A Case Study of MEDiCAM prepared for ODI

Roo Griffiths and Ly Vichuta[1]

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1 Roo Griffiths is an independent researcher and editor in Cambodia (www.griffiths-saat.org.uk). Ly Vichuta is Director of Legal Support for Children and Women (LSCW), a Cambodian local NGO (www.lscw.org).

1. Background to the research

The extent to which networks can influence policy or carry out other functions is affected by different constraints in any given location. In Cambodia, there are varying constraints, including political and social factors. The study of networks in Cambodia is a new area; there has been comparatively little research carried out in this field. It is important to note how constraints can affect the potential of a network to carry out its mandate and/or influence policy, and what specific strengths and weaknesses there are in Cambodia affecting the environment in which networks operate. A previous research study on the COSECAM network identified preliminary findings on networks in Cambodia. Building on this study, this research project aims to supplement these initial findings by analysing a further three networks in the country.

1.1 Objectives

This research project was contracted by the Research and Policy in Development (RAPID) programme of the Overseas Development Institute (ODI). The aim of the project was to produce case studies of three NGO networks in Cambodia to back up the initial COSECAM study, which dealt with the effectiveness of the network model within the country in terms of influencing policy and carrying out its own mandate. The project used the function/form framework (as detailed by the RAPID website) to identify: i) the functions of the network; ii) the network's structure and how this affects its functions; iii) the ways in which it attempts to carry out its functions; and iv) its successes and failures to do so.

1.2 Methodology

The research was carried out over 45 days between 1 April and 15 July 2006. It was decided to select three NGOs (the NGO Committee on the Rights of the Child – NGOCRC; MEDiCAM – membership organisation for NGOs active in the health sector in Cambodia; and ECPAT Cambodia) as the networks for focus. The reasons for these choices were as follows: i) NGOCRC and ECPAT Cambodia were selected owing to the background of the researchers, both of whom work or have worked within the fields of child sexual exploitation, trafficking and children's rights in Cambodia, and owing to the significance of the issue in Cambodia (which makes for a great deal of funding and therefore a great many NGOs/networks); ii) MEDiCAM was selected owing to its prominence in Cambodian society and the its importance of the work it carries out.

Research took the form of a brief literature review of background information on i) the network itself; ii) the context in which the network carries out its activities; and iii) the current debate on networks and the function/form framework. This was followed by the development of a questionnaire for participants. Three members of staff from each network and one staff member from each of four NGO member organisations for each network were to be identified to be interview participants. Interviews were for the main one-on-one, although some respondents worked by email with the questionnaires.

1.3 Constraints and caveats

Despite the proliferation of NGO and other reports on Cambodia, there has not been much research carried out in this area. The idea of studying the significance and impact of networks is relatively new (although see Bradley, 2005, for the exception to this, on networks in natural resources management, and RAPID's preliminary findings on the MEDiCAM network on its website). This means that the findings from this report are preliminary and should not be taken as confirmed conclusions: it is recommended that findings lead to further discussion in the future. It is hoped that findings of all four studies will be synthesised as a first step towards this.

It was originally decided that three staff of the network would be interviewed and four staff from member organisations. Two network staff were interviewed, and this was deemed sufficient, primarily because of the high capacity and knowledge of the participants. It was difficult to set up meetings with four: time constraints and lack of incentives meant that many people were not interested in responding. In the end, three were identified and it was deemed that this number would in fact be sufficient.

Technology problems should be included here: a comprehensive power cut/network crash deleted the original, almost complete, draft of this paper, which proved to be irretrievable.

1.4 Structure of the paper

Interview participants spoke of issues of relevance to all sections of the report. It was therefore decided that findings from interviews were to be incorporated throughout the paper: there is no individual section on findings. Section 1 has introduced the research. Section 2 of the paper will detail a background of MEDiCAM, looking briefly at its background, structure, objectives and activities. This section will analyse the functions of the network. Section 3 will supply a brief analysis of the country context, for the purpose of identifying major challenges faced by a network in carrying out its mandate in Cambodia (external environment). Section 4 will then look at the successes and failures of the network in carrying out its mandate, according to participants and according to further analysis of the primary and secondary information. Section 5 will make an analysis of the ways in which activities are constrained by the form of the network and the challenges identified in Section 3. Section 6 will give brief initial conclusions. Annexed to the document will be a brief bibliography, a list of MEDiCAM members, organisation details, a list of interviewees and a summary of the questionnaire used.

2. Organisational overview

2.1 Structure of MEDiCAM[2]

MEDiCAM is a non-profit and non-partisan membership organisation for NGOs active in Cambodia's health sector. Every year, it gathers approximately 110-15 members from both international and local NGOs, with UN and bilateral agencies joining at associate member level, and individuals at observer level. MEDiCAM was created in July 1989, while the country was still suffering an economic embargo and diplomatic isolation from western nations. A group of NGOs active in the health sector started to gather and exchange information, eventually adopting the name MEDiCAM (MEDical+CAMbodia). Thanks to the energy and goodwill of several NGO pioneers, the association slowly took shape: a General Assembly of members convened and adopted a Charter, a Steering Committee was elected, etc. In 1991 the Ministry of Health of the then-State of Cambodia's government formally recognised MEDiCAM as the umbrella organisation officially representing NGOs active in Cambodia's health sector. As such, MEDiCAM representatives have been invited to almost all official meetings related to health in the country and the organisation actively contributes to both the policymaking and the implementation of health sector reform, engaged in by the government since 1996.

Before 1996, the association was run by a handful of NGO leaders who volunteered their time, while being responsible for large programmes in their own respective NGOs. Upon request from the General Assembly in June 1996, the Steering Committee raised sufficient funds (from ICCO, MSFHolland/Amsterdam, Pact and WHO) to achieve institutionalisation. Since its inception, MEDiCAM had been under expatriate direction. In September 2003 the important change to local leadership was made. The entire transformation was completed in April 2004, when the Ministry of Interior gave MEDiCAM its status as local NGO representing NGOs active in the health sector in Cambodia.

Current supporters include CIDA, USAID/URC, AIH and VSO. However, MEDiCAM membership fees make up the largest contribution to its annual running (US$60,259 in 2005). There are three levels of membership: full membership (open to all non-profit associations and NGOs operating in the health sector in Cambodia); associate membership (open to all international, bilateral organisations, UN agencies as well as institutes involved or interested in the health sector in Cambodia); and observer membership (for individuals who are not working for a health programme, but who are interested in the health sector and wish to participate in and benefit from all MEDiCAM activities). The membership fees for full and associate members depend on the budget of the organisation involved: from US$3,000 a year for those with a higher than US$1,350,000 budget per year, and correspondingly less for those with less. For an observer, the flat rate is US$75.

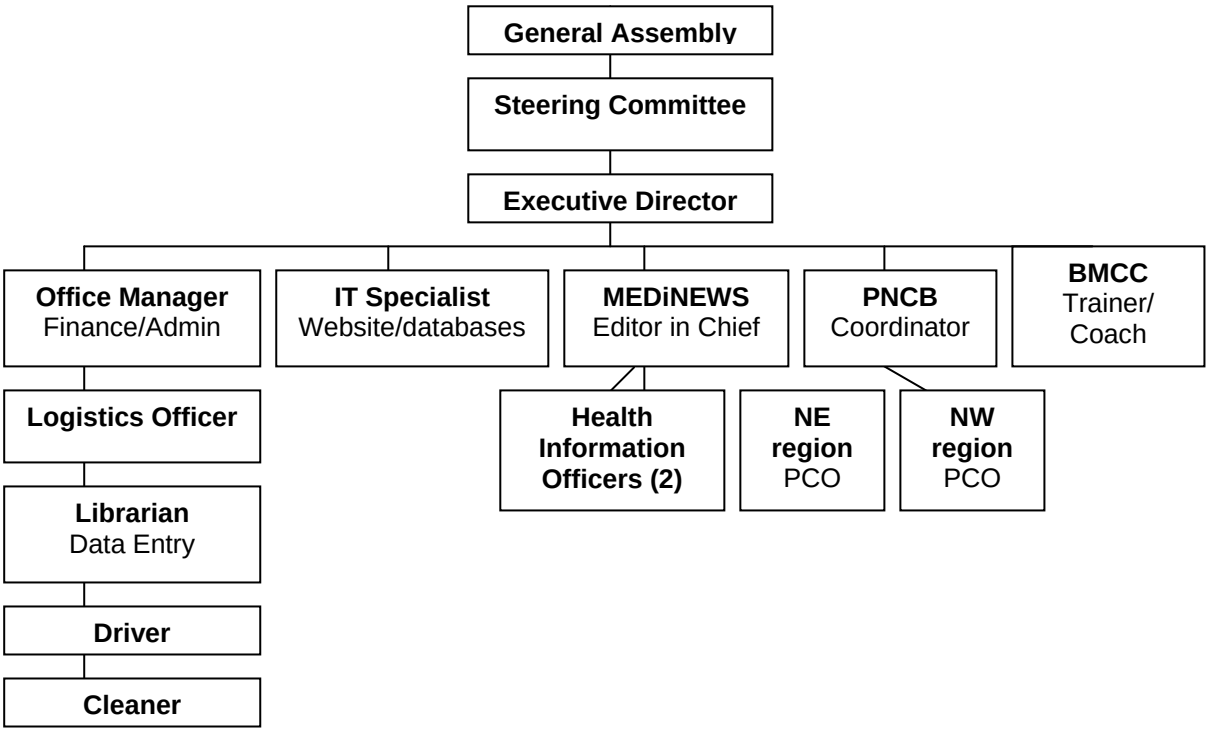
A minimum amount of participation is required from members. This participation may take several forms, such as, attending the monthly meeting, actively participating in Discussion/Working Groups, responding to survey questionnaires, sending to MEDiCAM documents of interest, sharing information, etc. The three following tasks are mandatory for all members:

- Once a year: Respond to the yearly MEDiCAM NGO mapping questionnaire (What health projects do you run and where?)
- Once a year: Respond to the MEDiCAM Position Paper Questionnaire (What do you think of the health sector reform progress?)
- Applicants are invited to read, approve and sign the MEDiCAM Charter before applying.

[2] This section is taken from the MEDiCAM website and from the annual report.

MEDiCAM has full statute, charter, financial and narrative reporting and strategic planning documents in place. Information is open to the public and freely available. The 4Ms (MEDiCAM membership monthly meeting) is held on topics of interest, and those interested from among the network can attend every month; there are regular network meetings and an annual meeting of the whole network. There were 116 members at the end of 2005.

Figure 1: Organisational structure of MEDiCAM



Source: Taken from MEDiCAM Annual Report. Note: there is no advocacy staff member or line shown here: however, there is an advocacy coordinator working bow the executive director. Nonetheless, advocacy is dealt with through the various working groups.

2.2 Objectives and activities

The vision of MEDiCAM is to work towards improved health status in Cambodia by building bridges between the health sector's NGO community and the Royal Government of Cambodia (RGC). Its mission is reflected by the fact that it is the primary networking agency for the country's health-related NGOs. It seeks to link all health sector stakeholders by representing the voice of its NGO members, facilitating policy-advocacy, building capacity of MEDiCAM's members and health partners, and sharing quality information.

These are reflected in the following activities:

1) Information sharing
2) Facilitating advocacy
3) Capacity building for members, through Building Management Capacity for Cambodian NGOs project (BMCC) and Provincial Network Capacity Building project (PNCB)
4) Representing the NGO community

Covering all of these activities, MEDiCAM also provides the following services:

- Email networking
- Library facilities
- Health-related databases
- Organisation and facilitation of working groups addressing specific health issues
- Special health-related events (conferences, workshops, courses)

- Bilingual activities in all areas
- Orienting visitors
- Compiling in-country vacancies and maintaining folder of qualified health volunteers

2.3 Functions of MEDiCAM according to the RAPID framework

RAPID uses the network definition of Portes and Yeo (2001) which suggests that networks can fulfil six, non-exclusive functions: filter; amplify; invest/provide; convene; build communities; and facilitate. According to Bradley (2005: 8), 'networks may function in a variety of ways, but generally speaking, they aim to either bridge the gaps between different sectors and interest groups or else to build consensus and capacity within one particular group, so that it can advocate for its own agenda'. RAPID also details the supra-functions or roles which guide their work: **agency**, which 'denotes a network that is charged by its members to become the main agent of the change they aim to achieve' and **support**, which 'supplies the network members with the resources (goods and services) it needs to carry out their own research and policy advocacy'.

In terms of the **functions** of MEDiCAM, an analysis of the above objectives and the roles and responsibilities of the various parts of the network shows that, to differing extents, MEDiCAM covers all six of the functions mentioned above. As with most networks, MEDiCAM's objectives and activities do not fit neatly into a one-factor-per-function pattern; mostly, the functions carried out are covered by more than one activity.

Filtering
MEDiCAM filters information from its members and from current events in its field to its members and the general public, particularly through MEDiNEWS, databases and website facilities. There is also an Email network available for up-to-date news and for information on current job opportunities and volunteer availability. Members can choose areas they are interested in for frequent update.

Amplifying
MEDiCAM also plays an amplification role, in terms of channelling information into documents and reports, particularly for government officials, for example its annual position paper for the Consultative Group Meeting (where the donor community, CSO representatives, the private sector and policymakers meet annually to make decisions regarding the development agenda of Cambodia), which represents the position of NGOs in terms of achievements, challenges and recommendations in improving health sector development. MEDiNEWS and databases/websites also lead to amplification of research and information; advocacy carried out through the Secretariat and Working Groups also reflects this function. Dissemination takes place in a variety of forms, particularly Email.

Investing/providing
MEDiCAM provides capacity building and widens access for member NGOs, through its BMCC and PNCB programmes and through provision of access to other training opportunities. No financial investment is made into individual NGOs.

Convening
MEDiCAM fulfils a convening function within the network by organising the 4Ms, the AGM, external advocacy meetings, external conferences etc. and information exchange meetings.

Building communities
MEDiCAM does not build communities directly, except in terms of its investment function above through capacity building to members.

Facilitating

MEDiCAM carries out facilitation activities through its capacity building (investment) role, and by enabling Working Groups to deal with advocacy etc. MEDiCAM also hosts a series of resources (online databases, libraries) useful for NGOs working in the health sector in Cambodia and provides orientation services for new arrivals to Cambodia working for the network's members.

In its **agency** role, MEDiCAM carries out information exchange, leads advocacy, carries out capacity building and represents the NGO community. In its **support** role, MEDiCAM enables NGOs to build capacity through training and supports the advocacy Working Groups.

Please see Figure 2 for a breakdown of MEDiCAM's objectives, responsibilities, activities and functions.

Figure 2: MEDiCAM activities, responsibilities, activities and functions

Objective	Responsibility	Activity	Functions
Information exchange	Secretariat (particularly MEDiNEWS, Office Manager and IT)	4Ms meeting; MEDiNEWS, the monthly newsletter crossing a wide agenda of health sector topics, available in English and Khmer and widely distributed among members and officials; and the website/database facility	Filtering Amplifying Convening Facilitating **(Agency)**
Facilitating advocacy	Working Groups and Secretariat	Formulating positions for development of Cambodia's health system, and advocacy with the RGC in specific areas (e.g., reproductive health, child survival)	Amplifying Convening Facilitating **(Agency and Support)**
Capacity building for MEDiCAM members	Secretariat (particularly PNCB and BMCC departments)	BMCC addresses NGO needs in strategic planning, programme design, proposals/reports, M&E, and human resources and financial management PNCB widens access and provides training on primary healthcare, HIV/AIDS counselling, M&E etc	Investing/providing (Building communities) Facilitating **(Agency and Support)**
Representing the NGO community	Secretariat (particularly Executive Director, Health Information Officers)	Involvement in CG; government TWGs; JAPR; Health Congress; COCOM; GFATM; and many MoH working groups. Preparing annual position paper to CG meeting	Amplifying Convening Facilitating **(Agency)**

3. External environment: challenges

Findings in this sector come both from interviews with all four networks covered in the series, and also from research analysis of current conditions. Sections 3.1 and 3.2, on culture and the NGO climate, represent an overview of general conditions in Cambodia, drawn mainly from the previous study on COSECAM with some adaptations according to factors identified in the interviews with MEDiCAM. Section 3.3 is a general overview of the political situation regarding health sector reform, as an introduction to external environment factors affecting MEDiCAM. It is not a specific review of issues that may have occurred within the network.

3.1 Cultural challenges

According to Bradley (2005: 36), 'it is important to consider Khmer culture and how it can affect networks and their functioning'. Cambodian culture has been through a difficult recent history. This is exemplified most famously in the Pol Pot era and its tearing asunder of local relationships and communities. As villages were separated and as the population was turned against one another during the purges and the 're-education' of the era, so trust between people became impossible. Families were compelled to betray each other; marriages were forced; and the paranoia of the central regime meant that nobody was safe and anybody could disappear at any given time. This regime was then followed by years of poverty, instability and guerrilla warfare from the deposed Khmer Rouge.

This has had an effect on present-day Cambodian society and its institutions. All interviewees responded that trust was a big problem in networking in Cambodia. Although organisations in Cambodia may be working towards a common goal, the issue of jealousy and suspicion leads them to hide their work from other 'competing' organisations, making it difficult for local NGOs who are interested in networking to cooperate with others. In some cases, it is difficult to organise workshops or meetings because participants do not want to share information or do not trust other participants because they do not know them. But, even when people are known, trust can be absent: as one interviewee stated, 'I don't trust anyone in my country, except my family, and often not even them'. This is also identified in Bradley (2005: 43), 'according to a member of the Forestry Network, "Some people are active, while some are free riders. For example, I myself tried to develop a proposal and then other members copied from me. Some people do not accept others' ideas for improvement.'

This is exacerbated by other aspects of Khmer culture: some of these are traditional and some have been adopted as a result of the recent history of the country. As Bradley (2005: 36) states, 'many Khmers hesitate to ask others for help … questioning is not common in Asian culture. Questioning may be perceived as a way of accusing or looking down on someone.' This is a part of the wide Asian concept of 'losing face' and often leads to actors preferring not to communicate with others so as not to seem lacking in knowledge, or to them agreeing with something without really being committed. Khmer reluctance to 'lose face' means that participants are often not motivated to join training or to admit failure. Capacity is growing steadily, and many Cambodians are fully involved in building the capacity of other Cambodians. These actors can be treated with suspicion or jealousy. Capacity is generally seen as low of local NGOs in the countryside: it is hard to attract staff with capacity to fill jobs outside the capital, as conditions are poor and infrastructure is weak. It can be difficult to reach those outside Phnom Penh with capacity building. Khmer society is also hierarchical, which means that people build relationships within the patron-client system so that they can obtain 'security and opportunities in return for support and agreement with his/her decisions. This system makes it very difficult to ensure genuine participation' (ibid: 37).

3.2 Challenges in the NGO climate

It is often hard to motivate people to attend meetings; in some cases, participants will not attend without receiving a per diem, even if the meeting is close by and short. This is in

particular because of the high prevalence of NGO meetings and jargon in Cambodia, much of which is difficult for members of local NGOs to cope with and which can contribute to workshop/bureaucracy overload. This has an effect on efforts to coordinate among members, particularly if they are outside the capital and the network is heavily centralised: Cambodia is sometimes as seen as the 'Republic of Phnom Penh' because of the difference in infrastructure and conditions between the capital and the provinces.

In addition, the NGO climate in Cambodia is hard to work in. The format for proposals and reports for local NGOs is difficult to master, and concepts such as indicators, objectives and other are not widely understood. As such, it is difficult for participants to understand or agree on comprehensive approaches and strategies. Capacity is growing, but donors find that preparation of the necessary documents, accountability and monitoring are still weak. Furthermore, 'donors have a disproportionate amount of influence over policy process in Cambodia and therefore research needs to be aware of donor considerations' (ODI, 2005a). There is a high level of competition for funding; CSOs, donors and the government often blame each other for a lack of trust between stakeholders; and 'more money often equals a louder voice' (ODI, 2005b).

At the same time, there is a 'general environment of mistrust, and 'finger pointing' between CSO community and the government'. CSOs are sometimes seen as confrontational, rather than as engaging with the government and providing constructive criticism (ODI, 2005a). MEDiCAM points out that reform should include moves towards a situation whereby 'the Ministry of Health, NGOs, civil society and their multilateral and bilateral donors agree on a broad framework for the roles of NGOs that maximizes their partnership and minimizes misunderstanding, competition and mistrust' (ODI, 2005b).

3.3 Challenges in the political arena

As Bradley (2005: 8) suggests, 'In Cambodia, civil society has been given a relatively large degree of freedom to form associations or networks, both formal and informal.' However, the recent political climate in Cambodia has made it difficult for people to speak out or to perform advocacy activities. At the end of 2005, human rights activists were jailed for defamation of political authorities; some prominent figures were forced to flee (Development Weekly, 6-12 Feb 2006). All have recently been released, pardoned and/or allowed to return, and Prime Minister Hun Sen has made claims that he is going to work towards decriminalising defamation. Many believed that such actions were orchestrated for the benefit of donors prior to the Consultative Group meeting whereby donors allocate aid to Cambodia (Cambodia Daily, 2006b, 23 February). Whether or not this is the case, the temporary stability appears at the current time to be holding, although it can still be difficult for NGOs to appear to be criticising the government. This makes it hard to hold dialogue and promote advocacy. In the case of MEDiCAM, this is exemplified by the facts that, 'while lots of work goes into policy development and ensuring that policy process is participative, the implementation of these polices clearly takes a backseat to political considerations in Cambodia' (ODI, 2005a).

Corruption still plays a big role in Cambodian politics and the government suffers the burden of heavy bureaucracy. There are often many actors involved and issues can cross ministries; squabbling among ministries and officials leads to problems in the application of policies. In the health sector, issues underlined (MEDiCAM, 2006) have arisen in terms of transparency and accountability in policies and in budget disbursements. Also identified is a lack of clear policy and strategic planning on the part of the government, particularly in terms of recruitment, training and salaries to health providers. MEDiCAM also underlines as key the need to strengthen certain areas of the health system, including public sector management; private sector engagement; and involvement of CSOs. There is a lack of quality information available in the area of government health sector reform (ODI, 2005b).

4. Strengths and weaknesses

This section arises from interviews with the staff of the network and the member NGOs, and an analysis of the information supplied. It concludes by summarising the strengths and weaknesses according to the six functions it carries out (see Figure 2).

4.1 Information exchange

Strengths
MEDiCAM's meetings (4Ms) were seen as a good focal point, with the management responsive to suggestions on improvements to the content and other areas. This is an interactive meeting, which responds to member suggestions; these recently included shortening the time of meetings, improving translation services, and renovating meeting rooms. The fact that meetings also took place in the provinces ensured wider access. Newcomers attending meetings had increased from 58 in 2004 to 128 in 2005. Most of those attending were Khmer. MEDiNEWS, the monthly newsletter crossing a broad agenda of health sector topics, was of high quality and widely read. Being available in English and Khmer, it was accessible to all those involved, and was also available in the provinces. 726 are taken each month, 578 by members, 178 by government (local and central) and 80 by the MEDiCAM PNCB project centred in Battambang and Stung Treng. 80.77% of the readership was Khmer in 2005, and the majority of readers were in the provinces. This shows a clear broad readership and strong access for local actors (see Figures 3 and 4, from MEDiCAM's Annual Report 2005). Figures obtained from surveys also show a high degree of relevance in the newsletters: 98.61% respondents said that the articles were current and 72% used the information in their work.

Figure 3: Who's reading MEDiNEWS?

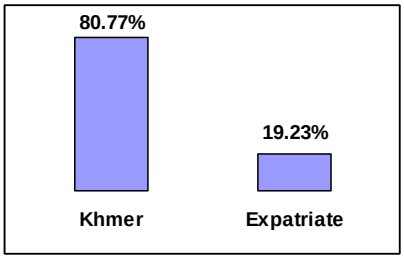
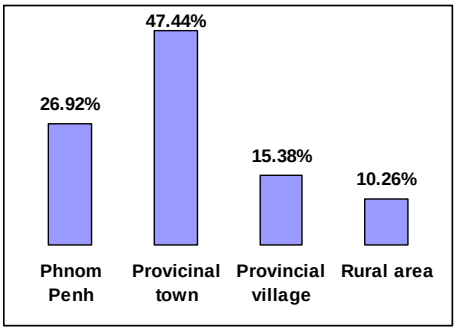


Figure 4: Where are the readers located?



In terms of the website/database facilities, the website (www.medicam-cambodia.org) is up-to-date, with functions to search the online document library and to download MEDiNEWS issues. Membership and advertising information, events and training announcements, and employment requests are also available. In databases, the MEDiCAM Membership Directory enables up-to-date information of all contacts. The NGO Health Projects in Cambodia offers records from most NGO health projects in Cambodia to prevent duplication of activities. The Health Experts in Cambodia database classifies both Cambodian and expatriate specialists. In addition to these electronic facilities, the MEDiCAM library is available for all, with regional offices also. In 2005, the total number of documents reached 5,106. 909 requests to use the documents were made. Email networking is seen as priority, and email send-outs are efficient and well received.

Weaknesses
There was an identified need to represent in meetings the voices of constituencies, with proactive engagement from the NGO community in the health sector. 4Ms attendance had declined slightly (from 526 in 2004 to 517 in 2005 overall). In addition, it was noted that there was a need for continued encouragement of engagement from members in terms of provision

of information for the newsletter. The use of the library had declined (from 151 total visitors in 2004 to 120 in 2005). This showed a need to disseminate more on the issue.

4.2 Facilitating advocacy

Strengths
MEDiCAM was seen as having made an active contribution to policymaking and implementation of health sector reform, and had been engaged by the government since 1996. In particular, the Reproductive Health Promotion Working Group (RHPWG) has made a number of achievements, particularly: developing a male involvement concept guideline to integrate the practice into RH policy; and integrating male involvement into various national strategies. The NGO-Child Survival Working Group (NGO-CSWG) has been able to share its best practices for scaling up and integrating NGO voices into policy formulation and change. NGO-CSWG has been accepted as part of the national child survival steering committee and contributed to the development of the Cambodian Child Survival Strategy. A national child health campaign initiated by the NGO-CSWG and led by the MoH has been prepared. It was seen that, generally, advocating through MEDiCAM was effective because of its high profile and the high level of acceptance that the RGC feels towards its involvement. Advocacy of all types is also performed regionally, by providing a forum for health partners (especially low-profile national NGOs) and government officials and allowing dialogue between them.

Weaknesses
There were problems identified in terms of finding time for WGs, owing to member time commitments. Also, there were some conflicts in terms of leadership and management, with regards to MEDiCAM and the Chair. It was still recognised as difficult to collect successful innovative interventions and practices and formulate them into policies. And there was a need to work more on dealing with policymakers (particularly in the RHPWG), with a continued focus on evidence-based information and seniority/competency of WG members, and on involving senior officials from ministries and support agencies. Furthermore, it was seen as necessary to highlight the need for consensus among diverse actors and for commitment of NGO members.

4.3 Capacity building for MEDiCAM members

Strengths
BMCC achievements include training to help reinforce existing national policies, guidelines and protocols to the grassroots level, provided by MEDiCAM after the organisations involved carry out a self-assessment and participate in a SWOT analysis. This programme is working in two phases: Phase 1, which was completed in 2005, and Phase 2, which is currently running. In Phase 1, it was emphasised by participants that there was a great deal of value in the training, especially because coaching visits were made helping them to implement practices in daily work. 85% of participants were very happy with courses; 93% participated in follow-up coaching. Tangible changes noted by participants included: increased confidence; improved reporting formats and processes; ability to draft strategic plans (for the first time); and improved financial management.

PNCB widens access and provides training on primary healthcare, HIV/AIDS counselling, M&E etc. Training and coaching is usually done in collaboration with the national programmes or with NGO partners who have relevant practical experience and expertise. There is a regional resource centre and regular regional meetings; there is close involvement with the Provincial Health Office. In 2005, four trainings were provided on technical health training, with 102 NGO staff attending (37 of whom came from resource-constrained NGOs on scholarships). Annual Sharing Events (ASEs) also take place to strengthen collaboration between NGOs and health partners. These enable agreement on a number of action points.

Weaknesses
In PNCB, MEDiCAM is hoping to act more as a facilitator than an implementer, something it recognises as a challenge. It is also necessary to further close the gap between grassroots NGOs and policymakers. For both PNCB and BMCC, a focus is needed on attracting NGOs to participate in the capacity building, given that many NGOS do not have staff capacity building included in their budgets from donors and partners. For BMCC, to increase buy-in, there is a need to introduce cost-sharing. BMCC also identifies a need to advocate a culture of encouraging NGO line managers to think critically about training impact before joining, in order to enable personal as well as organisational development.

4.4 Representing the NGO community

Strengths
MEDiCAM has a powerful position in terms of representing the NGO community. MEDiCAM members are invited to most events and official meetings in the country. With the RGC, MEDiCAM is heavily involved in the TWGH (Technical Working Group on Health) Secretariat, a small group of high-level actors who develop and oversee the agenda for the TWGH (along with WHO, UNFPA, DFID and senior MoH officials). It is also involved in TWGs for the six key areas of the Health Strategic Plan. The MoH has accepted recommendations made by MEDiCAM to be formulated into policy. The RGC has also accepted other recommendations from MEDiCAM in the area of health, regarding Joint Monitoring Indicators (JMIs) and cash disbursements from the RGC to ministries and provincial departments. The link between MEDiCAM members and the RGC is made through the 4Ms meetings: the minutes of the TWGH are always published in MEDiNEWS. In addition to the RGC, representation has occurred in terms of obtaining GFATM funding and of enabling the approval of the Health System Strengthening Proposal by GFATM. This occurred hand-in-hand with other NGO networks.

Weaknesses
Although MEDiCAM has a good relationship with the RGC and with other NGO networks, engagement between NGOs and MEDiCAM still needs to be strengthened to enable representation to be complete. MEDiCAM also identifies shortages in terms of human resources and expertise.

4.5 Summary: strengths and weaknesses in implementation of functions

- The network is identified as being very strong in **filtering** information in terms of its newsletters, meetings, and databases etc. However, there was a need to encourage more NGO member involvement.
- The network is identified as very strong in **amplifying**, although there are some problems of human resources and some areas for focus, such as continuing to build relationships with government in advocacy and encouraging NGO member participation.
- The network is identified as strong in **investing (building communities)**, with many trainings taking place. There is a need to focus on encouraging NGO participation and on enabling buy-in of local actors.
- The network is identified as strong in **convening**, although it was stated there was a need to increase NGO participation.
- The network is identified as strong in **facilitating**, although it was again noted that there was a need to increase NGO participation. In addition, particularly in PNCB, MEDiCAM needs to act more as a facilitator than an implementer.

It is to be noted here that the main issue is encouraging NGO member participation. It should also be noted that weakness outlined in this section have already been acknowledged for action by MEDiCAM actors.

5. Impact of form on function

According to RAPID, it is necessary 'to define how [a network's] structural characteristics (organisation, skills, resources, etc), or organisational practices affect its capacity to carry out its functions satisfactorily'. Here we use RAPID's key factors to analyse their contribution to the strengths and or weaknesses detailed above. These are: governance; localisation and scope; capacity and skill; resources; membership; communications; external environment; and strategic and adaptive capacity.

5.1 Governance

Governance in MEDiCAM is identified as strong. MEDiCAM has a clear charter and a strong reporting system. Public financial reports are freely available. Strategic planning takes place, and is also freely available for analysis. The Secretariat has a defined workplan. MEDiCAM has a very high profile in Cambodia; members as well as other actors had a clear understanding of objectives and strategies. Many members are heavily involved in MEDiCAM work; others do not participate. However, membership requires participation, according to the charter, which goes some way to ensuring that there is action on the part of the members.

5.2 Localisation and scope

MEDiCAM has a central office in Phnom Penh but also works provincially, with regional offices in Battambang and Stung Treng. Many of its activities, particularly in capacity building, take place regionally. In addition, all publications are widely available, and meetings take place in all areas; it has been shown in this report that most of those reading the newsletter are based outside Phnom Penh. Many of the local members are provincial NGOs.

MEDiCAM works at all levels of the policy process, but in particular in policy formulation and policy implementation. It has had considerable successes in terms of recommendations to government and to GFATM, for example. It is recognised that it is more difficult to actually turn best practice into policy. As ODI (2005a) states, 'policy advocacy and analysis is about providing opportunities for public debate with and among different stakeholders and people have different ideas about objectives that can compete with and complement each other and this discussion enriches the process and assist in exploring the best option'. MEDiCAM has a high level of ability in this area. Capacity building then follows as, with a close relationship between MEDiCAM and the RGC, programmes can be designed that follow policy and suggested actions.

5.3 Capacity and skill

Secretariat capacity has been identified by all interviewees as very strong. MEDiCAM is a purely Khmer NGO, with two expatriates working in advisory roles. Therefore, not only capacity but also ownership is high. All documents produced by MEDiCAM are of a professional level. It has been noted that all the activities of MEDiCAM are carried out to a high standard. MEDiCAM has also accepted the need to work from empirical, evidence-based experience towards impacting policy, and is showing itself more than capable of moving in this direction. MEDiCAM has also shown that it is able to self-assess, and to find solutions to any internal problems identified.

MEDiCAM has noted that there is a problem of quality regarding work provided by CSOs/NGOs: it is natural to note that, with such high membership, there are going to be areas of weakness in terms of information brought by members.

5.4 Resources

MEDiCAM has good and secure funding, and its access to technology is particularly good, especially for a country such as Cambodia, where there are often numerous problems. In terms of staff, human resource capacity is high in the Secretariat, as noted above.

5.5 Membership

Membership criteria are strict (seen in more detail in Section 2). Members joining have to commit to fulfil certain obligations: this contributes to enabling buy-in. Members are all part of the General Assembly, with the power to make decisions, which goes some way to neutralising the somewhat hierarchical nature of the Secretariat. Members are also obliged to fill in surveys about their own work and give their opinions on country health sector reform, which helps MEDiCAM to obtain fuller knowledge of the issues and to keep track of its members and the chance to improve NGO participation.

5.6 Communications

MEDiCAM has an appropriate communications strategy and staff members responsible for it. Members are all aware of it. Resources are available in support of this. Most communications take place by Email; MEDiCAM encourages members to consider signing up to Email before joining (although this is not obligatory). The IT department is fully able to deal with sending news and information by email; the website is always up-to-date.

5.7 External environment

A great deal of the information on the external environment has been covered already, in Section 3 of this report. In fact, most of the problem areas for MEDiCAM arise from issues of external environment. There are some difficulties in the policy context, in terms of civil and political freedoms and room for manoeuvre at the government level. This makes it difficult to have an influence on policy, although MEDiCAM has nevertheless been successful in advocacy. As we have seen, although a great deal of work is done on developing participatory policy processes, policy implementation is actually constrained by political considerations. There is also a lack of information and quality work available from the government.

One of the major factors affecting work in Cambodia is the cultural milieu. Trust has been identified as significant in impacting both the network and the policy arena. Generally, relations between individuals, both in and outside a network, are traditionally hierarchical, such as patron-client. Young give way to old and less powerful give way to more powerful, regardless of experience or education. This can lead to difficulties in generating a participatory process, whereby all voices are heard. Added to the issue of distrust in Cambodia, both within and outside the network, this can impact the success of functions of the network. It is difficult to maintain a horizontal structure against the traditional culture.

Weak networking has been noted among CSOs in Cambodia, with a lack of harmonisation of research and advocacy efforts. In addition, there is a general environment of mistrust, and ‘finger pointing’ between the CSO community and the government (ODI, 2005a). ‘CSOs are sometimes not willing to work together … [and] CSOs, donors and the government blame each other for lack of trust between the stakeholders’ (ODI, 2005b). Lack of trust makes it difficult for actors to work together and to share work.

In addition, the NGO climate in Cambodia is peculiar, as ‘donors have a disproportionate amount of influence over policy process in Cambodia’ (ODI, 2005a). Seeking funding can be competitive; this also has an effect on fundraising, as does the requirement by donors for those seeking funding to go through complicated funding processes which are hard for those with fewer skills to understand. As noted, smaller NGOs can often be drowned in the process of trying to influence policy: ‘more money often equals a louder voice’ (ODI, 2005b).

All member NGOs stated that these issues were significant, but it was difficult for them to detail how this affects the functions of the network or the implementation of activities. It is important to be aware of the impacts of these factors in programming; as Bradley (2005)

states, ‘encouraging the openness of networks … ensures that the network broadly reflects community interests’, and this can lead to better implementation of all functions.

The network has access to sufficient external technology (Cambodia has some glitches in this area, but things are relatively good and improving), and demand is assured.

5.8 Strategic and adaptive capacity

The network was identified by all interviewees as able to deal with changes in interests, but only to the point where interests still followed the common goal. MEDiCAM is also able to deal with external changes, which reflects positively for all of their functions, keeping work relevant and pertinent. MEDiCAM has shown itself able to deal with reform in a number of areas, by continually updating its outputs and its strategies to meet demand, and by continually self-assessing and asking for assessment from members to be able to adapt to fit the climate. The network is flexible and covers a number of functions, and has the capacity to adapt further. Decisions are made by the whole network, by members and by the network itself.

The network is partly dependent on (steady) international NGO/donor funds, but is mostly driven by membership fees. It is possible to see a situation where MEDiCAM is completely sustainable in the future, owing to the importance that the organisation itself attaches to financial sustainability.

6. Brief conclusions

This paper has given a brief review of one network in Cambodia, detailing its form, its functions, its strengths and weaknesses, and the effect of these on the former.

The network is identified as a very strong one, despite some weaknesses in a few areas. It is noted that MEDiCAM is particularly strong in that it is able to identify and deal with its own problems. Many of the issues it has are associated with the external environment, rather than the internal structure, and MEDiCAM shows that it is making efforts toward solving these too, or at least working towards long-term solutions in Cambodian society. The main internal issue for MEDiCAM is NGO member participation (although it could be said that this is also external, as this issue can arise from Cambodian cultural norms). MEDiCAM is going some way to finding a solutions to this too, having identified it as an issue.

It is clear that MEDiCAM is able to adapt to future demands and conditions, and is capable of addressing its own weaknesses through its strong structure and the high capacity of its administration.

Although it has been noted that the environment in Cambodia is difficult for CSOs, MEDiCAM represent an example of ‘doing it right’: a strong structured network, making clear and apparent impacts in terms of impact on policy, with a focus on empirical evidence and on ownership and self-assessment.

Annex 1: References

Networks

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MEDiCAM documents

MEDiCAM Membership Application Documents, Charter and Renewal Form

MEDiCAM Organization Overview and Services

MEDiCAM Strategic Plan 2004-6

MEDiNEWS, Volume 4, Issue 12, December 2005

www.medicam-cambodia.org

Annex 2: MEDiCAM members

Associate Members

Bilateral Agencies

CIDA	Canadian International Development Agency
GTZ-SHSRP	GTZ-Support to the Health Project Sector Reform Programme
USAID	United States Agency for International Development

Foundations

AHI	Asian Health Institute
ICCO	Interchurch Organization for Development

Institutes

IRD/CAS	Research Institute for Development/Center for Advanced Study

International Organizations

AMCROSS	American Red Cross
DFID	Department for International Development
WB	The World Bank

UN Agencies

UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

Full Membership

International NGOs

24HTV-CA	24Hour Television Charity Committee Cambodia
ADRA	Adventist Development and Relief Agency
AOI	Odontologique Internationale
AOC	Asian Outreach Cambodia
CAMA	CAMA
CECI	Canada Center for Int'l Study and Cooperation
CARE	CARE International in Cambodia
CARITAS	CARITAS Cambodia
CRS	Catholic Relief Services
CCFC	Christian Care for Cambodia
CWS	Church World Service
CESVI	Cooperazione E Sviluppo
DSF	Douleurs Sans Frontières
E&D	Enfant Et Developpement
FHI/IMPACT	Family Health International/Impact
FIDR	Foundation for International Development/Relief
FWAB-CBHEP	Friends Without a Border CBHEP
GRET	Groupe de Recherche et d'Echanges Technologiques
HI-B	Handicap International Belgium
HI-F	Handicap International France
HNI	Health Net International
HU	Health Unlimited
HKI	Helen Keller International
HAI	HelpAge International
ICC	International Cooperation for Cambodia
IRIS	International Resources for the Improvement of Sight
JOCS Cambodia	Japan Overseas Christian Medical Cooperative Service Cambodia
LD	Louvain Développement

MHD	Malteser Germany
MKL	Maryknoll
MSF-B	Médecins Sans Frontières - Belgium
MED	Mekong Eyes Doctor
MCC	Mennonite Central Committee
NOMAD RSI	NOMAD Recherche Soutien International
PFD	Partners for Development
PSF	Pharmaciens Sans Frontières
PLAN	Plan International
Policy	Policy Project
PSI	Population Services International
PATH	Program For Appropriate Technology in Health
SCA	Save The Children Australia
SHARE	Services for the Health in Asia & African Regions
SHCH	Sihanouk Hospital Center of Hope
Sok Sabay	Sok Sabay
SUMH	Supporters For Mental Health
TASK	TASK-SERVANTS
URC	University Research Co.
VSO	Voluntary Service Overseas(UK)
WR-C	World Relief Cambodia
WVC	World Vision Cambodia
WVC	

Local NGOs

AFESIP	Agir pour les Femmes en Situation Précaire
ADF	Agriculture Development Foundation
ACCY	Association For Care of Children and Youth
ADOVIR	Association for Development and Over Villager's Right
BK	Bandos Komar
BSA	Buddhist Study Association
CCMA	Cambodia Christian Methodist Association
CHHRA	Cambodia Health and Human Rights Alliance
CADFP	Cambodian Association for Development of Farmer and the Poor
CDRCP	Cambodian Development and Relief Center for the Poor
CFEDA	Cambodian Family Economic Development Association
CHC	Cambodian Health Committee
CHEC	Cambodian HIV/AIDS Education and Care
CWF	Cambodian World Family
CHETTHOR	Chet Thor
CLA	Children and Love Association
CCWD	Community of Cambodian Women for Development
CSCS	Cooperation for a Sustainable Cambodian Society
HFP	Health Family Promotion
HAD	Hope Association for Development
IDA	Indradevi Association
KFA	Khmer Farmer Association
KHANA	Khmer HIV/AIDS NGO Alliance
KRDA	Khmer Rural Development Association
KHA	Khmer Traditional Medecine Health Association
KWCD	Khmer Women's Cooperation for Development
KNTO	Kum Nit Thmey Organization
LEJ/CCN	Leucaena
MSC	Marie Stopes Cambodia
MS	Mith Samlanh/Friends

NAS	Nak Akphivath Sahakum
NLF	New Life Foundation
OEB	Operation Enfant de Battambang
PFHAD	Partner For Health And Development
PNKS	Ponleu Ney Kdey Sangkhem
PSP	Ponleu Sokhapheap
RACHANA	RACHANA
RACHA	Reproductive and Child Health Alliance
RHAC	Reproductive Health Association of Cambodia
SP	Sovann Phoum
TPO	Transcultural Psychosocial Organization
WDA	Woman Development Association
WOMEN	Woman Organization for Modern Economy and Nursing

Observer Members

1 individual at the current time

Taken from www.medicam-cambodia.org, 10 July 2006.

Annex 3: MEDiCAM details

Contact Information

Dr. Sin Somuny, Executive Director
Telephone: 885-23 211 486, 885-23 214 540
Fax: 855-23 214 540
E-mail Address: info@medicam-cambodia.org
Postal Address: CCC box # 281 Po Box 1164 Phnom Penh Post Office
Website: www.medicam-cambodia.org

Staff

Dr Sin Somuny	Executive Director
Dr Sok Sovannarith	PNCB Project Coordinator
Mrs Mith Leakhena	BMCC Management Trainer/Coach
Mr Eam Lon	PCO-Stung Treng
Mrs Khy Nearyroth	PCO-Battambang
Ms Steph Quinn	Management Advisor (PNCB/BMCC)
Dr Hun Ratana	Advocacy Coordinator
Mr Ung Bunthoeun	Health Information Officer
Mr Ou Sovanndara	Health Information Officer
Mr Im Sarun	MEDiNEWS Editor-in-Chief
Mr Chad Brobst	MEDiNEWS Editorial Advisor
Mr Pouv Sopheak	IT Officer
Mrs May Eth	Office Manager
Mr Lach Khun	Data Entry/Library Assistant
Mr Som Chan	Security/Logistics Officer
Mrs Vet Soneath	Housekeeper
Mr Buth Sophea	Night Guard
Mr Kim Deavuth	Weekend Guard

Steering Committee (2005)

Dr Var Chivorn	Chair	Associate Director, RHAC	Cambodian
Ms Chan Theary	Member	Country Director, RACHA	Cambodian
Mr Andrew Boner	Member	Country Director, PSI	Expatriate
Dr Mary Mohan	Member	Program Manager, PFD	Expatriate
Mr Richard Vreeman	Treasurer	Head of Mission, MSF-HB	Expatriate
Dr Gary Jacques	Member	Executive Director, SHCH	Expatriate
Mr Leonard Uisetiawan	Member	Coordinator, ADRA	Expatriate

Annex 4: Interviewees

MEDiCAM
Dr Sok Sovannarith, PNCB Project Coordinator
Dr Ou Sovanndara, Health Information Officer

Members
Dr Dim Vy, Project Manager, HelpAge International (based in Battambang province)
Mr Ean Kim Chhay, Director, ACCY, (based in Takeo province)
Mr Sok Cham Roeun, Executive Director, KFA (based in Kandal province)

Annex 5: Questionnaire

This questionnaire is a summary of questions asked: it was adapted as necessary, and more questions were posed as necessary as seen on the RAPID function-form webpage. Interviews were carried out in Khmer and English as necessary.

A: Background

1. When was the network formed?
2. Why was it formed?
3. Who are its major donors?

B: Functions

1. What are the main objectives of the network?
2. How do you rank them in terms of importance?
3. What activities have you carried out/do you carry out to fulfil each objective?
4. What else does the network carry out, outside its objectives?
5. Does the network have a long-term business plan? What is it?

C: Management and organisation

1. Do you have a governance agreement? Including what? Is it a formal document?
2. What kind of management system is there? Are there incentives? Is there a clear structure? What is it?
3. What kind of organisational mission is there?
4. Is the network centralised? What work does it do outside Phnom Penh?

D: Resources and communications

1. Does the network have access to research from non-members?
2. Does the network have access to databases and sources?
3. How is knowledge shared within the network and outside?

E: Staff

1. Are there staff employed specifically to network and make links with others?
2. Do staff have relevant skills and capacity?
3. Are there staff capacity-building initiatives within the network? What kind?
4. Does the network as a whole have sufficient and adequate staff?

F: Membership

1. Is membership voluntary, free, fee-based, means-tested, open, or by invitation only?
2. How diverse are the members?

G: Strategic and adaptive capacity

1. Can the network address differences in the interests/values of its members?
2. Can the network respond to opportunities in the policy context?
3. Is the network sustainable? How?
4. Does the network have the capacity to adopt new skills?
5. How does the network make decisions?

H: External environment

1. At what stage of the policy process does the network intervene (agenda-setting, formulation, implementation, M&E)?
2. Who are the key policymakers and institutions?
3. How does the policy process work?
4. What is the extent of civil and political freedoms?
5. What difficulties are there with advocacy?

6. What determines the attitudes inside and outside the network? Are people united towards the common goal?
7. Does the issue of trust/unwillingness to share achievements affect MEDiCAM? How?
8. Does the issue of trust/unwillingness to share achievements affect the network as a whole? How?
9. Does the issue of trust/unwillingness to share achievements affect the policy arena? How?
10. Is there a demand for the network's products and services? Who demands it? Government, civil society, donors?

I: Other

1. Please can we have as much documentation on the network as possible (annual reports, website address, organisational chart, mission statement etc).