Project Summary

CORE Group Country Collaboration Model:
Development of a National Community Participation Policy in Cambodia

Overall Objective: To support a multi-sectoral, participatory process resulting in a national policy on community participation in health.

Cost: $50,000 (CORE Group funded by USAID)
$3,000 (American Red Cross)
$ Time of Partner Organizations

Timeframe: 1 year (July 30, 2007 – September 30, 2008)

PVO Partner: American Red Cross

Other Partners: Ministry of Health (Department of Planning and Health Information), Ministry of Rural Development, Ministry of Women's and Veteran's Affairs, Ministry of Interior, UNICEF, BASICS, WHO, MEDICAM (Cambodian Health Consortium), USAID Mission in Cambodia and Cambodian Red Cross.

Outcome: The Community Participation Policy for Health (CPP) reached final draft in July 2008. CORE Group resources were used to facilitate a highly participatory process that engaged stakeholders at the national, provincial, district and community levels, and across a broad spectrum of governmental and private organizations involved in community health programs. The CPP is a significant departure from current policies on community participation in both its' depth and scope. The new policy broadens the range of activity *options* for community volunteers to include: surveillance, reporting, health promotion, community mobilization, and community-based treatment. Community volunteer activity under the prior set of policies was limited primarily to reporting between health centers and communities. The CPP also proposes a volunteer- base based on a ratio to households rather than a fixed quota. The previous policy called for one male and one female volunteer per community and up to 35 per health catchment area. The CPP outlines a clear support structure for volunteers and defines incentives to be provided to the volunteer.

Background on Revision of the CPP in Cambodia

In the early 1990s the Kingdom of Cambodia (KoC) embarked on a series of reforms to rebuild and redefine government after decades of civil war, foreign occupation and genocide which resulted in neglected and inefficient structures of civil service. In the health sector, reforms included restructuring services that were previously defined by administrative breakdown to services based on population coverage. For example, prior to the reforms, each commune had a health center, each district a referral hospital, and each province a tertiary care facility. Given that communes and districts varied in size and population, this system resulted in significant inefficiencies with some facilities overburdened and others underutilized. Moreover, district hospitals were providing primary care rather than acting as referral facilities further exacerbating system inefficiency. After reviewing other systems in Asia, the KoC decided to reclassify health coverage based on population and geographic accessibility. The redefined catchment areas were referred to as Operational Districts (OD) and could cover anywhere between one and four administrative districts. Each OD would have one referral hospital and a quantity of health centers based on population. Generally speaking, one health center would cover an average of two communes.

This new structure (established by 1993) effectively meant the closure of health facilities. In order to ensure community participation in this process, the MoH met with health centers and commune councils in all 24 provinces. Councils and health center staff participated in the defining the new catchment areas and placement of health centers in a way that maximized access by all communes under its jurisdiction. This was the first substantive act of community participation in health.

In addition, the MoH wanted to ensure that the reduction in the number of health facilities would not negatively affect care seeking. They adopted a structure developed by UNICEF in 1994 as part of a nutrition program referred to as “Community Feedback Committees.” Under the UNICEF program these committees were responsible for establishing a communications link between health centers and communities. As health centers were being consolidated, MoH adopted the community feedback model to ensure a formal communication mechanism existed with communities to inform them about new health center locations, services and continued changes occurring within the health system.

By 1999 these committees became part of a draft policy and were called *Village Health Support Groups (VHSGs).* Contrary to the *group* inference, the policy proposed only 2 VHSG members per village – one male and one female. This structure became official in 2003 under the *Policy for Community Participation in the Development of the Health Centre (PCPDHC).* In addition to the VHSGs, the policy established the Health Center Management Committee comprised of VHSG representatives from each commune, Health Center staff and Deputy Commune Chiefs. After approval of the PCPDHC, a set of draft guidelines were developed to facilitate implementation but never enacted. Nonetheless, VHSG representatives were elected in the majority of villages throughout the country and regular contact with the health centers was initiated.

Precursors to the CPP in Cambodia

The (1) *National Policy on Primary Health Care, (2) Implementation Guidelines for the National Policy on Primary Health Care*, and the (3) *Policy for Community Participation in the Development of the Health Centre (PCPDHC)* were the three principle documents related to health volunteers in the country prior to the current revised policy. The PHC policy and guidelines were formulated by an Inter-ministerial Committee on Primary Health Care, and were published in 2000 and 2002 respectively. The *PCPDHC* was published in 2003 by the Ministry of Health. Subsequent guidelines for implementing the PCPDHC were developed but never enacted. The Ministry of Rural Development's Guidelines on Establishing Village Health Volunteers in the Community Action for Social Development as well as guidelines for specific National Program volunteers (i.e. HIV/AIDS, Malaria, etc.) and NGO programs are also disseminated on a smaller scale for specific health volunteer programs. In general, these policies lacked clarity, exhibited inconsistencies and failed to reflect the true diversity, nature and challenges community health volunteers in Cambodia

Between 2003 and 2006 it became clear that there was some confusion about the policy as well as a lack of clarity on the intersection between VHSGs and other community health agents. The Ministry of Health, the Ministry of Rural Development and other relevant line ministries had been supporting a variety of health volunteer programs, as were national and international NGOs. Added to this were volunteers recruited for specific national initiatives, such as HIV/AIDS and Malaria. On the ground, there was a real lack of cohesion, overlap in areas and varying operating procedures and incentives for volunteers within the community.

In 2006 the Ministry of Health, the Ministry of Rural Development and the Ministry of the Interior and UNICEF conducted a joint assessment to better understand the level of awareness of existing community participation policies and assess potential similarities and discrepancies between those policies. The *Joint Assessment of Community Health Volunteers* confirmed discrepancies between policies and a lack of clarity on use of volunteers. In addition, they surveyed numerous stakeholders including provincial, district and health center staff and members of the NGO community and found limited awareness about the policies and their mandates. One of the main recommendations proposed was the development of a more comprehensive national community participation policy that would create clearer guidance and reflect all health volunteers operating within the community.

ARC & CORE Group Involvement

In 2007, the American Red Cross was operating a child survival program in Cambodia that recruited and trained 2,000 community health volunteers based on the Care Group Model. Based on their experience and the environment in Cambodia, ARC felt it was a good platform to respond to a CORE Group RFA that offered grants of $5,000-$50,000 to support "projects to expand the scale and impact of community-based approaches to child health through coordinated PVO action and learning at the country level." The original concept submitted by ARC was to conduct a study on community health volunteers to try and demonstrate how community participation models, such as the Care Group Model, improve health outcomes. CORE Group gave preliminary approval but requested that ARC develop more of a policy component. In response, ARC consulted with a number of stakeholders, ultimately meeting with Dr. Kiry, Director of Planning within the MoH. Dr. Kiry was supportive of conducting a policy revision process based on the results of the *Joint Assessment of Community Health Volunteers* recently completed as well as the prominence community volunteers would have within the new Health Sector Plan which was in the process of being finalized. ARC revised its concept to focus on assisting the MoH in revising the current Community Participation Policy. In July of 2007, CORE allocated $50,000 to support the policy development effort.

The CPP Revision Process

In Cambodia, the general procedure for developing policy is to first establish a Task Force representing the relevant ministries and stakeholders, supported by a secretariat or similar coordinating body. Research is conducted, a draft policy formulated and feedback sought from various interested and affected parties. A similar process was followed for the development of the CPP. However, perhaps because of the nature of the topic or perhaps due to NGO/PVO involvement, some felt that there was a broader spectrum of opinion sought and incorporated at various stages of the policy drafting process leading to a more consensus-oriented and informed policy. This was particularly important given the impact the policy would have at the grassroots level with essentially every village affected by this policy.

ARC consulted various stakeholders including, most importantly, the MoH's Department of Planning to determine the best use of resources available through the grant. It was through these discussions that ARC refined its concept and concluded that the facilitation of policy revision could potentially be a strategically effective use of the resources.

Once funded, one of the initial steps was to develop the Task Force as per policy development protocol in Cambodia. While the Task Force was the official vehicle for moving the process forward, other groups or entities also played important roles which

were not necessarily pre-defined but evolved over the course of the project in response to gaps or needs. The following is a summary of the key players, their roles and responsibilities:

MoH Department of Planning: The Department of Planning is ultimately responsible for formulating policy within the Ministry of Health. The Director of Planning provided the necessary authority and directive needed to move the process forward. He not only chaired the Task Force but also was part of the Secretariat.

Secretariat: The Secretariat was a four-person body comprised of a paid consultant (contracted for 5 days/month) the Director of Planning and two other members from the Ministry of Health. The purpose of the Secretariat was to serve as the overall coordinating body. The consultant had previously coordinated the joint assessment on community participation conducted in 2006 and was recommended by the Director of Planning. She coordinated and provided content for many of the planning meetings and consultative events and continually pushed the process forward. She consulted closely with the Director of Planning soliciting suggestions and approval at each step along the way. The other two members of the Secretariat had very limited involvement.

Task Force: The CPP Task Force was made up of key representatives from the Ministry of Health, Ministry of Rural Development, Ministry of Women's Affairs and Ministry of Interior, as well as UNICEF, WHO, Cambodian Red Cross, USAID, BASICS, MEDICAM, and the Secretariat. The Task Force defined the basic components and outline for the policy which was further detailed, edited and refined through a series of regional consultative meetings and focus group activities.

MEDICAM: MEDICAM is a membership organization for NGOs active in Cambodia's Health sector (similar to the CORE Group). MEDICAM and its members played a pivotal role by organizing the consultative process in two provinces which gathered input from provincial, district and commune level representatives – including volunteers themselves from eight of Cambodia's twenty-five provinces. MEDICAM also solicited input from its membership through a NGO sub-advisory group and kept its members informed through its website and newsletters (with articles written by the Secretariat consultant). It also administered a volunteer survey amongst its members to better understand the diversity of volunteer activities. MEDICAM elected an NGO representative to the Task Force who turned out to be one of the most active members of that body. Finally, MEDICAM was provided a small grant funded directly by ARC to help mobilize its members and support the consultative process.

American Red Cross: ARC took the initiative to start the process and effectively picked up where the 2006 joint assessment left off. It was the instigator and a crucial driver in propelling the process forward. Beyond administering the grant, ARC worked in close coordination with the Secretariat planning events. ARC's Representative in Cambodia helped to recruit non-ministry Task Force members and reinvigorated their engagement when the process began to lag. As a member of MEDICAM, ARC also organized one of the two provincial consultative stakeholder meetings.

What is remarkable is that the entire process took less than a year with the bulk of activity occurring in the latter three months. The following is a timeline of key events in the development of the Community Participation Policy.

September 2007 – Secretariat established; first NGO meeting on CPP.	**April 2008** – Mini-Grant provided to MEDICAM for 50% of Advocacy Officer's time to increase NGO participation.
October 2007 – NGO Sub-advisory group (via MEDICAM) established.	**May 2008** – Three Regional consultative events held in 2 provinces.
December 2007 – Taskforce members confirmed.	**June 2, 2008** – Secretariat conducts 1-day workshop with 3 sub-task teams to consolidate feedback and draft policy content under each of the 3 components.
January 2008 – First taskforce meeting; policy development roadmap approved.	**June 6, 2008** – Four focus group discussions conducted by Secretariat consultant and NGO Taskforce representative with a total of 20 health volunteers.
February 2008 – Secretariat prepares draft outline of policy components; Taskforce refines and approves outline.	**June 10, 2008** – MEDICAM, ARC and Secretariat supports two consultative workshops at provincial level with broad representation from 8 provinces and one NGO consultative workshop in Phnom Penh held to review rough draft of policy.
March 2008 – Taskforce members assigned to one of 3 sub-task committees: (1) Community Health Package; (2) CP Structures, and (3) Support Mechanisms.	**June 20, 2008** – MoH convenes Final National Consultative workshop with participation from Taskforce members, Director Generals from the representative Ministries, provincial and district health representatives and NGO representatives – 60 participants in total.
April 2008 – Secretariat compiles information on national volunteer programs, conducts comparative analysis of existing policies and review of global evidence base on various aspects of community volunteer programs.	**July 2008** – Final draft of CPP completed and disseminated to Taskforce members.

As the table indicates, it really wasn't until the last 3-4 months that major consultative events and policy drafting occurred. The process had a very slow start for a number of reasons. First, the formation of a task force is a bureaucratic process requiring official identification of participants, written invitations and responses. This took nearly three months to accomplish. While this time was not wasted as preparatory work was required, no official activities could take place until the task force was formed. March and April also happen to be months where a number of Khmer holidays occur and thus most task force members were not available to work during those months. Finally, the process was competing with a larger MOH priority – completion of its comprehensive Health Sector Plan (HSP 2008-2015). While the HSP interrupted the CPP revision process, it was a motivator to complete the revision as the health sector plan mandated a more intensive effort for involving the community in health. Ultimately, the threat of an imposing deadline for expenditure of funds helped accelerate the revision process in the final months and ARC's representative started playing a more active role —in

collaboration with the Secretariat— to motivate task forces members and push the process forward.

What is also important to note is the role that the national, regional and even local consultations played in the process of formulating policy. Some of these meetings were PVO-specific, others involved MoH officials and still others had a mix of representatives. Consultative workshops involved participants from three provinces in addition to the consultative meetings and workshops held in Phnom Penh. Participants represented a wide cross-section of those that would be affected by this policy from senior ministry and NGO officials to health volunteers themselves. Regional consultative events bookended the first draft policy and played two important roles. The first set of consultations helped to inform the drafting of the policy while the second set of consultations helped to modify and refine the policy once drafted. This was a departure from past processes where regional consultations were held only after the policy had been drafted. A number of these consultations took advantage of previously planned meetings to discuss the CPP. For example, MEDICAM held its annual sharing event in Siem Reap as well as regional events in Siem Reap and Battambang to which ARC requested that the CPP be added as an agenda item. In addition, CPP was discussed at every MEDICAM meeting as well as countless informal discussions held with stakeholders. Each of these events was taken as an opportunity to inform the construction of a policy based on the premise that input from a broad spectrum of stakeholders would help produce a better policy. An ancillary benefit of this process strategy will be the sense of ownership created beyond Phnom Penh and the MoH as well as an existing familiarity of the policy among the many who participated.

Challenges and Lessons Learned

Aside from the issue of time, the process had some specific challenges it had to overcome. The three principal challenges in developing the CPP:

1. Original role envisioned by the Task Force was not realized.
2. Involvement and active participation among stakeholders oscillated.
3. Disparate perspectives on volunteer roles and incentives posed a threat to reaching consensus.

CPP Task Force: Originally, it was envisioned that the Task Force be the key driver of the policy development process with sub-task committees meeting independently to discuss, gather input, and formulate their respective components of the policy. By May 2008 however, it was clear that this was not transpiring. The sub-task committees, each led by ministerial staff never organized independently as expected. Competing priorities, a series of national holidays, and possibly even lack of per diems for subtask meetings effectively brought the process to a standstill.

ARC started to take a more direct role by working to re-engage Task Force members through phone calls and individual meetings. At one point ARC's Country Representative was making weekly trips to Phnom Penh primarily for the CPP. Through this effort, the process which had stalled was effectively jumpstarted again. It was also decided that the sub-task groups needed were given too much responsibility. They needed a more limited but strategic role. In June, the Secretariat held a crucial one-day workshop of the taskforce. They provided each subtask group with an outline, guidance and set of criteria (informed through the consultative process to date.), and asked them to draft their section of the policy. This change in strategy from the sub-tasks being *formulators* of policy options to *deciders* of policy options that are given to them proved much more successful. By the end of the one-day workshop, a policy had been drafted.

Stakeholder Participation: Initially, the challenge was first to create awareness of the existing policies, the limitations of them, and to generate support for a new community participation policy. Even some national level MoH officials were unaware of the specifics of the existing Primary Health Care Policy and the Policy for Community Participation in the Development of the Health Centre. Awareness was even more limited at provincial and district levels, which in some cases had no copies of the existing policies. Without an appreciation for the current policies, it would be difficult to mobilize stakeholder involvement around the development of a new policy. In order to create awareness and motivate stakeholders, the Secretariat consultant and ARC Representative were continually networking via telephone and individual meetings to explain the process, solicit input, provide updates and pressure groups to commit time and energy to the process. The persistent informal networking that took place was just as critical as the more structured events.

On the NGO side, CORE Group advised ARC to initially organize the US PVO community. This meeting occurred during the first month of the process. While the intent was to ensure PVO collaboration —one of CORE's principal goals— it actually had the unintended effect of de-motivating a key group – MEDICAM. In Cambodia, MEDICAM is the recognized structure for health NGOs. MEDICAM leadership felt alienated by this action, which generated some initial reluctance to engage in the process. During the initial meeting a number of PVOs recommended that MEDICAM be the venue and mechanism for NGO input rather than the CORE Group of PVOs. A representative from MEDICAM was selected to sit on the task-force and report back to MEDICAM. However, MEDICAM management's involvement in the process was still quite limited. This changed when ARC and MEDICAM agreed to have MEDICAM's Advocacy Officer apportion 50% of his time to support the CPP effort paid for by ARC through a min-grant.

Disparate Perspectives: There were certain aspects of the policy that were anticipated to generate debate. It was unclear how, or even if, consensus could be achieved given the conviction some held with regard to positions on scope of volunteer activities, number of volunteers, and incentives. BASICS, for example, felt strongly that the policy should permit volunteers to be involved in community-based treatment. Within the MoH,

however, there was some hesitance to expand their role beyond promotion. Some stakeholders argued that volunteers would not work without cash incentives (i.e. per diem) while others were vehemently opposed to it. ARC's representative felt that at any point the process could be derailed given the strong opinions held and the knowledge that this policy could effect community participation for years to come.

Ultimately, consensus was derived in these and other areas by designing flexibility within the policy. In many cases, *options* were provided rather than mandates. For example, the policy allows for community-based diagnosis and treatment by volunteers but doesn't require it and moreover states that it should follow national guidelines. The taskforce also agreed on a list of specific in-kind incentives as well as additional cash or in-kind support based on the premise that *no volunteer should have to pay out-of-pocket expenses to fulfill their responsibilities*. The policy intentionally leaves it to the Provincial and Operational District leadership to determine how best to employ the policy and which of the menu of options they will use.

Outcome

The result of this process has been an evidence-based policy with comprehensive input and vetting across multiple sectors from the highest levels of government down to the principal target group of the policy – the community volunteer. With one exception: those interviewed (ARC, Secretariat, MoH/DoP, USAID, UNICEF, BASICS) felt the process was highly participatory and were satisfied with the end result. The Director of MEDICAM felt the policy should have received more intensive input from the Ministry of the Interior and more time dedicated to development and overall review. Ultimately, the final policy is one that is clearer, more detailed and in a number of respects quite different from the policies that preceded it (see Annex 1: Community Participation Policy for Health). Below is a summary of the key changes:

Component	PHC (2002) & CPDHC (2003)	Community Participation Policy for Health (2008)
Membership and Structure	• VHSGs are comprised of one man and one woman per community; there can be up to 35 VHSGs within a HC catchment area.	• VHSGs can be comprised of all types of community health volunteers (TBAS, CDOTs, VMWs, etc.) and should have a ratio of 1 volunteer for every 10-50 households in a community.
	• A group leader has to be selected with consensus of all VHSGs.	• 1 VHSG Leader is elected by the community.
Scope of Work	• Role of the VHSG is to provide health information and ensure regular communication between the Health Center and community.	• A menu of activities can be undertaken by the VHSG related to health information systems, provision and follow-up of information and essential services and provision and follow-up of essential diagnosis and treatment services.
Incentives	• One possible option for providing an incentive for volunteers is an exemption on the payment of 'user fees' for curative and preventative health services.	• Support responsibilities to the volunteer are outlined for community, health center, OD, PHD and commune councils; the policy stipulates seven specific non-cash incentives (incl. exemption of user fees) and clarifies that no volunteer should have to pay out-of-pocket expenses in order to fulfill their responsibilities.

Next Steps

American Red Cross used the remaining CORE Group funds to translate the policy into Khmer. It was then presented to a larger multi-lateral technical working group on September 12, 2008. The incoming Minister of Health (Cambodia just had national elections) is anticipated to authorize the policy in the next few months and develop operational guidelines before the end of the year.

Field Implications

The revision of the Community Participation Policy for Health was undertaken to strengthen and support the important work of community health volunteers in Cambodia. The revised policy clarifies community structures, scope of work, and supportive mechanisms to maximize community participation. Conceptually, the CPP places all community health volunteers under one operating structure regardless of their affiliation or scope of work. This means that all health volunteers are considered VHSG members and as such, will have to coordinate with the MoH. It also means that the volunteer is entitled to a minimum package of support from the MoH (I.D. cards, free health care, training, etc.). NGOs or other ministries that have community health volunteers will not lose control of those volunteers but will have to coordinate and receive endorsement for their programs from province and district health directors. The policy broadens rather than limits the potential menu of activities that can be undertaken by a health volunteer and doesn't require that all volunteers conduct the same activity. It effectively leaves it to the NGOs, other ministries and the health officials to agree on the scope of work in each specific case. This flexibility means that NGOs will likely continue to conduct project specific activities and may even expand the role of the volunteer as long as it is agreed upon with provincial and district health leadership. This uniform framework for community participation should promote greater collaboration among health volunteer groups, increase recognition and stature of the health volunteer and ensure minimum standards of support.

Considerations for Replication

With a relatively small investment of $50,000, a PVO (ARC) demonstrated that it could be a central catalyst for change by facilitating policy development in its niche area - community participation. Once approved, this policy will substantively affect the shape and character of community involvement in the health sector in every village of Cambodia. While it is important to recognize the role and contribution of the CORE Group, it is equally important to understand the environment and conditions that allowed the "plug-in" of money, time and leadership to have the impact that it did. Below are some important and, in some cases, requisite factors in the development of the community participation policy that should be taken into account if considering replication in other countries:

The right place at the right time: The MoH and other ministries had just completed an assessment of community participation the year prior which, among other recommendations, called for the development of a revised community participation strategy. Moreover, the MoH was in the final stages of development of its 8-year strategic plan of which community participation was an integral component and cross-cutting theme throughout.

Leadership: Without the senior leadership and support provided by the Director of Planning within the Ministry of Health, this policy would not have been possible. As a principal in MoH policy development, it was his endorsement, support and direction that was essential for success. On the NGO side, it was American Red Cross' Representative in Cambodia that developed the concept through extensive consultation, put the process in motion and provided the needed leadership when momentum had slowed. Finally, MEDICAM, given its mandate and extensive network provided an effective mechanism for NGO input and consultation from the provincial level on down.

Effective manager: The consultant hired with the CORE Group funds was effectively the day-to-day manager of the process. Given the complexity and multi-agency involvement required for policy development, this was a role that necessitated someone with considerable knowledge of the stakeholders and processes, solid diplomacy skills, and a comfort level working with both government and non-governmental agencies alike.

Persons Interviewed for this report

Person	Title	Organization
Robert Kolesar	Representative in Cambodia	ARC
Sujata Ram	Maternal Child Health Advisor	ARC
Lynette Walker	Deputy Director	CORE Group
Kristina Mitchell	Consultant	CPP Secretariat
Dr. Lo Veasna Kiry	Dir. of Planning	MoH
Dr. Sek Sopheanarith	Child Health and Nut. Specialist	USAID
Prateek Gupta	Advisor	BASICS
Dr. Thor Rasoka	Advisor	UNICEF
Dr. Sin Somuny	Executive Director	MEDICAM

- Report prepared by Chris Bessenecker, 11/3/08