Report

Building political ownership and technical leadership

Decision-making, political economy and knowledge use in the health sector in Cambodia

Harry Jones

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Harry Jones and the Cambodia Economic Association Centre for Policy Studies

Key messages

- The health sector is marginal to core political interests in Cambodia and donors play an influential role
- A relatively strong demand for knowledge in policy is belied by selective implementation, and challenges of institutional mis-alignment, poor pay and low capacity
- The supply of knowledge on health in Cambodia is fragmented and there are many missed opportunities for linking research and policy
- Politically savvy programming should attempt to 'go with the grain' of some political economy dynamics, facilitating and enabling government ownership of service delivery
- Research and technical support at decentralised level should be given high priority

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Abbreviations

ADB	Asia Development Bank
ASEAN	Association of South East Asian Nations
AusAID	Australian Agency for International Development
CBHI	Community-based health insurance
CDRI	Cambodia Development Resource Institute
CPP	Cambodian People's Party
CRDB	Cambodian Rehabilitation and Development Board
GDCC	Government-Donor Coordination Committee
HCMC	Health Centre Management Committee
HEF	Health Equity Fund
HSSP II	Health Sector Programme Support II
IDPs	International development partners
MEF	Ministry of Economy and Finance
MoH	Ministry of Health
MoP	Ministry of Planning
NCHADS	National Centre for HIV/AIDS, Dermatology and STD
NGO	Non-Governmental Organisation
NHIS	National Heath Information System
NIPH	National Institute for Public Health
NMCH	National Maternal and Child Health Centre
OD	Operational health district

ODI	Overseas Development Institute
PHD	Provincial health departments
PM	Prime Minister
SNEC	Supreme National Economic Council
SWiM	Sector-wide management approach
TWG	Technical Working Group
TWGH	Technical Working Group for Health
UNDP	United Nations Development Program
VHSG	Village Health Support Group
VHSGs	Village Health Support Groups

Executive summary

This study looks at the dynamics of decision-making in the health sector in Cambodia. Taking a broad view, from the formulation to the implementation of health policy, it assesses how knowledge, policy and power interact to shape processes, decisions and outcomes. It was commissioned by the Social Development Research Centre of AusAID in Canberra, carried out in partnership with AusAID Cambodia, and undertaken jointly by the Overseas Development Institute (ODI) and the Centre for Policy Studies of the Cambodian Economic Association.

1.1 Sector background and history

In line with broader trends of economic, political and social transformation since Cambodia's emergence from conflict, there has been an overall improvement in health-related indicators. Reforms since the 1990s have focused on building universal access to quality healthcare, and have attempted to build universal coverage and improve health service management and governance. The current system is structured within the Ministry of Health (MoH) with a broad mandate that includes development of policies, resource mobilisation, monitoring and evaluation, and training. Service delivery is delegated to line departments, provincial health departments (PHDs) and operational health districts (ODs). Despite good progress, the sector faces on-going challenges in maternal mortality and child nutrition, issues with access for the poor, and governance problems.

1.2 Political economy of the health sector

The politics of health in Cambodia: The health sector is marginal to the core strategic interests of the (dominant) ruling party in Cambodia, the Cambodian People's Party (CPP), as there is less scope for capturing rents. This means that there is relatively more space for evidence-based management of the sector, although issues which do present some opportunities for rent-capture (e.g. drugs procurement) have nonetheless proven resistant to reform. The route to greater government ownership of the sector would be for health-related activities to be seen by the CPP as a way to win legitimacy at the ballot box through 'gift giving', as part of mass patronage practices, as this could see high efficiency, low leakage and the beginning of a 'results-based' accountability relationship with citizens. Although at the moment health is not strongly prioritised as a 'gift' for CPP constituents, there are some suggestions that the Government is taking increased ownership, and some indications that health-related gifts are being given.

The role of donors: International development partners (IDPs) are highly influential in the sector, due to the very large proportion of the budget funded by aid. Donors tend to have a high level of influence on the sector's agenda and on policy-making; the MoH has strong incentives to maintain good relations to keep funds flowing. However the Government

implements measures only selectively, and often only when they come with additional financing. A clear impact of IDP influence is a high level of fragmentation, at the policy level but possibly even more so at the implementation level, with many donors channelling funds through NGOs and a high instance of pilots without many examples of 'scale up'.

Ministry decision-making: Decision-making in the MoH is fairly hierarchical and centralised, as a result of the elite patronage system. Formal processes and products are of relatively low importance for decision-making, compared to behind-the-scenes negotiations. Staff with good technical knowledge hold some powerful positions in the ministry, probably due to requirements of dealing with donors, but whatever the reason, this is a major asset to the sector. Technical staff are nonetheless restricted in their operations, constrained like all civil servants by the realities of the patronage system. These factors lead to a strong role for a few key personalities in the ministry, hence, the embedding of technical capacities in the ministry is at a relatively early stage.

Service delivery: Ownership of and accountability for service delivery is hampered by institutional issues at the decentralised level, in particular the non-alignment between the health system and local government structures. Health service delivery is undermined by poor incentives for health workers, which leads to low capacity and a lack of skilled health professionals, however the Government has no real political will to increase salaries for the civil service.

1.3 The knowledge-policy interface

Demand for knowledge and research: At the policy level there is relatively strong demand for knowledge and research. The demand is relatively broad and 'agnostic' where IDP financing is involved, but practical knowledge, as well as regional and especially Cambodian voices of experience seem particularly influential. The demand for knowledge is not well institutionalised in the MoH and the demand for technical information is particularly low at the implementation level.

Supply: A large amount of research is produced in the sector in the form of reviews and assessments for specific projects and programmes, while the domestic research community is relatively weak on health. This has led to a fragmented knowledge base, especially given that no stocktaking or syntheses are produced.

Linking: Some established channels for feeding ideas and analysis into policy-making are relatively functional, such as MoH taskforces and technical working groups. However, the overall picture is of a multitude of missed opportunities for linking research and policy, predominantly because of poor engagement. At the implementation level, there are few well-functioning processes for bridging knowledge and action, and one of the most crucial policy spaces, budgetary disbursements to the districts, is entirely lacking in systems for drawing on health-related evidence.

1.4 Recommendations

For the next phase of AusAID programming:

- Politically savvy programming should attempt to 'go with the grain' of some political economy dynamics, and should attempt to encourage and facilitate increasing government ownership of service delivery. Efforts to tackle issues of rent-seeking need to be realistic and well informed.
- A sustainable model should be built for evidence-informed management of the sector by focusing on the demand for, and supply of, knowledge and intermediary functions.
- High priority should be given to support at the decentralised level.

Suggestions which could be implemented immediately:

- Action on pressing issues should begin with a study on decision-making and political economy at decentralised levels, to identify opportunities for improving health governance and outcomes. Other gaps in knowledge would need to be filled now to inform the next phase of support.
- Ongoing issues include drawing more regularly on political economy analysis, building a better understanding of and/or engagement with the CPP, taking a targeted approach to engagement with key individuals, and making much greater efforts to publish and communicate research findings in Khmer and English.

2 Introduction

This study looks at the dynamics of decision-making in the Cambodian health sector. Taking a broad view from the formulation to the implementation of health policy, it assesses how knowledge, policy and power interact to shape processes, decisions and outcomes. It attempts to combine a political economy perspective with a view of the production and use of knowledge, in order to generate practical recommendations for programming and engagement in the sector, as well as measures to improve evidence-informed policy and practice.

It was commissioned by the Social Development Research Centre of AusAID in Canberra, and carried out in partnership with AusAID in Cambodia. The research was undertaken jointly by the Overseas Development Institute (ODI) and the Centre for Policy Studies of the Cambodian Economic Association. The study draws on a review of published academic literature, systematic document reviews, more than 30 key informant interviews, field trips and two illustrative case studies (see appendix 1). The study could have been made more methodologically robust with more time and greater resources, but given these practical constraints, we have provided an analysis which is relatively comprehensive and which the authors believe provides a decent degree of accuracy concerning the salient issues in the sector. The purpose of the study was also to test and refine a methodology for assessing the knowledge-policy interface and for building practical recommendations from that, so there was some degree of experimentation and methodological adjustment throughout the process.

The study is structured as follows: Section A gives an overview of the health sector in Cambodia and its organisation; Section B discusses the key political economy dynamics of the sector, and their implications; Section C analyses the interface between knowledge and policy in the sector; and Section D outlines key recommendations. Appendix 1 provides two illustrative case studies and appendix 2 provides a table summarising the influence of different types of knowledge on policy in the sector.

3 Key facts and formal organisation of the sector

3.1 Current situation in the Cambodia health sector

By the turn of the century, Cambodia began to move away from a post-conflict context into an era of economic, political and social transformation. In the health sector, there has been an overall improvement in health related indicators. The HIV/AIDS prevalence rate declined from 1.6% in 2000 to an estimated 0.7% in 2009, and was projected to decline and stabilise at 0.6% after 2010. Malaria cases declined from 11.4% in 2000 to 4.4% in 2008, while the fatality rate was 0.335% in 2009, below the Cambodian Millennium Development Goal (CMDG) of 0.4%. The prevalence of all forms of tuberculosis per 100,000 people declined from 928 in 1997 to 664 per 100,000 people in 2007 (MoP, 2010). The under-five mortality rate decreased from 124 deaths per 1,000 live births in 2000 to 83 per 1,000 live births in 2005, and to 54 in 2010. The overall improvement in health outcomes is the result of various reform efforts since the early 1990s that have led to improved physical infrastructure and service delivery.

Despite the positive trends, the health sector in Cambodia needs to overcome a number of critical challenges to the quality of health services and access to service delivery. Two issues—maternal mortality rate and child malnutrition—remain a great challenge. While the maternal mortality rate has seen a significant drop from 472 per 100,000 live births in 2005 to 206 in 2010 (MoH, 2010), it remains high compared to South-East Asia's average at 145[1]. Child malnutrition has experienced some improvement; the rate of children under five with stunted growth (height for age) declined from 50% in 2000 to 40% in 2010. However, this rate is still "17 times of what is expected in a healthy population" (Martinez et al., 2011 p.31).

Access to quality health services is a key problem for Cambodian people, despite continuous increases in government expenditures in the health sector. The budget for health has risen 20% over the past several years, reaching $167 million in 2011 (CDC-CRDB, 2011), constituting 12% of the overall government budget. Statistics indicate that as a percentage of overall government spending, Cambodia leads other countries in South-East Asia with the exception of Thailand[2]. However, given its low base, the amount has not met the financial needs that accompanied population growth. Inadequate public health financing results in low staff salaries, leading to a lack of incentive for service delivery, drug shortages and under-funded, under-maintained health facilities. The poor quality of service delivery in the public health sector has led to increased use of private health services which constitutes (without counting self-help) approximately "two thirds of care episodes" (World Bank, 2011, p. 4). The use of private services has not only led to high out of pocket expenditures, but also exposes patients to unregulated and poor quality services[3]. As one third of Cambodians live below the poverty line, most of them in rural areas, and a large proportion live barely above the poverty line, the high out-of-pocket expenditure on health will potentially drive the rural poor deeper into poverty.

1 Calculated from maternal mortality rates in World Development Indicators 2010, http://data.worldbank.org/indicator/SH.STA.MMRT (accessed 23 July 2012): 3 in Singapore, 24 in Brunei, 29 in Malaysia, 48 in Thailand, 59 in Vietnam, 99 in the Philippines, 200 in Myanmar, 220 in Indonesia, 300 in Timor Leste and 470 in Laos.

2 According to the World Bank (2012), public health expenditures as a percentage of government expenditure in the region are as follows: Brunei 8.5; Myanmar 1; Cambodia 10.5; Indonesia 7.8; Laos 5.9; Malaysia 9.2; Philippines 7.6; Singapore 8; Thailand 12.7; and Vietnam 7.8.

3 Use of private health services increased from 48.2% to 56.8% of all health services in 2010. The public sector's share of service provision was only 21.6% in 2005 and increased slightly to 28.9% in 2010. See, Ministry of Health, National Health Strategic Plan 2008-2015, 44. It should be noted that some private hospitals such as the Kantha Bopha Children's Hospital, the Angkor Hospital for Children and the Sihanouk Hospital Center of Hope have provided the best free health care to Cambodian children and adults.

The quality of health service delivery has been impacted by the quality of health system governance. The Government's recurrent funds face problems of mismanagement, making its reach to local areas less effective than planned[4]. Consequently, there is a variation in quantity and quality of service delivery, disproportionately disfavouring rural areas and poor people. Despite some improvement, such as the addition of web-based data entry and the development of a new maternal death database and surveillance system in 2009[5], the National Heath Information System (NHIS) remains inadequate, due to shortage of staff and disincentives associated with low salaries. These conditions have impacted MoH's ability to monitor non-communicable diseases and regulate the private sector - a key health care provider.

Cambodia's heavy reliance on financial and technical support from international donors for research and health provision further circumscribes its ability to respond to health challenges. Despite discussions of improving aid effectiveness through aid alignment and harmonisation, and a sector-wide management approach (SWiM), donor funding remains largely fragmented, and insufficient coordination prevents the maximum impact on health outcomes from being achieved. Due to concern over fiduciary risk associated with weak public financial management, donors have largely chosen to channel most of their funds through NGOs. Responding to criticism of weakening the public system, a small group of donors have more recently created a common pooled fund, but many believe their inflexible guidelines continue to constrain MoH action.

3.2 Key policy and reform history

A range of health-related policy reforms, with three overarching objectives, began in the early 1990s, designed to strengthen health system management.

The first objective was to promote universal access to quality health care. Under the influence and legacy of socialism between 1979 and 1996, the Government, in theory, adopted free universal health coverage. Severe shortages of funds, personnel and infrastructure rendered health services insufficient. Beginning in 1996, the MoH devised a national health coverage plan introducing a decentralised health service system. A new health administrative system was created based on population density rather than territorial districts. It included operational districts (ODs) with a population catchment of 100,000 to 200,000 and a network of health centres with a population catchment of 10,000. Assignment of functions was delegated to ODs. With the implementation of decentralisation in 2002, elected local councils were incorporated into the new health management system by having commune chiefs serving as chair of the Health Centre Management Committee (HCMC), and village chiefs as chair of the Village Health Support Group (VHSG).

The second objective was to establish universal health coverage. An attempt was made to improve the quality of health services by introducing user fees via the National Charter on Health Financing, in order to resolve health budgetary constraints. The introduction of user fees created barriers for the poor—a challenge that led to a quest for universal coverage. In 2005, the MoH approved a master plan for social health insurance combining different schemes. The master plan contains compulsory health insurance for people in the formal sector; the Health Equity Fund (HEF) for the poor, and community-based health insurance (CBHI). The MoH later adopted a Master Plan for Social Health Protection (2009-2015) to lay out strategies and implement plans for Social Health Insurance.

Broadening access to health care was also accompanied by efforts to improve health service management and governance. The Government, with assistance from development partners, particularly the Asian Development Bank, has tried to identify different ways to improve health services. Two systems—contracting in and contracting out—were adopted (Bushan, 2004). Contracting out is an arrangement where the Government provides compensation to private providers—mostly NGOs—for their services. Contractors have total authority over staff as well as procurement. Contracting in is an arrangement that use the existing health system, but with added compensation for health management teams through budget supplements. Contracting out was piloted in 11 health districts but discontinued in 2009, due to the heavy financial burden that exceeded the MoH's budget. The MoH eventually opted for contracting in, which was first piloted in 23 districts and selected national hospitals. There was also a plan to upgrade the Health Information System as reflected in the Health Information System Strategic Plan 2008-2015.

Other key policy areas include some initiatives to address specific critical health problems including, but not limited to, HIV/AIDS prevention, maternal health, child health and nutrition. Detailed discussions will appear in later sections of this study.

4 Ministry of Health, National Health Strategic Plan 2008-2015.
5 Mid-term Review of National Health Strategic Plan, 2011.

3.3 Structure of the health system

The Ministry of Health (MoH) has a broad mandate that includes development of policies, legislation, strategies, guidelines, resource mobilisation and allocation from external and internal sources, monitoring and evaluation, research, information gathering and training. These policies and strategies are framed in line with short- and medium-term national strategic development plans.

Key actors in health policy-making include relevant technical departments within MoH, development partners, health NGOs and other ministries and national authorities and committees. MoH houses three general directorates including (i) the Directorate General for Health; (ii) the Directorate General for Administration and Finance; and (iii) the Directorate General for Inspection. The key technical body in the MoH is the Directorate General for Health, which supervises eight departments with different roles and responsibilities, including the Department of Planning and Health Information (DPHI), the Department of Health Prevention (DHP), the Department of Hospital Services (DPS), the Department of Human Resource (DHR), the Department of Essential Drug and Food (DDF), the Department of Communicable Disease Control (CDC), the Department of International Cooperation (DIC) and the Department of Internal Audit (DIA).

Besides the MoH, there are important national programmes, centres and institutions such as the National Maternal and Child Health Centre (NMCH), the National Centre for HIV/AIDS, Dermatology and STD (NCHADS) and the National Institute of Public Health (NIPH), among others. Specific health policies or guidelines can be initiated by any of these concerned technical health departments and national centres. Development partners, including both bilateral and multilateral agencies, have played important roles in Cambodia's health policy formulation and implementation, through the provision of both financial and technical assistance. Some health NGOs including MEDiCAM, Médecins Sans Frontières, and others are also well placed to provide input for health policy-making.

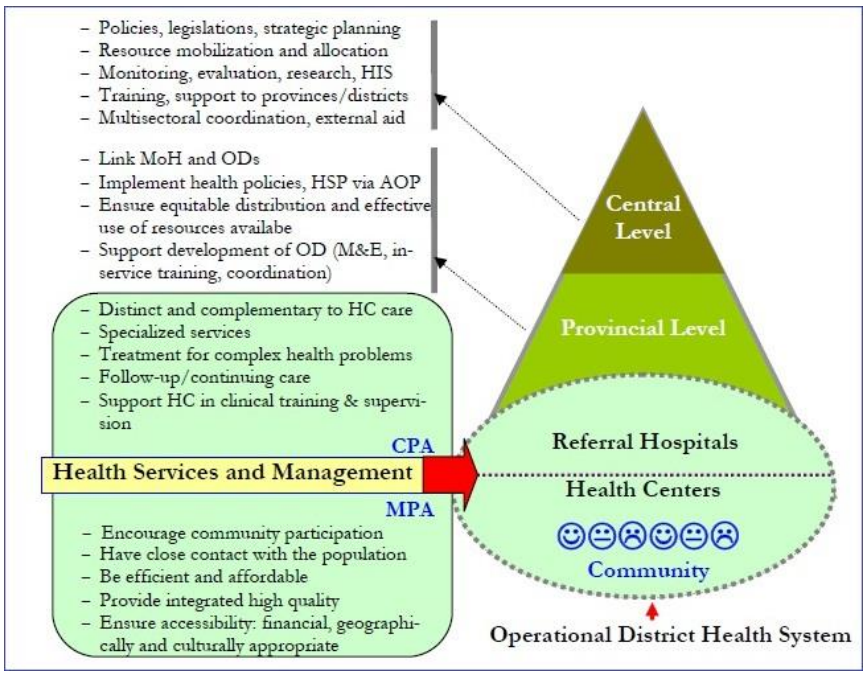
Cambodia's heavy reliance on international assistance has to a great extent shaped health policy-making. In 2004, to promote aid effectiveness and policy development dialogue, the Cambodian government and donors agreed to establish the Government-Donor Coordination Committee (GDCC). The GDCC oversees 19 Technical Working Groups (TWGs) focusing on specific thematic areas. Members of TWGs include key government officials in relevant ministries, representatives of donor agencies and NGO leaders. The key tasks of TWGs include strategy development, resource mobilisation, capacity development coordination and promoting aid effectiveness.

The Technical Working Group for Health (TWGH) within MoH plays a key role in policy development to respond to key issues in health-related matters in Cambodia. Under TWGH, there are other sub-groups working on specific health-related matters including, among others, nutrition, maternal health and HIV/AIDS. Through TWGH consultative meetings, development partners and NGOs are able to influence the policy-making process by providing key technical input.

The normal policy-making process begins with initiation by specific health departments. Major strategies/policies are first presented and discussed in a series of meetings within the relevant TWGH subgroups, which then report to the TWGH. Final products are decided by people with decision-making authority within MoH on behalf of the Cambodian Government. National level health policies and cross-ministerial issues require endorsement from a higher-level authority in the Government.

Below the MoH are its line departments, Provincial Health Departments (PHD), Operational Health Districts (OD), Referral Hospitals and Health Centres (see Figure 1 for details). As these divisions are based on population size, they do not neatly correspond to other administrative divisions of the country. The PHDs serve as liaison with MoH and are responsible for interpreting policies and implementing plans and strategies. PHDs also support the ODs to enhance service delivery and resource allocation through in-service training, monitoring and evaluation, and coordination. Health centres are health facilities closest to the community which provide basic health services, while a referral hospital provides more comprehensive services (Song and Hohmann, et al., 2003).

Figure 1: Health system organisation



Source: Ministry of Health, Health Strategic Plan 2008-2015 diagram.

4 Political economy of the health sector

This section discusses the implications of national and sector-specific political economy trends for the health sector. It assesses implications for decision-making and the policy process in the sector, highlighting key drivers of change and windows of opportunity.

4.1 The politics of health

The health sector is marginal to the political economy of rule in Cambodia. The central feature of the political economy of Cambodia is a pervasive elite patronage system, which supports and is supported by the dominance of the ruling Cambodian People's Party (CPP). Through its patronage network and formal control, the CPP is entwined with and effectively in control of all institutions of the State, including the executive, as well as the military, judiciary and police (Calavan et al., 2004). This dominant position allows the CPP and its leaders to function in a very systematic and strategic manner, extracting rents from key assets, in particular, drawing revenues from the exploitation of natural resources—timber, land, fisheries and oil (Un and Hughes, 2011) and redistributing those rents via the patronage system to help maintain the CPP's power. Key informants indicated that the health sector does not affect the CPP's core interests, and offers relatively smaller opportunities for rent capture than elsewhere.

There is more space for evidence-based management of the sector, because it is relatively marginal in this way. Efforts at reform in politically sensitive areas have frequently made no headway or produced just a façade of change with innumerable detailed plans and rich rhetoric (Calavan et al., 2004). Although there are downsides to being marginal, experience has shown that in less politically sensitive cases there is more space for rational decision-making and modernising reforms (Un and Hughes, 2011). Many interviewees felt that the health sector compared favourably to other sectors in the country, in terms of being managed in a more 'idealistic' and evidence-based manner, due to being less politically sensitive.

However, some areas of the sector present reasonable opportunities for capturing rents, and these have proven more resistant to reform and rational management. One such area is the procurement of supplies for hospitals, for example pharmaceuticals are bought at roughly six times the international market price per unit, and an unusually large proportion of the sector budget goes to such supplies (World Bank 2011)[6]; one informant called procurement "a no-touch area". Broadly speaking, as the sector is not core to CPP's strategic interests, the ability to press for reforms is relatively unpredictable and issue-specific: depending on behind-closed-doors deals between CPP and businesses, and resistant to the extent that those businesses possess influential contacts or pay large bribes to the Government.

The route to political ownership of the sector would be for health to be seen by the CPP as an appropriate 'gift' for constituents. In the past 10 to 15 years, there has been a marked trend of the CPP working to maintain power and win legitimacy not by coercion, but by presenting itself as a party that was able to provide visible infrastructure projects to rural Cambodians (Craig and Pak 2011). Through this system of 'mass patronage', party funds and personal networks are mobilised to provide gifts to constituencies as a political strategy for winning votes, in what has been labelled '*sobaraschon*' (benefactor) development (Hughes 2006). Of course, this is far from the ideal functioning of a

6 Another example of resistance to change is the regulation of private providers in the health sector. To date, Cambodia has laws on management of pharmaceuticals , laws on management of private practice of the medical profession, paramedical and medical aid services, a law on abortion, the criminal code, and Decree No.38 on Contracts and other Liabilities (for tort/negligence); however, a comprehensive medical law to regulate private medical practice is still absent.

democracy, and the effectiveness of such a system in meeting economic and social goals is certainly constrained. However, the shift of decision logic from looking to hold onto power through buying votes and coercion, to seeing some kind of service delivery as the best response, is a highly significant and potentially positive step towards a better development-oriented system.

Developmental patromonialism?

Recent pioneering research (Booth and Kelsall, 2010) has altered the way development practitioners look at patromonialism. Studies in Africa and Asia have suggested patronage systems can be 'developmental' i.e. broadly good for the economic and social progress of a country, given two criteria: rent seeking and distribution must be based around a single centralised system, and elites must have a relatively long-term horizon. Some scholars have suggested this might characterise the CPP regime in Cambodia (Heder 2005; Un, forthcoming).

This would likely lead to a much stronger drive for effectiveness and more solid foundations for accountability in the sector. In areas of service delivery and infrastructure provision where the Government feels under pressure to deliver, leaders within the sectors have the opportunity and flexibility to explore effective ways of answering the needs of the public – and success here involves working within patrimonialist norms rather than against them (Un and Hughes 2011). The system for delivering gifts is highly organised, with ministers assigned a province in a system of Provincial Working Groups, and other high ranking officials designated constituencies from the district working group. In many cases, funds are also transferred from the party's central office for provincial working groups with poor resources, and in general the money mobilised through CPP networks is distributed with almost zero leakage (Craig and Pak 2011). More generally, in sectors seen as crucial to CPP's strategic interests, corruption is restricted. One might expect that over time such gift-giving could build citizens' expectations for service delivery from the Government, and potentially a more 'results-based' accountability[7].

The current situation, however, is that health service delivery does not meet this expectation because health is not generally viewed by the CPP as having strategic importance. Preferred 'gifts' are visible, one-off, top-down projects with tangible benefits, and both CPP interviewees for this study and a recent study (World Bank 2012) suggest preferences are currently for roads, schools and other infrastructure. What constrains the health sector from being seen as suitable for giving gifts to constituents is that much of the service delivery involves recurrent expenditure, rather than once-off, many activities are not highly visible, benefits can be diffuse (e.g. preventative care, broad changes in health outcomes), and many local people do not link health service provision to their local government (through which most gifts are currently given) often choosing to go to private providers instead.

There are, however, some suggestions that the Government is taking increasing ownership of health services. CPP informants report that the achievements of the health ministry are perceived as CPP achievements, and indications from some provincial level pilots have shown ownership of services by local governments at that level (e.g. OD Angkor Chum, 2010[8]). **There are small indications that health could be increasingly seen as a good 'gift' for constituents** in order to buy legitimacy at the ballot box. It seems to be no coincidence that 100% of buildings for health centres envisaged under the coverage plan have been delivered, and there are many other top-down, one-off interventions in the sector which could be suitable (e.g. vaccinations, public toilets). There have been publicised events where the Prime Minister's wife gave nutritional supplements to children, but this has not yet been repeated on a larger scale (for more on the political dynamics around nutrition see appendix 1). The Government also increased its share for equity funds to 70%, with the remaining 30% funded by donors.

4.2 The role of donors

International development partners (IDPs) are highly influential in the sector. While a strong donor presence is a broad, longstanding national trend, it is more prominent in the health sector, probably because it is marginal to the

7 On the other hand, the CPP's pattern of gift giving contains a menacing element aimed at excluding non-supporters and rendering recipients unlikely to question the quality or value of gifts, and for this reason some have argued that it may not be a stable route towards accountability (Hughes, 2006)

8 Operational District of Angkor Chum (2010), Community Based Health Cooperative in Angkor Chum OD, Siem Reap: Sub-agreement description, September 2010.

CPP's interests and offers limited opportunities for rent capture. As a result, funds flowing into the sector from IDPs take on high importance for domestic stakeholders in the sector, illustrated by the fact that the significant majority of the MoH's budget is funded by aid (World Bank 2011, p.42). This provides a strong incentive for these stakeholders to keep good relationships with donors and to be open to donor ideas; and through control of funding flows donors retain not only a place at the table, but the capacity to enforce some of their decisions and preferences. **A significant portion of the responsibility for effective management of the sector therefore lies with IDPs**.

Donors tend to have a high level of influence on the agenda for the sector. Interviewees nearly all felt that the policy-making agenda in health was highly donor driven, with a history of reforms being initiated by IDPs. To some extent this is inevitable, given the marginality of the sector to the CPP, its dependence on international funding (hence the incentives for bureaucrats) and the relatively high proportion of donor funding channelled into the sector compared to others (hence the more active donor involvement). The MoH is likely to be highly receptive to donor advice for as long as these three factors continue. However this is not a highly damaging phenomenon, and on some issues government ownership and constructive partnerships between IDPs and the MoH have been built around issues which were first pushed by donors (see our case study on maternal mortality, appendix 1).

However, the Government implements measures selectively and the reality of implementation is often very different from policy on paper, or as envisaged in policy dialogue efforts. The common view is that "donors set the structure of reforms, while the CPP negotiates the substance" (interview). Government effectively retains a veto power which it exercises generally where reforms may challenge vested interests, or where measures do not come with additional financial support (notwithstanding some notable exceptions), with some interviewees perceiving increasing government leadership[9]. A strong example can be found in our case study on nutrition (appendix 1), whereby a good 'evidence-based' policy was put in place, but that evidence has not influenced the Government to provide additional budgetary commitment.

A major impact of high donor influence is fragmentation. It is probably fair to say that the context is not ideally suited to effective sector-wide approaches (SWAps), due to the lack of government ownership of the sector, and also that there are systemic constraints within agencies which prevent better coordination (e.g. budget cycles, differences in tolerance for fiduciary risk, different political priorities). Undoubtedly, important moves have been made toward better coordination with the Sector-Wide Management (SWiM) (Vaillancourt et al 2011), and the Health Sector Support Programme II (HSSP II), even if these did not include all major development partners in the sector. The majority of interviewees felt that the history of donor involvement in the sector is one of waves of overlapping, and not necessarily mutually supportive or compatible, reforms, of multiple priorities and proliferation, and poor coordination on the part of IDPs. This fragmentation at the policy level reduces possibilities for coherently managing the sector, and for bringing reforms and responses in line with emerging evidence.

Fragmentation continues and may be even higher at the implementation level. Few IDPs channel funds through government budgets, with most preferring project support – interviewees from IDPs and government both felt that greater attention should be paid to strengthening government systems and that fiduciary risk issues had been given too much weight. A large portion of aid spend in the sector is channelled through NGOs; one estimate is that 70 NGOs are operating in the health sector (Vivirito et. Al 2010) but interviewees put the figure in the hundreds, often with more than 10 NGOs working with one single hospital. Ndaruhutse (2011) argues that service delivery is dominated by NGO projects more than government service projects, along with a large role for (the unregulated) private service providers. It seems that donor-funded work is very frequently in the form of pilot projects, often with multiple pilots carried out in a similar area without any attempt made to compare or learn between them, and each competing with the other for 'scale up'. Interviews also noted the MoH's unhappiness with pilot projects that had no plan for 'scale up'.

4.3 Ministry decision-making

Decision-making in the Ministry of Health and elsewhere in the health system is fairly hierarchical and centralised. This is another direct result of the elite patronage system, through which a significant proportion of staff effectively buy their jobs, and are indebted to channel funds to their superiors. This again reflects a national trend whereby power is concentrated and centralised in a patronage system around Prime Minister Hun Sen (Heder, 2005).

9 There are some notable examples of increasing government ownership over donor initiated reforms (for example, health equity funds are now only 30% funded by IDPs), and some interviewees argued that the Government has been increasingly assertive recently, proud of progress in the sector (for example on maternal mortality), with a will to have a sense of leadership, and feeling more able to challenge donors.

Even those at the top of the hierarchy in the health sector come under the PM and various other figures more central to the regime.

This means that formal processes and products are of relatively low importance for decision-making and the functioning of the health system more broadly. To a greater or lesser extent the majority of civil servants and other staff are in their positions by virtue of being seen as loyal, with the most trusted individuals given the most lucrative positions. This means that any decisions, especially those involving deviation from previous plans or doing something new, must be negotiated behind closed doors, to fit with the constellation of interests involved in the patronage system, and to avoid embarrassing or being seen to speak against one's superiors. The idea of taking part in a formal meeting without already knowing the preferred outcome, or of following a recommendation from a report just because it seems likely to improve service delivery, is alien to this way of doing things.

This also leads to a strong role for a few key personalities at the Ministry. Deliberation and the transmission of ideas and knowledge operate in informal circuits, where practical and experiential knowledge, trust and influencing skills are of utmost importance. Combined with the vertical and centralised nature of the patronage system, this means that, effectively, the Minister and the Secretaries of State head the two main groups of decision-makers, both with veto power. In addition to these two main groups, perhaps no more than two directors of departments can be described as true 'decision makers' in the Ministry, and they themselves must follow the wishes of the Secretaries of State and the Minister. Especially in the context of very low turnover at the top level of government, the way things are done depends heavily on the nature of the individuals in these positions.

The challenges of inter-ministerial coordination

Inter-ministerial collaboration is difficult in Cambodia, and has real consequences; for example, the issue of nutrition (see appendix 1). There is no clear legal basis or consistent practice for how an inter-ministerial body should be established, responsibilities divided and incentives shared. There are also problems with a lack of sufficient human resources or organisational capacity, and a lack of incentives to cooperate.

The most significant challenge is the patronage-based nature of Cambodian bureaucracy which makes each ministry (and departments within the same ministry) into a 'domain' of power, serving the interests of the ministers' patronage network. Patronage interests compounded by bureaucratic politics impede inter-ministerial collaboration.

So far, both government-wide and in relation to health issues, inter-ministerial cooperation has happened through the establishment an inter-ministerial committee or working groups (e.g. food security and nutrition national committee). These committees have often been initiated by donors and, once established, they are the leading group which takes on most of the responsibilities and incentives that come with it. In many cases this has created jealousy, and further discouraged participation from other member ministries.

Lessons for making an inter-ministerial committee work include:

- The committee can function well depending on the leadership of the chair of the committee, who will also likely have to take on more work than the other members.
- The committee needs to take into account the knowledge, expertise and roles of the people before assigning/asking them to join the committee (often ministries do not send the right people, or consistently send the same person).
- Compromise plays a crucial role in the meeting.
- Ministry officials often look to incentives (per diem, allowances) when they are asked to join inter-ministerial committees.
- Interviewees reported that the role donors can play in facilitating inter-ministerial work is appreciated, as a neutral broker.

Staff with technical knowledge hold powerful positions in the Ministry of Health, relative to other ministries. This is partly indicative of a broader trend, which has seen the rise in power of advisors and technocrats under Hun Sen, who has increased the role of expertise in key government bodies. Some interviewees suggested that technical staff are promoted within the bureaucracy primarily to meet demands for dealing with donors and expatriate counterparts. On the other hand, there is evidence in some sub-sectors, especially where technocrats are relatively insulated from political pressure, for example in NCHADS, that there is strong demand for technical assessments and research-based inputs (Un and Hughes 2011), and some of our interviews suggest there is genuine desire to have evidence-based or knowledge-based policies or strategies in the MoH. Clearly, it is difficult to know the 'real' demand for technical assessments and research-based inputs, given these are a requirement of much donor programming and unlikely to diminish in the near future.

The capacity and expertise of the secretaries of state and directors of key departments in the Ministry are assets to the sector. There seems to be limited cause for concern about the extent to which this is a reaction to donor presence in the sector. Their influence puts incentives on ministry staff to have sufficient technical capacity, and this in turn increases the power of staff in the ministry who have some expertise in health. It is likely that this, in turn, is an important factor in the role seen for research and analysis in policy-making in the health sector, compared to others.

Technical staff are nonetheless still restricted in the kinds of decisions they can make and types of tasks they can perform. They are informally called '*sachkaam*'- people who bear the burden of hard work for comparatively little reward (compared to rents generated in other ministries). While they are in their positions for being trusted and politically aware, to some extent their positions are dependent on their non-involvement in more political tasks, such as allocating budgets or interfering with rent-seeking. Like all civil servants they are constrained by the realities of the patronage system, and their space to operate over and above relatively administrative tasks depends on their skill as political operators, negotiating between various interests and groups behind the scenes.

Technical capacities are not strongly embedded in the Ministry. Within the health ministry itself, the number of well-qualified technical people is low and they are in charge of a large number of technical issues. The required experience, practical knowledge and capacity gets concentrated in those few individuals actually making decisions. This kind of situation is not unique to health, but was seen by interviewees to be worse than other ministries. It reflects the lack of proper incentives to attract qualified staff, and the need to find individuals who can also be trusted by those higher up[10]. These limits to knowledge-based policy-making are compounded by the fact that ministry research units tend to be backwaters, due to limited financial incentives (official or unofficial), although some progress has been made in small, self-contained units (e.g. NCHADS, HSSP II secretariat), headed by high profile individuals who can manage the politics, and where they are allowed to offer performance incentives to staff.

4.4 Service delivery

Ownership of and accountability for service delivery is hampered by institutional issues at the decentralised level. First, there is poor alignment between the health system and local government structures, and the absence of greater coordination between health deconcentration and public administration is, according to many interviewees, the major issue in health service provision. Health services have been decentralised to operational districts since 1996, but boundaries for ODs were formed based on populations living in the catchment areas and, therefore, bear little resemblance to commune, district or provincial boundaries. Second, although the Ministry of Health nominally has responsibility for managing the health system, funding is given directly to the provincial level from the Ministry of Economy and Finance. Interviewees reported that decentralised levels still place high importance on fulfilling vertical reporting requirements to the MoH, and wait for approval in order to make changes to service delivery. However it could be argued that the MoH has limited capacity to influence service delivery through not being party to the allocation of funds.

The way the health sector links up with the ongoing processes of decentralisation and deconcentration will be crucial to its success. There is serious commitment on the part of the CPP to genuine decentralisation as a way of enabling them to better understand local needs and, hence, win legitimacy and local elections. This institutional issue is crucial to many existing policy problems, such as nutrition (see appendix 1). In this context, finding ways to make stronger links (formal and informal) between local government structures and the health system seems crucial to

10 It might also reflect the fact that MoH is a less lucrative place compared to some other ministries.

building ownership over health services; and may be just as important as the formal process of functional assignment. There may be a limited window of opportunity to influence the dynamics: as design and development occurs, there is the opportunity for local actors to set precedents and establish ways of working, but after these have been laid down it may become much harder to break out of established grooves.

The provincial level may be the most suitable articulation point. So far, experiments with health management committees have been mixed at the commune level (Ndaruhutse, 2011). However, success has been seen at the province level, with MEF funds distributed to this level and cascaded down, and the ability for leaders at this level to send orders down the hierarchy to lower levels. URC experience bringing provincial governors and provincial health directors together with district governors and OD members seems to have been highly promising. Making links to provincial party working groups may also bear fruit. The way the local government system is given ownership over health, and the systems for bridging evidence and information into management at these levels, seems likely to be crucial to the development of the sector.

Implementation is severely undermined by poor incentives for health workers. This has had severe effects on service delivery, for example on the issue of maternal mortality (see appendix 1). In general, government workers are paid below a living wage throughout the civil service, and salaries for health staff vary from $30 to $50 per month which is well below liveable wage (Vivirito et. al 2010). This opens the door for corruption, with government health staff needing to supplement their salaries, often taking informal fees in exchange for services, and concentrating their time and energy on private practices (Jarrah 2008). Seen as 'hard work with poor pay', **poor incentives lead to low capacity and a lack of skilled health professionals**. This issue has been somewhat mitigated at the Ministry level through allowing staff to benefit from donor projects, and for service providers (in the case of the salary supplement for midwives). However more generally, implementing staff still lack incentives and major capacity issues continue.

Interviews indicate that the Government has no real political will to increase salaries for civil servants. Previous action on this issue has seen donor-funded merit-based pay initiatives. However, according to some interviewees, power sectors left out of such initiatives have lobbied for them to be shut down. Two other causes are possible: some speculated that the Government might not want civil servants to have sufficient pay for fear that it might lead to independence, and diminish the strength of the patronage system; or the Government has not fully reformed its revenue collection system, with tax revenue at only 12% of GDP, insufficient to cover increased salaries of government civil servants.

5 The knowledge-policy interface

This section looks at the demand for knowledge, the supply, and efforts to link the two.

5.1 Demand for knowledge and research

At the policy-making level there is a relatively strong demand for knowledge and research, in some respects. This was directly reported by interviewees in the MoH, and also reported by many interviewees working closely with the ministry[11]. This would triangulate with the findings in the previous section, which highlight how the incentives for key decision-makers in the MoH give them the space to draw on research and analysis; indeed, the positions of authority and scope granted for discretionary decision-making are premised on their ability to handle technical issues, which drives them to apply their knowledge and expertise on a daily basis. This applies to some issues more than others, and there is less likely to be demand around issues such as procurement, where technical staff are less likely to be able to convince party members behind the scenes.

Where financial support from IDPs is involved, demand for knowledge seems to be relatively broad and 'agnostic' – without any strong preference for type of knowledge, using whatever is available. This reflects incentives for MoH staff when dealing with donors, as discussed in the previous section.

However, our interviews and case studies do indicate that **some types of knowledge are valued more highly, and are possibly more influential, than others**. Lessons from other countries of stable, successful programmes in action are considered particularly helpful, especially coming from neighbouring countries and others in the region. For example, the MoH has been actively pushing to obtain lessons from Thailand on how to set up and run community-based nutrition programmes, and policy-makers interviewed argued that more should be done to share knowledge and experiences with neighbouring countries and others. This demand for practical knowledge from experience, again, would reflect the incentives of MoH staff[12].

As well as greater credibility being given to regional voices, there were some signs that **Cambodian voices of experience** are influential in the MoH and high level policy and party decision-making. This reflects the dominant embedded type of knowledge used for decision-making, which is experiential knowledge applied in informal circuits[13]. Our case study on maternal mortality illustrates this well: the midwives forum, where Cambodian health workers spoke frankly about the difficulties of their work to an audience including key party decision-makers, was central to effective policy-level action.

The demand for knowledge is not well institutionalised or embedded in the MoH. Largely concentrated in a few qualified, but-overworked, individuals, and partly driven by diverse and fragmented donor demands, there is a certain lack of direction, systematisation and focus in the handling of the knowledge base for the sector. Our interviews with MoH staff show that policy makers do realise the need to develop a research agenda for the sector, and discussions in some MoH working groups have touched on that issue seriously on a number of occasions. There seems to be a need for some horizon-scanning and identification of evidence-needs for the sector over the next 5 to 10 years. Such an effort

11 Individuals within the MoH clearly expressed the realisation that they need evidence to help set the agenda and formulate policy. Interviewees working closely with the MoH also reported that key policy-makers appreciate the roles of evidence and lessons learnt in policy-making process.
12 Rather than shaping policy functioning as a process of determining a goal and then finding a way to achieve it, the imperative is to look for programmes of activities which might be possible, profitable or fundable, and which will boost the stability of the regime or the well-being of the population without jeopardising key funding flows or relationships. Hence, observing a programme in action is more useful than identifying a need.
13 For more on embedded types of knowledge, see Jones et al. (2012)

could potentially help focus analytical efforts as well as give the MoH space for greater technical leadership in the sector. However, there is also the crucial issue of lack of resources for research activities, both financial and human, which would need to be solved to get any movement towards institutionalisation.

At the implementation level, indications are that technical capacity and the demand for knowledge are relatively low. According to our interviewees, management and decision-making based on information, assessment and analysis is largely absent from service-delivery – this reflects in some ways the space granted to lower levels in a hierarchical informal system, as well as the stronger role for the CPP in vetting and overseeing policy implementation (compared to the development of policies and plans). While the need for certain types of information is institutionalised through the *annual operational plan* (AOP) process and the HMIS, these are largely paper exercises, with little interest in or space for strategic or active management.

5.2 Supply

A large amount of research is produced in the sector in the form of reviews and assessments for specific projects or programmes. Often carried out as commissioned consultancies, they are generally initiated and/or conducted (i) as projects or programmes currently implemented by the Government with support from donors and NGOs, (ii) by teams leading periodic reviews of programming such as the Mid-term Review of the Health Strategic Plan, (iii) by NGOs who support specific projects or programmes, and (iv) by universities or research institutes. According to interviewees, the quality of this work varies, but is often relatively high.

The domestic research community is relatively weak on health. This seems to be due to limited funding from the international community and the perception of low strategic importance of the sector by political and policy actors, which means health experts are not well connected to key decision-makers. Some specific organisations are listed and strengths and weaknesses discussed in the box below.

Domestic research capacity for health

The National Institute for Public Health (NIPH) sits within the MoH structure, with a research and training mandate. It has engaged in research activities, receiving external funding or collaborating with other research institutes, for example participating in the 2005 CDHS and an EU study on health reforms in Asia, and is currently planning to set up a research agenda for the health sector. Since its establishment in 1997 the NIPH has largely focused on training, as no budget has been provided for research activities. Given this, and limited capacities, (currently there is a staff of around 10 researchers only, half of whom are epidemiologists) the NIPH is not currently a strong player in the domestic research community.

The Cambodia Development Resource Institute (CDRI) is a major research institute outside the Government, but they do not have a major programme of work in the sector. Currently, CDRI, through its Social Development (SD) unit, is working on health issues with support from a DFID project called 'Rebuild', however they face capacity gaps in the sector as well as broader issues, such as turnover. They have also faced problems obtaining information, clearances and collaboration from MoH staff, and shown insufficient understanding of decision-making in the MoH. This suggests CDRI's position as an independent research institute may be hampering its chances of carrying out relevant, influential work.

The Supreme National Economic Council (SNEC) is part of the MEF, and entrusted with the task of advising the Prime Minister on economic issues, having carried out some influential pieces of research and formulated some key policies. It is both well-funded (having been supported by a number of donor agencies such as UNDP, ADB and the World Bank), and well embedded in high-level decision-making, given connections to the PM. However, at the moment there are no health specialists in SNEC, which has a limited capacity and only a small pool of qualified researchers, due to new recruits requiring political clearance.

MEDiCAM undertakes research activities on health issues. It is relatively well embedded, with membership in key policy-making bodies such as the TWG Secretariat, however its research team is relatively small (three to four staff with one senior researcher) and currently works more like a freelance consulting firm looking

for research partners and funding opportunities.

This leads to the overall knowledge base being fragmented, with studies generally assessing questions and issues which fit the specific needs of donor and NGO projects and programmes (hence, they are fairly narrow in scope and not aligned to government priorities). There is, according to our interviewees, generally little effort to provide broader relevance through the questions assessed, and certainly little effort to communicate findings or even make reports publicly available – interviewees frequently reported that good work can often remain 'buried' in projects or programmes.

According to some, **studies might reflect the divergent ideological preferences of donors** with relation to, for example, health system financing (insurance vs. taxation), which likely further increases fragmentation (Jones et al., 2012). This issue is of high importance given the current situation of people not seeing the Government as the body primarily responsible for healthcare (as opposed to NGOs or the private sector), especially in light of the importance of building CPP ownership over health services.

There is also **no systematic compilation, stocktaking or synthesis of the many studies produced**. While the DPHI within MoH is meant to play this role, financial and capacity constraints have prevented them from doing so, and while MEDiCAM kept a library to compile studies, interviews indicate that the library has not been updated in the last two years or so. In this context, interviewees perceived that research and action in the sector is often 'reinventing the wheel'.

There have been some large-scale surveys which have proven valuable and influential in the sector. Conducted under the leadership of the Ministry of Planning, examples of these include the Cambodia Demographic and Health Survey (CDHS) which was done in 2005 and 2010, Socio-Economic Survey (most recently in 2008), and the population census in 2008. Although they have had some shortcomings (such as insufficient dissemination to provincial levels and the omission of some useful variables such as nutrition), they are perceived as credible and important by government and development partners for the formulation of new policies and adjustment of ongoing work – as can be seen, for example, in our case study on maternal mortality (see appendix 1).

At the implementation level, the Health Management Information System is the most prominent supply of knowledge, containing data collected from service delivery throughout the country[14]. Maintained by the MoH, this database was initiated by development partners and NGOs, and later transferred to the Government. However, while the HMIS has been increasingly used by the MoH and other stakeholders, **the quality and utility of the data is a concern**. The system requires a large amount of data entry and bureaucratic form-filling as part of the Annual Operational Planning process, and the dataset has a number of inconsistencies. Interviewees at MoH agreed with this observation and attributed the problem to a lack of state budget and competent staff to maintain and update the databases.

Systems are in place to capture and channel feedback from implementers at PHDs and lower levels, however it is not clear whether this is currently producing valuable information and insights. In the current system, health officials and agencies responsible for policy implementation can raise their concerns and provide feedback to the central level through various forums including Provincial Joint Annual Performance Review (Pro-JAPR), national JAPR, and other forums including the Annual Health Congress. Various national programmes, centres, provincial health departments and their lower level vertical links (ODs and health centres) are also required to send regular reports upward to the ministry. Some interviewees reported that these inputs have focused largely on the difficulties of meeting performance targets and the lack of incentives for health staff, rather than reporting health problems or discussing adjustments to programmes.

The extent to which perceptions and ideas of communities and service recipients are elicited and channelled into policy or implementation is unclear. To engage the community and commune councils, new mechanisms were created to promote popular participation in the health delivery system, including Health Centre Management Committees (HCMCs) and Village Health Support Groups (VHSGs). According to a recent review, these seem to be functioning relatively well to promote participation and choice for the community in health service delivery, however there are few channels through which people can directly voice their needs and concerns to service providers (World

14 There are also other programme-based databases/list of indicators (e.g. that on child nutrition kept at the NMCH).

Bank, 2012). While upward accountability mechanisms seem to be functioning well (often due to reporting being linked to pay supplements and budgetary disbursements), downward accountability is indirect and/or ad hoc through NGO-arranged forums. Feedback from the local level and the community voice has been brought to the national level more by supporting NGOs than through the Government hierarchy.

For a more detailed assessment of the types of knowledge and their tendency of use in policy and implementation in the sector, see the table in appendix 2.

5.3 Linking

Some established channels for feeding ideas and analysis into policy making are relatively functional. Interviewees argued that two forums were particularly important: the taskforces (of which there are four, one for each of the key objectives in health), and the Secretariat of the Technical Working Group (TWG) on health. It is through these (rather exclusive) forums that donors can bring attention to important issues and hold practical yet technical discussions on policy problems and responses. These spaces for discussion have real importance in the policy process, not just through their formal constitution but also through the presence of high level technical staff and key decision-makers.

The overall picture is of a multitude of missed opportunities for linking research and policy. Of the large number of studies carried out in the sector, interviewees reported that very few resulted in concrete changes in policy or practice. The influence of different types of studies depends on four factors: political receptivity, alignment with a donor agendas, relevance to ongoing programmes, and engagement throughout the study.

- **Political receptivity**: The MoH and the Cambodian government in general tend to ignore research findings that are politically sensitive, such as those involving civil service and pay scale reform. Where receptivity is built there can however be large successes, for example the midwife reforms, where the 2005 CDHS led to drastic reforms in training, hiring and compensation for midwives (see section D for more on this).
- **Alignment with a donor agenda:** For politically non-sensitive issues the Government is more likely to agree to new policy changes if it also aligns with the development partner agenda, which in turn means additional foreign aid into the sector. For example, the alarming findings on malnutrition in the 2010 CDHS provoked strong policy interest in the issue when combined with donor interest (for more see appendix 1).
- **Relevance to ongoing programmes:** Especially for smaller studies, only those initiated as a part of an existing project, and those produced by NGOs who work to support specific government policies or initiatives, are likely to get interest from policy-makers. These often provide insights on how to improve or adjust an existing policy, strategy or implementation guidelines, whereas other studies, for example pilot projects conducted by NGOs outside existing guidelines, are frequently ignored.
- **Engagement throughout studies:** Leaders within the MoH tend to be supportive of recommendations of studies that engaged in consultation with relevant health officials, or studies that included co-investors.

Interviewees argued that **poor uptake of research has, on the whole, been a function of poor engagement**. Most studies have engaged policy-makers only at the dissemination stage, which seems to be the major factor in their limited policy impact. Given what has been said in the previous section about the need to work through informal channels and to give decision-makers time to negotiate potential changes behind the scenes, it is not surprising that being presented with finalised results at the end of a process by independent consultants is not met with eager uptake. Our interviews indicate that **despite limited institutional and human capacity, policy-makers in the MoH are keen to provide inputs to proposed research activities**. Policy-makers interviewed indicated that MoH might play two possible roles: providing inputs to the design of proposed studies, and where possible, acting as co-investors. A proposal has been made by technical officials to the higher level of the ministry to form a team of about 10 technical level policy-makers to undertake such roles. Although monetary incentive plays a role (part of the motivation behind the proposal is to generate extra income for technocrats), this would nonetheless improve evidence-based policy-making in the sector.

At implementation level, the indications are that **there are few well-functioning processes for bridging knowledge and action**. The AOP process is, in theory, set up to provide channels and spaces for evidence and information to feed into decisions on service delivery, however interviewees reported that the process does not function this way. Two possible causes of this are limited space and incentives for staff at this level to actively manage delivery, and an overly

intricate and time-consuming process which apparently takes up a large proportion of the year with ‘box ticking’ exercises. Similarly, despite the various reporting systems and forums for implementers at PHDs and below, the top-down nature of the system means that messages do not flow up through the hierarchy effectively and these voices are not considered a key input for policy consideration.

There is one particular space worthy of note for lacking any clear system for drawing on evidence to inform decision-making: the budget negotiations between the MEF and districts, which are clearly crucial to the functioning of health and other services in the country. According to our interviewees this process does not include any assessment of district level data, such as the burden of disease or the magnitude of different problems and issues to be tackled.

6 Recommendations

Based on the findings of the study, the following recommendations can be made for AusAID Cambodia and other international development agencies engaging in the health sector in the country.

6.1 Recommendations for the next phase of programming

At the time of writing, it seems likely that HSSP II will be extended by one year, with the start of 2015 most likely to be the starting point of the next phase of AusAID support to the sector (Pearson, 2012). The following recommendations represent principles and ideas which could help guide the overall approach for this next phase of programming.

6.1.1 Politically savvy programming

1. Effective support for Cambodia's health sector may involve designing elements of programmes to 'go with the grain' of political economy dynamics. This has the potential to have a high impact on health outcomes.
   a Attempting to work with the trend of mass patronage, by encouraging health to be seen as an appropriate 'gift' to constituents (e.g. disbursing vaccinations, dietary supplements, medicines), would be likely to garner the required behind-the-scenes approvals and ownership which could see broad, fast and effective roll-out with minimal leakage.
   b This could involve providing funding and/or in-kind resources for relatively top-down, one-off solutions to certain problems – for example, vaccinations, bed nets, or nutritional supplements. Key local government actors (and possibly CPP working groups) should be engaged, and it would be important that there were space for government and/or CPP to claim some credit for handouts. The issues of branding and publicity would need to be carefully considered.
   c Patronage-based distribution helps trickle down resources and allow for services to reach local people to some extent; yet it is far from being systematic and equitable. Complementary activities could be carried out to compensate for the downsides of mass patronage. One important priority would be public education and awareness to make the demand for health services better informed. Mitigation should be made for areas which are under-prioritised by the patronage system, for example through ensuring that NGOs focus service delivery on areas with low political priority.
   d Programmes could limit downsides through making gifts selectively available – for example, on issues where citizen demand is more likely to coincide with good medical advice, and by making the volume of gifts available proportional to the burden of disease or magnitude of the problem.
   e IDPs may want to limit their exposure to risk in such a programme through focusing on impact. Although it may often involve a 'second best' response to problems, the nature of handouts means they are suitable for conducting highly rigorous impact evaluations, which would establish improvement in health outcomes attributable to the programme, with a high level of certainty. Full randomised control trials are unlikely to be possible given the (required) lack of control over disbursement; however a variety of quasi-experimental methods should still be able to establish the value of the programme beyond reasonable doubt.

2. It should be recognised that medium- to long-term prospects for sustainability and effectiveness in the sector hinge on whether greater political ownership by the Cambodian government[15] can be built over health service delivery.
   a IDPs should formulate a basic theory of change and some principles and assumptions relevant to Cambodian context about how political ownership can be built in the sector. From that, they should identify strategic

15 Specifically, for the health sector to be seen as a key policy area for building legitimacy and popularity of the Government, and one which should be actively managed by high level decision-makers in the CPP as well as the Government in order to produce the desired results

entry points or issues on which it is acceptable for them to work, or where their programmes can in some way contribute to health sector programming.

b Some plausible elements of such a theory could be: increasing the extent to which the CPP sees health as a viable 'gift'; raising awareness about health 'gifts' building expectations for the Government to deliver on the part of Cambodian citizens; increasing the perceived importance of health by key levels of government and the general public; supporting the ability of government to systematically manage and deliver services and health outcomes.

c As well as potentially targeting programme support around a top-down 'gift-giving' dynamic, the other major entry point is the ongoing decentralisation reform, and the way the health system joins up with local government.

d Goals around government ownership are as important, if not more so, as 'good governance' and fiduciary issues, which should be approached with pragmatism ('good *enough* governance' may be the most appropriate mantra). It is likely that successful, visible delivery of health services, combined with an increasingly healthy and able population (over a demographic timescale), are much more likely to lead to long-term transformation, not just in human development indicators, but in the ability and willingness for Cambodians to hold their government to account.

e Support could work better and donors' political risk could be more easily managed if programmes revolved around strong outcomes and impact goals, and were realistic and flexible about how these were achieved. The health sector is lucky to be suited to objective assessments of needs and of the impact of programming, and programme design efforts should draw on impact evaluation expertise from an early stage.

3. **Efforts to tackle systemic issues of corruption and rent-seeking in the sector need to be informed by the findings of this study** (and ideally, further and more focused work). The findings indicate that issues of corruption and rent-seeking are small in the health sector compared to other sectors. Possible implications include:

   a It is imperative that IDPs make clear and explicit decisions about the extent to which they are aiming to promote governance and institutional change, and the extent to which their focus is on promoting health outcomes for poor Cambodians.

   b In the authors' opinion, a realistic approach would jettison any hopes of making inroads to broader systemic trends around rent-seeking or issues around politics and accountability, from what is a marginal sector. It should recognise the fact that these issues are comparatively small in health, compared to other sectors. It would also understand the limits of technocratic governance and accountability reforms pushed by external actors in the absence of any strong domestic demand for this in the near future, or stronger government ownership of effectiveness in health.

   c Rent-seeking and corruption *can* be tackled in the sector, but a flexible, opportunistic and responsive approach is needed. Rather than making a series of non-negotiable demands and conditions, IDPs could prepare to change focus if it appears that vested interests and behind-the-scenes deals block the way in one area. Achievable institutional and governance goals are incremental rather than idealistic, recognising the likelihood of policies which appear 'perfect' on paper but lack resonance in local context.

   d An 'outcomes-based' funding mechanism could put in place a beneficial incentive for reforms, given the importance of donor funding to the sector. A menu of desired changes could be laid out with associated budgetary tranches to be released in response to not only policy changes but actual indicators of outcomes and behaviour change. This could be used as one tool for donor coordination, with different partners assigning different levels of funding to different options, according to their own priorities and fiduciary risk tolerance.

6.1.2 Embedding knowledge-policy links

4. **IDPs should improve financial support for building a sustainable model for evidence-informed policy-making in the sector**. This could help deepen and embed the required capacities, practices and structures of professional sector management, to go along with (hoped for) increases in government ownership and funding. This could revolve around three main elements:

   a *Supply*: Supporting existing Cambodian organisations to produce policy-relevant research and make links to policy

   b *Intermediaries*: Supporting intermediary organisations to help link knowledge and policy

   c *Demand*: Building the demand for and capacity to use research on the part of the Government.

5. **To improve the supply of knowledge:**

   a Funding should be provided for domestic research on health. Incentives could be provided to encourage researchers to communicate their work or otherwise engage with policy and practice. A small fund could be provided to support fast, reactive research to emerging government priorities in the sector.

b As much as possible, research commissioned by IDPs and others may benefit from fitting within existing policy and implementation frameworks. Stocktaking studies could be commissioned by IDPs to ascertain the knowledge base on certain issues.
c It is important to recognise the role IDPs have in potentially fragmenting domestic research capacity through too much work being carried out in 'consultancy mode'. This would mean being prepared to provide some level of core support to policy research organisations, and potentially setting aside a fixed proportion of the money spent on international consultants to go towards strengthening national capacity in this area[16].

6. On **intermediary functions**, a major effort needs to be made to **consolidate knowledge and lessons learned across project implementation**. It would seem that the ideal home for such a facility might be MEDiCAM, which is already established as the umbrella organisation for health NGOs.
   a A facility should be set up to make comparisons across pilots and NGO projects in similar or related areas. It should synthesise lessons learned, and provide a neutral, independent review. Its function could be strengthened to make comparisons across pilots and NGO projects in similar or related areas.
   b It should create incentives for adaptation and learning. This could be done by focusing both on rewarding success (e.g. prizes for innovative practice or independent scores for projects) and providing support for lagging initiatives (e.g. having flexible technical capacity to deploy where needed).
   c Facilitating networking and peer-to-peer learning would be crucial as well, using study tours to successful projects and borrowing staff from successful projects as 'consultants' to new ones. Interaction and discussion could be facilitated through online discussion platforms and workshops or conferences.
   d IDPs could provide specific financial support for establishing a depository centre for documents, reports and policies in the form of a physical library and/or a web-based library.

7. The demand for and use of knowledge could be enhanced.
   a One approach to this could look to build government engagement with and coordination of research in the sector by setting up a 'contact group' in the MoH who would be informed from the design stage of donor-commissioned studies and, given space, input into research questions and management of the work, and provide feedback into reports.
   b More ambitious, such a group (with the involvement of key decision-makers) or another unit in the MoH could be supported to define the 'knowledge agenda' for the Ministry. This would look at recent trends and upcoming challenges, potential policies and programmes, and identify key areas where more knowledge is needed over the next five years; it would involve a series of consultations as well as scoping studies and horizon-scanning.
   c Another approach could be to support an exchange scheme for key managerial and technical staff. Sending key Ministry or provincial staff to secondments in similar positions in other ASEAN countries or other developing countries would not only provide a welcome incentive for such staff to hold the post, but would likely greatly improve their capacity, and in the long term, broaden the technical capacity within the sector and widen the pool of potential decision-makers. The success of the Phnom Penh Water Supply Authority is partly attributed to such secondments.

8. Possibly the most important **priority for linking knowledge and policy is at the decentralised level;** this also represents a promising entry point for improving health outcomes. Given the positive trend of decentralisation and the likely window of opportunity to set new relationships, this is an urgent priority for action (and assessment – a more focused study is needed to assess the best level of engagement).
   a Efforts should be made to make the annual operational planning process more suitable for facilitating decentralised decision-making. From our interviews, there seemed to be some demand for cutting back on the largely paper exercise, to reduce bureaucracy. Reforms to the system should focus on building devolved responsibility for planning, assessment and reporting, allowing provinces to set their own goals, and report on their own terms by their own methods[17].
   b It is important for IDPs to provide on-demand and flexible technical assistance for provincial level management of health.
   c Efforts should be made to facilitate links between directors of health and provincial governors. Spaces for deliberation, decision-making and management could be set up to convene key actors from the health system and local government structures. Provincial health directors could be given leadership training.

16 A nominal figure should be selected – it will necessarily be arbitrary, but experience elsewhere has shown that putting a number on research communication helps enormously regardless of the true value – and then a small campaign led within the donor community could contribute to the pot.
17 Schon (1973) has shown how this system in some contexts has helped generate a great deal more enthusiasm and commitment to change, and ultimately was a key factor in the success of the programmes.

d Some of these activities need to begin as soon as possible; for example, technical assistance and brokering links between the health system and local government. Others need to be flexible and respond to the emerging process of design and development.
e To complement this, IDPs could work with central organisations to develop and clarify the roles of the MoH and MEF in health delivery. Functions such as overseeing needs-based distribution of finances, and supporting and rewarding performance could be envisaged for the MoH.

6.2 Suggestions which could be implemented immediately

As well as using the above for guidance in formulating the next phase of support, there are a number of things which can be done before 2015.

6.2.1 Pressing issues and trends

9. Given that the process of deconcentration and decentralisation is ongoing, it is possible that major opportunities to achieve changes at lower levels will be lost in a few years' time, once new arrangements have settled into established institutional grooves. The following would seem sensible:
   a It is quite urgent to conduct a study of decision-making and political economy at decentralised levels – to review experiences to date and suggest the most appropriate levels and modalities for linking health and design and development. This should assess not just issues around functional assignment, but around engagement and relationships between key actors at these levels (e.g. between district governors and health officials).
   b Depending on the findings of the study, it could be opportune to put in place some support for health at the decentralised level before the full successor to HSSP II is in place. Areas might be support for leadership and capacity building, institutional strengthening and innovation, and improving evidence-informed management at this level. Support would need to be flexible enough to react to demand and leadership where it emerges.

10. There are a number of other gaps in knowledge which will be important to fill before it is time to design the next phase of support, in particular:
   a There is an urgent need for a detailed political economy analysis of staff incentives and salary supplements in the health sector, especially in service delivery, to inform IDP support.
   b An issues-focused political economy study could be carried out on nutrition to identify the most realistic and appropriate entry points and measures.
   c CPP or ex-CPP members, or researchers who are knowledgeable and well connected to the CPP, could be employed to write a think-piece on how to improve political ownership over health services.

6.2.2 Ongoing priorities

11. **Support and programming in the health sector needs to be informed by political economy analysis**. This would enable donors to, at a minimum, approach various institutional issues, questions of incentives, ownership and leadership with due diligence and precaution – and if done well, could highlight opportunities as well as risks. Failure to achieve reform objectives is related in part to the lack of differentiation of interests in the reform, and the ability to use such distinction to inform intervention decisions (Hughes and Hutchison, 2012). In light of this, appropriate options may include:
   a Commissioning studies on issues of specific interest and importance (suggestions for these above).
   b The design of key programmes and instruments should incorporate review and inputs by a political economy expert. The 'theory of change' and intervention logic must be based on a sound and realistic understanding of political economy issues.
   c The identification of project partners and potential 'champions' in government also needs to be informed by a political economy analysis, to ground engagement in a realistic understanding of the modus operandi of different actors (Hughes and Hutchison 2012).
   d Establish a small 'reference group' of experts (international and domestic) on political economy in Cambodia, perhaps on a draw-down contract, to use as a resource for key issues and decisions, at important junctures and crises, for ongoing advice and inputs to programming.

12. Effective programming intervention may require better understanding and/or engagement with the CPP, which is in aggregate terms, the sole key actor in Cambodia's development:
   a At a minimum, this should involve looking to understand the CPP perspective, and plans and interests on the sector. This could be done through the suggestions for improved political economy analysis mentioned above.
   b A more involved step would be finding individuals. Engagement with the CPP might involve strategic partnership with key CPP members, or people who have connections within the CPP who are prepared to

discuss such matters with IDPs. They could be used to provide informal channels to test specific development ideas with CPP members, or to suggest actions on one side or the other.

c A more involved approach could be active dialogue between IDP programme staff and key parts of the CPP hierarchy, if this were politically acceptable. Relevant CPP members could be invited to workshops to provide input to programming, or to explain requirements and programme needs. Exactly how to do this would need to be discussed on a case-by-case basis, with support possibly from the reference group.

d Particular attention should be paid to how IDPs can work to influence budgetary commitments for the sector at various levels, and early engagement should be made with the key individuals and committees prior to key moments in programming cycles.

e There should also be very careful attention paid to issues of publicity and branding of IDP efforts, and the framing of sector assistance.

13. **A targeted, systematic approach should be taken across IDPs to engage key individuals in the sector:**
    a One measure could be more careful planning and monitoring of interactions with key sector individuals, coordinated (if possible) across IDPs operating in the sector. Drawing on good practice from fields such as lobbying and negotiation, simple tools could be used to track meetings and engagement with individuals.
    b Partnership and influencing approaches should be differentiated between technical staff and more political appointments (with the proviso that this categorisation represents two ends of a spectrum, rather than two unique 'types'), recognising the strengths and limitations of each.
    c Technical staff are more likely to take on board messages from research and analysis, but may have limited ability to undertake more political tasks such as dividing budgets. This could mean IDPs would be prepared to offer them 'cover' for such tasks, and allow any 'blame' to be commonly attributed to them, where it might strengthen the hand of key allies.
    d Political appointments should be approached differently. Successful programme intervention requires the attention of high profile political individuals within the power hierarchy. Lessons from the experiences of changing maternal mortality policies suggest that a strategy of 'stepping up hierarchies' can be effective: inviting staff in influential positions to attend an event, in the hope that they will bring a superior to the next event, who may then, in turn, bring their superior. Influencing these kinds of individuals is likely to require IDPs taking a back seat, giving prominence to Cambodian 'champions', and brokering practical knowledge and voices of experience.

14. Much greater efforts could be made to **communicate the findings and recommendations of research** or synthesis of existing works in an accessible way. This may include:
    a Finding ways to ensure that key studies are published is a priority. This issue should be discussed from the outset of a research project and actively followed-up on completion of the work.
    b Ensuring all major studies and consultancies produce short policy briefs or 'good practice' notes is essential. These should be published in both Khmer and English, and disseminated in a targeted manner according to a simple but strategic communications plan.
    c To get government attention and cooperation in any research, IDPs should demonstrate their plans/commitments to provide resources to address the issue under the planned study.

Appendix 1: Illustrative case studies

This appendix looks at two case studies to examine more closely factors around political economy, and bridging research and policy, through illustrative examples.

6.2.3 Case study 1: *Nutrition*

Child nutrition is still a big issue in Cambodia. Although poverty has been significantly reduced (from 47% in 1994 to 26% currently), chronic malnutrition in children under 5 years (stunting) has not improved and remains stagnated, at close to 40% in 2005 and in 2010. Progress in underweight children also stagnated between 2005 and 2010 (28.2% and 28.3% respectively). For acute malnutrition, the trend was reversed and the rate of wasted children under 5 years increased from 8.4% in 2005 to 8.9% in 2008, and 10.9% in 2010. Malnutrition is closely related to poverty. In 2010, in the lowest wealth quintiles, twice as many children were stunted than in the highest (National Institute of Statistics 2005, 2010). However, other factors have also been at play, including nutritional relevant behaviour, nutrition health related services, availability and access to balanced and micro-nutrient rich food, and access to safe drinking water, good hygiene and sanitation.

Nutrition has had political support, but that is not enough to bring the issue to the top of the Government's agenda. Nutrition is marginally salient to the country's patronage power structure, and therefore has had support, at least rhetorically, from the Government for reform. For example, the Prime Minister Hun Sen serves as Honorary President of the National Council for Nutrition (NCN). He also presided over key national seminars relating to food security and nutrition held in 1999, 2003, 2009 and 2012. The Prime Minister's wife has also been shown in MoH bulletins and annual reports giving Vitamin A to children, another symbol of political support. However, nutrition is not important to patronage politics, so government budget allocation to the sub-sector has been limited. At the same time, there is no attempt to mobilise resources through patronage networks to address the issue, with the exception of gifts of rice during the election years and periods of natural disasters. In fact, in the last five years, the priority of the sector has been reduced.

New alarming data and alignment with donors' agendas are the two main factors leading to the recent attention on nutrition issues. The findings of the 2010 CDHS suggest that Cambodia, in terms of child nutrition, is now off-track for the CMDGs and NSDP targets; it also shows that it has one of the highest prevalence of short children in the region, and that efforts made in recent years (as represented by the 2005 and 2010 CDHS findings) were ineffective, and thus need re-consideration. Such alarming and explicit findings presented a bad image for Cambodia. This negative image is politically sensitive for the Government, which has actively campaigned on effective development. So the Government felt that something needed to be done about it—a tendency that is in line with donors' agendas.

Interviews for this study suggested that because of low capacity, and more importantly limited budget, **the MoH has conducted limited studies to generate knowledge on nutrition**. Significant studies in the past on the issue of nutrition were conducted by one particular NGO, Helen Keller. It conducted a number of surveys (on vitamin A in 1993, on micro-nutrients in 2000) which led to the formulation of a number of pilot projects relating to nutrition. Lessons learnt from these pilot projects helped inform the formulation (1994) and revision (2007) of the Vitamin A policy. Currently, it is working with the MoH on the formulation of a Micro-Nutrient Policy. Now that nutrition is high on the agenda, these smaller pieces of evidence gain new currency and significance.

Interviews indicated that **health officials see the need for evidence-based studies to inform policy formulation and implementation.** Policy makers interviewed for this study expressed the need for additional indicators concerning weight gain during pregnancy, better understanding of behaviour of pregnant women in seeking specific supplements during pregnancy, and the need for specific data on individual and household consumption. Policy-makers stressed the need for analysis of health system governance at the sub-national level that is imbedded in the decentralisation and deconcentration mechanisms and types of incentive schemes for government officials. They also expressed their willingness to learn from best practices found in other countries. However, it should be emphasised that only studies that have been done as a part of existing government policies, and with engagement from policy-makers, are likely to get attention in this case.

Despite the progress, a number of challenges were identified, the first of which is the limited impact that evidence can have on government budget commitments. To make a policy evidence based is one thing, but to generate budgetary commitment to implement the policy is another. Experience in the nutrition sub-sector shows that, while the Government easily agrees to newly generated evidence, when it comes to funding necessary actions to address a problem, it still looks to donors for financial support. Otherwise, the evidence and the policy that donors and NGOs help create will be just another paper on the shelf. Micro-nutrient supplementation was studied three times in the country and shown to be effective each time, but the intervention for scaling up did not occur, leaving the current coverage at 4%. Asked why the evidence has not led to more scaling up, a high ranking health official plainly said: '*…because the Government has no money; we are waiting for donor support.*'

Another problem is the limited attention to the roles of sub-national level governments (both the de-concentrated offices and sub-national administration) in providing feedback to the policy level. Interviews with national level MoH officials indicate that they have plans to include nutrition indicators into the Health Information System (HIS) so that nutrition can be integrated into the AOP and regularly monitored. However, despite the talk about decentralisation and more focus on the community level, there has not been much discussion on how to make health officials at PHD and lower levels, together with sub-national administrations, more able to provide feedback into the policy-making process. In other words, they are still seen as implementers whose job is to meet targets set by the national level.

Nutrition is a cross-cutting issue and has been addressed in a number of cross-cutting policies and strategies. There are five cross-cutting policies and strategies: (i) the Cambodia Nutrition Investment Plan (CNIP 2003-2007) which has been coordinated through the National Council for Nutrition (NCN) and chaired by MoP; (ii) the 2009 National Nutrition Strategies (NNS 2009-2015); (iii) strategies such as the Strategy for Agriculture and Water (SAW 2010-2013); (iv) National Rural Water Supply, Sanitation and Hygiene Strategy (2010-2015), developed by MRD and; (v) the National Social Protection Strategy for the Poor and Vulnerable (NSPS 2009-2014).

Cross-sectoral coordination has proved to be problematic, both in health and other sectors. It is very likely that this challenge will exist in efforts to set up a holistic response to nutrition issues. Experiences from other parts of the Government suggest it is easy to write cross-sector policies and create a cross-sector working group. However, to make them work effectively and efficiently has proven very difficult, for a number of reasons. The first issue is the absence of a clear legal basis on how an inter-ministerial body should be established, responsibilities divided and incentives shared. The second, and probably much more critical, issue is the difficulties reflected in the patronage-based nature of the Cambodian bureaucracy which makes each ministry (and departments within the same ministry) into a 'domain' of power, serving the interests of the ministers' patronage network. Patronage interests compounded by bureaucratic politics impede inter-ministerial collaboration. At the technical level, the lack of cooperation comes from a simple lack of human resources and incentive to cooperate. This lack of cooperation leads to limited information/data sharing among ministries and departments within the same ministry (including the MoH).

6.2.4 Case study 2: Maternal Mortality

Given its rapidly declining rate, the maternal mortality issue has undergone significant positive development. Until the release of the 2010 Cambodia Demographic and Health Survey (CDHS), the maternal mortality rate was alarmingly high, facing an upward trend with a death rate of 437/100,000 live births in 1997 and 472 in 2005, before slightly declining to 461 in subsequent years. Drastic improvement was detected in the 2010 CDHS which recorded the death rate at a maximum of 288/100,000 live births. Interviews conducted for this study cited the maternal mortality rate at 206, below Cambodia's MDG set at 250. However, the figure remained high in comparison to the South-East Asian region's average of 145.

Major killers are post-partum haemorrhage, eclampsia, unsafe abortion and obstructed labour[18]. Maternal mortality contributes to 17% of all deaths among women aged 15-49[19]. Maternal mortality is multi-factorial, with underlying issues including a lack of health staff, adequate facilities and finance, both at the supply and demand sides. First is the lack of skilled birth attendance. There are only 0.77 skilled birth attendants per 1,000 population, lower than the World Health Organization's recommended ratio of 2.5 skilled birth attendants for 1,000 population. Although the number has improved, by 2010 there were still 45% of women delivering at home, down from 89% in 2000 and 78% in 2005. This availability is skewed toward urban areas where access to skilled attendants is at 86% compared to 48% in rural areas[20]. Only 61% of hospitals have secondary midwives available 24 hours per day; and the rate is much lower for health clinics, at 7%[21]. However, there has been a dramatic increase in the availability of midwives. Interviews show that 52% of all clinics have secondary midwives, while all health centres throughout the country have primary midwives.

Despite much improvement, maternal health care remains a challenge. Poor demand for health care is closely linked with affordability for patients. A large proportion of maternal and neonatal deaths occur within 48 hours of delivery, and part of that is attributed to the absence of postnatal care. While 89% of urban mothers receive postnatal care, the figure is only 67% for rural mothers. There are three main reasons: 65% mentioned "no money," 40% "not wanting to go alone," and 36% "long distance from health clinic"[22]. Access to health financing remains limited. Most spending on reproductive health in terms of research and services is funded by bilateral and multilateral donors. An

18 USAID, Cambodia Global Health Initiative, (Cambodia: USAID, 2011). However, there are conflicting figures, the Cambodia Demographic and Health Survey 2010, places the death rate at a maximum of 288.
19 Ministry of Health, National Emergency Obstetric and Newborn Care: Assessment in Cambodia, (Ministry of Health, 2009).
20 The National Institute of Statistics, 2010 p. 126.
21 MOH 2010,14.
22 The National Institute of Statistics, Cambodia Demographic Health Survey, 2010, 128.

innovative financing tool, the Health Equity Fund (HEF), is only available in 49 out of 77 health districts. There are other problems beside geographical coverage issues: HEF partially covers the poor but not the marginally poor.

Access to health facilities is also limited by their lack of availability. Cambodia has an insufficient number of Critical Emergency Obstetric Neonatal Care (CEmONC) and Basic Emergency Obstetric Neonatal Care (BEmONC) units. Five provinces, Kampong Speu, Kandal, Mondul Kiri, Oddar Meanchey and Kep have no CEmONC and BEmONC[23]. By 2009, Cambodia had only 1.6 EmONC and 0.9 CEmONC services per 500,000 people, well below the UN's recommendation of four basic and one comprehensive EmONC facilities per 500,000 people[24]. Statistics available in 2002 estimated that approximately 20-29%, or 130 per 100,000 maternal deaths, we due to unsafe abortion. Due to limited accessibility to qualified abortion services, 51% of abortions were done through traditional inducement methods. Other abortion services were offered by providers in the private sector whose quality and regulation are generally poor[25]. Weak resources, corruption and conflict of interests among health officials and doctors means that tighter regulation of the private sector will be difficult to achieve.

The 2005 CDHS and the Midwifery Review were important studies in promoting action. The review showed a shockingly high maternal mortality rate, closely linked with the lack of availability of skilled midwives. Officials at MoH, notably politicians, initially intended burying the finding over concerns about "losing face". Actors involved in the review, such as UNFPA, and technocrats at MoH, such as Dr. Eng Huot (Secretary of State, known as a competent technocrat) and Dr. Kom Kanal (a respected technocrat leading the NMCH), saw the results as an opportunity to address the issue of underpaid and under-supplied nurses – an issue closely linked with the high maternal mortality rate.

Efforts to increase the number of, and incentives for, midwives through training and salary supplement have been difficult, as the issue is cross-ministerial and involves government funding. However, pockets of success exist in the health sector. There are collaborative efforts among a mixed group of actors (or champions) who could bring the issue to the attention of top leadership; the shortage of midwives being an inter-ministerial issue. The study showed that the nursing profession was not rewarding, with long training and low salaries discouraging women from becoming midwives. Those that already were midwives were poorly motivated.

The National Midwifery Forum in 2005 was a key event in promoting policy change. Representatives of UNFPA, Drs. Eng and Kom found a sympathetic partner in the Council of Ministers, the National Population Committee, who co-sponsored the forum at the Council of Ministers—the pinnacle of Cambodian centralised power. The Forum was chaired by Deputy Prime Minister Sok An, whose presence drew senior participants from relevant ministries across the Government. At the Forum, evidence was presented and nurses' personal experiences were movingly recounted. Deputy Prime Minister Sok An promised to convey the message to Prime Minister Hun Sen.

The Prime Minister's endorsement produced rapid and effective results. The Forum led to the issuance of a government directive (2007 *Prakas*) that authorized an increase in basic salary for midwives and incentives for midwives in health centres and referral hospitals. Subsequent policy changes stipulated the Government's priority in recruitment and training of midwives, and the creation of a new training curriculum.

Other important health policies and strategies are devised based on scientific research findings. For example, the Cambodia EmONC Improvement Plan 2010-2015 was drafted based on the results of the study "National Assessment of Availability, Quality and Utilization of Emergency Obstetric and Newborn Care", conducted in 2008 to understand the high rate of maternal death. The plan has a clear goal to reduce maternal and newborn mortality and morbidity, purposefully stressing improvement of coverage and use of quality – an EmONC that is inclusive. It contains mechanisms for monitoring and evaluation with a clear set of indicators. The plan also addresses key interventions that are aimed at resolving delays in making the decision to seek care, and in receiving care at the required facility. The plan contains detailed processes of implementation that are broad based in terms of links to NGOs and other government institutions, and include a preparation stage and service-delivery stage—education campaigns, infrastructure improvement, training staff, and improving the quality and quantity of EmONC. The plan also contains mid-term correction mechanisms based on a three-year study of "formative evaluation and lessons learned."

Another example of knowledge-based policy formulation is the Fast Track Initiative Road Map for reducing Maternal and Newborn Mortality (FTI). In 2010, Prime Minister Hun Sen announced that the highest priority in health is to reduce maternal mortality. In response to the Prime Minister's appeal, and with donor support, the MoH developed FTI. The plan identifies four key components:

(1) Assuring universal access to emergency services by improving and expanding Emergency Obstetric and Newborn Care;

(2) Expansion of availability of skilled birth attendance;

(3) Improvement of family planning through availability of modern contraceptive methods;

(4) Improvement of availability of abortion services in public health clinics, along with regulative strengthening.

The strategic initiative also addresses issues of an enabling environment. It calls for (1) increasing campaigns and education on reproductive health issues, including birth spacing and contraceptive use; (2) removal of financial barriers to access to key reproductive and maternal health services; and (3) improving data gathering, taking into account the recognition of the significance of statistics in policy formulation. Overall, FTI represents knowledge-based and evidence-based policies and strategies that take into account various studies and reports. It incorporates

23 Ministry of Health, National Emergency Obstetric and Newborn Care: Assessment in Cambodia, 2009.
24 Ministry of Health, Cambodia EmONC Improvement Plan For Implementation 2010-2015, 2009, p.14.
25 Ministry of Health, Fast Track Initiative Road Map.

international best practice guidelines, monitoring and evaluation, benchmark indicators and targets, and a responsibility matrix. The Mid-term Review for HSP II calls FTI a "sound, relevant approach to tackling maternal and newborn mortality."[26]

Our interviews found there are health officials, particularly technocrats, who are open to new information and knowledge that might help them design policies and address certain health issues. One senior official at the MoH stated that "there must be a survey conducted first or analysis made first before any intervention could begin." However, inadequate financial and human resources have severely limited health officials' ability and initiative to undertake studies on their own. Thus, most researches were initiated and funded by bilateral or multilateral donors and international NGOs. Arguably, research on the maternal health issue in particular, and the health sector in general, can be seen as "donor driven". However, within the donor-driven context, there is a positive trend, a pattern of partnership between donors and MoH (in this case the NCMCH). Each study, even though initiated and funded by donors, went through a consultative process incorporating input from the Government. So it can be argued that the MoH and its various national programmes have created an enabling environment for the search for evidence and new knowledge, and has the political will to use that knowledge to correct certain health issues, if resources are available.

Interviews and desk research for this study indicate that there is a willingness to acquire new knowledge and evidence. There have been efforts through donor assistance to upgrade health information systems. MoH has a web-based data entry through which data can be input from the provincial health department. By 2009, a better maternal death data base and surveillance system had been developed to improve the under-reporting of maternal death[27]. However, despite recent improvements, the mechanisms for generating data and new research are limited. There is a lack of staff, and the available staff are not highly motivated due to low salaries. The department of health information is considered as the "paper department", where there is no opportunity for earning extra income.

26 Mid-term review of Health Strategic Plan, 2008-2015.
27 Mid-term Review of National Health Strategic Plan, 2011.

Appendix 2: Matrix on types of knowledge used in policy in the Health Sector in Cambodia

Types of Knowledge	Policy Impacts	Challenges
A. Big scale surveys		
A1. CDHS, Socio-Economic Survey, Census National regular surveys, but conducted with donors' technical and financial support Big sample, considered to be statistically significant Quality often reliable	Produced alarming data on health issues (e.g. maternal health (2005) and nutrition (2010)) which attract policy-makers' attention Helped open 'windows' for smaller but relevant research to gain attention from curious policy-makers to seek confirmation and cross checking Used as baseline for health implementation (e.g. 2008 Census is used to identify target for HC to perform in relation to maternal health)	Can lead to changes only when in combination with other key factors, including: donor agenda and political receptivity Although translated into policy, not sufficient to convince the Government to put more budget to implement the policy Not widely shared to sub-national level implementers The participation of key stakeholders in the design process not clear (e.g. NIPH was involved in the 2005 CDHS, but not the 2010) A number of additional variables not included (e.g. individual

		consumption)
B. Research and evaluation work		
B1. Research initiated by NGOs Some initiated as a way to assess/test some existing pilots; some with discussions with policy-makers, some not as much Disseminated through workshop to which policy-makers are invited; some are presented at TWG meetings	Policy impacts depending on the study's relevance to existing policy or strategy; their relevance depending in turn on whether they were initiated as part of existing policy or pilot and whether it has engaged policy-makers in its design Those that get attention from policy-makers used either (i) as a case study to find ways to better understand existing policy (and its implementation), and/or (ii) as an additional piece of information to confirm a bigger study/survey More likely to shape an ongoing adjustment/ improvement of an existing policy rather than creating a new one	Many studies but not well coordinated Many are not considered as relevant (i.e. not initiated as part of the MoH's existing framework and agenda) Studies carried out as pilot/model are more practical, but not all pilots are appreciated by MoH (unless they are initiated/done under existing policy framework and with collaboration with the ministry) Some studies have limited discussion with policy-makers especially in research design Some studies are not reliable in terms of quality
B2. Research initiated as parts of programmes/ projects Initiated by DP or policy-makers as a part of a project/ programme, Funded by DP and conducted by external consultants, sometimes with policy-makers as co-investigators, sometimes not Disseminated to policy-makers and more likely to be presented at TWGs	Providing policy-makers with progress status, recommendations, strategies and challenges of a programme/ project More likely to shape an ongoing adjustment/ improvement of an existing policy or to create a new strategy or guideline (not policy)	Policy-makers still not really engaged in the design of the study, making some of the questions not really relevant to policy-makers' needs (the exception is when policy-makers are engaged as co-investors) No central coordination/filing mechanisms among studies that take place within various programmes/projects Findings and recommendations that are sensitive and touching on group interests more likely to be ignored

B3. Research initiated by outsiders (i.e. University or any institutions besides implementers) Initiated by outsiders (e.g. research institutes from abroad, universities) or DP Conducted in collaboration with local research institute (e.g. NIPH, CDRI, MEDiCAM) Disseminated to outsiders and sometimes policy-makers	Driven by outsiders' agendas, and sometimes, not seen as relevant/urgent for policy-makers Might attract some DPs' attention Can feed into policy or existing agenda if the local research institutes have existing connections in the policy-making mechanisms (e.g. TWG)	Sometimes serving only their own agenda Consultation with policy-makers on the design of the study often very limited Dissemination to policy-makers often not well conducted Policy-makers having little interest in these kinds of studies
B4. Mid Term Review Focusing on the whole health sector, if it covers sector-wide issues such as the HSPI and HSP II Done by an independent research team, but funded by DPs Consulted and disseminated to key informants especially DP and policy-makers Dissemination and validation workshop Focusing on specific project or policy strategy such as Fast Track Initiative	Providing policy-makers and DPs with findings on the progress, lessons learned and recommendation for review Policy and Strategy for next 5 years Provide recommendations for implementation adjustment	Policy makers more likely to accept recommendations that are not politically sensitive. However, those findings and recommendations that are politically sensitive and touch on vested interests more likely to be ignored MoH tend to support recommendations that might lead to new funding from DP
C. Data/Database Management Systems Initiated, supported by DP and NGO, but then transferred to MoH DP and NGOs still need to provide assistance even after the database is transferred to the Government Made available to DP, NGO, PM and the public via website (e.g. HiS, Drug Inventory Database, Health Equity Fund)	Mainly for monitoring purposes Used as the sources of updated statistics on health performance, which is in turn useful for various evaluations Used as a basis for AOP Used for policy formulation and intervention	The quality of the databases is sometimes questionable The capacity of government staff to ensure the sustainability and quality of the database is still limited Can indirectly help foresee what new policies are needed in the future, but this is more likely to happen as a way to reinforce an existing initiative/idea Lack qualified staff; lack of incentive among staff due to low salary.

D. Feedback from sub-national level Happened through Provincial Joint annual performance review (Pro-JAPR), national JAPR, and other forums including annual Health Congress Happened through regular reporting system	Focusing the implementation of specific projects/ programmes on the ground, governance challenges (staff management, incentives, collaboration with NGOs) Providing feedback on the implementation of existing policy, which might lead to adjustment in existing guideline	Sub-national level caring more, meeting targets, set up the national level and incentive problems Relying on supporting NGOs as the ones who introduce and bring ideas to the national level to shape policy formulation Problems associated with corruption, patronage are generally suppressed

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