Document of
The World Bank

FOR OFFICIAL USE ONLY

Report No: PAD1647

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 21.7 MILLION

(US$30 MILLION EQUIVALENT)

AND A MULTI-DONOR TRUST FUND GRANT

IN THE AMOUNT OF US$50 MILLION EQUIVALENT

TO THE

KINGDOM OF CAMBODIA

FOR A

HEALTH EQUITY AND QUALITY IMPROVEMENT PROJECT (H-EQIP)

April 28, 2016

Health, Nutrition and Population Global Practice
East Asia and Pacific Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective as of December 31, 2015)
Currency Unit = Cambodian Riels
KHR 4055 = US$1
US$1.38573 = SDR 1

FISCAL YEAR
January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AOP	Annual Operational Plan
BSP	Budget Strategic Plan
CPA	Complementary Package of Activities
DBF	Department of Budget and Finance
DFAT	Department of Foreign Affairs and Trade
DLI	Disbursement Linked Indicator
DP	Development Partner
DPHI	Department of Planning and Health Information
EEP	Eligible Expenditure Program
EMF	Environmental Management Framework
EMP	Environmental Management Plan
FM	Financial Management
FMM	Financial Management Manual
FY	Fiscal Year
GIZ	German Agency for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit*)
GDNT	General Department of the National Treasury
HC	Health Center
HCWM	Health Care Waste Management
HEF	Health Equity Fund
HEFI	Health Equity Fund Implementer
HEFO	Health Equity Fund Operator
HEFP	Health Equity Fund Promoter
H-EQIP	Health Equity and Quality Improvement Project
HMIS	Health Management Information System
HRMIS	Human Resource Management Information System
HSD	Hospital Services Department
HSP-3	Third Health Strategic Plan
HSSP	Health Sector Support Program
IAD	Internal Audit Department
IDA	International Development Association
IFMIS	Integrated Financial Management Information System
IFR	Interim Financial Report
IRM	Immediate Response Mechanism
JICA	Japan International Cooperation Agency
KfW	German government-owned development bank (*Kreditanstalt für Wiederaufbau)*
KOICA	Korea International Cooperation Agency
M&E	Monitoring and Evaluation
MDTF	Multi-Donor Trust Fund
MEF	Ministry of Economy and Finance
MOH	Ministry of Health
MPA	Minimum Package of Activities
NAA	National Audit Authority
NBC	National Bank of Cambodia
NCD	Non-communicable Disease
OD	Operational District
OOP	Out of Pocket
OPD	Outpatient Department
PAE	Public Administrative Establishment
PCA	Payment Certification Agency
PDO	Project Development Objective
PFM	Public Financial Management
PHD	Provincial Health Department
PMD	Preventive Medicine Department
PHRD	Policy and Human Resources Development

PWD	People with Disability	TA	Technical Assistance
QAO	Quality Assurance Office	TOR	Terms of Reference
RGC	Royal Government of Cambodia	TSA	Treasury Single Account
RH	Referral Hospital	UHC	Universal Health Coverage
RPF	Resettlement Policy Framework	UHS	University of Health Sciences
SA	Social Assessment	UNFPA	United Nations Population Fund
SDG	Service Delivery Grant	UNICEF	United Nations Children's Fund
SHP	Social Health Protection	USAID	U.S. Agency for International Development
SOA	Special Operating Agency		
SOP	Standard Operating Procedure	WHO	World Health Organization

Regional Vice President:	Victoria Kwakwa
Country Director:	Ulrich Zachau
Senior Global Practice Director:	Timothy Grant Evans
Global Practice Manager:	Toomas Palu
Task Team Leader:	Somil Nagpal

KINGDOM OF CAMBODIA

Health Equity and Quality Improvement Project

Table of Contents

Page

List of Tables & Figures

PAD DATA SHEET

Cambodia

Health Equity and Quality Improvement Project (H-EQIP) (P157291)

PROJECT APPRAISAL DOCUMENT

EAST ASIA AND PACIFIC

Health, Nutrition and Population Global Practice

Report No.: PAD1647

Basic Information			
Project ID	EA Category	Team Leader(s)	
P157291	B - Partial Assessment	Somil Nagpal	
Lending Instrument	Fragile and/or Capacity Constraints [ ]		
Investment Project Financing	Financial Intermediaries [ ]		
	Series of Projects [ ]		
Project Implementation Start Date	Project Implementation End Date		
19-May-2016	30-Jun-2021		
Expected Effectiveness Date		Expected Closing Date	
01-Jul-2016		30 -June-2021	
Joint IFC			
No			
Practice Manager/Manager	Senior Global Practice Director	Country Director	Regional Vice President
Toomas Palu	Timothy Grant Evans	Ulrich Zachau	Victoria Kwakwa

Borrower:	Kingdom of Cambodia		
Responsible Agency:	Ministry of Health		
Contact:	Huot Eng	Title:	Secretary of State
Telephone No.:	855-23-722873	Email:	enghuot@online.com.kh

Project Financing Data(in US$, millions)					
[ ]	Loan	[ ]	IDA Grant	[ ]	Guarantee
[X]	Credit	[X]	Grant	[ ]	Other

Total Project Cost:	174.20	Total Bank Financing:	30.00

Financing Gap:	0.00

Financing Source	**Amount**
BORROWER/RECIPIENT	94.20
International Development Association (IDA)	30.00
Free-standing Multi-donor Trust Fund (MDTF) Program	50.00
Total	174.20

Expected Disbursements (in US$, millions) (IDA)

Fiscal Year	2017	2018	2019	2020	2021	
Annual	6.0	6.0	6.0	6.0	6.0	
Cumulative	6.0	12.0	18.0	24.0	30.0	

Institutional Data

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Poverty and Equity

Cross Cutting Topics

[ ] Climate Change

[ ] Fragile, Conflict & Violence

[X] Gender

[ ] Jobs

[ ] Public Private Partnership

Sectors / Climate Change

Sector (Maximum 5 and total % must equal 100)

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	60		
Health and other social services	Other social services	15		
Public Administration, Law, and Justice	Central government administration	10		
Public Administration, Law, and Justice	Sub-national government administration	10		
Public Administration, Law, and Justice	Compulsory health finance	5		
Total		100		

☑ I certify that there is no Adaptation and Mitigation Climate Change Co-benefits information applicable to

this project.

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Health system performance	55
Human development	Population and reproductive health	15
Public sector governance	Administrative and civil service reform	10
Human development	Child health	10
Social dev/gender/inclusion	Participation and civic engagement	10
Total		100

Proposed Development Objective(s)

To improve access to quality health services for targeted population groups with protection against impoverishment due to the cost of health services in the Kingdom of Cambodia.

Components

Component Name	**Cost (US$, millions)**
Component 1: Strengthening Health Service Delivery	74.20
Component 2: Improving Financial Protection and Equity	70.00
Component 3: Ensuring Sustainable and Responsive Health Systems	30.00
Component 4: Contingent Emergency Response	0.00

Systematic Operations Risk-Rating Tool (SORT)

Risk Category	**Rating**
1. Political and Governance	Substantial
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	High
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
OVERALL	Substantial

Compliance

Policy		
Does the project depart from the CAS in content or in other significant respects?	Yes [ ]	No [X]
Does the project require any waivers of Bank policies?	Yes [ ]	No [X]
Have these been approved by Bank management?	Yes [ ]	No [X]
Is approval for any policy waiver sought from the Board?	Yes [ ]	No [X]
Does the project meet the Regional criteria for readiness for implementation?	Yes [X]	No [ ]

Safeguard Policies Triggered by the Project	**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**

Legal Covenants			
Name	**Recurrent**	**Due Date**	**Frequency**
Institutional Arrangements (Schedule 2 Section I.A)	**X**		CONTINUOUS
Description of Covenant			
Obligation of the Recipient to maintain, throughout the Project implementation period, a health sector steering committee, technical working group and Project implementation team in the Ministry of Health, all with functions, staffing and resources satisfactory to the Association.			
Name	**Recurrent**	**Due Date**	**Frequency**
Project Operational Manual (Schedule 2 Section I.B)	**X**		CONTINUOUS
Description of Covenant			
Obligation of the Recipient to carry out the Project in accordance with the Project Operational Manual, and not amend, waive or abrogate any provisions of the manual unless the Association agrees otherwise in writing.			
Name	**Recurrent**	**Due Date**	**Frequency**
Annual Operational Plans (AOPs)		September 30 of	YEARLY

(Schedule 2 Section I.C)		each year	

Description of Covenant

Obligation of the Recipient shall furnish to the Association, not later than September 30 of each year, an annual operational plan for Project for the following fiscal year, in substance satisfactory to the Association, covering the activities and expenditures proposed for the subsequent year of Project implementation, including the Government, IDA and trust fund (TF) relative shares in the cost of the AOP.

Name	Recurrent	Due Date	Frequency
Environmental and Social Safeguards (Schedule 2 Section I.F (b) and (c))	**X**		CONTINUOUS

Description of Covenant

Obligation of the Recipient to ensure that the Project is carried out in accordance with the provisions of the Environmental Management Framework (EMF), Resettlement Policy Framework (RPF) and Indigenous Peoples Planning Framework (IPPF), not amend, abrogate or waive any of their provisions unless the Association agrees otherwise, and report on their status of implementation as part of the annual progress reports.

Name	Recurrent	Due Date	Frequency
DLI Reporting and Verification (Schedule 2 Section I.E)		July 31 of each year	YEARLY

Description of Covenant

Obligation of the Recipient to submit annual reports by the MOH on the status of achievement of the Disbursement Linked Indicator (DLI) targets by July 31 of each year.

Name	Recurrent	Due Date	Frequency
Contingent Emergency Response (Schedule 2 Section I.H)	**X**		CONTINUOUS

Description of Covenant

Obligation of the Recipient to adopt a satisfactory Emergency Response Manual for Component 4 of the Project and, in the event of an eligible crisis or emergency, ensure that the activities under said component are carried out in accordance with such plan and all relevant safeguard requirements.

Conditions

Source Of Fund	Name	Type
IDA	Cross-effectiveness (Article IV 4.01 (a))	Effectiveness

Description of Condition

The Financing Agreement and the MDTF Grant Agreement have been tied by a cross-effectiveness condition to ensure that they are executed and come into effect at the same time.

Source Of Fund	Name	Type
IDA	Project Operational Manual adoption (Article IV 4.01 (b))	Effectiveness

Description of Condition

Condition of effectiveness requiring the adoption of the updated Project Operational Manual, in form and substance acceptable to the Association.

Source Of Fund	Name	Type
IDA	Withdrawal Conditions (Schedule 2 Section II B.1 (b) (i))	Disbursement

Description of Condition

The Recipient may not withdraw the proceeds of the financing and the MDTF Grant allocated to Subcomponent 3.1 unless and until it has furnished evidence satisfactory to the Association that it has achieved the respective DLI(s) in accordance with the DLI verification protocol specified in the Project Operational Manual and has reported a corresponding amount of Eligible Expenditure Programs (EEPs)

Source Of Fund	Name	Type
IDA	Withdrawal Conditions (Schedule 2 Section II B.1 (c) (i))	Disbursement

Description of Condition

The Recipient may not withdraw the proceeds of the Financing as may be allocated to Component 4 unless an eligible crisis or emergency has occurred, all related safeguards instruments and requirements have been completed, the emergency response implementing entities have adequate staff and resources, and the recipient has adopted the Emergency Response Manual, acceptable to the Association.

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Somil Nagpal	Team Leader (ADM Responsible)	Senior Health Specialist	Health Financing	GHNDR
Sreng Sok	Procurement Specialist	Procurement Specialist	Procurement	GGODR
Reaksmey Keo Sok	Financial Management Specialist	Consultant	Financial Management	GGODR
Carmenchu D. Austriaco	Team Member	Finance Officer	Disbursement	WFALN
Da Lin	Team Member	Program Assistant	Administrative support	EACSF
Dinesh M. Nair	Team Member	Senior Health Specialist	Health Service Delivery	GHNDR
Erik Caldwell Johnson	Team Member	Senior Social Development Specialist	Governance	GSURR
Frederick Yankey	Team Member	Sr Financial Management Specialist	Financial management	GGODR
Juan Martinez	Safeguards Specialist	Sr Social Scientist	Social Safeguards	GSURR
Leah April	Team Member	Sr Public Sector	Public Financial	GGODR

		Mgmt. Spec.	Management	
Manush Hristov	Counsel	Senior Counsel	Legal (primary)	LEGES
Nareth Ly	Team Member	Operations Officer	Operations and management, Safeguards	GHNDR
Ria Nuri Dharmawan	Team Member	Counsel	Legal	LEGES
Saroeun Bou	Team Member	Communications Officer	Communication	EAPEC
Sokbunthoeun So	Team Member	Public Sector Specialist	Public Financial Management	GGODR
Tomo Morimoto	Team Member	Senior Operations Officer, Human Development	Operations and Management	GHNDR
Wasittee Udchachone	Safeguards Specialist	Consultant	Environmental Safeguards	GENDR

Extended Team

Name	**Title**	**Office Phone**	**Location**
David Griffith	Consultant		
Susanne Schroth	Consultant		
Udo Mba Kalu	Consultant		

Locations

Country	**First Administrative Division**	**Location**	**Planned**	**Actual**	**Comments**

Consultants (Will be disclosed in the Monthly Operational Summary)

Consultants Required? Consulting services to be determined

I. STRATEGIC CONTEXT

A. Country Context

1. Cambodia has experienced remarkable economic growth and macroeconomic stability since the early 2000s. It grew by an average annual rate per capita of 7.8 percent during 2004–2014, ranking among the top 15 economies in the world in terms of economic growth. The gross domestic product per capita according to the Atlas Method increased by more than threefold, from US$300 in 1995 to around US$1,020 in 2014. The main drivers of growth have been garment, manufacturing, agriculture, tourism and, more recently, construction and real estate. Economic growth eased in the aftermath of the 2009 global crisis while remaining strong at 7.2 percent during 2010–2014, on average. Growth eased slightly to 7.0 percent in 2015, in the context of a slowdown in China and appreciating U.S. dollar; stronger domestic demand, boosted by a construction boom, low oil prices, and fast credit growth, would be partly offsetting the moderation in the garment, tourism, and agriculture sectors.

2. The sustained economic performance has lifted a large proportion of the population above the national poverty line, but Cambodia is still one of the poorest countries in the Southeast Asia region. Between 2004 and 2012, the poverty incidence under the national poverty line declined from 50.2 percent to 17.7 percent of the population, reaching the country's Millennium Development Goal before the 2015 deadline. Most of the poverty reduction occurred between 2007 and 2009, when the headcount rate declined by 20 percentage points, driven by a significant hike in the price of rice, the main agricultural product of Cambodia. Despite this progress, the vast majority of the families that rose above the poverty line did so by a small margin, leaving them at risk in the event of an adverse shock. Poverty reduction in Cambodia has been accompanied by shared prosperity—the real consumption growth of the bottom 40 percent of the distribution was larger than that of the top 60 percent—and a decrease in inequality, with the Gini coefficient going down from 0.351 to 0.308 between 2008 and 2012.

3. The overall welfare of households, described by nonmonetary indicators, improved significantly throughout the period 2004 to 2014. Still, several challenges remain. Cambodia achieved most of the Millennium Development Goal targets, including those related to poverty reduction, child mortality, and maternal mortality. Targets have been nearly achieved in primary education, whereas areas such as gender equality and environmental sustainability have seen less progress. Moreover, the incidence rate and death by tuberculosis remain high. Cambodia's Human Development Index in 2013 was 0.58, well below the East Asia and Pacific average of 0.70 and also below the medium-income countries' average of 0.63.

B. Sectoral and Institutional Context

4. Cambodia's population of approximately 14.7 million in 2013 has made steady and significant progress in health outcomes over the past decade. The maternal mortality ratio fell from 472 per 100,000 live births in 2005 to 170 in 2014. Under-five mortality decreased from 83 per 1,000 live births in 2005 to 35 in 2014. The total fertility rate has also fallen from 3.4 in 2003 to 2.7 in 2014.[1]

[1] Cambodia Demographic and Health Survey, 2014.

5. Despite dramatic improvements in maternal and child health, inequities persist across health outcomes by socioeconomic status, by geographical areas, and between urban and rural populations. In 2014, child mortality was 76 deaths per 1,000 live births for the poorest quintile compared to 19 in the wealthiest. A recent decline in full immunization between 2010 (79 percent) and 2014 (73 percent) remains a concern.[1] Child malnutrition remains high despite economic growth and in 2014, 32 percent of children under five years of age were stunted, which is approximately 500,000 children. Non-communicable diseases (NCDs) are a growing burden due to an aging population and lifestyle changes.

6. In 2014, the total health expenditure was approximately US$1 billion, corresponding to over 6 percent of gross domestic product and US$70 per capita and this is one of the highest in the region. Public financing for health has increased steadily since 2008, from US$104 million to US$241 million in 2014 but only accounts for 20 percent of total health expenditure. Out-of-pocket (OOP) payment accounts for 60 percent and is an important source of debt and impoverishment for the poor. Based on data from the 2013 Cambodia Socioeconomic Survey, approximately 6.3 percent of the population endured catastrophic spending and 3.1 percent had to incur debt to pay for health expenditures. The impact is even greater for the elderly and disabled for whom 8.6 percent and 13.4 percent incur catastrophic spending, respectively.

7. Health sector reforms began over twenty years ago with the extension of physical infrastructure, continued through innovations in health financing and access to services, and now incorporate district health sector management and administration. One of the main achievements for which Cambodia is well known is the creation of health equity funds (HEFs)[2] which currently cover more than three million people. HEFs have successfully reduced catastrophic spending, increased utilization of health services by the poor, and provided a reliable source of financing to health facilities. While coverage has been expanded, there are design, management, and implementation bottlenecks that result in poor utilization of the scheme.

8. To increase utilization and quality of care in underperforming locations, the Ministry of Health (MOH) established special operating agencies (SOAs), either based in a provincial referral hospital (RH) or in an operational district (OD). SOA staff collectively and individually signed contracts, which set annual performance targets, and achievement of these targets triggered payments, known as Service Delivery Grants (SDGs).[3] Progress toward, and achievement of, targets were monitored by the Service Delivery Monitoring Group within the MOH. Targets were revised annually to drive improvements in service delivery. These supply-side inputs have helped increase deliveries in public facilities, allowed more staff to be employed, and reduced stock-outs of important drugs and supplies. They have also given

[2] HEFs currently use a third-party payer to purchase health care (and associated costs such as transport and food) for the identified poor from a public health care provider, and claims are verified by an international agency.

[3] These are an innovative funding mechanism consisting of block grants to facilities, implemented through the Royal Government of Cambodia's (RGC) establishment of SOAs as described in Royal Decree No. NS/RKT/0308/346. Designation as an SOA provides public service delivery organizations with a degree of autonomy in making optimal use of their human and financial resources to deliver services. Under the Second Health Sector Support Program (HSSP2) implementation, SDGs were paid from HSSP2 pooled funds (starting with a development partner [DP] share of 90 percent in the first year and decreased gradually to 60 percent by 2013 and to be maintained at this level until the project closing date of June 2016) and the RGC (started from 10 percent and increased gradually to reach 40 percent in 2013 and to be maintained at this level until the project closing date of June 2016).

facilities extra funds to improve service quality and have provided bonus payments to individual staff where targets have been achieved or surpassed.

9. The quality of health services in Cambodia is suboptimal. Preliminary findings from a recent World Bank study indicate that beneficiaries may be incurring high OOP payments due to the perceived poor quality of care in certain public facilities, even when they are covered by a HEF. In addition to some remaining gaps in infrastructure, Cambodia faces a major challenge with the skills and competencies of its health workforce and needs both pre-service and in-service training improvements and a renewed focus on competency-based training. In addition, the absence of a well-coordinated monitoring and evaluation (M&E) mechanism and limited data quality have hampered the effective monitoring of health sector performance and evidence-based decision-making.

C. Higher Level Objectives to which the Project Contributes

10. The RGC's Health Strategic Plan 2016-2020 (HSP-3) is currently undergoing stakeholder discussions in its draft form and is expected to be finalized by mid-2016. The policy priorities that have so far been identified in HSP-3 are (a) increasing equitable access to effective and efficient health services; (b) reducing maternal death, newborn, infant, and child mortality, and malnutrition; (c) reducing the burden of communicable diseases; (d) reducing the burden of non-communicable and chronic diseases; and (e) reducing impacts on human health due to major public health concerns. To better measure sector performance and progress towards achievement of the objectives under HSP-3, a costed M&E Plan and a detailed indicator framework for M&E have been developed as part of HSP-3.

11. The proposed Health Equity and Quality Improvement Project (H-EQIP) also contributes to the RGC's broader development agenda, as defined by the National Strategic Development Plan (2014–2018) and the Rectangular Strategy 3. Similarly, the Rectangular Strategy mentions that "expanded coverage, strengthened quality, and affordability of health care services remain a concern in the health sector" and that this requires further attention of the government along with the strengthening and expansion of social safety net systems, enhancement of sanitation and nutrition, and improvement in gender equality.

12. The new global Sustainable Development Goals, to which Cambodia has committed, include a focus on universal health coverage (UHC)[4] whereby all people receive the health care they need without suffering financial hardship. This is seen as a long-term goal in the Cambodian context, though it is proceeding steadily as and when fiscal space becomes available.

13. The World Bank Group recently conducted consultations and engaged with the RGC and stakeholders across Cambodia to inform the forthcoming Country Engagement Note. The RGC and stakeholders identified health as a top developmental priority for Cambodia. Social health protection (SHP) for the poor and other vulnerable groups emerged as a key theme. The project is one of the priority projects identified in the forthcoming World Bank Group's Cambodia Country Engagement Note (FY2016–2017), which is planned for the Board of Executive

[4] Sustainable Development Goals 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

Directors discussion on May 19, 2016. In addition, the proposed project's activities are closely linked with the World Bank Group's twin goals to reduce extreme poverty and enhance shared prosperity, as well as with the Bank's Health, Nutrition, and Population Global Practice's focus to assist clients accelerate progress toward UHC.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

14. The project development objective (PDO) is to improve access to quality health services for targeted population groups with protection against impoverishment due to the cost of health services in the Kingdom of Cambodia.

Project Beneficiaries

15. The project beneficiaries are the population of Cambodia, particularly the poor and vulnerable,[5] and health care providers working in the public health sector.

PDO Level Results Indicators

16. The PDO indicators are the following:

(a) Increase in the number of health centers (HCs) exceeding 60 percent score on the quality assessment of health facilities;

(b) Reduction in the share of households that experienced impoverishing health spending during the year;

(c) Reduction in OOP health expenditure as percentage of the total health expenditure; and

(d) Increase in the utilization of health services by HEF beneficiaries.

III. PROJECT DESCRIPTION

A. Project Components

17. The H-EQIP will build on the innovations supported in HSSP2, particularly HEFs and SDGs, and aims to increase the sustainability of these innovations by improving their resourcing and management as envisaged in the RGC's HSP-3. It will further strengthen the results-based focus of both HEFs and SDGs with a specific goal of improving the quality of health service delivery and utilization of services by the poor. In addition, the project will use a multipronged approach to strengthening health systems, especially to support improvements in quality of care,

[5] The targeted population groups are as defined by the RGC for coverage under HEFs, currently comprising the poor. The poor, in turn, are defined by the Ministry of Planning through a questionnaire survey conducted in collaboration with the Department of Local Administration of the Ministry of Interior. Persons with disabilities are defined according to the law on the protection and the promotion of the rights of persons with disabilities and the inter-ministerial *Prakas* no. 2492 on classification of types and levels of disabilities.

by focusing on enhancing provider knowledge through both pre-service and in-service training, improved availability of critical infrastructure, and strengthening public financial management (PFM). Using a set of disbursement linked indicators (DLIs), the project will disburse funds against targets achieved on these health system-strengthening measures. Another key strategic shift is to attain institutional sustainability through a transfer of responsibility for third-party HEF verification from an internationally recruited firm to an independent government agency, which will be established by June 2018, and extending this responsibility to include verifying SDG results at all levels of the health system.

Component 1: Strengthening Health Service Delivery (US$74.2 million equivalent)

18. This component will expand the current SDGs into a mechanism for providing performance-based financing to different levels of the Cambodian primary and secondary health system based on achievement of results. SDGs were introduced as part of HSSP2 and are intended to provide supplementary funds to SOAs in addition to their budgetary funds from the MOH, strengthen internal health service delivery contracting, and promote decentralization.[6] A working SDG system has been established with detailed manuals and institutional arrangements, and there is wide ownership and acceptance of the model. This has translated into improved management, better provider behavior, and strengthened health service delivery. However, several challenges remain, particularly in relation to the SDG scheme's complexity and loss of focus on results.

19. In the redesigned system, the payment of SDGs to HCs and hospitals will be more closely linked to performance in the delivery of basic and comprehensive packages of services, respectively. These packages of services are detailed in the Minimum Package of Activities (MPA) and Complementary Package of Activities (CPA) and include critical reproductive, maternal, neonatal, child, and adolescent health services. Nutrition will be among the services prioritized, with a focus on early breastfeeding, vitamin A supplementation, deworming, iron folic acid supplementation, and growth monitoring. Improving full immunization coverage of children under one year of age will also be a priority.

20. The project aims to use performance-based payments under SDGs along with fixed grants to health facilities, particularly by streamlining the funds flow and reporting arrangements envisaged for the same. The new fixed lump-sum grants will form part of the SDG system through a joint *Prakas*[7] to be issued by the Ministry of Economy and Finance (MEF) and MOH, and they are intended as a complement to the facilities' operational budget, initially US$6.8 million for 2016 (see Annex 3 for details). Costing for future years is based on the RGC continuing to fund the same amount every year, subject to concurrent evaluations indicating that the system is successful in achieving the intended objectives.[8]

[6] The current coverage of SDGs is 36 SOAs, with a proposed expansion to 40 in 2016. They are focused in poorer locations of the country.

[7] *Prakas* is a proclamation or a ministerial/inter-ministerial decision signed by the relevant minister(s). A proclamation must conform to the constitution and to the law or sub-decree to which it refers.

[8] While the expectation is that the RGC will continue to fund the lump-sum grant every year and may even increase the same to ensure sustainability of the program, the RGC has indicated that this will be contingent upon successful implementation.

Subcomponent 1.1: Service Delivery Grants: HCs (US$35.2 million equivalent)

21. The project will provide SDGs to HCs to help finance the MPA of HCs. Over and above the fixed grants, the amount and payment of the performance grants will be based on the utilization (that is, quantity) of services provided and on the quality of services. The quantity- and quality-based financing formula will be detailed in the joint *Prakas* and the SDG Manual. Initially, the OD,[9] with its HCs will be considered as one unit and will implement the joint *Prakas* issued by the MOH and the SDG Manual, specifying services to be provided, the financing linked to these, and how an aggregate performance score will be derived based on the quantity and quality of services delivered by the HCs. The quantity and quality of service delivery by the HCs, including utilization by the poor and vulnerable will be systematically determined by the respective OD through a new, standardized supervision checklist to be detailed in the updated SDG manual and applied quarterly. The results would be cross-checked and verified by an independent agency (initially by the Health Equity Fund Implementer [HEFI], and, after its establishment, by the independent government agency acting as a payment certification agency [PCA] proposed for HEFs). Once the results have been verified, the MOH will inform the MEF to make relevant SDG payments. Eligible categories of expenditure for SDGs at the HC level would include minor works, goods, and emergency purchase of drugs and/or recurrent costs, including supplies, short-term staff, consumables, communications, maintenance, transportation, accommodation, training, other incidental expenses, and performance bonuses for health workers.

Subcomponent 1.2: Service Delivery Grants: Hospitals (US$33.0 million equivalent)

22. This subcomponent aims to incentivize improvements in the quality of care at the secondary level, improve performance in capacity-building activities for in-service and pre-service candidates, and promote utilization of services by HEF beneficiaries. Using a new standardized supervisory checklist, to be included in SDG Manual, hospitals will be measured quarterly on their performance on structure, process, and outcomes. Structural measures will comprise the context in which care is delivered, including infrastructure, staff, financing, and equipment. Process measures will include the technical and interpersonal process and actions that make up health care as reflected in the transactions between patients and providers and staff throughout the delivery of health care. Facilities will also be encouraged and rewarded for initiating quality improvement processes, including self-assessments of quality and patient safety, continuous quality improvement, peer-to-peer evaluations, and adverse event audits. Outcomes refer to the effects of health care on the status of patients and populations and will be considered to be a result of inputs and processes of care. The results will be cross-checked and verified by the independent agency (initially the HEFI and subsequently the PCA). Eligible categories of expenditure for SDGs at the hospital level are similar to those of HCs and include minor works, goods, drugs, and/or recurrent costs, including supplies, short-term staff, consumables, communications, maintenance, transportation, accommodation, other incidental expenses, and performance bonuses for health workers.

[9] In due course, this responsibility of ODs may shift to councils being created as part of the Sub-national Democratic Development reform.

Subcomponent 1.3: Service Delivery Grants: Provincial Health Departments (PHDs) and ODs (US$6.0 million equivalent)

23. These SDGs aim to strengthen the management of ODs and PHDs. The performance of ODs and PHDs will be measured every six months by the quality assurance office (QAO) of the MOH, against their self-reported activities on a scorecard to be detailed in the SDG Manual, measuring key supervisory processes and health system outputs. These include (a) timely completion of quality checklists for health facilities in their jurisdiction; (b) contribution to capacity-building activities for in-service and pre-service training; (c) drug stock-outs in health facilities, human resources availability; (d) Health Management Information System (HMIS) reports submitted; and (e) quarterly review meetings and system functionality. Similar to the other SDG grants, the proposed independent PCA will verify the performance of the PHDs and ODs. Eligible SDG categories of expenditure for ODs and PHDs will include minor works, goods, and/or recurrent costs, including supplies, short-term contracts, consumables, communications, maintenance, transportation, accommodation, other incidental expenses, and performance bonuses.

Component 2: Improving Financial Protection and Equity (US$70.0 million equivalent)

24. This component will continue to support and expand the HEF system and co-finance with the RGC the cost of health services for the poor. The current HEF system is expected to evolve with changes in government policy on beneficiaries and benefit packages and SHP. This will make it possible for standalone initiatives such as vouchers to be fully integrated into the HEF system. This component will build on the current success of the HEF system, aiming to improve the quality of services, increase utilization by the poor, and ensure sustainability by transferring implementation responsibility to the RGC.

25. The HEFI, currently an international firm, provides independent verification of the benefits provided to individual patients. These functions are expected to be transferred to an independent PCA[10] to be established as a public administrative establishment (PAE). Verification by the HEFI is led by a team of field-based monitors who conduct household interviews, bedside monitoring, and document reviews and work with key stakeholders to make sure that the benefits reported are the actual benefits delivered to the poor. These functions will be transferred to the PCA. The PCA will also serve as a monitoring and verification agency for the performance-based grant payments envisaged under Component 1. The transition of the HEFI to the new PCA will be a process led by the MOH and the PCA is expected to take over the HEFI functions by June 2018.[11] A concrete transition plan will be developed by project effectiveness and a working group will be set up to operationalize the plan. There is strong ownership within the MOH to establish the national verification agency.

26. The Health Equity Fund Operators (HEFOs) were contracted nongovernmental organizations or community-based organizations under HSSP2 whose roles were to facilitate and monitor HEF beneficiary access to services, distribute transportation reimbursements and caretaker food allowances, conduct post-identification interviews, and administer facility

[10] The exact name of this agency may be changed subject to discussions within the MOH to better reflect its roles and responsibilities.
[11] The current HEFI contract is expected to continue until end 2018.

payments at the end of each month. The HEF system was always envisaged as a transitional arrangement leading to a national health insurance scheme for the poor, and to sustain progress in this regard, some of the roles of the current HEFOs are expected to be incorporated into the facilities themselves and the PCA. The residual roles of HEFOs can then be undertaken by Health Equity Fund Promoters (HEFPs) with a patient advocacy role whose main functions would be to: (a) conduct post-identification of the poor; (b) measure and report on consumer satisfaction; (c) raise awareness and promote HEF utilization among the very poor; and (d) where relevant, promote the utilization of HEFs as well as wider health services among the underserved population in identified remote and difficult-to-access communities. Recent studies show that lack of understanding of how HEFs work is one of the main barriers to utilization, and addressing this issue would be a key HEFP role. The detailed envisaged functions of the PCA and HEFP are described in Annex 2.

27. The HEFs finance health care user fees and other associated health care costs of eligible poor beneficiaries. The RGC is currently financing 40 percent of the direct benefit costs of HEFs. It is expected that this share will remain unchanged in 2016 but would will gradually increase over the lifetime of the project. The IDA Credit and the multi-Donor trust fund (MDTF) grant will finance their agreed share up to an annual cap of US$6 million for each completed year of the project, and any remaining gap thereafter is expected to be fully covered by the RGC. Based on the current expenditure trends, a conservative estimate for the costs for HEF over the five-year period is approximately US$70 million, including operating costs for HEFPs. A detailed costing plan is provided in Annex 2. Expansion of the beneficiary groups and the benefit package, as well as the expected improvement in utilization, would require additional resources.

Component 3: Ensuring Sustainable and Responsive Health Systems (US$30.0 million equivalent)

Subcomponent 3.1: Health System Strengthening (US$15.0 million equivalent)

28. This subcomponent will support a program of activities designed to improve supply-side readiness and strengthen the institutions that will be implementing project activities. This includes the implementation of comprehensive pre-service and in-service training programs for health workers, equipping health facilities to meet minimum standards for the provision of obstetric and neonatal care, carrying out enhanced health service quality monitoring, improved timeliness of SDG and HEF payments, and establishment of sustainable health service purchasing arrangements.

29. Financing for this subcomponent will be provided based on results tracked by DLIs, which are a set of tracer indicators with annual targets, aimed at measuring performance against health system strengthening actions. The DLI approach reimburses the government for delivery of results against eligible expenditures referred to as Eligible Expenditure Programs (EEPs). Once achievement of a DLI target is verified, funds would be transferred to the MEF against the defined EEPs, which is a portion of the government contribution to HEFs under the H-EQIP, as set forth in the Project Operational Manual. Clear guidelines on measuring the results will be agreed at the beginning of implementation and included in the Project Operational Manual. If the annual DLI target for each respective year is not fully met by the end of the year, payment will be delayed until the result is fully achieved in a subsequent year. The aim is to ensure that the

agreed results are achieved and the financing continues to encourage the RGC to reach the agreed targets. This approach is being used more frequently in World Bank-financed operations as it is expected that it would result in more sustained improvements in service quality. Table 1 provides the agreed DLIs for the project, and Annex 2 provides the detailed breakdown of all annual DLI targets and values specified for each DLI, as well as the DLI verification protocol, which is further detailed in the Project Operational Manual.

Table 1. DLI Indicators

Supply-side Readiness
DLI 1: Comprehensive pre-service training program in foundational courses for medical and nursing professionals implemented by University of Health Sciences (UHS)
DLI 2: Comprehensive in-service training program on MPA for health workers implemented by the MOH
DLI 3: C2[12] hospitals fully equipped to provide emergency obstetric care and neonatal care
Institutional Strengthening
DLI 4: Health service quality monitoring in the MOH enhanced
DLI 5: Sustainable health purchasing arrangements established by RGC
DLI 6: Timeliness of HEF and SDG payments improved

Subcomponent 3.2: Health Infrastructure Improvements (US$13.0 million equivalent)

30. Approximately US$13 million from Component 3 is expected to finance civil works according to the priorities identified by the MOH in its civil works plan 2016–2020. Prioritization will be based on access issues, attention to remote areas, concerns around patient safety, and improvement of maternal and neonatal survival. A joint assessment with the RGC, to identify priorities for infrastructure investments, will be undertaken and the final list of civil works will be identified in the first half of 2016. The expected type of investments will include maternity wards and other infrastructure for emergency maternity and neonatal services, HCs, and hospitals.

Subcomponent 3.3: Project Management, Monitoring, and Evaluation (US$2.0 million equivalent)

31. Project management will be integrated into the responsible departments of the MOH. This component will support provision of technical and operational assistance for the day-to-day coordination, administration, procurement, financial management (FM), environmental and social safeguards management, and M&E of the project, including the carrying out of financial audits of the project. The subcomponent will also support capacity strengthening of responsible departments within the MOH to smoothly transfer the responsibility of project management from the currently existing secretariat under HSSP2 to the relevant departments, as well as to support other implementation needs.

32. A technical assistance (TA) grant from the Japan Policy and Human Resources Development (PHRD) Trust Fund (TF), a programmatic TF administered by the World Bank, of an amount of US$1 million will provide complementary financing to Component 3. The grant is

[12] C2 hospital refers to a CPA-2 hospital. The MOH classification system for hospitals is: CPA-1 - Referral hospital with minor surgery (with general anesthesia); CPA-2 - Referral hospital with surgery (with general anesthesia) and supplementary activities more than CPA-1 but fewer than CPA-3; CPA-3 - Referral hospital with surgery (with general anesthesia) and supplementary activities and specialized activities.

expected to contribute to the strengthening of Cambodia's M&E systems in the health sector and implementation of the M&E Plan developed under HSP-3. Strong focus on improving M&E will help ensure availability of relevant, timely, and high-quality health and health-related data to allow for evidence-based policy formulation, decision making, management, and planning. The grant will also support capacity building at decentralized levels to improve reporting and monitoring. Support will be provided in the following five areas: (a) strengthening sector performance reporting through annual monitoring missions and publication of annual health sector performance reports with rigorously verified results; (b) data quality monitoring and capacity building in M&E, including improvement in data management, analysis, interpretation, reporting, use, and dissemination (at the central and decentralized levels); (c) quality assessment of health services in complementarity with Level 2 (L2) quality assessments[13] (to be carried out in alternative years when an L2 assessment does not take place); (d) strengthening of medical record systems, including expansion of the Patient Medical Registration System database; and (e) support for upgrading the HMIS, including development of policy/regulation, protocols/guidelines, and maintenance/upgrading of the information technology system. This financing has been approved in principle but will become available upon formal endorsement by the Japanese government and the PHRD Unit and will be funded by the Japan PHRD TF under its Performance and Results with Improved Monitoring and Evaluation window.

Component 4: Contingent Emergency Response (US$0 million)

33. The objective of the contingent emergency response component, with a provisional zero allocation, is to allow for the reallocation of financing in accordance with the IDA Immediate Response Mechanism (IRM) to provide an immediate response to an eligible crisis or emergency, as needed.

34. In the event that the component is triggered, the standard IRM contingency emergency response component-specific objective to 'provide immediate and effective response to an eligible crisis or emergency' will be incorporated and the Results Framework revised through formal restructuring. In addition, the component will be monitored using appropriate indicators identified as part of the standard items required to be established before triggering.

B. Project Financing

35. The RGC has requested an IDA Credit of US$30 million equivalent. Australia, Germany, and South Korea have pledged an amount of approximately US$50 million equivalent as a recipient-executed World Bank-administered MDTF.[14] The IDA Credit and MDTF grant will proportionally co-finance Components 1, 2, and 3, excluding government counterpart financing

[13] The L1 assessments focused more on structure and some processes, and have since been replaced by more advanced L2 assessments that focus more on processes, provider knowledge, and competency, and with a stronger focus on attaining better health outcomes.

[14] This amount is based on the estimated US$ equivalent of the total donor contributions expected to be pledged for recipient-executed activities under the MDTF at the time of appraisal. The project scope and Results Framework have been appraised as inclusive of this total estimated amount of MDTF contributions. The Grant Agreement between the Bank and Cambodia will include the total amount of the initial installments deposited by the donors in the MDTF account, and this amount will be amended as and when the donors deposit additional installments of their total pledged contributions in accordance with the schedule of payments specified in the MDTF Administration Agreements between the Bank and the respective donors.

for Components 1 and 2, as specified in the respective Annual Operational Plans (AOPs). The MEF confirmed that government financing for the project will be maintained at 40 percent of total financing for 2016, with an expectation that their share would increase in the subsequent years to support Components 1 and 2. Based on the current costing estimates of SDGs (with an expectation that these will be rolled out nationwide after five years) and HEFs (especially with the anticipated expansion of HEF beneficiaries and revision of the HEF benefit package), projected costs to sustain the two programs are approximately US$74 million and US$70 million, respectively. A complementary grant supporting the project, from the PHRD TF, is under preparation and will provide an additional US$1 million for complementary activities related to the project, as set out in paragraph 32.

36. It is expected that the MDTF grant resources will be committed through administration agreements with all MDTF donors before effectiveness and will be available for joint co-financing of the project as agreed. A cross-effectiveness provision has thus been made in the Project Financing Agreement to ensure that the MDTF Grant Agreement is signed and effective at the same time as the Financing Agreement. However, in case the MDTF co-financing does not materialize for some unforeseen reason, the project will be restructured to promptly commence implementation of the activities and either additional resources will be sought through an IDA additional financing mechanism or the project will be scaled down through a restructuring to limit its scope to the available IDA resources.

37. The project will use the Investment Project Financing instrument. The first two components will use performance-based financing at the health facility, district, and provincial levels, with a focus on quality. Component 3 will be a mix of traditional investment financing and disbursement against EEPs linked to the achievement of targeted results for DLIs to support health system strengthening. Component 4 will provide an immediate response to an eligible crisis or emergency, as needed. The RGC contribution will be for SDGs and HEFs; Component 3 will be fully financed by the Bank and the MDTF. Component 4, if triggered, will be fully financed by IDA under the IDA IRM mechanism.

Table 2. Project Cost and Financing by Component and Sources (in US$ millions)

Project Components	Project Cost[15]	IDA	MDTF	RGC	PHRD (complementary financing)
1. Strengthening Health Service Delivery	74.2	7.5	12.5	54.2	0
2. Improving Financial Protection and Equity	70.0	11.25	18.75	40.0	0
3. Ensuring Sustainable and Responsive Health Systems	30.0	11.25	18.75		1.0
4. Contingent Emergency Response	0	0		0	0
Total	**174.2**	**30.0**	50**.0**	**94.2**	**1.0**

[15] The total project cost excludes the complementary financing by the PHRD.

C. Lessons Learned and Reflected in the Project Design

38. The project is informed by various analytical and advisory works carried out on utilization of HEFs, quality of care, and other health system issues in Cambodia, including those undertaken by the World Bank-executed part of the HSSP2-MDTF.[16] The project incorporates lessons from HSSP2 and World Bank experience in social health insurance and DLI-based operations. In addition, a PFM assessment was conducted during project preparation to determine whether the MEF, MOH, and related implementing agencies have acceptable PFM arrangements in place and can be used for managing funds under the project. This was based on an assumption that the ongoing PFM Reform Program, driven by the MEF and implemented by the MOH, has sufficiently strengthened and improved PFM in the sector.

39. The core principles informing project design are the following:

(a) **Financing a part of the broader government program.** The project finances a subset of activities identified under HSP-3. It also builds on planned health sector reforms, the Results Framework for HSP-3 and additional support for PFM, which is being provided as part of the World Bank's support to the RGC.

(b) **Focus on results.** There is increasing evidence that incentivizing results rather than financing inputs leads to enhanced service delivery and use. The proposed project aims to improve social protection and quality of health services by introducing performance-linked and results-based mechanisms at all levels of the health system: PHD, OD, and health facility. In addition, a DLI approach is envisaged at the central level under Component 3, to encourage establishment of appropriate institutional arrangements as well as system strengthening that will be key to implementing this operation.

(c) **Mainstreaming implementation arrangements.** The proposed project will be situated in the context of the entire government program, where the project will support a part of the larger program. The project aims to improve sustainability of government programs by directly financing a part of the RGC's programs using their own funds flow mechanisms. It will also support the transition of key accountability functions and systems to the respective MOH departments instead of relying on parallel implementation entities for the project.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

40. The institutional arrangements are based on lessons from HSSP2 as well as the PFM reforms envisaged in the country. The implementing agency for the project will be the MOH, acting through its technical departments and national programs, as well as the PHDs, ODs, RHs, and HCs. Within the MOH, the project will be implemented through the Department of Planning and Health Information (DPHI) and the Department of Budget and Finance (DBF) using

[16] The HSSP Bank-executed Trust Fund (BETF) supported strengthening health sector governance and stewardship in areas such as decentralization, health care financing, quality and FM.

mainstream MOH processes and will not involve a parallel project implementation unit or secretariat. However, the project will have a provision to strengthen these departments' capacity and skills through additional consultants or advisors. The additional consultants or advisors will be used for strengthening the DPHI/DBF/procurement unit functions as a whole and not specifically for the project activities. Other MOH departments participating in project implementation will include (a) the Internal Audit Department (IAD); (b) the Department of Human Resource Development; (c) the Hospital Services Department and the QAO; (d) the Preventive Medicine Department; (e) the Department of Personnel; (f) the Department of Food and Drugs; and (g) the Department of International Cooperation.

41. The QAO will play an integral role in driving quality improvements in service delivery. Located in the Hospital Services Department, this unit of the MOH will be staffed with full-time equivalent government and contracted personnel, including both national and international staff. In addition, secondments from DPs will also be sought initially to strengthen this institution. The unit will be responsible for the overall delivery of the SDGs, including preparation and review of quality measurement tools, tracking quality performance through supervision checklists and periodic Level 2 assessments, maintenance of an online monitoring dashboard, client satisfaction surveys, technology solutions, stewardship of counter verification for SDG payments, and the policy framework for quality strengthening.

42. To ensure the sustainability of HEFs and SDGs and support government programs, the project's special account under the ongoing arrangements of HSSP2 will be replaced with a treasury account with subaccounts for the RGC and DPs' co-financing. Ultimately, funds will be transferred directly to health facilities, once these are verified by the PCA and processed through the FM systems of the government. With regard to the governing structure, there will be a project director under the minister and two project managers for technical (director of the DPHI) and administration and finance (director general for administration and finance).

43. The guiding documents for the project will be an updated Project Operational Manual, including the updated SDG and HEF manuals, and chapters detailing the DLI verification protocols and other standard project fiduciary, safeguard, implementation, and M&E requirements, as well as relevant *Prakas* to be developed. In addition, AOPs will be submitted for no-objection to the World Bank and the TF donors by September 30 of each year, detailing the project work program and budget for each government fiscal year and specifying the allocation and sources of funding for all project components, including the relative financing shares of all eligible expenditures by the IDA credit, MDTF grant, and RGC counterpart funds.

44. **Donor arrangements.** Australia's Department of Foreign Affairs and Trade (DFAT), German government-owned development bank (*Kreditanstalt für Wiederaufbau* [KfW]), and the Korea International Cooperation Agency (KOICA) will pool support through the establishment of a new MDTF administered by the World Bank, both supporting the recipient-executed part as well as the World Bank-executed part of the project. The World Bank-executed part will finance TA and analytical activities of areas that are closely linked to successful achievement of the

project objectives.[17] In addition to contributions by the Bank and MDTF pooling partners, the U.S. Agency for International Development (USAID) is expected to contribute to the MDTF, and Japan will finance activities to support the strengthening of health sector M&E and implementation of the M&E Plan under the proposed US$1 million PHRD grant complementary to IDA/MDTF. Agreement on the harmonized arrangements for pooled TA, including pooled resource management, decisions on activities, joint supervision, and program review and reporting, have been agreed upon by the contributing partners and they will be spelled out in the administrative agreements to be signed by the World Bank and each partner. Independent TAs will also be provided from the German Agency for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit* [GIZ]), Japan International Cooperation Agency (JICA), and United Nations agencies to fully complement the activities under the Project and close coordination will be ensured through regular coordination meetings on pooled and non-pooled TA partners.

45. Other partners working in the areas of UHC and SHP under the RGC's HSP-3, such as GIZ, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), World Health Organization (WHO), and USAID have agreed to establish working relationships for coordination and dialogue with the H-EQIP pooling partners. Under HSSP2, the Joint Partnership Interface Group was the program partner forum for consultation and decision making on issues arising in the program. Building on the strengths of this kind of collaboration in HSSP2, the functions of this forum will be revised to serve as a coordinating mechanism for donors, both pooling support through the H-EQIP and those managing individual program accounts, to focus on information exchange; coordination of financial and technical cooperation; identification, filling, and supporting of potential gaps; and strategic decision making in achieving the goals of UHC and SHP under the umbrella of HSP-3.

46. The specific design of the new coordination mechanism is currently under discussion among DPs and is expected to be agreed by the start of the project on July 1, 2016. Proposed revisions under discussion include agreement on a detailed coordination plan among DPs to identify activities from the sectoral plan to be funded through individual program accounts, and activities to be funded through pooled plus individual accounts; participation in annual joint review field visits to review sector priorities, performance, and coordination among DPs; regular bimonthly meetings; and other specific arrangements for improved harmonization. The DPs are also considering the option to use the broader coordination umbrella of *Providing for Health* (P4H) as an appropriate mechanism for this kind of coordination.

B. Results Monitoring and Evaluation

47. The Results Framework of the project will be aligned with that of the RGC's HSP-3 with regard to indicator definition, baselines, and targets. The draft HSP-3 Results Framework will be finalized by the end of March 2016.

48. Data sources include routine data such as the improved HMIS and the National Programs, as well as periodic surveys such as the Cambodia Demographic and Health Surveys and the

[17] Topics that are currently being discussed for this purpose include HEFI and HEFO transition, PFM capacity assessment, quality monitoring, data and analytics on financial protection and access, citizen engagement and awareness, impact evaluation of SDGs, and performance incentives.

Cambodia Socioeconomic Survey. The project indicators have been selected based on (a) the feasibility to monitor on a regular basis through routine data and planned surveys and (b) quality-related indicators that will be monitored through L2 quality assessments and quality scorecards to be developed under the project.

49. Rigorous M&E will be carried out, characterized by: (a) independent verification to verify the results under Components 1 and 2 and (b) verification of the DLI targets achieved and to determine the amount of DLI disbursements under Component 3. Focus on quality aspects will be ensured through development of a standardized supervisory checklist that incorporates quality dimensions, as well as institutionalization of L2 quality assessment in the QAO. In the years that an L2 quality assessment will not be carried out, the MOH will conduct a rapid quality assessment with support from the PHRD grant. All these will be carried out in close coordination with the other activities in support to strengthening M&E in the health sector under Component 3. See Annex 3 for a more detailed description of the M&E arrangements.

50. For the verification and disbursement of DLIs, the project will largely rely on the Performance and DLI Report, to be produced by the MOH, detailing the performance of the project including DLIs. A rapid performance assessment will verify the results reported in the Annual Report and this will be a World Bank-executed activity, using external consultants where appropriate and necessary. These results will be discussed as part of a Joint Annual Review conducted with all MDTF partners. Final agreements on the status of DLI achievement will be documented in an aide-memoire and endorsed by the World Bank, MDTF partners, and RGC.

51. A midterm review of the project is expected to be conducted in July 2019.

C. Sustainability

52. **Financial sustainability.** Government funding for health care has increased significantly in recent years. The government has already indicated its commitment to financial sustainability by financing an increasing share of the costs of HEFs and SDG from the national budget, commencing with 40 percent at the start of the project. Cambodia will need to increase prepaid/pooled financing for health which, for a country with a high level of informality, implies increasing and improving government spending on health to attain and sustain progress toward UHC. There is also a need to ensure available resources by improving allocation and removing inefficiencies. The project should have a positive effect on financial sustainability by addressing these issues.

53. **Institutional sustainability.** One of the main objectives of the project is to ensure the institutional sustainability of the HSSP2 support to HEFs and SDGs by integrating them into the RGC's health sector program. Currently, institutional capacity to implement HEFs lies outside the public health system, so this capacity will be systematically transitioned to an independent government agency. Component 3 also supports the implementation of the RGC's PFM strengthening plan, especially FM performance and strengthening of the QAO. Component 1 will introduce additional reforms to increase utilization of services by the poor and vulnerable and improve the quality of services provided and includes strengthening of the ODs and PHDs in their supervision roles and strengthening the capacity of the QAO. The MEF and MOH have clearly taken full ownership of the project and are leading consideration of policy options for the

project design, with a view to securing institutional sustainability through strengthened domestic implementation and supervision capacity.

54. **Technical sustainability.** Most of the project financing will be used for strengthening the existing HEF and SDG systems. Support will be provided to ensure that the capacity built under HSSP2, particularly the HEFI role, is transferred to the PCA in a systematic and time-bound manner and units within the MOH are fully staffed to carry core quality strengthening functions.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

55. **The overall project risk is Substantial**. The most significant risks are fiduciary. Evidence supporting the rating includes: (a) the findings in the 2011 Integrated Fiduciary Assessment Review[18] that more competitive procurement and international price benchmarking of pharmaceuticals, equipment, and medical supplies could save more than US$50 million a year, or one-third of government health spending and (b) misappropriations documented in the Global Fund financed program.[19] While there has been some progress in allocating government budget funds directly to a number of health agencies designated as budget entities, this has not been applied uniformly across the health sector. A review of the government's progress in implementing program budgeting and a new FM information system is under way.

56. The following factors will help reduce the fiduciary risks: (a) funds transferred to facilities for HEFs and SDGs are primarily for operating costs and incentives with much reduced scope for capital expenditure; implementation manuals exist for both these programs and include eligible expenditures; (b) the project will support implementation of the national PFM reform program within the MOH; and (c) an independent verification mechanism already exists for HEFs and will also be introduced for the results-based elements of SDGs and will be strengthened through establishment of a PCA.

57. **Governance risk is rated Substantial**. Governance of the health sector has been constrained by (a) limited ability of the government to manage and coordinate multiple initiatives; (b) proliferation of several types of schemes, tried, implemented, or funded by different DPs; and (c) ineffective regulation of public and private providers. The project, along with other key donors, intends to support the consolidation of all the initiatives, moving toward a common system of SHP to achieve UHC.

58. **The design and institutional capacity risks are also Substantial**. Mainstreaming into government systems is an important step to ensure sustainability; however, there will be constraints of capacity, resourcing, and stakeholder alignment. As part of project preparation, independent procurement and FM assessment (including PFM) have been carried out to assess the risks and propose appropriate mitigation measures.

[18] Report No. 61694-KH.
[19] Office of the Inspector General. 2010. *Country Audit of Global Fund Grants to Cambodia*. Audit Report No: GF-OIG-09-014, Global Fund, Geneva.

59. Risks associated with safeguards are fourfold: (a) potential impacts from civil works and incremental health care waste generated from health service delivery supports; (b) potential use of parts of the SDGs for activities related to pesticides for vector-borne diseases control such as dengue; (c) potential impact on ethnic minorities present in the project area; and (d) although a minor risk, potential for land acquisition that could lead to physical displacement and land donation as part of the implementation of the project. Details are provided in section VI. Appraisal Summary.

60. In consideration of the IDA17 climate change agenda, this operation has been screened to identify and, if relevant, address any potential short- and long-term climate change and disaster risks. Options to address climate change include: (a) infrastructure design of the project that will take into account measures in Environmental Management Framework (EMF) to prevent impacts from flooding; (b) support for improvement of health care waste management practices in health facilities to reduce potential public health impact to nearby residents and health facilities staff from infection during flooding; (c) support for improvement of water availability at health facilities; (d) support for improvement of service delivery at the health facilities and at the communities where schedules of health outreach activities at the communities can be flexible depending on local season and weather; and (e) the a flexible design of the project to allow reallocation of the project funds under the IDA IRM mechanism, as needed to provide immediate response to eligible crises or emergencies.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

61. **Investments under this project will improve efficiency, equity, and financial protection and the project is economically and financially justified.** The project will help tackle inefficiencies by introducing financial incentives to increase utilization of essential interventions (interventions such as immunization, family planning, and nutrition interventions that have high benefit-costs ratios[20] and large positive externalities) and improve quality of health services; by simplifying implementation arrangements of HEFs and SDG and reducing their administrative costs; and by strengthening PFM. The project will also reduce inequities and enhance financial protection. By improving and further promoting HEFs, by reducing geographical inequities in access to services, by improving technical and perceived quality of care in public facilities, and by expanding eligibility of HEFs to other vulnerable groups, it will encourage more poor, disadvantaged and vulnerable groups to use free services provided by government health facilities. In addition to improving health outcomes and addressing inequities in health service utilization, this will help reduce total OOP spending of these population groups by up to US$739 million.[21]

62. **Investing in quality makes economic sense**. Poor quality of care is a double obstacle to improved health outcomes. It deters utilization and reduces the effectiveness of care in achieving good health outcomes. When the baseline quality is low—which is the case in Cambodia[22]—and

[20] For stunting, this ratio is estimated at between 3.6 and 48; for rural sanitation the ratio is between 4 and 8.2.
[21] This is in present value (2015), spread over the duration of the project and in comparison to a 'status quo' scenario as detailed in the annex on Economic Analysis.
[22] World Bank. 2013. *Cambodia's Quality of Care Study*. Washington, DC: World Bank.

the disease prevalence is high, efforts that raise quality of care can be extremely cost-effective.[23] Quality improvement efforts under this project will therefore make a considerable difference.

63. **Financing and sustainability.** The annual RGC budget for health was around US$250 million in 2014. This represents a substantial increase over time and the RGC has clearly committed to increase spending on health for the next three years. Of this US$250 million, approximately US$15 million a year is the RGC contributions to HEFs and SDGs under HSSP2. The project would increase annual health expenditures by approximately US$18 million per year, which was around 7 percent of the 2014 budget - and expected to be a still smaller share of the total health budget at the closure of the project. Direct payments for health services—HEFs and SDGs— will amount to just under US$1 per person per year. While this is a small and evidently sustainable increase, given the high rates of economic growth and RGC's demonstrated commitment to increasing the health budget, it still represents a substantial increase to much-needed flexible financing at the facility level. As estimated in more detail in Annex 6, the project will potentially reduce total OOP spending by the poor by a net present value of US$183 million.

B. Technical

64. The technical design for the project has been arrived at after extensive review of the analytical work already undertaken by the MOH, World Bank, and other DPs in the country; experience of the HEFs and SDGs in HSSP2; and extensive stakeholder consultations, also drawing on the expertise and experiences of the invited experts, consultants, and the World Bank team. The country's context on the current status of the health system, performance of the HEF system, concerns around quality of health care services and OOP, and planned reforms in PFM systems, along with insights available from global experiences in similar contexts, have informed the project design. This has been important to ensure that all the planned activities are well grounded in the realities of the situation, they take into account the various constraints and challenges that Cambodia still faces, and they are yet progressive and transformative enough to bring about the much necessary expansion of access, quality, and financial protection needed in the country.

65. The technical design of the project is based on a growing global understanding that transforming the input-based health systems to result-based systems can change the persistent underperformance of countries' health services. This design benefitted specifically from the performance-based financing and the DLI approaches being used globally. The services and interventions financed under the project are cost-effective and are expected to have a significant impact on the RGC's four key priorities for maternal and child health, communicable diseases, NCDs, and health system strengthening.

C. Financial Management

66. The project will apply procedures and fiduciary requirements acceptable to IDA, through the Supplementary FM Manual detailing, among other things, clear controls and payment

[23] Improving the quality of treatment of diarrhea among children, for example, can cost as little as US$14 per life saved. [Peabody, J. W., M. M. Taguiwalo, D. A. Robalino, et al. 2006. "Improving the Quality of Care in Developing Countries." In *Disease Control Priorities in Developing Countries*, edited by D. T. Jamison, J. G. Breman, A. R. Measham, et al. Oxford University Press and the World Bank.]

processes, segregation of duties, financial reporting, DLI-based disbursement protocols, and so on. An assessment of the FM arrangements has been carried out for this project in accordance with OP/BP 10.00, and the overall FM risk is assessed as High. The main risks are associated with: (a) limited experience of the accounting and finance staff of the DBF in World Bank-funded operations; (b) inadequate capacity of the staff at HCs and budget entities at provincial levels to implement program-based budgeting and budget entity related policies and procedures; (c) in some cases, delay in the release of funds due to constraints on availability of funds and long government procedures; and (d) inadequate documentation of policies and procedures of the government's newly reformed system. Mitigation measures have been put in place to address those risks. Some of the key measures are: (a) a supplementary FM Manual detailing the payment processes, service standards, and monitoring mechanisms of the payments made; (b) hands-on support from FM consultants; (c) adoption of the current accounting software used in HSSP2 as an interim measure before the Integrated Financial Management Information System (IFMIS) is rolled out; and (d) risk-based internal audits of the project by the MOH's IAD.

67. Disbursement of the DLI-based payments will be based on the MOH fulfilling the following requirements: (a) demonstration that the amount of HEFs used as EEP exceeded the amount being requested from IDA in the prior year and (b) achievement of the agreed annual DLI targets, documented in an annual DLI report/aide memoire endorsed by the World Bank, MDTF partners, and the RGC.

68. Funds from the Bank will be transferred to a pooled pass-through designated account for IDA and MDTF) maintained by the General Department of the National Treasury (GDNT) under a Treasury Single Account (TSA). The GDNT will then transfer the whole amount from a pooled pass-through designated account to the project bank account at the National Bank of Cambodia (NBC). The project bank account will be managed by the MOH and payments to health facilities and others will be made from this account.

D. Procurement

69. Procurement under the Project will be governed by 'Guidelines: Procurement of Goods, Works, and Non-consulting Services by World Bank Borrowers under IBRD Loans and IDA Credits and Grants by World Bank Borrowers', dated January 2011 (revised July 2014) and 'Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers', dated January 2011 (revised July 2014). The World Bank Standard Bidding Documents and Request for Proposal documents will be used for all tenders requiring international competitive bidding and consultant selection requiring international participation respectively. Cambodia's Updated Procurement Manual for all Externally Financed Projects/Programs, promulgated pursuant to Sub-Decree 74 on promulgating the Updated Standard Procedures for Implementing All Externally Financed Projects/Programs, dated May 22, 2012 and harmonized bidding documents will be used for tenders under national competitive bidding and other low-value procurements. This will be reflected in the project Financing Agreement as well as in a joint *Prakas* between the MOH and MEF. The procurement unit of the MOH will be responsible for all procurement activities at the national level, while the subnational-level budget entities (HCs, hospitals, ODs, and PHDs) will carry out their own procurement activities, except some significant/critical items that will not be available locally at the subnational levels. Such items will be procured centrally by the procurement unit of the

MOH on behalf of and based on the request of the subnational-level budget entities. The procurable items under the project will include: (a) minor renovations and repairs of health facilities and equipment at the subnational levels, where the expected value of contracts will not exceed US$10,000 per package and (b) upgrading of HCs and hospitals, office equipment, HEFP, and advisory services for implementation of the various components. The expected value of a contract at the national level will not exceed US$5 million per package.

70. Key procurement risks identified include: (a) limited capacity and procurement oversight at the central level, where the MOH procurement unit staff are not familiar with DP-financed procurement and staff have limited English proficiency; (b) limited capacity and oversight at the subnational levels, where a majority of subnational-level budget entities are not familiar with DP-financed procurement and activities at subnational levels that take place all over the country; (c) delays in procurement cycle management due to slow technical inputs for procurement start-up; and (d) governance-associated risks.

71. **The procurement risk is assessed High.** The high risk emanates from the nationally distributed nature of activities at the subnational levels, limited number of experienced procurement staff. Risk mitigation measures have been discussed and agreed with the government and detailed in an action plan in annex 3.

72. In the event that Component 4 may finance goods, works, and/or consultant services required for an eligible crisis or emergency, the applicable procurement methods and procedures under the relevant provisions of the Bank's Procurement Guidelines will be further detailed in the Emergency Response Manual.

E. Social and Environment (including Safeguards)

73. Social and environmental safeguards aspects of the project will be implemented by the MOH, including the Resettlement Policy Framework (RPF), Indigenous People Planning Framework (IPPF), and the EMF, acting through its technical departments, national programs, as well as the PHDs, ODs, RHs, and HCs. The project has nationwide coverage and includes provinces where concentrations of indigenous peoples reside and the predominantly indigenous peoples' inhabited provinces of Mondulkiri and Ratanakiri.

Social (including Safeguards)

74. A social assessment (SA) was carried out in a participatory process through free prior and informed consultations with ethnic groups, to assess the project's potential effects on local communities and examine alternatives where adverse effects may be significant. In particular, the SA reviewed the existing barriers for ethnic women and children to receive proper health services, including those related to language, traditions, customs, values, and so on. In accordance with the findings of SA, an IPPF has been prepared and disclosed both in-country and in the World Bank's External Website on December 7, 2015, including steps to be taken to address barriers for ethnic minorities benefiting from the project and the negative impact that may occur, if any. The IPPF has been subsequently updated and re-disclosed in-country on April 1, 2016 and on the World Bank's site on April 11, 2016. The IPPF includes the relevant elements for preparing the Indigenous Peoples Plan during project implementation.

75. The H-EQIP is designed for social inclusion determined to ensure local participation by commune members. The project will involve indigenous communities as key beneficiaries. Experience has shown that incorporating culturally appropriate considerations for ensuring the full participation of indigenous communities in the health services is key to the project's success; specifically applying the Indigenous Peoples Planning Framework which was prepared during project design and which indicates clear measures for adapting the project activities to increase the indigenous people's attendance and benefits from health. The project will continue to ensure appropriate attention to gender issues as well as indigenous people's issues and improve the quality and skill sets of health services providers.

76. An RPF has been prepared and disclosed in-country on December 7, 2015 and in the World Bank's External Website on December 7, 2015 to address any potential land acquisition and resettlement issues that may occur during project implementation. Screening criteria and relevant protocols have been included as part of the RPF.

77. The institutional arrangements for social safeguards are based on the implementation experience of HSSP2 as well as the PFM reforms envisaged in the country. The implementing agency for the project will be the MOH, including the RPF, IPPF, and the EMF, acting through its technical departments, national programs, and the PHDs, ODs, RHs, and HCs. The MOH departments participating in project implementation will include: (a) the DPHI; (b) the DBF; (c) the IAD (d) the Procurement Unit; (e) the Department of Human Resource Development; (f) the Hospital Services Department (HSD); (g) the Preventive Medicine Department (PMD); (h) the Department of Personnel; and (i) the Department of International Cooperation. Additionally, the MOH will coordinate with the Resettlement Department of the MEF and the Inter-ministerial Resettlement Committee for technical advice, if required.

78. During the HSSP2 implementation, a comprehensive review of land acquisition conducted by the MOH and supported by 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), according to the provisions of the HSSP2 Land Acquisition Framework Policy and Procedures. The World Bank team as well as MOH representatives assessed a selected number of health facilities where the project financed civil works to monitor and verify social impacts that trigger OP 4.12. The review found that no negative impacts on private asset owners occurred during the HSSP2 implementation period. It also found that the MOH kept all necessary documents in the project file.

79. **Gender aspects.** As part of the SA, a series of 54 focus group discussions were conducted in selected target villages with male and female participants. Health services affected the entire population; however, women are especially affected and sometimes excluded from health services. For instance, focus group discussions reported outreach related to child and pregnant women vaccinations. However, only 38 percent of focus group discussions reported having received any type of antenatal care, postnatal care, maternal, or child health outreach activities aside from vaccinations and/or deworming, and only 23 percent reported having received any health outreach relating to infectious diseases (for example, tuberculosis, malaria, HIV/AIDS, dengue) other than general commodity distribution (that is, bed nets without instruction). During project implementation, specifically for year 1, gender analysis will be

conducted at different levels of SAs at the commune level and will be embedded in the social safeguard instruments as well. The SA will describe the gender-related impact to identify the risks that might affect the switch to implementation strategy for each component. Gender-disaggregated data, where available, will be tracked during project implementation.

Environment (including Safeguards)

80. The project support will include construction and/or rehabilitation of selected health facilities. Potential impacts from these activities include temporary and site-specific impacts from civil works, impacts from incremental health care waste from the SDGs, impacts from use of pesticide for dengue vector control, and so on, which can be mitigated through preparation and implementation of good Environmental Management Plans (EMPs). The project is, therefore, classified as Category B. It triggers two environmental safeguards policies: Environment Assessment (OP/BP 4.01) and Pest Management (OP 4.09). To address the potential environmental and health impacts from the H-EQIP, the MOH has prepared an EMF that includes a generic EMP and an Environmental Code of Practices to address impacts from civil works, as well as a Health Care Waste Management Plan and Pest Management and Monitoring Plan. The project will also finance repairs/installations of on-site incinerators at selected health facilities to minimize implementation gaps and minimize impacts from improper health care waste management practices. Public consultation on preparation of the draft EMF was conducted by the MOH on November 5, 2015, in Phnom Penh. The final EMF was disclosed in-country on December 4, 2015 and in the World Bank's External Website on December 7, 2015. The EMF has been subsequently updated and re-disclosed in-country on April 1, 2016 and on the World Bank's site on April 11, 2016.

81. For the H-EQIP, the HSD and civil works engineering team of the DBF are responsible for implementing the environmental safeguards. The HSD has direct responsibility for health care waste management and infection prevention and control. The civil works engineering team is responsible for monitoring the construction of health facilities financed by the project. However, they have limited capacity on the World Bank's safeguards policies and EMF implementation. The World Bank will provide technical and operational support to the EMF implementation. The MOH, with support from the World Bank, will continue to provide training to relevant stakeholders, including at subnational level, in implementation of the safeguard policies triggered by the project.

F. World Bank Grievance Redress

82. Communities and individuals who believe that they are adversely affected by a World Bank-supported project may submit complaints to existing project-level grievance redress mechanisms or the World Bank's Grievance Redress Service. The Grievance Redress Service ensures that complaints received are promptly reviewed to address project-related concerns. Project affected communities and individuals may submit their complaints to the World Bank's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of World Bank non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention and World Bank management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service, visit

http://www.worldbank.org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, visit www.inspectionpanel.org.

G. Citizen Engagement

83. The RGC has begun to use the community to hold HCs accountable for quality service delivery. As part of its Sub-national Democratic Development reform, the government has adopted an innovative Social Accountability Framework, which outlines the responsibilities of service providers (in particular, schools, HCs, and communes) to make information about budget expenditures and performance available to the communities they serve and to engage with these communities to evaluate performance and develop actions plans for improvement. On the demand side of the Accountability Framework, civil society organizations inform communities of their rights to public services and the standards they should expect. They also engage communities in assessments of service provider performance and the development and monitoring of joint annual action plans with local government entities to improve service quality. The Implementation Plan for Social Assessment Framework was piloted in 2015 and will be rolled out across at least 120 districts over the next three years. The H-EQIP will make use of the Implementation Plan for Social Assessment Framework monitoring indicators as perhaps the best mechanism for systematically engaging citizens in the assessment of health service providers in the country. To comply with citizen engagement requirement, the project will track the proportion of health centers with functioning health center management committee as a citizen engagement indicator. These committees involve communities.

Annex 1: Results Framework and Monitoring

Country: Cambodia

Project Name: Cambodia Health Equity and Quality Improvement Project (H-EQIP) (P157291)

Results Framework

Project Development Objectives	
PDO Statement: The PDO is to improve access to quality health services for targeted population groups with protection against impoverishment due to the cost of health services in the Kingdom of Cambodia.	
These results are at	Project Level

Project Development Objective Indicators

Indicator Name	**Baseline**	**Cumulative Target Values**					
		YR1	**YR2**	**YR3**	**YR4**	**YR5**	**End Target**
Increase in the number of HCs exceeding 60% score on the quality assessment of health facilities (Number)[24]	Baseline to be collected by year 1	Baseline + 10%	Baseline + 20%	Baseline + 30%	Baseline + 40%	Baseline + 50%	Baseline + 50%
Reduction in the share of households that experienced impoverishing health spending during the year (Percentage)[25]	0.9 (2014)	0.8	0.8	0.8	0.7	0.7	0.7
Reduction in OOP health expenditure as percentage of the total health expenditure	59.7 (2013) 61.0 (2012)	59	58	57	56	55	55

[24] Based on a composite quality checklist covering structural, process, and outcome domains. The checklist will be implemented quarterly. Two-yearly L2 assessments will allow cross-checking of data.

[25] Measured every three years by the CSES. The next CSESs are in 2017 and 2020. Targets are tentative and based on downward trends in figures from 2004 and 2010.

(Percentage)[26]							
Increase in utilization of health services by HEF beneficiaries (Percentage)[27]	51	55	60	66	73	81	81

Intermediate Results Indicators

Indicator Name	Baseline	Cumulative Target Values					
		YR1	YR2	YR3	YR4	YR5	End Target
Percentage of HCs having stock-outs of 14 essential medicines[28] (Percentage)	4.73 (2014)[29]	<5	<5	<5	<5	<5	<5
Proportion of health centers with functioning health center management committees	Baseline to be collected by Year 1	Baseline + 5%	Baseline + 10%	Baseline + 15%	Baseline + 20%	Baseline + 25%	Baseline + 25%
Percentage of HC, CPA-1, CPA-2, and CPA-3 facilities that receive payments based on performance that includes quality scores within 90 days of the end of the quarter	0	50		60		70	70
Reduction in the variance in score on HC quality assessment[30]	53 percentage points (2015 L2 assessment)			48 percentage points		43 percentage points	43 percentage points
Percentage of CPA-1, CPA-2, and CPA-3 facilities having a 60% quality score in the previous quality assessments (Percentage)[31]	Baseline to be collected by Year 1	Baseline + 10%	Baseline + 20%	Baseline + 30%	Baseline + 40%	Baseline + 50%	Baseline + 50%

[26] Figure from annual National Health Accounts. Data will be available one year in arrears.
[27] Data from the MOH Health Financing Database in the DPHI. Figure for 2014. Possible to count individual patient numbers at HC level using this, so baseline covers both HCs and hospitals.
[28] The 14 medicines are aluminium hydroxide 500 mg; amoxicillin 250 mg; cotrimoxazole 120 mg; cotrimoxazole 480 mg; ferrosulfate + folic acid 200 + 0.4 mg; metronidazole 250 mg; ORS (sachet); paracetamol 100 mg; paracetamol 500 mg; phenoxy methyl penicillin 250 mg; promethazine 25 mg; oxytocin 10 ui/1 ml; rifampicine + isoniazide 150 + 75 mg; microgynon 0.15/0.03 mg.
[29] HSP-3 draft framework, Indicator 68. Data provided from the MOH annual report.
[30] A health facility survey building on the L2 assessment measuring structural process and outcome measures.
[31] Based on a composite Health Facility Quality Index covering structural, process, and outcome domains, to be conducted every six months.

Outpatient Department (OPD) consultations (new cases only) per person per year[32]	0.59 (2014)	0.75	0.80	0.85	0.90	0.95	0.95[33]
Number of UHS courses that adopt competency-based curricula with trained faculty and use of skills laboratory (DLI 1)	0	2	9	17	22	25	25
Percentage of HCs, hospitals, and OD/PHD receiving HEF and SDG payments within the specified timelines (DLI 7)	0	40	50	60	70	80	80
Percentage of HMIS reports submitted on time	95	95	95	95	95	95	95

Indicator Description

Project Development Objective Indicators

Indicator Name	Description (indicator definition)	Frequency	Data Source/Methodology	Responsibility for Data Collection
Increase in the number of HCs exceeding 60% score on the quality assessment of health facilities (Number)[34]	Based on a composite Health Facility Quality Index covering structural, process, and outcome domains.	Six monthly	Standardized supervisory checklist	MOH
Reduction in the number of households that experienced impoverishing health spending during the year	Share of households paying 40% or more of capacity to pay (measured as per WHO guidelines). Based on one month recall of expenditures.	Every three years	Socioeconomic survey	CSES
Reduction in OOP health expenditure as percentage of the total health expenditure	Level of OOP expenditure expressed as a percentage of total expenditure on health (Indicator 67 in HSP-3 M&E Framework).	Annually	National Health Accounts (1 year in arrears) Administrative reporting system Household surveys	MOH

[32] Data from the HMIS. Indicator 57 in the HSP-3 Framework. Targets according to the HSP-3 Framework. Would indicate improved quality of service if figure increases.
[33] Targets set by the MOH in the HSP-3 Framework.
[34] Based on a composite Health Facility Quality Index covering structural, process, and outcome domains.

Increase in the utilization of health services by HEF beneficiaries	Defined as total number of individual HEF users in both HCs and hospitals using outpatient services/ total eligible HEF population, expressed as percent.	Annually	HMIS	DPHI in MOH

Intermediate Results Indicators

Indicator Name	Description (indicator definition and so on)	Frequency	Data Source/Methodology	Responsibility for Data Collection
Percentage of HCs having stock-outs of 14 essential medicines (Percentage)	Number of essential drugs (14 listed) that experienced stock-outs at HCs x 100 / 14 list of essential items endorsed by the MOH[35]	Annually	HMIS	DPHI in MOH
Proportion of health centers with functioning health center management committees	There will be a mid-year and end-year assessment of health center management committees; clear definition of 'functional' to be determined during baseline	Annually	Health Center Management Committees	MOH ODs
Percentage of HC, CPA-1, CPA-2, and CPA-3 facilities that receive payments based on performance that includes quality scores within 90 days of the end of the quarter	Number of HCs, CPA-1, CPA-2, and CPA-3 hospitals having quality assessments done through a standardized supervisory and paid within 90 days of the end of the quarter	Annually	SOA quarterly review reports	MOH
Reduction in the variance in score on HC quality assessment[36]	Difference in percentage points between highest and lowest scores in HC quality assessments (measuring structural process and outcomes quality)	Every 2 years (in 2017 and 2019)	A health facility survey building on the L 2 assessment measuring structural process and outcome measures	MOH
Percentage of CPA-1, CPA-2, and CPA-3 facilities having a 60% quality score in the previous quality assessments	Percentage of CPA-1, CPA-2, and CPA-3 hospitals out of the total CPA-1,CPA-2, and CPA-3 hospitals that had a quality assessment and received a 60% aggregate quality score	Quality score measured quarterly through a standardized supervisory checklist	Standardized supervisory checklist	MOH
OPD consultations (new cases only) per person per year[37]	Utilization of outpatient services at public health facilities among the total population	Annually	HMIS	DPHI/MOH

[35] Indicator 68 in the HSP-3 Framework. Essential list according to the MOH definition and attached as annex.
[36] A health facility survey building on the L2 assessment measuring structural process and outcome measures.

	and among children aged under 5 years. Total OPD consultations (new cases) / Total population Total under-5 OPD consultations (new cases) / Total children aged under 5 years			
Number of UHS courses that adopt competency-based curricula with trained faculty and use of skills laboratory (DLI 1)	Number of courses following the new competency-based curricula and use of skill laboratories	Annually	UHS annual report	MOH
Percentage of HCs, hospitals, and OD/PHD receiving HEF and SDG payments within the specified timelines (DLI 7)	Percentage of HCs and hospitals out of total eligible hospitals that receive payment within specified timeline	Annually	MOH annual report	MOH
Percentage of HMIS reports submitted on time (Communicable diseases, HC1, and HO2[38] to Operational District Offices)	Number of HC1 and HO2 reports submitted to the ODO on time x 100 / Total number of HC1 and HO2 reports	Annually	HMIS	DPHI/PHDs/ODs/RHs/ HCs

[37] Indicator 57 in the HSP-3 Framework. Would indicate improved quality of service if figure increases.
[38] HC1 and HO2 are the titles of standard data formats required from HC and RH levels respectively.

Annex 2: Detailed Project Description

KINGDOM OF CAMBODIA

Health Equity and Quality Improvement Project (H-EQIP)

Component 1: Strengthening Health Service Delivery (US$74.2 million equivalent)

1. This component will build upon the existing SDG system and expand it into a mechanism for providing performance-based financing to different levels of the health system. SDGs were introduced as part of HSSP2 and have been a major driving force to build up the internal health service delivery contracts, and promote decentralization and de-concentration of accountabilities. A working system has been established with detailed manuals and institutional arrangements, and there is wide ownership and acceptance of the model. These arrangements have translated to improved management, better provider behavior, and strengthened health service delivery. However, several challenges remain, particularly in relation to the system's complexity and loss of focus on results.

2. This component will strengthen the SDGs as a mechanism for providing performance-based financing to different levels of the Cambodian primary and secondary public health system based on achievement of results, namely against the delivery of a basic and comprehensive package of services. This package will include critical reproductive, maternal, neonatal, child, and adolescent health services. Nutrition will also be one of these indicators prioritized covering early breastfeeding, vitamin A supplementation, deworming, iron folic acid supplementation, and growth monitoring.

3. The project proposes to introduce four key programmatic shifts in the way the SDGs currently operate:

(a) Grants will be provided to HCs, hospitals, ODs, and PHDs based on performance, which will be regularly monitored by ODs, PHDs, and the MOH and verified through a third-party mechanism as is currently used for HEFs.

(b) Grants will be differentiated by purpose and results: grants to HCs to increase utilization and quality of their MPA services; grants to hospitals to improve the quality of their CPA services and their participation in capacity building and promoting equity; and grants to ODs (or councils) and PHDs to improve management and supervision.

(c) Autonomy will be provided to HCs, hospitals, and ODs/ PHDs for utilizing the grants in their respective eligible expenditure areas.

(d) Performance on predefined criteria will be measured through a set of standardized supervision checklists that will be owned by the MOH's QAO and will be periodically updated.

4. The project aims to use SDGs to complement the RGC's proposed lump-sum grants to health facilities, particularly by streamlining the funds flow and reporting arrangements envisaged for the same. The SDGs will consist of a fixed element entirely financed by the RGC through the new lump-sum grants being introduced in the 2016 budget, while the RGC and IDA/MDTF will share costs for the performance-based element of the SDGs. The MEF and MOH will issue a joint *Prakas* and the SDG manual will be updated to include the criteria for distribution of the fixed grants, performance measurement mechanisms for SDGs and the calculation of performance incentives, as also the eligible categories of expenditure for which SDG funds can be spent. Together, the SDGs aim at incentivizing performance and making available additional flexible funds for health facility operating costs over and above their operational budgets as defined in their AOPs. The fixed element of these grants are budgeted at US$6.8 million for 2016 and calculations are based on their continuation for the same amount every year throughout the lifetime of the project. The performance-based element is budgeted at US$8 million per year, to be equally shared by the RGC and IDA/MDTF.

Table 2.1. Annual 2016 Lump-sum Grants to Health Facilities by Type

Facility			Budget (KHR)			Budget (US$)		
Type	**RHs**	**HCs**	**Per facility (million)**	**Total (million)**	**Per Capita**	**Per facility**	**Total**	**Per capita**
HC	–	1,174	12	14,088	939	2,927	3,522,000	0.235
CPA-1 Hospital	53	–	100	5,300	353	24,390	1,325,000	0.088
CPA-2 Hospital	29	–	150	4,350	290	36,585	1,087,500	0.073
CPA-3 Hospital	18	–	200	3,600	240	48,780	900,000	0.060
TOTAL	**100**	**1,174**	**462**	**27,338**	**1,823**	**112,683**	**6,834,500**	**0.456**

Table 2.2. Proposed SDGs by Level and Type (US$ millions)

Level	Fixed - RGC	Performance - H-EQIP		Total
		RGC	IDA/MDTF	
HC	17.6	8.8	8.8	35.2
CPA-1 Hospital	6.6	3.3	3.2	13.1
CPA-2 Hospital	5.4	2.7	2.7	10.8
CPA-3 Hospital	4.5	2.3	2.3	9.1
OD/PHD	0.0	3.0	3.0	6.0
TOTAL	34.1	20.1	20.0	74.2

5. The fixed RGC costs assume a continuation of the new lump-sum grants annually at the same level. The performance-based element of SDGs assumes an overall 50 percent co-financing by the RGC, starting at 40 percent in 2016 according to the share of SDGs co-financed by the RGC currently and increasing over the remaining period.

Subcomponent 1.1: Service Delivery Grants: HCs (US$35.2 million equivalent)

6. The project will provide SDGs to HCs to help finance the MPA for HCs, which is currently being revised. Grants will be based on the utilization (that is, quantity) of services provided and quality of services. Initially, the OD with its HCs will be considered as one unit and ODs (and in due course, councils) will implement the *Prakas* issued by the MOH, specifying

services to be provided, the financing linked to these, and how an aggregate performance score will be derived based on the quantity and quality of services delivered provided by its HCs. The quantity and quality of service delivery, including utilization by the poor, will be systematically determined by the respective OD/council through a standardized supervision checklist. As mentioned, results will be cross-checked and verified by the same PCA proposed for HEFs. Once the results have been verified, the MOH will inform the MEF to make the payment. Eligible categories of expenditure for SDGs at the HC level would include minor works, goods, and emergency purchase of drugs and/or recurrent costs, including supplies, short-term staff, consumables, communications, maintenance, transportation, accommodations, training, other incidental expenses, and performance bonuses for health workers.

Subcomponent 1.2: Service Delivery Grants: Hospitals (US$33.0 million equivalent)

7. This subcomponent aims to incentivize improvements in the quality of care at the secondary level, performance in capacity-building activities for in-service as well as pre-service candidates, and for their promotion of utilization of services by HEF beneficiaries. To achieve this, the project will introduce a specific performance-based financing approach to improve the quality of the targeted services at CPA-1, CPA-2, and CPA-3 hospitals,[39] and introduce a system for the CPA level to improve pre-service practical training to university students and to provide on-the-job training support for improving technical quality of the HC staff. Using a standardized supervisory checklist, hospitals will be measured on their performance on structure, process, and outcomes. Structural measures will comprise the context in which care is delivered, including infrastructure, staff, financing, and equipment. Process measures will include the technical and interpersonal process and actions that make up health care as reflected in the transactions between patients and providers and staff throughout the delivery of health care. Facilities will also be encouraged and rewarded for initiating quality improvement processes, including continuous quality improvement, peer-to-peer evaluations, and adverse event audits. Outcomes refer to the effects of health care on the status of patients and populations and will be considered to be a result of inputs and processes of care. Eligible categories of expenditure for SDGs at the hospital level are similar to HCs and include minor works, goods, drugs, and/or recurrent costs, including supplies, short-term staff, consumables, communications, maintenance, transportation, accommodation, other incidental expenses, and performance bonuses for health workers.

Subcomponent 1.3: Service Delivery Grants: PHDs and ODs (US$6.0 million equivalent)

8. These SDGs aim to strengthen the management of ODs and PHDs. The performance of ODs and PHDs will be measured quarterly against their self-reported activities on a scorecard measuring key supervisory processes and health system outputs, for example, timely completion of quality checklists for health facilities in their jurisdiction, contribution to capacity-building activities for in-service and pre-service training, drug stock-outs in health facilities, human resources availability, HMIS reports submitted, quarterly review meetings, system functionality, and so on. Similar to the other grants, the proposed PCA would verify their performance. Eligible SDG categories of expenditure for ODs and PHDs will include minor works, goods,

[39] CPA-1: Referral hospital with minor surgery (with general anesthesia); CPA-2: Referral hospital with surgery (with general anesthesia) and supplementary activities more than CPA-1 but fewer activities than CPA-3; CPA-3: Referral hospital with surgery (with general anesthesia) and supplementary activities and specialized activities.

and/or recurrent costs, including supplies, short-term contracts, consumables, communications, maintenance, transportation, accommodation, other incidental expenses, and performance bonuses.

Box 1: Standardized Supervisory Quality Checklists

Regular measurement and analysis of quality measures is a core principle of all improvement work and is a central component of results-based financing programs that incentivize quality performance measures. Measurement methods feasible for use as part of a one-time assessment of quality of care (for example, to evaluate a program intervention) may be impractical for use for routine measurement of care as in a results-based financing program or health care improvement intervention.

The standardized supervisory quality checklist forms one of the most commonly used methods for routine measurement methods of quality. The checklist conforms to SMART (Specific, Measurable, Accepted, Relevant, or Time-bound) quality indicators and enable measurement in objectively verifiable ways. Besides measuring performance, the checklist forms an important element for supportive supervision and building capacity. Routine measurement of clinical quality and standardized supervisory quality checklist scope is being expanded to include other measurement approaches, including review of patient charts, records and/or registers, periodic patient and provider interviews, and periodic observation of care. In addition, technology solutions such as tablets to record information and online dashboards that support the accuracy, timeliness, and visibility of performance data are increasingly being used.

Component 2: Improving Financial Protection and Equity (US$70.0 million equivalent)

9. The HEFI, which is currently an international firm, provides independent verification of the benefits provided to individual patients. This will become an independent PCA[40] to be established as a PAE. Verification by the HEFI is led by a team of field-based monitors who conduct household interviews, bedside monitoring, and document reviews and work with key stakeholders to make sure that the benefits reported are the actual benefits delivered to the poor. These functions will be transferred to the PCA. They will also serve as a monitoring and verification agency for the performance-based grant payments envisaged under Component 1. While the PCA will be under the umbrella of the MOH, it will keep its independent status as a PAE. The transition of the HEFI to the new PCA will be a gradual process led by the MOH, and the PCA is expected to fully take over by June 2018.[41] A concrete transition plan is being developed and a technical working group will be set up to operationalize and monitor the implementation of this plan.

10. The HEFOs were contracted nongovernmental organizations or community-based organizations under HSSP2 whose roles were to facilitate and monitor HEF beneficiary access to services, distribute transportation reimbursements and caretaker food allowances, conduct post-identification interviews, and administer facility payment at the end of each month. The HEF system has evolved and some of the roles of the current HEFOs would be incorporated into the PCA. The HEFO's responsibility can thus be transformed into a patient advocacy role whose main functions would be to: (a) conduct post-identification of the poor; (b) measure and report on consumer satisfaction; (c) raise awareness and promote HEFs among the very poor; and (d) promote the utilization of HEFs as well as wider health services among the underserved

[40] The exact name of this agency may be changed subject to discussions within the MOH to better reflect their roles and responsibilities.
[41] The current HEFI contract is expected to continue until end 2018.

population in identified remote and difficult-to-access communities. Recent studies show that lack of understanding of how HEFs work is one of the main barriers to utilization, on which the transformed HEFOs— that could now be called HEFPs—could focus their attention. Detailed functions of the PCA and HEFP as currently envisaged are described in Table 2.3.

Table 2.3. Functions of the PCA and HEFP

PCA	HEFP
• Maintain the patient management registration system which includes specific tools for the management of the HEF system. Specific modules for SDG results will need to be developed. • Support the QAO in the MOH to maintain and update quality checklists. • Support the ODs and PHDs to assess performance specified in the HC and hospitals SDGs. • Review and comment on quarterly reports prepared by ODs and PHD supervision teams. • Independently verify claims for reimbursement for HEF and for SDGs. • Certify and submit verification reports to the MOH. • Certify the claims for payment by the MEF via the MOH through a country-owned system. • Verify quarterly the quality of HEF benefits provided to individual patients.	• Conduct post-identification of the poor. • Undertake activities aimed at increasing the understanding of the benefits of using public facilities (especially primary care facilities) among the HEF beneficiaries and underserved population living in remote and difficult-to-access communities. • Mobilize the population to take part in public health and preventive health activities. • Provide information and guide/support in use of services by the HEF beneficiaries through dedicated team members ('patient concierges') deployed at kiosks/counters in these facilities. • Carry out sample-based beneficiary satisfaction surveys to understand user and non-user experiences with the health system. • Collect, compile, and report problems perceived by HEF cardholders and relay complaints about the system and/or facilities to the community-based and MOH complaints mechanisms. • Recommend ways to ensure that utilization, payment, and verification systems are up-to-date and able to meet the evolving needs of the ministries.

11. In terms of financing to ensure sustainability of the HEF, the RGC is currently financing 40 percent of the direct benefit costs of the HEFs. It is expected that this share would increase over the lifetime of the project and will also cover operating costs. The project IDA/MDTF financing would finance 50 percent of the expected total HEF costs up to US$12 million (up to US$6 million per year), to contribute to the remaining costs that will be fully covered by the government. Based on the calculations of the World Bank team, the total projected costs for HEF over the five years is approximately US$70 million without including the costs of the new PAE that can be financed from a mix of the DLI-based payments, RGC contribution and, preferably, a transaction fee on HEF and SDG costs. The exact financing of the costs of the PAE will be included in the subdecree or other appropriate instrument creating the PAE.

Table 2.4. Estimated Cost Projections for HEF in the next Five Years

Year	Direct Benefit Costs (US$, millions)	HEFP Costs (US$, millions)	HEFI cost - *not included in cost (financed through DLI, RGC, and/or transaction fees (US$, millions)	Total HEF Cost (US$, millions)	IDA/ MDTF Share	RGC Share
2016	12.0	0.5	0.25*	12.5	6	6.5
2017	13.0	0.5	0.50*	13.5	6	7.0
2018	13.5	0.5	0.75*	14.0	6	8.0

Year	Direct Benefit Costs (US$, millions)	HEFP Costs (US$, millions)	HEFI cost - *not included in cost (financed through DLI, RGC, and/or transaction fees (US$, millions)	Total HEF Cost (US$, millions)	IDA/ MDTF Share	RGC Share
2019	14.0	0.5	0.75*	14.5	6	8.5
2020	15.0	0.5	0.75*	15.5	6	9.5
	67.5	**2.5**	**3.00***	**70.0**	**30**	**40.0**

Component 3: Ensuring Sustainable and Responsive Health Systems (US$30.0 million equivalent)

12. The objective of this component is to further strengthen the MOH's systems and support the management of the project. This component would be closely coordinated with other TA programs of DPs and ensure that there is no duplication of any activity already being undertaken. This component includes a mix of regular investment lending approaches and results-based financing using DLIs.

Subcomponent 3.1: Health System Strengthening (US$15.0 million equivalent)

13. This subcomponent will support the carrying out of a program of activities designed to improve supply-side readiness and strengthen the institutions that will be implementing project activities. This includes the implementation of comprehensive pre-service and in-service training programs for health workers, equipment of health facilities to meet minimum standards for the provision of obstetric and neonatal care, carrying out of enhanced health service quality monitoring, improved timeliness of SDG and HEF payments, and establishment of sustainable health service purchasing arrangements.

14. Financing for this subcomponent will be provided based on results tracked by DLIs, which are a set of tracer indicators aimed at measuring performance against health system strengthening actions. The DLI approach reimburses the government for delivery on the targets (results) against eligible expenditures. Once achievement of the DLI is verified, funds would be transferred to the MEF against the defined eligible expenditures and can be used within the sector according to the RGC rules. Clear guidelines on measuring the result are agreed and included in the Project Operational Manual. If the annual DLI target for each respective year is not fully met by the end of the year, payment will be delayed until the result is fully achieved in a subsequent year. The aim is to ensure that agreed results are achieved and the financing continues to encourage the government and its departments to reach the agreed targets. This approach is being used more frequently in Bank-financed projects as it places the emphasis on results rather than inputs. Table 2.5 provides the DLIs for the project and the breakdown of all annual DLI targets and DLI values, as well as their verification protocols.

15. With respect to DLIs, the project will use the existing government structure to support implementation of the project. Technical support for project implementation of the DLIs will be provided mainly by the DPHI. The DPHI will also have the primary responsibility to collate information from various units within the central MOH, PHDs, and ODs to report on the DLIs.

16. DLI performance will be assessed every six months during the joint project review missions. An annual DLI status report will be due every year by July 31 and an additional

optional semiannual report can be submitted by January 31 every year. These DLI status reports will be compiled by the DPHI, and will be sent to the World Bank through the H-EQIP project director. The semiannual joint project review missions led by the World Bank, with participation of pooled DPs (to be completed by June and December), will provide an opportunity to review and validate the contents of the DLI status report. For DLI indicators that would require independent verification, the World Bank will, in consultation with the DPHI, conduct a performance assessment. The performance assessment will entail recruitment of consultants or firms before the joint review mission, and findings will be fed into the joint mission report and policy dialogue with the RGC.

17. Once the DLI reports are verified and achievement of DLI indicators is confirmed and documented in an aide-memoire, the MOH will submit the project's Interim Financial Reports (IFRs) containing a note on the government contribution to HEFs used as EEPs (submitted to the World Bank through the project director) before the semiannual joint review missions. Based on the signed aide memoire confirming achievement of the DLIs, the signed project IFRs, and a withdrawal application by the client, the World Bank will trigger the disbursement. Draft templates of the DLI status report will be included as part of the DLI operational manual, which will be prepared before commencement of the project.

18. **DLI component costing, funds flow, eligible expenditures.** Project funds will be part of, and additional to, the overall MOH budget and flow through existing government mechanisms. Disbursements for the first year will be made at the time of IDA project effectiveness and subsequently at the beginning of each fiscal year (FY) based on achievement of DLIs of the preceding year. Disbursement on project effectiveness, and in subsequent years, will be contingent upon the borrower fulfilling two requirements: (a) demonstration that the government contribution to HEFs used as EEPs in the prior year exceeded the amount being requested from IDA and (b) achievement of agreed targets of DLIs, documented in a DLI status report and verified by the World Bank. Efforts will be made to synchronize the disbursement of IDA funds with the RGC's budget cycle. DLI measurement, reporting, and fund release will therefore be timed so that for DLI status reports submitted by July 31, resources are available just before the start of the next Cambodian FY. On project completion, the final DLI achievement (for year 4), whether submitted on time in July 2020 or with a delay in January 2021, will be verified by the World Bank by June 30, 2021.

19. When deciding on the amount to be disbursed based on DLI achievement, a discrepancy of up to 5 percent between the government's and the World Bank's verification will be accepted as having achieved the target. Partial achievement of a DLI target, with a lower threshold of 60 percent (for those that are expressed as scalable numeric targets), will result in a partial disbursement on a pro-rated basis. Disbursements for any DLI will be capped at the amount allocated for that year for the concerned DLI target, which means, over-achieving the DLI targets will not lead to increased disbursements and using the allocation of the following year. Disbursements withheld due to non-achievement of DLIs in a given year can be disbursed in the subsequent years once the DLI target is achieved. At the closing of the project, in case of underachievement of targets, only the prorated value of the achieved DLIs will be released, unless the closing date is extended.

Table 2.5. DLIs Value and Targets

DLIs	Year 0[42]	Year 1[43]	Year 2[44]	Year 3	Year 4	Means of Verification
DLI 1: Comprehensive pre-service training program in foundational courses[45] for medical and nursing professionals implemented by UHS	**DLI Target:** 1. Competency-based pre-service curricula in foundational courses updated for at least 2 training courses to be delivered by UHS for medical and nursing professionals 2. Standards of operation adopted by UHS for faculty on how to use and maintain the UHS integrated skills laboratory	**DLI Target:** 1. Competency-based pre-service curricula updated for at least 7 additional training courses 2. At least 12 faculty trained on how to use the integrated skills laboratory	**DLI Target:** 1. Competency-based pre-service curricula updated for at least 8 additional training courses 2. At least 29 additional faculty trained on how to use the integrated skills laboratory 3. At least 230 medical and nursing students trained based on the new competency-based curricula	**DLI Target:** 1. Competency-based pre-service curricula updated for at least 5 additional training courses 2. At least 59 additional faculty trained on how to use the integrated skills laboratory 3. At least 510 additional medical and nursing students trained based on the new competency-based curricula	**DLI Target:** 1. Competency-based pre-service curricula updated for at least 3 additional training courses 2. At least 69 additional faculty trained on how to use the integrated skills laboratory 3. At least 875 additional medical and nursing students trained based on the new competency-based curricula	**Statement of DLI:** Achievement approved by Rector
	DLI Value: US$800,000	**DLI Value: US$800,000**	**DLI Value: US$800,000**	**DLI Value: US$800,000**	**DLI Value: US$800,000**	**Total: US$4,000,000**
DLI 2: Comprehensive in-service training program on MPA for health workers implemented by the MOH	1. At least 13 MPA in-service training modules reviewed and updated by the MOH. 2. At least 20 PHDs complete a health worker's	1. At least 20 PHDs have reduced the number of health workers requiring training on 5 prioritized in-service training modules by at	1. At least 20 PHDs have reduced the number of health workers requiring training on 5 prioritized in-service training modules by at	1. At least 20 PHDs have reduced the number of health workers requiring training on 5 prioritized in-service	1. At least 23 PHDs have reduced the number of health workers requiring training on 5 prioritized in-service	MOH Annual Report

[42] Year 0 refers to the one year proceeding effectiveness.
[43] Year 1 refers to the period between effectiveness and June 30, 2017.
[44] Year 2 refers to the one-year period after year 1, and so on.
[45] A set of foundational courses have been identified for revision to become competency based, covering subjects of dissemination anatomy, clinical examination skills, clinical diagnostic, maternal nursing 1, 2, 3; operative nursing, emergency nursing and first aid, pediatric nursing.

	training needs assessment for at least 5 prioritized in-service training modules to quantify number of person requiring training.	least 10%. 2. At least 10 PHDs have provided annual training activity reports on in-service MPA training to the MOH based on the MOH's new human resource management information system (HRMIS)	least 20%. 2. At least 15 PHDs have provided annual training activity reports on their in-service MPA training to the MOH based on the new HRMIS.	training modules, by at least 30%. 2. At least 20 PHDs have provided annual training activity reports on their in-service MPA training to the MOH based on the new HRMIS.	training modules, by at least 40%. 2. At least 23 PHDs have provided annual training activity reports on their in-service MPA training to the MOH based on the new HRMIS.	
	DLI Value: US$400,000	**DLI Value: US$400,000**	**DLI Value: US$400,000**	**DLI Value: US$400,000**	**DLI Value: US$400,000**	**Total US$2,000,000**
DLI 3: C2 hospitals fully equipped to provide emergency obstetric care and neonatal care	1. Updated guidelines adopted by the MOH, detailing the facilities and human resources criteria to be met by C2 hospitals for the provision of emergency obstetric and neonatal care 2. Baseline survey carried out and costed plan developed by the MOH for addressing C2 hospitals' facilities and human resources gaps for the provision of emergency obstetric and neonatal care	At least 10% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines.	At least 20% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines.	At least 30% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines.	At least 40% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines.	MOH Annual Report and verified through a performance assessment.
	DLI Value: $400,000	**DLI Value: $400,000**	**DLI Value: $400,000**	**DLI Value: $400,000**	**DLI Value: $400,000**	**Total $2,000,000**
DLI 4: Health service quality monitoring	1. Supervisory checklists measuring service delivery performance for	1. At least 80% of PHD and OD staff have been trained and have used	The second nationwide L2 assessment of HCs and C1, C2, and C3		The third nationwide L2 assessment of HCs and	MOH Annual Report

in the MOH enhanced	HCs and C1, C2, and C3 hospitals field tested and disseminated by the MOH to at least 80% of PHDs and ODs by MOH. 2. The QAO of the MOH adequately staffed according to the MOH plan with full-time qualified experts and contractual staff.	the supervision checklists at least 2 times over the previous calendar year. 2. L2 assessment tool and protocols reviewed, updated, and approved by the MOH.	hospitals completed and disseminated by the MOH. [46]		C1, C2, and C3 hospitals completed and disseminated by the MOH.	
	DLI Value: US$500,000	**DLI Value: US$500,000**	**DLI Value: US$1,000,000**		**DLI Value: US$1,000,000**	**Total US$3,000,000**
DLI 5: Sustainable health purchasing arrangements established by the RGC	1. Transition manual adopted by the MOH, specifying the roles, responsibilities, functions, operational milestones and costs for the transition of health service purchasing functions from the HEFI to the PCA. 2. PCA has been formally established.	1. PCA management board and operational guidelines established. 2. PCA has established counter verification capacities.	1. PCA fully staffed and operational. 2. PCA has established integrated health output and FM software.	1. PCA carries out HEFI functions.		MOH Annual Report and verified through a performance assessment
	DLI Value: US$500,000	**DLI Value: US$500,000**	**DLI Value: US$500,000**	**DLI Value: US$500,000**		**Total US$2,000,000**

[46] Indicator cannot be delayed beyond year 3.

DLI 6: Timeliness of HEF and SDG payments improved	Financial procedure guidelines and standards for HEF and SDG disseminated by the MOH among key OD, PHD and central staff	At least 50% of HCs and hospitals have received HEF and SDG payments within the timelines specified in the guidelines.	At least 60% of HCs and hospitals have received HEF and SDG payments within the timelines specified in the guideline.	At least 70% of HCs and hospitals have received HEF and SDG payments within the timelines specified in the guideline.	At least 80% of HCs and hospitals have received HEF and SDG payments within the timelines specified in the guideline.	MOH Annual Report and verified through a performance assessment
	DLI Value: US$400,000	**DLI Value: US$400,000**	**DLI Value: US$400,000**	**DLI Value: US$400,000**	**DLI Value: US$400,000**	**Total US$2,000,000**

Table 2.6. DLI Definitions and Verification Protocol

DLI 1	Indicator Identification Data and Compliance Information
Indicator	Comprehensive pre-service training program in foundational courses[47] for medical and nursing professionals implemented by the UHS
Compliance condition	Based on the Health Workforce Development Plan, the UHS will develop a detailed paper outlining key steps to strengthen quality of health professionals' pre-service education and training to produce competency-based and highly skilled health workforce.
Compliance specification	The paper will include a phasing plan for making 8–10 foundational courses competency based, target indicators, and key costs for the rollout of the strategy for strengthening pre-service education. Paper approved by Rector of the UHS.
Means of verification	Statement of DLI achievement approved by Rector.
Compliance verification procedure	Semiannual partners' mission will verify performance by review of records, physical observation of facilities, and meetings with faculty and students. Record of findings will be incorporated in the aide memoire.
DLI milestones	Baseline: (a) Competency-based pre-service curricula in foundational courses updated for at least 2 training courses to be delivered by the UHS for medical and nursing professionals; (b) standards of operation adopted by the UHS for faculty on how to use and maintain the UHS integrated skills laboratory Target year 1: (a) Competency-based pre-service curricula updated for at least 7 additional training courses and (b) at least 12 faculty trained on how to use the integrated skills laboratory. Target year 2: (a) Competency-based pre-service curricula updated for at least 8 additional training courses; (b) at least 29 additional faculty trained on how to use the integrated skills laboratory; and (c) at least 230 medical and nursing students trained based on the new competency-based curricula. Target year 3: (a) Competency-based pre-service curricula updated for at least 5 additional training courses; (b) at least 59 additional faculty trained on how to use the integrated skills laboratory; and (c) at least 510 additional medical and nursing students trained based on the new competency based curricula. Target year 4: (a) Competency-based pre-service curricula updated for at least 3 additional training courses; (b) at least 69 additional faculty trained on how to use the integrated skills laboratory; and (c) at least 875 additional medical and nursing students trained based on the new competency-based curricula.
Responsible department	UHS Cambodia

DLI 2	Indicator Identification Data and Compliance Information
Indicator	Comprehensive in-service training program on MPA for health workers implemented by the MOH
Compliance condition	HR, MOH develops a (a) detailed plan for competency-based development needs for health workers posted in HCs at CPA hospitals and Regional Training Centers and (b) a plan for introduction of a new 'Human Resource Management Information System' (HRMIS) for provinces to report annually on the in-service trainings.
Compliance specification	The paper for competency-based development for health workers in HCs will include a phasing plan, target indicators, and key costs for the rollout of the strategy for strengthening pre-service education. In addition, a plan will also be developed for introduction of the HRMIS, which includes phasing, dissemination strategy, costs, indicators, and targets. Plan endorsed by secretary of state and the MOH.
Means of verification	MOH Annual Report
Compliance verification	Semiannual partners' mission will verify performance by review of hospital and PHD

[47] A set of 8–10 foundational courses have been identified for revision to become competency based covering subjects of dissemination anatomy, clinical examination skills, clinical diagnostic, maternal nursing 1,2,3; operative nursing, emergency nursing and first aid, pediatric nursing.

procedure	training records, post-training evaluation score, and meetings with faculty and students. Record of findings will be incorporated in the aide memoire.
DLI milestones	Target year 0: (a) At least 13 MPA in-service training modules reviewed and updated by the MOH and (b) at least 20 PHDs complete a health worker's training needs assessment for at least 5 prioritized in-service training modules to quantify number of person requiring training. Target year 1: (a) At least 20 PHDs have reduced the number of health workers requiring training on 5 prioritized in-service training modules by at least 10% and (b) at least 10 PHDs have provided annual training activity reports on in-service MPA training to the MOH based on the MOH's new HRMIS. Target year 2: (a) At least 20 PHDs have reduced the number of health workers requiring training on 5 prioritized in-service training modules by at least 20% and (b) at least 15 PHDs have provided annual training activity reports on their in-service MPA training to the MOH based on the new HRMIS. Target year 3: (a) At least 20 PHDs have reduced the number of health workers requiring training on 5 prioritized in-service training modules by at least 30% and (b) at least 20 PHDs have provided annual training activity reports on their in-service MPA training to the MOH based on the new HRMIS. Target year 4: (a) At least 23 PHDs have reduced the number of health workers requiring training on 5 prioritized in-service training modules by at least 40% and (b) at least 23 PHDs have provided annual reports on their in-service MPA training to the MOH based on the new HRMIS.
Responsible department	Human Resources Department, MOH

DLI 3	**Indicator Identification Data and Compliance Information**
Indicator	C2 hospitals fully equipped to provide emergency obstetric care and neonatal care
Compliance condition	Based on a Facility Assessment survey, the DPHI will develop a strategic plan for facility strengthening for improved emergency obstetric care and neonatal services developed.
Compliance specification	Strategic plan for facility strengthening for emergency obstetric care and neonatal includes a phasing plan, target indicators, and key costs for the rollout. Strategic plan endorsed by the World Bank's procurement specialist and MOH.
Means of verification	MOH Annual Report
Compliance verification procedure	Before the semiannual partners mission, a contractor hired by the World Bank will carry out a rapid sample-based performance assessment. Results of performance assessment feeds into mission and key agreements recorded in the aide memoire.
DLI milestones	Target year 0: (a) Updated guidelines adopted by the MOH, detailing the facilities and human resources criteria to be met by C2 hospitals for the provision of emergency obstetric and neonatal care and (b) baseline survey carried out and costed plan developed by the MOH for addressing C2 hospitals' facilities and human resources gaps for the provision of emergency obstetric and neonatal care. Target year 1: At least 10% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines. Target year 2: At least 20% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines. Target year 3: At least 30% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines. Target year 4: At least 40% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines.
Responsible department	DPHI, MOH

DLI 4	**Indicator Identification Data and Compliance Information**
Indicator	Health service quality monitoring in the MOH enhanced
Compliance condition	Plan for capacity strengthening of Quality Assurance Unit developed
Compliance specification	Plan details staffing, key outputs and activities, and costs. Plan endorsed by the MOH

	and secretary of state.
Means of verification	MOH Annual Report with relevant outputs as attachments
Compliance verification procedure	Semiannual partners' mission will verify performance by review of outputs, reports, and government orders. Record of findings will be incorporated in the aide memoire.
DLI milestones	Target year 0: (a) Supervisory checklists measuring service delivery performance for HCs and C1, C2, and C3 hospitals field tested and disseminated by the MOH and (b) the QAO of the MOH adequately staffed according to the MOH plan with full-time qualified experts and contractual staff. Target year 1: (a) At least 80% of PHD and OD staff have been trained and have used the supervision checklists at least 2 times over the previous calendar year and (b) L2 assessment tool and protocols reviewed, updated and approved. Target year 2: The second nationwide L2 assessment of HCs and C1, C2, and C3 hospitals completed and disseminated by the MOH.[48] Target year 4: The third nationwide L2 assessment of HCs and C1, C2, and C3 hospitals completed and disseminated by the MOH.[49]
Responsible department	QAO, MOH

DLI 5	**Indicator Identification Data and Compliance Information**
Indicator	Sustainable health service purchasing arrangements established
Compliance condition	A strategic plan for building the MOH capacity for health purchasing to be developed
Compliance specification	*Prakas* for establishment of a PCA issued
Means of verification	MOH semiannual report with relevant outputs as attachments
Compliance verification procedure	Semiannual partners' mission will verify performance by review of outputs, reports, meeting minutes, and government orders. In addition, where required before the semiannual partners' mission, a contractor hired by the World Bank will carry out a rapid sample-based performance assessment of activities completed, including counter verification. Record of findings will be incorporated in the aide memoire.
DLI milestones	Target year 0: (a) Transition manual adopted by the MOH, specifying the roles, responsibilities, functions, operational milestones, and costs for the transition of health purchasing functions from the HEFI to PCA and (b) PCA has been formally established. Target year 2: (a) PCA management board and operational guidelines established and (b) the PCA establishes counter verification capacities. Target year 3: (a) PCA fully staffed and operational and (b) PCA establishes integrated health output and FM software. Target year 4: (a) PCA carries out the HEFI functions.
Responsible department	DBF, MOH

DLI 6	**Indicator Identification Data and Compliance Information**
Indicator	Timeliness of HEF and SDG payments improved
Compliance condition	Implementation Plan for 'SDG and HEF' detailing fund flow instruments, processes, bank accounts, and standards for HEF and SDG payments established
Compliance specification	MOH secretary of state approves Implementation Plan
Means of verification	MOH semiannual report
Compliance verification procedure	Before the semiannual partners mission, a contractor hired by the World Bank will carry out a rapid sample-based performance assessment. Results of performance assessments will feed into mission and key agreements will be recorded in the aide memoire.
DLI milestones	Target year 0: Financial procedure guidelines and standards for HEF and SDG disseminated among key OD, PHD, and central staff by the MOH. Target year 1: At least 50% of HCs, hospitals, and ODs/PHDs have received HEF

[48] Indicator cannot be delayed beyond year 3.
[49] Indicator cannot be delayed beyond year 3.

	and SDG payments within the timelines specified in the guidelines. Target year 2: At least 60% of HCs and have received HEF and SDG payments within the timelines specified in the guidelines. Target year 3: At least 70% of HCs and hospitals have received HEF and SDG payments within the timelines specified in the guidelines. Target year 4: At least 80% of HCs and hospitals have received HEF and SDG payments within the timelines specified in the guidelines.
Responsible department	DBF, MOH

Box 2: DLI Approach to Paying for Results

A DLI approach shifts the focus from paying for inputs to paying for results. DLIs are a series of output and process indicators against which funds will be disbursed to the RGC on a semiannual basis. The credit will reimburse EEPs of the RGC upon achievement of outputs/processes highlighted in the DLI matrix. Three key elements define a DLI approach: (a) agreeing on DLI indicators, including defining success measures, means for verification, and delivery schedules; (b) defining the price of each indicator and payment modalities; and (c) defining the eligible expenditures programs/line items that will be reimbursed. The following table is an illustrative example of how one such DLI can be used.

Focus Area	Year 0	Target Year 1	Target Year 2	Target Year 3	Target Year 4	Means of Verification
DLI 3: C2 hospitals fully equipped to provide emergency obstetric care and neonatal care	Updated guidelines adopted by the MOH, detailing the facilities and human resources criteria to be met by C2 hospitals for the provision of emergency obstetric and neonatal care	At least 10% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines.	At least 20% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines.	At least 30% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines.	At least 40% of C2 hospitals above the baseline have met the criteria specified in the updated guidelines.	MOH Annual Report and verified through a performance assessment.
	DLI Value: US$400,000	**DLI Value: US$400,000**	**DLI Value: US$400,000**	**DLI Value: US$400,000**	**DLI Value: US$400,000**	**Total US$2,000,000**

Subcomponent 3.2: Health Infrastructure Improvements (US$13.0 million)

20. Approximately US$13 million from this component is expected to finance civil works as per priorities identified by the MOH in their civil works plan 2016–2020. Prioritization will be based on access issues, attention to remote areas, concerns around patient safety and improving maternal and neonatal survival. A team of two consultants financed by the World Bank and KfW will conduct an assessment on the expressed needs by the RGC to determine the priority facilities to be targeted for this subcomponent.

Subcomponent 3.3: Project Management, Monitoring, and Evaluation (US$2.0 million equivalent)

21. Project management will be integrated into the responsible departments of the MOH. This component will support provision of technical and operational assistance for the day-to-day coordination, administration, procurement, FM, environmental and social safeguards management, and M&E of the project, including the carrying out of financial audits of the project. The subcomponent will also support capacity strengthening of responsible departments within the MOH to smoothly transfer the responsibility of project management from the currently existing secretariat under HSSP2 to the relevant departments, as well as to support other implementation needs.

22. A TA grant from the Japan PHRD TF, a programmatic TF administered by the World Bank, of an amount of US$1 million will provide complementary financing to Component 3. The grant is expected to contribute to the strengthening of Cambodia's M&E systems in the health sector and implementation of the M&E Plan developed under HSP-3. Strong focus on improving M&E will help ensure availability of relevant, timely, and high-quality health-related data to allow for evidence-based policy formulation, decision making, management, and planning. The grant will also support capacity building at decentralized levels to improve reporting and monitoring. Support will be provided in the following five areas: (a) strengthening sector performance reporting through annual monitoring missions and publication of annual health sector performance reports with rigorously verified results; (b) data quality monitoring and capacity building in M&E (including improvement in data management, analysis, interpretation, reporting, use, and dissemination (at central and decentralized levels); (c) quality assessment of health services in complementarity with L2 quality assessments (to be carried out in alternative years when L2 Assessment does not take place); (d) strengthening medical record systems including expansion of Patient Medical Registration System database; and (e) support for upgrading the HMIS including development of policy/regulation, protocols/guidelines, and maintenance/upgrading of the information technology system. This financing has been formally endorsed by the Japanese government and will be funded by Japan PHRD TF under its Performance and Results with Improved M&E window.

Component 4: Contingent Emergency Response (US$0 million)

23. The objective of the contingent emergency response component, with a provisional zero allocation, is to allow for the reallocation of financing in accordance with the IDA IRM to provide an immediate response to an eligible crisis or emergency, as needed.

24. In the event that the component is triggered, the standard IRM contingency emergency response component-specific objective to 'provide immediate and effective response to an Eligible Crisis or Emergency' will be incorporated and the Results Framework revised through formal restructuring. In addition, the component will be monitored using appropriate indicators identified as part of the standard items required to be established before triggering.

Project Financing

25. The RGC has requested an IDA credit of US$30 million. Australia, Germany, and South Korea have pledged an amount of approximately US$50 million equivalent to the recipient-executed part of the World Bank-administered MDTF. [50] MEF confirmed that government financing for the project will be maintained at 40 percent of total financing for 2016, with an expectation that their share would increase in the subsequent years to support Components 1 and 2. Based on the current costing estimates of SDGs (with an expectation that these will be rolled out nationwide after five years) and HEFs (especially with the anticipated expansion of HEF beneficiaries and revision of the HEF benefit package), projected costs to sustain the two programs are approximately US$74 million and US$70 million respectively. The detailed costing is shown in Table 2.7.

26. It is expected that the MDTF grant resources will be committed through administration agreements with all MDTF donors before effectiveness and be available for joint-co-financing of the project. A cross-effectiveness provision has thus been made in the Project Financing Agreement to ensure that the MDTF Grant Agreement is signed and effective at the same time as the Financing Agreement. However, in case the co-financing does not materialize for any unforeseen reason, the project will be restructured to promptly commence implementation of the activities and either, additional resources will be potentially sought through an IDA additional financing mechanism, or the project will be scaled down through a restructuring to limit its scope to the available IDA resources.

27. The project will use the Investment Project Financing instrument. The first two components will use performance-based financing at health facility, district, and provincial levels, with a focus on quality. Component 3 will be a mix of traditional investment financing and disbursement against an EEP linked to the achievement of targeted results for DLIs to support health system strengthening. Annex 3 provides more details. A small part of Component 3 intended for traditional investment financing will cover project management costs. Component 4 will provide an immediate response to an eligible crisis or emergency, as needed. The RGC contribution will be for SDGs and HEFs; Components 3 and 4 will be fully financed by the Bank and MDTF.

[50] This amount is based on the estimated US$ equivalent of the total donor contributions expected to be pledged for recipient-executed activities under the MDTF at the time of appraisal. The project scope and Results Framework has been appraised as inclusive of this total estimated amount of MDTF contributions. The Grant Agreement between the World Bank and Cambodia will include the total amount of the initial installments deposited by the donors in the MDTF account, and this amount will be amended as and when the donors deposit additional installments of their total pledged contributions in accordance with the schedule of payments specified in the MDTF Administration Agreements between the World Bank and the respective donors.

Table 2.7. Proposed Financing Plan by Funding Sources (in US$, millions)

Source	US$, millions	Comments
IDA	30.0	Additional IDA financing may sought if available and needed
Australia via MDTF Germany via MDTF Korea via MDTF	50.0	Approximate RETF grant at current exchange rates[51]
TOTAL Health Partners	80.0	
Government of Cambodia	94.2	This includes (a) the government's lump-sum grant of US$34.0 million over five years to support the SDGs (assuming continuation beyond 2016 at same rate); (b) 50% of the remaining SDG projected costs over five years; and (c) the remaining amount of total HEF projected costs for five years, after deducting the IDA/MDTF share of approximately US$30 million over five years.
Complementary financing from the Bank Japan PHRD TF	1.0	Subject to endorsement by the government of Japan

Summary Cost Table

28. A summary of project cost according to component and activity is as given in Table 2.8.

Table 2.8. Summary Cost Table for All Components

Component/Sub-component/activity	Estimated Cost (US$, millions)						
	IDA	**%**	**MDTF**	**%**	**RGC**	**%**	**Total**
Component 1: Strengthening Health Service Delivery	**7.5**	**10**	**12.5**	**17**	**54.2**	**73**	**74.2**
Subcomponent 1.1: Service Delivery Grants for HCs	3.3	9	5.5	16	26.4	75	35.2
Subcomponent 1.2: Service Delivery Grants for RHs CPA-1, CPA-2, CPA-3	3.075	9	5.125	16	24.8	75	33.1
Subcomponent 1.3: Service Delivery Grants for PHDs and ODs	1.125	19	1.875	31	3.0	50	6.0
Component 2: Improving Financial Protection and Equity	**11.25**	**16**	**18.75**	**27**	**40.0**	**57**	**70.0**
Package 1: Direct benefit costs	10.8	16	18.0	27	38.7	57	67.5
Package 2: HEFP costs	0.45	18	0.75	30	1.3	52	2.5
Component 3: Ensuring Sustainable and Responsive Health Systems	**11.25**	**38**	**18.75**	**62**	**0.0**	**0**	**30.0**
Subcomponent 3.1: Health System Strengthening	5.625	38	9.375	62	0.0	0	15.0

[51] This figure excludes the World Bank Central Unit management costs, currency fluctuations and World Bank-executed activities.

Component/Sub-component/activity	Estimated Cost (US$, millions)						
DLI 1: Comprehensive pre-service training program in foundational courses for medical and nursing professionals implemented by UHS	1.5	38	2.5	62	0.0	0	4.0
DLI 2: Comprehensive in-service training program on MPA for health workers implemented by the MOH	0.75	38	1.25	62	0.0	0	2.0
DLI3: C2 hospitals fully equipped to provide emergency obstetric care and neonatal care	0.75	38	1.25	62	0.0	0	2.0
DLI 4: Health service quality monitoring in MOH enhanced	1.125	38	1.875	62	0.0	0	3.0
DLI 5: Sustainable health purchasing arrangements established by the RGC	0.75	38	1.25	62	0.0	0	2.0
DLI 6: Timeliness of HEF and SDG payments improved	0.75	38	1.25	62	0.0	0	2.0
Subcomponent 3.2: Health infrastructure improvement	4.875	38	8.125	62	0.0	0	13.0
Package 1: Construction of health facilities	3.375	38	5.625	62	0.0	0	9.0
Package 2: Medical equipment	0.8625	38	1.4375	62	0.0	0	2.3
Package 3: Furniture	0.2625	38	0.4375	62	0.0	0	0.7
Package 4: Construction supervision	0.375	38	0.625	62	0.0	0	1.0
Subcomponent 3.3: Project management, M&E	0.75	38	1.25	62	0.0	0	2.0
Complementary financing from the Bank Japan PHRD TF							1.0*
Component 4: Contingent Emergency Response	0	0	0	0	0	0	0
TOTAL PROJECT COST	**30.0**	**17**	**50.0**	**29**	**94.2**	**54**	**174.2***

*Note: *Complementary financing from the Bank Japan PHRD TF is not included in total.*

Annex 3: Implementation Arrangements

KINGDOM OF CAMBODIA: Health Equity and Quality Improvement Project (H-EQIP)

Project Institutional and Implementation Arrangements

1. The institutional arrangements are based on the implementation experience of the HSSP2 as well as the PFM reforms envisaged in the country. The implementing agency for the project will be the MOH, acting through its technical departments, national programs as well as the PHDs, ODs, RHs, and HCs. Within the MOH, the project will be implemented through the DPHI and the DBF using mainstream MOH processes and will not involve a parallel project implementation unit or secretariat. However, the project will have a provision to strengthen these departments' capacity and skills through additional consultants or advisors. The additional consultants or advisors would be used for strengthening the DPHI/DBF functions as a whole, and not specifically for the project activities. Other MOH departments participating in project implementation will include: (a) the IAD; (b) the Department of Human Resource Development; (c) the HSD; (d) the PMD; (e) the Department of Personnel; and (f) the Department of International Cooperation.

2. With regard to the governing structure of the H-EQIP, the secretary of state has been appointed as the project director. Under the project director will be two focal points—director of the DPHI and director general for administration and finance. As an oversight function, a Steering Committee will be established. The TOR and composition of this committee had been communicated and agreed at negotiations.

3. The QAO will play an integral role in driving quality improvements in service delivery. Located in the HSD, this unit will be fully staffed with full-time equivalent government and contracted personnel including both national and international staff. In addition, secondments from the Department of Personnel will also be sought initially to strengthen this institution. The unit will be responsible for the overall delivery of the SDGs including preparation and review of quality measurement tools; tracking quality performance through supervision checklists and periodic L2 assessments; maintenance of an online monitoring dashboard; client satisfaction surveys; technology solutions; stewardship of counter verification for SDG payments; and Policy Framework for quality strengthening.

4. The roles and responsibilities of key actors are summarized in the Table 3.1.

Table 3.1. Roles and Responsibilities of Key Actors

MOH (central level)	DPHI system	Responsible for: (a) conducting capacity assessment and planning for operational capacity building of the PHDs, ODs, and RHs who will implement the SDGs; (b) undertaking needs assessment, prioritizing among investment options, and planning for construction/renovation of facilities in accordance with the Health Coverage Plan; (c) annual planning and ensuring monitoring of the grants; (d) midyear review and joint annual review reports for the MOH and DPs; (e) producing project semi/annual progress reports; (f) periodical updates to the HEF implementation guidelines including bundled

		packages, standard treatment guidelines, and pricing; (g) updating the SDG Manual, together with other concerned departments, as needed; and (h) conducting the various reviews carried out by the MOH, including the midterm and completion reviews.
	DBF	Responsible for: (a) the FM of project funding; (b) releasing project funds to implementing units; (c) helping to build FM capacity of health facilities; (d) providing quarterly and annual FM reports, including disbursement rates of government and project funds and financial expenditures reports; and (e) producing quarterly financial monitoring reports. In addition, the civil works engineer team under the DBF will work on civil work monitoring and environmental safeguards implementation and monitoring.
	IAD	Undertake periodical, risk-based internal audits of facilities funded under the project.
	Procurement unit	Support any required procurement which is being undertaken at the central level. In addition, it will also contribute to building capacity at the field level to undertake small procurements using the SDG and HEF funds.
	Department of Personnel	Responsible for building the capacity of and monitoring the implementing units on the Performance Management and Accountability System.
PHD		Supervision of provincial RHs as well as of the ODs, coordination with health facilities to facilitate timely settlement of advances and timely payments flowing under the SDGs and lump sum grants.
ODs		Primary care manager assisting the HCs and RHs for establishing the AOP, conducting quarterly and annual performance reviews, monitoring the AOP implementation progress, and monitoring reporting data quality. The ODs will also undertake periodical performance and quality assessment using checklists.
PCA		Act as the PCA for both the SDG (Component 1) and HEF (Component 2).
HEF promoters		Promote HEF and serve as Patient Advocacy Organization whose overall goal will be to increase utilization of HEF cards at health facilities.
Hospitals (CPA-1, CPA-2, and CPA-3)		Health Service Provider—referral services according to comprehensive services ascribed to them. Also, play key role in pre-service and in-service training for students and health workers from the HCs.
HCs		Health Service Provider—primary care services close to the patients, including the maternal and child health, nutrition, communicable diseases, and in due course, also the NCDs.
HSD and QAO		Responsible for monitoring implementation progress on the areas of quality of care and monitoring implementation of environmental safeguards. The QAO will undertake development of and periodical update of the quality checklists, with TA from the DPs. The QAO will also be responsible for conducting quality assessments on an annual basis.
PMD		Responsible for supporting the SOAs for establishing the NCD services and monitoring the social safeguard implementation.
Department of International Cooperation		Responsible for facilitation, coordination, and improving transparency in the ministry by putting information relating to

	project support on the ministry's website. They are expected to be a 'one-stop shop' where interested parties can obtain information relating to all the support being provided to the health sector to strengthen transparency and accountability through enhanced oversight.

5. **Donor arrangements.** The H-EQIP culminated from extensive consultations among the DPs and the government to develop a common understanding of the country's priorities, ensure clear synergies in the interventions, and to collaboratively develop the design of the proposed project that would support the government's development agenda. On this basis, several DPs, including the DFAT, KfW, and KOICA, will pool support through establishment of a new MDTF administered by the Bank, through which these DPs will channel their funds. USAID will also contribute funds to the MDTF to support specific analytical work and TA that contributes to achieving the PDO. Japan is also expected to finance a complementary PHRD grant for TA to strengthen the health sector M&E mechanism.

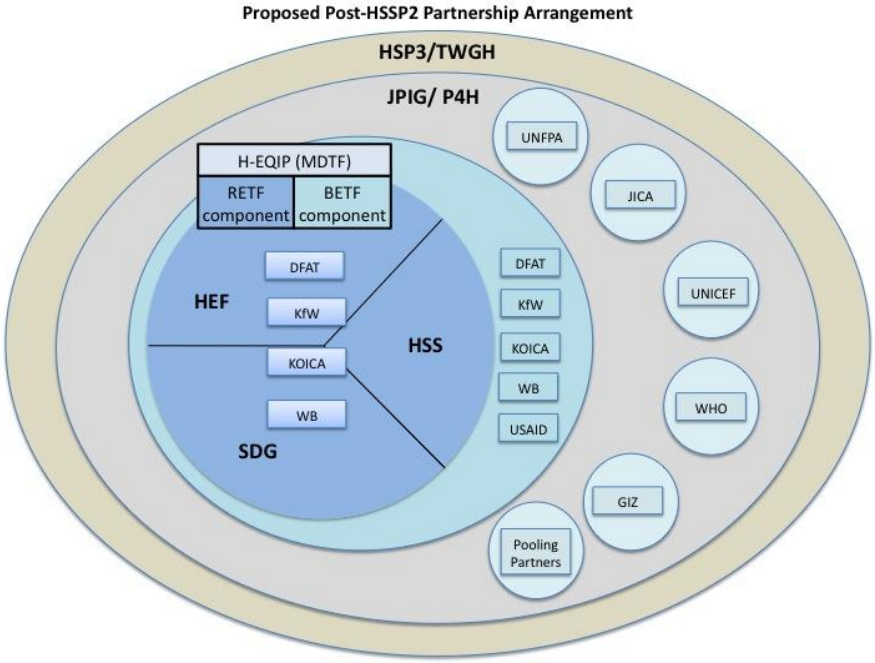
6. Donor arrangements under the HSSP2 were governed by the joint partnership arrangement between the DPs supporting the HSSP2 and the government, which defined the specific operational guidelines, pooled resources management, joint supervision and reporting, and other harmonized arrangements for the program.

7. Other partners working in areas of the UHC and SHP under the RGC's HSP-3 such as the GIZ, UNFPA, UNICEF, WHO, and USAID have agreed to establish working relationships for coordination and dialogue with the H-EQIP pooling partners. Under the HSSP2, the Joint Partnership Interface Group was the program partner forum for consultation and decision making on issues arising in the program. Building on the strengths of this kind of collaboration in the HSSP2, the functions of this forum will be revised to serve as a coordinating mechanism for donors, both pooling support through the H-EQIP and those managing individual program accounts, to focus on information exchange; coordination of financial and technical cooperation; identification, filling, and supporting of potential gaps; and strategic decision making in achieving the goals of the UHC and SHP under the umbrella of the HSP-3.

8. The specific design of the new coordination mechanism is currently under discussion among the DPs and will be agreed on by the start of the program on July 1, 2016. Proposed revisions under discussion include agreement on a detailed Coordination Plan among DPs to identify activities from the Sectoral Plan to be funded through individual program accounts and activities to be funded through pooled and individual accounts; participation in annual joint review field visits to review sector priorities, performance, and coordination among the DPs; regular bimonthly meetings as well as other specific arrangements for improved harmonization. The DPs are also considering the option to use the existing global coordination forum of *Providing for Health* (P4H) as an appropriate mechanism for this kind of coordination.

9. A broader partnership arrangement for coordination will continue to exist through the Health Partners Group while the regular Technical Working Group for Health will continue to provide the main forum for government and DP consultation, with wide membership from governmental and nongovernmental agencies, private organizations, and bilateral and multilateral organizations.

Figure 3.1. Post-HSSP2 Partnership Arrangement



Financial Management, Disbursements and Procurement

Financial Management

10. An FM Assessment was carried out in accordance with OP/BP 10.0. The assessment is based on work carried out and information available to the team from a PFM Assessment carried out for the MOH; knowledge gained from FM reviews during the implementation of the ongoing HSSP2; review of audit reports of the ongoing project; and discussions with the MOH financial staff. This also included meetings with the related MEF and MOH departments and visits to three provinces, namely, Takeo, Kampong Cham, and Prey Veng province. The assessment is carried out to determine if the existing PFM arrangement of the RGC being used in the MOH is adequate for the project.

11. The overall FM risk for this project is assessed as High. The main risks are associated with (a) limited experience of the accounting and finance staff of the DBF in managing the externally financed project, weak capacity of the staff at the HCs, and budget entities at provincial levels to implement program based budgeting and budget entity related policies and procedures; (b) delay in the release of funds due to constraints on availability of funds and long processes of the government procedures; and (c) inadequate documentation of policies and procedures of the government's new reform system. Key mitigating actions to be undertaken include (a) having in place acceptable, revised Financial Management Manual (FMM)/Guideline to be used for by the project taking into account, among others, the RGC's unified chart of accounts, steps and payment processes incorporating service standard from receipts of invoices until payment, mechanism to track length of time each payment step takes, DLI disbursement protocols, and other specific requirements; (b) further enhancing capacity of government staff in

FM by materializing training provided in the HSSP1/HSSP2 and focusing on hands-on training at all levels; (c) adopting/introducing the current accounting software used in the HSSP2 to the DBF before the RGC's IFMIS' roll out; (d) recruiting two full-time qualified FM consultants to provide coaching/mentoring support and training to the DBF during initial start-up of the project; (e) recruiting four qualified FM consultants to provide FM support to provincial level entities of the MOH in implementing accounting system; and (f) getting the MOH's IAD to carry out the risk based internal audit of the project twice a year.

12. **Staffing.** At the national level, there is lack of skilled professionally qualified accountants in the MOH and MEF; however, some of the staff have received training which resulted in improvement of the FM capacity. Despite this improvement, the ministries will continue to rely on consulting staff who have requisite qualifications to support project FM functions. With the abolition of the HSSP2 secretariat at the start of the H-EQIP, the FM function of the project will be mainstreamed into the DBF of the MOH. The mission team assessed that the capacities may be adequate with some transitional support from local FM consultants. For the first two years of the project, it is suggested to have two full-time equivalent local FM consultants to support the DBF in carrying out the project's FM responsibilities and in providing coaching, mentoring, and hand holding of staff of the DBF in implementing the project's FM requirement laid out in the FMM of standard operating procedure (SOP) and supplementary project FMM. Based on experience of the current HSSP2, the director of DBF can take up a role as finance officer to oversee the FM function while five or six staff of the DBF who have knowledge in accounting and finance can take up roles as cashier and assistant accountants to review and process payments for health facilities, suppliers, consultants, and contractors. The designated FM staff will be encouraged to involve with the ongoing HSSP2 to familiarize themselves with the system and disbursement practices. The local FM consultant should help carry out Training Needs Assessment for FM for the DBF's staff and the MOH's subnational entities and formulate a medium-term FM Capacity Building Plan. This plan should be ready by no later than six months after effectiveness.

13. At the subnational level, accounting and reporting duties are sometimes performed by a clinical staff who acts as a cashier to assist the management in maintaining the books of account and facilitates timely release of disbursements of funds. Some facilities have used performance based budgeted operational funds for contracting additional accounting staff due to the burden of keeping different accounts and fulfilling various reporting requirements. There is a lack of knowledge on the existing FMM and the government's unified chart of account and the account codes other than those routinely used in their daily FM tasks. The mission noted a general lack of training and guidelines on the program based budgeting implementation and on the new responsibilities of budget entities. Hands-on training led by local FM consultants is required to enable the subnational entities of the MOH (PHD, SOAs, and other ODs) to strengthen their FM system and to build their FM capacity. To achieve this, four local FM consultants will be engaged to support and on-the-job training to all the MOH's subnational entities for the first two years of the project implementation. Further needs will be assessed afterward.

14. **Planning and budgeting and government's contribution.** The Cambodian Budget System reflects the fiscal decentralization structure prescribed by the PFM reform program. The budget is processed at central, provincial, district, and commune levels of the government. The national budgeting process usually starts mid-March with the MEF issuing a budget circular to

the line ministries for the preparation of Budget Strategic Plan (BSP), a three-year rolling plan. After evaluating the line ministries' BSPs, the MEF will formulate its Annual Budget Plan and issue a second circular to the line ministries for preparation of their (nonwage) annual budget proposals. Starting from September, the line ministries will enter into technical negotiations with the MEF which has to consolidate the different proposals until early October, submit the overall budget to the Council of Ministers, and subsequently to the National Assembly in November for approval.

15. The budget preparation at the MOH is the responsibility of the Budget Working Group which is chaired by the director general of budget and administration and made up of the directors of the four programs for reproductive maternal newborn child and adolescent health, communicable diseases and NCDs, and system strengthening and other representatives from the PHDs and DPHI. At the subnational levels, the Budget Working Group, headed by the respective directors of programs, prepare their AOPs when the budget call is received from the MEF. The actual AOPs are submitted bottom-up from the ODs and provincial RHs to the PHDs for consolidation in the provincial budget. All consolidated PHD budgets are then submitted to the MOH for consolidation in the BSP before submitting to the MEF.

16. In the past, capital budgets and funds from external sources were not included in the line ministries' BSP. However, due to the PFM reform program recommendations, both funds will be included in the BSP from 2016 budget year on. The MEF obtains capital budget requests from the MOH and other line ministries; however, the MOH is never certain which of the capital budget requests will be approved in the current year (when needed) or any of the subsequent budget years. Due to the rigidity of the budget ceilings, there is lack of flexibility on what each subnational level may include in their physical budget targets.

17. There are government funds to finance the SDG and HEF at the sharing percentage agreed between the Bank and the government annually. The MOH will work with the MEF to ensure that the project's annual budget and the government fund co-financed SDG and HEF will be included in the RGC's annual budgets.

Fund flows

18. For traditional financing, a pooled DA for the IDA credit and the MDTF will be maintained at the NBC by the GDNT as sub-TSA account under the TSA's system of the MEF. This sub-TSA account is a pass through account where all funds will be transferred to the project account maintained at the NBC. The MEF is the project account's owner while the MOH is authorized to administer this project account for payments to health facilities, consultants, suppliers, and contractors. The DA is denominated in US$ and checks are used as the means of payment.

19. The government's contribution will have a similar modality as the DA. The MOH will make a request to the MEF for the amount of government funds. The GDNT will transfer the requested amount to the US$ denominated government fund bank account at the NBC which is administered by the MOH. The first advance for the government fund for the project will be equal to the first six-month budget forecast. The subsequent replenishment to the government fund bank account will be done on a quarterly basis based on the amount in the IFR. The fund

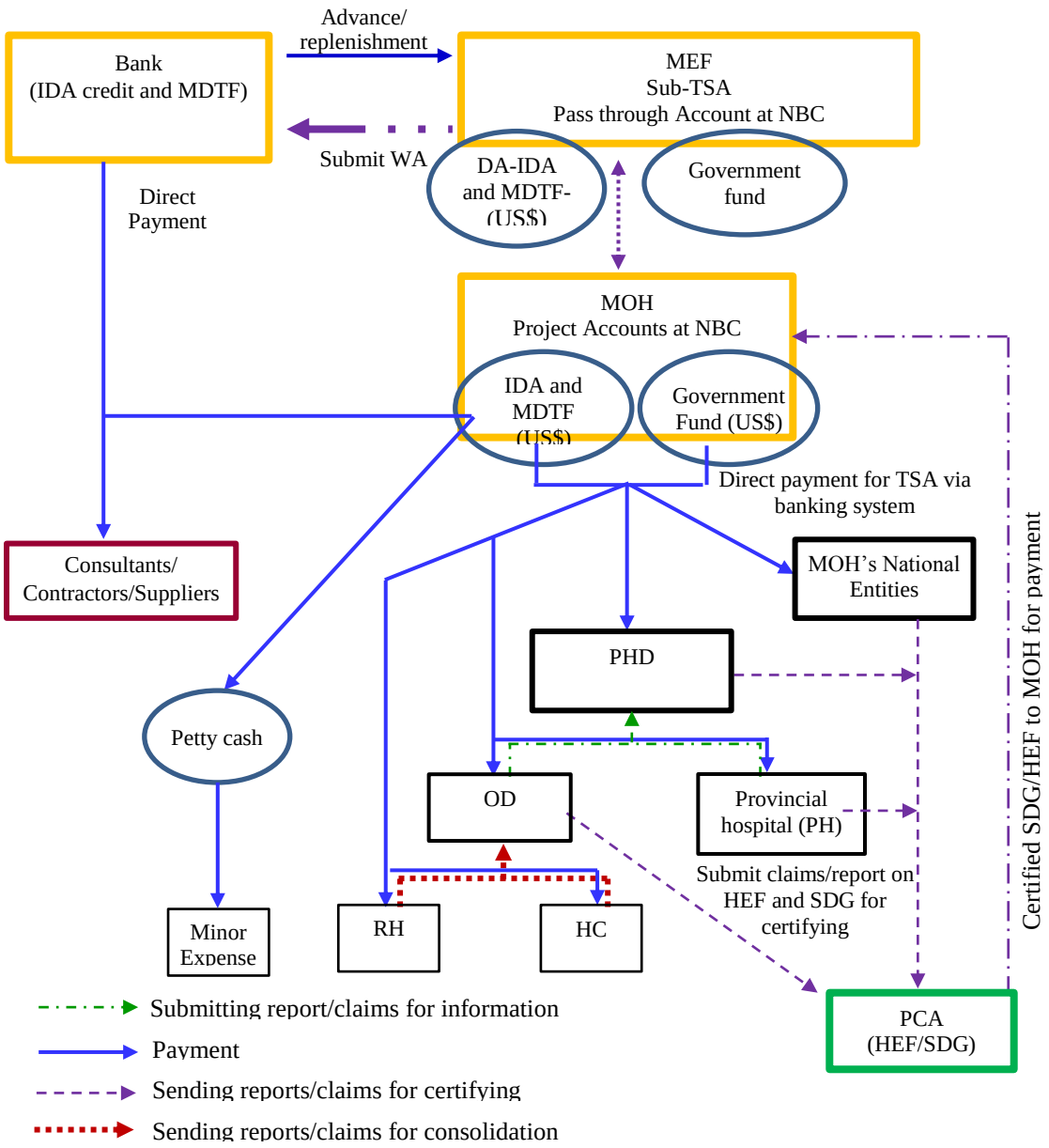
balance at the year-end will be carried over to the next fiscal year and will be deducted from the request for funds for the next fiscal year.

20. The project's bank signatory for the project account and the government fund bank account will be detailed in the supplementary FMM.

21. For the DLI part, the funds from the Bank will be transferred to the RGC's bank account under the TSA.

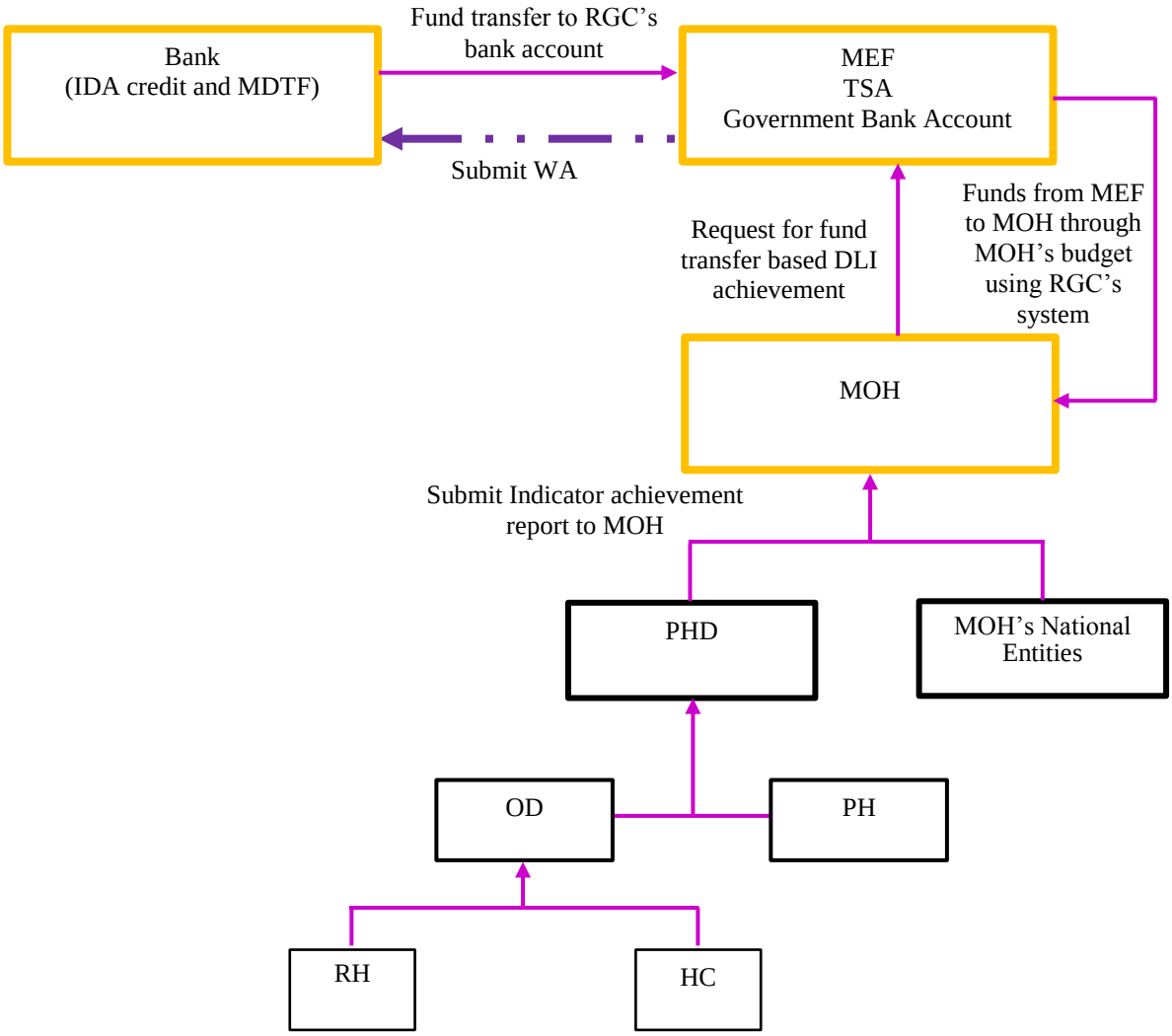
22. Figure 3.2 depicts the fund flows for traditional financing for Components 1, 2, 3.2, 3.3, and 4. Figure 3.3 illustrates the fund flows for the DLI part (Component 3.1).

Figure 3.2. Fund Flow Diagram for Traditional Financing (Components 1, 2, 3.2, 3.3, and 4)



Note: WA= Withdrawal Application;

Figure 3.3. Fund Flow Diagram for DLI (Component 3.1)



Note: WA = Withdrawal Application.

23. **Accounting and maintenance of accounting records.** The project will follow the government's fiscal year from January 1 to December 31 and adopts cash basis of accounting, except for cash advance to implement the project's activities. Cash advance will be treated as an advance until liquidation with full supporting documents. It has been agreed that the DBF of the MOH will be responsible for the FM of the project. The MOH's DBF will be responsible for maintaining accurate accounting records for the project, maintaining adequate supporting documents, preparing timely financial reports, ensuring the timely release of funds to the MOH's national and provincial entities and putting in place satisfactory auditing arrangements for the project as required. Supporting documents for expenses paid by the national and subnational entities of the MOH will be maintained at their respective offices for auditing purposes.

24. Currently, the MOH's DBF uses Microsoft Excel software to maintain its accounting record and produce a monthly expense report. There is no computerized accounting software yet. The MEF's IFMIS is still in the early stage of implementation in the MEF from July 2015 and its

related provincial treasury from 2016. A plan to roll out the IFMIS in the line ministries is not yet definite. During this transition period, it is suggested that the MOH's DBF will adopt/maintain the current accounting software (QuickBooks) to account for the project's financial transactions. However, there is a need to set up a new company database in the existing QuickBooks software by using the RGC's unified chart of accounts. This should be done before the project's effectiveness.

25. Similarly, at the subnational level, no computerized accounting software is in use. Accounting records such as cashbook and reports are prepared in Excel. To enhance capacity of the subnational staff in FM, especially for HCs who will receive a lump sum grants from the government, a support from local FM consultants is envisaged.

26. **Internal control and internal audit.** The government's financial controls in managing funds and reporting will be used. However, there is a lack of detailed written FM procedures for the government's system, except there are some rules, regulations described in the various ministerial *Prakas*. During the assessment, the mission learned that the government's payment procedures/fund transfers involve departments within ministries applying similar internal control measure over the same payment. The control processes will involve (a) the MOH's DBF preparing the request, including the payment order (mandate) which will be signed by the minister before being submitted to the MEF; (b) the MEF reviews the Financial Affairs Department and internally proceeds to get approval on the payment order from a designated management of the MEF; (c) the payee is contacted to deliver the approved (signed) payment order and related documents to the GDNT; and (d) then the GDNT process using its internal approval processes before the transfer funds can be made. These processes are lengthy, require high-level approval, and are known to take a long time. There is a high risk of long delay in payment and it might impede integrity of the payment process when payees/beneficiaries are involved in the payment processes. Given that the MOH's DBF is in charge of FM and the government payment procedures in the DBF is adopted, there is a need to updated the current HSSP2's FMM to document various roles and responsibilities of different staff and management of the DBF, payment processes and procedures within the DBF, segregation of duties, the RGC's unified chart of accounts, and strengthening of controls over soft expenditure such as stationary, fuel, training and workshop, format and submission timeline of the IFR, internal audit report and external audit report, and so on.

27. Petty cash will be set up according to the policy outlined in the SOP/FMM for minor expenses. Payments should be done by checks or bank transfers. Payment by cash shall be minimized and confined only to small expenses where check payments is not feasible. Contracts with suppliers or service providers for regular purchases of items such as office supplies, fuel, repair and maintenance of equipment/vehicles and so on, should be done with payments made to the suppliers' bank accounts. Invoices/receipts must be original and obtained from the suppliers. Self-written invoices are not accepted.

28. In the MOH, there is the IAD which has received technical support in audit methodology training from the HSSP1 and HSSP2. The mission learned that the IAD has applied the knowledge gained from training into the internal auditing activities of the government financed activities and other development financed activities such as the Global Alliance for Vaccines and Immunization (GAVI) upon request. The IAD's Annual Budget Plan and Audit Plan is included

in the three-year rolling plan in the MOH's AOP. The IAD's budget is under the General Department of Budget and Administration which is one of the budget entities in the MOH. The mission is aware that the IAD experienced a lack of funds to properly carry out its function. To enable the IAD to properly carry out its mandate, the MOH should ensure that the IAD be provided with sufficient budget for its operations. It is also suggested that the IAD will carry out internal audit activities of the project twice a year and send a copy of the internal audit reports on the project's activities to the Bank within 60 days after completion of the audit. Subject to further assessment of the quality of the internal audit report, the project may engage additional support to provide capacity building to the IAD in carrying out the internal audit of the project. If the internal audit reports are not submitted to the Bank or the IAD is unable to carry out internal audit on the project's activities, the Bank may request the project to engage a consulting firm to build capacity of the IAD and to work with the IAD to perform an internal audit of the project.

29. **Financial reporting.** The project is required to prepare quarterly IFR that meets the Bank's requirements and the annual financial statements in line with the unified chart of accounts. Submission of the financial reports will be in accordance with agreed timeline. Submission date for the IFR is 45 days after the end of the quarter.

30. **External audit.** The project's annual financial statements will be audited by an independent, private external auditing firm. This will be done in accordance with the TOR acceptable to the Bank and the annual audited report together with management letter will be submitted to the Bank no later than six months after the end of each fiscal year. The audit will cover all sources of funds (the DP funds and all RGC's contribution in the project) and will integrate a review of the post review procurement packages at the subnational levels at a percentage based on the auditor's risk assessment, but not less than 5 percent of the total post review procurement packages. The selection of the external auditor should be included in the audit bundling arrangement managed by MEF. Should the Bank see an improvement in the financial statements audit carried out by the National Audit Authority at any point during project implementation the Bank has the discretion to request the MOH to discuss with the National Audit Authority to have it audit the project's annual financial statements.

31. The project audited financial statements will be subject to public disclosure. The mechanism for disclosure is to be agreed.

Implementation Support and Supervision Plan

32. Implementation support for FM functions will be provided more frequently to the task and client teams in the first year of project implementation. The Bank will then limit its review biannually thereafter depending on the updated project FM risk assessment and progress. The FM missions will include reviews of the continuous adequacy of the FM arrangements, progress with FM capacity building activities, adequacy, and timeliness of preparation of the IFRs, and progress in implementation of the agreed FM actions and recommendations from project audits.

33. **Required FM actions.** The Table 3.2 identifies the FM actions required, which will be reflected in the Project Operational Manual.

Table 3.2. FM Actions

Required Actions	Responsibility	Timing
1. Assign designated five or six FM staff within the DBF with specific job description	Director general for administration and finance	Before signing of the Financing Agreement
2. Develop FM Capacity Building Plan for staff of the DBF	Director general for administration and finance with support from local FM consultants	Six months after effectiveness
3. Set up a new company database in the existing QuickBooks by using the RGC's unified chart of accounts	FM consultants	Before effectiveness
4. Update the current HSSP2's FMM to document various roles and responsibilities of different staff and management of the DBF; payment processes and procedures within the DBF; segregation of duties; the RGC's unified chart of accounts; and strengthening controls over soft expenditure such as stationary, fuel, training and workshop, format, and submission timeline of IFR, internal audit report, and external audit report.	FM consultants	Before effectiveness
5. The IAD to carry out an internal audit of the project's activities twice a year and submit the internal audit report to the Bank no later than 60 days after completion of the audit	MOH's IAD	Continuous
6. Submit a copy of the related audit report and management letter of the MOH conducted by the National Audit Authority to the Bank after these reports are submitted to parliament	MOH	Annually

Eligible Expenditures Program and Disbursement Arrangements for Component 3.1—DLI Based Approach

34. The EEP will be used as basis of expenditures when the DLIs have been met. After discussion with the MEF and MOH, a portion of the government contribution to HEFs under the H-EQIP has been identified as EEPs under this project.

35. The EEPs will be reported through the project's IFRs and they will be audited as part of the project's annual financial statement audits. In the project's IFRs and audited financial statements, there will be a note of the total amounts of HEFs that the government has contributed the amount of these HEFs used as EEPs for subcomponent 3.1, based on agreement in the AOP. The RGC has to demonstrate that the amount of EEPs recorded in the IFRs exceeds the amount being requested from IDA in the particular reporting period.

36. IDA will disburse funds based on achievement of DLI targets. Disbursements are planned to follow the government budget cycle ensuring that funds are available at the start of the implementation of each budget year. Disbursement on the project's effectiveness and in subsequent years will be contingent upon the recipient demonstrating that (a) the amount of HEF used as EEPs exceeds the DLI related amount being requested from IDA in the related prior year and (b) that the agreed targets of DLIs have been achieved and documented in annual DLI status report verified independently by the Bank.

37. Disbursements withheld due to non-achievement of DLIs in a given year may be released in subsequent years once the DLI target is achieved. Partial achievement of a DLI target (for

those that are scalable) may result in a partial disbursement on a pro-rated basis. Disbursements for any DLI will be capped at the amount allocated for that year for the concerned DLI target, that is, over-achieving the DLI targets will not lead to ever increasing disbursements and dipping into the allocation of the following year. IDA, in consultation with the RGC, may cancel or reallocate funds if there is severe underachievement. At the end of the project, if there is underachievement of any DLIs, the RGC may request an extension of the closing date to enable complete fulfillment of the relevant targets.

Disbursement Arrangements—Traditional Financing for Components 1, 2, 3.2, 3.3, 3.4, and 4

38. The primary disbursement methods will be reimbursement, advances, special commitment, and direct payments. One pooled DA (for IDA credit and the MDTF) will be opened at the NBC administered by the MEF under the TSA system. The DA will be denominated in U.S. dollars. The ceiling will be variable based on six monthly forecast. Supporting documentation required for eligible expenditures paid from the DA is the IFR. Direct Payments will be documented by records. The frequency of reporting of expenditures paid from the DA shall be quarterly.

39. The minimum application size for reimbursements, special commitment, and direct payments will be equivalent to US$100,000.

Disbursement for Component 4—Contingent Emergency Response

40. No withdrawal shall be made under Component 4 until the government has (a) prepared and disclosed all safeguards instruments required for activities under Component 4 of the project, if any, and the government has implemented any actions which are required to be taken under said instruments; (b) established adequate implementation arrangements, including a positive list of goods and/or specific works and services required for emergency recovery, satisfactory to IDA, including staff and resources for the purposes of said activities; and (c) prepared and adopted an Emergency Response Manual, acceptable to IDA, so as to be appropriate for the inclusion and implementation of activities under Component 4. The Emergency Response Manual will be developed during the first year of project implementation, or in any event before the release of any funds under Component 4.

41. Disbursements will be made either against a positive list of critical goods and/or against the procurement of works and consultant services required to support the immediate response and recovery needs of the RGC. All expenditures under this component, should it be triggered, will be in accordance with OP/BP 10.00 and will be appraised, reviewed, and found to be acceptable to the Bank before any disbursement is made. All supporting documents for reimbursement of such expenditures will be confirmed by the MOH, certifying that the expenditures were incurred for the intended purpose and to enable a fast recovery following the crisis or emergency, before the withdrawal application is submitted to the Bank. This verification would be sent to the Bank together with the application.

42. Disbursements from the MDTF and IDA credit shall be made against the following expenditure categories:

Table 3.3. Project Cost by IDA Credit Expenditure Categories

Category	Amount of the Financing Allocated (expressed in SDR)	Percentage of Expenditures to be Financed (inclusive of Taxes)
(1) SDGs under Part 1 of the Project	5,400,000	100 % of the Financing's agreed share of the cost specified in the approved AOP for each FY
(2) HEF Grants under Part 2 of the Project	8,100,000	100 % of the Financing's agreed share of the cost specified in the approved AOP for each FY
(3) Eligible Expenditure Programs under Part.3.1 of the Project	4,100,000	100 % of the Financing's agreed share of the cost specified in the approved AOP for each FY
(4) Goods, works, non-consulting services, consultants' services, Operating Costs and Training under Parts 3.2 and 3.3 of the Project	4,100,000	100 % of the Financing's agreed share of the cost specified in the approved AOP for each FY
(5) Emergency Expenditures	0	100%
TOTAL AMOUNT	21,700,000	

Table 3.4. Project Cost by MDTF Grant Expenditure Categories[52]

Category	Amount of Grant Allocated (US$, millions)	Expenditures to be Financed (inclusive of taxes)
(1) SDGs under Component 1 of the project	12.5	100% of the Bank's agreed share of the cost of the approved AOP for each FY
(2) HEF grants under Component 2 of the project	18.75	100% of the Bank's agreed share of the cost of the approved AOP for each FY
(3) EEPs under Component 3.1 of the project	9.375	100% of the Bank's agreed share of the cost of the approved AOP for each FY

[52] The amounts indicated are indicative based on the estimated total MDTF contributions. Actual amounts will depend on the US$ equivalent that the World Bank receives from the donors as periodic installments over the life of the MDTF.

(4) Goods, works, non-consulting services, consultants' services, operating costs, and training under Component 3.2 of the project	9.375	100% of the World Bank's agreed share of the cost of the approved AOP for each FY
TOTAL AMOUNT	50	–

43. The project will provide retroactive financing for eligible expenses paid by the Government incurred on or after July 1, 2015, for the maximum amount not exceeding SDR 4,340,000 (US$6, 000,000 equivalent).

Disbursement Arrangements (all components)

44. The project will have a disbursement deadline date (final date on which the World Bank will accept applications for withdrawal from the recipient or documentation on the use of the MDTF and credit proceeds already advanced by the World Bank) of four months after the closing date of the project. This 'grace period' is granted to permit orderly project completion and closure of the credit account via the submission of applications and supporting documentation for expenditures incurred on or before the closing date. Expenditures incurred between the closing date and the disbursement deadline date are not eligible for disbursement. All documentation for expenditure forwarded to IDA for disbursements will be retained and be made available to the external auditors for their annual audit and to IDA and its representatives, if requested.[53]

45. In the event that auditors or the IDA implementation support missions find that disbursements made were not justified by the supporting documentation (including IFRs and DLI reports), or are ineligible (either due to nonadherence to the EEP or due to the underachievement of DLIs in Component 3.1), the IDA may, at its discretion, require the recipient to: (a) refund an equivalent amount to IDA or (b) exceptionally, provide substitute documentation evidencing other eligible expenditures.

46. Financing covenants include the following:

- Submit quarterly interim unaudited financial report to the World Bank no later than 45 days after the end of the calendar quarter.

- Submit the annual audited financial statements and management letter to the World Bank no later than six months after the end of the fiscal year.

[53] The general conditions require the recipient to retain all records (contracts, orders, invoices, bills, receipts, and other documents) evidencing eligible expenditures and to enable the Bank's representative to examine such records. They also require the records to be retained for at least one year following receipt by the Bank of the final audited financial statement required in accordance with the legal agreement or two years after the closing date, whichever is later. Recipients are responsible for ensuring that document retention beyond the period required by the legal agreement complies with their government's regulations.

Procurement

Applicable Procurement Guidelines and Procedures

47. Public procurement in Cambodia is governed by Public Procurement Law enacted in January 2012. Article 3 of the law provides an exception to follow procurement guidelines and procedures agreed between the RGC and DPs for the project financed by the DPs. Accordingly the updated SOPs and updated Procurement Manual for all Externally Financed Projects and Programs issued under sub-decree 74 dated May 22, 2012 has been agreed and applicable for the World Bank-financed/administered projects/programs. The updated SOPs and Procurement Manual contain principles, rules, and guidelines for planning, supervision, and procurement procedures for all externally financed projects/programs. These SOP/Procurement Manual include comprehensive complaints, disclosure, and transparency regime to be followed. The SOP/Procurement Manual apply at central level. Public Procurement Law enacted in January 2012 also provides for the policy and procedures for procurement under government owned, financed projects/programs. The law establishes the General Department for Public Procurement within the MEF as responsible body for regulatory responsibilities. The law also provides for disclosure and complaints rules to be followed by both bidders and public officials. Both documents are publicly available on the MEF website.

48. The enabling Legal Frameworks are generally comprehensive and incorporate fundamentals of a modern procurement legislation. The key challenge, however, lies with the capacity to implement the Legal Framework and to provide oversight for the implementation. Staff capacities are weak and procurement is yet to be a profession developed within the public service.

49. Procurement under the project will be governed by 'Guidelines: Procurement of Goods, Works, and Non-consulting Services under IBRD Loans and IDA Credits and Grants by World Bank Borrowers' dated January 2011 (revised July 2014), and 'Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits and Grants by World Bank Borrowers' dated January 2011 (revised July 2014). The World Bank's standard bidding documents and request for proposal documents will be used for all tenders requiring international competitive bidding and consultant selection requiring international participation respectively. Cambodia's updated Procurement Manual for all Externally Financed Projects/Programs, promulgated pursuant to sub-decree 74 on promulgating the updated SOPs for Implementing All Externally Financed Projects/Programs, dated May 22, 2012, and harmonized bidding documents will be used for tenders under national competitive bidding and other low-value procurements. This will be reflected in the project Financing Agreement as well as in a joint proclamation (*Prakas*) between the MOH and MEF.

Assessment of the Agencies' Capacity to Implement Procurement

50. The Procurement Capacity Assessment of the project implementing agencies were carried out during post pre-appraisal mission on December 2–18, 2015 in accordance with the World Bank Office Memorandum from OPCPR dated July 15, 2002 on 'Revised Instruction for Carrying out Assessment of Agency's Capacity Assessment to Implement Procurement; Setting of Prior-Review Thresholds and Procurement Supervision Plan'. Key procurement risks

identified include: (a) limited capacity and procurement oversight at central level, where the MOH procurement unit staff are not familiar with the DP financed procurement and staff have limited English proficiency, (b) limited capacity and oversight at subnational levels, where a majority of subnational level budget entities are not familiar with DP financed procurement and activities at subnational levels take place all over the country; (c) delays in the procurement cycle management due to slow technical inputs for procurement start-up; and (d) governance associated risks. The overall procurement risk is assessed High. The high risk emanates from the nationally distributed nature of activities at the subnational levels, limited number of experienced procurement staff, and governance associated risks at all levels. Risk mitigation measures have been discussed and agreed with the government and detailed in an action plan below. The residual procurement risk under the project is considered to be Substantial.

51. The procurement unit of the MOH will be responsible for all procurement activities at the national level while the subnational level budget entities (the HCs, hospitals, ODs, and PHDs) will carry out their own procurement activities, except some significant/critical items that may not be available locally at the subnational levels. These items will be procured centrally by the procurement unit of the MOH on behalf of and based on the request of the subnational level budget entities. This arrangement enforces the integration into the government institutional structure and is different from the arrangement for the HSPP1 and HSSP2 that was based on the MOH secretariat. All procurement done at the subnational levels will be subject to post review by the Bank and to integrated FM audit assignment by the independent auditor. The MOH has an important role in providing training and guidance to the subnational level procuring entities before and during the procurement process.

52. The procurable items under the project will include: (a) minor renovations and repairs of health facilities and equipment at the subnational levels with the expected value of contracts not exceeding US$10,000 per package and (b) upgrading of the HCs and hospitals, office equipment, HEFPs, and advisory services for implementation of the various components. The HEFPs will be selected from the existing HEFOs. The expected value of contract at the national level will not exceed US$5 million per package.

Risks and Mitigation Measures

53. The following risk mitigation measures have been agreed with government:

Table 3.5. Risk Mitigations Measures on Procurement

Risk/Risk Area	Mitigation Measures	Period of Implementation of the Measure
Weak capacity and procurement oversight at the central level	High prior review by the World Bank and lowered prior review thresholds. Post review by the World Bank annually on sample of 15% of contracts. Hire one procurement consultant in first year or engage more qualified staff. The World Bank will provide procurement training to all project staff before and during the project implementation. Additionally,	Before and during the project implementation and annually

Risk/Risk Area	Mitigation Measures	Period of Implementation of the Measure
	potential staff will be exposed to international training programs through an allocated fund under the project.	
Weak capacity and oversight at subnational levels	The project design includes training of concerned subnational level budget entities before start and during the period of implementation of subprojects. Independent FM auditor will carry out annual integrated FM audit and procurement ex post review at least for 5% of the subproject procurement contract. An integrated fiduciary audit will also be carried out annually by the Bank or consultants engaged by the Bank.	Before and during the project implementation and annually
Delays in procurement cycle management	Keep tracking the form of procurement actions and monitoring progress. Appoint focal persons to provide technical inputs for each package and provide training to evaluation committees for each package.	Before and during the project implementation
Governance associated risks	The project design includes a communication strategy to inform stakeholders about the project which will bring more awareness. The SOP and Procurement Law provide grounds for enhanced mitigation of governance risks and each bidding documents/request for proposal will provide for channels and contacts of both government and the World Bank through which interested parties may lodge their procurement complaints.	During implementation
Misrepresentation of staffing/documents in the bids/proposals of bidders	The project implementing agencies (at national level and subnational levels) shall carry out due diligence in verifying the proposed staffing and the documents submitted directly with the proposed staff/consultants, former clients of bidders, and other associated entities/manufacturers. Fraud and corruption policies in the World Bank guidelines as well as in the bidding documents/request for proposals and contracts shall be applied during misrepresentation.	During the bid/proposals evaluation process and contract execution.

54. Based on the current governance and procurement environment and the past performance of the project implementing agencies, the overall procurement risk is High. However, the

identified risks will be managed and mitigated through the above agreed action plan, and the residual procurement risk of this proposed project is Substantial.

Procurement Plan

55. A Procurement Plan for the first 18 months of the project is given in Table 3.6. Procurement activities will only comprise of Component 3, mainly in relation to TA, project management, goods, and civil works.

A. Goods and Works and Non-consulting services

56. **Prior review threshold.** Procurement decisions are subject to prior review by the World Bank as stated in appendix 1 and based on the World Bank's Procurement Guidelines.

Table 3.6. Procurement Prior Review Threshold (Goods, works, and nonconsulting services)

	Procurement Method	Prior Review Threshold (US$)
1.	ICB and LIB (Goods)	All packages
2.	NCB (Goods) packages	Each package is estimated to cost > 300,000
3.	ICB (Works) packages	All packages
4.	NCB (Works) packages	Each package estimated to cost > 1,000,000
5.	Direct Contracting (Goods)	Each package estimated to cost > 5,000 and procured at the national level
6.	Direct Contracting (Works)	Each package estimated to cost > $5,000 and procured at the national level
7.	Advance procurement and advance contracting	All packages regardless of value

Note: ICB = International Competitive Bidding; NCB = National Competitive Bidding; LIB = Limited International Bidding

57. **Any other special procurement arrangements.** Advance procurement and advance contracting have been finalized at the negotiation.

58. Summary of the procurement packages (including those that are subject to retroactive financing and advanced procurement)—only international competitive bidding and national competitive bidding packages are included in this summary plan.

Table 3.7. Summary of Procurement Packages

Description	Estimated Cost (US$, million)	Procurement Method	Domestic Preference (Yes/No)	Review by Bank (Prior/ Post)	Comments
Procurement of Works					
Construction of the HCs, maternity and neonatal at the RH, and provincial RHs.	11.2	NCB	Yes	Prior	3 packages
Procurement of Goods					
Medical equipment/tools	1.0	NCB	No	Prior	3 packages, 2 for prior review (above US$0.3 million each)
Health furniture	0.5	NCB	No	Post	3 packages

B. Selection of Consultants

59. **Prior Review Threshold.** Selection decisions subject to prior review by the World Bank as stated in appendix 1 based on the World Bank's Consultant Guidelines.

Table 3.8. Procurement Prior Review Threshold (Selection of Consultants)

	Selection Method	Prior Review Threshold	Comment
1.	Competitive methods (firms)	Each package estimated to cost > US$100,000	
2.	Single source selection (firms)	All packages	
3.	Selection of individual consultants	All fiduciary and legal positions	
4.	Single source selection (individual consultants)	Each package estimated to cost ≥ US$10,000	
5.	Advance procurement and advance contracting	All packages regardless of value	

60. **Shortlist comprising entirely national consultants.** The short list of consultants for services, estimated to cost less than US$200,000 equivalent per contract, may comprise entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. If there were no sufficient number of national firms available, international advertisement (request for expression of interest on United Nations Development Business) can be applied.

61. **Any other special selection arrangements.** Advance procurement and advance contracting have been finalized at the negotiation. The HEFPs will be selected from the HEFOs currently engaged under the HSSP2 project on the basis of single source selection method with some modification to their TORs.

62. **Consultancy assignments with selection methods and time schedule.** Most of the consulting services are expected to be provided by individual consultants, except assignments listed in Table 3.9 are expected to be provided by the current health operators under the ongoing HSSP2 project through the single source selection method.

Table 3.9. Consultancy Assignments

Description of Assignment	Estimated Cost (US$)	Selection Method	Review by Bank (Prior/Post)	Comments
HEFPs	2.5 million	Single Source Selection	Prior	All 11 current health operators under the ongoing HSSP2 project are expected to provide the services with amended TORs

Environmental and Social (including safeguards)

63. The project is classified as category B. It triggered two environmental safeguards policies including Environment Assessment (OP/BP 4.01), Pest Management (OP 4.09), and two social safeguards—Involuntary Resettlement (OP/BP 4.12) and Indigenous Peoples (OP/BP 4.10).

64. To address the potential environmental, health, and social impacts from the H-EQIP, the MOH has prepared relevant safeguards instruments such as: (a) an EMF that includes a generic EMP and an Environmental Code of Practices to address impacts from civil works, a simple Health Care Waste Management Plan and a simple Pest Management and Monitoring Plan; (b) a RPF to address any issues that may occur for subprojects identified during implementation with screening criteria and relevant protocols; and (c) an IPPF to address the requirements of the indigenous peoples policy. Under OP 4.10, free, prior, and informed consultation leading to broad community support will be applied during the implementation of the program.

Environmental Issues

65. The project will support constructions and/or rehabilitations of selected health facilities—the number and types of health facilities and their initial costs have been identified during appraisal stage. The final list of civil works, specific costs, and detailed engineering design will be conducted in the first half of 2016. Sites for repairs/installations of small on-site utilities will be identified during the project implementation. The expected type of investments include additional maternity wards and other infrastructure to existing health facilities to facilitate emergency maternity and neonatal services, reconstruction of debilitated or existing HCs, expansion of two existing hospitals, and repairs/installations of small on-site utilities (for example, incinerators). The generic construction impacts from civil works are expected to be minor, temporary, and site-specific. While impacts from incremental health care waste and potential use of pesticides for vector-borne diseases control such as dengue will occur in the longer term but are site-specific and can be mitigated through preparation and implementation of good EMP.

66. These civil works are similar to the support provided under the HSSP2 and follows generic EMP and Environmental Code of Practices that are built on the HSSP2 EMP to avoid and/or mitigate any possible adverse impacts from such activities. Other new infrastructure constructions will be screened per guidance provided in the EMF. Specific subproject EMP will be developed if needed.

67. Further, there are associated risks from incremental HCWM from increased utilization of health services. The same guidelines and basic health care facility designs applied for the HSSP2 will be adopted in the H-EQIP. In addition, the project will finance repairs/installations of on-site incinerators at selected health facilities to minimize the government HCWM implementation gaps and minimize impacts from improper HCWM practices. Additional measures on HCWM are provided in the EMF. The project may also support activities related to pesticides/larvicides to control vectors of dengue. Under the HSSP and HSSP2, all pesticide products have successfully passed WHO's Pesticide Evaluation Scheme, a system set up to promote and coordinate the testing and evaluation of pesticides for public health. The same approach taken

under the HSSP and HSSP2 are adopted in the H-EQIP. Further, an updated Pest Management and Monitoring Plan has been prepared and adopted in the H-EQIP.

Social and Indigenous Peoples

68. An SA was carried out in a participatory process through free prior and informed consultations with ethnic groups, to assess the project's potential positive and adverse effects on local communities, including but not limited to ethnic groups and examine alternatives where adverse effects may be significant. In particular, the SA reviewed the existing barriers for ethnic women and children to receive proper health services including those related to language, traditions, customs, values, and so on. Focus group discussions with free prior and informed consultation have been conducted as part of the SA through which perspectives of ethnic groups have been collected and reflected in the project design. In accordance with the findings of the SA, an IPPF has been prepared and disclosed with steps to be taken to address barriers for ethnic minorities to benefit from the project and to address negative impacts that may occur, if any. Due to the nature of the program the consultation with indigenous peoples/ethnic minorities undertaken during the SA did not foresee any potential adverse effects of implementing the proposed H-EQIP. The consulted indigenous peoples/ethnic minorities did not express any concerns about possible negative impacts of the proposed program due to its focus on improving access to quality health services and increasing protection against health related impoverishment through increased utilization of the HEF. During the consultation process conducted as part of the SA, participants overwhelmingly expressed support for the program if it would result in positive improvements to the health of their communities and the cultural appropriateness of services available at the hospital and the HCs. The IPPF has been prepared based on findings and recommendations from the SA. The IPPF includes the relevant elements for preparing the Indigenous Peoples Plan during project implementation.

69. The H-EQIP is designed for social inclusion determined to ensure local participation by the commune members. The project will involve indigenous communities as key beneficiaries. Experience has shown that incorporating culturally appropriate considerations for ensuring the full participation of indigenous communities in the health services is key to project success; specifically, for adapting the project activities for increasing indigenous people's attendance and benefits from health. The project will continue to ensure appropriate attention to gender issues as well as indigenous people's issues and improve the quality and skill sets of health services providers.

Resettlement

70. A RPF has been prepared to address any issues that may occur during project implementation. Screening criteria and relevant protocols have been included as part of the RPF.

71. During appraisal, it has been identified that project will support constructions and/or rehabilitations of selected health facilities whose sites and initial costs have been identified. The expected types of investment include additional maternity wards and other infrastructure to existing health facilities to facilitate emergency maternity and neonatal services, reconstruction of debilitated existing HCs, and expansion of two existing hospitals. Sites for repairs/installations of small on-site utilities, for example, incinerators will be identified during project

implementation. The MOH confirmed that the new hospitals will be constructed in existing provincial RH compounds, which are state lands that have been donated to the MOH. The resettlement impacts will be at the level of land donation which will follow specific protocols highlighted in the RPF.

72. During the implementation of the HSSP2, a comprehensive review of land acquisition conducted by the MOH and supported by 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), according to provision of the Land Acquisition Framework Policy and Procedures. During the implementation of the HSSP2, the World Bank team as well as the MOH representatives assessed the selected number of health facilities where the project financed civil works to monitor and verify that there is no social impact that triggers OP 4.12. The review found no other negative impact on private assets occurred during the HSSP2. It also found that the MOH keeps all necessary documents in the project file.

73. During implementation of the HSSP and HSSP2, the MOH has gained some good experience implementing World Bank-financed programs with its specific requirements such as those under the World Bank's policies triggered by the HSSP2. For the H-EQIP, PMD, HSD, and civil work engineer team of the DBF, under the MOH, are responsible for social and environmental safeguards, respectively. The HSD has direct responsibilities on HCWM. It had prepared the national guidelines and declaration on HCWM guidelines, infection prevention, and control guidelines and provide training to national and subnational level institutions to implement the guidelines. The civil work engineer team is responsible for monitoring the construction of health facilities financed by the project. The PMD had conducted a SA and prepared an IPPF and RPF. However, it has limited capacity on the World Bank's safeguards policies and in RPF, IPPF, and EMF implementation.

The World Bank will provide capacity building and operational support to the implementation of the RPF, IPPF, and EMF. The MOH, with support from the World Bank, will continue to provide training to relevant stakeholders, including at subnational level in the implementation of the safeguard policies triggered by the project.

Annex 4: Implementation Support Plan

KINGDOM OF CAMBODIA

Health Equity and Quality Improvement Project (H-EQIP)

Strategy and Approach for Implementation Support

1. The World Bank team will include the task team leader(s) (senior health specialist and/or senior economist), operations officer, procurement, and FM specialist based in-country. Safeguard specialists based in the region will periodically follow up on implementation of the safeguard aspects. Further operational and fiduciary management support will be provided from the region as and when required. Expertise from the Health, Nutrition, and Population Global Practice, as well as from other practices will be drawn upon, in particular with respect to DLIs, health service delivery and PFM. Specialists on DLIs from the Health, Nutrition, and Population Global Practice team will be consulted if the progress report highlights/indicates any need on specific topics.

2. In addition to the IDA credit, the World Bank-executed part of the MDTF (World Bank-executed trust fund) will be used to conduct analytical work and TAs that would contribute to meeting the PDO. This will be provided as a complementary support to the ongoing Cambodia Health Programmatic Analytical and Advisory Activities, which has as its objective to generate evidence and engage in policy dialogue with the RGC, to contribute in developing and implementing policies for improved access to health services by the poor and strengthening the RGC's capacity to move towards UHC. The World Bank-executed trust fund will finance costs associated with carrying out the analytical work, as well as World Bank operational and supervisory work including fiduciary assessments, oversight, and supervision of recipient managed activities, task-level M&E, and recipient and donor relationship management.

3. A part of training and knowledge sharing will be provided by the World Bank from its own resources, and additional resources will be sought for relevant support as and when the need arises. The team will also draw upon the expertise in-country from various DPs (bilateral, multilateral including UN agencies) as well as nongovernmental organizations and international firms operating in Cambodia.

4. The World Bank will provide formal implementation support on a semiannual basis jointly with other DPs that are contributing to the MDTF. The DPs and IDA will jointly approve the annual work plans and the agreed share of financing (disbursement percentages) for these expenditures among the IDA credit, MDTF grant, and government counterpart funds. Given the long history of donor harmonization and arrangement in Cambodia, the partners are working in a coordinated fashion, discussions are ongoing to identify additional TA needs and resources available among the DPs, to continuously explore the possibility of leveraging support from different resources and to enhance efficiency in coordination.

Implementation Support Plan

5. Table 4.1 provides a view of the anticipated needs during the implementation period. Areas are tentatively identified as specified in the following tables.

Table 4.1. Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	• Health financing • PFM in health • Health system strengthening (training) • MNCH, nutrition • FM • Procurement • Community engagement and social accountability • Environmental safeguards • Social safeguards	• Health economics • PFM • Health, nutrition and population • Training • Operations • FM • Procurement • Social sector specialist • M&E • Environment specialist • Social safeguards specialist	US$200,000	• DFAT • KfW • KOICA • USAID • GIZ • JICA • WHO • UNICEF • UNFPA
12–60 months	• Health financing • PFM in health • Health system strengthening (training) • MNCH, nutrition • FM • Procurement • Citizen engagement and social accountability • Environmental safeguards Social safeguards	• Health economics • PFM • Health, nutrition and population • Training • Operations • FM • Procurement • Social sector specialist • M&E • Environment specialist • Social safeguards specialist	US$300,000	• DFAT • Kfw • KOICA • USAID • GIZ • JICA • WHO • UNICEF • UNFPA

Table 4.2. Skills mix required (5 years)

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Task team leader	80	0	In-country
Health financing	20	10	Regional and Washington D.C
DLI/performance-based	20	10	Regional and Washington D.C
Health, nutrition, and population	24	10	Regional and Washington D.C
Operations	40	10	In-country and regional
PFM	20	10	Regional and Washington D.C
Gender/social safeguards	10	10	Regional and Washington D.C

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Environment specialist	10	10	Regional
FM	20	10	In-country and regional
Procurement	10	10	In-country and regional
Social development	8	0	In-country
Communication	5	0	In-country

Annex 5: Sector Analysis[54]

KINGDOM OF CAMBODIA

Health Equity and Quality Improvement Project (H-EQIP)

Sectoral and Institutional Context

1. Cambodia's population of approximately 14.7 million in 2013 has witnessed steady improvements in health status during the past decades. Cambodia is on track to achieve the health-related Millennium Development Goals as indicated by preliminary findings of the 2014 Cambodia Demographic and Health Surveys. The maternal mortality ratio fell from 472 per 100,000 live births in 2005 to 206 in 2010 and 170 in 2014. Under-five mortality decreased from 83 per 1,000 live births in 2005 to 54 in 2010 and 35 in 2014. The total fertility rate has also fallen from 3.4 in 2003 to 2.7 in 2014.

2. However, challenges remain and these include high neonatal mortality, high numbers of children being stunted, the double disease burden of high communicable diseases/NCDs, as well as high rates of adolescent pregnancy. There are also significant concerns around the quality of care and persisting inequalities in health outcomes by socioeconomic status and between urban and rural populations.

3. The new global Sustainable Development Goals, to which Cambodia has committed, include a focus on UHC whereby all people receive the health care they need without suffering financial hardship. This is seen as a long-term goal in the Cambodian context, though—proceeding steadily as and when fiscal space becomes available. The country's health care system is composed of OD-based [55] public health sector and a fast growing private sector. Private facilities account for an estimated 70 percent of outpatient treatment episodes of which 80 percent is provided by formally qualified providers and about 20 percent by the informal (unqualified) sector including drug vendors, traditional and religious healers, and birth attendants. The vast majority of qualified providers are public sector staff working in their free time, so-called 'dual practice'. In the public sector, each OD has a number of HCs providing primary health care services (the MPA) and a RH providing second or third line health services (the CPA). There are currently 91 ODs with 101 RHs, 1108 HCs, and 109 health posts. Each of the 25 provinces has a health department and there are eight national hospitals.

4. The quality of health care services in Cambodia is low. In addition to some remaining gaps in infrastructure, Cambodia faces a major challenge with the skills and competencies of its health workforce, and needs both pre-service and in-service training improvements and a renewed focus on competency-based training. Results from L1 and L2 assessments indicate that many health workers perform poorly on standardized tests of knowledge and lack the skills to effectively treat common and important ailments in children or mothers. Of particular concern is that the cadre of health workers providing primary health care in public HCs have limited knowledge of how to handle common diseases such as malaria, pneumonia, and diarrhea. In

[54] Sections other than on 'Quality of Care' are excerpts from *Health Systems in Transition*, Vol 5. No. 2 2015, Asia Pacific Observatory on Health Systems and Policies. The World Bank is a member of Asia Pacific Observatory.
[55] OD that typically covers about 100,000 population may include several administrative districts.

2003, a small two-member staffed QAO was established within the MOH but is under-resourced and underprepared for taking on this massive task of providing policy guidance, regulatory frameworks, accountability mechanisms, and coalition building across all levels of government, civil society, and the private sector. However, there is strong policy support for quality improvement because of the high priority given by the RGC in all recent strategy papers, including a Master Plan for Quality Improvement in Health for 2010–2015 and the draft HSP-3, to improving the quality of care. Cambodia now has considerable experience using quality measurement tools (L1 and L2 assessments) that provide both structural and process measures of quality. These monitoring mechanisms need to be better integrated into the health system and clearly aligned with routine health management and information systems.

5. In 2014, total health expenditure was approximately US$1 billion, corresponding to over 6 percent of gross domestic product and US$70 per capita and this is one of the highest in the region. Approximately 20 percent of total health expenditure is financed by the government and this is steadily increasing with the 2014 budget (US$241 million) being more than double that in 2008 (US$104 million). Around 70 percent of this budget is managed at the central level (including equipment, supplies, and drugs to be distributed to health facilities) and 30 percent at the provincial level. The DPs contribute approximately 20 percent of overall spending (that is, roughly the same amount as the RGC). The DPs provide technical and financial support to particular health institutions, health facilities and pooled funds through the HSSP2 (IDA 4470-KH and MDTF Grant TF093574).

6. OOP spending is high in Cambodia and accounts for more than 60 percent of total health expenditure, 40 percent of which goes to pharmaceuticals and 60 percent as user fees to the public and private sector. Health spending remains an important source of debt and impoverishment for the poor. Based on data from the 2013 Cambodia Socioeconomic Survey, approximately 6.3 percent of the population endured catastrophic spending and 3.1 percent had to incur debt to pay health expenditures. The impact is even greater for the elderly and disabled for whom 8.6 percent and 13.4 percent incur catastrophic spending respectively. Around 20 percent of Cambodians with NCDs such as diabetes and hypertension, incur catastrophic expenditures. Cambodia will not achieve UHC until it is able to address these high levels of OOPs.

7. The financing of the Cambodian public health system remains fragmented. RGC has introduced schemes to reduce OOP, to improve the staff terms and conditions and to improve the quality of care. First HEFs were introduced in 2000 to pay hospital user fees on behalf of the identified poor population to health providers and they also subsidize treatment-related travel and subsistence costs. Expansion into HCs began later, from 15 percent in 2009 to 100 percent at the end of mid-2015. This covers 3 million people and 100 percent of the poor identified by the government's ID Poor mechanism. While coverage has been expanded, there are design, management, and implementation bottlenecks that result in poor utilization of the scheme. Recent assessments suggest that HEFs have been most successful at the hospital level and less so at HCs. HEFs also face the following limitations: (a) unsustainable and complex implementation structure that lies outside of the government; (b) persistent low utilization of HCs; (c) insufficient reimbursement to facilities based on their actual costs; and (d)exclusion of vulnerable groups not captured by the government's ID Poor system such as the migrants, elderly, people with disabilities (PWDs), and the near poor. The World Bank recently completed collection of data

for a study on the causes of low utilization and the results are being analyzed. The MOH is reviewing the costings of different benefit packages and looking at the feasibility and sustainability of options, such as adding different vulnerable groups to the HEF or creating a social health insurance scheme for the informal sector.

8. Another important intervention was the introduction of the 'Midwifery Incentive', whereby midwives received extra payments for each delivery done in the public health facility. To increase utilization and the quality of care, SOAs were created at selected ODs and provincial RHs and these semiautonomous bodies were able to introduce performance-based financing into their own facilities. These supply-side inputs have significantly increased deliveries in public facilities, have allowed more staff to be employed and reduced stock-outs of important drugs and supplies. On top of this, the RGC/MOH continues to finance salaries, the majority of drugs and supplies, training, and supervision.

9. The development and expansion of both the HEFs and the SDGs were very strongly supported by the two World Bank and MDTF-financed Health System Strengthening Programs (HSSP and HSSP2). However, the RGC is still developing its overall policy towards health financing and on how to achieve UHC. Development of a social health insurance system is emerging as an option with the creation of a National Social Security Fund for the formally employed, and a National Social Security Fund for civil servants and government employees, but only the former has started to provide health insurance. Social health insurance system for the non-formal sector (that is, the vast majority of the population) is also being explored.

10. It is clear that much work remains to be done on the existing systems and this needs to be done while RGC is deciding the future financing/policy of the health system. In the process of preparing the HSP-3 the following main bottlenecks were identified in achieving UHC: (a) the low utilization of primary care health facilities by poor and vulnerable populations (despite HEF coverage); (b) the poor quality of services (despite SDGs), (c) weak management systems for human resources, and (d) extensive use of poorly regulated private health providers, and pharmacies and laboratories. To improve health outcomes, there is a need to improve public service delivery, and to license and regulate private providers. Strategic purchasing from the private sector may also be an option to explore, augment access, and influence the quality of services. As a result of the experience gained in the two HSSPs (HSSP and HSSP2), it has become increasingly clear that improving the quality of care and financial protection of the poor are key to improving health impacts in Cambodia. In addition, building both into the government systems are important to creating a sustainable system both in terms of institutional capacity and financially.

Quality of Care

11. **The quality of care is suboptimal.** The limited coverage of important interventions is further aggravated by the poor quality of care. Results from L1/L2 assessments indicate that many health workers perform poorly on standardized tests of knowledge and lack the skills to effectively treat common and important ailments in children or mothers. Of particular concern is that the cadre of health workers who provide primary health care in public HCs have limited knowledge of how to handle common diseases such as malaria, pneumonia, and diarrhea.

However there is now a window of opportunity for quality improvement because of the high priority given by the RGC in all recent strategy papers to improving the quality of care.

12. **Efficiency and effectiveness of health service delivery can be enhanced through a focus on the quality of care provided by health systems.** Overall, there seems to be little understanding of the cost of poor quality and safety both to the system and to patients, and thus when the HEF, SDGs, and other health-financing schemes pay for services without monitoring quality, it invariably results in the purchase of poor quality services. Suboptimal quality care is expensive—management of medical error, increased length of hospital stay, and ineffective use of medications in primary care are all examples of issues with significant resource implications. The quality of care and efficiency can be enhanced at the same time. Indeed, resources released from improved quality of care can potentially be harnessed to improve health systems in their path to UHC. A strategic approach to purchase health care services based on quality, or to encourage participating systems to engage in quality improvement activities, can improve patient outcomes and systems efficiency. Quality will be assessed and improved using a variety of methods including staff use of clinical guidelines, inventory assessment, procedure observation, review of patient files and facility data, interviews with management, providers, and patients, and exit interviews with patients.

13. **Leadership and governance is a vital aspect of health systems that pursue UHC and that place quality of care at their core.** However, the QAO of the RGC health system is led by a small two-member unit within the MOH and is clearly underprepared to take on this massive task of providing policy guidance, regulatory frameworks, accountability mechanisms, and coalition building across all levels of government, civil society, and the private sector—key to providing a collaborative stewardship on the development of health systems that provide quality care to all individuals and populations. These systems must be capable of regulating quality in a mixed health system. Further, accreditation mechanisms need to be carefully designed for local contexts with the close involvement of professional councils and associations.

14. **Measurement of quality of care presents a complex challenge to those tasked with monitoring the success of health systems.** Systematic and sustainable measurement of quality through standardized mechanisms that take into account both a results and process oriented approach is key. The government of Cambodia has now experience using quality measurement tools (L1 and L2 assessments) that provide both structural and process measures of quality. These monitoring mechanisms need to be better integrated into the health system and clearly aligned with routine health management and information systems utilizing appropriate information communication technology infrastructure.

15. **Health workers are at the core of all health systems and are considered a key determinant of effective quality service delivery as part of UHC.** Many countries face a critical shortage of appropriately trained and well-supported health workers. Attention to the retention, adequate distribution, training, motivation and performance of health workers within health systems that seek to achieve UHC can use quality of care provision as an entry point for system wide improvements. Indeed, quality improvement initiatives can be designed to cut across professional boundaries.

16. **Quality issues in primary health care and hospitals, both as a principle as well as the first level of care.** Indeed, the quality of primary health care warrants pertinent attention, given the volume of primary care provision and its impact on population health. Hospitals consume a large proportion of health spending in Cambodia and most countries. While the role of hospitals varies—given the wide spectrum of size and complexity—strong seamless coordination with primary care is vital. Improving the capacity of hospitals to focus on complex cases by integrating with primary health care can decrease delay of care and improve health service delivery. Reforms in purchasing and provision of hospital services as part of UHC can embed quality of care measurement within system design.

17. **Non-state providers such as private health workers, nongovernmental organizations and donor groups, contribute significantly to service provision in most countries and this is expanding rapidly.** These actors need to be included in efforts towards quality UHC. This can include strategic purchasing of high-quality hospital and primary care services from non-state providers. Standardizing the quality of care delivered by health workers in the private sector warrants focused attention. Clear regulatory mechanisms to ensure quality as well as functional arrangements for interactions between state and non-state providers are required for health systems to achieve UHC.

Annex 6: Economic Analysis

KINGDOM OF CAMBODIA

Health Equity and Quality Improvement Project (H-EQIP)

The Project's Expected Contribution to Development

1. **Alignment with RGC's priorities.** The dual PDO of improving quality of public health services and protecting the poor and other vulnerable groups from impoverishment due to cost of health services is well aligned with the country's priorities, as outlined in RGC's HSP-3, and with the country's broader development agenda, as defined by the National Strategic Development Plan 2014–2018 and the Rectangular Strategy 2013–2018.

2. **Alignment with World Bank priorities.** The PDO also supports the World Bank Group's Twin Goals of reducing extreme poverty and enhancing shared prosperity, as well as the World Bank's Health, Nutrition and Population Global Practice's goal of assisting clients accelerate progress toward UHC. The project will assist Cambodia's move towards UHC in several ways: increasing service utilization, especially among the poor and vulnerable; improving the quality of those services, which will benefit all service users; and increasing financial protection for the poor and vulnerable.

3. Increasing financial protection will have a direct impact on poverty, not only in the short term, but also over the longer run through the project's contribution to human capital formation.

4. **Payoffs from investing in health are considerable.**[56] Global evidence shows that making the right investments in health stimulates economic growth. The Lancet Commission on Global Health 2035 estimated that between 2000 and 2011, health improvements alone accounted for as much as 11 percent of economic growth in low- and middle-income countries. Improving access to and quality of essential health services is critical to building all citizens' capabilities and enabling them to compete for jobs and opportunities generated through inclusive and sustainable development. Countries with weak health and education conditions find it harder to achieve sustained growth. Economic evidence also suggests that a 10 percent improvement in life expectancy at birth is associated with a rise in economic growth of about 0.3–0.4 percentage points a year. Disease hinders institutional performance too. Lower life expectancy discourages adult training and damages productivity. Similarly, the emergence of deadly communicable diseases has become an obstacle for the development of sectors like the tourism industry, on which so many countries, including Cambodia, rely.

Rationale for Public Involvement

5. Without government intervention, health markets are likely to produce poor health outcomes, due to both market failures—externalities, asymmetry of information, public goods, monopolies—and equity concerns—critical services may be beyond many people's capacity to pay.

[56] Jamison, D.T., L.H. Summers, G. Alleyne, K.J. Arrow, S. Berkley, A. Binagwaho *et al*. 2013. "Global Health 2035: A World Converging within a Generation." *The Lancet* 382 (9908): 1898–1955.

6. **Cambodia already has an extensive network of government health facilities.** While addressing many of these concerns does not necessarily call for the provision of services by the government—they can to a large extent be addressed through regulation and government financing—public delivery of health services in Cambodia is already a reality. A network of public health facilities—comprising 101 RHs, 1,108 HCs, and 109 health posts —organized in 91 ODs, is established. The investments targeted at these health facilities under this project will contribute to improving the quality of care, efficiency, and equity of the services they deliver.

Investing in quality makes economic sense

7. **Poor quality of care is a double obstacle to improved health outcomes.** First, it deters utilization. This is clearly a problem in Cambodia, where a large proportion of HEF beneficiaries prefer to pay for services in the private sector rather than seeking free care from public facilities mainly because of the poor perceived quality.[57] Second, the poor quality of care reduces the effectiveness of care in achieving good health outcomes. For health care services to improve health outcomes, they have to be effective and safe as practiced. Interventions that are efficacious in clinical trials have frequently been shown to be less effective when implemented in resource-constrained health systems in low- and middle-income countries.[58,59]

8. **Cost-effectiveness and quality of care are intertwined.** Many essential health interventions are known to be highly cost-effective. These include, for example, the full immunization of children with all recommended vaccines and the provision of magnesium sulphate to women who are considered to be at risk of preterm birth. These interventions' cost-effectiveness, however, is conditional on their being delivered adequately: that is, to the right patient/client, at the right time, and in the right way. For that to be the case, many conditions need to be met. For example, the provider needs to be able to make the correct diagnosis, s/he needs to adhere to the right treatment protocol, the necessary medicines and medical supplies need to be available, and so on. Many of these conditions are directly related to the quality of care. Investing in the quality of care will not only result in better health outcomes (more averted disability adjusted life years, because of the increased success rate of interventions resulting from improved safety and effectiveness of clinical practice), but also considerable efficiency gains (by increasing service utilization and avoiding waste of scarce resources).

9. **Improving quality of care can itself be very cost-effective.** Peabody et al. (2006) estimate that quality improvements can result in as much as a 5 percent annual reduction in child mortality rates. They argue that similar results would be obtained if the effect of better quality on morbidity and disability were simulated. Considering two specific health conditions that are common among children in low-income countries, namely pneumonia and diarrhea, they estimate the cost-effectiveness of quality improvement interventions. In both cases, they find that, when the baseline quality is low and the disease prevalence is high, interventions that raise the quality of care can be extremely cost-effective. For the treatment of pneumonia in children,

[57] World Bank. *Health Equity Fund Utilization Study: Are Beneficiaries Enjoying their Benefits?* Phnom Penh: World Bank. (forthcoming).
[58] Das J, P.J. Gertler. 2007. "Variations in Practice Quality in Five Low-Income Countries: A Conceptual Overview." *Health Aff* 26 (3):w296–309.
[59] Leonard K.L., M.C. Masatu. 2007. "Variations in the Quality of Care Accessible To Rural Communities in Tanzania." *Health Aff* 26 (3):w380–392.

the cost-effectiveness ratio of quality improvement is between US$132 to US$800 per life saved; for the treatment of diarrhea, it is less than US$500 and can be as low as US$14 per life saved.[60]

10. **Investing in quality can have a lasting impact.** A recent study conducted in the Philippines[61] was able to demonstrate that the effects of quality improvement interventions could still be observed five years after the interventions were discontinued.

11. **Baseline quality is low in Cambodia.** Preliminary findings from a quality of care survey conducted by the World Bank in 2013[62], indicate that, in addition to remaining gaps in infrastructure, the country faces a major challenge with the skills and competencies of its health workforce. Quality improvement efforts can therefore make a considerable difference, which increases their cost-effectiveness.

12. **Consistent and rigorous measurement of quality of care is critical.** A thorough study of the quality of care in India,[63] which used standardized patients, found serious quality deficits in the performance of health care providers, with poor adherence to treatment protocols and prescription of unnecessary or harmful treatment being extremely widespread. The study found that structural quality measures were only weakly associated with the observed quality of care. These findings, which are not unlike those of the Cambodia Quality of Care Study, highlight an urgent need to adopt more robust quality measures that move beyond structural elements of quality, such as those incorporated into the Cambodia Level 2 quality assessment tool, the use of which will be supported by this project.[64]

13. **Widespread use of the L2 Quality Assessment tool will help identify areas where quality improvement is most urgently needed and where quality improvement efforts will have the greatest impact.** The impact of these efforts will be further enhanced by the introduction of financial incentives that explicitly link payment of providers to improved quality of care (as measured using the L2 quality assessment tool).

Improving efficiency

14. The project will help tackle inefficiencies in a number of ways:

    (a) By introducing incentives to improve quality of health services and get more value for money

[60] Peabody, J. W., M. M. Taguiwalo, D. A. Robalino, et al. 2006. "Improving the Quality of Care in Developing Countries." In *Disease Control Priorities in Developing Countries*, edited by D. T. Jamison, J. G. Breman, A. R. Measham, et al. Oxford University Press and the World Bank.

[61] Quimbo, S., N. Wagner., J. Florentino, O. Solon, and J. Peabody, 2015. "Do Health Reforms to Improve Quality Have Long-Term Effects?" Results of a Follow-Up on a Randomized Policy Experiment in the Philippines. *Health Econ*., doi: 10.1002/hec.3129.

[62] World Bank. 2013. *Cambodia's Quality of Care Study*. Washington, DC: World Bank.

[63] Das J, A. Holla, V. Das, M. Mohanan, D. Tabak, B. Chan. 2012. In urban and rural India, a standardized patient study showed low levels of provider training and huge quality gaps. *Health Aff* (Millwood); 31(12): 2774-84.

[64] Preliminary data following the adoption of the L2 QA tool in nine provinces show that, in general, health facilities score about 50 percent points lower on the L2 assessment than they do on the L1, which focused on structural quality.

(b) By introducing incentives to increase utilization of essential interventions such as immunization, family planning and nutrition education, that have high benefit-costs ratios[65] and have large positive externalities resulting in larger benefits to society than to just the individual

(c) By simplifying implantation arrangement of HEFs and SDG and reducing their administrative costs

(d) By strengthening PFM to better track flows and reduce wastage

15. **A large share of the funding under the project will be tied to results (either through results-based financing arrangements or through the use of DLIs).** Both SDGs and HEFs will have a greater results focus. This focus on results, accompanied by increased autonomy granted to health providers, will help strengthen the overall health system and generate better value for money:

(a) The different actors in the health system will have greater clarity as to what is expected of them.

(b) They will be held accountability for their performance.

(c) They will be more motivated to analyze and act upon data, which, because of the external verification, will itself be of better quality.

(d) Their increased autonomy in the use of the additional funding will allow them to experiment with innovative ways to achieve expected results.

Investing in equity

16. **More effective HEFs will improve equity and financial protection.** In principle the HEFs, which were introduced in 2000 and which, since 2014, cover all hospitals and HCs of the country, could to a large extent protect the poor seeking care at public health facilities from catastrophic spending on health and reduce socioeconomic inequalities in health. Yet, design, management, and implementation bottlenecks result in a number of issues:

(a) Targeting can still be improved. The ID Poor system suffers from both inclusion and exclusion errors.[66] As a result, not all the poor are currently covered by a HEF: the 2014 Cambodia Demographic and Health Survey, for example, revealed that only 24 percent of women of reproductive age in the lowest wealth quintile are covered through a HEF. A recent HEF utilization survey conducted by the World Bank[67] found that, among a random sample of current HEF cardholders, around a quarter

[65] For stunting, for example, this ratio is estimated at between 3.6 to 48, for rural sanitation the ratio is between 4 and 8.2.
[66] World Bank. 2013. "Where Have all the Poor Gone? Cambodia Poverty Assessment 2013." Washington, DC: World Bank.
[67] World Bank Health Equity Fund Utilization Study: Are Beneficiaries Enjoying their Benefits? Phnom Penh: World Bank. (forthcoming).

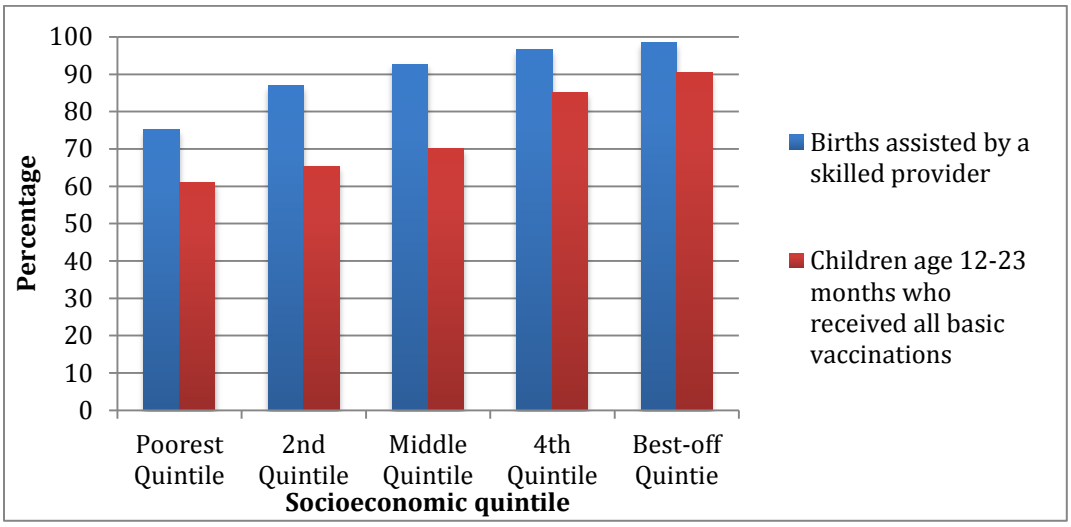
(25.5 percent) were near poor, while a further quarter (23.9 percent) could be categorized as better-off.

(b) The utilization of HEFs remains relatively low. Based on the same HEF utilization survey, only one-third of the beneficiaries have ever used their HEF card for outpatient care, and only half of them have ever used it for inpatient care.

(c) HEFs presently only target the poor, even though the near poor, who still represent a large share of the population, remain vulnerable to small economic shocks.

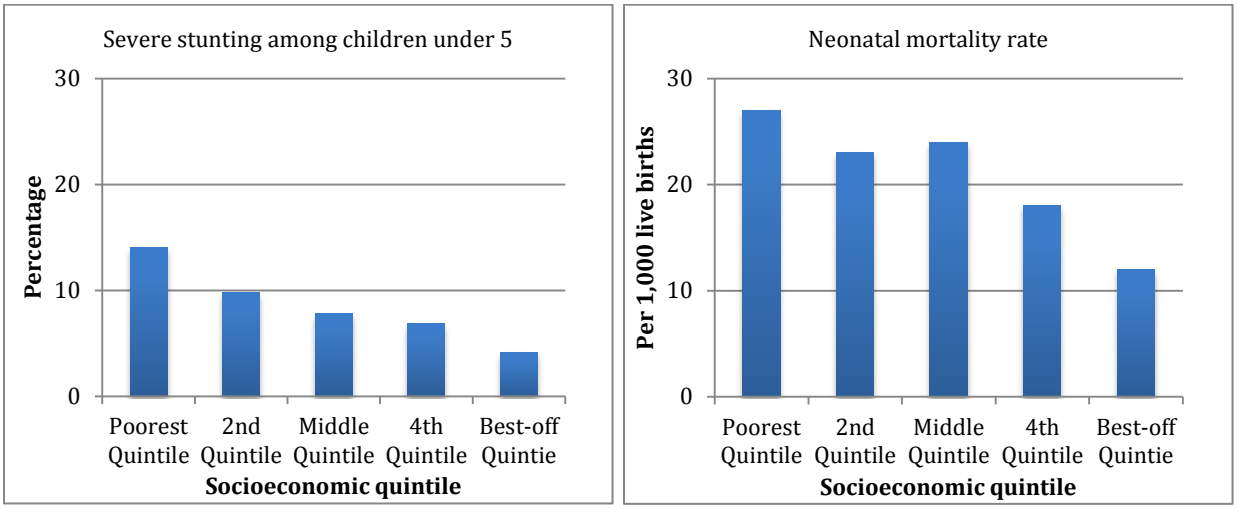
17. As a result, considerable socioeconomic inequalities in both health service utilization and health outcomes can still be observed, as illustrated in Figure 6.1 and Figure 6.2, respectively.

Figure 6.1. Socioeconomic Inequalities in Health Service Utilization



Source: DHS 2014.

Figure 6.2. Socioeconomic Inequalities in Health Outcomes



Source: Demographic Health Survey 2014.

18. The project aims to help address some of these issues, thereby improving both equity in health and financial protection, in the following two ways:

(a) By improving and further promoting HEFs, and by expanding eligibility to other vulnerable population groups, the project will encourage more poor and vulnerable to use services provided by government health facilities while at the same time increasing these users' financial protection by reducing OOP spending and therefore the risk of impoverishment due to spending on health care.

(b) By improving the quality of care—both technical and perceived—and increasing staff motivation, the project will remove some of the non-financial barriers that the poor currently face to access health services in public facilities, while also increasing the likelihood that the services they receive in those facilities meet their needs.

19. **Adopting a pro-poor pathway to UHC is an efficient way to achieving health and financial protection.**[68] The project is designed to be strongly pro-poor:

(a) It focuses interventions and financing on the lowest levels of service delivery (that is, facilities within the OD), which tend to be disproportionately used by the poor.

(b) It increases the share of government funding going to primary health care, making overall government spending on health more pro-poor.

(c) It focuses on health services (and health outcomes) that are most inequitably distributed (such as reproductive health).

(d) It aims to address existing inequities in the financing of public sector health providers.

[68] Jamison D.T., L.H. Summers, G. Alleyne, K.J. Arrow, S. Berkley, A. Binagwaho *et al.* 2013. "Global Health 2035: A World Converging within a Generation." *The Lancet* **382**(9908): 1898–1955.

(e) It aims to strengthen HEFs, which by definition are expected to increase financial protection for the poor (and soon also other vulnerable groups).[69]

(f) It will continuously monitor its effects on the poor and vulnerable (for example, by tracking OOP payments and, more importantly, impoverishing spending) and act upon the findings as and when necessary.

Estimating the project's value for money and establishing its economic justification

20. The project will primarily benefit the poor and other vulnerable populations in at least two ways: by increasing financial protection and by improving health outcomes.

21. The three first components of the project will contribute to this in a synergetic manner. To estimate the magnitude of these benefits, it is necessary to consider the main pathways:

(a) Increased financial protection, which implies a reduction in OOP payments and in the number of households facing impoverishing spending on health care, will be achieved through:

- Promotion of HEFs (and the entitlements they offer) among HEF beneficiaries—this will increase their usage of free health services provided by public facilities;
- Improved quality of care (both technical and perceived) in public facilities—this will further increase service utilization by HEF beneficiaries in those facilities;
- Extended coverage of HEFs to other vulnerable groups, PWDs, and older people;
- Increased utilization of public facility services by poor and near poor who are not covered by a HEF, thanks to improved technical and perceived quality of care provided by those facilities—the increased likelihood of being correctly diagnosed and treated will reduce the average cost per episode of illness.

(b) Improved health outcomes will be achieved through:

- Improved quality of care in public facilities, leading to an increased likelihood of being correctly diagnosed and treated and to reduced health care-associated infections;
- Increased coverage of effectively delivered essential health interventions thanks to (i) the incentives that performance based financing introduces, (ii) enhanced service readiness and (iii) the increased use of public services by HEF beneficiaries.

[69] The per capita OOP spending on health of PWDs and people older than 60 in Cambodia was shown to be dramatically higher than that of the general population (US$472 and US$ 323.9 per annum, respectively, as compared to US$231.3 per annum for the general population) [GIZ. 2015. *Access to Health Care and Associated Out-of-pocket Expenditure for People with Disabilities, People with Chronic Diseases and Old People in Cambodia: Analysis of Cambodian Socioeconomic Survey data 2004, 2007, 2009, 2010, 2011, 2012, and 2013.* Phnom Penh; GIZ.]

22. Data sources used to inform estimates of the project's main benefits:

(a) Estimates of the size of the three groups of targeted HEF beneficiaries—the poor, PWDs, and older people (>60)—were taken from Axelson, Hennicot, and Jacobs (2015). These already account for overlaps between the groups

(b) Utilization data for the poor and for older people was extracted from several sources: the HEF utilization survey conducted by the World Bank and referred to earlier, the MOH Annual Health Financing Report 2015, and the MOH's HMIS database, which includes data on number of cases per year disaggregated by inpatient and outpatient care and by age.[70]

(c) Data on costs of reimbursing both direct and indirect benefits of HEFs were obtained from the MOH Annual Health Financing Report 2015, while estimates of OOP payments were taken from the HEF utilization survey referred to earlier

23. **Estimates of the project's main benefits are based on a set of relatively conservative assumptions.** To the extent possible, these assumptions are in line with those made by Axelson, Hennicot, and Jacobs (2015)[71] for their own estimations of the cost of alternative policy options for covering the poor and vulnerable in Cambodia[72]

(a) Only one-third of current HEF beneficiaries (that is, the poor) use their card for outpatient care. On average, those who use their card for outpatient care do so for only around 40 percent of their OPD visits, which already account for 1.65 visits at public facilities per card user per year.[73]

(b) Current HEF beneficiaries who use their card for inpatient care do so for most of their hospitalizations and the average number of hospitalizations per beneficiary per year is slightly higher among those who use their card than among those who do not.

(c) The rates of utilization, by current HEF beneficiaries, of outpatient and inpatient services in public health facilities will grow, at a gradually increasing pace, from their current levels (that is, 0.54 visits per beneficiary per year and 0.06 hospitalizations per beneficiary per year, respectively), which are relatively low by international

[70] http://hismohcambodia.org/public/homepage_en.php
[71] Axelson H, J.C. Hennicot, B. Jacobs. 2015. "Costing of Policy Options for Covering the Poor and Vulnerable for Implementing the Cambodian Health Financing Policy 2015–2020." Phnom Penh: GIZ and ILO.
[72] The second scenario they consider assumes that HEFs will also cover PWDs and older people (that is, older than 60), in addition to the poor.
[73] This assumption and the next one are based on a combination of different pieces of information extracted from mainly two sources: the HEF utilization survey conducted by the Bank and the MOH Annual Health Financing Report 2015.

standards,[74] to levels that are already closer to those standards (1 visit per beneficiary per year and 0.08 hospitalizations per beneficiary per year, respectively).[75]

(d) The HEF utilization survey conducted by the World Bank indicates that current HEF beneficiaries who use their card still pay, on average, US$4 per outpatient visit and US$40 per hospitalization. A large share of these payments is likely the result of poor quality of care in public facilities (for example, the need to purchase medicines and supplies outside the facility because of stock-outs at the facility). These amounts are assumed to gradually go down as the quality of care in public facilities improves.

(e) Legal coverage for the two additional groups (PWDs and older people) will start at 100 percent from project year 1.[76]

(f) In the absence of data on service utilization by PWDs in the HMIS, PWD utilization rates are assumed to be the same as those for older people.

(g) Utilization of health services provided by public facilities will grow at a gradually increasing pace among new HEF beneficiaries (it will take time to inform them about their new entitlements and for them to become aware of the improved quality of care in public facilities and to adjust their health seeking behavior). By the end of the project, the utilization rates will reach 1.3 outpatient visits and 0.1 hospitalizations per beneficiary per year, that is, a bit higher than for the poor.

(h) Both current and new HEF beneficiaries will continue to use services from private providers, for which they will pay out of their pocket. The amount they pay OOP, however, will decrease gradually, in accordance with their increased use of services at public facilities and improvements in the quality of those services.

(i) PWDs and older people will be entitled to the same package of benefits as the poor.

(j) Unit costs for services provided by public facilities to the poor, PWDs and older people are assumed to be the same. These are assumed to increase annually due to inflation (3 percent) and other factors such as advances in medical technology (an additional 2 percent).

(k) A discounting factor of 3 percent (that is, equal to the assumed annual inflation) is used in the calculation of present values.

[74] It is important to note, however, that, when combining both public and private providers, utilization rates for outpatient care tend to be high among both the poor and the near poor, at 4.5 visits per person per year.

[75] The assumed annual increases are larger than those assumed by Axelson, Hennicot, and Jacobs 2015—which were 5percent per year for outpatient care and 2 percent per year for inpatient care—, because of the expected beneficial impact of improved perceived quality of care in public facilities, enhanced efforts to sensitize the poor about their entitlements and the move towards performance based financing. For both outpatient and inpatient care, the rate of utilization of public services by beneficiaries who use the card is assumed to remain constant at 1.65 visits per year and 0.12 hospitalizations per year, respectively.

[76] This assumption is reasonable because both groups are easily identified: PWD already have a card issued by the Ministry of Social Affairs, Veterans, and Youth Rehabilitation; older people have identification cards/family books that specify their age.

24. **Increased use of card by poor HEF beneficiaries.** Based on the assumptions laid out above, an increasing share of poor who are HEF beneficiaries will opt to use their card and obtain free services at public facilities. For both outpatient and inpatient care, the proportion will rise to 61 percent for outpatient care and to 69 percent for inpatient care by the end of the project (see Table 6.1).

25. **Reduced OOP spending on health care by poor HEF beneficiaries.** As a result of the increased number of poor HEF beneficiaries using their card and the improved quality of care in public facilities, annual per capita OOP spending on health care for this population group will see a 27 percent decrease over the course of the project, from around US$71 in 2016 to around US$52 per beneficiary per year by the end of the project (see Table 6.1).[77] Without the project, they would spend almost double that amount. Given that the poor are per definition already below the poverty line, the expected reduction in OOP spending also represents a reduction in impoverishing spending.[78]

Table 6.1. Use of HEF Card and Average OOP Spending On Health Care By The Poor

	2016	2017	2018	2019	2020
OPD					
Expected number of beneficiaries using their card for OPD	940,062	986,164	1,059,509	1,187,802	1,454,283
Proportion of HEF beneficiaries using their card for OPD (%)	36	39	43	49	61
Expected OOP spending for OPD per beneficiary per year (US$)					
Card users	17.9	15.3	11.6	7.8	4.6
Non-card users	84.5	88.7	93.3	98.0	103.0
Card users and non-card users combined	60.2	60.2	58.5	54.1	43.2
IPD					
Expected number of beneficiaries using their card for IPD	1,331,735	1,353,388	1,393,739	1,472,358	1,648,163
Proportion of HEF beneficiaries using their card for IPD (%)	52	53	56	60	69
Expected OOP spending for IPD per beneficiary per year (US$)					
Card users	4.9	4.6	4.1	3.5	2.7
Non-card users	17.6	18.5	19.4	20.4	21.4
Card-users and non-card users combined	11.0	11.1	10.9	10.2	8.6
Expected OOP spending (OPD+IPD) per beneficiary per year (US$)					
With the project	71.2	71.2	69.4	64.3	51.7
Without the project	74.5	78.3	82.3	86.4	90.8

[77] The main reason why per capita OOP spending is still relatively high at the end of the project is that a considerable proportion of beneficiaries is still not making use of public services.
[78] Not accounting for errors of inclusion due to imperfections in the targeting mechanism.

26. **Increased share of the total population covered by HEFs.** Expanding HEFs to also cover PWDs and older people (>60) will, in 2016, translate in an increase in HEF coverage from around 17 percent to around 24 percent of the total population of the country. With the addition of these two groups, HEFs will count approximately 1.2 million new beneficiaries (see Table 6.2). The present value (2015) of the additional cost to HEFs, over the five-year period of the project, will be approximately US$32 million, or almost 50 percent more than if eligibility remained limited to the poor. This additional cost is equivalent to around US$4.5 per new beneficiary per year.

Table 6.2. HEF Beneficiaries and Card Users by Category

	2016	2017	2018	2019	2020
Poor	2,578,363	2,535,759	2,490,838	2,443,391	2,393,248
PWD (non-poor)	665,452	678,950	692,533	706,140	719,707
Older people (60+) (non-poor and non PWD)	523,359	557,568	596,409	640,387	689,095
TOTAL	**3,767,175**	**3,772,277**	**3,779,780**	**3,789,918**	**3,802,050**

27. The expansion of HEFs and their more consistent use by beneficiaries will bring about a reduction in the total OOP spending by poor and other vulnerable groups of around US$739 million (in present value 2015), spread over the duration of the project (see Table 6.3). In other words, this amount represents the project's impact on total OOP spending by these population groups. It is the difference between (a) the amount people in the three groups will have paid under a status quo scenario (whereby the poor are covered by HEFs but make only limited use of public facility services and whereby the other two groups are not covered at all by HEFs), and (b) the amount people in the three groups will likely still spend OOP under the project, despite increased coverage of HEFs, improved quality of services in public facilities, and higher rates of utilization of public facility services by HEF beneficiaries. Even without the expansion of HEFs to PWDs and older people, the project will still reduce total OOP spending by the poor by US$183 million.

Table 6.3. Reduction in Total OOP Spending by Poor and Other Vulnerable Groups

	2016	2017	2018	2019	2020
Poor	8,453,752	17,851,775	32,104,106	54,004,884	93,526,664
Present value (2015): **US$183,073,903**					
PWD (non-poor)	37,127,083	43,987,437	54,266,620	71,123,891	103,909,756
Older people (60+) (non-poor and non PWD)	36,691,189	44,043,492	54,571,659	70,699,891	99,490,073
Present value (2015): **US$555,711,336**					
TOTAL	**82,272,025**	**105,882,705**	**140,942,385**	**195,828,667**	**296,926,492**
Present value (2015): **US$738,785,239**					

28. While the analysis focuses on the main expected benefits, it is important to recognize that the project will positively impact the health system in other ways as well. These other benefits, however, are harder to quantify. For example, better the quality of care in public facilities will not only benefit the poor and vulnerable; it will benefit all users, both in terms of improved health outcomes and reduced OOP spending. Improved financial protection also has several economic spin-offs, as it frees up resources at the household level that may be used now for highly productive investments in nutrition and education, or channelize household savings for

greater investments and economic development in the country. Improved quality of care will also reduce wastage and improve the overall efficiency of the system, and so will many of the health system strengthening activities carried out as part of Component 3. The use of performance-based financing for the first two components will contribute to strengthening the health system by (a) better aligning the financial incentives provided to health workers and managers with the objectives of the health system; (b) increasing accountability for results; and (c) improving the quality and use of data. Improved targeting of the poor will reduce errors of inclusion and exclusion, thereby increasing financial protection for those who need it most.

Financing and sustainability

29. **While the investments under this project are relatively small, they can make a big difference.** The annual RGC budget for health was around US$250 million in 2014. This represents a substantial increase over time and the RGC has clearly committed to further increase spending on health over the next three years. The remarkable economic growth and macroeconomic stability that the country has been experiencing for over a decade will certainly facilitate this increase in spending. Of this US$250 million, approximately US$15 million a year is RGC's contributions to HEFs and SDGs under the HSSP2. The project will increase annual health expenditures by approximately US$18 million per year, around 7 percent of the budget. Direct payments for health services—HEFs and SDGs—will amount to just under US$1 per person per year. While this is a small and sustainable increase, given the rate of economic growth (greater than 7 percent per year in recent years) and RGC's commitment to increasing the health budget (already at about 20 times the project's annual investments), it represents a substantial increase in funding at the facility level, which can make a real difference.

The World Bank's value added

30. The World Bank's value added goes beyond the project's direct contribution to Cambodia's economic development, already highlighted above; it adds value in the following ways.

(a) By strengthening underlying government systems, such as PFM, information systems and procurement, the project will enhance the efficiency of the use of existing health resources; it will also encourage other DPs to increase their reliance on government systems.

(b) The project will pave the way for more comprehensive health financing reforms, which the World Bank is well positioned to support because of the breadth and depth of its technical and analytical expertise and its global knowledge.

(c) The Bank can leverage expertise from across the World Bank Group to support the project in areas such as social protection, labor practices, or good governance.

31. **Proposed investments are not duplicative.** It is important to emphasize that activities under the project are not currently being undertaken or planned by other DPs.

Annex 7: Mapping of Health Partners Investments in the Project Component Areas

KINGDOM OF CAMBODIA

Health Equity and Quality Improvement Project (H-EQIP)

Partner	Project/Program	Project Duration	Project Amount	Description
Component 1: Strengthening Health Service Delivery				
DFAT	Partnering to Save Lives	08/2013–07/2016	AUD 14 million	- Objective: To save the lives of women and neonates in Cambodia through improved coverage, quality, and utilization of reproductive, maternal, and neonatal health services. - Partners: CARE Australia, Marie Stopes Australia, Save the Children Australia
GIZ	Mother and Child Health Improvement Program	2011–2016	€3.64 million	- Objective: Improve maternal and child health in Cambodia by reducing maternal and child mortality - Program finances: Procurement of medical equipment, rehabilitation of health facilities to provide basic emergency obstetric care, awareness raising, and behavioral change - Focus on improving neonatal care and access of women with disabilities to reproductive and child health services.
JICA	Improving Continuum of Care With Focus on Intrapartum and Neonatal Care in Cambodia	2016–2020		- Objective: Strengthen the continuum of care, with a focus on intra-partum and neonatal care in target provinces.
KOICA	Integrated Maternal, Newborn, and Child Health Program	01/2011–12/2016	US$3.43 million	- Objective: Ensure that more women and children, in particular those hardest to reach, access quality maternal, newborn, and child health services. - Program finances: Capacity-building of health care managers and clinical staff through technical advice and training; on-the-job support through coaching and supervision; procurement of health supplies; minor refurbishment of facilities; referral systems; mass media communication promoting behavior, and social change.
	Cambodia Eye Health Improvement Program	2014–2016	US$207,143	- Objective: To reduce the blind rate among the population - Program finances: Civil works, equipment - Implemented by Heart to Heart Foundation
	Clean Water, Sanitation, and Mobile Clinic	2015–2017	US$136,411	- Objective: To increase accessibility for clean water and sanitation and strengthen the health of Cambodian people by preventing

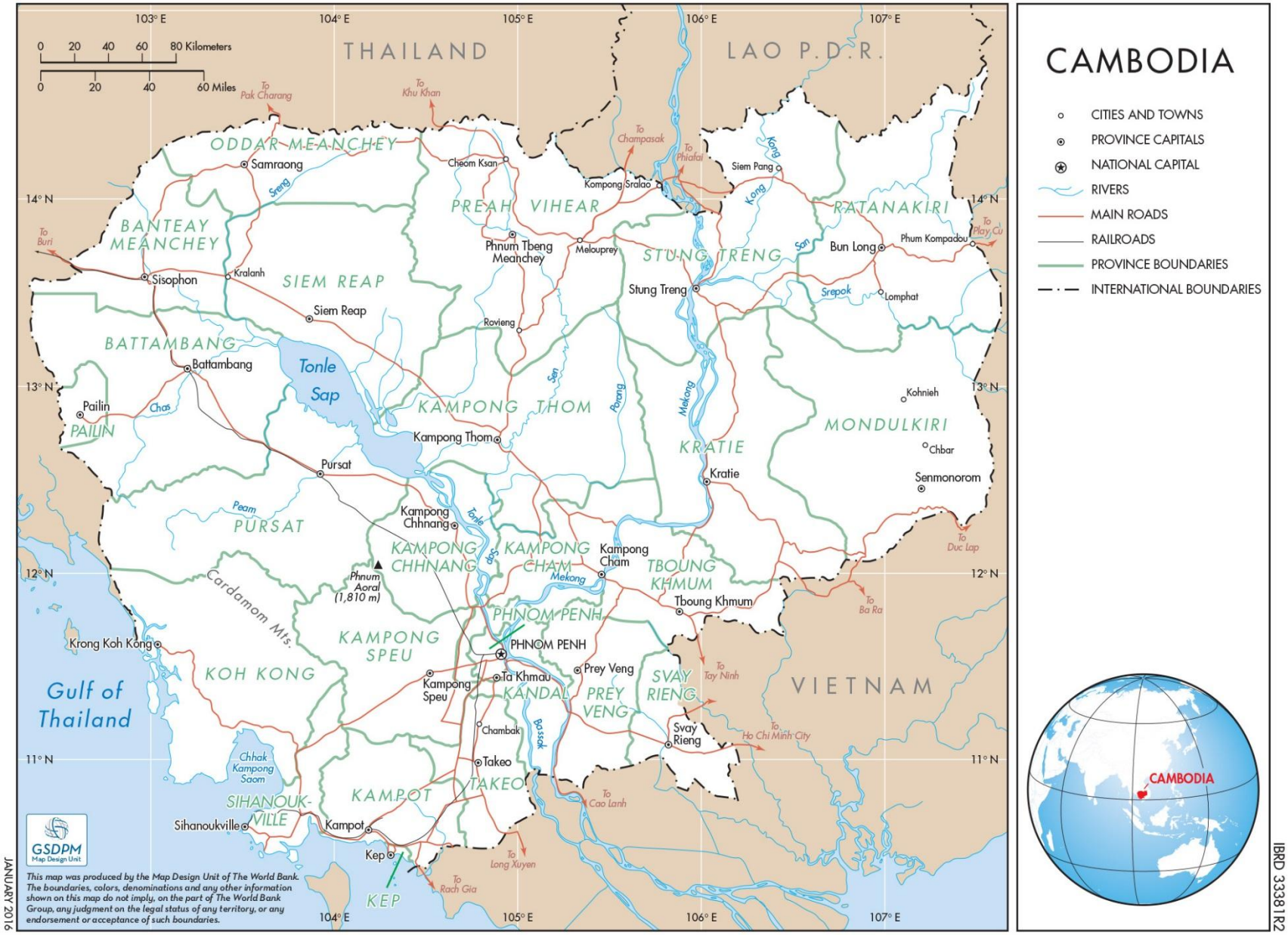
	Project			the spread of malaria, AIDs, and waterborne disease - Program finances: Equipment, training - Implemented by Global Care
	Educational and Research Competency Enhancement of Nursing Facilities in Cambodia	2016–2016	US$291, 262	- Objective: To reduce infant mortality rate, health promotion of women, and production of female professionals. - Program finances: Equipment, training - Implemented by Ewha Women University
UNFPA	Improving Quality of Sexual and Reproductive Health and Rights Services and Information	2016–2018	US$8.3 million	- Objective: To increase the availability and use of integrated sexual and reproductive health services that are gender-responsive and meet human rights standards for quality of care and equity in access, - Focus on family planning, maternal health, and HIV - Program finances: Policy, strategy, guidelines, protocol, and manual development at national level; knowledge management at national and subnational levels; capacity development at national and subnational levels.
UNICEF	Integrated early childhood survival, care, and development	2016–2018	US$25, 300	- Objective: To ensure that children under five years of age and pregnant women have improved and more equitable use of early childhood survival, care, and development interventions, and practices. - Support capacity-building of government ministries, officials, and service providers to plan, budget, and deliver IECD services - TA to the MOH for HIV testing and care for mothers and children, maternal neonatal tetanus elimination, integrated antenatal and postpartum care, community care for mothers and newborns, integrated management of child illnesses - Technical support for development of costed plans, M&E Framework for universal access to WASH - Support implementation of National Strategy for Food Security and Nutrition (2014–2018) , civil registration system, including birth registration, and facility-based registration and monitoring - Strengthen integration of PMTCT into maternal and child health system
USAID	Quality Health Services	01/2014–01/2019	US$16.49 million	- Improve quality of basic newborn care through assisting the MOH to roll out the newborn care protocol. - Improve detection, referral, and management of neonatal complications - Improve timeliness and quality of care provided to women with obstetric

				complications at RH - Improve family planning, with emphasis on long-acting and permanent methods - Improve counseling, screening, and referral of malnourished and severely malnourished children and related diseases such as tuberculosis.
	HIV Flagship	11/2012–11/2017	US$30 million	- Develop technical innovations to enhance impacts and reduce costs of targeted HIV prevention for most at-risk populations - Improve quality and integration of HIV and treatment services - Increase use of strategic information including surveillance, monitoring, evaluation, and data utilization - Promote local technical leadership and capacity building to strengthen the quality and impact of prevention, care, and treatment services
	NOURISH Project	06/2014–06/2019	US$16.25 million	- Increases essential nutrition by households, use of improved sanitation facilities, hygiene behaviors - Increases parent/ caregiver-level practices that support positive child development - Increases the capacity of private and public sector partners to promote healthy behaviors
Component 2: Improving Financial Protection and Equity				
GIZ	SHP Program (SHP III Technical Cooperation)	9/2015–12/2016	€8 million	- Objective: Ensure that poor and vulnerable groups have more equitable access to health services of appropriate quality - Program finances: International and long-term advisers at national and provincial level; capacity development in partner organizations; equipment, civil works, and training
JICA	Social Protection System in Cambodia	TBD	TBD	- Objective: Improve SHP system in Cambodia - Program finances: Study on current status, issues, and needs of SHP system in Cambodia; study tours to Japan and Thailand for senior representatives of various ministries; consultative workshop to identify areas for assistance and formulation of the project.

KfW	Vouchers for Reproductive Health Services and Health Services to Vulnerable Groups	2009–2017	€16. 8 million	- Objective: Ensure that poor women, disabled persons, and elderly are able to access quality health services - Implemented in six provinces (Kampong Thom, Kampong Speu, Kampot, Kep, Prey Veng, and Svay Rieng) - Program finances: Treatment costs for selected services, social support (transportation and food), trainings, equipment, investments for improved accessibility of HFs
USAID	SHP Project	12/2013–12/2018	US$13.69 million	- Strengthen the Cambodian government's capacity to administer SHP systems and ensure the quality and efficiency of the HEF operation and expansion - Strengthen community oversight/ civil society governance oh SHP system - Improves financial access to priority health services for the poor and most at-risk populations - Leverages quality improvements of services through health financing schemes
Component 3: Ensuring Sustainable and Responsive Health Systems				
DFAT	Identification of Poor Households (ID Poor) Program	05/2012–02/2016	AUD 6 million	Objective: To support the Ministry of Planning to develop standardized procedures for identifying poor households to be entitled to subsidized health and social services - Focus on expansion of rural ID Poor program to cover 100% of rural communes, develop urban ID Poor tools and procedures, new tools and procedures for implementing in eight provincial towns - Partners: GIZ and Ministry of Planning
	TA for Human Resource for Health	04/2008–12/2016	US$1.33 million	- Objective: Provide TA on human resource development for health in Cambodia - Partners: WHO Cambodia
JICA	Expansion of National Maternal and Child HC	03/ 2014–02/ 2017	JPY 1.19 million	- Objective: Improve the quality of maternal and child health care services in Cambodia - Program finances: Construction of a new training center and renovation of existing facilities
	Improvement of Svay Rieng RH	03/ 2015–12/2020	JPY 1.10 million	- Objective: Improve quality of health services in Svay Rieng Province, especially for poorest segment of population - Project finances: Upgrading of Svay Rieng RH facility and equipment

KOICA	Improving the function of the Cambodia-Korea Friendship Building at National Pediatric Hospital	2013–2016	US$2.33 million	- Objective: To improve the capacity of medical service at NPA and strengthen the public sector - Project finances: Civil works, equipment, and training
USAID	Empowering Communities for Health	10/2014–09/2019	US$15 million	- Develop the technical capacity of the existing cadre of community-based volunteers - Support Commune Councils and HC Management Committees to strengthen their governance, budgeting, planning, and oversight systems - Develop stronger referral systems for communities to local government health facilities to generate demand for health services and improve community health outcomes
	Applying Science to Strengthen and Improve Systems (ASSIST)	01/2012–01/2018	US$0.5 million	- Provide technical support to MOH in improving its stewardship role - Strengthen the role and capacities of Professional Councils in establishing licensing and registration criteria and continuing education requirements
WHO	SHP	2016–2017		- Provide support the development and implementation of the HSP-3 2016-2020 as well as implementation of UHC Roadmap aligned with HSP-3 milestones - Support implementation of National Health Financing Policy towards UHC - Support production and institutionalization of National Health Plans, such as National Health Accounts and Health Financing report - Assist costing of health services in relation to Financial Protection expansion and support policy implementation based on study - Support implementation of GAVI HSS for immunization
	Improving Quality of Health Services	2016–2017		- Facilitate development of Health Workforce Development Plan (2016–2020) - Capacity development for use of HRH information for policy and program planning - Technical support to introduce regulatory mechanisms and processes for the introduction of accreditation of training institutions in health - Strengthen capacity of Health Professional Councils to introduce registration and licensing system for health practitioners - Technical support to strengthen the regulation and monitoring of private sector - Technical support for implementation of

				MOH's CPA and MPA guidelines - Facilitate revision and implementation of national clinical practice guidelines - Technical support for implementation of activities on health systems strengthening with support for Global HSS grant


CAMBODIA
CITIES AND TOWNS
PROVINCE CAPITALS
NATIONAL CAPITAL
RIVERS
MAIN ROADS
RAILROADS
PROVINCE BOUNDARIES
INTERNATIONAL BOUNDARIES
THAILAND
LAO P.D.R.
VIETNAM
Gulf of Thailand
ODDAR MEANCHEY
BANTEAY MEANCHEY
BATTAMBANG
PAILIN
SIEM REAP
PREAH VIHEAR
STUNG TRENG
RATANAKIRI
KAMPONG THOM
KRATIE
MONDULKIRI
PURSAT
KAMPONG CHHNANG
KAMPONG SPEU
KAMPONG CHAM
TBOUNG KHMUM
KANDAL
PREY VENG
SVAY RIENG
TAKEO
KAMPOT
KOH KONG
SIHANOUK-VILLE
PHNOM PENH
Tonle Sap
Cardamom Mts.
Samraong
Sisophon
Kralanh
Siem Reap
Battambang
Pailin
Pursat
Kampong Thom
Kampong Chhnang
Kampong Cham
Kratie
Stung Treng
Bun Long
Phum Kompadou
Lomphat
Kohnieh
Chbar
Senmonorom
Tboung Khmum
Prey Veng
Ta Khmau
Kampong Speu
Svay Rieng
Chambak
Takeo
Kampot
Kep
Sihanoukville
Krong Koh Kong
Phnum Aoral (1,810 m)
Cheom Ksan
Kompong Sralao
Siem Pang
Phnum Tbeng Meanchey
Melouprey
Rovieng
0 20 40 60 80 Kilometers
0 20 40 60 Miles
103° E
104° E
105° E
106° E
107° E
14° N
13° N
12° N
11° N
To Pak Charang
To Khu Khan
To Champasak
To Phiafai
To Buri
To Play Cu
To Duc Lap
To Ba Ra
To Tay Ninh
To Ho Chi Minh City
To Cao Lanh
To Long Xuyen
To Rach Gia
GSDPM
Map Design Unit
JANUARY 2016
This map was produced by the Map Design Unit of The World Bank. The boundaries, colors, denominations and any other information shown on this map do not imply, on the part of The World Bank Group, any judgment on the legal status of any territory, or any endorsement or acceptance of such boundaries.
IBRD 33381R2