WHO COUNTRY COOPERATION STRATEGY

CAMBODIA

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The Cambodia Country Cooperation Strategy is part of a corporate effort to develop and improve instruments for articulating WHO's strategic agenda in and with countries. This document is the result of a pilot process intended to contribute to strengthening WHO's country work in the context of the Organization's corporate strategy.

1 INTRODUCTION

This WHO Country Cooperation Strategy (CCS) defines the broad framework for WHO's work with the Royal Government of Cambodia for 2001-2005.

The CCS articulates a coherent vision and selective priorities for the entirety of WHO, as distinct from those of government and other development partners. It is based on a systematic assessment of Cambodia's development challenges and health needs; the Royal Government of Cambodia's policies and expectations; and the activities of other development partners.

While a clear aim is to ensure greater responsiveness to country needs, the CCS also reflects WHO's own values, principles and corporate and regional strategies. Important elements include WHO's intention to be more selective in its range of activities and to foster strategic thinking, putting greater emphasis on its role as policy adviser and broker and moving away from direct programme support except in emergency situations. WHO globally intends to broaden its partnerships at country level and work with other development partners in a complementary way.

Cambodia is rebuilding itself almost entirely, after the devastation of its people and institutions by

war and conflict. Change is very much the order of the day. The Royal Government of Cambodia is committed to improving the health status of its people and progress is being made, despite formidable obstacles. Development agencies too are changing. New donors are beginning to play a part in Cambodia. Several existing development agencies are engaged in rethinking their country strategies. And collectively they are considering how to work more collaboratively, within the framework of a sector-wide approach. It is thus a particularly opportune moment for WHO to review its own country cooperation strategy.

2 GOVERNMENT AND PEOPLE: HEALTH AND DEVELOPMENT CHALLENGE

The Legacy of the Past

The past 30 years of conflict have left Cambodia desperately impoverished. With a per capita income of less than US$ 300 per year, and 40% of its 11 million people living on less than US$ 10 per month, it is one of the poorest countries in the world. According to the UN Human Poverty Index, Cambodia ranks 73rd out of 78 developing countries, with one of the lowest Human Development Index rankings (137 out of 174 globally in 1999) including some of the worst human development indicators in South East Asia.

In the period following the 1991 Paris Peace Accord and the 1993 elections, the Government embarked on the transition from a centrally planned to a market economy. Economic growth increased from around 1.2% in 1991 to nearly 7% in 1996, and inflation was brought under control. However, in 1997 and 1998 a combination of factors − domestic political upheaval, suspension of IMF and World Bank macro-economic support due to concerns about poor revenue performance, and the financial crisis in South Asia − caused economic growth to slow to only 1%. In 1999, GDP growth rebounded to 4.3% with increased exports (especially garments), expansion in tourism and favourable crop harvests. Domestic revenues increased, mainly due to the successful introduction of value-added tax and revenue gained from companies bidding for garment export quotas. A 5.5% growth is projected for the year 2000.

Public expenditure in the social sector was low during the 1990s. In 1998, less than 1.5% of GDP was spent by the government on health and education together. Government recurrent expenditure on health increased from US$ 1 per capita in 1998 to US$ 1.7 in 1999, some 0.63% of GDP compared with an average of 2% for the least developed countries. Further increases will be needed to meet the US$ 5 per capita required at district level to maintain a basic district health service.

Optimism and Challenges

With the more stable situation that has prevailed since the 1998 elections, the Government no longer has to be preoccupied with security. For the first time in many years, it is in a position to concentrate on economic and development issues.

At the February 1999 Consultative Group (CG) meeting, the Prime Minister stated *"our main objectives are to reorient spending priorities from defence and security towards the social sector – notably education, health, agriculture and rural development".* The IMF recently re-engaged and the World Bank provided a new credit of US$ 30 million following the signing of the Country Assistance Strategy.

Despite these optimistic signs, the challenges facing the government are daunting :

Law and order

Preliminary results from a good governance survey supported by the World Bank indicated that the judicial system is perceived as being corrupt. The wide availability of guns, a weak civilian police force, and an ineffective legal system pose a real threat to stability. This issue is being addressed in the government's action plan for "good governance" being developed with support from the World Bank.

Budget reform

A budget decentralisation strategy exists but full implementation has yet to be achieved. Corruption remains an issue. The existence of monopolies in government procurement causes

some concern.

Public sector reform

Institutional capacity in the public service is weak in all sectors. The most pressing issue is civil service pay, currently equivalent to US$ 10-20 per month, which does not constitute a living wage when average monthly household expenditure varies from US$ 80 in rural areas to US$ 250 in the cities. Whilst salaries remain at this level, poor performance and "survival" corruption are almost inevitable.

Health Profile

There have been improvements in health outcomes in recent years. The infant mortality rate has decreased from 115 in 1993 to 89.4 per 1000 live births in 1998, and the under-five mortality rate from 181 to 115 per 1000 live births in the same period. Access to contraceptives remains low with a contraceptive prevalence rate of only 16% in 1998, but has certainly improved from the 1995 figure of 7%.

Cambodia was certified as polio free in October 2000, with no cases of poliomyelitis since March 1997, and a surveillance system for acute flaccid paralysis (AFP) which meets the required international standard. The malaria case fatality rate has fallen from 0.7% in 1996 to 0.4% in 1998, and the target to lower leprosy prevalence to fewer than 1 case among 10,000 people by the year 2000 was reached in 1998. All referral hospitals and health centres with hospital beds provide DOTS to treat TB patients. In 1998, the case detection ratio reached 50%, (8% higher than the average for the Western Pacific Region). The cure rate is 89% for sputum positive patients, consistent since 1995, and the treatment success rate is more than 93%. Even so, TB still accounts for over 10,000 deaths per year.

The fact is that, despite marked progress, the health status of the people of Cambodia is among the lowest in Asia. Life expectancy in 1999 was only 52.2 for males and 55.4 for females. The maternal mortality ratio was 473 per 100,000.

To date, the under-resourced publicly funded health services have had little to offer the rural poor. At least one-fifth of the population have no access to them at all. Overall rates of utilisation are low at around 0.3 visits per person per year. Unofficial charges in public facilities have been widespread, and for most people the purchase of medicines from both legal and illegal pharmacies is the main source of health care. This is reflected in the fact that, whilst government spent only US$ 1 per capita in 1998, private out-of-pocket spending was on average about US$ 30 per person. 11% of GDP per capita is spent by households on health. Health care expenditure is an important cause of indebtedness. Results from an OXFAM study on landlessness indicate that 44% of the people who recently lost their land, did so because they had to pay medical expenses.

Childhood morbidity and mortality are associated with adverse living conditions and poor nutrition, especially acute respiratory infections, diarrhoea, malaria, vaccine preventable diseases and, more recently, dengue haemorrhagic fever. UNICEF and WFP (in the Cambodian Human Development Report) give figures of 56% and 49% for stunting and wasting, respectively.

Cambodia has one of the most rapidly growing HIV/AIDS epidemics in the Region. The 1999 estimate for prevalence in the sexually active population was 3.75%. In blood donors it increased from 0.1% in 1991 to nearly 4% in 1996, and in commercial sex workers, from 9% to 40% over the same period. It is estimated that some

500,000 to 1 million Cambodians will be infected with the virus by the year 2006. The UN Common Country Assessment states that *"Apart from the human cost in terms of suffering and loss, the economic cost will be sizeable. It is estimated that between now and 2006, at least US$ 2.8 billion of GDP will be foregone. This figure does not include the cost of care and treatment."*

Cambodia has the highest rate of amputations due to land mine injury in the world, and there are currently about 40,000 amputees in the population. Only since 1995 have injuries due to road traffic accidents started to exceed those due to land mines and unexploded ordinance.

Mental health is also recognised by the Ministry of Health as a major contributor to morbidity.

Health Sector Development

Health is one of the sectors receiving priority attention both from Government and external partners. A process of reform, led by the Ministry of Health (MoH), aims to improve equity in access to and utilisation of good quality services, with a particular focus on services for the poor. The main thrust of the reforms has been to change from an administratively organised to a population-based system, in both the distribution of facilities and the allocation of financial resources. The Ministry of Health is now acknowledged to be one of the strongest ministries. This is against a background of the effective dismantling of the health system during the Khmer Rouge period and a Ministry of Health that did not have a budget allocation until 1993.

The overall goal set by the MoH is:
"To promote people's health enabling them to participate in the development of the socio-economic sector and reduce poverty in Cambodia".

This is to be achieved by implementing strategies on a number of fronts, including reducing the incidence of communicable disease, promoting the health of women and children and strengthening evidence-based policy development. Improving the quality and efficiency of health services as a whole will be a priority. In the public sector, this will include extending the coverage of public health services; enhancing the professional capacity of government health staff; improving health management systems at each level; upgrading technology and management within referral hospitals; and ensuring an appropriate supply of drugs, equipment and supplies.

Government and People

The government will seek to both motivate and control the private sector as a true partner of the MoH in service delivery, and will strengthen health legislation and enforcement. There will be a determined effort to promote consumer awareness and health-promoting behaviours.

In order to achieve effective management of the health sector, the MoH has decided to develop a National Health Master Plan to describe the key strategies and activities that the MoH will

undertake to “ensure the health of the people”, with due attention to the costing of options. The first step was a Joint Sector Review undertaken in November 2000.

Progress

Even with the very low level of public resources available (0.35% of GDP in 1998 and 0.63% of GDP in 1999), progress has been impressive:

? in policy-making, technical inputs are in place and national capacity is being built to develop policies, formulate operational strategies and plans, and set in place management mechanisms and monitoring systems. Both Government and NGOs have started translating policies into action.

? the range of services to be made available at different levels of the system has been defined in the form of minimum (MPA) and complementary (CPA) packages of activities. The 1996 Health Coverage Plan specified existing and future locations of health centres and referral hospitals to maximise access for the majority of the rural population. The coverage plan is being used by most donors who support health infrastructure development. In some rural areas, non-profit organisations are being contracted to run public health facilities. Initial results show encouraging increases in utilisation and improved quality of health services. In Phnom Penh, health rooms have been opened to provide those living in squatter and slum communities with access to quality health services at an affordable price. Separately, work is in hand to improve the quality of private health care in the city through accreditation, approved provider schemes and training in the rational use of drugs. A planning manual has been prepared for provincial level planning, and the MoH has developed a set of national indicators for monitoring health sector performance.

? government commitments to increase health spending are reflected in a 50% increase in the MoH budget for 2000, and the intention to provide a further increase to 1.5% of GDP by 2002-3. A Priority Action Programme was introduced by the Ministry of Economy and Finance in September 2000. Funds are disbursed as a quarterly advance, protected from cuts. Budget authority is given

to the spending unit. This budget reform initiative is a potential vehicle for donor funds. A

national Health Financing Charter provides a legal framework for collecting user fees at facility level. These 'official fees' are intended to reduce unofficial charges, and thus decrease the financial disincentive to using services and the burden on the poor, who are exempt. Income is used at facility level to fund operational costs and staff incentives. 35 districts, selected as Accelerated Development Districts from a total of 73, receive direct cash advances for planned activities. When the funds are accounted for, the Ministry of Economy and Finance automatically reimburses the districts. This has improved cash availability at the operational districts and led to better health services and reduced health expenditures for the people.

? the Ministry of Health is improving linkages with the community through the establishment of health centre management committees and feedback committees. These committees are contributing to increased utilisation of publicly funded services. Studies have been carried out to gain a better understanding of consumer needs and health-seeking behaviour in different settings. Progress is also being made in health promotion and response to disease outbreaks.

Obstacles

These achievements and the overall improvement in health outcomes together provide a strong base from which to build a revitalised health system. Despite this, the Government of Cambodia's main objective is not yet being achieved. Except in a few areas where additional resources and semi-autonomous management have been provided, rates of utilisation are not increasing. In some of the provincial hospitals, utilisation rates are actually decreasing as patients are treated at the private clinics of doctors who also work in the public sector. The MoH is concerned that, if this situation continues, people will lose what little confidence they have in the public sector.

The reasons for slow progress include:

Insufficient funds, staff and accountability

While there have been improvements in public service delivery over the past several years, several factors are consistently identified as contributing to the low quality and coverage of health services, and the subsequent poor health status of the population: (i) insufficient funds for running costs and salaries, (ii) lack of sufficiently trained and motivated staff, and (iii) lack of accountability for financial

and staff management. Human resources - the deployment, supervision, motivation, competence and adequacy of training of health personnel - represents the most significant issue to be faced. But these issues cannot be tackled in isolation. In the absence of management improvements (transparency, accountability, working towards one plan with clear outcomes, control over budget, control over staff), increased resources for running costs and salaries will have a short-lived and limited effect on improving the quality and delivery of health care services.

Low levels of remuneration

Low levels of remuneration are a particular problem, since they do not provide sufficient incentive for health workers to do their jobs well. Government officials, development agencies and NGOs agree that the full benefits of investment in infrastructure, training and equipment will not be realised without effective action on public sector pay. This is not an issue that can be resolved by the MoH alone. National Public Administrative Reform is gathering momentum with the proposed introduction of living wage salaries for priority groups. This will not cover the whole civil service and will take some time before it can be implemented, so interim strategies – through different forms of salary supplementation – are being used by development agencies. It is urgent to build a consensus on how salary supplementation should be managed, since it could distort priorities and increase inequity in service provision, if not well handled.

Poor quality private health care

While the Royal Government of Cambodia has begun to tackle the problem of poor quality and exploitative private health care, progress remains limited – not so much due to lack of legislation since a Medical Act has been passed, but due to the lack of means to enforce it.

In summary, many of the basic building blocks of the health sector are in place but performance is severely constrained by the economic and institutional environment in which it has to operate. The conclusion is that much depends on fiscal reform, reallocation of priorities within the national budget, strengthening the rule of law and renewal in the civil service. The MoH has developed a Boosting Strategy to tackle obstacles within its own remit. This strategy focuses on ensuring access to sufficient financial and human resources, improving management of resources, and increasing demand for and utilisation of services. Changes are beginning, but their effects will not be seen overnight. The most difficult strategic question facing the Government and its development partners is therefore what to do in the mean time.

Government and People

Emerging Health Policy Issues

The basic thrust of Government policy is clear: *"revitalising health services, controlling communicable and preventable diseases, and building capacity to manage resources and deliver essential services more efficiently, and promoting a greater sense of responsibility in each individual for the protection and enhancement of personal and family health".* Some policy questions, however, remain to be resolved.

Much of the policy and systems work carried out to date assumes a major role for the state in service provision. At the same time, there is a great deal of interest in the roles of the private and voluntary sectors as service providers in both rural and urban areas, largely through contractual mechanisms. Given the human and financial resource constraints facing the public sector, a clear vision of the role of government in the future is needed – particularly in the proposed sector-wide approach. The MoH has developed a Safe Motherhood policy and strategy with the assistance of WHO and UNFPA. Whilst this policy provides a vision of what should or might be, MoH officials admit that it is not affordable and that the minimum and complementary packages of activity do not include sufficient drugs and equipment for maternal health care. There is need for a clear policy on how to manage the gap between the ideal and the affordable, with strategies which the country can afford and which donors are willing to support.

Whilst major health service development is taking place in districts where the majority of the population live, a significant minority of people - among the poorest and most vulnerable in the country - are in areas where they cannot be reached by formal health services. The national malaria programme has been a pathfinder in providing services to people in remote and poorly served areas. The Ministry of Health has just finalised a policy and standard "outreach" guidelines to help address the problem of under-served and unreached sections of the population, and is supporting pilot health posts in remote provinces.

Routine health information activities are presently confined to curative services, with the information being used to improve planning and management. Additional and more detailed information is needed for running disease surveillance and prevention programmes. The Ministry of Health is reviewing the overall need for data, how best to gather the information, and coordination between the National Disease Control Programmes and the two responsible departments (Planning, and Communicable Disease Control).

National programmes are becoming more involved in health system development. The EPI, TB and malaria programmes all anticipate working more closely with the health sector reform, so that their specific disease control activities can support the development of general services, and involve civil society as well as other agencies. The Ministry of Health is pursuing integration of health services as a priority, focusing on supervision, planning and training. Tools have been developed, including supervisory checklists and a planning manual which stresses the need for one overall planning process at operational district and provincial levels. The next step is to explore ways of involving civil society.

Clearly a range of different approaches is required to tackle Cambodia's health problems. The populations most affected by malaria, for example, are different - and live in different places - from those vulnerable to HIV/AIDS. Surveillance of the AIDS epidemic requires different systems and is unlikely to benefit from being combined with those used by routine services. Integration cannot be an end itself and, given the health profile of Cambodia and the growing expectations of the population and its development partners, there is a need to deliver results.

3 DEVELOPMENT ASSISTANCE: AID FLOWS, INSTRUMENTS AND COORDINATION

Overview

In 1998, external assistance constituted 12% of GDP and surpassed the total level of government expenditures. All public investment is financed by donors, and donor funding exceeds government expenditure in all the social sectors. Donor funding in health amounts to about US$ 30-40 million per year.

The return of peace and stability will not immediately diminish Cambodia′s need for external assistance. However, with the shift from ‵emergency response′ to ‵development assistance′, there is already evidence of changes in the identity of Cambodia′s development partners. And, despite the government′s explicit request for external partners to work within the framework of national policies and strategies, unlinked projects have started to proliferate, each competing for the time and attention of officials, and undermining the institutional capacity that development assistance is supposed to build.

Since external funds are needed to cover most of the non-wage costs in the health sector, the availability of donor funds can also significantly influence priority setting. Cambodia recognises the need for and welcomes technical assistance. However, it is critically important to ensure consistency - or at least clarity - in the advice provided. In some areas, such as HIV/AIDS, where there are said to be as many as 30 foreign advisers in country, this is already a challenging task.

NGOs have played a significant role in Cambodia. They provide about 13% of all development assistance, and are active in several sectors. Whilst it does not act as a formal co-ordination body, MEDiCAM is a membership organisation of 100 NGOs working in health in Cambodia. Its key objective is to strengthen co-operation between NGOs, the government and international organisations.

The Minister of Health has stated that most donor assistance bypasses the government budget system and involves direct funding of project contractors. During the first eight months of 1999, only 0.5% of external funds were channelled through the budget system of the MoH. Much donor assistance is not distributed equitably. Government officials are more and more forthcoming about their concern that external assistance is so donor driven, and about their desire for a shift from ‶donorship″ to ‶ownership″.

At a macro level, much depends on the current negotiations with the IMF. A point of contention

concerns whether a reduction in the size of the civil service (by 6,000 out of 163,000) is a sensible condition to place on the loan. Some argue that the potential political fallout is not justified by the limited financial return. Moreover, given the weakness of public service provision, it is not at all clear what size of work force is actually required. If, however, the IMF resumes lending, the way will be open for budget support from other donors.

Donor Coordination

At the Tokyo Consultative Group meeting in early 1999, four priorities were agreed between government and donors: forestry, public sector reform, fiscal reform and demobilisation. Four donor working groups were convened locally to interact regularly with government and to monitor action in these areas. Subsequently, in part on the urging of the World Bank and the UN system, a fifth working group has been formed for the 'social sector'. There remains some way to go in defining the objectives and *modus operandi* of these working groups. However, they do represent an important opportunity to develop a common analysis of the problems facing Cambodia and a more co-ordinated approach on the part of donors to working with the highest levels of government to address them. Critically, they also involve most of the major donors working in the country.

The Common Country Assessment has been completed and the process of developing the United Nations DevelopmentAssistance Framework (UNDAF) has proceeded. The UNDAF process has been helpful in defining the role of the UN organisations at a time when the development assistance environment is changing. However, at the same time, UNICEF, UNFPA, the World Bank and WHO are all in
the process of developing their own business plans. The UN is shifting increasingly to programme support and a focus on policy advice rather than financial support.

Within the health sector, the main agency co-ordination mechanism is CoCom, set up in 1993 as a means of co-ordinating external support to re-establishing the Ministry, and today managed by the MoH. WHO was very much part of its establishment and has strongly supported it, given the significant role it has played in enabling the MoH to not only function, but become as strong as it is today. Twelve sub-committees deal with specific areas of policy, and the structure is replicated at provincial level. Much of the initial work of these subcommittees has now been institutionalised into the new departments of MoH. Whilst CoCom has been

important in supporting MoH in its development and in gaining consensus in several key areas of policy, some question its current value and effectiveness. The next steps in revising CoCom are not clear, especially given the MoH's decision to move towards a sector-wide approach, and increasing calls for partnership and coordination amongst the partners in the health sector. Reviewing CoCom's terms of reference is one of the tasks defined for the SWAp working group.

Towards Sector-wide Management

The health sector is leading the field in moving towards the development of a sectorwide approach. The idea has support from the highest levels of government, including the senior Minister of Finance. As the MoH proceeds on its step-by-step approach towards a SWAp, it committed itself to conduct a 'sector review' at the end of 2000 and use it to develop a Health Master Plan. It will be important to ensure that there is a shared understanding of the purpose of the exercise among all the different actors. The external partners, particularly those who encourage the Ministry to move in this direction, have to be honest about their own ability and willingness to participate. Many opportunities for joint work, joint reviews and joint planning are simply not taken up.

While funding through a single channel with one set of management arrangements is clearly very attractive to the MoH, the Ministry acknowledges that a sector-wide approach can proceed without including the 'pooling of funds', which could, if agreed, be introduced at a later stage in the process. It has therefore chosen to move ahead with a 'sector-wide management' approach, which reflects the emphasis on common strategies and common plans. There is consensus about the need to bind donors into key aspects of health sector policy and strategy.

Donors Active in the Health Sector

The following section focuses only on major trends and issues, the most obvious of which is that the scene is changing: new donors are coming in and several existing donors are engaged in re-thinking their country strategy.

The current **World Bank** programme in Cambodia contributes to the building and rehabilitation of facilities and to disease control. Without World Bank support to date, the Health Coverage Plan could not have been implemented. The new Country Assistance Strategy calls for a significant expansion in support, and a commitment to a sector-wide approach in health. The relationship

with WHO must be one of collaboration and complementarity based on a shared analysis of key problems. The

challenge will be to draw the World Bank into a team with the MoH and other partners to work together to achieve a Cambodian Health Sector Strategy, not an agency strategy.

The **Asian Development Bank** has provided two major loans totalling US$ 30 million. One focuses on the rehabilitation of health facilities in five provinces. This is complemented by support for skills development. Within the five provinces, the ADB project supports an experimental approach to contracting. Selected districts can either contract in a management team to help run public services according to normal government rules with standard rates of pay, or they can contract out service provision to a non-profit organisation, who can run the district according to terms agreed in the contract. Initial results from the three districts using contracting out are encouraging, but there is some concern that the model is unlikely to be affordable on a large scale.

The ADB and World Bank projects are managed by a combined, but separately funded, Project Co-ordination Unit with the Secretary of State of the MoH as its Director. This could be a cause for concern, if it limits systems development in such key areas as contract management and procurement. However, the Project Coordination Unit is to be integrated into the finance department of the MoH. Experience in other countries suggests that where financial incentives are provided to staff, it is very difficult to dissolve these kinds of units once they have been established.

In recent years, **UNICEF** has worked closely with the MoH on the health coverage plan and the development of district health systems. It also contributes strongly in the areas of essential drugs, EPI, polio, nutrition, IMCI and Safe Motherhood. A similarly close relationship also exists with **UNFPA** in the field of reproductive health. Both organisations are in the process of preparing new

5-year programmes for 20015, UNFPA including staff members from UNICEF and WHO in their planning team.

DFID has worked closely with the MoH since the resumption of operations in 1991, and is now the largest financier in the partnership (with NORAD, UNDP and WHO) that supports the health sector reform programme being executed through WHO. Support for malaria from DFID (also through WHO) was discontinued with the advent of funding from the **European Commission.** The EC also supports AIDS and STI control.

Development Assistance

Several agencies, including NGOs such as **MSF** and **Healthnet,** have supported the MoH in developing provincial and district health systems. **GTZ,** which has concentrated on training through the Public Health Institute, is now seeking a more substantive role, both in policy development and in funding service provision in selected provinces. **USAID,** on the other hand, is working primarily on reproductive
health issues through a network of NGOs, especially **World Vision, FHI/IMPACT** and **Health Unlimited,** in accordance with a US law which restricts their direct work with the Royal Government of Cambodia. USAID works through WHO to support the
National Malaria Programme.

JICA continues its support to MoH in maternal and child health and has commenced a support programme for TB, in which it works closely with WHO. **AUSAID** is active in health, especially EPI, and recently played a major role in supporting the joint effort of the MoH and the Ministry of Rural Development in formulating a national primary health care policy.

WHO : Current Country Programme

4 WHO: CURRENT COUNTRY PROGRAMME

WHO and Cambodia

Cooperation between the World Health Organization and Cambodia began in 1953, focusing on such projects as malaria control and maternal and child health. The programme expanded but was suspended from 1975 until 1980, when periodic technical consultation and other forms of support for some programmes (e.g. rehabilitation of the water and sanitation works in Phnom Penh; prevention and control of diseases such as malaria, diarrhoea, tuberculosis; development of human resources with specific focus on medical education and nursing) were extended by WHO to the country under the auspices of UNICEF or the International Committee for the Red Cross (ICRC). In March 1991 a WHO office was re-established in Phnom Penh and a new programme of support was initiated. In May 2000 the WHO team consisted of 70 people, including 20 internationally recruited professional staff members and 10 volunteers. In 2000/01 the country budget is US$ 6.7 million, including an estimated US$ 3.7 million in extrabudgetary funds. About 60% of the budget is for technical assistance and other personnel.

Key Programme Areas

Key areas where WHO provides support include:

? *Health Sector Reform* where a team, funded jointly by DFID, NORAD, UNDP and WHO, works to strengthen the capacity of the national health administration to manage existing health services, improve the national health system and plan for future health system development; to support prioritisation of health care needs; and to establish effective coordination mechanisms at national and provincial level, (including a sector-wide approach), in order to make better use of external resources to the health sector. One aim is to achieve a strengthened rural health infrastructure, capable of providing quality basic health services to the majority of the population.

? *Human Resources for Health,* to increase MoH capacity in health workforce planning, production and utilisation; to improve coordination, relevance, effectiveness and efficiency of basic training programmes for all professionals, especially physicians and nurses/midwives; and to strengthen the coordinated system for continuing education of all health professionals.

? *Malaria and Dengue Haemorrhagic Fever Control,* where support is given to the National Malaria Programme, through Roll Back Malaria, to reduce mortality and

morbidity associated with malaria in Cambodia, and to increase institutional capacity to control mosquito-borne diseases.

? *Essential Drugs,* to assist the MoH in developing a long term drug policy, and ensuring the availability of vaccines and the rational use of essential drugs, at all levels of the health care system. The intended outcome is to assure the quality, safety and efficacy of locally produced and imported drugs and vaccines.

? the planning and implementation of *a National Integrated Management of Childhood Illness* strategy, which will build government capacity to reduce mortality and morbidity from the main causes of disease in children below 5 years of age, including acute respiratory infections particularly pneumonia, diarrhoeal diseases, measles, dengue haemorrhagic fever, malaria and malnutrition in young children.

? *the National Immunisation Programme,* in close partnership with UNICEF, to reduce morbidity and mortality from diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis by providing immunisation against these diseases for every child in Cambodia, with the introduction of Hepatitis B immunisation and injection safety. The eradication of poliomyelitis was certified in 2000.

? capacity strengthening of the Ministry of Health and a national *AIDS programme* to reduce HIV transmission and the morbidity and mortality associated with HIV infection, and to introduce a syndromic approach to the management of sexually transmitted diseases.

? *Environmental Health,* where WHO is promoting healthy settings, helping the Government to monitor water quality and strengthening capacity for training and management in water and sanitation.

? *Nutrition, Maternal and Child Health, Prevention of Blindness, Mental Health, Leprosy, and Blood Transfusion Service,* where WHO provides substantial support to the Government through consultants and staff.

? *a variety of coordinating mechanisms,* sub committees and working groups.

Members of the WHO team have actively contributed to Common Country Assessment and UNDAF activities, to the Programme of Administrative Reform, and to working groups set up to monitor activities following the Consultative Group meetings. They are active in UN system theme groups, especially that on HIV/AIDS. They also participate in joint reviews and planning

missions of other external partners. They are supporting the Government's response to the need to develop a Poverty Reduction Strategy paper. All members of the team have a responsibility to share information, particularly technical information available through WHO, and all play a role in advocacy.

5 WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO Corporate Policy Framework

A WHO Country Cooperation Strategy needs to reflect the Organisation's corporate policy framework and regional strategies, alongside the health needs of the country and the activities of other development partners.

WHO's mission, as set out in its constitution, remains the attainment, for all people, of the highest possible level of health. A number of challenges have emerged from the significant changes in international health in the last decade, including a new understanding of the causes and consequences of ill-health; the greater complexity of health systems; increasing prominence for 'safeguarding health' as a component of humanitarian action; and a world increasingly looking to the UN system for leadership. WHO has developed a corporate policy framework to guide its response to this changing global environment and to enable WHO to make the greatest possible contribution to world health.

The policy framework continues to reflect the values and principles articulated in the global Health For All policy, which was re-affirmed by the World Health Assembly in 1998 with new emphases on:

? adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction

? playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise

? triggering more effective action to improve health and to decrease inequities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others

? creating an organisational culture that encourages strategic thinking, global influence, prompt action, creative networking, and innovation.

WHO's Goals and Priorities

WHO's goals are to build healthy populations and communities and to combat ill health. To attain these goals, the following four interrelated strategic directions have been set:

? reducing excess mortality, morbidity and disability, especially in poor and marginalised populations

? promoting healthy lifestyles and reducing factors of risk to human health that arise from environmental, economic, social and behavioural causes

? developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair

? developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

In addition to these strategic directions, WHO has also defined limited specific priorities, based on criteria which include the potential for a significant reduction in the burden of diseases using existing cost-effective technologies (particularly where the health of the poor will demonstrably benefit), and the urgent need for new information, technical strategies, or products to reduce a high burden of diseases. The specific priorities are: malaria, HIV/AIDS and TB; maternal health; mental health; tobacco; non-communicable disease; food safety; safe blood; health systems; and investing in change in WHO.

Regional Emphasis

Within the WHO corporate strategy and in the light of emerging health challenges in the Region, the WHO Regional Office for the Western Pacific has tailored its own supporting framework for action around four outcome-oriented themes: combating communicable diseases, building healthy communities and populations, developing a stronger health sector, and reaching out (which encompasses information technology, external relations and public information). The 1999 Regional Committee Meeting made TB a special regional project, in recognition of the fact that one quarter of all TB victims (some 2 million people) live in the region. Three quarters of them are in the prime of their productive and reproductive lives, and the majority bear a double burden of disease and poverty.

6 STRATEGIC AGENDA FOR CAMBODIA: THE NEXT FIVE YEARS

WHO's Mission in Cambodia

WHO's mission in Cambodia is to collaborate with the Government and other concerned parties in improving the health of the peoples of Cambodia by supporting health promoting policies, the sustainable development of health services, and the development and implementation of programmes aimed at reducing the burden of disease and contributing to poverty alleviation and gender equity.

Justification for the WHO Strategic Agenda

The document so far represents WHO's view of the issues that need to be addressed in working to improve the health of people in Cambodia. It is based on a shared analysis of the present situation, arising from the WHO country team's close working relationship with the government and their recent involvement in CCA, UNDAF and PRSP exercises; and on discussions held by Regional and HQ members of the CCS team during their two missions in Cambodia.

WHO's Country Cooperation Strategy takes fully into account this appreciation of the special characteristics of the current Cambodian context. Conflict has left Cambodia decimated,

impoverished and with little institutional or human resource base. Its health and human development indicators are lagging behind, and the spread of HIV/ AIDS is a serious threat. At the same time, the government is displaying commitment, sound strategy and leadership in seeking to improve the country′s health status and the Ministry of Health is developing its own capacity in some areas. Fluctuations in the multitude of development agencies active in Cambodia, strong partnerships and the MoH′s commitment to sector-wide management all point to scope and need for changes in approach. And WHO specifically needs to review its strategy in the light of corporate goals and local developments - such as increased support from other agencies for areas previously assisted by WHO, and the success of national programmes (e.g. for polio and leprosy) which allows the Organization to change its focus from campaigns to support for disease surveillance.

This shared assessment provides the justification for the shifts in content and function outlined in this section. Implicit in this is the idea that WHO has played, and will continue to play, a role in helping to set the overall agenda for health

development, a process in which the MoH takes the lead. Implicit also is the notion of change and flexibility.

This section focuses on identifying priorities for WHO's support to Cambodia, drawing on the totality of the Organization's resources and working in partnership with others. It identifies operational principles, strategic functions and WHO's strategic objectives, based on the national goals of the Royal Government of Cambodia.

Principles

The key principles that govern the proposed shifts from WHO′s current programme of work to its new strategic agenda are to:

? be more selective and focused in determining which part of government′s and the health sector′s programme to support

? leave room for responding to requests as they arise, while defining the boundaries within which WHO will respond

? emphasise WHO′s role of policy advisor and broker

? differentiate WHO′s work and performance from that of government, whilst continuing to work as government′s key partner in health

? explicitly take into account the strategies and activities of other partners

? seek out opportunities to increase and strengthen our partnership with other agencies and actors

? maintain the visibility and credibility of WHO, focusing on what the Organization does best and paying due attention to its weaknesses.

The operational principles which will guide WHO in Cambodia include: ? working within government policy and planning frameworks

? pursuing a partnership approach, within the national plan and framework, and promoting and participating in joint reviews and joint planning

? pursuing a capacity-building approach with an explicit time frame for hand-over of responsibilities; supporting the Royal Government of Cambodia in its shift from "donor-ship" to "ownership"

? moving from influencing others to supporting national capacity for influencing others; enabling the government to be more strategic, with a more

comprehensive view of - and more support for - health issues and the health sector as a whole

? reaching the whole country, and monitoring potential and emerging problems (both system and health problems)

? being simultaneously more proactive, and more demand-led. WHO will function as a resource centre, providing or facilitating support on the issues identified in its strategic agenda.

WHO Strategic Functions

This Country Cooperation Strategy defines not only what WHO will do, but how it will do it − function as well as content. WHO has identified five key functions in its work at country level:

F1 supporting routine long-term implementation

F2 catalysing country-specific adaptation of guidelines, technical strategies and innovations; seeding large-scale implementation

F3 supporting research and development, policy experimentation, development of guidelines; stimulating the monitoring of health and health sector performance; trends assessment and anticipation

F4 providing information and advocacy, sharing knowledge (global, regional, inter-country) for appropriate policy options and positions; including case studies of good practice, generic guidelines and standards, and study tours

F5 providing specific high level policy and technical advice; serving as broker and arbiter; exercising influence on policy, action and spending of government and development partners.

WHO Strategic Agenda: WHO Components and National Goals

The management of WHO′s work in Cambodia will be organised in three components: health sector policies, systems and partnerships; health services access and quality; and healthy settings and populations. These components were chosen to group areas of work in a way that makes sense for WHO′s medium term priorities in Cambodia, and to link with national Cambodian goals and targets. They may well change over time, along with other aspects of the CCS, in keeping with its nature as a strategic document.

The primary thrust of WHO′s contribution will be to strengthen the government′s capacity to develop policies, implement strategies, achieve change and realise targets. The introduction in Cambodia of a sector-wide management approach for

health development will re-define some of the ways in which WHO works with government, and

introduce new areas of emphasis. For example, WHO will have a greater role in strengthening the Ministry's capacity to manage the process, and will work directly with other partners to ensure they are engaged in the process. A sectorwide management approach will also require revision of how WHO organises its own work.

Component 1
Health sector policies, systems and partnerships

The National Development Goal to which WHO can contribute is:

"To implement health sector reform and a sector wide approach, leading to improved and equitable access and utilisation of quality affordable health services; regulate both the private and the public health sector, establishing and maintaining standards for public safety and quality control; with improved quality of planning, deployment, training, management, supervision and performance of the health workforce.

To achieve improvements in health status MoH recognises it needs to strengthen its own sectoral management, in order to ensure: a coherent sector policy and budget based on a partnership which maximizes the impact and value for money of the combined donor, government and community resources; improved Ministry of Health capacity to lead and manage health services and resources; more flexible funding arrangements to ensure essential expenditures are covered; greater sustainability through government ownership of donor funded activities".

WHO has identified this component as a continuing high priority. It has invested substantially in this area, and successfully attracted resources and the cooperation of other development agencies to work within the government's policy framework. Work in 2000 is approaching a critical stage as the government undertakes its health sector review. WHO will concentrate half its effort on this component over the next 5 years.

1.1 Policy and regulation

supporting performance monitoring; policies for the private sector, public safety and quality control

By catalysing country-specific adaptations, supporting research and development, providing information, advocacy, and high level policy and technical advice, WHO will seek to strengthen the capacity of MoH to develop – and make effective use of - a health sector policy and indicator framework, covering both public and private aspects of the health sector. A key goal

will be improving the national health system, and planning for future health system development. WHO will assist the Ministry in framing its regulatory functions, including registration, public safety and quality control. One feature will be to develop strategies for private sector participation in health services delivery, based on appropriate technology and professional ethics, and to ensure adequate oversight of its work. WHO will also help the Ministry to promote consumer knowledge of health care provider qualifications, and expectations of provider performance.

1.2 Institutional reform, public sector reform and fiscal reform

*supporting public administration and management reform; health sector reform, human resource for health, institutional analysis and capacity; public expenditure reform; f*inancing options

WHO will similarly support work on a range of issues arising from institutional, public sector and fiscal reform. Particular emphasis will be given to strengthening planning, production, use and management of the health workforce, including human resource database activities, registration and accreditation systems. This will be achieved through advice, advocacy and information to the Ministry on defining staffing roles in the health sector, improvements in basic training and continuing education for all professionals, staff deployment and performance management.

This work will take place within the context of an overarching management reform framework, and encompass support for sector management and links with public expenditure management. Issues include providing a sector focus and input to the programme of administrative reform; decentralising financial and administrative functions; improving resource allocation; developing a health sector expenditure framework; and monitoring and evaluating health financing schemes.

1.3 Partnership and cooperation

supporting development partnerships between government and other national and external entities ; WHO collaboration and partnership with UN agencies and specific partners

WHO will support the government in developing partnerships with other national and external entities, including in relation to poverty reduction strategies and the Comprehensive Development Framework. Key aims will be to promote joint working, under government

leadership, among health sector agencies, and to establish effective coordination mechanisms at national and provincial level to secure better use in the health sector of external resources. This would cover Cambodian ownership and management of a SWAp process. WHO will work directly with other partners to ensure that all work collaboratively within a framework of government policies, strategies and priorities.

This work represents a continuation of several years effort. WHO is regarded by the government and other partners as a neutral broker, and has an established record of promoting effective coordination mechanisms.

Component 2
Health services: access, quality and utilisation

The National Development Goals to which WHO can contribute are:

"To provide basic health services to all people, with community participation, especially health promotion, preventive and curative health care, so as to meet the critical needs of the people, particularly the poor and those 85% living in rural areas.

To reduce mortality and morbidity from communicable and non-communicable diseases, with special emphasis on maternal and child illnesses: immunise every child in Cambodia against diphtheria, pertussis, tetanus, measles, poliomyelitis and tuberculosis; prevent the spread of HIV infection in Cambodia while providing care and support for those infected and affected by the epidemic; take into account new priorities such as elderly, disabled groups and emerging health problems.

To collect regular, reliable data on health behaviours, incidence of diseases, services utilisation and costs; health sector performance and use the information to improve performance and health status".

Provision of full-time provincial coordinators to work with national counterparts has been a key element of WHO's strategy to date. Given the development of some national capacity and the activities of other partners in this area, WHO intends to reduce its effort in this component by as much as a quarter. This will include

withdrawal from routine implementation activities, but WHO will remain involved in the development of strategies for integration and systems development.

2.1 Integrated delivery of interventions

supporting IMCI, safe pregnancy, tuberculosis, malaria, HIV/AIDS, blood safety, immunisation

To help meet the goals of improving health indicators and reducing maternal mortality, WHO will strengthen the capacity of the MoH on a number of specific fronts, including:

?planning and implementing a national Integrated Management of Childhood Illness strategy, which will build capacity to reduce mortality and morbidity in children under five from acute respiratory infections (particularly pneumonia), diarrhoea, malaria, dengue haemorrhagic fever, measles and malnutrition

?national programmes to control malaria, dengue, tuberculosis and leprosy, through support to service delivery at operational district and provincial level

?increasing immunisation coverage throughout the country for the 6 target diseases, including campaigns for measles and tetanus in women of childbearing age; maintaining surveillance of AFP following achievement of the eradication of poliomyelitis; and introducing Hepatitis B vaccination

?helping the national AIDS programme to reduce HIV transmission and the morbidity and mortality associated with HIV infection, by promoting 100% condom use, blood safety and home based care strategies; introducing a syndromic approach to the management of sexually transmitted infections, and continuing to support surveillance

?the implementation of the national Safe Motherhood Strategy.

More broadly, WHO will help the MoH to identify relevant lessons from within Cambodia and elsewhere, sharing best practice and catalysing adaptations to Cambodia's own circumstances, to promote the provision of publicly funded health services in rural and urban areas.

2.2 Support system building blocks

*supporting integrated surveillance, planning and management in districts and pro*vinces;
the community/health system interface, consumer education

Key priorities will be supporting the government in its efforts to improve the management of existing health services, and achieve a strengthened rural health infrastructure capable of providing quality basic health services to the majority of the population. Existing health centres must be enabled to provide the full minimum package of activities, and integrated district health services revitalised by direct participation from the community, requiring the establishment and development of local management committees. Supervision and support activities need strengthening in order to improve service performance at central, province and district levels.

WHO will assist the MoH in developing a long term drug policy, to ensure the availability of drugs and vaccines, and their rational use, at all levels of the health care system. The broader programme will include monitoring of drug quality and manufacturing practices and equipment. WHO will also offer advice on improving hospital hygiene, including contaminated waste disposal.

On the systems front, WHO will support :

? the introduction of a revised health information system, focusing on information quality, analysis and use, together with strengthening the computerised system at province level

? the development of an integrated disease surveillance system, and the capacity for rapid recognition of, and response to, outbreaks of infectious disease

? enhanced research activities encompassing demography and health survey.

WHO will act as an advocate to promote the public health functions of the Ministry of Health.

Component 3
Healthy settings and populations

The National Development Goal to which WHO can contribute is:

"To improve the health and nutritional status of the Cambodian population through improved access to healthy settings and safe water and by improved family health and nutrition knowledge and practices".

In recognition of the substantial health gains which can be made, this is a component where WHO intends to increase its activities from a current 15% of WHO effort to 25%.

3.1 Health and environment
including water safety, sanitation, food safety, healthy schools, healthy cities, and healthy markets

WHO will assist the MoH to conceptualise and implement work outside the traditional health sector to promote healthy settings, with an initial emphasis on Healthy Cities and Healthy Market places. This will include enabling community members to prevent and manage health problems at household level.

One specific area of activity will be to support the Ministry with customised best practices, technical advice and advocacy in order to expand public access to safe water and improved sanitation. This will include community development projects which provide water points, sanitation facilities, and water user hygiene education at village level, and the promotion of community management of public facilities. There will be need for strengthened capacity for training and management in water and sanitation. WHO will support schemes to monitor water quality; and to regulate the provision by both public and private sectors of adequate and safe water to rural and urban communities.

3.2 Social change, life styles and health promotion
supporting responses to mental health problems, suicide, substance abuse, road traffic accidents, tobacco use, emerging NCDs

Mental health, tobacco and non-communicable diseases are WHO global priorities. In Cambodia, WHO will draw widely on its range of functions to support the government in promoting public awareness of healthy life styles, and addressing current problems which have so far been given little attention, including mental health, suicide, substance abuse, and road traffic accidents. In particular, WHO will encourage Cambodia to participate in the development of the global Framework Convention for Tobacco Control and to adopt a comprehensive tobacco control policy that includes an advertising ban, regulates product constituents, price and distribution, encourages smoking cessation and builds tobacco control coalitions.

Shifts in Effort and Functions

WHO's strategic agenda for the next five years in Cambodia demonstrates shifts from the present position in terms of both effort and function. More effort will be put into supporting work on health sector policies, systems and developments, less into health services and quality, and more into healthy settings and populations. Analysis has shown that, functionally, much of WHO's existing country work is essentially "upstream" - that is, it is concerned with providing high level policy and technical advice, advocacy, sharing knowledge and supporting research and development. With one exception, the new agenda calls for a further reduction in the function of 'supporting routine long term implementation'. That exception is in the development of partnerships and work within the UN Country team, where the role of the WHO staff is considerably more hands on.

Table 1 illustrates a rough estimate of both the amount of effort and the range of functions allocated for each of the three selected components, currently and in the new strategic agenda. It reflects the contribution of the whole of WHO, including region and headquarters, not just the Cambodia country team. So, for example, it shows that the proportion of WHO effort devoted to *healthy settings and populations* will increase from 15% to 25%. This will be accompanied by a shift under this component from routine long-term implementation to a marked increase in sharing information and advocacy.

In undertaking this exercise, it was realised that the division into functions and content areas is somewhat artificial when the reality is that achievements in one component, such as *health sector policies, systems and partnerships,* contribute to achievements in other components. There are many overlaps, links and opportunities for mutual support between the three components defined by the CCS Cambodia team. Each component provides potential entry points for strengthening capacity in other components.

Components	HEALTH SECTOR POLICIES, SYSTEMS AND PARTNERSHIP			HEALTH SERVICES: ACCESS AND QUALITY		HEALTHY SETTINGS AND POPULATIONS	
Sub-components	**Policy and Regulation** Performance monitoring, private sector, public safety and quality control	**Institutional, Public Sector, and Fiscal Reform** Health sector reform, public admin, mgmt reform; human resource for health, institutional analysis and capacity; resource allocation; financial disbursement and auditing systems; financing options	**Partnership and Cooperation** Partnerships of government and all agencies: PRS, CDF, SWAp; partnership of WHO with UN agencies, other Member States and other entities	**Support to Integrated Delivery of Interventions** IMCI, safe pregnancy, tuberculosis, malaria, HIV/AIDS, blood safety, immunisation	**Support System Building Blocks** Drugs, integrated surveillance system, planning and management systems in districts and provinces (incl. supervision and information), community-health system interface, continuing education	**Health and the Environment** Water safety , sanitation, food safety, healthy schools, healthy cities, healthy markets	**Social Change, Life Styles and Health Promotion** Suicide, substance abuse, mental health, road traffic accidents, tobacco, emerging NCDs
EFFORT							
% currently	10	22	10	23	20	10	5
% for new agenda	15	20	15	15	10	15	10
FUNCTIONS							
Current level							
F1	10	5	20	15	15	20	20
F2	20	30	15	20	15	25	25
F3	20	15	20	15	25	15	15
F4	20	25	25	25	25	15	15
F5	30	25	20	25	20	25	25
New level							
F1	0	0	10	0	0	0	0
F2	15	25	5	25	35	30	10
F3	25	10	0	10	25	15	15
F4	30	30	40	30	30	30	45
F5	30	35	45	35	10	25	30

Functions

F1: Supporting routine **long-term implementation**.
F2 Catalysing country-specific adaptation of guidelines, technical strategies and innovations; seeding large-scale implementation.
F3 Supporting research and development, policy experimentation, development of guidelines; stimulating the monitoring of health and health sector performance; trends assessment and anticipation
F4 Providing information and advocacy, sharing knowledge (global, regional, inter-country) for appropriate policy options and positions; (includes case studies of good practice, generic guidelines and standards
F5 Providing specific **high level policy and technical advice**; serving as broker and arbiter; exercising influence on policy, action and spending of government and development partners

7 SUPPORTING AND IMPLEMENTING TH E STRATEGY

Implications for WHO

WHO′s Country Cooperation Strategy for Cambodia has substantial implications for the roles and functions of all levels of the Organization. Effective implementation will require shifts at country, regional and headquarters levels, together with changes in both technical and administrative repertoires, the allocation of funding, the use of information, and approaches to monitoring and evaluation.

The most significant implication of the CCS is the need to enhance the capacity of the Organization as a whole to deliver the strategic agenda at country level. This will be achieved by establishing a WHO team at country level with support, facilitation and resource functions, drawing on technical and financial resources at all levels of the Organization.

The key changes to be made are:

? using *a common Plan of Action* for all parts of WHO as the key management tool for programme implementation and annual review. It would define clear objectives and outputs, together with the responsibilities of all partners; cover both regular budget and extra-budgetary sources of funding; and be reviewed annually, with modifications as required.

? WHO functioning as *a resource centre,* being called upon when needed, changing its operations from being supply-driven to demand-led.

? *restructuring the WHO country office* in Cambodia around the three CCS components, with one core staff member with relevant skills for each component plus one for programme administration and one for management. The WHO Representative plus these five core staff will comprise the country office management team.

? *reviewing the staffing of the country office* to reflect the CCS agenda, with fewer staff in future working on the health services component and more on health sector policies, systems and partnerships. The current level of staffing can be

reduced as capacity is built and strategic outcomes achieved. These staff members will be employed through a variety of contractual mechanisms. The staff mix must have sufficient long-term staff to maintain both an organisational memory and a working relationship with the MOH; and it must provide sufficient experience, seniority and statesmanship to support the shift to "upstream" functions.

? *using new ways to provide technical assistance* and administrative support, with over time a greater focus on partnership; brokering; joint planning, implementation and evaluation, while always mindful of system-wide capacity building. There will be a shift from programme and project management skills towards those in capacity-building, facilitation and general management.

? *updating staff profiles and capacities,* both technical and administrative, with further decentralisation of administrative functions to the WHO country office.

? *strengthening monitoring and evaluation,* paying more attention to technical inputs and assessing achievements against the CCS and WHO's purpose. The emphasis will be on measuring the difference WHO has made, and the process employed, not simply the funds utilised. This will require the identification of appropriate tools and indicators, and the establishment of a clear link between CCS evaluation and staff appraisal and development.

A change of this magnitude will require a comprehensive change management strategy to be pursued over a number of years. The result should be to enhance WHO's responsiveness and effectiveness, and to implant a more outcome and business-oriented

culture.

The Next Steps

Current work in Cambodia on poverty reduction strategies and a sector-wide management approach will influence considerably the contents of this WHO country cooperation strategy. It will therefore be reviewed jointly with the Royal Government of Cambodia once the sector-wide Master Health Plan has been drafted. Future revisions will be undertaken with the close involvement of government colleagues. Like the UNDAF, WHO′s CCS should be regularly reviewed to ensure that it remains appropriate to the context, both within WHO and at country level.