

The Experience of the Catholic Relief Services Community-Based Primary Health Care Programme

**Gary Deigle with
Mok Samoeun**

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1 Introduction

The most critical issue in the health care system in Cambodia is the limited institutional and human resource capacity of the country. Specific problems that plague the health care system are limited budgetary resources, weak management, underutilisation of health facilities, with competing and unregulated private health providers, lack of basic equipment and supplies, and low motivation, knowledge and skills among health staff. All of these factors contribute to the overall poor quality of health care for rural communities.

Catholic Relief Services (CRS) has been implementing a community health services project in Battambang Province in northwestern Cambodia since 1993. The initial objectives of the project involved the construction and repair of district hospitals and clinics, the improvement of management support systems, the improvement of maternal and child health practices, and the strengthening of clinical services provided by the district and commune levels of the Department of Health. At this time the programme primarily provided material and technical assistance to commune and district health facilities and staff.

During the course of implementation of the initial CRS strategy, it was observed that linkages between health centres and the communities they served were generally weak, as demonstrated by utilisation rates and health centre outreach activities such as immunisations. In addition, knowledge levels of community members regarding health promotion and disease prevention measures were low, and diseases resulting from unsafe water and inadequate sanitation were frequent. To address these issues and to better serve the needs of the population in the project area, CRS began a Community-Based Primary Health Care Programme (CBPHCP) in two districts in Battambang Province in 1994.

2 Community Health Structures in the CRS Project Area

There are three types of community health structures in operation in the CRS project area:

- *Village Health Committees (VHCs)* Locally elected to manage village health activities, such as health education, water and sanitation

projects, referrals, participatory rural appraisals, and monitoring and evaluation. These committees receive intensive support from CRS to develop their capacity to manage and implement health promotion and disease prevention activities.

- **Village Health Volunteers (VHVs)** Volunteers who receive training from CRS, and are then responsible for health education, facilitating immunisation and other health centre outreach activities, village health information systems, referrals, and regular meetings. In villages where VHCs also exist, VHVs are automatic members of VHCs.
- **Traditional Birth Attendants (TBAs)** CRS provides training to these local women on safe delivery, breast-feeding, nutrition for pregnancy, and identification of high risk pregnancies. They are responsible for normal deliveries in the village, reporting, and patient education. TBAs are also automatic members of VHCs in villages where they exist.

All of the people involved in these activities live and work at the village level. They have all been trained in their specific roles and have a relationship with the health centre and the communities where they live and work.

3 Government Health Centres: Health Centre Quality of Service

With the implementation of the National Health Coverage Plan for Cambodia in 1996, the Royal Government of Cambodia began addressing the issues of coverage and quality of public health services. Establishment of the health centre Minimum Package of Activities (MPA) in 1997 was one of the fundamental steps taken in this process. The MPA is the standard for health centre operations. The activities it covers are divided into service activities (e.g. consultations, minor surgery, immunisations, antenatal and post-natal care, safe delivery and patient health education) and management activities (e.g. collection of statistics for the service area, inventory reporting, management of medication and equipment, monitoring and follow-up of village health volunteers, participation in monthly meetings at the operational district level, and maintenance of buildings).¹

CRS has been providing technical and material support for the development of the health centre Minimum Package of Activities. In 1997, Quality of Service Checklists were developed by CRS staff to provide tools for the evaluation of service quality in the MPA. The checklists developed, and in use at this time, cover infection control, common diarrhoeal diseases (CDD), acute respiratory infection (ARI), and accounting systems.

Also in 1997, two health centres that were providing the highest quality of service in the CRS project area were selected as pilots for the development of accounting systems. To allow health centre staff to gain experience in accounting and budgeting, a small budget (\$50/month) was provided by CRS to help cover health centre operating costs. CRS staff conducted training on health centre accounting. These two health centres then began using the new accounting system with regular follow-up and monitoring, using Health Centre Account Checklists developed by CRS staff.

4 Community and Health Centre Co-Management/Co-Financing

In mid-1998, a process of piloting Health Centre Co-management/Co-financing (CM/CF) strategies began in Battambang Province with a workshop initiated by the Department of Health with the involvement of health staff and NGOs operating in the health sector. At this workshop different models for the implementation of co-management/co-financing were reviewed and alternative models were proposed. The CRS/Battambang Health Programme presented a model developed by CRS and health centre staff for proposed pilot implementation in two health centres in the project area. This was accepted by the Provincial Department of Health and was then implemented in the two health centres.

The model presented here is an example of a strategy for health centre service quality assurance and sustainability and community involvement in the management and financing of primary health care interventions.

The principal purposes of the co-management/co-financing committees can be summarised as follows:

1. Improve the quality of health centre services
2. Provide quality control for delivery of MPA services
3. Promote transparency in health centre operations and finances
4. Improve overall management capacity
5. Set co-financing/co-management policies agreeable to health providers and users of health centre services
6. Increase the sustainability of the health centre services
7. Increase utilisation of the health centre
8. Increase resources for health centre operations
9. Increase motivation of health centre staff
10. Facilitate the flow of information from the community to the health centre and vice versa
11. Create a system for community 'owners' of the health centre to participate in the management and financing of their health centre

Committees consist of the following members:

- Two elected members from each village: one woman and one man
- Two health centre staff: health centre chief, mid-wife/accountant
- A committee chief, deputy chief, and recorder, identified by the committee. The health centre chief cannot be the committee chief or deputy.

5 Setting Health Centre Fees and Exemptions with Community Involvement

One of the most important activities conducted following the formation of the co-management/co-financing committee is the setting of fee schedules for health centre services. The process used in this model is designed to set appropriate fees according to the ability of people in the communities to pay. This requires the input of the community representatives and the people in the villages that they represent.

Community representatives conducted informal surveys of people in their villages to seek their views on appropriate fees for certain services: out-patient consultation, ante-natal care and delivery. After all the community representatives had collected this information, it was presented to the next co-management/co-financing committee meeting.

Discussions between members of the co-management/co-financing committee, other health centre staff, and the community representatives arrived at consensus on an appropriate fee schedule.

Later, the committee raised the issue of exemptions. It was decided that those people who work as volunteers in promoting community health and health education, such as VHVs, trained TBAs, and VHC members, should be exempt. Buddhist Monks and children referred from school are also exempt. However, how could the poorest community members be identified for exemption from paying for health centre services? There are no regular tax records or other documentation of income or assets in Cambodia. Additionally, both CM/CF health centres have patients who come from other areas that are not in their normal service area.

After much discussion, the committee decided that health centre staff would give exemptions to those people who came to the health centre and said they had no resources to pay. Generally, people from the rural villages in Cambodia will pay for a service if they have the money and the fee is reasonable. If they cannot, they inform health centre staff and receive exemption. In the future, other ways of identifying the poorest, such as wealth ranking, may be tried.

6 Health Centre and Community Contract

After these activities had taken place and were documented, the committee began drafting the health centre/community contract. This is a contract required by the Ministry of Health for all areas where co-management/co-financing is implemented. The contract documents the procedures for the operation of CM/CF, such as the health centre fee schedule, CM/CF meeting minutes, health centre utilisation etc. The community agree to pay fees for services, to participate in the election of community representatives, and to provide information and feedback. Monthly meetings of the co-management/co-financing committee are also required in the contract.

The two health centres in the CRS project area have now had CM/CF committees in operation for more than one year. Committees meet monthly and

health centre utilisation initially increased by 103% on average for the two health centres and later levelled off at 96%.

7 Lessons Learned and Future Plans

A number of important lessons emerged from this initial experience. It became clear that without the strong commitment of health staff to improve the quality of their health services and to involve community members actively in the process of developing co-management/co-financing, this strategy will not be successful. A number of preconditions were seen to be necessary before implementing this kind of strategy. Co-management/co-financing should not take place before there is an acceptable level of health centre service quality, regular working hours, appropriate medicines in stock, an effective accounting system, and community interest in using the health centre's services.

At the community level, commitment to and confidence in the committee is vital. Information should be made available to village authorities and community members regarding the purpose and objectives of the co-management/co-financing committee and the role of community representatives, so that informed decisions can be made when voting for candidates and establishing committees. CM/CF committee members should be volunteers and not receive any salary or other benefits besides exemptions from payment for health centre services. Health centre fees must be decided with the input of the communities they serve, to ensure

willingness and ability to pay. The health centre accounting system must be transparent if CM/CF members and villagers are to have confidence in the staff and feel comfortable to pay fees for service. There should be a finance report to community representatives during CM/CF meetings and members should be encouraged to monitor accounts and inventory.

The pilot showed that community health structures (VHCs, VHVs, TBAs) can be very effective in facilitating the implementation of co-management/co-financing. They can help disseminate information to the communities about the objectives of CM/CF before election of community representatives and can provide feedback to health centre staff during monthly meetings at the health centre. Alongside the use of information for ensuring transparency and accountability, it was also noted that publicising work hours, fees, services available, and medicines and treatments available at health centres and in the villages can further increase health centre utilisation.

This process is still in the pilot stage and will continue to be reviewed and adapted as it is expanded to additional health centres in the CRS project area. The process of strengthening the quality of service and implementing accounting systems in three additional health centres has begun, with a view to organising community and health centre co-management/co-financing there too. The experience of the CRS project confirms the potential for bringing health staff and village health structures together in a system of co-management and co-financing.

Note

¹Ministry of Health, *Health Centre Manual*, Kingdom of Cambodia, 1st edition, 1997.