

**THE INTERNATIONAL HEALTH PARTNERSHIP (IHP)
IN CAMBODIA**

STOCK TAKING REPORT

Prepared for: THE INTER-REGIONAL COUNTRY HEALTH SECTOR TEAMS MEETING

LUSAKA, ZAMBIA

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Background

The Royal Government of Cambodia (RGC) and development partners (DP) have committed to working on harmonization, alignment and results. Cambodia is an OECD/DAC pilot country and is implementing the Government Action Plan on Harmonization, Alignment and Results (HAR) through Technical Working Groups and the Council for Development of Cambodia (CDC). In October 2006, under their respective commitments to the Paris Declaration, the RGC and development partners signed a 'Declaration by the Royal Government of Cambodia and Development Partners on Enhancing Aid Effectiveness' - a statement expressing their willingness to work together to implement the RGC's Action Plan on HAR for 2006-2010.

This commitment came on the heels of the publication of Cambodia's Aid Effectiveness Report of 2006. The report noted that development assistance in Cambodia remains highly fragmented and competitive, thus recommending that the RGC and development partners in all sectors, especially the health sector, adopt and implement the principles of the Paris Declaration such that:

- 1) The RGC demonstrates leadership and ownership over development policies, plans, strategies and development actions such as the National Strategic Development Plan (2006-2010) that consolidates Poverty Reduction Strategy Paper, Socio Economic Development Plan and Cambodia specific MDGs. Institutionalising the CDCF as follow up modality for the annual CG meetings in 2007 reaffirmed the country leadership in H&A processes. The formulation of the Health Strategic Plan (HSP) 2008-2015, and strengthening 3-Year Rolling Plan/MTEF and Annual Operational Plan processes will be the basis for H&A within IHP.
- 2) Development partners, in-country and international, align their programs with the RGC's strategies, institutions and procedures and support only those programs which fall within the priorities articulated in the NSDP and HSP;
- 3) RGC and development partners arrangements are harmonized, transparent and collectively effective;
- 4) Resources are managed for maximising results by undertaking the following: a framework for monitoring the implementation of the NSDP and the annual progress review of the NSDP; and the rolling 3-year Public Investment Program (PIP) which is based on the annual reviews of the NSDP implementation.
- 5) The role of all stakeholders, including civil society organizations (CSOs) and the private sector is strengthened in planning and implementation of development assistance programs to enhance transparency and mutual accountability for development results.

In late 2006 Cambodia participated in the 14 country Paris Declaration Monitoring Survey and the results were documented and launched in early 2007. Although the indicators were self-reported and involved a degree of subjective interpretation, the data provides a baseline against which future progress can be measured.

On the institutional side the Monitoring Survey found that the RGC has undertaken impressive steps, towards enhancing aid effectiveness, including:

- Strengthened the Council for Development of Cambodia (CDC) chaired by the Prime Minister;
- Assigned the Cambodian Rehabilitation and Development Board (CRBD) as a focal point and "one stop service" for aid coordination, allocation and utilization;
- Established a high level Government-Donor Coordination Committee (GDCC) to provide policy guidance and top-level coordination, involving ministers, heads of bilateral, multilateral and CSO organizations and ambassadors;
- Replaced existing coordination mechanisms, at the sectoral level, with joint-donor Technical Working Groups (TWGs); and
- Developed policies, strategic frameworks and practical guidelines for effective management of aid in-consultation with DPs.

As a result, there is little ambiguity about the RGC's preferences regarding key aspects of aid and the way it is utilized. While acknowledging the importance of external aid to the development of Cambodia the RGC underlines the need for DPs to undertake the following steps:

- Harmonize their practices and align all activities with Cambodia's development priorities;
- Shift cooperation away from stand alone projects towards sector/thematic and/or program based approaches;
- Utilize appropriate in-country national mechanisms, delivery systems and human resources;
- Minimize administrative burden of local partners;
- Ensure greater transparency over resources and activities;
- Fund programs through direct sector or general support funds;
- Coordinate with the CRBD, CDC prior to entering into bilateral agreements; and
- Enhance local capacity through technical assistance

Within this context, it is vital that the IHP adds value by providing forums for public-private, including CSOs, dialogue to help the MOH achieve its national health priorities as laid out in the HSP2 while supporting accountable and transparent mechanism for implementation.

To this end, health partners, whether signatories to the global IHP compact or not, participate in discussions about the relevance and implementation of the IHP in Cambodia in an effort to use the IHP as a vehicle for harmonization and alignment within the health sector.

Existing Coordination Groups

Cambodia has an extensive structure of coordination groups and mechanisms for health. The Technical Working Group for Health (TWGH) has 74 official members, is a MOH led and has broad participation from multiple MOH departments, national programs and institutions, other line ministries, CDC and bilateral and multilateral development partners (DPs), including NGOs and other CSOs working in the health sector.

Reporting to the TWGH are multiple programmatic and disease specific sub-TWGs which also have diverse memberships. The TWGH is a strategic group and focuses on broader health sector initiatives, including health systems while the sub-TWGs focus on specific technical and cross-cutting issues, such as policy and capacity building within the broader remit of the health sector. The TWGH structure is replicated at the provincial level.

The TWGH Secretariat, with representatives from the MOH and Health Partners(HPs), facilitates the smooth functioning of the TWGH, including the formulation of Joint Monitoring Indicators (JMIs), setting of annual workplans and identifying the monthly meeting agenda.

There are also groups/departments focused on increasing harmonization and alignment, these include the MoH Task Force on Deepening Harmonization and Alignment (H&A), the MoH Department of International Cooperation, and the MoH Department of Planning and Health Information. The health partners themselves convene groups in an attempt to harmonize and align among DPs, these include the Health Partners group, the WG for H&A, Salary Supplement Working Group, and the Health Sector Support Project (HSSP) Partners.

The Global Fund CCM, or CCC (Country Coordinating Committee) as it's referred to in Cambodia, includes many of the same development partners and civil society groups as the TWGH, but largely not the same individual members. The CCC is also chaired by a different Secretary for State for Health and includes national programs (e.g. HIV/AIDS, TB and malaria), representatives from other line Ministries (Education, Women's and Social Affairs), the multi-sectoral National AIDS Authority and MEDICAM, an umbrella organization consisting of over 100 CSOs in Cambodia.

To assist with coordination within HIV/AIDS, a Government-Donor Joint (GDJ) TWG for HIV/AIDS has been established which is chaired by the National Aids Authority (NAA) and has a diverse membership of development partners, CSOs and government line-ministries. In an effort to better coordinate among development partners, there also exists the Development Partners Forum for HIV/AIDS.

Under NAA leadership sector-wide costed operational plans (i.e. Health Sector Strategic Plan for AIDS 2008-2010 (NCHADS); MoEYS Strategic Plan 2008- 2012; MoWA Strategic Plan 2008 – 2012 and MoND Strategic Plan 2007-2011) have been developed to support harmonisation and alignment of development partner support and clarity in implementation arrangements and processes by national partners.

The GDJ-TWG on HIV has guided the development of the National AIDS Spending Assessment (incorporated into the 2008 UNGASS Report), the revised SRA, NSPII and its re-costing (currently under development), all of which have assisted to clarify priorities for development partner engagement and increased harmonisation of effort on both the part of government and partners.

Harmonization within HIV/AIDS itself is still a challenge as responsibility for most of HIV/AIDS lies with the National Center for AIDS, Dermatology and STIs (NCHADS) while PMTCT lies with the National Maternal and Child Health Center (NMCHC). There are also efforts underway to link HIV/AIDS with reproductive health programs, also part of the NMCHC. Maintaining ongoing and open dialogue between the national program, MOH and the DPs is critical to ensuring harmonization.

Existing Health Policies and Strategies

A Health Sector Plan (HSP2) for the period 2008-15 is currently being developed. The MOH Department of Planning and Health Information (DPHI) is leading the process with the TWGH providing oversight.

The HSP2 development is a highly participatory process both within the MOH and with active participation from health partners, including civil society. **Consultation between stakeholders highlighted the following challenges:**

- Lack of human resource quality and quantity, inadequate deployment, especially to rural areas, and low salaries and incentives for staff working in the public health sector;
- High level of 'dual employment' of health professionals in both the public and private sectors;
- Inadequate skills, technical competencies and limited management capacity towards accountability due to low quality of practical training sites and limited quality of teaching staff;
- Inadequate financial flow and logistics support for drugs and commodities;
- Insufficient human and financial resources to maintain and scale up services and coverage of HEF and SHI;
- Low level of quality of care at health facilities (public and private) both in terms of a lack of standards of medical care and the delivery and organization of services;
- Limited health systems governance at provincial level, and management capacity at district and facility levels;
- Ineffective regulatory mechanisms and weak coordination between public and private (including NGO) health services;
- Weak enforcement of health legislation and compliance with standard guidelines and practices, and quality assurance (lab and drug quality control);
- Lack of reliable health information and reporting system, comprehensive preparedness plan, emergency response system and epidemiological data;
- Fragmented aid architecture, including predominate attention given to disease control programs by donors, undermines MOH's stewardship role;
- Fragmentation of activities, funding, monitoring and supervision, and administrative lines of authority;
- Limited integration of the private sector, including NGOs, service provision into a national health policy implementation framework;

- Low utilization of public health services due to quality, access (physical, and direct and opportunity costs) and other barriers (e.g. cultural, gender, women's empowerment in decision making, education, security, etc.); and
- Inappropriate health practices and health seeking behaviour.

Many of the above challenges were also identified in the Health Sector Strategic Plan (2003-2007) Medium-term review conducted by the MOH in March 2007. Through dialogue and consensus with key stakeholders the MOH systematically designed the HSP2 to address many of the above challenges as a means to achieving the RGC's health priorities and the Cambodia Millennium Development Goals (CMDGs).

The HSP2 will be implemented through three programs – Reproductive, Maternal, Neonatal and Child Health (RMNCH), Communicable Disease Control, and Non-Communicable Disease Control. The goals under each are: Goal 1: To reduce maternal, new born and child morbidity and mortality with increased reproductive health; Goal 2: To reduce morbidity and mortality for HIV/AIDS, Malaria, TB and other communicable diseases, and Goal 3: To reduce the burden of non-communicable diseases and other health problems. A key challenge under the HSP2 is the growing likelihood of population morbidity and mortality from non-communicable diseases before a parallel decrease in communicable diseases takes place. This 'double burden' demands continued improvements in the current health system developed for communicable diseases and MCH, while developing new skills and systems to meet the demands of non-communicable diseases with the need for life-long and costly treatment, and increased prevention efforts through greater multi-sectoral approaches.

The participatory process being used in development of the HSP2 also has brought to the forefront a number of issues that need to be resolved to improve H&A: a) a better understanding of the overall costs of scaling-up, taking into account not just direct program costs, but also the cost of equity funds and other proposed financing initiatives (e.g. community-based health insurance); b) identifying steps to reduce fragmentation and improve alignment of external support, including through greater clarity on available modalities; c) ensuring that the Joint Annual Performance Review process can influence future resource allocations; and d) inclusion of these elements in a rolling Medium Term Expenditure Framework (MTEF) for health. Additionally, the approach to be adopted by the MOH to harmonize practices around financial incentives and to ensure proper pay to MOH staff will influence the cost and effectiveness of the HSP2.

The process of developing the HSP2 is concentrated in the MOH. Many of the systemic and financial constraints to improving performance, however, require action by other parts of government - notably the Ministry of Economy and Finance (MOEF). Similarly, although the precise form of the proposed decentralization and deconcentration of power from national to provincial level has yet to emerge from the political process, it is already evident that successful implementation of health program is going to be increasingly dependent on collaboration with Provincial Governors and their administrations. Strategies for strengthening the relationship between health and finance and with provincial authorities, binding them into future agreements in relation to sector financing and resource allocation, need to be carefully developed. This will also require systematic and coordinated efforts of capacity building at sub national level. The predictability and coherence of external funding is a major challenge in the health sector. Bilateral and certain multilateral donors can be prevented by their own internal policies from making longer term commitments outside of specific projects or diseases. However, where possible, a joint effort will be made by the DPs at the country-level to support the MOH's priorities by providing predictable and coherent funding.

Financing

Currently, the challenges faced in financing health care in Cambodia are characterized by:

- Low level of government health spending, with current budget spending at a little more than 1% of the GDP, despite substantial increases;
- Low level of public funding (< 40%) reaching the service delivery
- High level of private, out of pocket household spending that accounts for approximately two-thirds of the health expenditure; and
- Rising level of donor funding for health care reaching USD 5-6 per person (2007).

The RGC is also focusing its efforts on increasing the share of the government's expenditures for health over the total health expenditures which implies a gradual shift from donor funding towards a sustainable national health budget.

The MOH has been working to strengthen advocacy efforts between MOH and MOEF, improve financial planning, implementation and monitoring systems and by identifying gaps between resources available and those needed to achieve health goals.

Since 2004, the MOH staff have used the Annual Operational Plan (AOP) and the 3 Year Rolling Plan (3YRP) as tools to formulate strategic and yearly budgets and perform resource gap analysis. Over the last three years, AOPs have already proven to be valuable and effective tools in the allocation and monitoring of resource flows to and within the sector. Work is currently underway such as the introduction of Program-Based Budgeting (PBB) to ensure better links and compatibility with the budget processes within and beyond the sector. The AOPs also serve as a basis for providing information to the Ministry of Planning (MOP) for the developing the PIP.

However, for the RGC to be able to deliver effective and sustainable funding in the long-term health sector financial systems and management tools (i.e. designing of a coherent PIP for health, including recurrent costs for maintenance and training and to integrate the PIP for health into AOP and 3YRP) will need to be designed and implemented at all levels of the health sector to allow efficient implementation of government resources.

Staff capacity at the national and provincial levels will also need to be strengthened in strategic budgeting, PFM reform implementation, use of provincial AOPs for provincial budget negotiations and implementation and monitoring increased allocation of funding to health priorities.

At the global level, The Global Fund for AIDS, TB and Malaria (GFATM) proposal process places considerable uncertainty on long-term external funding, particularly when the GFATM support constitutes a significant proportion of external health financing; the potential shortage of finance for the purchase of traditional vaccines that could result from GAVI's focus on new antigens; a concern for sustaining the procurement of commodities for the AIDS program in the context of a large number of patients already on ART; the challenge of maintaining a coherent approach to information systems development; and the workload imposed by the fact that Cambodia has been selected for at least nine new pilots/initiatives/studies in international health (WHO Report). Each of these demands closer examination to see whether action by IHP signatories, or others, could help relieve unnecessary constraints.

A draft report of the recently completed World Bank *Financial Management Assessment of the Health Sector (draft 2.1)* in Cambodia concludes that the present overall fiduciary risk is high. However, the report also states that if the mitigating actions recommended are put in place and reforms are made, this risk could be reduced to medium. The authors conclude that the planned Financial Management Reforms Program (PFMRP) offers significant opportunity for strengthening public financial management at line ministries. This, combined with the implementation of the reports recommendations, provides development partners an opportunity to consider new and unprecedented funding modalities under HSSP2.

How to Operationalize the IHP

The IHP was signed by Cambodia in September 2007 to foster better coordination of development assistance at the country level. The intent is to utilize the political leverage of the signatories at the global level to address long-standing concerns at the country level, specifically in relation to health systems strengthening and better coordination of development cooperation.

It is vital that IHP is seen to add value to what exists (e.g. mechanisms such as the TWGH) and that it helps move existing processes forward and produces results. The IHP must help in changing mind sets and behaviours intra and inter development partners and the RGC that are counter to H&A of development assistance in Cambodia. The IHP should expect to limit transaction costs and enable the health partners and the RGC to work more effectively and efficiently.

All four main elements of the IHP approach are relevant to the Cambodian situation:

- 1) A focus on *national strategic plans* - including national health financing policy - as a template around which to align external assistance;
- 2) Identifying and mobilizing the resources to act on *health systems constraints* for the achievement of more ambitious health outcomes - particularly in relation to the health MDGs;
- 3) Better *use of aid resources* through the application of the Paris Principles in the health sector; and,
- 4) More *effective accountability* between government and its development partners.

All these elements are central to the ongoing efforts of the MOH and health partners to deepen the sector-wide approach in health. However, it is first important to understand how Cambodia can operationalize IHP and the challenges and opportunities stakeholders will face in doing so.

In developing this stock taking report multiple documents were reviewed and consultations were held with key stakeholders in the MOH, development partners (e.g. multilateral, bilateral and CSOs) and with those working in-country on the design of new proposals for Global Programs such as GAVI. Discussions with stakeholders highlighted the following issues:

- 1) The Secretariat of the TWGH has been proposed to serve as the IHP Country Team and is considered an appropriate mechanism (and one which already exists, in keeping with the IHP objective of not creating new institutions) for Government – DP collaboration on IHP issues. The Secretariat includes high-level chairmanship, membership of several key departments at MoH, representatives of bilateral and multilateral agencies (selected on a rotating basis by those constituencies), an umbrella organization for health-related NGOs (MEDICAM), and WHO. The World Bank serves as an alternate on this body, and will be a member by mid-2008.
- 2) Although the IHP has been discussed on several occasions, including TWGH and Secretariat meetings, and health partners meetings, many RGC and development partners are not fully clear about its concept. There is variable understanding of what IHP stands for, how it will be operationalized or what the value added is. RGC and non-RGC stakeholders are concerned about duplication and the potentially large transactional costs anticipated and associated with having yet another partnership or mechanism for donor coordination.
- 3) While many relevant activities are strongly underway, there have not yet been major new IHP events in Cambodia. MOH has clearly indicated that its first priority is the successful development of the new HSP2, a final draft of which is due at the end of February 2008. This document represents a fundamental underpinning of the IHP process, and MOH attention (in close consultation with health partners) has been strongly engaged with its development, as well as several related activities with a strong bearing on successfully meeting IHP objectives, such as the development of a new multi-partner Health Sector Support Program. Attention cannot turn fully to additional IHP expectations until this process is well in hand;

these activities are also intimately connected to IHP goals. This process and timeline is in keeping with stated principles of the IHP (Concept Note), including that:

"[The IHP] will be country-driven and tailored to reflect country needs, plans and systems; institutionally light to avoid further complicating the global health architecture and adding to the administrative burden for countries; [and] fully aligned with countries' national development frameworks".

- 4) There is no code of conduct or memorandum of understanding (MOU) between the DPs in the health sector. The formulation of an agreement will serve as an opportunity to clarify responsibilities and roles, standardize and harmonize practices such as per-diem rates (sub-decree 10), salary incentives (sub-decree 98) and other possible upcoming agreements such as modified PMG rates for service delivery staff.
- 5) Development partners need to clearly map out who will be working on community based health insurance (CBHI) initiatives and where to maximize resources and avoid duplication.
- 6) Proposed new projects should be presented to and discussed by the TWGH, led by the MOH, for endorsement to ensure they are aligned and harmonized with RGC and DP priorities.
- 7) Development partners need to ensure that the Technical Advisors they fund are not only technical experts but also have the necessary skills to transfer their knowledge and skills to RGC counterparts. This also requires that the RGC identify and dedicate promising individuals to be mentored and commit to keeping them in positions once the expat Technical Advisor departs.
- 8) Each donor currently has its own peer-review, monitoring, evaluation and reporting systems which are time intensive and make it virtually impossible to study trends and be strategic. A joint and harmonized system, where feasible, should be developed and implemented.
- 9) Proposals for submission to global funding partnerships for health, such as the Global Fund and GAVI, are developed and managed by separate mechanisms: In the case of the GF, through the country coordinating mechanism (CCC); for GAVI, proposals are developed with the Immunization Coordinating Committee (ICC), and approved by the High Level Steering Committee which includes representation of the MOEF. The Ministry of Health raised the issue as to whether separate bodies are needed and whether a more streamlined process might be possible. In considering the way forward, it will be important to ensure that any new proposal does not compromise the CSO voice that has been institutionalised under the CCC. Indeed, it may well be that stronger linkages between the oversight bodies may be more effective than their actual merger.
- 10) Financing from the GFATM has made a significant contribution to the improvement of health outcomes in Cambodia - particularly in relation to HIV and AIDS. Having been successful with a total of 10 proposals in all except Round 3 – the GFATM has become a major financier of health sector activities in Cambodia. If the HSP is to become the template around which a growing number of partners align, the question arises as to how the GFATM - *without* its own country presence - can meaningfully participate in the development of the HSP. This will be particularly important if - as is intended under IHP - a review of national plans becomes an integral part of how partners make their funding decisions. More immediately, a shift away from the round-based proposals of the GF towards multi-year programmatic funding under the HSP is clearly desirable.
- 11) IHP provides an opportunity to focus on systems bottlenecks. This could include reviewing donor and MoH perceptions regarding assumed versus actual causes of morbidity and mortality. While there are many different sources of data there is a need to pull together the most accurate picture possible of the overall burden of disease to inform an evidence-based discussion over policy and funding priorities. Leading on from this should be a review of specific health systems issues. These might include work on a) health financing strategies and social protection moving beyond equity funds; b) a review of the human resource development plan with a particular focus on quality distribution and incentives - as well as linkages with overall

administrative reform; c) quality issues in general and particular focus on legislation and work with the extensive private sector - which in turn raises issues around the overall role of the state in a system that is likely to continue to rely on both private and voluntary provision of services.

- 12) Under decentralization, IHP provides an opportunity to focus on health sector financing and resource allocation. Although the precise form of the proposed decentralization and deconcentration of power from national to provincial level has yet to emerge from the political process, it is already evident that successful implementation of health programmes is going to be increasingly dependent on collaboration with Provincial Governors and their administrations. Strategies for strengthening the relationship between health and finance and with provincial authorities binding them into future agreements in relation to sector financing and resource allocation need to be carefully developed. At the national and provincial level the MOH and the DPs need to work in partnership to identify how they will work towards co-financing of provincial block grants.

Concrete Next Steps

The Ministry of Health is deeply engaged in formulating its HSP2 (2008-2015), and in developing an implementation plan. MOH has conveyed its priorities, intentions, and processes to Development Partners, and has a timetable for its activities. The IHP is considered a useful mechanism especially to encourage and facilitate further DP harmonization, and the process of DP alignment with expressed MOH strategies and priorities. While Government institutions will benefit from further support and strengthening, it is not intended that new structures or requirements be imposed. Rather, the burden falls substantially on DPs to better harmonize ways of working with and supporting MOH. Next steps are focused on such process facilitation.

Consultative meetings with key stakeholders (i.e. DPs, MOH, CSOs, GFATM and GAVI recipients), in the health sector, as part of this stock taking exercise has helped identify the concrete actions listed below that will boost both the momentum behind and the credibility of the IHP at the country level. It will also reinforce priorities identified at the country, regional and global levels to better coordinate development assistance and to increase investment in health systems strengthening to accelerate the achievement of health MDGs.

- **IHP awareness and advocacy:** Develop a "core script" agreed by key MOH officials and development partners, defining the IHP in Cambodia - what it is trying to do, who is involved, what is the added value, what is planned and when.
- **Forums for dialogue:** Maximize use of existing forums (TWGH and its Secretariat, Health Partners Group, and several others), and elaborate others where lacking (MOH and Health Partners with other Ministries, civil society, private sector, non-resident Global Health Partnerships).
- **Implementation processes for the Health Strategic Plan (HSP):** Establish in-depth dialogue among Health Partners to support implementation of the HSP, on subject areas agreed with MOH (possible examples: human resource development, health care financing, service delivery, developing the evidence base).
- **Communications and harmonization:** Use available resources, when agreed, to support tracking and coordination of activities; to liaise between MOH and DPs, and among DPs.

Conclusions:

Prior to the signing of IHP+, development partners in Cambodia demonstrated clear commitment to harmonization and alignment and seek to add value to this process through the IHP+. Participation in the Lusaka Meeting, February 28-March 1, will enable the six person Cambodia delegation (MOH, MOEF, WHO and MEDiCAM) to further clarify ways to realize the goals of the International Health Partnership.

Annex I

Key Resources and Source documents Reviewed

Global and Cambodia Specific Documents on Enhancing Aid Effectiveness

- Paris Declaration on Aid effectiveness (2005)
- Survey on Monitoring The Paris Declaration, OECD, 2006
- Declaration by RGC and Development Partners on Enhancing Aid Effectiveness (2006)
- RGC harmonization, Alignment and Results Action Plan (2006-2010)
- The Cambodia Aid effectiveness Report, RGC and CRDF- CDC, 2007

Global IHP Documents

- Generic TOR for stock-taking reports (Annex A of the Lusaka meeting TOR)
- IHP Concept Note and IHP Compact, September 2007
- IHP+ Workplan
- IHP Updates
- A Common Framework for M&E of the scale up for better health
- Minutes of meetings of IHP+ and Scaling-up Reference Group (SuRG)

Global Health Partnership Documents

- CCM Case Study –Cambodia Harmonization and Alignment, GFATM, 2007
- GAVI Alliance Health System Strengthening (HSS) Application (Draft) for Cambodia, February 2008

Royal Government of Cambodia Documents

- Cambodia Millennium Development Goals Report (CMDG), RGC, 2003
- Achieving the CMDGs –Update, Ministry of Planning (MOP), 2005
- National Strategic Development Plan (NSDP) 2006-10, MOP, 2006
- NSDP Annual Progress Report, 2006

Health Sector

- Health Sector (HS) Review, MOH, 2003-2007
- Health Sector Strategic Plan (HSSP) Mid-term Review, MOH, 2007
- Joint Annual Performance Review (JAPR), Department of Planning and Health Information, 2007
- Health Sector Plan2 (Draft), MOH, 2008-2015
- Health Information System Strategic Plan (HISSP), MOH, 2008-2015
- The 4th Health Sector Consolidated Annual Operational Plans (AOP), MOH, 2008
- A Common Framework for Monitoring Performance and Evaluation of the Scale-up for Better Health (Draft),WHO and the World Bank, 2008
- Strategic Framework for Health Financing in Cambodia, MOH, 2008-2015
- Financial Management Assessment of the Health Sector, World Bank, 2008
- Cambodia Development Partners in Health Sector-Design of the Next Phase of Support Report, Oxford Policy Management (OPM), 2008
- Review of the Technical Working Group on Health and its Secretariat, MOH, 2007
- Power Point Presentation on the Review of the TWGH, TWGH, 2008
- Second National Health Workforce Development Plan, MOH, 2006-2015
- Institutional Development Plan for the Cambodia Health Sector, OPM, 2006
- The First Health Sector Three Year Rolling Plan, MOH, 2005
- Merit Based Pay Initiative (MBPI) Operational Manual, 2007
- Health Partners Harmonization on Per Diem Rates, MOH

Annex 2

List of MOH and Development Partners/Consultants

Below please find a list of Senior MOH and DP staff and/or consultants whose insights have been critical to the development of this stock taking report.

- 1) Dr. LO Veasnakiry, Director of Department of Planning & Health Information, MOH
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