Support to the Health Sector Reform Programme

CAMBODIA

Progress Review
MAIN REPORT

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SUPPORT TO THE HEALTH SECTOR REFORM PROGRAMME CAMBODIA

Progress Review
13 – 30 March 2006

Main Report

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ABBREVIATIONS / ACRONYMS

ADB	Asian Development Bank
AFD	Groupe Agence Française de Développement
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (German Federal Ministry of Economic Cooperation and Development)
CAAFW	Cambodian Association for Assistance to Families and Widows
CHIC	Center for Health Insurance Competence
CIDA	Canadian International Development Agency
CIM	Centre for International Migration and Development
CMDG	Cambodian Millennium Development Goals
COPE	Client-Oriented, Provider-Efficient Services
CPA	Complementary Package of Activities
DED	Deutscher Entwicklungsdienst (German Development Service)
DFID	Department for International Development (of the United Kingdom)
DPHI	Department of Planning and Health Information
EF	Equity Fund
EFQM	European Foundation for Quality Management
GRET	Groupe de Recherche et d'Echanges Technologiques
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH (German Agency for Technical Cooperation)
HAT	Hospital Assessment Tool
HC	Health Centre
HCAT	Health Center Assessment Tool
HEF	Health Equity Fund
HICG	Health Insurance Consultative Group
HIV/AIDS	Human Immuno-Deficiency Virus/Aquired Immune Deficiency Syndrome
HRD	Human Resources Development
HMT	Hospital Management Training
HSMT	Health Service Management Training
HSO	Health Service Organisation
HSP	National Health Sector Strategic Plan 2003 – 2007
HSSP	Health Sector Support Project
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illnesses
ISO	International Organization for Standardization
JAPR	Joint Annual Progress Review
JICA	Japan International Cooperation Agency
KfW	Kreditanstalt für Wiederaufbau (German Development Bank)
MEDICAM	Medical Cambodia (Umbrella Organisation for NGOs)
MD	Medical Doctor
MDG	Millennium Development Goal(s)
MLVT	Ministry of Labour and Vocational Training
MoH	Ministry of Health

MOSA	Ministry of Social Affairs
MPA	Minimum Package of Activities
MPH	Master in Public Health
NCHP	National Centre for Health Promotion
NGO	Nongovernmental Organisation
NIPH	National Institute of Public Health
NSSF	National Social Security Fund
OBA	Output-Based Aid
OD	Operational District
OPD	Out-patient Department
PBCI	Provider Behaviour Change Intervention
PHD	Provincial Health Department
PPM	Programme Planning Matrix
PPMRH	Phnom Penh Municipal Referral Hospital
PPR	Project Progress Review
PSI/C	Population Services International Cambodia
QA	Quality Assurance
QI	Quality Improvement
QIWG	Quality Improvement Working Group
QM	Quality Management
RDP	Rural Development Programme
RGC	Royal Government of Cambodia
RTC	Regional Training Centre
SEAMEO	South East Asian Ministers of Education Organisation
SHI	Social Health Insurance
SHSR-P	Support to the Health Sector Reform Programme
SKY	*"Sokapheap Kroussat Yeugn"* (Khmer for: Health for our Families)
SOP	Standard Operating Procedures
SQHN	Sun Quality Health Network
SWiM	Sector-wide Management
TROPMED	Tropical Medicine
TWG	Technical Work Group
UCLA	University of California Los Angeles
UHS	University of Health Sciences (Phnom Penh)
UNFPA	United Nations Population Fund
UNSW	University of New South Wales (Australia)
URC	University Research Co
USAID	United States Agency for International Development
USG	Urban Sector Group
WB	The World Bank
WHO	World Health Organization

0. SUMMARY OF FINDINGS AND RECOMMENDATIONS

(A) FINDINGS

Framework Conditions

Although there have been notable improvements in the health of the Cambodian population over the last decade, key health indicators in Cambodia are behind those in the Asia and Pacific region.

Gender Aspects

Access to health services remains more difficult for women than for men, especially in rural areas.

Development Strategy

Within the context of the national development plan, MoH has developed the Health Sector Strategic Plan (HSP). The HSP forms the basis for planning and financing of health services and directing international support during 2003-2007.

Health-related Legislation

The legal framework for the health sector reform is not yet sufficiently developed. Several Ministerial decrees and sub-decrees have been adopted but some areas still need regulation.

External Support

Several international agencies and bilateral donors are supporting the development of the health sector. Official development assistance accounts for more than half of the consolidated public funding to the sector.

Sector-Wide Management (SWiM)

The objectives and indicators of the Cambodian government (Cambodian Millenium Development Goals – CMDG; HSP) and of the major development partners are in the same line and contributing to the fulfilment of the international MDGs.

The Support to the Health Sector Reform Programme (SHSR-P) is actively participating in the SWiM process. SHSR-P activities focus on quality assurance, but also cover social health insurance and human resource development.

The SWiM process has contributed to a strong ownership of programmes and projects by the MoH, and to a better coordination and cooperation among MoH Departments as well as with other Ministries.

There seems to be room for the simplification of SWiM-related institutional arrangements, planning systems, and procedures. The focus of the monitoring system should be shifted from activity and input monitoring to impact monitoring.

SHSR-P Strategy and Concept

The SHSR-P has been conceived for a total duration of 10 years, with an ongoing first phase of three years (March 2003 to February 2007). The concept of SHSR-P was developed in compliance with the HSP.

The SHSR-P approach comprises activities on three levels, i.e. policy, institutional and health center level.[1] It enables innovative measures to be implemented at the local

[1] For easier reading, institutional level and health centre level are combined into “implementation level”.

level, with the lessons learned being reported back to the policy level to be considered in strategy development.

SHSR-P Management

Management of the SHSR-P is marked by clear leadership; active role in networking with relevant institutions, stakeholders and experts; good teambuilding and teamwork; high motivation of SHSR-P staff.

Collaboration with Government Institutions

The Ministry of Health (MoH) has the overall responsibility for the SHSR-P and is also the implementing institution for the SHSR-P. SHSR-P also interacts closely with the related institutions/units under the MoH.

The staff situation in the MoH and related institutions is inadequate, in terms of numbers and qualification. Budgetary resources are being disbursed long behind schedule; only fractions of the amounts approved are actually being disbursed.

Cooperation with KfW

Collaboration between KfW and GTZ is envisaged in the field of quality management for the contraceptive social marketing and social franchising activities of Population Services International Cambodia PSI/C.

Cooperation with other German Development Organisations

The German Development Service (Deutscher Entwicklungsdienst – DED) has been effectively supporting the implementation of the SHSR-P in the fields of information technology, maternal and child health, and nursing care.

The Center for International Migration and Development (CIM) has been complementing the implementation of the SHSR-P in the areas of hospital management, radiology, dermatology, and oral health care.

Implementation Status SHSR-P

Focal Area 1: Health Service Delivery

SHSR-P has – in cooperation with DED – contributed to strengthening the capacity of the provincial health departments and operational districts and improving the performance of the referral hospitals in Kampong Thom and Kampot. However, the quality of service provision in remote health facilities does not yet meet the minimum requirements.

Focal Area 2: Behaviour Change and Communication

The SHSR-P has cooperated in the development of guidelines for clients and providers' rights. Another activity was the training workshop SHSR-P had organised at the Kampot referral hospital on Provider Behaviour Change Intervention.

Focal Area 3: Quality Improvement

The SHSR-P, in cooperation with The World Bank and other stakeholders, was successful in strengthening the MoH to develop the culture for quality in health, and in supporting the implementation of quality improvement programmes.

A Reward & Reinforcement Scheme was introduced in Kampot province in 2003. Hospital Care Quality Circles started their activities in Kampot province.

So far, there is no comprehensive concept for the accreditation system. The multitude of quality standards being developed has no clear conceptual framework.

Focal Area 4: Human Resources Development

The effectiveness of SHSR-P's contributions in human resource development is facilitated through the excellent collaboration with the Department of Human Resource Development and development partners, particularly UNFPA and DED.

At the RTC Kampot, the contributions of KfW, SHSR-P and DED have resulted in an increased application rate of students; the increased capacity is fully used.

Focal Area 5: Health Financing / Social Health Insurance

SHSR-P activities contribute to creating awareness of Fair Financing / Social Health Insurance (SHI) among policy makers and to capacity building of stakeholders. SHSR-P is also supporting the policy development for SHI and developing pilot SHI schemes.

At the referral hospital in Kampong Thom, modalities for linking the Health Equity Fund HEF with SHI will be developed. The feasibility of *Output Based Aid* (OBA) models linked with SHI is subject of the envisaged cooperation with KfW.

In cooperation with the GTZ-supported Rural Development Program (RDP) in Kampot and Kampong Thom, SHSR-P is supporting the development and application of a tool for the pre-identification of poor households.

Focal Area 6: Institutional Development

The establishment of the Health Service Management Training (HSMT) and Hospital Management Training (HMT) courses at the National Institute of Public Health (NIPH) was successful. However, NIPH's productivity in terms of research projects and consultancies is still low.

Development Effects and Impacts

The SHSR-P contributes to the achievement of the development objectives of the Royal Government of Cambodia and, in particular, to the CMDGs on health. The SHSR-P also contributes to strengthening policymaking and good governance in the health sector. At the institutional level, the SHSR-P helps to increase the capacity for planning and management.

(B) RECOMMENDATIONS

Strategy and Approach of the SHSR-P

SHSR-P should continue supporting the implementation of the Health Sector Strategic Plan (HSP) in close partnership with the development partners, with a focus on the priorities formulated during the Joint Annual Progress Review (JAPR) 2006.

Concentration of Intervention Areas

SHSR-P should focus on priority areas where it has already proved its strengths. Accordingly, the following three focal areas are proposed as components for the second phase of the project (1) Quality Improvement, (2) Human Resource Development, and (3) Social Health Insurance.

Proposed Future SHSR-P Components

(1) Quality Improvement: Support the MoH to operationalise the National Policy for Quality in Health.

(2) Human Resource Development: Strengthen the capacity of health personnel to meet the priority health problems more effectively.

(3) Social Health Insurance: Develop capacities and mechanisms for the expansion of SHI schemes

Cooperation with KfW

For a closer cooperation of the GTZ-supported SHSR Programme and KfW's Reproductive Health Programme II in the coming years, two proposals had already been submitted prior to the mission:

A) Quality assurance for Sun Quality Health Network clinics: SHSR-P will assist in developing the implementation of the accreditation system.

B) OBA voucher schemes for reproductive health linked with CBHI: SHSR-P could provide technical assistance in the field of SHI to the feasibility study.

Two additional options (C and D) are being proposed by the project progress review (PPR) team:

C) Strengthening the training capacity of the four regional training centres (RTC) and related hospitals (future teaching hospitals) in Kampot, Battambang, Kampong Cham and Stung Treng.

D) Provision of clinical training in emergency medicine at selected referral hospitals (future teaching hospitals).

Cooperation with DED and CIM

The cooperation in the field of human capacity building in the RTC and future teaching hospitals should be expanded. The proposed training programme in emergency medicine, in particular traumatology, could become a useful and promising cooperation with DED and maybe even with KfW.

The cooperation with CIM could be continued with the intention of supporting special clinical areas.

Monitoring System

The monitoring system of SHSR-P should be restructured towards impact-orientation.

1. INTRODUCTION

The programme "Support to the Health Sector Reform" (SHSR-P) is being implemented in the framework of technical cooperation between the Royal Government of Cambodia and the Government of the Federal Republic of Germany. The implementing agency for the project is the Ministry of Health (MoH). The German contributions to the SHSR-P are being provided by the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, on behalf of the Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (BMZ).

The ongoing first phase has a planned duration of three years (March 2003 to February 2007) which will – pending approval from the German Government – be extended to July 2007. In view of the implementation of a second phase, a programme progress review (PPR) mission was conducted in Cambodia from 13 to 30 March 2006 by a team of four consultants[2]. The purpose of the mission was to assess the status of implementation and to formulate recommendations as to the future of the SHSR-P.

The PPR mission started with a briefing with the project coordinators[3] and visits to senior officials of the MoH in Phnom Penh where guiding principles for the PPR were agreed upon. On 14 March 2006 the implementation status of SHSR-P was presented to and discussed with the SHSR-P team. Between 15 and 17 March 2006 the PPR team attended selected sessions of the Joint Annual Performance Review (JAPR) where officials of government institutions and representatives of bilateral and multilateral development organisations were also interviewed. The interviews were carried through to 27 March 2006. Visits were paid to hospitals and health centres in Kampong Thom and Kampot provinces and to the Kampot Regional Training Centre.[4] Since the complexity of the SHSR-P required a tight schedule for numerous interviews, time was limited for an in-depth planning for the envisaged second phase of SHSR-P.

The findings and recommendations of the PPR team were presented and discussed in a workshop on 28 March 2006 with the management and staff of the SHSR-P, during which recommendations for the envisaged second phase were also formulated. The findings and recommendations together with the concept were presented to and discussed with senior officials of the Ministry of Health (MoH) and related institutions, and representatives from multilateral and bilateral development organisations supporting the health sector reform in Cambodia, on 29 March 2006. The findings resulting from the PPR as well as the proposals for the envisaged second phase of SHSR-P were laid down in a Summary Report on 31 March 2006. The present main report resumes the contents of the Summary Report in more depth.

The consultants wish to express their appreciation and gratitude to all those who have provided valuable information to the PPR team. Special thanks are due to the management and staff of the SHSR-P for the excellent support during the entire mission.

[2] Dr. Helmut Goergen, Dr. Helge Neutatz, Dr. Sok Po, Ms. Markéta Zelenka. The team was backed in health insurance matters by Ms. Nicola Wiebe from GTZ Eschborn, Social Protection Division.

[3] Ms. Anne Erpelding, Programme Coordinator; Dr. Chhom Rada, Deputy Programme Coordinator.

[4] See Annex 2: Persons Contacted.

2. FRAMEWORK CONDITIONS

Health Indicators

Although there have been notable improvements in the health of Cambodians over the last decade key health indicators in Cambodia are behind those in the Asia and Pacific region.

Table 1: Key health indicators in Cambodia

	2003	2004
Infant mortality rate (per 1,000 live births)	97	66
Under-5 mortality rate (per 1,000 live births)	140	83
Maternal mortality (per 100,000 live births)	450	437
Life expectancy at birth (years) - males	50	60
Life expectancy at birth (years) - females	57	65

Sources: For 2003: Cambodia Demographic and Health Survey – CDHS 2000.[5]
For 2004: Cambodia Inter-Censual Population Survey – CIPS

Communicable Diseases

Communicable diseases account for 83 % of the reported disease burden for all age groups. The rural poor, particularly young children and women of reproductive age, are the most vulnerable. Acute respiratory infection, neonatal tetanus, haemorrhagic dengue fever, and diarrhoea, exacerbated by malnutrition, are the major causes of child mortality and morbidity.

The leading causes of early deaths are accidents and injuries (43%), followed by communicable diseases (37%).

Cambodia has still the highest HIV prevalence in Asia, but it has been successful in arresting and reversing the growth of the epidemic. The estimated prevalence decreased from about 2.8% in 1998 to below 1.9% in 2004. Similarly, the tuberculosis (TB) epidemic shows a declining trend.

Access to Health Services

As part of the health sector reform, a Health Coverage Plan (HCP) was launched in 1996 to improve geographic accessibility to health services. Health administrative districts were realigned along population density figures. Today, 967 health centres and 70 referral hospitals are structured within 75 Operational Districts (OD) in 24 Provincial Health Departments (PHD).

However, poor Cambodians, especially in rural areas, are underprivileged as far as access to and utilisation of health services is concerned. Health care expenses are a major reason for sales of valuable assets such as cattle and house, indebtedness, landlessness, and poverty. Many poor communes and districts lack properly equipped health facilities of acceptable quality. The lack of resources to pay for health services,

[5] The 2005 CDHS will be available in late 2006.

and poor knowledge about the need and availability of public health services further limit poor people's utilisation of health services.

User Fees for Health Services

MoH instituted user fees for health services in 1996 through the Health Financing Charter (HFC) in response to the unpredictable informal fees that were being charged in most MoH facilities and that had contributed to a marked shift from public to private providers. The HFC authorised MoH facilities to charge user fees and a formula for allocating the resulting revenue was established. The HFC also exempted the poor from paying user charges. However, these exemption schemes turned out to be unacceptable for the service providers since no reimbursement regulation was provided by the Government. Studies accordingly show that the cost of health services for the poor remains high.

Quality of Health Service Delivery

The quality of public health services is generally low. The main hindering factor is insufficient qualified staff. Many MoH facilities have staff shortages; in particular, remote health centres are seriously understaffed, especially midwifery and reproductive health services. A large proportion of health providers lack the necessary curative and preventive skills to provide effective health care. The utilisation rates are stagnant or increasing only slightly.

Table 2: Average utilisation figures in public health services

	2000	2003/2004
Attendance rate at public HC (new contact/inhabitant/year)	0,31	0,40
Antenatal care coverage (ANC 2)	40,9%	45%
Family planning users	16%	24%
Delivery coverage	5,6%	9,7%
Vaccination (DPT3)	50%	84%
Bed occupancy rate	50,7%	60,7%

Source: National Health Statistics, MOH, 2004

Human Resources Development

The lack of trained health care providers remains the key constraint in improving the performance of public health providers and provision of services to the poor. Public providers will continue to be an important source of health services in both public and private sectors. At the same time, the capacity of government resources to finance these providers through the budget is severely constrained. Appropriate personnel policies and incentive structures need to be introduced to rectify the human resource imbalance between rural and urban areas.

The MoH Health Sector Strategic Plan 2003–2007 (HSP) identifies human resource development as one of the six key areas of work. The strategy calls for enhancing the

skills through quality education, expanding the number and skills of midwives, and strengthening workforce planning and management to reduce inappropriate distribution and ensure efficient use of personnel.

But structural constraints in human resource development also exist in the linkages of responsibilities between departments. One example is with the Human Resources and Personnel Departments, both still in the process of fine-tuning their respective jurisdictions. While one unit drafts job descriptions the other unit concurrently administers task-related training. The planning of training and utilisation of training capacities – real time demands – must adjust to the existing setup, as there is a critical problem of limited employment capacity in the civil service. In 2005 only 60 of 100 newly-graduated midwives were employed in the public sector despite the urgent need in qualified midwives, especially in remote areas. NGOs and the private sector are successfully recruiting the rest.

Limited Institutional Capacity

The Ministry of Health has made significant efforts to reach the institutional and human capacity to effectively plan, manage, and finance the health sector at all levels. Most of the Provincial Health Departments and Districts teams are sufficiently staffed in terms of numbers but are still in need of further capacity building. At present, most of them are undergoing systematic training in health service planning and management. Nevertheless, the performance of basic curative and preventive services remains poor. Low salaries of civil servants and health care providers imply that the key personnel in MoH have to look for other sources of income and are often not available full-time to fulfil their responsibilities.

Private Commercial Health Sector

The decree which stipulates the conditions for licensing of private health care providers (Prakas 020/21) has been in force since 2003. In four out of 24 provinces it has not been implemented so far. Still, the majority of private facilities are not yet officially licensed; however, the number is gradually increasing.

Table 3: Private health care providers in Cambodia in 2004

Private Facilities	Total	Licensed	Unlicensed
Polyclinics	33	12	21
Clinics	50	20	30
Maternities	14	5	9
Labs	32	6	26
Dental Clinics	10	8	2
Plastic Surgery Rooms	6	1	5
Consultation Rooms	1827	693	1134
Dental Consult.Rooms	376	50	326

Source: Report of Joint Annual progress Review 2005

It is estimated that more than 80% of the private services are run by health personnel who are employed in public health services. Officially, they are authorised to run their private business before and after official work hours.

In 2004, the MOH issued official letters to close down 10 unlicensed private facilities. Due to the lack of qualified staff, supervision and quality control of private facilities remains a major problem.

Gender Situation in the Health Sector

Access to health services remains more difficult for women than for men, especially in rural areas. Costs for health care services are a major obstacle. Since ANC services are considered inexpensive and deliveries in health care facilities are expensive, traditional birth attendants and deliveries at home are normally preferred. Home deliveries by trained attendants are more expensive at home than in the Health Centre (HC).

Employment of women in the health sector depends largely on the level of education. Although girls' enrolment in primary schools is almost equal to that of boys, it is low at the secondary level. Reasons for drop-outs are early marriage, poor living conditions, girls helping in the household, sickness, living in remote areas combined with lack of transportation, and fear of security. Traditional gender roles also impede women's further education and training.

Steps to improve the situation have been taken. As it had been realised that many women do not meet the entry requirement (grade 12) for nursing schools, it was lowered to grade 10, so that more women can now access the courses. Unequal education also contributes to the rare presence of women in higher positions in public health institutions. Women are scarcely represented at higher ranks in the MoH, at the PHD and OD levels.

In general terms, "gender" is associated in Cambodia with women only. Equal opportunities and access for both sexes are not much considered. Initiatives to include men in birth spacing and reproductive health are therefore notable examples of integration of gender aspects in health care.

Contracting of Health Services to NGOs

After piloting in some provinces, the Government has expanded the contracting of health services to NGOs in 11 districts. The results show that contracting of health services can effectively improve access and utilisation of health services in rural areas in a relatively short time, especially for the poor. The contracting approach provides reliable services of acceptable quality, particularly in remote areas, provided that reliable sources for funding are available in the longer run.

Development Strategy

Within the context of the national development plan, MoH has developed the Health Sector Strategic Plan (HSP) and the Medium-Term Expenditure Framework (MTEF). To achieve the overall goal of improving health status and reducing poverty, the HSP identifies twenty strategies and eight core strategies that are structured in six priority areas: health service delivery, behaviour change, quality improvement, human resource development, health financing, and institutional development. The HSP forms the basis for planning and financing of health services and directing international support during 2003-2007. The progress of implementation is monitored through Joint Annual Progress Reviews (JAPR), which are chaired by the Minister of Health.

Health-related Legislation

The legal framework for the health sector reform is not yet sufficiently developed. Several Ministerial decrees and sub-decrees have been adopted but some areas still need regulation, for example social health insurance and decentralisation of the health sector.

External Support

Several international agencies and bilateral donors are supporting the development of the health sector. Official development assistance accounts for more than half of the consolidated public funding to the sector. Major partners include Asian Development Bank (ADB), Agence Française de Développement (AFD), Belgian Technical Cooperation (BTC), Department for International Development (DFID), German Agency for Technical Cooperation (GTZ), Japan International Cooperation Agency (JICA), Kreditanstalt für Wiederaufbau (KfW), United States Agency for International Development (USAID), The World Bank (WB), World Health Organization (WHO), and other United Nations (UN) agencies.

3. SECTOR-WIDE MANAGEMENT (SWiM)

SWiM Set-up

Initiatives to coordinate and jointly implement development programmes/projects in the health sector were first taken during the Joint Health Sector Review in 1998. The rationale behind these initiatives was the realisation that piecemeal aid projects cannot adequately support the development of a sustainable health sector strategy and that different donor-specific procedures entail high transaction cost. The MoH, confronted with a complexity of funding modalities of different donors, was strongly interested harmonising the procedures.

The basic idea was to create a “Sector-wide Approach (SWAP)” with a “basket fund” through which all financial contributions would be channelled, and to establish common implementation arrangements. Since some donors felt that the national capacity to manage available resources in the health sector was still limited, no agreement was reached and, instead, the so-called “Sector-wide Management (SWiM)” – a system of interrelated bodies with steering and coordinating functions – was adopted in 2001.

Institutional Arrangements

The responsibility for the overall coordination of the implementation of the Health Sector Strategic Plan 2003–2007 (HSP) is with the Department of Planning and Health Information (DPHI) of MoH. The institutional arrangements for the SWiM comprise a system of coordinating bodies as follows:[6]

- Health Sector Steering Committee
- Senior Management Group for Strategic Plan Implementation
- Technical Committee for Implementation of Health Strategic Plan
- MoH Coordinating Committee for Health (CoCom) – transformed in November 2004 into Technical Working Group Health (TWGH).

[6] MoH: SWiM Framework – Institutional Arrangement for Sector-wide Management, 25 March 2003.

Under the TWGH, the composition of the eight sub-working groups was revised in December 2005:

(1) Technical Working Group for the Implementation of the HSP
(2) Health Service Delivery Working Group
(3) Behaviour Change and Communication Working Group
(4) Quality Assurance Working Group
(5) Human Resource Development Working Group
(6) Health Financing Working Group
(7) Institutional Development Working Group
(8) Coordination Support Working Group

Implementing Arrangements

The basis for the SWiM is the Health Sector Strategic Plan 2003–2007 (HSP). The implementing arrangements comprise:

- Medium Term Expenditure Framework
- Operational Plan Framework
- 5-Year Implementation Framework for HSP
- Joint Annual Health Sector Review
  (changed in 2005 into Joint Annual Performance Review – JAPR)
- Mid-Term Evaluation of HSP
- End-Term Evaluation of HSP
- Health Partners Meeting – coordinated by WHO

Since 2003, the annual operational planning (AOP) and budget cycles of the MoH have been synchronised. The MoH has published a planning manual to assist operational districts (OD) in the procedures for review, planning and budgeting. This combines local “bottom-up” and central “top down” planning, with the Provincial Health Departments (PHD) acting as the interface.

Health Sector Support Project (HSSP)

Under the SWiM, international development agencies and bilateral donors support components of the HSP. The core of the SWiM is the Health Sector Support Project (HSSP) which is jointly financed by MoH, ADB, WB, DFID, and UNFPA. Total funds for the first phase (2003–2007) amount to US$ 84.4 million, and a second phase is envisaged.

The objectives of the HSSP are (i) to increase the accessibility and the quality of health services and (ii) to assist in the implementation of the HSP and strengthen the sector’s capacity to manage resources efficiently. There are three components of which the objectives can be mapped directly to the six priority areas of the HSP: (1) improved delivery of health services, (2) support to priority public health programs, and (3) strengthening of institutional capacity. The HSSP supports contracting of health services to nongovernmental organisations (NGOs) in 11 poor operational districts.

Other SWiM Stakeholders

- AFD
- Belgian Technical Cooperation
- European Commission

- JICA
- MEDICAM[7]
- UNICEF
- University Research Co (URC)
- WHO

USAID, with an annual contribution of US$ 30 million, is a major partner in the development of the Cambodian health sector. Much of its support is directed towards the work of international and local NGOs. USAID is to date not directly participating in the SWiM process. However, URC, as one of the major contractors for USAID, is a member in several Working Groups.

Comparison of Objectives and Indicators

Comparing the objectives and indicators of the Cambodian government (Millenium Development Goals of Cambodia – CMDG; Health Sector Strategic Plan – HSP) and of the major development partners, it becomes evident that they are in the same line and contributing to the fulfilment of the international MDGs. In particular, maternal and child health is a concern in almost every health programme/ project, sometimes covered by special components.

For monitoring purposes data of the health information system (HIS) of the MoH are widely used. Surveys and baseline studies are also conducted by several stakeholders. The terminology used in the documents is not always consistent.

Gender Aspects

The improvement of the situation of women in terms of maternal health and birth spacing is part of almost every programme/project concept. Other gender aspects are not specified in the planning documents.

The HIS of the MoH does not include gender disaggregated information on specific diseases, for example in the health center report form (HC1). Gender disaggregated data would facilitate the analysis, and health strategies could be better targeted to men and women.

Role and Participation of SHSR-P in the SWiM

During the planning/preparation of the HSP an agreement was reached between WB and GTZ to the effect that both agencies would further quality improvement in health services in the pilot province of Kampong Thom and thus contribute to the implementation of the HSSP, and HSP, respectively. The details were laid down in the Minutes of Meeting of 08 February 2003, and the joint financing agreement covers a three-year period up to June 2006.

Since then, the SHSR-P has been actively participating in the SWiM process. The outputs of the SHSR-P are being appreciated by the MoH and other partners as important elements to the overall development of the health sector. The transparency of SHSR-P activities and the openness of SHSR-P management to collaborate with other development partners have been highlighted by interviewees during the PPR mission.

[7] MEDICAM = Medical Cambodia, an umbrella organisation for NGOs, also represents GRET in the SWiM process.

SHSR-P activities within the SWiM focus on quality assurance, but also cover social health insurance and human resource development. Since SHSR-P cannot produce all essential elements for quality improvement alone, it has to intensify its cooperation in this area with the other stakeholders.

SHSR-P is playing an active role in the SWiM process, mostly based on the initiative and talent for networking of the SHSR-P programme coordinator[8]. The cooperation with other programmes/projects allows a higher added-value of the SHSR-P outputs than one might expect when considering its limited financial resources – compared with other donors.

To accelerate quality improvement activities in Kampong Thom and address the low motivation of health workers, SHSR-P was asked in June 2004 by WB to submit a boosting proposal. This proposal combined funds for a performance-based incentive scheme and funds to establish an equity fund at the Referral Hospital. Due to different contractual formalities between WB and GTZ International Services, this proposal unfortunately did not materialise.

Assessment of the SWiM Process

On the whole, the SWiM process is seen by the PPR team as an internationally outstanding example of coordination of development efforts undertaken by the national Ministry and external development partners, including nongovernmental organisations (NGO).

The SWiM process has without a doubt contributed to a strong ownership of programmes and projects by the MoH, and to better coordination and cooperation among MoH Departments as well as with other Ministries. However, it seems that the SWiM institutional arrangements are somewhat complex (4 coordinating bodies on different levels; 8 working groups with a total of 124 permanent members; overlapping missions/functions). It is also the impression of the PPR team that the initiative to carry forward and to coordinate the SWiM process is predominantly taken by the international and bilateral development partners.

There seems to be room for the simplification of SWiM-related planning systems and procedures (e.g. annual operational plans). It would be an advantage if the stakeholders could agree on a common set of objectives and indicators that reflect impacts at the target group (beneficiaries) level and all the more because it is difficult to attribute impacts to single programmes/projects. Likewise, the focus of the monitoring system should be shifted from activity and input monitoring to impact monitoring. It might also be helpful to conduct baseline studies jointly.

Such issues will certainly be examined in the forthcoming assessment of the SWiM process, which is scheduled as a preliminary activity of the Mid Term Review (MTR) of the HSP and the HSSP, to be conducted from July through September 2006.

There is an ongoing debate about the appropriate structure, form and intensity of coordination and implementation of development programmes/projects in the Cambodian health sector. The basic issue is whether or not to transform SWiM into a deeper SWAp (Sector-Wide Approach) – with pooling of donor contributions into a

[8] Ms. Anne Erpelding

"basket fund" and establishing common implementation arrangements, including harmonised systems for reporting, monitoring and auditing. The MoH, together WB and DFID, seem to be in favour of a SWAp whereas other partners have shown reluctance to such a transformation. In the view of the PPR team, the most important thing is effective coordination of development efforts whatever form the institutional and implementation arrangements may take.

4. SHSR-P PLANNING AND MONITORING

4.1 SHSR-P Strategy, Objectives and Indicators

SHSR-P Strategy and Approach

The predecessor of the SHSR-P was the project *Training of Health Personnel and Family Planning*, which was implemented from 1995 to 2002. SHSR-P has been planned for a total duration of 10 years, with an ongoing first phase of three years (March 2003 to February 2007).[9] The basis for the implementation of the first phase is the offer of GTZ of June 2004, replaced by the amendment offer of 15 June 2004, and the corresponding commission of BMZ of 2 August 2004.

The concept (programme planning matrix – PPM) of SHSR-P was developed in compliance with the six priority areas of work as laid down in the HSP. In line with the division of labour among the donors, SHSR-P mainly supports two priority areas, i.e. quality management, and health financing. The others, namely health service delivery, institutional development, human resource development, and behaviour change and communication, continue to receive support from the SHSR-P as well, but to a lesser extent.

Issues related to the private commercial sector development have also become part of the SHSR-P concept, such as certification/accreditation standards.

The SHSR-P approach comprises activities at three levels, i.e. (a) policy level: contribution to guidelines and standards; (b) institutional level: strengthening the National Institute of Public Health (NIPH), the PHD, OD and Referral Hospitals; (c) Health centre level: introduction of quality standards for health services, and staff training.[10] This approach enables innovative measures to be implemented at the local level, with the lessons learned being reported back to the policy level to be considered in strategy development.

Concurrence with Development Goals

According to Cambodia's Socio-Economic Development Plan 2001–2005 and the Rectangular Strategy, poverty reduction is the overarching goal. The National Poverty Reduction Strategy Paper (NPRSP), which builds upon the Socio-Economic Development Plan, states that the health sector is one of the priority sectors for poverty alleviation, with the HSP as the guideline for action.

[9] The 1st phase will probably be extended to July 2007.

[10] For easier reading, institutional level and health centre level are combined into "implementation level" in the following text.

Equally, poverty alleviation is the primary development goal of the German government. The international development goal of halving the proportion of people living in extreme poverty by 2015 is being supported. The promotion of the health sector, especially in the field of reproductive health, is one of the priority fields of action for German development cooperation in Asia.

The objectives of SHSR-P, as outlined below, are in line with the development priorities defined by both governments.

SHSR-P Objectives and Indicators

The objectives and indicators of the SHSR-P are laid down in the offer of GTZ to BMZ of 15 June 2004 which constitutes the basis for programme implementation. Realising that the overall planning matrix was too ambitious, the management of SHSR-P decided to adjust several objectives and indicators. The updated versions of objectives and indicators (21 July 2005) read as follows:

Overall Objective

Selected institutions at different levels in the health sector (public and private) fulfil their tasks according to the quality requirements of the sector reform.

Indicators:

(1) Number of public hospitals (from the current 68 existing ones) and private clinics with a licence corresponding to quality criteria.

(2) Proportion of public health centres (from 812 currently existing ones) with a quality seal.

(3) Proportion of clients satisfied with the services provided in the public sector (measured by interviews with clients, 80% of them women).

(4) Social health insurance is incorporated as a concept in the health policy and has been introduced in the programme region with special consideration of the poor.

Objective for the 1st Phase

Selected public institutions of the health sector start to apply principles of quality assurance and social health insurance as elements of the sector reform.

Indicators:

(1) Priority quality standards for the accreditation of health services have been put into force and tested in both pilot provinces.

(2) The offer of services of the National Institute of Public Health (NIPH) has expanded; the demand for services has increased by 40%.

(3) Identified poor (of which 80% are women and children) have free access in 30 of 50 health centres and 2 of 3 hospitals in Kampong Thom province.

(4) Instruments for monitoring the quality of health services have been developed and introduced in 15 of 50 health centres and in one of the three hospitals in Kampong Thom province.

(5) Three pilot measures in the area of social health insurance have been developed, applied, and documented for the use at national level.

Target Group

The target group for measures concerned with quality improvement, health financing and human resource development are all clients of health services, in particular the poor and disadvantaged members of the Cambodian population. The target group for German involvement in the sub-sector of reproductive health consists, in particular, of women and girls, young persons, and mothers and children.

Assessment of Strategy and Indicators

The strategy followed by SHSR-P has proven successful, in particular, the division of labour with the other donors and the three-level approach. The PPR team agrees to the concentration made on two priority areas of work and to the widening of the project concept to include the private sector.

Appropriateness of the indicators:

- The indicators for the overall objective are suitable for measuring its achievement; however, indicators 1 to 3 are not quantified.
- The indicators of the objective for the 1st phase are suitable for measuring its achievement, but they show some weaknesses:
  - Indicator 2 is not related to the objective.
  - Indicator 3: see statements in Section 4.2 below.

As to the question whether the objective of the 1st phase is achievable within the given time frame, the PPR team believes that it will be achieved partly; the prospects seem to be very good in the area of quality improvement (on policy and institutional levels) and rather limited in the area of social health insurance.

4.2 Consideration of Gender Aspects

Gender in the SHSR-P Concept

The SHSR-P concept (GTZ offer to BMZ of 15 June 2004) anticipates a gender-related impact, i.e. as far as women as clients of health services are concerned, and in the area of training.

Indicator 3 for the SHSR-P's overall objective has a focus on women. However, the formulation indicates no real gender relevance. No improvement in the situation of women derives from the fact that 80% of the clients to be interviewed are women. The percentage of female clients interviewed should rather represent the real percentage of female clients at the health services – which in some cases might indeed get up to 80%. Rather, statements on the quality of specific services for women would be more gender-relevant.

A focus on women is also set in indicator 3 of the objective for the second phase. It states that 80% of the identified poor receiving free access to health services have to be women and children.[11] Once free access for identified poor is provided, utilisation rates are likely to increase, hence the target of 80% women and children will most probably be met without specific action by SHSR-P, as these constitute the majority of clients at health centres.

[11] Free access to health services refers to the coverage of health service costs for identified poor by the Equity Fund in place in Kampong Thom.

Given the situation of gender inequality in access to health services, free access for identified poor is highly gender-relevant, since women and children constitute the majority among the poor. The SHSR-P contributes indirectly to the improvement of women's and children's health by its involvement in the identification process of poor households.

Gender awareness and training

The SHSR-P has contributed to the participation of women in continuing education and English courses in Cambodia and abroad. By advocating their participation, the SHSR-P has also contributed to gender awareness in the respective institutions.

Gender Aspects in Surveys

A baseline survey on clients' satisfaction at the referral hospitals in Kampong Thom and Kampot has been conducted on behalf of the SHSR-P by the Center for Advanced Study. However, information in the survey is not presented according to the respondents' sex. Information on possible different treatment of men and women by health care staff, different levels of client satisfaction, variations of user fees or unofficial money requests to men and women would have been useful for planning adequate measures.

4.3 Monitoring and Evaluation

Monitoring System and Processes

The groundwork for the monitoring system of SHSR-P was established in February 2005 with external support. In addition to the indicators for the overall objective and the objective for the first phase, indicators have been formulated at the activity level for the six Focal Areas. This was done to be able to monitor trends better in the status of implementation.

The responsibilities of the SHSR-P team members include monitoring tasks for the six Focal Areas. So far monitoring has been undertaken concerning indicators for the overall objective and for the objective of the first phase, and activities. Achievements in the Focal Areas are being reviewed quarterly in the provinces with PHD and at the end of each year. A structured monitoring system has not yet been established, but is in preparation.

Monitoring of Objectives

- Indicator 3 for the overall objective refers to the proportion of clients satisfied with the services provided in the public sector. As a first step, a baseline survey[12] was conducted in November/December 2005 which will provide the SHSR-P with baseline data for monitoring.
- Concerning indicator 2 of the objective for the first phase, the increased demand for services of the NIPH has not yet been systematically documented. However,

[12] Satisfaction of Clients visiting Kampong Thom and Kampot Referral Hospitals. Center for Advanced Studies, April 2006.

on request, data on research, consultancies and training courses were provided by NIPH.

- Concerning indicator 3 of the objective for the first phase, data on free access to health services for identified poor are not yet available since the identification process in Kampong Thom took longer than expected as this is a joint collaboration with the GTZ Rural Development Program and the provincial authorities. In addition, the distribution of the priority access cards for poor beneficiaries, has not yet been concluded.
- A monitoring tool for the service delivery quality in health centres, including 14 checklists (Indicator 4 of the objective for the first phase) is being applied.

Monitoring of Assumptions

In the SHSR-P concept (Programme Planning Matrix – PPM of March 2004), the following assumptions[13] are stated:

- For the overall objective:
  - Commitment of the MoH/Government and the donor community to implement the Health Sector Reform;
  - Ongoing political stability in the country;
  - Improved financial management and transparency on the side of the Government.

  Assessment: The first two assumptions have certainly proved true. As to the the third assumption, there are serious efforts underway by the MoH and the Ministry of Economy and Finance (MoEF) to improve the financial flow from the Treasury to the MoH and to the provinces. An inter-ministerial working group supported by WHO has been set up to iron out operational difficulties.
- For the objective of the first phase:
  - The MoH will provide competent counterpart staff;
  - The German Government provides committed funds and support.

  Assessment: These assumptions have widely proved true; however, the assignment of qualified staff to the NIPH remains unsatisfactory.

e-VALuation of SHSR-P

In 2003, GTZ introduced a new computer-aided evaluation tool for its programmes/projects, called e-VAL.[14] It is based on interviews with representatives of three groups:

- Group I: 4 persons associated with GTZ
- Group II: 4 representatives of partner institutions (counterparts)
- Group III: 4 beneficiaries (target group) and/or intermediaries

Between 21 February and 27 April 2005, 12 interviews were conducted for the SHSR-P with the interviews being carried out by an external consultant.[15] The outcome of the e-VALuation can be summarised as follows:

[13] According to the Goal-oriented Planning Method (ZOPP), assumptions are conditions for the successful implementation of a project which cannot be influenced by the project management.

[14] The process is called e-VALuation.

[15] Mr. Hubert Trapp

- Success of project today: The success of the SHSR-P is perceived more positively by the counterparts (75%) and beneficiaries (71%) than by GTZ (50%). The probability of achieving the objectives is rated as "high risk with medium possibility to influence".
- Expected future success: The degree of expected success in one year's time is graded on average at 84% (GTZ: 80%; counterparts: 88%).
- Impacts: Capacity development is mentioned by all three groups as the most prominent impact of the SHSR-P, both in terms of contributing to project success and relevance.
- Contributions: With 88%, 85% and 80% respectively, the GTZ contribution is perceived equally important by all interviewees. Likewise, the CIM/DED contribution is within the same range (79/72/72). This seems to indicate that the German TC is viewed as a relatively homogenous package. The MoH's contributions also fall in the same range (59%, 88%, 72%).
- Strengths: Of the statements listed, the two most frequently mentioned refer to the GTZ input, i.e. capacity building and advisory services.
- Weaknesses: The points listed here do not reflect the perceived weaknesses of GTZ's mode of delivery but rather cases when the SHSR-P does not or cannot fulfil the expectations of the counterparts.

5. ORGANISATION OF SHSR-P IMPLEMENTATION

5.1 Integration of SHSR-P and Collaboration with Government Institutions

The Ministry of Health (MoH) has the overall responsibility for the SHSR-P and is also the implementing institution for the SHSR-P. An Implementation Agreement was concluded between GTZ (GTZ Office Phnom Penh, Country Director Dr. T. Engelhardt) and the MoH (Secretary of State for Health, Prof. Eng Huot) on 16 / 23 August 2004. In this agreement, the objectives and indicators for the SHSR-P, as well as the contributions of both Governments are laid down.

At the political level of the MoH, two of the five Secretaries of State[16] oversee activities of the SHSR-P in the areas of Quality Improvement / Social Health Insurance and Institutional Development, respectively.

On the departmental level of the MoH, the SHSR-P is interacting closely with:

- Department of Health Planning and Information
  Cooperation: formulation of a strategy for implementing the Social Health Insurance Master Plan; development of methods for the identification of poor households;
- Department of Hospital Services, including the Quality Assurance Office
  Cooperation: development of quality standards and accreditation systems;
- Department of Human Resources Development
  Cooperation: support of training programmes;[17]
- Preventive Medicine Department

[16] Dr. Mam Bun Heng and Prof. Eng Huot

[17] Refer to Section 6.4 for details.

Cooperation: contribution to the formulation/documentation of clients and providers' rights.

SHSR-P also interacts closely with the following institutions/units under the MoH:

- National Institute of Public Health (NIPH)
  Cooperation: training of staff in planning and research methods; study in view of autonomy of the NIPH; support of the Health Service / Hospital Management Training courses with support from SEAMEO-TROPMED;[18]
- Regional Training Centre Kampot (RTC-K)
  Cooperation: training courses for nurses and midwives;[19]
- Provincial Health Departments of Kampong Thom and Kampot provinces
  Cooperation: planning and monitoring systems (annual operational plans – AOP); support of the PHD teams in quality management;
- Provincial/Referral Hospitals in Kampong Thom and Kampot provinces
  Cooperation: reinforcement of the referral system; support of quality improvement; training in hospital management and financial management;
- Health centres in Kampong Thom and Kampot provinces
  Cooperation: quality improvement; technical staff training; reward and reinforcement system.

Assessment

The officials and technical staff in the MoH and related institutions demonstrate a strong spirit of ownership and cooperation towards SHSR-P.

On the other hand, the staff situation in the MoH and related institutions can be considered a hindering factor for the further development of the health sector:

- The Quality Assurance Office (QAO) under the Hospital Services Department remains understaffed. The former head[20] was recently appointed Deputy Director of the Department of Hospital Services (to which the QAO belongs). The successor is not yet familiar with the subject.
- The NIPH lacks qualified staff for both research and teaching. Four persons who underwent postgraduate training under the former GTZ health project have left the NIPH, mainly because of the inadequate remuneration system.
- The provincial hospitals and health centres are understaffed; the personnel in place are not sufficiently qualified.

MoH budgetary resources are being disbursed long behind schedule; only fractions of the amounts approved are actually being disbursed. This leads to delays in implementation.

5.2 Cooperation with other GTZ Projects and German Development Organisations

Cooperation with the German Development Service (DED)

[18] SEAMEO = South East Asian Ministers of Education Organisation. Refer to Section 6.4 for details.
[19] Refer to Section 6.6 for details.
[20] Dr. Sok Po

The German Development Service (Deutscher Entwicklungsdienst – DED) has been supporting the implementation of the SHSR-P in specific fields. The basis of the support is the Cooperation Agreement between SHSR-P and DED, updated on 14 February 2005. The following three DED experts are presently working within the framework of the SHSR-P:

- IT Expert[21] at the NIPH
  Task: support to the NIPH Information Center
- Maternal and Child Health Advisor[22] in Kampong Thom
  Tasks: The advisor assesses the quality of midwifery services and knowledge at selected health centres in Kampong Thom province. The advisor contributes significantly to the improvement of maternal and child health. Training needs are identified, reported, and followed up. Results of the assessments are communicated to the RH and the ODs.
- Nursing Care Advisor[23] at the Referral Hospital in Kampong Thom
  Tasks: looking after nursing practice including existing equipment, assessing sanitation, and quality and working conditions.

The extension of the DED advisory services on mother and child health is being discussed. It is the wish of the SHSR-P management as well as of the counterparts in Kampong Thom to extend this cooperation.

In connection with a new intervention, the training of nursing preceptors, DED has decided to expand its commitment to all the four Regional Training Centres by recruiting a further three Nursing Care/MCH Advisors.

Achievements

The contribution of the two DED advisors in Kampong Thom is substantial to the SHSR-P as they provide important feedback on needs and realities at the target group level.

Nursing care and midwifery are promoted at the referral hospital in Kampong Thom.

Antenatal care (ANC) and Integrated Management of Childhood Illness (IMCI) are promoted at health centres. On-the-job trainings are provided on immunization of children, nutrition, etc. This is done in cooperation with the IMCI and WHO.

Supervision at health centres is provided with input and interventions given on-site, if necessary. Real cases are documented and reviewed for training purposes with the midwives.

Change agents, ie. personnel to promote awareness on the importance of ANC-checks at community level, have been trained with support from GTZ and started their activities. Monitoring of the changes achieved by this measure will be carried out by DED later this year.

Cooperation with the Centre for International Migration and Development (CIM)

[21] Mr. Klaus Peter Glatzel
[22] Ms. Urte Heitmann
[23] Ms. Young Sook Cha-Jaeckel

The Centre for International Migration and Development (CIM) has been complementing the implementation of the SHSR-P mainly in the areas of hospital management and training of X-ray technicians. Occasional contacts exist with the experts in dermatology and oral health care. At present, the following three CIM experts are in post:

- X-ray Technician[24] at the Human Resources Development Department
  Tasks: training of doctors and technicians in radiology; curriculum development and materials for trainings for X-ray-technicians;
- Advisor for Dermatology[25] at the University of Health Sciences
  Tasks: postgraduate courses in dermatology; advising the institutional set-up of the Dermatology Department; strengthening quality assurance;
- Oral Health Advisor[26] at the University of Health Sciences
  Tasks: teaching; advisory services regarding the institutional development.

The two hospital management advisors who were based in the RH of Kampong Thom and Kampot completed their assignments in August 2005. Due to different working modalities (see below), which impeded cooperation, it was decided not to extend this setup.

Planning and implementation of, and reporting on, activities of the CIM experts is being done independently of the SHSR-P since the CIM experts have, according to their contracts with a Cambodian entity, to comply with the plans and regulations of the institutions to which they are assigned. However, there is a regular exchange of information between the CIM experts and SHSR-P management in areas of mutual interest, e.g. quality assurance.

Cooperation with KfW

In the framework of financial cooperation between the Kingdom of Cambodia and the Federal Republic of Germany, KfW has been supporting the health sector since 1994. The *Reproductive Health Programme* is presently in its first phase; a second phase (2006–2008) is under preparation. The main component is the supply of contraceptives to the public health system as well as to NGOs.

During the first phase, construction of buildings and provision of equipment for the RTC Kampot have been financed by KfW. The most recent contribution was the construction of a dormitory for 60 students.

With a view to expand the provision of contraceptives to larger portions of the population, a cooperation agreement has been concluded between KfW and *Population Services International Cambodia* (PSI/C); PSI/C will provide low dose oral contraceptives through its social marketing system. The second element of the cooperation is the expansion of the *Sun Quality Health Network* (SQHN) of service providers, aimed at improving the quality of reproductive health services for vulnerable population groups through the private sector.

[24] Mr. Mam Bun Song
[25] Dr. Christoph Bendick
[26] Dr. Wolfgang Schmidberg

A closer collaboration between KfW and GTZ is envisaged during the Reproductive Health Programme II in the field of quality management for the contraceptive social marketing and social franchising activities of PSI/C. Together with the QA Office of the MoH, GTZ will develop an accreditation system for PSI/C supported clinics. This could be a first step towards introducing a quality management system in the hitherto unregulated private sector.

A feasibility and design study for the so-called Output-based approach (OBA) will also be financed by KfW within the Reproductive Health Programme II. OBA provides a unit reimbursement to subsidise health services. Payment will be managed by issuing vouchers with cash value for the services provided. These payments can be combined with health financing schemes. OBA is expected to improve the quality as well as the demand for reproductive health services.

Cooperation with Malteser International

The German NGO Malteser International is promoting community development in the Oddar Meanchey province, a project financed by the German government. In this context, initiatives to establish community-based social health insurance schemes, combined with two village health centres, are being undertaken.

The Malteser International country representative[27] in Cambodia is in occasional contact with SHSR-P management; exchange of information is taking place. However, it is felt by the PPR team that there is room for a closer cooperation. Areas of common interest are methods for identification of poor households, quality assurance in health services, and linking village funds with social health insurance schemes.

Cooperation with Other GTZ-supported Projects

SHSR-P systematically draws on experiences of GTZ-supported projects in Cambodia, in the Asian region and of the social security sectoral project within GTZ:

- Rural Development Program (RDP) in the Provinces Kampot and Kampong Thom (PN 2001.2530.3)
  Cooperation: development of a standardised method for the identification of poor households (Most Vulnerable Household List – MVHL).
  The identification list and the priority access cards constitute the basis for the provision of free access to health services for the identified poor, provided through the Equity Fund (financed by WB) in Kampong Thom.[28] The SHSR-P introduced and advocated this identification method in the health sector.
- Food Security and Nutrition Policy Support Project (PN 2005.1971.0)
  Cooperation: development of a standardised method for the identification of poor households (Most Vulnerable Household List – MVHL). The project concluded in December 2005.
- GTZ Sectoral Project “Strategies for the Reforms of Social Security Systems” (PN 2002.9215.1)
  Cooperation: support to the development of solitary health insurance systems especially in the informal urban and rural sector.
- Promotion of Women’s Rights Project (PN 2000.2202.0)

[27] Ms Nathalie Bocking, Project Manager / Country Representative

[28] In Kampot province no Equity Fund is yet in place.

Cooperation: support to the study "Gender Based Violence and HIV/AIDS in Cambodia – Links, Opportunities and Potential Responses" of the GTZ Backup Initiative, printed in August 2005.

6. SHSR-P IMPLEMENTATION STATUS

6.1 Focal Area 1: Health Service Delivery

WHAT WAS PLANNED?

SHSR-P activities in this focal area had been planned to improve the planning and management capacity of Provincial Health Departments (PHD) and Operational Districts (OD), including an improvement of the referral system.

MAIN FINDINGS

With specific management training (e.g. HSMT, HMT, quality management (QM), financial management) and equipment and advisory support, SHSR-P (in cooperation with DED) has contributed to strengthening the capacity of the provincial and district health departments in Kampong Thom and Kampot. The acquired competence of the management teams at PHD and OD level is illustrated, for example, by the following facts:

- The teams have introduced and use a computerised Health Information System (HIS); the data are up-to-date, print-outs are available immediately.
- They conduct regular supervisions to lower service levels (the effectiveness of the supervision, however, cannot be assessed).
- Ambulances for referrals are available at referral hospitals and are used, a regular referral case review takes place (information on costs and affordability could not be obtained).
- Quality improvement teams have been set up, action plans are worked out, meetings take place regularly.

Furthermore, efforts to improve the performance of the referral hospitals and health centres in Kampong Thom and Kampot concentrated on human capacity building as well. They included special training visits in hospitals of other provinces, training of health centre staff with the COPE method,[29] and a special focus on nursing and midwifery in collaboration with DED. Obviously, these activities have their positive effects.

However, the PPR team is concerned about the low quality level in remote health facilities. On the other hand, the PPR team knows very well how difficult it is to attract and keep qualified staff in remote areas. In spite of improvements during the past years, as presented at the Joint Annual Progress Review 2006, important public health output data are still far below the targets and indicate that poor quality of service provision, at least in some areas, does not yet meet the minimum requirements. For example in 2004, the average outpatient department (OPD) utilisation rate in Kampot was 0.24, in Kampong Thom 0.42 (country average 0.40, the target being 1.0); the

[29] COPE = Client-oriented, provider-efficient services: a learning process to improve quality of reproductive health services

antenatal coverage (ANC2) in Kampot was 40.5% and in Kampong Thom 29.4% (country average 45.2%, the target being more than 80%).[30]

PROBLEMS AND REMAINING QUESTIONS

The quality of health service delivery depends on various important factors, but above all, on staff motivation, which, however, is unlikely to improve unless:

- the remuneration of health staff is substantially improved (first steps have been done);
- quality management is a duty for all health providers and teams;
- private practice is licensed and transparent, so that overlapping with public services is reduced.

It is crucial to consider the complexity of the task when the improvement of health services performance is the aim (especially at policy level). Nevertheless, it has to be noted that in all of the three areas mentioned above some progress can be observed.

6.2 Focal Area 2: Behaviour Change and Communication

WHAT WAS PLANNED ?

SHSR-P activities in this focal area had been planned to enable the health personnel to respond better to perceived needs of the clients and to enlighten them about their rights.

MAIN FINDINGS

The PPR team appreciates SHSR-P's commitment to cooperate in the development of guidelines for clients' and providers' rights. This document is now distributed for discussion and ready for testing. The creation of the clients and providers rights charter is a very important step towards quality improvement through involvement of the consumer's (demand) side.

Another appreciable activity was the training workshop SHSR-P had organised at the Kampot referral hospital on Provider Behaviour Change Intervention (PBCI). PBCI is one of the tools to increase communication skills and understanding of clients' feelings. Client satisfaction was assessed in Kampot and Kampong Thom as part of the Quality Improvement (QI) programme. The results were not yet available.

As a more programmatic consideration, the conceptual position of BCC as a separate and vertical programme seems to be questionable. BCC is considered as a key area of work. In practice, it is likely that communication issues are covered more effectively if integrated in relevant focal areas such as Human Resource Development.

RECOMMENDATIONS

- Training on Provider Behaviour Change Intervention should be continued; preferably as an integrated module in training courses on Quality Management and Health Service Organisation (e.g. in the Hospital Management Training – HMT and Health Service Management Training – HSMT at the National Institute of Public Health – NIPH). This will help to meet the target groups more extensively.

[30] Source: National Health Statistics, MoH 2004. The targets correspond to WHO recommendations.

- Communities need to be involved in training on communication skills and behavioural change issues; the newly created commune councils could play an important role.
- Marketing technologies should be used (in cooperation with the National Centre for Health Promotion – NCHP) to reach the various target groups through appropriate messages, channels and instruments.

6.3 Focal Area 3: Quality Improvement

BACKGROUND

Undoubtedly, clients of health services have clear expectations regarding the quality of the health care service. They want to be received and treated respectfully and effectively at affordable costs. On the other side, the health personnel (the "providers") know quite well what quality in health service delivery means since many protocols and guidelines have been introduced.

However, in Cambodia's national health policy *quality* as a concept was new in the context of the health delivery system. The MoH recognised this fact and emphasised in the HSP 2003-2007 as a core strategy to the introduction and development of a culture of quality in public health services and the development and implementation of minimum and optimum quality standards for the public and the private sectors.

First steps to develop the conceptual and legal framework for quality improvement of health care delivery have been made:

- The introduction of the *Minimum Package of Activities* (MPA) presenting the list of activities and required qualifications for health centres (HC). They are binding for all public services. To achieve full MPA status of HC is one of the health sector priorities of the HSP;[31]
- The *Complementary Package of Activities* (CPA) applies for public referral hospitals; according to the degree of specialisation it is differentiated in CPA 1-3.

With regard to private health services there is no mandate yet from MoH that they have to follow up these tools as well.

WHAT WAS PLANNED ?

SHSR-P activities in this focal area had been planned to support the MoH in developing a framework for quality assurance (QA). It supports the preparation of an accreditation system and capacity building at PHD and OD level for implementation of the quality improvement (QI) programme.

MAIN FINDINGS

SHSR-P's strategic approach to QA in the Cambodian context

Strengthening the MoH at central level to develop a culture for quality in health combined with support to the implementation of QI programmes proved to be a very

[31] According to the JAPR reports, in 2005, 439 out of 966 HC (=45%) were providing full MPA, in 2004 only 30%.

successful strategic approach for the last three years. This included to realise that QA is a prerequisite for introducing SHI.

Key persons in both the MoH and among the development partners appreciate the appropriateness and effectiveness of SHSR-P's support. This applies especially to the "system approach", which means to combine policy development with piloting of QI projects in the local context.

At central level

At central level, SHSR-P in cooperation with WB and others provided substantial support to institutional development in the MoH, including equipment and conceptual development. Some achievements merit special attention:

- The quality improvement working group (QIWG)[32] was established. It meets bimonthly and provides conceptual guidance and coordination of all stakeholders for QA/QI;
- The quality assurance office (QAO) was established in the Hospital Services Department of the MoH. It is the technical core unit for the conceptual development and implementation of QI programmes;
- The QAO started an assessment of all quality related documents that are used or at least available in the country. More than 200 protocols, guidelines and checklists have been collected; however, categorisation and analysis have not yet been done;
- Furthermore, the QAO prepared the "National Policy for Quality in Health", which describes the rationale and principles of QI and determines strategies for implementation. This policy paper, signed by the Secretary of State[33] in October 2005, can be considered as a milestone in the MoH's endeavour to introduce a quality culture in the health sector.

Thus, at present there is a remarkable commitment at the MoH with regard to quality improvement. Unfortunately, the QAO faces serious staffing problems. This may endanger the current momentum in the MoH unless more qualified personnel are appointed in due time.

At implementation level

The PPR team appreciates SHSR-P's tremendous efforts to implement QI interventions in Kampong Thom and Kampot provinces. Apart from equipment and management support, QI teams have been set up in the PHD and OD (refers to Focal Area 1). Further technical assistance, however, seems to be necessary to increase the impact of this programme.

To some extent, however, the PPR team was concerned that apparently more energy is invested to control and monitor the quality of service delivery than to improve the performance of the providers. This may be a transitory phenomenon during the implementation of a new programme; nevertheless, it has to be taken into consideration.

[32] Chaired by Prof. Koum Kanal, Director of NMCH

[33] Dr. Mam Bun Heng

SHSR-P'S conceptual approach for quality improvement

SHSR-P has developed a comprehensive ("multi-pronged") concept for the implementation of QI programmes including the areas of capacity building, management, infrastructure, and incentives.[34] In one important pilot project this concept has already proved to be successful; another is in preparation:

- At the Phnom Penh Municipal Referral Hospital (PPMRH), it demonstrated in cooperation with GRET how the linkage of QA (provided by SHSR-P) with an SHI scheme (urban SKY[35] run by GRET) can be realised;
- In Kampong Thom OD, GRET will start establishing a rural SKY insurance scheme; SHSR-P will be in charge of quality improvement of the contracted health services (a selection of up to six HC in KT OD and the referral hospital).

Relevance of the QA pilot interventions

The experience with the above mentioned pilot projects is of utmost importance for setting up community based health insurance schemes (CBHI). The pilot interventions described below are necessary for testing innovative methods for performance improvement. Useful experience has been made already and needs further analysis.

- The *Reward & Reinforcement Scheme* in Kampot was started in 2003, but an assessment of the providers' perception, outcome, and impact has not yet been done. Based on the visits of some HC participating in the R & R scheme, the PPR team believes that:
  - Prizes seem to be too valuable; they are sponsored mainly by GTZ from the beginning on the PHD and RACHA – this may hamper ownership and understanding of the R&R scheme as a method or self-monitoring;
  - Besides rewarding the better performing HC, the scheme envisages to support (instead of punishing) the weaker ones. Here, more efforts by the OD teams may be necessary; otherwise the opportunities of the scheme are not used properly (the PHD has already announced the development of support modules for the health centres below the threshold score).

  The R & R system can be a useful monitoring instrument if the above mentioned issues are considered. The checklist used for the scoring has to be in line with standard HCAT checklists (as developed in Kampong Thom). The competitive element can have stimulating effects provided that the lower ranking services do not feel stigmatised and get support without punishment.

- In 2004, the *Hospital Care Quality Circles* intervention in Kampot province started with much enthusiasm as an outcome of the HMT, initiated by members of the Kampot RH. The four RH in Kampot met bi-monthly to disseminate skills and knowledge in hospital management. In 2005, WHO joined the project with the objective to include IMCI.

  However, a recent assessment by SHSR-P points out that the Quality Circles are at risk of losing effectiveness since too many topics were covered without clear

[34] For consistency reasons it is recommended that the component "QI projects" is left out of this multi-pronged concept, since this is already identical with the implementation of the programme.

[35] SKY = *Sokapheap Kroussat Yeugn"* (Khmer for: Health for our Families)

objectives and without appropriate methods to monitor the implementation of QI. It is necessary to redefine achievable objectives, as well as methods and indicators to monitor the progress. GTZ and WHO are requested to continue providing logistical and technical support.

The PPR team would like to stress that QC are a valuable method of self-monitoring. The benefits from successful actions need clarification, preferably in terms of professional satisfaction rather than monetary incentives. Further technical assistance is indispensable. The improved methodology of QC should be disseminated in the country (maybe with social marketing methods; for tentative TOR see annex 6).

Quality monitoring of health service delivery

With the MPA and CPA the MoH has developed two instruments that determine the scope and level of health services to be offered. Certainly, they need some adjustment and complements but, can be considered as first appropriate instruments of a Cambodian accreditation system.

- The *Health Centre Assessment Tool* (HCAT) was developed in 2004/05 with support of SHSR-P and finalised in January 2006. It is conceived as guidance for the monitoring of the implementation of MPA, both for external assessors and self-assessment by the HC team itself. The updated HCAT is a useful instrument. It includes 14 checklists covering the major organisational and management aspects and the operating procedures for some priority diseases (acute respiratory infection - ARI and diarrhoea). Some considerations for improvement concern are:
  - The check lists should be strictly structured according to the three main groups as outlined below (see under accreditation system).
  - "Clean water" as priority topic is missing.
  - In the introduction it would be useful to elaborate the value of self-assessment in order to counterbalance too much top-down monitoring.
- The *Hospital assessment tool* (HAT), conceived for the monitoring of implementation of CPA in public referral hospitals, was drafted by University Research Co (URC) in cooperation with the QAO. After revision of the draft, the MoH wants to start application of the HAT in provinces, where QA teams are already in place such as Kampong Thom, Kampot, Pursat and Siem Reap.

These two monitoring methods are further elements of a comprehensive accreditation system. They need adjustment and complements in order to become standard tools to be used in both the public and private sector. The missing elements concern, especially, the standard operating procedures for preventive, promotive and curative services (at present, the HAT does ask about compliance with some treatment procedures).

For private providers, the MoH has issued a decree (Prakas No 021, 2003) stipulating the preconditions for opening (licensing) private medical services. The major problem is that only a fraction of the existing facilities apply for a license and there are no sanctions for those that operate without a license.

Table 4: Private health care providers across the country in 2004

Private Facilities	Total	Licensed	Unlicensed
Polyclinics	33	12	21

Clinics	50	20	30
Maternities	14	5	9
Labs	32	6	26
Dental Clinics	10	8	2
Plastic Surgery Rooms	6	1	5
Consultation Rooms	1827	693	1134
Dental Consult.Rooms	376	50	326

Source: Report of Joint Annual progress Review 2005

Other national quality standards for private providers are not in place. Many NGOs use their own methods for quality monitoring, some of them being well adapted, for example, the *Quality of Care Standards for Sun Quality Health Network* (run by PSI) and the methodology used by GRET with regard to social health insurance. Experiences from the private sector also have to be taken into consideration.

All in all, there seems to be certain confusion about the variety of terms in use (e.g. minimum and optimum standards, certification and/or accreditation) and the huge number of various quality checklists that are utilised (or not) especially in the private sector. Obviously, there is a strong need to develop a comprehensive and integrated system, which is binding for all health care providers.

Accreditation System

Developing an accreditation system in Cambodia is repeatedly mentioned as one of the priority objectives. However, some of the senior officials in the MoH and among development partners stress that this can be achieved only in the long run. At the outset, it needs to be clarified, what actually is envisaged – an accreditation system according to international standards such as ISO 9100, EFQM[36] or a Cambodian accreditation system referring to what is achievable in the country within the next decade?

The PPR team has experienced that there is a tremendous gap between the ambitious intentions at central level and the reality on the ground in the districts[37]. This should be reflected in the accreditation system to be developed.

So far, a comprehensive concept for an accreditation system is lacking. The multitude of quality standards already existing in the country has no clear conceptual framework. The development of a comprehensive concept for a Cambodian accreditation system in health, including regulations and monitoring methods for both public and private sector, needs to be enhanced.

Standard operating procedures need a long time to be developed. A core group at MoH has been established (QAO, GTZ, PHD Kampot, PHD Kampong Thom), and professional associations, particularly the Medical Council, should be involved as well.

The PPR team appreciates the idea of introducing a quality seal to be awarded once a defined score is achieved.

[36] ISO = International Organization for Standardization, Version 9100 is for health services; EFQM = European Foundation for Quality Management

[37] This observation is confirmed by some results of the JAPR, e.g. that only 45% of all HC provide full MPA.

WB – GTZ collaboration in quality assurance

Apparently, there is a profound common understanding between WB and GTZ on the rationale and necessary activities at both central and peripheral level as outlined in the Minutes of Meeting (08 February 2003) and practiced during the last three years. In addition, the joint work in Cambodia benefits from the rich experiences with QI and QM in many countries facing similar socio-economic conditions.

At times, the implementation might have been hampered by administrative constraints at WB level. More important may be the danger of too high expectations from *assuring and managing* quality. The efforts to *assure* the quality of health service delivery seem to be stronger than those actually to *improve* the quality, i.e. to strengthen the service provision.

OPEN PROBLEMS AND REMAINING QUESTIONS

- The collection of the available (about 200) standards, protocols, and guidelines has been carried out by the QA Office; however, they are not yet further analysed and classified.
- Who actually is in charge of formulating a comprehensive concept of a Cambodian accreditation system in health, including licensing–accreditation for the public and private sectors?
- So far, the Medical Council is not fully involved in the quality improvement programme; however, it is represented in the QA Working Group.
- There is common understanding that quality regulations can function only with sanctions (also called “reinforcement“) – what happens in practice at district and health service levels?
- The terminology may be confusing: QA – QI – QM. What actually are the differences between the terms and to what extent are they understood?

RECOMMENDATIONS

At central level

- The QA Office as a core unit needs to be strengthened; the appointment of additional staff has been promised by MoH. If considered useful, SHSR-R and WB should offer additional technical assistance.
- Regarding the accreditation system to be developed reference should be made to the professional environment in the provinces rather than high level expectations according to international standards. To underline this purpose, it would be useful to talk about a specific “Cambodian accreditation system for health”, which will be developed in several steps in the coming years.
- The MoH in its endeavour to develop a Cambodian accreditation system should proceed in cooperation with its partners to first prepare such a comprehensive concept paper, in which the regulations for both public and private sectors are listed, the monitoring tools described and the responsibilities determined. A clear conceptual framework is one condition to better integrate all private providers. This document will determine the conceptual framework for institutional regulation and management as outlined in the National Policy for Quality in Health (III.b). QAO is in charge of drafting this paper, and SHSR-P and WB could contribute TA.

- It is suggested categorising the quality standards and checklists in three groups (and it would be very useful to insist on the application of this structure throughout all relevant documents):
  - *Structural standards* encompassing infrastructure, equipment, maintenance, logistics, and waste disposal;
  - *Standards for health service organisations (HSO)* including management, leadership, providers and clients' satisfaction and community involvement;
  - *Clinical performance standards* including the standard operating procedures (SOP) for the different preventive, promoting and curative services.
- It could be useful to introduce two seals, one to be achieved with a rather modest score and another as seal for excellence to be awarded only with a higher score (further operational considerations for the implementation of a Cambodian accreditation system are outlined in annex 5).
- SHSR-P should initiate the professional dissemination (marketing) of QI strategies and concepts to policy makers, professionals, and the general public using specific channels; an advisor (national or international) with special expertise needs to be engaged. This work could be part of social marketing of Social Health Insurance.

At implementation level

- SHSR-P is encouraged to further develop its "multi-pronged" concept for QI and adjust it for the implementation of:
  - the rural SKY project in Kampong Thom in cooperation with GRET, which is starting in early 2006;
  - additional schemes in other OD in Kampong Thom or Kampot may be considered (in cooperation with local nongovernmental agencies such as Malteser International or Cambodian Association for Assistance to Families and Widows - CAAFW);
  - the private Sun Quality Health Network (SQHN) in Kampong Thom province in cooperation with Population Services International (PSI) and KfW, which is in preparation.
- Based on the experiences in Kampong Thom, tools (a modified HCAT) for the accreditation of HC as contracted providers within a social insurance or social franchising scheme have to be prepared gradually.
- The assessment of the R&R scheme in Kampot should be conducted, the operational conclusions should focus on methods to operationalise "reinforcement" of the lower ranking HC, and the concept of prizing should be reconsidered.
- The *Hospital Care Quality Circles* in Kampot needs further technical assistance (by SHSR-P and WHO) and advocacy (marketing) to become an excellent method for self-assessment.

6.4 Focal Area 4: Human Resources Development

WHAT WAS PLANNED ?

SHSR-P activities in this focal area had been planned to strengthen health staff's capacity in management and priority clinical areas.

MAIN FINDINGS

SHSR-P's overall contribution and strategic focus

SHSR-P's support to human resources development (HRD) matches with one of Cambodia's central concerns. Putting one focus on management capacities of the leading teams in provinces and districts and another on improvement of the practical (clinical) training of nurses and midwifes, is fully in line with the needs in the health sector.

The effectiveness of SHSR-P's contributions is very much promoted through the excellent collaboration with MoH's Department of HRD[38] and some development partners, particularly UNFPA (in the area of safe motherhood and birth spacing) and DED (practical training of nurses and midwifes).

Regarding focus one, besides courses abroad ("District Management" in Manila and "Quality Management" in Heidelberg) the management courses organised at the NIPH have utmost significance.[39] In addition to training, SHSR-P promotes other useful initiatives, such as the monthly hospital management meetings (chaired by the Hospital Services Department of MoH).

The second focus, improving the practical training of nursing and midwifery students, is implemented in close cooperation with DED, whose nursing advisors are engaged to strengthen the linkage of regional training centres and the related referral hospitals and to improve the teaching conditions in the hospitals (designated teaching hospitals – a long term objective). Trainings for preceptors (clinical instructors) will begin at the end of 2006. A fruitful cooperation exists with the MoH and exemplary hospitals in other provinces (e.g. Angkor Hospital for Children, Sihanouk Hospital Centre of Hope).

The PPR team is very much in favour of the commitment in this area since the referral hospitals in the country (outside Phnom Penh) are obviously in dire need of assistance to improve their clinical performance, nursing and midwifery being priority disciplines. The team appreciates DED's decision extending its commitment through the recruitment of three additional nursing advisors. This would allow extending the activities to the other training hospitals, which are related to the four regional training centres.

Support to Kampot Regional Training Centre (RTC)

At the Kampot RTC a very useful and comprehensive cooperation with KfW and DED had been launched. The DED advisor completed her assignment in June 2004. KfW's strong input has created ideal institutional conditions in terms of facilities, equipment, and accommodation for the students. As a result, the application rate for Kampot RTC has dramatically increased; the increased capacity is fully used. The teachers and students' satisfaction with learning conditions and teaching output is obviously very high.

[38] Director Mrs. Keat Phuong

[39] See further notes under 6.6 Focal Area 6.

SHSR-P's and DED's support focused on development of new training strategies (curriculum development) and on strengthening of the teachers and preceptors capacity in modern methodologies and course management.

The experience at Kampot RTC and the related teaching hospital is particularly suitable to demonstrate how German development cooperation can obtain synergistic effects if the strengths of the individual agencies are well coordinated.

Clinical trainings

SHSR-P has organised numerous long-term, short-term and on-the-job trainings, some in cooperation with CIM (e.g. for x-ray technicians), others in cooperation with the hospitals in Kampot and Kampong Thom (e.g. anaesthesia and pediatric disease management at Angkor Hospital for Children). However, in view of the variety of topics and the considerable fluctuation of the number of trainees, it is not evident if SHSR-P organised these trainings on the basis of needs assessments or other conceptual considerations (e.g. concentration on an area).

During the mission the PPR team has learned that injuries through road accidents have dramatically increased; now ranking at position three[40] for health problems of inpatients. This should be taken into consideration for future planning.

SHSR-P's input to human resources development and institutional development under gender aspects

The SHSR-P's support to capacity building in the health sector is widely recognised among the partners. Its special support given to women has been pointed out repeatedly. Trainings and conferences abroad sponsored have been attended mainly by men, which reflects the existing gender disparities at higher ranks. In 2004 and 2005, the participants of in-country trainings (specialised courses, English courses and report writing) were between 11 and 24% female. The SHSR-P has successfully advocated women's attendance in the HMT and HSMT courses at NIPH. A quota of at least one woman has been introduced. Awareness on the importance of women's participation has been raised.

The RTC Kampot has set its priority on women as participants in the courses and housing in the RTC's compound is consequently reserved for women (90%). By doing so, the director and his team have responded to the constraint that families in Cambodia would rather let their son leave home for a training course than their daughter. Strict rules according to cultural traditions are being applied so that parents will be more likely to let their daughters participate.

The Director of HRD at the MoH, one of the few women in a high position at Cambodian institutions, stressed that unfortunately there is no follow-up and regular monitoring of students who have graduated from courses.

RECOMMENDATIONS

- The training plans should be based on needs assessment in the provinces or conceptual considerations (e.g. the priorities as formulated in the HSR). SHSR-P

[40] Inpatients per health problem in 2004: ARI 32,712, Diarrhoea 14,935, Road accidents 12,556, Malaria 9,890 (Source MoH, Dept. Planning and Information)

should concentrate on a few selected priority areas in cooperation with relevant development partners.

- SHSR-P should continue the cooperation with DED to promote practical training of nurses and midwifes and the improved linkage of RTC with (future) teaching hospitals. This should include the gradual extension to the other three RTC in Battambang, Kampong Cham and Stung Treng and the related designated teaching hospitals.
- It is proposed that KfW as well should explore the possibilities for a cooperation including infrastructural and equipment support to the three RTC and related hospitals. This would provide the opportunity to continue the successful joint German development cooperation.
- SHSR-P should envisage supporting the framework of an Emergency Support Programme (launched by MoH, University of Health Sciences (UHS), WB and other partners) a specific training programme in select referral hospitals. At present, this is concentrated on obstetric emergencies; however, with regard to the dire need it should also be extended to the area of traumatology, particularly with regard to the increasing number of road accidents. Once again, DED for personnel (or CIM) and KfW for equipment will be contacted to explore possibilities for cooperation.
- Continue advocating gender equality and encourage women to apply for training courses. Promote additional preparatory courses (mainly for women to meet the qualification requirements) at the respective training institutions to avoid lowering the quality of the training.
- Support the Personnel Department and HRD at the MoH in the planning, follow up, monitoring of graduates (e.g., the creation of alumni databases) with special attention to women and their professional career.

6.5 Focal Area 5: Health Financing / Social Health Insurance

EVOLUTION OF SOCIAL HEALTH INSURANCE IN CAMBODIA

In 1996, the Royal Government of Cambodia introduced official user fees in public health facilities including exemption schemes for poor clients and also set forth rules for the utilisation of the incomes from the fees. After an amendment in 2005, 60% are to be used as supplement for health staff salaries, 39% to improve the health service and 1% to be handed over to the treasury. However, the government did not mobilise any reimbursement for the health care providers. Within a few years it became evident that the exemption schemes would fail. Providers were not ready to treat free of charge and as a result, poor clients were even more marginalized.[41]

The MoH recognised the need of alternative financing mechanisms as outlined in the HSP. MoH started promoting the creation of Health Equity Funds (HEF) as a tool to channel funds for health care for the poor directly to the providers. One element of the National Health Insurance Master Plan promotes voluntary Community Based Health Insurance (CBHI) schemes, addressing the non-salaried households just above the poverty line to protect them into falling into poverty.

[41] According to an OXFAM study (February 2004) 60% of farmers, who had to sell land were forced to do so to cover health expenditures, mostly hospitalisation for their family.

In 2002, a Law on Social Security Schemes was passed stipulating that social security schemes will be created under the National Social Security Fund (SSF) for the private formal sector. Although SHI is not explicitly mentioned this law is an important step since it will allow for risk-pooling across the worker populations in Cambodia. In 2002, the Health Insurance Consultative Group (HICG) was appointed, and in 2003, MoH, with the support of WHO, developed the first draft of a Social Health Insurance Master Plan. This Plan was approved and launched in March 2005 and acts as a framework for SHI activities.

The first HEF supported by several donors in the context of the HSSP started in 2000. The first CBHI projects started with support from the French *Groupe de Recherche et d'Echanges Technologiques* (GRET) in Kandal province in 1998 and Takeo province in 2002. In spite of much scepticism regarding sustainability and many operational questions, the number of HEF has considerably increased, in particular in the contracted districts.[42] The number of CBHI has also doubled during the last two years.

Table 5: Development of HEF and CHBI in Cambodia

	2004	*2005*
Number of HEF	14	22
Poor patients assisted by HEF	34,512	99,801
Number of CBHI	3	6
Persons insured in CBHI	1,676	12,398

Source: JAPR Reports 2005 and 2006, HEF Forum 2006 Report

WHAT WAS PLANNED ?

SHSR-P activities in this focal area had been planned to create awareness and understanding of Fair Financing / Social Health Insurance (SHI) among policy makers and capacity building of stakeholders. Furthermore, SHSR-P supports the policy development for SHI and develops pilot SHI schemes.

MAIN FINDINGS

Overall progress in social protection /insurance

Taking into consideration that SHSR-P started working in this focal area only in 2004, the achievements, in particular, regarding awareness creation and policy development, are impressive. The PPR team considers two major reasons to explain this progress:

- One is GTZ's outstanding competence and commitment in this field, represented by an excellent team of experts in Cambodia, the valuable backstopping support from the expert in the GTZ-supported SHI programme in the Philippines and through valuable professional support from the Health, Education and Social Protection Division in GTZ headquarters.
- Second, the fruitful partnership with several development partners, in particular WHO[43], International Labour Organization (ILO), and GRET in cooperation with the MoH, which created the momentum for policy development both at central and

[42] In the context of the Health Sector Support Programme (HSSP) there are 11 districts in Cambodia, in which nongovernment organisations are contracted to manage the district with financial support from donors.

[43] Mrs Aviva Ron and Ms Maryam Bigdeli

implementation levels. According to the PPR team's observation, this harmonised partnership is decisive for the further development of SHI in Cambodia.

Congruence with government policies and institutional reforms

The commitment towards universal coverage with SHI is fully in line with national strategic priorities as outlined in the HSP and the SHI Master Plan. To some extent, the implementation is even ahead of institutional building. For example, in the formal sector the designated umbrella institution, the National Social Security Fund (NSSF) is about to be set up. Regarding the different member groups it is now quite clear that NSSF will cover formal private sector under MOLVT while MOSA will cover the public formal sector (civil servants except the military).

Awareness raising at national level

SHSR-P in cooperation with WHO, ILO and other partners has made outstanding contributions in creating awareness and understanding of SHI among policy makers and key stakeholders. The main activities included:

- Organisation of two study tours to the Philippines to study the experiences from and lessons learned with SHI. This included the attendance at an SHI training course developed by GTZ SHI Programme in the Philippines. It might be useful to include the experiences from Vietnam and even Laos.
- Sponsoring participation at the International SHI Conference in Berlin.
- Organisation of the first National Symposium on SHI in November 2005 as part of the activities of the SHI Committee, which is supported by GTZ. The cooperation with development partners is extremely important to meet some scepticism among some donors and at the Ministry of Economy and Finance. In spite of the encouraging progress so far advocacy of SHI remains of priority importance.

A series of achievements at central level can be considered as key steps for introduction of mechanisms of SHI / Fair Financing:

- The inter-ministerial SHI Committee (the former HICG) has been re-established (after a longer period of passivity) and a WG has been established.
- The updated version of the SHI Master Plan 2005 (prepared by WHO in collaboration with MoH) was submitted and translated to Khmer.
- The Proposal for a *Roadmap for Legislation of SHI in Cambodia* was developed with the support of WHO and GTZ. (December 2005).
- The Draft Guidelines for the Implementation of Community Based Health Insurance prepared by MoH in cooperation with WHO and GTZ were disseminated for discussion (November 2005).
- The first Equity Fund Forum in February 2006 provided a useful platform to discuss all important issues. It was decided to repeat it annually.

The listed documents provide a solid strategic and conceptual basis for further development of the still small network of SHI.

Implementation of SHI pilot projects

As a contribution to the implementation of the SHI Master Plan, SHSR-P started testing different projects, which are of great interest to all partners.

Pilot project 1: Cooperation with GRET has started to set up an urban "SKY" SHI scheme in Phnom Penh. Target groups of this voluntary insurance scheme are garment workers, beer girls, motor bicycle taxi drivers, market vendors and household helpers of expatriate staff.

SHSR-P's contribution consists of QI activities according to the "multi-pronged" approach to improve the performance of the Phnom Penh Municipal Referral Hospital (PPMRH), the contracted provider for the urban SKY scheme.

For five years already, PPMRH has had an Equity Fund, which is managed by the NGO Urban Sector Group (USG)[44]. Here, the potential modalities for linking HEF (re-imbursement of provider based on fee-for-service tariffs) with SHI (provider payment based on capitation fees) can be studied and developed for testing.

Pilot project 2: In cooperation with GRET a rural SKY network including selected health centres and the referral hospital is in preparation for Kampong Thom district. GRET has already had experience with similar schemes in Takeo and Kandal provinces. SHSR-P's contribution will be in terms of financial support in setting-up the scheme and technical assistance in ensuring an acceptable quality of care. At the referral hospital in Kampong Thom, an Equity Fund (EF) has recently been established. It is funded by WB through the HSSP and managed by the NGO *Action for Health*. Here again, the modalities for linking HEF (based on fee-for-service) with SHI (based on capitation fees) will be explored, developed and tested in cooperation with WB and GRET.

In cooperation with the GTZ-supported Rural Development Programme (RDP) in Kampot and Kampong Thom, SHSR-P is supporting the development of a standardised tool for the pre-identification of poor households. By means of a community based targeting process most vulnerable households are identified and provided with priority access cards. This tool is extremely important for facilitating the linking process of EH and SHI.

PROBLEMS AND REMAINING QUESTIONS

- So far, the membership of the existing community-based health insurance (CBHI) schemes is still very low (below 10% of the target groups). What are solutions to attract more individuals or households out of the target groups?
- The coverage of voluntary CBHI schemes is very low as well. What are the prospects for scaling up and achieving progress towards universal social health insurance coverage?
- The possible mechanisms of a linkage between EF and SHI have not been explored in practice. Therefore, the feasibility of proposed options (EF only as purchaser of SHI cards versus EF as payer and player in quality control and claim processing) needs to be examined more closely.
- The QI approach, including all determinants ("prongs") of the concept applied by the programme, is quite expensive. Will SHSR-P continue funding as it has done at PPMRH?

[44] From this EF, which is funded by Rockefeller Foundation, on the average 120 patients per month are assisted.

RECOMMENDATIONS

With regard to advocacy of SHI at central level

- Strengthening the SHI Committee as an umbrella unit and the WG for SHI is crucial for the whole process of SHI development in Cambodia.
- The same applies for a separate SHI unit in the MoH (at present, the Bureau of Health Economics and Finance in the Department of Planning and Health Information is responsible).
- Technical advice for the legislation process should be offered (involving the WHO/ILO/GTZ consortium).
- The National Symposium for SHI should be organised annually.
- Support the implementation of SHI management trainings for different target groups; study tours to neighbouring countries including Vietnam and Laos should continue to be organised with WHO, ILO and others; policy makers should also get to know more closely existing CBHI initiatives in Cambodia.
- However, it is advisable to study the respective experiences from the Philippines and Vietnam (with some reservation), because these models cannot be simply transferred to Cambodia.
- In view of the needs one may advocate strengthening the efforts since this might give further momentum to the process towards Fair Financing. Cambodia's relatively low socio-economic level may be a reason to be prudent in the expectations and to make sure that all activities are well coordinated with the government and the development partners. It seems wise to concentrate the development of new SHI schemes primarily on urban areas rather than in rural settings where the reluctance to join these schemes may be greater.
- The institutions responsible for formal sector insurance (Ministry of Social Affairs – MOSA, Ministry of Labour and Vocational Training – MLVT) should be involved in the development of voluntary SHI schemes; contents and modalities of cooperation should be explored.
- The operational studies for the application of a standardised tool for the pre-identification of poor households are to be supported, advocating for a final design that fulfils the requirements of EF and CBHI.
- Social Marketing of SHI needs to be initiated.[45]

With regard to piloting CBHI schemes

- Different models and experiences of CBHI in Cambodia should be documented, e.g. using the *GTZ InfoSure* tool, which offers systematic comparison of specific elements.
- Continue cooperation with GRET in support to the urban SKY at PPMRH; this includes development and testing of linking mechanisms for SHI and EF (in cooperation with USG and RF).
- Implement, in cooperation with GRET, a rural SKY scheme in Kampong Thom OD. Regarding the development of linking mechanisms of EF with SHI, a cooperation with WB and *Action For Health* should be envisaged.

[45] Tentative terms of reference are presented in annex 6.

- Take initiatives to investigate the possibilities for scaling up the social health insurance coverage, in particular through the development of CBHI. Potential approaches include:
  - Cooperation with MEDICAM in order to identify national or international NGO, communities or other institutions that are interested and have a potential for CBHI;
  - Agreements with the Cambodian Association for Assistance to Families and Widows (CAAFW), Malteser International, and others to cooperate with and jointly develop additional project proposals;
  - Agreements with EF implementers (WB, Action for Health and GRET in Kampong Thom and RF[46], USG[47] and GRET in Phnom Penh) on joint development and testing of linking mechanisms.
- Provide technical assistance for the feasibility and design study for Output-Based Aid (OBA) / voucher schemes (financed by KfW) to be linked with CBHI schemes; a number of critical questions which are essential for both insurance schemes, EF and OBA approaches have to be covered, e.g. managing agency, provider payment schemes and scope of benefits.
- Assess the possibilities of implementing another CBHI scheme in Kampot province in cooperation with a local executing agency (e.g. Malteser International or CAAFW) and possibly in cooperation with KfW (for the OBA approach).
- Explore in cooperation with the SHI unit in the MoH needs and modalities for a local institution to support existing and upcoming CBHI with regard to organisation, management, training and public relations.
- Prepare operational studies, for example on linking modalities of SHI and EF, in the regional context (Philippines, Vietnam, Laos, Thailand and others).

6.6 Focal Area 6: Institutional Development

WHAT WAS PLANNED ?

SHSR-P activities in this focal area had been planned to support the National Institute of Public Health (NIPH) to become an autonomous institution and in running management training courses.

MAIN ACHIEVEMENTS

NIPH's semi-autonomous status

With the support of SHSR-P and the SEAMEO-TROPMED[48], the entire NIPH staff attended a workshop to acquire the necessary skills and eventually worked out the NIPH's first strategic plan 2006-2010. The vision is to meet a public health training and a research institution regional and international standards and to become a semi-autonomous institution. The strategic plan constitutes a valuable basis for NIPH's institutional development.

[46] Rockefeller Foundation

[47] Urban Sector Group (Cambodian NGO)

[48] SEAMEO-TROPMED = South East Asian Ministries of Education Organisation – The Regional Tropical Medicine and Public Health Network is composed of four regional centres in Indonesia, Malaysia, the Philippines and Thailand. Its role is to promote health, to prevent and control tropical diseases and public health problems.

The process towards a semi-autonomous institution is cumbersome and long; by no means could SHSR-P have accelerated this process. Finally, however, with the support of the Secretary of State[49], the file is now at the Prime Minister's Office, where the final decision will be taken. The NIPH's directors expect that with higher managerial independence, including the utilisation of additional incomes through course fees, the institute's professional capacity and managerial effectiveness ("hire and fire") will increase. This, in fact, seems to be a precondition if the NIPH wants actually to become the leading public health institution in Cambodia by 2010.

The NIPH's productivity in terms of number of important research projects[50], consultancies, and short training courses is meagre and needs to be improved.

Management Training

The most effective and successful trainings are the Health Service Management Training (HSMT) and the Hospital Management Training (HMT). SHSR-P was and still is very much involved in the courses' organisation. Both courses are fully in line with the MoH's health policy. Scholarships for participants are provided by the donor community[51].

More than 90% of PHD and OD management staff[52] have attended the HSMT. At present, the second HMT with 42 participants (6 per hospital) is being conducted, and there is a high demand for the next one.

An evaluation of the HMT, sponsored by SHR-P and conducted in 2005 by the College of Public Health[53], University of Manila, Philippines, acknowledged the importance of the course and NIPH's efforts to attain a high degree of quality, and in addition, proposed a number of changes for improvements with regard to the curriculum and teaching methodology.

Master of Public Health (MPH) Course

The preparation of the MPH course remains disappointing. For many years GTZ has been committed to fostering the development of an MPH course. The HMT and HSMT can be considered as preparatory steps providing some modules for the MPH course. For some time, however, due to structural changes and the loss of qualified team members, no substantial steps were made, and only with the appointment of the new Vice-Director in September 2004, the preparatory work for the MPH course was taken up again.

A number of critical observations and questions result in some reservation regarding SHSR-P's further commitment; the main issues of concern are:

- A lack of a clear concept and implementation plan which outlines NIPH's plans and actions and the role of funding partners.
- A clear concept for the implementation of the course is not available; this would include an action plan and time plan as well as a cost analysis and financing plan.

[49] Dr. Mam Bun Heng

[50] Only six were conducted between 2003 and 2005

[51] Course fees are USD 2.500 (for tuition fees, teaching material, incentives for trainers).

[52] This regards the management teams from 24 provinces and 73 operational districts (OD).

[53] Prof. Caragay and his team.

- The pool of available lecturers for the different areas of expertise appears to be insufficient; it is still open to what extent lecturers from the University of Health (UHS) and other institutions and abroad (e.g. SEAMEO-TROPMED) are envisaged.
- Potential development partners, for example the stakeholders in the SWIM (for technical support and scholarships) in Cambodia, are apparently not involved; so far, only WHO is involved in the WG representing the development partners.
- The expected roles of supporting partners (University of California in Los Angeles (UCLA), USA; New South Wales University, Australia; University of the Philippines, Manila; SEAMEO-TROPMED; GTZ/University Bielefeld) are not clear.

However, there are also encouraging events with regard to the preparation of the course:

- The MoH has appointed a working group (WG), which is committed to submitting a first draft curriculum of the MPH course by the end of 2006. The WG is composed of the heads of different departments and centres in the MoH and representatives of other organisations and meets regularly. In the last meeting, for example, the rationale for the development of a MPH course, criteria for eligibility, and course modules were discussed.

  Study tours to neighbouring countries are planned to learn about experiences with similar courses (funded by the Rockefeller Foundation).

- In January 2006, a first consultative meeting with experts from international public health schools was organised to discuss appropriate programmes and institutional design for the establishment of a Cambodian School of Public Health (CSPH) at the NIPH. The invited experts (from University of California in Los Angeles (UCLA), University of New South Wales (UNSW) University of Bielefeld, and Rockefeller Foundation) presented their institutions, types of programmes and grading approaches. It was agreed to discuss areas in which they would be able to provide guidance or support in further meetings.

Relevance of support to NIPH, including SEAMEO-TROPMED collaboration

From the beginning in 1995, the setting up and strengthening of NIPH was one of the core activities of Cambodian–German cooperation in the health sector. The construction of new facilities including an auditorium, classrooms, a canteen, a hostel and a library, the establishment of a national reference laboratory and support to capacity building resulted in increasing recognition as a national institute of public health. In spite of ongoing problems recruiting and maintain a sufficient number of qualified staff, successful trainings such as HSMT and HMT are conducted, the status of semi-autonomy is expected soon and the preparations for an MPH course have started with support from MoH and other donors. It could be argued that further support from SHSR-P is not necessary.

On the other hand, several arguments advocate a further close cooperation of SHSR-P and NIPH, provided that NIPH would definitely be interested in intensifying the collaboration:

- SHSR-P could provide substantial support to the establishment of an MPH course, which meets international standards. GTZ in cooperation with several German

universities has acquired much experience in curriculum development, organisation of such courses and in modern teaching and communication methodology. This would include contracting of external lecturers and examiners.

- The graduation of Cambodians as specialists in public health should be possible at a national institute in Cambodia itself and not be limited to private universities and public health schools in neighbouring countries and abroad. This would save costs, ensure the relevance of course contents to the realities in Cambodia, facilitate the family situation of the graduates, and finally, strengthen Cambodia's scientific capacity in public health.
- SHSR-P could assist the NIPH in organising new short courses that are in line with priorities of the national health policy and correspond to SHSR-P's priority focal areas, for example a short course on Social Health Insurance and Quality Management.
- SHSR-P's strength includes the potential input of the network of GTZ-supported programmes in the South East Asian region (Philippines, Vietnam, Thailand, Laos and Indonesia). This network will be helpful in enhancing NIPH's cooperation with SEAMEO-TROPMED concerning ongoing training courses, the preparation and implementation of the MPH course (e.g. through external lecturers and examiners), and joint operational studies and research.

SHSR-P's input to institutional development under gender aspects

The support provided by the SHSR-P in the area of human resources development in terms of gender is interlinked with its input to institutional development. The empowerment of women, providing skills and knowledge combined with advocacy for a better gender balance in the institutions themselves, raises awareness on gender issues at the latter. This represents an important input to institutional development on gender.

Gender issues at the MoH are discussed and worked on in a committee of the TWG-H. A report on gender issues and the progress made was in draft form for internal discussions only at the time of the mission. According to the information gathered no Gender Focal Point has yet been established at the MoH.

RECOMMENDATIONS

- SHSR-P should more substantially support the preparation of a MPH course, which meets international standards, provided that:
  - the NIPH expresses a clear interest in such support,
  - agrees jointly with all supporting partners on the areas and extent of contributions,
  - shares in a transparent way with all partners the ongoing and planned procedures.
- SHSR-P's contribution (in cooperation with SEAMEO TROPMED) could concentrate on:
  - participation in curriculum development and course organisation,
  - cost analysis and financing plan to be endorsed by the MoH,
  - involvement of external lecturers in special areas and external examiners,
  - monitoring of course management, output and scientific level.

- SHSR-P should continue to promote NIPH's collaboration with SEAMEO-TROPMED; the MPH course would facilitate the integration in this network.
- SHSR-P should, in cooperation with NIPH, MoH, WHO and other development partners, examine the relevance and opportunities to organise short courses in Quality Management and Social Health Insurance.
- SHSR-P should further support HMT and HSMT with special regard to the adjustment of the training manuals.
- Advocate a more gender balanced composition of the faculty members at NIPH for the Master's course; promote the consideration of gender-sensitive contents in the curriculum for the Master's course at NIPH.

6.7 Status of Bilateral Contributions

The contributions by the governments of the Kingdom of Cambodia and the Federal Republic of Germany to the implementation of the first phase of SHSR-P are specified in the Implementation Agreement concluded between the GTZ (Country Director, Dr. Thomas Engelhardt) and the MoH (Secretary of State for Health, Prof. Eng Huot) on 16 and 23 August 2004.[54]

6.7.1 Contributions of the Government of the Federal Republic of Germany[55]

Provision of experts

GTZ shall make available for the project

- *a seconded expert on health management*

Contribution to date: 37 person/months (PM)
Ms. Gertrud Schmidt-Ehry: 10 PM, Ms. Anne Erpelding: 27 PM

- *the following experts:*
  - *seconded short term expert on health sector development up to 3 PM*
  - *a regional short term expert on health insurance up to 10 PM*
  - *a regional short term expert on academic institution development 24 PM*
  - *local experts up to 276 PM*

Contribution to date:
- Seconded short term expert: 6 PM (Prof. Georg Heinrich)
- Regional short term expert on health insurance: 1.2 PM (Matthew Jowett)
- Regional short term expert on academic institution development: 17 PM (SEAMEO)
- Local experts: 151 PM

Supply of materials and equipment

GTZ shall supply the following items to equip the technical infrastructure:

- *Vehicle*
- *Equipment and consumables*

Contributions to date:

Laptop Computers	14
Desktop Computer	18
LCD Screens	2

[54] Text in *Italics:* Quotations from the Implementation Agreement; contributions as of March 2006.
[55] The following information is counted from March 2003 (beginning of the first phase) to March 2006.

Printers	12
TV sets	6
Video DVD Player	5
Air Conditioners	7
Refrigerators	2
Photocopiers	5
Autoclave/Sterilizers	1
Motorbikes	6
Car (to NIPH)	1
X-Ray Cassettes and grids	18
VAMOS medical equipment	1
Anaesthetic medical equipment	1
Vital signs Monitor	1

Basic or further training outside the Project

GTZ shall provide basic training (or further training) for up to 20 Cambodian experts.

GTZ shall assume the following costs in this connection:
- *basic/further training courses;*
- *language instruction;*
- *living expenses;*
- *travel expenses.*

Contribution to date: 80 Cambodian experts trained

Operating and administrative costs

GTZ shall bear the operating and/or administrative costs associated with the processing of the German contribution to the Project.

Contribution to date: USD 43,075

Other contributions

GTZ shall provide local subsidies. The details of this local subsidy shall be laid down in an agreement between GTZ and the recipients of the local subsidies.

Contribution to date: USD 282,159

6.7.2 Contributions by MoH

Provision of experts and auxiliary personnel

MoH shall
- *provide a qualified manager to lead the overall Project*
- *provide the following experts to work in the Project:*
  - *qualified health managers and medical doctors in the Provincial Health Department and Referral Hospitals according to MoH staffing patterns*
  - *a director, deputy director and qualified health and other professionals in the academic institutions (NIPH)*
  - *at least one Quality Assurance manager for the MoH QA Office*
  - *at least one expert for social health insurance*
  - *experts in the relevant programme departments (HRD, Planning Department, Finance, etc)*

Contribution to date:

- 1 coordinator for German Cooperation[56]
- 6 officials of Kampong Thom Provincial Health Department
- 7 officials of Kampot Provincial Health Department and RTC
- 7 officials of academic institution (NIPH)
- 2 quality assurance managers[57] and administrative support
- 2 MoH officials appointed to work with social health insurance component
- 5 officials of MoH Departments (Human Resource Development; Health Planning and Information; Finance; Preventive Medicine; National Centre for Health Promotion), available part time

Costs

MoH shall ensure that the costs to be specified in the plan of operations are budgeted for and made available in due time.

Contribution to date: USD 1,443,639 (Kampong Thom and Kampot Provinces)

Provision of sites, buildings and work premises

MoH shall
make available to the Programme free of charge the following sites and buildings, including equipment, running costs and furnishings, insofar as such equipment and furnishings are not supplied by GTZ: office premises in the National Institute of Public Health or an equivalent building and in the two provinces Kampto and Kampong Thom.

Contribution to date:
- 7 office rooms at NIPH
- 1 meeting room available at NIPH
- 1 Kampong Thom field office
- 1 Kampot field office

All offices are provided with free electricity and water except Kampong Thom office where electricity is not provided.

7. DEVELOPMENT EFFECTS AND IMPACTS

Overall Development Impacts

Poverty and health are closely interrelated, as poverty can lead to health problems while illness often leads families into poverty. SHSR-P contributes improving the quality of the health system and, as such, to poverty reduction of the Cambodian poor. Economic benefits can also be expected from the development of social health insurance schemes and from access of poor families to free health care. SHSR-P also contributes to strengthening policy making and good governance in the health sector.

Impacts at Target Group Level

One serious health problem is often sufficient to push an entire family into poverty. SHSR-P supports the extension of health services to the poor by improving providers' skills, and the facilitation of the access of the poor to health services.

Health service improvements will result in three forms of economic benefits to the target groups: (i) health improvement that leads to better work productivity, (ii) reduc-

[56] Dr. Sok Kanha
[57] Dr. Sok Po and Dr. Sinoun

tion in days lost due to sickness or health care, and (iii) savings in expenditure on health care due to better and more efficient health services.

Increased efficiency in health service delivery, increased staff knowledge and skills, and improved quality of services helps provide better value for money to health care clients in general.

Impacts at Institutional Level

SHSR-P supports the MoH in preparing and monitoring annual operational plans. By this SHSR-P strengthens MoH's capacity to plan, finance and manage the provision of health services.

SHSR-P helps increase the capacity for planning and management at decentralised levels and thus contributes to the efficiency of the health system.

Provincial and district officials acquire skills to better identify specific health needs in their area and to address them within the context of national policy and strategy. Increased capacity at health centres will enable gradual incorporation of vertical disease management approaches into an integrated system with considerable cost-efficiency savings.

The holistic approach of SHSR-P with exchange of experiences between three levels (target group, institutional and policy level) allows high returns from comparatively small investments.

Social Impacts

SHSR-P specifically addresses the constraints often faced by the poor on seeking health care services; it does not have any adverse social impact.

Gender-related Impacts

Women in Cambodia are disproportionately burdened by health problems. Women and girls comprise more than 50% of the target group. Rural women in particular perceive the cost of using health services as high. The SHSR-P is classified as a **G1** because it addresses the causes of the structural gender disparities existent in Cambodia by:

- The promotion of and advocacy for free access to health services for the identified poor.
- The support and advocacy provided to women's attendance of training courses. This will contribute to an increased employment of women in the health sector.
- The promotion of awareness on the disproportional representation of women in training programs and institutions. In the long run this will contribute to overcoming of gender disparities.

Environmental Impacts

The SHSR-P has no significant environmental effects. Handling and disposal of hazardous medical waste such as syringes and needles is being addressed in the Hospital Management Trainings (HMT).

Unintended (Negative) Impacts

The PPR team has not identified any unintended (negative) effect that could be caused by the SHSR-P.

Contribution to the Development Objectives of the Royal Government of Cambodia (RGC)

SHSR-P contributes to the achievement of the development objectives of the Royal Government of Cambodia and, in particular, to the CMDGs on health:

- CMDG 4 – Reducing Child Mortality
  through the training given to midwives on ANC and IMCI by the DED advisor in Kampong Thom and through other training courses in both provinces.

  The increased awareness at community level on ANC-checks as well as the training provided to health centre personnel on nutrition, immunization of children and vitamin A for children adds to the reduction of child mortality.
- CMDG 5: Improve Maternal Health
  ANC-checks and the training of midwives also contribute to improved maternal health.

The progress towards achieving the CMDGs has been slow. Infant and child mortality rates are still comparatively high. Given the stagnant trends in these rates in the past years, the achievement of the CMDGs will be difficult unless reproductive and child health services improve considerably. Similarly, the maternal mortality ratio remains high and is not falling as rapidly as required to achieve the target of 150 by 2015. Achieving the goals of ensuring universal access to reproductive health services will need continued efforts.

8. RECOMMENDATIONS

The recommendations stated below are, in the main part, the result of a one-day workshop held on 28 March 2006 with the management and team of the SHSR-P and the PPR team.

8.1 SHSR-P Strategy and Approach

FUTURE STRATEGIC DIRECTIONS AND FOCAL AREAS OF THE PROGRAMME

Strategic Objective

To continue supporting the implementation of the Health Sector Strategic Plan (HSP) in close partnership with the development partners with a focus on the priorities formulated during the Joint Annual Progress Review (JAPR) 2006.

Strategic Approach

- At central level, to provide support to the focal departments in the MoH, relevant national centers, and institutions;
- At implementation level, to support strengthening the capacity of PHDs, ODs, and training institutions; strengthening the clinical performance of health providers and assessing the relevance of applied concepts;
- To increase effectiveness and impact of the support through close cooperation with development partners;
- To enhance cooperation with programmes and projects with similar objectives in neighbouring countries in the Southeast Asian region.

Focal Areas

In the first phase, SHSR-P adjusted its planning matrix to the six focal areas as formulated in the HSP 2003-2007, but emphasis was placed on the three key areas of Quality Improvement, Human Resource Development and Health Financing. This was due to the priority given by both the MoH and SHSR-P to these areas and in addition, GTZ's special capacity in these areas. In discussions on the most suitable future components of the SHSR-P, the PPR team has drawn two conclusions:

- Increasing the impact of the SHSR-P implies concentration on few components;
- SHSR-P should focus on priority areas where it has already proved its strengths.

Accordingly, the following three focal areas are proposed as components for the second phase of the project:

- Quality Improvement
- Human Resource Development
- Social Health Insurance

Some of the activities of the former six key areas will be continued under the three new components, for example training courses (BCC, management training, MPH course).

INTERVENTION AREAS

SHSR-P's operations at central level take place in Phnom Penh. The interventions at implementation level concern the urban area of Phnom Penh, and Kampong Thom and Kampot provinces, including OD and health service level, as well as the regional training centre in Kampot. In view of the ongoing and planned activities it is proposed to maintain this geographical focus in the new phase and, in connection with the proposed expansion of the collaboration with DED and KfW, to expand gradually to the RTCs Battambang, Kampong Cham, and Stung Treng.

CONSIDERATION OF GENDER ASPECTS

It is recommended to:

- Reformulate the indicator 3 (client satisfaction) of the overall objective in order to include gender relevant information;
- Ensure that gender relevant information is being taken into consideration in future studies and surveys;
- Propose the adaptation of the HC1 form with gender-disaggregated information. The additional information gained on specific diseases should be used to better adapt health services to men and women.

IMPACT MONITORING SYSTEM

It is recommended to:

- Establish an impact-oriented monitoring system for SHSR-P;
- Conduct baseline-studies and/or assessments once impact-oriented indicators are defined;
- Include methods and instruments for the assessment of client satisfaction and provider satisfaction;
- Contribute to the improvement of the data quality in the HIS.

8.2 Proposed Future SHSR-P Components

COMPONENT 1: QUALITY IMPROVEMENT

Objective

Support the MoH to operationalise the National Policy for Quality in Health

Activities

(1) Support the development of guidelines (Prakas) for the implementation of QI procedures as outlined in the National Policy for Quality in Health (NPQH),

(2) Capacity building for QI at central level and in the provinces and districts,

(3) Support the QA Office in the MoH to develop and introduce a Cambodian accreditation system for public and private health facilities and health care providers,

(4) Support the application of a monitoring system to measure quality improvement of services at health centres and hospitals using indicators and benchmarks,

(5) Advocacy and marketing of QI,

(6) Support PHD/OD in Kampong Thom and Kampot implementing and monitoring quality standards for health centres to be contracted as providers within insurance schemes (both private providers such as Sun Health Network clinics managed by PSI and public providers for the Sky network managed by GRET).

COMPONENT 2: SOCIAL HEALTH INSURANCE (SHI)

Objective

Develop capacities and mechanisms for the expansion of SHI schemes

Activities [58]

(1) Advocacy and marketing of SHI among policy makers, partners and target population (in cooperation with WHO and others),

(2) Support the SHI Committee and the MoH in the development and implementation of the conceptual, legal, and regulatory framework for SHI (in cooperation with WHO, ILO; WB and others),

(3) Strengthen the SHI unit in the MoH (at present, the Bureau of Health Economics and Finance in the Department of Planning and Health Information) in it's function of capacity building for SHI schemes (in cooperation with WHO, WB and others),

(4) Support the further development of ongoing CBHI in cooperation with GRET and other NGOs to increase efficiency and membership of the insurance schemes,

(5) Promote the extension of a network of SHI schemes in cooperation with potential executing agencies (such as Medicam, CAAFW, Malteser International),

(6) Promote and pilot modalities for EF-SHI linkage (in cooperation with WB, WHO, and others),

(7) Cooperate with KfW to prepare and conduct the feasibility study concerning OBA (voucher) approaches in linkage with CBHI and support the possible implementation of such a scheme in cooperation with a local executing agency,

(8) Explore in collaboration with the SHI unit in the MoH feasibility of and modalities for a local, non-state institution to support existing and upcoming CBHI with regard to institution building, management, capacity building and public relations (e.g. Centre of Health Insurance Competence - CHIC),

[58] Activities 4 and 8 are additional activities recommended by the PPR team.

(9) Support the development and introduction of standardised procedures for poverty identification to improve the access to health services for the poor,

(10) Continue documentation of best practices, lessons learnt as input for policy development and scaling-up of SHI schemes.

COMPONENT 3: HUMAN RESOURCE DEVELOPMENT

Objective

Strengthen the capacity of health personnel to meet the priority health problems more effectively

Activities

(1) Support training for health personnel at hospital and health centres according to needs and priorities,

(2) Support management training (HMT, HSMT, QM) for various levels of service providers,

(3) Strengthen the training capacity of the future teaching hospitals linked to RTCs in the field of nursing and midwifery (in cooperation with DED),

(4) Organise training in Emergency Medicine at referral hospitals with special focus on obstetrics and traumatology (a cooperation with DED and KfW is subject to negotiations),

(5) Develop and introduce a post-training follow-up mechanism to ensure application of acquired skills / knowledge,

(6) Explore needs and possibilities of cooperation in the establishment of MPH course at the NIPH.

8.3 Options for Outsourcing of Activities in the 2nd Phase

Since in the second phase SHSR-P is required to outsource an important share of its programme activities, the PPR team has assessed the options and would consider the following activities as suitable:

(a) *Social Marketing of Social Health Insurance and Quality Improvement*

This component encompasses two areas, which are closely linked to each other. The objective of the component is to design and implement activities, which include, apart from traditional methods of health promotion, marketing methods that proved to be effective both in commercial and social sectors

- regarding SHI, to improve the effectiveness of the dissemination of well targeted information on CBHI principles and benefits;
- regarding QI, to disseminate information on health service quality, clients and providers' rights and community participation.

(b) *Strengthening the training capacity of the future teaching hospitals linked to regional training centres - RTC (in cooperation with DED)*

This activity focuses on the development of new training strategies (curriculum development) for the RTC and the linked referral hospitals (future teaching hospitals). This includes strengthening of the teachers and preceptors' capacity in modern methodologies and course management.

SHSR-P intends to continue this sub-component in close cooperation with DED. It is recommended to gradually extend the support from Kampot to the other three RTC in

Battambang, Kampong Cham and Stung Treng and the related designated teaching hospitals.

(c) *Support to the Emergency Support Programme with special focus on a Training programme in traumatology*

The increasing number of road accidents has revealed the dire need of support in improving the capacity in traumatology at referral hospitals. This activity should be designed as a cooperation between DED (for personnel) and KfW (for equipment) and SHSR-P (for training methodology).

(d) *Explore needs/possibilities of cooperation in the establishment of MPH course at NIPH*

This activity would presuppose an agreement between SHSR-P and NIPH on several controversial points with regard to procedures, cooperation and tasks. Possible support areas for a potential subcontractor, which most likely should be a university institution, could be curriculum development, course organisation, lecturing in special areas, monitoring, and field studies.

8.4 Recommendations Concerning GTZ-KfW Cooperation

For a closer cooperation of the GTZ-supported SHSR Programme and KfW's Reproductive Health Programme II in the coming years, two proposals (A and B) had been submitted prior to the mission. Two additional options (C and D) proposed by the PPR team result from the needs encountered in the services and the favourable opportunities for German development cooperation.

(A) Quality assurance for Sun Quality Health Network Clinics

KfW provides financial assistance to the expansion of the PSI run Sun Quality Health Network (SQHN) clinics in the GTZ-assisted provinces of Kampong Thom and Kampot. PSI is planning to award quality seals to these clinics in the case they meet the requirements of an accreditation system for reproductive health services. SHSR-P will assist the MoH and PHD/OD to develop and monitor the implementation of the accreditation system.

(B) Implementation of OBA voucher schemes for reproductive health linked with CBHI

GTZ would provide technical support including an expert in the field of SHI to prepare and accomplish a feasibility and design study (financed by KfW) for the introduction of Output Based Aid (OBA) voucher schemes for private reproductive health service providers in one of the GTZ-assisted provinces. This study will have to include the prospective linking mechanisms with a CBHI to be started in the same district (supported by GTZ in cooperation with a local executing agency).

Kampot province appears to be more suitable for the testing of OBA schemes (covering only reproductive health services) since in Kampong Thom an Equity Fund (covering the whole range of curative and preventive benefits) has already been established and linkage modalities with CBHI will be developed and tested. Thus, the test in Kampot can spearhead the feasibility and modalities of the linkage between the voucher scheme (to meet the needs of the very poor) and SHI schemes (to meet the needs of the non-poor and less-poor)

Furthermore, GTZ is, on behalf of the BMZ, supporting the introduction of an instrument for the pre-identification of the poor.[59] This instrument, once officially endorsed by the RCG, will be used in public services and by Equity Fund operators as well. It has to be assessed how OBA schemes can match with this instrument as well.

(C) Strengthening the training capacity of the four regional training centres (RTC) and the related hospitals (future teaching hospitals) in Kampot, Battambang, Kampong Cham and Stung Treng

As recognised by the MoH, the joint support from KfW, GTZ and DED (infrastructure, equipment, curriculum development, training of trainers, management and clinical training) has resulted in remarkably improved performance of the regional training centre (RTC) Kampot and also of the related referral hospital (future teaching hospital).

The expansion of KfW's support to the three other RTCs would perfectly enhance the MoH's human capacity building programme. DED has already decided to recruit an additional three nursing advisors for the clinical training in nursing and midwifery at the three future teaching hospitals and GTZ would provide support to improve the management of the RTC, training skills, and curriculum development.

(D) Provision of clinical training in emergency medicine at selected referral hospitals (future teaching hospitals)

KfW, GTZ and DED are recommended to explore the possibilities of strengthening selected referral hospitals' capacity in emergency medicine, one of the core tasks of hospitals. At present, in line with the priorities of the HSR, an emphasis is put on obstetric emergencies; however, with regard to the dire need it should be extended also to the area of traumatology, particularly with regard to the increasing number of road accidents. This could be organised in coordination with an Emergency Support Programme envisaged by MoH, UHS, WB at central level. The support to this special training programme could include for example, for DED, the recruitment of two orthopaedic surgeons and clinical training; for KfW, equipment and maintenance support; for GTZ, management and training of trainers.

8.5 Recommendations Concerning Cooperation with GTZ-Assisted Projects and Other German Development Organisations

Rural Development Program (RDP) Kampot / Kampong Thom

Development of an instrument for the pre-identification of poor households (rather than post-identification, which must be carried out at the health service). This instrument will be used in both SHI schemes and EF.

Deutscher Entwicklungsdienst (DED)

The excellent cooperation in the field of human capacity building in the RTC and future teaching hospitals should be continued and even expanded.

DED is considering the assignment of a further three senior nursing advisors. GTZ should make sure that SHSR-P's contribution is be planned accordingly.

The proposed training programme in emergency medicine, in particular traumatology, could become a useful and promising cooperation with DED and maybe even KfW.

[59] Targeting – Identification of Poor Households in Cambodia (PN 2005.2178.1)

DED would be the most appropriate organisation to recruit orthopaedic surgeons who would be working integrated in a broader health support programme.

Center for International Migration and Development (CIM)

The cooperation with CIM could be continued with the intention to support special clinical areas, which might be identified as priority areas with a special need in support.

8.6 Recommendations for the Remaining Period of the Ongoing Phase

FOCAL AREA 1

- Assess how the data compiled in the new computerised HIS are interpreted and used at provincial and district level. Accordingly, prepare in coordination with MoH and NIPH, adjustments of current trainings (as part of HMT and HSMT or continuing training at PHD and OD level).

FOCAL AREA 3

- Reach agreement on a comprehensive certification/accreditation concept; support the QAO to develop a first draft concept.
- Assess the Reward & Reinforcement system (with focus on second R) and develop in cooperation with the PHD a concept for "reinforcement" of the poorly performing health centres in the districts.

FOCAL AREA 5

- Explore possibilities for accelerating the scaling-up of CBHI schemes. This includes consultations with potential local executing agencies, such as CAAFW and Malteser International, as well as with the umbrella organisation MEDICAM.
- Start cooperation with *Action For Health* on linking mechanisms of EF-CBHI.
- Evaluate experiences from other countries regarding the linkage of SHI-EF.

FOCAL AREA 6

- Recommend and support NIPH to organise a follow-up consultative meeting with supporting partners both in Cambodia and abroad to discuss the concept and schedule of preparation of MPH course and the potential contributions from partners.

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