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PROJECT PAPER

ON A

PROPOSED ADDITIONAL GRANT

IN THE AMOUNT OF US$ 12.69 MILLION

TO THE

KINGDOM OF CAMBODIA

FOR A

SECOND ADDITIONAL FINANCING
FOR THE
SECOND HEALTH SECTOR SUPPORT PROGRAM

September 11, 2014

Health, Nutrition & Population GP
East Asia and Pacific Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective August 28, 2014)

Currency Unit	=	AUD
AUD 1.07	=	USD1

Currency Unit	=	KHR
KHR 4,058.94	=	USD1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF1	The First Additional Financing
AF2	The Second Additional Financing
AfD	Agence Française de Développement
AOP	Annual Operational Plans
AUD	Australian Dollar
AusAID	Australian Agency for International Development
BTC	Belgian Technical Cooperation
DBF	Department of Budget and Finance
DfID	United Kingdom Department for International Development
FM	Financial Management
FY	Fiscal Year
GBP	Great Britain Pound
GGF	Good Governance Framework
HCs	Health Centers
HCW	Health Care Waste
HEFs	Health Equity Funds
HSP2	The Second Health Strategic Plan
HSSP2	The Second Health Sector Support Program
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IFRs	Interim Financial Reports
IP	Indigenous People
IPPF	Indigenous People Planning Framework
JPIG	Joint Partnership Interface Group
KOICA	Korean International Cooperation Agency
M&E	Monitoring and Evaluation
MDTF	Multi Donor Trust Funds
MEF	Ministry of Economy and Finance
MOH	Ministry of Health
NCB	National Competitive Bidding
ODs	Operational Districts
PDO	Program Development Objective

PHDs	Provincial Health Departments
POC	Priority Operating Cost
RGC	Royal Government of Cambodia
RHs	Referral Hospitals
SDGs	Service Delivery Grants
SDR	Special Drawing Rights
SOAs	Special Operating Agencies
SOP	Standard Operating Procedures
TWGH	Technical Working Group for Health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WHOPES	WHO's Pesticide Evaluation Scheme

Regional Vice President:	Axel van Trotsenburg
Country Director:	Ulrich Zachau
Sector Director:	Xiaoqing Yu (Through June 30, 2014)
Global Practice Senior Director:	Timothy Grant Evans (From July 1, 2014)
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KINGDOM OF CAMBODIA

SECOND ADDITIONAL FINANCING FOR THE SECOND HEALTH SECTOR SUPPORT PROGRAM

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KINGDOM OF CAMBODIA

SECOND ADDITIONAL FINANCING
FOR THE
SECOND HEALTH SECTOR SUPPORT PROGRAM

DATA SHEET

Basic Information – Second Additional Financing (AF2)	
Country Director: Ulrich Zachau Practice Manager/Senior Director: Toomas Palu/ Timothy Grant Evans Team Leader: Laura L. Rose Program ID: P150472 Expected Effectiveness Date: September 19, 2014 Lending Instrument: RE Additional Financing Type: Additional Financing	Sectors: Health (44%); Central government administration (24%); Sub-national government administration (24%); Other social services (4%); Compulsory health finance (4%) Themes: Health system performance (33%); Administrative and civil service reform (17%); Child health (17%); Population and reproductive health (17%); Participation and civic engagement (16%)
Basic Information - Original Program	
Program ID: P102284 Program Name: Second Health Sector Support Program Lending Instrument: Investment Project Financing	Environmental category: B Expected Closing Date: December 31, 2015 Joint IFC: None Joint Level: None
AF2 Program Financing Data	
[ ] Loan [ ] Credit [x] Grant [ ] Guarantee [ ] Other: Proposed terms:	

AF2 Financing Plan (USD m)	
Source	**Total Amount (US$ in million)**
Total Program Cost: Cofinancing: MDTF : Additional Financing from Australia and the Korea International Cooperation Agency Recommitted: 0 Borrower: 0 Total Bank Financing: IBRD IDA: New: 0 Recommitted: 0	12.69 Million

Client Information

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Responsible Agency: Ministry of Health

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AF2 Estimated Disbursements (Bank FY/USD in million)

FY	**2015**	
Annual	12.69	
Cumulative	12.69	

Program Development Objective and Description

Original Program development objective: Support the implementation of the government's Health Strategic Plan 2008-2015 to improve health outcomes through strengthening institutional capacity and mechanisms by which the government and development partners can achieve more effective and efficient sector performance.

Program description: The program will be delivered through four components. Component A focuses on strengthening health service delivery, Component B on improving health financing, Component C on strengthening human resources, and Component D on strengthening health system stewardship functions.

Safeguard and Exception to Policies	
Safeguard policies triggered: Environmental Assessment (OP/BP 4.01) Natural Habitats (OP/BP 4.04) Forests (OP/BP 4.36) Pest Management (OP 4.09) Physical Cultural Resources (OP/BP 4.11) Indigenous Peoples (OP/BP 4.10) Involuntary Resettlement (OP/BP 4.12) Safety of Dams (OP/BP 4.37) Projects on International Waterways (OP/BP 7.50) Projects in Disputed Areas (OP/BP 7.60)	 [x]Yes [ ] No [ ]Yes [x] No [ ]Yes [x] No [x]Yes [ ] No [ ]Yes [x] No [x]Yes [ ] No [x]Yes [ ] No [ ]Yes [x] No [ ]Yes [x] No [ ]Yes [x] No
Does the project require any waivers of Bank policies? Have these been endorsed or approved by Bank management?	[ ]Yes [x] No [x]Yes [ ] No

Conditions and Legal Covenants:		
Financing Agreement Reference	Description of Condition/Covenant	Date Due
None	None	None

I. Introduction

1. This Project Paper is to reflect additional donor receipts into the Multi Donor trust Fund (MDTF) to support the Second Additional Financing (AF2) of the Second Health Sector Support Program (HSSP2). The additional funds consist of AUD 9.5 million (US$8.86 million equivalent) and US$4.5 million (US$1.25 million in 2014 and US$3.25 million in 2015) from the Government of Australia and the Korea International Cooperation Agency (KOICA) respectively. These funds will provide additional grant financing for the Program (US$12.69 million) and for Bank management and supervision (US$0.67 million). The additional grant financing of US$12.69 million increases the total MDTF envelope for the Program to US$112.23 million and the total financing envelope for the HSSP2 to US$142.23 million, including IDA funds.

2. The HSSP2 became effective on January 19, 2009 with a financing plan of US$110.0 million pooled fund (exclusive of Government contribution) that included: an International Development Association (IDA) Credit of Special Drawing Rights (SDR)18.50 million (US$30.0 million equivalent), GBP 35.0 million (US$50.0 million equivalent) from United Kingdom's Department for International Development (DfID), and an initial allocation for the first 2 years of program implementation of AUD 37.2 million (US$30.0 million equivalent) from the Australian Agency for International Development (AusAID)[1].

3. The HSSP2 underwent three restructurings: in 2010, 2012, and 2014. The 2010 restructuring was to reflect the Royal Government of Cambodia's (RGC) decision to cancel the Merit-Based Performance Incentive and all other salary supplement and incentive schemes. The 2012 restructuring was to reflect the full trust fund resources available under AusAID and DfID and the additional contribution from AusAID of AUD 8 million (US$8.5 million equivalent) as part of its original commitment to fund beyond the first two years based on funding availability. The MDTF Grant Agreement was amended to reflect the additional funding in October 2012 to US$86.08 million. The first Additional Financing (AF1) of US$13.44 million (exclusive of Bank management and supervision cost) was approved on October 31, 2013, which included a scheduled payment from the DfID for GBP 4.7 million (US$7.2 million equivalent) and an additional contribution from AusAID for AUD 8.5 million (US$7.8 million equivalent). This brought the total MDTF contribution to US$99.53 million. The restructuring in 2014 was to extend the program closing date by 18 months (from July 1, 2014 to December 31, 2015) to allow time for completion of civil works and procurement of medical equipment. The extension was approved on June 11, 2014.

II. Background and Rationale for Additional Financing

4. The AF2 will provide financing to sustain and consolidate gains in the health service coverage under the Program, particularly for the poor. The additional funds will fill a nine month financing gap for health equity funds (HEFs) and service delivery grants (SDGs) between July 1, and March 31, 2015. It will also allow time for the World Bank, Australia, KOICA and the Ministry of Health (MOH) to develop the next phase of support to the health sector and align

[1] Development assistance from the Australian Government now comes from the Department of Foreign Affairs and Trade.

with the future investment operations of the Third Health Strategic Plan which is expected to commence implementation in 2016. The Amendment once approved will be effective retroactively as of July 1, 2014.

5. The Program Development Objective (PDO) is to support the implementation of the government's Health Strategic Plan 2008-2015 to improve health outcomes through strengthening institutional capacity and mechanisms by which the government and development partners can achieve more effective and efficient sector performance. While the PDO has not changed, the results framework has been revised to reflect the results which can be attributed to the Program and which are measurable.

6. Progress towards achieving the PDO and implementation ratings is Moderately Satisfactory, and the program is mostly on track to meet its development objectives. There has been steady progress towards achieving Cambodia's health millennium development goals which are the higher level outcomes to which the program contributes. According to the Cambodia Demographic Health Survey (2010), between 2005 and 2010:

- Infant mortality fell by 51 percent (from 37 to 18 per 1,000 live births).
- Child mortality fell by 52 percent (from 19 to 9 per 1,000 live births).
- Under-5 mortality fell by 35 percent (from 83 to 54 per 1,000 live births).
- Maternal mortality fell by 56 percent (from 473 to 206 per 100,000 live births).
- Total fertility rate fell from 3.4 to 3.0 with moderate increase in modern contraceptive prevalence rate from 27 percent to 35 percent.

7. Most program level indicators show improvement and are on track to achieve their targets. The team will also use AF2 as an opportunity to review and strengthen the monitoring and evaluation (M&E) framework, building on the recent portfolio review of M&E frameworks in Cambodia. Between the HSSP2 2008 baseline and 2013:

- Deliveries at health facilities increased from 39 to 80 percent.
- DPT-HepB3 (immunization) rose from 84 to 95 percent.
- The HEFs covered more than 75 percent of the poor in the country with a total number of beneficiaries of about 2 million.
- The number of poor patients receiving HEF support for their health care utilization increased from 152,000 to 1,196,735.

8. A Program Completion Review covering the period May 2008-December 2013 done by DfID rated the HSSP2 as an "A+" project that moderately exceeded expectation. According to the DfID assessment, factors that contributed to this progress include: (a) large health facility infrastructure improvements; (b) a coherent safety net with wide and expanding population coverage; (c) improvements in the numbers of health staff (notably midwives); (d) improved outreach; and (e) facility and individual incentives through HEFs and SDGs to SOAs. Together, there have been large increases in public health service coverage and access for the poor. Sustainability is likely. The HSSP2 has succeeded in building the capacity – both human and physical – to sustain these achievements. HEFs and SDGs are the performance based payments to health facilities and individuals to continue the functioning of the system. Over time,

government financial commitment to HEFs and SDGs has risen progressively from none in the first year of the project to 40 percent of the budget in 2014. These funds are held in a separate account which pools HSSP2 contributions with the government's contributions and ensures that the AF2 maintains and increases total funding to HEFs and SDGs and coverage will increase rather than shift to other priorities.

9. SDGs are internal performance based contracts between provincial health departments and 36 Special Operating Agencies (SOAs). Under HSSP2, the SDGs have expanded to 36 Special Operating Agencies (SOAs). SDGs are used to finance salary top ups as well as operation costs, including outreach. AF2 will maintain financing for the 36 SOAs. While performance monitoring and accountability arrangements for the 36 SOAs continue to improve, the possibility of SDG transitioning toward a mechanism that could better align with the HEFs will be explored with HSP3.

10. HEFs cover 55 of the 81 Operational Districts (ODs) in the country and AF2 will support expansion into six additional ODs. These 61 ODs will cover approximately 2.2 million people or nearly 80 percent of the poor in Cambodia. Identification of the poor uses the government's IDPoor mechanism. HEF's compensate facilities for waived user fees and are an important demand side incentive for service providers.

11. Financial support to the project activities that support strengthening human resources (Component C) and health stewardship functions (Component D) will not be included in AF2. In the case of human resources, the project objectives have been achieved. Support to human resources has exceeded its target of training secondary midwives and the percentage of health centers with a secondary midwife rose from 53 percent in 2011 to 75 percent in 2013. Training institutions have been established and are financed through user fees or provincial revenues. The existing staff at health facilities is sufficient to effectively implement SDGs and HEFs including those in the six new ODs.

12. Improving quality of health services delivered by staff is part of a new USAID financed project on Quality Improvement. The government has agreed to begin quality assessment of facilities supported under HSSP2 using the new level 2 assessment tool no later than October 31, 2014. Successful implementation of the tool will be an important element of a potential HSSP3.

13. The programmatic analytical and advisory assistance (PAAA) financed from the Bank executed part of the MDTF has supported most of the activities initially included in the HSSP2 component on strengthening health sector governance and stewardship in areas such as decentralization, health care financing, and financial management. Continued support for the decentralization and de-concentration reform is being provided through Australia (bi-lateral funding) and UNFPA. A new PAAA focuses on health care financing, social protection, and financial management. Additional support for financial management is also provided as part of the Bank's support to public administration reform. Success in these areas has and will continue to be dependent on broader reforms of the government in areas beyond the health sector such as civil service salary, decentralization, and commitment to the transparency of the budget and procurement.

14. The AF2 will not finance outreach and operating costs. This is due, in part, to the limited funds available for AF2 and also previous agreement that the government would progressively finance recurrent costs to improve long term sustainability of the Program. The 2014 national budget includes allocation for outreach and operating costs and the 2015 annual operational plan instructs all provinces to incorporate financing for outreach services under the national budget. Facilities can continue to use the user fees generated at health facilities (including from HEFs and SDGs) to cover these expenses. Bilateral and multilateral donors, UN agencies and NGOs will also continue to fund outreach.

15. Donor Collaboration: HSSP2 was designed and supported by seven Program Partners, including the World Bank, AusAID, DfID, Belgian Technical Cooperation (BTC), Agence Française de Développement (AfD), UNICEF, and UNFPA, with coordination through the Joint Partnership Interface Group (JPIG). AusAID and DfID pooled funds through an MDTF managed by the World Bank, and UNICEF and UNFPA made contributions directly to the MOH pooled fund account. BTC and AfD managed their funds separately using harmonized procedures. BTC has now left Cambodia, and DfID and AfD ended their participation in 2013. In addition to AusAID, the remaining donors will continue to support HSSP2: UNICEF will pool US$0.4 million on an annual basis, and UNFPA will provide approximately US$4 million per year on a discrete funding basis. In addition, KOICA has joined JPIG and has committed US$4.5 million to the MDTF for 2014-2015.

16. Disbursements: Total disbursements from the IDA Credit and MDTF as of 26 August 2014 were SDR16.62 million and US$97.35 million, equivalent to 90 percent and 98 percent of the total allocated credit of SDR18.5 million and US$99.53 million MDTF, respectively. The contracts for continuation of HEFs and SDGs have been signed and will disburse quickly once the AF2 is effective.

17. Legal Covenants: All legal covenants have been substantially complied with. The Joint Annual Operational Plan and Appraisal was completed in January 2014 rather than before September as required in the covenant. It comprised: (i) joint technical pre-appraisal of the AOP in August 2013; (ii) commitment of resources for 2014 from each Program Partner and the Government during the Joint Review Mission in October/November 2013; and (iii) joint appraisal and approval of the AOPs in January, 2014.

18. Reimbursement of counterpart funds for the HEFs and SDGs improved substantially in 2013 and 2014. There are no outstanding audit reports or Interim (unaudited) Financial Reports (IFRs) as of 8 July 2014. The audited financial statements for year 2013 were submitted on 28 March 2014 and the audit opinion is unqualified (clean).

III. Proposed Changes

Program Description

19. The current program funds available are sufficient only to cover civil works and procurement of equipment. The AF2 will allow continuation of the HEFs and SDGs over a nine

month period, i.e. through March 31, 2015. The following is a summary of the anticipated extended activities as a result of the AF2.

- **Component A: Strengthening Health Service Delivery.** Continue financing of SDGs in 36 SOAs.

- **Component B: Improving Health Financing.** Continue financing HEFs in 55 ODs and expansion into 6 additional ODs. These 61 ODs cover approximately 2.2 million people or nearly 80 percent of the poor in Cambodia. Support to further strengthening and developing an institutional framework for health financing, including making progress toward the establishment of national oversight institutions for HEFs and social health insurance is being supported by a new Programmatic Health analytical and advisory assistance (P145030).

- **Component C: Strengthening Human Resources.** No additional funding.

- **Component D: Strengthening Health System Stewardship Functions.** No additional funding.

20. The table below represents the proposed changes and revised cost estimates by Program Component with the AF2.

Table 1: Program Cost by Components and Sub-Components (In US$ million)

Program Component and Sub-Components	**Support under AF2**	**Original Financing and AF1 approved for MDTF in October, 2013**		**Additional Financing-AF2**
		IDA	MDTF (AusAID and DfID)	MDTF (AusAID and KOICA)
Component A: Strengthening Health Service Delivery 1. SDGs in support of SOAs 2. Strengthening health service management, supervision and public health function • Reproductive, Maternal, New Born and Child Health • Communicable Diseases • Non Communicable Diseases 3. Health Service Delivery network	Continued support of SDGs in 36 SOAs.	15.0	46.77	3.51
Component B: Improving Health Financing 1. Improving Health Financing for the poor	Continued support of the HEFs with expansion to 6 more ODs (from 55 to 61).	3.80	17.65	9.18

2. Support to Health Financing Polices and Institutional Capacity				
Component C: Strengthening Human Resources • Strengthening training institutions and programs • Strengthening Human Resource Management	Implementation of these activities will close on June 30, 2014	3.40	11.24	-
Component D: Strengthening Health System Stewardship Functions 1. Strengthening Health System Stewardship function 2. Support to Policy development and implementation 3. Strengthening Institutional Capacity 4. Strengthening Private Sector Regulation and Partnership 5. Governance and Stewardship functions of national programs and center 6. Strengthening Community Participation	Implementation of these activities will close on June 30, 2014	7.80	23.87	-
Total		**30.00**	**99.53**	**12.69**

21. The scale up of the Program **(**Grant TF093574**)** reflects the additional receipts from donors and the proceeds of the Grant will be allocated against Category 7 as follows:

Table 2: Proceeds for the Cambodia AF2 for HSSP2- Grant No. TF093574

Category	**Amount Grant Allocated (Expressed in US$)**		**Percentage of Expenditures to be Financed (inclusive of Taxes)**	
Current	Current	Revised	Current	Revised
1. SDGs	1,596,476	No Change	100% of the Grant's agreed share of the cost of the approved AOP for each FY, up to June 30, 2010	No Change
2. HEF Grants	2,508,315	No Change	100% of the Grant's agreed share of the cost of the approved AOP for each FY, up to June 30, 2010	No Change
3. MBPI related payments	180,000	No change	100% of the Grant's agreed share of the cost of the approved AOP for each FY, up to June 30, 2010	No Change

4. Goods, Works and Services, Operating Costs and training under the program other than under Categories (1) through (3)	11,550,719	No Change	100% of the Grant's agreed share of the cost of the approved AOP for each FY	No Change
5. Unallocated		No Change		
6. POC under Part C of the program	340,438	No Change	No Change	No Change
7. SDGs, HEF Grants, goods work and services, operating costs and training under the program	83,359,452	12,695,325	100% of the Grant's agreed share of the cost of the approved AOP for each FY starting July 1, 2010	100% of the Grant's agreed share of the cost of the approved AOP for each FY starting July 1, 2014
Total	**99,535,400**	**112,230,725**		

22. During negotiations for HSSP2, it was agreed that the government would provide counterpart financing for HEFs and for SDGs, with an increasing percentage each year. In 2013, the HSSP2 financing share for HEFs and SDGs was 60 percent, with 40 percent counterpart funds provided from the RGC budget. Counterpart financing has been fully integrated into the MOH budget since 2014 and the financing share for HEFs and SDGs remains at 40 percent.

Results Framework

23. The Program's results framework has been revised to only include targets that can be attributed to the Program's activities and can be measured. In some cases, the type of indicator has also been revised, such as from PDO level to intermediate level and vice-versa. All relevant core indictors are included. The six month additional financing for HEFs and SDGs allows the HSSP2 to report outcomes for the entire 2014 and is consistent with the government's targets for 2014. Given the achievements so far and continue funding for HEFs and SDGs, it is likely that the 2014 targets will be achieved. These indicators and targets are aligned with that of the government's own health strategic plans new results framework is in **Annex 1**.

IV. Appraisal Summary

Economic and Financial Analysis

24. The economic and financial analysis undertaken for the original program concluded that a strong rationale existed for the program. The program was designed to support the government's own HSP2 and interventions and reforms promoted through the respective national programs broadly reflected international good practice and can reasonably expect to generate significant

health outcomes. The AF will continue to support these interventions and particularly, the HEFs and SDGs, therefore economic justification for the AF2 remains strong.

25. In terms of sustainability, the original program concluded that external financing is likely to be needed over the period of the HSSP2 implementation, but with the expectation that the government budget will take on an increased share of financing over time. External financing and funding predictability were deemed necessary, however, if the goals of HSSP2 were to be met, thus reducing some of the risks that the government faces. Under the AF2, the government will continue to provide a share of the counterpart financing for the HEFs and SDGs, and will integrate routine operational costs into the government budget. To strengthen organizational capacity to implement and monitor health sector progress, targeted technical assistance is being provided through the HSSP2 partners as well as a second program of analytical and advisory assistance (P145030) referenced above, including: M&E, quality of care, health financing policy reforms, and public financial management reform.

26. Financial Management (FM): The World Bank's FM team carried out an assessment of the FM system of the HSSP2 in December 2013 and January 2014. The overall FM risk is substantial. Financial management is still supported by a team of local consultants to ensure compliance with financial policies and procedures and reliability of financial reports and their timely submission. The existing FM system is still relevant and FM measures are provided to further strengthen the current FM system. Some of the main actions include: (a) introducing accounting software to selected SOAs and/or Provincial Health Departments (PHDs); (b) involving internal auditors of MOH into an audit of the HSSP2's operations under the support from the internal audit consultants; (c) placing more control over soft expenditures by establishing agreed standard rates as much as possible to minimize self-producing receipts/invoices; and (d) updating the chart of accounts to enable financial reports in line with the Government's new chart of accounts. The submission of the quarterly integrated technical and financial audit reports and the IFRs have improved substantially. As of July 8, 2014, there are no outstanding audit reports or IFRs. The audit of the annual financial statements for 2013 was received before the deadline and the audit opinion is unqualified (clean). The current arrangement for an external quarterly integrated technical and financial audits, IFRs, and annual audit of the financial statements will continue under AF2.

27. Procurement: The proposed AF2 will follow the same procurement arrangement designed for the on-going HSSP2 program, but take into account: (a) the updated procurement legislation including the public procurement law promulgated in 2012, the Standard Operating Procedures -- SOP (including the Procurement Manual) for all Externally Funded Projects/Programs in Cambodia issued under Sub-Decree 74 dated May 22, 2012; and (b) the World Bank's Procurement and Consultant Guidelines dated January 2011 and the updated national competitive bidding (NCB) Annex based on the above updated SOP. The Financing and Grant Agreements will be amended accordingly to reflect these changes.

28. The procurement risks identified during the preparation of AF2 are: (a) capacity constraint of procurement unit of HSSP2 Secretariat; (b) delays in progress at the national level procurement, (c) delay in decentralized procurement; and (d) governance associated risks. The overall procurement risk for AF2 is high. However, this risk will be mitigated through the agreed

action plan included in the procurement section of **Annex 3.** The residual procurement risk is substantial.

29. Safeguards: The original program is classified as category B. It triggered Environment Assessment (OP/BP 4.01), Pest Management (OP 4.09), Indigenous Peoples (OP/BP 4.10), and Involuntary Resettlement (OP/BP 4.12). The same safeguard policies are triggered under AF2. Although AF2 does not finance civil works, the Framework for Land Acquisition Policy and Procedures and the Environment Management Plan have been updated following lessons learned from HSSP2 and AF1 and in anticipation of a potential third additional financing. As preparation for AF2, the Indigenous Peoples Planning Framework (IPPF) was also updated taking into consideration findings from the social assessment conducted based on free, prior and informed consultations with IP communities. All were disclosed on June 25, 2014. The implementation of the various safeguard policies – described below – has been satisfactory.

30. Social: Ill health is a leading cause and consequence of poverty in Cambodia. Health care remains for many expensive, of poor quality and difficult to access. Key social development issues pertaining to health in Cambodia, include: (a) uneven distribution of growth and significant difference between urban and rural and rich and poor households' access to health services and outcomes; (b) different health needs and challenges among women and men; (c) high vulnerability to poor health and poverty among the poor and ethnic minorities and in remote and difficult to access areas; and (d) limited capacity for community participation in health service delivery. HSSP2 aims to ensure improved and equitable access to essential quality health care and preventative services. Target beneficiaries are women, children and the poor, all of whom are exposed to high health risks and are disadvantaged in accessing affordable health care. Given the program's focus on maternal and child health, children and women of reproductive age in particular are expected to benefit from the program, which will extend the health network and make it more affordable. During the implementation of HSSP2 and AF1, measures were taken to address constraints of access to health care services identified by the indigenous peoples (IP). During the preparation of AF2, social assessments (including free, prior and informed consultations with IP communities) were conducted which confirmed continued support of IP communities to program activities. The Framework for Land Acquisition Policy and Procedures prepared during the preparation of HSSP2 was updated for AF2 taking into account the lessons learned from the HSSP2 and AF1. The IPPF was also updated based on findings from social assessment undertaken during this AF preparation.

- *IP*. The social assessment conducted during the preparation of AF2 found that IP communities still face particular challenges in accessing health services and tend to be particularly vulnerable to poor health. Many minority groups live in rough-terrain - highland and border areas that are hard to reach, and are generally poorer than average. The sheer physical geography of these settings poses special challenges, as well as costs, in terms of accessing, providing and maintaining health care services. The IPPF developed under HSSP2 has been updated under AF2. The nature, scale and scope of impact that may occur on IP under AF2 are expected to be the same as those under HSSP2, and IP communities will continue to benefit from the program. During the implementation of HSSP2 and AF1, steps were taken to address issues found during preparation based on the free, prior and informed consultations with

affected IP communities. Such measures include: building technical capacity of health facility staff at primary care level for providing quality health services to IP; providing SDGs, particularly to areas where most IP reside, to improve the functioning of health facilities; 24 hours opening and improve staff attendance so that IP can access health care services at any time as needed; financing health outreach activities so that IP in remote and difficult to access communities can receive basic preventive and curative services; establishment of HEFs to pay for health care services on behalf of poor IP; and construction of new health facilities for bringing health services closer to IP. Regular exit interviews were conducted with users including those from ethnic minorities as part of the implementation of HSSP2 and AF1, which found that they are satisfied with the services provided and that no negative impacts occurred to them under the program.

- *Involuntary Resettlement.* Although no civil works is financed under AF2, the Land Acquisition Framework Policy and Procedures developed under the original program has been updated. A comprehensive review of land acquisition conducted during the original program carried out by MOH under the support of the World Bank confirmed that almost all construction sites were on state land. In a few instances, private land was acquired (either through voluntary donations or land swap, or against compensation at market prices agreeable to affected people), as per provision of the Land Acquisition Framework Policy and Procedures. According to the inventory, all plots of land acquired were less than 5 percent of the owners' properties, and no physical relocations took place.

31. Environment. The AF2 will continue to finance activities that will pose possible environmental risks related to use of pesticides such as for control of vector-borne diseases (e.g. malaria and dengue) and improper management of health care waste (HCW). HEFs purchase the benefits directly from hospitals and health centers that may use those funds to procure drugs and supplies along with financing administrative costs. SOAs may also use part of their SDGs to support the administrative costs of outreach activities which include using larvicides for dengue control.

- *HCW.* Guidelines under the existing HCW Generation and Management Plan are deemed adequate for AF2 activities and compliance during HSSP2 has been good. The Guidelines incorporate best HCW management practices and are intended for practical application at health care facilities. Training on the Guidelines has been provided to health facility staff all over Cambodia by the Department of Hospital Services of the MOH. Compliance with the guidelines will continue to be monitored during regular program supervision, particularly maintenance of incinerators. Health facilities are expected to finance any cost associated with implementing the guidelines from the HEF payment and SDGs to the facility for health benefits.

- *Pest Management.* Control procedures are set out in the Pest Management and Monitoring Plan. The program only supports purchase of larvicides (Abate/BTI) for dengue control. These are considered to pose very low risks to humans if used correctly and certified by WHO's Pesticide Evaluation Scheme (WHOPES). The

products are transported in safe containers provided by the vendors and used containers are disposed of according to best practice; they are not used for storage or other purposes.

32. Program risks are identified in the Operational Risk Assessment Framework, and the overall risk rating by the team is Substantial, attributed mainly to capacity constraints (fiduciary) and overall governance risks. These institutional factors would potentially have a large impact on program implementation and likelihood of materializing is considered high. The AF2 will, however, build on the activities and implementation arrangements that have worked, without major changes in the institutional set up but complementary with targeted technical assistance (national and international) where there are capacity gaps.

ANNEX 1: RESULTS FRAMEWORK AND MONITORING[2]

CAMBODIA: SECOND ADDITIONAL FINANCING FOR THE SECOND HEALTH SECTOR SUPPORT PROGRAM

Arrangements for Program Results Monitoring

Program Development Objective (PDO): to support the implementation of the government's Health Strategic Plan 2008-2015 to improve health outcomes through strengthening institutional capacity and mechanisms by which the government and development partners can achieve more effective and efficient sector performance.

PDO Level Results Indicators*	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Percentage of births delivery by trained health personnel **Quality. Many deliveries by untrained people**		C	%	58 2008, NSDP Update	65	70	75	80	85 2013, NSDP Update	≥85	Annually	HMIS/JAPR	DPHI
				Achievement	64.48	69.78	71	74.68			Source: HMIS		
Percentage of births delivery by trained health personnel at health facility **Quality. Many deliveries by untrained people**		C	%	39 2008, NSDP Update	45	50	55	60	65 2013, NSDP Update	68	Annually	HMIS/JAPR	DPHI
				Achievement	50.22	58.64	61.39	66.33			Source: HMIS		

[2] The Results Framework was revised during the Level II restructuring in December 2010, and has been updated as part of AF2 to better align with the Program's contributions to the PDO and program activities.

Percentage (and number) of children under 1 year immunized with DPT-HepB3. **Coverage**		C	% and #	84	86	88	90	95	95	95	Annually Once every 5 years	NIP Strategic Plan 2008-15, Updated April 2011, p. 36. HMIS/JAPR CDHS 2010 CDHS 2015	DPHI MOP MOP
	Achievement				298,917 (95%)	340,242 (92%)	311,608 (94%)	336,549 (95%)			Source: HMIS for number; JAPR for percent		
Percentage of currently married women using a modern contraceptive method **Coverage**		**D** Data not reliable.	%	26 2008, NSDP Update	37	40	45	46	49	39 (target revised in new NSDP; earlier targets overly ambitious)	Annually Once every 5 years	HMIS/JAPR CDHS 2010 CDHS 2015	DPHI MOP MOP
	Achievement				22.32	28.25	29.19	30.48			Source: HMIS		
Percentage of HIV+ pregnant women receiving Antiretroviral drugs for PMTCT		**D** Project does not finance HIV/AIDS intervention. Covered by other donors	%	27 2008	40	50	55	60	65 HSP2 M&E	68	Annually	PMTCT Program, NMCHC	NMCHC
	Achievement				32.3	56.3	61.1	65			Source: PMTCT Program, NCHADS		

TB cure rate		**D** Project does not finance TB interventions. Covered by other donors	%	90 2008, HSP2 M&E	>85	>85	>85	>85	>85 2011, JAPR 2010	>85	Annually	CENAT	CENAT
	Achievement				92	92	92	91			Source: CENAT		
Number of malaria cases treated at public health facilities per 1,000 population		**D** Project does not finance Malaria interventions. Covered by other donors	#/1,000 population	4.10 2008, JAPR 2010	4.0	3.8 HMIS	3.6	3.4	3.7 2011, JAPR 2010	2.9	Annually	CNM	CNM
	Achievement				6.16	4.07	4.30	3.09			Source: CNM		
Percentage (and number) of children aged 6–59 months who received 2 doses of vitamin A supplement within the last 12 months **Coverage**	☐	C	% and #	89 2008, HMIS	90	96	96	96	96 NNP	96	Annually Once every 5 years	NNP HMIS/JAPR CDHS 2010 CDHS 2015	DPHI MOP MOP
	Achievement				2,098,061 (98%)	2,458,553 (95%)	2,429,712 (92%)	2,670,798 (98.9%)			Source: HMIS		
Percentage of children aged 12-59 months who received mebendazole		**D** Similar to coverage of Vit A.	%	71 2008, JAPR 2010	85	88	96	96	96 NNP	96	Annually	NNP HMIS/JAPR	DPHI

				Achievement	86	92	83	103			Source: HMIS		
Percentage of pregnant women receiving iron folate supplementation **Coverage**		C	%	80 2008, HSP2 M&E	75	83	85	86	87 NNP	88	Annually Once every 5 years	NNP HMIS/JAPR CDHS 2010 CDHS 2015	DPHI MOP MOP
				Achievement	83	80	89.69	91			Source: NNP		
Percent of poor population covered by Health Equity Funds **Social Protection**		**R** Moved from Intermediate Level	%	57 2008, DPHI	75	80	85			NA	Annually	Annual Report, DPHI	DPHI
				Achievement	73	77	78	78			Source: DPHI		
INTERMEDIATE RESULTS Intermediate Result (Component one): Strengthened Health Service Delivery													
Intermediate Results Indicators	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Consultations (new cases) per person per year: • All consultations		**D** Project not accountable for all consultation, just priority groups	#	0.54 2008, JAPR 2010	>0.5	0.6	0.6	0.6	0.6 HSP2 M&E	=>0.7	Annually	HMIS/JAPR	DPHI

Intermediate Results Indicators	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
				Achievement	0.54	0.64	0.64	0.63			Source: HMIS		
• Children under 5 years		C		1.1 2008, JAPR 2010	1.3	1.3	1.5	1.5	1.5 HSP2 M&E	1.9	Annually	HMIS/JAPR	DPHI
				Achievement	1.00	1.51	1.57	1.45			Source: JAPRs		
Percentage (and number) of pregnant women attending at least 2 antenatal care consultation	☐	C	% and #	81 2008, NSDP update	80	85	90	92	94 2013, NSDP Update	88	Annually Once every 5 years	HMIS/JAPR CDHS 2010 CDHS 2015	DPHI MOP MOP
				Achievement	83% (291,853)	72% (551,744)	86.24 (876,461)	87.01 (1)			Source: JAPR		
Percentage of deliveries by C-section **Quality.**		**D** May incentivize unnecessary procedures	%	2.0 2008, NSDP Update	2.0	2.5	3.0	3.0	3.2 2013, NSDP Update		Annually	HMIS/JAPR	DPHI
				Achievement	1.4	2.0	2.43	2.83			Source: JAPR		
Case detection rate of smear (+) pulmonary TB (%)		**D** Project does not finance	%	69 2008, NSDP	>70 39,900	>70 39,900	>70 39,900	39,900	>70 2013, NSDP		Annually	Annual Report, CENAT	

Intermediate Results Indicators	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
		TB interventions . Covered by other donors		Update					Update				
				NA	62	66	NA	NA			Note: *CENAT no longer measures this indicator*.		
Percentage of families living in high malaria endemic areas (<1km from forest) of 20 provinces have sufficient (1 net / 2 persons) treated bed nets (LLIT / ITN)		**D** Project does not finance TB interventions . Covered by other donors	%	75.6 2008, JAPR	75	80	85	85	90 2011, JAPR		Annually	Annual Report, CNM	CNM
				Achievement	75	82	95	95			Source: CNM		
Dengue case fatality rate reported by public health facilities		C	%	0.68 2008, NSDP Update	0.7	0.6	0.6	0.6	<0.6 2013, NSDP Update	0.7%	Annually	Dengue Program Annual Report HMIS/JAPR Annual Report, CNM/DCP	DPHI CNM/DCP
				Achievement	0.3	0.3	0.5	0.46			Source: CNM		
Percentage of children under 5		**D**	%	48	-	50	55	60	65	NA			

Intermediate Results Indicators	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
years with pneumonia receiving correct antibiotic treatment at public facilities		Only measured every 5 years. IMCI indicator (below, to be revised to cover quality).		CDHS 2005					HSP2 M&E		Once every 5 years	CDHS 2010 CDHS 2015	MOP MOP
				Achievement	NA	64.2	NA	NA			Source: CDHS 2010		
Percentage of children under 5 years with diarrhea having received ORT and Zinc at public health facilities		**D** Only measured every 5 years. IMCI indicator (below, to be revised to cover quality).	%	58 CDHS 2005	-	50	75	85	95	NA	Once every 5 years	CDHS 2010 CDHS 2015	MOP MOP
				Achievement	NA	52.6	NA	NA			Source: CDHS 2010		
Percent of health centers implementing Integrated Management Childhood Illnesses services		C	%	69 2008, JAPR 2010	75	80	85	90	95 2013, JAPR 2010	70	Annually	Annual Report, DCDC	Note: Decline from 2011 to 2012 due to attrition of staff and increase in number of HCs; Indicator refers to minimum

Intermediate Results Indicators	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
													number of 2 staff trained in Integrated Management Childhood Illness per HC DCDC
				Achievement	78	95	98	97			Source: DCDC		
Percentage or Number of adults with diabetes treated at public health facilities		**D** Project does not cover treatment of diabetes at all public health facilities nor as part of HEF package	%	3.5% 2008, NSDP Update	3	4.5			<0.55 2013, NSDP Update	NA	Annually	HMIS/JAPR	DPHI DPM
				Achievement	845	1,863	2,345	2,082			Source: HMIS		
Percentage of Essential Drugs (15 items listed) at HCs that faced stock- outs		**D** Not within control of the project	%	12.87 2008,JAPR 2010	<5	5	5	5	5 HSP2 M&E	<5	Annually	HMIS/JAPR Annual Report, DDF	DPHI DDF
				Achievement	6.5	5.35	4.71	4.18			Source: DDF		

Intermediate Results Indicators	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Intermediate Result (Component Two): Strengthened Health Financing and Protection of the Poor													
Percentage of Government health expenditure at provincial level and below		**D** Not in control of the project	%	29.8 2008, DBF						NA	Annually	NHC/JAPR Report (2013, page 55) Annual Report, DBF	DBF
	Achievement				31	27.14	31	25.77			Source: DBF		
Percentage of referral hospitals implementing Health Equity Funds		C	%	61 2008, DPHI					NA	NA	Annually	Annual Report, DPHI	DPHI
	Achievement				67	72	73	70			Source: DPHI		
Percent of Health Centers implementing Health Equity Funds		C	%	13 2008, JAPR 2010	15	20			NA	NA	Annually	Annual Report, DPHI	DPHI
	Achievement				14	23	30	36			Source: DPHI		

Intermediate Results Indicators	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Number of cases receiving Health Equity Fund assistance • OPD		C	#	152,000 2008					NA	NA	Annually	Annual Report, DPHI	DPHI
				Achievement	312,713	621,628	769,284	1,033,316					
• IPD				Achievement	102,205	123,353	78,122	137,637					
• Deliveries				Achievement	15,629	25,388	25,150	25,782					
Percent of poor population covered by Health Equity Funds **Social Protection**		**D** Move to PDO Level	%	57 2008, DPHI	75	80	85			NA	Annually	# of poor (estimated by ID Poor system) that live in ODs covered by HEFs	DPHI
				Achievement	73	77	78	78			Source: DPHI		
Number of individuals insured under CBHI schemes		**D** Project does not support CBHI, just HEFS	#	79,873 2008, NSDP Update					NA	NA	Annually	HMIS/JAPR Annual Report, DPHI	DPHI
				Achievement	130,397	170,490	237,441	166,663			Source: DPHI		

Intermediate Results Indicators	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Government health expenditure per capita		**D** Not in control of project	US$/cap.	7.75 2008, HSP2 M&E	8.46	9.82			NA	NA	Annually	Annual Report, DBF	DBF
	Achievement				8.64	10.78	11.59	13			Source: DBF		
Intermediate Result (Component Three): Strengthened Human Resources													
Ratio of MOH secondary midwives per 10,000 population per location		**D** No target values and better indicator for secondary midwives now available	Ratio/ 10,000							NA			
• Country ratio				1.35 2009, DP					NA		Annually	Personnel database, DP	DP
• Provincial average				1.40 2009, DP					NA		Annually	Personnel database, DP	DP
• Provincial median				1.74 2009, DP					NA		Annually	Personnel database, DP	DP
• Country ratio	Achievement				1.34	1.32	1,39	1.67			Source: DP		
• Provincial average	Achievement				1.38	1.37	1.42	1.74			Source: DP		
• Provincial median	Achievement				1.26	1.20	1.27	1.57			Source: DP		

Intermediate Results Indicators	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Percentage of health center having at least one secondary midwife		**N**	%						75	85	Annual	Annual Report, NMCHC	NMCHC
				Achievement			56	66			Source: NMCHC		
Intermediate Result (Component Four): Strengthened Health Sector Stewardship and Institutions													
Percentage of external funds for health included in AOPs		**D** Very process oriented and data not available	%	NA					NA	NA	Annually	Sector AOP DIC Database DBF	Note: Achievement for 2012 will be reported in Annual Health Financing Report due in July, 2013. DPHI,DIC,DBF
				Achievement	66.4	64.4	98.7	121.6			Source: AOP		
Percentage of functioning HCMCs *		**D** Not within control of the project and data not available	%	NA					NA	NA	Annually	Annual Report, NCHP	NCHP
				Achievement	NA	85%	85%	85%			Source: NCHP		

Intermediate Results Indicators	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Percentage of private entities licensed: - Polyclinics - Consultation cabinets - Maternity clinics - Dental clinics		**D** Not supported by the project	%	56 2008, JAPR 2010	5	77	82	87	NA HSP2 M&E	>95	Annually	Annual Report, DHS	DSH
	Achievement				72	93	100	100			Source: DHS		
Percentage of licensed private Pharmacies and Depots		**D** Not supported by the project		NA	NA	100%	100%	NA		100			
	Achievement				59	94	100	100			Source: DDF		
Arrangements for Program Results Monitoring													

Intermediate Level Results Indicators*	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			

Intermediate Level Results Indicators*	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Technical content and results-focus of AOP process improves based on Mid-Term Review (MTR) and Final Evaluation.		**D** No specific way to measure	Qualitative	PAD assessment			Improvement over baseline		Improvement since Mid Term Review	Improvement since Mid Term Review	Mid Term Review and Final Evaluation	Mid Term Review and Final Evaluation	External consultancy team and JPIG/ MOH
				Achievement	NA	NA	Improved	NA			Source: MTR Report, 2011		
Number and percentage of MOH central institutions and provinces submitting AOP and 3YRPs according to schedule and in MOH format		**D** Very process oriented and levels already very high	# and %	79% (2008)	85%	90%	95%	95%+	95%+	95%+	Annual	AOP database, HMIS	DPHI
				Achievement	NA	100%	100%	100%			Source: DPHI		
AOP resource allocation of program budgets reflecting HSP2 and JAPR priorities (1.MCH; 2.CDs; and 3.NCDs)		**D** No targets. Relevance not clear	#							NA	Annual	Sector AOP and JAPR	DPHI
				Achievement	NA	MCH: 8.9% CDC: 19.4% NCD: 2.2%	MCH: 20% CDC: 57% NCD: 3%	MCH: 17% CDC: 53% NCD: 2%			Source: DPHI		

Intermediate Level Results Indicators*	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Rate of Program execution for • pooled DP • Government funds		**D** Regularly monitored as part of implementation support	% %	NA 105% (JAPR 2009)	95% 95%	95% 95%	95% 95%	95% 95%	95% 95%	95% 95%	Annual Annual	HSSP Secretariat JAPR	HSSP Secretariat DPHI
• pooled DP					41%	59%	62.1%	61.5%			Source: DPHI		
• Government funds				Achievement	63%	94.8%	95.39%	96%					
Share of operating cost budget reaching contracting ODs		**D** Difficult to measure, not entirely in control of the project, and adds relatively little value	%	0	10%	20%	25%	30%	40%	NA	Annual	DBF, HSSP Secretariat	HSSP Secretariat
				Achievement	10%	20%	25%	30%			Source: IFRs		
Proportion of ODs implementing SDGs and internal contracting meeting at least 80% of their performance targets		C	%	0	60%	70%	80%	90%	100%	100%	Annual	SDMG	SDMG
				Achievement	NA	93%	100%	100%			Source: DPHI		

Intermediate Level Results Indicators*	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Financial Management Improvement Plan (FMIP) developed and Implemented		**D** Very process oriented and no longer relevant**.**		NA	FMIP developed	FMIP implemented	Continuous	HSSP2 progress reports	HSSP Secretariat	FMIP implemented			
				Achievement	Implemented	Implemented	Implemented	Implemented			Note: Based on DBF Training of Trainers (TOT) Training and Supervision activities.		
Number of MOH staff receiving POC payments financed by the program.		**D** No longer relevant		0						NA			
				Achievement	0	0	239 (from May 2011)	237 (up to June 2012) (1 staff retired in January 2012; 1 staff study abroad August 2011)			Note: POC scheme ended 1 July, 2012 Source: Personnel Department		

Intermediate Level Results Indicators*	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Annual health planning summits (JAPR and JAPA) conducted with wide stakeholder participation		**D** Monitored during implementation support	#		JAPA and JAPR conducted	JAPA and JAPR conducted	JAPA and JAPR conducted	JAPA and JAPR conducted	JAPA and JAPR conducted	JAPA and JAPR conducted	Annually	DPHI	MOH
	Achievement				Conducted – March 2010	Conducted – March 2011	JAPA: December 2011, JAPR: March, 2012	JAPA: December, 2012 JAPR: March, 2013			Source: DPHI		
Percentage of HSP2 indicators that have • baselines • targets		**D** Monitored during implementation support	%	48 out of 68 or 70.6% NA	68 or 100% TBD	68 or 100% TBD	68 or 100% TBD	68 or 100% TBD	68 or 100% TBD	100%	Annually	HMIS/DPHI	MOH
• baselines	Achievement				83%	98%	98%	98%	83% (53/64)		Note: Decline due to introduction of new Indicators and deletion of a few indicators.		
• targets	Achievement				73%	90%	90%	90%	73% (47/64)		Source: DPHI		

Intermediate Level Results Indicators*	Core	D=Dropped C=Continue N= New R=Revised	Unit of Measure	Baseline	Cumulative Target Values**						Frequency	Data Source/ Methodology	Responsibility for Data Collection
					YR 1 (2009)	YR 2 (2010)	YR 3 (2011)	YR4 (2012)	YR5 (2013)	YR6 (2014)			
Selected key HSP2 indicators disaggregated by location and sex		**D** Monitored as part of implementation support	#	NA	Indicators selected	Baselines and targets established	Targets met	Targets met	Targets met	Targets met	Annually	HMIS/DPHI	MOH
				Achievement	PHDs: Yes Sex: No	PHDs: Yes Sex: No	PHDs: Yes Sex: No	PHDs and ODs: Yes Sex: Yes			Source: DPHI		
Health personnel receiving training through the program (number)	X	C	#							NA	Annual	HSSP2 progress reports	HSSP Secretariat
				Achievement	43,989	20,359	31,053	37,867			Source: HRD		
Health facilities constructed, renovated, and/or equipped through the program.	X	C	#							NA	Annual	HSSP2 progress reports	HSSP Secretariat
				Achievement	0	0	0	143 – including Health Centers, Health Posts, Addition-al Delivery Rooms and Referral Hospitals (2)					

CDHS–Cambodia Demographic Health Survey; CENAT–National Center for Tuberculosis and Leprosy Control; CNM-National Center for Parasitology, Entomology and Malaria Control; DBF–Department of Budget and Finance; DCDC–Department of Communicable Disease Control; DDF–Department of Drug and Food; DHS–Department of Hospital Service; DIC–Department of International Cooperation; DP–Donor Partners; DPHI–Department of Planning and Health Information; HRD–Human Resource Department; JAPA–Joint Annual Performance Appraisal ; JAPR–Joint Annual Performance Review; HMIS–Health Management Information System; MOP–Ministry of Planning; NCHP–National Center for Health Promotion; NIP–National Immunization Program; NMCHC–National Maternal Child Health Center; NNP-National Nutrition Program; NSDP– National Strategic Development Plan; PMTCT– Prevention of Mother to Child Transmission; POC – Priority Operating Costs; SDMG- Service Delivery Monitoring Group

ANNEX 2: OPERATIONAL RISK ASSESSMENT FRAMEWORK
CAMBODIA: SECOND ADDITIONAL FINANCING FOR THE SECOND HEALTH SECTOR SUPPORT PROGRAM

<table>
<tr><th colspan="7">1. Program Stakeholder Risks</th></tr>
<tr><td colspan="2">1.1 Stakeholder Risk</td><td>Rating</td><td colspan="4">Moderate</td></tr>
<tr><td colspan="2" rowspan="3">Description:
The principal stakeholders are government, other development partners, and civil society organizations. Government ownership and commitment to implement its HSP2 remains strong. The recipient and Bank interests, objectives, and motivation for undertaking this operation are well aligned.

Sustainability of key reforms and financing mechanisms supported by the program – including Health Equity Funds (HEFs) and Special Operating Agencies (SOAs) – will require policy agreements among various RGC stakeholders, including MOH, Ministry of Economy and Finance (MEF), and National Commission for Democratic Development (NCDD). These discussions are on-going and have improved over the past six months with the establishment of a new donor technical working group on health care financing and more frequent meetings between the MOH, MEF, and development partners.

The risk of major donor disagreements over the interventions remains low particularly with donors who are members of the HSSP2- Joint Partnership Interface Group (JPIG). Four donors and development partners are currently members of JPIG, while other bi-lateral donors are also aligned to supporting the government's health sector plan implementation.</td><td colspan="5">Risk Management:
The Technical Working Group Health (TWGH) meetings chaired by Ministry of Health (MOH) are the key forum that brings together development partners and civil society representatives. Joint Annual Program Reviews and Joint AOP appraisals will continue to be held for program implementation coordination and monitoring. MOH's task force on Harmonization & Alignment and Department of International Coordination will facilitate this coordination. Also development partners have established a corresponding working group on harmonization and alignment to ensure their involvement. The Bank is also active in other TWGs related to other major reform areas (Public Financial Management, Public Administration Reform, Decentralization), which provide opportunity for coordination of reform efforts.</td></tr>
<tr><td>Resp:
Bank</td><td>Stage:
Implementation</td><td>Recurrent:
☐</td><td>Due Date:</td><td>Frequency:</td><td>Status:
Ongoing</td></tr>
<tr><td colspan="5">Risk Management:
Donor coordination and communication and consultation mechanisms with the government continue to be maintained to ensure smooth ongoing implementation. Active discussion and engagement between donors will be conducted at the regular JPIG meetings and government consultation as an ongoing process for implementation follow up and discussions. The team will continue to lead the Joint Review Missions to identify progress made and key sector reform agendas.

Activities supported under the new Programmatic analytical, and advisory assistance, such as analysis of the utilization and impact of HEFs, is also being used to bring together relevant parties.</td></tr>
<tr><td>Resp:
Bank</td><td>Stage:
Implementation</td><td>Recurrent:
☐</td><td>Due Date:</td><td>Frequency:</td><td>Status:
Ongoing</td></tr>
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2. Implementing Agency (IA) Risks (including Fiduciary Risks)						
2.1 Capacity	Rating	**Substantial**				
Description: Ministry officials are familiar with the proposed interventions as they are continuation of on-going activities are familiar with Bank procedures. The HSSP2 Secretariat is still not fully mainstreamed into the MOH line departments. The HSSP Secretariat relies heavily on a group of individual procurement consultants for carrying out all procurements, except small procurements delegated to SOAs at the sub-national level. MOH has resisted implementing original agreements to mainstream HSSP2 financial and procurement management into the Department of Budget and Administration. Capacity of –Department of Budget and Finance needs to be strengthened to support program implementation as well as implementation of public financial management reforms. The program will increasingly delegate resources directly to service delivery level (through HEFs, SDGs, etc.), but Financial Management and procurement capacity for health centers, hospitals, and Operational Districts needs to be further strengthened. Institutional structures and capacity for oversight of key program financing mechanisms remain relatively weak, including for Health Equity Funds and performance contracting with Special Operating Agencies. The MOH has indicated the intention to establish a semi-autonomous organization to manage HEFs, but this will take time. Currently HSSP2 depends on oversight from local Non-Governmental Organizations (contracted through the program) and a USAID-financed Health Equity Fund Implementer to monitor and verify compliance of HEF payments. The contract of USAID-financed HEF Implementer will be ended by the end of 2015. Oversight of SOAs by central MOH and PHDs remains inadequate, and arrangements for SOA performance monitoring and capacity building need to be enhanced.	**Risk Management:** Capacity building technical assistance for SOAs through training on financial management for six new SOAs workshop conducted for the dissemination of the updated SDG manual to all SOAs, and more regular field visits from service delivery monitoring groups to SOAs. World Bank team and development partners of HSSP2 will engage in AOP planning and monitoring process to further support and strengthen. The current group of individual procurement consultants will still be required for this additional financing. The procurement unit of HSSP2 secretariat should provide more hands-on procurement trainings to the SOAs. In addition, the Bank procurement specialist will continue to provide procurement training/clinics to the procurement unit of HSSP2 secretariat when necessary to help ensure necessary controls are in place for sound procurement practices. Agreements have been reached on (i) priorities to strengthen HEF management and oversight, (ii) strengthening oversight mechanisms and independent monitoring for SOAs; (iii) and Bank Executed Trust Funds to support analytic work on HEF utilization. USAID has contracted out a HEF Implementer for providing capacity building and oversight for social health insurance, including HEFs, up to end of 2015. Discussion among stakeholders will be held regarding institutional arrangement for fiduciary oversight on HEFs after the contract of USAID-financed HEF ends. A new level two quality assessment tool has been adopted by MOH and will be applied to all health facilities in 2014/2015, thereby providing information that will be helpful for monitoring SOAs.				
	Resp: Bank/ Client	Stage: Preparation / Implementation	Recurrent: ☐	Due Date:	Frequency:	Status: Ongoing

2.2 Governance	Rating	Substantial				
Description: The HSP2 outlines priorities for strengthening health sector governance, including policy development, stewardship, and regulation, and MOH has made progress on many of these areas. Significant challenges remain, however, in terms of implementation capacity of central MOH; establishing necessary policies, regulations and institutions (e.g., for health insurance, regulation of private sector, decentralization, autonomous hospitals, etc.). With respect to government, the responsibilities of MOH and oversight processes through its Good Governance Framework (GGF) are clear. The GGF is an essential anti-corruption action plan to strengthen the governance capacity. The GGF includes various elements for improving transparency and accountability through strengthened procurement arrangements, strengthened financial management, enhanced public disclosure, involvement of civil society, a complaints mechanism, a code of conduct, sanctions, and timely implementation of audit recommendations and addressing audit observations. The FM Manuals and Operational Manuals have clear lines of responsibilities. While some mechanisms are in place for local health sector oversight Health Center Management Committees (HCMCs), these are not yet functioning effectively, and the role of local district and commune councils in oversight of health services needs to be further defined. The Bank provided technical and financial support for piloting of health community scorecard (through HSSP2 and the Demand for Good Governance Program) with encouraging results.	**Risk Management:** The GGF elements associated with procurement has been incorporated in the updated SOP for all Externally Funded Projects/Programs in Cambodia promulgated through Sub-Decree 74 on May 22, 2012. The World Bank team will work closely with MOH team to ensure the satisfactory implementation of the GGF including strengthening complaints handling and sanctions mechanism, and disclosure. Civil society continues to be engaged and participates at the monthly TWGH meetings and is involved as observers in major bid opening of contracts financed under the program. The AF2 will use social accountability mechanisms; strengthen Health Center Management Committees, and local complaints mechanisms and monitoring through SDG contracts. In addition, there will be coordination by the World Bank local governance team, to support for implementation of Social Accountability Framework and possibly through financing for local governments.				
	Resp: Bank/Client	Stage: Implementation	Recurrent: ☐	Due Date:	Frequency:	Status: Ongoing
3. Program Risks						
3.1 Design	Rating	**Low**				

Description: This is an AF to an ongoing Specific Investment Loan which MOH is already familiar with. Moreover, AF will only finance HEFs and SDGs. Major design issue relates to better consolidating financing through HEFs and SDGs, and seeking to align increasingly with national systems.	**Risk Management:** The implementing agency and the program team will provide additional implementation support to avoid implementation delays of those activities. The team will work closely with MOH, MEF, and partners to consolidate HEF and SDG financing into a single financing scheme, and support strengthening of national systems so that these can be mainstreamed in next phase of support after AF.					
	Resp: Bank	Stage: Preparation/Implementation	Recurrent: ☐	Due Date:	Frequency:	Status: Ongoing
3.2 Social and Environmental	Rating	**Low**				
Description: Inadequate handling of medical waste generated by program activities. Potential negative impact use and management of pesticides to control dengue. Many minority groups live in rough-terrain - highland and border areas that are hard to reach, and are generally poorer than average.	**Risk Management:** The existing Health Care Waste Generation and Management Plan are deemed adequate and compliance during HSSP2 has been good. Training on HCW management has been carried out by Department of Hospital Services (DHS) at provincial level. The task team will continue to monitor HCW management at health facility level during the implementation of AF2. The larvicides are considered to pose very low risks to humans if used correctly and certified by WHO's Pesticide Evaluation Scheme (WHOPES). The existing Pest Management and Monitoring Plan (PMMP) will continue to be used with the AF2. The products are transported in safe containers provided by the vendors and used containers are disposed of according to best practice; they are not used for storage or other purposes. The Indigenous Peoples Planning Framework (IPPF) developed under HSSP2 has been updated under AF2. The nature, scale and scope of impact that may occur on IP under AF2 are expected to be the same as those under HSSP2, and IP communities will continue to benefit from the program. During the implementation of HSSP2 and AF1, steps were taken to address affected IP communities. Such measures include: building technical capacity of health facility staff at primary care level for providing quality health services to IP; providing SDGs, particularly to					

	areas where most IP reside, to improve the functioning of health facilities; 24 hours opening and improve staff attendance so that IP can access health care services at any time as needed; financing health outreach activities so that IP in remote and difficult to access communities can receive basic preventive and curative services; establishment of HEFs to pay for health care services on behalf of poor IP; and construction of new health facilities for bringing health services closer to IP. Regular exit interviews were conducted with users including those from ethnic minorities as part of the implementation of HSSP2 and AF1, which found that they are satisfied with the services provided and that no negative impacts occurred to them under the program.					
	Resp: Client	Stage: Preparation / Implementation	Recurrent: ☐	Due Date:	Frequency:	Status: Ongoing
3.3 Program and Donor	Rating	**Low**				
Description: Donor collaboration and coordination continues to be strong. The program interventions are confirmed by the current donors. Government will continue to be required to play a strong role in donor coordination.	**Risk Management:** The team will continue to promote effective donor coordination through active dialogue with other donors through Joint Review Missions, frequent consultative meetings and monthly Sub-operation Groups and JPIG Meetings. The Joint Program Appraisal and Quarterly Review meetings will continue to be facilitated by the government with participation of all donors.					
	Resp: Bank	Stage: Preparation/ Implementation	Recurrent: ☐	Due Date:	Frequency:	Status: Ongoing
3.4 Delivery Monitoring and Sustainability	Rating	**Substantial**				
Description: Recruitment and contract management may present a risk for timely implementation and delivery of interventions as has often been the experience thus far, particularly for HEFs and SOAs. The program currently provides a large share of the AOP budget to finance operating cost. Under AF the program will not finance the operating costs. RGC also contributes to HEFs and SOAs progressively in the	**Risk Management:** Intensive supervision missions, frequent review of the implementation action plans, and diligent follow up with MOH to improve its contract management will be continued. Additionally, technical assistance will be provided where needed. HEFs and SOA counterpart share of financing by RGC will be continued. RGC is committed to full coverage of HEF by 2015.					

life of the program.	Resp: Client/Bank	Stage: Preparation/ Implementation	Recurrent: ☐	Due Date:	Frequency:	Status: Ongoing

4. Overall Risk	
Preparation Risk Rating: **Substantial**	**Implementation Risk Rating:** **Substantial**
Description: The overall preparation risk is Substantial because of the fiduciary risks.	Description: The Implementation Risk Rating is Substantial due to capacity constraints. The proposed AF will fund expansion of program activities and has strong support from the client and development partners.

ANNEX 3: REVISED IMPLEMENTATION ARRANGEMENTS AND SUPPORT
CAMBODIA: SECOND ADDITIONAL FINANCING FOR THE SECOND HEALTH SECTOR SUPPORT PROGRAM

I. Procurement Legislation Framework

During the implementation of the on-going HSSP2 program, new legislations on public procurement in Cambodia became effective. These include the public procurement law enacted on January 14, 2012 and the RGC's Updated SOPs and Procurement Manual for all Externally Financed Projects/Programs in Cambodia promulgated through Sub-Decree 74 on May 22, 2012. Significant improvements were made and incorporated in these legislations compared to the legislations mentioned in the original procurement capacity assessment report. However, a few provisions still need to be made in line with the World Bank Procurement Guidelines. On this basis, the NCB Annex was updated. For AF2, the above applicable national legislations and updated NCB Annex will be incorporated in the Financing and Grant agreements.

Applicable World Bank Guidelines. The procurement to be financed by this proposed additional financing and remaining procurement to be undertaken during the extended period from July 1, 2014 to December 31, 2015 will be carried out in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits" dated January 2011, and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated January 2011.

II. Assessment of the agency's capacity to implement procurement

The assessment of the capacity of the HSSP2 secretariat identified several procurement associated risks as follows: (a) capacity constraint of procurement unit of HSSP2 Secretariat; (b) delay of progress at the national level procurement; (c) delay of decentralized procurement; and (d) governance associated risks. The overall procurement risk for AF2 is "high". However, the risk will be managed and mitigated through the following action plan, and the residual procurement risk of this additional financing is **"substantial".**

Action Plan to Mitigate Procurement Associated Risks

1. To address the risk associated with the capacity constraint of procurement unit of HSSP2 secretariat, the current group of individual consultants will still be required for this additional financing. The World Bank procurement specialist will continue to provide procurement training/clinics to HSSP2 secretariat when necessary.

2. To address the risk associated with the delay of progress at the national level procurement, all concerned units/departments of MOH still need to further improve their collaboration, and the procurement unit should continue close monitoring of the procurement activities and their progress. Timely consultation with the World Bank should still continue for appropriate solutions for any bottleneck.
3. To address the delay of decentralized procurement, the procurement unit of HSSP2 secretariat should provide more hands-on procurement trainings to the SOAs. Some

procurement packages, for which only the suppliers from the national level can execute the contracts, should be procured at the national level either by the SOAs with the assistance of the procurement unit of HSSP2 secretariat, or by the procurement unit of HSSP2 secretariat on behalf of the SOAs.

4. To address the risks associated with the governance, the following measures have been agreed:

   (a) The updated SOP for all Externally Funded Projects/Programs in Cambodia promulgated through Sub-Decree 74 on May 22, 2012 incorporates the Good Governance Framework (GGF). The GGF includes various elements for improving transparency and accountability through strengthened procurement arrangements, strengthened FM, enhanced public disclosure, involvement of civil society, a complaints mechanism, a code of ethical conduct, sanctions, and for addressing program-specific implementation risks. This SOP will be applicable for this additional financing. The World Bank team will work closely with MOH team to ensure the satisfactory implementation of the SOP, including the GGF;

   (b) Though significant improvements were made and incorporated in the new legislations frameworks of the RGC, a few provisions still need to be made in line with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits" dated January 2011 that will be applicable for this additional financing. Therefore, the NCB Annex was updated and will be attached to the financing agreement for this additional financing; and

   (c) In addition to the prior review supervision, the World Bank will carry out the procurement ex-post review annually at a rate of 15% of all post review contracts. Furthermore, the integrated technical and fiduciary review will be conducted if needed.

III. Procurement Plan

An updated procurement plan for HSSP2 including the procurement packages under this AF2 is being prepared, and will be finalized and agreed by the World Bank before effectiveness of this additional financing.