Technical approach paper

Global health partnerships and country health systems: the case of Cambodia

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In recent years Global Health Partnerships (GHPs) have delivered welcome additional resources to the health sector. Cambodia has been extraordinarily successful in attracting GHP funding, especially from the Global Fund to Fight AIDS, TB and Malaria and the GAVI Alliance. This paper finds signs that such funding has contributed to strengthening the country's health system by supporting well run programmes that have delivered results.

Yet, GHPs have also contributed towards a growing misalignment between donor support and stated government priorities and have had some negative impacts. The paper also explores how these may have served to undermine broader health systems development efforts.

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1. Introduction

Donor support plays a major role in the financing of health care in Cambodia, accounting for around two thirds of overall public spending.[1] This support is, however, provided in a fragmented manner and has been poorly aligned with government priorities.[2,3] Harmonisation and alignment are high on the government's aid agenda; in the health sector a sector wide approach (called SWiM) is emerging[4], and Cambodia is a first wave International Health Partnership (IHP) country.[5]

At the time of this research study, in early 2008, Cambodia was in the process of developing its second Strategic Health Plan (HSP2 2008-2015). HSP2, which places strong emphasis on improving maternal health outcomes, aims to form the framework for alignment of donor support. Under the previous plan (HSP1 2003-2007) there was considerable progress, particularly with respect to child health indicators, TB cure rates, and reduction in HIV incidence and prevalence.[6,7,8] These achievements were delivered through the development of strong and effective disease-specific programmes, with considerable support from Global Health Partnerships (GHPs – also known as Global Health Initiatives) and other donors. But lack of progress on maternal health indicators – which are considered useful to assess the competence and strength of a health system[9] – was not only out of line with agreed priorities but, importantly in the context of this study, a reflection of weaknesses in the overall health system.

Cambodia has been particularly successful in accessing GHP money, receiving grants from the Global Fund to Fight AIDS, TB and Malaria (GFATM) for the three diseases and health systems strengthening (HSS) in all but Round Three. The total lifetime budget of these grants is US $209 million (maximum approved) of which $111 million has been disbursed to date.[10] Cambodia has also received a dedicated HSS grant of $1.8 million from the GAVI Alliance. The latter underwrites the delivery of a Minimum Package of Activities by allocating block grants to health centres on the basis of a Performance Based Management Agreement.[11]

We sought to describe the ways in which GHPs − principally the GFATM and the GAVI Alliance − engage in Cambodia, and their effects on health systems, so as to inform emerging good practice. The GFATM and the GAVI Alliance have become major financiers of international health; in 2007 they injected an additional $2.16 billion into the system. In the very limited and nascent literature on interaction between GHPs and health systems, experience in Cambodia had not received attention.[12,13] The study aimed, in particular, to elicit evidence on two key questions, which have major implications for the development of health systems:

- **Are the GHPs supporting the right things?** In other words, do they align their support with government priorities or with other measures of need such as the burden of disease?
- **Are the GHPs doing things right?** Are they providing support in ways which strengthen health systems, aligning as far as possible with government systems and harmonising as far as possible with other donors?

2. Methods and analytical framework

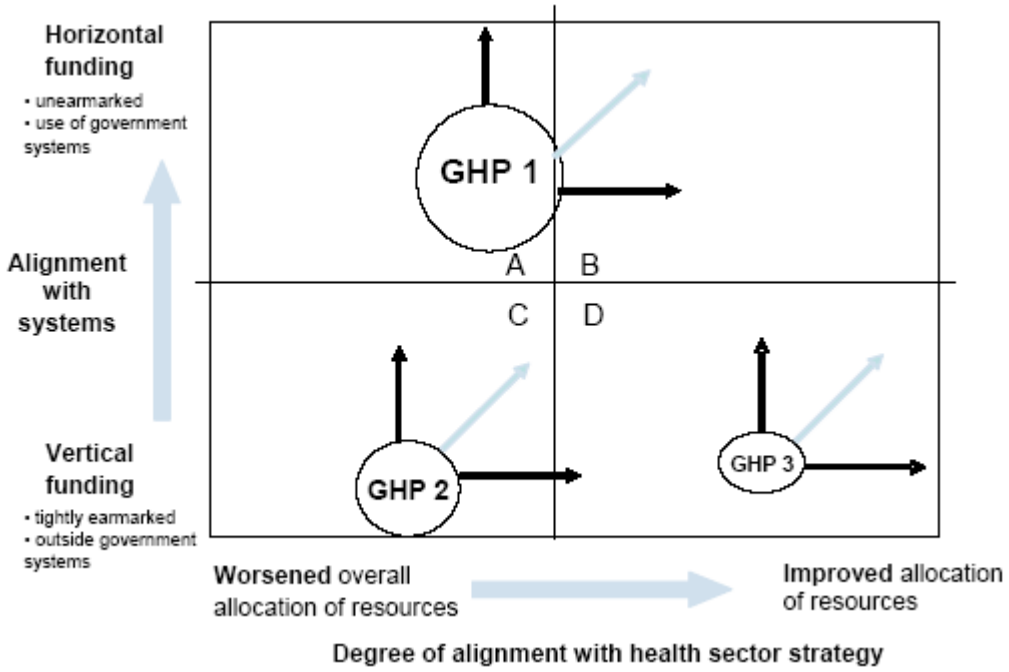
Qualitative methods were used to identify and explore examples in which support from GHPs strengthened health systems or missed opportunities to do so (as well as documenting possible negative effects). The intention was to seek ways to measure both the positive and negative effects of various GHP practices.

A sample of informants was identified based on knowledge and experience of health sector planning and/or involvement in planning or administering GHP resources. This included eight senior government officials who direct national programmes which have received funding from GHPs, and one planner. Fifteen informants represented multilateral and bilateral agencies, technical providers and a consortium of NGOs. They were interviewed in English, with a question guide adapted depending on the background of each informant. To provide an additional perspective to the analysis, a national researcher with direct experience of GHP proposal development and review and of working inside a GHP-supported programme, was present at all interviews, which were carried out in January and February 2008.

Figure 1 presents the analytical framework for the study. It assesses the extent to which GHP financing supports health systems strengthening based on two key dimensions: (i) the degree to which the approach strengthens government systems (reflecting the use of government systems and flexibility in funding, i.e. lack of earmarking); and (ii) the extent to which the allocation of resources is aligned to government

priorities (as set out in the health sector strategy) or whether it distorts the pattern of resource allocation. *Improved* allocation is, therefore, used here in the sense that allocation is more in line with government priorities and not against any objective measure such as burden of disease or cost effectiveness.

Figure 1. Mapping GHPs against alignment and systems criteria



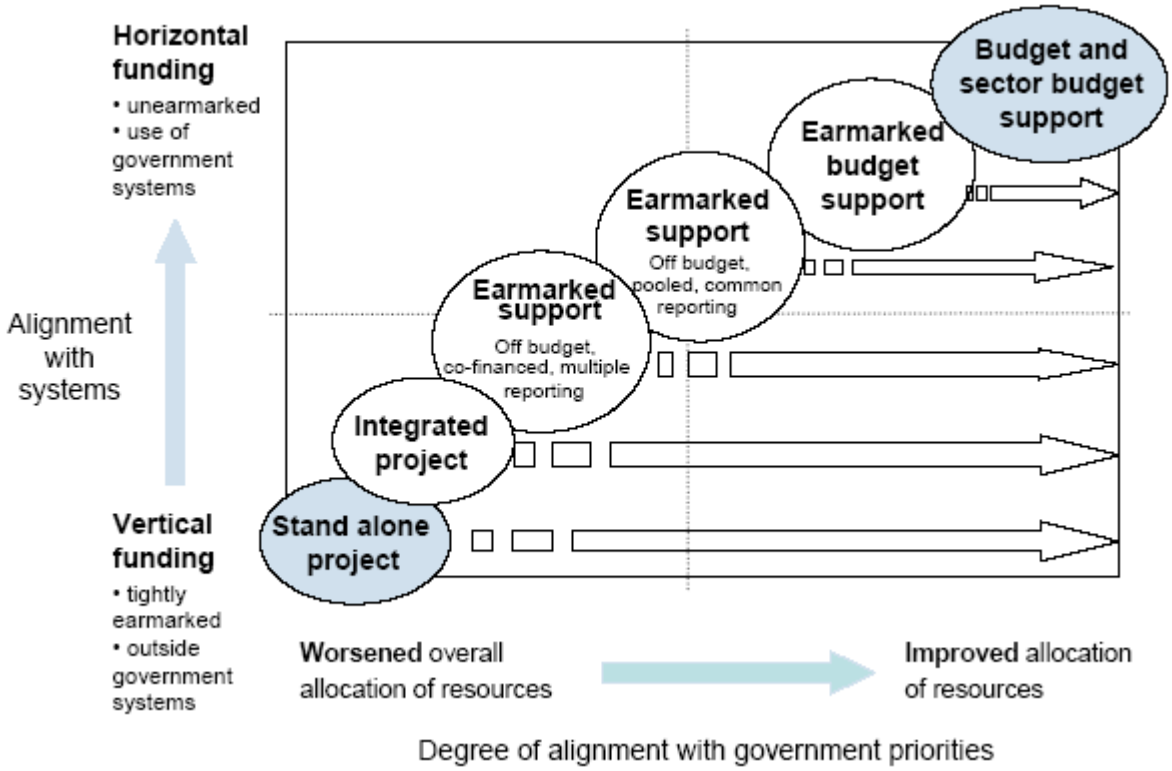
The framework implies that the best way of strengthening health systems is to make as much use of government systems as possible and to ensure the allocation of resources reflects national, rather than donor-led, priorities. This does not suggest that budget support will always be the best approach[14] but that a drawback of alternative approaches is that they may have a limited, and sometimes harmful, effect on the development of sustainable health systems.

In Figure 1, the position of GHPs (or GHP supported activities) represents the extent to which they support health systems strengthening. In short, the horizontal axis asks whether the financing instrument is *supporting the right things*; the vertical axis whether it is *doing things right.* The figure illustrates a situation in which different GHPs provide different levels of funds (reflected in their size), employ various degrees of earmarking and use of government systems (determining their vertical position), and have different effects on resource allocation patterns (determining the horizontal position). The key questions to consider are: a) whether, and how, they can move up and/or to the right as they must if they are to strengthen systems as a whole; and b) if they can, whether they should – reflecting the trade-offs between meeting GHP objectives and broader health systems strengthening.

Figure 2 illustrates the deployment of different aid modalities (e.g. from stand-alone projects to full budget support) which might be used by all donors including GHPs. It shows the differing impacts they may have on the overall allocation of resources in the sector and the extent to which they strengthen systems.[15] It shows, for example, that while general budget support will *always* be aligned with government priorities and systems, projects *may* be aligned with government priorities (as shown by the arrow) but are likely to make less use of national systems.

Local context, however, remains important. It is unreasonable, for example, to expect the GHPs to be using more flexible modalities than other donors in a particular setting; one might, however, expect them to at least seek to match the flexibility of instruments already in place.

Figure 2. Mapping different aid instruments against alignment and systems criteria



3. Findings

Supporting the right things: is GHP support aligned with national priorities and the burden of disease?

The findings suggest that aid flows for health and HIV have not been closely aligned to Cambodian health priorities or the burden of disease.[16 17] The National Strategic Development Plan (NSDP)[18] set out the intention of spending the majority of health resources on primary health care, including the expansion of the Minimum Package of Activities and Complementary Package of Activities over the period 2003-05. In practice, around 60% of donor funding has been allocated to HIV and other infectious diseases. This misalignment is likely to have increased as the GFATM has approved grants for over $85 million since 2005.

In almost all countries the share of donor support for HIV is higher than the share of the burden of disease.[19] Cambodia is no exception, with a share of donor support exceeding by over 30% the share of the HIV burden.[20, 21] HIV prevalence has recently decreased (from an estimated 1.5% in 2001 to 0.8% in 2007)[22] as HIV funding has increased, so the imbalance is likely to have become larger (this refers to an imbalance within the sector and does not imply that there is sufficient funding to meet Cambodia's HIV targets).

The study also found that donor support created imbalances *within* and *between* programmes. In this respect Country Coordinating Mechanisms, Principal Recipient and sub-Principal Recipient arrangements effectively drive where resources, particularly external ones, flow within programmes, sometimes with irrational consequences. For example, informants argued that because of institutional rivalries over control of funds, the prevention of mother to child transmission (PMTCT) programme was inadequately funded. Hence, despite a well funded AIDS programme – it is estimated that only 25-41% of HIV positive pregnant women received PMTCT.[23]

Positive impacts of GHP financing on health systems

Despite the lack of hard data, examples given by the informants suggest that GHP funding has had some positive impacts on health systems. For instance, by supporting the establishment of laboratory and x-ray

facilities across national programmes and in six referral hospitals, which are being used to provide a wide range of services; strengthening antenatal care through the PMTCT programme, which has increased deliveries in health care facilities; increasing utilisation of the public sector health system; providing training in opportunistic infection management to health workers, which has cross-over value for a broad range of health conditions; and strengthening of general paediatric services through paediatric AIDS care sites.

In some cases the benefits have been intentional, reflecting the way in which the programmes were designed, in others they have been unintentional, for example through decisions at the operational level by hospital directors which promoted a more horizontal approach (e.g. bonuses were shared between all staff and not just those working on disease programmes as had been planned).

At the time of the study, the GAVI Alliance HSS activities had only come on stream for three months, so implementation and experience were limited. Nonetheless there appeared to be widespread support for the new funding stream. Its benefits include developing the capacity and building blocks for health systems strengthening from the bottom up; linking immunisation planning, management and delivery to the planning and delivery of other primary health care services; linking with other initiatives in the sector (e.g. provincial level HSS supported by the GFATM); linking incentives to results; and paying salary supplements in line with prevailing government norms.

Negative impacts of GHP financing on health systems.

The negative impacts identified are widely dispersed and difficult to quantify. The GHPs have not necessarily created these problems; rather they have exacerbated them through the scale of their support and approaches to delivering aid. This is particularly notable in relation to salary supplementation, where inducements supported by GFATM grants, although not outrageously high, have been out of line with those paid by other donors (although little hard data is available to substantiate this). The GAVI Alliance's HSS grant, on the other hand, aligned its level of support with one of the government supplementation schemes. Informants raised concerns about the strong incentives such supplements create to favour the delivery of one service over another. GHPs have also contributed to fragmentation of the sector by developing parallel systems. The National Centre for HIV/AIDS, Dermatology and STDs (NCHADS), for example, has established its own system for procurement of anti retroviral drugs.[24]

4. Could GHPs have done more to strengthen health systems?

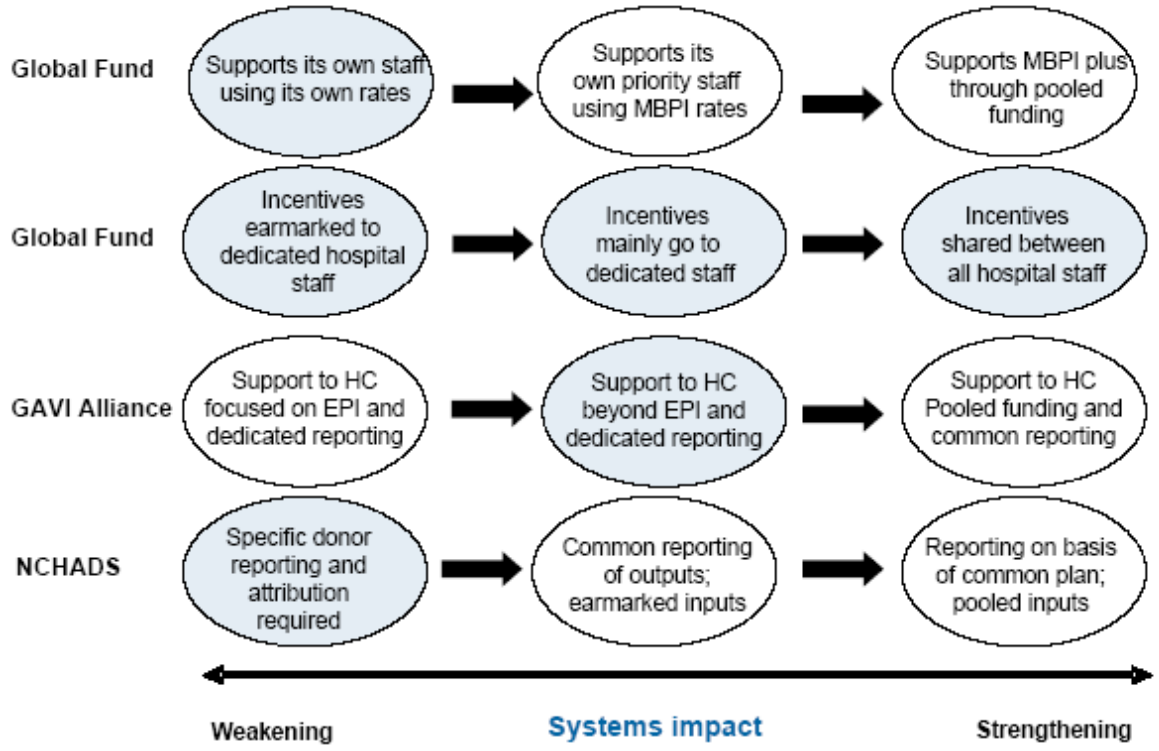
It is increasingly well established that GHP resources which support activities for disease-specific outcomes also ought to generate positive synergies for health systems.[25] In the context of this study, obtaining hard data on the actual impact of the GHPs on health systems was almost impossible. However, twelve practices or activities supported by GHPs were reviewed and compared with what might have constituted a horizontal approach. What emerged from the review was that opportunities had been missed which could have been exploited to strengthen health systems.

For example, the GFATM might have supported the government's strategy (and scales) to salary supplementation for public servants (the Merit Based Pay Initiative – MBPI) by providing pooled funding to the initiative as a whole. In practice, the GFATM supported staff working on specific programmes at its own (higher) rates. An intermediate approach would have been to support only Fund-identified programme staff (not necessarily those chosen as part of the MBPI process) but to use existing MBPI rates.

In 2003, NCHADS and partners launched the Continuum of Care (CoC) programme to increase access for antiretroviral therapy (ART) and opportunistic infection (OI) services for persons living with HIV, which included incentive payments to health care providers supported by the GFATM and other partners. The CoC guidelines recommended a team of seven staff, receiving a salary incentive of $60 per month each. The intention was to offer training to staff who would be dedicated to ART/OI for three-four days per week. In practice this caused morale problems and some facilities chose to share the allocation between all staff. In effect, this has resulted in a more horizontal approach in spite of the intended policy rather than because of it.

Four of these examples are presented in Figure 3. The figure maps actual GHP practices (in blue; in the case of the second example all three practices were adopted by the GHP) against what would have constituted a horizontal approach (in the right hand column). The picture is mixed; in some cases a horizontal approach was adopted, in others not. In other words, opportunities have been missed which could have been exploited to strengthen health systems.

Figure 3. The systems impact of GHP financing: four examples



Note: MBPI: Merit Based Pay Initiative; HC: health centres; EPI: expanded programme on immunization; NCHADS: National Centre for HIV/AIDS, Dermatology and STDs

5. Constraints to developing more horizontal approaches

Despite explicit corporate initiatives by the GFATM and GAVI to strengthen health systems, the research identified five primary constraints to doing so more effectively and systematically in Cambodia.

1) GHP funding channels hinder healthy aid relationships by not supporting the SWAp arrangements. The failure of the GHPs to harmonize and align has undermined an effective sector wide approach. The main organisational beneficiaries of GHP funds – the disease programmes and/or GFATM Principal and Sub Recipients – lack incentives to engage in sector planning processes as they are almost fully funded from external sources. The arrangements have negative consequences for the quality, balance, and inclusiveness of the sector strategy. The GHPs will need to find ways to support the SWiM, ideally by co-financing the Health Sector Support Project 2 (HSP2), or by providing parallel financing in a harmonised way.

HSP2 offered the GFATM an opportunity to align with government priorities by supporting the establishment of provincial block grants and health equity funds – genuine systems strengthening activities. The 2007 Cambodia Health Sector Review[26] suggested that the GFATM consider supporting health equity funds as part of its future programmes, with the more flexible pooled donors acting increasingly as 'lenders of last resort' for programmes less attractive to the GHPs. This opportunity seems to have been missed, and disease specific applications for GFATM grants are still being developed.

2) Institutional arrangements. Institutional interests and arrangements appear to constrain GHP support for the HSP2. For example, informants reported that the Country Coordinating Committee (CCC) has a vested interest in keeping certain items off the agenda which can undermine support for horizontal initiatives or harmonisation and alignment – salary support being an example frequently cited. Additionally it was argued that because of the GFATM-related benefits to CCC members, the CCC is less concerned with identifying HSS opportunities or addressing negative externalities of disease specific programmes.

3) Physical constraints. The lack of GHP country presence is an obstacle to harmonization, alignment and support for horizontal initiatives as it is difficult for major GHPs to be involved in policy dialogue on

pooled funded approaches. Silent partner arrangements can help alleviate this problem but more fundamental changes in the way the GFATM operates are still required. For example, it could participate in the Joint Annual Performance Review process rather than having separate missions.

4) Limited flexibility in GHP approach constrains horizontal approaches. Informants were broadly supportive of the short term focus on performance in GHP programmes, but noted the difficulty − for example of fixed five year grant agreements with the GFATM − of making the changes needed to accommodate or exploit opportunities for more horizontal approaches which arise in the mid-term.

5) Lack of strategic information for alignment. The national programmes supported through GHP funding should not be punished for their success, and their achievements need to be safeguarded. Yet future GHP allocations should not be allowed to exacerbate the misalignment between available resources and country priorities. This would further displace the fiscal space the government needs to implement HSP 2. It is difficult to see the case for further large disease-specific programme grants in Cambodia. However, the GFATM seems to have no mechanism for assessing whether or not programmes are over-funded given competing needs in the sector (it appears that GFATM Technical Review Panel lacks sufficient information to ensure a more balanced resource allocation). Such mechanism might have prevented the growing degree of misalignment between country priorities and donor allocations.

6. Conclusions and recommendations

Cambodia has successfully attracted GHP funding; this has been used to support disease-specific programmes that have achieved successful results and appear to have had some positive impacts on the country's health system. However, disease-specific programmes attract financial resources away from other government efforts,[27] and in the case of Cambodia, have contributed to a large and growing misalignment between donor support and country priorities. The operation of these programmes, independent from other government structures and systems has undoubtedly served to undermine accountability. The earmarking and additionality requirements of GHPs are fundamentally at odds with alignment. It is difficult to see how this might change in the absence of any mechanism for global resource allocation, and systems to prevent additional support being given to countries (and programmes) which are already over-funded in relative terms. Another issue is the distortion in the allocation of resources to which they (and other donors) have contributed. The challenge is to ensure the GHPs and other development partners do the right things, and do them well – including the provision of support to emerging horizontal initiatives in the sector.

We present three key recommendations:

- Any future GHP grants must be harmonised and aligned with current efforts to develop the SWiM approach. In Cambodia, the HSP 2 provides promising vehicles for the GFATM and GAVI Alliance to better align and harmonize their support behind HSS initiatives. More broadly, where sector wide approaches (or co-financing arrangements) are in place or emerging, grant proposals should be required to provide compelling reasons why GHP funds should not be disbursed through such channels.

- The GHPs need to be thinking ahead about how to amend their approaches in line with emerging reforms at country level. In Cambodia, large scale funding through national programmes is likely to run counter to efforts to develop a provincial block grant approach. Integration will not be simple and will need to be properly planned to ensure that performance is not adversely affected. This will be extremely challenging for a development partner with no country presence.

- GHPs need to give stronger global messages about harmonization and alignment. These messages need to be reflected in their structures and processes, for example, in terms of incentives for operational staff or guidance to the GFATM Technical Review Panel (TRP) as well as the composition of the TRP membership. Donors at global level – through Board representation and other fora – will have a key role to play in making this happen.

The International Health Partnership in Cambodia will be an important test for all signatories, including the GFATM and the GAVI Alliance. The design of HSP 2 has now been completed; the GFATM in particular needs to find ways of buying into it. If the GFATM is unable to support HSP 2, serious questions about the nature of its commitment or ability to support the IHP Compact[28] will be asked.

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