EAS Briefing Note 1

Evidence Advisory System Briefing Notes: Cambodia

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GETTING RESEARCH INTO HEALTH POLICY AND PRACTICE

GRIPHEALTH

Contents

1 Introduction

There has been a growing global concern for improving the use of evidence to inform health policy in recent years. Increasingly there is recognition that individual projects or programmes building evidence synthesis skills, may be limited in their effect without a broader consideration of the systems in place which 'embed' or 'institutionalise' evidence informed policy making practices (Alliance for Health Policy and Systems Research and WHO 2007).

The GRIP-Health programme is a five-year project supported by the European Research Council which studies the political nature of health policy to understand how to best improve the use of evidence. This explicitly political lens enables us to focus on the contested nature of health issues as well as the institutions that shape the use of evidence in health policy making. We understand institutions as including both formal structures and rules, as well as informal norms and practices (Lowndes and Roberts 2013). The GRIP- Health programme follows the World Health Organisation's view that Ministries of Health remain the ultimate stewards of a nation's health, and further play a key role in providing information to guide health decisions (World Health Organization 2000, Alvarez-Rosette, Hawkins et al. 2013). As such, GRIP-Health is particularly concerned with the structures and rules created by government to gather, synthesise, or otherwise provide evidence to inform policy-making.

This working paper is one of a series of six briefs covering a set of countries in which the GRIP-Health programme is undertaking research. This brief presents an overview of what is termed the 'Evidence Advisory System' (EAS) for health policy-making within the country of interest, which is taken to encompass the key entry points through which research evidence can make its way into relevant health policy decisions. This can include both formal (government mandated) and informal structures, rules, and norms in place.

Individual reports in this series can be useful for those considering how to improve evidence use in specific country settings, while taken together the reports identify the differences that can be seen across contexts, permitting reflection or comparison across countries about how evidence advisory systems are structured – including which responsibilities are given to different types of bodies, and how well evidence advice aligns with decision making authority structures.

This paper describes the Evidence Advisory System (EAS) for health policy-making in Cambodia, a lower middle-income country in Southeast Asia, and a member of the Association of Southeast Asian Nations (ASEAN). Compiling this work involved drawing on a variety of sources, but particularly useful has been a report by Jones (2013) written for the Overseas Development Institute (ODI), entitled: *Building political ownership and technical leadership: Decision-making, political economy and knowledge use in the health sector in Cambodia* (Jones 2013). We also have drawn on insights provided by several key informants interviewed in the country with a knowledge of the health sector.

Cambodia is a unitary state with some ongoing efforts towards administrative and political decentralisation which affects health policy-making and planning, but with a great deal of authority remaining in the hands of the national Ministry of Health (MoH). Although one of the principles of the Annual Operational Plan 2008-2015 is for a 'participatory process' (Ministry of Health 2008), decision-making in the MoH is generally hierarchical. Cambodia is also a recipient of high levels of international donor aid, which has significant implications for policy-making including in regard to the use of evidence. Cambodia's political history, particularly the period of rule under the Khmer Rouge in the 1970s, also has had important impacts on the level of bureaucratic and academic expertise that the country has had to build upon in recent decades.

Whilst there appears to be a demand for evidence and research in health policy-making in Cambodia, this demand is not well institutionalised or embedded in the MoH. A considerable amount of research is produced in the sector in the form of reviews and assessments for specific projects or programmes. This work is often conducted by commissioned consultancies, and is perceived by Jones (2013) to be of variable quality (Jones 2013). Some information types are institutionalised through for example, the annual operational plan (AOP) process and the health management information system (HMIS), but these are largely considered to be tokenistic measures. The domestic research community is relatively weak in regard to health, particularly due to limited funding and the low strategic importance accorded research by political and policy actors in the health sector (Jones 2013).

In general, the EAS for health policy-making in Cambodia thus appears to be somewhat fragmented and lacking capacity in areas that might provide policy-relevant evidence to particular policy decision points in the country. There is a lack of strategy in the handling of the evidence and knowledge base for the health sector, and management and decision-making based on research evidence and analysis is largely absent from health policy-making and service delivery. However, policy makers are aware of the need to develop a research agenda for the sector, and some MoH working groups have seriously considered the issue.

2 Background

Cambodia has a population of 15.6 million people as of 2015, and is classified by the World Bank as a lower middle-income country, with a per-capita GDP of US$1159 (The World Bank 2016, The World Bank 2016). The country was once the centre of a thriving Khmer empire, but its recent history has included several particularly troubling periods.

Between 1867 and 1953 Cambodia was under French colonial rule, gaining full independence in 1953. An extended period of civil war followed, including the genocidal Khmer Rouge regime which was in power between 1975 and 1979, and which purged many educated classes within its broader actions. It was not until the Paris Peace Accords in 1991 that a cease fire was imposed, mandating democratic elections. The UN-sponsored elections in 1993 helped restore some semblance of normalcy under a coalition government. Factional fighting ended the first coalition government, but a second round of elections in 1998 led to the formation of another coalition government and renewed political stability. Since this time, there have been elections

in 2003, 2008 and 2013, and power has been in the hands of Prime Minister Hun Sen and the Cambodia People's Party (Young 2013, Central Intelligence Agency 2016, The World Bank 2016).

The country's ruling elite have now been in power for over 30 years. While there is no consensus on how they have retained power throughout the transition to an electoral democracy, some scholars have suggested this is due to a complex, culturally-specific patronage system that underpins the political system (Petersson 2015).

Cambodia's national institutions have undergone marked changes with the changes to its political regimes (Tey, Narith et al. 2015). Today, Cambodia is a constitutional monarchy, with the Prime Minster as the Head of Government and a Monarch as Head of State. Executive power is exercised by the Prime Minister. The legislative branch of the Cambodian government is made up of two chambers of parliament, the National Assembly and the Senate. The judicial branch is independent from the rest of government, as specified in the constitution; however, until 1997 the country did not have a judicial branch of government despite it being a requirement of the constitution (Cohen and Lee 2011, McCarthy and Un 2015).

Cambodia has experienced consistently strong annual growth over recent decades, arguably the fastest amongst post-conflict societies, with average GDP growth rates of over 8% between 2000 and 2010, and over 7% since 2011. The bulk of this growth has come from the tourism, garment, construction and real estate, and agriculture sectors (Central Intelligence Agency 2016). With this rapid economic growth has come the creation of employment opportunities, and poverty has subsequently declined considerably, from approximately 48% in 2007 to 19% in 2012 (Asian Development Bank 2014).

Along with strong economic growth, Cambodia has undergone significant progress in health and other social sectors in recent decades; for example, substantial improvements have been made in maternal health, early child care, and primary education in rural areas. The maternal mortality ratio of deaths per 100,000 live births declined from 472 in 2005 to 170 in 2014, and under-five mortality rate decreased from 83 per 1000 live births in 2005 to 35 per 1000 live births in 2014. Cambodia has also been seen to be successful in combatting HIV/AIDS, tuberculosis and malaria (The World Bank 2015). For example, adult HIV prevalence peaked at 2.0% in 1998, but by 2013 had fallen to an estimated 0.7% (Vun, Fujita et al. 2014, UNAIDS 2015). However, despite such improvements, Cambodia remains one of the poorest countries in Asia, and still faces many challenges. The country has been accused of suffering from widespread corruption, with resources, including development aid, "in a constant risk of being directed to sustain the patronage networks that keep the ruling elite in power" according to one report (Petersson 2015). Whilst 'poverty' declined to below a fifth of the population (Asian Development Bank 2014), three quarters of the population remain poor or 'near poor' – below or just marginally above the poverty line (Ear 2012). The majority (about 90%) of those in poverty live in the countryside (Hill and Menon 2013, The World Bank 2015). Thirty-two percent (or approximately 0.5 million) of children under age five are stunted, 82% (12.2 million) of the population do not have access to a piped water supply, and 63% (9.3 million) do not have access to appropriate sanitation (The World Bank 2015).

According to the Demographic and Health Survey 2014, health care provision in Cambodia is predominantly undertaken by the private sector (National Institute of Statistics, Directorate for Health et al. 2015). National demographic and health surveys suggest that approximately one-fifth of treatments are carried out by the public sector, half by private hospitals, clinics, pharmacies and private consultations with trained health workers, and a further fifth by the non-medical sector (mainly shops and markets). This is the case in both urban and rural areas. Estimates vary, but survey data suggest two-thirds of health spending is financed by consumer out-of-pocket payments (National Institute of Statistics, Directorate for Health et al. 2015).

Today there are three main levels of the Cambodian health system. These are the central level, which consists of the MOH, national institutes, national hospitals, national programs, and training institutions; the second level, which consists of the Provincial Health Departments and referral hospitals in provinces; and the third level, which consists of the operational districts (ODs), themselves made up of a referral hospital and a network of health centres (Ministry of Health 2008, Jones 2013).

3 Primary decision making points for health

While there is a general use of terminology such as 'Evidence Based Policy' or 'Evidence Informed Policy' in the health sector, what 'policy' is, is all but unambiguous. Indeed there is no single definition of policy – with a range of concepts from projects and programmes, to sector-specific plans, to broad statements of intent all considered policy at times (Hogwood and Gunn 1984). Policy is also not allocated to a single body; rather, policy decisions affecting health can take place across a range of governmental levels and create a complex process of negotiation between different authorities.

This lack of a universal object of study complicates policy research. However, there are some types of decisions common to many countries' health sectors, for which research evidence is often held as critical. This allows a basic classification of decision types to provide at least a starting point for comparisons of country evidence advisory systems, as follows:

- Public Health and Health Promotion: Usually high level decisions affecting large segments of the population. Can involve agencies outside the health service and broader sectoral interests. Often the responsibility of national legislatures, ministries of health, or devolved authorities. Common examples: tobacco control, occupational health, healthy eating, sanitation, etc. A broad range of evidence will be relevant to such decisions, including epidemiological, economic, social attitude, and others which speak to relevant decision criteria.
- Health Service Priority Setting and Management: Decisions concerned with the allocation of resources across the health system or the structure of service provision and funding, including priorities within the system. Often the responsibility of Ministries of Health or national health services. Common examples: health system priorities, health worker responsibilities, resource generation or allocation decisions, etc. Relevant evidence forms include health technology appraisals/assessments (HTA), epidemiological and clinical studies, health services research etc.
- Programme Planning: Decisions within the remit of specialised agencies, such as programmes dedicated to individual conditions (malaria, HIV, cancer, etc.). Decisions within these bodies often require evidence both about efficacy or cost effectiveness of different prevention and treatment options, but equally often are informed by locally generated data (e.g. routine data from surveillance or facility information).
- Service Provider Decision Making is the most specific and tailored to individual cases. It can be health centre or hospital policies, or individual clinician decisions about patient care. Relevant evidence may include specific case details or specific realities of the context as well as more top-down use of guidelines.

In addition to these types of health decisions, this working paper also recognises that decision making for health can take place at different levels within government hierarchies, with authority for decisions, and entry points for evidence resting in: national level bodies, sub-national (regional) level bodies, and local level bodies at times. In different country settings the various decision types listed above might be addressed at any of these three levels or may cut across more than one level. For instance, at the national level, the Ministry of Health usually functions as a decision point for certain types of decisions, but movements towards de-centralisation might lead to the shifting of decision-making from national levels to sub-national or local levels (England is a case study of that). This permits consideration of whether systems of evidentiary advice are well aligned with the decision authority structures in a setting. There can also be important considerations on the ways that national evidence systems link to influential non-state decision makers (e.g. development partners in low and middle income settings, or corporate bodies granted authority for health policy decisions).

3.1 National Bodies

According to the MoH, the central (national) level is where policy, legislation, strategic planning, and resource allocation takes place for the health sector (Ministry of Health 2008).

3.1.1. Legislature

Cambodia has a bicameral Parliament consisting of the Senate and the National Assembly. The National Assembly is elected for a five-year term by proportional representation. The members of the Senate are appointed by the King or the National Assembly, or elected by the commune councillors of the country's provinces. The legislature makes health decisions that are captured in laws and approves official budget allocation (Tey, Narith et al. 2015), while executive regulations (such as royal decrees, sub-decrees, and proclamations) are proposed by relevant ministries or the Council of Ministers (Peng, Phallack et al. 2012).

Besides law-making, the Parliament is also responsible for holding the Government to account in respect of its policies and administration. In terms of health policy, the Parliament approves sectoral budgets, mobilizes and allocates resources, and exercises advocacy, but its capacity is constrained in several respects. For instance, the role of the Parliament in influencing national policy is, according to Tsekpo & Hudson (2009), limited by institutional resource constraints, such as an independent Budget Office, and by its constrained capacity to debate Government budget and scrutinize relevant evidence due to inadequate structures and capacities (Tsekpo and Hudson 2009).

3.1.1 Ministry of Health

The Ministry of Health (MoH) is a Cabinet ministry and the Minister is nominated by the Prime Minister and formally appointed by the King of Cambodia with the approval of the National Assembly. The MoH has the mandate to monitor the country's health status, advise central government on health policies and legislation, formulate strategies and develop programmes to address the country's health problems, and implement, monitor and evaluate all health programmes and activities in the country in collaboration with other sectors and agencies.

The MoH contains three general directorates: the Directorate General for Health; the Directorate General for Administration and Finance; and the Directorate General for Inspection. The key technical body in the MoH is the Directorate General for Health, which has responsibility for eight departments with different roles and responsibilities, including the Department of Planning and Health Information (DPHI), the Department of Health Prevention *(sic)* (DHP), the Department of Hospital Services (DPS), the Department of Human Resource (DHR), the Department of Essential Drug and Food (DDF), the Department of Communicable Disease Control (CDC), the Department of International Cooperation (DIC), and the Department of International Audit (DIA).

Inter-ministerial collaboration is reportedly difficult in Cambodia, with no clear legal basis or consistent practice for how inter-ministerial bodies should be established, responsibility divided, and incentives shared. Where inter-ministerial cooperation has appeared around health policy issues, it has been through the establishment of an inter-ministerial committee or

working group (e.g. food security and nutrition national committee), often initiated by donors (Jones 2013).

3.1.2 Other National Bodies

Besides the MoH, there are numerous national programmes, centres and institutions important to the Cambodian health system, including the National Maternal and Child Health Centre (NMCH), the National Centre for HIV/AIDS, Dermatology and STD (NCHADS) and the National Institute of Public Health (NIPH). These technical health departments and national centres sit within the MoH structure, and can initiate specific health policies or guidelines (Jones 2013). The Ministry of Economics and Finance (MEF) stands out as one of the most important other decision making bodies in Cambodia affecting health. It is responsible for financing the health system, and particularly important for health policy decisions with budgetary or financial implications in the country.

3.2 Sub-National Bodies

Below the MoH are its line departments: Provincial Health Departments (PHD), Operational Districts (OD), Referral Hospitals and Health Centres.

The PHDs liaise with the MoH and are responsible for interpreting and implementing policies and programmes. PHDs also support the ODs with service delivery and resource allocation through in-service training, monitoring and evaluation, and coordination. Health centres are health facilities closest to the community, and provide basic health services. Referral hospitals provide more comprehensive services (Song and Hohmann 2003).

Systems are in place to capture and channel feedback to the MoH from implementers at PHD and lower levels, however Jones (2013) has said that it is unclear whether and the extent to which this is resulting in the communication of valuable information and insights (Jones 2013).

3.3 Development Partners

International development partners (DPs or donors) are highly influential in the Cambodian health sector as a large proportion of the budget is funded by aid (about 52% of the health budget (Bank 2011)). The Council for the Development of Cambodia (CDC), chaired by the Prime Minister and composed of senior ministers from several government agencies, is an interface between DPs and the government across a range of sectors. It is the highest decision-making level of the government for private and public sector investment (Council for the Development of Cambodia, Cambodian Investment Board et al. 2016).

3.4 Summary

Table 1 summarises the key decision-making points for health policy-making in Cambodia.

Table.1 Institutional responsibility for decision-making in the Cambodian health sector

Function	**Responsibility**
Financing of the health system	MEF
Allocation of finances between priority areas	MEF; parliament; MOH DG for Administration and Finance
Broad health policy-making	MoH (particularly the Minister, 6-7 Secretaries of State, and the 2 Directors of Departments; and the DG for Health)
Specific health intervention policies	MoH (particularly the Minister, 6-7 Secretaries of State, and the 2 Directors of Departments; and the DG for Health)
Specific health services decisions*	MoH (particularly the Minister, 6-7 Secretaries of State, and the 2 Directors of Departments; and the DG for Health), and the Provincial Health Departments and Operational Districts

* Above practitioner-level.

Acronyms: DG = Directorate General; MEF = Ministry of Economy and Finance

4 Entry points for research evidence – The evidence advisory system

For research evidence to inform policy, it must have a conduit through which it can reach decision makers who might be usefully informed by it. There may be a wide range of structures and norms in place, both formal and informal, which, taken together, form the evidence advisory system for health decision making. Taking as our starting point the stewardship role of Ministries of Health (and, by extension, national legislatures which govern ministries), we separate between:

1. 'Formal systems'– taken here to represent the officially mandated agencies tasked with evidence synthesis and provision for decision making processes. These can be within national governments (for example, Ministry of Health Research Departments), Semi-autonomous bodies (such as the National Institute of Health and Care Excellence – NICE – in the UK), or independent agencies, so long as they have a formal mandate to provide evidence to inform policy; and

2. 'Informal systems' – representing the systems of evidence provision that are not dictated by any formal decree or rule to provide evidence, but which are found to play important roles in evidence provision.

4.1 Formal systems (including rules for evidence synthesis)

4.1.1 Ministry of Health.

The bureaucratic structures within the Ministry of Health (MoH) provide the most obvious places where comparative evidence of intervention effectiveness for specific health issues can be used to guide health programme allocation. That said, there appear to be significant capacity limitations in programme offices to play this role fully. There is some acknowledgement and limited institutionalisation of the promotion of the use of evidence in policy-making within the MoH (Ministry of Health 2007), but the supply of policy-relevant data has been identified by Jones (2013) as a concern (Jones 2013). The Health Management Information System (HMIS) is the country's most prominent source of data and evidence on health service delivery in the country to guide decision-making (Jones 2013).

4.1.2 Technical Working Groups

In 2004, to promote aid effectiveness and policy dialogue, the Cambodian government and donor agencies established the Government-Donor Coordination Committee (GDCC). The GDCC oversees 19 Technical Working Groups (TWGs) focused on specific thematic areas. The TWGs have a broad and inclusive membership, with sub-national and civil-society representation, and meet monthly. They are a forum for discussion of issues, strategies and new research, but their effectiveness in doing this is considered variable. TWGs have no veto power, but have a gatekeeping role, ensuring that policy is in line with national priorities.

The Technical Working Group for Health (TWGH) and its sub-groups working on specific health-related issues (e.g. maternal and child health, communicable diseases, non-communicable diseases, and health system strengthening) are co-chaired by the Minister of Health (or a Secretary of State) and the WHO country representative, with representation from, for example, different MoH Departments, the NIPH, and large hospitals. The TWGH and its sub-groups play an important part in the health-policy making process. Major policies and strategies are first presented and discussed in a series of meetings within the relevant TWG subgroups, which then report to the main TWG. However, the final products are decided by people with decision-making authority within the MoH. National-level health policies and cross-ministerial issues require endorsement from a higher-level authority in the Government.

There are also other ad hoc working groups, committees and tasks forces, which develop guidelines or policy on specific health issues and report to the main TWGH. The entry points for research evidence from such groups are through institutions such as the Department of Planning and Health Information (DPHI), although Jones 2013 reports that their capacity in this role is limited (Jones 2013).

4.1.3 Other National Bodies

Some influential surveys providing evidence relevant to health policy-making have been conducted under the leadership of the Ministry of Planning (MoP), for example the Cambodia Demographic and Health Survey (CDHS) which was conducted in 2008, 2010, and 2014, the Socio-Economic Survey, which was most recently conducted in 2008, and the population census in 2008. Despite some shortcomings, these are generally considered a reputable source of information by government and DPs for the formulation of policy (Jones 2013).

In terms of technical bodies, the National Institute for Public Health (NIPH) is one of the most notable within the Cambodian system. The NIPH is a semi-autonomous institute under the MoH with a mandate to undertake research, knowledge translation, and training – although it has reportedly largely focused on training, as no budget has been provided for research activities. Given these resource constraints, including limited staffing capacity, the NIPH is not currently considered a strong player in the domestic research community. However, it does appear to have a clear mandate to serve an evidence advisory role, and according to Jones (2013), it is perceived to be credible within government (Jones 2013).

In terms of policy decisions with important financial implications, the Supreme National Economic Council (SNEC), part of the MEF, advises the Prime Minister on economic issues. The SNEC is considered to have conducted some influential research and been involved in the development of some key policies. It is both well-funded (having been supported by a number of donor agencies such as UNDP, ADB and the World Bank), and given its connections to the Prime Minister, strongly embedded in high-level decision-making. However, currently there are no health specialists in SNEC, and it has limited capacity and only a small number of qualified researchers (Jones 2013).

In terms of donor-funded evidence use, research projects are often focussed on programme evaluation. They have often been critiqued for lacking coordination, resulting in duplications of efforts and inefficient use of resources, and lacking integration in terms of data collection and analysis (Jones 2013). Prior to each monthly TWGH meeting is a meeting of the major DPs, called the Health Partners Meeting. This meeting is chaired by representatives of the World Health Organization, and brings together various NGOs and DPs so that they can improve coordination and, at least in theory, present a common voice at the TWGH.

Key in-country informants also explained that development partners have developed a donor consortium to support the Health Sector Support Programme (HSSP) – a joint donor initiative to fund at least part of the health sector plan, said to be highly influential. These groups provide further opportunities to share research evidence and discuss health policy proposals (ReBUILD Consortium 2016)(Personal Communication, May 2016).

4.1.4 Sub-National Bodies

According to Jones (2013), systems are in place to channel feedback from implementers at Provincial Health Departments (PHDs) and lower levels, however it is unclear whether this has much influence in informing policy decisions-making. PHDs and their lower-level vertical links (ODs and health centres) are also required to send regular reports to the Ministry, reports that

reportedly have focused largely on the challenges of meeting performance targets and the lack of incentives for health staff, rather than reporting health problems or presenting ideas on how to improve programme design and delivery (Jones 2013).

4.1.5 Non-Governmental Bodies

Various non-governmental organisations (NGOs) are also relatively well institutionalised as a source of data and evidence for the health sector; however, they also face resource constraints, and are often not well integrated into decision-making systems. For instance, Jones (2013) describes the Cambodia Development Resource Institute (CDRI) as a major research institute outside of Government, with a programme of work in the health sector. However, it has reportedly experienced capacity issues, and problems obtaining information, clearances, and collaboration from MoH staff. It has also reportedly demonstrated insufficient understanding of decision-making in the MoH, which hampers its ability to conduct relevant and influential work (Jones 2013).

MEDiCAM is an umbrella organisation that aims to coordinate the activities of member NGOs in the health sector, provide a focal point to strengthen links between civil society and the government, and maintain a central repository of evidence relevant to the health sector (Medicam 2016). It is considered to be relatively well embedded in decision-making processes, with membership of key policy-making bodies such as the TWG Secretariat; however, key in-country informants explained that its research team is relatively small, and it currently works more like a freelance consulting firm looking for research partners and funding opportunities (Personal Communication, June 2014).

4.2 Informal Systems

There are also some more informal, less institutionalised sources of research evidence that can be useful for policy and planning. The most influential of these, arguably, involves the activities of Development Partners (DPs). This is because, despite not being formally part of the government, DPs have a high level of influence on health-sector agenda-setting and policy-making, contributing to the generation of health data and information in a range of different forms. However, Jones (2013) has argued that the coordination of donor-funded research has been problematic (Jones 2013); critiqued as tending to be aligned with global health objectives rather than national health priorities (Hughes and Conway 2003). A recent literature review found that much research in the past decade in Cambodia has focused on high profile infectious diseases (such as HIV/AIDS, malaria, tuberculosis, and avian influenza), with relatively little addressing health systems and non-communicable diseases, despite the considerable mortality and morbidity burden associated with these (Goyet, Touch et al. 2015).

There are also local academic research centres which can play a role in evidence provision, yet which may not hold formal mandates or agreements to do so. For example, the University of Health Sciences, which has mainly been a training institution for doctors, dentists, and nurses has recently produced a new strategic plan in which they state the intention to strengthen research capacities. However, the domestic research community is relatively weak, with limited

funding, and the perception of low strategic importance of the sector by political and policy actors, which means health experts are not well connected to key decision-makers.

4.3 General comments

A considerable amount of research is produced in the Cambodian health sector, with local research being increasingly productive since 2000 (Goyet, Touch et al. 2015), particularly in the form of reviews and assessments for specific projects and programmes (Jones 2013). Jones (2013) describes how this research, often carried out by commissioned consultancies, is generally initiated and/or conducted,: (i) as projects or programmes implemented by the Government with support from donors and NGOs; (ii) by teams leading periodic reviews of programming such as the Mid-term Review of the Health Strategic Plan; (iii) by NGOs that support specific projects or programmes; and (iv) by universities or research institutes (Jones 2013).

However as noted earlier, there is also concern with the variable quality of research undertaken, and the overall knowledge base is fragmented, with studies often examining issues that fit the specific needs or ideologies of donor and NGO programmes (Jones 2013). There is no evidence of systematic compilation or synthesis of the many studies produced. The DPHI within the MoH is meant to play this role, but financial and technical constraints have prevented it from doing so. MEDiCAM has kept a library to compile research studies, but interviews suggest this has not been updated in recent years. Little provision has been made to improve the collection and relevance of evidence, or to improve communication of findings including through making reports publicly available (Jones 2013).

5 Discussion

This document aims to map the key decision-making points within the Cambodian health system, and the points of entry for policy-relevant evidence. Undertaking this task allows for reflection on whether and how the evidence advisory system as a whole is aligned to ensure that policy-relevant evidence can reach the key decision-making points where it can be of most use. It also, however, allows for identification of strategic challenges and issues that may need to be considered by those wishing to improve the use of evidence for health policy-making in the country.

It is widely noted that the ruling Cambodia People's Party (CPP) dominates the institutions of the state; however, the health sector is not one of the CPP's core interests. This can mean that health decisions have low priority, but it also may mean there is greater scope for the use of evidence in decision-making the sector. For the most part, however, health sector decision-making is considered to be fairly hierarchical and centralised, reflecting the elite patronage system that authors have noted (Un 2005, Jones 2013). As a consequence, there is little

institutionalisation of formal processes for the use of evidence, and the use of evidence has relatively low importance or influence in health sector decision-making (Jones 2013).

Despite some steps towards decentralisation of responsibilities to provincial level, lower levels of the health sector must fulfil vertical reporting requirements to the MoH, and gain national approval in order to make changes to service delivery. However, the capacity of the MoH to influence service delivery is constrained by the allocation of funds – this being a responsibility of the MEF.

In recent years, key developments that have increased the supply of potentially policy-relevant evidence include an increased amount of research produced in the sector, with local research increasingly productive since 2000 (Goyet, Touch et al. 2015), particularly in the form of reviews and assessments for specific projects and programmes (Jones 2013). This has been accompanied by a proliferation of stakeholders producing evidence and attempting to link this evidence to policy processes. However, such even so, such research is often carried out by commissioned consultancies, and initiated and/or conducted: (i) as projects or programmes implemented by the Government with support from donors and NGOs; (ii) by teams leading periodic reviews of programming such as the Mid-term Review of the Health Strategic Plan; (iii) by NGOs that support specific projects or programmes; and (iv) by universities or research institutes (Jones 2013). There is a lack of a clear national policy to support and guide the production and use of health research. Furthermore, according to Jones (2013), the quality of this work varies considerably, and the overall knowledge base in the health sector is fragmented, with studies often addressing issues which fit the specific needs or ideologies of donor and NGO programmes. There is also no apparent systematic compilation or synthesis of the many studies produced. The Department of Planning and Health information (DPHI) within the MoH could in theory play this role, but financial and technical constraints have prevented it from doing so. It was noted in interviews that MEDiCAM has a library to compile studies undertaken, but that this has not been updated in recent years (Jones 2013).

The overall picture is one of a multitude of unrealised opportunities for linking research and policy. Policymakers are aware of the need to develop a research agenda, but are limited by resource constraints – human resource and other institutional constraints. The findings suggest there is considerable scope for improved institutional structures, rules and norms for the provision and uptake of evidence into policy systems in Cambodia. There are many challenges to this, especially given the country's resource constraints, but is an important area for longer-term capacity building.

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