

- Version not yet approved by MoH Cambodia -

The Early Steps of The Global Fund in Cambodia

January 2002 – October 2003

Katharina Kober & Wim Van Damme

Department of Public Health, Institute of Tropical Medicine

Antwerp, Belgium

Email: kkober@itg.be

Sponsored by:

**Directorate General Development Cooperation, Belgium (Framework Agreement with the
Institute of Tropical Medicine)**

Acknowledgements

We wish to thank all people who contributed to this study. In Cambodia we are above all very grateful for the time everybody was ready to reserve for our interviews, in spite of their busy schedules. The feedback on an earlier draft from key people from the MoH and other actors, as well as the additional information they provided for the update of our study report was also much appreciated. Our Cambodian assistant and translator very much facilitated the field research. In Europe we thank the Global Fund Secretariat in Geneva, from which we received valuable feedback and who readily shared many documents with us. Our colleagues at the Institute of Tropical Medicine, too, made time to review and discuss earlier stages of the draft with us. This study was funded by the Directorate General of Development Cooperation, Belgium. This is an independent study and the responsibility for the selection and the interpretation of the findings in this study lies solely with the authors.

Table of contents

Acknowledgements

A.	Introduction	1
B.	Study approach.....	2
C.	Background.....	3
	The Cambodian context.....	3
	Overview of the Global Fund in Cambodia	7
	Overview of major dates.....	8
D.	Findings	9
	Proposal preparation.....	9
	The CCM as a partnership mechanism.....	10
	Flexible guidelines	11
	Strengthening systems and building on local priorities	12
	The Global Fund as a “financial instrument, not an implementing entity”	14
E.	Conclusions	15

A. Introduction

The *Global Fund to Fight AIDS, TB and Malaria* is a significant new initiative in the international health arena and has generated a high amount of interest due both to the magnitude of the funding it is committing to country programs and the innovative features of its approach. The Global Fund was formally launched in January 2002, and its objectives are to make available and manage additional resources to fight AIDS, TB and malaria, and to rapidly disburse these to effective prevention and treatment programmes in the countries with greatest needs.¹

The total pledges made so far to the Global Fund amount to US\$4.8 billion until 2008. This amount, though substantial, is still only a fraction of what is needed on a global scale to fight AIDS, TB and malaria.² By November 2003 the Fund had completed three proposal rounds with the call for round four to be issued on 10 January 2004. Approvals by the Fund total US\$2.1 billion over two years to 224 programmes in 121 countries with the actual disbursements until November 2003 totalling over US\$155 million.³

The Fund's main principles include the establishment of a simplified and innovative process with efficient, effective and transparent disbursement mechanisms, support of programmes that reflect national ownership and respect country-led formulation and implementation, and focus on performance by linking resources to the achievement of clear, measurable and sustainable results.⁴ The main innovative features of the Fund are its emphasis on partnerships and participation of stakeholders from civil society at the recipient country as well as the international level and furthermore the decision to base the disbursement of funds on the results achieved by the recipients. Based on the premise that it is of paramount importance to put a huge effort into the fight against AIDS, TB and malaria as the biggest health problems of our times, the Global Fund promises to be a new, slim mechanism for an effective and efficient fight against these diseases. Not slowed down by a heavy bureaucracy it presents its work as "guided by three major imperatives: Raise It. Spend It. Prove It."⁵

¹ The Global Fund, *The Framework Document of the Global Fund to fight AIDS, Tuberculosis and Malaria*, <http://www.theglobalfund.org>, accessed August 29, 2003.

² The WHO Commission on Macro-Economics and Health calculated that an annual amount of US\$ 9 billion was needed in order to tackle AIDS, TB and malaria worldwide.

³ The Global Fund, *Progress Report – November 2003*, <http://www.theglobalfund.org>

⁴ The Global Fund, *Framework Document*

⁵ The Global Fund to Fight AIDS, TB and Malaria, *Annual Report*, 2003, p.15.

While the Fund has an explicit focus on three diseases, it has also stated its commitment to support “programmes that address the three diseases in ways that contribute to the strengthening of health systems”.⁶ Indeed, a major new initiative such as the Global Fund is likely to affect health care systems in a variety of direct and indirect, positive and negative ways.

We present the findings of a case study in Cambodia of the initial in-country steps of the Global Fund from its inception in January 2002 until October 2003. The aim of the study was to report the country’s experiences with the preparation for the Global Fund proposals and the functioning of Global Fund related institutions, and to describe the initial and likely future effects of the Global Fund on the Cambodian health care system. We identify lessons, which we think are relevant for the ongoing successful implementation of Global Fund supported activities both in Cambodia and in other countries.

B. Study approach

Cambodia was chosen as a case study because it successfully submitted proposals in the first and second rounds of the Global Fund, and because we perceived the country’s efforts to establish a dialogue with all stakeholders as well as its general openness around the Global Fund processes as exceptional. Both authors of this report look back on several years working experience in the country and are well acquainted with the Cambodian health system. We conducted the main field research in Cambodia from 1 to 20 July 2003, complementing this with a further, one-week research visit in November 2003. The time covered by the present study stretches from the Global Fund’s first call for proposals on 31 January 2002 until the end of October 2003. Since the first funds to Cambodia were only disbursed in August 2003 our study is not concerned with issues directly related to programme implementation. The focus of this report is on the pre-implementation phase, on the initial processes around proposal preparation and creation of the Global Fund mechanisms in the country. Further field research in Cambodia may be conducted once the implementation of the approved programmes is at an advanced stage.

The methods used during the field work were qualitative. They consisted of semi-structured interviews with staff from the senior levels of the MoH, from bilateral and multilateral agencies as well as from international and local NGOs, who represent their constituencies at the Country Coordinating Mechanism (CCM) or are otherwise involved in any of the processes related to the Global Fund in Cambodia. Every Cambodian respondent was asked about his preferred language for the interview to be conducted in and, although most

⁶ Ibid.

of them chose English a Cambodian translator was present at the majority of sessions in order to facilitate the mutual understanding between interviewer and respondent. Data recording was done by note taking during the 22 conducted interviews. The notes of each interview were typed up on the same day the interview took place. In order to minimise the recall and information bias, unavoidable in an interview study covering a period as long as 22 months, we triangulated the information obtained from the interviews as far as possible with data from the available written documentation. We reviewed documents related to and relevant for the Global Fund in-country processes, such as minutes of meetings, written communication between different parties, guidelines, plans and other written tools produced either in the country or by the Global Fund. In addition, we reviewed documents related to the organisation of the Cambodian health system in general.

As part of the research process we produced a draft summary of the opinions expressed in the interviews during our field visit in July, and fed this back to all stakeholders we had interviewed in Cambodia and to the Global Fund secretariat for their comments. We also submitted the findings to an academic peer review by people not familiar with the local Cambodian Global Fund arrangements. As a consequence of this review process we decided, first, to extend the original coverage period by three months to 31 October 2003, the reason for our revisiting Cambodia in November 2003. Second, to present the findings in a way and format, which would make them accessible to readers without insider knowledge of the Global Fund in Cambodia. Third, to focus on the identification of lessons useful for the successful further development of the Global Fund in other countries.

C. Background

This chapter is meant to provide the reader, who is unfamiliar with Cambodia, with the contextual background necessary to understand our findings and conclusions presented in chapters D and E. We have divided it into two paragraphs, the first shortly illustrating the specific context of the Cambodian health system and the situation of AIDS, TB and malaria, the second outlining the structure of the Global Fund in Cambodia and the evolution of the proposal preparation processes.

The Cambodian context

The recent history. In 1991 Cambodia emerged from decades of violent political turmoil, the murderous Khmer Rouge regime and years of foreign domination with its political, economic and social foundations shattered. The Khmer Rouge (1975 – 79) had not only destroyed what health infrastructure was there but actually murdered almost all of the 1000

Cambodian medical doctors - less than 50 survived the regime. A long period of civil strife followed and was officially ended only by the Paris Peace Accords in 1991. The first democratic elections under a UN administration⁷ took place in October 1993 and it was only after this that substantial western aid started to flow into the country. Khmer Rouge armed activities in several parts of the country continued to drain the country's revenue and to undermine efforts to rebuild public services and systems until 1998, when they were finally defeated.

The health system and its actors. The Cambodian MoH adopted health district development as the official national policy and by 1996 a health coverage plan had been designed that divided Cambodia's 22 provinces into 69 operational districts (ODs) of between 100,000 and 200,000 inhabitants. Each OD was equipped with one referral hospital and a network of health centres each covering on average a population of 10,000 to 12,000 people. By 2003 considerable achievements have been made, e.g. 81% of the planned 940 health centres have been reconstructed or newly built and essential equipment and essential drugs are supplied in adequate quantities. However, serious problems, such as poorly motivated health staff, low quality of care and poor access to health services remain.

Due to the almost complete annihilation of skilled Cambodian human resources during the Khmer Rouge period many foreign experts got involved in the task of rebuilding the Cambodian nation, and foreigners continue to have an extraordinarily high presence in the Cambodian health system until today. This continues to pose a particular challenge for the MoH, even though its role has been gradually strengthened over the years. The latest health sector strategic plan 2003 – 2007, supported by the World Bank, ADB and DFID and endorsed by WHO, has again a strong focus on institutional strengthening of the central MoH, using the sector-wide management (SWiM) approach, the Cambodian version of a lower mechanism of donor coordination than a sector-wide approach (SWAp). Most of the multilateral and bilateral support to the health system in Cambodia goes to the central level of the MoH and to the vertical national programmes, particularly to HIV/AIDS. The presence of foreign NGOs in Cambodia has always been strong, and, as civil society in Cambodia is developing, the number of national NGOs is also growing rapidly, particularly in the field of HIV/AIDS. Most of these NGOs are donor-funded.

⁷ UNTAC, the UN Transitional Authority of Cambodia was with 21,000 administrative, military and police staff the biggest UN's peacekeeping force up to date.

Health financing. The financing of the health system poses some particular challenges in Cambodia. Total health expenditure is estimated at US\$19 per capita per year (= 8.1% of GDP) only around US\$2.6 of which (or 1% of GDP) come from the government.⁸ Private out-of-pocket expenditure is thought to amount to more than 75% (almost US\$15 per capita) of total spending on health. External resources make up the remainder, circa 12% of total health expenditure. This enormous share of out-of-pocket expenditure is mainly spent in the burgeoning and almost completely unregulated private-for-profit sector, and frequently translates into catastrophic health expenditure, often causing people to take up debts, sell productive assets and leading them into poverty.⁹ The Cambodian public health system is thus seriously under-funded and additional financial resources – such as those forthcoming from the Global Fund – are necessary to improve access to essential services for the poor.

Health status. Health status in Cambodia continues to be poor relative to other Asian countries in the region. A maternal mortality ratio of 473 per 100,000 live births, an infant mortality rate of 95 per 1000 live births and an under-five mortality rate of 125 per 1000 live births are among the worst in the region.¹⁰ Infectious rather than chronic diseases still constitute the major health issue in Cambodia, even though the latter are on the rise.

Tuberculosis. Cambodia is one of the 22 high burden countries for tuberculosis in the world. The annual incidence rate of all forms of tuberculosis is estimated at 540 per 100,000 population, and the annual mortality from TB (all forms) is 90 per 100,000 population. The HIV prevalence among TB patients increased from 2.5% in 1995 to 7.4% in 2002.

The National TB Programme is implemented by the National Center for Tuberculosis and Leprosy Control (CENAT) in Phnom Penh with around 20 health professionals. The management capacity of the CENAT is considered as being quite strong and it has been receiving considerable support from JICA who started a five-year technical cooperation project in 1999.

Malaria. Malaria is an endemic public health problem mainly in the mountainous and forested regions of Cambodia, above all along the border areas with Laos, Thailand and Vietnam. About 5% of the population, most of them ethnic minorities, temporary migrants and plantation workers, live in areas of high malaria transmission. The majority (88%) of

⁸ WHO, 2002 (using 2000 data). The *Cambodian Medium Term Expenditure Review* gives different figures: In 2001 public spending on health was US\$8.3\$ per capita, of which 33 % came from the government, 67% from external sources.

⁹ A survey by Oxfam found that 46% of people who had recently lost their land did so as a result of debts related to health expenditures, see Biddulph R, *Landlessness and development research report: Cambodia Land Study Project*. Sept 2000, Oxfam, Oxford 2000.

¹⁰ Source: WHO *World Health Report*, 2002.

cases are due to infections with *P. falciparum*. The *P. falciparum* strains in Cambodia are among the world's most multi-drug resistant.

The National Malaria Programme is implemented by the National Malaria Center (CNM). The CNM has developed a good management capacity and has been receiving strong technical assistance over several years from the EC and WHO.

HIV/AIDS. The first case of HIV infection was detected in Cambodia through the screening of blood donors in 1991. In 1993 the first cases of AIDS were diagnosed. In 1997 the HIV prevalence rate among adults soared at 3.2 % but has, since then, decreased to 2.8 % in the year 2000.¹¹ Especially among direct sex workers the HIV prevalence has dropped from 42 % in 1998 to 29 % in 2002. This decline in prevalence is attributed to both the effect of preventive interventions, including a 100 % condom use programme, and a rising mortality of people with AIDS. Still, with an adult prevalence rate of 2.8 % Cambodia remains the country with the highest HIV prevalence in the Asia-Pacific region.

The national response to HIV/AIDS is less streamlined than for TB and malaria. The National Center for HIV/AIDS, Dermatology and STD (NCHADS) was established in 1998 within the MoH. It has some 50 staff and is responsible for overseeing and implementing the MoH's response to the HIV/AIDS epidemic. The National AIDS Programme is implemented nationwide through Provincial AIDS Offices. In 1999 the National AIDS Authority (NAA) was created to coordinate the intersectoral response to AIDS. Its policy board consists of the secretaries of state from a total of 12 ministries. At provincial level Provincial AIDS Secretariats have been established and District AIDS Secretariats are planned.

Apart from these two national bodies there is a multitude of other actors within the area of HIV/AIDS in Cambodia. The member agencies of the UN Theme Group on HIV/AIDS have a variety of projects and between them are providing substantial financial and technical assistance to NCHADS and NAA, to various Cambodian ministries and NGOs. The major bilateral donor agencies involved in the Cambodian response to HIV/AIDS are DFID and USAID, the former mainly working with the Cambodian government, the latter through funding of NGOs. Besides these bilateral and multilateral agencies there are nationwide more than 110 NGOs working in the field of HIV/AIDS.

¹¹ Source: UNAIDS, 2001.

Overview of the Global Fund in Cambodia

Structure. By 31 October the Cambodian stakeholders had established the following structures for the Global Fund: One CCM¹² of 27 members from a broad range of constituencies; one Principal Recipient (PR) of 7 members from the MoH; one New Proposal Technical Review Panel (NPTRP) for the third round of proposals of 17 people from various constituencies; and one CCC Sub-Committee (CCCSC) of 6 members, from various constituencies. The Local Fund Agent in Cambodia is KPMG. On 1 September 2003 the CCM agreed to the renewal of KPMG's first contract with the Global Fund, ending on 15 October 2003. The creation of a Principal Recipient Technical Review Team (PRTRT), composed of members from the PR and already existing working groups from the three focus diseases, was still under discussion. The total number of Sub Recipients (SRs) was given by the PR as 21: fifteen for two approved HIV/AIDS proposals, five for one approved malaria and one for one approved TB proposal.¹³

Proposals. Cambodia submitted a Country Coordinated Proposal (CCP) in each of the Global Fund's first three rounds of calls and was successful in Round One and Two. In the 1st round (deadline 15 March 2002), the Global Fund approved the HIV/AIDS component of the proposal "*Partnership for going to scale with proven interventions for HIV/AIDS, TB and Malaria*". The total funding request was US\$15.9 million and the 2-year approved funding is US\$11.2 million. A Program Grant Agreement (PGA) was signed in January 2003 for a two-year period from 3 February 2003 to 2 February 2005. The first disbursement of US\$2.4 million was made in August 2003. In the 2nd round (deadline 27 September 2002) the Global Fund approved the Cambodian CCP for all three diseases. The total funding request was US\$31.5 million. The 2-year approved funding is US\$5.3 million for HIV/AIDS, US\$5.0 million for malaria and US\$2.5 million for TB. The PGA was signed on 14 October 2003. By the end of October 2003 no disbursements had been made for the 2nd round proposal because the Principal Recipient was still preparing to meet some conditions prior to disbursement. The proposal submitted by Cambodia in the 3rd round was not approved by the Global Fund, reportedly because the Global Fund prefers to wait with the approval of new grants in cases where the implementation of proposals, approved in round One and Two has not yet shown results.

¹² In Cambodia the Country Coordinating Mechanism (CCM in the Global Fund terminology) is called CCC.

¹³ Issues relating to the sub-recipients and to the LFA are not explored in detail in the present study, because they are rather considered part of the implementation phase of the Global Fund programmes.

Overview of major dates

	Round 1	Round 2	Round 3
	Included disease components (underlined) <u>AIDS</u> <u>malaria</u> <u>TB</u>	Included disease components (underlined) <u>AIDS</u> <u>malaria</u> <u>TB</u>	Included disease components (underlined) <u>AIDS</u> <u>malaria</u> <u>TB</u> + HEF ¹⁴
Official call for proposals	31 January 2002	02 July 2002	20 March 2003 (not exact?)
First meeting to establish a CCM	04 February 2002		
First CCM meeting	15 February 2002		
Presentation of CCP to CCM	13 March 2002	25 September 2002	29 May 2003
Deadline for proposal submission	15 March 2002	27 September 2002	31 May 2003
Notification of application outcome	June 2002	?	October 2003
	Approved disease components (underlined) <u>AIDS</u> <u>malaria</u> <u>TB</u>	Approved disease components (underlined) <u>AIDS</u> <u>malaria</u> <u>TB</u>	Approved disease components (underlined) AIDS <u>malaria</u> <u>TB</u>
	Total budget requested: US\$15,945,803 2-year approved budget: US\$11,242,538	Total budget requested: US\$31,514,667 2-year approved budget: US\$12,889,081	
Selection of Principal Recipient	19 August 2003		
Number of Sub-Recipients	11	10	
PGA signed	27 January 2003	14 October 2003	
First disbursement	August 2003		
	Total amount disbursed by October 2003: US\$ 2,528,866.67		

¹⁴ HEF= Health Equity Fund. Cambodia submitted a cross-cutting proposal aimed at improving the access to health services for the poor. On request of the Global Fund this proposal was integrated in the HIV/AIDS component.

D. Findings

The Global Fund brings in very much welcome new resources for the fight against AIDS, TB and malaria in Cambodia. The lively exchange of opinions and the active participation of a broad range of stakeholders that distinguish the Global Fund at the international level also characterise it on the ground in Cambodia. The establishment of the Global Fund's structures in the country is by no means an easy task and has proved to be very intensive and time consuming work for most people involved in it. People in Cambodia have many divergent, and very often critical, views of the Global Fund in their setting, views which are nevertheless held together by the overall desire to make it work for the country.

The findings of our study will be presented under the following five headings, (1) proposal preparation, (2) the CCM as a partnership mechanism, (3) flexible guidelines, (4) strengthening systems and building on local priorities and (5) the Global Fund as a financing instrument.

Proposal preparation

Despite the restricted time frame for proposal preparation,¹⁵ and thanks to the high and dedicated input from many individuals, Cambodia managed to submit three Country Coordinated Proposals, two of which obtained Global Fund approval in the first two rounds.

Still, the application processes for all three rounds were generally viewed as too rapid and time-consuming, and many thought that the time constraint had a negative effect on the quality of the proposal preparation activities. It was for example regretted that for the third round of the Global Fund most new proposals could only be reviewed by one person per proposal and not by several people, as was originally planned in order to ensure higher fairness and transparency.

The limited time was more problematic for the preparation of the HIV/AIDS than for the TB and malaria proposals. Regarding the two latter, it was the respective National Programmes for TB and malaria who took the leadership in coordinating the NGOs. Both Programmes could fall back on already existing Technical Working Groups, namely the Roll Back Malaria Committee and the Interagency Coordinating Committee for TB, while in the field of HIV/AIDS a comparable working group did not exist. In TB and malaria, a limited number of actors are working in an equally limited number of priority interventions, where the technical leadership of the National Programmes is unchallenged. The

¹⁵ Changing formats for proposal submission to the Global Fund between rounds compounded the difficulty of preparing proposals on time.

coordination of the HIV/AIDS response in Cambodia is a much more complex task. The amount of actors, among them many international NGOs, is much higher, and has been increasing over the past few years, reflecting also a wider array of sometimes strong opinions regarding priority interventions. This situation meant that new working groups had to be established, compromises to be negotiated, decisions to be made regarding inclusion of actors etc., all of it time-consuming processes, which it was not easy to complete in a satisfactory manner within the short time frame for proposal preparation.

The time constraint particularly affected the role of the CCM in two respects. First, CCM members did not always get sufficient time to thoroughly review the Country Coordinated Proposals before approving and endorsing them with their signature, as required by the Global Fund. The time for an incorporation of suggested changes to a Country Coordinated Proposal by CCM members was extremely short. This time pressure may have led to compromises of the kind where proposals were signed despite residual concerns regarding parts of their contents in order not to imperil their timely submission to the Global Fund. Second, the CCM was not able to put much time into facilitating the proposal development process for Cambodian NGOs interested in writing their own proposals. It is possible that the lack of recourse to external technical support prevented some Cambodian civil society organisations from submitting proposals.

The CCM as a partnership mechanism

Setting up the Global Fund mechanisms and structures in Cambodia required the commitment and joint efforts of a wide range of stakeholders. An inclusive and balanced CCM has been established, which has the potential to develop into an important new coordination and decision-making mechanism in the Cambodian health system between the government and all other partners. The CCM has 27 members, including representatives from the government (9), United Nations/multilateral/bilateral agencies (9), NGOs (5), the private for profit sector (1), Persons Living with HIV/AIDS (1), and the academic/educational sector (2). Its members put a lot of work into it and into reviewing the final proposals and many of them even assumed additional tasks in other Global Fund related committees. The CCM met on average every two months from its first meeting on 15 February 2002 until the end of October 2003, and saw some lively and long debates on central issues.

CCMs are central to the Global Fund's commitment to local ownership and participatory decision-making", and it is "one of the explicit expectations of the Global Fund that the CCMs draw on the full engagement of all stakeholders and have transparent internal

communication”.¹⁶ However, there are still a number of issues that make it difficult for the Cambodian CCM to assume fully the functions as foreseen for it by the Global Fund and become a real partnership mechanism.

Language. This has been identified by many as a barrier for the participation of all CCM members since the CCM meetings are conducted in English with no translation service provided. Particularly the representatives of the Cambodian civil society felt they could not adequately follow the discussions in the CCM meetings let alone take active part in the discussions.

Global Fund money. Everybody agreed that the increased funding the Global Fund can bring is desperately needed in Cambodia, yet it was noted by some that the decision-making role of the CCM was made difficult by the amount of money at stake. Particularly those agencies whose effective work with the Cambodian health system is dependent on a good relationship with the MoH considered it a quite problematic decision to say no to proposals the government wanted to see through.

Human resources, time and funds. Respondents from several constituencies reported that regular participation and active involvement in CCM work beyond the quarterly meetings is difficult. Lack of human resources, time and funds are responsible for this, and respondents feared this might hamper the continuity of the CCM during the implementation phase of the Global Fund programmes.

Roles and responsibilities of the CCM. The need for a conflict of interest policy, particularly, but not only, with regard to the relationship between CCM and PR, has been acknowledged by many and the Global Fund Secretariat has requested the CCM to prepare one. Yet, the “roles and responsibility [of the CCM] re the PR functioning” have not yet been clarified.¹⁷ Due to the described human resource and time constraints only a limited number of actors are available for work for the Global Fund in Cambodia and thus several representatives have functions in more than one structure. This was perceived as problematic in terms of effective, efficient and transparent cooperation between all Global Fund structures in the country.

Flexible guidelines

The Global Fund stresses that it is country-driven and that consequently every country should use as far as possible its existing systems for managing the Global Fund in-country mechanisms, such as coordination structures, monitoring and evaluation of programmes,

¹⁶ The Global Fund to fight AIDS, TB and malaria, *Annual Report 2002/2003*, p. 47/48.

¹⁷ Minutes of CCC meetings on 1 July 2003 and 1 September 2003.

and channelling of the funds. It is against this background that the Global Fund avoids issuing general rules and strict guidelines. Countries with existing structures and mechanisms in place can use this principle of flexibility to minimise the creation of additional new mechanisms for managing the Global Fund system.

Cambodia, however, has for example no past experience with channelling funds directly from the MoH to NGOs. Anxious due to the uncertainty caused by the absence of clear guidelines from the Global Fund in Geneva and the need to establish quickly a mechanism, a rather elaborate structure was eventually created for the new proposals to go through before they reach the CCM. The accounting system is new for the Sub-Recipients and participants in a Sub-Recipient training workshop found it rather burdensome. While there is a tradition of coordination forums of MoH and NGOs, there is no precedent for a partnership body with a mandate as extensive as that foreseen for the CCM. The lack of clear guidelines means that there is a lot of uncertainty both around elementary issues, such as the roles and responsibilities of the various new entities created for the management of the Global Fund, and around programme details, such as the payment of salaries and incentives from Global Fund money. Cambodia needs to seek guidance from the Global Fund on a one by one basis and subsequently, in a time-consuming process, interpret and negotiate this on the ground.

Strengthening systems and building on local priorities

The Global Fund, while focussing on three diseases, also claims to “support efforts to strengthen underlying health systems (...) consistent with national strategic plans”. This principle is related to the claim that Global Fund programmes “build on existing national priorities, including (...) poverty reduction strategies and sector-wide approaches”.¹⁸

Disease focus. Many people in Cambodia felt that the Global Fund, with its focus on AIDS, TB and malaria, did not fit very well with the Cambodian *Health Sector Strategic Plan, 2003 – 2007* (HSP), where HIV/AIDS, malaria and TB are, of course, issues but other priorities figure more prominently.¹⁹ It was anticipated that the concentration of huge amounts of money on the three diseases would contribute to a further weakening of other health programmes, such as Mother and Child Health.

¹⁸ Both principles are listed in a variety of Global Fund publications, of which the latest is the *Annual Report 2002/2003*, p.11.

¹⁹ The overall goal of the Strategic Plan does not specifically mention any of the three diseases but includes improving the health of mothers and children. In the Plan’s “eight essential core strategies” the strengthening of obstetric and paediatric care is the only specific medical issue among such things as improving coverage and access for the poor, provider behavioural change, quality improvement of services, health financing and institutional development. See Cambodia MoH, *Health Sector Strategic Plan 2003-2007*, 2002, p. 23.

Review structure. When Cambodia submitted its cross-cutting Health Equity Fund proposal in Round Three, it became clear that it is difficult for the Global Fund to take into account proposals “that evolve from national plans and priorities”,²⁰ when these cannot be clearly categorised under one of the three disease headings. The Health Equity Fund proposal aims at improving access to health care for the poor, justifying its inclusion in the country coordinated proposal to the Global Fund on the grounds that “HIV, TB and malaria affect the poor disproportionately to the non-poor”.²¹ Access to health services for the poor is widely perceived as the most pressing issue by actors in public health in Cambodia. In the National Poverty Reduction Strategy ill health is singled out as “the major cause of impoverishment” and “providing access to good quality care for the poorest”²² figures among the priorities of the Strategy. Cambodia managed to resubmit its Health Equity Proposal under the heading of HIV/AIDS, yet this disease focus is likely to be too narrow to adequately capture cross-cutting themes. This points to a wider contradiction between the Global Fund system and its rhetoric. While the Global Fund is, on the one hand, saying that it intends to “support efforts to strengthen underlying health systems”²³ it has, on the other hand, a review structure in which disease specific experts figure more prominently than health system specialists.

Lack of clear rules. The Global Fund’s lack of clear rules was seen by some as hampering rather than supporting efforts to strengthen the health system. For example, the lack of clear limits for the payment of salary supplements by the Global Fund was perceived as frustrating the efforts of several multilateral and bilateral partners to introduce a system of performance based salary incentives for MoH staff, which had already been developed, negotiated and agreed with the MoH. It was feared that the Global Fund’s flexible rules would allow for higher salaries for national staff, thus creating distortions and increasing the incentive for Cambodian health professionals to move to where the ‘big money’ is. Higher salary incentives would enable the staff in the Cambodian health system to compete with salaries paid in the NGO and international agency sector but create inequalities both within the MoH departments and between the MoH and other ministries. While this is, of course, a valid concern it has also to be kept in mind that the Global Fund is not the only donor to provide considerable resources for the response to HIV/AIDS.²⁴ And, neither is it a new problem in Cambodia that well-trained people do not stay in the government

²⁰ The Global Fund, *Annual Report 2002/2003*, p. 10.

²¹ see letter from Hong Sun Huot, the Cambodian minister of health, to the Global Fund Secretariat from 20 June 2003.

²² Cambodian Council for Social Development, *National Poverty Reduction Strategy 2003-2005*, Dec. 2002, pp. 33, 105.

²³ Ibid.

²⁴ USAID, for example, according to the Mid Term Expenditure Plan 2003 – 2007 of the MoH, has given \$ 27 Mio to the HIV/AIDS programme in only 2 years. The salaries and rates of NGOs who are receiving substantial funding from USAID are known to exceed considerably those of other NGOs.

service but prefer to work for organisations offering better pay and more opportunities, nor is it new that a specific Programme Management Unit is created within the MoH to pay competitive salaries. Of course, the fact that this problem is not exclusive of the Global Fund does not diminish its importance in having a potentially damaging effect on the capacity and job satisfaction in other, no less important, MoH departments.

Capacity building. With the decision for the MoH to be the Principal Recipient, Cambodia has chosen the option to build on an existing structure of its health system. However, managing the Global Fund in Cambodia means a high workload and is a heavy administrative and managerial burden for the small group of MoH staff who make up the Principal Recipient. The team needed considerable external technical input for its preparations to meet the conditions prior to the disbursement of funds and it is very likely, according to a number of assessments, that strong expert assistance will remain important for the management of successful programme implementation. Several respondents regretted that the technical input had remained unique for the Principal Recipient, and they hoped that in the future it would be possible to put some thought into strategies to make wider MoH structures benefit from Global Fund related capacity building.

The Global Fund as a “financial instrument, not an implementing entity”²⁵

Since the Global Fund does not have a presence on the ground it has fallen to other partners to provide the necessary technical support to the MoH and other actors in the health system to create the Global Fund in-country structures and mechanisms. For the permanent in-country staff of these partners the Global Fund has meant a high amount of extra work, on top of their regular professional commitments. In order to assist the Principal Recipient and the CCM to prepare for the disbursement of Global Fund money three fulltime expatriate advisors, each working between three and six months, were hired by multilateral and bilateral partners in 2003. It is clear that the costs the Global Fund is saving by remaining a slim institution, particularly in terms of time and human resources, has to be taken over by organisations with a permanent in-country presence. These organisations have a genuine interest for major initiatives like the Global Fund to benefit the health systems they have been supporting for years. This situation caused some frustration since it was felt that the Global Fund’s “new way of doing business”²⁶ was an implicit criticism of other development partners’ track record in the country while at the same time relying heavily on the support of just these partners.

²⁵ This is the first principle of the Global Fund, see e.g. in its *Annual Report 2002/2003*, p. 10.

²⁶ Tommy Thompson, Chair of the Global Fund Board, in: *Annual Report 2002/2003*, p. 7.

E. Summary and Conclusions

The Global Fund was launched in January 2002 to make available and manage large amounts of additional funds for the fight against AIDS, TB and malaria and rapidly disburse these to the countries in greatest need. It describes itself as a “financial instrument not an implementing entity” and established a number of key principles such as efficient and transparent disbursement mechanisms, support of programmes reflecting national ownership and strengthening health systems, a focus on performance based disbursement, and an emphasis on partnerships between governments, NGOs and the private sector.

This report presents the findings of a case study of the early steps of the Global Fund in Cambodia from January 2002 until the end of October 2003. During three weeks in July, and one week in November 2003, we conducted 22 semi-structured interviews with representatives of the government, the civil society, bilateral and multilateral agencies and international NGOs who were members of the CCM or in other ways involved in the Global Fund in Cambodia. Furthermore we reviewed relevant documents in the country as well as from the Global Fund website and incorporated the stakeholders’ feedback on our draft summary of interviews. The aim of this study was to report the stakeholders’ different views and experiences regarding the pre-implementation phase of the Global Fund in the country and identify lessons that may be useful for the further successful development of the Global Fund both in Cambodia and in other countries.

In 1991 Cambodia emerged from decades of violent political turmoil. After the Paris Peace Agreements in October 1991 the UN Peacekeeping Forces (UNTAC) moved in and Cambodia was put under UN administration until the first general elections in 1993. The Khmer Rouge, who infamously ruled the country from 1975 to 1979, had destroyed the health infrastructure and killed almost all Cambodian medical doctors. A high number of foreign experts became thus involved in the task of rebuilding the health system. Today, bilateral and multilateral donors and aid agencies continue to have a high presence in the Cambodian health system. Still, the MoH has been gradually strengthened and the latest health sector strategic plan 2003 – 2007 puts a strong emphasis on its further institutional strengthening. The public health system is underfunded, and the very high share of out-of-pocket expenditure is mainly spent in the unregulated private-for-profit sector. Cambodia’s health status continues to be poor relative to other countries in the region. TB, malaria and HIV/AIDS, each of which has a designated National Center, are very significant health problems.

Cambodia has established a fully fledged Global Fund architecture as suggested by the Global Fund guidelines. In each of the Global Fund’s three calls for proposals, in January 2002, July 2002 and March 2003, Cambodia submitted one country coordinated proposal.

In the first round the HIV/AIDS component, in the second round all three disease components were approved for a total 2-year budget of over US\$24 million.

Our findings show that the Global Fund fuelled a lively exchange of opinions and active participation of many different actors, held together by the overall desire to make the Global Fund work in Cambodia. While we tried to interview representatives of a broad range of in-country stakeholders, we could not get the views of all people involved in the Global Fund in Cambodia. What we present in our findings are opinions and viewpoints of individuals as expressed in the interviews. All opinions documented in this study do, of course, depend on the angle from which the particular respondents are looking at the Global Fund and can, while valid, only present part of the picture. This may be influenced by an 'expatriate bias' due to the high number of expatriates involved in the Global Fund in Cambodia, voicing their opinions more easily than their Cambodian colleagues. A tendency to highlight exclusively the aspects of the Global Fund in Cambodia they perceived as negative while taking the undeniable positive developments for granted, was noticeable. Still, many of the findings and conclusions of this case study are not exclusive to Cambodia but concur with those of other studies of the Global Fund in various countries.

Apart from bringing very much needed resources for the fight against AIDS, TB and malaria, the Global Fund has undoubtedly initiated a new and promising dynamic in Cambodia. For the first time the MoH is channelling money to NGOs and, equally for the first time, actors from the civil society are represented in a decision-making committee together with the Cambodian government. The Global Fund's open and participatory overall approach, and the readiness of the representatives of the Global Fund secretariat to listen, take seriously and react to local concerns were very much appreciated in Cambodia.

Two major observations, both related to the disparities between the **Global Fund's discourse at international level and the reality on the ground**, emerge from our findings. The first is related to the intention of the Global Fund to build on existing country structures rather than to create new and additional ones. Our findings show that the Global Fund in its initial phase in Cambodia is perceived as an initiative that requires the creation of entirely new institutions and the adaptation of old ones. Both are very human resource intensive and time-consuming processes. The second observation concerns the Global Fund's principle that its programmes strengthen existing health systems and take into account local priorities. In Cambodia the Global Fund is perceived more as a new vertical programme whose focus on the three diseases excludes proposals that cannot be earmarked under AIDS, TB or malaria, even when they are based on nationally defined and widely agreed priorities for the health system.

Other major findings reflect what has been documented in other countries, too. Thus, **proposal preparation time** was generally perceived as too short, hence affecting the quality of the proposal preparation activities, such as the creation of the new Global Fund structures and the review process of new proposals. Particularly the role of the CCM regarding proposal approval and support to potential new applicants suffered from the restricted time frame. It was thought that by starting the proposal preparation before the formal call for proposals was issued these problems could be avoided.

In the **absence of clear guidelines** from the Global Fund, many details of the preparation process and also of fundamental issues such as the CCM's mandate need to be negotiated on the ground, a time-consuming process and potentially problematic when disbursement of funds and implementation of programmes start before the CCM's responsibilities have been agreed upon. It may slow down progress at every stage of the Global Fund processes.

Also the importance of a **shared language** for the participation of civil society has been remarked on in other studies. In Cambodia, as long as the language of all meetings and all written communication is English, effective inclusion of those who are not sufficiently conversant in English is not possible. A simultaneous translation service at all CCM meetings and written translations of the main Global Fund guidelines and documents would facilitate open debates and informed participatory decision-making, increase transparency, and foster the sense of ownership of the civil society representatives. Participation and transparency are important features of the Global Fund and to assure them it is important to give all stakeholders an equal chance to formulate their different opinions in a constructive manner.

A particular concern in Cambodia was how to make the wider structures of the MoH and the health system benefit from the considerable amount of **capacity building** that is being provided to the Principal Recipient, a group of seven staff from the MoH. Now that the disbursements for Round One have started it is not likely that the momentum of the Global Fund in Cambodia will soon slow down. Quarterly reporting by Sub-Recipients and Principal Recipient, along with other ongoing issues such as the finalisation of the procurement plan and the concurrent preparation for the Round Two programmes, will mean high workloads for MoH as well as expatriate staff involved in the CCM. This will make it difficult to gain 'breathing space' in order to develop strategies for making the health system profit from the big amount of technical input into the GF structures.

The **CCM in Cambodia**, pivotal for the Global Fund and a real innovative structure, is currently the topic of a study commissioned by the Global Fund itself. While the focus of our study was not exclusively on the CCM, several important findings relate to it. First, the CCM in Cambodia is indeed a new and potentially very important participatory mechanism.

For the first time, representatives of a wide range of actors, including the budding civil society, not only sit around one table but also have been given the mandate to make decisions.

The CCM during proposal preparation. Time consuming commitment in CCM activities, such as dissemination of information relating to the Global Fund, facilitation for “national stakeholders wishing to scale-up their activities”, and “oversee[ing] the monitoring and implementation of the proposals”²⁷ is difficult for some constituencies without extra funding.²⁸ This may result in either a situation where members representing only those constituencies who have enough extra capacities shoulder these responsibilities of the CCM, or where the CCM limits its role and functions only on a minimal scale, thus forgoing the opportunity of becoming an important partnership mechanism.

As long as it is not clear what role the CCM should and can play regarding assistance and support for civil society organisations interested in applying for Global Fund funding, potential new applicants may be discouraged from preparing a proposal. This may result in a ‘(pre) selection bias’ in the sense that mainly proposals from experienced NGOs or ministries continuing with proven interventions enter and pass the review process. The proposals of small and less experienced NGOs, who lack the money for an external consultant, may have more innovative ideas but not pass the review process because they are in need of substantial technical improvement.

The CCM during implementation. For further proposal preparation processes, but particularly with regard to the implementation phase of the Global Fund programmes it will be important for the CCM to clarify its roles and responsibilities. Continued quality support of the implementing actors during programme implementation has been identified by the World Bank as a major factor for success of its MAP1 Program for Africa.²⁹ And, according to the Cambodian Monitoring and Evaluation Plan for the first round of the Global Fund, the CCM will have an extensive and important role during the implementation phase, not least the provision of support to various other bodies.³⁰ This poses big challenges for the CCM, the stakeholder constituencies it represents, and the Global Fund. In order to have a realistic discussion of and decision about the future roles

²⁷ The Global Fund, *Guidelines for proposals*, March 2003, p. 6.

²⁸ It may be interesting to look to lessons learned from comparable programmes such as the MAP in Africa. The World Bank, drawing lessons from their MAP1 Program, notes that there are “no funds for knowledge management associated with MAP1 lending” and recommends that this be “corrected through the funding of [...] a technical support team which can provide [...]operational assistance to MAP projects ‘on demand’”. In: World Bank; ACTAfrica; AIDS Campaign Team for Africa, *Second Multi-Country HIV/AIDS Program (MAP2) for Africa*, Draft, January 2002, p. 12.

²⁹ The World Bank draws another lesson from MAP1, namely that “adding to the eligibility criteria [of programmes] would have little impact. Success in MAP will hinge not on setting cumbersome up-front conditions but on sustained vigilance and quality in implementation support.” In: World Bank, January 2002, p. 12.

and functions of the CCM, the constituencies represented in it need to take a clear stance about their possibilities and intentions of budgeting for this kind of work. Considering the expanding role of the CCM, the Global Fund itself, too, might find it appropriate to consider making resources available for its functioning.

This study documents that the early steps of the Global Fund in Cambodia present a mixed picture. Its promise to bring important additional resources for the fight against AIDS, TB and malaria is being confirmed. Its principle of involving a wide range of stakeholders has been applied during the pre-implementation stage in Cambodia and is enhancing commitment and a sense of ownership among many actors. Yet, the Global Fund's desire to use existing systems and to avoid a heavy administrative workload has been realised to a lesser extent. This may need extra attention. However, it has to be kept in mind that the Global Fund is a dynamic initiative, moving forward with a considerable pace, and that therefore the present study can be no more than a spotlight on one part of this process. It can, like other studies that have been conducted of the Global Fund in countries where implementation has not yet started, point out some early lessons and issues which may need to be followed-up during the implementation of the Global Fund programmes.

³⁰ PR, *Monitoring and Evaluation Plan*, p. 20.