Developing Health Sector Capacity in Cambodia

The Contribution of Technical Cooperation

Patterns, Challenges and Lessons

FINAL REPORT

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Prepared By:

Anthony M. Land

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The views and opinions expressed in this report are those of the author and do not necessarily reflect those of either the RGC or development partners. The author is solely responsible for any errors or omissions.

Anthony M. Land

Glossary of Terms

AusAID	Australian Agency for International Development
ADB	Asian Development Bank
AFD	Agence Francaise de Developpement
AOP	Annual Operational Plan
BMZ	German Federal Ministry for Economic Cooperation and Development
BTC	Belgium Technical Cooperation
CAR	Council for Administrative Reform
CCM	Country Coordinating Mechanism
CD	Capacity Development
CDC	Council for the Development of Cambodia
CENAT	National Centre for Tuberculosis & Leprosy Control
CRDB	Cambodian Rehabilitation and Development Board
CV	Curriculum Vitae
D&D	Decentralisation and Deconcentration
DAC	Development Assistance Committee of OECD
DFID	Department for International Development
DIC	Department for International Cooperation (MoH)
DP	Development Partner
GBS	General Budget Support
GDCC	Government-Development Partner Coordination Committee
GTZ	German Technical Cooperation Agency
H-A-R	Harmonisation, Alignment and Results (Action Plan of the RGC)
HRD	Human Resources Development
HSP	Health Strategic Plan
HSSP	Health Sector Support Project
JAPR	Joint Annual Performance Review
JICA	Japan International Cooperation Agency
JMI	Joint Monitoring Indicator
MBPI	Merit-Based Pay Initiative
MCH	Maternal and Child Health
MEDICAM	Membership Organisation for NGOs Active in Cambodia's Health Sector
MEF	Ministry of Economy and Finance
MOH	Ministry of Health
NCHADS	National Centre for HIV/AIDs, Dermatology & STD
NCHP	National Centre for Health Promotion
NMCHC	National Maternal and Child Health Centre
NGO	Non-Governmental Organisation
NIPH	National Institute for Public Health
OD	Operational District
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
PAR	Public Administration Reform
PBA	Programme-Based Approach
PBSI	Performance Based Salary Incentive
PFM	Public Financial Management
PHD	Provincial Health Department
PIU	Project Implementation Unit
PMG	Priority Mission Group
RGC	Royal Government of Cambodia
RHAC	Reproductive Health Association of Cambodia
STD	Sexually Transmitted Disease
SWAP	Sector-Wide Approach

SWIM	Sector-Wide Management
TA	Technical Assistance
TB	Tuberculosis
TC	Technical Cooperation
TOR	Terms of Reference
TWG	Technical Working Group
UNAIDS	United Nations Programme on HIV/AIDS
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNV	United Nations Volunteers
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organisation

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Executive Summary

This report presents the findings of the second part of a study commissioned by the Royal Government of Cambodia to examine the contribution of technical cooperation to capacity development in the Cambodian public sector. The first study provided a general and country-wide overview of trends and experiences in the use of technical cooperation across the entire public service. This second study explores the various issues raised in the first report in the context of the health sector. The findings of both studies serve two purposes. First, to support the efforts of the RGC and development partners to improve aid effectiveness. Second, to serve as an input to the Global Study on Technical Cooperation and Capacity Development that has been commissioned by a consortium of development partners.

Fieldwork was carried out over a two week period in March 2008. Interviews were conducted with officials from the Ministry of Health and development partners. With the exception of a one-day visit to Takeo Province, all interviews took place in Phnom Penh. An inception meeting was arranged on the second day of the mission, while three debriefing sessions were organised at the end.

Ch 2: "Developing Health Sector Capacity" provides a rapid assessment of the current capacity of the sector. It also reflects on a number of challenges associated with the development of capacity in the health sector.

Genuine progress has been made to put in place a basic health care delivery system that is performing in selected areas. But progress has been uneven rather than system-wide. There are particular concerns about the overall quality of care delivered. An underlying fragility to the entire health delivery system is recognised.

Senior management in the Ministry displays greater assertiveness and confidence in taking stewardship of the sector. The process of developing two consecutive Health Strategic Plans is testimony to this. It is also reflected in the way the Ministry interacts with its many development partners via the Technical Working Group mechanism. Progress is being made to discuss and define the contours of a sustainable health delivery system and to invest in the development of some of its key components. Such initiatives suggest a growing ability to engage in organisational innovation and learning.

Improvements have been made to core functions at the headquarter level. The planning function was singled out as having made most improvement. A number of the Ministry's national programmes and centres have reported impressive results over the last five years. The general view is that service delivery capacity at provincial and operational district levels does not yet meet acceptable standards. Whilst improvements have been made in terms of increasing access to health facilities, improving skill levels of medical staff and in developing procedures and guidelines, the quality of care remains an area of concern.

Developing public sector capacity is a formidable task in any situation. In a sector as complex as health those challenges are all the more pronounced. Developing and then sustaining the capacity of an entire system to deliver health care services must be viewed as a long-term challenge. Dimensions to take account of include:

Being Clear About Vision and the Direction Of Change **-** any long-term strategy to develop health system capacity needs to be based on a clear idea of the kind of system envisaged.

Managing a Complex Web of Actors **-** account needs to be taken of the many actors involved in the delivery of health care in Cambodia. The most significant is the Ministry of Health, itself a complex entity. There are numerous non-governmental organisations, both international and local working as service providers and capacity builders. Privately-owned clinics and pharmacies represent *de facto* major providers of health care services. Development partners can also be considered as part of the health care delivery system.

Developing the Right Mix of Capabilities **-** A system as complex as health depends on a wide range of individual skills and organisational capabilities. A key challenge is to strike the right balance between the development of "back office" or managerial capabilities and "front office" or clinical/medical capabilities.

Addressing the Issue of Staff Motivation and Retention **-** The health sector is not immune to the wider challenges of motivating and retaining staff within the Cambodian public service. Pay is a critical issue but is only one part of the motivation equation. Providing a working environment that inspires productivity and responsibility is also critical.

Balancing the Supply and Demand Sides of Capacity Development **-** Capacity development is often thought of in terms of the supply and/or development of skills, systems, equipment and structures. Experience suggests that incentives to translate capacity into organisational performance depend on pressures for change from the outside: from the political leadership and from service users.

Balancing Service Delivery and Capacity Development **-** A challenge for stakeholders is to strike the right balance between investing in the development of sector capacity while ensuring the on-going delivery of services. This is a classic dilemma, but is particularly acute where capacities are weak and where the pressures to show results are significant.

Taking Account of Systemic Reforms **-** While the Ministry of Health can shape many aspects of its capacity, it is also influenced by features of the public administration system of which it is part. Systemic reforms critical to the future capacity and performance of the sector include: public administration reform, public financial management reform and decentralisation & deconcentration.

Ch 3: "The Contribution of Technical Cooperation" describes salient features of the TC "landscape" in the health sector and summarises how TC has, in aggregate, contributed to the development of sector capacity.

The TC "Landscape"

A Large Number of Providers **-** There are at least 20 official development agencies active in the sector as well as an estimated 100 NGOs and technical agencies. There

are over 100 on-going projects financed by development partners. A significant proportion of external assistance is categorised as technical cooperation. Latest figures suggest roughly 30%.

Providing TC in Many Different Ways **-** TC can be part and parcel of programmes that include financial assistance. TC can also be provided as a discrete project combining a package of measures. Elsewhere, TC can be more stand-alone in nature. A distinction can be made between long-term residential TA personnel working as part of a larger CD initiative and the technical inputs provided by short-term consultants. Volunteers fielded by development partners represent another category of TA personnel.

Some development partners finance technical cooperation but do not get directly involved in implementation. For others, technical cooperation is core business, with programmes comprising a mix of inputs aimed at strengthening individual and organisational capacities. Others focus on the provision of short and long term experts, rather than on financing technical cooperation projects/programmes.

The Different Roles Performed by TA Personnel **-** TA personnel perform a multitude of functions, which are only sometimes linked to capacity development. Usually, multiple roles are played but these may not be well defined. Many short-term TA personnel are recruited to provide discrete technical inputs. Long-term TA personnel perform a variety of functions. They may function as advisors with a brief to impart knowledge and skills, to accompany change processes and to develop systems and procedures. In other situations, they play a more "hands-on" role bolstering the implementation capacity of the host organisation. Many TA personnel continue to perform a management and control function.

Working at Different Levels of the Health Sector **-** An informal "division of labour" is emerging with agencies distinguishing their support by health issue, geographical area or actor. This offers opportunities for complementarity. Considerable support is provided at the national level across Ministry departments, national programmes and centres. At the field level, technical cooperation is organised according to geographic area (eg: by province), thematically (by health issue) or organisationally (supporting particular institutions). Many development partners active at the field level try to maintain a link at the national level so that experiences from the field can be fed into national processes, and vice-versa.

Contribution to the Development of Health Sector Capacity

TC has made an important collective contribution to the development of health sector capacity. Quantifying the extent and nature of that contribution is, however, not easily done. TC has helped to:

- Increase the knowledge and skills of health workers particularly clinical staff, to perform basic duties in the workplace as well as to develop specific specialisations.
- Strengthen the management and organisation of national programmes by helping to develop policy frameworks, implementation strategies, procedures and guidelines.

- Improve core ministerial functions, most notably planning and information management.
- Promote the innovation and piloting of novel delivery modalities and financing mechanisms that contribute to the overall development of national health systems.
- Tackle issues of individual and organisational performance and accountability through the development and testing of various performance-based incentive schemes.
- Work on aspects of the demand side of capacity development, particularly in terms of promoting community empowerment and education.

The support of development partners is not always positive and can undermine capacity. Shortcomings identified are not unique to the health sector but reflect the way in which development cooperation programmes are conceptualised, designed and delivered. The consequences include:

- A lack of local ownership for initiatives that have been largely conceived designed and implemented by development partner personnel.
- The resultant syndrome of "tolerated" TC whereby TC support is accepted on the basis of the resources it brings rather than on the relevance of the support it might provide.
- A proliferation of TC projects managed through separate project management arrangements that can undermine efforts to build sector coherence and the development of core capacities, while overwhelming the absorptive capacity of the host organisation.
- Decisions on where to invest in capacity development can be influenced more by the policy priorities of development partners than those of local stakeholders.
- A tendency to focus TC on achieving the short term implementation needs of individual projects rather than focusing on a more systematic process of human resources and organisational development.
- The fielding of TA personnel that lack appropriate skills and attitudes that are critical to the development of constructive working relationships based on trust and understanding and that provide the basis for effective knowledge exchange and learning.
- Strategies for engaging in capacity development work are poorly defined, and based on an inadequate analysis of existing capacity strengths and weaknesses, opportunities and constraints.

Ch 4: "Towards more Effective Practice" draws on the recommendations for effective practice highlighted in the first report, in order to discuss issues related to enhancing country ownership and responsibility for TC management and actions required to improve the quality of capacity development work.

Promoting Greater Country Ownership and Responsibility for TC Management

The health sector is taking concrete actions to exercise leadership, ownership and responsibility for the management of aid in general and technical cooperation in particular. Mechanisms are falling into place to enable it to do so. These mechanisms should help to reduce the various counter-productive consequences of un-coordinated

and supply-driven TC that characterised the sector in the past and should contribute to promoting greater coherence of the sector itself.

Most of the actions being taken address aid management in general, and in this respect the challenges of managing TC are part and parcel of those that concern aid management more generally. Two of the principal building blocks for enhanced Cambodian ownership and management of TC in the health sector are the Health Strategic Plan and related planning and budgeting processes, and the Health Technical Working Group mechanism.

The Health Strategic Plan and Related Planning and Budgeting Processes - Progress has been made in strengthening the planning function within the health sector. The Ministry is finalising its second strategic plan (HSP 2), which sets out a vision for the sector including for capacity development. It also offers a framework for harmonising and aligning external aid behind a Ministry-owned development strategy.

These developments allow the Ministry of Health to take greater charge of agenda setting, determining needs and assessing the value or otherwise of proposed external assistance. The Ministry has taken the position that it would like to embrace all development partners whether that means working through project or programme-based approaches. For the Ministry, the critical issue is that development partners agree to support its priority expenditures and that they use the strategic and annual operational plans as the basis for doing so. This is the understanding of the Ministry's SWIM or sector-wide management approach.

For a group of development partners these developments provide an opening to work through pooled funding arrangements. Other development partners continue to work through project modalities, and are able to use the Ministry's planning framework as a basis for aligning support and seeking complementarities among different providers.

The Technical Working Group (TWG) System - The health sector TWG system comprises the main health technical working group (TWG-H) and its secretariat, a set of technical sub-working groups, and most recently a set of provincial technical working groups. The TWG-H is considered to be among the stronger and more effective in Cambodia.

Given the complexity of the sector and the large number of development partners involved, having an effective mechanism in place to promote greater harmonisation and alignment of external inputs behind a government-led strategy is crucial. From the perspective of technical cooperation and capacity development, the value of the TWG rests in the following:

- It provides an opportunity for dialogue and information sharing that can help overcome compartmentalisation arising from separately funded and administered projects and can help build greater coherence and complementarity across different areas of intervention.
- The technical sub-working groups are valued for the opportunities they offer for collective problem-solving and for promoting a stronger sense of coordinated response to tackling specific health issues. They are also used to review the Terms

of Reference and CVs of proposed short and long-term TA personnel, on a collegial basis.

- While the responsibility for approval or rejection of proposals ultimately rests with the Ministry of Health, the TWG can play a useful consultative role in reviewing draft proposals prior to their formal submission.
- A challenge for the future is for the TWG-H to be more pro-active and to devote more time to guiding sector policy and to furthering harmonisation and alignment. In this context, TWG members could think more systematically about the contribution of technical cooperation to the implementation of HSP 2 and to capacity development.

Improving the Quality of Capacity Development Work

The first report identified a variety of issues that need to be taken account of as a basis for improving the quality of capacity development work. In the context of this case study, four key issues emerged out of discussions with respondents.

Linking TC Provision to a Sector-Wide CD Strategy for Health **-** The absence of any kind of articulated capacity development strategy makes it difficult for partners to harmonise and align external support behind a country-led process. It also makes it difficult to engage in an effective dialogue about capacity development, to reach some kind of common understanding on what it involves and on what external partners can do to assist, and to encourage learning.

The attention that is now being given to human resources development and institutional development, within the context of HSP 2 offers an opportunity for the Ministry of Health and development partners to engage in a dialogue on capacity development, to agree on a common framework of action and to monitor progress and draw lessons of experience.

Developing a strategy for capacity development that features as an integral part of the wider health strategic plan will be an important achievement. It should help ensure that capacity development is treated as a key strategic issue, intrinsic to the achievement of health sector objectives that can be discussed and reviewed at high level meetings rather than solely as a technical detail. It could also be a place where some common principles on the role of TC in developing capacity can be discussed.

A “road map” for capacity development at sector level is equally important for guiding actions at the sub-sector levels Thinking more strategically about the factors that promote and inhibit organisational growth and performance, recognising that capacity development involves much more than training alone, and knowing how to make effective use of technical cooperation as an instrument for capacity development are important here. Having a clearer understanding of such issues should mean that managers are better placed to analyse their capacity challenges and to identify the kind of change strategies required.

Managing Diversity – Harnessing Innovation and Bottom-Up Approaches **-** In promoting comprehensive CD strategies, it would be wrong to suggest that such comprehensive and formal approaches are necessarily the only way to promote

capacity development in complex organisational settings. There is indeed much value to be gained by creating space for innovation and experimentation.

The challenge is to set a clear course but at the same time to manage diversity. In this way, the many contributions of development partners undertaken across different parts of the sector can contribute constructively to the greater whole. There are several examples where lessons from the field are being fed into a policy process and helping to develop system-wide rules, procedures and mechanisms.

Improving the Effectiveness of TA Personnel **-** Many respondents argued that the effectiveness of TC interventions is shaped by the quality of engagement between TA personnel and local counterparts. In this regard the following issues were identified:

- The effectiveness of TA personnel depends as much on soft skills or process skills, as on formal technical skills. Too often, TA personnel are not well equipped to impart their knowledge within the environment they are working in and to engage constructively with local staff.
- The increasing use of national TA personnel can go some way to overcome inter-cultural and communication issues. Yet, being a national TA does not automatically mean knowing how to approach the task of capacity development and of facilitating change.
- How the capacity development role of TA personnel is defined in the first place and the extent to which there is a shared understanding of that role is critical for effectiveness. In the absence of clearly defined Terms of Reference, confusion over the precise role that TA is expected to perform can quickly result, causing dissatisfaction on all sides.
- Organisations that have a clearer sense of purpose and that have staff that are sufficiently motivated are better able to use external resources and to share responsibility for results. There are examples where directors have a real sense of organisational leadership and are able to use the presence of TA personnel to address wider organisational objectives.
- Cambodian staff is today generally more demanding of TA personnel. There is greater confidence among local staff to engage TA personnel and as need be to question and challenge the advice being provided.
- Many respondents are of the opinion that Cambodia has less need today for long term residential TA than was the case in the past. Others recognised that in specific areas, the deployment of long term TA personnel is still needed. Decisions about the appropriateness of deploying long or short term TA should be based on a careful and shared diagnosis of need.

The Relationship between Capacity Development and Incentives **-** Most observers would acknowledge that a key challenge to the sustainability of capacity development in Cambodia revolves around issues of staff motivation and retention. While a variety of financial and non-financial factors can impact on staff motivation and retention, the issue of low pay has been singled out as a pervasive problem in Cambodia.

The efforts currently being taken by the Cambodian Government and development partners, including within the health sector to work towards a long term solution to the problem of pay is therefore encouraging. Specifically, proposals to put in place a common merit-based salary supplementation scheme that replaces the hitherto

fragmented approach to salary supplementations, and that is aligned behind a longer term pay and compensation reform process is an important development.

From the perspective of this study, these developments are significant, in that they illustrate the fact that any discussion about how to develop sustainable capacity has to take account of motivation and incentive issues. It also illustrates the absolute importance for development partners to work collaboratively and behind a government-led strategy towards resolving such motivation and pay issues, thereby avoiding the distortionary effects of separate and project-specific incentive schemes.

Ch 5: "Concluding Remarks"

This assignment set out to understand the contribution that technical cooperation has made to the development of capacity in the health sector. In the time available it has been possible to begin to understand the complex relationship between technical cooperation and capacity development, including of factors that shape effectiveness. But the study has barely scratched the surface.

The study used as its frame of reference the analysis conducted during the first study. Many of the underlying issues relating to the aid relationship between development partners and Cambodian stakeholders raised in that report are equally relevant to the health sector.

This review of TC experiences in the health sector provides illustrations and examples of the contribution, both positive and negative that TC can make to the development of capacity. The report also confirms the validity of the recommendations for improved practice proposed in the first report and provides examples of how the Ministry of Health, the NGO community and development partners are actively taking steps to improve TC practice.

It is also hoped that the report stimulates sufficient interest among stakeholders involved in capacity development in the health sector to further investigate the factors that can promote as well as inhibit effective engagement for capacity development.

1. Introduction

This report presents the findings of the second part of a study commissioned by the Royal Government of Cambodia (RGC) to examine the contribution of technical cooperation (TC) to the development of capacity in the Cambodian public sector.

The first study, which took place in October 2007[1], provided a general and country-wide overview of trends and experiences in the use of technical cooperation across the entire public service and proposed various recommendations on ways to improve TC effectiveness.

The purpose of this second study, for which field work was carried out over a two week period in March 2008, was to explore the various issues raised in the first report in the context of the health sector. It was agreed that the research should scan the entire sector for emerging trends and patterns rather than focus on the experiences of a few projects and programmes. The consequence, however, is that the perspective of the report remains at the conceptual and strategic level rather than at the operational level. According to the Terms of Reference, the main objectives were to:

1. Improve understanding of current and emerging practices/mechanisms related to needs identification, provision, management and monitoring of technical cooperation

2. Evaluate the capacity development impact of technical cooperation practices/mechanisms

3. Make recommendations on technical cooperation needs identification, provision, management and monitoring.

The findings of this study, together with those of the first study are expected to serve two purposes. First, to support the on-going efforts of the RGC and development partners (DPs) to improve aid effectiveness through implementation of the Harmonisation and Alignment Agenda. Second, to serve as an input to the Global Study on Technical Cooperation and Capacity Development (CD) that has been commissioned by a consortium of development partners and that will report on its findings to the Accra High Level Forum in September 2008.

1.1. Some Caveats

It is important to note that this is a report about technical cooperation and its relationship to capacity development. It has not been written by a health sector specialist nor is it written primarily with a health professional audience in mind. Nor is it a study of health sector policy issues *per se*, nor an evaluation of the performance of the sector in relation to specific health outcomes. While trying to understand the factors that influence TC effectiveness with respect to capacity development, it refrains from judging the performance of any individual projects, programmes or organisations. Many other studies commissioned by the RGC and its development

[1] Land, A & Morgan, P. (2008) *Technical Cooperation for Capacity Development in Cambodia – Making the System Work Better.*

partners have done that. Rather, the study attempts to draw insights from various experiences from across the health sector to feed the wider discussion on how best to develop sustainable capacity and how technical cooperation, as an instrument of international development cooperation, can contribute to that end.

It is important to recognise the large number of studies that have recently been commissioned on the health sector, many of which have contributed to the preparation of the Health Strategic Plan 2 (HSP 2). Most of these studies address issues that relate to the interests of this study, and where necessary are referred to in the text, but a conscious effort is made to avoid duplication. This is particularly so as regards the wider discussion on harmonisation and alignment within the health sector.

The Terms of Reference for the study emphasise the independence of this assignment, the need for objectiveness in the analysis, as well as balance in the identification of strengths and weaknesses. The importance of presenting the report in a concise manner was also emphasised.

The report is structured as follows:

Following this introductory chapter, chapter 2 provides a rough assessment of the current capacity of the health sector and discusses some of the challenges involved in developing health sector capacity.

Chapter 3 goes on to describe some of salient features of the TC "landscape" in the health sector. It then summarises some of the ways in which TC at an aggregate level has contributed – both positively and negatively – to the development of health sector capacity.

Drawing on the recommendations for effective practice highlighted in the first report, chapter 4 then considers the collective actions that need to be taken by the Ministry of Health and development partners to improve TC practice for capacity development, and comments on the progress that is being made in relation to a number of related issues.

A final chapter offers a brief summing up of the report findings.

1.2. Methodology

Fieldwork was carried out over a two week period in March 2008. With the exception of a one-day visit to Takeo Province, all interviews were conducted in Phnom Penh.

Interviews were conducted with a large number of informants from the Ministry of Health (MoH) and development partners (DPs). The table below as well as annex 2 provide further information on persons interviewed and organisations visited.

MOH	**Departments (6)**: Personnel, Human Resources Development, Planning (+ HSSP), Dept. for	**Centres (4)**: MCH TB (CENAT), NCHP NCHADS	**Institutes (1)**: NIPH	**PHD (1)**: Takeo **OD (2)**: Kirivong, Angroka

	International Cooperation, Preventive Medicine			
DP	**Multilateral (3)**: World Bank, WHO, UNICEF,		**Bilateral (5)**: AFD, JICA, GTZ, BTC, USAID, DFID	
NGOs	**I-NGOs (1)**: Care		**L- NGOs (2):** Medicam, RHAC	

The research relied primarily on qualitative data collection and, therefore, it is important to emphasise that most of the findings presented are based on the views and opinions of persons met. While the consultant was provided with various background materials on the health sector and on a selection of individual projects and programmes (see annex 3 for a complete list), the lack of analytical material and data pertaining to the specific issue of technical cooperation and its contribution to capacity development, (beyond a project specific context), is noteworthy. This is not entirely surprising. As remarked in the first report:

"The topics of capacity and capacity development are inherently ambiguous and lend themselves to a multitude of interpretations and conclusions. Judgements about what does and does not work in the Cambodian context remain largely anecdotal. There is little systematic evidence on the effectiveness of TC or its contribution to capacity development".

It is also necessary to note that the time available for fieldwork was insufficient to enable a detailed and comprehensive analysis either of the current capacity of the health sector or the aggregated effectiveness of TC interventions. In view of the recognised complexity of the Cambodian health sector, and the very large number of development partners involved, doing so would have required a much longer and intensive engagement. This study, therefore, provides no more than a "rapid appraisal" or "snap shot" of the current situation and should be read in that light.

Finally, while a good number of people and organisations were met over a short period of time, it was not possible to meet all stakeholders. A number of Ministry of Health (MoH) departments, centres and programmes at headquarter level could not be met while only one visit was made outside of Phnom Penh. Several development partners were also not interviewed as well as the large number of non-governmental organisations (NGOs) that are active in the sector. Examples cited in this report are necessarily selective and not fully representative. It also means that some good examples will certainly have been missed.

An informal inception meeting was arranged on the second day of the mission to agree on the scope of the study, while three debriefing sessions were organised at the end of the mission; first a debriefing with the Secretary General of the CDC/CRDB, second a presentation to the Health Sector Technical Working Group (TWG) Secretariat meeting (both on Friday 28th March); third a presentation to an informal meeting of development partners at the JICA country office (Monday 31st March).

The international consultant was accompanied during the two weeks by a senior official of the CDC/CRDB.

1.3. Some Concepts and Terms

The following concepts and terms are used in this report:

Capacity[2] **-** The ability of people, organisations and society as a whole to manage their affairs successfully.

Capacity Development - The process whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time.

Promotion of Capacity Development - What outside partners (domestic or foreign) can do to support, facilitate or catalyse capacity development and related change processes…. This is by no means equivalent to the provision of technical cooperation.

Technical Cooperation – The provision of know-how in the form of personnel, training, research and associated costs… covering contributions to development primarily through the medium of education and training… whose primary purpose is to augment the level of knowledge, skills, technical know-how or productive aptitudes of the population.[3]

According to the study TORs[4], TC is also understood to include provision of monetary incentives to Government staff associated with the implementation of a project or programme that is designed to build and augment the capacity of Government.

The definition of TC therefore remains very broad and in practice is used and applied in many different ways by development partners.

Technical Assistance Personnel – There is no formal definition of technical assistance personnel. In this report, TA personnel refers to personnel provided by development partners on a short or long term basis to support the implementation of development cooperation initiatives. In this context, TA personnel can perform multiple roles linked to advice giving, capacity development, support to task execution (gap-filling) and project management. They may be part and parcel of a larger TC project or may be deployed on an individual basis. TA personnel often also support the design/programming of development cooperation initiatives and participate in reviews and evaluation studies.

Harmonisation - Efforts to streamline, simplify and coordinate approaches and procedures of development partners, meaning both among development partners and with those of Government.

Alignment - Efforts to bring policies, procedures, systems, funding, planning and monitoring cycles of development partner activities in line with those of Government.

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[2] See section 2.2. of the first report for a more elaborate discussion of capacity. The definitions of capacity, capacity development are promotion of capacity development provided here are taken from OECD/DAC (2006) The Challenge of Capacity Development.

[3] Definition provided in study TORs and based on OECD/DAC Statistical Reporting Directives (2007), paras 40-44.

[4] See more details in annex 1.

2. Developing Health Sector Capacity

Before looking at the way TC has contributed to the development of health sector capacity in Cambodia, this chapter provides a rough snap-shot assessment of the current capacity of the sector. It also reflects on a number of challenges associated with the development of capacity in a sector as complex as health.

Looking at capacity first, rather than at TC is done deliberately. As the definitions of capacity and capacity development provided in the first chapter emphasise, the process of capacity development, even in an aid dependent country, needs to be understood as an internally driven process. While development partners can play a critical role in supporting country efforts to develop capacity, it would be wrong to equate capacity development uniquely with the support provided by development partners. Moreover, TC is but one albeit significant instrument for capacity development. Equally it is important to remember that not all TC is necessarily provided with a view to developing capacity.

2.1. A "Helicopter" View of Health Sector Capacity

This "rapid appraisal" of capacity within the health sector *is based primarily on the views and opinions of persons interviewed* during the field mission. This is not presented as a comprehensive or scientific analysis, but rather as a qualitative "snap shot" of the current situation.

Genuine but Uneven Progress, Coupled by an Underlying Fragility - From a historical perspective, and taking account of the wider constraints related to the rebuilding of state and society in Cambodia, genuine progress has been made in putting in place a basic health care delivery system that has demonstrated an ability to perform in selected areas[5].

But progress has been uneven rather than system-wide. There are particular concerns about the overall quality of care being delivered and of the ability of the system to provide a level of service commensurate with current needs and that is also capable of keeping pace with future requirements.

An underlying fragility to the entire health delivery system is recognised. This can be attributed in part to the general challenge of putting in place an integrated health care system composed of a large number of interdependent parts which demands a high level of coordination both horizontally across various departments, programmes and centres, and vertically, between headquarter, provincial and field levels.

Equally, it can be attributed to more fundamental and systemic issues that go beyond the health sector *per se* and that have to do with public sector management in general and pay and human resources management issues in particular.

[5] Notable achievements have been recorded for instance in relation to Ante-Natal Care (ANC), reduction in HIV/AIDS infection rates and access to ARV treatment and reduction of TB incidence.

The high dependence of the sector on external funding, provided through a large number of multilateral, bilateral and NGO development organisation initiatives exacerbates the situation (see further chapter 3).

Leadership, Ownership and Vision - A common remark of respondents was that senior management in the Ministry has over recent years displayed an increasing sense of assertiveness and confidence in managing the sector[6]. The process of developing Health Strategic Plan 1 (HSP 1) and now Health Strategic Plan 2 (HSP 2) is held out as testimony to this growing confidence and willingness to take stewardship of the sector.

This is also reflected in the way the Ministry interacts with its many development partners. While the sector remains highly dependent on external resources, both financial and technical, Ministry management is beginning to use the Technical Working Group (TWG) mechanism as a way to guide policy dialogue and to improve the harmonisation and alignment of external support. The recent establishment of the Department of International Cooperation (DIC) should bolster the capacity of the Ministry in this regard.

Health System Development - Progress is also being made to discuss and define the broader contours and features of a sustainable health delivery system and to invest in the development of some of the key components. Examples include the testing of equity funds and social health insurance mechanisms, piloting alternative approaches towards service delivery including through various internal and external contracting arrangements and exploring ways of working with non-governmental organisations (NGOs) and the community. Such initiatives suggest a growing awareness and ability to engage in organisational innovation and learning. This is, however, only a start. The mechanisms to facilitate and coordinate organisation-wide learning across the many different parts of the MoH remain relatively undeveloped.

As already noted, the delivery of health care depends on the coordinated actions of a large number of health departments, programmes and initiatives[7]. As in any large and complex system, this poses a challenge to management to ensure coherence among the different parts of the system, and to ensure that services are provided in an integrated manner at the point of service delivery. This requires that mechanisms are in place to enable an appropriate level of steering, coordination as well as priority setting[8]. The preparation of HSP 2, and associated three year rolling and annual operational plans as well as the establishment of the Technical Working Group mechanism represent steps towards building greater coherence across the different parts of the delivery system.

Core Functions - The general opinion is that improvements have been made to core Ministerial functions of planning, budgeting, and human resources, at the headquarter

[6] This is also noted in a number of recent reports. See for example the review of SWIM: MoH (2007) *Medium-Term Review Health Sector Strategic Plan 2003-2007: An Assessment Of Progress Under Sector-Wide Management (SWIM)*

[7] There are for example 7 departments under the Directorate General for Health, and 9 National Centres managing various national programmes.

[8] The anticipated organic law on decentralisation will likely encourage a higher level of delegated authority and greater autonomy of action for various parts of the Ministry.

level. The planning function was singled out as having made most improvement[9]. By contrast, public financial management, procurement and human resources management are considered to be weaker and in need of on-going support to meet future challenges. The human resources management function is critical for guiding any long term human resources and organisational development strategy. Further strengthening of public financial management and procurement capacity will be critical for the overall functioning of the health system as well as for advancing the implementation of the harmonisation and alignment agenda, particularly with respect to the use of national systems and procedures by development partners.

National Programmes and Centres - A number of the Ministry's national programmes and centres that work on specific health issues have reported impressive results over the last five years. Part of this success can be attributed to improvements made to individual and organisational capacity, both in relation to programme management and service delivery. The assistance of development partners – both technical and financial - has certainly played a part in improving performance. Examples include the national programme on TB control through the direction of CENAT and the fight against HIV/AIDS through the stewardship of NCHADS. Yet in certain areas such as maternal and neonatal health, there remains an acute shortage of specialists, such as paediatricians and midwives.

Provincial and Operational District Levels[10] - The general view of respondents is that service delivery capacity, at the operational district level is still inadequate, despite some notable improvements in health indicators[11]. This is particularly so in remoter parts of the country. Whilst important steps have been taken to enhance service delivery, by improving the skill levels of medical staff in relation to selected health issues and in developing procedures and guidelines for administering preventive and curative treatment, the quality of care remains a concern.

Various factors account for the difficulties of raising performance standards. These include issues of general management and to a lesser extent clinical skills, as well as to a lack of infrastructure, equipment and operating budgets. It also has to do with broader issues of human resources management including pay and incentives. The absence of strong demand side pressures for quality care on the part of the community (health seeking behaviours) and the fact that most people in fact continue to seek medical care outside of the government system reinforces this situation. Various initiatives are being taken to find ways to improve the quality of care, such as through contracting arrangements that have helped to improve overall management[12] and practice in the workplace, and in remoter areas, by working through NGOs. The need to raise professional standards through external and self regulation is also noted.

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[9] The development of the first and second HSP and associated Annual Operating Plans (AOP) across all parts of the Ministry are cited as evidence of this growing capacity.

[10] There are 20 provincial and 4 municipal Health departments overseeing 76 Operational districts, which in turn supervise 69 referral hospitals, 942 health centres and 67 health posts.

[11] Various national programmes that depend on the services of staff posted at the operational district level complain about the lack of capacity to implement their programmes.

[12] The 2007 Cambodia Health Services Contracting Review (Sadiq, A et al, 2007. *Strategic Review of Contracting for health services in Cambodia,* Conseil Sante) noted that while in some instances, contractors had contributed to strengthening the management capacity of operational districts (including health centres and hospitals), in others, contractors had largely performed a substitution role, taking on the management responsibilities normally performed by operational districts.

2.2. Challenges of Developing Capacity in the Health Sector

Developing public sector capacity is a formidable task in any situation. It is all the more challenging in a country such as Cambodia given its recent political, economic and social history (see the first report[13] for more elaboration on these wider contextual factors). In a sector as complex and multi-faceted as health, faced with rapidly changing demands, due to epidemiological and demographic change, as well as a rapid pace of technological innovation (vaccines, drugs, diagnosis and equipment) those challenges are that much more pronounced.

Developing and then sustaining the capacity of an entire system to deliver health care services must, therefore, be viewed as a long-term and on-going challenge. In a rapidly evolving environment, with the emergence of new demands and challenges for health care delivery, managing a process of continuous improvement and adaptation so as to assure effective performance will remain a core task of the Ministry.

The following paragraphs sketch out a selection of capacity development challenges.

Being Clear About Vision and the Direction of Change - Discussions about capacity usually end up with questions being asked about capacity "for what", and capacity "for whom". The point here is that any long-term strategy to develop health system capacity needs to be based on a fairly clear idea of the kind of system envisaged. Otherwise, the risk is that the wrong mix/types of capacities will be developed. Given the complexities involved, the need for prioritisation and sequencing is also important. While having a clear picture of where one wants to go may not be entirely feasible, being clear about the direction of change is nevertheless crucial.

Interviewees acknowledged that progress is being made on clarifying the vision among stakeholders, but that some fundamental issues still need to be sorted out. While the new health strategic policy states that the Government sector is expected to play a stewardship role in an overall health system, further discussion is needed on the precise roles that the public and private sectors are expected to play.

Managing a Complex Web of Actors - In developing health sector capacity, account needs to be taken of the many actors involved in the delivery of health care in Cambodia, each of which will be confronted with its own unique capacity challenges. The most significant is the Government through, principally, the Ministry of Health. As already noted, the Ministry is itself a complex entity operating at headquarter, provincial, district and community levels and through a multitude of departments, programmes, centres and training institutions. A number of other ministries and layers of government also interact with the Ministry of Health in a number of different ways which can both facilitate and constrain the Ministry's capacity to perform.

Non-state actors also play a significant role in the delivery of health care services. There are numerous non-governmental organisations, both international and local working primarily at the community level but also interacting with higher levels of

[13] Key challenges identified in the first report relate to the supply of human resources, the state of the education system, incentives and motivation, lack of demand-side pressures, power and interests, approach to public service reform.

the health care system as service providers or capacity builders[14]. Recognised as an integral part of the delivery system, NGOs can also be considered legitimate recipients of capacity development support. The role of the private sector should not be under-estimated. Privately-owned clinics and pharmacies represent *de facto* major providers of health care services in both urban and rural areas, and sometimes compete with health centres and referral hospitals for patients.

Development partners can also be considered as part of the health care delivery system, through their involvement in policy dialogue, programme and system development, financing and project implementation. Given the continued high level of dependence on external funding to meet operational costs, the influence of DPs cannot be underestimated. As the next chapter illustrates, this is by no means an homogenous group, comprising an array of organisations with different mandates, capabilities and ways of engaging with the system.

Developing the Right Mix of Capabilities - A system as complex as that of health relies on a wide range of individual skills and organisational capabilities. Determining the correct mix of skills and capabilities, is a daunting task but one that is fundamental. The task of determining which capabilities are critical and which mix of capabilities best supports the achievement of current and future needs of the sector has to be given the attention it deserves by managers and staff at all levels.

A recurring challenge for the sector seems to be to strike the right balance between the development of "back office" or managerial capabilities and "front office" or clinical/medical capabilities[15]. Each of these principal categories can be further broken down.

Included within the "back office" capabilities are the familiar core functions of planning, budgeting, procurement, monitoring & evaluation, and human resources management that are common in most medium and large organisations. In addition, capabilities associated with the specific management of health services such as health financing, training, health research, contracting, quality assurance, drugs and facility management (hospitals and health centres), among others need to be considered. And in the current context of the health sector in Cambodia, particular attention needs to be given to capabilities for exercising appropriate forms of leadership at different levels of the system, for managing complex change processes, for building and managing relationships between different actors and for engaging constructively with external stakeholders including development partners.

Under the rubric of "front office" capabilities is a plethora of technical-related capabilities linked to the delivery of particular medical services, the most obvious being those related to promotive, preventive and curative health care delivery. These capabilities are based on a set of procedures, systems and protocols/guidelines, as well

[14] More information on NGO providers can be obtained by accessing the MEDICAM web-site at www.medicam-cambodia.org

[15] The issue of balancing "front office" and "back office" capabilities is discussed in various reports prepared by Oxford Policy Management for the MoH. See for example: OPM (2007) *Institutional Development Plans For The Cambodian Health Sector -Summary Report*

as on an appropriate mix of human resources: midwives, nurses, doctors and para-medics that have both general and specialised skills[16].

There are also important capabilities that may on the surface seem less apparent to health professionals. These are critical to any organisation that needs to manage complexity in a rapidly changing environment and relate to the capability for adaptation and renewal, and to the management of change. Knowledge, learning and innovation are crucial in this regard.

Addressing the Issue of Staff Motivation and Retention **-** The health sector is not immune to the wider challenges of motivating and retaining staff within the Cambodian public service, an issue that was raised in the first report. Finding ways to retain and motivate staff poses one of the most significant challenges to sustaining capacity gains and to improving the quality of service delivery.

It was reported that staff is not well motivated and often perform below expected standards. There are real difficulties in posting qualified personnel to remoter parts of the country. Various departments also reported a high turn-over of staff as trained personnel move on to "greener pastures" either in the private sector, among NGOs or with development partners all of which are able to offer more attractive conditions of employment including higher pay and attractive professional development opportunities.

The loss of personnel creates difficulties for succession management and often results in the familiar problem of the "missing middle" whereby organisations end up being strong at the top and bottom but weak in the middle precisely where skills are needed to support implementation. This also creates a vicious cycle of demand for technical assistance to "re-build" or "substitute for" the capacity that has been trained and subsequently lost.

Adequate pay is only one part of the motivation equation. Lack of attention to human resources management more generally including the development of appropriate mechanisms[17] to reward performance and sanction non-performance, provide career development opportunities and provide a working environment that inspires productivity and responsibility is also noted.

Balancing the Supply and Demand Sides of Capacity Development **-** It is usual to think about capacity development in terms of the supply and/or development of skills, systems, equipment and structures, all of which represent what might be described as the technical realm of capacity development work. International experience suggests that attention also needs to focus on factors that influence the demand for change. Developing the capacity of any organisation to perform depends on the willingness of decision-makers and technical staff to learn and to embrace change. Often this is stimulated by pressures imposed from outside the organisation. In a public sector context, demands for performance improvement can come from two principal sources; first from the political leadership and second from service users. In the absence of

[16] Of course having access to predictable budgets, adequate infrastructure, equipment and materials, as well as logistic support is critical too.

[17] The term "appropriate" is used in the sense of what is perceived by local stakeholders to be reasonable and fair.

either, there is no guarantee that working on the supply side alone will translate into improved performance. Part of the challenge for those involved in capacity development work is therefore to understand the context within which change needs to take place and to correctly identify the drivers and/or barriers to change. There are no golden rules here. In some contexts, political pressure from above may be key to change, especially where service users are not articulate or empowered. In others, pressure from below may be key to stimulating action. It is also possible that the motivation for change comes from public servants themselves as well as through the efforts of development partners to stimulate new thinking and test out new practices.

Balancing Service Delivery and Capacity Development **-** A major challenge for the Ministry and other health sector participants is to strike the right balance between investing on the one hand in the development of sector capacity while at the same time ensuring the delivery of services. This is a classic dilemma that most organisations face, but is particularly acute in a situation where capacities are recognised to be weak but where the pressures to show results in terms of improved health care are significant. Too much attention to capacity development and getting the system right and the provision of services may be neglected. Too much attention to ensuring service delivery today can result in an under-investment in the development of sustainable capacity and an over-reliance on quick fixes, capacity substitution approaches and the creation of parallel structures, financed and managed by development partners. Finding ways to strike the correct balance in the context of the health sector should be discussed by local stakeholders and development partners as part and parcel of the process of developing a capacity development strategy for the sector.

Taking Account of Systemic Reforms - It is important to recognise that the health sector is part of a wider public administration apparatus. While the Ministry of Health can shape many aspects of its capacity, it is also influenced by features of the larger system. Systemic reforms that are critical to the future capacity of the Ministry and performance of the sector include: public administration reform (PAR), public financial management reform (PFM) and decentralisation & deconcentration (D&D). It will remain critical for the Ministry to take account of and engage in these cross-cutting processes, as it implements its own capacity development strategy.

3. The Contribution of Technical Cooperation

This chapter begins by briefly describing some of salient features of the TC "landscape" in the health sector in Cambodia. It then summarises some of the ways in which TC at an aggregate level has contributed – both positively and negatively – to the development of capacity in the sector. Given the complexity of the health sector and the large number of actors involved, no attempt is however made to attribute in precise terms the specific contribution of TC providers to particular capacity development outcomes.

3.1. The TC "Landscape"

"Technical Cooperation" is a very broad term, which is used and applied in many different ways. It is also delivered through a heterogeneous group of actors. This

makes the task of drawing general conclusions about its contribution and impact on capacity development that much more difficult. To help understand "*What we are talking about*", this section offers a brief overview of the TC "landscape".

A Large Number of Providers **-** The Cambodia 2007 Aid Effectiveness report[18] highlights the large number of development partners that are supporting the development efforts of the Cambodian government and people. According to the report, this has resulted in a proliferation of projects and initiatives. There are typically many development partners engaged in any single sector, with resultant challenges of coordination on the part of Government and raising questions about the overall efficiency and effectiveness of such support.

The health sector provides perhaps the most acute example of this situation. There are at least 20 bilateral and multilateral agencies active in the sector as well as an estimated 100 NGOs and technical agencies providing various services. It is estimated that there are over 100 on-going projects in the sector financed by development partners[19].

A significant proportion of external assistance to the health sector is categorised as technical cooperation. Latest figures suggest roughly 30%[20]. Yet, even here, figures need to be treated with some caution as the criteria upon which data is captured is interpreted in different ways. There are also no figures on the exact number of technical assistance personnel working in the sector. The Ministry of Health recognises the challenge of capturing the full nature and extent of the TC support that is being channelled through different parts of the sector. In view of the un-reliability of data, much of the information presented here is based on information provided by respondents during interviews and should be treated as indicative in nature.

Providing TC in Many Different Ways **-** Technical cooperation is provided in many different ways. In some instances, TC support is part and parcel of programmes that include financial assistance. In other instances, TC is provided as a discrete project with a clear focus on capacity development and combining a package of measures that might include Technical Assistance personnel, training and equipment. Alternatively, TC can be more stand-alone in nature. Examples include bursaries for overseas training, or the deployment of individual TA personnel without an accompanying budget or project. The category of TA personnel can also be disaggregated. A distinction can be made between long-term residential TA personnel and the short-term technical inputs provided by consultants. Volunteers fielded by various development partners represent another sub-category of TA personnel.

Development partners such as DFID, AusAID, the World Bank and USAID finance technical cooperation but do not get directly involved in implementation. Private firms, NGOs and individuals from the consultancy sector or from public sector organisations are contracted to provide technical cooperation services which can range from large multi-dimensional support programmes often linked to financial

[18] Royal Government of Cambodia, *The Cambodia Aid Effectiveness Report*, May 2007

[19] In fact, the health sector accounts for the largest share of total official annual development aid (close to 20% in 2006).

[20] This is a preliminary figure based on latest monitoring data. The figure would probably be higher but is brought down by the significant amount of non-TC funding allocated to HIV/AIDS.

assistance to the provision of individual experts. They can also finance twinning arrangements between institutions in the north and south.

Box 1: AusAID – Taking practical steps to harmonise and align support

After an absence of 5 years, AusAID is returning to the health sector. However, rather than setting up a separate project, AusAID will mainly finance the work of agencies already active in the sector. The bulk of its funding will therefore be channelled through the HSSP 2 / Pooled funding arrangement. From AusAIDs perspective, this is considered to be a more effective way to provide resources in support of harmonisation and alignment and believes there would be little value-added in setting up a separate project structure.

AusAID will also provide smaller amounts of technical assistance support through other channels. These include UN specialised agencies such as the WHO, UNICEF and UNFPA to work on specific areas such as avian flu, and human resources development. To a more limited extent, it is co-funding the work of other bilateral agencies such as GTZ for example in relation to its on-going pilot project on linking community-based health insurance with equity funds in Kampot.

For some agencies, such as GTZ, JICA, BTC and UNDP, technical cooperation is core business. Technical cooperation projects and programmes typically comprise a mix of short and long term technical assistance personnel, the provision of training and related learning opportunities (on the job learning, study tours and peer exchanges etc) and the supply of equipment. This package of inputs are usually guided by an intervention logic aimed at progressively strengthening individual and organisational capacities – in some instances over a medium to long term period.

UN specialised agencies focus more on the provision of short and long term expertise, rather than on financing technical cooperation projects/programmes. WHO for instance is a major provider of technical expertise to the health sector in Cambodia where it runs one of its largest offices worldwide with some 23 residential experts working across different parts of the Ministry of Health. Technical cooperation provided through WHO consists primarily of the provision of residential experts, but it also provides short-term expertise.

The Different Roles Performed by Technical Assistance (TA) Personnel - As already noted, technical cooperation is often associated with the deployment of TA personnel. It is often assumed that their primary function is to develop capacity. In practice, TA personnel can perform a multitude of functions, which may or may not be linked to the objective of capacity development. Usually, multiple roles are played but these are typically not well defined. The Ministry of Health has experience of TA personnel performing various roles:

- Many short-term TA personnel are recruited to provide discrete technical inputs. This might be during the project design, implementation or evaluation phase. Such inputs do not necessarily contribute to capacity development.

- Long-term TA personnel may be recruited as advisors with a brief to impart knowledge and skills to counterparts, to accompany change processes and to develop systems and procedures. They may be part of a larger technical cooperation intervention, or recruited on an individual basis. Here the role is more easily defined as being oriented towards capacity development.

- In other situations long-term TA personnel may play a more "hands-on" role bolstering the implementation capacity of the host organisation by focusing on task accomplishment but in the process doing less advising or coaching. This is often referred to as gap-filling.

- Many TA personnel also continue to perform a management and control function. This is usually the case where TA is linked to a project (either a discrete TC project or a combined TC and financial assistance project) where there is some form of project management structure. TA personnel may in these circumstances have responsibility for preparing budgets and financial reports, as well as managing procurement, personnel and logistics associated with the project. In some instances, a dedicated project coordinator is fielded. In other circumstances, an advisor, ostensibly recruited to develop capacity also functions as a manager.

- TA personnel can also perform other roles. Examples include research, advocacy work, networking or the brokering of relationships between different actors and stakeholders.

Working at Different Levels of the Health Sector - As already noted, there are many development partners involved in technical cooperation work across the health sector. According to some respondents, an informal "division of labour" among providers has begun to emerge with agencies distinguishing their support in terms of health issue, geographical area or actor. The work of the Technical Working Group for Health – discussed in the next chapter – is helping to bring a little more structure to this division of labour, but there is a long way to go[21]. While some smaller agencies such as BTC have focused their work geographically by working in particular provinces, larger agencies such as JICA have tended to work with particular health sector institutions such as CENAT and MCH on specific health issues, while also supporting a number of cross-cutting issues, such as pre-service training. Typically, support provided at the national level, aimed at policy and systems development, is followed up with support to selected operational districts. Similarly, GTZ, which has focused it support in the area of quality assurance, social health insurance and human resource development, works with central MoH departments in policy/ guidelines development and also supports implementation in selected geographical locations.

WHO fields support across a large number of health sector areas – both clinical and management - while UNICEF focuses on those areas that have a direct bearing on child health and welfare. USAID works primarily with civil society organisations and targets most of its support at the community level. Members of Health Sector Support Project 1 (HSSP 1) provide support in different ways across a wide range of areas based on the priorities identified in the health sector plan so TC interventions might appear at central or provincial levels or may target clinical or management functions.

[21] EU member states are exploring ways to reduce fragmentation by limiting the number of sectors and sub-sectors they are involved in. Delegated cooperation whereby the resources of one member state are administered by another is one way of addressing this challenge. Setting a ceiling on the number of sectors a specific member state can support and how many can support any given sector are other ways.

Box 2: WHO – Providing Technical Expertise and Global Knowledge

The provision of expertise by WHO is guided primarily by priorities identified by the Ministry of Health and Health partners but provision can also be influenced by other agendas for instance, global and regional health priorities. Provision is also influenced by the funding priorities of the agencies that finance the WHO itself, who may wish to focus on particular health issues.

The roles and functions of TA personnel are recognised as having changed over the years as capacity within the sector has increased. For instance, WHO experts are considered to play more of a facilitation role aimed at reinforcing capacity across the health sector, rather than capacity substitution aimed at implementation which was the case previously. There has also been a shift from the provision of highly specialised clinical experts to the provision of health system experts in line with changing capacity challenges of the sector. Whereas in the past, WHO experts were positioned in the provinces, they are today working exclusively at the central level.

Overall, considerable support is provided at the national level where development partners support various initiatives across Ministry departments, national programmes and centres. This may have an organisational, thematic or programme focus. Typically, more than one development partner may be involved. At the field level, technical cooperation is also organised according to geographic area (such as a particular province or set of operational districts), thematically (dealing with particular health issues) or organisationally (eg: supporting the working of specific NGO providers). The resultant "patchwork" of support poses a real challenge for coordination and for assuring complementarity of effort. Many development partners that are active primarily at the field level try to maintain a link at the national level so that experiences from the field can be fed into national processes, and vice-versa. The following examples may help to illustrate patterns of supply.

- The *department of Planning and Health Information* receives support from the HSSP partners (Monitoring and evaluation), from WHO (planning and health information), from GTZ (social health insurance) and soon from AFD (advisor on contracting). The HSSP Project Implementation Unit is also formally annexed to the planning department.

- The *National Maternal and Child Health Centre* (NMCHC) has been receiving considerable support from JICA since the mid-1990s but also receives various forms of direct and indirect TC support from other development partners. DFID is providing support on safe abortions while WHO is providing assistance on nutrition. UNICEF and UNFPA are working both at headquarter levels and in the field on various aspects of maternal and child health. USAID meanwhile supports the work of a number of international NGOs such as Care and local NGOs such as RHAC that work at the community level on issues related to reproductive health as well as on other aspects of maternal and child health. The Centre is also a recipient of the Global Fund for PMTCT (Prevention of Maternal-to-Child Transmission of HIV/AIDS).

- The *National Institute of Public Health* (NIPH) has received long-term support from GTZ to develop capacity. While the level of GTZ support has been reduced in recent years, other agencies have become active. Examples include the United States Centre for Disease Control and Prevention as well as the Rockefeller foundation. The Institute has also forged collaborative agreements with a number

of overseas tertiary education institutions in Vietnam the Philippines, the United States and Australia.

3.2. Contribution to the Development of Health Sector Capacity

Given these patterns of TC support, and taking account of the challenges of capacity development described in chapter 2, what can be said about the contribution of TC to health sector capacity development? TC in all its diversity has without doubt made an important collective contribution to the development of health sector capacity. However, quantifying the extent and nature of that contribution across the myriad of initiatives implemented over the years and across a sector which itself is so diverse is not easily done. Moreover, it is difficult to judge the extent to which different initiatives have purposefully complemented one another. In some instances, this has surely been by design, and with good effect but in others, opportunities for complementarity may have been missed. What can be concluded is that as a collective effort, important contributions have been made towards the progressive strengthening of capabilities across the sector. TC has helped to develop health sector capacity by:

- Increasing the knowledge and skills of health workers particularly clinical staff, but also para-medics, to perform basic duties in the workplace as well as to develop specific specialisations related to the treatment and management of particular health problems, examples of which include TB, and HIV/AIDS.

- Strengthening the management and organisation of national programmes (run through Centres, Institutes and departments), and health facilities (hospitals and health centres), by helping to develop policy frameworks, programme implementation strategies, procedures and technical guidelines.

Box 3: JICA's support to TB and MCH

JICA has worked closely with two national centres since the mid-1990s; CENAT and NMCHC on tuberculosis control and maternal and child health care, both of which are set as priority health issues of JICA's support based on the request from the MoH and its national policy. JICA is recognised for its expertise in these fields based on its own experience in improving TB and MCH after World War II.

In both cases, the strategy has been to support both the strengthening of clinical and management skills of staff as well as to strengthen organisational capacities related to systems and procedures. Such capacity support has been combined with infrastructure support through construction of the CENAT and NMCHC buildings.

The approach has been to work initially at the headquarter level (responsible for policy-making, programme management and technical support to the provincial level) and then to progressively extend support to provincial and sub-provincial levels. Support has involved a combination of short and long term TA, training in Japan as well as the organisation of in-country training programmes.

JICA recognises the value of the sub-TWG system to strengthen cooperation among development partners involved in the MCH and TB sub-sectors. It is working with GAVI/HSS in selected districts to explore synergies between technical cooperation provision and the financing of health care delivery. It also values the opportunities offered by other partners to tackle issues of pay and

incentives as this is regarded as critical to sustaining the technical capabilities that have been developed through JICA assistance.

- Improving core ministerial functions, most notably planning and information management that has enabled the Ministry to prepare consecutive health strategic plans as well as departmental and provincial level annual operational plans, and to be able to report on progress at the Joint Annual Performance Review.

- Promoting the innovation and piloting of novel delivery modalities and financing mechanisms that have the potential to contribute to the overall development of national health systems. Examples include equity funds and social health insurance, external and internal contracting [22], as well as the building of partnerships between communities, NGOs and government service providers.

Box 4: GTZ – Contributing to health Systems Strengthening

GTZ support to the Ministry of Health is guided by HSP 2. Support is directed at three main areas that are seen as contributing to overall health systems development: social health insurance, quality assurance, including charter on patients' rights, and human resources development (health managers and technical staff through pre- and in-service training).

GTZ combines work at the field level where new ideas and systems can be tested out with support at the national level to reinforce the link between policy and practice. While GTZ support typically involves the fielding of long term TA personnel, which involves the increasing use of national TA but also experts sourced from the region, emphasis is placed on the use of process approaches. This is time intensive - for example it took the best part of two years to develop the patients' charter - but considered preferable to an expert-led approach where the emphasis is on product delivery, but where there is a risk of weak ownership and where the potential of learning is not realised.

GTZ recognises that staff motivation and retention are difficult and risk undermining the sustainability of it support. .In this regard it considers it a critical task for MoH to improve human resources management including remuneration.

- Helping to tackle issues of individual and organisational performance and accountability through the development and testing of various performance-based incentive schemes, such as the Performance Based Salary Incentive (PBSI) scheme in NCHADS, MBPI in the Ministry (not yet implemented) and at provincial level, through contracting and similar arrangements (HSSP partners, BTC, GAVI).

- Working on aspects of the demand side of capacity development, particularly in terms of promoting community empowerment and education. Equally working on some of the soft aspects of capacity development such as promoting new working

[22] Experimentation with Contracting began in the 1990s and has followed various modalities. For further information, see Sadiq, A et al, 2007. *Strategic Review of Contracting for health services in Cambodia, Conseil Sante.*

practices, changing mind-sets, stimulating innovation, and helping to build individual confidence and organisational legitimacy[23].

Box 5: USAID – Working with Civil Society

USAID is a major provider of technical cooperation to the health sector. TC services are provided through third parties, primarily international and to a growing extent local NGOs and to a more limited extent through commercial consultancy firms.

The focus of support is at the community level, where the main objective is to build the capacity of local NGOs (primarily via the support of International NGOs) to function as complementary providers of health care services, as well as to function as capacity builders. The focus is also on the empowerment of the community to better understand health issues as well as their rights and responsibilities vis a vis health care services.

This is no more than a summary list indicating broad areas of impact. TC in its various forms has without doubt played an important role in accompanying the process of capacity development within the health sector. A more in-depth analysis of TC experiences might help to better understand how different approaches and methodologies contribute to the development of individual and organisational capacities.

That said, the support of development partners is not always positive. There are indeed many shortcomings in the way TC is delivered that need to be recognised. Many of these shortcomings are not unique to the health sector but reflect a number of systemic challenges that relate to the way in which development cooperation programmes are conceptualised, designed and delivered. Some of these shortcomings, which were examined in more depth in the first report, carry implications for the relevance, effectiveness and sustainability of the support offered.

Given the level of TC activity within the health sector, it was not possible, nor desirable to single out specific instances of good or bad practice. But based on the remarks of respondents, it is clear that the issues raised in the first report regarding the sometimes negative impacts that TC can have on the development of capacity, suggests that these are certainly as relevant to the health sector as to any other. The list below sets out some of the more significant areas, *without in any way attempting to quantify the extent and magnitude of their effect.*

- A lack of ownership on the part of Cambodian officials for initiatives that have been largely conceived, designed and implemented by development partner personnel, and a commensurate reluctance to critically review and if need be reject offers of support that are not considered relevant.

- The resultant syndrome of "tolerated" TC whereby TC support is accepted on the basis of the resources and benefits/perks it brings rather than on the relevance of the support it might provide to meeting sector objectives.

[23] According to a JICA evaluation of its support to the MCH programme respondents interviewed about the support received commented less on the specific knowledge received but more on the pride and confidence they felt as a result of involvement in what is now considered a very successful programme.

- A proliferation of development partner funded TC projects often managed through separate project management arrangements that place a considerable administrative burden on the host organisation, draw personnel away from core duties and that in the process risk to undermine efforts to build sector policy coherence and the development of core capacities.

- The simultaneous implementation of different projects represents a major challenge for coordination and for managing diversity whether at the field level, the departmental level or the sector level. Despite intrinsically good intentions, the multiplicity of initiatives can easily overwhelm the absorptive capacity of the host organisation with risks of duplication of effort, distortion of priorities, the receiving of conflicting or contradictory advice, and the missing of opportunities for synergy.

- Decisions on where to invest in capacity development can be influenced more by the policy priorities of development partners than those of local stakeholders. The classic example is the area of HIV/AIDS where the global resources that are now available tend to result in a sometimes disproportionate funding of this sub-sector to the detriment of other spending areas. The result is that TC is drawn to high visibility areas, where there is funding and a pressure to disburse, whilst other areas that also deserve support might end up being overlooked.

- A tendency to focus the capacity development support provided through TC on achieving the short term implementation needs of individual projects rather than focusing on a more systematic process of human resources and organisational development defined by sector-wide priorities and needs. This can particularly affect the provision of in-service training.

- The fielding of TA personnel that lack appropriate skills and attitudes that are critical to the development of constructive working relationships based on trust and understanding and that provide the basis for effective knowledge exchange and learning. Linked to this is inadequate attention to the assignment of counterparts and of proper definition of the respective roles and responsibilities that TA personnel and their counterparts are expected to play.

- In this regard, the strategies for engaging in capacity development work through technical cooperation remain often poorly defined, and can be based on an inadequate analysis of existing capacity strengths and weaknesses, opportunities and constraints.

4. TC for CD – Towards more Effective Practice

Drawing on the recommendations for effective practice highlighted in the first report, this chapter considers the collective actions that can be taken by the Ministry of Health and development partners to improve TC practice for capacity development.

The first report concluded that while there continues to be much criticism levelled at technical cooperation, in the Cambodian context, genuine steps are being taken by the

Government and by development partners to improve practice. The report goes on to argue that further improvements can be made by tackling the issue from two mutually reinforcing perspectives:

First, from the perspective of promoting greater country ownership and responsibility for the management of technical cooperation.

Second, from the perspective of improving the way capacity development work is conceptualised, designed and implemented.

4.1. Promoting greater Government ownership and responsibility for TC management

Tackling issues related to TC management and ownership is fundamental in a sector as complex and demanding as health. The first report underscores the need for actions to:

- *Reduce Fragmentation through increased harmonisation and alignment*
- *Promote RGC responsibility for design, procurement and management of TC*
- *Strengthen RGC Capacity for TC Management*

These action areas are of undoubted relevance in the health sector, given the challenges involved in developing sustainable capacity across the entire sector and given the multiple and differentiated forms of support that are being provided by development partners.

The first report concluded that the government together with development partners are already making serious efforts to tackle these issues. A large part of the impetus for doing so is coming from the Government's aid effectiveness agenda and in particular through its commitment to address issues of harmonisation and alignment[24].

Without a doubt, the health sector has started to take concrete actions to exercise greater leadership, ownership and responsibility for the management of aid in general and technical cooperation in particular. Although the steps taken constitute work in progress, there are reasons for some optimism, with real prospects of increased Government ownership and of technical cooperation being better harmonised and aligned behind a sector strategy. Further progress will depend on the current momentum being maintained and on the commitment of all parties to further consolidate and deepen the progress made thus far.

Two of the principal building blocks for enhanced Cambodian ownership and management of technical cooperation in the health sector are considered to be:

- The Health Strategic Plan and related planning and budgeting processes
- The Health Technical Working Group Mechanism[25]

[24] See RGC (2006) *Action Plan on Harmonisation Alignment and Results*.

[25] Cambodia has also joined the International Health Partnership initiative as one of seven first wave countries, which encourages development partners active in the health sector to actively promote the

4.1.1. The Health Strategic plan and related planning and budgeting processes

As was already noted, the Ministry of Health and development partners have made progress over the past five years towards strengthening the planning function within the health sector. The Ministry is now in the process of finalising its second strategic plan (HSP 2) which will cover the period 2008-2015, and which has been developed in close cooperation with development partners[26].

Although the plan is considered by some to be so broad as to enable almost any proposal to be fitted in, the general opinion is that HSP 2 represents a major step forward towards articulating a long-term vision to guide development of the health sector including for capacity development. In so doing it offers an invaluable framework for harmonising and aligning external aid, including technical cooperation and for strengthening Ministry ownership of its development strategy.

Besides the HSP 2 document, a good number of departments, programmes and centres have developed their own respective strategic plans that provide a basic roadmap for priority setting and for the more detailed development of annual operational plans (AOPs). An example is the plan of the Department of International Cooperation (DIC) which identifies specific technical cooperation needs to help it meet its departmental mandate and objectives.

The combination of strategic plans and AOPs offer a basis upon which development partners and the government can identify priority actions and areas for external support. This has the potential of enabling the Ministry of Health to take greater charge of agenda setting, determining needs and assessing the value or otherwise of proposed external assistance. This is needed at three levels. First, at the overall sector level where key strategic priorities have to be determined, second at the department, programme and Centre level where more operational priorities need to be identified, third at the provincial level where a recurring challenge is to formulate a coherent plan that takes account of the various initiatives emanating from national programmes as well as province-based development partners and NGOs.

From the point of view of the MoH, the main concern is that development partners agree to support its sector priorities and that they use the strategic and annual operational plans (as well as the TWG mechanism, discussed below) as the basis for doing so. This would represent a step towards realising a more harmonised and aligned programme, even if the support of development partners is guided through different implementation modalities. This is the understanding of the Ministry's SWIM or sector-wide management approach[27].

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harmonisation and alignment agenda. This is a new development and to date no concrete actions have been taken, though it is understood to be interested in exploring issues of TC provision more closely.

[26] HSP 2 has been drafted and launched in April 2008 during the joint annual performance review.

[27] A similar example of an emerging sector-wide approach that embraces different delivery modalities is the Public Financial Management Reform Programme (PFMRP). See the first report for more information.

For a number of development partners this more robust planning framework offers an opportunity to work through pooled funding arrangements, as described in the box below. For others who work through project modalities, the planning framework provides a reference point for negotiating areas of assistance and for ensuring that proposed support is harmonised with the contributions of other development partners.

Box 6: Pooled Funding– A Mechanism for Promoting Country-Managed TC

The experience of the Health Sector Support Programme Project (HSSP1: 2003-2008), and its transition into a pooled fund – currently with the support of two bilateral agencies (DFID and AusAID) and two multilateral agencies (World Bank and UNFPA)[28], provides an example of the opportunities created for harmonising and aligning TC support behind the health sector plan.

While the idea is to encourage the use of common management arrangements through the use of pooled funds, provision is also made for other development partners, who are unable to pool their resources, to join the programme by channelling their support through discrete accounts. In this sense, the arrangement might be likened to a "loose" SWAP.

- The intention is that resources will be used to support the core strategic priorities identified within the HSP 2. It is anticipated that funding will target the financing of MBPI, infrastructure development, service delivery grants and human resources and institutional development.

- Prioritisation will be determined by the annual operational planning process within which TC needs (whether in the form of individual TA inputs or more structured TC support) are expected to be identified.

- Although not yet decided, provision may need to be made to earmark the financing of a number of strategic TA posts to support the implementation of priority areas and to support the strengthening of core capabilities. (This was the arrangement under HSSP 1 where for instance the posts of M&E and procurement advisor were identified).

- Alternatively, development partners outside of the pooled fund mechanism might be in a position to mobilise TA personnel to fill such posts. De facto this is already happening. For instance, with AFD funding, the Ministry will recruit a contracting adviser who will be expected to work not only on AFD support at provincial level (Takeo province) but equally with the wider roll-out of contracting arrangements that will be financed by the pooled fund partners. Something of a similar nature may be arranged with BTC.

- MoH will be expected to take charge of developing terms of reference for TC providers and for leading the recruitment and selection process, even though the actual procurement will continue to be outsourced to a specialised procurement agency. TC providers hired through the programme should, in principle, be accountable on a day-to-day basis to the responsible department. In this respect, TA personnel will be expected to perform primarily CD/advisory roles with limited or no management responsibilities.

- The complexity of the programme and the likelihood that parallel management arrangements will still be required (financial management and procurement) means that some form of PIU structure will still be retained. The intention however is that any remaining functions performed by the PIU should be progressively shifted to the Ministry. The time-table for doing so is still under discussion.

[28] Other development partners might still join.

- There are risks involved in a pooled approach that relies on the Ministry's own planning process. If the plans of the ministry do not offer adequate guidance on capacity development and TC provision, proposals for support may be made on a rather ad hoc basis. Support may well be needed to assist departments to prepare appropriate CD plans including the carrying out of capacity needs assessments. By relying on Ministry systems, however, development partners are inevitably encouraged to support the development of Ministry capacity to address human resources management and organisational development. (The issue of CD strategies is further discussed elsewhere).

- Pool funding arrangements do not necessarily provide the best mechanism for financing the needed innovation and experimentation for health system development, as the tendency is for funding to be channelled to meet core ministry capital and recurrent expenditures identified in the plan. This is where non-pool development partners that specialise in technical cooperation may be well positioned to offer complementary funding that can support such needed work with the assistance of TC.

- The basis for evaluating the performance of the programme will be indicators set by HSP2. The advantage here is that the pool partners avoid micro-management and refrain from imposing separate monitoring and evaluation arrangements. The disadvantage is that the opportunities for learning about the detailed process of capacity development and the factors that make TC effective may be lost.

4.1.2. The Technical Working Group (TWG) System

The health sector TWG system comprises the main health technical working group (TWG-H) and its secretariat, a set of 8 technical sub-working groups (a further 3 are soon to be established) that focus on specific health-related programmatic and cross-cutting themes and most recently a set of provincial technical working groups that bring together all actors active in health care delivery at the provincial and sub-provincial levels.

Overall, this network of health TWGs is considered to be among the stronger and more effective in Cambodia. Given the complexity of the sector and the large number of development partners involved, having an effective mechanism in place that is able to promote greater harmonisation and alignment of external inputs behind a government-led strategy is absolutely crucial[29].

While much more can be done to improve its effectiveness, the progress made to date is widely recognised. A recent evaluation of the health TWG system[30] underlines the achievements made and describes it as providing a unique opportunity to further the harmonisation and alignment agenda.

From the perspective of technical cooperation and capacity development, the actual and potential value of the TWG is considered to rest in the following:

[29] It should be noted that development partners involved in the health sector also have their own forum for exchange. Development partners mainly multi-lateral, bi-lateral and NGO representative are holding monthly HP (Health Partner) meeting, which is scheduled one week prior to the TWGH-Secretariat meeting. Meanwhile MEDICAM provides an essential forum for bringing together the very many small and large, national and international NGOs that are active in the health sector.
[30] Wilkinson (2007) *Review of the TWG-H and its Secretariat*.

- It provides an opportunity for dialogue and information sharing on who is doing what and where. In the process, it can help to break down the compartmentalisation that easily arises from separately funded and administered projects and helps to build greater coherence and complementarity across particular programmatic or thematic areas of intervention[31]. At a minimum, it enables members to identify areas of duplication or of need, where progress is being made and where problems are being encountered. It can also encourage more transparency and accountability among partners vis-à-vis their contribution towards the implementation of commonly agreed objectives.

- The eight sub-TWGs are valued for the opportunities they offer for collective problem-solving regarding technical issues and for promoting a coordinated response to tackling specific health issues. This was noted in relation to the sub-working groups on TB, HIV/AIDS, and MCH. The director of CENAT for instance remarked that the TB sub-working group includes NGOs and has helped ensure that they all follow a standard approach. Managed well they can contribute to what was described by two programme managers as more team-based or partnership based ways of working.

- It was also reported that the sub-TWGs are being used increasingly to review the Terms of Reference and CVs of proposed short and long-term TA. This is done on a collegial basis, and has the potential for promoting greater complementarity of effort between agencies, and of avoiding un-necessary duplication. It also means that the results of work undertaken by TA can be more easily shared and evaluated among sub working group members.

- The issue has been raised how far the TWG should function as a peer review mechanism to actually approve or reject development partner project proposals. The general view is that the responsibility for approval or rejection ultimately rests with the Ministry of Health. However, the TWG can play a useful consultative role by reviewing draft proposals prior to their formal submission[32].

- It has been pointed out that a main challenge for the future is for the main TWG-H to be more pro-active and strategic and to devote more time to guiding sector policy, to the identification of sector needs and to furthering harmonisation and alignment. For this to happen, it has been proposed that every third TWG meeting be reserved to address a specific sector-wide strategic or policy related issues such as health care financing, human resource and so forth[33]. In this context, TWG members could be encouraged to think more systematically about the contribution of technical cooperation to the implementation of HSP 2 and more specifically to supporting capacity development. Something on a similar line could conceivably

[31] It is noteworthy that the TWG-H has a membership of 74 (47 MoH members and 27 DP members)

[32] A separate coordination structure, the Country coordinating Mechanism (CCM) is in place to review and oversee the Global Fund. A concern raised in the TWG evaluation is the link between the TWG and the CCM. Given the magnitude of funding channelled through the CCM, it is important that a process is in place to ensure that this does not work in parallel to the TWG. A suggestion has been made to use the TWG-H to pre-review proposals to be submitted to the Global Fund in order to address issues of harmonisation and alignment.

[33] This was recommended in the 2007 review of SWIM and also proposed in the TWG evaluation report.

be done at the sub-working group level and likewise at the provincial level, and could provide the basis for developing a more coherent approach to CD support.

- The Provincial level TWGs are less well developed but their potential role in promoting information sharing and supporting a more coordinated approach to priority setting, budgeting and planning should be clear in provinces such as Takeo where there are reported to be over 25 development partners and NGOs active at provincial, operational district and community levels.

Box 7: The Department for International Cooperation (DIC)

In response to the recognised challenges of coordinating the large number of development partner inputs to the health sector and to help ensure aid effectiveness and efficiency, the DIC has been established as the focal point for interactions between the Ministry of Health and development partners. To this end, it will among other things:

- provide support to the TWG mechanism
- review all new DP proposals
- maintain a data-base of all external inputs
- monitor and evaluate all external assistance

To achieve its objectives, the DIC depends on the participation and cooperation of the entire MoH as well as development partners.

4.1.3. A Reflection on the Meaning of "Demand" Driven

Although the developments described above should help to strengthen the hand of government in agenda setting and in negotiating the nature and magnitude of technical cooperation support, in reality final decisions are likely to reflect the outcome of a negotiated process. In any partnership involving two parties, this is to be expected. Despite formal commitment to government ownership and leadership, development partners are guided by their own agendas and ideas (eg: particular policy issues they may wish to advocate, changes in funding levels, regional and global agendas such as avian flu, HIV/AIDS that need to be addressed). They are also bound by certain legal and procedural constraints (use of own country experts, maintenance of separate financial systems, priorities determined by other funders) that determine the way they work and what they can offer.

It would also be unrealistic to expect local stakeholders to be able to fully anticipate and articulate all their needs. In this regard, a negotiated process founded on trust and frank exchange can be helpful for identifying genuine priorities.

The notion of demand "priming" can be considered in this respect. Pilot initiatives and related experiments in institutional innovation can serve as avenues of exploration and learning that bring to light options that may not necessarily have been thought about. Provided that such exploration takes place within an agreed programme of learning and exchange, and under country leadership and supervision, and that "salesmanship" on the part of development partners is avoided, technical cooperation can make a constructive contribution to the determination of needs and priorities.

Similarly, the point was made during discussions that needs are often best identified through an iterative process of joint learning, rather than through formal and once-off negotiation rounds. This is where the TWG mechanism can be helpful as a forum for exchange but it can also happen at the operational level where development partners interact on a day to day basis with the staff of programmes and departments. In this regard, some of the technical cooperation agencies that have established close working relationships with particular programmes or organisations, can be well positioned to identify new needs and to assist in expressing demands.

Where local organisations are headed up by charismatic and capable leaders, the potential for this is that much greater as such leaders are more likely to have their own ideas on how their programmes/organisations need to grow and can think about the potential value of technical cooperation from a wider strategic perspective.

4.1.4. Summing Up

Mechanisms seem to be falling into place to promote stronger Ministry ownership and stewardship of the sector. Used properly these mechanisms should help to reduce the various counter-productive consequences of un-coordinated and supply-driven TC that characterised the sector in the past and should also contribute to promoting greater coherence of the sector itself, as well as creating opportunities for stronger complementarity of external inputs. Most of the actions being taken address aid management in general, and in this respect the challenges of managing TC are part and parcel of those that concern aid management more generally.

The optimism expressed here does not suggest naivety or an underestimation of the practical challenges involved in making such mechanisms work and over-coming self-interest and the desire on the part of some to maintain the status-quo. In the end of the day, success will depend on the collective willingness and commitment of the Ministry of Health together with development partners to work productively towards a common goal based on the principle of mutual accountability.

4.2. Improving the Quality of Capacity Development Work

The challenges of building sustainable capacity in the health sector, as highlighted in chapter 2, underline the importance of country stakeholders and development partners having in place a shared understanding of the issues at stake. In practice, development partners, government officials, and NGO representatives can easily find themselves working with different and sometimes incongruent mental models about the meaning of capacity, and how it is understood to develop. Indeed, much of the literature on capacity development that has been published in recent years by development partners is influenced by western concepts of organisation, management and change that may not necessarily strike a chord with, or take appropriate cognisance of developing country contexts. This can lead to different assumptions being made among stakeholders about the nature and extent of capacity challenges and of the contribution that external partners can play in supporting local processes.

To contribute to improving the design and implementation of technical cooperation interventions for capacity development, the *first* report, therefore, suggested the need for action to:

- *Encourage greater discussion and learning among stakeholders about capacity development and the contribution of technical cooperation*
- *Improve the conceptualisation and design of technical cooperation support*
- *Improve the quality of TA Personnel*
- *Pay greater attention to the relationship between Technical Cooperation, Public Service Reform and capacity development*
- *Strengthen the capacity of development partners to provide appropriate forms of support for capacity development*

These action areas are considered relevant and important to the health sector. While it was not possible to examine each of these action areas in the context of the health sector in a systematic way, a number of key issues that relate to these action areas were identified during interviews and are discussed below. They are presented under the following headings:

- Linking TC provision to a sector-wide CD strategy for health
- Managing Diversity – Harnessing Innovation and Bottom-Up Approaches
- Improving the Effectiveness of TA Personnel
- Recognising the relationship between capacity, incentives and performance

4.2.1. Linking TC Provision to a Sector-Wide CD Strategy for Health

In many countries, the absence of any kind of articulated capacity development vision or strategy at the national, sector or sub-sector level makes it difficult for partners to harmonise and align external support behind a country-led process. It also makes it difficult to engage in an effective dialogue about capacity development, to reach some kind of common understanding on what it involves and on what external partners can do to assist, and to encourage learning and synergy.

In this regard, the attention that is now being given to human resources development and institutional development, within the context of HSP 2 is promising, as it offers an opportunity for the Ministry of Health and development partners to engage in a dialogue on capacity development, to agree on a common framework of action and to monitor progress and draw lessons of experience over time.

Box 8: The potential Value of a Sector-Level CD Strategy

- **Theory meets practice.** The sector level seems to be an appropriate level at which to bring together conceptual ideas from the top with operational realities and dilemmas that emerge from the bottom.

- **Encouraging a country-owned agenda**. The sector level offers the opportunity for CD strategies to become an integral part of a sector development strategy. It can help country partners take ownership of capacity development, no longer treated as something separate that donors do to help, but something that is an integral part of the sector development process for which local stakeholders need to take charge.

- **Helping to harmonise and align external support.** It provides a potential framework around which the role of development partners in supporting a country-led CD strategy can be discussed in more concrete terms both in relation to "what" and "how" questions, and especially in relation to the possible contribution of TC.

- **Promoting Dialogue and Learning**. The process of preparing a CD strategy is as important as the product that emerges. This is because it encourages stakeholders to engage in discussion about capacity issues and in the process to confront sometimes divergent notions and views on what is important. It can help generate a common language that makes the shift away from sometimes symbolic reference to CD.

Work is already underway within the Ministry to develop a comprehensive proposal for institutional development[34]. Draft documents prepared for the Ministry raise important questions about the direction of change, discuss strategic choices regarding human resources and organisational development and offer some scenarios for managing the change process. They also set the sector's institutional development agenda within the wider context of public administration reform including the issue of pay and performance, public financial management reform and the impending decentralisation and deconcentration reforms[35].

Developing a strategy for capacity development that features as an integral part of the wider health strategic plan will be an important achievement. It should help ensure that capacity development is treated as a key strategic issue, intrinsic to the achievement of health sector objectives, that can be discussed and reviewed at high level meetings (eg: at TWG meetings and at the JAPR), rather than solely as a technical detail. It could also be a place where some common principles on the role of TC in developing capacity can be discussed.

A "road map" for capacity development at the sector-wide level is equally important for guiding actions at the sub-sector levels, where departmental heads, directors of centres or programme managers will need to be able to develop and steer their own capacity development processes. Thinking more strategically about the factors that promote and inhibit organisational growth and performance, recognising that capacity development involves much more than training alone, and knowing how to make effective use of technical cooperation as an instrument for capacity development are important here. Having a clearer understanding of such issues should mean that managers are better placed to analyse their capacity challenges and to identify the kind of change strategies required. Ultimately, it should be able to help translate higher order objectives for capacity development into operational actions that can be reflected within the three year rolling plans and annual operational plans.

[34] OPM, 2008. *Organisational Development Priorities in the Cambodian Health Sector*. Draft report

[35] In view of some remaining uncertainties regarding the pace and extent of these reform processes, it is important that any plan for institutional development in the health sector retains a degree of flexibility so as to be able to adjust as need be to possible policy changes or shifting of priorities.

4.2.2. Managing Diversity – Harnessing Innovation and Bottom-Up Approaches

While a sector level CD strategy can help to harmonise and align external support behind a common country led agenda, it should also leave space for innovation and experimentation. This is especially the case in complex systems where uniform and planned approaches are not always able to address and anticipate needs[36].

The health sector has already many examples of pilot initiatives and experiments at the field level that have contributed to organisational learning and to influencing change. As earlier chapters have demonstrated, the capacity challenges of the sector are multiple and in many areas development partners have had a considerable impact on strengthening human skills and organisational capabilities, and of developing new systems at project, programme and departmental levels.

The value of a CD plan should be to help manage diversity and to ensure that organisational learning takes place. Currently, many innovative practices are not sufficiently known to others. Many of the potential synergies or opportunities for complementarity arising from different "experiments" have sometimes been under-exploited. This has also resulted in criticisms of there being too many disconnected pilot activities that add insufficient value to one another.

Box 9: Capacity development through learning and innovation

Various partners (HSSP, BTC, GTZ, GAVI) have been working with the Ministry to test out ways to improve service delivery at the operational district level. The main idea has been to stimulate performance improvement at the point of service delivery through mechanisms that link performance to pay, as well as to the provision of capacity development support. Experimenting with different modalities including the contracting out of management responsibilities to third party organisations, as well as the use of different approaches to strengthening management capacities, lessons have been drawn on the many challenges involved. A recent comprehensive review of these experiences, financed by AFD, has helped the Ministry take a policy decision on a future course of action. While the envisaged pooled fund partners are expected to support the financing of service delivery grants linked to the implementation of a new round of contracting, other agencies may be in a strong position to provide technical assistance to support the roll-out of the system across different provinces and operational districts.

Some parts of the Ministry have moreover demonstrated an ability to set in train an organisational development process. The successes of NCHADS and CENAT underscore the importance of strong leadership at the sub-sector level in setting a course of change and making effective use of external support. This does not necessarily mean that there is a formal strategy of change in place but that there is strategic reflection and action at work.

The challenge for the Ministry of Health and its development partners is really to set a clear course but at the same time to manage diversity, by creating space for

[36] The advantages and disadvantages of using formal strategies to promote capacity development is briefly discussed in the first report under section 5.3.2. Readers wishing to find out more about different approaches to capacity development may wish to refer to section 6.4. of Baser, H & Morgan, P (2008*) Capacity, Change and Performance – Study report*. ECDPM.

innovation and experimentation. In this way, the many contributions of development partners undertaken across different parts of the sector can contribute constructively to the greater whole. There are several examples (see box below) where lessons from the field are being fed into a policy process and helping to develop system-wide rules, procedures and mechanisms.

Box 10: Feeding the Policy Process from the Field

The Health sector offers various examples whereby experiences from the field can be fed into national level policy processes:

- The work of development partners including GTZ, BTC, HSSP, USAID and UNICEF on Health Equity Fund, social health insurance and the contracting of service delivery offers a repository of knowledge and experience that is now being used to develop national systems.

- The support provided by another group of development partners to tackle issues related to pay and performance is also helping to develop a shared understanding of the problem and to develop a common approach. MBPI, PBSI within the HIV/AIDS sector and performance-based pay linked to service delivery at the operational district level offer important insights into the relationship between capacity development, incentives and motivation, and performance improvement. As emphasised in the evaluation of the PBSI, the experiences gained need to be inserted into a learning process that can ultimately inform policy decisions.

4.2.3. Improving the Effectiveness of TA Personnel

While there is little doubt of the need to improve the planning and coordination of technical cooperation support, and to deepen harmonisation and alignment with a view to promoting government ownership, many respondents argued that the effectiveness of TC interventions is shaped by the quality of engagement between TA personnel and local counterparts. In this regard, the following issues were raised[37].

Balancing Hard and Soft Skills - While agreeing that TA personnel are recruited primarily for the technical expertise they offer, respondents argued that the effectiveness of TA personnel in the workplace depends as much on what may be described as soft skills or process skills. In this regard, respondents recognised that still too often, TA personnel are not well equipped to impart their knowledge within the environment they are working in and to engage in a constructive way with local staff. Some of the soft skills that respondents identified as being important include:

- Being a good listener
- Being a good communicator and facilitator / mentor
- Being sensitive to cultural norms and values in the workplace and in society more generally

[37] This discussion considers the relationship between TA personnel and their counterparts in general and does not distinguish between TA personnel who are part of a larger technical cooperation intervention and those that might be provided on an individual basis. See the working definition of TA personnel provided in section 1.3.

The challenge of balancing hard and soft skills is not a new issue and certainly not one specific to the health sector, or indeed Cambodia. Various development partners have long recognised the need to balance skill sets and today are taking steps to better ensure that the right kind of "experts" are sent to the field. For instance JICA recognised already some ten years ago that the profile of the TA personnel they were sending was sometimes not suitable with emphasis placed on implantation of knowledge rather than on the facilitation of learning, both individual and organisational. Today, much greater attention is given to ensuring that TA personnel have appropriate communication and management skills. Similarly, AFD has recognised that the success of interventions depends tremendously on the quality of relationships that are built between TA personnel and the counterpart organisation. To help identify suitable personnel, it is now a requirement that TORs are accompanied with contextual information describing the organisational environment, including political and cultural factors, within which the TA will have to work. GTZ has also developed a management tool box ("Capacity WORKS") which aims at improving soft and process skills and is piloting its application in different TA-related activities.

Use of National TA Personnel - The increasing use of national TA personnel, as is common in the health sector, can go some way to overcome the inter-cultural and communication concerns mentioned above, including that of language, and their deployment can be particularly helpful at the sub-national levels where communication is predominantly in Khmer.

Several agencies such as BTC and GTZ, and international NGOs such as Care routinely work with teams combining international, regional and national TA. Yet, being a national TA does not automatically mean knowing how to approach the task of capacity development and of facilitating change. One international organisation for instance acknowledged the real difficulties in orienting national TA personnel away from a "doing" role towards performing a facilitating function.

Clarifying Roles and Responsibilities – A key issue that can have consequences for the relationship between TA personnel and counterparts is how the roles and responsibilities of TA personnel have been defined in the first place. In the absence of clearly defined Terms of Reference, and related to this appropriate performance indicators, (linked in the case of wider TC projects to an implementation strategy) confusion over the precise role that TA personnel is expected to perform can result, causing dissatisfaction on all sides. Crucial here is that there is a shared understanding of that role among; the development partner who is funding the TA, the counterpart organisation that is receiving the TA and the TA his/herself who has to perform the function.

It is equally important to clarify the roles and responsibilities of counterparts. The well-known difficulties of assigning appropriate counterpart staff to work with TA personnel were mentioned on various occasions. Typically, a highly experienced expert is assigned a very junior counterpart, causing difficulties with respect to relationship building and absorptive capacity. That said, it is often the younger, more educated and enthusiastic staff members who recognise the opportunities for learning from international experts.

Short or Long-Term TA Personnel - Discussions also focused on the appropriateness of fielding long-term residential TA personnel. A large number of respondents on the Cambodian side questioned the need for such long-term personnel in today's circumstances arguing that sufficient capacity was now in place, especially at senior levels. It was felt that the real value of TA personnel was in providing short term technical inputs to address particular problems. Yet, other respondents recognised the continuing need for long term inputs, especially where there was need to accompany complex change processes, such as those related to decentralisation and the introduction of new service delivery performance contracts.

A principal concern about long term residential TA is that the counterpart organisation becomes dependent on the TA personnel who risks to play a substitution role rather than a facilitating role. An approach that can help avoid this trap is to arrange for intermittent or serial TA personnel inputs over the long term. The advantage here is that while enabling the TA and counterpart to develop a relationship of trust and understanding over time, the respective responsibilities of the two sides are clearly defined around sequential and time-bound actions.

JICA's work with CENAT and NMCHC over the years illustrates changing patterns of TA personnel deployment reflecting changing patterns of need. As the support[38] has evolved through various phases associated with increased organisational capacity and confidence, the use of long-term TA personnel has reduced significantly. More emphasis is now placed on the intermittent deployment of experts to provide specific inputs and then to monitor from a distance. Even when away, modern IT technology enables experts to keep in touch on an "as needs" basis by email and voice-over IT mechanisms.

Managing TA Personnel - An equally important factor that can shape the quality of relationships and the effectiveness of TC is the extent to which the host organisation pro-actively "manages" TA personnel. It was clear from interviews that in various parts of the Ministry, senior staff, particularly at director level, have a real sense of organisational leadership and understand the importance of managing personnel. In these cases, they recognise the potential value of external expertise and are able to harness their presence towards addressing wider organisational objectives.

These insights suggest that the effectiveness of TA personnel and TC more generally is contingent on the quality of management and leadership of counterpart organisations. Those that already have a clearer sense of purpose and that have staff that are sufficiently motivated are more likely to make effective use of external resources and to share responsibility for results.

Another related observation was that Cambodian staff is today generally more demanding of TA personnel. Whereas in the past, TA expertise was generally unquestioned, today, with higher levels of education, growing practical experience and familiarity with the English language, there is greater confidence among local staff to engage TA personnel, and as need be to question and challenge the advice being provided. These developments should indeed contribute to more productive

[38] The support consists of on the job learning for capacity development conducted by the Japanese TA personnel in combination with equipment provision and training in Japan and/or the third countries.

engagement enabling a shift from the dependency syndrome that characterised relationships in the past.

The above observations point to a number of conclusions:

- The importance of understanding the local organisational context and of developing an appropriate and customised intervention strategy

- The need for flexibility and adaptation to take account of changing circumstances and needs

- The need for the design of interventions to be the product of a collective effort based upon a shared understanding of the situation and a clear identification of roles and responsibilities

- The need to properly prepare TA personnel for their assignment and as necessary to develop relevant skills needed for capacity development work

- The need for host organisations to take charge of the preparation of Terms of Reference for TA personnel, to be actively involved in the selection process and to be fully involved in the supervision of TA personnel.

4.2.4. The Relationship between Capacity Development, Incentives and Performance

Most observers would acknowledge that one of the biggest challenges to the sustainability of capacity development in Cambodia and to translating capacity gains into more effective individual and organisational performance revolves around issues of staff motivation and retention. While it is well known that a variety of financial and non-financial factors can impact on staff motivation and retention, the issue of low pay has been singled out as a pervasive problem in Cambodia cutting across the entire public service. The first report commented on the centrality of this issue, and attention has already been drawn to this issue in earlier chapters.

Many persons interviewed during the first study where at pains to distinguish between the capacity of the Cambodian public sector, and the capacity of the Cambodian people. The point being made was that there are now many capable Cambodians, the challenge is to create conditions to attract and retain them within the public service.

The efforts currently being taken by the Cambodian Government and development partners, including within the health sector to work towards a long term solution to the problem of pay is therefore encouraging. Specifically, proposals to put in place a common merit-based salary supplementation scheme that replaces the hitherto fragmented approach to salary supplementations, and that is aligned behind a longer term pay and compensation reform process is an important development.

From the perspective of this study, these developments are significant from several perspectives. It illustrates the fact that any discussion about how to develop sustainable capacity has to take account of motivation and incentive issues. This

necessarily means broadening the discussion of capacity development from purely technical dimensions to broader human resources management issues that may require engaging in more politically sensitive discussions. It also means recognising that CD issues at a sector level cannot be de-linked from wider systemic issues that may need to be tackled beyond the immediate sector. It also illustrates the absolute importance for development partners to work collaboratively and behind a government-led strategy towards resolving such motivation and pay issues, thereby avoiding the distortionary effects of separate and project-specific incentive schemes.

5. Concluding Remarks

This assignment set the ambitious task of understanding the contribution that technical cooperation has made to the development of capacity in the health sector of Cambodia.

This has proven to be an enormous challenge due to the complexity of developing capacity within the health sector and the multiplicity of initiatives that have been carried out with the support of technical cooperation.

In the time available, and based on the various insights of persons interviewed, it has been possible to begin to understand the complex relationship between technical cooperation and capacity development, including of factors that shape effectiveness. But the study has barely scratched the surface. While a number of cross-cutting issues have been identified, the study falls short in extracting more thorough lessons of experience. This would require a more dedicated investment of time and effort.

The study used as its frame of reference the analysis conducted during the first study, which readers of this report are encouraged to consult. Many of the underlying issues relating to the aid relationship between development partners and Cambodian stakeholders that were raised in that report and that shape patterns of behaviour and practice have been found to be equally relevant to the health sector. However, this report has not dwelt on those issues in detail, although they do need to be kept in mind.

As a compendium to the first report, this review of TC experiences in the health sector provides illustrations and examples of the contribution, both positive and negative that TC can make to the development of capacity. The report also confirms the relevance of the recommendations for improved practice proposed in the first report and provides examples of how the Ministry of Health, the NGO community and development partners are actively taking steps to improve TC effectiveness.

Chapter 2 examined the enormous challenges involved in developing capacity in the health sector. Not surprisingly it concluded that despite significant progress - growing leadership, confidence, emerging core capabilities and systems - capacity development will remain a permanent challenge as the health system evolves towards ever increasing levels of performance.

Chapter 3 attempted to “unpack” the TC “landscape” emphasising its heterogeneity and trying to distinguish the different ways in which TC has engaged in capacity development work. Some of the collective contributions that TC has made towards

developing health sector capacity were identified at an aggregate level, suggesting a certain degree of complementarity of action. Equally, some of the practices associated with technical cooperation delivery that have had the effect of undermining capacity were also highlighted.

Chapter 4 considered factors that are likely to influence the future effectiveness of TC. It concludes that there are good prospects for more effective engagement for capacity development. On the one hand, the conditions for stronger government leadership and management of technical cooperation are beginning to fall into place, as part and parcel of the larger Government – development partner agenda to implement the harmonisation, alignment and results agenda. This is a mutual responsibility requiring actions on the part of both the Ministry of health and its development partners to review practices and modify behaviours.

On the other hand, there is clear evidence of learning and innovation taking place in the area of capacity development. While challenges remain in terms of clarifying how capacity development is conceptualised and understood among stakeholders, and how technical cooperation programmes can best support local processes, there is a real opportunity for stakeholders to jointly develop a strategic framework for capacity development at sector level, that provides direction but also space for innovation and experimentation.

It is hoped that this first exploration of TC for CD in the health sector provides insights that can reinforce the findings and recommendations presented in the first report. It is also hoped that the report stimulates sufficient interest among stakeholders involved in capacity development in the health sector to further investigate the factors that can promote as well as inhibit effective engagement for capacity development.

Annexes

Annex 1: TORS

Annex 2: List of Persons Met

Annex 3: List of Sources Consulted

Annex 1: TORS

A CASE STUDY ON THE PROVISION, MANAGEMENT AND IMPACT OF TECHNICAL COOPERATION ON CAPACITY DEVELOPMENT IN THE HEALTH SECTOR OF CAMBODIA[39]

TERMS OF REFERENCE

MARCH 2008

I. Background

1. The development of national capacity and the strengthening of national systems are major components of the Government's Rectangular Strategy. They are also fundamental to the successful delivery of the targets on the National Strategic Development Plan (NSDP) and Government's associated core reform programmes. In this context, development assistance that is provided in the form of technical cooperation is intended to make a direct and significant contribution to the development of national capacity and to the delivery of the NSDP objectives. Technical cooperation is therefore a critical component of the development assistance that is provided to Cambodia.[40]

2. Recent studies undertaken globally as well as in some partner countries have shown that technical cooperation has not had the impact that is intended, or, at the very least, has not provided sufficient evidence of results when measured in terms of sustainable capacity development. In Cambodia, recent evidence has highlighted the extent of the challenge that exists with respect to: (i) making technical cooperation demand-driven and effective; and (ii) establishing systems to ensure that effectiveness is measured and monitored.

3. Three considerations in particular have combined to result in a decision by Government, in concurrence with its development partners, to undertake a study that will consider the provision, management and impact of technical cooperation.

    a) A Government-Donor study in 2004 found that approximately half of all ODA was spent on technical cooperation (12.7% for international staff, 11.8% for training, 8.2% for operations/equipment, 8.1% for national staff, and 2.5% for monetary incentives). The two main findings of the study, first that evaluation is severely constrained by data quality and, second, that little of a qualitative nature can be said with certainty about the use, management arrangements or impact of technical cooperation, remain highly relevant.

    b) In November 2006, a meeting of development partners revealed that different views were held regarding the provision, mandate and management of technical cooperation. CDC, as the Government aid coordination focal point was requested to undertake a study and at the June 2007 Cambodia Development Cooperation Forum (CDCF) meeting a joint development partner statement observed that, "we welcome the planned government review of technical cooperation and commit to engaging fully in this process".

    c) Prior to commissioning a more detailed review, preliminary analysis was undertaken for the 2007 Cambodia Aid Effectiveness Report. The findings of the 2004 study were broadly confirmed as the Aid Effectiveness Report found that, although data quality remains a concern, approximately 50% of ODA (i.e. equivalent to USD 275 million) is dedicated to technical cooperation, as compared to an average of 20% across all Least Developed Countries (LDCs). Complementary qualitative reporting from the Technical Working Groups (TWGs) also suggested that the introduction of sector programmes has indicated some duplication and overlap in the provision of technical cooperation in some sectors. Associated ambiguity and uncertainty in management arrangements and reporting lines had, in some cases, been the source of the increased tension reported by development partners in November 2006.

4. In the context of its broader aid management policy, which advocates closer partnerships and more programmatic forms of aid based on NSDP priorities, the Government commissioned an independent study on the provision and management of technical cooperation and its impact on capacity development in Cambodia in November 2007.

[39] These terms of reference are revised and formulated based on a national study conducted in November 2007, "A Study on the Provision and Management of Technical Cooperation and its Impact on Capacity Development in Cambodia".

[40] See Section Two for a definition of technical cooperation that will be used for the purpose of this exercise.

5. Based on the recommendations described in the independent study, and as part of an on-going global exercise to improve the capacity development impact of TC, a case study has been identified as a required next step.[41] This case study is intended to facilitate a partnership-based process that develops an enhanced common understanding of TC design, provision, management and impact at the sector level that, in the context of increased use of programme-based approaches, will result in technical cooperation support making a greater contribution to the development of national capacity.

6. This terms of reference therefore sets out an approach for the retainment of one international expert, working under the supervision of the Ministry of Health (MoH) and cooperating closely with government institutions and development partners, to undertake a case study that will provide: (i) a deepened understanding on the provision and management of TC, and its impact on developing institutional capacity of health sector, which then (ii) will provide inputs that are necessary to facilitate the formation of a Government policy guideline on the provision, management and monitoring of technical cooperation for development results.

II. Definitions

7. For the purposes of this exercise, and consistent with OECD/DAC terminology, technical cooperation is defined as follows:

   "The provision of know-how in the form of personnel, training, research and associated costs… covering contributions to development primarily through the medium of education and training… whose primary purpose is to augment the level of knowledge, skills, technical know-how or productive aptitudes of the population."[42]

   In the case of Cambodia, technical cooperation is understood to include, but not be limited to:

   a) International and national staff paid from ODA resources and engaged on either a long or short-term basis;

   b) In-country or overseas training of either a long or short-term nature;

   c) Operational support, the provision of equipment and other resources intended to support the implementation of projects or programmes that are designed to build and augment the capacity of Government; and

   d) The provision of monetary incentives to Government staff associated with the implementation of a project or programme that is designed to build and augment the capacity of Government.

8. To ensure that a comprehensive, coherent and accurate understanding of technical cooperation provision is developed, all forms of technical cooperation will be considered in this study.[43] In particular, the study will consider the extent to which technical cooperation design and provision is premised on national demand based on a fully-developed capacity assessment/strategy and how this has informed the design and delivery of technical cooperation support as well as contributing to development results.

III. Objectives

9. The primary rationale for the use of technical cooperation in Cambodia is to contribute to capacity development.[44] Development partners have collectively noted the link between ownership and capacity development and have observed that country ownership of policies and programmes is premised on the capacity to exercise it.[45] Arrangements for providing technical cooperation must therefore be increasingly associated with enhancing Government's ability to develop the capacity to exercise effective ownership over its development programme. Built on general understanding that has come out of the independent study, conducted in November 2007, on the provision and management of technical cooperation and its impact on capacity development in Cambodia, this case study will seek to understand the provision of TC

[41] See http://www.jica.go.jp/cdstudy/index.html for details of this global study in which Cambodia participates.
[42] See OECD/DAC Statistical Reporting Directives (2007), paras 40-44.
[43] The provision of monetary incentives should be considered only as context as separate review processes are taking place with regard to pay reform and the use of incentive and performance schemes.
[44] For the purposes of this study, capacity development is to be defined in the context of the 2006 OECD/DAC Reference Document, "The Challenge of Capacity Development: Working Towards Good Practice" (page 12).
[45] See OECD/DAC (2006), 'The Challenge of Capacity Development', para 11

illustrated by the current processes and arrangements that have been in place in the health sector.

Objective 1: Improved understanding of current and emerging practices/mechanisms related to needs identification, provision, management and monitoring of technical cooperation

This will include a reflection on all stages from needs identification to monitoring through to evaluation of technical cooperation, and its contribution to capacity development.

10. In the context of the Paris Declaration and the establishment of national aid management initiatives, Cambodia is moving towards new forms of support that are informed by the development of sector development plans and a more partnership-based approach to supporting sector programmes. In the context of these new aid modalities (such as budget support) and new approaches to partnership, including through budget support, it is reasonable to suppose that approaches to technical cooperation must also be tailored and adapted so that they are compatible with these new modalities. By exploring both positive and negative contributory factors, a consensus may be established on how to design and manage technical cooperation in a coherent, rational and cost-effective manner in accordance with a sector strategy that includes an assessment of capacity needs.

Objective 2: Evaluation of the capacity development impact of technical cooperation practices/mechanisms

Built on lessons learned, from the health sector, on the effectiveness of TC contribution to institutional and human capacity development (including the effectiveness of PIU), to explore emerging practices at sector level that are informed by programme-based approaches and to provide guidance – and examples of good practices and the subsequent results - on how technical cooperation activities may be designed, delivered and managed effectively in a manner that supports capacity development.[46]

11. Concern related to the use of technical cooperation resources has been a longstanding concern of both Government and its development partners. Based on the findings of the 2007 Aid Effectiveness Report and discussion at the June 2007 CDCF meeting, it is necessary to develop a common understanding on matters related to the use of technical cooperation as a basis for developing policy guidance on the future use and management of technical cooperation resources.

Objective 3: Recommendations on technical cooperation needs identification, provision, management and monitoring

Based on the findings of the study, make specific recommendations for establishing a sector-wide process for identifying technical cooperation needs and for managing all aspects of technical cooperation provision, management and monitoring.

IV. Scope of Work

12. The consultant is required to conduct a case study in consideration with the Global Study on TC framework special focusing to the complementarity of TC with various forms of supporting in achieving expected results, as well as detailed descriptions indicated Annex.

13. Informed by the objectives described above, the consultant is required to prepare a case study that builds on and take forward what is already known about technical cooperation in Cambodia, in particular the recently-completed independent study.[47] The consultant is also required to make recommendations that can be used as inputs to a Government Guideline that is based on the following considerations:

[46] A "sector" is, in this instance, intended to mean a well-defined body or programme of work related to the functions and responsibilities of a ministry, or a group of ministries, supporting the implementation of a sector strategy or reform programme.

[47] See the list of attached references and readings to gauge what is already understood about technical cooperation in Cambodia as well as further afield.

a) *Information Management* - taking into account the utility of collecting and analysing data, describe the impediments to more complete and accurate development partner reporting of technical cooperation.[48]

b) *Design of Technical Cooperation Support Programmes* - consider the nature of the preparatory process that precedes the delivery of technical cooperation support. In particular, the study should assess the extent to which Government leads or manages the production of a coherent 'sector-wide' approach to capacity development that then informs the design of technical cooperation programmes.

c) *Provision of Technical Cooperation* - informed by interviews and existing data, summarise and assess current practices before proposing measures that would strengthen procedures for identifying technical cooperation needs and for increasing Government participation in the needs assessment and design and development of technical cooperation programmes (including the recruitment and procurement of technical cooperation goods and services). Technical cooperation provided in the context of a Project/Programme Implementation Unit (PIU) should be included in this analysis, together with some reflection on the appropriate mix of technical cooperation activities. A reflection on experience in the use of South-South cooperation is particularly encouraged.

d) *Management of Technical Cooperation* - based on interviews with Government and development partners, describe the range of management practices that currently exist between the MoH and development partners. Identify both desirable and less desirable practices, consider the basic components of a technical cooperation package in the current partnership-based aid environment (including the 'soft skills' that effective technical cooperation may require), provide recommendations on how good practices might be replicated, under what conditions they might be transferable and under what conditions nationally-led management might lead to more effective use of technical cooperation resources. A particular focus should be placed on the SWiM and the management of technical cooperation in the Health Sector programme, including on the use and experience of using coordinated or pooled technical approaches. A discussion of the range of reporting and line management arrangements, i.e. to whom they are accountable, would also be welcomed, especially with regard to the manner in which this affects ownership and implementation.

e) *Monitoring the Performance and Impact of Technical Cooperation* - based on interviews with Government and development partners, describe the range of monitoring arrangements that currently exist. Identify both desirable and less desirable practices, provide recommendations on how good practices might be replicated, under what conditions they might be transferable and under what conditions nationally-led monitoring arrangements might lead to more immediate impact and to more sustainable capacity. When considering impact, the consultants are to comment on issues related to both short and long-term monitoring as well as to sustainability and the relationship between health sector work and the Government's core reform programmes, in particular the PFMRP and PAR. Examples of where technical cooperation support has played a strategic, but more difficult to monitor, facilitating and bridge-building role should also be considered. Evidence emerging from Government and development partner evaluations that have been undertaken should also be reflected, together with an indication of how these evaluations have been used to inform policy and practice.

f) *Identifying Good Practices and Those That Require Reform* - the Aid Effectiveness Report demonstrates that the development partnership in Cambodia is robust enough to withstand direct but objective observations regarding good and bad practices, whether they be on the part of Government or development partners. The consultant is therefore encouraged, where appropriate, to make use of local examples that address the use of technical cooperation in programme-based approaches, the use of PIUs and reporting arrangements.

g) *Maximising the Benefits of an Independent Exercise* - it is emphasised that the consultant is asked to provide inputs to a Government Guideline that will be taken forward in dialogue with development partners, not to draft the Guideline itself. The consultant is therefore mandated by Government to make full use of the independence in undertaking this exercise so that the consultant may bring to bear all of their global expertise and experience. These principles should inform the

[48] Reporting is intended to be undertaken accordance with the questionnaire used to prepare the Aid Effectiveness Report (see AER, Annex Three, questions 20 and 23)

production of a set of recommendations that objectively describe the current environment in Cambodia and the full range of steps that might be taken to maximize the capacity development impact of technical cooperation.

V. Methodology

14. Based on consultations with the MoH, and in dialogue with the sector development partners, following study points will be identified for the study:

    a) One strategy can be selected for the study out of five strategies such as Health System Governance;
    b) Different modalities can be selected such as one multi donor funded project and one/two bilateral donor projects; and
    c) Geographic Balance should be considered such as Phnom Penh and one/two provinces, in consideration with time constraint.

15. The consultant is expected to make use of contextual material including desk reviews and evaluations provided by Government as well as based on the own research, and is required to identify the source of any data or other assertion made in the report. Government institutions and development partners are encouraged to provide documents to the consultant (via the P+H TWG and the Health TWG to ensure efficient document management). These may include evaluations or studies specific to the provision of technical cooperation in Cambodia. Global references are not required as it is assumed that the consultant already have access to the material.

16. During the mission in Cambodia, the consultant, together with the CRDB/CDC, in collaboration with MoH, will hold a broad range of preliminary interviews with Government institutions and its development partners of the health sector (both individually and through the TWG structure).

17. The main source of information for the study is to be:

    a) The views of Government officials and development partners, nuanced appropriately by the consultant in the final report;

    b) Based on dialogue at the inception stage, a more detailed consideration of technical cooperation mechanisms and their impact in identified sectors and thematic areas;

    c) A review of policy documents, Government and development partner reports; and

    d) International studies and reports.

    Interviews with personnel – both Government and development partners – who are directly involved in technical cooperation programmes, the implementation of programme-based approaches and the management of core reform programmes in the health sector are particularly encouraged, as is the use of the TWG structure. The MoH, in collaboration with development partners, are requested to provide names and contact details of proposed interviewees to CRDB/CDC, together with all relevant documentation (case studies, evaluations etc).

18. As noted in the scope of work, the consultant is to submit the final report based on his/her own views, incorporating those comments that the consultant deems relevant. While applying global experience the consultant is required to ensure relevance to the Cambodia case to provide inputs and recommendations that will enable the national dialogue on technical cooperation to move forward.

VI. Outputs

19. The following outputs, which are to be guided by the Objectives and Scope of Work identified above, are required:

    - An inception briefing to ensure that the work is relevant to MoH needs.
    - Present and discuss the key findings of the case study at a debriefing meeting of Government and development partners.
    - Submission of a draft report based on the key findings of the mission.

- Submission of a final report based on comments received from Government and development partners (fifteen days after receiving comments from RGC and DPs).[49]

VII. Management Arrangements

20. The study will be implemented over a twenty-seven-day period (fifteen days for the consultant spent in Cambodia), commencing 5th March 2008 by one independent consultant.

21. This exercise, and the report that will be produced, have been commissioned by CRDB/CDC (in consultation with the Partnership and Harmonisation TWG) and the MoH with reference to the Joint Study on Effective Technical Cooperation for Capacity Development.[50] On behalf of Government, CRDB/CDC will lead the exercise and will be responsible for its overall management. The consultant will be managed by, and will report directly to the Secretary General, CRDB/CDC, in consultation with MoH.

22. At least two CRDB/CDC staff will be assigned full-time to work with the international consultant for the period of the case study. To ensure some sustainability in the exercise the consultant is required to maximize all 'learning by doing' opportunities associated with this exercise and to provide briefings to CRDB/CDC as requested.

VIII. References

Key Cambodia Readings

Scaling Up for Better Health in Cambodia, April 2007, WHO

Health Sector Review, August 2007, HLSP

Health Strategic Plan 2008-2015 - Accountability, Efficiency, Quality, Equity, December 2007, Ministry of Health

Contracting review

SWiM Review

IHP Stock-taking Report

HSSP1-related documents (such as Aide Memoire)

Technical Cooperation for Capacity Development in Cambodia: Making the System Work Better, January 2008, Tony Land and Peter Morgan

Cambodia Aid Effectiveness Report, 2007, CRDB/CDC

Capacity Building Practices of Cambodia's Development Partners, 2004, CRDB/CDC

Evaluation of the Technical Assistance Provided by the International Monetary Fund, Volume II, Technical Assistance in Cambodia (especially section III), 2005
http://www.imf.org/external/np/ieo/2005/ta/eng/pdf/013105c.pdf

Guideline on the Role and Functioning of the TWGs, 2007, CRDB/CDC

Joint Government-Donor Strategy for Phasing Out Salary Supplementation Practices in Cambodia, January 2006, TWG-PAR

National Operational Guidelines, 2006, CRDB/CDC

National Strategic Development Plan (NSDP), 2006-2010, Government of Cambodia

Strategic Framework for Development Cooperation Management, 2006, CRDB/CDC

Technical Assistance and Capacity Development in an Aid Dependent Economy: The Experience of Cambodia, Godfrey et al, 2002, World Development Vol 30

The GDCC and TWGs: A Review, 2006, CRDB/CDC

[49] The Report, if appropriate, will be used as an input to develop a technical cooperation guideline.

[50] The purpose of the joint study is to help move forward the current discussions and efforts for more effective technical cooperation for capacity development, by providing empirical evidence on how to make better use of technical cooperation as a part of the overall drive towards country-led capacity development. The study, which responses to the RGC primary interest also, aims at providing inputs in the policy-level discussions at the Third High-Level Forum on Aid Effectiveness in Accra in September 2008.

The Implementation of a Merit Based Pay Supplement Incentive, Sub-Decree 98 of 2005, Government of Cambodia

Other Readings

A vision for the future of Technical Assistance in the International Development System, 2003, Oxford Policy Management

Between Naivety and Cynicism: A Pragmatic Approach to Donor Support for Public-Sector Capacity Development, 2004, Ministry of Foreign Affairs, Denmark

Building Coherence Between Sector Reforms and Decentralisation: Do SWAPs Provide the Missing Link? 2003, Tony Land and Volker Hauck, ECDPM Discussion Paper.

Capacity for Development: New Solutions to Old Problems, 2002, UNDP/Earthscan

Developing Capacity through Technical Cooperation, 2002, UNDP/Earthscan

Harmonising the Provision of Technical Assistance: Finding the Right Balance and Avoiding the New Religion, 2002, Baser, H. and P. Morgan. ECDPM Discussion Paper 36

Review of Technical Assistance in Afghanistan and Capacity Building in Afghanistan, 2007.

Scoping Study on Capacity Development for Service Delivery in Pakistan, 2007, Watson D.

Study on the Provision of Technical Assistance Personnel: What can we learn from promising experiences? 2007 (draft), ECPDM

Technical Cooperation Success and Failure: An Overview, 2001, Morgan P.

Technical Cooperation, 2002, Development Policy Journal (Special Edition)

The Challenge of Capacity Development: Working Towards Good Practice, 2006, OECD/DAC

The Management of Public Service Reform: A Comparative Study of Experiences in the Management of Programmes of Reform of the Administrative Arm of Central Government, 1998, T. Land et al (eds), ECDPM.

Annex 2: List of Persons Met

Royal Government of Cambodia

Name	Designation	Institution
CDC/CRDB		
H.E. Chhieng Yanara	Secretary General	CDC/CRDB
Central MoH		
Dr. Lo Veasnakiry	Director, Planning Department	MoH
Dr. Or Vandine	Director, Department of International Cooperation	MoH
Dr. Mey Sambo	Director, Personnel Department	MoH
Ph. Keat Phoung	Director, Department of Human resources Development	MoH
Dr. Parak Pisethraingsey	Director, Preventive Medicine	MoH
Dr. Uy Vengky	Executive Administrator, HSSP	MoH
National Centers and Institutions		
Dr. Ung Sam An	Director	National Institute of Public Health
Dr. Mao Tan Eang	Director	National Center for Tuberculosis & Leprosy Control (CENAT)
Prof. Koum Kanal	Director	National Centre for Maternal and Child Health
Dr. Lim Thaipheang	Director	National Centre for Health Promotion
Dr. Mean Chi Vun	Director	National Center for HIV/AIDs, Dermatology & STD (NCHAD)
Takeo Province		
Mr. Phann Vann	Deputy Director	Takeo Provincial Health Dept
Mr. Prak Bunthoern	Director	Angroka Operational District
Mr. Pheng Tun	Director	Kirivong Operational District

Development Partners

Name	Designation	Institution
Multilateral Organization		
Dr. Michael O'Leary	Representative	WHO
Toomas Palu	Task Manager, HSSP	World Bank
Dr. Suomi Sakai	Resident Representative	UNICEF
Philip Courtnadge	Aid Effectiveness Advisor	UNDP (CDC/CRDB)
Bilateral Organization		
Jean-Marion Aitken	Health & Population Adviser	DFID
Dr. Nicolette Hutter	Programme Support Officer	DFID
Kate Crawford	Director, Office of Public Health	USAID
Shoko Sato	Project Formulation Advisor (Health Sector)	JICA
Dr. Chhom Rada	Dep. Programme Coordinator	GTZ SHSR-P
Dr. Dirk Horemans	Project Co-Director PBHS Projects	BTC
Luize Guimaraes Scherer Navarro	Project Officer	AFD
Eiichiro Hayashi	Aid Coordination Advisor	JICA
Mikio Masaki	Aid Coordination and Partnership Advisor	JICA (CDC/CRDB)

NGOs		
Sharon Wilkinson	Country Director	CARE
Dr. Var Chivorn	Associate Executive Director	RHAC
Dr. Sin Somuny	Executive Director	Medicam

Other Persons Met

Name	Designation	Institution
Russel Craig	Consultant	Oxford Policy Management
James Lee	Consultant	
Katarina Kovacevic	Consultant	

Annex 3: List of Main Sources Consulted

Baser, H & Morgan, P (2008) *Capacity, Change and Performance – Study report*. ECDPM

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Note: In addition to the above sources, the author was provided with various unpublished documents and grey literature providing background information on particular projects and development partner country programmes.