ReBUILD Consortium

Understanding contracting in Cambodia: findings from interviews with key informants and health service managers and providers

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SreytouchVong, Joanna Raven and David Newlands

Liverpool School of Tropical Medicine, Pembroke Place, Liverpool, L3 5QA
www.rebuildconsortium.com

Email: rebuildconsortium@lstmed.ac.uk

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ReBUILD is working for improved access of the poor to effective health care and reduced health costs burdens in post-conflict and post-crisis countries. We are doing this through the production of high quality, policy-relevant research evidence on health systems financing and human resources for health, and working to promote use of this evidence in policy and practice.

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Authors:

Sreytouch Vong is a health system researcher. She is a principal investigator of ReBUILD and a lead researcher of contracting based in Cambodia. Former research fellow of CDRI, she is currently a independent consultant on health system and public health.

Joanna Raven is a health systems researcher, leading on the contracting research within the ReBUILD consortium. She is currently Lecturer in Health Systems at the Liverpool School of Tropical Medicine.

David Newlands is an Associate researcher at the Institute for International Health and Development at Queen Margaret University in Edinburgh. His work is primarily focused on health economics in low and middle income countries. He has a particular interest in maternal health.

For correspondence regarding this report, please contact rebuildconsortium@lstmed.ac.uk

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Cover picture: Courtesy Joanna Raven

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Abbreviations

ANC	Antenatal Care
CBHI	Community Based Health Insurance
HC	Health Centre
HCMC	Health Centre Management Committee
HEF	Health Equity Fund
HSR	Health Sector Reform
HSSP2	Health Sector Support Project 2
HW	Health Worker
IDI	In-Depth Interview
KII	Key Informant Interview
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MOH	Ministry of Health
NGO	Non-Governmental Organisation
OD	Operational District
OPD	Outpatients Department
PHD	Provincial Health Department
PMAS	Performance Management and Accountability System
RH	Referral Hospital
RGC	Royal Government of Cambodia
SDG	Service Delivery Grant
SOA	Special Operating Agency
VHSG	Village Health Support Group

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Executive Summary

Introduction

Over the last two decades, Cambodia has implemented several policy initiatives and interventions to improve health service delivery. The contracting of services in the health sector has been happening since the late 1990s. Since 2009, an internal contracting model, Special Operating Agencies (SOA), with performance incentives, monitoring mechanisms and a greater level of autonomy for district health management has been followed.

This study aims to address research gaps on the drivers for change in contracting models, and on the current contracting arrangement in Cambodia. It seeks to understand the change process in health contracting arrangements in Cambodia by identifying the drivers for change and to document the implementation processes of the current SOA contracting model. Lastly, it examines the perceived implications of the SOA on service coverage and equity. This report presents findings from the qualitative methods conducted in this study.

Methods

The study was carried out in four districts, located in different provinces, where SOAs have been implemented since 2009/10. In depth interviews were conducted with managers of SOAs and health facilities (12), and with health care providers from referral hospitals and health centres (13). Key informant interviews were conducted with representatives of the Ministry of Health (MoH) and donors (12).

Key findings

1. Reasons for changes in contracting arrangements

Interviews with national level key informants, managers and health care providers revealed several key drivers for change in the contracting arrangements. These included: (1) wider health sector reform; (2) costs of contracting with NGOs and the sustainability of this arrangement; (3) limited ownership of health services by local managers in contracting schemes under contracting with NGOs; (4) national and local capacity to manage contracting; (5) other reasons such as: issues of civil servant status for health care managers and providers, and harmonisation of donor funds and support.

2. Perceptions of implementation of SOA

- ***Selection of SOA districts:*** In order to become an SOA, an operational district (OD) applies to the Council of Ministers and undergoes an assessment that includes management capacity, infrastructure and staffing. Districts that perform well in the assessment are selected to become SOAs.
- ***Development of contracts:*** The degree of involvement of the SOA managers in the development of the contract and target setting varied across the study districts. For example, in one district the OD targets are set by the OD and Provincial Health Department (PHD) with little involvement from the MoH. However, in another district the MoH and donors played a greater role in setting these targets. The contracts between OD and the health facilities are prepared by OD, and then discussed in meetings with facility managers.

- ***Difficulties in achieving targets set in the contracts:*** (1) Targets are set centrally using population data that is seen as unreliable (due to overestimations of the population and inaccuracies due to migration in and out of the district). (2) As baseline data on utilisation was too high and did not reflect the real situation, targets were set too high. (3) There is competition between facilities in the same district: each has a target to achieve and therefore tries to attract clients to their facility. As there are a limited numbers of clients, some facilities cannot meet their targets.
- ***Monitoring of contracts:*** There are four levels of monitoring conducted in SOA: the Service Delivery Monitoring Group (SDMG) at the central level monitors the OD, PHD monitors the OD; OD monitors the health facilities; and the facility managers monitor the health workers. Study participants perceived monitoring as being useful. Monitoring acts as a tool to correct mistakes and improve performance of health workers, including punctuality, changing bad habits and providing good quality care such as correct treatment and completion of documents. Monitoring can help with clarifying individual's roles and responsibilities as tasks are clearly divided amongst the staff so that each person knows what they are expected to do. It also ensures that the data is more reliable - by going into the community and verifying that community members actually used the services, staff at health centres do not falsify the facility records.
- **Challenges in monitoring:** There are infrequent visits by the central monitoring team due to lack of time, few incentives to travel and limited capacity. The PHD should conduct quarterly monitoring visits to the districts. In reality this happens once or twice a year due to lack of specific budget for monitoring SOAs, general monitoring budget being too small for the planned frequency of visits, and lack of incentives for PHD officials from the SOA for monitoring work. SOA managers regularly monitor the facilities in their districts including availability of staff and services being provided, and do spot checks within the community to verify the data at the facility. However, SOA managers rarely sanction the facility managers or staff when they find mistakes.

3. Perceived effects of SOA on how services are delivered

- ***Ownership of the district health services*****:** Managers described ownership as a key benefit of being an SOA, enabling them to be more innovative, and having autonomy to make decisions and manage district healthcare staff.
- ***Behaviour of health managers and workers*****:** Respondents perceived that SOA has had a positive effect on behaviour of health managers and workers in the districts, as a result of the incentive sharing process and monitoring mechanisms. Staff were more likely to wear full uniforms, be punctual, be more responsible and committed to their role, be on standby 24 hours and be friendlier towards clients. There were also improvements in the cleanliness of facilities.
- ***Private practice:*** Government employees conducting private practice is not banned in SOAs as long as this is out of government hours and does not interfere with meeting targets. SOA does not provide enough incentives to prevent private practice. Staff, particularly specialists, may leave their government job if unable to conduct private practice.

4. Perceived effects of SOA on service coverage and equity

- ***Increases in service coverage:*** key informants, managers and health workers reported that service coverage has increased in districts where SOA was introduced and gave several reasons including: improved public trust in health facilities; facilities open and staff available 24 hours per day; clear contracts and incentives encourage staff to be punctual, provide services and achieve targets.
- ***Perceived increases in use of services by the poor:*** Three main reasons were highlighted by key informants, managers and health workers: all SOA districts are also equipped with Health Equity Funds (HEF) which allow the poor to use services without paying fees; SOA has improved the attitudes of health workers, who behave well towards all clients irrespective of socio-economic status; and facilities are open 24 hours.

Conclusions

- SOA can enhance some aspects of performance of health care providers through adherence to work regulations stipulated in contracts and rewarded with incentives. Perceived improved quality of care has increased public trust in the health facilities, contributing to the perceived increase in service utilisation.
- Managing contracts in SOA is a complex process requiring capacity in planning and monitoring at different levels in the health system. Failure to establish and enforce effective performance monitoring could undermine effectiveness of service delivery.
- Improvements in the operation of SOA include: strengthening monitoring by the central and provincial levels; having reliable baseline data for specific performance indicators; and designing incentive schemes that address the issue of dual practice.

1 Introduction

1.1 Background and rationale of the study

There has been much effort and commitment to strengthen the Cambodian health system to provide better quality of care. There is evidence that health outcomes have improved: life expectancy has risen from 49 years in 1990 to 62 years in 2010; the infant mortality rate has halved from 95 per 1000 live births in 2000 to 45 /1000 live births in 2010; maternal mortality has decreased from 437 per 100,000 live births in 2000 to 206 per 100,000 live births in 2010 (NIPH, MOH, & Macro, 2001; NIS, MoH, & Macro, 2011).

Despite these achievements, many challenges remain in the health care system. These include a shortage of skilled health care providers, maldistribution of health workers with many working in the capital Phnom Penh, poor quality of care and low utilisation of health care services (Sok 2012; Asante et al 2011).

In order to address these issues, the Royal Government of Cambodia (RGC) introduced significant health sector reforms. Between 1996 and 2008, the Ministry of Health has reformed health financing, health planning and health service management. These reforms responded to the health workforce capacity, fragmented management and service delivery, low rural coverage of health services and inequitable access to services by socially excluded and economically marginalised groups (John Grundy, 2009). In 1998, the RGC introduced contracting of health services to non-governmental organizations (NGOs).

Since the introduction of this external contracting model in 1998, there have been many changes to the contracting models. The current model "Special Operating Agencies" (SOA) is a form of internal contracting. Contracting is a complex process that requires a good understanding of the nature of the work, thorough planning, negotiation and monitoring. The arrangements themselves are not static, rather they continue to adapt as the situation on the ground changes to respond to new emerging issues.

There has been limited research on the new contracting arrangements in Cambodia. Past studies focused on the external contracting interventions, but apart from one study (Khim and Annear 2013) there is little on the process of contracting. The current arrangement is new and employs the principles of contracting. However, as it is an internal arrangement it is anticipated that it must conform to the bureaucratic environments, capacity and management framework of the government.

The purpose of the study is three-fold. Firstly, it examines the process of change that resulted in the current model, providing an understanding of how the new arrangement were made, who and what institutions were involved in influencing the configuration, the actors' perceptions of new arrangements in relation to the bureaucratic environment and existing management and regulation of health districts.

Secondly, the study will look at the constraints and challenges in the implementation of the SOA, whether or not they have been and have not been anticipated and how they were addressed, for example, the coping strategies employed by health districts to address fund delays and staff shortages and the capacity constraints.

Thirdly, it will look at the perceived consequences of the SOA on service coverage. So far there have been few attempts to document these. Another report entitled "Report on Analysis of Secondary Data - The performance of contracting and non-contracting districts in extending primary health coverage" focuses on the analysis of existing quantitative data to examine the effects of SOA on service coverage and equity

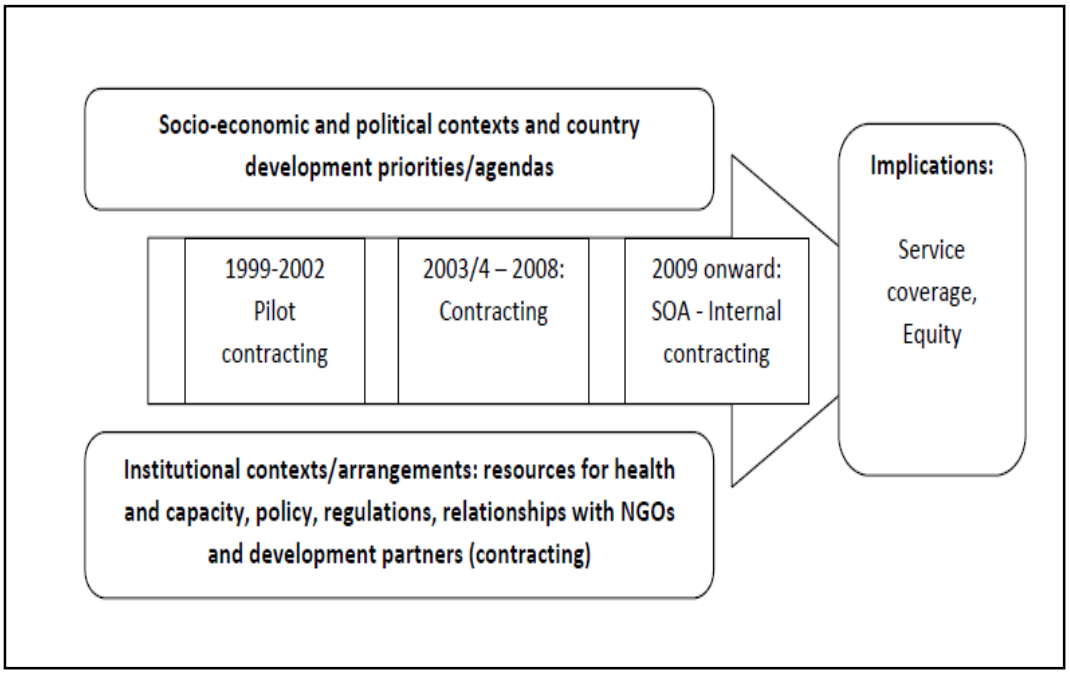
1.2 Research Objectives

1. To understand the change process in contracting arrangements in the Cambodian health sector, by identifying the drivers for change, the reasons behind the arrangements and the contextual factors at the times
2. To document the processes of implementation of the current contracting model (SOA) including the contextual and health system factors which facilitate or constrain the implementation and how these factors have been addressed
3. To examine the implications of the SOA on service coverage and equity (this is also presented in the Report on Analysis of Secondary Data - The performance of contracting and non-contracting districts in extending primary health coverage)

1.3 Research framework

A conceptual framework for the research was produced (figure 1). This explains the possible factors driving the change towards internal contracting. Although depicted as linear relationships in the figure, it is understood that in reality the change process is more complicated than this. The transition in contracting models operates within the framework of the overarching country development agenda and sectoral arrangements and policies. In this case, public sector reform is an overarching reform agenda that supports the drive towards internal contracting. The Health Strategic Plan 2008-2015 provides guiding principles and strategies for achieving better health outcomes, including those of Cambodia MDGs for health. The institutional contexts and arrangements influence how the contracting model is designed and implemented. The effects of the contracting model on service coverage and equity are illustrated in the box "implications". Service coverage and equity are inherently linked to and are products of the way the contract is formed, managed, executed and monitored. For example, health service coverage is linked to how indicators and targets are set, whereas equity may be linked to the number of eligible poor receiving health services and the operation of the Health Equity Fund.

Figure 1: Understanding contracting in Cambodia - research framework



1.4 Organization of the report

This report is organized in six main sections. Section 1 provides an introduction to the research background, research framework and objectives of the study. Section 2 focuses on a synthesis of the literature on contracting. Section 3 describes the research methodology used in this study. This is followed by a presentation of the findings from the study. In section 5, the findings are discussed. Finally, the last section includes the study conclusion and policy implications.

2. Background to contracting

Contracting is a process of fulfilling the conditions as agreed to in the contract by contracting parties, usually termed the principal and the agent (Perrot, 2004). The principal is the party that needs services or goods delivered whereas the agent is the party that delivers or produces services or goods.

A number of reasons in favour of contracting include increased likelihood of getting good providers, better planning and contract preparation, higher cost predictability and increased equity (Taylor 2003). Increasing the efficiency of resource utilisation is one of the objectives of contracting. Given the scarce resources usually in the public sector, contracting, if implemented correctly in the right context would increase the efficiency of existing resources being used – in theory optimal providers are contracted to provide services with the lowest possible cost.

Models of contracting vary and two external contracting models have been frequently referred to – contracting out and contracting in. 'Contracting out' refers to an arrangement whereby a service provider is engaged through a contract to provide services with maximum control over the resources and how services should be delivered. 'Contracting in' is whereby an external service provider is brought in to manage and operate service provision institutions with some control over resources and services arrangements (Bhushan et al., 2007; Schwartz & Bhushan, 2004). Both contracting out and contracting in are external contracting because they involve external actors in contractual arrangements. Internal contracting is a form of relational contracting whereby responsibility is delegated to peripheral units under the same legal entity (Perrot, 2006). Employing performance based incentives or pay-for-performance mechanisms are the tools that have been frequently used within the contracting framework.

All forms of contracting have advantages and disadvantages dependent upon the contexts of capacity, environment and culture in which they exist. Regulatory mechanisms, enforcement, alignments of interests, and coherent policies are among the prime requirements for contracting to be implemented successfully (Eldridge and Palmer 2009). However, contracting and performance-based incentives are not a magic bullet and there are several challenges and drawbacks in their application. They include potentially high embedded transaction costs, increased capacity to plan, prepare, manage and monitor contract, increased costs for contract management and monitoring and the potential detriment to other services outside the contract (Ashton 1998; Mills and Broomberg 1998; Eldridge and Palmer 2009).

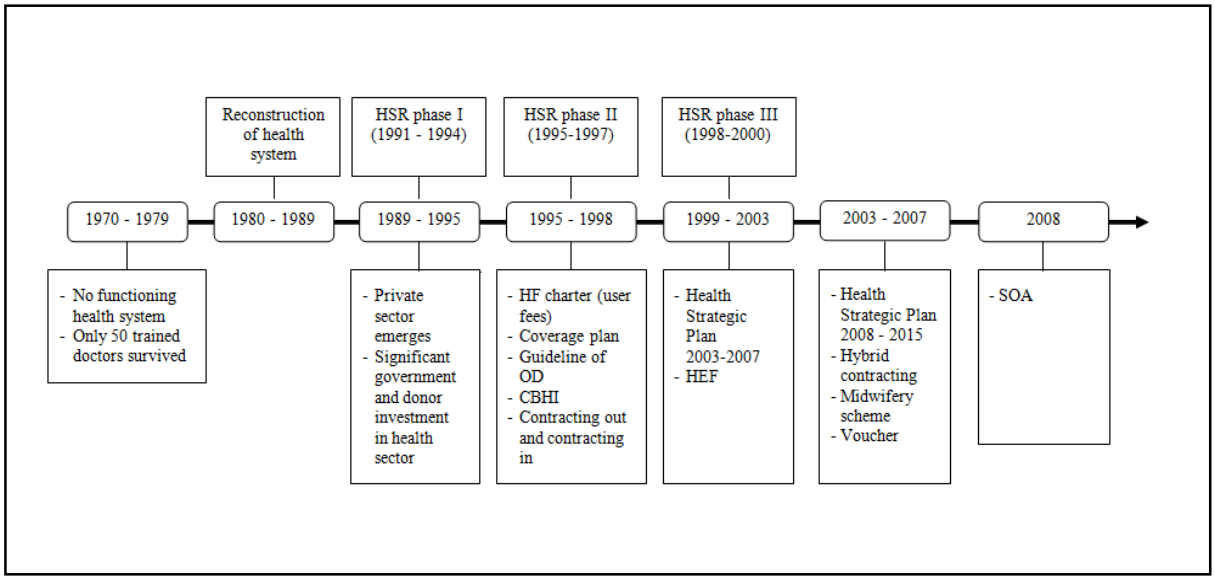
Despite these concerns, many developing countries have used contracting as a tool for improving social and public health services provision.

2.1 Contracting in Cambodia

After two decades of civil war, Cambodia barely had a health system, with ruined and empty health facilities and fewer than a hundred health professionals left in the country. The MoH tried to reconstruct the health system with few resources, an international blockade, isolation, and continued domestic armed conflict. After the UN sponsored national elections and national unification in 1993, Cambodia adopted a liberal market economy and opened up to foreign investments. The rehabilitation and redevelopment of the health system attracted significant interest from international development agencies. Between 1989

and 1995, there was significant investment in the health sector from government and donors, and the first health sector reform (HSR 1) was implemented between 1991 and 1994. HSR 2 was implemented between 1995 and 1998 in which the health coverage plan and financing charter were established and user fees were introduced at public facilities (MOH, 2007). Contracting was introduced from 1999. Figure 2 illustrates health policy development in Cambodia over the last four decades.

Figure 2: Health policy development in Cambodia



Source: Adopted from (MOH, 2007) & (Ovesen & Trankell, 2010)

Contracting has been employed in Cambodia since the late 1990s in efforts to speed up the recovery of rural health system and improve health services delivery. There have been three major phases of contracting. The first phase was the pilot phase of contracting between 1999 and 2002/3, followed by a second phase of "hybrid contracting". Finally, Special Operating Agency (SOA), a form of internal contracting was introduced in Cambodia in 2009.

In the first phase, external contracting was implemented in five health districts, of which two districts used "contracting out" and three used "contracting in". It was shown to be effective in improving health services, particularly maternal and child health services, through increasing the coverage of health services, achieving better equity and reducing out of pocket expenditure but at a cost almost twice as high as standard districts (Bhushan et al, 2007).

In the next phase (2004-8), "hybrid contracting" was introduced in 16 health districts. A number of INGOs were contracted to provide management services to 11 health districts. Five other districts were contracted by their respective provincial department using performance contract and received funding from the Belgian Development Agency (BTC). In both models, performance contracts, incentives, monitoring and capacity building of local health management were the main features (Khim & Annear, 2011; MOH, 2007).

Contracting continues to the present, with a significant change in form to "internal contracting", under the new health strategic plan (2008-2015) with an emphasis on accountability, efficiency, equity and quality. This period also saw the transformation of public service institutions into semi-autonomous institutions, SOAs, with greater management autonomy. The development of SOAs brought about a big shift in management arrangements, allowing more autonomy for the districts to manage their resources. Internal contracting was part of this change in management.

In this present phase of internal contracting, contracting parties are purely from MoH peripheral units i.e. health districts and provincial health departments (PHD). MoH and health partners (as funders) have an indirect relationship with contracting parties. Thirty SOAs were established by the end of 2010 and six more SOAs were introduced by 2013 (MoH, 2014). The SOAs are based on internal contracting arrangements where the SOA is contracted by their respective PHD. All parties in the contract are under the MoH umbrella.

The shift to internal contracting represents a return to government-run health services after many years of external contracting. Bound by the contract, the district management teams have to demonstrate that they have the capacity to manage their districts. As a precaution, before being given SOA status, the Operational Districts (ODs) were assessed on their management capacity to determine their eligibility and to ensure they adapt well to the roles and requirements in the contract. A capacity development phase was called for and was implemented during the first year (MoH, 2009).

Current contracting arrangements are characterised by three distinct features: a period of capacity development, performance incentives and additional financial inputs. All SOA districts received a period of capacity development provided by a contracted NGO that is experienced in contracting for health services. The boosting focuses on three major areas: financial management, performance incentive and management and planning/contracting.

Performance incentive management and monitoring continue to be one of the main features of this model and is the central component of SOA as part of the performance management and accountability system (PMAS)(MOH, 2009). Part of the SOA efforts was to improve the performance of health workers and health service delivery through larger incentives and performance monitoring and evaluation.

Funding for SOA districts comes from two major sources: the central and district level. The government budget and Service Delivery Grant (SDG from donor pooled funds) are channelled to the districts. At the OD level, user fee income comes partly from HEF reimbursements and in some ODs from Community Based Health Insurance (CBHI)(Vong, 2013)

3. Methodology

3.1 Selection of study sites

Four operational health districts (OD) were selected for this study using the following criteria: currently designated as a Special Operating Agency (SOA); range of experience of previous contracting schemes; range of services covered by SOA; and geographical spread. Table 1 provides information about the selected districts. Written permission to conduct the study in these districts was provided by the central MoH.

Table 1: Characteristics of the study districts

District (province)	SOA	Previous contracting	Level of service covered	Geographical area	Population / number of health facilities
Memut (Kampong Cham)	Yes (1st July 2009)	• 1999-2002/3 contracting out managed by SCA • 2004-2008 contracting managed by SCA	Primary and secondary care	Lower east plateau bordering Vietnam	135,500 1 referral hospital 10 health centres
Peariang (Prey Veng)	Yes (2009)	• 1999-2002 contracting-in managed by Healthnet International • 2004-2008 contracting managed by Healthnet International	Primary and secondary care	Central south plains	193,500 1 referral hospital 15 health centres
Samrong (Oddor Meanchey)	Yes (2010)	• 2005/2006 – 2009: performance contract supported by BTC • 2006-2008: PMG	Primary care only	Upper North Mountainous	219,000 1 referral hospital 23 health centres
Bati (Takeo)	Yes (2010)	None	Primary and secondary care	Plain	202,026 1 referral hospital 13 health centres

SCA: Save the Children, Australia; BTC: Belgian Development Agency; PMG: Priority Mission Group

3.2 Methods of data collection

Key informant interviews:

Interviews were conducted with representatives from the MoH and donor organisations who were knowledgeable or involved with previous and current contracting schemes. 12 interviews were conducted between August and November 2013. Four interviews were conducted with representatives of the Health Sector Support Project 2 (HSSP2) and Department of Personnel of the Ministry of Health. 8 interviews were conducted with representatives from AfD, World Bank, URC, Unicef, UNFPA, BTC, CARE and AusAid. The interviews aimed to explore the drivers for change of the contracting models, the role of those

facilitating the change of contracting arrangements, how local providers were included in planning for change, and the benefits and challenges of SOA implementation. See Annex 1 for the topic guide for key informant interviews.

In depth interview with managers and health workers:
In depth interviews were conducted with 27 managers and health care providers working in the 4 study districts.

- Managers of SOA are those who were involved in SOA working in the Provincial Health Department, and managers of the operational district involved in SOA.
- Facility managers: managers of the referral hospitals and health centres were selected for the interview. Each district has one referral hospital, and we selected one health centre in each district.
- Health workers at the referral hospitals and health centres: from each of the selected referral hospitals, one doctor and one midwife / nurse were selected; from each of the selected health centres, one midwife / nurse was selected.

The interviews explored the following areas: the different contracting models which have been implemented in the district; how the current model of SOA is being implemented; challenges in implementation of SOA and any coping mechanisms; benefits of SOA; effects of SOA on service utilisation and health system performance; and the continuation and scaling up of SOA. See Annex 1 for topic guides for interviews with managers and health workers.

3.3 Data management and analysis

The recordings of the interviews were first transcribed word for word into Khmer. These transcripts were then translated into English and checked against the Khmer transcript and recording for accuracy. For the interviews where recording was declined, the detailed notes were written up as word documents in English.

Data were analysed using a framework approach which facilitates rigorous and transparent analysis (Ritchie & Lewis, 2003). The transcripts were read by the research team to identify emerging themes. A coding framework was developed based on these themes and was used to code the transcripts. Charts for all themes were then developed and used to create narratives that describe similar and divergent perceptions, develop explanations and find associations between them.

3.4 Ethics

Ethical approval for this study was obtained from the Liverpool School of Tropical Medicine (no.12.20) and the National Ethics Committee for Health Research in Cambodia. Informed consent was obtained from each participant prior to starting the interviews.

3.5 Limitations

It was difficult to identify respondents who have experienced the different models of contracting (over the 15 year period) as many had moved employment.

4. Findings

The findings are presented in five main themes: drivers for change of contracting arrangements, implementation of the SOA arrangement, monitoring of SOA, effects of SOA on the way that services are delivered and effects of SOA on service coverage.

4.1 Drivers for change of contracting arrangements

Emerging from the interviews with national level key informants, provincial and district managers, and health care providers were several key drivers for change in the contracting arrangements. These included: (1) wider health sector reform (2) costs of contracting with NGOs and the sustainability of this arrangement (3) limited ownership of health services by local managers in contracting schemes under contracting with NGOs (4) national and local capacity to manage contracting (5) other reasons such as: issues of civil servant status for health care managers and providers and harmonisation of donor funds and support.

4.1.1 Part of the wider health sector reform

Transition to SOA was part of the wider public sector reform agenda of the government of Cambodia. The Council of Administration Reform (CAR) promotes public administrative institutions to become autonomous and take responsibility for managing services. Within the health sector, establishing operational districts as SOA, in theory, grants them power to make decisions at the district level about how to manage and provide quality health care services.

"The main goal of CAR is to promote and encourage public administrative institutions. Therefore SOA was introduced as they are semi-autonomous. Personally I think it was because the CAR at the council of ministers became interested in service delivery to the population, especially the poor. As a result, they reformed the ways the services are delivered" (KII7, Male, Donor)

4.1.2 Cost and sustainability

The study shows that the high running cost of contracting with NGOs was an important reason for the change of arrangements. Hiring NGOs and expatriate staff to manage contracts was expensive and as these costs were largely covered by donor contributions, the financial sustainability of this contracting arrangement was threatened. This high cost was a barrier to rolling out contracting with NGOs to other districts and another contracting arrangement was required. In some districts, managers and health workers were unhappy that so much money was spent on expatriate staff. Therefore, the introduction of SOA was seen as a "cost saving" approach, as money would not be spent on expatriate workforce, and would be kept within the health system. However, donors explained that SOA may be cost-saving for the government, but not for donors as they must invest time and money into coordination amongst the donors funding the government programme.

"…We thought that if we continued Contracting with NGOs, we could hardly expand because its service fee was expensive. For example, if we had 10 million Dollars, we could only operate at 10 facilities. However, in SOA, we could operate at 30 offices if we had 6 million Dollars. Why is it? Donors will not always support us; thus, the government must make its own strategies…We thought that if we continued

contracting with NGOs, there was no financial sustainability. Then, we changed to SOA. It reduces some burdens." (KII2, Male, MoH).

"If we continue to hire NGO for contracting, MoH does not have money to pay for that, at the same time staff at lower level such as PHD, OD, RH and HCs were not happy because NGO took much money, so there is little money left for development" (KII7, Male, Donor).

4.1.3 National and local ownership

Another key reason for the change in contracting arrangements, was regaining national and local ownership of the provision of health services. Under NGO contracting, NGOs made decisions about planning, budgeting, resourcing and providing health services with little input from district and provincial health managers. The local managers had no authority to manage the health services, allocate budgets or hire and fire staff and were only involved when the NGO could not solve a problem or required help with hiring staff. At sub-national level, managers and health workers described the management under contractors as "completely employed by NGOs", and they perceived this as "being forced" or "pressured" to work with little ownership of the health system.

In SOA, the district is semi-autonomous, and can make most decisions in relation to managing the health services in the district. As a result, managers have a sense of responsibility to fulfil their role in health service provision in the district. The role of the PHD in managing health services is clearer and this has helped the PHD be more responsible and attentive to their work. In addition, the MoH at the national level has taken ownership, with less reliance on NGOs to manage and provide health services.

"They did that to promote the ownership of the state; that was why they switched to internal contracting in order to make the Operational Districts (ODs) or the management team of each OD increasingly take responsibilities in the area that they manage rather than the NGO." (KII6, Female, Donor)

"The change from contracting with NGOs to SOA is to gain national ownership and national pride" (KII8, Male, Donor)

"...he [district governor] used to ask 4 to 5 health providers to accompany him somewhere without going through contractor, but this was not allowed. The relationship between the OD and the local authority did not go well because they went through the Contractors… Before contracting, the local authority used to supervise us and assist each other, they still had the feeling of depending [helping] on each other" (Manager, Peariang)

4.1.4 National and local capacity to manage contracting

The capacity to manage contracting at the national and local levels was an important contributing factor to the switch to SOA. The change to SOA was in order to further build the capacity of government managers to manage their health services. Some key informants and managers reported that the capacity of district and provincial health managers to manage contracts and service delivery was developed in districts where contracting with NGOs was implemented over a long period. The experience of working

with NGOs, helped build the skills, knowledge and confidence of local managers to manage the health services on their own. However, other key informants explained that during the contracting with NGOs phase, the NGOs operated very independently and did not build the capacity of the local managers to manage their health services.

"The capacity in the contracting OD is enough to run SOA. The main reason is to achieve sustainability by having ownership, for example, OD manages planning and budgeting by themselves. They plan by themselves and implement by themselves. For me I think SOA has capacity in both planning and budgeting and the shift to SOA is in order to follow the Paris declaration that prioritizes existing system…The important thing is using government system and building capacity of the government system…" (KII1, Male, MoH)

"I think that first it is because of the maturity of contracting. For those who had gone through from the pilot until now, they have already had around 10 years. In these 10 years, there were two contracting schemes; thus, we think that they might be able to manage themselves. Those who came later and worked for one scheme for 5 years can also work together. Thus, they can help each other" (KII7, Male, Donor).

4.1.5 Other reasons for change

Health care managers and providers who were employed by the NGOs during the previous contracting arrangements for four years or more lost their civil servant status and associated benefits. This was not acceptable to the government, health managers and staff. Within SOA, all staff and managers remain employed by the government and are civil servants.

"In contracting out, staff lost their employment seniority. Staff complained about that. If the MoH decided to continue contracting out, they have to solve this problem with thousands of staff" (KII1, Male, MoH).

Additionally, some donors perceived that SOAs were created in order to harmonise the support from the major donors in the health sector so that funding could be pooled to finance the SOAs. This would avoid fragmented funding or duplication of funding for health programmes. They also related this to the Aid Effectiveness Treaty: effective use of donor funds. It is interesting to note that, none of the representatives from the MoH, nor the managers and health workers at sub-national level raised this as a reason for the introduction of SOA.

"…When it changed to SOA, it might relate to the Paris Treaty which talks about the Harmonization of Donors Fund. Donors thought that if one donor donated on this and other donor donated on that, the funding would overlap in one system. Thus, they wanted to create one system – SOA - that all donors could channel the funds through and they could just monitor it." (KII7, Male, Donor)

4.2 Implementation of SOA

4.2.1 Selection of districts for SOA

In order to become an SOA, an operational district applies to the Council of Ministers and undergoes an assessment that includes management capacity, infrastructure, staffing, and availability of a capacity building agency to support their transition to SOA status. Districts that perform well in the assessment are selected to become SOAs. Some donors reflected that through this assessment, only well performing districts become SOAs.

"We already select the better facilities to run SOA, so its nature is already good. In general, if we have 10 students, there must be 2 or 3 outstanding students. Thus, these outstanding ones already have their potential. So does SOA" (KII11, Male, Donor)

4.2.2 Development of policy and guidelines

Key informants reported that the development of the policy and guidelines for implementation of SOA was carried out at the central level of the MoH. This was supported by an external agency - Oxford Policy Management – who helped prepare the business plan, terms of reference and implementation guidelines. Some key informants explained that this was done in consultation with sub-national level institutions.

"The minister just pointed out how to do it. But, we are the ones who put it into practice. It was very difficult to achieve SOA as you have seen. We can't just sit there and work it out alone; we need involvement from all the people in our units. We conducted workshops to find out how to perform the tasks. For example, at that time, the ministry also had experts like Oxford Policy Management who helped us develop terms of reference and business plan. We created the business plan through cooperation with the lower level institutions. For the terms of reference, we also cooperated with them. We had only the ideas to assist in forming the guideline, and we received all the information from the lower level. We had ideas of what to do and how to do it and we prepared the guidelines. For example, SDG guideline, SOA guideline, and guidelines on how to recruit staff under SOA, and guidelines for expenditure are led by the ministry. However, at the same, it required participation from others." (KII3, Male, MoH)

4.2.3 Involvement of province and district in establishing SOA

Key informants reported that, despite ODs having to apply to become an SOA, the change to SOA was initiated by the central MoH, with little involvement of the sub-national levels. Some key informants reported that there were workshops and training provided to managers and health workers in the districts that were changing to SOA. Others did not know if or how local managers and health workers were involved in the change process.

"I think this is the policy; it is the decision here (central), not there (sub-national). It was not the decision from the providers…For service providers, it did not mean that they did not know it; they also knew it, but we didn't let them participate in the decision making of becoming SOA" (KII4, Male, MoH)

"There was no participation from the sub-national level in the decision to make the change from contracting with NGO to SOA. I dare to say that. It was made from the reform of the Council of Ministers."(KII2, Male, MoH)

"Surely, they did engage local managers and providers. They arranged training several times, and I also participated. There were a lot of workshops facilitated by OPM and the ministry. It is before SOA started." (KII11, Male, Donor)

4.2.4 Development of the contracts

The findings show that there are four levels of contract in SOA. These include contracts between (1) MoH and PHD (2) PHD and OD (3) OD and RH or HC (4) RH or HC with individual health workers. Respondents revealed that the contract template produced by MoH in the SOA manual was adapted for making contracts at the different levels.

For the contract between MoH and PHD, managers reported that the indicators are identified by the MoH and are included in the SOA contract template. However, OD managers could discuss with PHD to add additional indicators to the contract.

At sub-national level, respondents described the content of the contract to include: (1) work regulations such as punctuality, attendance during working hours, holiday entitlement, wearing uniform at work, and roles and responsibilities of the health care providers; (2) professional ethics including good behaviour towards clients and banning informal payments misuse of supplies and equipment, attracting clients to private practices, and carrying out private practice within working hours; (3) service delivery targets; and (4) management, planning and monitoring.

The degree of involvement of the SOA managers in the development of the contract between the PHD and OD varied across the study districts. For example, in one district, the OD targets are set by the OD and PHD with little involvement from the MoH. However, in another district, the MoH and donors played a greater role in setting these targets. The contracts between OD and the health facilities are prepared by OD, and then discussed in meetings with facility managers. The key indicators used for monitoring SOA are in Annex 2.

"…they prepare, then draft the contract and deliver it to us. We just look through it" (Manager, Memut)

"PHD and us discuss indicators, but MoH prepares contract. At this point it is finished the process making contract between us and PHD. Then, it becomes our responsibility to distribute this contract further to the hospital and health centre for every indicator set." (Manager, Peariang)

"In my OD...I and the provincial health department together set 27 targets…the ministry already determined 27 indicators. Let's say the maternal check-up was set to be 80 percent, 80 percent of the estimated pregnant population in our area…" (Manager, Bati).

The contracts between the OD and the health facilities are prepared by the OD, and then discussed in meetings with all facility managers or meetings with individual managers. District targets are used to set the targets for the individual health facilities.

"For me, I sign contract directly with OD director...OD prepares that contract, but they ask us to look at contract if we can follow and fulfil terms in contract. If we agree to follow the contract, we can sign that contract…" (Facility chief, Memut).

The contracts between managers and health workers were prepared by the managers of facilities. Based on the contract between the facility and OD, they developed contracts for individual health workers, sharing the responsibilities for achieving the targets across the whole workforce. Health workers were not engaged in the preparation of the contract.

"The chief called a meeting and explained to us. When we understood all points, they gave us the contract paper to look at…Before signing, they gave us the contract to review whether we could accept. We had rights to deny the condition, which they raise... They prepared it, then just gave it to us to look at if we agree or not. If not, no need to sign." (Health Worker, Memut).

"The [contract] preparation is based on my boss. [I] just know that everything depends on my boss first. If my boss said ok, that's ok; if he said no, that's no." (Health Worker, Samrong).

4.2.5 Achieving targets

Health managers and workers reported that they often had difficulty in achieving the targets set in the contracts. Several challenges were identified. Firstly, targets are set using population data which was seen as unreliable – there is an overestimation of the population, and there are inaccuracies caused by migration in and out of the district. Secondly, the baseline data on utilisation of services used for setting the targets is seen as inaccurate. As the baseline was too high and did not reflect the real situation of utilisation, the targets were set at too high a level. In addition, managers reported that targets are increased every year and it was difficult for already well performing districts to meet high targets. Thirdly, competition among health facilities for patients in the district was another reason for not reaching targets. Each health facility has their own target to achieve, and therefore tries to attract clients to their facility. As there is a limited number of clients, not all health facilities can achieve their target. In order to reach the targets, health workers visited homes in the community to provide services such as consultations, antenatal examinations and vaccinations. However, it was not always possible for health workers to leave the facilities to do outreach work as it would leave the facilities understaffed.

"We got 112 [of ANC patients] because of what? It was because there were many patients migrated into the area. Those immigrants were not the target population, so the outcome increased. However, they came temporarily and went back, so the number decreased, and there even were more people moved out, for instance, there were 100 people came in to the district, but 200 moved out. This is what we are worried about." (Manager, Memut).

"...performance in the district in the first year of SOA decreased because when they did [started] it, they did not do the study to collect data for baseline data, just to make sure how specific data is, then we can set for this or that number, that could be successful, this is what I mean. So, when we started, we adopted what is not so reliable, what is not much studied to use as our baseline data..." (Manager, Bati).

"My place is facing issue of outpatients, because other facilities rarely let their clients pass by to use services here, they have achieved their target already too. While my Referral Hospital is in the middle of other facilities, so the population around this area is the same, but many health centres absorb the clients." (Facility chief, Samrong).

"If we cannot complete our target, we visit the community to distribute medicine and for consultation. Sometimes we go to their house for consultation, even they don't need any service, just only ask for medicine, we also record to fulfil our number set in plan. In general, consultation is 2000Riel or 1500Riel, but when we need more clients to fulfil the plan, they don't pay for service, we still can provide medicine for them." (Health worker, Memut).

4.3 Monitoring

Results of the study show that there are three levels of monitoring within SOA: monitoring from central level MoH; monitoring from PHD; and monitoring within the OD.

4.3.1 Central level: process and challenges

The monitoring from central level is conducted by the Service Delivery Monitoring Group (SDMG) from the central MoH, which is part of the HSSP2 and is made up of heads or deputy heads of departments in MoH. They are expected to carry out visits to the SOA districts and review the district reports. However, the monitoring visits do not happen as regularly as planned for several reasons: group members have other responsibilities within the MoH and so cannot allocate enough time to this task; some members have limited capacity in carrying out monitoring; and they receive few incentives to travel to the provinces for monitoring, especially when they can earn more from doing private practice in Phnom Penh.

Some donors reported that they were concerned about the quality of this monitoring as they thought SDMG members were reluctant to criticise their colleagues at the PHD or OD levels.

"It is a problem of the SDMG. Among the SDMG members, some are very competent who can replace consultants in conducting field monitoring. However, they don't have enough time to perform their job because they have other roles. Some are deputy directors so they have so many tasks to do. Some SDMG staff are not competent. I can say that they are like rotten wood" (KII2, Male, MoH).

"The SDMG, monitoring group from the ministry is supposed to conduct monitoring every quarter, but in fact, they only do this twice per year. The SDMG consisted of 4 members, but sometimes only 1 of them went for monitoring. They have more work, and sometimes they have job outside [private practice], as the per-diem for monitoring is $20/day, if they stay in Phnom Penh and do one operation, they earn $300." (KII1, Male, MoH).

"Generally, donors didn't ask for such monitoring, but asked for external monitoring. However, the government disagreed. I don't trust them… I went with their team once and never went with them again. I don't know, maybe we have different working procedure…For example, we can't evaluate performance just by glancing at documents. We can't do that. I spend a lot of time on it; with a planning document with so many pages, how can we assess whether it is good or bad with just a quick look – just only it includes indicators and activities? We have to look at whether the activities are relevant to the mentioned objective and we also look at their past planning" (KII5, Female, Donor).

"Structure is there, but no function, they don't want to punish their colleagues there, I don't see that part is functioning" (KII8, Male, Donor).

4.3.2 Province level: process and challenges

The PHD is supposed to conduct quarterly monitoring visits to the districts. However, according to the key informants monitoring only happens once or twice a year. Factors contributing to the poor monitoring included: lack of specific budget for monitoring SOAs; general monitoring budget for the whole province is so small that it cannot support the planned frequency of visits; and PHD officials do not receive any incentives from the SOA for monitoring work.

Reports from managers and health workers revealed differences in the monitoring from the PHD in the four districts. In Bati and Memut, the PHD carry out quarterly monitoring visits to each SOA to assess the planning, monitoring and accounting systems. They track the progress of achieving the targets set in the contact, find out reasons for any delays, and help the OD to find solutions. They also ask about the plans for the monitoring visits within the district and how well they are implemented. In Peariang, the PHD carry out monthly visits to the OD. In addition to the above activities, they visit the health centres and assess the records and reports, and sometimes discuss with villagers about the services they have received. The managers and health workers in Samrong report monitoring by the OD chief who is also the deputy director of the PHD.

"The monitoring from ministry and provincial level is not smooth. Sometimes PHD just conducts monitoring once or twice every year only…" (KII1, Male, MoH).

"There is SDG for management and service provision of the Special Operating Agency. However, there is nothing for the provincial department who is the commissioner. How will they feel when they also establish the team as well?" (KII2, Male, MoH).

"…In general, PHD doesn't receive any incentive; we call it only the commission and get no incentive as the fund for SOA – SDG will directly go to ODs. Sometimes the PHDs complain… We can see that their work load has been increased and they have to work harder, but they have no incentive" (KII12, Male, Donor).

"They [PHD] would come to inspect our planning, accounting system, monitoring system... Once per trimester, they come to see our progress and check the result of the previous trimester... They would ask

if we develop plan for monitoring work, and if we have they would ask whether we do our visits according to the plan..." (Manager, Bati).

"The PHD team also comes to monitor every month. They have a separate evaluation form, and they also monitor here and each health centre. Sometimes they even check up with the villagers…They have their own check list. They check everything like whether technical team convene monthly meeting regularly or not and whether they solve the problems or not" (Manager, Peariang).

4.3.3 District level: process and challenges

The SOA managers regularly monitor the facilities in their districts. Activities include looking at the availability of staff, cleanliness and organisation of the facility and equipment, the quantity of services being provided, work plans, budgets and expenditure, and carrying out spot checks within the community to verify the data at the facility. This is linked to the targets and the incentives that the facility and individual healthcare providers receive. Despite SOA managers being allowed to place sanctions on the facility managers or staff when they find mistakes, they rarely do this.

Donor key informants explained that it was important that monitoring be done not only by the SOA managers but by national and provincial levels as the data from the districts can be faked so that managers and health care providers can receive incentives as they have reached their targets. Policy makers gave no views on the trustworthiness of district level data.

"Even though we see good outcomes, monitoring from the national and provincial level is still weak. However, for SOA themselves, they have strengthened their monitoring. To achieve the targets, the SOA themselves monitor their outcomes. If not achieved, they have to do something to strengthen the human recourses and service delivery, making services more available. Sometimes, they unexpectedly check the health centre to see if itis open and if there are any staff standing by. They monitor and even have spot check in the community. For instance, there are such cases in this report; they will check if the villagers actually access the services" (KII6, Female, Donor).

"I never see any sanctions being applied since we adopt SOA. It is different from contracting. During contracting, they have sanctions… It is punishment for those who make the mistake" (KII11, Male, Donor).

"They wrote the fake name in the register list, indicating that this person is accessing care. For example, for immunisation, they just wrote someone's name who never accessed the service; for ANC, they just recorded some women's name, who was not pregnant…If there is proper monitoring to follow up activities, it will improve; then I will trust the data" (KII5, Female, Donor).

Facility managers reported that they monitor the departments on a monthly basis and assess health worker behaviour towards the clients, appearance of the health worker, health worker attendance and punctuality, drug storage and prescription, cleanliness and record keeping. The thoroughness of monitoring varied across the districts and facilities. In Peariang, managers not only monitor individual staff at facility, but they also visit clients in the community to check that the records are correct and also to

obtain their views on the quality of services provided by their health workers. In Memut, some facility managers explained that they did not monitor their staff as they did not have enough time. In Samrong, the OD team verifies the checklist and monitoring report produced by the health centre chief and obtains feedback from the clients about the services provided in the health facility.

"We visit the village or community. We ask people in the community to lead us to clients and after that we interview them about the staff of health centre" (Facility chief, Peariang).

"To tell you the truth, I have no time to monitor them, just until a difficult case happens, I will solve it...For everyday activities, we can see every day... if staff break the contract, first, I warn him/her, then I will ask him or her to write that they will follow the contract on the second time. Finally, on the third time, I will terminate the contract" (Facility chief, Memut).

"For indicators and staff management, the health centre chief is responsible for that, but OD comes to verify what the chief has reported, to verify if my staff evaluation is right or wrong and evaluate client satisfaction" (Facility chief, Samrong).

4.3.4 Perception of managers and health workers on monitoring

Managers and health workers were positive about monitoring. They identified that monitoring can act as a tool to correct mistakes and improve performance of health workers, including being punctual, changing behaviour and providing good quality care such as correct treatment according to guidelines and completion of documents. It can help with clarifying individual's roles and responsibilities as tasks are clearly divided amongst the staff so that each person knows what they are expected to do. Monitoring ensures that the data is more reliable - by going into the community and verifying that community members actually used the services, staff at the health centres do not falsify the facility records.

"It is very important. If there is no such evaluation and monitoring, the work cannot be done smoothly and we cannot work effectively. Sometimes we have mistakes, when they come, they will give us advice. Thus, we improve ourselves for better performance…For instance, now we have mistakes, so what should we do to be better for next quarter and further… it is really important. We have to have it – we cannot miss it. If we did not have it, it would be slipping into disorder" (Manager, Memut).

"…Many benefits. First, we improve. For example, we do not know all aspects (of treatment), and when they monitor, they can help us. When they come and see that there is lack of good hygiene, we can ask officers to improve it. Also, if patients' utensil is dirty, we can correct accordingly. We have too many tasks here". (Health worker, Peariang).

"…SOA is about monitoring system… In the past, we didn't have a monitoring system, so the data provided might not be true or might not be clear. After the implementation of SOA we established proper monitoring system, so that the information or data provided to us is true. How could it be fake as our monitoring team went there [to monitor their work] … when our monitoring team went to inspect ANC, we select only one, two or three places to inspect in the village. We took the name list and went to inspect. In the morning we

were in the health centre and in the afternoon we went to inspect in the village. So they didn't dare to make false report by reporting us over or under what they have achieved. That's why the report is true." (Manager, Bati)

4.4 Effects of SOA on how services are delivered

There is evidence from the interviews that SOA has affected service delivery processes: local ownership of the district health services; changes in the behaviour of managers and health workers including punctuality, provision of 24 hour services, friendlier attitude to clients, and improved quality of care; and allowing dual practice.

4.4.1 Ownership of the district

Managers described ownership as a key benefit of making the contract with SOA. The SOA manager can be more innovative, does not have to follow procedures, and can make their own decisions. The SOA manager has the authority to manage the district staff, for example, managers can resolve staff problems, and can fine or punish the staff according to the regulations.

"Current system is good...with SCA (Save the Children Australia), we depended on the organization but now we are self-managed...I just know that contractor kept observing us every day...but now health centre chief manages by themselves, runs it by themselves and monitors staff by themselves" (Facility chief, Memut).

"…with SOA, the OD is the cover page which makes the decision on how the services should be increased not like in the contracting period…" (Manager, Peariang).

4.4.2 Punctuality

Most respondents reported that punctuality – arriving and leaving work on time according to their duty roster – is good under the SOA regime. The contract encourages staff to be punctual so that they can receive the financial incentive. Punctuality was also good under the contracting with NGO arrangements, but this was enforced more through punishments such as suspension and withdrawal of pay. In districts where there had not been any contracting arrangements, punctuality was seen to have improved since SOA introduction. On the other hand, in districts where contracting arrangements had been in place, managers and health workers reported that SOA rules were less strictly enforced, so that staff could leave the facility for short periods of time to attend to private patients. Some key informants reported that in some SOA districts, managers and health workers do not respect working hours and are frequently late or leave the facility when it is quiet to conduct their private practice.

"…SOA is different from non-SOA. For non-SOA, no matter where it is, if you visit there at 3 or 4pm, you will see no one there and they only leave the phone number. Sometimes when people telephone the staff, they would answer that they are still on the way. Thus, what is the quality? In addition, they also have changed their habits and attitudes and the way they speak to the patients. In the past, they used to get up at 7 or 8 am, but now they change – they have to come to work on time, and be on duty… In the past, they

used to come late and treat the patients badly… Now, they have slogan that, "Services are to serve people." (KII4, Male, MoH).

"The respect for working hours and ethical issues has improved because we have that contract...contract is really important, it regulates even working hours." (Manager, Peariang).

"We have signed the contract with them, so we need to work even though we have a lot of work at home. We need to wait until we finish work at the health centre, then we can do the work at home." (Facility chief, Peariang).

"It seems not strict, when we do not have any patient, we can leave a bit early. Some staff have other tasks to do, so they can call us to let us know that they are busy and what time they will arrive at work place… here, staff work full time, except when they are busy, they go for a while and come back." (Facility chief, Memut).

4.4.3 Providing 24 hours service

Respondents reported that the SOA had improved the availability of 24-hour services at public facilities. 24-hour services were initiated in previous contracting regimes, and have continued in SOAs. In Bati, where contracting was not implemented before, the provision of 24 hour services started after entering SOA. Prior to this, staff were frequently absent from the facility, particularly in the evenings and at night. Managers and health workers attributed the increased availability of services to the strict regulations of SOA and also to user fees. They explained that health workers are attracted to stay in the facilities so that they can provide services and generate income through user fees.

"...in our health centre there are staff on stand-by all the time...in other places, for example, Popel or Svay Anthor sometimes they went there, but didn't see the medical staff." (Health worker, Peariang).

"There were no permanent 24 hours service here before, like there were services but there was no staff.... in the past, there was only name, no staff..." (Health worker, Bati).

"…Before, they came to the health centre but didn't meet our staff, so then they didn't come anymore. Now they come here more because whenever they come they can meet our staff. Even night time or day time they still can meet our staff." (Health worker, Samrong).

4.4.4 Health workers' attitude toward clients

All respondents reported that health workers' attitudes and behaviour towards clients have improved since the implementation of SOA. In Memut and Samrong, some health workers and managers perceived that attitudes and behaviour towards clients had improved during the previous contracting regimes, but further enhancement had been made during SOA. They reported that this was due to the contract as it includes attitude and behaviour indicators that are linked to the provision of incentives. Health workers in Bati and a manager in Samrong also explained that by being friendlier to clients, staff can attract more clients to their facilities and fulfil the targets set in the SOA contract.

"Staff behaviour has changed. It has improved since the time we worked for Save [SCA]...they advised us about the way we talk to patients. We have to avoid using bad words…Honestly speaking, staff behaviour was better during Save [SCA] period if compared to the time we switched to work under the government. However, now, there is a strong focus on our behaviour." (Health worker, Memut).

"We have reduced a lot of inactivity, bad behaviour like inappropriate words to patients. We have changed a lot." (Manager, Bati).

"[We change] a lot especially related to the behaviour of staff. In the past staff didn't ask first and waited to be asked so and so. But now they ask - what do you need or please sit down first. Changes in working and the behaviour of staff, like facial expression, we just smile and behave friendly, patients will like us." (Health worker, Bati).

"Staff change the way they talk to patients because before we had low sense of responsibility..., in short it was because of little money [incentive]". Our work is better than before. Having the incentive from SOA, makes us work better." (Health worker, Samrong).

"Before poor people did not often come to use services at the facility because of the way staff would speak to them, staff didn't treat them carefully as they thought that treating poor patients -they] didn't get money from them, so just simple treatment is enough. We didn't treat patients well because we also didn't have monitoring" (Facility chief, Samrong).

4.4.5 Dual practice

All respondents reported that dual practice continues in SOA districts. Government employees conducting private practice are not banned in SOAs. It is at the discretion of the manager as long as it occurs out of government working hours and does not interfere with meeting targets. Policy makers recognised that the SOA did not provide enough incentives to managers and health workers to stop them from carrying out private practice. They recognised that some staff, such as specialists and surgeons, would leave the government job if they were unable to do some private practice. Allowing staff to do some private practice was seen as a motivating factor.

"If that unit is too strict and does not allow staff to work in private sectors, they would all quit. Sometimes we have to do it differently from the contract, which states that staff have to work 8 hours a day. We even allow the specialists to work for 4 hours a day in order to avoid their resignation. For example, if we do not allow a surgeon to operate in any other clinics besides the state hospitals, they will all quit work… If I am a specialist, I would demand high wages. If they provide me with low salary, they should let me work less in order to give me more time to work outside. This is the challenge for me as well because we can't follow the system without tolerance and flexibility otherwise other people will stop working." (KII3, Male, MoH)

"The incentive of SOA is still less, so after public working hours, they still go for private practice" (KII1, Male, MoH).

"It's a bit easier than before. We can take some time to see our patients outside...When we are busy outside, we just inform to our department to make sure that there are people on stand-by in the hospital. We can go out for a while to look after our patients at home and just ask another colleague to take our place…For staff, it seems the current system is better. We can take some time during working hour to go home to look after our own patients. We can possibly do consultations with 5 or 6 or up to 10 patients per day. So it's good for those who run their clinic at home, but it's a bit difficult for those who do not havea private clinic…"(Health worker, Memut).

"SOA is better as it is less strict. We have time to work outside. When we have free-time, we can go to work outside" (Facility chief, Peariang).

4.5 Perceived effects of SOA on service coverage

4.5.1 Perceptions about changes in coverage of services

Key informants, managers and the majority of health care providers (apart from in Memut where they thought coverage was similar to before SOA introduction and in Samrong where they perceived outpatient service utilisation to be reduced) reported that coverage of services has increased since the introduction of SOA. Table 2 shows the reasons for the perceived increases in service coverage in the SOA districts.

Table 2: Reasons for perceived increases in service coverage in SOA districts: different perspectives

MoH representatives and donors	Health managers and providers
Public have more trust in the SOA facilities	Improved public trust in health facilities – provide better quality of care (improved staff attitude and better treatment)
Facilities are now open for 24 hours per day	Staff being available 24 hours per day
Staff are more punctual and stay at facilities because of incentives attached to punctuality and availability of services	Increased community awareness of the availability of and need for services
Staff have received more training since being in SOA and this has improved the services that they deliver	Clear contracts with targets for provision of services, incentives and monitoring in the SOA scheme
	Low service fees because of HEF and CBHI

"The utilization in SOA is better than non-SOA because it has 24 hours service, for example, 1 non-SOA health centre takes about 100-200 clients, compared to SOA, it receives thousand clients. It is because of in SOA, staff obey regulation better, they have monitoring system and spot check, then when coming late, the incentive will be deducted. Both SOA and non-SOA commit to have 24 hours service, but in real practice for non-SOA, the 24 hours service does not happen" (KII1, Male, MoH)

"… patients come and meet the doctors whenever they come, thereby encouraging them to trust and increasingly use public services" (KII7, Male, Donor)

"I think it is better to have SOA. In terms of utilization, SOA is better than that of non-SOA. This is because of the staff. Staff seem to perform better. Performance here refers to their regular presence at the facility, staff are on duty. I observe that at the very beginning of switching to SOA, there were less people using the services. The situation is getting more stable as time goes by. This may be because during contracting with NGOs, NGO was the supplier and there were adequate medicines and so on." (KII11, Male, Donor)

"Because people have better understanding and we have sent our staff to different communities to give some advice on risks during delivery." (Health worker, Memut).

"The benefit of SOA is significant. First of all, it has improved the community's understanding and perspective towards health care service. The communities have broader understanding on health care issues now. They will go to the health centre for any treatment and won't resort to blindly buying any medicine like before. I went to monitor the two communes and was told that the villagers would come to the health centres whenever they feel unwell." (Manager, Peariang).

"The rate of service delivery has been increasing due to the fact that, in the past we didn't have sufficient equipment such as heart monitor or x-ray." (Manager, Peariang).

"They just know that our staff work here regularly so that they come to use services here...because when they come they always meet our staff so they just like to come more. But before when they came, they didn't meet our staff so they didn't like to come anymore." (Health worker, Samrong).

The main reason for the perceived reduction in outpatient utilisation was that there are now many more health centres and so there is competition between them for patients.

"Most poor people hold the CHC form [to access health equity fund (HEF)] that requires them to use the service at a health centre first. If health centre refers them to the referral hospital, the HEF of CHC will cover the fee for them [to pay to us], but if patients come to use service at the hospital directly, CHC does not pay for that….Because of that, the health centres try to get more patients for themselves as well, we just get the left overs [customers] from them" (Health worker, Samrong).

"In the past there were many people come for outpatient service because of less number of health centres" (Health worker, Samrong).

4.5.2 Utilisation of services by the poor

All key informants, managers and providers reported that there have been increases in utilisation of health care services by the poor. The main reason given for this increase was the existence of the Health Equity Fund (HEF). There is greater awareness amongst the population about the HEF and the services that they can access. Previously, poor members of the community were reluctant to attend for healthcare as they were unable to pay. Health workers also reported that it is easier to identify the poor as the HEF provided them with identification cards. Without these cards, they found it difficult to identify the poor and this affected how the poor perceived the services.

"In the past, the poor did not come much as they were afraid that the doctor would ask for money, and it was hard for them to say that they didn't have any. Until the equity fund - this fund pays for them, so more of them come." (Manager, Bati).

"For the poor, in the past we didn't have the card to certify that those are really poor. When they come they have to spend their own money, but now, poor people have a card, when they come they only need to show the card, we will not charge them as there is the NGO and pagoda that supports them." (Health worker, Bati).

"Most of the non-SOA OD isn't equipped with HEF, so the poor will have difficulty especially with transport costs to reach health facilities." (KII1, Male, MoH)

"Actually, all SOAs are attached with Health Equity Fund which is a financial assistance to remove financial barriers for the poor accessing services. SOA promotes full-time services - they regularly stay (to provide the services) or at least they follow shifts to make sure that they don't close the facility like non-SOA facilities. This is the key factor that when people come, they can see the health staff…both the poor and rich will see health staff when they come." (KII11, Male, Donor)

They also identified two other reasons that may have contributed to the perceived increase in utilisation of services by the poor. SOA has improved the attitudes of health workers and in particular has emphasized the importance of treating everyone the same regardless of their socio-economic status. SOA ensures that health care facilities are open 24 hours per day so people can access services at any time. This is particularly important for the poor who may find it difficult to travel to the facility, and in the past would have made the journey only to find that there are no health workers available. By knowing that staff will be available, the poor access the health care services.

"… with regard to equity, firstly, it is about the attitude of the service providers. They serve equally to both the poor and the rich. Secondly, it is about the working hours. People are confident that health providers are there for them. Thirdly, there are Health Equity Funds at every SOA. The Health Equity Funds is a factor which encourages people to use the service." (KII2, Male, MoH)

"SOA contributes to the increase usage of services by the poor. It could be because the patients could always meet the doctor." (Health worker, Bati).

5. Discussion

This study explored the reasons for change in contracting arrangements to the current SOA model, how SOA is implemented, and the perceived consequences of SOA on coverage and equity in service provision. The study found that the main drivers for changes in contracting with NGOs to SOA in Cambodia were wider public policy changes, national and local ownership, cost and sustainability and local capacity in managing contract. The degree of involvement of the SOA managers in the development of the contract

and target setting varied across the study districts. Several challenges in achieving the targets were identified, such as unreliable population data, baseline data being set too high, and competition for clients between health facilities. Monitoring of contracts was seen as beneficial as it can help improve the performance of health workers and ensure the reliability of data. However, there were also challenges with monitoring including infrequent visits from central and provincial level monitoring teams, and SOA managers rarely placing sanctions on facility staff when mistakes were found. Factors contributing to the poor monitoring from central and provincial level included: lack of specific budget and incentive for monitoring SOAs, general monitoring budget being too small for the planned frequency of visits, PHD officials not receiving incentives from the SOA for monitoring work, and differing capacity of team members to undertake monitoring activities.

SOA has had several perceived effects on service delivery which include: managers feeling ownership of their district health services; improved behaviour of health staff including punctuality and provision of 24 hour services, wearing a uniform, improved attitude towards clients, cleanliness of facilities, and conducting private practice. There were mixed views of the effects on quality of care.

The qualitative data suggests that SOA has improved utilisation of services at public facilities. Three main reasons were highlighted: improvements in the attitudes of health workers; availability of 24-hour health facilities; and the existence of HEF, which allows poor people to use services without paying fees.

5.1 National and local ownership of health service delivery

Delivering health services is often seen as a key government function, and as a government becomes more established, it may wish to resume control (Palmer, Strong, Wali, & Sondorp, 2006). This study suggests that the switch to internal contracting through the introduction of SOA enabled the MoH to take ownership of health services, with less reliance on NGOs to manage and provide services. Khim and Annear (2011) report that the public expected the MoH to take on a stewardship role. This placed pressure on the MoH to manage the health services using existing structures and managers, thus introducing the SOA model. Experiences from other countries where contracting out to NGOs was employed as a way of providing services in the context of fragile health systems show that national ownership of health services is a key driver for change. In Rwanda and Bangladesh, the central governments decided to scale up contracting but retained ownership of financial management (England, 2004; Rusa, Schneidman, Fritsche, & Musango, 2009). This suggests that the MoH wanted to retain ownership of the health system, despite relying on external assistance.

Ownership of health services at local, district and provincial level, was also an important driver for change to the SOA arrangements. Our study found that local ownership was limited under external contracting with NGOs, but in the SOA they were more satisfied as they were managers and service providers in their own districts. A review of contracting models with NGOs found that the PHD in particular were not satisfied with contracting as they had lost control over the district health services and felt challenged by contractors (Feenstra, 2001). Another study also identified that, there is greater local ownership in SOA, compared with contracting with NGOs (Khim & Annear, 2013). SOA enhances the sense of responsibility for managers and provides autonomy for local managers to manage and budget their health services.

However other studies indicate that performance based contracting with NGOs did promote local ownership through innovative and decisive management (England, 2004; Soeters & Griffiths, 2003). These studies were done in the early stages of health sector reform, whereas our study contrasts perceptions of ownership during previous and current contracting arrangements.

5.2 Cost and sustainability

The issue of cost and sustainability of contracting is another factor influencing the changes in contracting arrangements. There are high costs involved in contracting with NGOs, raising several issues. This study found that managers and health workers were unhappy with the amount of money spent on local and expatriate NGO staff, whilst they worked in the same place but received less salary and incentives. This lack of transparency and perceived unfairness affected motivation of health workers.

In the earlier period of contracting with NGOs there was a rapid expansion of coverage, contributing to a reduction in infant, child and maternal mortality (Bhushan et al., 2007). However, contracting-out districts had almost twice the recurrent costs of the non-contracting districts. Although it was cost-effective, there were doubts as to the sustainability of this model, particularly when it relied heavily on donor funding. Financial sustainability of the model may have been an important consideration for the government in scaling up contracting (Bhushan et al., 2007; Khim & Annear, 2011). Previous studies on contracting in Cambodia also confirmed that an initiative that relies heavily on external funding would not be a sustainable mechanism in the long run and contracting to NGOs remains only a viable short and medium term option for strengthening health systems (Sadiq, Biacabe, & Bayulken, 2007).

The issues of cost and sustainability of contracting is debated in the literature. Experience from contracting out in Afghanistan found that costs are increased by using expatriate staff to develop the NGO's capacity to manage contracts (Palmer et al., 2006). This suggests that contracts managed by local managers reduces costs and has implications for the sustainability of the scheme. In the United Kingdom (UK) and Jamaica, contracting with external partners was more expensive. Jamaica's experience in contracting out cleaning and portering services cost 25% more than the public cost (Mills & Broomberg, 1998). In the UK, the transaction costs of preparing for competitive tendering is about 7% of annual contract value (Mills & Broomberg, 1998). These costs have implications on scaling up or sustaining contracting in the long term, particular in poor countries such as Cambodia.

However, other experiences in western countries illustrated that contracting with external parties does reduce cost. Hospitals in the UK that were contracted out reduced their costs by 34% (Mills & Broomberg, 1998), and in South Africa contractors were successful in delivering services at lower cost than public sector, mainly through using lower cadres of staff and ensuring higher productivity (Mills & Broomberg, 1998). This suggests that it may not be the contracting mechanism that saves costs, but the more efficient use of human resources.

5.3 Local capacity to manage contracting

Contracting requires high institutional capacity to develop, manage and monitor contracts. Capacity at the district and provincial levels to manage contracting is an important factor influencing the shift from

contracting with NGOs to SOA. In this study, managers, health workers and key informants from MoH perceived that district and provincial management teams had enough capacity to run and implement contracting on their own. For those districts that had experience of working with NGOs for almost ten years, this had helped develop their managerial capacity. While, the districts that had not gone through contracting, could learn from other districts and adopt management practice for their own districts. In addition, one of the criteria for selection as an SOA was the existence of an NGO to build managerial capacity in the district. The NGO supported the local management team for the first 1-2 years to manage the contracts.

Other literature suggests two views on the role of contracting with NGOs in building local managerial capacity. Firstly, contracting with NGOs does not build capacity, knowledge and skill for managers and local providers because of a lack of involvement and information sharing among contractors and OD staff (Khim & Annear, 2011). Knowledge and skills transfer would be more effective if the government staff at district level worked alongside NGO contractors in managing the health services. Secondly, previous contracting with NGOs did build competency and new knowledge amongst local managers as there was intensive technical support in developing effective contracts and monitoring contractors (England, 2004; Sadiq et al., 2007).

5.4 Impact of SOA on behaviour of managers and health workers

This study found that SOA has had a positive effect on the behaviour of health managers and workers in the districts, including being punctual, providing 24-hour service, and having better attitudes towards clients. One main reason for this behaviour is the inclusion of punctuality, attendance, and other quality indicators in the contracts with attached incentives. In the districts where contracting with NGOs had taken place, staff were used to working in this way and continue to do so.

However, some behaviour such as punctuality and carrying out private practice is less adhered to in SOA compared with contracting with NGOs. SOA management tends to be more flexible and there is more consideration of individual needs.

5.5 Private practice in SOA

This study found that government health staff do conduct private practice during and after working hours. Private practice is not banned in SOAs, but rather it is at the discretion of the facility and SOA manager so that it occurs out of government working hours and does not interfere with meeting targets. SOA does not provide enough incentives to prevent private practice. Staff, particularly specialists, may leave their government job, if unable to conduct private practice.

Private practice cannot be strongly prohibited in SOA for several reasons. Firstly, the additional incentives from the SOA provided to health workers are not comparable to what they can earn from private practice. Secondly, health workers rely on additional income from private practice to supplement their low government salary. If private practice is prohibited, then staff may leave government service and engage purely in private practice, worsening the already critical shortage of government health workers. Sadiq et al., (2007) found that the prohibition of private practice amongst government health workers has largely been ignored. Khim and Annear (2013) stated that although private practice among primary health care

providers appears to have reduced during SOA, many medical doctors at referral hospitals maintain private practice for income generation. This suggests that the additional incentives provided by SOA do affect the behaviour of primary health care providers, but not highly skilled workers such as medical doctors perhaps because of the amount of incentives and their ability to generate substantial earnings from private practice. However, the Cambodia Rural Market Study identified that two-thirds of public providers also work in private sector, but dual practice was 25% less frequent in SOA than non-SOA districts (World Bank, 2013).

5.6 Target setting and monitoring

There appear to be two main challenges in implementing SOA: target setting and monitoring. This study shows that managers and providers have difficulties in achieving targets for several reasons: targets are set using population data which was seen as unreliable – overestimations of the population, the use of denominators in calculating targets, and inaccuracies caused by migration in and out of the districts; the baseline data on utilisation was too high and did not reflect the real situation meaning targets were also set too high; and competition between facilities - each health facility has a target to achieve and therefore tries to attract clients to their facility, and as there is a limited number of clients, some facilities cannot meet their targets. A recent study also identified a similar challenge – there is a lack of complete data for some indicators and the definition of denominators made it difficult to set realistic targets for some indicators (Khim & Annear, 2013).

Monitoring the performance of the health services is an important aspect of contract management (Mills & Broomberg, 1998). However, there are weaknesses in monitoring from central and provincial level health departments e.g. infrequent visits and limited capacity to conduct thorough monitoring. Khim and Annear (2013) also identified similar issues with monitoring by the PHD and central government as monitoring had not been included or budgeted for in their annual operation plans. Including monitoring activities in the annual operation plan is vital if effective monitoring is to be conducted.

Monitoring by the OD management team appears to be regular, however, there is a conflict of interest as the OD manager also serves as the SOA manager, and therefore there are some implications for the quality of monitoring. In piloting contracting in Cambodia, NGOs were contracted by MoH to monitor and evaluate health facilities that enrolled in the contracting pilot (Eldridge & Palmer, 2009).

A recent study in Cambodia suggested strengthening vertical accountability, routine monitoring and independent performance monitoring in SOA (World Bank, 2013). Our study also suggests that monitoring should be improved through the use of a third party.

Weak monitoring is not exclusive to the Cambodian context. There is evidence from other countries that the state has low capacity to monitor the performance of contracting (Mills & Broomberg, 1998). Low and middle-income countries considering adopting contracting arrangements, should invest in the development of robust monitoring mechanisms.

6. Conclusion

The SOA model aims to improve quality and delivery of public health services, to reorient the behaviour of healthcare providers towards the principles of motivation, loyalty, service and professionalism, to promote prudent, effective and transparent performance-based management, and develop sustainable service delivery capacity within public administration.

This study found that SOA is perceived as enhancing the performance of health care providers e.g. through punctuality, wearing a uniform, friendlier attitude to clients, and improved adherence to work regulations through the use of incentives. This improved quality of care has created greater public trust in the health facilities and contributed to the perceived increase in utilisation of services.

Although SOA is seen as a tool to enhance health system performance, monitoring performance and realistic target setting are the major challenges in the implementation of this scheme.

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Annex 1: Data collection tools

A. In depth Interview with Manager of Health Facility: Topic Guide

Introduction

1. How long have you been working here?
2. Can you tell me what your roles are in this facility?
3. When did the facility start?

History of contracting

4. Was there any contracting in the health facility before? Can you tell me about that?
   - How did it work at that time?
   - What was your relation with the contractor?
   - What are the reasons for the contracting to finish? What's next?

SOA

5. What do you know about SOA in this district?
   - How does it work in this facility?
6. Please tell me how you make contract.
   - Who develops the contract?
   - How are you involved in contract development?
   - What is the content of the contract?
   - What are your responsibilities in that contract?
7. Can you tell me how contracts are monitored?
   - How often?
   - By whom?
   - What do they actually look at?
   - What do you think of this monitoring?

SDG

8. How do you receive SDG/Bonus from OD?
   - What are the criteria?
   - How often do you receive the bonus?
   - Are there any challenges with the process?
   - How is the bonus rewarded to individual staff? Based on what?
9. What are the challenges in the process of receiving SDG/Bonus?
   - Have you experienced any delay/shortage of budget? Why?
   - How do you manage that challenges?
   - How does it affect your staff?
10. In what ways do you use SDG for your health facility?

Effects of SOA

11. Since the SOA started in this district, have you seen any changes in utilization of services? How it different from previous?
    - Can you give me any examples of the changes?
    - Why have there been these changes?
    - Why have there not been any changes?
    - In what way does the SOA contribute to the change?
12. Since SOA started in this district, have you seen any change in equity of use of services? How it different from previous?
    - Can you give me any examples of the change?
    - Why have there been these changes?
    - Why have there not been any changes?
    - In what way does the SOA contribute to the change?
13. In what way does the SOA affect the performance of your staff?
    - Attendance
    - Behaviour
    - Available of 24 hours service
    - Cleanliness of facility

Challenges, benefits and future of SOA

14. What are the challenges of SOA?
15. What are the benefits of SOA?
16. Do you think SOA should continue? Why?
    -Scaling up to other districts?
17. What have we learned so far from SOA?

18. Anything else you would like to add?

B. In depth Interview with Health Care Staff: Topic Guide

Introduction

1. How long have you been working here?
2. Can you tell me what your roles are in this facility?
3. When did the facility start?

History of contracting

4. Was there any contracting in the health facility before? Can you tell me about that?
   - How did it work at that time?
   - What was your role in the contracting at that time?
   - What are the reasons for the contracting to finish?
   - What's next?

SOA

5. What do you know about SOA in this district?
   - How does it works in this facility?
6. Please tell me how you make the contract? What does the contract cover?
   - Who develops the contract?
   - How are you involved in contract development?
   - What is the content of the contract?
   - What are your responsibilities in that contract?
7. Can you tell me how contracts are monitored?
   - How often?
   - By whom?
   - What do they actually look at?
   - What do you think of this monitoring?
8. How do you receive Bonus?
   - How is the bonus rewarded? What are the criteria?
   - How often?
9. What are the challenges in the process of receiving Bonus?
   - Have you experienced delay/shortage of salary/bonus? Why?
   - What have you done in that case?
   - How does it affect you?

Effects of SOA

10. Since the SOA started in this district, have you seen any changes in utilization of services?
    - Can you give me any examples of the changes?
    - Why have there been these changes?
    - Why have there not been any changes?
    - In what way does the SOA contribute to the change?

11. Since you involved in SOA, have you seen any change in the use of services from poor people? How it different from previous?
    - Can you give me any examples of the change?
    - Why have there been these changes?
    - Why have there not been any changes? In what way does the SOA contribute to the change?
12. How does SOA affect the care that provided in this facility? What do you think about this? (probe: attendance, behaviour, available of 24 hours service, cleanliness of facility)
13. Has it made any difference to the way that you provide care?

Challenges, benefits and future of SOA

14. What are the challenges of being a SOA provider?
15. What are the benefits of SOA?
16. Do you think SOA should continue? Why?
    -What about scaling up to other districts?
17. What have we learned so far from SOA?

18. Anything else you would like to add?

C. In Depth Interview (IDI) with Director of PHD/Focal Point of SOA at PHD: Topic Guide

Introduction

1. How long have you been working here?
2. Can you tell me what your roles are in this facility?
3. Can you tell me briefly about health facilities in your province? (How many OD, HC, HP…)

History of contracting

4. Was there any contracting in the health facility/province before? Can you tell me about that?
   - How did it work at that time?
   - What was your relation with the contractor?
   - What are the reasons for the contracting to finish?
   - What's next?

SOA

5. What do you know about SOA in this province?
   - How does it work in this province

6. Please tell me how you make the contract?
   - Who develops the contract?
   - How are you involved in contract development?
   - What is the content of the contract?
   - What are your responsibilities in that contract?

7. Can you tell me how contracts are monitored?
   - How often?
   - By whom?
   - What do they actually look at?
   - What do you think of this monitoring?

SDG

8. How is the SDG/Bonus allocated?
   - What are the criteria?
   - How often is it allocated?
9. What are the challenges in the process of receiving SDG/Bonus?
   - Have you experienced any delay/shortage of budget? Why?
   - How do you manage that challenge?
   - How does it affect your staff?
10. In what ways do you advise OD director or facility manager to use SDG in the health facilities?

Effects of SOA

11. Since SOA started in the province, have you seen any change in utilization of services?
   - Can you give me any examples of the change?
   - Why have there been these changes?

- Why have there not been any changes? In what way does the SOA contribute to the change?

12. Since SOA started in this province, have you seen any change in equity of use of services?
    - Can you give me any examples of the change?
    - Why have there been these changes?
    - Why have there not been any changes? In what way does the SOA contribute to the change?
13. In what way does the SOA affect the performance of staff?
    - Attendance
    - Behaviour
    - Available of 24 hours service
    - Cleanliness of facility

Challenges, benefits and future of SOA

14. What are the challenges of SOA?
15. What are the benefits of SOA?
16. Do you think SOA should continue? Why?
    - What about scaling up to other districts?
17. What have we learned so far from SOA?

18. Anything else you would like to add?

D. In depth Interview with OD (SOA) Director

Introduction

1. How long have you been working here?
2. Can you tell me what your roles are in this facility?

History of contracting

3. Was there any contracting in the health facility before? Can you tell me about that?
   - How did it work at that time?
   - What was your relation with the contractor?
   - What are the reasons for the contracting to finish?
   - What's next?

SOA

4. What do you know about SOA in this district?
   - How does it works in this district?
5. Please tell me how you make the contract? What contract covers?
   - Who develops the contract?
   - How are you involved in contract development?
   - What is the content of the contract?
   - What are your responsibilities in that contract?
6. Can you tell me how contracts are monitored?
   - How often?
   - By whom?
   - What do they actually look at?
   - What do you think of this monitoring?

SDG

7. How do you receive SDG/Bonus?
   - What are the criteria for receiving this?
   - How often?
   - Are there any challenges with the process?
8. What are the challenges in the process of receiving SDG/Bonus?
   - Have you experienced any delay/shortage of budget or bonus? Why?
   - How do you manage that challenges?
   - How does it affect your staff?
9. In what ways do you use SDG in your district? How do you know if health facility manager use this?

Effects of SOA

10. Since SOA started in this district, have you seen any changes in utilization of services?
    - Can you give me any examples of the changes?

- Why have there been these changes?
- Why have there not been any changes? In what way does the SOA contribute to the changes?

11. Since SOA started in this district, have you seen any changes in equity of use of services?
    - Can you give me any examples of the change?
    - Why have there been these changes?
    - Why have there not been any changes? In what way does SOA contribute to the changes?
12. In what ways does the SOA affect the performance of staff? Please give some examples
    - Attendance
    - Behaviour
    - Available of 24 hours service
    - Cleanliness of facility

Challenges, benefits and future of SOA

13. What are the challenges of SOA?
14. What are the benefits of SOA?
15. Do you think SOA should continue? Why?
    -what about scaling up to other districts?
16. What have we learned so far from SOA?

17. Anything else you would like to add?

E. Key Informant Interview

Introduction

1. Can you tell me how long have you been working here?
2. Can you tell me what your roles are in this institute?

History of Contracting

3. How did the idea of contracting come about? Who initiated? At that time who participated in the introduction of contracting?
4. Could you tell me your experiences and understanding of contracting models? Let's start with CO and CI. How was the process? How is it different?
5. What is your perception of contracting with NGOs?

SOA

6. Can you tell me why SOA was established?
7. Why did contracting change to SOA *(probe for operating cost, autonomy, capacity building, ownership and staffing)*?
8. Who/ which institute participated in the change process?
9. What are the special features that make SOA different from previous contracting arrangements?
10. How would you describe the nature of involvement of various actors in the SOA?
11. How are the local providers incorporated in the planning for change of contracting to SOA?
12. How is progress of SOA being measured?
13. Are there any policies to support the establishment of SOA?
14. Could you tell me the role of your institute in supporting SOA?

Challenges, benefits and future of SOA

15. What are the challenges of SOA implementation? (probe for service quality, service coverage, equity and staff performance)
16. What are the benefits of SOA?
17. Do you think SOA should continue? Why?
18. What have we learned from SOA?

19. Anything else you would like to add?

Annex 2: Indicators used for monitoring SOA

	Indicator	Baseline	Target
Goal 1: Reduce maternal, new born and child morbidity and mortality with increased reproductive health			
1	Percent of married women of reproductive age attending public facilities using modern contraceptive methods		
2	Percent of pregnant women attending two ANC Visits		
3	Percent of deliveries by trained health professionals (home and facility combined)		
4	Percent of deliveries by C-section		
5	Percent of pregnant women receiving iron/folate supplements		
6	Percent of children under 1 year who are fully immunized		
7	Percent of children 6-59 months receiving vitamin A supplements		
8	Number of new OPD consults per capita		
9	Total number of OPD consults per capita		
10	Number of new OPD consults per capita under 5 years		
11	Total number of OPD consults per capita under 5 years		
Goal 2: Reduce morbidity and mortality of HIV/AIDS, Malaria, TB and other communicable diseases			
1	Percent of HIV positive pregnant women receiving ART for PMTCT		
2	Percent of PLHAs receiving ART surviving after 12 months		
3	Severe malaria case fatality rate		
4	Dengue case fatality rate		
5	TB case detection rate (smear +ve pulmonary TB)		
6	TB cure rate		
Goal 3: Reduce the burden of non-communicable diseases and other health problems			
1	Number of diabetes cases treated at public sector facilities		
2	Number of hypertension cases treated at public sector facilities		
3	Percent of injuries of head trauma from road traffic accidents receiving treatment or road traffic accident fatality rate		
Goal 4: Improved organizational capacity, systems and processes			
1	Actual expenditure as a percent of the approved budget		
2	Percent of health centers with functioning HCMCs		
3	Annual organizational capacity assessment score		
4	Annual quality of care assessment score		
5	Percent of essential drugs with stock outs		
	For hospital		
6	Average length of stay		
7	Bed occupancy rate		
8	Turnover rate		