

## **Speech for the 10<sup>th</sup> Year Evaluation Team**

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**(This speech is accompanied by a PowerPoint Presentation)**

### **Introduction:**

RHAC is a Cambodian NGO, founded in April 1996 by staff who had been working on the Family Health and Spacing Project (FHSP) managed by Family Planning International Assistance (FPIA). From its origins within the FHSP, RHAC inherited approximately 30 staff, one clinic in Phnom Penh offering primarily reproductive health (RH) services and a small community-based distribution (CBD) system. It was initially funded as an NGO through USAID's SEATS Project and, during 1996, was accepted as an associate member of the International Planned Parenthood Federation (IPPF). In April 1999, RHAC became a direct recipient of funds from USAID/ Cambodia through a bilateral Cooperative Agreement (CA). By that time, it was operating four clinics (two in Phnom Penh and one each in Battambang and Sihanoukville), had 346 volunteer members providing outreach, and nascent programs in youth reproductive health and HIV/AIDS prevention.

### **Slide #1: Mission**

The current RHAC's mission is "to enable the Cambodian people to exercise their rights to achieve optimal quality of life through model services, gender-sensitive health communication and training, focusing on family health, including sexual and reproductive health, maternal and child health, and HIV/AIDS."

### **Slide #2: Organizational Structure**

RHAC is governed by seven National Council members whom are elected for every two years, two members have to be women, one member has to be a HIV Positive Person, and one member has to be under 25 year old; and RHAC is managed by a management team, comprised of the Executive Director, the Associate Executive Director, and the Director of Clinical Services. RHAC's management philosophy is team work, team decision, participation, and share the success and failures. RHAC has 510 fulltime staff and a network of 20000 volunteers/Peer Educators. It operates seven programs : RHAC's established Clinical Services, Outreach and Health Center Support Program, Youth Health Program, HIV/AIDS for Vulnerable Groups, Training, Contracting Service for Health Services, and Health Care Financing. All of the programs are supported by Monitoring and Evaluation Component, IEC and Market Research Component, Finance, Inventory and Administration Component.

### **Slide #3: What We Do?**

RHAC services cover a range of continuum of health care services which include not only sexual and reproductive health, but a range of HIV/AIDS intervention, maternal and newborn care, child health, TB, which we focus mainly C-DOTS, and health system strengthening which include the MoH funded contracting health services, the strengthening public health information system, and the health equity funds. For the contracting, RHAC is a sub-contractor to the Health Net International and is responsible for managing the government health services in Pres Sdach OD.

#### **Slide #4: Where We Do?**

RHAC programs are in 11 provinces out of 24 provinces/municipalities in Cambodia, covering 26 Operational Districts out of 76 in the country . When providing direct support to the public sector, RHAC's approach is to fully cover one OD before expanding the support to another, and has worked closely with government counterparts and other partners, particularly USAID's CA, to ensure that there is no gap and no overlap.

#### **Slide #5: Who are our direct beneficiaries?**

The total population in the 26 OD, where RHAC is active is about 4 millions , in those ODs, RHAC is working with and for rural couples, including pregnant women, young people aged from 10-24, children under five, factory workers, rubber plantation workers, construction workers, young entertainers, fishermen, the Men have Sex with Men, and Casino Workers.

#### **Slide #6: How We Do?**

The way that RHAC organizes its intervention is coming from the idea that to improve the health care of the people there should be a full participation from three groups: the government (in this case the public health system established by the Ministry of Health), the private sector, and the community. RHAC's program has been designed to work with all these three sectors/groups.

Our RHAC's established clinics have been established not only to serve the urgent needs of the people, but to set an example for other private clinics that the acceptable or even high quality of care could be achieved within our limited resources. RHAC clinics also show the clients about how their rights are respected, and what is a quality service look like. The clinics indirectly educate the clients on how to meaningfully interact with a service provider. RHAC's clinic model is a show case for other service providers and the clients. It is rare to find a clinic, where the providers respect the clients in Khmer tradition with smile; and it is rare to find a clinic, where clients could ask many questions as they want to or are encouraged to ask questions; our clinics are the places where women and men trusts and disclose all their personal problems, not only physical but emotional problems as well.

We also provide direct support to the public sector through RHAC's Outreach and Health Center Support Program. Its precursor (FPIA/FHSP) and then RHAC has a long history on this partnership with the government, beginning in 1995, we assisted the public health sector to develop community-based distribution of family planning methods through volunteers at health centers. Through working with the government counterparts, RHAC has been able to expand its scope of support from family planning toward a more elements of health center Minimum Package of Activities. The support include improve health services management and technical knowledge through working partnership between RHAC and the government staff at various level, from the national level down to the health center level. RHAC also provides financial support to the government field staff to enabling them to perform their duties, e.g. per diem and transportation for outreach activities, provides the health centers with basic instruments, e.g. scale, IUD kits, ....we work hand in hand with the operational district management to develop the OD's Annual Operation Plan, and we together with the OD jointly monitor the progress of the plan. RHAC staff participates regularly the Provincial Technical Working Group, various technical working at the national level, and RHAC is a member of the Technical Working for Health, and also a member of the Global Fund's Cambodian Coordination Committee for HIV/AIDS, TB, and Tuberculosis.

We have worked closely with the community, it is part of our existence, RHAC is actually a membership organization, and our members are volunteers and they are responsible for electing the National Council Members. For this reason, RHAC has been well placed in working and mobilizing the support of the volunteers. RHAC's goal in this regard is building a strong community network to respond to the health need in their community and to enable the community to work in close partnership with the government health system and other civil society. RHAC has been able to establish a network of ten thousand people in the rural villages and ten thousand others in the work place. They are the community resources and RHAC has been able to expand the scope of the community network from family planning to HIV/AIDS, MCH, nutrition, infectious diseases, and illicit drug use.

### **Slide #7: Our Program Structure:**

To support the three sectors/groups, RHAC has organized herself into these six service delivery components, and several other supportive components as seen in the organization chart. I will explain briefly each of these components.

### **Slide #8: Clinic**

This slide show you a reason why we need to have the clinics, and our team will inform you in a more detail about the services, in addition to what I said earlier, I would like to add more information behind the success of our clinics. Although there is space constraint, each of our clinic is designed for various specific target groups, take into consideration the social, cultural and administrative barrier in accessing health services, e.g. a separate waiting areas for women and men, for adolescent. We are probably

different from other providers on the way we care and interact with our clients, all of our effort is toward client satisfaction, the friendliness of our staff, the friendliness of the clinic environment, the clear guidance (with proper written technical guidelines) for our staff, a strong quality of care which have been rigorously conducted by both the clinic staff and the staff from the headquarter with a clear scoring system and a clear action plan to follow up, the comprehensiveness of our sexual/RH/HIV/AIDS services which we are working toward a one stop shopping services, the convenience clinic location, clinic hours for specific target groups, the pricing policy for the poor and for the marginalized, and a clear guidance to clients when referral services are needed. For your information, RHAC was awarded the highest commitment to quality of care in 2005.

### **Slide #9: The Outreach and Health Center Support Program**

This program has been evolving from a CBD program in 1995 to the HDT program in 1999, and then to the Outreach and Health Center Support Program in 2003. This reflects the way RHAC has learned from the community (the rural villagers), the government counterparts, and the donors, and RHAC is always ready to change herself to respond to the need of the country. This is an example of RHAC as a learning organization. As an organization, RHAC needs to carefully balance the need of the three clients or sometime we say two clients: the direct beneficiary and the donor.

This Outreach and Health Center Support Program has two components: one is the outreach, which we work closely with the community, the other is the health centers, which we work closely with the government health centers, and at the same time we have been able to build bridge between the government health center and the community volunteers. Our continued effort is to focus on building the capacity of existing community structure, e.g. the commune council to take a more proactive approach toward social issue development, particularly the health and the education for their people.

Our Outreach and Health Center Support Program has long experience in strengthening and mobilizing all the sectors at the village and commune levels, e.g. in 2004 as a pilot project for Community-based Vitamin A Distribution, we were able to utilize the existing RHAC's community network and have been able to mobilize the support of existing community structure, e.g. education sector, agricultural sector, religious sector, and local authority to form the community support group to support the work of our community volunteers. This approach was seen as a success as it increased the vitamin A coverage from below 18% to more than 80%. This community-based VAC distribution approach is now replicated to 12 OD. A number of success elements of this program are included in the recent revised National VA policy. This is part of RHAC's approach in advocacy, our soft approach. I could elaborate more when we have time on what is RHAC's approach toward policy change at the national level.

### **Slide 10: Vulnerable Group Program:**

This program covers a number of different target groups (the factory workers, young entertainers, rubber plantation workers, fishermen, construction workers, and MSM). All

are considered marginalized groups and have limited access to the public health sector. These groups are beyond reach of the current public health system. RHAC apply its three pronged approach including, peer to peer educators, referral to high quality services, and enabling environment (involving the managers/business owners in the program implementation). All the peer educators are volunteers. The peer education, such as group education, one-on-one talk may look simple, but the effectiveness of this approach is really depending on our staff behavior/attitude in addition to the technical knowledge. Proper attitude such as verbal and body languages, frequent visits to the volunteers, use the language that the target group feels comfortable and friendliness attitude have built trust between the volunteers and RHAC staff. RHAC is lucky that through our work, we have been always working with the community and it is part of our life that we know how to put ourselves in a right way.

### **Slide #11: Youth Health Program**

Similar approach as mentioned in the case of Vulnerable Group Program, we use the three pronged approach: the peer educators to discuss and share the accurate information and referral for services, the provision of youth friendly services, and the enabling environment, which we work with parents, local authorities, local school principals, ... a number of donors consider youth as a lesser priority on HIV/AIDS, but there are many anecdotal evidences that premarital sex is on the rise, social issues particularly the un - employed young people, migration and the young married couples who have limited knowledge and limited access to health information or health services, and youth violence and drugs are more wide spread now. Many donors , due to financial reasons, keep youth at a lower priority, but for RHAC, we are convinced that addressing the need of young people is one of the priorities. In our youth program, we have two peer educators per village, two peer educators per classroom, these educators are supported by the established youth advisory groups and RHAC staff. Most of the educational activities are initiated and conducted or organized by young people, e.g. the quiz show, the village edutainment, the local theatre, and the group education. RHAC started the youth program in mid 1997, in 1999, the percentage of under 25 year old who come to our clinic was about 20% but now it reaches 30% of the total clients. For us, we believe that reaching younger clients on sexual and RH/HIV/AIDS is more cost effective than reaching the older target groups.

### **Slide #12: Health Equity Fund**

What we have done, vision...as in the slide (we do it in SHV and Pres Sdach, talk about pre and post identification, using MoP tool, ..)

### **Slide #13: Achievement Highlight:**

Each year RHAC provide services directly to approximately 300000 clients (excluding the clients served through the support of public sector , such as delivery or immunization or ), among this clients, 200000 clients are diagnosed and treated with reproductive tract infections, 58194 clients received HIV test which accounted for about 25% of the total

VCCT clients in Cambodia. With the support to the public sector, 51000 children received full immunization, 299596 children received VAC (March Round 2007), 12000 pregnant women received assisted delivery, 4500 CDOT clients, and hundred thousands clients received health educations from the various programs.

#### **Slide #14: M&E Reporting System**

To measure the results of the various programs, RHAC has a strong M&E system, we have a centralized data base system for all of our programs, and we also have a strong clinic data base to keep track the number and type of services served by the clinics. In addition to the routine statistic, RHAC has a clear written guideline on Monitoring and Evaluation. The monitoring data is collected by the project staff themselves, while the evaluation data is collected by independent interviewers. The M&E component is responsible for analyzing the data and writing the report. After each round of the monitoring or the evaluation, a meeting with relevant project staff is organized to discuss the finding and to establish the action plan for project improvement.

#### **Slide #15: Expenditure by Sources**

USAID has been increasing its support to RHAC, and at the same time, RHAC has been able also to diversify the funding sources throughout the years. Although the number of donors decline from 1999 to 2007, we have seen that RHAC has consolidated its efforts on a bigger donors, except that IPPF and its ally dropped (Japan Trust Fund through IPPF) its support to RHAC in 2006.

#### **Slide 16: Cost Share:**

From the beginning cost share required by USAID was around 20% plus, but due to RHAC good performance in fund diversification during the early year, USAID has required RHAC to increase the cost share. Although it is below the USAID cost share requirement which set at 40%. The cost share by USAID increased over the year due to, 1) increase in USAID support to the organization, 2) due partly to the drop of support from IPPF and its associated funding sources after IPPF issued a regulation that it cut funding support to members who sign the Mexico Policy, and 3) during the past several years, RHAC has been focused more on expanding the program through the support from USAID rather than looking for more funding sources. Although it is good for RHAC to have a more diversified source of funding, RHAC thinks that USAID is still the vital donor for all RHAC's programs. Other donors tend to compliment what RHAC has done with USAID, e.g. GF support drugs and health education program.

#### **Slide 17: Operational Budget:**

This slide indicates the effectiveness of RHAC's administration and the economic of scale. RHAC has been able to reduce the percentage of its administrative cost from close to 30% in 2001 to below 15% in 2006.

### **Slide 18: What accounted for RHAC's success or accomplishments?**

Three principal factors, we believe, accounts for RHAC's success. First is the fact that throughout RHAC's short history, we have been blessed with strong support, guidance and total commitment by our main donor, USAID. Each of the successive OPHE Directors and CTOs have given RHAC all the support - financial, moral, goodwill and technical guidance – we needed and sought. USAID support is absolutely critical, obviously on the funding side and otherwise, because without the USAID support, there is no way RHAC would be in the strong position it is in now as an organization and what RHAC does. Having strong USAID support is important psychologically for RHAC as an organization and for its staff. It makes us feel proud, drives us to aim higher and we feel committed to achieve success because it will be major blow for us to disappoint USAID.

Second factor is RHAC's organizational values which are based on commitment to help improve Cambodian society's health and well being. We pride ourselves as a learning organization which means we are open to new ideas, new ways of doing things for better and more effective results, we condition ourselves/staff to innovation and we constantly strive to improve from month to month and year to year.

Transparency of RHAC leadership and its commitment to staff capacity development are important factors to RHAC's success. Our single minded focus on our work and rather than be concerned on getting credit or earning visibility has earned RHAC the respect and appreciation of MoH and other partners in the health sector which again contributed to RHAC's success. Leadership by example, equality, gender-sensitivity etc.

Third and just as important is the RHAC staff who are extremely dedicated, hard working and loyal to RHAC and its mission. Despite being a local NGO and salaries are lower than other international NGOs, we have an excellent retention rate. Many of our senior staff have been offered much higher salary and positions in other organizations but many choose to stay with RHAC because they feel committed to RHAC and its work. RHAC takes its staff seriously and expands lot of resources to improve staff capacity across the board and in turn, RHAC staff are extremely loyal to the organization and all have a strong sense of pride being part of RHAC.

### **Slide 19: What are the constraints/Failures in our story ?**

As much as we have accomplished, we have failed in many areas. One of RHAC's greatest strength is its work at the community level but it took much longer to understand and gain the community trust because in the first few years, we took it for granted that community would welcome us as we are helping them. We did not understand that our work in the community will be more effective if we built meaningful relationships in the community and that we need to know that our work will be effective if and when the community would want our services. It takes time and effort to build bridges in the community and initially, we were in hurry to get things done without laying the foundations. In the course of our work, we learned a great deal how to work more effectively at the community level and gained much appreciation for our staff and

volunteers who work at the community level. An important lesson learned is Don't rush and push it but work patiently with community for the community to want the services.

We have not been successful in diversifying our donor base partly because there are no donors as open, supportive, strategic and generous as USAID. Though we have seven to ten donors, they are all very minor in funding relative to USAID support.

Related to our lack of donor diversification is our failed efforts to team with an established US based NGO for future growth of RHAC and for us to be able to access US donors. Our sole attempt to team up with one such US based organization on a sizable USAID RFA failed but we are committed in finding such an organization to team up with in the future.

Another area we looked at but has not gained much success is to achieve some financial sustainability by venturing into private sector by franchising RHAC clinic model. Due to lack of financial resources and technical expertise in business development, we have not been able to do much but we still believe that there is good potential for commercial success in private clinics for profit.

Finally, one area where we have less than ideal outcome is our lack of proper documentation and dissemination materials. There is a great deal of information from RHAC's experience which needs to be written up properly and disseminated in the near future.

### **Slide 20: Future Visions/Dreams**

Without sounding too confident, we feel that RHAC's program delivers effective results in terms of providing services at the community level, reaching the vulnerable groups and improving the capacity of the health centers and sustaining the performance of MoH service delivery. Our vision is to expand our reach to more ODs in the next 5 years.

Second, we wish to give a strong push to establish few private clinics for profit by catering to upper middle income Cambodians by offering quality services but will have to adapt RHAC clinic model by adding additional services. A serious but realistic business plan needs to be developed for investors and donor support. If such a venture succeeds, the profits will sustain some of RHAC's services for the poor.

RHAC will endeavor to team up with an established US based organization to bid on future RFA's and to seek US based donors so RHAC can do more in more provinces and ODs.

RHAC will devote resources and effort to document more professionally our work, our approaches and our success and failures for wider dissemination.

Finally, I would like to say that the story of RHAC goes with reestablishment of USAID in Cambodia. RHAC is a product of USAID's wisdom. It was conceived, nurtured and

brought into maturity by the strategic support of USAID. In that we are grateful to USAID and we are committed to earning the support and confidence of USAID. Thank you very much.