



Research Report

OPA model in linking with health and care systems in Cambodia

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Executive summary

To improve the well-being of older people in Asia, HelpAge International and HelpAge Cambodia are piloting an Older People's Association (OPA) model in Bangladesh, Cambodia, and Indonesia. These multifunctional community-based organisations mobilise older people to improve their own lives and contribute to community development across several domains including health and social welfare. Health-related activities include health check-ups and referrals, health education, and financial and social support. This research aimed to identify strategies for appropriate integration of health and care activities of OPAs into health and social welfare systems in Cambodia. Using secondary data sources, phase one of this research identified that Cambodia is experiencing an ageing population, with older people facing vulnerabilities due to social and geographic isolation, poverty, and lack of access to clean water and sanitation. Data sources showed that older people also face an increased burden from non-communicable diseases (NCDs), with high rates of disability also reported in some observational studies. While policies such as the *National Population Policy* (of which the *National Ageing Policy* falls under), *National Health Care Policy and Strategy for Older People* and *National Multisectoral Action Plan for the Prevention and Control of Noncommunicable Diseases* have been implemented to address Cambodia's ageing population and increasing burden of NCDs, lack of social security for older people remains an area for increased action. Despite improvements in recent years, Cambodia's health system faces inadequate service coverage and quality issues with high OOP payments and low access to health insurance representing barriers to universal health care (UHC). Using focus group discussions and key informant interviews with OPA stakeholders in Cambodia, phase two of this research identified that OPAs addressed their members' health concerns by providing health education sessions, home visits, transportation, health check-ups, and referrals. OPAs sometimes collaborated with local health centres to deliver these activities, which provide a useful model for OPAs to integrate with the health system at commune level. While the research found that OPAs assist members to obtain ID Poor cards, this concession was not entirely suitable for older people. Participants called for a Senior Citizen Equity card that aligned with the unique health and social

vulnerabilities of older people. Recommendations of the research included strengthening collaborations between OPAs and health practitioners to increase health education and health check-ups, and increased advocacy for older people's allowances, prioritisation in vaccinations and services for NCDs. These findings demonstrate that OPAs could be an appropriate model for addressing older people's health concerns in Cambodia and other low-income countries in Asia.

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List of abbreviations

AAAQ	Availability, Accessibility, Acceptability, and Quality Framework
CAN	Cambodian Ageing Network
CBO	Community-Based Organisations
CDC	Council for Development of Cambodia
COVID-19	Coronavirus Disease
CRDB	Cambodian Rehabilitation and Development Board
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HCP	Health Coverage Plan
HEF	Health Equity Fund
KII	Key Informant Interview
MoH	Ministry of Health
MoI	Ministry of Interior
MoP	Ministry of Planning
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MIPAA	Madrid International Plan of Action on Ageing
NCD	Noncommunicable Disease
NGO	Nongovernment Organisation
NSDP	National Strategic Development Plan
OD	Operational District
OPA	Older People's Association
OOP	Out-Of-Pocket
PHD	Provincial Health Department
RGC	Royal Government of Cambodia
SDG	Sustainable Development Goals
THE	Total Health Expenditure
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
WHO	World Health Organization

1. Background

1.1 HelpAge International

HelpAge International is an international nongovernment organisation (NGO) and secretariat of a global network of organisations focused on enhancing older people's lives globally¹. HelpAge International's vision is *'a world in which all older people can lead dignified, healthy and secure lives.'* To this end, HelpAge International works with *'older women and men in low and middle-income countries for better services and policies, and for changes in the behaviours and attitudes of individuals and societies towards old age.'*

1.2 HelpAge International and older people's associations

Older People's Associations (OPAs) are a major component of HelpAge International's and HelpAge Cambodia's work. OPAs focus on active engagement of older populations both alongside and within the communities they operate in. Whilst there is no universal OPA model, these groups often focus on themes relevant to older people including livelihoods, rights and empowerment, and health. Through research and practical support, HelpAge International aims to establish contextually appropriate best practice for these groups and support OPAs to be more effective, sustainable, and able to engage at local, sub-national and national levels.

1.3 Health and older people

The global population is rapidly ageing, with an increasing proportion in older age groups.² The proportion of the world's population over 60 years old is projected to increase from 12.3% in 2015 to 21.5% in 2050.³ This demographic shift can be attributed to reductions in mortality among infants and children in low- and middle-income countries, as well as declining mortality rates among

¹ HelpAge International 2020, About us: Our values, vision and strategy, HelpAge International, retrieved 30 September 2020, <https://www.helpage.org/who-we-are/our-values-and-ambitions/>.

² WHO 2015, World report on ageing and health, WHO, retrieved 27 September 2020, <https://www.who.int/ageing/events/world-report-2015-launch/en/>.

³ United Nations, Department of Economic and Social Affairs, Population Division 2015, World Population Ageing 2015, United Nations, https://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf.

older people in high-income countries.⁴ This ageing population has profound implications for how countries arrange their healthcare systems and policies, with a need to have an increased focus on supporting older people in ‘*healthy ageing*’ – defined as the ‘*process of developing and maintaining the functional ability that enables wellbeing in older age.*’⁵

On a global front, it is acknowledged that health systems often do not adequately adapt to or provide the resources and services required by ageing populations.⁶ Considering this, there are several policies which promote worldwide adoption of ageing-appropriate healthcare (see Annex 1).

1.4 SANA Phase II

HelpAge International is currently implementing the following project in several Asian countries: *Improving the well-being of older people, their families and their communities in Asia, through resilient and self-sustaining community-based organisations and improved social protection* (SANA Phase II). The intended outcomes of the project are:

- 1) Older people and other members of OPA/community-based organisations (CBOs) have improved health, increased opportunities for income generation and more effective care in the community; and
- 2) The dignity of older people is enhanced through the increased coverage and adequacy of social pensions.

To this end, HelpAge International and HelpAge Cambodia are piloting an intergenerational and multi-functional OPA model at village level in Bangladesh, Cambodia, and Indonesia. Previous research commissioned under this project has explored the variations and impacts of the OPA models between countries⁷, and the strengths and weaknesses of OPAs across health, income security and social integration.⁸ More investigation is needed to build on such research to

⁴ WHO 2018, Ageing and health, WHO, retrieved 27 September 2020, <https://www.who.int/news-room/fact-sheets/detail/ageing-and-health>.

⁵ Ibid.

⁶ Ibid.

⁷ McClosky, M & Meyers, S, N.D., ‘Action research to assess the OPA model in Bangladesh, Cambodia, Indonesia and Viet Nam (SANA Phase II)’, HelpAge International, retrieved 11 November 2020.

⁸ Howse, K 2017, ‘Older People’s Associations in East and Southeast Asia: a four country study’, Oxford Institute of Population Ageing and HelpAge International, retrieved 11 November 2020.

further review how health and care activities of OPAs can integrate with health systems in Cambodia specifically.

1.5 Research

A qualitative study was conducted as part of the SANA II project in Cambodia. The primary aims of this research were to:

- 1) Identify strategies for appropriate integration of health and care activities of OPAs into health and social welfare systems, in order to increase their positive impact on health of older people and their communities; and
- 2) Develop and record the methodology used for this research to enable replication in other countries.

This research was carried out over three phases. Phase one was a situational analysis of the health situation and health and care systems, policies, and rights. Phase two used primary data to identify approaches for linking OPA activities with healthcare systems and policies. Phase three was a feedback and codesign process, which provided stakeholders with an opportunity to add contextual details and knowhow into the interpretation of the results and preparation of recommendations.

Two overarching frameworks were used to guide this research. First, the research team used the social determinants of health framework to explore external factors that might impact the health of older people in the country.⁹ The research team also used the availability, accessibility, acceptability, and quality (AAAQ) framework to assess health and care systems for older persons in Cambodia, as well as to identify how OPAs can best link with these systems.¹⁰

The methodology, guidelines, and tools for this primary and secondary research were documented and can be used to replicate the research in other countries (see Research Toolkit). These tools include templates for conducting a situational analysis of health and healthcare services, guidelines for conducting key

⁹ Marmot, M & Wilkinson, RG 1999, Social determinants of health, Oxford University Press, Oxford, UK.

¹⁰ WHO 2016, Availability, accessibility, acceptability, quality Infographic, WHO, retrieved 30 September 2020, <https://www.who.int/gender-equity-rights/knowledge/AAAQ.pdf?ua=1>.

informant interviews (KIIs) and focus group discussions (FGDs), and data entry and analysis file. These tools are presented in easy-to-read language to ensure that stakeholders from various backgrounds and countries can easily adapt and replicate the process in other contexts.

2. Phase 1: Situation analysis

2.1 Research aims

Phase one was a situational analysis of the health situation and health and care systems, policies, and rights in Cambodia, assessed using secondary data sources. This assessment aimed to describe the main health issues and causes experienced by older people in Cambodia, and mapped out relevant healthcare systems, activities, and national policies and strategies focused on older people. Phase one also provided an opportunity to use OPA reports and previous research by HelpAge International and HelpAge Cambodia to present an overview of OPAs in Cambodia.

2.2 Cambodia

Cambodia's estimated population in 2019 was 15,552,211, with an annual growth rate of 1.4%.¹¹ The largest ethnic group in Cambodia is Khmer (97.9%) and most common religion is Buddhism (97.9%). Although only 24.2% of the Cambodian population live in urban settings, urbanisation is projected to increase by 3.25% each year.¹² Cambodia's economy has also experienced growth in recent years (with the exception of 2020), with the gross domestic product (GDP) growing at approximately 8% annually between 1998 and 2018. This economic growth led to Cambodia reaching lower middle-income country status in 2015; however, 12.9% of the population still lived below the poverty line in 2018.¹³

¹¹ MoP 2020, General Population Census of the Kingdom of Cambodia 2019: National Report on Final Census Results, retrieved 24 February 2021, <http://www.nis.gov.kh/nis/Census2019/Final%20General%20Population%20Census%202019-English.pdf>.

¹² CIA World Factbook, Cambodia Demographics Profile, retrieved 30 September 2020, https://www.indexmundi.com/cambodia/demographics_profile.html.

¹³ Asian Development Bank, Poverty Data: Cambodia, retrieved 2 March 2021, <https://www.adb.org/countries/cambodia/poverty#:~:text=Poverty%20Data%3A%20Cambodia,Cambodia%20is%200.7%25%20in%202019.>

2.3 Older people in Cambodia

Cambodia is experiencing population ageing, which means that the proportion of the country's older population has grown at a faster pace than younger cohorts.¹⁴ According to census data, there were 1,378,688 million older people (60 years and older) in Cambodia in 2019, who make up approximately 8.9% of the total population of Cambodia.¹⁵ The proportion of older people (60 years and older) is projected to increase to 10.4% by 2030 and then to 17.9% by 2050.¹⁶ One factor contributing to this is a rise in life expectancy from 55.3 years for males and 59.8 years for females in 1990 to 66.8 years for males and 72.7 years for females in 2017.¹⁷ Another contributing factor is the rapid drop in fertility rate across Cambodia, which fell from 5.7 in 1990 to 2.7 in 2017.¹⁸ Both these trends are projected to continue into the future, leading to older people making up an increasing larger proportion of the total Cambodian population (see Figure 1). This demographic shift may also increase vulnerabilities among older Cambodians.

¹⁴ MoSVY 2017, National ageing policy (2017-2030), UNPFA, retrieved 25 September 2020, https://cambodia.unfpa.org/sites/default/files/pub-pdf/NAP%202017-2030_%20Final_English-Printed.pdf

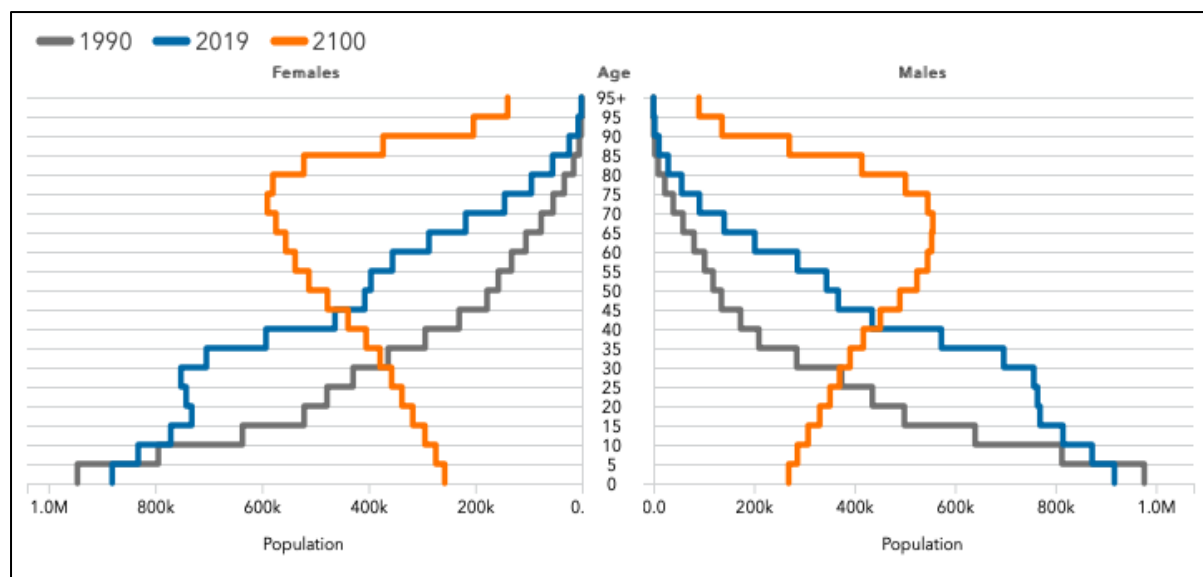
¹⁵ MoP 2020, General Population Census of the Kingdom of Cambodia 2019: National Report on Final Census Results, retrieved 24 February 2021, <http://www.nis.gov.kh/nis/Census2019/Final%20General%20Population%20Census%202019-English.pdf>.

¹⁶ United Nations, Department of Economic and Social Affairs, Population Division 2015, World Population Ageing 2015, United Nations, https://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf.

¹⁷ Institute for Health Metrics and Evaluation 2020, Cambodia, retrieved 30 September 2020, <http://www.healthdata.org/Cambodia>.

¹⁸ Ibid.

Figure 1: Population age structure in Cambodia, 1990, 2019, and 2100 projection



Source: Institute for Health Metrics and Evaluation 2020

Adult children often provide care for their older parents in Cambodian culture and are an important source of social care and support.¹⁹ However, the out migration of young people from rural areas to cities for employment means that older people are often left at home alone or with the care of grandchildren.²⁰ This dynamic represents a decline in the potential support ratio: the availability of social support and care provided by family members to older people. This issue can become more pronounced if older people develop chronic illnesses or disabilities, which can require increased assistance to access medical treatment or complete everyday activities. Moreover, majority of older people in Cambodia are women, with this sex-differential projected to increase further in the coming decade due to the differences in life expectancy between females (72.7 years) and males (66.8 years), as mentioned above.²¹ This situation means that older women are likely to experience long periods as widows without the financial

¹⁹ MoSVY 2017, National ageing policy (2017-2030), UNPFA, retrieved 25 September 2020, https://cambodia.unpfa.org/sites/default/files/pub-pdf/NAP%202017-2030_%20Final_English-Printed.pdf.

²⁰ Zimmer, Z & Knodel, J 2013, 'Older-Age Parents in Rural Cambodia And Migration of Adult Children: A Case Study Of Two Communes In Battambang Province', *Asian Population Studies*, vol. 9, no. 2, pp. 156-174, doi:10.1080/17441730.2013.797297.

²¹ MoSVY 2017, National ageing policy (2017-2030), UNPFA, retrieved 25 September 2020, https://cambodia.unpfa.org/sites/default/files/pub-pdf/NAP%202017-2030_%20Final_English-Printed.pdf.

support of their husbands, and due to discrimination in employment, older women may experience financial insecurity as they age.²²

Cambodia's older population are also vulnerable due to lack of access for fulfillment of basic needs. Research showed that many older Cambodians experience increased vulnerabilities from low literacy, low education, lack of access to basic facilities like a toilet, and high rates of poverty.²³ Census data showed that a high proportion of older people reported to have '*no education*', with rates highest among women aged 60-64 years (female 36.6% and male 16.2%) and 65+ (female 63.8% and male 23.4%).²⁴

Access to clean water and sanitation is also a potential issue for older people. Recent census data showed that during the dry season, 35.4% of the population obtained drinking water from a non-improved water source (those potentially not suitable for drinking), with lack of access higher in rural areas (41.2%) compared to urban areas (4.7%).²⁵ Similarly, census data also showed that 43.4% of the population used an unhygienic sanitation facility, with rates also higher among those in rural areas (50.1%) compared to urban areas (7.6%).²⁶ Although this data does not relate specifically to older people, lack of access to clean water, sanitation, and hygiene can be a major threat to Cambodia's older population in rural parts of the country.

2.4 Older people and health

The main causes of death among older people (60-89 years) in Cambodia are from noncommunicable diseases (NCDs) (78%), followed by communicable diseases (18.1%) and injuries (3.9%) (see Table 1).²⁷ In 2019, the five leading causes of death in Cambodia were: 1) stroke, 2) respiratory infections and tuberculosis, 3) neoplasms, 4) ischemic heart disease, and 5) digestive diseases.

²² MoSVY 2017, National ageing policy (2017-2030), UNPFA, retrieved 25 September 2020, https://cambodia.unfpa.org/sites/default/files/pub-pdf/NAP%202017-2030_%20Final_English-Printed.pdf.

²³ Knodel, J, Kim, S, Zimmer, Z & Puch, S 2004, Older Persons in Cambodia: A Profile from the 2004 Survey of Elderly, Population Studies Centre, University of Michigan, Institute of Social Research, retrieved 30 September 2020, <http://globalag.iqc.org/elderrights/world/cambodiaelderly.pdf>.

²⁴ National Institute of Statistics 2015, Cambodia Demographic and Health Survey 2014, <https://dhsprogram.com/pubs/pdf/fr312/fr312.pdf>

²⁵ Ibid.

²⁶ Ibid.

²⁷ Institute for Health Metrics and Evaluation 2020, Cambodia, retrieved 30 September 2020, <http://www.healthdata.org/Cambodia>.

Community-level observational studies showed similar results, revealing that older people faced hypertension, diabetes, respiratory diseases, osteoporosis, and fatigue.²⁸ This research also identified mental health issues experienced by older Cambodians, with 83% of study participants having suffered depression.

Table 1: Causes of death among those aged 60-89 years old in Cambodia, 2019*

Cause of death	Males	Females	Total
All causes	28,794	31,561	60,355
All NCDs	22,256	24,816	47,072
All communicable, maternal, neonatal, and nutritional disorders	5,288	5,655	10,943
Injuries	1,249	1,090	2,339
Stroke	4,451	6,579	11,030
Respiratory infections and tuberculosis	4,514	4,687	9,202
Neoplasms	4,711	3,939	8,651
Ischemic heart disease	4,145	4,024	8,169
Digestive diseases	2,932	3,359	6,291

Source: Institute for Health Metrics and Evaluation 2020

**Please note that figures are rounded to the closest whole number.*

Research shows a range of modifiable risk factors contributing to death and disability among older people in Cambodia. For example, data shows that the leading causes of death and disability among those aged 60-89 years old were: 1) tobacco use, 2) air pollution, 3) high fasting plasma glucose, 4) high systolic blood pressure, and 5) dietary risks (see Table 2).²⁹

²⁸ National Institute of Statistics & HelpAge Cambodia 2019, Report: Needs & Challenges of Older People, National Institute of Statistics, HelpAge Cambodia & Voice, retrieved 30 September 2020, <https://voice.global/publications/needs-challenges-of-older-people-in-cambodia-a-research-report/>.

²⁹ Institute for Health Metrics and Evaluation 2020, Cambodia, retrieved 30 September 2020, <http://www.healthdata.org/Cambodia>.

Table 2: Leading risk factors for death and disability among those aged 60-89 years old in Cambodia, 2019*

Risk factor	Males	Females	Total
Tobacco	9,916	3,421	13,338
Air pollution	5,137	5,849	10,986
High fasting plasma glucose	4,794	5,897	10,691
High systolic blood pressure	5,935	4,683	10,618
Dietary risks	4,569	4,813	9,383

Source: Institute for Health Metrics and Evaluation 2020

**Please note that figures are rounded to the closest whole number*

Disabilities are a challenge facing older people in Cambodia. Observational studies with older Cambodians showed that many experienced mobility issues from joint pain, weakness, back pain, and complications from NCDs.³⁰ Similarly, older people often reported difficulties performing physical tasks such as lifting things and walking, and difficulties seeing and hearing, all of which influence their ability to conduct necessary daily activities.³¹ These findings were supported by the 2014 census, which found that 9.5% of the Cambodian population had some form of physical disability (10.5% female and 8.5% male).³² However, when disaggregated by age, the data showed that physical disabilities were more prevalent in older age groups; the proportion of Cambodians with a physical disability was 1.8% among 5-14 years, 3.5% among 15-34 years, 13.2% among 35-59 years, and 44.2% among 60+ years.³³ Among older people with physical disabilities (60+ years), the most common form of physical disability was impairments with seeing (30.5%), walking (22.3%), concentrating (21.5%), hearing (17.0%), communicating (7.9%) and self-care (6.9%).³⁴

³⁰ Knodel, J, Kim, S, Zimmer, Z & Puch, S 2004, Older Persons in Cambodia: A Profile from the 2004 Survey of Elderly, Population Studies Centre, University of Michigan, Institute of Social Research, retrieved 30 September 2020, <http://globalag.iqc.org/elderrights/world/cambodiaelderly.pdf>.

³¹ National Institute of Statistics & HelpAge Cambodia 2019, Report: Needs & Challenges of Older People, National Institute of Statistics, HelpAge Cambodia & Voice, retrieved 30 September 2020, <https://voice.global/publications/needs-challenges-of-older-people-in-cambodia-a-research-report/>.

³² National Institute of Statistics 2015, Cambodia Demographic and Health Survey 2014, <https://dhsprogram.com/pubs/pdf/fr312/fr312.pdf>.

³³ Ibid.

³⁴ Ibid.

2.5 Policies and older people

There are several policies relevant to healthcare provision for older populations in Cambodia, however, these vary in terms of their coverage and degree of implementation. While Annex 2 includes an extensive list and details on implementation for each policy, there are several key policies worth considering, including:

- **National Ageing Policy 2017-2030:** This policy is the RGC's main strategy on health ageing in Cambodia. It aims to mainstream ageing into development procedures through nine priority areas, and functions alongside the 3-year *Action Plan for National Ageing* policy. Priority area 5 includes actions on OPAs and active ageing, which aim to support the establishment of OPAS across Cambodia and to enhance the role of OPAs.³⁵
- **National Multisectoral Action Plan for the Prevention and Control of Noncommunicable Diseases 2018-2027:** The policy aims to address the increasing burden of NCDs in Cambodia. It highlights the need for a multisector response, promoting action across various ministries and sectors to address NCDs. To this end, the strategy focuses on reducing exposure to risk factors for NCDs and strengthening multisectoral governance and resources for NCDs. The activities listed in the priority mainly focus on reducing exposure to risk factors for NCDs, such as tobacco and alcohol, the promotion of healthy diet and physical activity, and the reduction of exposure to indoor air pollution. There is limited focus on the role of the health system in the prevention and control of NCDs.³⁶
- **National Social Protection Policy Framework 2016-2025:** This policy focuses on two pillars: Social Assistance and Social Security. Social Assistance programs includes the Health Equity Fund (HEF), which provides free health care to families holding an ID Poor card. The policy

³⁵ MoSVY 2017, National Ageing Policy 2017-2030, MoSVY, https://cambodia.unfpa.org/sites/default/files/pub-pdf/NAP%202017-2030_%20Final_English-Printed.pdf.

³⁶ MOH 2018, National Multisectoral Action Plan For The Prevention And Control Of Noncommunicable Diseases 2018- 2027, MoH, http://moh.gov.kh/content/uploads/2017/05/NMAP-NCD_-13-06-2018-Signed_En.pdf.

also includes the Social Security Scheme, which encourages citizens to contribute funds to their pension schemes. This aims to provide income protection for older people.³⁷

2.6 Health system

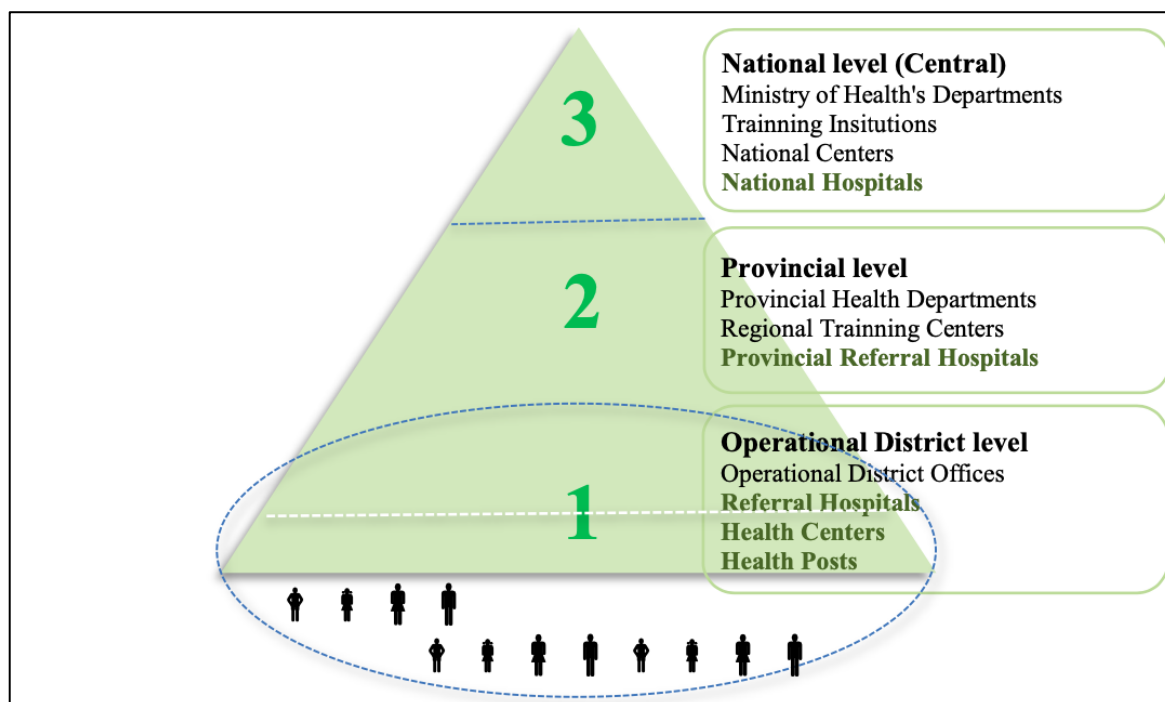
Cambodia's health system is led and managed by the MoH and is comprised of public and private services. The public system is structured across three levels: national, provincial, and operational (Figure 2). The Directorate-General for Health is responsible for overseeing health service delivery across all levels, including 24 provincial health departments (PHDs) and 81 operational districts (ODs).³⁸ As shown in Figure 2, each level of the system is responsible for a different function and service delivery.³⁹ At the community level, ODs oversee referrals hospitals, health centres, and health posts. Each health centre provides basic preventative and curative services, and less formal health posts are situated in remotes areas. Alongside this public system, the private system includes a wide variety of health services such as hospitals, health facilities and pharmacies, as well as non-medical health providers such as traditional birth attendants and traditional healers.

³⁷ CRDB & CDC 2017, National Social Protection Policy Framework 2016-2025, CRDB & CDC, http://cdc-crdb.gov.kh/en/twg-jmi/sector_strategy/National_Social_Protection_Policy_en.pdf.

³⁸ WHO 2015, The Kingdom of Cambodia Health System Review, WHO Regional Office for the Western Pacific, retrieved 28 September 2020, <https://apps.who.int/iris/handle/10665/208213>.

³⁹ Department of Planning & Health Information 2016, Health Strategic Plan 2016-2020, [http://hismohcambodia.org/public/fileupload/carousel/HSP3-\(2016-2020\).pdf](http://hismohcambodia.org/public/fileupload/carousel/HSP3-(2016-2020).pdf).

Figure 2: Three Levels of the Public Health System



Source: Department of Planning and Health Information 2016

Cambodia is also pursuing a decentralisation and deconcentration process, where the national government delegates authority to local governments.⁴⁰ At the community level, Commune Councils prepare annual activity plans and budgets for local services, including health centres. The health centre management committee, which includes local health authorities and community representatives, then review the progress of health centre plans and advocate for service improvements. Under this process, an ombudsman office should also be established to provide communities with a formal avenue to lodge complains about issues with government authorities at the community level.⁴¹

2.6.1 Health service quality

The Health Coverage Plan (HCP) is a framework for determining health system infrastructure at each level based on population and geographical criteria (see Table 3).

⁴⁰ Open Development Cambodia 2015, Decentralization and deconcentration, retrieved 01 February 2021, <https://opendevelopmentcambodia.net/topics/decentralization-and-deconcentration/>.

⁴¹ Ibid.

Table 3: Criteria for Establishment of Health Facilities

Facility	Population size	Accessibility
Health centre	Optimal size: 10,000 Range: 8,000-12,000	Within 10km or 2-hour walk maximum for the catchment area population
Referral hospital	Optimal size: 100,000 Range: 80,000-200,000	In populated area; within 2 hours' drive or boat journey and in rural areas; not more than 3 hours' drive or boat journey
Health post	Range: 2,000-3,000	Distance from a commune or village to the nearest HC is more than 15 km, with geographic barriers (river, mountain, or poor roads)

Source: Department of Planning and Health Information 2016

However, the criteria in this framework are not consistently applied, with low population density areas often experiencing inadequate health service coverage and high population density areas experiencing overcrowding, contributing to issues around accessibility of healthcare.⁴² Quality of care provided is also an issue, with reports of high patient dissatisfaction in some areas including lack of attentiveness of health workers, lack of availability of healthcare workers at night, unclean facilities, and poor communication between healthcare workers and patients.⁴³ These issues may explain why a large proportion (67.1%) of the population seek healthcare from the private sector for an injury or illness, followed by public sector healthcare providers (21.9%), and only a few (4.5%) sought assistance from a non-medical sector provider such as traditional healer.⁴⁴

2.6.2 Universal Health Coverage

Cambodia has made progress towards universal health coverage (UHC). The UHC index provides a measure of health service coverage across a population, and how much health services contribute to improved health. In Cambodia, the

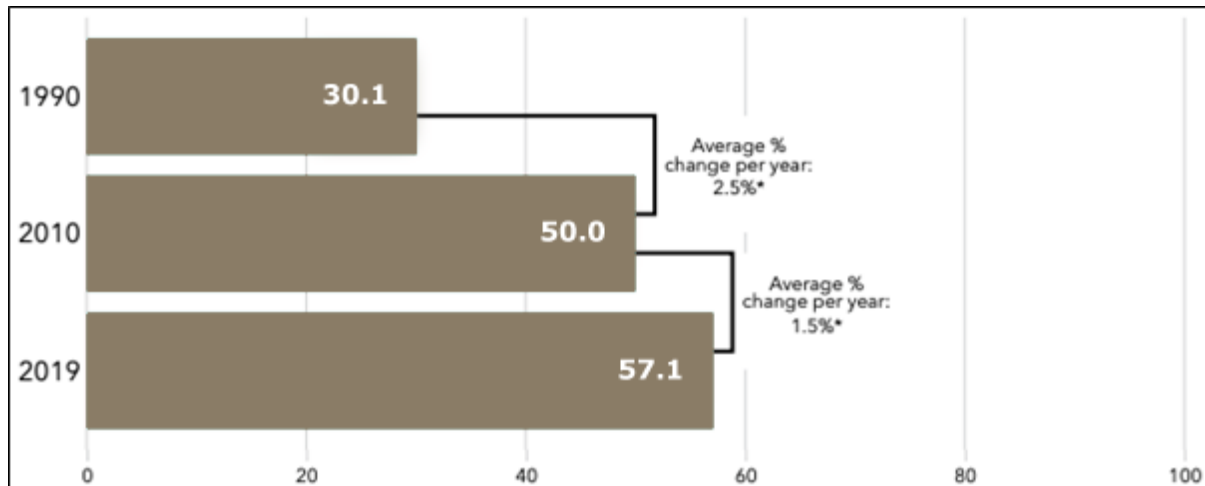
⁴² Department of Planning & Health Information 2016, Health Strategic Plan 2016-2020, [http://hismohcambodia.org/public/fileupload/carousel/HSP3-\(2016-2020\).pdf](http://hismohcambodia.org/public/fileupload/carousel/HSP3-(2016-2020).pdf).

⁴³ WHO 2015, The Kingdom of Cambodia Health System Review, WHO Regional Office for the Western Pacific, retrieved 28 September 2020, <https://apps.who.int/iris/handle/10665/208213>.

⁴⁴ National Institute of Statistics 2015, Cambodia Demographic and Health Survey 2014, <https://dhsprogram.com/pubs/pdf/fr312/fr312.pdf>.

UHC index increased from 30.1% in 1990 to 50.0% in 2010, and then to 57.1% in 2019 (see Figure 3).⁴⁵

Figure 3: UHC effective coverage index change in Cambodia, 1990, 2010, 2019



Source: Institute for Health Metrics and Evaluation 2020

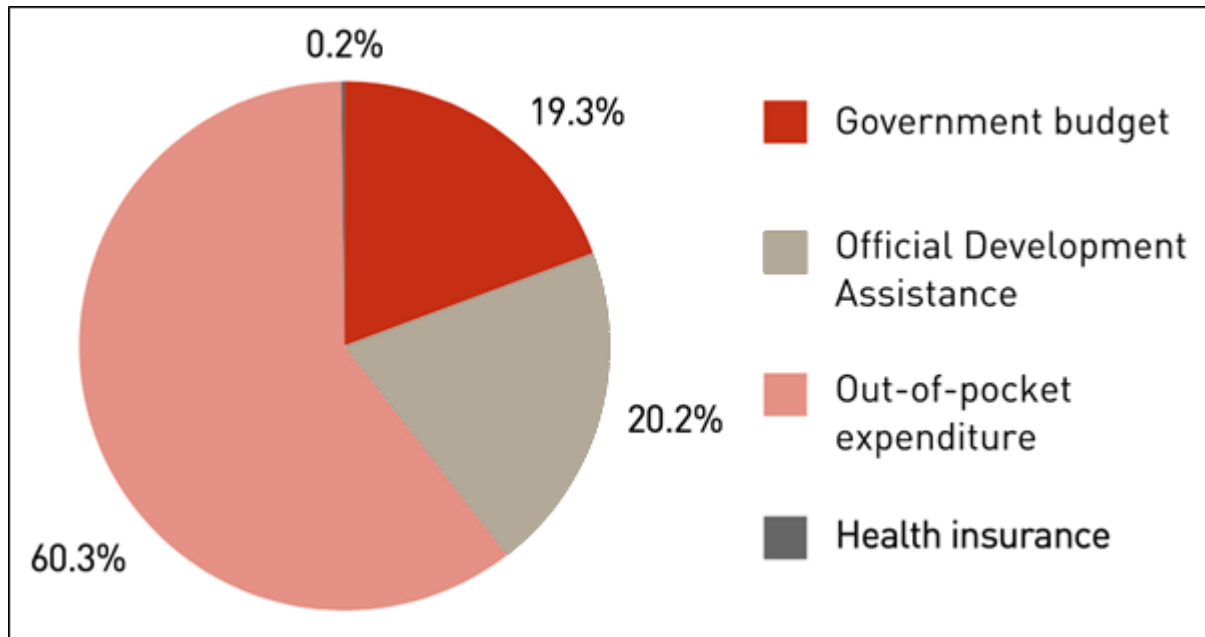
This data shows that Cambodia's health system still has progress to make to achieve UHC. High costs may also hinder access to healthcare in Cambodia. One study showed that patient out-of-pocket (OOP) payments accounted for the largest non-food expenditure for Cambodian households.⁴⁶ The study also showed that 60% of the country's total health expenditure (THE) was from patient OOP payments (see Figure 4). The government has had limited success at reducing these costs - as a proportion of THE, OOP payments have remained relatively stable over the past 15 years, ranging from 68.9% in 1995 to 61.6% in 2010.⁴⁷

⁴⁵ Institute for Health Metrics and Evaluation 2020, Cambodia, retrieved 30 September 2020, <http://www.healthdata.org/Cambodia>.

⁴⁶ WHO 2015, The Kingdom of Cambodia Health System Review, WHO Regional Office for the Western Pacific, retrieved 28 September 2020, <https://apps.who.int/iris/handle/10665/208213>.

⁴⁷ Ibid.

Figure 4: Share of total health expenditure by funding source, 2013



Source: WHO 2015

Evidence suggests that older people face increased challenges from high OOP, particularly if they have limited income or financial support to pay for treatment. In one study, older people spent 50% more per month on healthcare than younger people and were also more likely to experience catastrophic health expenditures.⁴⁸ This increased burden on older people is also demonstrated in census data - those aged 60+ years spent on average USD \$72.55 on first treatment healthcare, which included \$4.04 on transport and \$68.52 on healthcare. This amount was higher than all other age groups: \$51.15 among 40-59 years, \$52.88 among 20-39 years, \$25.64 among 10-19, and \$12.52 among 0-9 years.⁴⁹ These findings highlight the impact that high healthcare costs may disproportionately have on older Cambodians and heighten the barriers they face in accessing healthcare.

⁴⁸ Jacobs, B, de Groot, R & Antunes, A 2016, 'Financial access to health care for older people in Cambodia: 10-year trends (2004-14) and determinants of catastrophic health expenses', *International Journal for Equity in Health*, vol. 15, no. 94, pp. 1-9, [doi:10.1186/s12939-016-0383-z](https://doi.org/10.1186/s12939-016-0383-z).

⁴⁹ National Institute of Statistics 2015, Cambodia Demographic and Health Survey 2014, <https://dhsprogram.com/pubs/pdf/fr312/fr312.pdf>.

2.6.3 Health insurance

Lack of health insurance is an issue facing older people. Although data on older people specifically was unavailable, research showed that 86.0% of adult men (45-49 years) and 84.5% of adult women (45-49 years) did not have any health insurance.⁵⁰ The most common type of health insurance among adult Cambodians was through the Health Equity Fund (HEF), which specifically covered 13.5% of adult women (45-49 years) and 10.9% of adult men (45-49 years) of those who have health insurance.⁵¹ The HEF is the Cambodian Government's primary scheme to protect the poor from high health-care costs, providing beneficiaries with subsidised healthcare services, assistance with transportation, food, and funeral expenses.⁵² However, there is limited data on the proportion of older people who have access to health insurance or the HEF.

2.7 Older people's associations

In Cambodia, OPAs have been established both by the Royal Government of Cambodia (RGC) and HelpAge Cambodia (including other NGOs) (see Table 4). Both OPA models exist to serve older people but vary in how they have been established and operate. Government OPAs are established at the commune level, which then branch off into activities at village level. These OPAs are funded through the membership fees of their members. HelpAge Cambodia provides technical support to the RGC on the establishment and operation of OPAs.⁵³

Similarly, HelpAge Cambodia (and other NGOs) assist older people to establish OPAs at the village level, which are led and managed by volunteer members. Currently, approximately 60% of OPA members are female and 60% of OPA leaders are over 55 years old.⁵⁴ These OPAs are funded through membership fees, support from NGOs including HelpAge Cambodia, fundraising, funds provided by their local commune, and income-generating activities. These OPAs

⁵⁰ Ibid.

⁵¹ Ibid.

⁵² WHO 2015, The Kingdom of Cambodia Health System Review, WHO Regional Office for the Western Pacific, retrieved 28 September 2020, <https://apps.who.int/iris/handle/10665/208213>.

⁵³ HelpAge Cambodia 2019, Older People's Associations (OPA), retrieved 03 March 2020 <https://www.helpagecambodia.org/older-peoples-association/>.

⁵⁴ Ibid.

operate as multifunctional community-based organisations, which address a range of issues through activities on rights and entitlements, social care, livelihoods, and health. Health-related activities include health education and promotion, health screenings, referrals to visit health centre or hospital, home visits and social care for vulnerable or sick members, transportation to visit health centre, fundraising to pay for vulnerable members’ healthcare costs and medication, and advocating with health centres to provided discounted services for members. Moreover, OPA federations operate at either the provincial or commune levels. They are registered as an official association under the Cambodian Ministry of Interior (MoI), providing clusters of OPAs with a platform to share their knowledge and advocate for older people’s needs.⁵⁵

Table 4: OPA network in Cambodia

Government level	Government OPAs	HelpAge Cambodia OPAs
National	National Committee	Cambodian Ageing Network (CAN)
Provincial	OPA Federations (n=8)	
District		
Commune	OPAs (n=1,646)	
Village	Branch of commune-level OPAs	OPAs (n=170)

Source: HelpAge Cambodia 2019

3. Phase 2: Linking OPAs with systems/policies

3.1 Research aims

Phase two aimed to identify approaches for linking OPAs activities with healthcare systems and policies in Cambodia. To this end, primary data was collected from OPAs, NGOs involved with older people, government authorities at provincial and national level, and United Nations agencies. These interviews were guided by the following research objectives:

⁵⁵ Ibid.

- 1) Identify how OPAs identify and respond to priority health issues in their communities, including recommendations for how current approaches could be strengthened;
- 2) Describe the ways OPAs link with healthcare systems to respond to priority health issues, including success stories, lessons learned, and potential approaches towards this end; and
- 3) Describe barriers OPAs face in linking with healthcare systems, and identify what resources or approaches may help both OPAs and government to address these issues.

3.2 Sample and recruitment

The research team recruited stakeholders involved with OPAs in Cambodia using nonprobability, convenience sampling. This approach was suitable for identifying participants based on their availability and diverse perspectives on the research topic. To this end, the research team aimed to recruit participants from the following stakeholder groups:

- 1) OPAs
- 2) NGOs involved with older people, including implementing partners
- 3) Government authorities involved with healthcare services and/or OPAs, at both national and sub-national levels
- 4) United Nations agencies involved with older people and/or healthcare services.

Potential participants were identified by HelpAge Cambodia staff and were recruited via email, phone, or in-person. The sample included 22 participants, with further details provided below (see table 5).

Table 5. Participant details

	Male	Female	Below 60 years	60-69 years	70-79 years	80+ years	Disability	Total
Participants	15	7	15	2	3	1	4	22

* Age missing for one participant

3.3 Data collection

The research team trained a local research assistant to implement data collection. KIIs and FGDs were then conducted with participants in either English or Khmer dependent on the participants' preference. Data collection took place face-to-face and via online meetings, in response to the ongoing coronavirus-19 disease (COVID-19) pandemic. KIIs and FGDs lasted for approximately 60-90 minutes. Five different interview types were used for data collection, with a specific interview guide for each stakeholder group (see research toolkit). Data were collected using closed- and open-ended questions, including interview prompts. Data were recorded using notetaking and audio recordings, which were then transcribed verbatim. Data was then translated into English and uploaded to an Excel spreadsheet for analysis.

3.4 Data analysis

The qualitative data was cleaned before analysis, with minor spelling and grammar corrections made. Thematic analysis was then used to analyse the data, which aimed to identify common patterns or themes in the data.⁵⁶ This process involved coding the data, arranging codes into sub-themes, and then grouping these into overarching themes. A deductive approach was used to identify themes relevant to the research aims stated above, then an inductive approach applied to reveal themes not anticipated in the research plan. The research team met regularly throughout this process to discuss data analysis and interpretation of results.⁵⁷

4. Phase 3: Feedback and codesign

Phase three aimed to embed local contextual information and knowledge into the research outputs. First, participants and OPA stakeholders were invited to provide their feedback on draft versions of the research results, recommendations, and research toolkit. This feedback was then discussed during

⁵⁶ Braun, V & Clarke, V 2006, 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, vol. 3, no. 2, pp. 77-101, [doi:10.1191/1478088706qp063oa](https://doi.org/10.1191/1478088706qp063oa).

⁵⁷ Braun V, Clarke V 2019, 'Reflecting on reflexive thematic analysis', *Qualitative Research in Sport, Exercise and Health*, vol. 11, pp. 589-97. [doi:10.1080/2159676X.2019.1628806](https://doi.org/10.1080/2159676X.2019.1628806).

online meetings to improve the accuracy and interpretation of the research results as well as the usability of the toolkit. These meetings also provided stakeholders with an opportunity to provide their input into the codesign of the recommendations, which aimed to improve their relevance and overall impact.

5. Results

OPAs address health issues through health education

OPAs responded to health issues through health education with their members. These sessions usually focused on two topics: the importance of regular exercise to maintaining health and eating a healthy diet. Participants mentioned that OPAs had also recently introduced education sessions on COVID-19, which included information on personal hygiene and the importance of handwashing.

Participants recalled that health education sessions were primarily conducted by OPA health focal points; however, several participants cited that these sessions were sometimes delivered in collaboration with local health centres. This collaboration included local health centre staff providing training to OPA health focal points on health issues to ensure they had appropriate and accurate information to pass onto OPA members, as well as sometimes coming and presenting the information themselves. However, the participants reported that it was sometimes difficult to organise these collaborative sessions due to challenges around coordination and planning, and a lack of funding for local health centre staff to participate in the sessions. While it was unclear whether this collaborative approach was a formal arrangement between OPAs and the local health centre, participants reported a desire to conduct these sessions on a more scheduled or regular basis.

OPAs identify and respond to health issues through health check-ups and referrals

OPAs aimed to identify and respond to health issues by conducting health check-ups with members. Participants reported that OPA health focal points mainly carried out health check-ups, which included screening members for a range of health concerns such as high blood pressure, cardiovascular diseases, body weight, and diabetes. If a health issue was identified during these check-ups,

OPAs referred members to visit the local health centre or nearest hospital for further investigation and treatment. To ensure they received appropriate health care, some OPA members also required assistance to identify an appropriate health care provider and then were accompanied to the centre for their consultation.

Participants reported some involvement of government health authorities in conducting health check-ups for older people. Several participants noted that local health centres had conducted health screening for OPAs, however, these activities had recently been suspended due to the COVID-19 pandemic. Participants cited their desire for health authorities to recommence these health check-ups when safe to do so. Relatedly, some participants recalled that provincial health departments had also conducted mobile clinics and check-ups with their community. However, participants reported that these mobile clinics mainly focused on the general population, women, or children. This supported calls for more inclusion of older people in these outreach services.

OPAs provide home visits to support vulnerable members

Participants recalled that older people in Cambodia are often isolated and regularly left at home alone while their adult children migrated for work. Due to decreased mobility, participants reported that this situation left older people vulnerable in terms of access or transportation to local health centres or hospitals, medication adherence, and/or self-care. OPAs addressed this issue by conducting home visits to vulnerable members. During home visits, support included providing cash for food or medication, social engagement, and assistance with household tasks like cooking, cleaning, and self-care. OPA meetings were used to identify vulnerable members and their needs, assign a volunteer to conduct home visits, and allocate financial resources for cash or in-kind support. One OPA reported that they contacted older people's children to inform them if their older parents were unwell or required increased support.

OPAs provide support for members to access health services

OPAs provided support for members to access health services. This support mainly involved providing members with a small cash disbursement to pay for transportation to visit a local health centre or hospital for treatment. Several

participants also recalled that OPAs provided money to members to help pay for essential medications. OPAs sometimes conducted fundraising campaigns to pay for these support activities. For example, participants recalled that OPAs often organise blessing ceremonies for their members and the community. These ceremonies are organised to raise financial support for sick OPA members and their families, provide emotional and spiritual wellbeing, and raise funds to pay for medical expenses, such as to visit a health centre or pay for medication. Similarly, another participant described an initiative where they have a donation box in the village for their 'Elders Fund', which had so far received 10 million Cambodian riel in donations since its conception, to be used to support older people in a variety of areas.

Government called to improve access ID Poor card and introduce Senior Citizen's Equity card

Participants recalled that OPAs helped their members to obtain an ID poor card. This card grants access to the HEF, which entitles them to free or subsidised health care services. Helping OPA members to access the ID poor card was described as useful and cost-effective approach for increasing older people's access to health services. However, some participants reported challenges with this process. For example, one participant recalled that the process for assessing their eligibility and then obtaining the ID poor card were difficult and time-consuming. This was described as a potential barrier for more vulnerable OPA members to access the concession. Another participant said that there were no government policies or programs focused on increasing older people's access to ID poor cards, as this was the responsibility of individual communes. To this end, participants made calls for increased government action to help more older people access ID poor cards.

Participants reported that the ID poor card was not entirely suitable for older people in Cambodia. For example, applicants must meet a narrow eligibility criteria to obtain an ID poor card, which is based on a basic income test to determine if they are "poor". Although this eligibility criteria might be suitable for identifying those in very low-income groups, it does not account for the unique vulnerabilities of older people. Consequently, many vulnerable older people and OPA members are not eligible to obtain an ID poor card – even

though they might be experiencing significant financial barriers to access health care. To address this issue, several participants proposed that the government introduce a concession card specifically for older people. The eligibility criteria for this “Senior Citizen Equity” card could better align with the unique financial and social circumstances of older people. Concessions provided under the “Senior Citizen Equity” card could also be matched with the types of health and social care services that older people require for healthy ageing.

Health clinics and hospitals to improve service quality for older people

Participants claimed that health centres and hospitals could provide more acceptable and high-quality services for older people. For example, some participants cited that health centres should focus more on the specific needs or health concerns of older people, as services are currently targeted at meeting the requirements of the general public, mothers, or children. Participants also claimed that public health care centres – and the health system in general – need to focus more on NCDs, as they currently fail to provide the necessary services for early diagnosis and treatment for common NCDs like diabetes, or access to assistive devices such as wheelchairs or spectacles. More specifically, participants recalled that the public health system and health centres lack the essential medications for the types of diseases that are common among older people, particularly for NCDs such as hypertension and diabetes.

A lack of focus on older people extended to insufficient resources and training for health care workers. For instance, one participant recalled that there is no “essential track guideline” for health care providers to diagnose, treat, and prescribe medications for older people. It was reported that doctors and medical staff are not adequately trained to provide medical services for the unique health concerns and needs of older people. This is particularly evident in rural settings. Discrimination of older people was also an issue, with several participants recalling that health service providers sometimes described health concerns of older people as “*older people diseases*.” As a result, older people are often not provided with adequate care or treatment, resulting in a barrier to OPAs linking with health systems.

Inclusion of older people with disabilities was also an issue with health services in Cambodia. Participants cited that health centres lacked programs and facilities for older people with disabilities. One participant recalled that health centres had some basic facilities to help with mobility for older people. However, participants mainly reported that health centres did not provide any specialised or increased support for older people with other disabilities. This was identified as a major concern for the health and wellbeing of OPA members with disabilities, particularly regarding their access to health care and social support.

OPAs advocate with health care providers to respond to the health issues of older people

There was some evidence that OPAs raised health issues or concerns with health care providers on behalf of their members. For instance, one participant recalled how their OPA met with local health centre authorities and the health centre committee members to raise concerns about older people's health issues and needs. Another participant recalled that advocating and working alongside health centre authorities and the health centre committee members was a useful way for OPAs to increase access to health services for their members, as well as for improving the quality of those services to meet the needs of older people.

Proposed models for linking OPAs with health systems

Participants proposed models for linking OPAs with the health system in Cambodia. First, a participant recalled how one OPA developed a strong link and relationship with health authorities by including civil servants on its OPA committee. This included appointing the local health centre nurse as an OPA health focus point and appointing the village chief, commune chief, a school principal, and a teacher as members of the OPA committee. According to the participant, overlapping these roles created a collaborative arrangement between the OPA and the health system in order to address the health concerns of older people in that community.

Participants also proposed that OPAs could invite village health support groups (VHSG) to conduct health activities for OPA members or become OPA committee members. The VHSG is a formal component of MoH's public health system and is comprised of two community members selected by the community to provide

basic health services and outreach. According to participants, VHSGs could support OPA health focal points to conduct health education sessions and health check-ups for members and create a bridge between OPAs and government health system at community level. However, participants reported that this arrangement might be challenging because most VHSGs concentrate on more general health issues or those concerning mothers and children such as immunisation programs. Despite this, this model might be useful for creating stronger linkages between OPAs and the health system.

Advocate to prioritise older people in COVID-19 vaccination strategy

A government official suggested that the COVID-19 pandemic poses a significant threat to older people in Cambodia but also that OPAs and older people's organisations had not advocated the government to prioritise older people in any future COVID-19 vaccination strategy or policies. Consequently, the government official recommended OPAs and their networks increase their advocacy efforts around COVID-19 policies in Cambodia to highlight the increased vulnerability of older people during this pandemic and thus their increased need for health protections. Similarly, the government should ensure that older people are prioritised in future vaccination and health care programs as well.

6. Recommendations

1. Strengthen collaboration between OPAs and local health authorities to improve health education

OPAs should aim to strengthen collaboration with local health authorities, specifically commune councils, and health centre managers and management committees. OPAs could request these authorities to provide increased support to carry out health education sessions with members or providing training and resources to OPA health focus points on health education topics. OPA focal points could then pass this information onto their members, leading to improved quality and relevance of health education topics delivered. To strengthen collaboration, OPAs could also invite local health authorities to join the OPA leadership committee – an approach that had been successfully implemented and recommended by one OPA in the current research. In addition, OPA health focal points could invite VSHG members to contribute to health education

sessions, which would provide opportunities to share resources and knowledge about the kind of health threats and concerns of older people in that community.

2. Establish agreement and shared schedule for OPAs and local health authorities to conduct health check-ups

This research demonstrated that local health authorities and OPAs collaborate to deliver health check-ups for members. This approach has potential for strengthening linkages between OPAs and the health system, as well as improving early detection of diseases and referral processes for older people requiring further treatment. To scale up this collaborative approach, OPAs and local health authorities should establish agreements and shared schedules to conduct these health checks on a regular basis. Key stakeholders in this arrangement could be local health centre managers and management committees.

3. Increase promotion of and access to ID poor system among OPA members.

OPAs should work with commune councils to increase promotion of and access to ID poor cards for members. Helping OPA members obtain this concession was identified as a successful and cost-effective approach for increasing older people's access to health services. OPAs should work with commune councils to make the eligibility screening and application processes for the ID poor card more streamline and accessible for older people.

4. Advocate for Senior Citizen Equity card for older people

HelpAge Cambodia and the Cambodian Ageing Network should advocate with national-level authorities to introduce a Senior Citizen Equity card. This eligibility criteria for and concessions provided with this card would be specifically aligned with the unique financial and social vulnerabilities of older people in Cambodia. The introduction of this Senior Citizen Equity card would overcome some of the limitations associated with the ID poor card system, which is not entirely suitable for assisting older people to access the health care and social support needed for health ageing.

5. Advocate for increased focus on NCDs at sub-national level health care providers

This research suggested that health centres and referral hospitals may not provide the necessary services, treatments or medications for NCDs, which are common among older Cambodians. To address this issue, HelpAge Cambodia and the Cambodian Ageing Network should advocate to national-level authorities of the MoH to increase their efforts on service improvement for NCDs at sub-national levels of their health system. These advocacy efforts should be aligned with aims around improving service quality for NCDs as listed in MoH's *National Multisectoral Action Plan for the Prevention and Control of Noncommunicable Diseases 2018- 2027* and the *National Health Care Policy and Strategy for Older People*. HelpAge Cambodia and the Cambodian Ageing Network should also aim to raise these with national-level working groups on NCDs.

6. Advocate for prioritisation of older people in COVID-19 vaccination policy

Given the threat that COVID-19 poses to older people, participants in this research identified that OPA members and older people should be given priority access to any COVID-19 vaccinations. To this end, HelpAge Cambodia and the Cambodian Ageing Network should advocate national health authorities to prioritise older people in any ongoing or future COVID-19 vaccination policy. OPAs and OPA Federations could also assist the relevant health authorities in roll-out of any COVID-19 vaccines at the provincial and commune levels.

7. Expand home-care and support to access health services and treatment

This research identified positive examples of OPAs providing vulnerable members with home-care and support (transportation or cash) to access health services and treatment. Given the social, physical and financial isolation that some older people face in Cambodia, these informal support services provide vulnerable members with crucial social engagement and care and improved support to access to health care and treatment. OPAs and OPA Federations should aim to raise awareness around the success of this approach among other OPAs (including government OPAs) and health authorities, sharing their success

stories and model for providing home-care and support for vulnerable members to access health care and treatment.

7. Limitations

The research findings should be considered in light of several limitations. First, participants were recruited using a nonprobability, convenience sampling method. Consequently, the sample should not be considered to be representative of all OPA stakeholders in Cambodia. Second, several interviews were conducted online, which limited the research team's capacity to build rapport with participants. This may have limited the depth of the qualitative data collected during some interviews. Third, the research team are not Cambodian citizens and were not present in Cambodia for most of the research. These cultural and geographic barriers could have hindered the research team's ability to capture some of the more nuanced contextual information during interviews and access documents that were available only in the local language. To address these limitations, however, the research results, recommendations, and toolkit were shared with participants and stakeholders to provide their feedback and input as per the phase 3 methodology, the research assistant was a Cambodian national. This approach helped to improve the contextual and overall quality of the research outcomes.

8. Conclusion

This research aimed to identify strategies for appropriate integration of health and care activities of OPAs into health and social welfare systems in Cambodia. Phase one of this research showed that Cambodia is experiencing an ageing population, with older people experiencing increased vulnerabilities due to social isolation and remoteness, poverty, and lack of access to clean water and sanitation. An increasing burden from NCDs and barriers to accessing health care also represent challenges. Phase two of the study demonstrated that OPAs addressed their members' health concerns through health education, screening, and social support. Collaboration between OPAs and health authorities provided examples of how OPAs can integrate with health systems at the commune level.

While OPAs assisted members to access ID Poor cards, participants called for the introduction of a Senior Citizen Equity card, which better aligns with the use health and social vulnerabilities of older people. Other recommendations included advocacy for increased focus on NCDs and prioritisation of older people in vaccination programs such as COVID-19. Phase three involved participatory review processes in order to contextualise the research and make it a usable document. In conclusion, this study revealed that OPAs could be an appropriate model for addressing older people's health concerns in Cambodia and other low-income countries in Asia and should be actively promoted as such.

9. Annexes

9.1 Annex 1: Policies and older people – global

Name of Policy	Year(s)	Endorsed by	Overview
<i>Political Declaration and Madrid International Plan of Action on Ageing (MIPAA)</i> ⁵⁸	2002	United Nations	Article 15 is particularly relevant to this research, stating that <i>'we recognize the important role played by families, volunteers, communities, older persons organizations and other community-based organizations in providing support and informal care to older persons in addition to services provided by governments.'</i>
<i>Sustainable Development Goals (SDGs)</i> ⁵⁹	2015	United Nations	Establishment of OPAs supports several SDGs, but <i>SDG 3: Good Health and Wellbeing</i> is particularly pertinent to this research. Target 3.8 aims to <i>'achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.'</i>

⁵⁸ United Nations 2002, Political Declaration and Madrid International Plan of Action on Ageing (MIPAA), United Nations, Department of Economic and Social Affairs, <https://www.un.org/esa/socdev/documents/ageing/MIPAA/political-declaration-en.pdf>.

⁵⁹ United Nations 2021, Sustainable Development Goals, United Nations, <https://www.un.org/sustainabledevelopment/sustainable-development-goals/>.

Name of Policy	Year(s)	Endorsed by	Overview
UHC⁶⁰	N/A	N/A	UHC is an important aspect when considering health systems for older populations, particularly in contexts where health systems and/or resources are limited. WHO defines UHC as <i>'ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship.'</i>
World Report on Ageing and Health⁶¹	2015	WHO	Developed in response to MIPAA progress, the report outlines key challenges and opportunities relevant to promoting health in a demographically shifting world, including the need to uphold older people's rights, the diversity found within older populations and the links between supporting ageing populations and global development agendas. It also describes how the requirements of (often poorly aligned) health systems must adapt to the needs of older people, including addressing barriers such as cost and past negative experiences. OPAs are specifically recognised as a solution for supporting healthy ageing.

⁶⁰ WHO 2019, Universal Health Coverage, WHO, [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)).

⁶¹ WHO 2015, World report on ageing and health, WHO, https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf;jsessionid=181420C891CCB883FACBC3FD32EE16F1?sequence=1.

Name of Policy	Year(s)	Endorsed by	Overview
<i>Global Strategy and Action Plan on Ageing and Health</i> ⁶²	2017	WHO	This global strategy has five primary objectives: to get countries to commit to action, to develop age-friendly environments, to align health systems to the needs of the older populations, to develop sustainable and equitable systems of long-term care, and emphasise improved data, measurement, and research, and involve older people in all decisions that concern them.
<i>WHO Decade of Healthy Ageing (2021-2030)</i> ⁶³	2020	WHO	This ten-year plan outlines a global strategy for focused efforts to enhance the lives of older populations. Four areas of action are explicitly described, including: changing how we think, feel and act towards age and ageing; ensuring that communities foster the abilities of older people; delivering person-centred integrated care and primary health services responsive to older people; and providing access to long-term care for older people who need it.

⁶² WHO 2017, Global Strategy and Action Plan on Ageing and Health, WHO, <https://www.who.int/ageing/GSAP-Summary-EN.pdf?ua=1>.

⁶³ WHO 2021, Decade of Healthy Ageing 2021-2030, WHO, <https://www.who.int/initiatives/decade-of-healthy-ageing>.

9.2 Annex 2: Policies and older people – Cambodia

Name of Policy	Year(s)	Endorsed by	Overview
National Population Policy ⁶⁴	2016-2030	Ministry of Planning (MoP)	One of this policy's key objectives is to 'ensure social and health security to all elderly persons and specifically those living below the poverty line,' supported by four policy directions. Developed with technical assistance from United Nations Population Fund (UNFPA), this policy acts as an umbrella policy, encompassing other policies including the <i>National Ageing Policy</i> .
National Multisectoral Action Plan for the Prevention and Control of Noncommunicable Diseases ⁶⁵	2018-2027	MoH	This policy aims to address the increasing burden of NCDs in Cambodia, predominately cardiovascular disease, cancer, chronic respiratory disease, and diabetes. It acknowledges that addressing NCDs requires a multisectoral response, highlighting the need for action by various ministries and sectors beyond the MoH. To this end, the policy includes two strategy priority areas: 1) Reduce population exposure to noncommunicable disease risk factors, and 2) Strengthen multisectoral governance and resources for NCDs. Under strategy 1, the following activities are presented: 1) Accelerate tobacco control, 2) alcohol control, 3) promote healthy diet and physical activity, and 4) reduce exposure to indoor air pollution. Under strategy 2, the following activities are presented: 1) Develop multisectoral actionable plan and accountability mechanism, 2) Create an NCDD fund from tobacco and alcohol taxes.

⁶⁴ MoP 2015, National Population Policy 2016-2030, MoP, https://cambodia.unfpa.org/sites/default/files/pub-pdf/NPP_2016_2030_Booklet_%28English%29.pdf.

⁶⁵ MOH 2018, National Multisectoral Action Plan For The Prevention And Control Of Noncommunicable Diseases 2018- 2027, MoH, http://moh.gov.kh/content/uploads/2017/05/NMAP-NCD_-13-06-2018-Signed_En.pdf.

Name of Policy	Year(s)	Endorsed by	Overview
National Ageing Policy ⁶⁶	2017-2030	MoSVY	<p>Endorsed by the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY), this policy is a revised version of the 2003 <i>Policy for the Elderly</i> and falls under the umbrella <i>National Population Policy</i>. It aims to mainstream ageing into development procedures through nine priority areas, and functions alongside the 3-year <i>Action Plan for National Ageing</i> policy. The policy’s vision is to “continuously enhance and improve the quality of life of older persons in Cambodia with emphasis on ensuring them equal rights and opportunities” (p. 19). To this end, the policy includes two strategic goals: 1) “to ensure that older persons are enabled to fully participate with freedom and dignity for as long as they wish to in family, community, economic, social, religious and political activities”, and 2) “to ensure that younger persons are better equipped with knowledge that enables them to lead a more productive, healthy, active and dignified life in old age” (p. 19). The nine priority areas included in the policy are: 1) Ensuring financial security, 2) Health and Well-Being, 3) Living Arrangements, 4) Enabling Environment, 5) Older People’s Associations (OPAs) and Active Ageing, 6) Intergenerational Relations, 7) Elder Abuse and Violence; and 8) Emergency Situations. The policy also recognises Cambodia’s ageing population, acknowledging the intergenerational roles of both children and parents in ageing processes, whilst reinforcing the need to consider Khmer traditions in support for older people. However, the policy lacks details on how planned activities will lead to improved health and wellbeing outcomes for older people in Cambodia.</p>

⁶⁶ MoSVY 2017, National Ageing Policy 2017-2030, MoSVY, https://cambodia.unfpa.org/sites/default/files/pub-pdf/NAP%202017-2030_%20Final_English-Printed.pdf.

Name of Policy	Year(s)	Endorsed by	Overview
Action Plan of National Ageing Policy⁶⁷	2018-2020	MoSVY	This action plan is an outline of actionable approaches, including indicators, targets, cost, timeframes, and responsible ministries for ensuring implementation of the <i>National Ageing Policy</i> for 2018-2020.
National Health Care Policy and Strategy for Older People⁶⁸	2016	Ministry of Health (MoH)	This policy aims to promote ' <i>establishment of an age friendly environment in which the health system safeguards intrinsic capacity and functional ability through effective health interventions.</i> ' This objective will be achieved through six primary strategies: improving advocacy, awareness-raising and information sharing towards the integration of older people's health issues at all levels, promoting multi-sector collaboration and public-private partnerships towards integrated health services for older people in a continuum of care, health system strengthening to respond to the health needs of older people, research and knowledge management, human resources development, and social protection schemes. This policy has been launched but is very limited in implementation with only few actions (less than 10% of those proposed) taken by the MoH.

⁶⁷ MoSVY 2017, Action Plan of National Ageing Policy of National Ageing Policy 2017-2030, MoSVY, <https://www.helpagecambodia.org/wp-content/uploads/2020/04/National-Ageing-Policy-Action-Plan-2018-2020-Eng.pdf>.

⁶⁸ MoH 2016, National Health Care Policy and Strategy for Older People, MoH, Preventive Medicine Department, http://staging.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/cambodia/cambodia_national_health_care-policy-strategy-ageing-2016.pdf.

Name of Policy	Year(s)	Endorsed by	Overview
National Strategic Development Plan (NSDP)⁶⁹	2019-2023	MoP	The <i>NSDP 2019-2023</i> has limited discussion on promotion of health in older populations; however, section 7.3 describes increasing health service delivery. The policy also mentions establishment of 1,646 OPAs and potential for an elderly fund to be created, as well as the need for UHC and engaging community members and subnational levels in health activities.
Guidelines for the establishment and management of OPAs⁷⁰	2009, updated 2013	MoSVY	The guidelines outline processes for establishing and maintaining sustainable OPAs in Cambodia and were developed with support from HelpAge International and UNFPA. There are challenges with implementation due to disconnect between national and subnational levels, variation in commune level support, and a lack of specificity as to how government and OPAs should interact on an ongoing basis.

⁶⁹ MoP 2019, NSDP 2019-2023, MoP, https://data.opendevloppementmekong.net/dataset/087e8a03-f09d-4eb2-94f2-00d8d237b342/resource/bb62a621-8616-4728-842f-33ce7e199ef3/download/nsdp-2019-2023_en.pdf.

⁷⁰ MoSVY 2009, Guidelines for the establishment and management of OPAs, MoSVY, <https://www.helpage.org/silo/files/guidelines-for-the-establishment-and-management-of-older-peoples-associations-opas.pdf>.

Name of Policy	Year(s)	Endorsed by	Overview
National Social Protection Policy Framework⁷¹	2016-2025	CRDB and CDC	<p>Endorsed by the Cambodian Rehabilitation and Development Board (CRDB) and the Council for Development of Cambodia (CDC), this policy outlines shifts away from traditional support sources for older people (such as pagodas and families) as well as challenges with pension implementation. The primary goal of the framework is to “ensure income security and reduce economic and financial vulnerability of its citizens.” (p. x). The framework focuses on two pillars: Social Assistance and Social Security. Social Assistance includes actions on the following areas: 1) emergency response, 2) human capital development, 3) vocational training, and 4) welfare for vulnerable people. Social Security focused on five areas: 1) pensions, 2) health insurance, 3) employment injury insurance, 4) unemployment insurance, and 5) disability insurance. The policy includes the National Social Security Fund (NSSF) and ID Poor system. The NSSF includes several components, including Employment Injury Insurance (with support from the International Labour Organization) and social health insurance for those working in the formal sector. There are also pensions for civil servants. The ID Poor system provides support to those most vulnerable, and the policy proposes an elderly people protection program for those who hold an ID Poor card. Adaptation of this policy was part of a broader rethink of the <i>National Social Protection Strategy for the Poor and Vulnerable (NSPS-PV) 2011-2015</i>. There is still a fragmented approach to implementation between responsible ministries. Only 5% of the elderly are eligible for</p>

⁷¹ CRDB & CDC 2017, National Social Protection Policy Framework 2016-2025, CRDB & CDC, http://cdc-crdb.gov.kh/en/twg-jmi/sector_strategy/National_Social_Protection_Policy_en.pdf.

Name of Policy	Year(s)	Endorsed by	Overview
<p>National Social Protection Policy Framework (Cont.)</p>			<p>pension under this scheme. Challenges include that it is not inclusive to all who are vulnerable, driven by factors such as high levels of employment outside of civil service and increasing older populations. Pensions for private sector may start in upcoming years, but pensions for informal sector is unlikely at this stage. Recent support from development partners during COVID-19 is hoped to have advanced data collection and management of the ID Poor system.</p>

HelpAge International is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.

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