WHO Country Cooperation Strategy

Midterm Review

CAMBODIA
2009–2015

World Health Organization
Western Pacific Region

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TABLE OF CONTENTS

EXECUTIVE SUMMARY vi

SECTION 1. INTRODUCTION 1

SECTION 2. CAMBODIA'S HEALTH AND DEVELOPMENT CHALLENGES 2

2.1 Overview 2
2.2 Demographics and mortality 2
2.3 Socioeconomic development 3
2.4 Government and the macroeconomic environment 3
2.5 Progress and constraints 4
2.6 Health systems development 5

SECTION 3. DEVELOPMENT ASSISTANCE AND PARTNERSHIPS: AID FLOWS, INSTRUMENTS AND COORDINATION 8

3.1 Overview 8
3.2 Partnerships and coordination in health 9
3.3 International Health Partnership 11
3.4 United Nations (UN) System in Cambodia 12

SECTION 4. CURRENT WHO COOPERATION WITH THE GOVERNMENT AND PEOPLE OF CAMBODIA 13

4.1 Communicable disease control 13
4.2 Health systems 15
4.3 Maternal and child health 16
4.4 Noncommunicable diseases 17
4.5 Human resources and the Programme Budget within WHO 19

SECTION 5. WHO POLICY FRAMEWORK: STRATEGIC AGENDA AND PRIORITIES 20

SECTION 6. EXPECTED EVOLUTION OF WHO PRESENCE IN CAMBODIA 25

6.1 Changing national environment 25
6.2 Emerging global and regional issues 26
6.3 Engagement with the Regional Office and WHO headquarters 27

SECTION 7. CONCLUSION 28

ANNEXES

Annex 1. Programme Budget envelope for 2014–2015 29
Annex 2. Strategic intent and tracer indicators by WHO Cambodia technical teams 30
Annex 3. WHO Cambodia: Support needs from the WHO Regional Office for the Western Pacific and WHO headquarters 32

LIST OF TABLES

Table 1. Progress towards the Cambodian Millennium Development Goals (CMDG) 3
Table 2. Staff positions in WHO Cambodia, as of March 2014 18

ABBREVIATIONS

AMR	antimicrobial resistance
ANC	antenatal care
APSED	Asia Pacific Strategy for Emerging Diseases
ASEAN	Association of Southeast Asian Nations
CCC	Country Coordinating Committee
CCM	country coordinating mechanism
CCS	country cooperation strategy
CDC	Council for Development of Cambodia
CMDGs	Cambodian Millennium Development Goals
CDHS	Cambodia Demographic and Health Survey
CSO	civil society organization
D&D	Decentralization and Deconcentration
DFAT	Department of Foreign Affairs and Trade (Australian Government)
EENC	Early Essential Newborn Care
ERAR	Emergency Response to Artemisinin Resistance
EPI	Expanded Programme on Immunization
GDP	gross domestic product
GHPs	global health partnerships
HEF	health equity fund
HPV	human papillomavirus
HRH	human resources for health
HSP2	Health Strategic Plan 2008–2015
HSS	health systems strengthening
HSSP2	Second Health Sector Support Programme
IDU	injecting drug user
IHP+	International Health Partnership Plus
IHR	International Health Regulations
IMCI	Integrated Management of Childhood Illness
IMR	infant mortality rate
JMI	joint monitoring indicators
JPIG	Joint Partnership Interface Group
MCH	maternal and child health
MDG	Millennium Development Goals
NAA	National AIDS Authority
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NCD	noncommunicable diseases
NFM	New Funding Model
NMCHC	National Maternal and Child Health Center
NSDP	National Strategic Development Plan
NTD	neglected tropical disease
PNC	postnatal care
PEN	Package of Essential Noncommunicable Diseases Interventions for Primary Health Care in Low-resource Settings
RAI	Regional Artemisinin Initiative
RMNCH	reproductive, maternal, newborn and child health
STEPS	WHO STEPwise approach to Surveillance of NCD Risk Factors
SWiM	Sector Wide Management
TB	tuberculosis
TRIPS	Trade-related Aspects of Intellectual Property Rights
TWG	technical working group

TWG-H	Technical Working Group on Health
UHC	universal health coverage
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United National Development Assistance Framework
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

This document presents a midterm review of the *WHO Country Cooperation Strategy* (CCS) *2009–2015* for Cambodia. Since the CCS was drafted, the development context in Cambodia has changed markedly – and the country now faces new challenges associated with economic and social transition. To remain relevant and strategic in this dynamic policy environment, WHO is refocusing its support during the last two years of the CCS around three priorities:

1. **Universal access to an essential package of quality health services based on fairness in financial contribution and equity in access.** This includes support to health systems strengthening, health financing, human resources for health and the quality of service delivery.

2. **Technical excellence in disease and public health programmes.** WHO's disease control programmes fall under this strategic priority. The focus will be on improving coordination between different disease programmes, providing cross-cutting support on for example infection control and surveillance, generating evidence, and monitoring impact.

3. **Effective stewardship of the health sector and health partnerships.** Work in this area relates to WHO's leadership role in policy development and coordination of health partners and also includes engagement with the private sector and the decentralization agenda. Building national capacity and transferring skills and knowledge are key elements of the approach.

Under these strategic priorities, WHO will continue to support the implementation of the second *Health Strategic Plan 2008–2015* (HSP2). Key activities planned for 2014–2015 in support of HSP2 are summarized below and presented in full in Section 4.

Communicable Disease Control. The overarching goals across disease programmes are to: *streamline*, that is, focus on those population groups in which diseases are now concentrated; *synergize*, that is, integrate disease-control efforts with the health systems that underpin service delivery; and *sustain*, that is, ensure adequate resource mobilization in the changing donor environment, including from domestic revenues.

In HIV, WHO will support the Cambodia 3.0 Initiative that aims to achieve zero new HIV infections by 2020. WHO will also encourage integration between TB and HIV programmes, as well as integration of the prevention of maternal-to-child transmission and chronic care programmes with the rest of the health system.

In TB, WHO is assisting with the development of the 2014–2020 *TB National Strategic Plan*, which will form the basis of the New Funding Model (NFM) application for the Global Fund to Fight AIDS, Tuberculosis and Malaria.

In Malaria, WHO will continue to support vector-control efforts, while also working with the Government and regional partners to address emerging artemisinin resistance.

In emerging infectious diseases, WHO's focus will be on supporting Cambodia to achieve the core capacities required by the International Health Regulations (2005), as well as surveillance and outbreak response.

Health Systems. Health financing will be the cornerstone of WHO's health systems work in the next two years. In the short term, WHO will continue to engage with health equity funds, which now represent the main mechanism for addressing financial barriers to services for the poor and vulnerable. In the medium term, the focus will be on the emerging policy for social health insurance. A National Health Accounts survey will be carried out in the next two years, providing critical input to financing policy development.

In human resources for health, WHO's support will focus on pre-service training, expanding the newly established national exit examinations to other disciplines and setting up independent medical councils to regulate the conduct of health professionals.

Efforts to strengthen health information in the next two years will focus on improvements to civil registration and vital statistics.

Maternal and Child Health. WHO supports Cambodia's National Immunization Programme in three main areas: surveillance, expanding coverage of routine immunizations, and the introduction of new vaccines. Coverage of underserved communities will continue to be a priority.

In newborn and child health the focus is on Early Essential Newborn Care (EENC) and the Integrated Management of Childhood Illnesses (IMCI). The Government's *Fast Track Initiative Road Map to Reduce Maternal and Neonatal Mortality (2010–2015)* forms the basis of the Reproductive, Maternal, Newborn and Child Health (RMNCH) team's work. For reproductive, maternal and newborn health, WHO supported the National Maternal and Child Health Center (NMCHC) to update the safe motherhood protocol for health centres and referral hospitals, as well as for the maternal death audit protocol. A standardized in-service training package for midwives is being developed. In recognition of the growing burden of gender-based violence, WHO will assist in conducting a survey on the prevalence of violence against women and provide technical assistance to the Ministry of Health in developing clinical management guidelines on gender-based violence.

Persisting high rates of child and maternal under-nutrition mean that nutrition is now a priority for both the Government and development partners. WHO is working to scale up its support in this area, but at present capacity in the country office is limited.

Noncommunicable Diseases (NCDs). Work on NCDs has expanded dramatically during the first phase of CCS implementation, and it will continue to grow over the next two years. A new work programme will be established on disability, focusing on improved rehabilitation services. Other areas of support include developing national legislation on tobacco control and working with the Government to implement a ban on tobacco advertising, updating the road safety law, supporting development of a multisectoral action plan for the prevention and control of NCDs for 2014–2020, and improving water quality.

The post-2015 development agenda. As Cambodia's socioeconomic transition continues and its health system matures, so the nature of WHO engagement will continue to

change. Looking to the post-2015 period, there will likely be a much greater focus on governance, stewardship and national capacity-building to ensure the sustainability and institutionalization of reforms now under way. For WHO this implies working on a narrower range of programmes, but at a more upstream level. The "synergize, streamline and sustain" approach being pioneered in communicable disease control is thus likely to be relevant for all the WHO Cambodia programmes.

SECTION 1. INTRODUCTION

The *WHO Country Cooperation Strategy* (CCS) for Cambodia was drafted in 2008 to cover 2009–2015. Since then, Cambodia and its health sector have developed rapidly. The economy is growing steadily, with the country due to attain middle-income status in the next few years; poverty is falling; and urbanization is well under way. The health sector is also maturing and now faces a new set of challenges associated with economic and social transition: changing disease patterns and in particular the emergence of noncommunicable diseases (NCDs); a growing private sector active in the health market; and the challenge of ensuring quality as coverage expands.

The CCS was drafted in parallel with the *Second Health Strategic Plan* (HSP2) *2008–2015* and informed by it. HSP2 remains valid. However, in the future, health sector development will also be guided by two new national development plans: the *National Strategic Development Plan* and the *Rectangular Strategy for Growth, Employment, Equity and Efficiency*. Both were officially adopted following the general election in July 2013.

The donor environment has also changed markedly since the CCS was drafted: some long-standing bilateral partners have left; new ones have arrived; funding through existing global health partnerships has scaled up; and new regional partnerships have been established.

WHO Cambodia needs to remain strategic and relevant in this dynamic policy environment, providing effective technical support to the Government and continuing its leadership role among health partners. The CCS is the key strategic document guiding WHO's engagement with the Ministry of Health and health sector development in Cambodia. In November 2012 an external assessment recommended that the CCS be updated to reflect changes in the broader environment and WHO's evolving programme of support to Cambodia, including priorities for the final two years of CCS implementation.

This midterm review of the Cambodia CCS provides that update. To be consistent with and complementary to the existing CCS, it is structured in the same way:

- Sections 2 and 3 synthesize recent health developments and changes in the health partnership environment, including the harmonization and alignment agenda and WHO's role within it;
- Sections 4 and 5 provide an overview of WHO's support to Cambodia and set strategic priorities for the final two years of the CCS, 2014–2015; and
- Section 6 looks to the future and "scans the horizon" for future issues likely to be important in the next CCS.

Annex 1 provides a list of WHO programmes and the initial budget envelope for 2014–2015. Annex 2 presents the statements of strategic intent for each of the technical teams in WHO Cambodia and maps required support from the WHO Regional Office for the Western Pacific and WHO headquarters during the 2014–15 biennium. Annex 3 presents strategic intent and tracer indicators by WHO Cambodia technical units.

SECTION 2. CAMBODIA'S HEALTH AND DEVELOPMENT CHALLENGES

2.1 Overview

The years from 2009 to 2013 have been characterized by strong economic growth, with Cambodia due to attain middle-income country status in the coming years. There is a maturing political environment with peaceful elections being held in July 2013, returning the sitting Government to power. Related to these broader socioeconomic gains have been strong gains in health outcomes, particularly in maternal and child health and HIV.

However new health challenges are also emerging, notably NCDs. Progress to improve nutrition has been much slower than expected, with malnutrition contributing to more than 6400 child deaths annually.[1]

A number of challenges related to health systems development also remain, the most important of which are persisting high levels of out-of-pocket payments; poor quality of care, particularly in rural facilities; and stalled progress towards development effectiveness objectives.

2.2 Demographics and mortality

The Cambodia Demographic and Health Survey (CDHS) conducted in 2010 found better than expected reductions in infant, child and maternal mortality, a steady increase in the rate of skilled birth attendance, and continuing decline in HIV prevalence (see Table 1).

Progress in child health has been attributed to strong performance in immunization, the promotion of exclusive breastfeeding, improved access to health services and overall reductions in poverty. The halving of maternal deaths between 2005 and 2010 reflects better antenatal care, more deliveries in well-staffed, well-equipped health facilities, and increased access to contraception.

However, the 2010 CDHS also shows that newborn mortality remained virtually unchanged between 2005 and 2010, at 28 and 27 per 1000 live births, respectively. Further, significant inequities between rural and urban areas persist: rural children have a 50% greater chance of dying before the age of 5 than urban children. Differences in childhood mortality are also influenced by the education of mothers and by economic status: the infant mortality rate (IMR) if mothers have no schooling is 72 per 1000, more than double that for those with schooling; while IMR in the poorest quintile is double that in the highest

[1] Remarks on behalf of health development partners on the occasion of the 34th National Health Congress and 11th Joint Annual Performance Review, Ministry of Health, 28 March 2013.

Table 1. Progress towards the Cambodian Millennium Development Goals (CMDGs)[2]

Indicator	2000	2005	2010	CMDG target 2015
IMR per 1000 live births	58	66	45	50
Under 5 mortality per 1000 live births	124	83	54	65
Births attended by trained personnel	9.9%	63%	70%	87%
HIV and AIDS prevalence, % of adults aged 15–49 years	1.9	1.2	0.8	<0.6
Malaria case fatality rate per 100 000 cases	4.7	4.0	2.4	0.78
Prevalence of all forms of TB per 100 000 population	923	746	660	626
Married women using modern birth spacing methods	19%	27%	35%	60%

Source: CDHS 2010, from Mid Term Review of the Health Sector Strategic Plan, p.23

2.3 Socioeconomic development

Cambodia's economy has continued to grow strongly, with gross domestic product (GDP) per capita increasing from US$ 471 in 2005 to US$ 795 in 2010. The annual GDP growth rate has slowed during this time from 13% to 6%, but still remains positive and strong. Around one in five people (20.5%) still live below the poverty line, according to World Bank estimates, down from 50% in 2007.[2] Cambodia ranks 139 out of 184 countries in the Human Development Index, suggesting that human development is not keeping pace with economic growth.

Rates of urbanization are low, with just 20% of the population living in urban areas and the majority of the population depending on agriculture. At the same time, Phnom Penh is experiencing rapid growth and is increasingly a centre for population movement (through tourism, migration, etc.), which in turn has consequences for the spread of communicable disease.

2.4 Government and the macroeconomic environment

A peaceful election in July 2013 returned the incumbent Government to power, albeit with strong gains for the opposition. The vibrant political debate held around the election and the predominantly peaceful ballot are indications that Cambodia's transition to a stable political environment continues. Corruption exists in all levels of society and is widely recognized as a key constraint to equitable and sustainable development, although with the establishment of the Anti-Corruption Unit, the Government has indicated its commitment to address the problem of corruption.

The *National Strategic Development Plan* (NSDP) *2006–2010* set out the Government's approach to poverty reduction at the time the CCS was drafted. It was extended until 2013, and will now be replaced with a new NSDP covering the period beginning in 2014.

The "Decentralization and Deconcentration" (D&D) agenda, newly passed into law at the time the CCS was drafted, remains a key area of public policy reform. The agenda should result in delegation of administrative functions, including budget, finance and personnel from the central Ministry of Health to the subnational level. However, the details of how this will work in practice are yet to be agreed, and progress is slow. At present, control of health resources remains centralized with many donor funds still earmarked for specific diseases or programmes, which is likely to hamper

[2] http://data.worldbank.org/country/cambodia

implementation of D&D. An important aspect of D&D in health will be the shift from operational districts (used only in health) back to administrative districts used by provincial authorities. This will mean a new demarcation of health administrative areas which, combined with the shift to provincial-level governance, may require building of new health centres and providing these with necessary staff and equipment. This in turn will have implications for the recurrent budget.

2.5 Progress and constraints

Impressive improvements in health at the national level mask significant inequities among different population groups. Those with the worst health indicators tend to be the poor and those living in remote areas, but there are a complex range of factors that create pockets of deprivation – such as migration, registration with local authorities and ethnicity. Further work is needed to quantify the extent of these differences and understand their true impact. High-risk groups are not the same for all diseases; for example forest dwellers are at particular risk of malaria, while HIV is associated with the urban poor and injecting drug users (IDUs).

A threat to Cambodia's strong progress in maternal and child health is the emerging NCD epidemic and growing rates of injuries. The Ministry of Health estimates that the annual number of hospital admissions related to cancer, heart disease and diabetes grew by 82%, 45% and 49%, respectively, between 2008 and 2012; while the annual increase in road traffic accident admissions was 35%.[3] The 2010 STEPS survey found that 8 out of 10 people have one to two risk factors for developing an NCD, suggesting that the NCD burden on the health sector will continue to increase in coming years. Findings from the STEPS survey show that around 30% of adults are daily tobacco users; fruit and vegetable consumption is low; and that 15% of the population is overweight.

Gender inequality and violence against women also threaten maternal health and women's reproductive and other health more generally. A national survey on violence against women, using WHO's multi-country study methodology, is planned in collaboration with UN Women.

Cambodia has made strong progress in communicable disease control, especially in HIV and malaria, but challenges remain. It is one of the few countries in the world to successfully reduce HIV prevalence, and malaria deaths are at their lowest recorded level. However, emerging infectious diseases remain a real threat. Cambodia has recorded the highest number of cases of avian influenza H5N1 subtype. A study by Pasteur Institute of Cambodia found significant levels of infected chicken being sold in markets, suggesting a high potential for future outbreaks.

Finally, rates of under-nutrition remain unacceptably high: the 2010 CDHS found that 28% and 40% of children under 5 are under-weight and stunted, respectively, only a marginal improvement over the 2000 figures, while child wasting (acute malnutrition) has increased. Cambodia is one of the 15 worst countries in the world for child malnutrition. There is only a 2% disparity in the prevalence of underweight between young girls and boys. However, young rural children are 60% more likely to be underweight than their urban counterparts, and children from the poorest households are more than twice as likely (risk ratio 2.23) compared with children from the richest

[3] Ministry of Health, Health sector inputs to NSDP, 2013.

households to be underweight.[4] The reasons for these persisting high rates are not comprehensively understood, but international experience suggests that they are likely to be linked to poor coverage of water, sanitation and hygiene, and in particular poor hygiene, and to maternal feeding practices. Less than two thirds of people have access to improved water sources and less than one third to adequate sanitation, among the lowest in Asia.[5] Furthermore, 45% of pregnant women have anaemia, which is a risk factor for low birth weight.[6]

2.6 Health systems development

A key issue at the time the CCS was drafted was the need to ensure better integration between vertical programmes and health systems development. The 2011 midterm review of the HSP2 found that this remains a challenge, and better integration of planning, monitoring and reporting is needed. Specific challenges in health systems development are discussed below.

Health service delivery

There has been progress in community engagement, quality assurance and management of services, which are in turn helping to strengthen the provision, quality, utilization and coverage of services.[7] However significant disruptions to service delivery still occur, for example the Government runs out of routine vaccinations once or twice a year, pointing to weak systems underpinning service delivery. Further, significant physical, financial and sociocultural barriers to accessing services remain.

A key challenge is regulating services provided by the private sector. Private facilities account for an estimated 49% of treatment episodes, while the non-medical sector (drug vendors, traditional and religious healers, and birth attendants) attract around 21% of patients.[8] There is little recent information on the quality of services delivered by private providers, however a 2001 study found a high level of misdiagnosis and mistreatments.[9] Strengthening the Ministry of Health's stewardship of the private sector is therefore a key challenge, particularly in the context of the D&D agenda. Conflicts of interest – for example in relation to dual practice (doctors who work in both public and private facilities) and close links between private practitioners and pharmacies and laboratories, leading to over-prescribing – have hindered progress.

No systematic survey of service quality has been conducted in the public sector, but the increasing use of standard packages of care and performance-based payment mechanisms offer some means of quality assurance. However, strong monitoring – and in particular ensuring a match between data produced by the provinces and by the central level – is also needed.

4 United Nations Children's Emergency Fund. Underweight disparities 2013 [acceessed 2013 16 April]. Available from: http://www.childinfo.org/malnutrition_weightbackground.php.

5 FAO – Food Security Indicators [Internet]. 2012 [revised 2013] [accessed 11 April 2013]. Available from: http://www.fao.org/fileadmin/templates/ess/foodsecurity/Food_Security_Indicators.xlsx.

6 Worldwide prevalence of anaemia 1993–2005: WHO global database on anaemia. Geneva: World Health Organization, 2008.

7 Mid-Term Review of the Health Sector Plan, November 2011, p.13

8 Scaling Up for Better Health, World Health Organization, p.11

9 Vickery et al., 2001, Mystery Client Study

Human resources for health (HRH)

Since the CCS was drafted there has been significant progress in a number of areas of HRH including policy development, increased salaries, improved quality of health worker training, and the licensing of health workers, with the first national licensing exams for doctors, nurses and pharmacists held in 2013.

Remaining issues include health professional registration, the scaling up of the workforce to keep pace with population growth, and developing policies related to private sector provision. More broadly, institutionalizing a code of ethical behaviour and strengthening accountability to patients are key challenges.

In addition to improving the clinical skills of medical and paramedical staff, there is a need to improve the administrative and management skills of staff working in the central Ministry of Health, as well as those with responsibility for health working at provincial level and below.

Health financing

Government health spending has increased steadily over the period of the CCS: on average the health budget grew by 19% annually in real terms between 2008 and 2012, reaching US$ 197 million in 2012, which is equivalent to 12% of public expenditure. However, the Annual Operational Plans suggest that most spending is recurrent, with many activities funded predominantly by donors.

There has been little progress in reducing out-of-pocket payments, which still account for 61% of total health expenditure. Fee for service thus remains the predominant form of financing for health services in both public and private sectors. Initiatives to address financial barriers to accessing care include voucher schemes, health equity funds (HEFs) and community-based health insurance. HEFs have been the most successful: they now cover 80% of the poorest people in the country. The shift from individual schemes to a national health financing policy in support of universal health coverage is a major challenge for the coming period.

There are concerns about the efficiency of health spending, particularly in relation to pharmaceuticals where considerable savings could be achieved annually – up to one third of the health budget – through more efficient purchasing.

Mechanisms for allocating funds to the provincial level and below could also be more transparent, and while the D&D initiative should bring resources closer to service delivery level, progress has in reality been slow and financial resources remain concentrated at the centre. The D&D of resource management needs to be accompanied by measures to strengthen the budgeting process and expenditure tracking.

Governance

As in many countries, the concepts of governance and stewardship are poorly developed in Cambodia. The midterm review of HSP2 notes that there is no clear strategy for improving health sector governance, and no agreed means for monitoring progress.

Overall the Ministry of Health remains quite vertical, and collaboration across different departments is limited. This vertical structure is compounded by donor approaches to

financing the sector. Since the CCS was drafted in 2009, progress towards development effectiveness objectives has been slow; many of the challenges identified at that time, in relation to distortions in funding, high transaction costs and fragmentation of support, remain valid today. Slow progress is in part because there are no specific targets related to improving harmonization, alignment and the predictability of donor resources,[10] and in part because there are strong incentives to maintain vertical funding flows and reliance on external resourcing. For example, some Ministry of Health departments may prefer to have funds provided "off budget"to ensure they are "ring fenced" and thus at less risk of being diverted or cut.

The donor environment is now undergoing some profound changes with a number of European bilateral partners leaving, and new donors such as China and the Republic of Korea entering the health sector. These changes bring a new dynamic to health sector coordination efforts, which will be further discussed in the next section.

[10] The International Health Partnership Plus (IHP+) process did establish such targets but they were not yet institutionalized.

SECTION 3. DEVELOPMENT ASSISTANCE AND PARTNERSHIPS: AID FLOWS, INSTRUMENTS AND COORDINATION

3.1 Overview

Cambodia has enjoyed high levels of financial support from the international community over the last decade. Between 1992 and 2011, a total of US$ 12.13 billion in aid was disbursed by development partners. Health and HIV have been priority sectors, receiving 17% of this support. In line with overall aid increases, aid for health rose rapidly over the period of the CCS, from just over US$ 131 million in 2008 to US$ 199 million in 2010. However the most recent figures show that since 2010, aid for health and for HIV has begun to decline, suggesting that official development assistance to health may have peaked.

At the national level, Cambodia's mechanisms for aid coordination have continued to expand and strengthen. There is explicit commitment to development effectiveness at the highest level of Government, with the Prime Minister chairing the Council for Development of Cambodia (CDC), which oversees aid management and interactions with donors. Cambodia also attended the Fourth High Level Forum on Aid Effectiveness in Busan, Republic of Korea, and has committed to monitoring implementation of the Busan Agenda.

Reporting to the CDC are 19 technical working groups (TWGs) across different sectors, including health. Their responsibilities include promoting linkages the NSDP, supporting the development of sector strategies, managing financial flows, identifying projects for financing, and organizing sector reporting and review. In March 2013 a retreat of all TWGs and development partners agreed to the principle of results-based planning. A national results-based framework for development has now been agreed upon, called the joint monitoring indicators (JMIs). These are linked to the NSDP and should facilitate greater alignment of development assistance and a focus on results. The JMI related to health is contraceptive prevalence.

The TWG-Health (TWG-H) is regarded as one of the most active groups with broad representation from Government, multilateral and bilateral agencies, and nongovernmental organizations. It is chaired by the Secretary of State and co-chaired by WHO; it meets monthly. Reporting to the TWG are the provincial TWGs and a number of technical subgroups, however the latter vary in their effectiveness, with some meeting very rarely and others serving as forums for information exchange rather than coordination.

3.2 Partnerships and coordination in health

The health sector in Cambodia has been described as complex and fragmented – with at least 30 active partners. Recognizing this, efforts to improve the effectiveness of aid for health have been under way for a number of years. The Health Partners' Group, co-chaired by WHO and the Australian Government Department of Foreign Affairs and Trade (DFAT), is an important forum for frank and open discussion.

Sector-wide coordination began with Sector Wide Management (SWiM) in 1999, which aimed to establish a common framework for donor support. A 2011 report found that despite more than a decade of sector coordination activity, there are still a number of development effectiveness challenges in the health sector. Notably these include alignment with sector priorities, the need to reduce transaction costs associated with aid provision, and the need for Government to be more assertive in articulating priorities and managing development partners. The SWiM review also found that policy dialogue is fragmented and that joint reviews and monitoring of sector-wide performance have not eliminated the use of multiple monitoring and evaluation frameworks. These issues also featured in the 2007 SWiM review.

In 2008, the Second Health Sector Support Programme (HSSP2) was established, along with a pooled fund, to support the implementation of the *Health Strategic Plan 2008–2015* (HSP2). Seven partners channel their resources through HSSP2, accounting for around 80% of its resources. Four of these partners – Australia, the United Kingdom of Great Britain and Northern Ireland, the United Nations Children's Fund (UNICEF) and the World Bank – pool their resources. However, the remaining three – Belgium, France and the United Nations Population Fund (UNFPA) – contributed to the fund but kept their contributions earmarked. HSSP2 will likely be extended until December 2015, however the configuration of the pooled fund will change. As of mid-2013 Belgium and France had already left and the United Kingdom of Great Britain and Northern Ireland is in the process of phasing out. UNICEF will remain, but is providing only a small contribution of US$ 400 000 annually. Recently, the Republic of Korea joined the pooled fund. Continued support from Australia and the World Bank is conditional on matching funds from the Cambodian Government.

HSSP2 resources account for just 20% of donor funding for health in Cambodia, and key partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States of America are not part of it. Further, some observers feel that the HSSP2 has created a parallel process for planning and resource allocation within the health sector, separate from the national planning process.

Some partners also feel that the focus on pooling has consumed a disproportionate amount of donor energy, distracting attention away from important issues of policy reform and creating a divide between pooling and non-pooling partners. In the future there may be less interest in pooling and a greater focus on developing harmonized donor positions on, for example, health financing.

The experience of HSSP2 points to a key development effectiveness challenge in the health sector, namely weak national systems and plans. This makes it difficult for partners to align their support, channel financing through Government, or rely on Government systems for procurement, reporting, monitoring, etc. Although the overarching sector plan, HSP2, is reasonably prioritized, many health programmes remain very donor

driven and without a clear plan or budget framework with which donors can align. To address this, there is now a strong focus on supporting Government in its efforts to make the next Health Sector Plan, HSP3 (2016–2020), better prioritized, with a single, clear monitoring framework.

The changing landscape in development effectiveness in Cambodia, with the increasing importance of new donors such as China and the Republic of Korea, brings new challenges to donor coordination mechanisms.

Global health initiatives, partnerships and the International Health Regulations (2005). A significant share of health aid to Cambodia is for Millennium Development Goal (MDG) 6 that addresses HIV, TB and malaria, although in recent years the proportion has begun to drop: from 61% of total health aid commitments in 2008 to 47% in 2010.[11] Nevertheless, this remains a relatively high portion of total funding for the sector, so concerns expressed at the time the CCS was drafted, about distortions in sector funding, remain valid.

Global Fund to Fight AIDS, Tuberculosis and Malaria provides the bulk of support for MDG 6. The Ministry of Health has been implementing Global Fund grants since 2003; over the last decade cumulative disbursements have totaled US $319 million of which 50% has been for HIV, 35% for malaria, 8% for TB and 6% for health system strengthening (HSS). Grants are consolidated into a single stream of funding for each of the three diseases and for HSS. The support from the Global Fund makes up a significant proportion of the respective national programmes' total budget: namely, 39% for HIV (2010), 42% for TB (2012) and 83% for malaria (2012). Cambodia plans to apply for the Global Fund's NFM in 2014 for all the three diseases and HSS. A new subregional initiative of Emergency Response to Artemisinin Resistance (ERAR, see below) for malaria in the greater Mekong area will also receive funding from the Global Fund.

WHO is co-chair of the Cambodian Country Coordination Mechanism (known as the CCM) and plays and important role in Global Fund grant oversight and in the Country Coordinating Committee (CCC) executive committee (the senior decision body for Global Fund in Cambodia). WHO facilitates communication between the Global Fund secretariat in Geneva and principal recipients in Cambodia, which are mostly Government agencies. For malaria the principal recipient function was recently transferred to United Nations Office for Project Services, while WHO's technical staff provide support to the development of Global Fund proposals and the implementation and monitoring of all diseases and HSS grants, once awarded. Two WHO staff positions are supported full time by Global Fund grants: a malaria scientist and a pharmaceutical officer.

GAVI Alliance has approved US$ 40.5 million in funding for Cambodia for 2001 to 2016, including US$ 8.8 million on HSS; of its grants for immunization support, US$ 13 million for the pentavalent vaccine has been the largest. The Government is committed to the introduction of new vaccines, including the human papillomavirus (HPV) and rotavirus vaccines, however there are concerns that financial implications have not yet been fully considered – particularly as, once Cambodia reaches middle-income country status, it will no longer be eligible for GAVI support. Further, the HPV vaccine will require considerable planning as it involves a new target population (adolescent girls), a different counterpart (schools), and has the potential to be politically sensitive.

[11] http://www.who.int/gho/governance_aid_effectiveness/countries/khm.pdf

WHO will work closely with other partners such as UNFPA and UNICEF for successful introduction of HPV vaccine for strengthening prevention of cervical cancer.

In 2005, Cambodia committed to developing the core capacities required by the **International Health Regulations (2005)**, or IHR (2005), by June 2012. An extension until June 2014 was granted. During this time good progress has been made in surveillance and response to outbreaks, however development of point- of-entry policies has lagged behind. The annual review of Cambodian National Workplan for Implementation of IHR Minimum Core Capacities and ***Asia Pacific Strategy for Emerging Diseases*** **(APSED)** priority areas for 2012–2014 will be conducted and a second extension until June 2016 will be discussed.

APSED was developed in 2005 to meet the challenges of emerging diseases that pose serious threats to regional and global health security. It provided a common framework to strengthen national and regional capacities to manage emerging diseases, improve pandemic preparedness and comply with the core capacity requirements of IHR (2005). In 2010, three new focus areas have been added: public health emergency preparedness; regional preparedness, alert and response; and monitoring and evaluation. The past five years have led to a greater appreciation of the need to strengthen links among agencies responsible for confronting acute public health threats. These include animal health authorities, departments concerned with the response to humanitarian emergencies, and those tasked with food, chemical and radiological safety. APSED (2010) aims to establish stronger links among these related public health programmes, thereby ensuring a joint approach to preparedness and response to all public health emergencies. The Cambodia APSED/IHR implementation plan, 2012–2014, was developed in line with APSED (2010).

A new subregional initiative that has emerged during the period of the CCS is the **Emergency Response to Artemisinin Resistance (ERAR)** programme. Launched by the WHO Regional Director for the Western Pacific in April 2013 with funding from Australia DFAT and the Bill & Melinda Gates Foundation, it covers the six countries of the Greater Mekong Subregion[12] and aims to strengthen regional coordination and leadership on artemisinin resistance, expand surveillance of drug efficacy, improve access of mobile and migrant populations to health services (as these are the populations where resistance is emerging), and limit the availability and use of artemisinin monotherapies. Recently, the Global Fund has committed US$ 100 million to implement the Regional Artemisinin Initiative (RAI) project's work in the Mekong Subregion and WHO Cambodia will host the regional secretariat of this project.

3.3 International Health Partnership

Cambodia was a founding member of the International Health Partnership (IHP+) and continues to participate in the initiative. Through WHO and in collaboration with relevant departments of the Ministry of Health and the civil society organizations (CSO), IHP+ supported the midterm review of the HSP and is also supporting the strengthening of the TWG-H both at the national and provincial levels, facilitation of public–private dialogues, improving routine data quality assessments, and strengthening of CSO capacity to support and advocate for consumers. Discussions are also under way with the Department of Planning and Information of the Ministry of Health to develop

[12] Cambodia, China, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam.

databases of nongovernmental organization activity and of annual operational plans, using IHP+ support. These will need to be coherent with similar databases run by the CDC.

Utilizing the IHP+ framework and its support, WHO has been working actively in facilitating policy dialogue for better harmonization and alignment, and in enhancing a results-based approach for development effectiveness. WHO works closely with the World Bank as joint national-level facilitators of IHP+, as well as with the Joint Partnership Interface Group (JPIG) partners in HSSP2 and all health development partners.

3.4 United Nations (UN) System in Cambodia

Some 19 UN agencies are resident in Cambodia, forming the UN Country Team (UNCT). WHO is one of the largest agencies and along with UNICEF plays a lead role in health. In line with UN reform efforts, agencies are working to better coordinate their support through the *UN Development Assistance Framework* (UNDAF), 2011–2015.

The UNDAF sets out five result areas: economic growth, health and education, gender equality, governance, and social protection. WHO's main contribution is to the second area, health and education, which seeks to improve the coverage and quality of essential services. In health the focus is on expanding access to maternal and newborn health, immunization, and HIV testing, counseling and provision of antiretroviral therapy. This area also includes a strong emphasis on nutrition and on water and sanitation. WHO's work to increase financial protection from high health costs, through expanded coverage of health equity funds, is reflected in the fifth outcome area of social protection.

Planning for the next UNDAF, which will cover 2016–2020, began in late 2013 and accelerated in 2014. WHO will aim to ensure that NCDs, as an emerging global priority, are featured more strongly along with other continued health priorities.

SECTION 4. CURRENT WHO COOPERATION WITH THE GOVERNMENT AND PEOPLE OF CAMBODIA

4.1 Communicable disease control

This section provides an overview of strategic activities planned for 2014–2015. It is structured according to the four priority programmes of HSP2. Annex 1 and Annex 2 present programme and team structures of WHO Cambodia, along with budges and targets, and thus show how the activities described below are managed within WHO and within the country office.

Work on communicable disease control covers a broad spectrum, however, the guiding principles for programmes over the coming period can be summarized as "synergize, streamline and sustain". Streamline relates to the need to focus on those remaining groups in which diseases are concentrated, through for example the use of community health volunteers (Community-DOTS for TB, village malaria workers, home-based care for HIV). Synergize recognizes the need for better integration between disease control efforts and the health systems that underpin service delivery. Sustain refers to the changing donor environment and need to focus on resource mobilization, including from domestic revenues.

HIV/AIDS

Cambodia's success in reducing HIV and achieving universal access to HIV treatment has prompted the Ministry of Health to initiate the ambitious Cambodia 3.0 Initiative – the third-generation health sector response to HIV – which aims to achieve zero new HIV infections by 2020. This includes elimination of mother-to-child transmission of HIV and syphilis, sharper targeting of key populations and their sexual partners, and maximization of coverage and retention throughout the cascades of HIV prevention, care and treatment including treatment as prevention.

Photo by WHO / E. Pineros

Home-based care assistant provides home visits, Battambang Province, September, 2014.

WHO will support the Government to effect this transition. Specifically in the next two years, WHO will accelerate its support for the operationalization of the 3.0 Initiative in high-burden operational districts and consolidation of a robust strategic information system. A critical focus of the WHO support will be increasing the effectiveness of outreach programmes for IDUs, including decreasing the high dropout rate in the methadone maintenance programme, while working to strengthen the needle and syringe programme.

WHO will also encourage integration between TB and HIV programmes and the integration of the prevention of mother-to-child transmission and chronic care programmes with the rest of the health system. Areas where the HIV programme has developed capacity that can contribute to systems development include outreach to marginalized populations, longitudinal patient monitoring including recent trials on the unique identifier system and laboratory capacity.

A key issue in integration is the extent to which HIV services can be included in a package of services financed through HEFs; in the longer term, this issue is also relevant to nascent efforts to develop a national social health insurance scheme.

WHO's role in supporting HIV in coming years is particularly significant as other partners are now scaling back their work in this area. For example, UNICEF's support for HIV will drop from US$ 2 million a year to $300 000 by 2015, while UNAIDS is reducing its international staff.

Tuberculosis

WHO is assisting the Government with the development of the 2014–2020 *TB National Strategic Plan*, which will form the basis of the NFM application to the Global Fund. There will also be an effort to raise domestic resources: by 2030 the aim is that TB control will be primarily funded from domestic revenues.

The TB programme will continue to implement the global *Stop TB Strategy* with specific focus on the most-at-risk groups. Promoting access to and use of quality-assured data, diagnostics and drugs will be a critical aspect. There will also be an increased focus on monitoring and responding to drug-resistant TB.

Malaria and other vector-borne diseases

Photo by WHO / E. Pineros

Meeting of Village leader and village volunteers, Battambang Province, September 2014.

The malaria burden (incidence and related deaths) is currently at its lowest level in history, and the Government has a target to eliminate malaria by 2025. WHO continues to support vector control activities, with a focus on hard-to-reach groups in specific geographical areas. Village malaria workers have been a key factor in this success, through early diagnosis and treatment. Nonetheless, artemisinin resistance, which emerged in 2006, is a real threat with grave consequences for the Western Pacific Region and the global malaria community. WHO, therefore, has an increased focus on the control of artemisinin resistance, through monitoring the efficacy of antimalarial drugs in four provinces and providing emergency response if cases are detected. A new regional programme based in Cambodia, ERAR, will intensify these efforts (see Section 3).

In response to the increasing dengue caseload, WHO has scaled up its work in dengue control and supported the training of health workers in facility-based treatment of dengue. An indication of the effectiveness of this training is that although the number of cases seen in facilities has increased, the case fatality rate has declined to less than 1%, according to official data.[13]

[13] http://ojs.wpro.who.int/ojs/index.php/wpsar/article/view/200/270

WHO will continue to support elimination of neglected tropical diseases including leprosy, and will have a key role in coordinating drug donations.

Emerging infectious diseases

In the area of emerging infectious diseases, WHO's focus will be on supporting Cambodia to achieve the core capacities required by IHR (2005) (see Section 3). Specifically, the focus will be on strengthening capacities related to points of entry, that is, the response plans of airports, shipping ports and border control, and on food safety with the aim of controlling and containing zoonotic disease outbreaks. This is a complex area requiring cross-ministerial collaboration.

Surveillance and response to public health emergencies will continue to be an important pillar of WHO's support. This work crosses communicable disease and programme areas, including avian influenza and other new or emerging pandemic threats, antimicrobial-resistant strains of malaria and TB, and endemic diseases such as dengue and malaria.

Photo by WHO

A community meeting about H_5N_1 prevention in Kampong Chhnang province in Cambodia in March 2013.

4.2 Health systems

While health systems is a distinct programme of work within WHO, it has implications for all programme areas and therefore there will be a strong focus for horizontal collaboration across disease programmes.

Health financing will be the cornerstone of WHO's health systems work in the next two years. In the short term, WHO will continue to engage with HEFs, which now represent the main mechanism for addressing financial barriers to services. In the medium term, the focus will be on the emerging policy for social health insurance. With regard to the latter, WHO's role will be to provide technical advice and help coordinate partner inputs to the process. A National Health Accounts survey will be carried out in the next two years, providing a critical input to financing policy development. WHO will also support the Government to update the Health Financing Charter, the legal document operationalizing the policy.

In HRH, WHO's support will focus on pre-service training, expanding the newly established national exit examinations to other disciplines and setting up independent medical councils to regulate the conduct of health professionals. A national plan for the production of health workers is also under development, which will cover the same period as HSP3; it will take into account the growing level of private provision.

Efforts to strengthen health information in the next two years will focus on improvements to civil registration and vital statistics, including development of a national database. In relation to the national health information system, the focus will be on improving the quality of outcome data.

Photo by WHO

National dentistry exit exam, 2013.

WHO will also support improvements in quality of care by developing clinical guidelines and care pathways; surgical guidelines are currently being piloted. A midterm review of the quality improvement plan will also be carried out.

The trend of smaller families and increasing life expectancy at birth mean that the needs of an ageing population and corresponding chronic NCDs will require greater attention in the future. WHO will assist the Government in rethinking its model of care emphasizing the need to strengthen long-term care and rehabilitative services.

4.3 Maternal and child health

Work in support of the HSP2 programme on maternal and child health covers immunization (the Expanded Programme on Immunization or EPI); reproductive, maternal, newborn and child health; and nutrition.

Reproductive, Maternal, Newborn and Child Health (RMNCH)

Photo by WHO

Supportive supervision on Immediate Newborn Care in Takeo Province, August 2013.

In newborn and child health the focus is on Early Essential Newborn Care (EENC) and Integrated Management of Childhood Illnesses (IMCI), including pneumonia and diarrhoea control, as well as cross-cutting support including improving coordination and planning, strengthening the health workforce, addressing financial barriers to care, improving the quality of service delivery, and improving monitoring.

The Government's *Fast Track Initiative Road Map to Reduce Maternal and Neonatal Mortality* (*2010–2015*) forms the basis of the maternal and child health (MCH) team's work in Cambodia. It has four components for maternal and newborn care (emergency obstetric and neonatal care, skilled birth attendance, family planning, and safe abortion) and three cross-cutting components (behaviour change communication, removing financial barriers to care, and maternal death surveillance and response).

Additional focus areas for the next two years include finalizing a standardized in-service training for midwives, implementing the Maternal Death Audit Protocol (revised during the first half of the CCS), strengthening the skills of midwives for antenatal care and delivery, post-natal care through onsite coaching, and delivering in-service training to newly recruited midwives.

A specific priority area in RMNCH emerging from the 2010 CDHS is neonatal mortality. Over the first period of the CCS, WHO supported training for midwives and other health workers at provincial hospitals in immediate newborn care and follow-up supportive supervision to ensure new skills are used. Over the next two years, this support will be extended to all district referral hospitals and health centres. Care for management of preterm and low birth weight babies will also be a focus for the final two years of the CCS.

In recognition of the need to respond to gender-based violence, WHO will collaborate with UNFPA to support Ministry of Health efforts in development of clinical management guidelines on violence again women.

Nutrition

Persisting high rates of child and maternal undernutrition mean that nutrition is now a priority for both the Government and development partners. WHO is working to scale up its support in this area but, at present, capacity in the country office is limited. Over the next two years the focus will be in four areas: contributing to multisectoral interventions through the UN–Government partnership for nutrition, working with the National Nutrition Programme to develop a five-year nutrition action plan, reversing the recent decline in exclusive breastfeeding through better regulation of the marketing of breast-milk substitutes, and scaling up weekly iron folic acid supplementation for women of reproductive age.

Photo by WHO

Field observation at the Endline Survey for the UN Joint Programme for Children, Food Security and Nutrition in Cambodia, Kompong Speu Province, 18-19 March 2013.

Immunization

WHO provides support to Cambodia's National Immunization Programme in three main areas: surveillance, expanding coverage of routine immunizations, and the introduction of new vaccines.

Coverage of underserved communities, including migrants, ethnic communities and those living in remote areas, has been a key focus. To this end, two measles campaigns were conducted in 2011: a national campaign and a campaign focused on high-risk communities. The result has been no measles outbreak in the last two years, suggesting the approach is a successful one.

Cambodia is one of just four countries in the Western Pacific Region that has not yet eliminated tetanus. WHO works with UNICEF to target women of child-bearing age and those at risk of not having received the vaccine. In the next two years there will be an emphasis on trying to integrate targeting of high-risk groups into routine immunization.

WHO will be supporting the Ministry of Health to update the comprehensive multiyear plan for new vaccines to cover 2014–2020.

4.4 Noncommunicable diseases

Work on NCDs has expanded dramatically during the first phase of CCS implementation, and will continue to grow over the next two years. At present there are four programme areas: tobacco, alcohol and mental health; prevention and control of NCDs; violence and injury prevention; and environmental health. Emergency preparedness is also incorporated into this programme area.

In the next two years, a new work programme will be initiated on disability. It will focus on supporting rehabilitation systems strengthening in order to improve rehabilitation services for people with disabilities. WHO will work with the Government to strengthen its capacity to manage the Physical Rehabilitation

Photo by WHO / E. Pineros

Group leader for the Older People's Association and an officer of the village Rice Bank providing food security, Battambang Province.

Centre efficiently and support the transition of management from nongovernmental organizations.

Photo by WHO

Protect yourself from hefty fines and serious head injuries – wear a helmet.

Work through the Tobacco Free Initiative has focused on supporting Cambodia to meet its obligations as a signatory to the *WHO Framework Convention on Tobacco Control*. To date this has included developing national legislation and implementing a ban on advertising of tobacco products. In the coming years the priorities will be the passing of the Tobacco Control Law that will cover raising cigarette taxes, printing health warnings on tobacco products and the ban on tobacco advertising. Work on alcohol has progressed more slowly; in the next two years the focus will be on restricting the sale of alcohol to minors, increasing taxes and restricting advertising.

Updating the road safety law to cover helmet use (for motorcycle drivers and passengers), prevention of drink-driving, and use of seatbelts has been the focus of the violence and injury prevention programme. Other activities in this area include social marketing to promote helmet use, the provision of breath analysers and training of the police force in their use, as well as the training of journalists. Although the passage of legislation was stalled by the 2013 election, helmet use shows an upward trend. The priority for the next two years is finalizing the draft legislation and seeing it pass into law, as well as working on a law for reduction of drink-driving through an intersectoral approach.

A key activity over the next two years will be support for the development of a multisectoral action plan for the prevention and control of NCDs, 2014–2020. This will involve 12 line ministries with the Ministry of Health in the lead. A second major area will be negotiating the integration of the WHO *Package of Essential Noncommunicable Disease Interventions for Primary Health Care in Low-resource Settings*, known as PEN, into the package of care delivered at health centres and above. This work will be supported by the World Bank through HSSP2, and has clear implications for health financing policy, health worker planning and the essential medicines policy. A number of campaigns to address NCD risk factors will also be launched, including a salt reduction campaign and a healthy schools campaign. Work in NCD prevention will also seek to lay the foundations for a cancer prevention and control programme to be scaled up in the next CCS. Prevention of cervical cancer, which is one of major causes of female mortality, will be dealt as an integral part of the NCD strategy.

In environmental health, the current focus is water quality, an area in which WHO has a comparative advantage. Other areas include research related to health impacts of climate change, chemical safety (asbestos) and management of waste from health centres. In the future, occupational health is likely to become an increasing priority.

4.5 Human resources and the Programme Budget within WHO

As of October 2013, the WHO Cambodia office has a total of 55 staff positions as set out in Table 2. For the period of the CCS, staff numbers are expected to remain more or less stable. However, looking towards the next CCS, there needs to be a transition away from reliance on international technical assistance to national staff.

The Programme Budget allocation for 2014–2015 has increased by 14% over the previous biennium to US$ 18.6 million for technical programmes, excluding the budget for office administration (see Annex 1). However within this budget envelope financial shortfalls will remain in most programmes, both for staff cost and activity funds.

Under the new categories presented in the Programme Budget 2014–2015, communicable diseases including EPI has the largest budget allocation of US$ 6.9 million, followed by health systems (US$ 3.2 million), promoting health through the life-course including RMNCH and the health environment (US$ 3.1 million), NCDs (US$ 2.8 million), and preparedness, surveillance and response (US$ 2.4 million).

Table 2. Staff positions in WHO Cambodia, as of March 2014

	International professionals	National professional	Support staff
MCH, EPI and Nutrition	2	3	2
Communicable diseases & Emerging infectious diseases	11	5	4
Noncommunicable diseases	1	4	1
Health systems	4	-	2
Total staff in technical areas	**18**	**12**	**9**
Administration, management and support	3	-	12
Total staff in WHO Cambodia	**21**	**12**	**21**

Note: All funded positions, whether currently occupied or not, are included in the table.

SECTION 5. WHO POLICY FRAMEWORK: STRATEGIC AGENDA AND PRIORITIES

The CCS midterm review has provided an opportunity for WHO Cambodia to come up with a vision and mission statement as follows:

Vision: Attainment by all Cambodian people of the highest possible level of health.

Mission: Provide leadership to support the Government and people of Cambodia in response to their health needs.

This section presents the cross-cutting strategic priorities that will guide WHO's work in Cambodia during the final two years of the CCS in support of this vision and mission. These are closely based on the strategic priorities set out in the original CCS, however, the four to five focus areas described under each strategic priority have been updated to reflect the evolving work of the Office of the WHO Representative in Cambodia.

The work described below cuts across different programme areas and will require strong coordination among teams.

In order to review the team-specific work objectives, please refer to Annex 2 which provides an overview of strategic intents and the associated indicators as identified by each technical team in WHO Cambodia.

Strategic Priority 1. Universal access to an essential package of quality health services based on fairness in financial contribution and equity in access.

Cambodia's health system is in a period of transition. There are more resources than ever before available for health and an increasing demand for quality health services. Overall health outcomes are improving, but inequities are growing. At this critical juncture, it is important to establish the values that should underpin sector development in future: equity, solidarity and health as a public good. This is a political rather than a technical agenda.

Universal health coverage (UHC) has gained political traction in many countries – both as a vision for the sector and as technical agenda for achieving the goals of improved access and better financial protection. UHC is broader than health systems strengthening – it is a framework for scaling up the quality and impact of all priority disease and public health programmes, while also focusing attention on the systems issues which underpin service delivery. There are four focus areas under this strategic priority, described below.

a. **Delivery of Priority Health Services.** Work in this area will encompass:

- Promoting integration of disease programmes into the health system – this agenda applies to TB, HIV, MCH, immunization, nutrition and the service delivery aspects of the NCD programme.

- Addressing inequities in health outcomes by targeting underserved populations – this is an issue for EPI, MCH, HIV, TB – and although the target populations are different in each case, responses are likely to include common features. A key policy question related to reaching underserved populations is the balance between supporting outreach services and expanding facility-based coverage. The Ministry of Health is committed to expanding facility-based services, while many programmes feel outreach is still needed to reach specific populations in the short to medium term. The ongoing health facility survey will provide further information.

b. **Health Care Financing.** This is a major policy area for the coming period with implications for all WHO programmes. It has a number of elements including:

- Continuing work on financing mechanisms that target the poor (especially the HEFs, which have the greatest coverage). A specific issue here is how HEFs, which target the poor, can support prevention programmes that need to be delivered to the entire population, for example immunization and health education).
- Engaging with the development of national social health protection policy. The central issue here is what services, commodities and medicines will be covered under the new policy. This is relevant for disease programmes such as HIV, TB and immunization, where the Government will be increasingly expected to take on the financial cost of services currently funded by donors; for maternal and child health efforts, which report financial barriers to accessing services; and for NCDs, where a new package is in the process of being defined.
- Supporting Government efforts to push control and management of the health budget down to the subnational level; this should help improve quality of services by for example reducing stock-outs and ensuring continuity in delivery of key programmes. Linked to this, strengthening systems for financial management – at both the central and subnational level – will be key, including transparency and accountability and links to results. This will improve the efficiency of health spending, which will be increasingly important as Government resources replace donor spending.

c. **Human resources of health and quality of care.** As public health and disease control programmes are increasingly integrated into the health system, a common approach to health workforce development and planning becomes increasingly important. Priorities for the next two years include:

- Strengthening pre-service training through curriculum revision, accreditation of training institutions, institutionalizing exit exams across different professions, and expanding systems of registration for public and private providers.
- Coordinating and developing a strategic approach to in-service training. A number of WHO programmes plan to introduce or revise protocols for clinical care, and/or provide in-service training, including: MCH (newborn care), nutrition (exclusive breastfeeding, and care for undernourished children), as well as HIV (chronic care). These should be brought together under the umbrella of a health workforce quality improvement strategy. A specific example of how programmes can support the shift away from short-term, ad hoc training towards integrated support for career development and learning is WHO's support to extend the six-month applied epidemiology training to 12 months and get it internationally accredited.

- Revising the health workforce strategy to encompass the needs of all programme areas and take into account services provided in the private sector and the issues of dual practice. The revised strategy will build on the review of the existing health workforce plan completed in the first half of the CCS and will inform HSP3.

d. **Essential medicines and products.** Procurement, safety, quality and appropriate use of essential medicines are key issues in the sector with implications for all programmes. WHO's work in this area will include:

- With other partners, working with the Government to strengthen procurement, which has the potential to dramatically improve the efficiency of sector spending, and updating the essential drugs list – which will have implications for health financing policy and in particular the HEFs.
- Understanding the long-term costs of introducing new technologies, such as new vaccines, by carrying out a health technology assessment; again this is important for sustainable financing of the sector and to support the most cost-effective allocation of resources for medicines and health technologies.
- Promoting rational drug use and monitoring sale of counterfeit medicines, as part of the antimicrobial resistance (AMR) containment strategy and national medicine strategies. Strengthening regulatory capacity and enforcement in the pharmaceutical sector and improving governance, transparency and accountability of public procurement systems are both essential overarching strategies to reduce availability of poor quality medical products and improve the efficiency of procurement.

Strategic Priority 2. Technical excellence in disease and public health programmes

This strategic priority draws out five common themes that will guide the work of WHO's disease control programmes in Cambodia over the next two years.

a. **Co-coordinating and linking technical support to priority disease control areas to improve governance.** Poor coordination and overlapping mandates among various national programmes and centres are hampering the effectiveness of disease control efforts.[14] This is compounded by poor coordination among development partners. Better coordination and integration of support within WHO and among partners should help to encourage better governance by the Ministry of Health of communicable disease and NCD control efforts.

b. **Providing cross-cutting support to national programmes and centres.** Infection control, surveillance and monitoring of AMR will continue to be key areas of cross-cutting support for WHO in the final two years of the CCS. Surveillance activities currently occur across a number of different programmes – in the next phase the country office will look at the feasibility of moving towards a more integrated system.

c. **Generating evidence and monitoring impact.** The final two years of the CCS will include an increased focus on generating and using more evidence in providing policy and technical advice to the Government – and on monitoring the impact

[14] For example, between CDC and national disease programmes, various Ministry of Health departments responsible for behaviour change and risk communication, and NCHADS and the National AIDS Authority.

of WHO support to public health programmes – to understand where WHO's technical assistance and programmes have been particularly successful and why. This will help inform the next CCS.

d. **Supporting national implementation of global agreements and regional initiatives.** Work in this area will include:

- Supporting Cambodia to achieve the core capacities required by IHR (2005) and to implement commitments made under the WHO Framework Convention on Tobacco Control, as described in the sections above.
- Hosting the ERAR programme, which covers the Greater Mekong Subregion.
- Taking advantage of opportunities to engage with and coordinate cross-border initiatives across the Western Pacific Region, such as the Lower Mekong Initiative by the Government of the United States of America and the scheduled 2015 Association of Southeast Asian Nations (ASEAN) integration and agreement for transfer of skills across its region.

e. **Scaling up support for intersectoral work.** A number of priority programmes and issues, including nutrition (under-nutrition and unhealthy diet), food safety, road safety, physical inactivity, indoor air pollution, AMR, tobacco and alcohol control, and environmental health, require collaboration with other sectors. In the past this has not been an area where WHO has been very active, however in recent years and with the expansion of the NCD team and new work on "healthy borders" to contain AMR, this is becoming an increasingly prominent aspect of WHO's work in Cambodia. Typically, but not always, the involvement of other line ministries is coordinated by the Ministry of Health with support from WHO to ensure the programme maintains an anchor in the health sector. A challenge is that tensions can arise among ministries, particularly when the bulk of funding is directed to non-health agencies.

Strategic Priority 3. Effective stewardship of the sector and health partnerships

Work in this area relates to WHO's leadership role in sector development and coordination of health partners. The November 2012 country assessment highlighted this work as a strong point of WHO's work of the initial period of the CCS, and urged that the country office maintain its focus in this area over the remaining period of the this CCS and into the next. Five areas of support are highlighted below.

a. **Supporting policy development and advocacy.** The main focus during the last two years of the CCS will be working with the Government to develop HSP3. WHO's role includes gathering evidence, providing technical support to ensure the new health strategic plan is focussed on priority health and health systems issues as informed by the evidence, advocating the values of equity and solidarity in health systems development, and helping coordinate and negotiate the inputs of different development partners.

b. **Technical capacity-building and transfer of skills and knowledge.** The significance of building national capacity has grown over the period of the CCS, and now forms a central pillar of broader socioeconomic development in Cambodia. The TWG-H has recognized the need for partners to better coordinate their capacity development activities, ensure these are strategically focused and monitor impact.

To this end TWG-H has proposed development of a capacity development plan for the sector, which WHO will support. This should cover not only individual capacity but also institutional capacity, which in turn is linked to governance.

c. **Promoting development effectiveness.** Progress towards development effectiveness objectives has been frustratingly slow in the health sector, despite significant efforts from both the Government and partners. While the current development effectiveness "architecture" is elaborate, involving many sector and sub-sector coordination groups, the quality of policy dialogue is often poor and may not be resulting in better harmonization and alignment. The development of HSP3, the reconfiguration of the HSSP2 pooled funded, and (in the medium term) a likely reduction in vertical programme support, may provide an opportunity to revitalize the development effectiveness agenda. A rationalization in the number of coordination mechanisms, combined with a focus on improving the quality of plans and budgets at the sector and programme level, may be a way forward, and should facilitate better alignment.

d. **Engaging the private sector.** WHO's work with the private sector has been limited so far, and is unlikely to expand significantly in the next two years. However, it is recognized as a critical issue for the sector as a whole and will likely be a central feature of the next CCS. Relevant work in the coming two years includes getting information on standard treatment protocols out to general practitioners working in the private sector, working with private universities and other health worker training institutions on quality and accreditation, and supporting the registration of private pharmacies and monitoring their dispensing practices, including their supply of counterfeit medicines and artemesinin monotherapies used to treat malaria, as these encourage AMR.

Photo by WHO

Village health volunteers in Kampot province, September 2013.

e. **Engaging with D&D agenda.** D&D will have a major impact on the management and administration of health services. WHO has been asked by the Ministry of Health to support the update of the health coverage plan (last updated in 1996). This will show where public and private services are being provided and where the gaps are. A specific issue here is reconciling the operational districts that exist only in the health sector with the administrative districts used in all other aspects of local government. WHO will also contribute to the revision of the Government's Community Participation Policy for Health. Currently there are 14 different health activities assigned to community workers, each supported by their own programme, each with their own approach to incentives and monitoring. As part of D&D, these volunteers will in future be brought together and managed by the local authorities (commune councils). Experience from across WHO technical programmes will feed into the revision of the policy; the TB programme is leading this cross-cutting activity. Moreover, WHO will work closely with all partners to ensure communication is being empowered to enable them for decision-making about their health situation and status, and about needed health service provision at the community level.

SECTION 6. EXPECTED EVOLUTION OF WHO PRESENCE IN CAMBODIA

This section "scans the horizon" for emerging issues at the national and global level that are likely to affect WHO's engagement in Cambodia in the medium term. It also looks at the relationship with other levels of WHO. Annex 3 maps support required from the Office of the WHO Representative in Cambodia and the Regional Office for the Western Pacific for remainder of this CCS and into the future.

6.1 Changing national environment

As Cambodia's socioeconomic transition continues and its health system matures, so the nature of WHO engagement will change. In the post-2015 period there will likely be a much greater focus on governance, stewardship and national capacity-building to ensure the sustainability and institutionalization of reforms now under way. For WHO this implies working on a narrower range of programmes, but at a more upstream level, and with fewer international staff. The synergize, streamline and sustain approach being pioneered in communicable disease control (see Section 4) is relevant for the work of the entire country office.

Strategic priorities in the next CCS are likely to include:

- **Continuing WHO's core work on communicable disease, maternal and child health and NCDs.** For communicable disease control, the focus will be on emerging infectious diseases, improving the quality of disease control programmes and containing AMR. In MCH, improving the quality of service delivery is the key issue. In NCDs, the agenda will include strengthening primary health care to address and control NCD risk factors, scaling up support to screening and control, and expanding work on mental health.
- **National capacity-building.** The Government is already increasingly vocal in requesting this over the provision of international technical assistance. In the medium term, this will require a shift in the business model of all UN agencies, including WHO, away from provision of international expertise towards a greater focus on approaches such a mentoring. This, in turn, may require greater understanding within WHO of effective approaches to both individual and institutional capacity- building. In the context of D&D, it is important that capacity-building efforts focus not only on the central level but also at the subnational level.
- **Governance and stewardship.** The ultimate impact of capacity-building efforts should be better stewardship and governance of the health sector as a whole and at the programme and subnational level. This will require engagement with policy development and reform processes, as well as a stronger focus on monitoring and accountability. Identification of appropriate indicators to measure governance improvements, which has been a struggle in the past, will be important.
- **Monitoring financial flows.** As Cambodia approaches middle-income status,

levels of health official development assistance are likely to decline. Already, the global financial crisis of 2007–2008 has resulted in cuts in support from Japan and the United States of America. Government contributions to the sector are on the rise, however at present most increases are absorbed by the procurement of medicines and commodities, and the transparency of expenditures is poor. A strong focus on monitoring resource flows across the sector will contribute to better governance and accountability and also help ensure that the health priorities remain funded as development partners pull out.

- **Greater engagement with the private sector.** This is an important aspect of stewardship and likely to become increasingly relevant in Cambodia as the market economy grows, affecting many aspects of health from the promotion of unhealthy foods, the growth of private health worker training institutions, and public–private partnerships in service delivery. WHO needs to find new ways of engaging with these issues within its mandate, while maintaining its close relationship with the Ministry of Health. Strengthening regulation is one important entry point, which may in turn require greater expertise in development of legislation relevant to public health.
- **Responding to the changing donor environment.** In addition to declining aid levels and fewer bilateral partners, the UN presence in Cambodia is shrinking. UNICEF is scaling back its health and immunization programmes, while UNAIDS also is reducing support in area of HIV. This may mean WHO needs to take on new responsibilities. Even so, some form of coordination mechanism will still be needed, and the pooled fund will likely continue (though it will not represent the bulk of donor financing in the sector). Given the fragmentation reported in all areas of health, and the role of donor financing in reinforcing a vertical structure, more effective means need to be found of incentivizing horizontal ways of working.
- **Generating evidence.** Generating evidence on the relative disease burden across the sector is important to ensure that WHO efforts respond to priority health needs and to help inform dialogue with WHO donors. Such evidence can also be a key input to HSP3.

6.2 Emerging global and regional issues

There is also a range of emerging global and regional issues that are likely to be increasingly important in the next CCS. These include:

- **Climate change.** This is likely to mean an increasing number of natural disasters. WHO may wish to expand its role in supporting the Ministry of Health to be better prepared for emergencies, for example in supporting subnational emergency plans for the provision of health services during emergencies and the location of those services
- **Access to medicines.** This includes a complex agenda covering global trade agreements such as the Trade-related Aspects of Intellectual Property (TRIPS), particularly important in relation to antiretroviral therapies; the growth of counterfeit medicines and their link to AMR; and the growth of the Asian pharmaceutical industry – with positive (price) and negative (need for stronger regulation, pre-qualification) consequences.
- **Gender.** This issue is likely to be a prominent aspect of the post-MDG framework, which will in turn bring expectations of greater WHO engagement

with gender issues affecting the health sector. This area of work has been underfunded in Cambodia in the past, restricted to reproductive health and MCH.

6.3 Engagement with the Regional Office and WHO headquarters

The WHO reform agenda places a strong emphasis on monitoring performance, coherence across the work of the agency and communication. To this end the next CCS should aim to demonstrate links between its strategic priorities, funding flows (as reflected in the Programme Budget) and overall WHO priorities, as set out in the Global Programme of Work. Critically, it should also set measurable, time-bound targets for WHO's work.

A specific issue to be addressed in preparation of the next CCS will be the mismatch between available resources and identified priorities. At present a number of priority areas remain unfunded. These include mental health and nutrition (where the Ministry of Health has specifically requested support), gender and trauma care. More areas are likely to emerge as aid for health declines and donor partners pull out.

The assessment of country performance carried out in Cambodia in November 2012 recommended that the midterm review of the CCS map out support required by the country office from Regional Office for the Western Pacific and WHO headquarters, to help ensure a better alignment with country priorities. The specific needs of the different teams are set out in Annex 3.

SECTION 7. CONCLUSION

This midterm review sets out the vision and mission statements of WHO Cambodia for the first time, and reaffirms a strategic agenda for WHO's work in Cambodia over the next two years. It reflects the latest health priorities of the Government of Cambodia in a rapidly evolving country context, thus allows WHO to streamline our strategic approaches and redefine the focus areas for the next two years. The midterm review also previews issues which should frame the next CCS, from 2016 to 2020 and provides a solid basis for renewal of the CCS.

The challenges and opportunities discussed here are likely to resonate with many other countries in the Western Pacific Region. This is the so-called Asian century, and like Cambodia many of the countries in the Region are undergoing profound social, political and economic changes which in turn have significant implications for the type of support they require from WHO and the nature of WHO's engagement.

Ensuring that the Organization can keep up with this fast pace of change and is strategically positioned to respond to and proactively deal with these new challenges will be a key determinant of its relevance and effectiveness in future.

ANNEXES

ANNEX 1. PROGRAMME BUDGET ENVELOPE FOR 2014–2015

The table below shows WHO's new five categories and a list of 23 technical programmes under the Programme Budget 2014–2015. The figures indicate initial allocation of the "budget envelope" to priority programmes in WHO Cambodia, which represent the estimates of needed resources for both staff and activities and not necessarily the actual funding available. The budget envelope for office administration is not included in the table.

Categories and Programmes	('000 US$)
1. Communicable diseases	
HIV/AIDS	1150
Tuberculosis	1850
Malaria	2000
Neglected tropical diseases	628
Vaccine-preventable diseases	1371
Subtotal	**6999**
2. Noncommunicable diseases	
Noncommunicable diseases	1000
Mental health and substance abuse	40
Violence and injuries	400
Disabilities and rehabilitation	700
Nutrition	675
Subtotal	**2815**
3. Promoting health through the life-course	
Reproductive, maternal, newborn, child and adolescent health	1800
Ageing and health	
Gender, equity and human rights mainstreaming	400
Social determinants of health	
Health and the environment	950
Subtotal	**3150**
4. Health systems	
National health policies, strategies and plans	1139
Integrated people-centred health services	1385
Access to medicines and health technologies and strengthening regulatory capacity	470
Health system information and evidence	250
Subtotal	**3244**
5. Preparedness, surveillance and response	
Alert and response capacities	1255
Epidemic- and pandemic-prone diseases	1000
Emergency risk and crisis management	100
Food safety	60
Subtotal	**2415**
Total for technical programmes ('000 US$)	**18 623**

ANNEX 2. STRATEGIC INTENT AND TRACER INDICATORS BY WHO CAMBODIA TECHNICAL TEAMS

Technical units	Strategic Intent	Tracer indicators to monitor the unit's work in 2014-2015
HIV/AIDS & other sexually transmitted infections	To promote sharpening, streamlining, sharing and synergizing the responses to move towards the target set and to sustain services.	1. Cambodia 3.0 Initiative is operationalized in high-burden operational districts through support to the National Centre for HIV/AIDS, Dermatology and STD (NCHADS) and relevant stakeholders. 2. Coverage and quality of the harm reduction services are improved through support to the National Program of Mental Health and relevant stakeholders. 3. Sharing and synergies are promoted between HIV and other relevant programmes and services. 4. National Strategic Plan for National Blood Transfusion Services 2013–2017 is operationalized through support to the National Blood Transfusion Centre and relevant stakeholders.
Stop TB	To support the National TB Control Program to mobilize and utilize at least 80% of its resource needs for core activities by 2015	1. National Strategic Plan (2015–2020) is finalized and published through WHO support by December 2014. 2. Application for a TB grant from the New Funding Model of the Global Fund is developed and submitted through WHO support by December 2015. 3. At least two operational research papers are published through WHO support to generate evidence to maximize resources.
Malaria, vectorborne & other parasitic diseases	No more malaria by 2025 through implementation of malaria elimination strategy	1. Research and antimalarial drug efficacy monitoring are supported and the national malaria treatment guidelines as per national drug policy workshop's recommendations is revised and updated. 2. Malaria elimination strategies are updated and a costed national malaria strategic plan 2016–2020 is developed; application to Global Fund New Funding Model is developed and submitted through WHO support. 3. Dengue and other neglected tropical diseases (NTDs) strategic plans revised and updated.
Emerging disease surveillance and response	To make Cambodia safe and secure from health emergencies	1. The decision-making process of the International Health Regulations (2005) is facilitated for the second extension; planning and implementation of the two-year extension plan (June 2014 to June 2016) are supported. 2. Public health emergency response due to disease outbreaks and unusual health events is supported.
Health systems development	To develop a Cambodian health system that provides universal access to an essential package of quality health services based on fairness in financial contribution and equity in access	1. The development of Health Strategic Plan 2016–2020 in line with IHP+ principles and with a focus on universal health coverage (UHC) is facilitated. 2. Civil Registration and Vital Statistics (CRVS) Action Plan, based on the comprehensive CRVS assessment, is developed and implemented through WHO support to national counterparts (Ministry of Interior, Ministry of Planning and Ministry of Health). 3. Facilitation and capacity-building in the adoption of the International Classification of Diseases (ICD-10) at various levels of the health sector is supported. 4. Awareness building on substandard and counterfeit medical products, contributing to reduction of antimicrobial resistance (AMR), is coordinated through support to Department of Drugs and Food and other relevant institutions.

Technical units	Strategic Intent	Tracer indicators to monitor the unit's work in 2014-2015
		5. A system to produce National Health Accounts on an annual basis is developed through support to the Ministry of Health. 6. Formulation of the Strategic Health Workforce Plan is facilitated in order to guide the production and management of health personnel in line with the Strategic Health Plan 2016–2020.
Maternal and child health/Expanded Programme on Immunization	To maximize population access to quality RMNCH, EPI and nutrition health services	1. The new outreach guidelines with a focus on identifying and monitoring progress in high-risk communities is implemented through support to Ministry of Health. 2. Three modules of standard in-service training package for midwife (antenatal care, delivery and postnatal care modules) is completed through support to NMCHC/Ministry of Health. 3. Immediate newborn care is scaled up through WHO support to at least 80% of health centres in the whole country. 4. Routine Growth Monitoring and Promotion for children under 5 years of age is scaled up through WHO support by improving nutrition care, counselling and systematic screening for Severe Acute Malnutrition at EPI and outpatient department/IMCI services.
Noncommunicable diseases/ Environmental health	To provide technical excellence to Government to reduce burden of NCDs and their risk factors (including tobacco, unhealthy diet, physical activity and harmful use of alcohol), and improve environmental health for all Cambodians	1. National Strategic Plan for Prevention and Control of Noncommunicable Diseases 2013–2020 is implemented through support to Ministry of Health. 2. NCD services and integrate PEN in primary health care are scaled up through WHO's coordination and technical support to the Department of Preventive Medicine, Ministry of Health. 3. Cervical cancer prevention programme is implemented through support the Department of Preventive Medicine, Ministry of Health. 4. Multisectoral Action Plan for Prevention and Control of Noncommunicable Diseases 2014–2020 is developed through WHO's facilitation. 5. Salt reduction programme is implemented through WHO support. 6. Health Promoting Schools programme is implemented through support to the Ministry of Education, Youth and Sport. 7. STEPS survey is conducted in 2015 through support to Ministry of Health. 8. Risk assessment and risk management approaches are introduced for ensuring safe drinking-water; and environmental threats including from asbestos and from the impacts climate change are reduced through WHO support. 9. Implementation of the Sub-Decree on Health Warning and the Sub-Decree on the Measures for the Banning of Tobacco Product Advertising, Promotion and Sponsorship are enforced through support to the Government; Approval of the Sub-Decree on Smoke-Free Environment and the Sub-Decree on Increasing of Excise Tax on Tobacco products are supported by WHO; work on the approval of the draft law on Tobacco Control is advanced; the implementation of National Strategic Action Plan for Reduction of Alcohol use including mental health is strengthened through WHO support.

ANNEX 3. WHO CAMBODIA: SUPPORT NEEDS FROM THE WHO REGIONAL OFFICE FOR THE WESTERN PACIFIC AND WHO HEADQUARTERS

Communicable diseases

- Technical assistance to identify and promote synergies/integration between the HIV programme and the rest of the health system, building upon the systems and capacity developed through the HIV response.
- Technical assistance to streamline the HIV programme, shifting it from a generalized response to a focus on high-risk groups.
- Supporting HIV's contribution to the design and operationalization of the new subnational service delivery model and community system strengthening efforts in the context of D&D.
- Capacity-building of midlevel programme managers of National Center for HIV, Dermatology and STDs (NCHADS) and HIV focal points of Provincial Health Departments in strategic programme management for the smooth transition of the NCHADS leadership.
- Support on harm reduction.
- For TB, resource mobilization support required, particularly for the post-2015 period when many current donors are likely to leave Cambodia.
- For NTDs, coordinating global drug donations.

Emerging infectious diseases

- Support for the delivery of the applied field epidemiology training course.
- Technical assistance to develop laws on response to public health emergencies (for example, quarantine) related to IHR (2005).
- Advice on risk communications, and specifically support with managing media enquiries during outbreaks, allowing 24-hour coverage.

Maternal and child health/EPI

- Need the WHO Regional Office for the Western Pacific to take a more active role in negotiating with the GAVI Alliance, feeding back on common issues across country programmes, not just passing on information. Also require support to clarify with the GAVI Alliance that WHO's role is to support planning and provide technical support, not grant management, which GAVI is increasingly coming to expect.
- From WHO headquarters, cold chain logistics support for new vaccine introduction.
- From WHO headquarters and the WHO Regional Office for the Western Pacific, more support for routine immunizations including technical support on strategies to reach under-served populations.
- Support to manage the political aspects of introducing HPV, if the Government decides to go ahead.
- Need technical support from WHO headquarters and WHO Regional Office for the Western Pacific on strengthening implementation of maternal death audit activities, clarification of any technical question related to RMCHC and technical support to development of clinical management guidelines on gender-based violence.
- Technical and financial support from the WHO Regional Office for the Western Pacific for strengthening early essential newborn care (EENC) in public health facilities, especially immediate newborn care and management of preterm and low birth weight babies.
- Technical and financial support from the WHO Regional Office for the Western Pacific and WHO headquarters for improving the quality of Integrated Management of Childhood Illness (IMCI) especially the integration of prevention and control of pneumonia and diarrhoea.

- Technical and financial support for nutrition staff position and activities. Technical backstopping on the new linkage between nutrition and NCDs.

Noncommunicable diseases

- Specialized technical assistance to support new work on cancer prevention and control.
- The road safety programme will continue to need support in the areas of legislation and social marketing.
- In mental health, Regional Office or headquarters expertise needed to build capacity in WHO country office and in the national programme. Ministry of Health has specifically requested support in the area of mental health, but to date this remains unfunded.
- Violence and injuries – the Ministry of Health has requested support to strengthen the provision of trauma care and in developing legislation related to sexual violence.
- Environmental health, continued technical guidance and support from WHO headquarters on climate change, occupational health and health-centre waste.

Health systems

- Technical support on civil registration and vital statistics.
- Communications support.
- Technical assistance to increase the percentage of voluntary non-remunerated blood donation to 100% by the year 2020 including high-level advocacy and resource mobilization to support those activities.

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