Public Disclosure Authorized

Public Disclosure Authorized

89718

PROJECT INFORMATION DOCUMENT (PID)

SECOND ADDITIONAL FINANICNG OF THE SECOND HEALTH SECTOR SUPPORT PROGRAM

APPRAISAL STAGE

Project Name	Second Additional Financing for the Second Health Sector Support Program
Region	EAST ASIA AND PACIFIC
Country	Cambodia
Sector	Sector: Health (44%); Central government administration (24%); Sub-national government administration (24%); Other social services (4%); Compulsory health finance (4%)
Theme	Health system performance (33%); Administrative and civil service reform (17%); Child health (17%); Population and reproductive health (17%); Participation and civic engagement (16%)
Project ID	P150472
Parent Project ID	P102284
Borrower(s)	KINGDOM OF CAMBODIA
Implementing Agency	Ministry of Health
Environment Category	[ ] A [X] B [ ] C [ ] FI [ ]
Date PID Prepared	July 25, 2014
Date of Appraisal Authorization	July 15, 2014
Date of Board Approval	N/A

1. Country and Sector Background

The Kingdom of Cambodia is emerging as an increasingly confident state after a tumultuous last quarter of the 20th century. From a period of emergency support and rehabilitation, the Kingdom of

Cambodia has entered a sustainable development phase, based on consistent medium- and long-term policy directions. The economic growth rate in 2012 was 7.3 percent and poverty on a national level declined from 35 percent in 2004 to 20.5 percent in 2011. Yet, in spite of these achievements, Cambodia remains one of the poorest countries in Southeast Asia, and, rebuilding Cambodia's institutions along meritocratic lines is a long-term process.

There have been notable improvements in Cambodians' health over the last decade. From 2005 to 2010, the maternal mortality rate (MMR) dropped from 437 to 206 (per 100,000 live births) and the under-five (U5) mortality rate dropped from 83 to 54 (per 1000 live births). In 2000, 1 in 8 children born in Cambodia did not survive their fifth birthday, whereas by 2010, the rate improved to just 1 in 19 children. Cambodia is now on target to meet the Millennium Development Goals (MDGs for child and maternal mortality. The HIV/AIDS and tuberculosis (TB) epidemics have been arrested and reversed, with HIV/AIDS prevalence having fallen from 3 percent in 1997, to 0.9 percent in 2005, and to 0.7 percent in 2010.

But several challenges persist and new ones are emerging. Progress in reducing malnutrition is slow. With respect to MDG 1 (child nutrition), stunting showed a modest decline (from 50 percent in 2000 to 40 percent in 2010), but wasting increased (from 8 percent in 2005 to 11 percent in 2010) and underweight showed no change (28 percent in 2005 and 2010). Significant health inequities persist between socio-economic groups; there are considerable financial barriers to essential services, in particular for the poor (an estimated 70 percent of total per capita health expenditure of US$ 36 is funded out-of-pocket); there are concerns about quality of care and effectiveness of public sector (only 22 percent of the people who fall ill and use health services rely on government systems); and there are new public health challenges on the horizon – new communicable diseases (e.g. avian flu), as well as an increasing burden of non-communicable diseases and injuries.

The Government's Second Health Strategic Plan 2008-2015 (HSP2) is the guiding framework for all decisions in the sector. HSP2 emphasizes five key health system strengthening strategies: providing integrated health service delivery; ensuring an adequate level (and making effective use of) health financing; addressing human resource needs in the health sector; strengthening health system governance; and health information systems. These cross-cutting strategies are being applied with the objective of improving health outcomes in the three main program areas: reproductive, maternal, neonatal, and child health; communicable diseases; and non-communicable diseases.

2. Objectives

The development objective is to support the implementation of the government's HSP2 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.

3. Rationale for Bank Involvement

Links to the Country Assistance Strategy (CAS) and World Bank Health, Nutrition, and Population Strategy. The CAS for 2005-2008 (later extended to 2011) developed jointly by the World Bank, the Asian Development Bank (ADB), the United Kingdom Department for International Development (DfID), and the United Nations, called for increased investment in sectors critical to attaining the MDGs. For health, this means supporting Cambodia's commitment to provide affordable health services for the poor, improving service quality, reducing the burden of communicable disease, and enhancing sector capacity and performance. The CAS also called for deepening the sector wide approach initiated in the health sector. These jointly developed CAS objectives call for the World Bank to increase its financial and technical role in the health sector not least following ADB's stated intention to withdraw from financially supporting the health sector. The proposed program is in the World Bank CAS and the aims of the CAS are fully reflected in its design. Finally, this support is aligned with the World Bank "Healthy Development" strategy developed by the Health, Nutrition and Population Network that focuses on strengthening health systems and results.

Links to Past Experience. The World Bank has been engaged in the health sector since 1996 through the Disease Control and Health Development Project, and then through the ongoing Health Sector Support Project (HSSP 2003-2008), developing considerable experience, and building strong relationships with the government and other Program Partners. The World Bank is positioned to be an active and strategic partner in Cambodia's health sector development. On the basis of experience gained while moving from classic investment project support, to supporting the government's annual program through sector wide management arrangements (SWiM), the World Bank is also well placed to move towards more streamlined and sector-wide engagement in the health sector. The World Bank's experience in sector wide approaches internationally, and its robust fiduciary and safeguard policies give it a natural role in helping to ensure that the financial support provided to the sector is better coordinated and aligned with sectoral priorities.

World Bank's comparative advantage across sectors and in health. In addition to being a significant financier of Cambodia's health sector, the World Bank has been supporting key reforms in a number of other sectors in Cambodia; of particular relevance is its extensive engagement in both public finance management and public administration reform. This involvement places the World Bank in a unique position to provide both cross-sectoral and sector specific expertise.

4. Program Description

The original program (HSSP2) has a health system strengthening focus, with four components that are aligned to the government's HSP2. Components include: (a) *Strengthening Health Service Delivery* through (i) the provision of Service Delivery Grants (SDGs) and contracting for health services at provincial level and below; and (ii) investments for the improvement, replacement, and extension of the health service delivery network. (b) *Improving Health Financing* which will support (i) health protection for the poor through the consolidation of Health Equity Funds (HEFs) under common management and oversight arrangements and expansion of health equity fund coverage; and (ii) supporting the development of health financing policies and institutional reforms. (c) *Strengthening Human Resources* will focus on (i) strengthening pre- and in-service training; (ii) strengthening human resource management in the Ministry of Health. (d) *Strengthening Health System Stewardship Functions* by supporting (i) development of policy packages identified, strengthening the institutional capacity (in particular meeting the demands from decentralization and deconcentration); (ii) private sector regulation and partnerships; (iii) supporting governance and stewardship functions of the national programs and centers overseeing the three HSP2 strategic programs; and (iv) empowering new structures for increasing local accountability of health care providers to citizens. The AF2 will support continued financing of the HEFs and SDGs over a 6 month period, i.e. through December 31, 2014, and partially for 2015. The current program funds available are sufficient only to cover civil works and procurement of equipment. The following is a summary of the anticipated extended activities as a result of the additional financing to be provided.

The existing Multi Donor Trust Fund (MDTF) Agreement will be amended to include a second additional amount of US$12.69 million raising the total MDTF envelope to US$112.23 million. The additional funds consist of AUD 9.5 million (equivalent to US$ 8.86 million) 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. The above additional funds of US$12.69 million exclude US$ 0.66 million allocated for management and supervision costs administered by the Bank. The proposed additional Grant will be used for financing the SDGs and HEFs until the anticipated Third Additional Financing (AF3) is approved, which is expected to be processed in line with the Cambodia Interim Strategy Note, and the current program funds are sufficiently committed. The following is a summary of the anticipated extended activities as a result of the additional financing to be provided:

Component A: Strengthening Health Service Delivery. Additional financing from MDTF will continue financing of SDGs in 36 Special Operating Agencies (SOAs).

Component B: Improving Health Financing. Additional financing from the MDTF will continue financing HEFs in 55 Operational Districts (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.

5. Financing

Source:		(US$ in million.)
BORROWER/RECIPIENT		0
International Development Association (IDA)		0
Additional contribution to the HSSP2 MDTF		12.69
	Total	12.69

6. Implementation

The Ministry of Health (MOH) established a Joint Program Management Group to manage and oversee the implementation of program activities funded from the pooled account. This group, chaired by an appointed Secretary of State (responsible for overseeing the program), meets at a minimum on a quarterly basis to review progress reports, interim unaudited financial reports, semi-annual internal audit reports and annual audits, and recommend the release of funds from the pooled account against satisfactory financial reports, cash forecast and any agreed triggers. The program and annual operation plans are implemented by the respective health sector implementing units, including central health departments, national programs and provincial health departments. These implementation arrangements remain unchanged under the AF2.

Implementation/Supervision Reviews. The implementation and supervision of the program activities will follow the same process established at the start of the program, with continued joint implementation reviews by pooling partners aligned with specific MOH planning and review cycles, and quarterly reviews of fiduciary aspects.

Given the collaboration and participation required from the Program Partners under this program-country presence of the pooling partners with requisite skills is seen as crucial; the World Bank continues to have the presence in-country of a senior technical specialist, a senior operations officer, and a national operations officer. These supervision and implementation arrangements also remain unchanged.

7. Sustainability

The HSP2 relies on external financing over the long-term for the goals of the HSP2 to be reached and thus HSP2 has sustainability risks, including to what extent the projected Gross Domestic Product (GDP) and revenue increases materialize and what level of external financing is likely in the medium- to long-term. The percentage of government counterpart financing for HEFs and SDGs increased each year, and has been integrated into the MOH budget since 2014, increasing further prospects for sustainability. Separate from the issue of financing, sustainability will depend on ensuring that the MOH and related agencies/organizations have the requisite capacity to implement and/or monitor the programs and policies included in the HSP2. These risks are recognized, and the program actively seeks to support the MOH in strengthening the capacity where needed.

8. Lessons Learned from Past Operations in the Country/Sector

Sector Wide Management (SWiM) Review. The program has taken on board recommendations from the SWiM review, and the midterm review of HSP2 and HSSP2: to pool some donor resources; to improve alignment of resources with the government priorities; and to strengthen primary health care services.

Analytic and sector work. Analytical and sector work has contributed to the design of the HSSP2, ensuring that the program is fully aligned with HSP2. The program responds to study findings that indicate a low proportion of government and Program Partner resources reach front line health services at the provincial level and below. The key reports include: HSP2 Midterm Review, 2010; Integrated

Fiduciary Assessment and Public Expenditure Review, 2011; and Cambodia Poverty Assessment, 2013. A World Bank-executed portion of HSSP2 has supported an extensive program of analytic work during program implementation, reviews of health financing, surveys on health care markets and health seeking behavior, and a nation-wide survey on health workforce issues in Cambodia. A new study on the utilization and impact of HEFs is also planned.

Innovative policy pilots. The program supports the consolidation and scaling-up of HEFs, as an effective means of removing financial barriers faced by the poor in accessing essential health care, and providing the poor with protection from the impact of catastrophic health care related costs. The program applies lessons learned from performance contracting pilots with the NGOs that are providing resource allocation and monitoring to provinces and ODs.

HSSP2 implementation. The program builds on the positive experience of using joint monitoring arrangements from the current HSSP and plans to use the HSSP Secretariat experience and systems as the basis for continued support to line departments in the MOH. The original expectation for HSSP2 was to integrate accountability functions into line departments. This has largely occurred with respect to technical functions, particularly with the Director of Planning and Health Information being named as Program Coordinator. Fiduciary functions have not been transferred, however, and remain within the HSSP Secretariat.

World Bank support to other sectors in Cambodia. The main lessons learned and applied are derived from: (a) Good Governance Frameworks, financial management and procurement arrangements applicable to Cambodia's fiduciary and governance context; (b) principles of donor pooling arrangements established under the Public Financial Management Reform Project; and, (c) community-level engagement in program planning, implementation and monitoring (Rural Investment and Local Governance Project, and Basic Education Project).

Sector-wide approaches. The program team also reviewed applicable lessons from countries implementing sector-wide approaches, noting in particular approaches taken in the design of funding modalities and related implementation arrangements, such as joint planning and review mechanisms and memoranda of understanding.

9. Safeguard Policies (including public consultation)

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 were also triggered under the first additional financing (AF1). Although AF2 does not trigger the safeguard risk on involuntary resettlement (OP/BP 4.12) because no new civil works are planned, the Framework for Land Acquisition Policy and Procedures has been updated following lessons learned from HSSP2 and AF1. Implementation of the various safeguard policies – described below – has been satisfactory throughout the program implementation. During the preparation of AF2, the Environment Management Plan (EMP) and Framework for Land Acquisition Policy and Procedures have been updated following lessons learned from the original program and AF1, and the Indigenous People Planning Framework has been updated taking into consideration findings from the social assessment conducted based on free, prior and informed consultations with indigenous people. All were disclosed on June 25, 2014.

Environment:

AF2 will not finance civil works. The environmental risks are pesticides and 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. During preparation of AF2, the safeguards for civil works and asbestos management were found to be satisfactory and the EMP updated based on lessons learned from HSSP2 and AF1.

- *HCW.* Guidelines under the existing HCW Generation and Management Plan are deemed adequate 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 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 the 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.

Social

Ill health is a leading cause and consequence of poverty in Cambodia. Health care remains for many expensive, of poor quality and of difficult to access. Key social development issues pertaining to health in Cambodia, include: (i) uneven distribution of growth and significant difference between urban and rural and rich and poor households' access to health services and outcomes; (ii) different health needs and challenges among women and men; (iii) high vulnerability to poor health and poverty among the poor and ethnic minorities and in remote and difficult to access areas; and (iv) 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 making 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, and 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 Indigenous Peoples Planning Framework 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: (i) building technical capacity of health facility staff at primary care level for providing quality health services to IP; (ii) 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 to health care services at any time as needed; (iii) financing health outreach activities so that IP in remote and difficult to access communities can receive basic preventive and curative services; (iv) establishment of HEFs to pay for health care services on behalf of poor IP; and (v) 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.* This safeguard risk is not triggered under AF2 as no civil works will be financed. However the Land Acquisition Framework Policy and Procedures developed under the original program has been updated anticipating a potential third additional financing that could trigger the policy 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.

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

10. List of Factual Technical Documents

Following is a list of documents consulted during the preparation phase.

- Second Health Strategic Plan (2008-2015)
- Cambodia: Demographic and Health Survey, 2010
- Integrated Fiduciary Assessment and Public Expenditure Review, 2011
- Poverty Assessment, 2013
- Social Assessment, 2014

11. Contact point

Contact: Laura L. Rose

Title: Senior Health Economist

Tel: 5721+1365 / 855-23-861-300 Fax: 855-23-861-301

Email: Lrose@worldbank.org

Location: Phnom Penh, Cambodia (IBRD)

12. For more information contact:

The InfoShop

The World Bank

1818 H Street, NW

Washington, D.C. 20433

Telephone: (202) 458-4500

Fax: (202) 522-1500

Email: pic@worldbank.org

Web: http://www.worldbank.org/infoshop

13. Contact for Implementing Agency

Ministry of Health

Contact Person: *H.E. Eng Huot*

Telephone No.: (855-23) 722 873

Fax No.: (855-23) 880 260

Email: enghuot@online.com.kh