Options

PHNOM PENH URBAN HEALTH PROJECT
A sub-project of the Kingdom of Cambodia Health Sector Reform III Programme

First Report to the Department for International Development

Reporting Period: April - September 1999
Phnom Penh Urban Health Project
A sub-project of the Kingdom of Cambodia Health Sector Reform III Programme

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# TABLE OF CONTENTS

Abbreviations iii

1. INTRODUCTION AND SUMMARY 1

2. CONSULTANT ACTIVITIES 3
   2.1 Activities Undertaken During the Reporting Period 3
   2.2 Short-Term Consultants -Assignments Undertaken 4
   2.3 Workshops, Training and Key Meetings 5
   2.4 Research Studies 7
   2.5 Future Activities Planned 8

3. PROGRESS TOWARDS ACHIEVEMENT OF PROJECT OBJECTIVES 11

4. CONTRIBUTION OF PROJECT OUTPUTS TOWARDS ACHIEVEMENT OF PROJECT PURPOSE AND ACHIEVEMENT OF HEALTH SECTOR REFORM PROJECT OBJECTIVES 16
   4.1 Establishment of In-Country Management Unit 16
   4.2 Baseline Demand Survey (BDS) 17
   4.3 Capacity Building Within MHD and the "Perspective Shift" 17

5. POTENTIAL CONSTRAINTS TO PROJECT IMPLEMENTATION AND IMPACT 19
   5.1 Private Medical Providers' and MHD's Attitudes to the Approved Providers Scheme 19
   5.2 MHD Capacity and Sustainability 19
   5.3 The Need for Inter-Sectoral and Inter-Departmental Action and Community Involvement 20
   5.4 Sustainability of Demonstration Projects 21
   5.5 The Need for an Improved Health Information System 21
   5.6 Support to the Evolving Role of the MHD 21

6. FINANCIAL REPORT 23
   6.1 Overview 23
   6.2 Budget Revisions 28
   6.3 Contractual Issues 20

Appendices:
1. Sharon Wilkinson's CV
2. List of UHPTF Members
3. Activity Reports
4. Memorandum of Understanding
5. Dr Salan's Activity Plan
6. Terms of Reference:
   • Invitation to Bid for the Baseline Demand Survey
   • Gill Gordon
   • Ruairi Brugha
   • Chris Vickery
Urban Health Project Progress Report: April - September 1999

7. Baseline Demand Survey Work Plan and outline of methods
8. Selection criteria (approved by UHPTF) for APS participants
10. Actual expenditure to date against budget
ABBREVIATIONS

APS  Approved Provider Scheme
BDHDW BDS Dissemination and HSUP Design workshop
BIDS Baseline Demand Survey
DFID Department for International Development
HSR III Health Sector Reform Phase III
HSUP Health Services for the Urban Poor
IEC Information, Education and Communication
MHD Municipal Health Department
MoH Ministry of Health
PMP Private Medical Provider
Sow Scope of work
TAG Technical Advisory Group
ToRs Terms of Reference
UHPTF Urban Health Project Task Force
UNCHS United Nations Centre for Human Settlements
WHO World Health Organisation
1. **INTRODUCTION AND SUMMARY**

1. This report reviews progress against the provisional outputs of a working Log Frame during the first six months of implementation (April - September 1999) of the Phnom Penh Urban Health Project.

2. Following a process of competitive bidding, the contract to manage the Phnom Penh Urban Health Project was awarded to Options Consultancy Services Ltd. UK in April 1999.

3. The Project Manager was recruited and following an intensive briefing in UK was in post in Phnom Penh, Cambodia on 19 April 1999. These initial months have been fully utilised to ensure Municipal Health Department (MHD) ownership of the project through their involvement in project design and implementation. The siting of the project office within the MHD has facilitated this process.

4. The Urban Health Project Task Force (UHPTF) has provided a platform for the contribution of project components to urban health to be debated and project direction to be actively sought.

5. The major achievements for this start-up period include the establishment of a fully renovated, equipped, staffed and functioning project office. Agreement was reached on the location of the Health Services for the Urban Poor (HSUP) in Tonle Bassac and Boeung Kak and the Approved Provider Scheme (APS) within Brambpee Makara District of Central Phnom Penh.

6. The scope of work (SoW) for the contracting organisation to undertake the Baseline Demand Survey (BDS) was developed and agreed and invitations to bid were issued. Following selection training was provided by Options' Principal Investigator and the research initiated. The results of the qualitative baseline demand survey were disseminated through a workshop held 7 - 8 September 1999 in Phnom Penh.

7. The project has completed a geographical mapping of the APS area, located private medical providers, informed them of the proposed project and extended an invitation for their involvement. The MHD and Ministry of Health (MoH) has facilitated this process by endorsing the invitation of the first group meeting of potential approved providers at a meeting held at the MoH on 16 August 1999.

8. While the APS component of the project is still in its early design stage, the response from potential approved providers, was not encouraging initially. Given the HSR III LogFrame assumption that "Private Medical Providers (PMP) would want to work with Government Departments" the 16 August meeting was seen as critical to the testing of this assumption. From a total of 38 invited PMP 12 attended the meeting, however these 12 are interested in the ideas incorporated in an APS and the meeting ended on a positive note. A second meeting held 15 September, in which the PMP agreed to the in-depth study of their practices confirmed their continuing interest.

9. Early debate on the scope of the HSUP has raised issues regarding the design of the project, particularly the provision of health needs through a medical model which focuses exclusively on the provision of clinic based services. There is a
growing recognition among project partners, of the need to establish systems that will facilitate the delivery of sustainable health programmes whilst at the same time providing immediate health gains especially for the urban poor.

10 Options management team continues to work towards the purpose level objectives as stated in the Health Sector Reform (HSR III) Logical Framework. The outputs of the Phnom Penh Urban Health Project are being incorporated into an independent Logical Framework. The output indicators are being determined through a process of consultation with key secondary stakeholders and through the BIDS.

11 The BIDS has identified existing health seeking behaviour and economic and other barriers to accessing good quality health services. This new knowledge is being fully utilised in the design the HSUP component and will be used also to inform the scope and scale of the Approved Provider Scheme. In addition, the BIDS findings will assist with shaping policy and raising awareness amongst key secondary stakeholders of the health needs of the urban poor.

12 A short financial report can be found in Section 6, summarising expenditure to date against the budget, and the budget revision which was approved by DFID in September 1999.
2. CONSULTANT ACTIVITIES

2.1 Activities undertaken during the reporting period

13 Upon appointment Sharon Wilkinson, Options Project Manager has ensured communication between key departments and individuals. Project direction is actively sought through the Urban Health Project Task Force (UHPTF). The UHPTF with members drawn from government departments, international agencies and NGOs active in the project areas, has provided a platform through which issues central to the concept of urban health and the contribution of project components to urban health have been debated. (See Appendix 1 for copy of Ms Wilkinson's CV and Appendix 2 for list of UHPTF members).

14 The UHPTF is the key group through which project progress is discussed. A work plan covering the period May 1999 - March 2000 has been developed and agreed. Reports against planned activity are presented monthly to the UHPTF (Appendix 3).

15 Following discussion within the UHPTF, agreement has been reached on a number of issues. Members have provided key inputs into: the development of the criteria for the participants under the Approved Provider Scheme; selection of geographical areas for project interventions; terms of reference for the baseline survey and the design of the interventions for the HSUP component. Discussions continue around the development of robust and appropriate models from which pilot interventions can be expanded in the future.

16 A Memorandum of Understanding, in which the roles and responsibilities of the different organisations involved in project implementation drawn up by the Project Manager has been agreed (Appendix 4).

17 The UK based Technical Advisory Group (TAG) meets to discuss project progress, assist in the design of project components as the work programme evolves and identifies policy issues as they arise. Inputs have helped to focus the content and approach of the BDS and have assisted the Project Manager to articulate health policy development needs in the context of urban health. With this support the project aims to assist the MHD to define its role in the context of health sector reform and decentralisation to the provincial/municipality level. A key output of the PP UHP is new knowledge for policy development. Central to this is the process whereby research and learning from the operational context is translated in planning, policy and practice. To this end, the guidance provided by the TAG has proven invaluable as timely inputs into programme development are made available for the UHPTF.

18 In recognition that it is critical that the project involve MHD personnel not just as recipients of new information and knowledge, but as key actors in policy implementation, the project has actively involved MHD personnel in project activities. Personnel drawn from the technical department including Dr.'s Nge'eth Sovann, Kan Vanny, Mak Huon, MA, Vong Bun Sum and Ms Keo Sophat under the direction of the project management, have completed geographical mapping in

1 The UHPTF meeting of 12 May 1999, agreed the MHD's request to change the location of one HSUP project site to Boeung Kak since it had a more defined poor population and lacked more basic amenities than Boeung Salang. Tonle Bassac remained the second HSUP site. The central area of 7 Makara was chosen as the focal point for the APS since it has attracted the full range of private providers.
Dr. Sour Salan, the Project Manager’s MHD counterpart, has an agreed activity plan and meets on a regular basis with project management to discuss progress, raising issues of wider concern related to urban health. Dr. Salan has actively advanced project activities to support outputs (Appendix 5).

Consultative and co-ordination mechanisms are being developed to ensure key stakeholders are informed of progress and involved in the decision making process. Active links have been established with key organisations working in the project target areas including inter alia, United Nations Centre for Human Settlement (UNCHS), International Red Cross, Friends, Cambodia Women’s Clinics, Urban Sector Group, Mith Samlanh (Friends) and Action Nord Sud. The UHP management is invited to participate in the monthly Provincial Co-ordination Committee meetings hosted by the MHD. Efforts will also be made to ensure primary stakeholders in the target areas are fully involved in the design and implementation, including monitoring and evaluation, of health programme interventions.

Through interactions with NGOs and government bodies the project aims to stimulate debate on policy development to address the health needs of the most vulnerable in Phnom Penh.

A project office has been established in the MHD Chan Kok Chhuong, who has secretarial and accounting skills, has been engaged to support project activities and the office is now fully functioning.

2.2 Short-Term Consultants - Assignments Undertaken

Terms of Reference (ToRs) for short term consultant inputs have been developed and circulated to members of the UHPTF (Appendix 6). Briefings by short-term consultants, with key members of the UHPTF have been scheduled and members are kept fully informed of progress in each component of the project. To date ToRs have been developed for:

- Invitation to Bid for the Baseline Demand Survey (BDS)
- Gill Gordon Principal Investigator for the BDS
- Ruairi Brugha (Health Policy for the Private Sector)
- Chris Vickery (Health Service Delivery Specialist)

A key early input into the project was the engagement of Gill Gordon to work with the selected research team Crossroads Consultancy. Ms Gordon visited Cambodia against developed ToRs for the period 12 - 25 June. During this period she developed the study tools, trained the research team in participatory methodologies and provided key guidance to the research process.

Training ensured that the needs of the Baseline Demand Survey (BDS) were fully addressed in terms of community participation, study protocols, scope of information, and competency of the study team, to deliver needed outputs. (Documentation covering the study programme and an outline of the methodological tools employed are attached as Appendix 7. Further details on the methodology can be obtained from Options).
Ms Gordon returned to Cambodia 4 - 10 September 1999 to assist in the analysis, presentation of findings from the first phase of the BDS and to develop and train the Crossroads team in the research tools for the APS BDS and the household quantitative survey.

Dr Chris Vickery (Health Services Delivery Specialist) has provided key inputs into the design of the HSUP component. Dr Vickery was in Cambodia against developed ToRs for the period 6-16 September. During this visit he attended the Baseline Demand Survey and HSUP Design Workshop and through a process of interactive meetings in conjunction with the BDS findings and workshop outputs helped to formulate the design of the HSUP component. Dr Vickery's consultancy report is available from Options.

Dr Ruairi Brugha (Health Policy for the Private Sector Specialist) was in Cambodia against developed ToRs for the period 11-17 September. Through close interaction with potential approved providers and members of key health institutions Dr Brugha has been key in developing the overall approach to the planned APS. Dr Brugha's consultancy report is available from Options.

Workshops, training and key meetings

Baseline Demand Survey Dissemination and Health Services for Urban Poor Design Workshop, 7-8 September 1999

The BDS Dissemination and HSUP Design Workshop was held 7 - 8 September 1999. A separate report documents the details of the workshop and the findings of the BDS (both available from options). A summary follows here.

Workshop Objectives

To:

- Disseminate results of the BDS; review and obtain feedback from selected secondary stakeholders
- Describe the key outcomes from research and discuss the implications for the design of health services for the urban poor of Phnom Penh
- Identify major gaps in present service provision and information for the urban poor and specifically the most vulnerable groups
- Use results from the BDS and workshop outputs to develop recommendations and outline the parameters for the design of the HSUP
- Develop an understanding of the long term policy implications of the HSUP

The workshop process supported the anticipated outcomes including:

- Increased knowledge of urban poor health care issues through dissemination of the results of the qualitative BDS completed in Tonle Bassac and Boeung Kak urban poor areas
- Increased creative thinking about the HSUP component of the UHP
- A set of recommendations based on the research and workshop outputs and consensus on the parameters for the design of the HSUP
- Increased understanding of the long-term policy implications of HSUP

In recognition of the diversity of problems facing the residents of the project areas, participants of the workshop were drawn from non-governmental organisations.
(NGOs), including community advocacy groups, government and other agencies working directly in the areas. The project has drawn on their experiences and has incorporated successful approaches into the planning of the HSUP component.

31 The workshop brought together 54 participants from the MoH, MHD, NGOs, advocacy groups and international agencies. His Excellency Dr. Eng Huot, the Director General for Health, Government of Cambodia, officially opened the workshop and pledged his support to the efforts to address the urgent issue of urban health in Phnom Penh.

32 The results of the BDS were disseminated and the project used this knowledge, and workshop participant feedback, to design the HSUP. Participants to the workshop were centrally involved in setting the parameters for the HSUP components.

33 Key issues that emerged from the workshop were:

- **The need for a new approach to urban health care**

  It was agreed at the workshop that the HSUP project should not simply replicate existing service delivery models. Instead, the workshop advocated an approach that focuses on user groups and involves them in planning and implementing project activities. The workshop also advocated placing greater emphasis on preventive health care. Wider availability of oral re-hydration solutions, improved access to birth spacing methods including barrier methods for sexually active men and women, early detection and treatment of sexually transmitted infections, increased levels of immunisation coverage and access to clean water supplies were among the issues discussed.

- **The need for better partnerships and integration**

  It was agreed that an approach that fosters inter-departmental and inter-sectoral collaboration, and supports NGOs' existing work with communities will be essential if the growing health needs of the urban poor are to be adequately addressed. This approach would include involving the community in the design, development, implementation and monitoring of the health programme activities.

- **The need to address issues of quality**

  The BDS clearly demonstrated the need of the urban poor for fast, effective treatment, based on adequate diagnosis. Distance, time and opportunity costs were identified as the major barriers to accessing health care. For the urban poor of Phnom Penh, quality of care may be as much an issue as the actual cost of health care. The HSUP will need to address the issue of how best to take low-cost, or even free, high quality services into the urban deprivation areas.

- **Need for improved health communication and promotion**

  Lack of health education for the urban poor was an issue which emerged from the BDS. The study populations articulated the need for more information about family planning, AIDS and how to improve the environment in which they live. The study indicated that the urban poor recognise the limitations of the health information they receive. They are aware of contradictions in the marketing of harmful products such as alcohol and cigarettes while health messages extol avoidance of these. The
workshop emphasised that an effective health IEC campaign will be an essential component of the HSUP. The workshop also recognised the need for additional research to develop clear messages, interventions and materials that are appropriate for the target audience.

- The need to address policy issues

It was clear from the plenary discussions and small-group presentations at the workshop that there are major policy gaps and areas where existing health policy is not being adequately implemented. Uncertainty and lack of transparency in user fees, coupled with arbitrary and largely ineffective exemption schemes remain major barriers to health service utilisation by the urban poor. It is evident that these issues must be addressed if the HSUP is to reduce the dependency of the urban poor on self-medication and unregulated and untrained drug sellers.

A second policy issue relates to the legality of the squatter communities, and the implications this has for the provision of services and utilities. The prominent role taken by the MHD at the workshop and their full involvement in the proposed design of the HSUP will help to ensure that this issue is addressed.

2.3.2 Meeting with Private Medical Providers, 16 August 1999 and 15 September 1999

Private medical providers (PMP) from the Brambpee Makara area, in Central Phnom Penh, were invited to participate in a MoH facilitated meeting to promote the concept of an approved provider scheme (APS). 57 PMP from the area had been identified as potentially interested in the scheme. One of the selection criteria, debated through the UHPTF, was used to select those PMP who have a high potential to be incorporated into the scheme (see Appendix 8). 38 PMP were invited to the first meeting held on 16 August. While only 12 attended, there is growing interest in the scheme, as indicated in individual and group meetings since. The process of reviewing PMP capacity and needs is ongoing. A second meeting held with PMPs on 15 September was more positive, and the PMPs agreed to participate in the in-depth study of their practices (PMP audit).

2.3.3 WHO - HSR III Meetings

Options management is included in all key WHO-HSR III facilitated meetings. This has ensured that progress within the UHP is widely known and that information shared and that the UHP has access to broader thinking on the HSR agenda.

2.4 Research Studies

Following a process of competitive bidding, the baseline demand survey contract was awarded to Crossroads Consultancy Limited. Crossroads was able to field a strong team of researchers with highly developed quantitative research skills and some exposure to qualitative methodologies. Following training, the research team has followed the research plan and provided weekly reports on progress against the plan. The qualitative research in the HSUP sites (Tonle Bassac and Boeung Kak) was conducted first, followed by the quantitative household survey in the same sites, and the qualitative BIDS in the APS site (7 Makara). Crossroads has also facilitated capacity building within the MHD by providing a research fellow to assist in the mapping exercise of Brambpee Makara.
37 Work has also been initiated to complete a supply-side study to complement the baseline demand survey in 7 Makara (see paragraph 44).

2.5 Future Activities Planned

2.5.1 Baseline Demand Survey

38 The qualitative phase of the BDS for Tonle Bassac and Boeung Kak was completed, data analysed and the key findings, translated into Khmer, were disseminated at the BDS Dissemination and HSUP Design Workshop (BDHDW). Crossroads will also continue the study during October to complete the qualitative research within Brambpee Makara district. The household survey within Tonle Bassac and Boeung Kak will be undertaken during October. The household survey is a key component of the baseline survey and will provide the project with a statistical base from which progress will be measured. Full BDS findings will be available in November/December 1999.

2.5.2 Health Services for the Urban Poor

39 Options contracted Dr Chris Vickery as Health Service Delivery Specialist to assist in the facilitation of the BDHDW workshop and, using the parameters of the intervention agreed at the workshop, to facilitate the development of the HSUP strategy. Draft project component indicators and monitoring tools were also developed during this period.

40 The HSUP strategy was constructed and will be operationalised around three interrelated and mutually supportive pillars aimed at:

- Improving access to and performance of health services.
- Building capacities at the local level, specifically the MHD in relationship to working with the community and NGOs.
- Promoting participatory communication processes.

41 The design of the HSUP component raises policy-related issues in relationship to services for the urban poor, particularly in the context of limited or no existing MHD service delivery points.

Key policy outcomes of the HSUP component might include:

1. The relative importance to the urban poor of barriers other than purely financial ones when deciding to access health care.
2. The extent to which financial and non-financial barriers can be removed, and the problems encountered, best solutions, costs and consequences of doing this.
3. The extent to which demand for high quality services can be stimulated and the most successful approaches to doing this.
4. The extent to which harmful ideas about health can be changed and the most successful approaches to doing this.
5. The extent to which participation in, and ownership of health services can be developed, and if successful, identification of the user benefits and potential for the future.
6. The extent to which providers can be encouraged to improve the quality of the service they provide, how this is best achieved.
7. The extent to which the MHD can use the information to plan, contract, manage and supervise the provision of health services for the urban poor.
8. How the exemption scheme at primary and secondary level might be improved.
9. The extent to which the environmental causes of ill health can be addressed with community participation.
10. The costs of any measurable benefits from the above.

Discussions with the MHD are presently focused on the development of a contractual relationship in which we are agreeing the parameters of service delivery, including the service package and the monitoring and evaluation framework. Discussions held with municipal service staff indicate the design of the HSUP component meets with the approval of public health care personnel.

2.5.3 Approved Provider Scheme

Dr Ruairi Brugha, an Options contracted Health Policy for the Private Sector Specialist, has taken a leading role in developing the process whereby private medical practitioners will be brought into the APS. The specialist was in Cambodia in September 1999. During this consultancy we agreed to take advantage of the opportunities that exist in the private sector while strengthening the appropriate role of the MHD as regulator of service quality and care taker of the health of the poorest segments of the population of Phnom Penh.

Work has also been initiated to complete a supply-side study (PMP audit) to complement the baseline demand survey in 7 Makara. This study is required to analyse the PMP clinical and patient interactive environment in order to inform the scope of the APS. Approaches and study tools were developed by Dr Ruairi Brugha and the research is being conducted by Dr. Uy Vengky a medical practitioner with social scientist skills. The study will gather and analyse data on:

- Practice profiles (facilities and equipment, patient load, types of services delivered.
- Provider knowledge / reported diagnosis and treatment practices
- Actual practices (technical, communication skills, provider - patient interactions), through direct observation.
- In-depth exploration of the perceptions, constraints and range of factors that influence or determine provider behaviour.

Outputs from this research will be available in December 1999.

The findings of the PMP audit and the BDS in 7 Makara together will provide information on provider and consumer behaviour, and the factors which determine them. The results of these surveys will be used to determine the scope and strategies of the APS intervention to promote quality of private sector services and public health objectives which are consistent with government policy. Once participants in the scheme are identified, the "package" available will be agreed in consultation with them and contracts, agreeing medical protocols, reporting requirements and overall roles and responsibilities, will be drawn up. A workshop with PMPs to be held early in December 1999 will be the focal point for designing
the scope of the APS. The Health Policy for the Private Sector Specialist will provide further technical assistance at this stage.

46 Early indications suggest that it has yet to be determined if the `approval' of providers and `an extensive marketing campaign to encourage people to use their services', as was envisaged in the original proposal, is the most appropriate approach at this early phase in the development of the private health care sector in Cambodia. The acceptability and potential of this approach will be further explored with the different stakeholders and at the December workshop.

2.5.4 Logical Framework Development

47 The UHP Logical Framework will be finalised once the scope of the HSUP and APS components are finalised. The working LogFrame objectives are as follows:

Goal: Improved health status of urban poor in Phnom Penh (contributing to their productivity and social development)

Purpose: Increased utilisation of good quality essential health services in Phnom Penh, especially by poor people, through alternative service delivery models implemented and evaluated for their impact on access and equity. (ie. Adapted Output 3 objective on HSRIIII LogFrame).

Output 1: Improved accessibility of good quality essential basic health services for the urban poor through Health Services for Urban Poor pilot project

Output 2: Improved accessibility of good quality health services provided by private medical providers through an Approved Providers Scheme pilot project

Output 3: Increased knowledge of health needs and health seeking behaviour of urban poor in Phnom Penh through baseline demand survey

Output 4: Enhanced capacity of Municipal Health Department (and urban NGOs) to manage and monitor urban health service provision and to interface with NGO and private health providers

Output 5: Policy outcomes of UHP inform HSRG agenda

48 With a nested Logical Framework approach, the HSUP and APS components will have their own component LogFrames. The provisional purpose of the HSUP is: Increased utilisation of quality health services (primary and secondary through referral) by the urban poor in project sites. The provisional purpose of the APS is: Increased utilisation of health services provided by private providers through improved quality and removal of barriers to access (including where appropriate, financial barriers to accessing public health goods).
3. PROGRESS TOWARDS ACHIEVEMENT OF PROJECT OBJECTIVES

49 The project management has been reporting to the UHPTF against activities as it was too early in project implementation to measure progress against output indicators. As the programme develops and the scope of work is agreed the project is moving towards reports that reflect outputs and end of year achievements against purpose-level objectives. (See Appendix 9 for workplan covering September 1999 - March 2000).

50 The table below summarises project achievements and constraints within each of the working LogFrame outputs. This first report to DFID includes more detail in narrative form under Section 2. However, in future, this information will be captured in this tabular, summary format under Section 3, and will measure progress against output indicators.
4. CONTRIBUTION OF PROJECT OUTPUTS TOWARDS ACHIEVEMENT OF PROJECT PURPOSE AND ACHIEVEMENT OF HEALTH SECTOR REFORM III PROJECT OBJECTIVES

51 The Immediate Objective or Purpose of the Health Sector Reform Phase III Project is stated as: "To increase people’s, and particularly poor people’s access to and utilisation of good quality essential health services whether subsidised by government or paid for through public - private mix."

52 Options is engaged to deliver Output 3 which states: "Alternative service delivery models implemented and evaluated for their impact on access and equity."

53 The Urban Health Project’s Purpose (provisional) is: Increased utilisation of good quality essential health services in Phnom Penh, especially by poor people, through alternative service delivery models implemented and evaluated for their impact on access and equity.

54 While the Urban Health Project is itself in the early stages every effort is being made to keep the goal and purpose of the HSR III project in view.

55 There is more than sufficient demonstrable evidence that the poor suffer most from environmental hazards, poor water and sanitation. If the project is to maintain its focus, that is, ensuring access and equity in the provision of health services especially for the poor, then it must ensure that the urban poor are fully represented in the design and development of appropriate health services. To this end the BDS is both participatory and focussed on identifying and working with the most vulnerable groups in the urban poor areas. The APS preliminary objective is to improve quality of health care within the private sector and thereby increase access to good quality services by users willing and able to pay for such services. The UHP will explore the issues surrounding accessing quality care in the private sector and will work directly with providers to improve quality of care and ensure value for money.

4.1 Establishment of in-country management unit

56 The project office was established within the M HD, as a base from which Options could deliver DFID funding and technical resources, monitor project progress, contribute to the HSR III strategy while supporting MHD efforts to be centrally involved in project process. There is a clear understanding between project partners (MHD/WHO/Options) that the more the MHD participate in the work programme the more likelihood that they will appropriate the results.

57 The main duty of project management focuses upon the provision of implementation capacity to the UHPTF. Inputs are delivered against an agreed contract, under UHPTF leadership and guidance, ensuring the effective use of project resources. Options provides annual project and individual activity plans towards the achievement of project outputs and identifies and develops solutions to operational problems.

58 Options ensures financial and technical resources are provided in a timely manner, that narrative and financial reports are provided against schedule and that
information and new knowledge is disseminated to Government of Cambodia, project partners and donors including DFID.

4.2 Baseline Demand Survey (BDS)

59 The BDS is being undertaken to ensure the planned interventions are demand led rather than supply driven. The BDS will expose issues surrounding income, seasonality of illness, perceptions of severity and etiology. These factors in health seeking behaviour will be analysed and will form the basis of a range of possible solutions in health care provision.

60 The Crossroads team has done commendable work in collecting data on different aspects of health seeking behaviour. In feeding back this knowledge, Crossroads is helping the project to develop insights concerning the important areas of equity, community felt need and the interaction of health seeking behaviour with access to services of various kinds and of cultural meaning, the perception of health problems and community identified solutions, within the project's target areas.

61 These areas are of particular importance as the UHP stresses and aims to address the issues of equity and disparity. The team has exposed the fact that loans taken by the poor, to meet the high costs of health care emergencies, become a major burden on them in the form of debts incurred.

62 The role of environmental sanitation and the relationship with infection and malnutrition, and its effect on infant morbidity and mortality, have been extensively documented. It is now accepted that the non-availability of sanitation and potable drinking water is seen as one of the major limiting factors in the eradication of the cycle of deprivation that includes infection and malnutrition. The BDS is also pointing to community wide knowledge that lack of environmental sanitation underlies the majority of childhood illness experienced amongst the urban poor. This knowledge is highly indicative of the need for multi-sectoral collaboration to address the salient urban health problems.

63 The project aims to harness this community knowledge to encourage community collaboration with the MHD to address the underlying environmental issue of ill health.

4.3 Capacity Building within MHD and the "Perspective Shift"

64 There is a growing body of knowledge that Phnom Penh’s urban health care system, both public and private, is facing increased pressure. This includes a growing urban poor population with little or no purchasing power; a public health sector network which, with the introduction of "official" user fees and an inadequate fee exemption scheme, effectively excludes the poor; in addition, an unregulated private sector that currently absorbs about 80% of out-of-pocket expenditure most frequently via direct sales of pharmaceutical products from retail outlets.

65 In this context the APS and HSUP will test a number of management mechanisms to foster the development of policies aimed at developing more effective, efficient and equitable health services while increasing access especially for the urban poor. These are likely to include:
Provision of services, through APS and HSUP, around the Minimal Package of Activities (MPA).

- Enhanced regulatory and self-regulatory capacity within the private sector.
- Establishment of referral networks ensuring the poor can access hospital based services.
- Direct provision of services regardless of ability to pay.
- Better education of the consumer about the price and quality of health care including active promotion of selected approved providers.
- Addressing quality issues through a process of setting and monitoring of best practice.
- Establishment of transport links ensuring lack of finance to transportation does not act as a barrier to emergency services.
- Community participation in the design and monitoring of the project with the aim of opening up civil space to discuss roles and responsibilities of different organisations and groups in the delivery of appropriate health care.

However if the MoH and specifically the MHD is to take on board the lessons of this project there is an identified need to provide additional resources to the process of capacity building. At the very least, a programme of awareness raising and capacity building is needed if government agencies are to accept a more pro-active role of community involvement. A community based system is unlikely to thrive if it depends for its support on government departments characterised by chronic under funding, poor management and low motivation.

Early indications from the BDS also indicate that the project will need to take on board the broader organisational and institutional issues related to health. This will include supporting the MHD to work in new ways which will include inter-departmental and inter-sectoral collaboration. The BDS is also indicating a growing gap, in the areas of interpersonal relationships, waiting time, provision of a range of medication, between the supply of health care and what the public demand. This leads directly to under-utilisation of public health facilities. There is growing recognition that health service providers must try to address issues related to both the supply and demand of health care. There is also recognition that without additional resources, especially to address the information gap, enabling behavioural change and appropriate health practices these issues cannot be adequately addressed.
5. POTENTIAL CONSTRAINTS TO PROJECT IMPLEMENTATION AND IMPACT

5.1 Private Medical Providers’ and MHD's attitudes to the Approved Providers Scheme

Joel Montague's 1997 review of the Commercial Health Sector noted that the commercial health infrastructure is both disorganised and anarchic with many of its key practitioners suspicious of Government intervention or regulation. However, the review also noted that there were many PMPs who stated they would welcome training and other collaborative associations with the MoH (J.Montague pg 32-33). In the initial stages of contacting PMP through the mapping exercise few practitioners responded positively to our invitation to be included in the scheme. Suspicious of government intervention and fears of taxation abound.

At the 16 August meeting facilitated by the MoH, 12 PMP attended the briefing and sensitisation session. Following that meeting there is growing interest in an APS. A follow-up meeting of 15 September confirmed the interest of this group of PMP. Activities including a clinical audit, situational analysis and base-line demand survey, towards ensuring the development of this component progresses. The MHD's initial attitude to PMPs was one of control and regulate. This view is gradually softening to one of cautious cooperation.

5.2 MHD Capacity and Sustainability

Developing both individual and the institutional capacity of the MHD is stated as one of the aims of the project. At the individual level a close working relationship has developed between the Project Manager and her Government counterpart. In addition technical personnel within the MHD have been actively involved in the BDS process.

However we also recognise the limited absorptive capacity of the MHD. Due primarily to low salary levels, staff have to work in the private sector and manpower is not always available for programme implementation. This negatively translates into a low absorptive capacity of the MHD as a learning institution.

Due to the inadequacy of government revenue and resultant low salaries, government personnel need salary supplements if they are to commit additional time to project activities.

The project recommends the provision of additional supplementary salaried positions attached to the UHP. Through the involvement of a larger number of personnel, supported through training to develop functions in the areas of organisation, planning and management, the project will be well placed to identify mechanisms that that can ensure lessons learned can be utilised when the project is completed.

The issue of sustainability raises the issue of knowing to what extent communities and individuals will, or can, mobilise in the interests of their own health. The project will aim to gain improved and increased knowledge of:

- The existing situation in our target areas;
- The specific needs of our target groups;
- The existing dynamics between governmental, NGO and communities; and
- The demand for health care

This improved knowledge will be used to fuel the thinking of decision makers making it possible for the project to plan its interventions based on participatory diagnosis of the local situation. However there is a growing body of knowledge that simplistic views of "community participation" are less than appropriate in the Cambodian context.

5.3 The need for inter-sectoral and inter-departmental action and community involvement

One major outcome of the BIDS and the workshop to disseminate the findings is that of alerting the authorities to the scale, nature and urgency of health needs of the urban poor.

In feeding back the scope and scale of health needs, the project is supporting the "perspective shift" taking place within the MHD and official thinking about the limitations of existing health care practice. References are made more frequently to the indispensable elements of community involvement and inter-departmental and inter-sectoral action.

Early results from the BIDS also indicate that the urban poor recognise uncollected garbage as a source of disease. As in many other less developed areas of the world, the presence of uncollected waste bears testament to the manifest failure of urban management to adequately address the issue of urban solid waste collection and disposal. The MHD is acutely aware that factors underlying poor health indicators need to be addressed if any health intervention is to bring lasting benefits to the communities.

However MHD officials are also concerned that any official services provided to unlicensed settlements risks being labelled as "legitimising" squatter areas. Dialogue is on-going with Municipal authorities and key government officials to raise issues around policy including the identification of major policy gaps, areas where policy is not being adequately implemented and processes whereby research outcomes can be translated into policy development.

The BIDS was also intended to expose community structures, the "social capital" through which an appropriate response could be designed and implemented. The MHD is grappling with these concepts and trying to identify ways in which they can effectively engage the urban poor communities living in Phnom Penh.

There is growing awareness also that the MHD will need to examine more closely the costs and benefits of community involvement. In particular there is the identified need to look at the links between environment, community participation and health outcomes. The MHD recognises that this stream of work cannot be promoted without additional resources.

The SAB, UHPTF and MHD are looking for successful implementation of these pilot demonstration projects, however we are also keeping in view the need to go to scale to ensure comprehensive coverage of successful interventions.
In this context the project aims to disseminate the outcome of the BDS and work with the MHD to develop a common definition which puts people and their expressed needs at the centre of the process of project design.

5.4 Sustainability of demonstration projects

Two goals conflict in the provision of health services for the urban poor: low or no cost services for consumer versus programme sustainability. Future debate will need to focus on the development of programmatic guidelines to bring about sustainable interventions.

Ideas emerging include guidelines for setting prices for services (prices should be low enough so that potential consumers can afford them, but not so low as to imply, or drive, poor quality).

The manner in which any policy outcome from these interventions will be effectively mainstreamed into MHD/MoH projects and programmes remains opaque. In spite of the MHD assertion that it will mainstream successful pilots, the MHD remains weak in terms of status and capacity.

5.5 The need for an improved health information system

Key personnel in the MHD request additional DFID/WHO support for the regular mapping of general health including the state of nutrition/malnutrition in urban poor areas of Phnom Penh. Data collected would be updated periodically and used to identify those families presenting with frequent illness episodes. Efforts could then be undertaken to target information, education and nutrition programmes at such families.

5.6 Support to the evolving role of the MHD

A key operational issue to be addressed during the implementation of this project is whether the project, or more specifically the MHD, can in fact combine multiple goals and more particularly maintain the health goals, as outlined in the project document, under pressure to address wider environmental and civic agendas as well as to undertake service delivery.

The need for the MHD to define its role in relationship to these issues is critical. It is proposed that the project provides financial and management support to a small group of technical experts attached to the MHD. Over the next 18 months this technical group will work closely with the UHP management to be close to the lesson learning environment and to assist in the identification of policy implications of outcomes of this sub-project.

The technical team will also be charged with the development of a health plan for Phnom Penh based on the concept of healthy cities. The healthy cities concept recognises the need for interdepartmental and inter-sectoral collaboration including community involvement.

In dialogue with the Municipality there are indications that the MHD feel the time is right to re-visit the issue of "Autonomous Health Centers". In addition they wish to explore partnership with NGOs, invest in the expansion of primary care and assume
a stronger purchaser role on behalf of the poor as a mechanism for addressing the above situation.

92 The UHP welcomes the above initiatives and would welcome additional support to these initiatives by government and donors particularly in testing facility level organisational and financing reforms.

5.7 Inadequate project time-frame

93 Due to delays in the design and contracting of the UHP contract, Options has only 20 months, rather than 3 years as originally conceived, in which to achieve the scope of work. It will not be possible to assess project impact in such a short time.

94 The UHP management and the MHD strongly endorses the HSR III mid-term review recommendation that the HSR III project, and therefore the UHP, be extended for at least one additional year.
6. **FINANCIAL REPORT**

6.1 **Overview**

Total project expenditure for the first six months of the project (April - September 1999) was £108,251. The expenditure forecast for Year 1 (April 1999 to March 2000) is £242,575. Detailed information on actual expenditure against the budget (revised budget-see below), and forecast expenditure, broken down by individual budget lines is attached at Appendix 10.

6.2 **Budget Revisions**

After 3 months’ of implementation on the ground, Options as Project Managers, in consultation with the Urban Health Project Task Force, recognised that some amendments to the project activities proposed in the original technical proposal were required in order to fulfil the project’s objectives. These amendments required a reallocation of resources, that is a virement between budget lines, not exceeding the original budget ceiling of £457,598. DFID approved the revised budget in the form of a contract amendment.

A summary of the budgetary changes (in £ sterling) follow). The full details of and justifications for the budget revisions were stated in a fax to DFID dated 18 August 1999 (this can be obtained from Options if required).

<table>
<thead>
<tr>
<th>Budget</th>
<th>Original budget</th>
<th>Proposed revised budget</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Inputs</td>
<td>200,909</td>
<td>204,809</td>
<td>3,900</td>
</tr>
<tr>
<td>Reimbursable costs</td>
<td>123,689</td>
<td>106,007</td>
<td>17,682</td>
</tr>
<tr>
<td>Direct costs</td>
<td>133,000</td>
<td>146,782</td>
<td>13,782</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>£457,598</td>
<td>£457,598</td>
<td>-</td>
</tr>
</tbody>
</table>

6.3 **Contractual Issues**

As stated above, DFID Contracts Branch issued Options with a revised contract for the management of the UHP, dated 7 September 1999.
PERSONAL DETAILS

Name: Sharon Lannen WILKINSON

Contact address: Options Consultancy Services
129 Whitfield Street
London
W1 P 5RT

Tel: 0171 383 2494
Fax: 0171 388 1884
E-mail: info@options.co.uk

Year of Birth: 1949

Nationality: British

Key Expertise: More than 20 years experience in strategic planning, project development and project management for international, national and community-based health and development programmes. Experienced in negotiating with multiple donors and governments. Areas of expertise include, management of complex health programmes, reproductive health care, NGO development, institutional strengthening, training and human resource development, health promotion and community participation.

QUALIFICATIONS

1996 Centre for Development Studies
University of Wales Swansea
Health Planning and Development
MSc (Economics and Social Sciences)

1990 African Medical and Research Foundation
Community Health Planning and Management

1984 University of London: Brighton Polytechnic
Nursing Diploma (Part A)

1984 University of Sussex
BA (Social Anthropology: Upper Second Class Hons)

1971 Central Hospital, Warwick
State Registered Nurse
General Nursing Council for England, Scotland and Wales
Registration No: 49070
EMPLOYMENT RECORD

Health and Population Field Office, India
Head Programme Management and Development

Responsible for the development and management of £18 million of DFID-funded health sector projects throughout India. Working at central, state and local government levels to provide support to projects in the areas of health sector reform, malaria containment and research, social marketing of contraceptives, reproductive health programmes and capacity building of national institutes.

Specific tasks included:

- Managing a team of health professionals and advisers to ensure the delivery of effective technical assistance and monitoring and evaluation services to 16 DFID-funded health projects in a complex institutional environment. This involved the management of team skills, engagement of consultant and the establishment and implementation of financial systems. Also involved working with multiple stakeholders building confidence and support for pilot activities and testing interest in change. Projects were related to community level behaviour change, institutional development, knowledge generation and dissemination.

- Working with and advising Indian project managers to facilitate and support all aspects of project implementation. Tasks included the timely preparation and submission of workplans, managing and monitoring project implementation, and evaluating project impact. Participation in steering committees, organising and undertaking joint monitoring missions.

- Delivering technical advice to major malaria containment and research project with a specific focus on improving health status, achieving efficient use of resources, achieving equity with reference to access and utilisation of health services, provision of consumer choice and assisting authorities to look at cost, cost containment and control. Provided support to municipal and district authorities in State of Gujarat, initiated Technical Advisory Groups to support the integration of interdisciplinary and intersectoral malaria control activities into the existing health care delivery and health promotion systems. Ensured planning, implementation and monitoring of inputs and activities to achieve Government of India and DFID agreed outputs.

- Providing DFID with regular and accurate financial accounting and forecasting and providing technical professional reports, in accordance with contractual obligations, on all aspects of the health and population sector projects managed by the British Council in India.
Marie Stopes International, Kenya

Programmatic responsibility for expansion of service delivery facilities, contraceptive commodity distribution, information and communication related to fertility control and HIV/AIDS prevention, monitoring and evaluation of training in provision of fertility management services.

Designed and developed culturally appropriate health care programmes in East Africa. Established community based projects with emphasis on the development of community systems, including women’s development and youth programmes. Initiated and implemented sexual health programme for 8,000 annual intake into the National Youth service of Kenya. Programme initiation included needs analysis, curriculum development, and training of trainers and educational input supported by service delivery. (ODA Funded 1988-1995).

Provided programmatic management including human and financial resource management to achieve programme goals. Designed, developed and monitored the implementation of competency based and problem orientated training system, for traditional birth attendants, in collaboration with Ministry of Health in Kenya.

Included specific positions as itemised below:

Marie Stopes International, Kenya
Regional Adviser

Key responsibilities included: the identification of programme opportunities, proposal development and negotiation of funding in Kenya, Uganda, Tanzania, Malawi and Ethiopia. Key outputs included representation of MSI at donor meetings to encourage district focus and decentralisation in planning investments in the health sector. Programme identification and proposal development leading to funding via MSI from USAID, ODA, EEC and direct funding from FPIA, UNFPA, NORAD and AVSC.

Providing DFID with regular and accurate financial accounting and forecasting and providing technical professional reports, in accordance with contractual obligations, on all aspects of the health and population sector projects managed by the British Council in India.

Developed communications strategies and designed, developed and field tested prototype community participation and education materials for reproductive health projects supported by DFID, DANIDA, JHPIEGO and EU Initiated National Museum of Kenya Display. Trained NM educators in population effects and interpretation of demographic data.
Curriculum vitae: Sharon Wilkinson

Assisted in the development of support materials to use with visiting schools (ODA / NCPD supported). Prepared evaluation models and appraised IEC modules for sexual health amongst youth. Reproductive Health project National Youth Service of Kenya (DFID previously ODA funded project) Established project to improve family planning provision within National Youth Service of Kenya. Trained MoH affiliated qualified nurses in FP (AVSC supported).

1990 - 1993
Marie Stopes International, Kenya
Regional Director

Major responsibilities included the Initiation and establishment of national health programmes in Kenya, Tanzania, Uganda, Ethiopia, Malawi and Zimbabwe through project identification, proposal writing, staff identification and team development, establishing effective management information systems and programme monitoring and evaluation.

Outputs included the design and implementation of management information systems covering project monitoring and evaluation. This included setting of objectives, preparation and application of activity plans and establishment of effective financial control systems.

Co-ordinated management functions within programme areas including community based distribution, clinic based service statistics, activity monitoring and finance and accounting. Planned and implemented training workshops for senior staff. Agreed monitoring plans with Country Programme Directors and developed ToRs for formal monitoring visits. Established programmatic capabilities in collaboration with international and local agencies, through training initiatives and operations research activities. Developed regional training strategies for on-site training of supervisors and service providers.

1988 - 1990
Marie Stopes International, Kenya
Programme Director

Responsible for expansion of service delivery facilities across Kenya. Developing, monitoring and implementing reproductive health programmes, distribution and IE&C programmes. Major achievements include directing the programme from a single service delivery unit to a multi-clinic programme, including the establishment of three hospitals and 16 clinics, and the establishment IE & C programmes with key target groups in Kenya.

Provided programme assessment of service delivery and IEC, developed plans and prepared proposals for strengthening the local NGO, leading to the establishment of national
Curriculum vitae: Sharon Wilkinson

programmes including the initiation and development of a national youth HIV/AIDS prevention programme. Advised project managers on solutions to day to day problems in relation to project implementation. Monitored project management and finances and assisted local staff with monthly narrative and financial reports to donors. Responsible for the extension of services including growth in client service figures to areas of unmet need within Kenya.

1985 -1988

Marie Stopes International, Kenya
Programme Co-ordinator
Negotiated the registration of the international NGO and established local partner NGO to form nucleus of MSI supported programmes leading to the establishment of the first MSI affiliate clinic programme in Africa.
Major responsibilities included; site identification and refurbishment, staff recruitment, training and development of health promotion. Major achievements include; established and maintained contacts with reproductive health agencies leading to project support from AVSC, FPIA, NORAD, DANIDA, Pathfinder and WHO. Production, presentation and advocacy of rationales leading to the establishment of the legal right to advertise FP services in the Republic of Kenya. Project identification, proposal development and production leading to the initiation of MCH/FP outreach programmes within urban slums and piloted education and reproductive health service delivery programme with the National Youth Service of Kenya.

1984 - 1985

Imani School, Thika
Biology Teacher

1978 - 1980

African Inland Church/ International Red Cross
Programme Co-ordinator
In collaboration with International Red Cross and district authorities, established an integrated child nutrition and educational programme, in Uasin Gishu District: Kenya

1975 - 1978

Uasin Gishu Memorial Hospital, Eldoret Kenya
Deputy Matron
Assessed patients, formulated diagnosis, charted treatment and provided care. Specific responsibility to manage outreach clinical services and health professionals to establish rural provision of family planning services.

1972 - 1975

Kapsabet District Hospital, Government of Kenya, Kenya
Nursing Specialist
Initiated and established integrated maternal child health and family planning services within Uasin Gishu District.
Curriculum vitae: Sharon

1971 - 1972
Naburn Hospital, York UK
Staff Nurse
Setting and implementing nursing care plans as part of multi-disciplinary team.

CONSULTANCY EXPERIENCE

1998
DANIDA, Kenya
Evaluation of Community Based Primary Health Care Amongst the Maasai

October - November 1994
WHO, Ngara, Tanzania
Team Leader
Responsible for Reproductive Health Assessment, Including health status and needs of women and girls, review of service delivery and design of intervention programme in refugee camps.

July - August 1994
PATHFINDER, Rwanda
Responsible for:
Rapid Assessment and service delivery in Crisis Management of Rape Induced Pregnancy.

1994
European Union/MSI, Gaza; Palestinian Ministry of Health
Establishing Reproductive Maternal Child Health Programme.

1993
UNFPA: Jumiya ya Wanawake wa, Tanzania
(UWT): Evaluator
FP service delivery centre and community based distribution programme. Assessed the quality of services and care provided and the ability of UWT to extend programme. Made recommendations for training / service improvement and programme expansion

UNFPA, Dar es Salaam, Tanzania
Developed technical assistance project to strengthen the management capabilities of UWT FP programmes.

ADDITIONAL INFORMATION
Management Training and Courses attended:

1993
Open University
Professional Certificate in Management

October 1993
Alexander Hamilton Institute, USA
Certificate in Financial Management and Accounting

January- February 1988
Sundridge Park, Management Centre
The General Management Development Programme

November 1986
Price Waterhouse Associates, Nairobi, Kenya
Effective Supervision and Management Course
Teaching Experience:
Delivering clinical lectures to medical personnel on reproductive health and transcultural health care practices


Other Relevant Experience:

Developed communications strategies and designed, developed and field tested prototype community participation and education materials for reproductive health projects supported by DFID, DANIDA, JHPIEGO and EU

Prepared evaluation models and appraised IEC modules for sexual health amongst youth. Reproductive Health project National Youth Service of Kenya (DFID previously ODA funded project) Established project to improve family planning provision within National Youth Service of Kenya. Trained MoH affiliated qualified nurses in FP (AVSC supported).

Working with Kenyan national theatre on the content of drama productions related to safe sex practices: choices and aspirations. Initiated and established project to provide IEC and condoms through 500 plus private enterprises in Kenya (FPIA 1989 -1994).


Formulated and implemented marketing strategies leading to MSI providing 48% of all VSC in Kenya including addressing issues of male participation and access to reproductive choice. Advocacy for the provision of male only sexual health centres in Kenya and the right to advertise service provision.

Provided counterpart training within local (Kenyan) NGOs. Responsible for the development of strategies and training in male motivation. (ICS) Inputs into the development of Community Based Strategies to support and extensive rural outreach programmes (ICROSS).

Conference/ Workshop Lead Facilitator:

Interactive Teaching Workshop National Youth Service (June 1989 Gilgil - Kenya)
Training of Trainers Programme for COPE Services (PHS/TASO/MOH Entebbe Uganda (April 1992)
Focus groups training workshop NYS/PHS (August 1991), ICS (September 1992)
Training nursing practitioners "Addressing Cultural Needs" Thika (April 1992)
Essential Drugs and Medical Supplies Workshop Nairobi (June 1993), Tanzania (1993)
National Conference on Cervical Cancer Kampala. Uganda (October 1994)
Health Promotion and the Interface Between Ethnography and IEC (Gujarat 1996)
Strategic Planning Workshop DFID supported health projects. India. (1997)
Curriculum vitae: Sharon Wilkinson

Conference / Workshop Organiser/Administrator:

East African Fund Raising Workshop (February 1993). Responsible for financial arrangements/budgeting and accounting to organising committee.
Regional Strategic Planning Workshop. MSI affiliated organisations. Kenya (1992)
Organised and co-ordinated a four day international conference for Heads of MSI affiliated NGOs in Nairobi Kenya (1991). Included making all local arrangements, hiring of translators, liaison with external sponsors and participants, attending to crises, and supervising the editing of local documentation.

Conference Participant/Contributor:

Safe Motherhood International Conference Nairobi Feb 1987
Strategic Planning - MSI conference London 1989
Sustainable growth and Expansion MSI Conference Nairobi 1991
ODA Research seminar "Cultural Constraints to Acceptance of FP" Aberdare (Kenya Jan 1992)
VSC Male Involvement in FP Regional Workshop (Feb 1991)
The Management of Growth - MSI conference in Delhi, India Oct 1993
Facilitative Supervision and COPE AVSC (Uganda 1993, Kenya 1993 Tanzania (1994)
Reproductive Health in Refugee Camps (Geneva - UNHCR 1995)
Urban Malaria Control Strategies Gujarat (1997)
Ethnography of Malaria Surat Gujarat (1998)
Evaluation of Cost Effective Construction Technologies (Delhi 1998)

Academic & Professional Papers:

"Menstrual Regulation Counselling " Training Module for Nurse Practitioners in Kenya PHS Mimeo pp 68.
APPENDIX 2: LIST OF UHPTF MEMBERS
### URBAN HEALTH PROJECT TASK FORCE MEMBERS

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Designation</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dr Veng Thai</td>
<td>Chairman</td>
<td>Director, Municipal Health Department</td>
</tr>
<tr>
<td>2</td>
<td>Dr Mao Tan Eang</td>
<td>Vice</td>
<td>Deputy Director, Department of Planning and Health Information</td>
</tr>
<tr>
<td>3</td>
<td>Dr Sour Salan</td>
<td>Member</td>
<td>Deputy Director, Municipal Health Department</td>
</tr>
<tr>
<td>4</td>
<td>Mrs Sharon Wilkinson</td>
<td>Member</td>
<td>Project Manager, Phnom Penh Urban Health Project</td>
</tr>
<tr>
<td>5</td>
<td>Dr Henk Bekedam</td>
<td>Member</td>
<td>Team Leader, Health Sector Reform III Project - WHO</td>
</tr>
<tr>
<td>6</td>
<td>Dr Aye Aye Thwin</td>
<td>Member</td>
<td>Health Sector Reform III Project - WHO</td>
</tr>
<tr>
<td>7</td>
<td>Dr Hun Chhun Ly</td>
<td>Member</td>
<td>Health Sector Reform III Project - WHO</td>
</tr>
<tr>
<td>8</td>
<td>Dr Janet Cornwall</td>
<td>Member</td>
<td>Project Coordinator, Servants to Asia's Urban Poor</td>
</tr>
<tr>
<td>9</td>
<td>Mr Michael Slingsby</td>
<td>Member</td>
<td>Technical Advisor, UNCHS</td>
</tr>
<tr>
<td>10</td>
<td>Dr Net Ny</td>
<td>Member</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>11</td>
<td>Ms Chhin Chheav</td>
<td>Member</td>
<td>Director, Department of Hospitals</td>
</tr>
</tbody>
</table>
APPENDIX 3: ACTIVITY REPORTS
**Activity Report UHPTF Meeting 22 July 1999**

Reporting against activities as it is too early in project implementation to measure progress against indicators

<table>
<thead>
<tr>
<th>Activity clusters in log-frame</th>
<th>Activities planned for April - June 1999</th>
<th>Achievement against plans</th>
<th>Remarks</th>
<th>Activities planned for next quarter (July - September)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTPUT 1: Baseline Demand Survey</td>
<td>1.1. Research areas and strategy agreed 1.2. Identification &amp; training of local researchers / organisation 1.3. Qualitative Research initiated in agreed areas 1.4. Draft report process agreed</td>
<td>1.1. Administration officials in each area contacted. MHD letter of introduction, name tags etc. 1.2. Bids issued, Contract awarded to Crossroads Consultants. 1.3. ToRs agreed with G Gordon, Qualitative research underway 1.4. Briefing (Dr. G Gordon; Dr. S Salan) to UHPTF 16 June 1999 1.5. Geographical mapping of 7 Makara complete</td>
<td>Location agreed UHPTF 12 May (Tonle Bassac; Boeung Kak, 7 Makara) G. Gordon ensuring quality control via training</td>
<td>Completion of Qualitative survey in Tonle Bassac and Boeung Kak. Initiation of qualitative survey in 7 Makara. Initiation of qualitative survey Workshop to disseminate outputs 7 September 1999 (to be agreed by UHPTF)</td>
</tr>
<tr>
<td>OUTPUT 2: Approved Provider Scheme</td>
<td>2.1. Review existing situation - mapping 2.2. Establish criteria for Approved provider</td>
<td>ToRs for R Brugha to draft technical approach MHD Criteria for APs to be discussed at UHPTF 22 July Process for selection to be agreed at UHPTF 22 July</td>
<td></td>
<td>Mapping and contact with potential Approved providers in area</td>
</tr>
<tr>
<td>OUTPUT 3: Health Services for the Urban Poor</td>
<td>3.1. Agree geographical location and scope of HSUP 3.2. Agree health package (Options for service mix)</td>
<td>3.1. Locations agreed 12 May UHPTF 3.2. BDS initiated outputs to inform project design</td>
<td>Tonle Bassac and Boeung Kak areas agreed Strategies in development</td>
<td>Package and approach agreed</td>
</tr>
<tr>
<td>OUTPUT 4: Municipal Health Departments Capacity for policy planning and reform strengthened</td>
<td>4.1. Establish dialogue with MHD and other stakeholders 4.2. Consultants to provide international experience on contracting and policy development 4.3. MOU agreed 4.4. Logframe developed</td>
<td>4.1. Dr Sour Salan Counterpart. 4.1.1 Links (interagency AIDS / WHO Healthy City/ English Language Training) 4.2. TORs in draft 4.3. Final draft to be signed 4.4. In draft</td>
<td>In-house seminar re: APS/HSUP to be scheduled Activity plan agreed with Dr Salan Seminars will be scheduled as part of consultant inputs</td>
<td>MHD Inputs into Workshop 1 &amp; 2 First steps in policy formulation utilising baseline data Community participation and Interagency collaboration</td>
</tr>
<tr>
<td>OUTPUT 5: Project Office Established and fully functioning</td>
<td>5.1. Renovate office space and equip 5.2. Engage personnel 5.3. Attend monthly liaison / direction meetings with UHPTF 5.4. Financial system established</td>
<td>5.1. Renovation complete, equipment installed 5.2. Mr Chan Kok Chhuong engaged 5.3. UHPTF 21 April, 12 May, 16 June, 22 July 5.4. Bank account opened. Monthly reports to DFID, financial forecast in draft</td>
<td>5.3 Schedule of meetings?</td>
<td></td>
</tr>
</tbody>
</table>

## Activity Report

Reporting against activities as it is too early in project implementation to measure progress against indicators.

<table>
<thead>
<tr>
<th>Activity clusters in log-frame</th>
<th>Activities planned for July - September 1999</th>
<th>Achievement against plans</th>
<th>Remarks</th>
<th>Activities planned for next quarter (October - December)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTPUT 1: Baseline Demand Survey</td>
<td>1.1 Outputs of Qualitative Survey of Tonle Bassac and Boeung Kak Disseminated at 7 September Workshop 1.2 Qualitative Research initiated in agreed APS area 1.3 Quantitative study initiated 1.4 Draft report roces a reed</td>
<td>1.1 Geographical mapping of 7 Makara complete</td>
<td>Completion of BDS October 1999. Results disseminated at November Workshop (dates to be confirmed)</td>
<td></td>
</tr>
<tr>
<td>OUTPUT 2: Approved Provider Scheme</td>
<td>2.1 Review existing situation - mapping 2.2 Establish criteria for Approved provider 2.3 Workshop for interested PMP’s 2.4 FGD with PMP, discuss APS concept, constraint, practicalities 2.5 Clinical audit &amp; start process to identify training/equip needs 2.6 Approach agreed at 7 Sept Workshop 2.7. Discussion groups (RB)</td>
<td>ToRs for R Brugha consultancy inputs in draft MHD Criteria for APs agreed at UHPTF 22 July Process for selection agreed at UHPTF 22 July</td>
<td>Monitoring strategy, framework and tools developed Marketing strategy developed Contractual issues addressed APS launched</td>
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<tr>
<td>OUTPUT 3: Health Services for the Urban Poor</td>
<td>3.1 Agree health package (Options for service mix)</td>
<td>3.1 BDS outputs to inform project design Strategies in development</td>
<td>Package and approach agreed at November Workshop Monitoring strategy, framework and tools developed Programme initiated (facility; staffing; equipment; contracts)</td>
<td></td>
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<tr>
<td>OUTPUT 4: Municipal Health Departments Capacity for policy planning and reform strengthened</td>
<td>4.1 Establish dialogue with MHD and other stakeholders 4.2 Consultants to provide international experience on contracting and policy development 4.3 MOU agreed 4.4 Logframe developed 4.5 Capacity building plan</td>
<td>4.1 Daily meetings between Dr Salan and UHP management 4.2 MOU to be signed 4.3 In draft In-house seminar re: APS/HSUP to be scheduled Seminars will be scheduled as part of consultant inputs</td>
<td>MHD Inputs into Workshop 1 &amp; 2 First steps in policy formulation utilising baseline data Policy implications: Community participation and Interagency collaboration</td>
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<td>OUTPUT 5: Networkable and Functional</td>
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<td>Project Office Established and Fully Functioning</td>
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<tr>
<td>5.1 Networking NGO/international agencies and local community groups</td>
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<td>5.2 Attend monthly liaison / direction meetings with UHPTF</td>
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<td>5.3 Monthly reports to DFID, financial forecast completed, Finstats sent to DFID</td>
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<td>5.4 Financial system established</td>
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<td>5.1 Meetings with RACHA, UNFPA, FRIENDS,</td>
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<td>5.2 UHPTF: 22 July</td>
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<td>5.3 Schedule of meetings?</td>
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APPENDIX 4: MEMORANDUM OF UNDERSTANDING

MEMORANDUM OF UNDERSTANDING

Governing the management of the

PHNOM PENH URBAN HEALTH PROJECT

between

MINISTRY OF HEALTH
WORLD HEALTH ORGANISATION
MUNICIPAL HEALTH DEPARTMENT
and
OPTIONS CONSULTANCY SERVICES LIMITED
1 General Principals

The Ministry of Health (MOH) of the Royal Government of Cambodia, implementing and donor agencies recognize their common interests in regards to the implementation of the Phnom Penh Urban Health Project (the Project). These interests include:

a. Ensuring transparent, effective and efficient management of project finances.

b. Rapid implementation of the Project, so as to benefit the health of the urban poor communities living within the municipality of Phnom Penh.

c. Establishing clear procedures so that there is no confusion between the roles and responsibilities of concerned agencies.

d. Immediately advising and discussing with the appropriate parties any operational problems in an attempt to resolve them quickly.

1.2 This Memorandum of Understanding summarizes the implementing rules for the Project so as to achieve the above interests of all concerned parties. It is guided by the following principles:

a. The Ministry of Health (%.IoH) of the Royal Government of Cambodia is the Project client.

b. Options Consultancy Services Limited (Options), the executing agency, is primarily responsible to the MoH, and DFID, for implementing the Project.

c. The project is an integrated component of the Health Sector Reform (HSR) Phase III. The management of HSR III will provide technical assistance to both MoH and Options.

d. The contractual agreement includes the understanding that OPTIONS possesses technical knowledge for implementation including knowledge of financial systems and procedures for monitoring progress and achievements.

2 Overall Project Management

2.1 Contracting out the Project Management

The Urban Health Project is a component of the Ministry of Health and World Health Organisation's Health Sector Reform (HSR III) Programme.

It had been agreed between the Ministry of Health and donor agencies that the implementation of the Phnom Penh Urban Health Project will be contracted out, via competitive tender, to an external organisation. Competitive Bids were received and
evaluated and the contract was awarded by DFID (CNTR 93 6373) to OPTIONS Consultancy Services Limited (UK) in April 1999.

2.2 Management Arrangements

The Senior Advisory Board (SAB) and Urban Health Project Task Force (UHPTF)

The Ministry of Health is the client of the Phnom Penh Urban Health Project. The Ministry of Health is represented by the Senior Advisory Board (SAB). The project will be directed for the SAB by the Urban Health Project Task Force (UHPTF).

Multiple parties have an interest and will actively participate in the Project through the mechanism of the Urban Health Project Task Force (UHPTF). These parties include but are not confined to the following:

- Ministry of Health / Health Sector Reform Group
- Municipal Health Department
- WHO
- Representatives from NGOs and other programmes / projects related to urban health

The UHPTF has overall responsibility to provide direction to the Project and to monitor project implementation and the performance of the Management Consultant.

The SAB will receive quarterly reports from the UHPTF on progress against agreed objectives and the SAB will use this reporting mechanism to judge performance of the Management Agency, and to report to DFID. The SAB will receive briefings on key issues and provide inputs into the decision making process for endorsement.

If, upon recommendations of the UHPTF, the judgement of the SAB is to suspend or terminate the above contractual arrangements, or to withhold payments, then the SAB will communicate this in writing to DFID and the Management Agency.

The Health Sector Reform Group (HSRG) will receive regular monthly reports from the UHPTF. These reports will include:

- Agreed action plan and progress against the action plan;
- Progress against agreed outputs as stated in the Logical Framework;
- Constraints to progress and recommendations for decisions.

Project funding is supplied by the Department for International Development (DFID) directly to the Managing consultant OPTIONS. Payments to the Management Agency will be made against financial claims on a regular basis as agreed between the contracting
parties. Payments will proceed automatically unless the SAB directs DFID to cease payments for non-performance of contractual agreement.

**Municipal Health Department (MHD)**

The MHD will provide office space and utilities (water and electricity) for the Managing Consultant personnel during the life of the Project.

The MHD will provide counterpart personnel to work in close collaboration with the Management Agency to obtain the agreed outputs of the Project.

Areas identified for collaboration include:

- inputs into activity planning
- involvement in the Baseline Demand Survey
- access to and active involvement of health personnel for promotional activities
- support to the development of urban health project monitoring framework
- participation in monitoring
- participation in in-house seminars and workshops
- responsibility for monitoring and delivery of health services in HSU'P and APS (directly or through sub-contracting)

World Health Organisation (WHO): Health Sector Reform Phase III.

The WHO maintains a co-ordinating role ensuring close collaboration, feedback of lessons learned for policy development, and dissemination of information. WHO serves on the UHPTF and provides information and advice.

The Managing Consultant will report regularly to the Team Leader HSR III and will seek technical advice as appropriate and will ensure all key decision points are brought to the attention of the Team Leader HSR III.

**UK Based Technical Advisory Group (TAG).**

The UK based TAG will draw on their international experience and expertise to provide advisory inputs into the methodologies to be utilised and the design of the health services and approved provider scheme. Options will manage these inputs under the direction of the SAB MoH and will ensure that all policy and strategy implications of the project design and implementation are explicit, fully communicated and fed back into the project.
Changes in Work

The Urban Health Project will be implemented in collaboration with multiple partners. The work programme, including agreed package of services, mechanisms for delivery of those services and locations will be fully determined following completion of the Baseline Demand Survey. As a result of the survey the UHPTF may make recommendations to the SAB on changes in the work programme. These recommendations will be incorporated into the Managing Consultant's activity plans.

Signatures
APPENDIX 5: DR SALAN'S ACTIVITY PLAN
APPENDIX 6: TERMS OF REFERENCE

Invitation to bid for the Baseline Demand Survey
Gill Gordon
Ruairi Brugha
Chris Vickery
Request for Bids:

Baseline Health Demand Survey for the Urban Health Project

The Ministry of Health through the Urban Health Projects Task Force (UHPTF) is planning to conduct a Baseline Demand Survey on health seeking behaviour among the communities of Tonle Bassac and Boeung Kak and selected target groups within the city of Phnom Penh. Options Consultancy Services Ltd. will provide the principal investigator, study design and study instruments. Locally engaged researcher(s) or research organisation(s) will, under the technical guidance of the principal investigator, implement the study. The study will be implemented in two phases. Phase one will take place over the time frame June, July and August. Phase two is scheduled to take place during September, October and November.

The Ministry of Health and UHPTF seek qualified individual(s) or organisation(s) to conduct Phase one of the study, a detailed description of which is provided in Annex A.

The following particulars are given:

1. This study is commissioned by the management of the Urban Health Project funded through DFID / Ministry of Health, Cambodia. The principal investigators (Options Consultancy Services Ltd) seek co-investigators to undertake a Phase 1 of the Baseline Health Care Demand Survey. The first phase is qualitative and participatory in nature and will include a mapping of providers and utilisation patterns of existing health facilities.

2. The selected person(s) or organisation(s) will perform their responsibilities under supervision of the Project Manager (UHP) with technical direction by the Principal Investigator (Options consultant). The selected person(s) or organisation(s) is expected to provide regular reports and close liaison with these parties throughout the entire course of the study.

3. If selected, the person(s) or organisation(s) is/are expected to fulfil the following specific tasks.

- Review, and assist the Principal Investigator to revise the study instruments
- In conjunction with the Principal investigator conduct pre-testing of instruments
- Conduct data collection in the agreed study areas
- Provide clean transcripts of raw data in English
- Assist in data analysis
- Assist in the development of draft report and make in-country presentations to secondary stakeholders
Based on the description of research needs and the study objectives, interested person(s) or organization(s) are requested to provide two copies of their implementation capacity statements by 28 May 1999. The statements should include the following information:

- A list of key personnel, clearly identifying background and areas of expertise (areas to be addressed include qualitative research skills and field work experience, translation, administration and logistic backup and data analysis).
- An outline of recent similar work, briefly describing the nature of work, the client, work duration, and attaching an executive summary of previous reports if appropriate.
- An outline and time frames of any ongoing work.

An initial assessment of the time frame for field work is three months covering a study population within the geographical locations of Tonle Bassac, Boeng Kak and Makara.

The individual(s) / organisation(s) should provide a detailed budget indicating personnel charge out rates, overheads, transport and administrative expenses.

Interested person(s) or organisation(s) should provide their implementation capability statement to the following address:

Project Manager
Urban Health
Project
P.O. Box 1642
Phnom Penh

The qualified person(s) or organisation(s) will be selected through a competitive bidding process based on the merits of their research capacity and capability of implementing the research, as decided by a panel of experts from the Ministry of Health and UHPTF. The selected person(s) or organisation(s) will be informed of their selection by 1 June 99.

The selection panel reserve the right to seek further information about capacity, costings and implementation plans and to request changes in scope and time frame.
Study Description

Phase 1 Baseline Health Care Demand Survey - Urban Health Projects Phnom Penh

Introduction

The Urban Health Project (UHP) is part of the Health Sector Reform III Project (HSR III) which is being executed by the Ministry of Health (MOH) and the World Health Organisation (WHO). The purpose of HSR III, which is being funded by the United Nations Development Programme (UNDP), the Department for International Development (DFID), the Norwegian Agency for Development Co-operation (NORAD) and WHO, is to contribute to the reduction of poverty in Cambodia through the development of quality basic health services.

The UHP, which is being funded by DFID, will operate in Phnom Penh. The Managing Consultant is Options Consultancy Services Ltd.

Aims:

To improve the utilisation of good quality and affordable basic health services in Phnom Penh, particularly in poor communities, by implementing two projects which will establish new delivery systems involving the public and private sectors.

To gain a better understanding of the health care needs and health care seeking behaviour of the population of Phnom Penh and particularly the urban poor.

To use the information obtained from evaluating these projects to formulate strategies which will improve the workings of the health care market in Phnom Penh.

Objectives of the Study

The primary purpose of the BDS is to enable us to gauge firsthand community health needs and perspectives on the acceptability, affordability and accessibility of health services. These findings will then be used to:

- Inform the project's key secondary stakeholders about the issues facing poor people as they seek health care in Phnom Penh;

- Help to inform the design of the two pilot projects (Approved Providers Scheme (APS) and the two Health Services for Urban Poor (HSUP) sites and refine their performance indicators

- Provide a baseline against which changes will be measured during the lifetime of the project.
Both qualitative and quantitative approaches are needed to meet the above purpose. These approaches will be conducted in two sequential phases in order to optimise the quality of information gathered. The information generated in Phase 1 will inform the methodology of Phase 2. It is proposed that:

Phase 1 will be the qualitative, participatory research to be undertaken between June and August 1999.
Phase 2 will be the quantitative household survey to be undertaken between September and November 1999.

**BDS Phase 1: Qualitative, participatory research.**

The findings of Phase 1 will be sufficient to inform the design of the proposed APS and HSUP projects and will provide in-depth qualitative descriptions of the situation at the beginning of the project. Moreover, the findings of Phase 1 will help formulate the questions asked in Phase 2's household survey in such a way that they will make sense to the respondents (eg. Appropriate categories of expenditure, types of health service providers). This in turn will increase the validity of the quantitative information collected.

Particiative research will be carried out in communities in the 2 HSUP sites of Tonle Bassac and Boeng Kak and with communities in the APS area of 7 Makara, and may be extended to wider administrative area in order to provide a comprehensive picture of health needs and health seeking practice within one administrative district of Phnom Penh.

**Proposed information to be gathered by the BDS**

The parameters for the information which needs to be gathered by the BDS are:

- health seeking behaviour, perceived needs and service utilisation patterns;
- provision of services and service users perceptions of quality;
- costs (financial and other) incurred by service users;
- guided, but not limited, by the scope of the Minimum Package of Activities.

Within these parameters, the types of information to be gathered in Phase 1 to provide a depth of qualitative information in prescribed areas are listed below. This list is not exhaustive.

- Mapping of health facilities (allopathic and non-allopathic) by different groups;
- Analysis of utilisation records of health facilities to see where clients come from;
- Identification and ranking of criteria used in health seeking behaviour;
- Wealth/well-being ranking in order to identify proxy income group categories and to identify who is vulnerable;
- Key health problems and where clients go for different illness and why;
- Communities' perceptions of causes of illness;
- Communities’ perceptions of quality - what are the likes and dislikes about existing facilities; what information would they want to know before going to a new facility;
• Sources of information about facilities;
• What services communities' want;
• Costs of services; formal and informal - what language is used;
• Outpatient data from public allopaths; what is there caseload;
• Triangulation with Commercial Health Sector Review data.

Specifically the research team will undertake

1. A mapping of the different urban poor communities in Tonle Bassac and Boeung Kak to identify the target population and catchment areas to pilot health service delivery for the urban poor. The concept of community (ethnicity, occupation, location, gender) and communal structure among the urban poor will be explored.

2. The research will determine the most urgent health priorities of the urban poor, provide an assessment of household expenditure on medical care and how this expenditure relates to income and / or disposable income and to understand how decisions about expenditure on health care (preventive and curative) are made within this context. Medical care expenditures will be investigated together with the occurrence of indebtedness as the amount spent may not entirely reflect ability to pay. The vulnerability of female headed households and people with chronic illness and or disability will be examined.

3. The research will disclose community perceptions of the reason for illness and its relationship to vulnerability, income levels and access to health care, personal hygiene practice, child care and environmental conditions.

4. Assessment of care / treatment seeking behavior and practices related to perception of need (preventative, curative, emergency, chronic) will be undertaken. An important area for investigation concerns safe motherhood, including practices for anti-natal care, delivery and birth spacing. Common practices such as self-medication will be exposed. While over differentiation will be avoided, the analysis of health seeking behavior will encompass provider choices, perceived quality, expenditures in relation to socio-economic differentials such as ethnic background, occupational group, income / ownership of assets, gender and education. Analysis will indicate differentials in health care practices for priority groups such as adolescents, women and men.

5. An area of interest is to discern where the poor actually seek treatment if a doctor or pharmacy was not chosen In this context a description of traditional health practices will be provided. Utilization of traditional practices will be described in relationship to perception of quality, efficacy, and expenditure.

6. A detailed mapping and inventory of public and private health care providers and facilities, in the selected geographical areas of Tonle Bassac, Boeng Kak and 7 Makara, will be undertaken. The inventory will indicate type of services, qualifications of staff/providers (e.g.
trained/untrained, basic/specialist allopathic, traditional) with information regarding their location within the designated areas.

7 Health service delivery through out-reach activities will be listed and described. Description will include national immunization day campaigns, Direct observable therapy, community based distribution / promotion activities of government and NGO
CONSULTANCY TO INITIATE AND UNDERTAKE PHASE I & II THE PHNOM PENH URBAN HEALTH PROJECT BASELINE DEMAND SURVEY

1.0 Introduction

The Urban Health Project (UHP) is part of the Health Sector Reform III Project (HSR III) which is being executed by the Ministry of Health (MOH) and the World Health Organisation (WHO). The purpose of HSR III, which is being funded by the United Nations Development Programme (UNDP), the Department for International Development (DFID), the Norwegian Agency for Development Co-operation (NORAD) and WHO, is to contribute to the reduction of poverty in Cambodia through the development of quality basic health services.

The UHP, which is being funded by DFID, will operate in Phnom Penh. The Managing Consultant is Options Consultancy Services Ltd.

Aims:

To improve the utilisation of good quality and affordable basic health services in Phnom Penh, particularly in poor communities, by implementing two projects which will establish new delivery systems involving the public and private sectors.

To gain a better understanding of the health care needs and health care seeking behaviour of the population of Phnom Penh and particularly the urban poor.

To use the information obtained from evaluating these projects to formulate strategies which will improve the workings of the health care market in Phnom Penh.

1.1 Objectives of the Baseline Demand Survey

The primary purpose of the BDS is to enable us to gauge firsthand community health needs and perspectives on the acceptability, affordability and accessibility of health services. These findings will then be used to:

- Inform the project's key secondary stakeholders about the issues facing poor people as they seek health care in Phnom Penh;

- Help to inform the design of the two pilot projects (Approved Providers Scheme (APS) and the two Health Services for Urban Poor (HSUP) sites and refine their performance indicators

- Provide a baseline against which changes will be measured during the lifetime of the project.

Both qualitative and quantitative approaches are needed to meet the above purpose. These approaches will be conducted in two sequential phases in order to optimise the quality of information gathered. The information generated in Phase 1 will inform the methodology of Phase 2. It is proposed that:

Phase 1 will be the qualitative, participatory research to be undertaken between June and August 1999.
Phase 2 will be the quantitative household survey to be undertaken between September and November 1999.

1.2 BDS Phase 1 June - August: Qualitative, participatory research.

The findings of Phase 1 will inform the design of the proposed APS and HSUP projects and will provide in-depth qualitative descriptions of the situation at the beginning of the project from which impact indicators can be developed. The findings of Phase 1 will help formulate the questions asked in Phase 2's household survey in such a way that they will make sense to the respondents (e.g. appropriate categories of expenditure, types of health service providers). This in turn will increase the validity of the quantitative information collected.

Participatory research will be carried out in communities living within the catchment areas of the 2 HSUP sites of Tonle Bassac and Boeung Kak and with target groups in the APS area of 7 Makara.

BDS Phase 2 September - November: Quantitative Household Survey.

Based on the results of Phase 1, the household survey will collect a limited range of data on service utilisation patterns, costs and perceived quality. The findings of Phase 2 will provide a more extensive baseline for the two pilot projects. Measurable indicators for key issues which will be identified through Phase 1's participative research can be examined in a more "representative" way in order to gauge their importance. The household survey will be small in scope and will enable the project to measures changes in service utilisation patterns, cost and perceived quality, and expenditure patterns at the population level.

1.3 Proposed information to be gathered by the BDS

The parameters for the information which needs to be gathered by the BDS are:

- health seeking behaviour, perceived needs and service utilisation patterns;
- provision of services and service users perceptions of quality;
- costs (financial and other) incurred by service users;
- guided, but not limited, by the scope of the Minimum Package of Activities.

2 Objectives of Consultancy

The main objective of the consultancy is to initiate and implement Phase 1 and 2 of the BDS which will provide baseline information to enable the Urban Health Project Task Force to design, monitor and evaluate the impact of the Health Services for the Urban Poor (HSUP) and Approved Provider Scheme (APS) components of the Urban Health Project (UHP). The specific programme needs are as follows:

- To assess the health seeking behaviour and the use of health services by the target population in the designated areas for the pilot projects.
- b) To inform the design of the two pilot projects
- c) To assist the UHPTF/MHD and MoH to monitor and evaluate the impact of the APS and HSUP pilots

2.1 Specific Duties

In close collaboration with the Project Manager, the consultant will be required to:
a) Develop the qualitative research methodology and develop the research instruments

b) Ensure co-investigators are fully conversant with the methodology and participatory approach of the BDS. Provide necessary training for the interviewers, research teams and other relevant implementing counterparts. Pre-test research instruments in areas similar to the HSUP chosen sites of Tonle Bassac and Boeung Kak. To ensure the research instruments will be able to provide information that will meet the objectives of the study including the question: has the HSUP and APS made any impact in the communities served? Assist the co-investigators in establishing the parameters of the qualitative research and provide direction to ensure quality in execution. Incorporate process of analysis into training, provide inputs to support supervision and suggest a framework for the research report. Assist co-investigators in producing a report on the key findings of Phase 1 of the BDS survey. Participate in Workshop 1 to present main findings of Phase 1. In participation with the implementing agency design Phase 2 (household survey) of the BDS. Review draft report of the key findings of Phase 2 of the BDS.

3 Expected Outputs

3.1 Qualitative research design and methodology
3.2 Qualitative research instruments
3.3 Trained Phase 1 counterparts
3.4 Phase 1 research outputs
3.5 Analytical Report on qualitative research findings
3.6 Inputs into the design of Phase 2 household survey (sampling strategy and survey instruments)
3.7 Comments on Phase 2 report.

4 Phasing and duration

The Baseline Demand Survey will be conducted in two Phases:

Phase 1: The researchers will hold discussions with a range of groups defined by gender, age, ethnicity, residence and socio-economic status. This will include young and older men and women, Khmer and Vietnamese, extremely poor and poor, and where clear geographical differences in terms of the environment and distance from facilities, then these too will be taken into account.

The work for Phase 1 and start of Phase 2, is planned to be done in the following stages:

4.1 Stage I: Development, in UK and in consultation with S Wilkinson, K Chapman, E Smith, R Brugha/A Zwi, K Hanson, N Palmer, B McKay, C Vickery + DFID Adam Burke, of a work plan and Draft Qualitative Research Design (5 days)
4.2 Stage II: Development and testing of research instruments, training of investigators in Phnom Penh. Review outputs of the Municipal Health Departments Survey of provider facilities and location mapping within APS and HSUP areas, (15 working days - includes 2 days travel)
4.3 Stage III: Receive, and review, draft analysis of qualitative research outputs
4.4 Stage IV: Assist the researchers to produce a final report and plan the presentation of results (3 days in UK, 3 days in Cambodia)
4.5 Stage V: Presentation of key findings at workshop 1 (1 day in Cambodia)
4.6 Stage VI: Inputs into design of Phase 2 Household Survey (2 days in Cambodia)
(So Stages IV-VI 9 working days plus 2 travel days)

5.0 Management of the Consultancy

5.1 The consultancy will be managed by the UHP Project Manager (Sharon Wilkinson) in Phnom Penh and Options Contract Manager (Katie Chapman) in UK.

5.2 The UK based consultant will be engaged and will be required to work closely with the research team which will be recruited locally.
A:6/99
PHNOM PENH URBAN HEALTH PROJECT  
DRAFT TERMS OF REFERENCE  
FOR  
HEALTH POLICY FOR THE PRIVATE SECTOR SPECIALIST  
Consultancy to initiate and provide direction to the Approved Providers  
Scheme component

1. Introduction

The Urban Health Project (UHP) is part of the Health sector Reform III Project (HSR III) which is being executed by the Ministry of Health (MoH) and the World Health Organisation (WHO). The purpose of HSR III, which is being funded by the United Nations Development Programme (UNDP), the Department for International Development (DFID), the Norwegian Agency for Development Co-operation (NORAD) and WHO, is to contribute to the reduction of poverty in Cambodia through the development of quality basic health services.

The UHP is being funded by DFID, and operates in Phnom Penh. The Managing Consultant is Options Consultancy Services Ltd., in association with the Health Policy Unit of the London School of Hygiene and Tropical Medicine.

1.1 Overall Aims

The Phnom Penh Urban Health Project aims:

• To improve the utilisation of good quality and affordable basic health services in Phnom Penh, particularly in poor communities, by implementing two projects which will establish new delivery systems involving the public and private sectors.

• To gain a better understanding of the health care needs and health seeking behaviour of the population of Phnom Penh and particularly the urban poor.

• To use information obtained from evaluating these projects to formulate strategies to improve the workings of the health care market in Phnom Penh.

1.2 Approved Provider Scheme

The Approved Provider Scheme (APS) is a key output of the Phnom Penh Urban Health Project (UHP). The (provisional) purpose of this component is to improve utilisation of health services provided by private providers through improved quality and removal of barriers to access (including where appropriate, financial barriers). Experience gained through working with Private Medical Providers (PMPs) will inform Municipal Health Department
(MHD) policy on the modalities for relating to the private sector to improve health status.
To date, the UHP under the direction of the UHP Task Force has completed a geographical mapping of PMP in Brambpee (7) Makara, the area designated for the APS. In addition the MHD and UHPTF have agreed the criteria for incorporation into the APS. By the time of the consultant’s visit, the project will have contacted potential approved providers, will have provided a level of confidence in the APS proposal and will have negotiated potential approved providers’ time with the external consultant.

2. Objectives of the consultancy

The primary purpose of the consultancy input is to assist the UHPTF to design the strategies and implementation plan towards operationalising the Approved Provider Scheme (APS) in Phnom Penh.

2.1 The specific programme needs are as follows:

From UK:

a) Desk review of qualitative research tools for baseline demand survey in 7 Makara (comments on the draft tools should be sent to Gill Gordon by 20th August 1999).

In Phnom Penh:

b) Assist in the development of focus group discussion (FGD) and in-depth interview tools for PMPs.

c) Facilitate workshop / meeting of potential approved providers to elicit their interest in public-private partnerships and the range of services that could be provided under the scheme.

d) Assist the UHPTF to review and reformulate criteria for APs focusing on options for service delivery in line with technical feasibility, resource and time limitations.

e) Assist in the development and testing of clinical audit tools.

f) Identify process towards which the existing structures and relationships within the private sector and between providers, eg. referral and follow up systems, can be exposed.

f) Provide inputs into the development of the quantitative household survey tools for 7 Makara, and agree the process whereby the APS issues are addressed in the survey, in line with resource and time limitations.

g) Agree with UHPTF the current strategy and timetable and prioritise those activities for launching the APS.

h) To discuss with the Project Manager and her counterpart their roles in taking forward the activities.

i) To provide advice on the role and timing of technical assistance for the APS in the areas of marketing and contracting.
2.2 Specific Duties:

In close collaboration with the Project Manager the consultant will be required to:

- Undertake an orientation of the selected APS geographical area.

- Review draft report from the Baseline Demand Survey (Tonle Bassac and Boeung Kak).

- Facilitate a meeting of potential approved providers drawn from the 7 Makara area and establish an operational mechanism (technical advisory groups??) that will ensure each participant is fully informed of proposed interventions and process of involvement.

- Meet with the HSRIII Team Leader and delegated members of the Health Sector Reform Group to update them on progress of the APS component, the identified key issues including possible constraints.

- Meet with key members of the MHD and UHPTF to provide overview of the APS.

- To develop and test Focus Group Discussion and in-depth interview tools with medical personnel drawn from the Chamcar Mon Municipal Health Centre (Japanese Red Cross).

- To undertake FGD and In-depth interviews with selected Approved Providers ensuring issues such as referrals and follow-up are covered.

- Review Clinical Audit tools and test with Potential Approved Providers.

3. Expected Outputs

3.1 FGD and in-depth interview tools for PMP

3.2 Clinic audit tools for APS

3.3 Comments on the Baseline Demand Survey (TB/BK) report

3.4 Records of meeting with key stakeholders

3.5 An agreed work programme of process for operationalising APS

3.6 Report on Consultancy, including tentative policy outcomes of APS

4. Duration:

The consultant will undertake the desk review during the week commencing 16th August. The Consultancy visit will take place 10th - 17th September, that is 8 days in Phnom Penh.
An itinerary is being drafted and will be available as soon as meetings are confirmed.

5. **Management of the Consultancy**

5.1 The consultancy will be managed by the UHP Project Manager (Sharon Wilkinson) in Phnom Penh and Options Contract manager (Katie Chapman) in UK.

30 July 1999
PHNOM PENH URBAN HEALTH PROJECT
DRAFT TERMS OF REFERENCE
FOR
HEALTH SERVICE DELIVERY SPECIALIST
Consultancy to assist in the strategic development of the Health Services for
the Urban Poor of Tonle Bassac and Boeung Kak areas of Phnom Penh

1. Introduction

The Urban Health Project (UHP) is part of the Health sector Reform III Project (HSR III) which is being executed by the Ministry of Health (MoH) and the World Health Organisation (WHO). The purpose of HSR III, which is being funded by the United Nations Development Programme (UNDP), the Department for International Development (DFID), the Norwegian Agency for Development Co-operation (NORAD) and WHO, is to contribute to the reduction of poverty in Cambodia through the development of quality basic health services.

The UHP which is being funded by DFID, is operating in Phnom Penh. The Managing Consultant is Options Consultancy Services Ltd., in association with the Health Policy Unit of the London School of Hygiene and Tropical Medicine.

1.1 Overall Aims

The Phnom Penh Urban Health Project aims:

• To improve the utilisation of good quality and affordable basic health services in Phnom Penh, particularly in poor communities, by implementing two projects which will establish new delivery systems involving the public and private sectors.

• To gain a better understanding of the health care needs and health seeking behaviour of the population of Phnom Penh and particularly the urban poor.

• To use information obtained from evaluating these projects to formulate strategies to improve the workings of the health care market in Phnom Penh.

1.2 Health Services for the Urban Poor

The (provisional) purpose of the Health Services for the Urban poor (HSUP) component of the UHP is to increase utilisation of the Minimal Package of Activities (MPA) by the urban poor through improved quality and removal of barriers to access, (including financial barriers). The experience of working to improve the utilisation of MPA in an urban context will also inform the development of policy for improving the health status of the urban poor.

A participatory qualitative Baseline Demand Survey is being conducted in the urban poor areas of Tonle Bassac and Boeung Kak by Crossroads research team under the guidance of Gill Gordon, the Principal Investigator. The results of this survey will be ready for dissemination at a planned workshop of 7th - 8th September.
Both urban areas are characterised by a lack of adequate low cost housing, inadequate infrastructure and public services related to clean water, sanitation and solid waste disposal. Early results of the qualitative research indicate that residents seek health care beyond their residential areas and are subject to high cost and low quality medical services. It is likely that a combination of clinical and outreach strategies for health service delivery will be required.

2. Objectives of the Consultancy

The main objective of the consultancy is to review the BDS and to utilise the results of the survey in the design of the HSUP component of UHP.

2.1 The specific programme needs are as follows:

a) Outputs of the BDS are incorporated into the design of the HSUP.
b) Facilitation of the BDS dissemination and HSUP design workshop.
c) Design of technically and institutionally appropriate HSUP project component, within time and resource limitations.
d) Indicators developed for LogFrame, management, baseline survey and monitoring purposes.
e) Monitoring tools (both provider and user's perspectives) developed to monitor progress of HSUP component.

- Review background documents to draw on lessons learned from other organisations and UHP project notes.
- Undertake an orientation of the project areas of Tonle Bassac and Boeung Kak to gain first hand knowledge of the environmental and health situation of the communities of these areas.
- Review BDS report.
- Participate in and help facilitate the BDS dissemination / HSUP design workshop.
- Undertake post workshop discussions with key stakeholders incorporating views and experience in the design of HSUP, as appropriate.
- In consultation with the BDS Principal Investigator, Crossroads research team and key stakeholders, develop HSUP monitoring tools (provider and user perspectives).
- Provide BDS Principal Investigator with HSUP indicators for finalising household survey tool.
- If time allows, provide technical assistance to Approved Providers Scheme (APS) component through inputs into the development of clinical audit tools and guidelines on clinical standards.

3. Expected Outputs

3.1 Concise report on HSUP design to include sections on:

- Rationale - background and justification of approach - tentative policy outcomes
- Objectives (goal, purpose, outputs)
- Description of approach
- Management arrangements
- Financing mechanisms
- Monitoring mechanisms and agencies
- HSUP component LogFrame including indicators, and monitoring tools.
- Draft budget

3.2 If time allows, contributions to clinical audit and clinical standard tools for APS component.

4. Duration

The Consultancy will be conducted over the period 6th - 17th September, that is 12 days in-country. In addition, 4 days for preparation, travel and report-writing.

5. Management of the Consultancy

5.1 The Consultancy will be managed by the UHP Project Manager (Sharon Wilkinson) in Phnom Penh and Options Contract Manager (Katie Chapman) in UK.

30 July 1999
APPENDIX 7: BASELINE DEMAND SURVEY WORK PLAN AND OUTLINE OF METHODS
BASELINE DEMAND SURVEY - UPDATED RESEARCH PLAN

1. INTRODUCTION

The Crossroads team comprises of 12 (9 men and 3 women) Khmer personnel who will carry out group discussions and semi-structured interviews and a director, John Holloway, who, together with Dr Uy Vengky, is responsible for supervision, direction, quality of the data, analysis and writing the draft report.

The work will be done on a two-day cycle.

Day 1: **Fieldwork.**

Two teams of three (facilitator, note-taker and observer) will carry out group discussions using participatory tools. That is, 2 groups a day.

Two teams of two will carry out two semi-structured interviews each, making 4 interviews a day.

In the afternoon, the teams working with groups will complete and translate their scripts into English, using tape-recorder, notes and recall.

The people doing semi-structured interviews will translate their notes and complete the questionnaire form in English.

Day 2: **Completing notes and analysis.**

John and Vengky will 'interview' the notes and the teams and interviewers to cross check and clarify the information, add missing data and collect quotations. They will then write the final version in standard English. (They will begin this work with those doing semi-structured interviews on the previous afternoon.)

The team will then analyse the information under themes so that everyone is aware of what is being learnt progressively, where information is missing and how their research skills can be improved. It will also enable John and Dr Vengky to feed the information into the report headings as it goes along and guide the research effectively.

2. GROUP DISCUSSIONS

The research team has time to do 40 group discussions using participatory tools in Tonle Bassac and Boeung Kok before the September workshop and 12 groups in 7 Makara after the workshop.

The groups are selected on the following criteria:
<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>U</td>
<td>Ultra poor</td>
<td>People who cannot afford to pay anything on health care and have no assets to sell.</td>
</tr>
<tr>
<td>P1</td>
<td>Poor</td>
<td>People who can afford to pay 500-2000 riel (12.5 - 50 cents) on one day's health care but have problems paying 5000 or more riel for health care.</td>
</tr>
<tr>
<td>P2</td>
<td>Less Poor</td>
<td>People who can pay 5000 riel but have problems paying 10,000 riel.</td>
</tr>
<tr>
<td>P3</td>
<td>Better off</td>
<td>People who can pay 10,000 riel</td>
</tr>
<tr>
<td>BK1</td>
<td>Boeung Kok 1</td>
<td>On or near water, ultra poor</td>
</tr>
<tr>
<td>BK2</td>
<td>Boeung Kok 2</td>
<td>On fringe of land, poor</td>
</tr>
<tr>
<td>BK3</td>
<td>Boeung Kok 3</td>
<td>Near the Pagoda, richer.</td>
</tr>
<tr>
<td>TB1</td>
<td>Tonle Bassac</td>
<td>On the water, ultra poor</td>
</tr>
<tr>
<td>TB2</td>
<td>1</td>
<td>On the water, poor</td>
</tr>
<tr>
<td>TB3</td>
<td>Tonle Bassac</td>
<td>Over the river, poor</td>
</tr>
<tr>
<td>TB4</td>
<td>2</td>
<td>On the land, some UP, some better off</td>
</tr>
<tr>
<td>TB5</td>
<td>Tonle Bassac</td>
<td>On the land, tenements.</td>
</tr>
<tr>
<td>7 M 1</td>
<td>Tonle Bassac</td>
<td>Tenements, UP and P</td>
</tr>
<tr>
<td>7 M 2</td>
<td>4</td>
<td>Middle income</td>
</tr>
<tr>
<td>7 M 3</td>
<td>Tonle Bassac</td>
<td>Middle and high income</td>
</tr>
<tr>
<td>YM</td>
<td>Men aged 18 - 30</td>
<td></td>
</tr>
<tr>
<td>YW</td>
<td>Women aged 18 - 30</td>
<td></td>
</tr>
<tr>
<td>OM</td>
<td>Men aged 40 plus</td>
<td></td>
</tr>
<tr>
<td>OW</td>
<td>Young men</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Young women</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Older men</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Older women</td>
<td></td>
</tr>
</tbody>
</table>

The sample aims to obtain information from each type of group in the three project sites. The grid 'METHODS AND GROUPS' shows the number and type of groups and methods in Tonle Bassac and Boeung Kok. (See separate document)

The document PURPOSE, QUESTIONS AND METHODS describes how the methods relate to the research questions.

The groups and methods for 7 Makara will be selected after further discussions.
### NO. & METHOD

<table>
<thead>
<tr>
<th></th>
<th>NUMBER OF SESSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transect walk</td>
<td>8</td>
</tr>
<tr>
<td>2. Chart of health problems</td>
<td>8</td>
</tr>
<tr>
<td>Ma</td>
<td></td>
</tr>
<tr>
<td>3. Picture of healthy and sick person. Pair wise ranking of health problems. Taxonomy.</td>
<td>2</td>
</tr>
<tr>
<td>4. Seasonality calendar</td>
<td>1</td>
</tr>
<tr>
<td>5. Why did 'Mrs. X' die?</td>
<td>2</td>
</tr>
<tr>
<td>6. Health seeking behaviour</td>
<td>4</td>
</tr>
<tr>
<td>7. Role plays</td>
<td>2</td>
</tr>
<tr>
<td>8. Pair wise ranking of factors</td>
<td>2</td>
</tr>
<tr>
<td>9. Preference matrix of services</td>
<td>8</td>
</tr>
<tr>
<td>10. Coin with health costs</td>
<td>4</td>
</tr>
<tr>
<td>11. Strategies for access</td>
<td>8</td>
</tr>
<tr>
<td>12. Health communications</td>
<td>4</td>
</tr>
</tbody>
</table>

### 3. SEMI-STRUCTURED INTERVIEWS

The semi-structured interviews aim to obtain detailed information on illness history over the past month in a household, the type of treatment and total cost and detailed information on perceptions, stages in seeking care and the decision making process in one illness. This illness/need will be selected to get a purposive sample of.

- Acute illness
- Chronic illness
- Emergencies
- Child and maternal health

(Sexual health and reproductive health will probably be included under the other headings as this will be less sensitive. However, if it does not appear, the team will hold a group discussion with women and men separately on the topic.)

The team will have time to do 80 semi-structured interviews in Tonle Bassac and Boeung Kok, that is 10 in each zone.

They will interview at least 2 people in each zone with each of the health problems listed, making 35 interviews in BK and 45 in TB. They will aim to interview a
mixture of ultra poor and poor, young and old men and women, Khmer and at least 2 Vietnamese people.

The interview will also obtain information on household income, expenditure on health care, how they raise extra cash and the impact of this on the household. The interviewer will make an assessment of economic group from housing, furniture, TV and general property.

The last section asks questions about sources of health information and advertising, types of messages heard and action taken on them. Preferred sources and access to TV, radio and ability to read are also recorded.

4. APPROVED PROVIDER SCHEME

The qualitative demand survey for this component will be carried out between September 1 - 17. It will include 6 interview days, allowing for 12 groups and 24 semi-structured interviews.

5. QUANTITATIVE SURVEY

Crossroads will organise a four day workshop on the week of the 20 September to pre-test and finalise the questionnaire and train the team to interview and put the data onto the computer. The team will then work for 10 days collecting the data and entering it on the computer. If they also do the APS baseline, this would be a further 5-10 days depending on the sample size required and the length of the questionnaire.

Each interviewer is expected to complete and put on the computer four interviews a day, making a total of 240 interviews. This represents roughly a 10% sample of poor and ultra poor households.
<table>
<thead>
<tr>
<th>Date</th>
<th>Task</th>
<th>Who?</th>
<th>Number of days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>June</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Train Crossroads and test methods</td>
<td>GG, Crossroads whole team</td>
<td>5</td>
</tr>
<tr>
<td>20</td>
<td>Plan research</td>
<td>Crossroads team</td>
<td>5</td>
</tr>
<tr>
<td>27</td>
<td>Begin qualitative research in BK. SW begins PMP screen</td>
<td>SW, 1 Crossroads man</td>
<td>5</td>
</tr>
<tr>
<td><strong>July</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Qualitative research</td>
<td>Crossroads team</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>PMP screen</td>
<td>SW, Crossroads</td>
<td>5</td>
</tr>
<tr>
<td>19</td>
<td>Qualitative research</td>
<td>Crossroads team</td>
<td>5</td>
</tr>
<tr>
<td>26</td>
<td>PMP audit/interviews</td>
<td>SW/Crossroads</td>
<td>5</td>
</tr>
<tr>
<td><strong>August</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Qualitative research/PMP audit</td>
<td>Crossroads, SW</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>Qualitative research/PMP audit</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>16</td>
<td>Qualitative research/PMP audit</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>23</td>
<td>Qualitative research/PMP audit</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>30</td>
<td>Write final report of qualitative in BK and TB</td>
<td>JH, UV, team</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Prepare for workshop</td>
<td>GG</td>
<td>1 + weekend</td>
</tr>
<tr>
<td><strong>September</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Attend workshop for presentation of findings, project design,</td>
<td>GG, RB, JH, UV, Team</td>
<td>?</td>
</tr>
<tr>
<td></td>
<td>quantitative survey design</td>
<td></td>
<td>?</td>
</tr>
<tr>
<td>13</td>
<td>Begin qualitative work in APS</td>
<td>Crossroads team</td>
<td>?</td>
</tr>
<tr>
<td>20</td>
<td>Qualitative work in APS</td>
<td>Crossroads team</td>
<td>5</td>
</tr>
<tr>
<td>27</td>
<td>Qualitative work in APS</td>
<td>JH and UV</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Finish report</td>
<td>JH and UV</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Train in quantitative survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>October</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Begin quantitative survey BK and TB</td>
<td>Crossroads team</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>Quantitative survey BK and TB</td>
<td>Crossroads team</td>
<td>5</td>
</tr>
<tr>
<td>18</td>
<td>Analyse data</td>
<td>JH and UV</td>
<td>5</td>
</tr>
<tr>
<td>25</td>
<td>Analyse data and write report</td>
<td>JH and UV</td>
<td>5</td>
</tr>
</tbody>
</table>
Qualitative research in Tonle Bassac and Boeung Kok:

40 groups 80 semi-structured interviews.

Time = 40 working days x 12 people

Quantitative research in Tonle Bassac and Boeung Kok

240 interviews.

Time = 10 working days x 12 people

Qualitative research in 7 Makara

12 groups
24 semi-structured interviews

12 working days x 12 people

Quantitative research in 7 Makara

??? - depends on sample and scope of questionnaire. Crossroads researchers can cover this if it is within their contracted timeframe. Otherwise, this could possibly be done by MHD - to be decided later.
Selection Criteria for Approved Providers

As discussed and agreed at the UHPTF meeting of 22nd July 1999.

1. Qualified - medical allopathic practitioners (the MHD had asked that dentists be included in the APS but the UHPTF agreed that dentists will not be included since there is a need to concentrate on one type of practitioner at this stage, due to technical feasibility, limited resources and the pilot project's limited time-frame. The members of the UHPTF agreed to the suggestion that only private allopathic medical practitioners, drawn from singleton providers or polyclinics and maternity hospitals, would be eligible for the scheme).

2. Meet MHD criteria for facility registration

3. Prepared to be monitored and to allow interviews of patients

4. Caseload in excess of 15 per day

5. Prepared to provide the UHPTF with monthly reports on activities

6. Prepared to work towards public health goals as incorporated in the MPA
APPENDIX 10: ACTUAL EXPENDITURE TO DATE AGAINST BUDGET