Completion Report

Project Number: 32430
Loan Number: 1940-CAM (SF)
Grant Number: 3994-CAM
December 2010

Cambodia: Health Sector Support Project

Asian Development Bank

CURRENCY EQUIVALENTS

Currency Unit – riel (KR)

		At Appraisal	At Project Completion
		31 October 2002	10 July 2010
KR1.00	=	$0.00026	$0.00024
$1.00	=	KR3,835	KHR4,231

ABBREVIATIONS

ADB	–	Asian Development Bank
AOP	–	annual operational plans
CPA	–	complementary package of activities
DFID	–	Department for International Development of the United Kingdom
DPHI	–	Department of Planning and Health Information
HEF	–	health equity fund
HIS	–	health information system
HSSP	–	Health Sector Support Project
HSSP2	–	Second Health Sector Support Program
JAPR	–	joint annual performance review
JFPR	–	Japan Fund for Poverty Reduction
M&E	–	monitoring and evaluation
MOH	–	Ministry of Health
MOU	–	Memorandum of understanding
MPA	–	minimum package of activities
NGO	–	nongovernment organization
NSDP	–	National Strategic Development Plan
PHD	–	provincial health department
RTC	–	regional training center
SDR	–	special drawing right
TA	–	technical assistance

NOTES

(i) The fiscal year of the Government of Cambodia ends on 31 December.
(ii) In this report, "$" refers to US dollars.

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CONTENTS

BASIC DATA

A. Loan and Grant Identification

1.	Country	Kingdom of Cambodia
2.	Loan Number	1940-CAM (SF)
3.	Project Title	Health Sector Support Project
4.	Borrower	Kingdom of Cambodia
5.	Executing Agency	Ministry of Health
6.	Original Loan Amount (Asian Development Bank)	SDR15,154,000 ($20.00 million equivalent)
	Net Loan Amount	SDR14,144,612 ($21.48 million equivalent)
7.	Approved Grant Amount (Department for International Development)	$12,163,000.00
	Disbursed Grant Amount	$11,768,867.84
8.	Project Completion Report Number	CAM: 1233

B. Grant Data

1. Cofinancing Agreement Signing $ 10, 363,000 (Original)	18 March 2003
2. Approval and Amendment to MOU $ 1,800,000 (increase in grant)	18 February 2008
3. Closing Date	
- Original	31 January 2008
- Actual	14 June 2010
- Number of Extensions	1

C. Loan Data

1.	Appraisal	
	– Date Started	19 August 2002
	– Date Completed	02 September 2002
2.	Loan Negotiations	
	– Date Started	21 October 2002
	– Date Completed	23 October 2002
3.	Date of Board Approval	21 November 2002
4.	Date of Loan Agreement	07 February 2003
5.	Date of Loan Effectiveness	
	– In Loan Agreement	8 May 2003
	– Actual	28 February 2003
	– Number of Extensions	0
6.	Closing Date	
	– In Loan Agreement	30 June 2008
	– Actual	22 October 2009
	– Number of Extensions	1
7.	Terms of Loan	
	– Interest Rate	1% per annum during the grace period and 1.5% per annum thereafter
	– Maturity (number of years)	32
	– Grace Period (number of years)	8

8. Terms of Relending (if any)
   – Interest Rate
   – Maturity (number of years)
   – Grace Period (number of years)
   – Second-Step Borrower

9. Loan Disbursements

a. Dates

Initial Disbursement	Final Disbursement	Time Interval
10 June 2003	22 October 2009	76 months
Effective Date	**Original Closing Date**	**Time Interval**
28 February 2003	30 June 2008	64 months

b. Amount 15,154,000 (SDR) 20,000,000 (US$ equivalent)

Category	Original Allocation	Partial Cancellations	Last Revised Allocation	Amount Disbursed	Undisbursed Balance
Civil Works	3,951,000	(559,505)	4,510,505	4,586,869	(76,364)
Equipment and Vehicles	722,000	(994,096)	1,716,096	1,733,055	(16,959)
Drug Supply	68,000	19,011	48,989	0	48,989
Staff Development and Workshops	3,010,000	1,577,345	1,432,655	1,664,388	(231,733)
Consulting Services					
International	891,000	200,000	691,000	944,016	(253,016)
National	587,000	346,531	240,469	289,596	(49,127)
Contracting Nongovernment Organizations	3,609,000	(1,800,680)	5,409,680	4,354,686	1,054,994
Studies and Surveys	319,000	200,000	119,000	51,833	67,167
Implementation Cost	328,000	172,749	155,251	187,772	(32,521)
Operation and Maintenance	57,000	20,000	37,000	0	37,000
Interest Charge	384,000	0	384,000	332,397	51,603
Unallocated	1,228,000	818,645	409,355	0	409,355
Total SDR	15,154,000	0	15,154,000	14,144,612	1,009,388
Total US$ Equivalent	20,000,000[a]	0[b]	23,093,409[c]	21,475,623[d]	1,617,786[e]

[a] US$ equivalent per RRP. [b] US$ equivalent as of date of approval of cancellation. [c] Total of (d + e). [d] Actual US$ equivalent. [e] US$ equivalent at report preparation.

10. Local Costs (Financed)
   – Amount ($) $10.86 million
   – Percent of Local Costs 80.38%
   – Percent of Total Cost 30.85%

Source: ADB

C. Project Data

1. Project Cost ($ million)

Cost	Appraisal Estimate	Actual
Foreign Exchange Cost	21.34	21.69
Local Currency Cost	15.42	13.51
Total	36.76	35.20

2. Financing Plan ($ million)

Cost	Appraisal Estimate	Actual
Implementation Costs		
Borrower Financed	4.60	1.95
ADB Financed	19.49	20.97
DFID Financed	12.16[a]	11.77
Subtotal	36.25	34.69
IDC Costs		
Borrower Financed	0.00	0.00
ADB Financed	0.51	0.51
DFID Financed	0.00	0.00
Subtotal	**0.51**	**0.51**
Total	**36.76**	**35.20**

ADB = Asian Development Bank, DFID = Department for International Development of the United Kingdom, IDC = interest during construction,
[a] Inclusive of increase in grant financing of $1.8 million approved on 18 February 2008.

3. Cost Breakdown by Category ($ million)

Category	Appraisal Estimate	Actual
A. Base Cost		
1. Civil Works	6.36	8.39
2. Equipment and Furnishings	2.75	2.81
3. Consulting Services	11.52	3.56
4. Contracting Nongovernment Organizations	4.76	16.01
5. Staff Development and Workshops	3.97	2.49
6. Drug Supply	0.09	0.00
7. Studies and Surveys	0.90	0.88
8. Project Management	1.07	0.29
9. Operation and Maintenance	0.47	0.00
10. Taxes and Duties	2.58	0.26
B. Contingencies	1.78	0.00
C. Interest Charges	0.51	0.51
Total	**36.76**	**35.20**

4. Project Schedule

Item	Appraisal Estimate	Actual
Date of Contract with Consultants	Jul 2003	Jul 2003
Completion of Engineering Designs	Dec 2003	Dec 2004
Civil Works Contract		
Date of award	Jan 2004	Mar 2004
Completion of work	Jul 2006	Sep 2008
Equipment and Supplies		

Item	Appraisal Estimate	Actual
Dates		
First procurement	Jun 2003	Jul 2003
Last procurement	Dec 2006	Dec 2008
Completion of equipment installation	May 2007	May 2009
Start of Operations		
Completion of tests and commissioning	Dec 2007	…
Beginning of start-up	Jan 2008	…
Other Milestones		
First extension of loan closing date		Oct 2007
First reallocation of loan proceeds		Oct 2006
Second reallocation of loan proceeds		Oct 2007
First cancellation of SDR1,009,387.76		Oct 2009
Closing of loan accounts		Oct 2009

5. Project Performance Report Ratings

	Ratings	
Implementation Period	Development Objectives	Implementation Progress
From 30 Nov 2002 to 30 Apr 2003	Satisfactory	Satisfactory
From 31 May 2003 to 30 Nov 2003	Satisfactory	Highly satisfactory
From 31 Dec 2003 to 30 Apr 2006	Satisfactory	Satisfactory
From 31 May 2006 to 31 Dec 2009	Satisfactory	Highly satisfactory

D. Data on Asian Development Bank Missions

Name of Mission	Date	No. of Persons	No. of Person-Days	Specialization of Members
Fact-Finding	4–15 Mar 2002	5	30	a, b, f,
Appraisal	19 Aug–2 Sep 2002	7	28	a, b, c, d, f
Joint Inception	5–7 Feb 2003	2	6	a, e
ADB Review 1	28–30 Apr 2003	1	3	a
Joint Supervision and Review 1	1–10 Dec 2003	1	10	a
Joint Supervision and Review 2	22–26 Mar 2004	2	10	a, e
Joint Supervision and Review 3	25–31 Dec 2004	1	7	a
ADB Review 2	14–19 Mar 2005	1	6	a
ADB Review 3	6–8 Jul 2005	2	6	a, e
Joint Supervision and Review 4	31 Oct–11 Nov 2005	1	12	a
Joint Supervision and Review 5	7–13 Jun 2006	1	7	a, d, e
Joint Midterm Review and Supervision	3–17 Oct 2006	2	30	a, e
ADB Review 4	19–22 Jun 2007	1	4	a
ADB Review 5	26–29 Nov 2007	2	8	a, e
ADB Review 6	27 Aug–2 Sep 2008	1	7	a
ADB Review 7	8–12 Dec 2008	2	10	a, e
Final Review	2–4 Jun 2009	2	3	a, e
Project Completion Review	12–23 Jul 2010	3	30	a, e, f

a = project officer, b = counsel, c = control officer, d = national officer, e = project analyst, f = consultant.


CAMBODIA
HEALTH SECTOR SUPPORT PROJECT
(as completed)
LAO PEOPLE'S DEMOCRATIC REPUBLIC
THAILAND
VIET NAM
103°00'E
107°00'E
14°00'N
11°00'N
ODDAR MEANCHEY
Samrong
Cheom Ksan
BANTEAY MEANCHEY
Poipet
Sisophon
Mongkol Borey
SIEM REAP
Siem Reap
Tbeng Meanchey
PREAH VIHEAR
Siem Pang
RATANAKIRI
Banlung
Lumphat
STUNG TRENG
Stung Treng
PAILIN
Pailin
BATTAMBANG
Battambang
Moung Roessei
Tonle Sap
KAMPONG THOM
Kampong Thom
Mekong R.
KRATIE
Sambor
Sandan
Kratie
MONDULKIRI
Sen Monorom
Sre Khtum
Pursat
Krakor
PURSAT
Kampong Chhnang
Sdok
KAMPONG CHHNANG
Prek Kak
Chhlong
Snuol
Kampong Cham
Tonle Bet
KAMPONG CHAM
Memot
Krek
Gulf of Thailand
Koh Kong
KOH KONG
KAMPONG SPEU
Kampong Speu
PHNOM PENH
Prey Veng
PREY VENG
Takmau
KANDAL
SVAY RIENG
Svay Rieng
Bavet
Kampong Trabek
Sre Ambel
Kaaong
Anglassom
Takeo
TAKEO
KAMPOT
Veal Renh
Tani
Kampot
Kep
Tuk Meas
Preah Sihanouk
PREAH SIHANOUK
KEP
Bassac R.
Mekong R.
South China Sea
N
0 25 50 75 100
Kilometers
Provinces Covered by the Asian Development Bank
Provinces Covered by the International Development Association
National Capital
Provincial Capital
City/Town
National Road
Other Road
Railway
River
Provincial Boundary
International Boundary
Boundaries are not necessarily authoritative.
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I. PROJECT DESCRIPTION

1. The Health Sector Support Project (HSSP) was formulated as the first sectorwide management approach for health in Cambodia. The Asian Development Bank (ADB), the World Bank, the Department for International Development (DFID) of the United Kingdom, and the United Nations Population Fund cofinanced the project, providing $74.3 million. This was a flagship project of the Ministry of Health (MOH). It supported a range of strategies and interventions under the First Health Sector Strategic Plan (2003–2007) and supported government provision of basic health services to the poor and disadvantaged, including ethnic minorities, women, and children in targeted regions. The HSSP covered 21 provinces; of these ADB financed the implementation of project activities in 9 provinces and the World Bank in 12 provinces. The project design was the same in all provinces.

2. The ADB Board of Directors approved financing for a portion of the HSSP on 21 November 2002: a loan of SDR15,154,000 (equivalent to $20 million)[1] and ADB administration of a $12.2 million grant (an original amount of $10.4 million and an additional amount of $1.8 million[2]) from DFID.[3] The loan became effective on 28 February 2003. ADB financing improved access to quality health services in the 9 provinces by (i) upgrading commune health centers and district referral hospitals and (ii) enhancing the skills of health care service providers. The Health Care Financing for the Poor Project financed by the Japan Fund for Poverty Reduction (JFPR)[4] supported implementation of the project through the establishment of an equity fund that helped reduce the vulnerability of the poor when faced with catastrophic health shocks. MOH was the executing agency. The Department of Planning and Health Information (DPHI) of MOH was responsible for coordinating project implementation, under the overall guidance of a health sector steering committee headed by the secretary of state. The ADB-financed portion of the HSSP is covered in this project completion report, and is referred to as ”the project”'

II. EVALUATION OF DESIGN AND IMPLEMENTATION

3. The goal (impact) of the project was to improve the health status of the population, especially of the poor, women, and children, in target regions. The purposes (outcomes) of the project were (i) increased institutional capacity to plan, manage, and finance the health sector; (ii) accessible, affordable, quality basic health services developed especially for women and the poor; and (iii) increased utilization of health services especially by women and the poor. The project had three components (outputs): (i) improved delivery of health services, especially those targeting the poor and women; (ii) support for priority public health programs; and (iii) strengthened institutional capacity for management and human resources.

A. Relevance of Design and Formulation

4. The project was consistent with the government's overall goals of enhancing the health system to improve the health of the people, especially mothers and children, thereby contributing to poverty reduction and socioeconomic development. The first Health Strategic Plan (2003–2007) sought to ensure equitable and quality health care for all, especially for the poor and residents of areas in greatest need. The project was consistent with ADB's country strategy and program. ADB also supported the government's high-priority commitment to human development expressed in the

[1] Current loan value is $23.084 million.
[2] DIFD approved the additional $1.8 million grant on 18 February 2008.
[3] ADB. 2002. *Report and Recommendation of the President to the Board of Directors: Proposed Loan to the Kingdom of Cambodia for the Health Sector Support Project*. Manila.
[4] ADB. 2004. *Proposed Grant Assistance to Cambodia for Health Care Financing for the Poor.* Manila (JFPR 9057-CAM for $1.847 million).

National Strategic Development Plan (NSDP) 2008–2015, which addressed poverty reduction goals as applied to the health sector.

5. The project was fully aligned with the government's health sector development priorities. The project design was sound and the formulation process adequate. The midterm review resulted in greater priority being placed on reproductive, maternal, newborn, and child health services in accordance with government priorities. The government was highly committed to addressing heath sector priorities in the country as formulated in the National Health Strategic Plan 2003-2007. The original project scope was highly relevant and remained so at project closing. ADB's policy on the health sector has reinforced the country's development through a number of project-supported policy reforms. In addition the project increased the efficiency and equality of access to essential medical services for the poor, women, and children in rural areas.

B. Project Outputs

6. The project had three outputs and achieved most of its original targets—the overall physical accomplishment in terms of outputs was 95% (Appendix 1).

1. Output 1: Improved Delivery of Health Services

7. Output 1 aimed to improve health service quality, utilization, and access, especially for the poor, women, and ethnic minorities in 9 target provinces. Suboutputs are (i) building and civil works, (ii) medical and auxiliary equipment, (iii) training of health service providers, (iv) contracting services to nongovernment organizations (NGOs), and (iv) supplies and drugs.

8. **Building and civil works.** The project financed construction and renovation of health facilities to meet the standards of the minimum package of activities (MPA)[5] and the complementary package of activities (CPA)[6] according to MOH's Health Coverage Plan.[7] Specifically, the project financed construction and renovation of 50 health centers (against an original target of 128) and 15 health posts (an original target of 9), and renovation of 7 referral hospitals (an original target of 14) and 7 emergency facilities (an original target of 10) in referral hospitals across the nine provinces, providing special emphasis to safe-motherhood facilities. Priority was given to emergency units of referral hospitals, health centers in remote and poor areas, and health posts in sparsely populated mountainous areas inhabited by ethnic minorities.

9. The implementation of civil works, in scope, design, and schedule, was affected by (i) price escalation of up to 300% for steel bars ($1,200 per ton compared with $450 at project start); solid and hollow bricks ($0.13 versus $0.04); as well as crushed stone, coarse sand, and cement required for construction works; (ii) increases in food prices (e.g., rice from $0.39 per kilogram to $1.04), making it difficult to get construction foremen and workers at construction sites; (iii) unusual early start of the rainy seasons with strong winds negatively impacting ground civil works in 2006–2007; (iv) lack of land titles issued by the appropriate local authorities for the majority of health centers and health posts; and (v) de-mining of one project hospital site.[8]

10. The project did not meet the targets for the construction and renovation of health centers, referral hospitals, and emergency facilities, but reached the target for health posts in remote areas and covered most of the poor population including ethnic minority areas. The HSSP constructed

[5] The MPA is provided at health centers and includes a basic set of preventive, promotive, and outpatient curative health services.
[6] The CPA is provided at referral hospitals and includes appropriate curative care for first referral.
[7] The Health Coverage Plan was designed for the whole country in 1995, and subsequently revised with project support. MOH approved the new plan in 2003. It is the main policy document for health infrastructure development.
[8] Sre Amberl Referral Hospital.

and/or renovated 95 facilities for the entire country; the project contributed 83% of the HSSP achievements during 2003–2009. While the actual number of health facilities constructed was below the original targets, the project implemented 85% of the total civil works for health facilities nationwide during this period. Annual maintenance plans were developed as a part of provincial health department (PHD) annual operational plans (AOPs). This ensured that maintenance plans were in place for the health facilities constructed and renovated by the project. However, maintenance systems are still weak in some facilities due to lack of funding.

11. To expand minority access to health services, the project constructed new health posts in the remotest provinces with large populations of ethnic minorities, such as Kampong Chhnang Mondulkiri, and Ratanakiri. The 12 health posts built by the project in Mondulkiri brought the total number of health posts across the province to 19. In Ratanakiri, 9 health posts were built by various development partners. In addition the project succeeded in generating additional support, resulting in 6 health posts being built by the Japanese Embassy and 2 by the Spanish Embassy in the target provinces in 2009.

12. **Medical and auxiliary equipment.** The project supported the supply and maintenance of medical equipment to newly constructed and renovated health centers to provide MPA services, and to renovated referral hospitals to provide CPA services. Procurement and supply of equipment was closely coordinated with civil works. The project partly fulfilled the targets under this subcomponent. During 2006–2009, 85 MPA kits (target of 75) were procured and distributed to all rehabilitated health centers and health posts. CPA kits were supplied to 7 renovated referral hospitals (original target of 8). The project installed x-ray units, generators, and emergency equipment in all 7 renovated referral hospitals (target of 10), and provided operating ambulances for 5 referral hospitals (target of 5). While the supply of equipment to referral hospitals was below the original targets, all the facilities received all medical and auxiliary equipment. The project strengthened capacity for equipment maintenance in the Hospital Services Department by training health personnel on the use and maintenance of the equipment.

13. **Training of health service providers.** The project designed a comprehensive approach for the training of health center and referral hospital staff to deliver MPA and CPA services; and address training quality, relevance, and efficiency. This was based on the achievements of the ADB-funded Basic Skills Project,[9] which established the MOH continuing education system and the network of regional training centers (RTCs). With project support, MOH has developed 13 MPA training modules and commenced a comprehensive program of in-service training to enable health center staff to deliver these services. The project supported training of trainers (and health center staff) in the target provinces in the priority MPA modules, including child health, reproductive health, health promotion, and infection control. During 2003–2009, 3,586 staff were trained (56.7% of all trained under the HSSP), 53.8% of these were women. To promote the retention of health workers in ethnic minority areas, the candidates were recruited from ethnic minority groups with the ability to speak their own dialects and Khmer. In total, 155 midwives and nurses, including 103 female students (66.5%), from ethnic minority areas were trained at Stung Treng RTC in 2005–2007. The annual training involved a significant number of health workers from all referral hospitals and the majority of health centers and health posts. However, the achievement of the project was not assessed against the performance indicators due to a lack of data on health personnel staffing at the various facilities during project implementation. Supplementary Appendix A provides details of health staff trained under the HSSP 2003–2009.

14. **Contracting of services to nongovernment organizations.** The project supported the provision of alternative mechanisms for the delivery of health services to the poor by contracting

[9] ADB. 1995. *Report and Recommendation of the President to the Board of Directors: Proposed Loan to the Kingdom of Cambodia for the Basic Skills Project.* Manila (for $20 million).

health services to nongovernment organizations (NGOs) in 10 operational districts and establishing social protection funds—health equity funds (HEFs)[10]—covering about 800,000 poor. Improved affordability of and access to health services, in particular for the poor, women, and children were key objectives of the HSSP. Based on the success and lessons from pilot contracting under the Basic Health Services Project[11] , these activities were expanded under the HSSP to 11 operational districts, including 10 funded by ADB and 1 funded by the World Bank. This support ensured quality services in poor districts covering about 1.8 million people, including 800,000 poor. Two models of health services contracting[12] were introduced (contracting in and contracting out), in which NGOs were recruited under contract as health management agencies (Supplementary Appendix B).

15. While no disaggregated data is available for health service utilization by the poor in the operational districts, the utilization of health services, in particular maternal and child health care, has increased significantly in most of the project-supported districts. The data shows a notable increase in facility-based delivery, delivery by skilled health personnel, and antenatal care for pregnant women in most of the districts, including four previously contracted operational districts under the Basic Health Services Project. Facility-based deliveries increased from 20% in 2006 to 34% in 2009 in Memut operational district, from 54% to 64% in Pearaing, from 49% to 67% in Ang Rokar, and from 45% to 56% in Kirivong. The average rates of per capita outpatient consultation in 2009 were significantly higher than the national average of 0.54 in these contracted operational districts: Memut, 0.78; Pearaing, 0.93; Ang Rokar, 0.77; and Kirivong, 0.49. Utilization of health services also increased in almost all newly contracted operational districts (from 0.49 to 0.93 visits per person for outpatient consultations). To sustain the achievement of health service delivery through contracting and effectively manage health services after the termination of contracting arrangements, transition plans with exit strategies and work plans were prepared and implemented in all contracted operational districts.

16. **Supplies and drugs.** The project supplied MPA start-up drug kits to all new health centers in the target provinces. The kits contained a 6-month supply of basic drugs and contraceptives. These kits ensured that facilities became operational immediately upon opening and allowed preparatory time for joining the routine ordering cycle through the central medical store. Some shortfalls in provision of essential drugs were experienced during implementation due to delayed procurement or delivery by the supplier. The project assisted in liaising with the Essential Drug Bureau for timely review of the drug requests to resolve this issue.

2. Output 2: Support to Programs Addressing Public Health Priority

17. ADB funding was not allocated to activities under output 2; the World Bank, DFID, and the government financed this component. Therefore the performance targets identified in the original project framework were excluded from the project monitoring and evaluation (M&E) for the ADB portion of the HSSP. The World Bank portion of the HSSP supported (i) four national programs to control and prevent communicable diseases, including HIV/AIDS, malaria, and tuberculosis; and (ii) priority public health activities, including safe motherhood, immunization, and nutrition. ADB provided financing for prevention and control of HIV/AIDS[13] through the JFPR project (footnote 4)

[10] HEFs provide direct support to the poor and vulnerable through a national equity fund implemented in 10 health operational districts. It has paid for the cost of major health care expenditures of the poor as well as the cost of transportation and food for caretakers.

[11] Loan 1447-CAM: Basic Health Services for $20 million, approved on June 1996

[12] Contracting activities included management and monitoring of contracts with contractors, development and monitoring of performance contracts with the PHDs, and a household survey to evaluate the progress and outcomes of contracting. Staff employed under contracting retained civil service status but were formally seconded by the PHDs to the contractors.

[13] ADB. 2001. *Japan Fund for Poverty Reduction to the Kingdom of Cambodia, Lao People's Democratic Republic, and the Socialist Republic of Viet Nam for Community Action for Preventing HIV/AIDS*. Manila; ADB. 2000. *Technical Assistance to the Kingdom of Cambodia for Capacity Building for HIV/AIDS Prevention and Control*. Manila.

and also through the regional communicable disease control project;[14] while the Global Fund for AIDS, Tuberculosis and Malaria and United States Agency for International Development approved large programs for HIV/AIDS. The United Nations Population Fund later became a partner in the HSSP and supported the reproductive health component to improve accessibility, quality, and affordability of reproductive health services. Implementation of this component was closely coordinated with the investments of other international agencies, including the Global Fund for AIDS, Tuberculosis and Malaria; DFID; United States Agency for International Development; and United Nations agencies. ADB project investments in civil works, equipment, and training contributed to the achievements of key health indicators on reproductive health, HIV, tuberculosis, malaria, and nutrition.

3. Output 3: Strengthening Institutional Capacity

18. The project assisted MOH in strengthening national, provincial and district institutional capacity in management, planning, and evaluation. It specifically supported strengthening (i) provincial and district management capacity and supervision in the 9 target provinces, (ii) capacity for workforce planning and management in MOH, (iii) regional and national training capacity, and (iv) M&E. Under output 3, the project trained 89 hospital managers of district, provincial, and referral hospitals in health service management; and 926 staff in public health management. The number of supervision visits reached 90%, against a target of 70% in 2008 (385 to PHD operational districts and 6,659 at operational district health facilities). The project contributed to establishing a mechanism for improving joint annual performance reviews (JAPRs) by the government and development partners, disseminating the findings, and incorporating them into MOH policy-making and planning processes.

19. **Health service planning and management capacity strengthening.** The project contributed to the organization of annual sector reviews, with oversight from a suitable institution within MOH responsible for contracting and managing the reviews, disseminating the findings, and incorporating them into MOH policy-making and planning processes. The project trained 89 hospital managers of district, provincial, and referral hospitals (72% of the target of 123) in health service management. Primary health care workers from about 66% of PHDs and operational districts were trained in personnel management (376 health staff in total), against a target of 70%.

20. The project supported the enhanced capacity of MOH in sector planning and program coordination through a task force to formulate the Health Sector Strategic Plan 2008–2015. The government adopted the plan and launched it in April 2008 at the National Health Congress and the JAPR. The joint midterm review (2006) noted that the planning cycle was now proceeding more smoothly with all PHDs and operational districts regularly preparing AOPs. Annual sector reviews and identification of national priorities has occurred as part of the JAPR with the involvement of all sector stakeholders on a regular basis. The project also assisted MOH in establishing the mechanism for improving the JAPR.

21. The project supported MOH's efforts to strengthen the planning process to be more responsive and participatory. This included strengthening the participation of local communities and NGOs, and undertaking an analysis of the health situation and needs of the local catchment population. NGO participatory planning experience was valuable and provided examples of workable methodologies that could be adapted and scaled up. NGOs were considered as project stakeholders in their role as service providers in poor remote areas, and as health service contractors in advocacy and management of the HEFs. While no record is available to assess and

[14] ADB 2005. *Proposed Grant Greater Mekong Subregion: Regional Communicable Diseases Control Project (Cambodia, Lao People's Democratic Republic, and Viet Nam)* Manila. (Grant 0025, $30 million, approved on 31 October 2005.)

verify achievement against the performance target of community participation,[15] community health committees were established in all project target areas, and held meetings at least 1–2 times per year. This included undertaking a health situation analysis and needs assessments, adopting user fees, and assessing the quality of health services provided.

22. **Human resource planning and management capacity strengthening.** The project assisted in strengthening MOH capacity for human resource policy, planning, and management through a range of interventions. Based on the achievements of the Basic Skills Project, the project helped collect and update data on human resources at provincial and local health facilities. This information has been regularly updated through monitoring missions to the RTCs and the Human Resource Development Department of MOH, and at quarterly review meetings of RTCs in Phnom Penh. The functional analysis helped the Human Resource Development Department and RTCs address critical staff needs in rural and remote areas, and develop a rational human resources policy. This work resulted in the Second Health Workforce Development Plan (2006–2015), which MOH adopted in February 2006.

23. The project supported human resource development capacity-building, which included a continuous education program, revision of the training curriculum for nurses, further development of MPA modules, and adoption of the 2nd Health Workforce Development Plan 2006–2015. The design of the accreditation system for training courses was continued, and refresher training for teachers and clinical instructors was conducted. While the project has contributed to strengthening of planning, training, and management of health human resources, it made limited progress on placement of critical heath workers in rural and remote areas.

24. The project proposed specific strategies to resolve staff and skill shortages in poor remote areas, including the development of a primary nurse training course for the northeastern provinces. Among 155 trained nurses and midwives who passed primary education courses at Stung Treng RTC, 18 midwives and 14 nurses were from Rattanakkiri, and the same number from Mondulkiri. The project also tried to improve the incentive structure for health providers working in rural and remote areas, but it faced budget constraints and the user fees collected were not enough to address these problems.

25. **Monitoring and evaluation.** The project successfully supported M&E of health sector performance and health status as part of the overall policy, planning, and management support to central, provincial, and district facilities. The M&E unit established under the HSSP secretariat in the DPHI was responsible for monitoring the project's implementation progress and preparing and disseminating various reports. The unit has played a central role in institutionalizing the M&E system at the central level. It has also spearheaded the planning and organizing of the JAPRs and national health congresses since March 2005, and led drafting and production of the comprehensive JAPR and national health congress reports jointly with MOH. An important focus was to improve data use for planning, in particular for the development of the AOP. A total of 323 health managers from PHDs and operational districts were trained in M&E and data use.

26. The monitoring group comprising MOH and HSSP staff conducted the monitoring of contracting operational districts. The group reviews progress reports from the contractors on a quarterly basis and recommends release of the next tranche of payments. It also selects two to three remote villages and conducts household interviews on a set of key health utilization and health behavior indicators. The monitoring group also visits each of the operational district offices, referral hospitals, and health centers, including direct observation of clinical staff in patient examination and counseling, to ensure standards of quality of care and provider compliance with

[15] The performance target is measured as 70% of health centers hold community committee meetings at least every 2 months with at least 70% of villages represented at each meeting.

MOH protocols. In addition to the monthly supervision missions to operational districts, the HSSP health management monitors conducted monitoring visits, including spot checks, to health centers in noncontracting operational districts on a regular basis to oversee their functioning.

27. The project helped design the Health Information System Strategic Plan 2008–2015 and supported design of health information forms for health centers, referral hospitals, operational districts, and provinces. It helped design a comprehensive set of health information system (HIS) guidelines for use at all levels; prepared and updated curriculum for local data use training; designed and implemented HEF M&E; and supported the MOH monitoring group responsible for overseeing NGO contracting health services. A computerized database system was introduced in some operational districts; this has improved the timeliness and quality of reporting, and led to development of a new HIS database in July 2009. All PHDs and operational districts countrywide now use the computerized database system and send monthly reports to MOH in electronic format; the system will now be extended to referral hospitals and health centers. Increased capacity to analyze and utilize monitoring data at central and local level can further strengthen the sectorwide M&E system for effective planning, implementation, and monitoring of health sector performance.

28. **Project management.** The project was implemented using the existing management structure of MOH. The project implementation working group managed and coordinated project activities including procurement and disbursement. Several focal groups were established to ensure communication and coordination between the implementing units and the HSSP Secretariat on project implementation issues. The NGO monitoring working group was established to monitor health contractors' performance, review contractors' quarterly reports, and justify payments against the agreed outputs. While the focus groups conducted meetings two to three times a year, the supervisory activity of the implementation working group was limited to the JAPRs. This led to poor coordination between the HSSP Secretariat and other MOH departments.

29. The HSSP semiannual progress reports and JAPRs were produced and shared with the partners. However no evidence of feedback from partners on the reports is available. The work plans for project activities were integrated into provincial and operational district AOPs as part of the sectorwide approach from 2008. The project also produced four external independent audit reports for 2004–2007. The reports have been sent to all development partners. The recommendations and management comments indicated in the internal control part of the audit report have been widely discussed with all implementers and actions taken for improvement.

C. Project Costs

30. The total adjusted project cost was estimated at $36.76 million, of which $20.00 million was to be financed by ADB, $10.36 million by DFID (which was increased to $12.16 million in 2008 due to a supplementary grant of $1.80 million from DFID), and $4.60 million by the government. The project ended with an actual project cost of $35.20 million (95.76% of the total project cost at appraisal), of which $21.48 million was financed by ADB, $11.77 million by DFID, and $1.95 million by the government. The final project costs and funds utilization during project implementation are shown in Appendix 2. The ADB portion exceeded the appraisal estimate due to the appreciation of special drawing rights used to cover the price escalation for civil works and extension of NGO contracts. The significant increase in actual project costs against appraisal estimates in the Equipment and Vehicles category was largely due to MOH's issuance of a revised list of CPA medical equipment for the 10 referral hospitals in 2007. After a thorough review, the MOH determined that drugs and supplies were adequate from other funding sources, thus, there were no further activities or expenditures under the Drugs category for the duration of the project.

D. Disbursements

31. At closing, the project had a total disbursement of $21.48 million, or about 107% of the original and 93% of the current loan value. The loan account was financially closed on 22 October 2009, cancelling about SDR1,009,388 (equivalent to $1,617,786) from the total loan proceeds. For the ADB-administered DFID funds, the grant concluded with total disbursements of $11.77 million (excluding $0.18 million budgeted for administration costs), or about 97% of the total grant funds. The grant account was financially closed on 14 June 2010. Annual disbursements are in Appendix 3. ADB provided the project with an initial advance of $1.00 million in June 2003 to finance the cost of small expenditures under various categories. The imprest account was not utilized efficiently during the initial years as revealed in the low imprest account turnover ratio from 2003–2006. The imprest account turnover ratio improved from 2007 onwards when most civil works packages were awarded. The project refunded the unutilized imprest account balance of $41,901 to ADB prior to loan closing. The use of imprest account procedures had a positive impact on project implementation. It supported the project in its cash flow requirement since it had no excess funds to finance project activities in advance. Of the total disbursement of $21.47 million, 42% or $9.04 million was paid through the imprest account, while 48% or $10.27 million of expenditure was paid through direct payment, mostly to civil works contractors and NGOs. The remaining $1.65 million was disbursed for equipment using the commitment letter procedure and $0.51 million for capitalization of service charges.

E. Project Schedule

32. The project was approved on 21 November 2002, declared effective on 28 February 2003, and closed on 30 June 2009. Loan effectiveness was not delayed and the loan was extended for 1 year. Overall, project implementation was carried out according to the agreed implementation schedule. Some delays were experienced in the implementation of civil works, training, and capacity building; but the main activities ended within the stipulated time. The completed project facilities, particularly health centers, took more than 2 years to become fully operational. The delay was due to the additional cost of the health centers,, which was underestimated at appraisal, and the shortage of labor affecting civil works. The appraisal and actual project implementation schedules are in Appendix 4.

33. During the June 2007 JAPR, ADB, the World Bank, DFID, the United Nations Population Fund, and MOH confirmed the need to extend project implementation by 1 year to ensure the smooth transition of project activities to the planned second phase of HSSP. In October 2007, ADB agreed to the government request to reallocate the loan proceeds and to extend the loan closing date from 30 June 2008 to 30 June 2009. The additional DFID grant financing increased the total DFID grant funds from $10.36 million to $12.16 million to ensure implementation of ongoing project activities (to permit completion of planned civil works and delivery of medical equipment) and project sustainability after its completion (an exit strategy for NGO contracting of health services). Finally, an extension was also deemed necessary for continuation of HEF financing.

F. Implementation Arrangements

34. Project management was integrated into the existing MOH structures. The steering committee was responsible for overseeing project implementation. This included approving annual sector plans, reviewing implementation progress, ensuring compliance with covenants, and approving quarterly reports to be submitted to the three HSSP financiers. The steering committee was chaired by a secretary of state and reported directly to the Minister of Heath. However the committee did not hold regular meetings except for participation in the JAPRs, which may have reduced the opportunities for coordination and timely action on implementation issues. The project management structure included a director, a deputy director, a coordinator, a senior management

group, and an HSSP implementation working group.[16] DPHI was responsible for project coordination, while the Budget and Finance Department was responsible for project procurement and financial management. The DPHI director served as project coordinator responsible for day-to-day operations. No separate project implementation units were established to strengthen MOH capacity in project and financial management.

35. In the context of the sector-wide management, a new form of project management was envisaged to better integrate project activities into MOH and to strengthen MOH capacity in project management, financial management and procurement. No separate project coordination units were established to manage project implementation. Instead, the Project was implemented through the existing MOH structure utilizing some MOH staff with the assistance of experienced local and international consultants. Strengthened MOH capacity has made much progress in planning and coordinating processes in the framework of HSSP. However, managerial and planning capacity at PHD and operational district level was limited and further capacity building at local level is needed. The project implementation structure is in Appendix 4.

G. Conditions and Covenants

36. Twenty of the 23 major loan covenants were complied with satisfactorily (Appendix 5). The covenants relating to sector implementation arrangements and safeguards were all complied with. Three loan covenants—preparation of a Health Infrastructure Development Plan and Maintenance Plan; allocation of at least 60% of any increase over the preceding year of the budgetary allocation for recurrent expenditures in the health sector to PHDs and to national priority programs; and at least a 10% increase in the budgetary allocation to programs for health education and consumer behavior—were only partially complied with. The project was completed without any covenant being cancelled or significantly altered.

H. Related Grants

37. The JFPR grant supported the establishment of equity funds to complement the NGO contracting in 10 operational districts and help reduce the vulnerability of the poor when facing catastrophic health shocks (footnote 4). The grant was completed on 30 June 2010. The main objectives of the JFPR grant were to (i) establish HEFs to ensure direct support to the poor and vulnerable, and defray the major health care expenditures of the poor through partial or total exemptions, (ii) identify the poor and vulnerable eligible for the benefits under the HEFs through independent NGO surveys and assessments of the condition of the local population, and (iii) support the national fund manager in national administration of HEFs.

38. HEFs, funded by various development partners, were created in 17 operational districts throughout the country: 11 were covered under the HSSP (i.e., 10 funded by ADB with JFPR grant financing and 1 by the World Bank). HEF benefits for poor beneficiaries were coverage of direct costs (i.e., treatment costs) and indirect costs (i.e., transport cost and food allowances for caregivers). Most HEFs operate only at referral hospitals, but new schemes now cover consultations at health centers.[17] The full costs of hospital treatment are usually covered for the poor.

39. The JFPR grant has made an important contribution to the development and operation of HEFs by increasing access to health services and improving financial protection for the poor. In

[16] The senior management group was to convene to exchange information and issues for HSSP implementation to ensure the smooth running of project activities within MOH. The HSSP implementation working group, chaired by the project coordinator, includes directors and other representatives of MOH departments. The group facilitated the exchange of information among operations departments and units involved in HSSP implementation.

[17] The health center benefits mainly cover user fees but not transportation costs from home to the center.

most operational districts, the share of HEF beneficiaries significantly increased during project implementation. However, due to slow pre-identification of the poor, the HEFs did not cover all eligible beneficiaries. This left some poor households excluded from receiving benefits. Lack of awareness among the poor and vulnerable about HEF benefits remains the main issue in accessing the services, even for those eligible for HEF benefits. The JFPR project played a catalytic role in establishing HEFs as an effective social health protection mechanism and in developing a national strategy and policy framework for HEF implementation, such as the Strategic Framework for Equity Funds and the National Equity Fund Implementation and Monitoring Framework. The details of the JFPR grant achievements will be reported in the implementation completion memorandum.

I. Consultant Recruitment and Procurement

40. The consultants provided services in (i) medical equipment procurement and maintenance; (ii) contracting services to NGOs; (iii) human resource development; (iv) development of the CPA modules and revision of MPA modules; (v) financial management; (vi) procurement and disbursement; (vii) M&E; and (viii) civil works design, survey, and supervision (Appendix 6). Most of the consultants were recruited on an individual basis and engaged in accordance with ADB's *Guidelines on the Use of Consultants*. There were no major changes in the procurement and consulting packages during the implementation of the project, except for a change in selection method from quality- and cost-based selection to consultants' qualification selection in the engagement of the consulting firm for the midterm review of the Health Sector Strategic Plan 2003-2007. Procurement of civil works was conducted under local competitive bidding following ADB's Guidelines for Procurement and was packaged in 3 blocks for health facility construction or renovation, with no major delays or problems. In March 2005, the government approved and adopted the Standard Operating Procedures and Procurement Manual for all procurement under the HSSP. New procurement thresholds were developed by ADB and the government in order to harmonize procurement activities in Cambodia. An international construction supervision firm was recruited for civil works design, monitoring, and supervision of the construction. Civil works were completed satisfactorily under the firm's close supervision and monitoring. No significant problems were encountered in the process.

J. Performance of Consultants, Contractors, and Suppliers

41. Technical consultants were recruited as scheduled. Their inputs in the formulation of relevant programs, including health system planning, contracting service, human resource development, and M&E are considered to be generally satisfactory. Delays in civil works ranged from 6 to 15 months mostly due to price escalation and shortages of construction labor. However, the construction of health centers during the first 2 years of implementation was delayed by finalization of the health mapping facilities and related bidding and award of contracts, and lack of experience with the construction of health centers, particularly in remote areas. The quality of work was satisfactory. Generally, no serious deviations from the agreed specifications were made with regard to drugs, reagents, basic medical equipment, and other supplies. Overall, the performance of the civil works contractors, suppliers of basic medical equipment, and domestic and international consultants was satisfactory.

K. Performance of the Borrower and the Executing Agency

42. The government and MOH showed strong commitment to improving the accessibility and quality of health services, and implemented project activities as originally planned. The government demonstrated strong ownership of all components and activities. The project was successful in applying NGO contracting in health service delivery to improve utilization and coverage of health services, and all contractors achieved measurable results. Health planning and M&E were

substantially integrated into the existing MOH system through the use of AOPs for implementing units, and MOH's M&E framework. The project disbursement rate maintained steady progress through the life of the project, and the external audits of the project showed highly satisfactory performance. The MOH steering committee and working groups provided adequate guidance to the HSSP Secretariat through the mechanism of JAPRs and meetings. Throughout the project period, the government provided the required counterpart funds within an acceptable time. The performance of the HSSP Secretariat was good. It coordinated well with various government agencies, monitored major activities, and resolved project implementation issues. The HSSP consultants provided capacity building to MOH staff where appropriate. The performance of the government and the executing agency was satisfactory

L. Performance of the Asian Development Bank

43. ADB made serious efforts to coordinate project activities with other partners and to address implementation problems; it was responsive to needs that arose during implementation. ADB provided leadership and facilitated the mobilization of resources, and helped to solve implementation problems among donors. However, ADB's efforts to ensure proper implementation of the M&E program were less successful, which was also due to MOH's weakness in primary health service information systems. During project implementation, ADB fielded 21 loan review missions to review project progress. Harmonious relationships were maintained throughout project implementation, despite two changes in the ADB team leader, and excellent communication maintained between ADB and the HSSP Secretariat. Key project implementation issues relating to procurement, consulting and disbursement were promptly acted upon. The Cambodian Resident Mission in Phnom Penh provided regular support throughout project implementation. Overall, ADB performance was satisfactory.

III. EVALUATION OF PERFORMANCE

44. The project contributed to improving the health status of the population, especially for the poor, women, and children in target regions. Significant progress was made in expanding service delivery, which is reflected in improvements in core health indicators for the project impact and outcome. Notable achievements include (i) increased share of deliveries assisted by trained health personnel (from 33% in 2003 to 58% in 2008) and increased share of deliveries at public health facilities (from 4.3% in 2003 to 39% in 2008); (ii) increased utilization of antenatal care by pregnant women (from 48% in 2003 to 81% in 2008); and (iii) increased immunization rate for children under 1 year (from 69% in 2003 to 91% in 2008). For project impact, significant progress was made toward the Millennium Development Goals for the infant mortality rate (from 95 per 1,000 live births in 2000 to 61 per 1,000 in 2008) and the under-5 mortality rate (from 125 per 1,000 live births in 2000 to 83 per 1,000 in 2005). However, the maternal mortality ratio of 461 per 100,000 live births in 2008 is still far below the target of 305 per 100,000.

A. Relevance

45. The project is rated *highly relevant*. It supported the government's health policy to improve affordability and quality of health services. The project design and objectives were highly relevant and in line with the ADB country strategy and program, which emphasized reducing poverty by improving the health of poor families, women, and disadvantaged ethnic groups. The design was tailored to the needs of a country with limited capacity, facing severe economic and social challenges and reform opportunities, including low public spending on health services, inequity in access to health services, weak institutional capacity, and a severe shortage of health personnel in remote areas. At the same time, the environment for the project was favorable, featuring political stability and strong political support for health policy reforms. A sector development project provided crucial support to the government in key policy areas, including the NSDP 2008–2015, the Medium Term Expenditure

Framework, and Health Strategic Plan 2003–2007; and provided urgently needed facilities for meeting immediate institutional and service delivery needs. The HSSP adopted a sectorwide management approach and successfully provided a solid foundation for future sector development carried forward by other development partners for the second phase of the HSSP—the Second Health Sector Support Program, 2010–2013.

B. Effectiveness in Achieving Outcome

46. The project is rated *effective*. It has made significant contributions to the development of the health sector through the construction and rehabilitation of health facilities, and provision of medical equipment and supplies; as well as through contracting health services, expanding HEFs, and strengthening institutional capacity. Outcome 1 was increased institutional capacity to plan, manage, and finance the health sector. The performance indicators for outcome 1 relate to contributions to improved local management, planning, and monitoring capacity. The project fully achieved the performance target (100% of PHDs and operational districts producing AOPs against a target of 80%). In 2008–2009, MOH's budget allocations for local health systems increased to 92.6% for PHDs and 91% for operational districts, exceeding the target of 80%. The project contributed to the government's health sector strengthening agenda by supporting policy reforms for sectorwide development.

47. The performance indicator for outcome 2 (development of accessible, affordable, quality, basic curative and preventive health services for the population) was 25% reduction in health expenditure as a proportion of household spending for the lowest income quintile. The data on household health care expenditure by income level are expected from the next demographic and health survey. The indirect increased use of health services by the poor is indicated by the general increase of outpatient and inpatient annual statistics data (Appendix 8). The proportion of ill people seeking treatment in public health facilities as their first option increased for the general population by 38% (from 0.39 in 2003 to 0.54 in 2008), and the proportion of ill children seeking treatment increased by 78.5% (from 0.56 to 1.00). Bed occupancy rates increased for the general population by 13.7% (from 60.7 in 2003 to 69.0 in 2008).

48. Outcome 3 was the utilization and coverage of maternal health services, which significantly improved. Compared with the national utilization rate of 0.54 per capita in 2009, the rates of project-supported operational districts are higher (0.78 for Memut, 0.93 for Pearaing, 0.77 for Ang Rokar) except Kirivong (0.49 per capita). The positive changes in providing health services for women were measured by (i) increased percentage of pregnant women receiving antenatal care—81% in 2008 compared with only 48.4% in 2003; (ii) increased attendance at delivery by trained staff from 36% to 63%; and (iii) 44% of all deliveries occurring at health facilities (10.6% in 2003) (Appendix 8). Visible improvement has been achieved in family planning—28% prevalence of contraceptive utilization was achieved in 2008 (37.2% in Takeo Province compared with 35% in 2003 and 30.1% in Koh Kong Province compared with 19%). Stunting in children under 5 years declined from 2000–2008 (from 49% to 40%); but rates of underweight and wasting show little downward movement from 2005–2008. More than 90% of children under 1 year were immunized against measles in 2009 compared with the target of 70% (Supplementary Appendix C).

49. Key achievements for outcome 4 (control and mitigate the effects of infectious disease epidemics and malnutrition, with emphasis on the poor) include (i) 60% reduction in incidence of malaria from 10.3 new cases per 1,000 inhabitants in 2003 to 4.1 in 2008; (ii) 60% reduction of malaria mortality rate (from 3.6 per 100,000 inhabitants in 2003 to 1.46 in 2008). While the incidence of smear-positive pulmonary form remained the same (148 per 100,000 new cases) in 2003 and 2008, the case detection rate increased from 51% in 2000 to 69% in 2008, and the tuberculosis prevalence rate was from 212 per 100,000 inhabitants in 2003 to 297 in 2008 (Supplementary Appendix C).

C. Efficiency in Achieving Outcome and Outputs

50. The project is rated *efficient* in achieving the outcomes and outputs as demonstrated by (i) high disbursement and (ii) development of a comprehensive public health systems approach despite delays in implementation of the civil works. Both civil works and equipment targeted primary health (health centers and health posts) and the first referral level, and are considered cost-effective compared with tertiary investment. Technical work covering institutional capacity-building, policy development, and training was carried out with highly competent consultants, through intensive discussions with relevant stakeholders, and under timely and appropriate supervision by the executing agency and HSSP Secretariat.

51. Prior to the 1-year extension, the project had already completed the crucial activities scheduled within the original implementation period of 5 years. The extension was given to ensure uninterrupted service delivery during the transition period between the HSSP and the second phase of HSSP. Major issues and adjustments relating to civil works, equipment, and other planned activities were promptly resolved before midterm, triggering steady disbursements until completion in 2009. Despite delays, most of the project's quantitative and qualitative targets were achieved. The project completed the construction of health facilities in remote areas and covered most of the poor population including areas inhabited by ethnic minorities.

D. Preliminary Assessment of Sustainability

52. The project is rated *most likely sustainable.* The government developed national health policy and program priorities, reestablished primary health services functioning through a district-based health system, strengthened national programs for communicable diseases, and increased the capacity of the health system to manage resources and perform basic functions efficiently. The system of health planning, financing, and M&E has been institutionalized, with regular joint annual program reviews by the government and development partners, and annual operational planning systems developed from central to local operations planning systems. A policy framework for health financing, health staffing, and health planning was adopted; a national M&E framework established; and planning links for the budgeting cycle improved.

53. A midterm review of the NSDP recommended a reorientation of funding to rural areas and the provision of social safety nets. There was a 20% increase in social sector budgets between 2006 and 2008. There has been a substantial increase in the overall health budget, over the past decade, both from the government and donor funding. Almost half of the health budget is internationally funded. A high dependence on external finance may be considered a risk, however adoption of sectorwide approach has reduced the risk for abrupt cessation of funding through medium and longer-term financial commitments from both government and development partners.

54. The experiences of contracting heath services have resulted in development of a long-term health sector strategy and adoption of internal contracting arrangements. As part of the government's public service delivery reform for better performance and results, 17 special operating agencies were established in operational districts and referral hospitals, with contracts signed with PHDs as commissioners to provide financial management of health funds from various sources including aid assistance, HEFs, social insurance, and user fees. Expansion of HEFs has resulted in significant improvements in utilization of hospital services by the poor. While most HEFs are externally financed through donor funds, HEF schemes are being institutionalized and included in the social protection strategy. Development partners have confirmed their commitment to continuing financial support for the health sector under the second phase of the HSSP, including continued funding for HEFs and other priority activities initiated by the HSSP. This provides confidence in sustainability of the outcomes achieved by the project.

E. Impact

55. The project contributed to improving the health status of poor mothers and children. The establishment and expansion of social protection funds contributed to the government's poverty reduction initiative by reducing private health expenditures. While no separate impact evaluation was conducted at the project level, some preliminary assessments of the project impact can be drawn from the Population Census of Cambodia 2008. Many health status and service utilization indicators showed marked improvement during project implementation compared with NSDP targets. The infant mortality rate declined from 95 per 1,000 live births in 2000 to 61 in 2008; and the under-5 mortality rate decreased from 124 per 1,000 live births in 2000, to 83 in 2005. It appears that Cambodia is well within reach of the NSDP targets of 75 by 2010, and 70 by 2015. Significant progress has been achieved in neonatal deaths, declining from 37% to 28%, and in the total fertility rate, declining from 4.0 children on average per married woman of reproductive age in 2000, to 3.1 in 2008. Overall, the project contributed successfully to improving the quality and accessibility of health services. The quality and effectiveness of service delivery benefited from project support for clinical and management training and routine supervision.

56. The project also contributed to strengthening the country's health system through development of a sectorwide management system, joint M&E, incentive schemes, and health services contracting. Significant achievements were made in the areas of integrated supervision and management of health services contracting, which resulted in the improved health sector performance and advancement of the sectorwide approach in the country. This contributed to the development of the second phase of HSSP, covering seven development partners joined through common pooled and nonpooled funding of sector interventions. The project supported MOH's efforts to implement a transparent program and prioritize strategies to improve the performance of the health sector and service delivery for the poor.

IV. OVERALL ASSESSMENT AND RECOMMENDATIONS

A. Overall Assessment

57. The project is rated *successful* overall, based on the preceding project assessments of highly relevant, effective, efficient, and sustainable (Appendix 9). The project was successful in supporting the health sector in the targeted areas of Cambodia, achieving improvements in health sectors, and initiating policy reforms necessary for long-term sector development. Its focus on expanding access and increasing affordability of health services while putting in place measures to improve quality was highly relevant to the needs of the country. The project achieved most of the targets set at appraisal for the health outcome indicators.

58. In terms of contribution to the expansion of the health facilities network, the project made impressive gains. Fifty health centers were constructed or renovated, 7 emergency units were established at referral hospitals, and 15 health posts were constructed. Of the 95 MPA medical equipment and supplies kits planned to be provided at appraisal, the project provided 93. NGO contracting of health services in 10 operational districts substantially increased access, utilization, and coverage of all key reproductive, maternal, newborn, and child health indicators. In two of the operational districts, project interventions targeted ethnic minorities. As a result of strengthened provision of primary health care, the project achieved its objectives by (i) improving access to and quality of health services, and (ii) establishing a foundation for increasing efficiency and sustainability through user fees and HEFs.

B. Lessons

59. The success of NGO contracting of health services under the project provided the foundation for MOH's introduction of new contracting arrangements (internal contracting) based on the government's Policy on Public Service Delivery (2006) and adoption of MOH's procedures and guidelines on contracting arrangements. Many innovative features first developed under NGO contracting have been, or are in the process of being, adopted for internal contracting, including performance incentive schemes, monitoring indicators, M&E approaches and tools, and supervision arrangements. The internal contracting arrangements include performance agreements between MOH and PHDs, and service delivery contracts between PHDs and operational districts or referral hospitals; and are drawn directly from the NGO contracting implemented under the project. The success of NGO contracting has thus proved to MOH that internal contracting is feasible, cost-effective, and equitable; and can materially increase the extension of health benefits to the poor.

60. Building on lessons from the Basic Health Services Project, the project gave greater emphasis to close monitoring and supervision by MOH to ensure that civil works were closely coordinated with the supply of equipment and drugs under MPA and CPA guidelines. However, efficient planning, a well-executed plan, and close oversight by MOH would have allowed timely completion of civil works and avoided cost overruns. To improve the quality of civil works, implementation arrangements should incorporate closer supervision and monitoring at all levels.

61. In support of MOH's sectorwide management strategy, ADB's participation in the sectorwide management approach along with other partners in a jointly administered project proved the benefits of close collaboration among health partners. While HSSP was cofinanced by different donors and implemented through an integrated project implementation arrangement under the sectorwide management approach, the project was administered by each donor agency with different implementation schedules. The ADB funded activities under HSSP were closed in 2009 while the World Bank portion of HSSP has been extended to complete all the activities including construction of health facilities. This resulted in different reporting arrangements including project completion reports. The sectorwide management approach significantly helped the government improve planning and coordination in project implementation, avoided duplication, and provided the basis for a broader sectorwide approach. However, the process of harmonization and coordination of various activities among the partners has challenged and slowed implementation progress. Considerable time and effort was spent on the process.

C. Recommendations

1. Project Related

62. The JAPR, with participation of all key stakeholders, has proved to be a success, strengthening MOH capacity for sectorwide management, enabling MOH to clearly identify sector priorities for the following year, and contributing to an improved AOP formulation process. MOH should extend these joint approaches to project planning and formulation for improved harmonization of development partner activities and for better implementation of a sectorwide approach in the health sector.

63. While the sectorwide M&E system has been substantially strengthened, further improvements are needed to better monitor and evaluate the interventions under the sectorwide approach, particularly in areas of (i) moving to a unified reporting system, from parallel reporting by development partners, to reduce the burden of reporting requirements; (ii) increasing capacity to analyze and use data for planning; and (iii) strengthening central and local M&E capacity to better manage performance-based contracts.

64. Most of the facilities provided under the project are being used as planned. However, the lack of clear direction and responsibility regarding their use and maintenance has resulted in very limited resource allocation. Before handing over completed health facilities, communities and health authorities need to be trained in preventive and recurrent maintenance, and MOH must ensure that resources are allocated in the health facilities' budget so that buildings can be adequately maintained.

2. General

65. Both planning and M&E were closely integrated with DPHI throughout project implementation. Such arrangements should be adopted for future projects and programs as well. Future projects should include a component on the systematic strengthening of health information. The HIS needs at each level must be defined in relation to management needs, focusing on problem identification and problem solving. MOH should link project databases to the routine HIS to enable more effective and efficient project monitoring, as well as to maintain a record of outputs and outcomes over the life of a project.

66. The project has taken forward many important steps in support of decentralization principles that include HEF schemes, annual operations planning systems, and health contracting. To harmonize and align with government policy, more emphasis needs to be placed on strategic linkages between MOH planning and the decentralization and deconcentration strategy of the government, for a gradual and evidence-based approach to reform. To transit from the pilot status of health insurance schemes, every effort should be undertaken in future projects to link health schemes to the broader social safety net and social protection policies of the government. ADB’s support in the sector can take a broader approach including social protection and health to support social policy reforms and national development objectives on poverty reduction and human development.

PROJECT DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Results
Goal				
Improved health status, especially women, children, and the poor, in targeted regions	**By 2007:** Maternal mortality ratio reduced by 30% (437 to 305 per 100,000 women) Infant mortality ratio reduced by 12% (from 95 to 84 per 1,000 live births) Under-5 mortality rate reduced by 12% (from 125 to 111 per 1,000 live births) Reduction in the differential of under-5 mortality rate between the lowest income quartile and the highest income quartile from 2.12 to 1.6	Demographic and health surveys National Health Survey 2002 (baseline)	Royal Government of Cambodia continues to regard health as a high priority. Political and civil stability is maintained. Aggregate level of international support for health is maintained. Current annual economic growth rate is maintained throughout project period.	Maternal mortality ratio increased to 472 per 100,000 women in 2005 and slightly reduced to 461 in 2008 A fast track initiative to reduce maternal deaths launched in 2008 focuses on strengthening essential maternal and delivery health services. Infant mortality ratio reduced to 66 per 1,000 live births in 2005, and to 60 in 2008 Under-5 mortality rate reduced to 83 per 1,000 live births in 2005
Purpose				
1. Increase institutional capacity to plan, manage, and finance the health sector	**By 2007:** 80% commune health centers and referral hospitals meet minimum staffing levels 80% of all operating districts and 100% of provincial health departments (PHDs) produce an annual plan based on health and management information 80% of allocated Ministry of Health budget reaches PHDs, operational districts, and health centers	National health statistics reports Human resource development and personnel database statistics Baseline and evaluation surveys Baseline and final assessments	Ministry of Health (MOH) has capacity to absorb increased external inputs. National Program for Administrative Reform (NPAR) progresses. Royal Government of Cambodia maintains the allocation for the health sector at not less than 10% of national recurrent budget.	National and provincial annual operational plans (AOPs) were introduced from 2003 to 2005. Since 2006 all PHDs, operational districts, and referral health facilities produce and submit AOPs. In 2007, 58.5% of allocated health budget was used provincially and 83% at the central level. In 2008 the figures were 92.6% and 95.3% respectively.

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Results
2. Develop accessible, affordable, quality, basic curative and preventive health services for the population, especially for women and the poor	**By 2007:** 25% reduction in health expenditure as a proportion of household spending for the lowest income quintile	Demographic and health surveys National Health Survey 2002 (baseline)	Health Coverage Plan (HCP) accurately reflects health coverage needs. Mechanism to establish and collect user fees, and exemptions for the poor are rationalized.	No estimates available before the 2010 demographic and health survey Indirect increase use of health services by poor is indicated by the general increase of outpatient and inpatient annual statistics data
3. Increase utilization of health services, especially by women and the poor	**By 2007:** Proportion of ill people seeking treatment in public health facilities as first option increased for the general population (from less than 20% to 40%) and for the lowest income quartile Bed occupancy rates increased for the general population and the lowest income quartile At least 40% of deliveries attended by trained personnel (<25% now) At least 35% prevalence of contraceptive utilization (<19% now) At least by 70% of children under 1 year immunized against measles (<50% now)	Demographic and health surveys National Health Survey 2002 (baseline) National health statistics reports	Rural road reconstruction continues. HCP accurately reflects health coverage need.	The proportion of ill people seeking treatment in public health facilities as first option increased for the general population by 38% (from 0.39 in 2003 to 0.54 in 2008) The proportion of children seeking assistance increased by 78.5% (from 0.56 to 1.00) Bed occupancy rates increased for the general population by 13.7% (from 60.7 in 2003 to 69.0 in 2008) 58% of deliveries attended by trained personnel in 2008 28% prevalence of contraceptive utilization achieved in 2008 (37.2% in Takeo Province and 30.1% in Koh Kong Province) 84% of children under 1 year immunized against measles in 2008 (and 89% of children received BCG, measles, and three doses of DPT and polio vaccine)
4. Control and mitigate the effects of infectious disease epidemics and of malnutrition, with	**By 2007:** 20% reduction in incidence of smear positive pulmonary	National programs reports National health	Health sector strategy is implemented. Program strategies are fully	The incidence of smear-positive pulmonary form did not change (148 per 100,000

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Results
emphasis on the poor	form of tuberculosis (from 241 to 195 per 100,000 new cases per year) 20% reduction in incidence of malaria (from 11 to 8 new cases per 1,000 per year) 20% reduction in prevalence of HIV infection in women attending antenatal care (from 2.8% to 2.1%) 20% reduction in malnutrition (weight-for-age) in children under 5 years (from 51.8% to 41.4%)	statistics reports World Health Organization reports United Nations Children's Fund surveillance reports	developed and implemented.	new cases) in 2003 and 2008. Significant improvement in malaria control: 60% reduction in incidence (from 10.3 new cases per 1,000 inhabitants in 2003 to 4.1 in 2008) The National Center for HIV/AIDS estimates and projections report on reduction in prevalence of HIV infection in women attending antenatal care from 2.2% in 2003 to 0.84% in 2008 22% reduction in malnutrition (weight-for-age) in children under 5 years (from 45.2% in 2000 to 35.6% in 2005) Gradual reduction in malnutrition (weight-for-age) in children under 5 years in 2008–28.8%
Outputs				
Component 1: Improved delivery of health services, especially those targeting the poor and women				
Subcomponent 1.1: Building and civil works				
1.1.1. All building and civil works completed to meet HCP requirements for health centers, as well as critical renovations of referral hospitals in nine target provinces	**By 2007** and with acceptable quality in accordance with the contract conditions: 128 new health centers renovated or constructed in nine target provinces Nine new health posts constructed 14 existing referral hospitals renovated 10 emergency facilities at referral hospital established	Monitoring list of buildings constructed and renovated Contract completion certificates	Site access is possible during the wet season so that construction can continue. Quality local contractors are available to construct and renovate.	49 health centers renovated or constructed by December 2008 15 health posts constructed by December 2008 7 referral hospitals renovated by December 2008 7 emergency units at referral

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Results
				hospitals by December 2008
1.1.2. Maintenance plan and process developed for facilities renovated or constructed	Maintenance plans prepared and in place for all facilities constructed or renovated	Maintenance reports Supervision reports on utilization of manuals	MOH physical asset maintenance plan is developed, ratified, and implemented	PHDs design annual maintenance plans as a part of AOPs
Subcomponent 1.2: Medical and auxiliary equipment				
1.2.1. Minimum Package of Activities (MPA), Complementary Package of Activities (CPA), and/or auxiliary equipment, including for obstetrics and emergency care, procured and installed in renovated or newly constructed facilities in nine target provinces	Installation of MPA equipment kits (that include obstetric equipment) in 78 health centers and MPA training kits in 31 operational districts, and 9 PHDs in nine target provinces CPA kits (including basic, surgical, and obstetric equipment) supplied to 8 referral hospitals X-ray units, generators, and emergency equipment installed in 10 referral hospitals Operating ambulance provided to 5 referral hospitals	Project progress reports Delivery notes	Equipment lists are revised for CPA and MPA kits to include additional obstetric equipment. HCP does not change the basis for distribution and categorization of equipment. Hospital Services Department recruits technical personnel.	CPA kits supplied to 7 referral hospitals in 2007-2008 X-ray units, generators, and emergency equipment installed at 7 referral hospitals Operating ambulance provided to 5 referral hospitals
Subcomponent 1.3: Training of health center and referral hospital staff in nine target provinces to improve performance				
1.3.1. Capacity of the operational districts and PHDs in nine target provinces increased to deliver MPA and CPA training	Training of all operational district and PHD training teams in nine provinces Completion of refresher course by 70% of individuals in each operational district and PHD team	Training of trainer reports	Training-team members, who have clinical or managerial responsibilities, are available to participate in training as these individuals.	168 trainers for health workers trained in project provinces and operational districts 3,586 health workers trained in 9 target provinces and operational districts (39.6% of total trained PHC workers countrywide for the same period), including 72 doctors and medical assistants, 406 nurses, and 338 midwives

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Results
1.3.2. Health center staff in nine target provinces trained in MPA	Training of 70% of health center staff in one MPA module annually At least one follow-up support session annually for 50% of health center staff trained in MPA modules, including child health, reproductive health, health promotion, and infection control	MPA training and follow-up reports	Health center staff are available to participate.	2,287 health workers trained in MPA modules
1.3.3. Referral hospital staff trained in CPA programs in nine target provinces	Training of at least one doctor in basic surgery, one anesthetic nurse, and one instrument nurse	Project progress reports	Sufficient opportunities are available for clinical practice during CPA training.	172 staff from referral hospitals and operational districts in 9 provinces trained in CPA modules, including basic surgery, anesthetics, and instrument and operating theater
Subcomponent 1.4: Alternative mechanisms to improve management and financing of service delivery				
1.4.1. Level of services and management maintained and expanded in Memut, Ang Rokar, Kirivong, and Pearaing operational districts (previously contracted operational districts under the Basic Health Services Project)	In four previous pilot operational districts: As specified in contracts, increased utilization per capita, by the poor, of health services	Quarterly reports of contractors Quarterly reports of the monitoring team Household surveys	• Current contractors will agree to a 1-year extension and to revised terms of reference. All relevant levels of government remain committed to alternative service delivery management mechanisms.	The utilization of health services significantly increased. Compared with the rate of 0.54 per capita countrywide in 2009, the data showed 0.78 for Memut, 0.93 for Pearaing, 0.77 for Ang Rokar, and 0.49 for Kirivong
1.4.2. Health services strengthened and increased utilization in six newly contracted operational districts	In six newly contracted operational districts by the end of 2007: 100% of planned health centers providing MPA 100% of referral hospitals functional and utilized for adult, pediatric, tuberculosis,	Quarterly reports of contractors Quarterly reports of the monitoring team Household surveys	All relevant levels of government remain committed to alternative service delivery management mechanisms. MOH continues to provide drugs, equipment, and operating budget to	Utilization of services increased in almost all newly contracting operational districts (from 0.49 to 0.93 in 2009) except Sre Ambel (0.25 for the whole project period)

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Results
	and maternity inpatient care, with emergency surgical care available at referral hospitals or through referral to a facility that can be reached within 1 hour As specified in contracts, increased utilization per capita, by the poor, of health services		contracted operational districts.	
1.4.3. In all contracted operational districts, capacity of district health management teams increased to effectively manage health services after the termination of contracts and to sustain achievements	Work plans for transfer of responsibilities developed and implemented in all contracted operational districts	Quarterly reports of the monitoring team Review missions	No substantial decrease in economic status (drought, flood, etc.) in contracted areas so that the ability of operational district and PHD to pay for services is not compromised. Proposed civil service reforms and salary increases occur as planned.	Transition plans with exit strategy and work plans implemented in all contracting operational districts, 2008
Subcomponent 1.5: Procurement and delivery of MPA start-up drug kits				
1.5.1. MPA start-up drug kits provided to newly constructed health centers in nine target provinces	MPA start-up drug kits delivered to 83 newly constructed health centers	Delivery reports Project progress reports	International Development Association-funded components of the project enhance the capacity of drug supply system.	MPA start-up drug kits provided in 2003–2005 94 MPA kits provided in 2006–2009
Component 2: Support for Priority Public Health Program				
Not financed by ADB				
Component 3: Strengthening of institutional capacity for management and human resources				
Subcomponent 3.1: Strengthening health service planning and management capacity in nine target provinces				
3.1.1. Increased capacity at provincial and district levels to plan, manage, and evaluate health	70% of targeted PHD and operational district management teams complete health	Training records and reports Project review reports	PHD, operational district, and referral hospital health management staff are available to participate in	100 PHC managers were trained in hospital and health service management, and 926 in public health management

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Results
service delivery	management training 70% of planned supervisory visits completed at each level	Supervisory reports	training. National Institute of Public Health implements health management training course in 2003 as planned.	The number of supervision visits reached 90% in 2008 (385 to PHDs and operational districts and 6,659 to operational districts and health facilities)
3.1.2. Community participation in health center management strengthened	70% of health centers hold community committee meetings at least every 2 months with at least 70% of villages represented at each meeting	Meeting minutes or records	Communities agree to participate. Commune councils support the health center in health management and development.	Community health committees were involved in user-fee issues and health facility maintenance plans
Subcomponent 3.2: Strengthening of MOH human resource planning and management capacity				
3.2.1. Capacity of MOH for workforce management increased	• All target provinces complete functional analysis • 70% of PHDs and operational districts with at least one staff trained in personnel management	• Workshop proceedings • Functional analysis reports • Revised post and establishment lists	National, PHD, and operational district staff are available to participate in training and working groups. Prospective student qualifies for entry to selected university course. National Program for Administrative Reform guidelines are completed.	All target provinces completed the functional analysis and have been producing AOPs since 2006 227 PHC managers in pilot provinces were trained in health planning, and 376 in personnel management
3.2.2. Capacity of MOH for workforce planning increased	Health Workforce Development Plan 2004–2013	Health Workforce Development Plan 2004–2013	MOH continues workforce planning as a priority.	Health Workforce Development Plan, 2006–2015 developed in 2006
Subcomponent 3.3: Monitoring and evaluation				
3.3.1. Capacity for monitoring and evaluation in MOH strengthened	Qualified Monitoring and Evaluation (M&E) unit formed within the Department of Planning and Health Information An integrated system for M&E established Staff from all operational districts and PHDs trained in	Project progress reports Annual reviews	MOH can identify, recruit, and retain qualified people.	M&E unit was established as part of HIS Bureau under the Department of Planning and Health Information (DPHI) in 2005 Integrated M&E system was established in 2005 323 PHD and operational district health managers were

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Results
	M&E Improved quality of routine data collected for M&E M&E data is used for policy and program planning			trained in M&E and data use
3.3.2. Outputs, outcomes, and process indicators of the Strategic Plan regularly monitored and evaluated	Health information systems strengthened and integrated with financial reporting system Regular service delivery studies undertaken to assess the quality of services Demand-side studies undertaken twice to assess people's perception of quality of services Demographic health survey undertaken at the end of the project	Annual reviews Project reports	Complementary resources from other international agencies will be available.	HIS Strategic Plan, 2008-2015 currently being implemented by DPHI (MOH) • Quality Assurance Office established, quality of care assessment tool developed, 2008 • Regular client satisfaction surveys being conducted in pilot provinces • Next Cambodia demographic health survey to be conducted in 2010 per plan of the Ministry of Planning and MOH
Subcomponent 3.4: Project management				
3.4.1. Project activities, procurement, and distribution managed and coordinated efficiently and effectively to meet reporting and financial requirements	All reports produced on schedule and with acceptable quality All activities performed according to work plan	Project progress reports External audit statements Financial statements	Participants of advisory working groups are able to adequately participate. Key line department staff have the capacity and are able to participate in project-related activities.	Project semiannual reports of acceptable quality regularly produced and shared with partners Work plan activities integrated into provincial and operational district AOPs as part of the sectorwide approach since 2008
Project Activities				
Building and civil works Medical and auxiliary equipment	$7.7 million $0.8 million	• Project accounts • Project progress reports		$7.043 million

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks	Results
Training of health center and referral hospital staff	$1.6 million			$2.490 million
Alternative delivery management and financing mechanisms	$13.0 million			
MPA start-up drug kits	$0.1 million			
Health service planning and management strengthened	$1.0 million			
MOH human resource capacity strengthened	$1.1 million			
M&E	$3.1 million			
Project management and consultant services	$1.7 million			
Total	ADB $20 million DFID $10.4 million Government $4.6 million			ADB $21.48 million DFID $11.77 million Government $1.95 million

ADB = Asian Development Bank, AOP = annual operational plan, CPA = complementary package of activities, DFID =, Department for International Development of the United Kingdom, DPHI = Department of Planning and Health Information, HCP = health coverage plan, HSSP = Health Sector Support Project, M&E = monitoring and evaluation, MOH = Ministry of Health, MPA = minimum package of activities, PHC = primary health care, PHD = provincial health department.

ACTUAL PROJECT COSTS AND FINANCING PLAN

Table A2.1: Actual Cost versus Appraisal Estimates (Asian Development Bank-funded by component)
($ million)

Item	Appraisal Estimates			Actual Cost		
	Foreign Exchange	Local Currency	Total Cost	Foreign Exchange	Local Currency	Total Cost
A. Base Cost						
1. Improved Delivery of Health Services	**6.79**	**7.06**	**13.85**	**9.81**	**8.23**	**18.04**
a. Buildings and civil works	0.84	5.44	6.28	1.21	7.04	8.26
b. Medical and auxiliary equipment	0.69	0.00	0.69	2.40	0.00	2.40
c. Training		1.61	1.61	0.00	0.58	0.58
d. Alternative mechanisms for supporting poor	5.17	0.01	5.18	6.20	0.61	6.81
e. Supplies and drugs	0.09	0.00	0.09	0.00	0.00	0.00
2. Support to Programs Addressing Public Health Priorities						
3. Strengthening Institutional Capacity	**1.15**	**2.87**	**4.02**	**0.30**	**2.63**	**2.93**
a. Health services planning and management capacity strengthening	0.00	1.03	1.03	0.00	0.96	0.96
b. Human resource planning and management capacity strengthening	0.05	0.95	1.00	0.00	0.58	0.58
c. Monitoring and evaluation	0.77	0.34	1.12	0.00	0.21	0.21
d. Project management, taxes, and duties	0.34	0.53	0.88	0.30	0.88	1.18
Subtotal (A)	7.95	9.93	17.87	10.54	10.32	20.87
B. Contingencies						
1. Physical Contingencies	0.38	0.47	0.83	0.10	0.03	0.10
2. Price Contingencies	0.35	0.43	0.77	0.00	0.00	0.00
Subtotal (B)	0.72	0.90	1.62	0.10	0.03	0.10
Subtotal (A + B)	**8.67**	**10.82**	**19.49**	**10.11**	**10.86**	**20.97**
C. Interest Charges	0.51	0.00	0.51	0.51	0.00	0.51
Total	**9.18**	**10.82**	**20.00**	**10.62**	**10.86**	**21.48**

Source: Asian Development Bank estimates and Ministry of Health.

Table A2.2: Actual Cost versus Appraisal Estimates (Department for International Development-funded, by category)
($ million)

Item	Appraisal Estimates			Actual Cost		
	Foreign Exchange	Local Currency	Total Cost	Foreign Exchange	Local Currency	Total Cost
A. Base Cost						
1. Civil Works	0.00	0.00	0.00	0.00	0.00	0.00
2. Equipment and Furnishings	0.14	0.00	0.14	0.12	0.00	0.12
3. Consulting Services	1.08	0.71	1.79	1.04	0.68	1.72
4. Contracting NGOs	9.56	0.01	9.57	9.45	0.01	9.46
5. Staff Development and Workshops	0.00	0.00	0.00	0.00	0.00	0.00
6. Drug Supply	0.00	0.00	0.00	0.00	0.00	0.00
7. Studies and Surveys	0.47	0.01	0.48	0.45	0.01	0.46
8. Project Management	0.01	0.00	0.01	0.01	0.00	0.01
Subtotal	**11.26**	**0.73**	**11.99**	**11.07**	**0.70**	**11.77**
B. Contingencies	0.08	0.09	0.17	0.00	0.00	0.00
Total	**11.34**	**0.82**	**12.16**	**11.07**	**0.70**	**11.77**

Source: Asian Development Bank and Ministry of Health.

ANNUAL DISBURSEMENTS

Year	Quarter	ADB Funds		Counterpart Funds		DFID Funds	
		Amount	Cumulative	Amount	Cumulative	Amount	Cumulative
2003	II	1,000,000	1,000,000	-	-	-	-
	III	-	1,000,000	-	-	1,054,913	1,054,913
	IV	459,456	1,459,456	-	-	119,373	1,174,286
2004	I	309,717	1,769,173	100,000	100,000	-	1,174,286
	II	577,275	2,346,448	-	100,000	484,642	1,658,928
	III	218,327	2,564,775	-	100,000	681,620	2,340,548
	IV	13,059	2,577,835	62,430	162,430	259,287	2,599,835
2005	I	1,002,351	3,580,186		162,430	277,438	2,877,274
	II	557,386	4,137,572	54,668	217,098	478,924	3,356,197
	III	1,301,009	5,438,581	10,241	227,339	800,232	4,156,430
	IV	779,268	6,217,849	159,027	386,366	301,049	4,457,478
2006	I	471,391	6,689,240	-	386,366	950,063	5,407,542
	II	793,442	7,482,682	67,459	453,825	787,483	6,195,025
	III	565,016	8,047,697	32,148	485,973	573,124	6,768,149
	IV	854,639	8,902,336	40,168	526,140	498,124	7,266,273
2007	I	905,642	9,807,978	31,834	557,975	480,061	7,746,334
	II	1,045,624	10,853,602	155,704	713,679	476,478	8,222,812
	III	1,203,130	12,056,732	235,539	949,217	39,266	8,262,078
	IV	1,639,926	13,696,658	106,822	1,056,039	1,171,972	9,434,050
2008	I	785,832	14,482,490	188,233	1,244,272	35,620	9,469,670
	II	1,620,981	16,103,471	176,676	1,420,948	514,607	9,984,277
	III	1,965,590	18,069,061	185,652	1,606,600	535,428	10,519,706
	IV	1,070,766	19,139,827	113,050	1,719,651	500,578	11,020,284
2009	I	1,829,479	20,969,306	179,964	1,899,615	412,521	11,432,805
	II	173,769	21,143,075	-	1,899,615	232,198	11,665,003
	III	374,450	21,517,525	47,005	1,946,620	103,865	11,768,868
	IV	(41,901)	21,475,623	-	1,946,620		11,768,868
	Total	**21,475,623**		**1,946,620**		**11,768,868**	

ADB = Asian Development Bank, DFID = Department for International Development
Source: ADB

ACTUAL IMPLEMENTATION SCHEDULE AND STRUCTURE

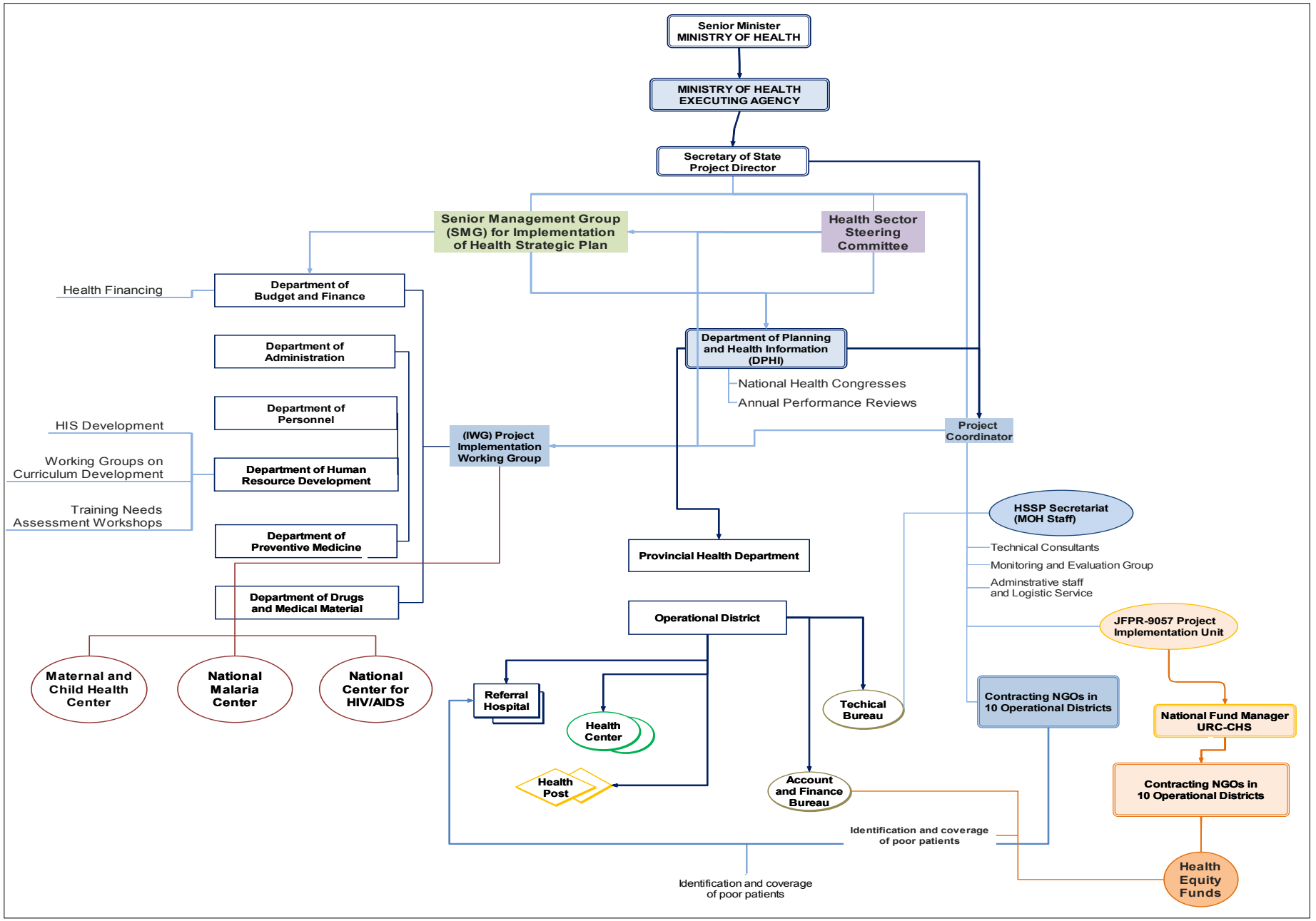
Table A4: Actual Implementation Schedule

Components / Outputs	Responsible Unit	2003	2004	2005	2006	2007	2008	2009	Assigned Weight (a)	Actual Progress (b)	Weighted Progress (a x b)
A. Improving Delivery of Health Services											
1 Building and civil works											
a. Buildings and civil works									15%	100%	15%
Design development	CWM										
Construction completed	CWM										
b. Maintenance	OM Unit										
2 Medical equipment											
a. MPA and CPA and auxiliary equipment									15%	100%	15%
Bid invitation	HSD										
Procurement	Proc. Unit										
b. Maintenance capacity	OM Unit										
3 Training of HC and RH staff									10%	100%	10%
a. Training capacity	RTC										
b. MPA training	PHD and OD										
c. CPA training	DHRD										
4 Contracting of health services									15%	100%	15%
a. Already contracted ODs											
b. Contract new ODs	NGO										
Contract 4 new Ods	NGO										
Contract Koh Kong Ods	NGO										
5 MPA start-up drug kits									0%	0%	0%
a. MPA start-up drug kits	Proc. Unit										
B. Strengthening Institutional Capacity											
1 Health services planning and management capacity									15%	90%	14%
a. Capacity of PHMT and DHMT											
Management training	NIPH										
Annual planning	PHD and OD										
Integrated supervision	MOH										
b. Community participation	PHD and OD										
2 Human resource development capacity									10%	80%	8%
a. Capacity of MOH											
Functional analysis	DPHI										
Capacity building	DPHI										
b. Workforce planning	DPHI and DHRD										
c. Capacity of RTCs	DPHI and DHRD										
d. Capacity of national training system											
CPA module	DHRD										
CPA building	DHRD										
Accreditation of training	DHRD										
e. Remote area placements	DPHI, RTC										
3 Monitoring and evaluation									10%	90%	9%
a. Capacity Building											
b. Monitoring and evaluation											
4 Project Management									10%	90%	9%

Planned
Actual

CPA = complementary package of activities, CWM = civil works manager, DHMT = district health management team, DHRD = Department of Planning and Health Information, HC = health center, HSD = hospital services department, MOH = Ministry of Health, MPA = minimum package of activities, NIPH = National Institute of Public Health, NGO = nongovernment organization, OD = operating district, PHMT = provincial health management team, PHD = provincial health department, RH = referral hospital, RTC = regional training center.
Source: Asian Development Bank and Ministry of Health

Figure A4: Project Management and Implementation Structure Implementation Flow Chart



COMPLIANCE WITH LOAN COVENANTS

Covenants	Loan Agreement	Status of Compliance
PROJECT SPECIFIC COVENANTS		
Health Sector Steering Committee		
1 A Health Sector Steering Committee (HSSC), chaired by a Secretary of State, MOH, shall be responsible for overseeing the implementation of the Project and the Health Sector Strategic Plan 2003 - 2007, and in particular, for (i) approving the annual sector plans, as well as the related work plans and procurement plans, (ii) reviewing implementation progress and resolving problems which may arise and require high level intervention, (iii) organizing the annual review meetings with inputs from the Project Implementation Working Group, (iv) ensuring MOH compliance with the Project covenants; and (v) approving semiannual reports for submission to the respective Project partners. The members of HSSC shall include the Director General of Health, the Director General of Administration and Finance, and representatives of MEF. The Director of the Department of Planning and Health Information shall serve as the Secretary of HSSC.	Schedule 6, para. 2	Complied with. The HSSC was established to fulfill its assigned tasks in 2003. It conducts annual meetings to approve the AOPs. The Second Health Strategic Plan, 2008–2015 was launched at the Joint Annual Performance Review and National Health Congress in 2008.
Project Director		
2 The Director General of Health (DG Health) shall serve as the Project Director. The Project Director shall be accountable for the timely and efficient execution of the program of work of the Project as approved by the HSSC. The Project Director shall be responsible for: (i) the management of the implementation of the approved annual work plan, (ii) approving project expenditures and procurement in line with approved plans and pertinent administrative procedures, (iii) ensuring the timely submission of required financial and technical reports, (iv) responding to requests for information from HSSC, and (v) approving the release of payments for contracting of health services based on the recommendations of the Committee for Health Sector Initiatives.	Schedule 6, para. 3	Complied with. A secretary of state for health was appointed as the project director in 2003.
Project Secretariat		
3 The HSSC and the Project Director shall be assisted by a Secretariat, which shall be responsible for administrative and logistical arrangements managed by the Project Coordinator. The Secretariat shall be located in the office of the Project Coordinator and shall comprise of about 3 staff.	Schedule 6, para. 4	Complied with. The separate project implementation units were not established, and the project coordinator was assisted by the HSSP Secretariat (established within DPHI), designated MOH staff (in total 40 MOH officers) with the help of experienced national and international technical consultants.
Project Coordinator		
4 The Director of Department of Planning and Health Information shall be the Project Coordinator. The Project Coordinator reports to the Project Director and shall be responsible for: (i) coordinating the preparation of the Project work plans, progress reports and budgets; (ii)	Schedule 6, para. 5	Complied with. The DPHI director served as project coordinator, responsible for day-to-day operations, and reported to the

Covenants	Loan Agreement	Status of Compliance
carrying out decisions of the HSSC as directed by the Project Director, (iii) ensuring the close liaison between MOH Departments, national programs, and Provincial Health Departments (PHD), and (iv) managing the Project Secretariat.		project director.
Department of Planning and Health information		
5 The Department of Planning and Health Information (DPHI) shall be responsible for (i) economic analysis, including health financing policies, participation in public expenditures reviews, medium term expenditure frameworks, developing and monitoring poverty reduction strategies; (ii) coordination of annual sector-wide planning, including the integration of the Project; (iii) organizing the Annual Sector Review Process; (iv) overseeing and/or undertaking additional planning tasks; (v) overseeing additional program monitoring and evaluation tasks; (vi) coordinating of information and drafting of semi-annual progress reports; (vii) coordinating, overseeing and where appropriate undertaking specific M&E surveys and studies; (viii) analyzing and updating policy and planning on the basis of evidence; (ix) coordinating a comprehensive functional analysis of the MOH; and (x) convening and acting as Secretariat to the Committee for Health Sector Initiatives.	Schedule 6, para. 6	Complied with.
Department of Budget and Finance		
6 The Director of Department of Budget and Finance (DBF) shall be responsible for all procurement and disbursement, excluding the procurement of consulting services and contracting of services to NGOs.	Schedule 6, para. 7	Complied with.
Implementation Working Group		
7 A Project Implementation Working Group (IWG) shall be established to facilitate the exchange of information between departments and units of the DPHI and DBF. The IWG shall be chaired by the Project Coordinator/Director of DPHI. The IWG shall meet on a weekly basis and shall be responsible for (i) facilitating, the preparation and implementation of the procurement and disbursement plans resulting from the sector plans approved by HSSC ; (ii) recommending solutions to operational problems for consideration by departmental directors and DGs; (iii) facilitating the preparation of semi-annual progress reports for submission to HSSC; and (iv) facilitating the collection and organization of information required for annual sector reviews.	Schedule 6, para. 8	Complied with. The HSSP Implementation Working Group was chaired by the project coordinator. It included directors and other representatives of key MOH departments. Meeting weekly (or as needed), the HIWG had to facilitate the exchange of information among operational departments and units involved in HSSP implementation, and especially between the two directorates general.
Annual Review		
8 The Borrower and the Executing Agency shall ensure that, no later than 30 April 2003 and in each year subsequently thereafter, an annual review of the health sector is organized.	Schedule 6, para. 9	Complied with. Joint annual health sector reviews were held since 2003.
Annual Operational Plan		
9 (a) The Borrower and Executing Agency shall ensure that, no later than 31 May 2003 and in each year subsequently thereafter, the Bank, DFID and IDA shall be provided with the annual operational plan for the health sector for the upcoming year. Further, no later than 31 Juiy of each year, the Borrower and the Executing Agency	Schedule 6, para. 10	Complied with. National and provincial annual operational plans were introduced from 2003 to 2005, and operational district and health facility plans from 2006.

Covenants	Loan Agreement	Status of Compliance
shall finalize and approve a three year rolling plan including the annual operational plan which incorporates the suggestions of the Bank, DFID and IDA. (b) No later than 15 October 2003 and in each year subsequently thereafter, the Borrower and the Executing Agency shall submit the final version of the annual operational plan, as approved by MEF, to the Bank, DFID and IDA for their review and comments.		
Health Services Administration Plan		
10 The Borrower, through the Executing Agency, shall submit by 30 April 2004 for review and concurrence of the Bank, DFID and IDA, during the 2004 annual review, a plan for strengthening the administration of health services. The Executing Agency's health sector institutional capacity building plan will include a review of current and future responsibilities, revised organizational charts, proposed numbers and profiles of key staff, and a training plan for developing capabilities. The Borrower shall ensure that the plan is implemented over the period 2004-2007.	Schedule 6, para. 11	Complied with.
Health Infrastructure Development Plan and Maintenance Plan		
11 The Borrower, through the Executing Agency, shall submit by 30 April 2004 for review and concurrence of the Bank, DFID and IDA, during the 2004 annual review, a Health Infrastructure Development Plan and a Maintenance Plan. The Health Infrastructure Development Plan shall indicate the type of health facilities proposed to be developed, their locations, the nature of civil works to be carried out, and implications for staffing of the proposed facilities; the Maintenance Plan shall cover maintenance of buildings, equipment and vehicles. The Borrower shall ensure that these plans are implemented over the period 2004-2007.	Schedule 6, para. 12	Partially complied with The draft Health Infrastructure Development and Maintenance Plan cannot be finalized until the projected population data by operational district is available; the current available data does not match health operational districts. A request for this information was sent to the Ministry of Planning in November, but to date no response has been received. The 2008 census subnational results have not been finalized.
Health Workforce Development Plan		
12 The Borrower, through the Executing Agency, shall submit by 30 April 2004 for review and concurrence of the Bank, DFID and IDA, during the 2004 annual review, (a) the Health Workforce Development Plan (1996-2005); and (b) the proposed Health Workforce Development Plan for the period 2004-2013 (HWDP). The Executing Agency shall adopt results from the MPA/CPA guidelines and from the Health Infrastructure Development Plan and propose specific measures for deployment, management and training of health providers. HWDP shall identify measures to establish a sector wide solution to low salaries. The Borrower shall ensure that HWDP will be implemented promptly.	Schedule 6, para. 13	Complied with. MOH approved the Health Work Force Development Plan 2006–2015 in November 2005.
Budget Allocation		
13 The Borrower shall ensure that: (a) the allocation to recurrent expenditures in the health sector shall be maintained at least at the current rate of 10% of the	Schedule 6, para. 14	Complied with. The share of public expenditures for health sector fell from 7.37% in

Covenants	Loan Agreement	Status of Compliance
Borrower's total recurrent budget; and (b) actual salary and non-salary expenditures in the health sector shall increase from 90% of allocated funds in the fiscal year of 2003 and 2004 to at least 95% in fiscal year 2005 and 2006.		2005 to 6.84% in the 2006 budget and to 7.29% in 2007. But it reached 12.5% in 2008 and was 11.1% in 2009. Actual salary and nonsalary expenditures in the health sector increased to 95.3% of allocated funds in the fiscal year of 2008 and 96% in fiscal year 2009.
14 The Borrower and the Executing Agency shall ensure that at least 50% of allocated funds from the Borrower's budget shall have been disbursed by 30 September of each year from fiscal year 2003.	Schedule 6, para. 15	Complied with. By 31 December 2005, about 83% of the national budget was disbursed in cash, 93% in mandates. At 30 September 2006, 68% was disbursed in mandates. By December 2006, 92.9% of the budget was disbursed in cash: 85.2% provincial and 96.6% national. By September 2007, 63.2% of the budget was disbursed in cash: 58.5% provincial and 65.1% national. By December 2007, 76.3% of the budget was spent in cash, 58.5% provincial and 83% national. By June 2008, 43% of the 2008 budget was spent in cash: 27% provincial and 50.3% national.
15 The Borrower shall (a) starting in 2003, allocate at least 60 percent of the new recurrent spending above the previous fiscal year for provincial and district hospitals, commune health centers and for programs that directly target the poor; (b) by 30 April 2004, review exemptions made in various cost-recovery arrangements in the health sector and propose mechanisms to effectively benefit the poor during the 2004 annual review; (c) by September 2006, evaluate various initiatives to improve the affordability thereof for the poor including social protection fund (equity funds) pilots and, if found effective and feasible, mainstream the implementation of such schemes in its health strategy, and (d) develop and subsequently implement a formula which incorporates, among others, poverty criteria and disease burden in allocating the health sector budget to provinces and districts.	Schedule 6, para. 16	Partially complied with. (a) 44% of the budget increase was allocated to provinces in 2007 and 46% in 2008; (b) (c) a strategic review on contracting experience was conducted in 2006; several other reviews of affordability and arrangements to benefit the poor were undertaken; a health sector strategy review was completed in September 2007.
16 The Borrower shall ensure that for each fiscal year, commencing in 2004 through 2007, the budgetary allocation, to programs for health education and consumer behavior shall be increased by at least 10%.	Schedule 6, para. 17	Partially complied with.
OTHER MATTERS		
Health Service Contractors		
17 The Borrower, through the Executing Agency, shall ensure that contracted districts will receive an operating budget at levels comparable to those of non-contracted	Schedule 6, para. 18	Complied with.

Covenants	Loan Agreement	Status of Compliance
districts. The Borrower's operating budget which is allocated to the contracted districts shall be disbursed in a lump sum by the Executing Agency's Department of Budget and Finance to the contractors, on a quarterly basis.		
18 The Borrower, through the Executing Agency, shall continue to provide civil service salaries, drugs, equipment and consumable supplies to the contracted districts through normal channels, and shall ensure the availability and timely delivery of the increased drug requirements created by increased utilization of public facilities.	Schedule 6, para. 19	Complied with.
Ethnic Minorities		
19 The Borrower and Executing Agency shall ensure that it will implement the Ethnic Minorities Development Plan, prepared in accordance with the Bank's guidelines, in order to increase the quality and access of coverage of health services received by ethnic minorities. The Borrower and Executing Agency shall further ensure that the ethnic minorities have equal opportunities to participate in ail training activities and placement of health workers. The Project's impact on ethnic minorities shall be observed during Project monitoring and evaluation.	Schedule 6, para. 20	Complied with. Health posts have been built in ethnic minority areas: Kampong Chhnang, Mondulkiri, Ratanakiri, Sihanouk Ville, Takeo. In total, 155 midwives and nurses, including 103 female students (66.5%), from ethnic minority areas were trained at Stung Treng RTC during 2005–2007.
Gender		
20 The Borrower, through the Executing Agency, shall ensure the implementation of the Gender Strategy, prepared and included in the Project and shall further ensure that in selecting the participants for all training activities, priority will be given to women so as to achieve at least the same proportion of women trainees as in the overall pool of the targeted staff with the ultimate goal of reaching gender equality in the training and placement of health workers.	Schedule 6, para. 21	Complied with.
Environment		
21 The Borrower and the Executing Agency shall ensure that the site selection, design, construction, rehabilitation work and operation of the health centers and referral hospitals shall be implemented in line with the Bank's environmental guidelines. Refuse handling and disposal measures for hazardous medical waste shall be carried out strictly in accordance with the prescribed design and operating guidelines of the health centers.	Schedule 6, para. 22	Complied with. Incinerators were built at each health center. Septic tanks and soak away system being placed where appropriate wastewater treatment pond with effluents and chambers have been built for hazardous medical waste at each referral hospital according to the land size. An international environmental specialist financed by the World Bank is conducting a review and design for environmental monitoring of the whole project.
Involuntary Resettlement		
22 Although no involuntary resettlement is envisaged, the Borrower, through the Executing Agency shall, prior to the award of civil works contracts, screen for involuntary resettlement effects, to ensure that there are no losses of	Schedule 6, para. 23	Complied with.

Covenants	Loan Agreement	Status of Compliance
land, income, housing, community facilities and resources that would require compensation to be paid in accordance with the Bank's policy on Involuntary Resettlement.		
Transparency		
23 The Borrower, through the Executing Agency, shall develop mechanisms, acceptable to the Bank, DFID and IDA, to ensure transparent budget management at the central level and the levels of the provincial health departments, operational districts and health centers no later than 30 September 2003. Such mechanisms shall be discussed during the 2004 annual review.	Schedule 6, para. 24	Complied with.

CONSULTING SERVICES

	Name of Contractor		Contract Value ($)		Contract Dates		
	Consultant's Name	Proc. Meth.	Estimated Price	Actual Price	Contract Signature	Contract Start	Contract Completion
I. Civil Work Management							
Civil Work Management	*Sheladia Associates*	QCBS	700,000	1,299,314	19/Nov/03		15/Jan/09
International Civil Works Team Leader	Mr. Timothy Grayling					Dec-03	01-Aug-06
	Mr. Surjya Kumar Tripathy					09-Oct-06	15-Jan-09
II. Improving Health Services Delivery							
Contracting Adviser	Ms. Sheryl Keller	Individual				23-May-03	13-Apr-05
Domestic Contracting Specialist	Mr. Sao Chhorn	Individual					
	Dr. Peng Kok	Individual					
	Dr. Seng Bundeth	Individual					
CPA Training Curriculum Development Specialist	Dr. Joost Abert Hoekstra	Individual				01-Jul-04	31-Jan-05
Financial Management Adviser	Mr. Ronald J. Davies	Individual				01-Jun-05	20-Oct-06
	Ms. Daisy Albao Valence	Individual					
	Mr. Myo Min	Individual				01-May-07	30-Jun-09
Equity Fund Implementer Services	Center for Human Services	SSS	634,040	717,436	3/Jul/08		31/Dec/09
Performance Evaluation for Health Services Delivery Contractors	SBK Reseach & Development	CQS	243,540	188,986	2/Dec/08		2/Mar/09
III. Strengthening Health Sector Institutional Capacity							
Health Workforce Management Adviser	Mr. John Dewdney	Individual				16-Aug-04	19-Nov-04
Technical Support to Implement Joint Annual Performance Review and Annual Operational Plan	*WHO*	SSS	326,000	326,000	24/Feb/06		
Social Protection Adviser	Mr. Maurits Van Pelt					14-Nov-06	31-May-08
Midterm Review for the Health Sector Stragegic Plan 2003-2008	*HLSP (Matt MacDonald Ltd)*	CQS	150,000	138,480	9/May/07		30/Jul/07
HIS Database Development Specialist	Mr. Eduardo Y. Chua	Individual				23-Apr-08	30-Jun-09
IV. Monitoring and Evaluation							
Monitoring and Evaluation Adviser	Dr. Vijay S. Rao	Individual				23-May-04	30-Jun-09
Health Management Monitor (domestic consultants)	Dr. Khuon Vibol	Individual					
	Dr. Chan Phal	Individual					
V. Project Management							
ADB Operation Chief	Mr. Krang Sun Lorn	Individual				1-Mar-03	30-Jun-09
Executive Administrator	Dr. Uy Vengky	Individual				1-Mar-03	31-Dec-08
International Procurement Adviser	Mr. Debabrata Majumdar	Individual				15-Jun-03	31-Dec-08
HSSP Secretariat							
Chief Financial Officer	Mr. Pheav Chin Lay	Individual				1-Mar-03	31-Dec-08
Project Accountant	Mr. Krang Makol	Individual				1-Mar-03	31-Dec-08
	Mr. Kang Taing Eng	Individual				1-Mar-03	31-Dec-08
Accounting Assistant	Ms. Lim Sophorn	Individual				1-Mar-03	31-Dec-08
	Ms. Seang Sorphorn	Individual				1-Mar-03	31-Dec-08
Procurement Officer	Mrs. Leng Sok Heng					1-Mar-03	31-Dec-08
Procurement Asisstant	Mr. Eng Nath	Individual				1-Mar-03	31-Dec-08
Executive Administrator Assistant	Mr. Phang Bunthoeung	Individual				1-Mar-03	31-Dec-08
	Mr. Kiv Sonissay	Individual				1-Mar-03	31-Dec-08
Receptionist /Clerk	Miss. Heang Dané	Individual				1-Mar-03	31-Dec-08
Secretary/Logistic	Ms. Chheng Sodavy	Individual				1-Mar-03	31-Dec-08

LIST OF EQUIPMENT

Table A7.1: Number of CPA Kits Supplied to Referral Hospitals, 2003-2008

No	Provincial Health Department	2003	2004	2005	2006	2007	2008
1	Kg. Cham						2
2	Kg. Chhnang						
3	Koh Kong						2
4	Mondulkiri						1
5	Prey Veng						2
6	Ratanakiri						1
7	Preah Sihanouk						
8	Svay Rieng						
9	Takeo						2

CPA = complementary package of activity.
Source: Ministry of Health of Cambodia; HSSP Semi-Annual Project reports 2003-2009

Table A7.2: Number of MPA Kits Supplied to Provincial Health Departments and Operational Districts, 2003-2008

No	PHDs & operational districts	2003	2004	2005	2006	2007	2008
1	Kg. Cham PHD	2	1	9	4	11	5
2	Kg. Chhnang PHD				1	4	
3	Koh Kong PHD	3			1		
4	Mondulkiri PHD						
5	Prey Veng PHD		2	7	1	12	
6	Ratanakiri PHD					5	
7	Preah Sihanouk PHD				3		2
8	Svay Rieng PHD	25	2	2	1	2	
9	Takeo PHD				1	3	2

PHD = Provincial Health Departments
Source: Ministry of Health of Cambodia; HSSP Semi-Annual Project reports 2003-2009

UTILIZATION OF HEALTH SERVICES

Table 8.1: Per Capita Consultations at Public Facilities (All New Cases)

Description	2003	2004	2005	2006	2007	2008
All new cases	0.39	0.40	0.50	0.54	0.51	0.54
Children under 5 yrs.	0.56	0.74	0.92	1.00	1.00	1.00

Source: Ministry of Health of Cambodia; National Health Statistic Reports 2003-2009; Joint Annual Performance Reports 2005-2009

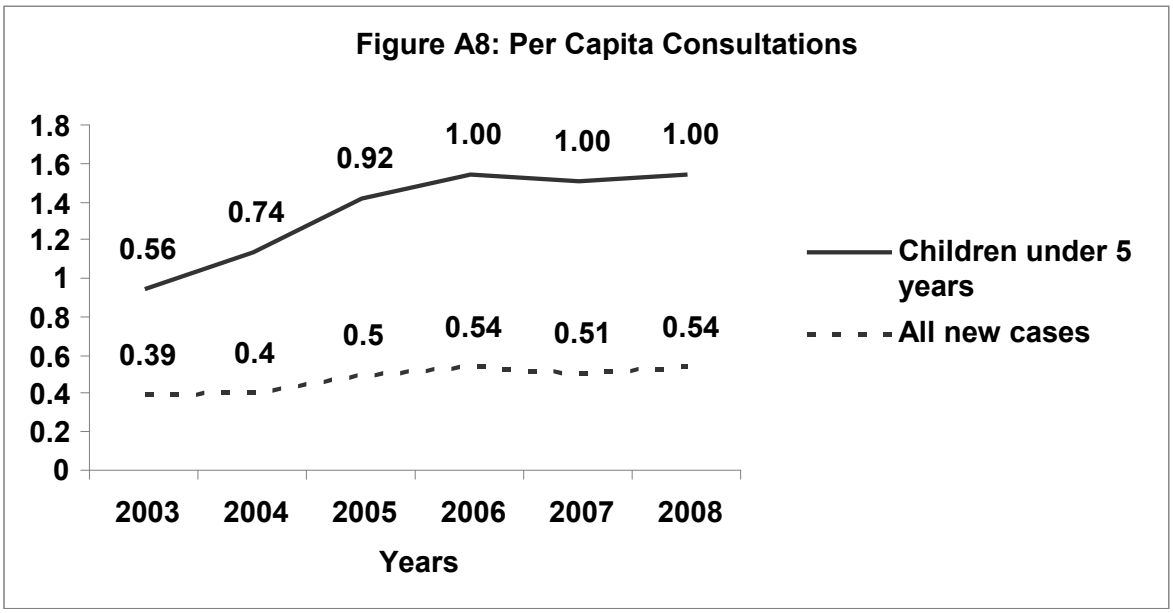


Table 8.2: Outpatient Utilization of Health Services (number of new outpatient consultation per capita per year)

Item	2003	2004	2005	2006	2007	2008	2009	PETS 2003	PETS 2004
I. Cambodia, in total	**0.39**	**0.40**	**0.50**	**0.63**	**0.51**	**0.54**	**…**		
II. Project Province and Operational District								**0.41**	**0.46**
Kampong Cham, in total	**0.35**	**0.41**	**0.46**	**0.72**	**0.53**	**0.55**	**0.51**		
OD Chamkar Leu (Stueng Trang)				0.62	0.48	0.44	0.56		
OD Memot				0.84	0.73	0.66	0.78		
OD Ou Reang Ov Koh Soutin)				0.57	0.42	0.39	0.48		
OD Ponhea Kraek (Dambae)				0.76	0.69	0.57	0.64		
OD Prey Chhor (Kang Meas)				0.82	0.67	0.62	0.66		
Kampong Chhnang, in total	**0.33**	**0.40**	**0.49**	**0.47**	**0.43**	**0.49**	**0.63**		
OD Kampong Tralach				0.73	0.40	0.48	0.61		
Koh Kong, in total	**0.15**	**0.19**	**0.19**	**0.63**	**0.24**	**0.40**	**0.39**		
OD Smach Mean Chey				0.75	0.55	0.47	50.00		
OD Srae Ambel				0.38	0.25	0.24	25.00		
Krong Prean Sihanouk, in total	**0.29**	**0.27**	**0.28**	**0.26**	**0.23**	**0.28**	**0.47**		
Mondul Kiri, in total	**0.80**	**0.69**	**1.00**	**0.88**	**0.72**	**0.66**	**0.68**	**0.78**	**0.64**
OD Saen Monourom				0.88	0.72	0.66	0.68		
Prey Veng, in total	**0.38**	**0.45**	**0.52**	**0.57**	**0.50**	**0.53**	**0.50**	**0.42**	**0.50**
OD Kamchay Mear				0.53	0.38	0.36	0.41		
OD Kampong Trabaek				0.47	0.28	0.27	0.33		
OD Pea Reang				0.99	0.89	0.88	0.93		
OD Preah Sdach				0.72	0.72	0.59	0.59		
Ratanak Kiri, in total	**0.48**	**0.45**	**0.57**	**1.16**	**0.91**	**0.74**	**0.66**	**0.65**	**0.44**
OD Ban Lung				1.16	0.91	0.74	0.66		
Svay Rieng, in total	**0.37**	**0.48**	**0.55**	**0.67**	**0.50**	**0.45**	**0.50**	**0.40**	**0.55**
OD Chiphu (Chantrea)				0.52	0.37	0.26	0.21		
OD Romeas Haek				0.99	0.75	0.61	0.61		
Takeo, in total	**0.41**	**0.51**	**0.61**	**0.71**	**0.57**	**0.65**	**0.56**	**0.45**	**0.52**
OD Ang Roka				1.03	0.91	0.90	0.77		
OD Bati				0.70	0.43	0.39	0.35		
OD Kiri Vong (Kaoh Andaet)				0.66	0.56	0.52	0.49		
OD Prey Kabbas (Angkor Borei)				0.67	0.65	0.94	1.01		

Source: Ministry of Health of Cambodia; National Health Statistic Reports 2003-2009; Joint Annual Performance Reports 2005-2009; HSSP Semi-Annual Project reports 2003-2009

Table 8.3: Inpatient Utilization of National and Provincial Health Services

(hospital admissions per 1,000 population per year)

Item	2003	2004	2005	2006	2007	2008	2009
I. Cambodia, in total	**23.00**	**20.24**	**20.80**	**27.62**	**37.72**	**169.60**	**...**
II. Project Province and Operational District							
Kampong Cham, in total	**15.29**	**15.73**	**14.56**	**18.86**	**22.06**	**21.33**	**24.18**
OD Chamkar Leu (Stueng Trang)				27.17	25.21	23.84	24.50
OD Memot				38.05	45.86	28.19	38.64
OD Ou Reang Ov Koh Soutin)				10.68	10.75	9.73	10.71
OD Ponhea Kraek (Dambae)				18.63	32.23	24.14	26.45
OD Prey Chhor (Kang Meas)				11.49	13.32	12.14	15.24
Kampong Chhnang, in total	**12.37**	**16.11**	**13.67**	**13.17**	**13.07**	**16.46**	**25.63**
OD Kampong Tralach				10.52	10.43	12.95	16.79
Koh Kong, in total	**11.49**	**13.23**	**10.68**	**10.14**	**9.97**	**15.65**	**...**
OD Smach Mean Chey				27.45	28.67	23.65	...
OD Srae Ambel				6.03	6.31	11.36	...
Krong Prean Sihanouk, in total	**15.99**	**16.57**	**17.85**	**13.48**	**17.98**	**18.14**	**28.92**
Mondul Kiri, in total	**33.23**	**28.19**	**53.88**	**21.77**	**20.13**	**14.98**	**17.56**
OD Saen Monourom				21.77	20.13	14.98	17.56
Prey Veng, in total	**11.08**	**13.06**	**...**	**7.91**	**10.81**	**8.28**	**17.48**
OD Kamchay Mear				3.24	6.70	3.92	7.21
OD Kampong Trabaek				11.64	12.46	10.13	15.08
OD Pea Reang				9.82	13.28	9.40	23.77
OD Preah Sdach				10.94	14.52	6.41	18.43
Ratanak Kiri, in total	**25.49**	**29.27**	**56.04**	**22.66**	**26.54**	**22.49**	**27.53**
OD Ban Lung				22.66	26.54	22.49	27.53
Svay Rieng, in total	**13.49**	**18.13**	**17.04**	**17.73**	**20.19**	**22.25**	**23.59**
OD Chiphu (Chantrea)				14.74	19.24	16.68	13.95
OD Romeas Haek				12.65	15.74	9.72	10.58
Takeo, in total	**16.61**	**21.59**	**20.73**	**19.50**	**25.36**	**21.31**	**18.61**
OD Ang Roka				19.93	29.63	17.53	13.68
OD Bati				10.23	7.82	7.70	10.07
OD Kiri Vong (Kaoh Andaet)				21.09	27.74	23.91	27.43
OD Prey Kabbas (Angkor Borei)				3.44	4.10	4.02	6.52

Source: Ministry of Health of Cambodia; National Health Statistic Reports 2003-2009; Joint Annual Performance Reports 2005-2009; HSSP Semi-Annual Project reports 2003-2009

Table 8.4: Deliveries at Health Facilities

Item	2003		2004		2005		2006		2007		2008		2009		DHS 2000		DHS 2005	
	Health Facility	At home	Health Facility	At home	Health Facility	At home	Health Facility	At home	Health Facility	At home	Health Facility	At home	Health Facility	At home	Health Facility	At home	Health Facility	At home
I. Cambodia, in total	**10.60**	**32.08**	**16.34**	**44.77**	**13.30**	**42.70**	**17.77**	**42.93**	**25.54**	**45.55**	**39.00**	**39.79**	**44.00**	**…**	**9.90**	**89.00**	**21.50**	**78.30**
HSSP/UNFPA supported ODs since 2004	6.98	…	10.58	…	9.23	…	16.88	…	20.92	…	29.37	…	…	…				
HSSP/UNFPA supported ODs since 2006	…	…	7.29	…	7.63	…	20.84	…	21.46	…	37.10	…	…	…				
II. Project Province and Operational District																		
Kampong Cham, in total	**4.72**	**30.74**	**7.09**	**46.12**	**7.22**	**46.62**	**10.14**	**48.56**	**14.51**	**48.64**	**25.98**	**47.83**	**40.00**	**…**	**5.20**	**92.00**	**12.30**	**87.50**
OD Chamkar Leu (Stueng Trang)							12.24	35.39	19.57	27.38	29.84	16.55	42.00	…				
OD Memot							19.98	79.83	21.94	64.21	0.57	52.47	34.00	…				
OD Ou Reang Ov Koh Soutin)							5.46	44.47	7.82	51.26	10.42	47.21	18.00	…				
OD Ponhea Kraek (Dambae)							21.28	54.26	33.15	49.66	40.22	38.42	51.00	…				
OD Prey Chhor (Kang Meas)							9.65	47.73	17.12	44.55	35.97	26.70	55.00	…				
Kampong Chhnang, in total	**7.19**	**37.98**	**13.49**	**45.83**	**16.89**	**38.05**	**22.07**	**38.31**	**28.52**	**33.15**	**50.51**	**22.52**	**64.40**	**3.90**	**6.30**	**92.80**	**17.70**	**82.40**
OD Kampong Tralach							29.81	55.12	42.83	44.69	69.52	24.49	62.40	17.11				
Koh Kong, in total	**6.99**	**13.77**	**12.05**	**25.68**	**15.95**	**24.72**	**16.12**	**23.08**	**17.47**	**20.74**	**35.14**	**27.02**	**49.00**	**…**	**6.80**	**90.20**	**28.60**	**71.10**
OD Smach Mean Chey							32.04	29.69	38.95	36.10	46.61	30.64	33.00	27.00				
OD Srae Ambel							20.17	43.25	20.67	31.72	32.36	28.56	46.00	3.20				
Krong Prean Sihanouk, in total	**9.14**	**14.13**	**11.05**	**18.68**	**12.00**	**19.02**	**8.92**	**19.38**	**18.16**	**16.53**	**26.48**	**17.32**	**59.00**	**11.00**	**10.30**	**89.70**	**28.60**	**71.10**
Mondul Kiri, in total	**6.64**	**35.38**	**5.59**	**26.80**	**14.07**	**23.40**	**22.85**	**21.08**	**18.25**	**20.59**	**22.36**	**18.17**	**24.00**	**18.17**	**6.10**	**93.50**	**8.60**	**90.60**
OD Saen Monourom							22.85	21.08	18.25	20.59	22.36	18.17	24.00	12.00				
Prey Veng, in total	**5.16**	**38.66**	**13.21**	**60.59**	**16.63**	**54.48**	**16.06**	**53.41**	**17.12**	**55.88**	**27.91**	**51.08**	**41.04**	**34.39**	**2.40**	**97.30**	**12.60**	**86.60**
OD Kamchay Mear							0.65	57.03	3.94	53.91	21.75	34.48	37.07	25.29				
OD Kampong Trabaek							4.08	62.88	4.70	70.08	10.08	62.95	33.47	44.76				
OD Pea Reang							54.38	11.45	49.81	12.05	47.82	8.50	63.79	7.35				
OD Preah Sdach							33.91	38.38	28.35	49.16	27.97	44.87	54.55	23.72				
Ratanak Kiri, in total	**9.82**	**27.74**	**8.74**	**19.26**	**16.41**	**25.45**	**21.19**	**25.05**	**20.89**	**27.53**	**25.77**	**22.10**	**29.00**	**31.00**	**6.10**	**93.50**	**8.60**	**90.60**
OD Ban Lung							21.19	25.05	20.89	27.53	25.77	22.10	29.00	31.00				
Svay Rieng, in total	**9.82**	**27.74**	**8.74**	**19.26**	**16.41**	**25.45**	**21.19**	**25.05**	**20.89**	**27.53**	**25.77**	**22.10**	**53.00**	**5.00**	**6.10**	**93.50**	**8.60**	**90.60**
OD Chiphu (Chantrea)							…	…	…	…	…	…	40.00	12.00				
OD Romeas Haek							…	…	…	…	…	…	52.00	3.00				
Takeo, in total	**10.22**	**34.99**	**19.25**	**45.34**	**22.46**	**36.06**	**26.65**	**32.15**	**40.34**	**24.51**	**55.29**	**13.74**	**52.00**	**7.00**	**9.00**	**90.40**	**29.00**	**70.60**
OD Ang Roka							48.84	23.99	61.92	14.59	81.02	1.99	67.00	9.00				
OD Bati							23.53	38.95	35.18	38.10	46.51	23.14	43.00	1.00				
OD Kiri Vong (Kaoh Andaet)							45.48	21.47	58.93	13.09	61.51	6.96	56.00	1.00				
OD Prey Kabbas (Angkor Borei)							14.27	48.83	37.47	26.99	56.16	11.14	58.00	4.00				

Source: Ministry of Health of Cambodia; National Health Statistic Reports 2003-2009; HSSP Semi-Annual Project reports 2003-2009

OVERALL ASSESSMENT

Criterion	Weight (%)	Assessment	Rating Value	Weighted Rating
Relevance	20	Highly relevant	3	0.6
Effectiveness	30	Effective	2	0.6
Efficiency	30	Efficient	2	0.6
Sustainability	20	Most likely	3	0.6
Overall Rating		**Successful**		**2.4**

Highly successful: Overall weighted average is greater than 2.7.
Successful: Overall weighted average is 1.6 or greater and less than 2.7.
Partly successful: Overall weighted average is 0.8 or greater and less than 1.6.
Unsuccessful: Overall weighted average is less than 0.8.

Source: Operations Evaluation Department. 2006. *Guidelines for Preparing Performance Evaluation Reports for Public Sector Operations*. Manila: Asian Development Bank.