PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: 89898

Project Name	Cambodia SP Cash Transfer Pilot Project
Region	East Asia & Pacific
Country	Cambodia
Sector(s)	Social Protection
Theme(s)	Social Protection, Health, Nutrition
Lending Instrument	RETF Small Grant
Project ID	P132751
Parent Project ID	
Borrower(s)	Kingdom of Cambodia
Implementing Agency	National Committee for Sub-National Democratic Development Secretariat (NCDD-S)
Environmental Category	{ }A {X}B { }C { }FI
Date PID Prepared	July 29, 2014
Estimated Date of Appraisal Completion	August 5, 2014
Estimated Date of Board Approval	N/A
Decision	Project authorized to proceed to negotiations upon agreement on any pending conditions and/or assessments.

I. Country Context

1. Cambodia has witnessed rapid economic growth accompanied by an impressive reduction in poverty in the past decade. Poverty reduction accelerated in the last decade, dropping from 53 percent in 2004 to 20.5 percent in 2011, equivalent to 3 million people, and from 59 to 24 percent in rural areas over the same period.[1] At the same time, there have been corresponding improvements in some human development indicators in this period, as well. Education-related indicators, such as literacy rates and net primary enrollment rates, also improved.

2. However, for the case of health, progress has been limited. According to the 2011 MDG Progress Report, under 5 child stunting decreased by only three percentage points, from 43 to 40 percent, between 2005 and 2010; if this trend continues, it is unlikely that the target of 25 percent would be met by 2015. Children 0-5 years old underweight have not shown any progress (remaining stagnant at 28 percent), while the percentage of children wasted actually increased from 8 to 11 percent during this period.[2] These trends put Cambodia off track to achieve the children nutrition related targets of Cambodia's Millennium Development Goals (CMDGs), compromising its present and future human development potential. The long-term consequences of child malnutrition are severe—leading to poorer cognitive development—

[1] World Bank (2013), "Where Have All the Poor Gone? Cambodia Poverty Assessment 2013".
[2] RGC (2011) Achieving Cambodia's Millennium Development Goals, pp. 7-8.

which affects both human capital formation and economic growth. Similarly, over 45 percent of women reported that they had received vitamin A and iron and folic acid supplements in the six-week period following the delivery of their last-born child, which may reflect the fact that only over 60 percent of women received comprehensive antenatal care or post-natal care. Persistent inequalities remain: 21 percent of women in the lowest wealth quintile did not receive antenatal care compared with only 1.5 percent of women in the highest quintile.[3] Only a third of women in the lowest quintile delivered their babies in health facilities, compared to 88 percent of women in the highest quintile. Inadequate contact with the health system prevents poor women from acquiring information on breastfeeding, complementary feeding practices, management of diarrhea, and hygiene practices, all of which are directly related to nutrition.

3. The Royal Government of Cambodia (RGC) has introduced several measures aimed at improving the coverage and quality of health and nutrition services through the public health system. The government's Rectangular Strategy prioritizes the provision of free health care for the poor, and the promotion of maternal and child health. However, with the exception of Health Equity Funds (HEF), supply-side interventions do not necessarily address barriers to access faced by poor households. As a result, utilization of these services among poor women and children remains low.

II. Sectoral and Institutional Context

4. International research shows that investing in maternal and child health and nutrition programs helps prevent future productivity losses and makes investments in education at later stages of the life cycle more efficient, by decreasing the probability of drop-out and repetition. Stagnant (and even declining) nutritional indicators among poor Cambodian women and children suggest that more needs to be done to promote healthier nutrition-related behaviors.

5. Cash transfers targeted to poor mothers and children can help address the demand-side constraints faced by poor Cambodian women to access health and nutrition services. This tool has been proven successful in many countries (e.g., Brazil, Mexico, Colombia, Philippines, and Indonesia) as one to encourage utilization of health services and to promote good health and nutritional practices.[4] They provide the flexibility to be tied to conditions that address specific demand-side issues (e.g. payments linked to compliance with prenatal and postnatal care). In doing so, these programs not only help reduce current poverty but also promote the accumulation of human capital. The way payments are made, or conditions attached to receiving payments, can be used to provide incentives to households to change their behavioral practices. This has been already demonstrated in the Cambodian context as well: the Scholarship for the Poor program, which, by paying a scholarship conditional on attending school, is a form of CCT, was found to have significantly increased enrollment.[5]

[3] World Bank (2013).

[4] Various evaluations of these programs are available. See for instance Fiszbein and Schady (2009), " Conditional Cash Transfers: Reducing Present and Future Poverty," World Bank.

[5] Filmer and Schady (2008), "Getting Girls to School: Evidence from a Scholarship Program in Cambodia," Economic Development and Cultural Change 56: 581-617.

6. In turn, increased utilization of health services can in some cases lead to improved nutrition, often due to complementary provision of nutritional education and supplements. For example, in Nicaragua, it has been shown that height-for-age for 0-5 year-old CCT beneficiary children increased by 17 percent; while in Mexico, the CCT has had an estimated impact on child height of approximately 1 cm for children between 12 and 36 months of age.[6] In fact, international research shows that investing in maternal and child health and nutrition programs helps prevent future productivity losses and makes investments in education at later stages of the life cycle more efficient, by decreasing the probability of drop-out and repetition.

7. Social protection (SP) has emerged as a priority for the RGC with the endorsement of the National Social Protection Strategy (NSPS) in December 2011. The NSPS, which is fully aligned with Cambodia's National Strategic Development Plan update 2009-2013 (NSDP), provides a coherent framework for social protection provision in Cambodia that seeks to reduce vulnerability and promote human capital development. The NSPS recognizes the importance of building human capital early in life through demand-side interventions targeted to poor and vulnerable women and children, which can complement existing social service provision. In this context, cash transfers are identified by the RGC as one of the main instruments for implementing the NSPS.

III. Project Development Objectives

8. The project development objective (PDO) is to help increase the utilization of essential health services by pregnant women and children (0 to 5 years of age) in targeted districts, and enhance the readiness of delivery mechanisms of the social protection system.

IV. Project Description

9. The Project comprises the following three components:

- ***Component 1: Support to the National Social Protection Strategy ($100,000):*** This component will be implemented by CARD. The component's main activities include: 1) updating the National Social Protection Strategy, 2) developing a unique registry of beneficiaries of social programs, 3) undertaking research activities, among them collaboration with the impact evaluation of the CCT Pilot (to be financed through a Bank executed TF), and 4) coordinating actors at the national level, including outreach events to disseminate information about the program and its impact evaluation.

- ***Component 2: Cash transfer and bonuses ($530,000):*** This component will be implemented by the National Committee for Sub-National Democratic Development Secretariat (NCDD-S). The component's main activities include: 1) basic cash transfers to enrolled beneficiaries through a "third party" financial institution, 2) cash bonuses for beneficiaries based on specific co-responsibilities relating to health service utilization and attendance to learning workshops; 3) financial institution fees for cash transfers, and 4)

[6] Fiszbein and Schady (2009).

provision of nutrition and sanitation workshops for enrolled beneficiaries. A basic cash transfer of $5 per month will be delivered regularly after enrolment to pregnant women or families with children aged 0-5 years that are categorized as IDPoor 1 or 2. Enrolment of pregnant women will be subject to establishing contact with the health center for antenatal care. Enrolment of children will be subject to presenting a birth certificate or vaccination card.

- ***Component 3: Strengthening of SP implementation systems ($220,000):*** Activities in this component include: 1) strengthening NCDD-S' management information system (MIS) to support implementation and monitoring and process evaluation; 2) strengthening the capacity of commune councils and district level staff to interact with service providers, respond to program needs including grievance redress, and monitor program implementation; and 3) other project administration costs.

V. Financing

Financing Source	**Amount**
BORROWER/RECIPIENT	
IBRD	
IDA: New	
IDA: Recommitted	
Others (AusAID financed RETF)	$ 850,000
Financing Gap	
Total	$ 850,000

10. The Project will be financed by a AusAID (DFAT) Trust Fund, with a Project closing date of April 30, 2016.

VI. Implementation

11. NCDD-S is designated as the implementing agency and will provide national level management and leadership to support sub-national implementation. The proposed arrangements for the implementation of the CT pilot are designed to be consistent with overall ongoing institutional development reforms in order to build a sustainable foundation for Cambodia's future SP system. NCDD-S will be responsible for facilitating overall implementation of the programmatic components of the CT pilot and will carry fiduciary responsibility for all components. NCDD-S has agreed to use its existing systems, which emphasize the role of decentralization, to coordinate with administrative districts, commune councils, and health centers at the selected pilot locations.

12. CARD will provide overall coordination and oversight for the implementation of the CT pilot, and will also be responsible for defining and implementing activities in Component 1, in its role as policy coordinator.

VII. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP 4.01)	X	
Natural Habitats (OP/BP 4.04)		X
Pest Management (OP 4.09)		X
Physical Cultural Resources (OP/BP 4.11)		X
Involuntary Resettlement (OP/BP 4.12)		X
Indigenous Peoples (OP/BP 4.10)	X	
Forests (OP/BP 4.36)		X
Safety of Dams (OP/BP 4.37)		X
Projects in Disputed Areas (OP/BP 7.60)*		X
Projects on International Waterways (OP/BP 7.50)		X

VIII. Contact point at World Bank and Borrower

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* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

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