



Review

Malaria intervention in Cambodia: Who benefits from international Aid?

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Abstract

Since the country's liberation in 1979 till the present, the Cambodian Malaria Program (CNM) has undergone many changes; from a state of complete disorganization to having an established structure with international recognition. In 2002, external aid to the CNM has been channeled through the Global Fund (GF), a novel funding agency established as a direct result of the global shift in thinking about the most appropriate funding model for public health in developing countries. With this reshuffle, the CNM has to follow the agenda of the international development agencies and has to embrace the strategy of elimination, even though it may not be in a position to deliver. This has given rise to a dilemma whether the development goal of the CNM should be defined by the country itself or by a program designed by outsiders. The paper describes the evolution of the CNM and it discusses the conflicting roles of three international development agencies attempting to emancipate Cambodians from the scourge of malaria and the structural impairment of the Cambodian government. The paper argues that the Cambodian government manipulates development aid and its citizens in the interest of maintaining the current political patronage. It further argues that international aid on Malaria is doing more harm than good to Cambodia development in the sense that it reinforces and maintains the current political patronage and suppresses social movement.

Keywords: Cambodia, malaria, Global Fund, non-governmental organizations, international development, health policies, patronage, structural impairment, aid pressure.

List of Acronyms and Abbreviations

A+M: Artesunate + Mefloquine; ACT: Artemisinin-based Combination Therapy; CNM: National Malaria Center (or Cambodian Malaria Program); CCC: Country Coordination Committee; CPP: Cambodian People Party; GF: Global Fund to fight HIV/AIDS, Tuberculosis, and Malaria; MC: Malaria Consortium; MoH: Ministry of Health; MoEF: Ministry of Economic and Finance; MBPI: Merit Based Pay Initiative; NHSP: National Health Strategic Plan; OD: Operational Health District; ODA: Official Development Assistance; OIG: Office Inspector General; POC: Priority Operational Cost; PSI: Population Service International; PFD: Partner for Development; NGOs: Non-Governmental Organizations; RDT: Rapid Diagnostic Test; WHO: World Health Organization; UNDP: United Nations Development Program; UNOPS: United Nations Office for Project Services; USAID: United States Agency for International Development.

INTRODUCTION

There is a link between development and malaria intervention programs (Prothero, 2002). 'Development' involves concepts of progress, imported ideologies and political economy, as well as political power. Yet if Hart's (2001) definition of the big 'D' of development is taken as a starting point, which describes it as "the project of intervention in the third world", this link becomes more obvious. Development, as many authors argue (Mosse and Lewis, 2005; Mosse, 2005; Brown and Purcell, 2004), entails intrinsic characteristics of underdevelopment within a nation. It is, therefore, crucial to analyze malaria intervention programs through a development lens, particularly in countries like Cambodia (This research paper is part of a broader interdisciplinary

research program called SOREMA (Society, Resistance and Malaria), as funded by the French National Agency for Research (2012-2014) and which involves scientists from the fields of anthropology, sociology, geography, environment, political development, entomology, epidemiology, biology and history, in an attempt to look at the issues associated with malaria intervention in Cambodia from a different angle, and draw-up a theory on the evolution of the infection, within the growing context of an emergence of anti-malarial drug resistance).

Cambodia is a good place to document the process of 'underdevelopment', for many reasons. First, the country is notorious for its dependence on external aid (Cambodia is aid dependent in the sense of government external funding to almost every public sectors (health, education, rural development...). Such a dependency is further characterized by conflicting roles among international development bodies (Ek and Sok, 2008; Sato, 2011; Godfrey, 2002). Furthermore, Cambodia has been an epicenter of malaria drug resistance since the 1950s (Wongsrichanalai et al., 2002), which makes it a good place to explore international interventions required to prevent its spread to Africa. Lastly, under the current proclamation made by the Cambodian elimination strategy – in line with global strategies of elimination (CNM, 2011; WHO, 2009) – the dynamics of interaction between the global and local have increased, making it necessary to have such dynamics documented.

It was expected that this analysis would fit into the discourse of the politics of international development, and provide a mirror of reflection for state and non-state actors working on malaria intervention programs in Cambodia. A number of papers (On the ground actors (WHO, NGOs) has produced abandoned activity reports, research surveys and strategic papers some for their donors and some as part of their monitoring framework, arguably to inform the result of their works.) have already discussed what is right and wrong with malaria interventions in Cambodia, for example, Global Fund (GF) audit reports, WHO program reviews, and various NGO reports (WHO, 2012; GF, 2013; MC, 2010). Nonetheless, I argue that these papers are biased, and reflect only the actions of others rather than their own, and that they miss some contextual interactions.

This paper discusses the policies and politics of malaria intervention in Cambodia, specifically the key players, including the national body assigned solely to malaria control – the Cambodian National Malaria Center (CNM), plus the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GF), the World Health Organization (WHO), and the "alternative development actors" who are grouped under the label of non-governmental organizations (NGOs). The paper documents the interactions between these key players, and by doing so, analyzes the ongoing process in Cambodia. I discuss inherent characteristics of

development, which is a discourse that by its very nature cannot reach a definite conclusion.

The international malaria program – the aim of which is to emancipate the global south of malaria suffering, arguably out of an act of altruism from the global north's perspective – can be traced to the time when the World Health Assembly launched the global malaria eradication program in 1955 (Jeffery, 1976). This approximately coincided with the declaration to fight world poverty, which some authors argued was when 'development' was inaugurated (Pieterse, 2009). While an earlier period witnessed some international malaria programs, they were the act of colonialists trying to maintain their powers rather than an act of good will; to free the occupied countries from malaria. Specifically, these efforts occurred was due to the weakening of the manpower needed to wage war, most of which lived in malarial habitats (Cleaver, 1977; Shah, 2010).

Developmental research projects in Cambodia, particularly those in the health sector and run by external aid agencies, tend to have disparate priorities (Ek et al., 2008; Godfrey et al., 2002; Nunberg and Taliercio, 2012; Hills, 2000). There are, however, no discussions on malaria intervention and aid. Godfrey et al. (2002) explored the impact of external technical assistance on local capacity development in the Cambodian aid-dependent economy. They suggested that 'technical assistance' was having a negative impact on local capacity development, in the context of intertwined contact between Cambodia's low-paid civil servants and donor-driven agendas. This was partly caused by the underfunding of the government, which allowed for a scenario in which civil servants sought refuge in donors' salary 'supplements'. In retrospect, donors needed these workers to implement their projects, resulting in qualified government workers being drawn away from their government work and jeopardizing Cambodian institutional development. Nonetheless, the discussions that have taken place on the future of technical assistance and its effectiveness have not been convincing, particularly in relation to the suggestion of a new deal in which donors would shift their focus to other dimensions of technical assistance. I argue here that the problem lies in the 'interventionism'; as it shapes the behaviors of interventionists and those who receive interventions.

Ten years later, Nunberg and Taliercio (2012) examined a similar interaction between international development assistance and Cambodian public services run by low-paid civil servants. The emphasis was, nonetheless, on the practices of the donors, which they termed a "collective action problem". In essence, they suggested that donors sabotage civil service capacity development through their competition for qualified government workers. Making the matter worse, these fragmented government institutions contradict their original purpose of building government capacity

(Nunberg et al., 2012). In addition, they explored intervention as result of such a pervasive collective action problem, emphasizing the need for agency-level civil service reforms – the Merit-Based Payment Initiative (MBPI). This intervention, although adopted, did not survive for long, having been accused of causing resentment between public administration staff and the military due to discriminatory pay and unfair selection processes.

In addition, Hardemen et al. (2004) examined the constraints on access to the Health Equity Fund (HEF) scheme in a very project-based context, particularly those projects that were managed by NGOs. They found that the financial, geographical, informational and intra-household circumstances of the patients resulted in significant barriers in terms of access to the services offered. They, nevertheless, highlighted the effectiveness of the scheme and the viability of such schemes when run by NGOs. From a critical point of view, this research exhibited bias in the sense that it did not seek to understand the role of agencies, and particularly the NGOs themselves, as barriers to health access for the poor. A few researchers questioned the sustainability of such a scheme, implying that HEF is not a panacea (Tangcharoenstien, 2011).

Discussing Cambodian health development from a different perspective are those studies that link polity to the results of development projects. Hills (2002), in his examination of a Cambodian-German health project, questioned the appropriateness of the approach taken by health development projects in light of the complexities and changing political situation faced. The project under observation was actually interrupted by a virtual coup d'état in 1997. Events like this lead one to question the whole concept of strategic planning within international development (Hills, 2002). Ek et al., (2008), in their examination of aid effectiveness in Cambodia, suggested that technical cooperation represented half of the external assistance given between 1998 and 2006. They also found out that aid over this period fragmented government institutions, incurring a number of costs such as due to the establishment of parallel implementing units.

What will be presented in this paper is the result of an ethnographic investigation within the Cambodian National Malaria Center (CNM) and the Ministry of Health (MoH) in 2012, based on interviews with staff from the WHO, NGOs, the MoH and other relevant actors. Meetings, workshops and conferences were also undertaken. Overall, about 50 national and expatriates were interviewed; ideas were discussed and exchanged regarding their reaction to malaria control. Some were visited several times to track the accuracy of the information received from the initial visit. A number of relevant malaria stakeholder's documents, including project reports and strategic papers from the National

Malaria Center, plus documents from donors and NGOs were also consulted.

I begin with an examination of the historical context and evolution of Cambodia's malaria programs, which have been assisted by external parties since the country's liberation in 1979 from the Khmer Rouge. Then, I will look at the CNMs designated roles in its fight against malaria in the country. Specific attention will be paid to the institutional political life of the CNM, stemming from its interaction with external actors, the accommodation of political agendas among its patrons (the government and MoH), and its staff members' 'survival' mentality. From there, the paper explores the roles played by key external players, including the GF, the WHO and NGOs. I argue that external aid has been captured by the patronage system, helping to maintain the status quo and impairing the CNMs institutional structure. I further argue that this impairment has manifested itself in the suppression of staff activities using 'mentality management'.

Cambodian national policies on malaria from 1979 to 2012

1979-1980s: The survival/reorganization phase

Cambodian health infrastructure was completely destroyed during the Khmer Rouge years between 1975 and 1979. Only 10 staff members from the 1950s malaria program survived to renew activities at the national level (CNM, 2001), while a mere 50 medical doctors remained throughout the country (MoH, 1999). Prior to 1984, the national program against malaria was run under the Department of Prevention and Treatment at the Ministry of Health. Treatment and preventive activities were centered in the city of Phnom Penh, and were available to people returning from malaria-endemic areas.

Reorganization efforts, including resource mobilization and human resource building, were the core activities of the department, assisted by a Vietnamese malaria team (Doung et al., 2012). Funding from the United National Development Program (UNDP), blocked during the Khmer Rouge period and amounting to around US1.8 million, was claimed by the National Malaria Program in 1980. These funds made possible in mid-1981 the purchase of 24 Toyota Landcruisers, 140 motorbikes and different types of anti-malarial drug (quinine, chloroquine, primaquine, fansidar, amodiaquine and tetracycline). The first human resource training occurred in the late 1980s (Doung et al., 2012), while training for microscopists at the provincial and district levels was the second human resource building activity carried out.

The funds provided by the UNDP were not the only resource used to purchase anti-malarial drugs. A large amount of drugs held by the Khmer Rouge were found in houses in Phnom Penh. An NGO (Medish Committee

from Holland and Vietnam), was also reported to have bought different supplies, including microscopes, anti-malarial drugs, insecticides, spray pumps and vehicles in 1980, before the WHO's supplies were delivered (Doung et al., 2012). The government also operated Cambodia's only drug factory, producing quinine. Overall, all the anti-malarial drugs purchased in the 1980s lasted for more than 10 years, serving both civilians and the military (It should also be mentioned, in a context of weak law enforcement, the question of counterfeit and non recognized drugs (including antimalarial) which have been source of regular trafficking, mostly those coming from China for the Khmer Rouge who fight against the Vietnamese near the Thai border area).

After liberation from the Khmer Rouge, the new government made each province autonomous of the national level. Each provincial government, including its health care activities, was given its own operating budget to cover development activities in its territory. Despite the existence of the Ministry of Health, the Provincial Health Departments were under the management of the Provincial Governor, meaning the Ministry of Health did not have any power to recruit staff at the provincial level, and that malaria activities were conditional upon both the national program and the provincial programs.

With hindsight, a visible national effort to fight malaria at this time did occur through the establishment of the CNM in 1984. The roles of the CNM have, over time, been expanded to include other vector borne diseases, including dengue fever, schistosomiasis and soil transmitted helminthes (Doung, 2005; CNM 2001). Health development plans have been developed on a yearly basis.

Mid-1990s to early 2000s: Structural reforms and the uptake of international agendas

The early 1990s marked Cambodia moving one step further away from civil war. The 1991 Paris Peace Agreement signed between the country's leader and the exiled king, led to a new proclamation and constitution in late 1993. The period also witnessed country-wide structural reforms, some of which had a significant impact on malaria intervention. The administrative reform, for instance, was argued to be necessary in order to address the problem of 'un-coordinated' support on Malaria, which was caused by the presence of external development agencies in each provincial administration (MoH, 1998). The administrative reform meant that the authority and responsibility for program development and budgetary control, at local health units, transferred from provincial governors to the MOH.

In 1992, along with the country's peace negotiations and partly due to the connection made in 1980 with the WHO, national malaria treatment guidelines were developed with technical assistance from the WHO

(Dounget al., 2005). Drug resistance monitoring, as part of the WHO's control strategy, were reintroduced in this year, concentrated in the northwestern part of the country (WHO, 2002).

Between 1993 and 2000, MOH health care activities (malaria control included) were guided by the Health Master Plan. Then, a new mainstream of world development programs was introduced and endorsed, after the establishment of the Millennium Development Goals (MDG), with health plans renamed the National Health Strategic Plan. The MOH Health Master Plan for 1994-1997 and MOH Health Master Plan for 1996-2000, were subsequently taken over by the National Health Strategic Plan for 2003-2008 and 2008-2015. Such replacements did not translate into a complete replacement of the national budget, however. The basic national budget was and still is allocated for what are termed colloquially *konsom athiheap* (priority action groups).

Another important factor affecting the way in which malaria control was heading during this period was the health sector reforms taking place, an organizational reform and a financial reform. The organizational reform took place around 1996, and transformed the administrative system into a population-coverage based model (MoH, 1999; Grundy, 2001), giving greater importance to the MoH and its decentralized units at the provincial level.

Presently, the basic health unit closest to the local population is the Operational Health District (OD), which covers the referral hospitals at the provincial level, then there are the health centers and health posts at the commune and village levels. Such a division is based on the health coverage plan framework linked to population and geographical access criteria. Health centers are located in areas with a population of between 8000 and 12000, with a central location 10 km from the surrounding population. As an example, in Koh Kong, a coastal province in the south-west of the country, in 2007 there were 2 ODs, 2 referral hospitals, 13 health centers and 2 health posts (MoH, 2008) for a population of 116,508 residing across 7 administrative districts (National Committee for Sub-National Democratic Development, 2009).

Nevertheless, quite a few places, mostly in the northeastern provinces inhabited by ethnic minorities, have been neglected in the spatial integration of the health delivery system, meaning national coverage is still incomplete.

Theoretically, the OD has distinct roles and responsibilities when compared to the administrative districts. According to the Cambodian Ministry of Health (2008), the OD's main role is to implement the operational district health objectives by: 1) interpreting, disseminating and implementing national policies and provincial health strategies, 2) maintaining effective, efficient and comprehensive services (promotional,

preventive, curative and rehabilitative) according to the needs of the population, 3) ensuring equitable distribution and effective utilization of available resources, 4) mobilizing additional resources for district health services and NGO support, and 5) working with communities and local administrative authorities.

In 1997, owing partly to these overall reforms with an emphasis on central planning, provincial malaria units were established. These units continue to be run under the Department of Health, which is the representative authority of the MoH in each province. Endorsement of the country-wide restructuring, notably through the accord on central planning, should not in fact ignore the difficulties faced during implementation.

The financial reforms that took place in 1996 attempted to allocate a budget to each health facility according to the services available and the size of the population served (MoH, 1999). The "health financing charter" was adopted jointly by the MoH and the Ministry of Economics and Finance (MoEF). Despite such efforts, financial resources for the health sector were mixed for the period. Government funding represented about \$2.70 per capita, while international donors and NGOs contributed about \$2 per capita. Private household expenditure was estimated to be between \$12 and \$18 per capita at the time (Knowles, 1996), while staff salaries were around \$12 per month for health workers in rural areas, among the lowest in the region (Knowles, 1996).

A study into the budget evolution of the CNM indicates that during the late 1990s, the government budget for the malaria program was minimal. The central budget amounted to around 112,449,440 Riels (equivalent to \$44,979) in 1995 and 546,758,592 Riels (\$218,703) (These are the budget reported in 1995 and 2000 annual report of CNM. While the budget was calculated in the national currency, riels, and where the rate of exchange of the year was not aware of, the conversion into USD uses the approximate exchange rate of the period of \$1=2500 riels. It is also important to note here that the budget account for the four programs ran by the center, not only solely for malaria) in 2000, with the majority being spent on staff salaries and transportation, which is still the case. Budgets were always released late and the amounts given were generally less than requested. Cash was not the only outgoing from the MoH to the CNM – gasoline accounted for 13% and other materials bought by the MoH for about 60% (Author collation in CNM annual report of 1995 and 2000). Because the national budget could not ensure everyone had access, many remedies, including health equity funds and user fee systems, were introduced and tested (Meessen et al., 2006; Ir et al., 2010; Hardemen et al., 2004).

From 1997 to 2002, the government budget for malaria was channeled through the Cambodia Disease Control and Health Department Project. This project was funded by a World Bank loan (Nong, 2005, WHO,

2001a). Despite subsequent increases in available funding during the period, the amount allocated from the national budget was still small.

The concept of central planning, driven partly by international development agendas, gave birth to a CNM national long-term strategic plan in 2001 (Nong, 2005). It has been suggested that the malaria program at this time experienced a paradigm shift from hospital-based curative activities to pro-active education, evaluation and control (CNM, 2001:5), though malaria strategies had been multifaceted prior to this. These strategies included prevention aspects, treatment and vector control. Arguably, this strategy was driven by the agendas of a few big international agencies, taking into account the underfunding and legacy of human resource depletion. Apart from the distribution of treated bed nets and health education, the social marketing of hammock nets, paralleled with the introduction of a user fee system, were the key parts of the prevention program.

A numbers of bi-lateral agencies and NGOs assisted provincial health programs. ODA, a bilateral aid agency from the UK (now called the DFID), provided volunteers (epidemiologists, lab technicians and clinicians) through the Volunteer Service Organization (VSO) between 1991 and 1996. Furthermore, up to 47 NGOs registered with the malaria program (CNM, 2001), including Médecins sans Frontières (MSF) from France, which was based in Pailin between 1998 and 2002, Action contre la Faim, which was located in Preah Vihear Province from 1993 to 1998, Care International and Racha in Koh Kong Province, and Health Unlimited in Ratanakiri Province. Some provided training to health professionals on diagnostic tests (Action contre la Faim, 1999), while in 2000, Nomad in Monduliri Province started various programs with an emphasis on the socio-cultural aspects of the infection (Nomad, 2002). These interventions, as already mentioned, were criticized for creating multiple strategies on health care in general at the provincial and district levels (MoH, 1999). Such interventions were perhaps necessary for the affected population at the time, but now are no longer viewed as appropriate for a government that has adopted central planning.

Finally, while the country was wrestling with reconstruction of its national infrastructure while facing a lack of both human and financial resources, global malaria agendas were imported by some prominent international organizations. The European Commission (EC) ran the Regional Malaria Control Program in Cambodia, Laos and Vietnam during the period 1997 to 2002, implementing the agenda of the global Roll Back Malaria Program (WHO, 2001b: 16), which was launched in 1998 and strengthened by the work of the WHO (MoH, 1999; Nong, 2005). These international agencies' agendas were continuously promoted and reinforced in Cambodia at that time, and have been since. However, the perceived positive aspects of these interventions cannot be ignored. The introduction of imported rapid

diagnostic tests (RDTs) with the ability to detect uncomplicated malaria at the village level, has contributed to a reduced death rate among affected populations. Furthermore, with the assistance of the EC over the period 1997 to 2002, the capacity of the provincial malaria supervisors improved (Doung et al., 2005; CNM, 2008). The downside of this so-called 'established structure' is reflected in the question: Is this structure in place to support mainstream program monitoring and project implementation, or is it really designed to benefit the affected population?

In a few words, the 1990s was a period of variety in the sense that many malaria control efforts were set up, some of which complemented each other, while others were contradictory. Overall, this period started-off with peace negotiations, which was then followed by an uncoordinated influx of external assistance, finished-off with restructuring and stable central planning. It would be an exaggeration to say that one, single event led to subsequent events, yet it is fair to say they certainly influenced each other, a signature of the complexity of the period.

2000 to late 2011: The rise and fall of the national program on malaria

The early 2000s marked a new era for the national program on malaria. In an attempt to control national activities in the areas of monitoring, coordination and data management, a top-down approach was implemented. One specific characteristic of this period that deserves attention is the increase in aid flowing to the CNM from the Global Fund (GF).

From 2002 to 2009, the CNM received almost full financial support from the GF (GF, 2010; Doung, 2012) (There were however political aspects between MoH and CNM which limited the roles of CNM, particularly in the area of drug management and curative basis), support designed to improve program management practices in the CNM. The GF financing mechanism can be best understood from the work of Snow et al. (2008), which identifies the funding channels that take place through the government, in particular the Communicable Disease Department of the MoH, plus the CNM in Cambodia. The GF grant required NGOs to take on a role as "the sub-recipients", reporting to the principle recipients, which were the MoH and CNM. This will be further explored in section 3.

GF funding led to the CNM budget being as high as \$6.5 million for each approved 5-year grant period. Three subsequent grants, with the first grant amounting to almost 4 million, the second \$6.5 million and the third \$5.5 million, were allocated for the Malaria program (Global Fund, 2010). The spending of the GF money was, however, problematic, as the fund was characterized by complicated rules and regulations,

which led to delays in disbursement (CNM, 2008; GF, 2010).

Parallel to the funding phenomena, a few critical interventions affecting malaria control are worth exploring. First and foremost, in 2002, the village malaria worker (VMW) scheme was introduced. This locally driven initiative, where local volunteers provide diagnostic testing and prompt treatment, was initially piloted in one province and later scaled-up nationwide. The effectiveness, efficiency and limits of this framework have been described in the work of Bourdier (2010, 2013), and a quick comment on this intervention is that it has been praised as a magic bullet by some who work in Malaria control circles in Cambodia (Author's observation during various meetings with organizations working on malaria eradication and control). It has also been described as leading to an annual decrease in malaria prevalence, and frequently described by many external actors (such as the WHO, CNM and NGOs) as a mechanism impacting directly upon the affected population. Perhaps amid the failing structure of the Cambodian health system, this framework appears to have helped achieve the longer term goal of eliminating malaria altogether. Cotter et al. (2013) have explored the striking changes in malaria epidemiology that have taken place in Cambodia under this initiative.

In 2003, Cambodia made the decision to switch its first line treatment drug to artemisinin-based combination therapy (ACT), with artesunate and mefloquine (A+M) being the first line treatment for *Plasmodium falciparum* malaria. This followed the detection of resistance to mefloquine combined with another drug partner in a project piloted in western Cambodia (Médecins sans Frontières, 2002; WHO, 2000). The A+M treatment regimen lasted for almost ten years before in 2010, Cambodia again moved to a new drug combination for its first line treatment, following preliminary evidence of resistance to A+M in the northwest and very south of the country (WHO, 2000). Because of the frequent changes in drug regimes and GF regulations, the country has faced a serious problem finding qualified manufacturers for the new treatments. As a result, drug stock limitations both in the public and private sectors have been inevitable and obvious. In June 2012, the recommended drugs across the country (some ACT, with DHA+ piperazine) in the private sector were not available. For example, Malarine, the ACT socially marketed to the private sector by PSI (Rozendall and Ros, 2003), was not available at the time of this field study (October 2011/August 2012), though its redistribution began in October 2012 among registered pharmacies in PSI targeted provinces.

The joy experienced at the CNM over the assistance it was receiving from the GF did not last long. Historically, international aid assistance reduces when countries in the West are hit by financial crises (see, for instance Clever, 1977), and in line with this, a reduction in the

financial commitment of some rich nations towards the GF amid the recent global financial crisis, saw significant decreases in funding volumes (see, for instance Usher, 2012). Concerns over corruption and misspending also affected the decisions of some other countries whether to invest in the fight against the global disease or not (Usher, 2012). As a consequence, the CNM's funding proposal for Round 10 in 2010 to the GF was rejected, while the grant for Round 11 was cancelled entirely by the GF.

It has been argued by the CNM that the GF's rejection of the grant in round 10 was linked to the perception that Cambodia had received excessive grants, and that it did not need further grant supplementation (Interview, April 2012). Nonetheless, such claims should not overlook the 2010 and 2013 audit reports of the Office of the Inspector General (OIG) at the GF, where allegations of fund mismanagement are to the fore. The reduction in funding from the GF was expected at the time to have a major consequence on the national program, given its dependency on previous GF grants (GF, 2010). Currently the

national malaria budget depends entirely on Single Stream Funding, which is a combination of grants from the AMFm (AMFm stands for the Affordable Medicine Facility [for] Malaria, a subsidy mechanism to decrease the price of ACT. This mechanism can be best understood from the work of Gelband and Seiter (2007) clearly explaining with the Global Subsidy for Antimalarial Drugs), plus the remaining funds from three previous GF funding rounds (It should be noted that Cambodia has received malaria funding from the GF over 5 rounds, as well as from the AMFm. Funding from the first three rounds has been closed, while the remaining rounds have been combined into one funding stream called Single Stream Funding, or SSF).

A final element marking the decline of the national program on malaria lies in the disappointment felt regarding its donor, the GF, which was exacerbated by the complex fund utilization processes. Actors complained of the GF's increasingly stringent regulations and policies, and more importantly of delays and postponements in disbursements. Some further compared the inability of the country to spend the GF's money as being a 'chicken and egg' situation. Were delays in funding disbursements from the GF due to the money not being used on time or was it the other way round? While the GF's regulations and policies will be explored in a later section, it is worth mentioning here that the restructuring of the grant led to changes in the principle recipients and grant approval delays. Only "essential activities", as quoted by the GF, were permitted to receive funds, while new grant agreements are still pending approval from both sides: the government and the GF.

2011 onward: The new direction – elimination of malaria by 2025

Notwithstanding its human and financial capacity, the CNM has been able to develop an overarching national malaria eradication strategy, indicating that Cambodia is moving a step further toward this goal, and shifting away from its previous control-only strategy. The aim is now to eliminate malaria by 2025 (CNM, 2011), with a pre-elimination step of 'no deaths due to the disease' by 2020 (CNM, 2011). Evidence of dramatic decreases in malaria incidence, at the rate of 9.7% per annum, plus the availability of funding, are perhaps factors encouraging the center to set such a goal. While some international actors have applauded the wisdom of producing a document oriented towards malaria elimination, some local actors view the strategy as more of a propaganda activity used to attract donors. Some critics have gone further, pinpointing some interlocking issues caused by the increase in GF policies and regulations, and their lack of rationality. These difficulties have impacted adversely upon the attitudes and mentality of national staff, those tasked with embarking on a quest to use the funding and pursue the goal of elimination.

Various strategic options have been proposed as part of the elimination mainstream, including but not limited to: (i) deal with the plight of migrants and mobile populations who suffer disproportionately from malaria and (ii) integrate decentralization efforts, as this will enable things like bed nets to be distributed more efficiently, (iii) improve bed net distribution, plus retreatment of bed nets distributed before LLIN's were available, (iv) health education, (v) research, (vi) scale-up village malaria worker teams, and (vii) introduce surveillance systems. Another critical concern that should be addressed is Cambodia's changing first line treatment regimens, and this last topic will be discussed in the fourth section of this paper.

Cambodia has now adopted the current global malaria strategy, with the international emphasis on malaria elimination being reflected in many strategic documents from multilateral and bilateral development agencies (See for instance the strategy paper of the WHO Mekong Malaria Program, the assessment on the national concerns of nations of the sub-Mekong conducted by WHO, USAID and DIFID). The elements and approaches used with regard to elimination are all embedded in the current Cambodian elimination strategy, which would seem unsurprising if not taking into account the human element within any analysis, which throws into question the capability of the country to plan, project optimism, and most importantly, convince that it is possible. Regardless of the end result of this strategy, what is obvious for the future of Cambodia's malaria intervention program is that as long as external aid remains the main source of

funding, interactions with external factors will involve politics, for this has always been, and will continue to be, the main problem. This dependence of the system on external aid, as well as external actors' inconsistency in terms of malaria interventions, will always slow down any initiatives, even if it does not drag them backwards. The dependence on external aid is always accompanied by development plans being patronized, and this patronization is made possible by the Cambodian government underfunding in almost every sector, as part of the politics of welcoming aid.

Structural impairment within the Cambodian government

I argue that past and present national strategies were and are driven by global agendas, made possible under the auspices of the CNM. Arguably, the interlocking institutional capacity described above, and which I term 'structural impairment', has allowed such external influence to take place. This impairment has been caused by a political working culture and political economy in the CNM that has allowed the leadership to harmonize external aid to the detriment of institutional capacity, so strengthening and expanding the patronage of the current ruling party

Let us first try to understand the functions of the national body. Under the malaria section, the CNM has run programs on bed net distribution, health education, the village malaria workers project, entomological research, tracking drug resistance (under the direct support of the WHO, or as part of the WHO drug resistance tracking agenda, falling under the research unit), epidemiological aspects and laboratory studies (CNM, 2010). Its organizational structure is similar to many other Cambodian institutions with identical functions, and is characterized by a leadership body which includes a director and a number of vice-directors. Staff promotions and appointments from department directors is centralized at the MoH level. Three departments (administration, accounting and a technical department) oversee the overall function of the Center.

Political working culture within the CNM (institutional leadership and staff dynamics)

The concept of a political working culture is appropriate to explain the daily interactions among CNM staff, and between themselves and with external actors. Each actor, from the Center's leader to individual staff members, is forced to work within the political system and policies of, not only the country, but also the global development project. While the term 'political' literally refers to the political system of the country, as steered by political parties, the politics discussed in this paper extends also to the hidden agendas of each development

institution and actor – be it CNM, the WHO, the GF or other NGOs. When these actors interact, since their own agendas are implicitly preferred, the resulting, opposing agendas create clashes and frustration, in turn leading to problems in terms of aid being effectively provided to those in need. In development terms, this is known as "aid effectiveness", and discussions regarding aid effectiveness rarely include these hidden agendas.

Leaders of the CNM are bestowed with particular authority to act in the interests of the ruling party. They welcome external aid and to a great extent ignore staff fragmentation, which research has suggested jeopardizes institutional capacity (see, for instance Godfrey et al., 2002). Yet this type of management is both ideological and allows for increased incomes among CNM staff, making them believe that, despite the fragmentation, if the current patronage is challenged they will lose their jobs. This fragmentation adds to the existing hierarchical structure and program sub-division. Staff roles and responsibilities are usually expanded (on top of their government jobs) to take on GF jobs or other development projects. Five elements of this fragmentation can be identified: 1) technical assistants (national and international individuals), 2) CNM staff directly implementing GF projects, 3) CNM staff indirectly involved in GF projects, 4) non-managerial CNM staff (further fragmented by some engagement in research projects, and 5) staff contracted to implement GF-national programs.

Local staff involved in technical assistance are the highest paid, followed by sub-contracted staff and then leading figures engaged in the management of GF grants. CNM members indirectly involved in the GF program or other external projects receive mainly transportation costs and *per diem* payments (\$20 for GF work, \$15 for government work and \$27 for NIH work) as the only means of compensation. Those considered to be in non-managerial positions receive mainly the government remuneration. The difference is considerable, with the first group earning about \$1500 per month, the second about \$1000 and the third between \$200 and \$400 a month. Government remuneration is graded according to staff position and level of education. For instance, the Center director is paid about \$400, while the lowest rank receives about \$50 per month. This rate of payment, however, does not include additional earnings from travel, which falls under the *per diem* payments. As one CNM staff member of the entomological unit pointed out:

My team members might officially earn less than NGOs workers, but the per diem they earn from traveling entitles them to something between \$600 and \$700 per month.

Authority and power expand beyond inherent roles within the CNM, and are associated with personal wealth

and connections to high ranking officials within the organization and elsewhere. This is a form of sub-patronage. The negotiated power of political figures at the CNM is also associated with their personal wealth earned independently of their CNM-generated income. For instance, my informants told me that the high living standards of the CNM's new director are supported by his wife's business. It is his position as CNM director, together with his socio-economic status, that allows him to adopt the rigorous administrative discipline mentioned by informants as being a self-protection mechanism (It has also been pointed out that while the director might not be aware of who will come to work as of the director personal characteristic that keep himself enclosed in the office, the center administrator has to leave his on-the-side- signature approval as a responsible implementer). Informants also talked about associations with retired leaders and other high ranking officials in the MoH and elsewhere, which to some extent enables staff to maintain their current positions.

Nepotism (where family members all work in the institution) is a direct result of the political patronage system within the CNM. High ranking officers offer employment opportunities to their family members, meaning members are mutually supportive. Nepotism is, therefore, self-sustaining in the long run. Staff appointments and promotions depend on there being a connection to high ranking officials at the MoH or a higher entity, depending on the level of the position. Staff without the means to bribe or form connections with senior officials experience inequitable employment distribution.

Acceptance by CNM staff of this political patronage system can be seen in their financial and physical support of the political propaganda activities of the ruling party. Staff are asked to pay \$20 every month to the CPP via a focal person appointed by the director. During the former director's leadership this was not an obligation, as informants stated that the previous director managed by means of the income received from development projects. However, this \$20 contribution has become compulsory for individual staff under the current director. In retrospect, the promise of enhanced social status if one is part of the system appears to be the *modus operandi* for some staff members, and this aids and abets such political patronage.

It would be an exaggeration to say that there is a unified CPP political 'spirit' among CNM staff members, but it would also be fair to say that anti-CPP feeling is minimal. A few staff members are health professionals who served in medical roles (as surgeons, medical doctors, pharmacists, nurses etc.) for several years in remote provinces, and have since been forced to work at the malaria center. Very few claim to be part of the opposition party movement, but those with independent sources of income and the ability to substitute employment, have defected completely from government service.

CNM members fight for social recognition among themselves by taking-on higher positions. As demonstrated earlier, those with a higher rank enjoy certain privileges, including being able to employ family members. This mindset makes the CNM a tumultuous working environment, one that encourages the defection of competitive staff to NGOs. As one previous CNM staff member (who defected) told me:

There is too much politics within the CNM. I went to work abroad for a while and was summoned to come back by the Minister of Health. I was advised to work outside the CNM if I wanted to continue working in Cambodia. (former CNM staff member)

A final structural impairment related to political patronage is the appointment of the latest CNM director. My informants suggested that the intimate relationship he has with the Minister of Health led to him being appointed, and his excellent and strict administrative practices at the MoH. This also represented a quest for order by the Minister of Health, with a national election looming.

We can therefore assume that the political working culture at the CNM encompasses a survival mentality, one that has been instilled within the staff there through a supplementation of salaries and the opportunity to create a social family network. The recent change in leadership at the CNM might represent a new leadership spirit, however, this is not significant enough to challenge the wider political working culture embedded within the national budgeting and staff compensation framework. Furthermore, this change in leadership appears to have been just another political trap carefully arranged to hide structural deficiencies and gain further political influence. This mentality, not only of survival but of the promise of enhanced social status within the system, has been maintained and reinforced by the options afforded within the external aid system.

Political institutional budgeting and the political economy of staff compensation

As suggested in the previous section, the political patronage system in Cambodia is reflected in the workings of the CNM, which forces civil servants to conform to the current system through the ad-hoc application of strict administrative processes, the uneven application of rules and regulations among staff and the provision of economic and professional benefits. Such a management style is used as a means to capture staff in order that they continue to give their support. To put it simply, staff have been oriented to such routines so that they will not have enough time and energy to think of other ways of working. Furthermore, the mentality of the CNM staff, who are ready to submit to this form of suppression, reinforces such a patronage scenario.

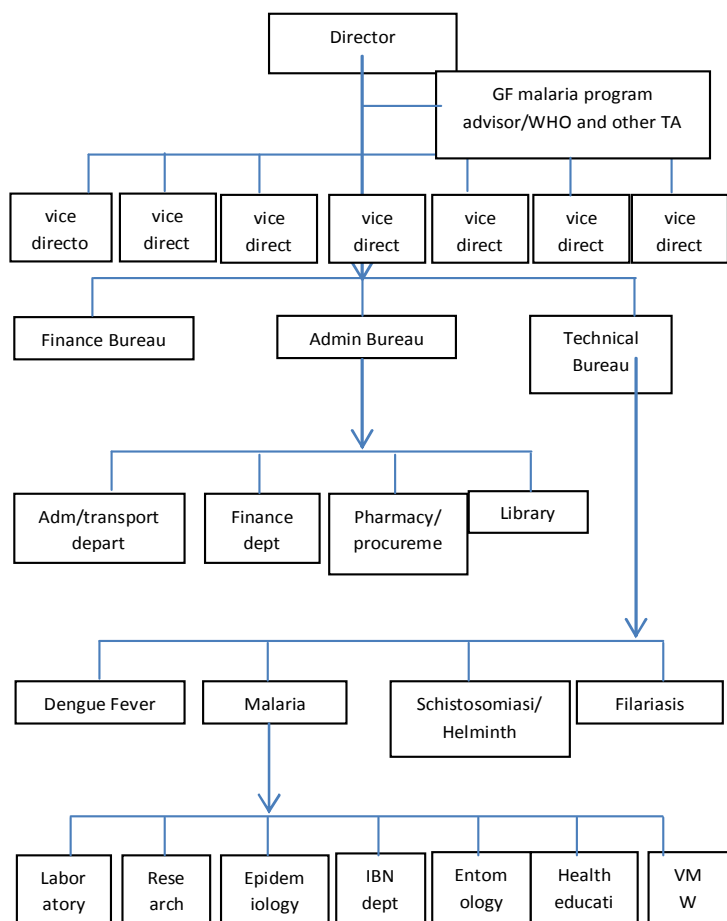


Figure 1. Staff fragmentation and hierarchy at CNM

Source: personal enquiries 2013.

The following arguments support this view, as I will look at the maneuvers used by the CNM to turn external aid into a tool to nurture such a patronage system. In other words, the organization utilizes international aid to maintain its existence and authority, based on two approaches: substituting the national budget with external aid, and using the political economy of a staff compensation system.

External Intervention at CNM contributing to staffs fragmentation

WHO-----> National (recruited from CNM and retired staff)
International

Nature of assistance: Technical Assistance on drug monitoring and national treatment guideline, containment project

Malaria Consortium----->national staffs (outside recruited)
International staffs

Nature of assistance: data management, epidemiology

Clinton Health Access Initiative--> national (outside and inside recruit)
International

Nature of assistance: procurement, public private partnership, severe malaria cases

The Global Fund---> contracting staffs: national (outside, CNM-on-leave staff (contractual arrangement). and international (TA, Financial management)

- Implementing staffs of the NM (paid based on POC)
- CNM staffs indirectly involved in project implementation (payment paid based on travel per diem)

Nature of assistance: national programs

Research project (periodical base)---> CNM

The substitution of the government budget with international aid is not a new topic. The GF has previously and vigorously investigated such conditions in Cambodia (OIG, 2010). In fact, it has succeeded in proving that the CNM national budget has, at some points, been reduced and then entirely replaced by GF funding. Despite the irony, such evidence and claims are not without foundation. It is important to recognize that

Table 1. Source of Funding for CNM from 2006 to 2011

Source of funding (in US \$)	2006	2007	2008	2009	2010	2011
Domestic sources	2,958	2,375	2,177	3,800	4,174	4,089
WHO/USAID	500	500	500	500	500	500
Department for International Development (DFID)	51	107	276	275	275	275
Bill & Melinda Gates Foundation	-	-	-	7,440	2,060	-
Total non-GF resources	3,509	2,982	2,953	12,015	7,010	4,864
Global Fund (incl. Round 9)	2,551	3,948	9,554	12,702	12,975	39,667
Percentage of GF of total	42%	57%	76%	51%	65%	89%

Source: OIG report (2010).

the source of the funding that comes from the Cambodian government for malaria control has been the subject of discussion in separate research studies, because of the number of national programs it runs across the country's 24 provinces and the structure of the health care system.

While accounting measures tend not to explain the reality behind this substitution of CNM funding, a discussion with a well-informed informant at the CNM highlighted the use of several proxies to support the accounting claims regarding CNM budget substitution. Firstly, the national budget has to be raised to the MoH, even if it will not be spent, to ensure that the following year's 5% budget increase can be claimed. Furthermore, the national budget covers only some foundational expenses, which are minimal, including staff salaries and administrative supplies. The majority of the budget, therefore, is practically covered by the GF.

Secondly, without any causal relationship related to volumes, the national budget for the program's so-called activities is just a figure which is not actually claimed from the MoH. The underlying reasons for this are three-fold and inter-related. First, the GF budget is overwhelming used to cover all program expenditures, and second, some expenses, specifically travel costs to the malaria endemic areas, are lower than the amounts covered by the GF. The GF budget offers a rate on accommodation and food of \$20 per day, as compared to \$15 for the CNM budget. This has led to staff preferring to use the GF rate when traveling to malaria endemic areas. This preference for using the GF budget is also linked to the administrative request process. The release of the CNM budget monies is a complicated process, and is to a great extent hampered by bureaucratic red tape. For example, signatures are required from staff at the MoH and the Ministry of Economic and Finance (MoEF), However, when making a claim against the GF budget, approval only from the relevant authority at the CNM level is required.

The final reason for staff preferring not to use the national CNM budget allocated by the MOH is a combination of the previous two concerns. A proportion of

the money, approximately 30%, claimed by the CNM, is taken away during these processes. It is important to understand that the release of money involves cash flowing from the MoEF to the national treasury, then to the MoH, and finally on to the CNM. If the money is not spent, due to the two processes described above, a full return to the national treasury must be made. Under such a scenario, the CNM would not be able to sustain the 30% loss sustained during the bureaucratic process. As a result, leaving the budget unclaimed is the preferred option for the CNM. The MoH also anticipates this, and so the necessary reallocation is ensured.

In short, there is empirical evidence that government funding is substituted for by external aid. While the accounting figures show a mixed story in terms of national funding, due to the multiplier function used in the subsequent years' budget increase policy, my qualitative investigation proves that budget substitution is of particular relevance to the government's bureaucratic processes and discriminatory payment rates applied with respect to GF funding, and how these differ from the government's own budgetary processes. The substitution of the national budget with GF funding can be illustrated by the scenario in which staff are underpaid, yet must contribute financially to the political system to maintain their social status. Meanwhile, the government makes the staff believe that their very survival relies on the continuation of the current political system. This argument becomes even stronger once the [lack of] political will of the current political system to initiate payments' reform is highlighted, which is the topic of the next discussion.

A final contestation which highlights the attempts of the current political system to manage the mentality of civil service staff, is linked to the government's approach to staff payments. Arguments behind staff payments being used politically are based on, a) the government's lack of will to perform substantive staff payment reforms, b) the government's adoption of an opportunistic approach to staff payments, aiming to benefit from the reform attempts imposed or negotiated into place by

donors with respect to staff contestations, and c) the government's willingness to depend on informal payments to sustain its presence, an activity then used to justify such informal payments in the first place. It is important to be reminded that the management mentality the current patronage system is based on uses continuous fear and a sense of insecurity among its staff. The government knows that comprehensive reforms on staff payments will have serious repercussions for the power structure that supports the current patronage political system.

Government staff payments have been low ever since the country's liberation in 1979. The arrival of rescuers from the Global North in 1993 induced a shift in the survival strategies of Cambodian civil servants. Salary supplements (incentives) for civil servants were imposed when engaging in rescue missions launched by the United Nations Transitional Authority in Cambodia (UNTAC) (UNTAC was the United Nations peacekeeping organization which operated in Cambodia from 1992–93. It was also the first occasion on which the UN had taken over the administration of an independent state, and organized and run an election), and the practice continued into later agreements with the majority of bilateral and multilateral agencies, reinforcing the government's motivation to depend on this form of informal payment (Nunberg et al., 2012). The emphasis on the 'chicken and egg' scenario within the informal payment system, as perpetuated by the government and donors, is not helpful. The cycle needs to be cut, and one side or the other has to instigate the action required to do so.

The analysis here only highlights the reason why the government does not embark upon the necessary reforms; it ignores the fact that the current government actually blocked reforms proposed by a former Minister of Finance, who was later demoted, who tried to introduce a salary increase for civil servants in the 1990s. In addition to this, another pay reform was actually introduced in 2005, but was rejected later by the current government when it was thought it would hurt its fiscal budgeting (Nunberg et al., 2012). While it can be argued that this latter scheme was donor-driven, and so received little commitment from the government, it can also be argued that no other serious attempts to improve staff payments have been made.

Before moving on, it is *prima facie* to first have an understanding of the 2005 reform scheme mentioned above. Nunberg et al. (2012) have described broadly the history, nature and challenges of the scheme. This civil service pay reform was known as the Merit-Based Pay Initiative (MBPI) and was introduced in 2005, then abruptly shut-down in 2009. The scheme aimed to introduce higher pay for civil servants based on a meritocracy selection process and a simple management performance element (Nunberg et al., 2012). It was also

a pilot project for the Ministry of Economics and Finance (MoEF), to be later expanded to other ministries.

The government's agreement to abide by the substance of the MBPI, for the immediate benefits it offered, can be argued to be a part of its control strategy with regard to staff mentality. The immediate effect of the scheme, as proposed, was that 81% of the budget would be borne by donors, covering 300 positions at the MoEF (Nunberg et al., 2012). The government should have been in a position to understand its budget capability and so predict the consequences of the scheme it had signed up to, however, its need to demonstrate a commitment to staff welfare – to garner their continued support – meant it did not do so.

The abrupt termination of the MBPI and the introduction of the Priority Operational Cost (POC) scheme is empirical evidence of the government's political stance on staff pay. A weighted analysis on the reasons leading to such an abrupt end to the scheme deserving of attention is the emphasis on the potential effect it would have on the "limited access orders" interplayed by the political patronage system (Nunberg et al., 2012). This is similar to the "order scenario" demonstrated above in the case of the MoH minister. My informants stressed that the MBPI created resentment and jealousy among civil servants at the MoH and elsewhere, due to the use of kickbacks and an unfair selection process. Rather than scale-up the scheme so that all civil servants could receive better pay, as was intended, the decision was to stop it; a decision taken more than likely so as not to hurt the government's coffers and to sustain the recurrent mentality among employees to be "ready to agree to everything".

The introduction of the POC by the government complemented the aforementioned politics on staff payments, and contributed further to the mentality of its employees. The POC appears to have been a strategic attempt to calm those who had not been in the MBPI scheme, while in the meantime provide a temporary remedy for those who had been paid by the scheme. The POC decided on the salary supplements to be paid (prior to the introduction of the MBPI), whereby donors undertook to pay government staff to implement development projects, on top of what was being paid by the government. Such a scheme relieved the government of its fiscal burden, and at the same time guaranteed that its presence was needed to govern staff survival. From undertaking to support the instantaneous effect of the MBPI scheme, to showing a lack of will to introduce staff payment reforms, and finally introducing a scheme that has little impact on its fiscal budget, the government of Cambodia can be argued to have utilized the politics of staff pay.

If this helps explain "the recurrent mentality of being able to take everything", the unclear decision on the POC scheme affected staff at the CNM a lot. Yet, there was no

visible reaction from CNM staff members. Prior to introduction of the POC scheme, staff at the CNM received salary supplements as “project running fees”. This meant government officials were added as key project implementation staff (like NGO personnel), and were rewarded with a rate set by the center. Upon the introduction of the POC scheme, a much lower rate was awarded to the same personnel, who had almost the same workload. The unclear decision on the POC also delayed payments to staff, further eroding any motivation to implement the center’s activities.

The structural impairment of the CNM can be summarized in a few sentences. As a government institution, the CNM cannot escape from the use of political patronage to influence and manage staff mentality. The government’s minimal budget is complemented by external aid, which facilitates a survival and coping attitude, and nurtures a system that oversees a poor health care system, including in the prevention and treatment of malaria. In addition, exploiting family and social networks is part of the government’s strategy to subjugate its staff and maintain low pay. Furthermore, low wages are also used as a means to garner political influence, while the reforms needed to introduce relatively appropriate staff pay are seen as leading to political upheaval.

New deal

The Global Fund as a novel mono-donor on malaria

The above section provides the context behind how Cambodian political patronage interplays within the institution of the government. Largely, this dynamic has allowed an inflow of aid to take place in order to suppress potential outrage from civil servants, allowing the present government to maintain its political power. This means the donor community is partly to blame for its own unconstructive and spontaneous response to structural impairment, perhaps also suppressing grassroots movements. One proverb that may be applied to international development that supports this view is, “the road to hell is paved with good intentions”. However, this should not be taken at face value, particularly with regard to the premise that the GF has undermined the CNM structure due to its pursuance of malaria reduction or elimination in Cambodia. I argue that the GF’s interaction with CNM leaders and staff represents a new form of colonization, but hidden behind the cloak of ‘international development’. Needless to say, such forces are reinforced in a country with weak governance such as Cambodia. This argument is rooted in two issues; the creation of the GF in response to the global agendas on malaria, and its interactions with the CNM.

The creation of the GF did not occur in a vacuum, but was in fact a response to a shift in thinking as to how aid

within the health sector could reach poor people in developing countries in a more effective way (Schocken, 2012). Supporting this logic, it appears that development experts are aware of this structural impairment in developing countries like Cambodia. Ironically, it also appears that nothing significant has been done to fix these impairments; it is more convenient to experiment with other strategies within developing countries, while continuing to support the idea of international assistance. As for the logic behind the establishment of the GF, Schocken (2012) suggested that traditional funding mechanisms, including those of the USAID and WHO, have been identified as inadequate, and so incapable of scaling-up to meet the pressing needs of recipient countries. Such a statement seems to further demonstrate the failure of traditional donors to deliver international assistance to developing countries in an effective manner, though, of course, they are still in existence and continue to deliver assistance, at least in Cambodia. Although not the focus here, this is but a minor demonstration that it is only when an entity malfunctions that new ideas or interventions are considered and/or introduced.

The GF was finally established in 2002, its aim being to act as a funding ‘pool’ within which donor countries could place their financial assistance in order to achieve MDG aims (Snow et al., 2008). MDG Goal 6 is particularly relevant to any discussion on malaria prevention activities in Cambodia, its aim being to half by 2015 the incidence of three of the world’s most prominent diseases: HIV/AIDS, Tuberculosis and Malaria. As the logic behind the establishment of the GF is linked to the limited efficiency of traditional aid delivery processes, the new mechanism was intended to take a business model-oriented approach (Schocken, 2012). Arguably this aligns with the GF’s ‘performance-based approach’, in which further disbursement is based on “the amount of budget spent” or “cost effectiveness”, and on the condition that receiving countries repay any lost funding when “fraud and malfeasance” are identified. The imposition of this model has been at the heart of the problem, and part of the ‘aid as a new form of colonization’ argument (to which we will return later).

The GF’s international structure has also been a contentious issue, and in hindsight characterizes the new form of colonization in the sense that it steers development outcomes based on an entity located thousands of miles away from Cambodia. My informants said that it takes months for the GF in Geneva to decide on a proposal that affects project outcomes, a story which does not necessarily paint a full picture of the GF’s international structure, but is sufficient to give an insight into the decision-making process as it flows from the national to the international level.

From the bottom-up, a decision starts with a request from a sub-recipient, which is then passed to a principle recipient, then on to the local fund agent and finally to the

GF in Geneva. Some decisions related to the selection of principals and sub-recipients go a different route, via the country coordinating committee (CCC) and its secretariat. From an optimistic point of view, these structures of course serve the GF in Geneva in the area of decision making, though their bureaucratic function seems to be ignored. The CCC entity, on the other hand, seems to exist only to conceal the GF's hegemony, with its role being influenced by the identities of its membership. The voluntary nature of its membership results in different people appearing at different meetings, leading to inconsistent decisions, those that should be based on Cambodian development needs (but are actually based on the CCC secretariat's orientations) (The CCC secretariat is based in an MoH building, and few people are contracted to take care of the CCC Board's meetings). The development of the GF structure has been, without doubt, a process in which entities like the Technical Evaluation Reference Group and the Office of the Inspector General (OIG) were largely established to provide better oversight of GF grants, or at least the appearance of better oversight (Aziz, 2009).

The accounting audits performed by the OIG arguably allow the GF to impose its business model approach, in which low costs and high performance levels are meant to support the end result of development. This accounting audit is meant to ensure cost transparency and so demonstrate the GF's effectiveness. Ironically, the GF has forgotten to include the drawbacks of its own accounting policies in the discussion taking place on the issue of aid effectiveness, though Bourdier (2008) argues that development should be a negotiation between actors. A further critical question to ask is: "do the two actors have equal power in this negotiation?" This situation also raises concerns about what happens at the CNM, if its staff are being forced to obey the authority of the OIG when auditing financial expenditures in the name of transparency and aid effectiveness. CNM staff told me that during the 2012 OIG audit, forced access to entire documents on employee's computers was part of the audit methodology, and this angered some CNM senior staff.

Furthermore, implementers view the GF's accounting policies as a hindrance to malaria assistance. In addition to the above governance structure, accounting policies illuminate another type of international influence which affects the CNM's autonomy. Documentation must be scrupulously collated, with a thorough justification required to ensure the proper use of funds, including accountability and transparency. However, the unintended consequences of these financial processes are completely ignored, for example, such arduous administrative processes prevent aid reaching the affected populations. Empirical examples can be found related to migrants and mobile populations in malaria endemic areas. Treated bed nets are the currently available protection on offer, however, the distribution of

these nets to migrants and mobile populations is hindered by audit processes requiring visible evidence to be given to the GF, for if it is not, there is a risk of the money having to be repaid due to "misuse of funding". The only strategy currently available to this group of people is through the adoption of an NGO loaning scheme among plantation owners, but the NGOs lack the legitimate authority to negotiate with extremely large plantations owned by a few local elites (Maybe the word 'legal bunch of Mafiosi' best describes these tiny groups of people who have team up with some country leaders to do what they want, regardless the proclamation of Cambodia being the country of rule of laws).

While CNM autonomy has been undermined by GF hegemony, the GF was able to justify all its actions when they were having a positive and significant impact in terms of lost funding due to Cambodia's corruption curse. Arguably, the most controversial finding is from the 2012 audit, which was conducted in June 2012, yet only published in late 2013. The significance of this finding is that the GF has since moved away from its principle of using the government to implement programs. Rather than use external actors from the UN apparatus, the United Nations Office for Project Services (UNOPS) has become the principal aid recipient, while the CNM has become the Project Implementing Partner. As demonstrated in its 2010 audit report (OIG, 2010), the GF's concerns were rooted in the areas of institutional capacity. The acknowledgement of having affected institutional capacity through the issue of staff fragmentation and "aid fungibility", (Aid fungibility is a concept developed recently by William Easterly (2006), and refers to a condition in which the government does not treat external assistance as additional to government funding, but as a substitute) has already been highlighted, though in a different way, in the previous section.

The GF's ascendancy has finally responded to a pressing need to show that its money is used effectively, as there has been a steady and increasing decline in contributions from donor countries (see, for instance, Blyther and Kendall, 2012). The GF has conveniently shifted the focus from its own effectiveness to the CNM, implicitly justifying this based on the results of the recent auditing report and concerns on corruption expressed by donor countries. While this shift in the principal recipient, from the CNM to the UN, was welcomed by most of the sub-recipient NGOs, questions regarding funding spent on the entity's set-up and operations have not disappeared. My informants have started to complain about their share of the burden, reflected in the large cuts to their budgets; much greater than the amounts lost through corruption.

I allege that the GF's course of action and interactions with the CNM, including its decision making process, and as reflected in its national and international structure, accounting policies and the quest for transparency (also

part of the business model approach), represent a new form of colonization under the name of malaria 'reduction' or 'elimination'. Such colonization has, of course, been made possible by the Cambodian leadership: subjugating to the GF the hegemony to maintain its own patronage, as demonstrated in the previous section through the introduction and maintenance of a 'staff survival' mentality.

The World Health Organization drawing global and national attention to the issue of drug resistance

Another entity which has significantly influenced the way malaria prevention and treatment has progressed in Cambodia is the World Health Organization (WHO). This institution differs greatly from the GF, both in terms of its structure and the nature of its interventions. The WHO has a country office in Cambodia, and is equipped with a few malaria program staff members. Furthermore, it has regional and sub-regional offices that implement different and arguably uncoordinated interventions. The country office works on intervention programs that emphasize the development of national treatment guideline for malaria, and the tracking of malaria drug resistance. The regional program focuses on containment of the spread of resistance to artemisinin in the west of Cambodia. There are many who doubt, even among the program's own staff, the importance of and compartmentalization of the containment zones. It is important to note at this stage that the WHO, unlike the GF, does not channel any funding through the government structure, but has its own country staff at both the WHO office and the CNM compound. These staff members manage the budget on behalf of the WHO's projects, though one principle person is employed to help coordinate the project, with a few other staff members involved who receive pay based on a travel allowance.

The monitoring of resistance to the anti-malaria drugs receives attention due to the historical resistance hampering world efforts to help those affected. The actions of the WHO, to "contain" the spread of drug resistance over the period 2009 to 2011 in Southeast Asia, are meant to display to the world that the organization has achieved something. This containment project, for which three zones were created across the country, was part of a strategy (Zone 1 was for areas where resistance strains were detected, zone 2 for areas that are close to zone 1 and zone 3 for further areas) criticized for not taking into account the spatial mobility of people. Bourdier (2010: 27) suggested that the containment concept was already "outdated" before it emerged. However, the acceptance of containment failure has been recognized only reluctantly among those who took part in the project, in order to justify its relevance. Some good knowledge is presumed to have

been acquired during the project, for example, the surveillance principles.

Notwithstanding the perceived failure of the containment concept in Cambodia (and its neighboring countries), the WHO (specifically its regional program) continues to project its influence and is seeking justification to continue the program. For example, in May/June 2012, the WHO conducted a program performance review to evaluate the impacts of its program over the previous five years. The review was also a way for the WHO to redirect its future development programs. This review resulted in a dissemination workshop being held in late February 2013, however, it created the wrong impression locally (At least the Cambodian actors perceived that the gap analysis exercise was leading to further funding from the WHO agency, in which another external actor displayed a very skeptical view). Another \$15 million was reported to have been earmarked for the cessation of the spread of drug resistance within the nations of Southeast Asia by the WHO. Implementing actors, in particular those working on operational research, reiterated that resistance to ACT had already been spotted in different countries in Southeast Asia. Whereas WHO country staff expressed skepticism as to the definition of "spread of resistance", this level of uncertainty is shared by some well-known scientists working on that topic (Didier Menard, personal communication, May 2012). A consultant from the WHO questioned whether the confirmed resistance in locations other than Cambodia represents a local emergence of resistance, or if the vector-borne disease has been imported from Cambodia. This 'inside-out' skepticism, together with the actions of the global network, demonstrates that some action is required, albeit the extent of its efficacy and efficiency needs to be assessed.

At least some if not all of the actors dealing with malaria are in agreement regarding malaria interventions. This does not refer to their skills, fields of expertise or even agendas, which undeniably differ, but more on what can be done regarding such interventions. The aim is to eliminate malaria from Cambodia, however, not everyone believes this is possible without clearing the forests. While focusing on the issue of drug resistance (This is not to say that they were or have been having prompt action on the issue, arguably. It has been focusing on the issue at least to be avoided from finger pointing that it did not do anything), the WHO has been criticized for influencing the flow of donor money into certain projects whose substance and strategies are questionable, as illustrated in the above paragraph.

The NGOs working on malaria have had nothing to say regarding the nature of the interventions put forward by the WHO. After all, the WHO has proven to be procedurally correct, dealing with the field first with its solid reviews and findings conducted by "external experts", and hitting the key points (despite the

reflections of this report). It also conducted a workshop that had consultative substance, and provided grounds for genuine participation from a range of players, who, presumably have fed into the initial design of the upcoming project. The tone of the language written and spoken by the WHO, in English, can be attributed to the silence among NGO actors (either due to their level of understanding, or because the words are coming from the mouths of English native speakers, so must be true). The section below illustrates the limited roles the NGOs have played in contributing their views as to what is happening on the ground.

The NGOs as alternative players

The adoration for NGOs, as actors working outside the state and private sectors, started in the mid-1980s (Tvedth, 2006; Pearce, 2003). Around the 1990s, they were heralded as having a comparative advantage to states (Mitlin et al., 2007). However, in the Cambodian context, this claim ignored the facts regarding the operation of such NGOs in the Cambodian context, as demonstrated earlier. This includes, but is not limited to, the central planning agendas followed, priorities imposed by the international community, the changing national leadership style, and the political economy dynamics illustrated by the incentives system. NGOs were explicitly prioritized to receive contracts for health service delivery to the community (Hardermen et al., 2004; Ir et al., 2010); local NGOs were provided with funds by international organizations to manage health center activities, under the rationale that they were good at project management, and could provide socio-political sustainability warranties (Hardermen et al., 2004). This approach can also be seen as a part of the questionable structural adjustment program, in which privatization is the means to an end, to ensure health services are provided to the poor (Pfeiffer, 2003).

As time passed, NGO skeptics emerged, those questioning the accountability and transparency of the sector, including issues around sustainability, north and south relationships, working approaches and effectiveness, as will be discussed later. Health related NGOs are in general alike. For instance, Meesen et al. (2002) noted that while implementing the Health Equity Fund project in India, NGO roles were limited by the funding available from donors, and tended to only produce short term results. Furthermore, Pfeiffer (2003) argued that the use of international staff members among such NGOs fragmented the Mozambique health care system and intensified social inequality in the country.

In the context of malaria intervention in Cambodia, the experiences of NGOs over time share distinct characteristics. From the 1980s to early 1990s, NGO operations were at the provincial level and hospital

based. They were criticized for creating multiple strategies (CNM, 2001), and for being dependent on and having limited negotiation power with international agencies. This contrasts sharply with the situation today, as the majority of NGO are confined to the conventional, monopolized donor system, the structure of which is characterized by numerous regulations and policies aimed at accountability and transparency. My informants told me that accountability procedures create frustration, and that work results tend to be distorted due to the administrative processes that need to be followed and the documentation required. Furthermore, as per the global trend with international aid, and as reflected in the GF's policies and regulations, NGOs are obliged to work under the local, national structure and respect the national authority. Overall, around 10 organizations are providing some form of malaria intervention in Cambodia, of which four are sub-recipients of the GF. One is a recipient of USAID funding, and the remainder are include both local and international NGOs who are the 'sub-sub' recipients or "partners" of the four international organizations. Only a few organizations are genuinely independent of the GF, or are in a sub-grant relationship with other donors.

Apart from the limitations imposed by the funding bodies in question and the national structure, the historical existence of NGOs, and the substance of their interventions, gives the impression that they are taking part in a win-win development game, with all actors benefiting simply by participating. Almost all NGOs have moved toward specialization in particular health fields, such as sanitation, rural development projects and malaria specific interventions. It has been suggested that this has occurred in order to appeal to funding bodies, however, the substance of the majority of interventions conducted by NGOs is extremely problematic. Some blindly expand to conduct clinical research on drug resistance, others provide community funding to commune councils – completely ignoring the country's political arrangements – while others project their expertise at providing so-called 'technical assistance', but then produce unrealistic and unviable strategies.

International organizations are totally dominant in the area of malaria interventions, which adds another dimension to the sector, as local NGOs are non-existent. Those NGOs that have a number of areas of specialization struggle to survive, as they are only sub-contracted by the PSI to create a uniform strategy in the western provinces of Cambodia. The creation of this 'bundle' of NGOs has been politically driven. One informant stated that the motivation for this move stemmed from the availability of funds emanating from the GF, and its use of contracted NGOs to work with the state. The bundled organization in question was created by leaders of the CNM, who expected it to absorb some of the available GF funding. This development has received a negative response from the GF, as well as

from the Minister of health, nonetheless, the organization still operates and the director continues to work as a civil servant.

The manner in which NGOs connect with one another reflects an ambiguity which leads more to a scenario of 'tight lips' and self governance than of preaching to others. The word "partnership", used by and between these organizations, does not reflect their relationships in practice. Reich (2002) states that partnership occurs when two or more entities work together to achieve a common goal and agree to share both effort and benefits, however, a few NGOs, in particular those that claim more prominent roles, arguably for self-benefiting purposes, invade the field by grouping a few NGOs under their own management, and then claim a partnership relationship. Further, a few organizations that are equivalent in terms of working structures and dependencies may establish a partnership with one another when funding is available from one side. As these organizations do not have a relationship based on significant values other than a patron-client relationship, but on money, they are unable to criticize each others' actions. Buzz words like "collaboration" are often used to depict the relationship between these NGOs and the state, but it is illusive. Arguably, they try to conceal the reality of the hegemonic relationship between the two actors, using the term "capacity building" when teaching local people to do things in the way the patronizing entities want. At the national level, most of the NGOs are sub-recipients of the GF funds, and are subjugated to the authority of the CNM in terms of how and where they should be working. At the sub-national level, even greater discrepancies in power dynamics reveal another side to the story. NGOs working on malaria interventions still hold significant power and dominate the underpaid health professionals. After 30 years of development in Cambodia, the term 'capacity building' has lost its meaning. Health professionals are taught to collect data and monitor processes so as to fit the unrealistic goals of the global network, particularly with respect to the elimination of malaria.

Unlike in the 1980s and 1990s, one positive aspect is that NGO activities across the country appear to be better coordinated under the CNM. As funding sources have turned out to be quite limited, so the approach of the GF towards the NGOs as a group, as well that of government agencies, has created advantages in terms of providing geographical coverage and avoiding overlap.

A good example of the limited role these NGO actors play, is the development of a national strategy for mobile and migrant populations. This strategy is separate from many of the other national strategies on malaria intervention, and has been promoted by one organization called Malaria Consortium (MC), amid the complexity of defining 'mobile and migrant populations'. The MC has a structure very similar to the current government, as it has experienced conflicting centralization and decentralization moves. The presumed role of the MC as

an institution which assists the CNM is another part of the problem. This role is perceived necessary to assist the development of diverse national strategies; for instance, the strategy for behavioral change and communication, and the national malaria survey, but bringing them together as a national strategy; to work as guiding principles for the sub-national actors.

However, a staff member of the organization leading the strategy development activities said it would lead nowhere. The paradigm shift within the GF's funding regulations means it is likely this strategy will be placed on the shelf at the CNM library. The role of the MC is self-defined, and the intention is to establish a national strategy framework, no matter how viable that strategy is. Delivering the paper-based strategy is also a matter of finances, as it is required by the funding. It is considered good to leave some tasks unfinished, so that future donors will be willing to buy in.

These sentiments were expressed at the last meeting I attended during the latter stages of my research on the strategy paper being developed. Participants from NGOs working on malaria interventions, representatives from the MC, and a vice-director from the CNM, all attended the meeting. Furthermore, a former full-time NGO worker (a Westerner of course) who had recently become a research coordinator after 20 years of service, made a significant input to the paper. An anthropologist recognized for his work on social interactions, particularly with respect to malaria in Cambodia, also attended the meeting. For the anthropologist, the focus of the strategy paper was misleading; it did not capture the whole dynamic of interactions, and in particular the characteristics of migrant populations in each province and the specifics of local dynamics. It was felt that this action represented yet another top-down approach that lacked local specifics. However, MC staff projected a different viewpoint. They argued that the development of the strategy had involved full consultation with the local authorities (health department directors in each province, provincial malaria unit supervisors and operational district health staff etc.). In fact, this consultation was just lip service, as those people involved had only a one hour workshop dedicated to their input. I attended one of the workshops; the people facilitating it rushed to write their notes and then hurried out for a break and for food. There are also conflicting dynamics between authorities and those in power at the top. For instance, the Malaria Unit supervisors are subject to the authority of the provincial governor, as well as the Ministry of Health and the CNM. Such strategies, once approved by a committee at the MoH, appear to have full legitimacy, handing implementing power as well as management authority to the CNM.

At the workshop, the concerns voiced by the Chair of the meeting could not be heard by those around the table. It seems appropriate here to describe the position and status of the Chair. He is the vice-director of the

CNM, and had been requested by the MC to lead the workshop, as it was concerned with “national property”. During the meeting, the Chair constantly raised the possibility of inviting an “expert” in to develop the strategy paper, due to the paper being small and not having the usual characteristics and structure of a national strategy document. Drawing on his knowledge of what was being done in one of Cambodia’s regions, his request was directed in particular at the WHO. It was not explicitly stated, but can be interpreted that he was preparing to withdraw his contribution in the midst of the unclear salary supplement policy and due to low government pay. Almost all the Western actors in the room tried to silence the vice-director, arguing that actors with local knowledge are the experts, and forgetting to view the concerns raised from another perspective, even one as far removed as the vice-director’s. However, the Western aid workers receive better pay and do not have to deal with the political agenda set by the “mentality management” of the Cambodian government, as described previously.

As the debate reached no conclusion as to what should (or should not) be done, other NGO representatives were proud to discuss their bed net loan scheme, which was providing nets to mobile populations via plantation owners. One NGO worker mentioned about the need to develop an “holistic approach”; to have multiple players from different disciplines involved, such as those from the labor management sector, as well as the forestry, mine and energy sectors (to cover dam construction workers). Again, another question to raise here is: How do these NGOs have the authority to take over this role; especially within the context of the political ‘mentality management’ working culture? The WHO staff member responded to the vice-director by referring to an element of its regional project which covers the mobile and migrant population, but this was his only response. As described earlier, this response again raises questions as to what the WHO is doing with all its intertwined regional and global responsibilities.

For this strategy, perhaps a more viable and realistic way to move forward would be to have it integrated with the overall malaria elimination strategy, and to be funded by both national and international budgets. This statement is based on the assumption that it could be adapted later according to conditions in each province. Such a proposal appears significant in light of the current structural authority and power of the Cambodian health system. As far as the current funding is concerned, the GF has not provided any ideas as to how to implement the strategy. The CNM’s malaria elimination strategy, meanwhile, as a partner of the GF, does suggest incorporating part of the mobile and migrant population into its implementing framework, yet it is unclear on what basis or strategy it is founded.

In short, as time passes, the roles of the NGOs working on malaria interventions in Cambodia have become very much constrained by the authority and

power of the donors and government institutions involved. Whether they claim to be either active agents of or alternatives to the state (with comparative advantages), appears to be outside of the current context. NGOs arguably self-define their roles, some of which are not needed by the country. The words used by such development agents, however, are used to disguise the reality; that they are either losing their sense of direction or concealing relationships that are not based on sound values. This situation is in sharp contrast to the NGOs’ philanthropic characteristics, as claimed when the sector was inaugurated. All of these points, together with the political hegemony that exists in the country, contribute to the argument that aid money benefits those who are working on malaria issues, rather than those who are directly affected by them.

CONCLUSION

As a country suffering from a quasi-total embargo, due to the civil war before, during and after the Khmer Rouge regime came to power, Cambodian malaria interventions were initiated by a few local health professionals with different external support, in order to address the country’s embryonic and critical needs. As time proceeded, the country could not escape the cycle of dependence on external assistance. Policies and strategies have subsequently been developed, ignoring the contextual locality at the sub-national level. In the meantime, the political will to fully take control of the country’s development has been sorely lacking, as reflected in the current “national structural impairment” situation that exists. The socio-political configuration in place has allowed the following scenario to develop.

Political patronage, under the philosophy of “mentality management”, facilitates the inflow of external aid, and the government might also be able to decide what types of aid should be allowed to flow into the country to suppress staff outrage, or that of the population as a whole, and allow it to survive. It also facilitates the maintenance of the political status-quo. The legacy of the massacres of the 1993 to 1997 period, and perhaps the failure of subsequent political leaders to ensure some sense of security, let alone prosperity, has contributed to the subordination to the current political system.

Confronted with local politics and policies, the only conventional donor for malaria programs, the GF, promotes its own agenda, policies and regulations, which, as time has moved on, have become stricter and more difficult to compromise. The establishment of the GF might demonstrate the good will of a group of people to assist those suffering from an avoidable and curable disease. Nonetheless, this help has not come without repercussions, particularly in terms of the pessimism that exists regarding its altruistic endeavors. When people act with good intentions, there are always some who believe

their good intentions are being manipulated, prompting them to seek out these manipulations using monitoring and evaluation frameworks, as well as audits. Therefore, an increasing number of policies and regulations are introduced to ensure funds are used in line with the relevant aid agenda. Largely, such actions arouse nationalistic sentiments and lead to dignity preservation among local people, through the denial of direct involvement. Yet such involvement in Cambodia remains limited due to a national survival scenario which is suppressed by the political patronage system. A few questions worth considering are: If one really wants to help another out of altruism, why care about where the assistance goes or how the money is spent? A new aid system avoiding the aforementioned scenarios is badly needed.

The work of the lead agency, the WHO, must be questioned, based on its obsession with the emergence of drug resistance, and having launched a containment project whose failure it has only reluctantly accepted. It has even sought justification for a similar project. Meanwhile, NGOs cannot escape from the donor-NGO relationship they find themselves in, or the 'partnerships' which just pay lip service to the word. For them, concealing their relationships with the government and dealing in capacity development jargon, they refuse to criticize the inappropriate actions of others. All of this has led, according to one critic, to the patronage system of the ruling government and those who work in this sector who have benefited the most. This critic, however, does not mean that the affected population, which is supposed to have been the beneficiary of aid, has not benefited at all, given the decreased incidence of malaria (Incardona et al., 2007), but it does call into question whether Cambodia could have done better without external aid.

The sensitive case of the survival strategy used by Cambodian civil servants, which leads to an adherence to political patronage on the promise of social status and survival, and uses aid as a substitute for low pay, poses significant questions on personal morality, and such a morality challenge should not have a place in Cambodian society at all. However, given the current political situation, as well as the actions of the current leadership, views on the future in terms of such a morality must be pessimistic rather than optimistic. It is always said among Cambodians that those who did survive the Khmer Rouge period did so because they were cunning and tricky enough to steal food. Such a statement, together with the argument that those who work in the government sector manipulate aid to maintain the status quo, should really be an impetus for a reconsideration of Cambodian values.

There are many reasons to assume that the frustration felt about the use of donors' money is known by the government. The awareness that Cambodia has to go beyond aid is accepted among Cambodian high-ranking

officials, in particular those working for the CNM. Nonetheless, the Cambodian government continues the politic of holding poverty hostage when dealing with the international community. This means that the need to maintain political support by allowing civil servants and certain parts of the population to flourish, as well as establishing a social network within government institutions (which then sustains a larger political network), suppresses any attempts to change the status quo in any meaningful way. Likewise, the consciousness that aid is not the long term solution to a country's development, but rather the political will of the country itself, is recognized among the donor community. Substantial evidence of this can be found in the "additionality conditions" set by the GF. While a number of researchers have argued that aid has many side effects (Mosse, 2005; Easterly, 2006), others have suggested that it is really up to the country itself to decide whether it steers national development or manipulates it to cover-up politically-motivated agendas (Abdulai, 2009; Holloway et al., 2009). In the Cambodian context, in which people appealed to and questioned the inaction of the international community during the Khmer Rouge period, it could be suggested that aid is critical. However, if a line is to be drawn in the sand, based on the view that the productivity generated by aid has reached a tipping point, and is now decreasing (as in the case of the GF and CNM), then where should this line be? Is it in years to come, or now?

Giving a country a significant amount of aid risks promoting a "culture of bagging", and this is particularly true in the case of Cambodia, where revenue substitution is very possible. This is not to say it cannot be right to beg, but rather that long-term begging should not embody the living spirit of a nation. It might be okay to beg when there are no choices left for a person or a nation, in order to survive, such as during Cambodia's recovery from the Khmer Rouge period. However, Cambodia has been begging now for more than 30 years, and there are no signs of it stopping. Linking this culture to malaria, and given the continuance of the inadequate health infrastructure, if not its reinforcement due to the current political patronage system, external assistance may be able to address the prevalence of malaria in the country, which is the result of social processes, and particularly in the midst of conflicting policies. But there is a chance such external help will fail to address the political and health system that sustains the disease. As such, it is highly likely that external assistance will not be able to prevent the re-emergence of malaria in newly established habitats (Obsomer et al., 2007), and particularly with the growth in new and large commercial cash crop growing areas, like rubber plantations (Obsomer, 2010), which arguably constitute the second realm of malaria epidemiology in Cambodia.

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