Manager (AMDA
Dr. Jean-Bernard Bouvier	Former Project Manager (SCF/F-EED)
	Health Promotion Officer (SCA)
	Health Promotion Officer (SCA)