	Provision of Basic Health Services in the provinces of Siem Reap, Otdar Meanchey and Kampong Cham **KAM 0200711**	

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Preparatory Document

for the

2nd Steering Committee Meeting

2009 Activity Result, Expenditure and Progress Report

&

Action and Financial Plan for 2010

Prepared by the Project Management Unit

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ABBREVIATIONS AND ACRONYMS

€	EUR (European Currency)
AFH	Action for Health
AOP	Annual Operation Plan
BCC	Behavioral Change Communication
BTC	Belgian Technical Cooperation
CAAFW	Cambodian Organization for Assistance to Families and Widows
CAR	Council of Administrative Reform
CB	Capacity Building
CBHI	Community Based Health Insurance
CDC	Communicable Diseases Control
CFDS	Cambodian Family Development Services
CHHRA	Cambodian Health and Human Rights Alliance
CKL	Chamkar Leu
CMS	Central Medical Store
CP	Cheung Prey
CPA	Complementary Package of Activities (Referral Hospital)
CR	Cambodian Riel
CRO	Consumer Rights Organization
DGDC	Directorate General of Development Cooperation (Belgium)
DHTAT	District Health Technical Advisory Team
DRH	District Referral Hospital
EAC	Equity Access Card
FMIS	Financial Management Information System
GAVI	Global Alliance for Vaccine and Immunization
GIS	Geographical Information System
GOC	Government Of Cambodia
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HC	Health Centre
HCMC	Health Centre Management Committee (HC community structure)
HEF	Health Equity Fund
HEFI	Health Equity Fund Implementer
HEFO	Health Equity Fund Operator
HFS	Health Financing Scheme (user fee)
HFU	Health Financing Unit
HIB	Handicap International Belgium
HIS	Health Information System
HMIS	Health Management Information System
HRD(P)	Human Resource Development (Plan)
HSSP	Health Sector Support Program
HSSP2	Second Health Sector Support Program
IEC	Information Education Communication (Health Promotion)
IFR	Interim Unaudited Financial Reports
IPD	In Patient Department
JLCB	Joint Local Consultative Body
JPIG	Joint Partnership Arrangement Development Partners Interface Group
KC	Kampong Cham
MBPI	Merit Based Performance Initiative
MEF	Ministry of Economy and Finance
MOEYS	Ministry Of Education Youth and Sports
MOH	Ministry Of Health
MOP	Ministry of Planning
MPA	Minimum Package of Activities (HC activities)
MSF-B	Médecins Sans Frontières Belgique
NCHP	National Centre for Health Promotion
NEX	National Execution
NGO	Non Governmental Organization

NHS	National Health Survey WB/ADB
NIPH	National Institute of Public Health
OD(O)	Operational District (Office)
OI	Opportunistic Infection
OMC	Otdar Meanchey
OPD	Out Patient Department
OT	Operating Theater
PAP	Priority Action Program (financial disbursement system running costs)
PBHS	Provision of Basic Health Services
PBHS2	Provision of Basic Health Services in the province of Siem Reap, Otdar Meanchey and Kampong Cham
PBHS-KC	Provision of Basic Health Services in the province of Kampong Cham
PBHS-SROM	Provision of Basic Health Services in the province of Siem Reap and Otdar Meanchey
PC	Prey Chhor
PHA	Provincial Health Advisor
PHD (O)	Provincial Health Department (Office)
PHTAT	Provincial Health Technical Advisory Team
PLWHA	People living with HIV/AIDS
PMG	Priority Mission Group
PMU	Project Management Unit
PRH	Provincial Referral Hospital
Pro TWGH	Provincial Technical Working Group Health
ProCoCom	Provincial Coordination Committee
PTAC	Project Technical Advisory Committee
QI	Quality Improvement
QIP	Quality Improvement Plan
RH	Referral Hospital
SCA	Save the Children Australia
SCA	Save the Children Australia
SDG	Service Delivery Grant
SHI	Social Health Insurance
SMT	Senior Management Team
SOA	Special Operating Agency
SR	Siem Reap
SWiM	Sector Wide Management
TA	Technical Assistant
TASC	Technical Advisory Sub Committee
TB	Tuberculosis
TFF	Technical & Financial File
TNA	Training Needs Assessment
TOR	Terms of Reference
TOT	Training of Trainers
URC	University Research Council
US$	United States Dollar
WB	World Bank

1. EXECUTIVE SUMMARY

By Mid-December 2008 the "Exchange of Letters" between the Cambodian and the Belgian governments validated the changes to the Specific Agreement of KAM0200711 including the associated Technical and Financial File as such approving the Consolidation Phase of the two existing PBHS projects. The consolidation phase (PBHS2), does integrate the PBHS in Kampong Cham project into the PBHS in Siem Reap and Otdar Meanchey project and is named "Provision of Basic Health Services in the provinces of Siem Reap, Otdar Meanchey and Kampong Cham" (PBHS2).
The Belgian contribution to PBHS2 is 3 Million Euro.
In the context of PBHS2 BTC has become a partner to the Second Health System Support Program (HSSP2) and a signatory to the Joint Partnership Arrangement (JPA). BTC does contribute to the HSSP2 through a discrete account.

The Provision of Basic Health Services Project continues to operate in the three provinces, three Provincial Health Departments, three Provincial Hospitals, and 8 Operational Districts (OD) (all ODs of Otdar Meanchey(1) and Siem Reap (4) and 3 of the 10 ODs of Kampong Cham being Cheung Prey, Prey Chhor and Chamkar Leu). The BTC Health Advisor represents BTC in the Joint Partnership Arrangement Development Partners Interface Group (JPIG). In this context BTC assumes technical lead roles for Health Care Financing, for Internal Contracting and for Health Information Systems which allows for increased participation in central level strategy and policy discussion on those subjects.

2009 has clearly been a starting up or transition year. HSSP2 introduced several new financing and implementation instruments and multiple new management guidelines and procedures. Some of those were even not yet finalized at the start of the program. Many of the implementation units did not have a clear understanding of the regulations which held up expenditure. SDG, SOAs and MBPIs have started with a lot of delays and in fewer places than planned.

As a result HSSP2 cumulative expenditure was only 11.15 Million USD or 41.54% of the total annual available budget of 26.85 Million USD.

The total PBHS2 expenditure was 5,857 Million Euro or 75% of the 7,787 Million Euro planned. HSSP2 reports BTC expenditure in National Execution as 345,779 USD. BTC however does regard the total amount transferred to HSSP2 secretariat BTC Discrete Account during 2009 being 467,864 USD as expenditure rather than the 345,779 USD reported by HSSP2 secretariat.

PBHS2, being fully integrated in HSSP2 and partially implemented in National Execution, was equally confronted with these new procedures. For the HSSP2 secretariat which was already overstretched PBHS2 represented an extra burden because of the special arrangements and additional workload.
Throughout 2009 it became clear that National Execution is not the ideal modality for managing a capacity building team of technical assistants which requires flexibility to adapt to changing situation throughout the year. The initial rather complex set-up of a BTC HEF implementer being funded through the HSSP2 secretariat using BTC funds was revised. It was decided to use own-management rather than NEX for the functioning of the HEFI office.

Because of the recruitment problems under NEX, the capacity building team remained limited to 5 TAs, only a fraction of the 11 staff required. NEX procedures also complicated and delayed the provision of logistic support for the capacity building. All this had an important impact on capacity building progress.

The combination of lengthy and hefty approval mechanisms, new non-routine procedures, delayed responses from central level departments and HSSP2 (secretariat and JPIG), as well as the shortage of capacity building TA made that no SOA, SDG or MBPI were established in the PBHS2 project areas

during 2009. Performance incentive for public health staff were severely delayed and 5 ODs and 2 PRHs did not receive performance incentives after 30th June 2009.

Notwithstanding all those changes and complications all 8 HEFs continued to function uninterrupted throughout 2009, although often with their funding severely stretched and the HEFI manager forced to apply unorthodox procedures. In 2009 the HEFs supported 24,551 hospitalization, 2,712 deliveries and 41,481 outpatient consultations for poor patients. This important increase is largely attributed to the effect of the pre-identification.

Despite 2009 being a transition year the supported Provinces, ODs and PRHs achieved good and sometimes even impressive health service results and coverage rates.
Important gains were made for most health output indicators. In general numbers and rates increased for hospitalizations, outpatient consultations, deliveries by trained personnel, deliveries in HC and RH, the numbers of surgeries and emergency surgeries. Vaccination coverage rates remained high. In some places results were really impressive. Only in Sotnikum and Kralanh RH did the number of hospitalizations diminish. The vaccination coverage rates in Otdar Meanchey went down but this is caused by an important change in the denominators used.

Higher user-fee revenues, often with substantial contribution from self-paid user fees, together with substantial increased government salaries and allowances resulted in a further increase in staff income at most levels.

Beside this general positive appreciation, several aspects of the presented results deserve additional comments:

- The synergy between the government delivery incentives and the voucher system for maternal health services continue to contribute to an accelerated increased number of deliveries at HC level in KC.
- A very laudable increase or better reporting in HC user-fees revenues gives a reassuring picture of the financing at this level.
- The proportion of HEF supported inpatients continued to increase from 52% in 2008 to 55% in 2009 in Kampong Cham, from 43% in 2008 to 45% in 2009 in Otdar Meanchey and from 27% in 2008 to 40% in 2009 in Siem Reap. For most hospitals HEFB represent the major part of their clientele and obviously also of their userfee income. In 2009 no assessments of admission criteria and hospitalization indications were done. It will be important to conduct some assessments during 2010 in order to limit the number of unnecessary hospitalizations.
- This year again the high utilization is confronted with and limited by the inadequate and delayed mobilization of government resources:
    - CMS Drug Supply: while the declared value of the yearly supply kept on rising substantially, the quantities of received drugs did not increase in proportion. Although recognizing improved drug supplies throughout 2009 the better functioning hospitals and HCs continue to face important shortage of drugs.
    - Staffing: the main shortages assessed in 2006 have not yet been improved in 2009. The numbers of doctors, nurses have not really changed. Shortages of midwives at HC level have been partially addressed in the project area through the training of 50 extra primary midwives by the project.
- Dual practice (in public and private) by government health staff creates huge conflicts of interest which will certainly impede further sustainable development of hospitals and health centers.

In 2009 the project assessed the presently used HEF post- and pre-identification tools and continued its evaluation of the Maternal Health Vouchers. The findings of the identification assessment have

been shared in a workshop and through the report "Assessment of HEF beneficiary identification in three operational health districts in Kampong Cham" (for summary see annex 7.).

The findings of the Maternal Health Vouchers evaluation have been published in the "BMJ, Pregnancy and Childbirth" as an article with the title "Using targeted vouchers and health equity funds to improve access to skilled birth attendants for poor women: a case study in three rural health districts in Cambodia" (for abstract see annex 8.).

The 11 SOAs (8 ODs and 3 PRH) hope that they will start receiving their Service Delivery Grant with effect of 1st January 2010. PBHS2 will need to strengthen its capacity building certainly in the field of financial management and quality improvement. Hence the HSSP2 secretariat will need to look at alternative ways of recruitment and attracting candidates and possibly at other training approaches.
In order to allow PHDs, ODs, and PRHs to budget for the required trainings and operational costs for capacity building using the HSSP2/BTC available funds it will be necessary to consider this in the setting of the provincial caps during the planning process for 2011.

An important weakness remains the absence of an external validation of the HIS provided figures. In 2009 little or no monitoring was done by PHDs and central level. Given that bonuses and incentives in the context of SDG are linked to the reported achieved results it has becomes crucial to establish and implement robust internal and external monitoring system soon.
It will be important for PHD teams to increase their involvement with SDG and SOA developments and to take their role as commissioner more seriously. The recently canceled MPBI scheme and the linked performance agreement, which tried to commit PHD teams to these responsibilities, will need to be replaced urgently by another motivation instrument.

In 2009 the AOP process has been given a strong new impetus, mainly because of the new compulsory linkage between AOP planning and HSSP2 funding. The PBHS2 has been assisting the DPHI with the development of a long awaited AOP database system. This system aims to simplify the work for the different planning levels and will allow for automatic aggregation and disaggregation and also facilitate the review process. In 2010 the DPHI plans to roll out the database system to all provinces. The DPHI has requested the project to support the training of PHD teams on the use of this database system.

In 2009 the HSSP2 Pooled Fund and related Cambodian Government counterpart funding did contribute substantial funding to the so-called "PBHS2 activities", through Service Delivery Grants and for HEF direct benefit expenses. Their contribution will increase further in 2010 and 2011. While funding arrangements for those strategies after the closing of PBHS2 still need to be agreed, the present understandings and funding trends are quite promising for the sustainability of Internal Contracting and HEFs.

2. MONITORING OF EXPECTED CORNERSTONES

The three year Consolidation Phase intends to assure the sustainability of the main project results of Phase I. The project aims at achieving Technical Sustainability through intensified targeted capacity building and through participating in the development of efficient health strategies and policies. Financial sustainability will be achieved by handing over financial responsibilities to the government and other health partners; this transfer has been planned for in the project design and is facilitated through the HSSP2 partnership. In this context a list of expected cornerstones is established and followed up yearly.

Area of Development	Cornerstone	Status at year end
	2009	
Transition from PMU to National Execution	Transfer of TA staff	Done
	Recruitment of new TA	Delayed
	Recruitment of Admin Staff	One person recruited other posts abolished
	Logistic arrangements operational	Progressed by end of year
HEF	Establishment of HEFI Office	Done
	HEFOs Contracted	Done
	New fund flows operational and control mechanisms operational	Done
	Pre-Identification of poor households	Distribution of Equity Cards finalized
	Monitoring HEF by MOH	Delayed
	Scaling-up plan and funding plan developed and agreed	Some attempts but delayed
	Institutional Arrangement agreed	Some attempts but delayed
SDG and SOA functioning	7 SOA established and receiving SDG	All contracts and documents finalized but only by year end
	Management Capacities assessed	Done
	Specific Management Capacities acquired	Partially
	PRH SDG Funding Policy	Temporary solution agreed
PHD Commissioner role and MBPI functioning	MBPI operational	Started in Q3 for PHD KC, SR and OMC delayed. MBPI system abolished
	PHD appropriates Commissioner Role	little progress
	Required capacities acquired	Delayed
	Monitoring of SOAs	Not applicable
	Monitored by Central level	Not Done
Evidence and Information for Policy Making	Define need, develop plan	Delayed
Independent Monitoring and Audits	Financial Quarterly Audits	Implemented
	Technical Audits	No progress
	External Monitoring	No progress
	2010	
Transition from PMU to National Execution	Recruitment of new TA	
	Logistic arrangements operational	
HEF	Prepare/plan hand-over of HEFI responsibilities in 2011	
	Monitoring HEF by MOH	
	Scaling-up plan and funding plan developed and agreed	
	Institutional Arrangement agreed	
SDG and SOA functioning	11 SOA established and receiving SDG	
	Management Capacities assessed	
	Planned Capacities build	
	PRH funding mechanism agreed	
	Development of Hospital and OD boards	
	SDG & SOA manual revised	

PHD Commissioner role and MBPI functioning	Develop alternative system to commit PHD team to their SOA/SDG commissioner role	
	PHD appropriates Commissioner Role	
	Required capacities acquired	
	Management Capacities re-assessed	
	Monitoring of SOAs	
	Monitored by Central level	
Evidence and Information for Policy Making	Define need, develop plan	
	Hospital Financing Policy	
	HC Financing Policy	
Independent Monitoring and Audits	Financial Quarterly Audits	
	Technical Audits	
	External Monitoring	
	2011	
End of project	Ending staff contracts	
	Household Survey	
	End of project evaluation	
HEF	New HEF Institutional Arrangements operational	
	HEFI responsibilities handed over	
	HEFO funding responsibilities handed over	
	Repeat pre-identification of poor households	
	Monitoring HEF by new structure	
	Scaling-up plan to XX new ODS and Hospitals, and funding plan revised	
SDG and SOA functioning	7 SOA established and receiving SDG	
	Management Capacities re-assessed	
	All required capacities acquired	
	PRH funding mechanism operational	
	Hospital and OD boards established and operational	
PHD Commissioner role and MBPI functioning	PHD appropriates Commissioner Role	
	Management Capacities re-assessed and all required capacities acquired	
	Monitoring of SOAs	
	Monitored by Central level	
Evidence and Information for Policy Making	Implement planned activities	
Independent Monitoring and Audits	Financial Quarterly Audits	
	Technical Audits	
	External Monitoring	
	2012	
Closing of project	PBHS lessons learned forum and document for distribution	
	Transferring remaining equipment, Final Report, ending staff contracts, closing of accounts, etc.	

3. INFLUENTIAL CONTEXT AND EVENTS IN 2009

National Level

1. January (1):Official Start of the Second Health Sector Support Programme
2. March : the JAPR / National Health Congress 2009 reviewed the 2008 results of the health sector against the AOP 2008 and accepts the priorities for the 2010AOP proposed during the Pre-JAPR two day workshop held in February
3. March: MOU on implementation of MBPI incentive scheme between RGOC/CAR/MOH and Health Development Partners was officially signed for 190 MBPI positions.
4. April: sub-decree signed by Prime Minister of RGOC on the establishment and the functioning of Special Operating Agency (SOA) for MOH for 30 SOAS (including BTC supported ODs and PRHs)
5. April (10): nomination letter by MOH for the establishment of working group on the development of "Client Satisfaction with quality of Public Services Tools"
6. April (20): nomination letter by MOH for the establishment of working group on development of "CPA2 Assessment Tools"
7. May: Introduced AOP 2010 guideline for the nationwide by MOH/DPHI
8. May: 1st HSSP2 Joint Review Mission
9. Jun (23): Cambodia's Ministry of Health and World Health Organization issued a statement saying it had found the first ever case of H1N1 virus. "Cambodia's first case of the new influenza A /H1N1 virus was confirmed by the Cambodian National Influenza Center on Tuesday June 23 2009."
10. June: Nomination letter by MOH officially nominating 30 health professionals to the post of SOA manager.
11. August: MOH organized a workshop for decentralization and de-concentration concept and practice between provincial authorities and provincial health departments.
12. September: the Pre-JAPA reviewed the draft AOPs of all implementation Units and agrees that requested HSSP2 financial plan for 2010 should come down from 58.X M USD planned to the 24.x M USD stated available in March
13. December (4): A letter of RGOC signed by MEF Minister to Country Director of World Bank on Decision on the termination of MBPI, PMG and other Salary Supplement Schemes.
14. December (4): A Sub Decree on Ending of Priority Mission Package and MBPI signed by Prime Minister to all CAR and other concerned ministries.
15. December (17): Reply by Development Partners to Sub Decree on Ending of Priority Mission Package and MBPI.
16. December (25): Approval of HSSP2 Pool Fund budget 2010 to all government health institutions, national institutes, national programs, national hospitals, national training institutions and Provincial Health Departments.

Provincial and Project Level

1. January: The approved Government budget of the Siem Reap province has increased almost double 85% from 4,825 Million Riel in 2008 to 8,916 Million Riel in 2009; this improvement will be maintained with Ministry of Economy and Finance for next year. In Otdar Meanchey

province the approved budget has increased 28% from 3,062 Million Riel in 2008 to 3,919 Million Riel. The mobilization of government budget remains under the classic "Chapter system" with a reformed chart of account in preparation of the future Program-Based Budgeting.

2. January: Annual Provincial Health Review meeting in Siem Reap
3. January: approval by CAR for the continuation and new PMG members to the total 85 heath staff in Siem Reap PHD and 53 health staff in Otdar Meanchey PHD.
4. February: A letter of MEF Minister approved MOH Minister's request for opening Discrete Designated Account at ACLEDA bank under the BTC funding support to HSSP2 and the approval letter of MOH to this MEF request letter.
5. February: Workshops on introduction of MBPI-SOA concepts to 4 eligible SOAs in Siem Reap and Otdar Meanchey PHDs.
6. February: Annual Provincial Health Review meeting in Otdar Meanchey
7. March: 8th Steering Committee Meeting for both PBHS projects decided that the co-management modality and account for KAM0200711will remain active till 31st December 2009. Dr. Dy Bun Chhem, SR PHD director will remain responsible for the co-management accounts. The PBHS KAM0300911 is officially closed but will continue to make payments for already committed expenditures.
8. April (2): SC decision to change implementation modality of HEF component form National Execution to Own-management.
9. April (1): MoH-PHD-KC performance agreement was signed by Dr. Nguon Sim An, PHD director and Prof Eng Hout (MoH).
10. April: URC NGO discussed with BTC PBHS-SROM about their project called "Better Health Service", possible collaboration on following assistance such as QI, MCH, CDC and HSS.
11. May (30): Dr. Nguon Sim An, the director of the PHD and previous PBHS project director becomes Member of Parliament and is officially replaced by Dr. Kim Sou Phyrun
12. May: Radio 95.5 Mhz in Siem Reap introduced a program allowing NGOs active in health sector to communicate their project interventions with beneficiaries.
13. June: Community Health Forum is introduced by MEDICAM for facilitating the communication between health care provider and users on health care service quality.
14. July: BTC letter to MOH on MBPI incentive support to the 3 PBHS supported provinces
15. July (28): Visit of Belgian Ambassador, H.E. Mr. Rudy Veestraeten
16. August (1): Mrs San Sophorn, recruited by the secretariat starts working as Project Office Administrator in Kampong Cham office.
17. August: Prakas by MOH on revision of health coverage plan for Siem Reap PHD with 4 ODs, 4 referral hospitals(before 3RHs), 79 health centers (before 66HCs) and 5 health posts (before 3HPs)
18. August: Visit of BTC HQ Finance Officer, Dirk De Cuyper
19. September: Dr. Nguon Sokomar, deputy director of Otdar Meanchey PHD and previously assistant to the PBHS co-director is transferred to the National Malaria Center in Phnom Penh.
20. September: MOH introduces a request to CAR for 40 supplementary MBPI positions: 20 for PHD Siem Reap, 10 for PHD Otdar Meanchey and 10 for PHD Kampong Cham

21. September (7-9): Visit of Mrs. Ann Dedeurwaerdere (Brussels), and Mr. Dirk Deprez, BTC Resident Representative in Vietnam handing over ResRep responsibilities for Cambodia to Mr. Dirk Deprez, including a visit of Siem Reap on 7th September
22. September: Performance Agreement was signed between HSSP2/MOH, represented by H.E. Prof. Eng Huot and Otdar Meanchey PHD represented by the PHD director, Dr. Ouk Kim Soeun
23. October: Letter of Understanding between MOH and BTC on the role of HSSP2/BTC TAs as Capacity Building Assistance on Internal Contracting (SOA & SDG) and MBPI for the PHD as commissioner.
24. October: 5 new health centers are inaugurated and become operational, 3 health centers in Sotnikum OD, 1 health center in Kralanh OD and 1 health center in Angkor Chum OD.
25. October: The Satellite clinic of Angkor Children Hospital construction is completed and will be inaugurated early next year 2010.
26. The training of 20 primary midwives at Regional Training Center of Battambang with financial support from BTC-PBHS-SROM was completed.
27. October: Dr. Chinsam Viseth announces that he will resign as he has been contracted by GTZ (as PHA for Kampong Cham) through negotiation with GTZ we can delay his departure until end of February 2010.
28. November: 2nd Joint Review Mission takes place
29. Mission November: Performance Agreement was signed with HSSP2/MOH by H.E. Prof. Eng Huot with Siem Reap PHD director, Dr. Dy Bun Chhem.

4. BACKGROUND

4.1. Project Description

By Mid-December 2008 the "Exchange of Letters" between the Cambodian and the Belgian governments validated the changes to the Specific Agreement of KAM0200711 including the associated Technical and Financial File and did as such approve the Consolidation Phase of the two existing PBHS projects. The consolidation phase does integrate the PBHS in Kampong Cham project (KAM0300911) into the PBHS in Siem Reap and Otdar Meanchey project (KAM0200711) and is named "Provision of Basic Health Services in the provinces of Siem Reap, Otdar Meanchey and Kampong Cham" (PBHS2).

During the first 4-year phase of the project, the project introduced, supported and implemented 1) Health Equity Funds in 8 RH and several HCs which financed 56,070 hospitalizations, 76,105 outpatient consultations and 3,678 deliveries of very poor persons, 2) performance incentive contracts with the health institutions covering almost 1700 personnel, 3) a major training component on clinical and managerial skills, 4) several Behavioural Change Communication initiatives, 5) Quality Assessments of RH & HC and major rehabilitation and equipping of RH & HC and construction of 6 new HCs and a hospital pharmacy, and 6) Institutional Capacity Building and Health Policy Strengthening at Provincial and Central Level contributing to the government's decision to adopt HEF and performance incentive mechanisms. The Mid Term Review of the project concluded that the project was very successful especially with regards to service utilization by the poor and by pregnant mothers, increased staff motivation and their improved behaviour , but that further support was required to assure ownership and sustainability. Based on strong recommendations of the Mid Term Review, Cambodia and Belgium decided to support a 3-year consolidation phase. The Belgian contribution to PBHS2 is 3 Million Euro.

The consolidation phase has adopted National Execution has main implementation mode. BTC became one of the seven partners in the multi-donor funded Health Sector Support Program 2009-2013 (HSSP2) as such assuring full harmonization with other major health partners and aligning with government procedures and the Health Sector Strategic Plan 2008-2015. This approach also guarantees sustainability, firstly because financial and managerial responsibilities are progressively handed over to government and to other partners, and secondly because building of the required technical capacity of counterparts has become one of the main project strategies.

The consolidation focuses its support on three components HEF, Capacity building for Contracting and Evidence based Policy Making.

During the first phase the project put in place 8 Health Equity Funds and supported them technically and financially for 100%. During the consolidation phase the project will continue to be responsible for HEF Implementer responsibilities and for the funding of the functioning of the HEF operators. The HEFI responsibilities are clearly defined in a HEFI Multiple Party MOU between the MOH, the HEFOs and BTC. A first step towards sustainability is being achieved as the major HEF expense, the HEF direct cost (userfees, food and transport for beneficiaries) is now being financed by the Pooled Fund and a yearly increasing contribution of Government Counterpart Funds. Before the end of the project the MOH will seek alternative funding sources for HEFOs expenses and identify the organization/agency/department to which BTC can hand over the HEFI responsibilities.

Performance incentive schemes to Health Districts and Provincial Hospitals of the first phase are gradually being replaced by a Government developed/owned mechanism called the Special Operating Agency. SOA status provides bigger autonomy and allows the institutions to benefit from Service Delivery Grants which fund performance incentives and other operational costs. The Performance incentive schemes for PHD teams were to be replaced by the Merit based Payment Initiative (MBPI), also a Government developed/owned mechanism. SDGs are being financed by HSSP2 Pooled Fund and a yearly increasing contribution of Government Counterpart Funds while MBPI positions for Siem Reap and Otdar Meanchey PHDs were going to be financed by PBHS2 for the first three years. A major responsibility of the consolidation phase is the capacity building of PHD, OD and PRH staff required for the management and the monitoring of SOA and MBPI systems. PBHS is supporting this capacity building by providing funding for local technical assistants, hired as consultants by the HSSP2 secretariat and by providing funding for training cost to the PHDs, PRHs and ODs. The detailed project responsibilities have been defined in an MOU between the MOH and BTC.

The fourth component aims to strengthen the capacity of the Department of Planning and Health Information (DPHI) of the Ministry of Health Evidence with regards to Evidence based policy making. The project would provide International Technical Assistance and financial resources for specific trainings focusing on the following three aspects:

1) assuring that data and documentation is routinely collected, readily available and properly analysed;
2) identifying additional data needs and in formulating appropriate ways to gather this data;
3) ensuring that relevant information is properly documented and is communicated to policy makers and the health partners.

Priority subjects will be the new and innovative measures in support of health system strengthening, such as health financing strategies, newly developed mechanisms for staff incentives (MBPI and PMGs), and the introduction of service delivery contracts, SOAs and SDGs.

Activities under National Execution mode need to be planned and budgeted for in the Annual Operational Plans of the different implementation units which are approved by the MOH. This AOP also specifies targets for the HSP2 indicators which become the basis for quarterly and annual reviews

The Provision of Basic Health Services Project supports those strategies in the three provinces, three Provincial Health Departments, three Provincial Hospitals, and 8 Operational Districts (OD) (all ODs of Otdar Meanchey(1) and Siem Reap (4) and 3 of the 10 ODs of Kampong Cham being Cheung Prey, Prey Chhor and Chamkar Leu).

4.2. Transition Year

2009 should be regarded as a transition year.

The Consolidation Phase started officially on 1st January 2009 when it took over funding and management responsibilities for most activities (HEF, Capacity Building and Performance Incentives) of PBHS in Kampong Cham project (KAM0300911) and from the First phase of PBHS in Siem Reap and Otdar Meanchey (KAM0700211).The PBHS in Kampong Cham project (KAM0300911) did close officially by 31st March 2009 but certain activities previously committed and contracted (construction) continued throughout the year. The First phase of PBHS in Siem Reap and Otdar Meanchey (KAM0700211) integrated in the Consolidation Phase project (KAM0200711) but continued to finance and coordinate First Phase activities and staff not covered by the Consolidation Phase until May 2009.

National Execution follows HSSP2 management and financial management procedures which are not really adapted to the management, coordination and support of a pool of technical assistants or HEFI management office. These procedures were not developed with the PBHS2 project activities in mind, quite logical as PBHS2 was only approved when the HSSP2 procedures were finalized.
In order to avoid problematic delays with staff payments and transfers, with capacity building running costs or a disastrous HEF interruption, the project took three necessary decisions:

1) To continue co-management modalities of KAM0200711 for the three first months of the consolidation phase and only start National execution with effect of 1st April 2009
2) To change the implementation modality for the HEFI activities (exclusive the Health Financing TA) from National Execution to Own-Management for the with effect from 1st April 2009 and for the whole period of the project
3) To continue paying certain capacity building running costs (office, vehicle, running costs, travel allowances, etc.) until the HSSP2 secretariat was ready to take over but not later 31st December 2009

With effect of 1st April the 2 previous PMUs were abolished and all their administrative and financial staff (7) laid off. It should be appreciated that for several months all remaining and new administrative and financial management tasks were implemented by a single staff member, the HEFI manager.

The HSSP2 procedures complicated the recruitment of required and planned staff.
It was initially planned to function with a team of 11 Technical Assistants (staff transferred from the first phase and new recruited) as of 1st April 2009. However because of recruitment problems the capacity building team remained limited to 5 TAs throughout 2009 and consisted only of previous first phase staff. This shortage of staff had an important impact on capacity building progress.

A combination of lengthy and hefty approval mechanisms, new non-routine procedures, delayed responses from central level departments and HSSP2 (secretariat and JPIG), shortage of capacity building TA made that no SOA, SDG or MBPI were established in the PBHS2 project areas during 2009. As a result performance incentive for public health staffs were severely delayed. 5 ODs and 2 PRHs did not receive performance incentives after 30th June 2009.

Throughout all those changes all 8 HEFs continued to function uninterrupted throughout 2009, although often with funding severely stretched and the HEFI manager forced to apply unorthodox procedures.

It should therefore be really appreciated that during a year of so many constraints most ODs and PRHs still achieved good and sometimes even improved health service results and coverage rates.

4.3. Reporting

Comprehensive annual reporting for HSSP2 program in general is done through the Interim Financial Reports and the Annual Performance and Monitoring report. By mid March draft 2009 year reports were available for review and revisions and the final reports are expected by the end of March.

This PBHS2 project year report aims to describe and report specifically on PBHS2 activities, financial management, results, challenges and perspectives. Based on those findings it proposes changes to planned activities and budget to be approved by the Steering Committee. The report uses a lay-out similar to the previous 5 year reports. Chapter 5 will describe the progress, results and challenges for the 4 project components. Chapters 6 and Chapters 7 will describe respectively the results and trends in utilization and coverage rates and the health financing results. The project support, through the 4 component activities, contributed to the achievement of those rates and results which can therefore be regarded as the combined output results of the project.

5. 2010 PROJECT PROGRESSES BY COMPONENT

The following 3 paragraphs will describe the developments, progress, results and challenges specific to each of the 4 project components, component 2 and 3 both being covered in paragraph 2.

5.1. Support to Consumer Rights Organizations

General Progresses, Strategic/Managerial Situation and Changes (KC & SR)

With the Consolidation Phase starting on 1st January, BTC becomes the Health Equity Fund Implementer (HEFI). From 1st May onwards first phase funding arrangements were are replaced by a shared funding mechanism, where direct benefit costs are covered by HSSP2 Pooled Fund and Cambodian Counterpart Funds and the operational and management costs are covered by BTC discrete fund. By 1st April all 8 contracts for the management and implementation of the HEF schemes were re-procured and finalized between HEFI-BTC and 3 HEFO NGOS.s The Multi Party Memorandum of Understands between the Ministry of Health, HEFI-BTC and HEFOs defining the roles and responsibilities of each party were signed simultaneously. The 8 HEF Schemes continue did function without interruption throughout 2009. So 2009 can be looked at as a period before and period after 1st April.

1. **<u>From January 01, 2009 to March 31, 2009</u>:**

- All Direct Benefit and Administrative Costs covered by BTC fund which follow the same benefit package as in 2008.
- Public tender to select HEFOs for the management of the 8 HEF Schemes of PBHS2 was conducted. The 3 local Non-Governmental Organizations, Action for Health; Association for Human Resource Development and Health Education and Cambodian Health and Human Rights Alliance, were selected for management the HEFs of the project.

- The agreement with MSF-F was started since mid 2006 on co-financing to support HIV/AIDS patients in Kampong Cham PRH. The implementation continues until March 31, 2009 with the following arrangement:
  - MSF provide 22$ per inpatient cost while the gap was supplemented by the project.
  - All HIV/AIDS inpatients were entitled to get support regardless of their socio – economic status.
- TB inpatients who are hospitalized in the Kampong Cham PRH and in the 3 district hospitals have been assisted from the second quarter of 2007. Each TB inpatient receives benefits from the project for food allowance (4,000 Riels/day) and round trip and referral transportation costs.
- The voucher system for maternal health services (ANC, delivery, PNC) and round trip transport was introduced starting with CP OD in the beginning of 2007 and expanded in the June and July to CKL and PC ODs respectively. The implementation continues to year 2009.
- Since November, 2008, the reducing transportation allowance has been introduced to HEFBs, who do not use a health center, except in case of emergency. The reduction is applied only to those HEFBs who are holding Equity Card (EC) of the Ministry of Planning (MoP). The reduction 25 % and 50 % of the total round trip transportation amount is applied to EC Holders whose residence in the Non HEF health centers and HEF health centers respectively. The reduction still continues to year 2009.
- Early 2009, Anlong Veng Health Center with Beds in Otdar Meanchey province was upgraded a CPA1 Referral Hospital.
- After one year of cooperation, with the availability of the Equity Cards, the project stopped its support to the voucher-based HEF schemes in Angkor Chum and Pouk health centers with beds in Angkor Chum OD/Siem Reap province with RHAC as initially planned from late March 2009.
- The Project stopped the Equity Card (EC)-based HEFs (after 6 months pilot) at Srey Snam HC/SRP with beds by end March 2009 and handed over the activities to RACHA to carry over.
- The HEF-supported Free Delivery services in SRP PRH initiated in mid 2006 stopped in late March 2009.
- HEF assistance to hospitalized TB inpatients in SRP PRH started mid 2005 on food and mosquito net ended in late March 2009.

2. <u>From April 01, 2009 to December 31, 2009</u>:

- During the Steering Committee in March, 2009, in order to ensure the continuing of the 8 HEF Schemes without interruption, it was decided that the Operational and Management Fund of HEF, except the costs of the 2 HEF Technical Assistants, became the Own Management Modality under HEFI-BTC (Regie).
- BTC becomes Health Equity Fund Implementer (HEFI)-BTC. The HEFI team was set up whose members are HEF Coordinator, 2 HEF Technical Assistants and HEF Manager.
- From May 01, 2009 the Direct Benefit Costs has been covered by Pooled Fund of HSSP2/MoH while the Administrative Costs has been covered by BTC Discrete Fund.
- The category of HEFBs and Benefit Package of HEFs has been modified since April 01, 2009 which the same benefit package and category of Health Equity Fund Beneficiaries (HEFB) for all 8 HEF Schemes.
- From April 01, 2009 the assistance to HIV/AIDS inpatients and TB inpatients have been provided only to the poor which follow the same category and benefit package as of other HEFBs.
- HEF support to the MSF-Identified Chronic Disease Clinic Outpatients in Sotnikum RH/SRP ended in April 2009.
- Continuing implementing the voucher system in the 3 ODs in KC province, following the same benefit package policy.

- The reduction of transportation for not passing health centers before coming to RHs for EC Holders still continues. During 2009, there were 6,425 (72 % of total HEFBs) have been reduced transportation for not passed through the health centers.
- Continuing to implement HEFs at the 6 health center with following the same benefit package policy as in 2008.
- Following the high proportion of Post ID HEFBs in the 3 DRHs since one year of introduction Pre Identification, the HEFB study to verify the correctness of the Post Identification and Pre Identification exercises was conducted. Dr. Ir Por had been contracted as a consultant and report writer of the study. The major findings:
    a. The proportion of poor who were missed out by Pre Identification conducted in 2008 is high with was 27 % in Cheung Prey OD, 17 % in Chamkeu Leu OD and 25 % in Prey Chhor OD.
    b. The Post Identification performance did not find major problems except some inclusion error in Prey Chhor hospital.
    c. The mismatching between Post and Pre ID Tools contributes also high proportion of Post ID HEFBs.
- The Direct Benefit reimbursement is always delayed by Pooled Fund of HSSP2/MoH secretariat.
- Documentation of results:
    a. Using Targeted Vouchers and Health Equity Funds to Improve Access to Skilled Birth Attendants for Poor Women: a Case Study in Three Rural Health Districts in Cambodia.
    b. Assessment of HEF Beneficiary Identification in Three Operational Health Districts in Kampong Cham.

Results of the HEF Implementation:

Generally, the utilization of both IPD and OPD for the HEFBs at all 8 RH-based HEFs increases in this year comparing to 2008, except for Sotnikum where the number of OPDs decreased. The substantial increase of the HEF patients is mainly in relation with the availability of the Equity Cards (Pre-ID 2008 by MoP/GTZ) and the promotion activities implemented by the HEFOs at community levels. Beside, the number of self-paying inpatients is noted decreased in some RHs especially in Siem Reap province, sharply in Sotnikum RH and Prey Chhor RH/KC.
The decrease is mostly possible in relation to the quality of the facilities, the attraction of the surrounding private clinics, the economic down, the poor quality control of the PHD monitoring team and perhaps partly the scheduled exit of the PBHS-SROM project.

However for Samrong and Anlong Veng RHs in Otdar Meanchey, number of the self-paid inpatients still remarkably increased. The increase is measured by the impact of the introduction of the CBHI by MHD-CHHRA and CAAFW. See data in above table 2.

- HEF Inpatient Beneficiaries at Referral Hospitals:

    - There were 14,033 (55 % of total IPD cases) IPD patients at the 4 RHs at Kampong Cham receiving support from HEF for user fees, food allowance, transportation and funeral costs. The total cost for all IPD HEFBs was $ 460, 293.

    - There were 10,499 (41% of total IPD cases) IPD patients at the 5 RHs (including few IPDs of 3 months at 3 HCs with beds) in Siem Reap and Otdar Meanchey receiving support from HEF for user fees, food allowance, transportation and funeral cost. The total cost for all IPD HEFBs was $463,371.

Table 1: HEF Inpatient Beneficiaries and Self Paying Inpatients at Referral Hospitals in Kampong Cham (Not TB):

RH	HEF Paid Patients				Self- Paying Patients				% of HEF Supports			
	2006	**2007**	**2008**	**2009**	**2006**	**2007**	**2008**	**2009**	**2006**	**2007**	**2008**	**2009**
PH	2,628	4,487	4,714	5,898	8,464	9,202	7,190	8,819	24%	33%	40%	41%
CP RH	1,508	1,910	2,178	2,556	1,217	986	979	1,242	55%	66%	69%	67%
CKL RH	2,646	2,490	2,261	2,833	1,667	1,473	1,432	1,257	61%	63%	61%	69%
PC RH	1,200	1,726	1,736	2,435	940	704	511	450	56%	71%	77%	84%
TOTAL	**7,982**	**10,613**	**10,889**	**13,722**	**12,288**	**12,365**	**10,112**	**11,268**	**39%**	**46%**	**52%**	**55%**

Table 2: HEF Inpatient Beneficiaries and Self Paying Inpatients at Referral Hospitals in Siem Reap and Otdar Meanchey (Not TB):

RH	HEF-Paid Patients				Self-Paid Patients				% of HEF Supports			
	2006	*2007*	*2008*	*2009*	*2006*	*2007*	*2008*	*2009*	*2006*	*2007*	*2008*	*2009*
Siem Reap RH	1,819	1,957	2,289	3,771	4,996	7,909	9,083	8,186	27%	20%	20%	32%
Sotnikum RH	1,085	1,224	1,282	1,618	1,609	1,505	1,368	852	40%	45%	48%	66%
Kralanh RH	378	1,030	1,003	1,439	1,409	1,515	1,405	1,154	21%	40%	42%	55%
A.Chum HCwBeds: *Apr08-Mar09*			370	108			1,334	217			22%	33%
Pouk HCwBeds: *Apr08-Mar09*			427	168			1,291	268			25%	39%
S.Snam HCwBeds: *Oct08-Mar09*			31	34			211	168			13%	17%
Subtotal for SRP	**3,282**	**4,211**	**5,402**	**7,138**	**8,014**	**10,929**	**14,692**	**10,845**	**29%**	**28%**	**27%**	**40%**
Samrong RH	1,356	1,262	1,007	1,824	1,043	1,657	1,444	1,877	57%	43%	41%	49%
A.Veng HCwBeds	1,736	1,587	1,189	1,537	780	1,117	1,503	2,271	69%	59%	44%	40%
Subtotal for OMC	**3,092**	**2,849**	**2,196**	**3,361**	**1,823**	**2,774**	**2,947**	**4,148**	**63%**	**51%**	**43%**	**45%**
Grand Total	**6,374**	**7,060**	**7,598**	**10,499**	**9,837**	**13,703**	**17,639**	**14,993**	**39%**	**34%**	**30%**	**41%**

Figure 1: Number of Self Paying and HEFB Inpatients by Hospitals, year 2006, 2007, 2008 and 2009 in Kampong Cham (Not TB):

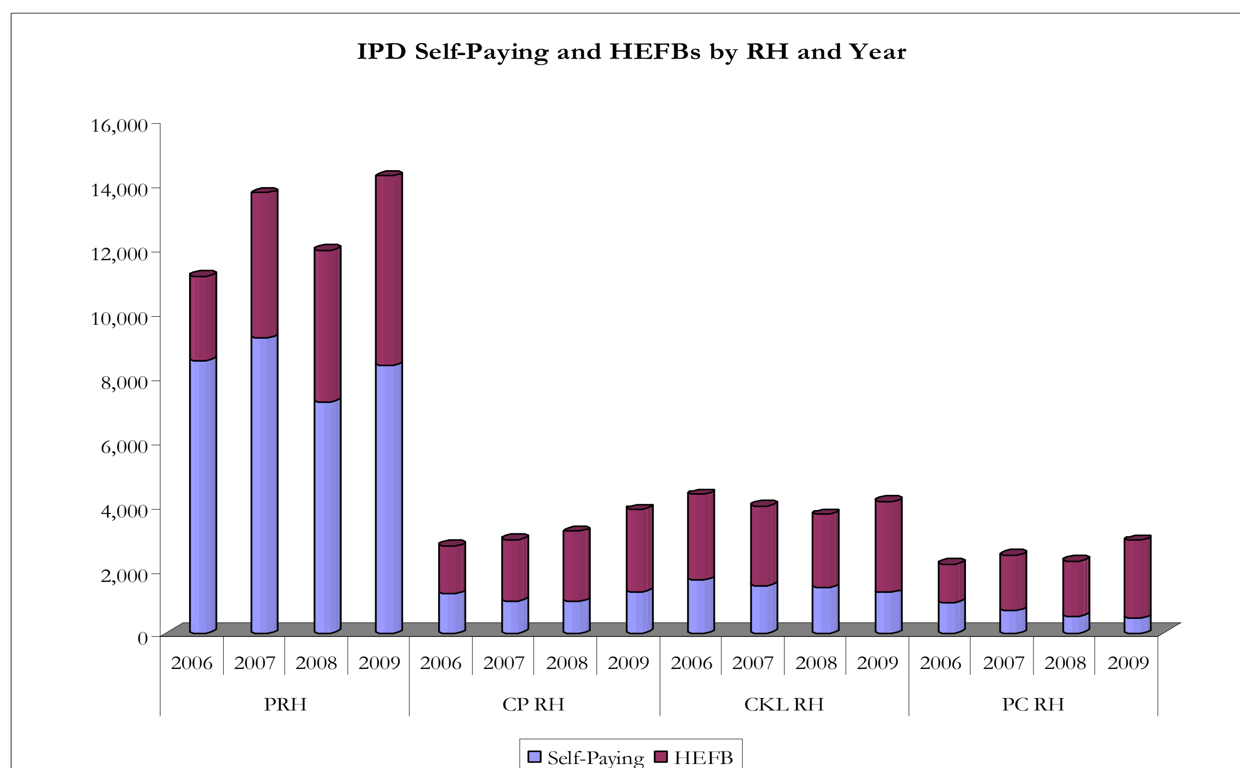


Figure 2: Number of Self Paying and HEFB Inpatients by Hospitals, year 2006, 2007, 2008 and 2009 in Siem Reap and Otdar Meanchey (Not TB):

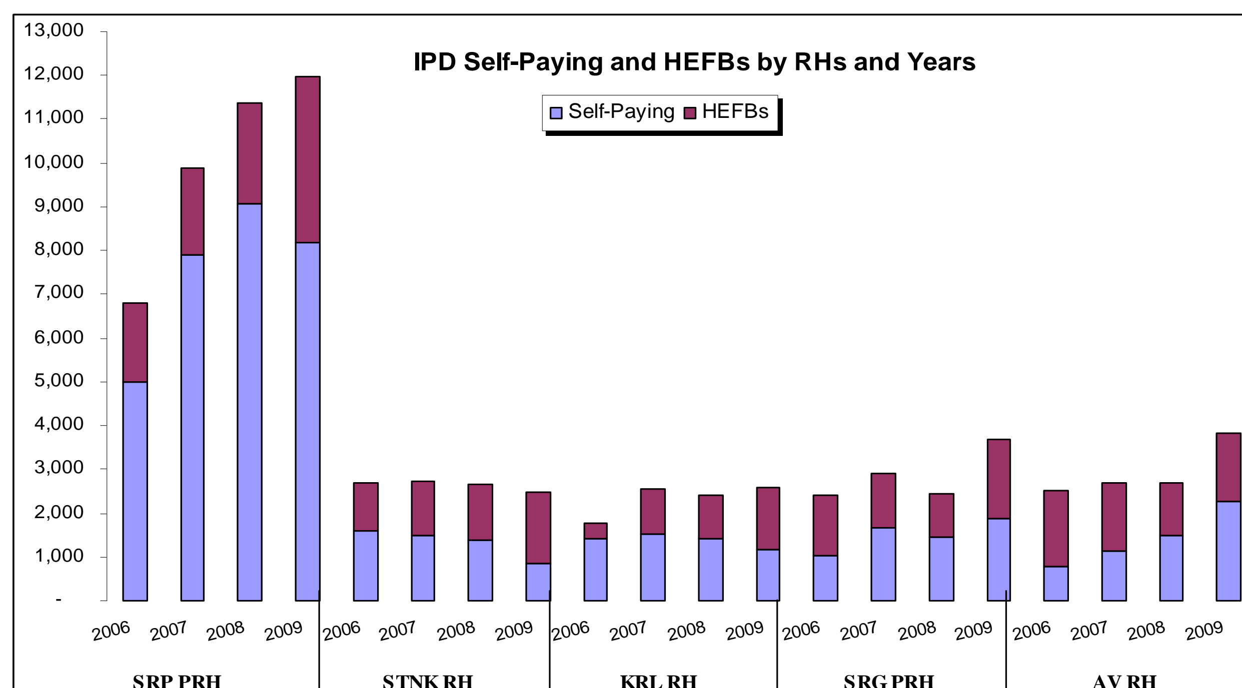


Table 3: HEF Beneficiaries by Specific Types/Groups to total HEFBs at Referral Hospitals in the 3 provinces 2009 (Not TB):

RH	% of Under 5	% of Delivery	% of Female	% of Cases Being Referred by HC and Lower Level	% of Inter Hospital Referral by Ambulance to Total HEFBs Referral
PRH_KC	16%	5%	55%	8%	100%
CP RH	12%	4%	68%	38%	25%
CKL RH	25%	10%	59%	7%	6%
PC RH	20%	7%	54%	17%	85%
PRH-SR	0%	9%	53%	9%	0%
STNK RH	2%	4%	60%	7%	61%
KRL RH	16%	5%	63%	1%	91%
PRH-OMC	20%	3%	55%	13%	100%
AV RH	22%	3%	53%	2%	70%
TOTAL	14%	6%	58%	11%	56%

In Kampong Cham, the proportion of under 5 HEFBs consisted of 17% of all HEFBs with the highest of 25% in Chamkar Leu RH. The assistance for delivery at RHs was 6% to all HEFBs with the most of 10% in Chamkar Leu RH. The Female HEFBs is 60% of all HEFBs in the 4 RHs with the top of 68% in Cheung Prey RH. The referred HEFBs by health centers in the 3 DRHs were very low. Only 28% of the HEFBs in the 3 DRHs were referred by health centers with the highest proportion of 38% in Cheung Prey RH even after the introduction of reduction transportation allowance. All the referral transport means at the PRH were by ambulance because all cases of referrals were to National Hospitals in Phnom Penh. The lowest referral means by ambulance shows in Chamkar Leu RH which can be explained that there is not ambulance locates permanent there as other 2 DRHs, so the HEFO has tried to use an ambulance, mainly from PRH, only with referred

HEFBs whose conditions were serious or emergency. The most common used mean for referral at the DRHs is by Taxi. In Prey Chhor RH, the percentage inter hospital referral by Ambulance was too high. This referral mean in Prey Chhor RH may be used for unnecessary condition of the patients which it needs further investigation.

No HEF patient was ever referred out by SRP PRH to the National Hospital.

Tow non-for-profit private hospitals for children are actively functional in Siem Reap: Kantha Bopha hospital and Angkor Hospital for Children. The maternity and especially the pediatric cases in Siem Reap and Otdar Meanchey, in general, go to these for-free facilities. However, the number of delivery in SRP PRH is noted increasing since the introduction of the For-Fee Delivery Services in the hospital in mid 2006 under the HEF intervention.

Based on an even average level of poverty of the Cambodia Socio – Economic Survey (CSES) of 2004, the poverty rate of Kampong Cham province was 37% while the country average was 35%. The Pre Identification poverty rate in 2008 in Cheung Prey/Bathey OD was 24%, in Chamkar Leu/Stung Trang OD was 26% and in Prey Chhor/Kang Meas OD was 28%. The utilization rates for IPD services at CPA1 level are estimated as below. The calculation is using different denominator of poverty rate of the CSES of 2004.

Table 4: Estimated IPD Utilization Rate per Capita in 2006, 2007, 2008 and 2009 in Kampong Cham:

Utilization of IPD services at CPA level/1000 cap./year	Poor				Non-Poor				Total			
	2006	*2007*	*2008*	*2009*	*2006*	*2007*	*2008*	*2009*	*2006*	*2007*	*2008*	*2009*
Cheung Prey RH	21	26	30	35	10	8	8	10	14	15	16	19
Chamkar Leu RH	45	43	16	45	17	15	13	12	27	25	22	24
Prey Chhor RH	18	25	25	35	8	6	4	4	12	13	12	15
Provincial Hospital	4	7	7	9	8	8	6	7	6	8	7	8

The poverty rate of each district hospital used for calculating is the aggregate poverty rate of the province (37%).

The number of utilization for the poor increased in all 4 RHs in 2009. The number of utilization of the non poor slightly increases in Provincial and Cheung Prey RHs comparing to 2008. However, the number of utilization of the non poor slightly decreases in Chamkar Leu whereas in Prey Chhor RHs the utilization of the non poor remains the same as of 2008.

Table 5: Estimated IPD Utilization Rate per Capita in 2006, 2007, 2008 and 2009 in Siem Reap and Otdar Meanchey:

Utilization of IPD services/1000cap/year	Poor				Non-Poor				Total			
	2006	2007	2008	2009	2006	2007	2008	2009	2006	2007	2008	2009
SRP RH, CPA3	15	15	18	29	47	72	82	73	29	41	47	49
STNK RH, CPA2	9	10	10	13	16	14	13	8	12	12	11	10
KRL RH, CPA 2	6	19	18	26	27	33	30	25	16	26	24	26
SR PRH+A.Veng RH	54	46	30	43	20	29	26	34	33	36	28	37

The poverty rate of each district hospital used for calculating is the aggregate poverty rate of the province (54% for SRP and 39% for OMC).

Siem Reap data was added by an estimated 20% of the total poor and non poor to compensate for the fact that most pediatric and a good part of maternity cases go to the local non-for-profit private hospitals.

Utilization of the poor increases for all referral hospitals in both SRP and OMC provinces in 2009. In contrasts, except for OMC, the utilization of the non-poor at RH level decreased if compared to 2008

HEF Outpatient Beneficiaries at Referral Hospitals and Health Centers:

- There were 4,397 (19% of the total OPD cases) cases of OPD patients at the 4 RHs receiving support from HEF for user fee and transportation cost. The total cost for all OPD HEFBs was $ 20,709.

- The total 7,902 (19% of total OPD cases) cases of OPD patients at five RHs in SRP and OMC provinces receiving support from the HEF for User Fee and transportation cost. The total cost for all OPD HEFBs was $30,542.

- There were 19,182 (25% of the total OPD cases) OPD cases at the 6 health centers have been assisted by HEFs. The total cost was $ 11,554.

HEF Targeted Services Support:

Beside the support to eligible poor patients, the HEF also provides assistance in favor of targeted services of special public health concern:

- Under a co-financing arrangement with MSF-F, all HIV/AIDS inpatients who are hospitalized in the Communicable disease and Pediatric wards of Provincial Referral Hospital have been assisted until March 31, 2009. MSF provides a maximum of US$22 for each HIV/AIDS inpatients; the project complements this up to the actual needs. The average cost for each HIV/AISD excluding the operational cost is $ 50.80. There were 102 HIV/AIDS inpatients have been assisted in this year with the total expenditure of $ 5,182 for the period of last 3 months. From April 01, 2009, the assistance to HIV/AIDS Inpatients was changed which has been adapted to the same benefit package and category as of other HEFBs.

- TB inpatients who are hospitalized in the PRH and in the 3 district hospitals have been assisted from the second quarter of 2007. Until March 31, 2009, each TB inpatient receives benefits from the project for food allowance (4,000 Riels/day) and round trip and referral transportation costs. The food allowance is provided by dried/smoked fish one time per week. The aim of the food allowance is to supplement more protein to the patients. The average expenditure for each TB inpatient is $ 41. From April 01, 2009, the assistance to TB Inpatients was changed which has been adapted to the same benefit package and category as of other HEFBs.

- Poor pregnant women living in Cheung Prey/Bathey, Chamkar Leu/Stung Trang and Prey Chhor/Kang Meas ODs have been provided coupons for 3 ANCs, a delivery and a PNC at the health centers of the ODs. The coupon distribution in Cheung Prey/Bathey OD started in February, in Prey Chhor/Kang Meas OD in June and in Chamkar Leu/Stung Trang OD in July of 2007. Only those health centers having a mid wife that have been selected to implement the voucher system. The aim of the voucher system is to promote safe motherhood. From November, 2008, the voucher distribution to pregnant women holding Equity Access Cards has been conducted by HEF Network members which continue to the year of 2009. The results of the implementation shown in table 6 below. The total expenditure for 2009 was $ 17,919 of which 24 % spent for administrative costs. The article of the result of the Voucher Implementation had been published.

Table 6: Result of Voucher Implementation:

Year	No. of Voucher Distributed	Used for ANC1	Used for ANC2	Used for ANC3	Used for Delivery (At HCs & RHs)	Used for PNC
2007	1,093	843	635	474	399	186
2008	1,632	1,219	863	666	876	499
2009	1,798	1,389	1,255	1,064	1,180	661
TOTAL	**4,523**	**3,441**	**2,753**	**2,204**	**2,455**	**1,346**

- Food and mosquito net support to TB inpatients in SRP PRH from January 01 to March 31, 2009: 85 cases = $3,807 (Riels 4,000 per 2meals/day/patient).
- Free-Delivery-Services in SRP PRH from January 01 to March 31, 2009: 329 deliveries = $2,393 (Riels 30,000/case paid by HEF to hospital). The HEF intervention to Free-Delivery-Services in SRP PRH was initiated in July 2006 and ended in March 2009.

Expenditure and Financial Analysis:

From January 01 to December 31 of 2009, the administrative and management cost of the HEFOs was under the BTC fund.
From January 01 to April 30 2009, the direct cost was covered by the BTC fund.
From May 01, 2009, all direct cost was covered by the Pooled Fund of HSSP2/MoH. The total expenditure of the 2009 can be summarized in the table 7 below:

Table 7: Total expenditure by Types in 2009 (USD):

Item	BTC Discrete Fund	Pooled Fund	TOTAL
HEFO	214,710		**214,710**
Direct Benefit	184,150	551,537	**735,688**
Management of HEFI-BTC	18,350		**18,350**
HEF TAs	27,780		**27,780**
TOTAL	***444,990***	***551,537***	**996,527**

Generally, in 2009 the total expenditure was increased comparing to 2008 due to the increased number of both IPD and OPD HEFBs. However, the proportional expenditure by types (e.g.: Administrative, User Fees and other Social Costs) remains in a similar proportion as in 2008.

Table 8: Total IPD HEFB cases and Total Expenditure in 2006, 2007, 2008 and 2009 (Including TB) at Referral Hospitals in Kampong Cham:

	2006	2007	2008	2009
Total IPD HEFBs	7,982	10,820	11,091	14,033
Total Expenditure (USD)	226,186	300,164	363,076	460,293

The total number of inpatients in all 4 hospitals increased in this year comparing to 2008.

Table 9: Total IPD HEFB cases and Total Expenditure in 2006, 2007, 2008 and 2009 (Including TB) at Referral Hospitals in Siem Reap and Otdar Meanchey:

	2006	2007	2008	2009
Total IPD HEFBs	6,374	7,060	7,598	10,499
Total Expenditure (USD)	$168,657	$257,871	$345,331	$463,371

Comparing with the results of the previous year's implementation, the total IPD HEF beneficiaries as well as the total expenditures in SRP and OMC are substantially increasing.

Table 10: Breakdown of Total Expenditure by Types of HEF Operation (By HEF Scheme) in 2006, 2007, 2008 and 2009 in Kampong Cham:

Year	% of Administrative Costs	% of User Fee	% of Transport	% of Food	% of Funeral	Total Expenditure (USD)
2006	32 %	40 %	10 %	17 %	1 %	226,441
2007	22 %	47 %	12 %	18 %	1 %	307,768
2008	19 %	50 %	12 %	18 %	1 %	381,488
2009	20 %	49 %	13 %	17 %	1 %	510,606

The total 2009 expenditures for HEF amounts $510,606. In year 2008 the expenditure was $ 381,488. Compared to last year the total expenditure is increasing 34%. The increasing of the expenditure is linked to the increase of IPD HEFBs (by 27%), increase of OPD HEFBs at RH (by 231%) and increase of Voucher utilization (by 35%) comparing to 2008. Per capita expenditure for 2009 is $0.29 comparing to $0.21 in 2008. Per capita expenditure increased due to the number of HEFB utilization and increased transportation and food allowance of the new benefit package policy of the project since April, 2009. The proportionally of expenditure by types in 2008 and 2009 are not changed, especially for the proportion of Administrative and User Fee.

Table 11: Breakdown of Total Expenditure by Types of HEF Operation (By HEF Scheme) in 2006, 2007, 2008 and 2009 in Siem Reap and Otdar Meanchey:

Year	% of Administrative Costs	% of User Fee	% of Transport	% of Food +	% of Promotion	Total Expenditure (USD)
2006	31%	52%	5%	11%	1%	$185,157
2007	28%	48%	8%	13%	3%	$273,786
2008	24%	38%	16%	18%	4%	$380,868
2009	22%	39%	16%	20%	3%	$500,777

Note: "Food+" includes: cremation and small supplies.

Food allowance expense in 2009 was 2% increase comparing to 2008 and 7% increase to 2007. The increase is due to the fact that the HEFO only considered the food payment to those who were actually in critical needs of food assistance during the period of their hospitalization even though the patients were in the extremely poor category. However, following the harmonized benefit policy revised in 2008, the HEFOs started to pay the food allowance in full amount for all HEF patients automatically.

Table 12: Total HEFBs and Expenditure by RH in 2009 (HEF at RH) in Kampong Cham:

RH	Total HEFBs		Expenditure	
	IPD	*OPD*	*% of Administrative Cost*	*Total (USD)*
PRH	6,138	590	12 %	223,027
Cheung Prey RH	2,575	3,322	24 %	107,088
Chamkar Leu RH	2,867	392	24 %	78,566
Prey Chhor RH	2,453	93	29 %	72,322
TOTAL	**13,993**	**4,397**	**19 %**	**481,002**

In Kampong Cham, IPD HEFBs increased in all 4 RHs, especially in PRH and Prey Chhor RH. The number of OPD HEFBs dramatically increased in Cheung Prey RH. The average total cost of benefit per IPD case is $ 33 which increased comparing to $ 32 of 2008. At Prey Chhor RH, with fewer patients shows the highest proportion in administrative costs (29%). The average total value of benefit per OPD case in RHs is $ 5.

Table 13: Total HEFBs and Expenditure by RH in 2009 (HEF at RH) in Siem Reap and Otdar Meanchey:

RHs	Total HEFBs		Expenditures	
	IPD	*OPD*	*% of Administrative Cost*	*Total (USD)*
STNK RH	1,618	3,245	31%	$90,114
KRL RH	1,439	297	28%	$62,574
SRP PRH	3,771	1,532	14%	$217,640
AV RH	1,537	283	30%	$48,755
OMC PRH	1,824	2,545	22%	$74,829
TOTAL	**10,189**	**7,902**	**22%**	**$493,913**

In Siem Reap and Otdar Meanchey, the total number of HEF beneficiaries for outpatient services significantly increased for most of the HEF hospitals except for Sotnikum RH where the OPD HEFBs decreased. The decrease is relatively due to the fact that the usual HEF supports to the Chronic Disease Clinic in Sotnikum ended in April 2009. Only CDC outpatients those are holding EC, are entitled to the HEF benefits.

Table 14: Average Expenditure per IPD by Types (USD) at RHs in 2009 (Not TB):

RH	Total Average per IPD	Average for User Fee per IPD	Average for Other Direct Benefit per IPD
PRH-KC	35.70	19.76	11.51
Cheung Prey RH	35.21	16.17	9.18
Chamkar Leu RH	26.77	13.86	6.36
Prey Chhor RH	29.19	14.92	5.57
PRH-SR	54.77	25.43	16.56
Kralanh RH	43.15	16.73	12.00
Sotnikum RH	46.51	14.30	14.44
PRH-OMC	33.87	11.92	11.07
Anlong Veng RH	31.57	10.73	9.44
TOTAL	**37.42**	**15.98**	**10.68**

The average costs in Cheung Prey RH shows the highest comparing to the 2 other DRHs and very closes to of PRH due to the highest costs of Administrative comparing to of the 2 other DRHs and higher amount of expenditure on transportation which can be explained on the geographic destination and low proportion of reduction transportation for not passing through health centers comparing to the 2 other DRHs.
The overall average cost per IPD in SRP and OMC provinces are, in general, higher because the total cost of the promotional activities are included as part of the HEFO general operation budget.

Figure: 3: The Expenditure per IPD, 2006, 2007, 2008 and 2009 at RHs in Kampong Cham:

- Average Direct Costs per IPD case:
  - in 2006 = $19.37.
  - in 2007 = $21.59.
  - in 2008 = $26.48.
  - in 2009 = $26.30.
- The average expenditure for user fee increases from $16.25 in 2008 to $16.64 in 2009.
- The average user fees jumped from $ 13.11 in 2007 to $16.25 in 2008 due to the increasing of user fee in the 3 DRHs.
- Average expenditure for the food allowance increased from $6.09 to & 6.31 per case due to increasing amount of food allowance because of inflation.

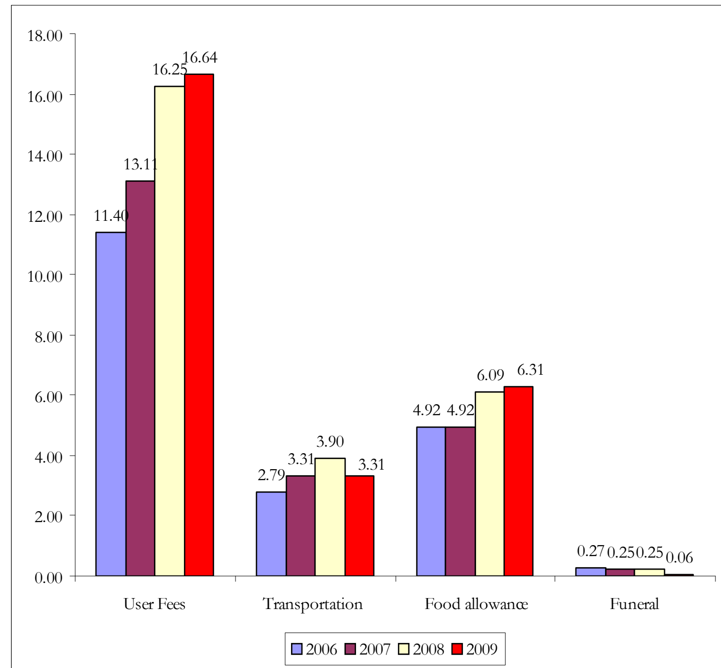
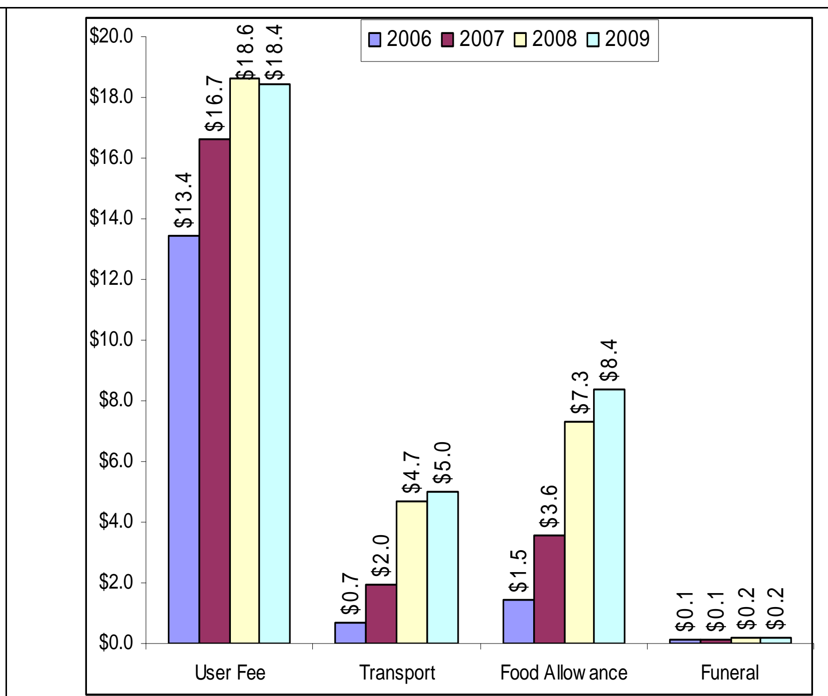


Figure: 4: The Expenditure per IPD, 2006, 2007, 2008 and 2009 at RHs in Siem Reap and Otdar Meanchey:

- Average Direct Costs per IPD case:
  - in 2006 = $15.7
  - in 2007 = $ 22.3
  - in 2008 = $ 30.8
  - in 2009 = $ 31.9
- Likely remain similar as 2008 for the average expenditure of user fee and transportation in 2009.
- Slightly increased in 2009 than 2008 for the average expenditure of food allowance



Health Equity Fund Operator (HEFO) Functioning:

The result of the bidding for the selection of HEFO for the management of the 8 HEF schemes of the project provided that:

- Action for Health (AFH) has been selected for operating the HEF schemes in PRH-KC, CP OD of Kampong Cham and SNK OD of Siem Reap.
- Association for Human Resource Development and Health Education (AHRDHE) has been selected for operating the HEF schemes in CKL OD and PC OD of Kampong Cham.
- Cambodia Health and Human Right Alliance (CHHRA) has been chosen for operating the HEF schemes in KRL RH, SRP PRH in Siem Reap province and Samrong PRH plus Anlong Veng RH in Otdar Meanchey.

After operating for 9 months of the HEFOs and with the positive evaluation by the team of HEFI-BTC, the 1 year renewable contracts with HEFOs were made by the end of December, 2009. The main functions of the HEFO can be summarized as following:

1. Identification of Health Equity Fund Beneficiaries (HEFB):

HEFO performs mainly the post identification at their office within the RHs. The standard Post ID tool of the Ministry of Health is used for the 3 HEFOs. The spot/home checks also introduced to verify the accuracy answers providing during the Post Identification. Its purpose is to discourage/minimize false answers during the interviews.

2. Spot/Home Checks and Feedback Interviews:

As requirement by the contract between HEFO and HEFI-BTC, the number of spot/home check should be not less than 20% of the total numbers of health equity fund beneficiaries (HEFB). All HEFBs who were conducted spot checks are requested to be interviewed to collect information on the services received at the hospital. The results of the interviews are put in the monthly and quarterly reports of HEFs and being used as feedbacks for improvement the services of both HEFO and the hospitals. The results are also used for discussion during quarterly meeting between HEFO, the hospitals, ODs, PHD and the project.

3. Data Records of the HEFBs:

All discharged HEFBs are recorded in the HEF Database and excel form and submitted to the project monthly. Most of information concerning on patient's profiles and socio-economic status, hospitalization records including diagnosis and expenditures can be found. The data is useful for further analysis of the poverty of the HEFBs and used for generation month and quarterly reports.

4. Follow up the Quality of the Health Services:

The HEFO is attending regularly the hospital and monthly OD meetings to brief the results and dealing with other issues arising from the HEF implementation. Everyday, the staff of the HEFO follows up the Health Equity Fund Beneficiaries (HEFB) who are hospitalized to check up with their conditions and the services provided by the health facilities. Any complaints or issues receiving during the follow up are addressed soon directly to the health facility for further actions.

5. Promotion Activities:

Many promotion activities are being conducted by HEFOs on HEF assistance to the communities. HEFOs have conducted many kinds of promotion activities such as organization quarterly meetings

with HEF network members and communities, attending in monthly OD meetings and making leaflets and T-Shirts for HEF promotion. The aims of promotion provides for both HEF assistance and for using public health facilities as well as health seeking behaviors.

Generally the HEFO performs with good results as we expected them to do within the contract. The result of the HEFB Identification Study also shows the accuracy result of the Post Identification of the HEFO within the hospitals, except minor problem in the Prey Chhor RH. The operator is actively conduct promotion with the communities on health equity fund/voucher and on using public health facilities. The cooperation between HEFO and the project are also good.

Table 15: Performance of HEFO in 2009 by Scheme using some Performance Indicators:

HEF Scheme /HEFO	Post Identification	Home/Spot Checks and Feedback Interviews	Data Record	Follow up Quality of Health Service	Promotion Activity	Financial Management
PRH-KC/AFH	2	3	3	4	3	3
CP OD /AFH	2	3	3	3	3	3
CKL OD /AHRDHE	2	2	3	3	3	4
PC OD /AHRDHE	4	3	4	3	3	4
PRH-SR/CHHRA	2	3	2	3	3	2
Kralanh OD/CHHRA	2	3	2	3	3	2
Sonitkum OD/AFH	2	4	3	3	3	4
OMC/CHHRA	2	3	2	3	3	2

Note:

1. *Excellence*
2. *Very Good.*
3. *Good.*
4. *Average.*
5. *Below average*
6. *Poor.*

Identification of Health Equity Fund Beneficiaries:

Except in STNK OD until mid year 2008, the only Post ID was dominated to identify the beneficiaries since inception of the HEFs of the project. Distribution of the Equity Cards, as result of the Pre ID by MoP/GTZ, completed in late 2008, except for Kampong Cham where the distribution completed by end of December, 2009 with some areas even in mid-January, 2010. Identification of the poor patients in the hospitals then mainly relies on these pre-identified ECs.

General economic situation in Cambodia (especially for SRP and OMC) has been down since after the world economic crisis in 2008 so the near-poor groups suddenly become poor or even very poor. Post identification using scoring questionnaires to interview in hospitals was therefore required in order to assist those patients who recently become poor and/or to assist those poor patients who missed the opportunity in obtaining the EC during the Pre Identification process and those from outside the Pre ID areas.

However, from the resulted of HEF implementation in 2009 shows the Post ID HEFBs is still high even after 1 year of introduction ECs. In Siem Reap province, 41% of the total HEF IPD patients and 51% of the total HEF OPD patients were identified by the Post ID tool. In Otdar Meanchey province, the proportion of total poor patients identified by the Post ID is lower. In particulars, the highest percentage Post ID for IPDs (52%) in SRP PRH is in relation with number poor patients from neighboring provinces and poor patients from the 4 urban communes in SRP town where no

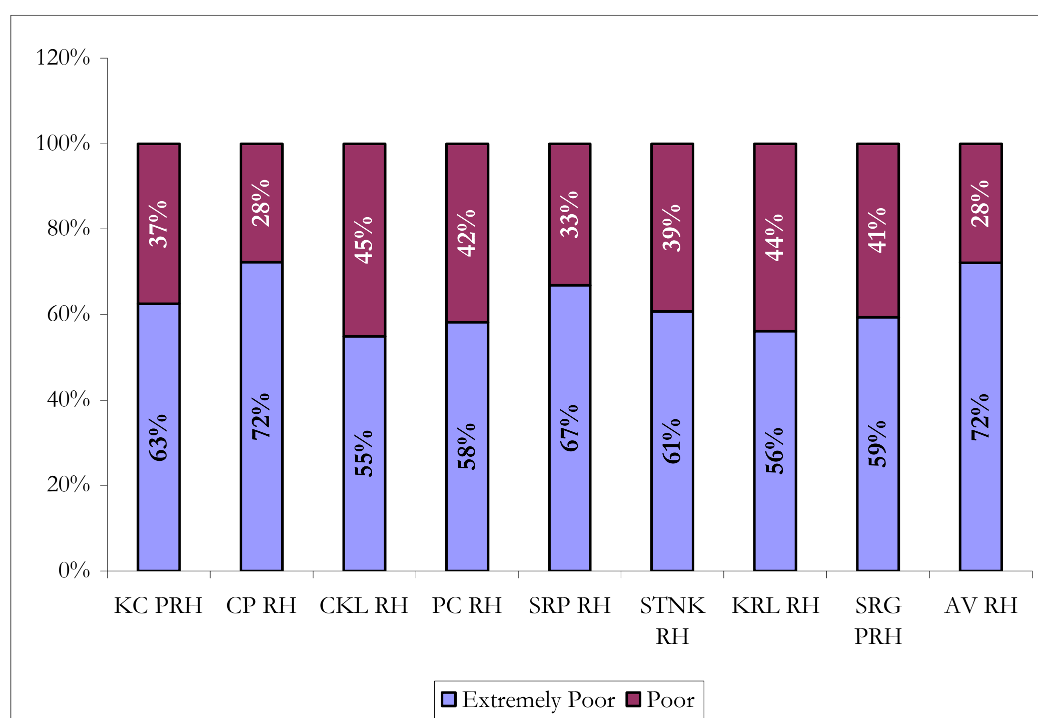
Pre ID took place. In Kampong Cham, the proportion of the Post ID HEFBs from those areas where the Pre ID completed is still very high. During 2009, the proportion of the Post ID IPD HEFBs at CP RH, CKL RH and PC RH were 30 %, 40 % and 49 % respectively. For the 3 RHs, the proportion of Post ID HEFBs was 39 % for 2009. Consequently, the HEFB Identification for the 3 ODs was introduced to see on the inclusion and exclusion errors of both Pre and Post Identification exercises. The Ministry of Planning is also planning to conduct an evaluation on its Pre Identification tool in 2010.

Table 16: Percentage of Post ID HEFBs in 2009:

RH	% of Post ID IPD	% of Post ID OPD
PRH-KC	86 %	86 %
CP RH	30 %	13 %
CKL RH	40 %	17 %
PC RH	49 %	32 %
PRH-SR	52 %	43 %
KRL RH	23 %	22 %
STNK RH	33 %	57 %
PRH-OMC	30 %	28 %
AV RH	37 %	18 %

Figure 5: HEF Beneficiaries per Level of Poverty 2009 in the 3 Provinces:

In order to be in line with the HEF guideline developed by the MOH, the PBHS2 reduced the levels of poverty of beneficiaries from 3 to 2 categories: extremely poor (=poor1) and poor (=poor2) which is also aligns with the category of poverty levels of the Pre Identification of the Ministry of Planning defined classified the poverty by two: Poor1 and Poor2. Same as previous years, the number of the IPD HEF beneficiaries is in the extremely poor category. For 2009, 64% (in average) of the total HEFBs is in the poor1 category. Regardless the levels of poverty status, the hospital user fee are paid for 100% by the HEFs to the 2 categories.



An assessment of the identifications of HEFB has been conducted to verify functioning of the Pre ID and Post ID methodologies. The main findings from this assessment can be summarized as following:

1. The proportion of poor who were missed out by Pre Identification conducted in 2008 is high with was 27% in Cheung Prey OD, 17% in Chamkeu Leu OD and 25% in Prey Chhor OD. The main reasons were that these families were excluded or not informed about the exercise by the Village Representative Groups and mobilization of the families during Pre ID exercise.
2. The Post Identification performance did not find major problems except some inclusion error in Prey Chhor hospital. The reason of the error may be because of the new staff of the HEFO. As the result, the new staff had been replaced.
3. The mismatching between Post and Pre ID Tools contributes also high proportion of Post ID HEFBs. The Post ID tool tend to give higher proportion poor and HEF eligible households than does the Pre ID tools with the same people.

Health Equity Fund Implementer (HEFI) Office:

1. Setting up HEF Implementation Office:

During the first phase of BTC projects, the HEF activities continued funding to 31 March 2009, which are the project of Provision of Basic Health Services in Kampong Cham took over four Health Equity Funds in Kampong Cham province and the project of Provision of Basic Health Services in Siem Reap and Otdar Meanchey took over four Health Equity Funds in Siem Reap and Otdar Meanchey provinces.

From April 01, 2009, BTC continue to act as the Health Equity Fund Implementer (HEFI) in the Consolidation Phase for the eight Health Equity Funds of the three provinces of Siem Reap, Otdar Meanchey and Kampong Cham; and establish, equip and staff a Health Equity Fund management unit for this purpose.

2. HEFI Team

The HEFI office is based in the compound of Provincial Health Department of Kampong Cham. One HEF TA is based in Provincial Referral Hospital of Siem Reap.

- 1 BTC Health Adviser
- 2 HEF Technical Assistants (TA)
- 1 HEFI Manager

3. Major Roles of BTC as HEFI

- Select and recruit of individual HEFO.
- Finance of HEFI/HEFO Administration & Management Costs.
- Reviewer/certifier of the monthly Direct Benefit Cost financial reports and supporting documents submitted by the HEFOs in order to provide assurance to MoH/HSSP2 prior to direct replenishment to the HEFO's.
- Oversee HEFO activities and provide required Technical Assistance for facilitating Quality Improvement in services.
- Prepare and submit monthly reports on the administrative and financial aspects of the respective HEFs and the overall HEFI operations to the HSSP2 Secretariat (MoH).

4. **Procurement of the HEFO**

The HEFI office started to recruit new HEF operator to operate HEF activities in the three provinces of Siem Reap, Otdar Meanchey and Kampong Cham from April 01, 2009 to December 31, 2009.

The three local non partisan, non political and nonprofit NGO(s), Action for Health (AFH), Association for Human Resources Development and Health Education (AHRDHE) and Cambodian Health and Human Rights Alliance (CHHRA) had been recruited to operate HEF activities (see HEFO Functioning for coverage of HEFO's areas/institutions)

5. **Procurement of HEFO Furniture and Equipment**

The purchasing of HEFO office furniture and equipment has been delayed due to time constraint. The project re-plans to purchase on February 2010.

6. **Auditing**

During the year 2009, the HEF activities have been conducted three external audits which were appointed by MoH/HSSP2. These audit missions have audited the accompanying special purpose financial statements for the disbursements of Direct Benefit Costs funded by Pooled Fund from quarter 2 to quarter 4.

The audit mission informed very few days in advance to the auditees. This could be difficult to prepare for the audit and also disturbed to the project work plan.

Though, there is no major finding from these frequent audits.

7. **Improvement of Accounting/Financial Work**

Since the start of HEF disbursement under Direct Benefit Costs funded by Pooled and Counterpart Fund, we have many difficulties on accounting/financial record using double entry accounting principle. From the fourth quarter we have improve a lot on using of the new financial accounting and financial management systems, processes and procedures.

In year 2010, HEFI office will plan to recruit a new consultant on Finance/Accounting, there will assist in the field of HEF finance and administration management.

8. **Reporting**

We prepared and submitted monthly and quarterly financial and activity reports funded by Pooled and Counterpart Fund to HSSP2/MoH within four weeks of the end of each month/quarter.

All times of replenishment were delays with payment to the bank of HEFOs from HSSP2/MoH. These delays may frustrate the functioning of HEF activity in the target areas.

Challenges and Perspectives:

Important trends and events appear in the 2009:

- Further increase in utilization for IPD and OPD cases for HEFBs. The utilization for self paying patients also increased in PRH and CP RH. However, the utilization for self paying patients decreased in CKL RH and PC RH.
- Increasing proportion of HEF paid patients amongst IPD patients raises the concern that the public hospitals are not attractive for the patients who are able to pay.
- HEF at health center levels have been terminated in the 6 HCs of the 3 ODs due to low impact on the utilization. The new HEF will be changed to new strategy from 2010 focused on the health centers whose Pre ID Card Holders is the most. Close follow up planned with proper monitoring put in place.
- The payment for Direct Benefit for HEFBs is under Pooled Fund of HSSP2/MoH from April 01, 2009. The reimbursement for direct costs, especially for user fees is always delayed due to the fund flows from HSSP2/MoH is always delayed.
- The termination of monthly admission criteria assessment from the early 2009 could impact on the number of unnecessary hospitalizations for both HEF paid and self paying patients at the DRHs.
- The number of HEFBs who passed through health centers before coming to RHs is still very low even the introduction of sanction for reduction transportation allowance from mid 2008. This may reflects the limited quality of the services provided at the health center level.
- Since early 2009, RHAC has introduced very similar maternal health intervention as of Voucher system in all health centers of the 3 ODs where the Voucher system is being implemented. This could be taken into consideration on the overlapped intervention and also double incentives to the health centers, especially for deliveries.
- Financial guideline for monitoring HEFO expenditure by the HEFI office needs to be finalized.
- Even HEFOs use the present HEF database for generate the reports and record profile of the HEFBs, it still shows some weaknesses from the system on extracting some information such as by ward and recording one day hospitalization of IPD HEFBs.

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5.2. Capacity Building in the context of the establishment of SOAs, SDG, and MBPI

For reasons of strong linkages and interdependency both project results 2 and 3 are discussed together.

Result 2: "Increased capacity in eight Operational Districts and two Provincial Referral Hospitals to provide better quality health services to the people in the respective catchment areas" and

Result 3 "Increased capacity of three Provincial Health Departments to manage service delivery contracts, to support Operational Districts and Referral Hospitals, and to ensure linkages with stakeholders at provincial and national levels"

In 2009, while continuing the performance contracts from PBHS-SROM and KC, the project focused on building capacity of PHD/OD/PRH management teams to prepare required preconditions and documentation for starting up of MBPI/SOA and eligibility of SDG.

The main differences in the capacity building approach with the previous phase are:

- A limited number of TA versus expanded set of capacity building responsibilities, the project planned for 9 TAs for the SOA/SDG/MBPI capacity building component but until the end of 2009 it operated only with 3 TAs.
- the funding of capacity building events (meetings, workshops, study tours, etc.) like travel expenses and other workshop expenses (writing materials, banners, documentation, refreshment, renting of meeting room) funded from BTC discrete fund is now channeled through the PHD , OD offices and is conditional to being listed in the AOP.
- Less flexible funding mechanisms for training (per diem, transport, etc.) resulted in several cancellation / delays for meetings, workshops and on the job training events. This also limited the possibility of inviting external resource persons (MOH / other experts) whom may be required as resource persons in some specific workshops or meetings.
- Complex and inflexible procedures (delaying fund, procurement, mission procedure, etc.) did not allow using the TA to their full capacity as they could not respond flexibly to the needs of counterparts considering their availability.

Following the TFF of the consolidation phase, this section of the report identifies three main areas of work.:

1) To continue temporarily the existing performance output based incentive contracting of PBHS.
2) To provide financial and technical support for the capacity building of OD, PRHs, RHs and HCs in order develop, establish and implement SOA and benefit from SDG funding.
3) To provide technical and financial support for the capacity building to PHDs in order to become qualified for MBPI status and for assuring the commissioner role.

For each area, the report describes process, results. Challenges and perspectives are summarized at the end of this chapter.

a. Performance output based incentive contracting:

The project continued the implementation of performance based incentives contracting with all levels of public health units from PHDOs, PRHs, ODOs, DRHs and HCs.

Process:

❖ **Siem Reap and Otdar Meanchey**

- For the first quarter 2009, Project continued the PBHS-SROM contract models for both Siem Reap and Otdar Meanchey PHDs
- From the second quarter 2009, the contracts were adapted to HSSP2 procedure using the PBHS-SROM model with some changes such as the rational to bridging the gap or transition from PBHS-SROM contracting to internal contracting, the signing parties from co-director to only PHD director as representative of PHD and HSSP2/BTC. All contracts were signed and sent to HSSP2/MOH in July 2009
- The condition of the contract terms emphasized mainly on maintaining good health service delivery with quality and preparation of all required documents for SOA/SDG by the deadline.
- Units under contract: both in Siem Reap and Otdar Meanchey, project continued only with the contracted facilities from 2008. Other new health facilities were not included as the budget was limited.
- The contract period is different between those who are eligible (Siem Reap Provincial Hospital of Siem Reap, Sotnikum OD, Siem Reap OD and Samrong OD) for 6 months from January to June 2009 and non eligible (Provincial Hospital of Otdar Meanchey, Angkor Chum and Kralanh ODs) for 12 months from January to December 2009.

- Due to time constraint, quarterly PHD Monitoring and Evaluation was conducted only once for all facilities with support from contract management TA. The results were used for the calculation of bonus incentives for each individual contract period. Areas of performance measurement such as outputs, supervision, contract monitoring, ownership and respect of golden rules were strictly applied.

❖ **Kampong Cham**

Similar to the approach of SR-OMC, the PBHS-KC performance contract continues for PHD until end of March 2009, end of Jun for CP, CKL and PRH and until the end of December 2009 for PC OD.

- The temporary contracts had been put in place for CP OD, CKL OD, PRH to the end of Q2 2009, and for PC OD until 31 December 2009. Since it was planned to start MBPI from 1 April, the performance contract of PHD were ended by 31 March 2009.
- The main purpose of temporary contract is to prevent the drop of performance of health staff and to stipulate extra works of managers for the preparation of SOA.
- The temporary contacts were already aligned with the design of SOA which is signed by two parties (SOA and PHD) in this context OD/PRH management team and PHD direction with copy to MOH. Funding for these contracts was from HSSP2-BTC.
- During quarter 2 2009, there was a delay of MBPI to bridge the performance contract at PHD office, the activities of Monitoring from PHD to ODs / PRH had been dramatically reduced. The PHD management team had conducted a discussion meeting together with OD management team and Project TA to discuss about the solution for performance monitoring. Based on data of HIS and direct observation from PHD direction and project TA, the meeting decided to accept the self evaluation results of ODs and PRH to be used as performance results.
- The performance incentive for all contracted institutions had been paid in December 2009 due to the new and complex procedure of HSSP2.

Table 2 : Number of Institutions and staff with PBHS performance contracts

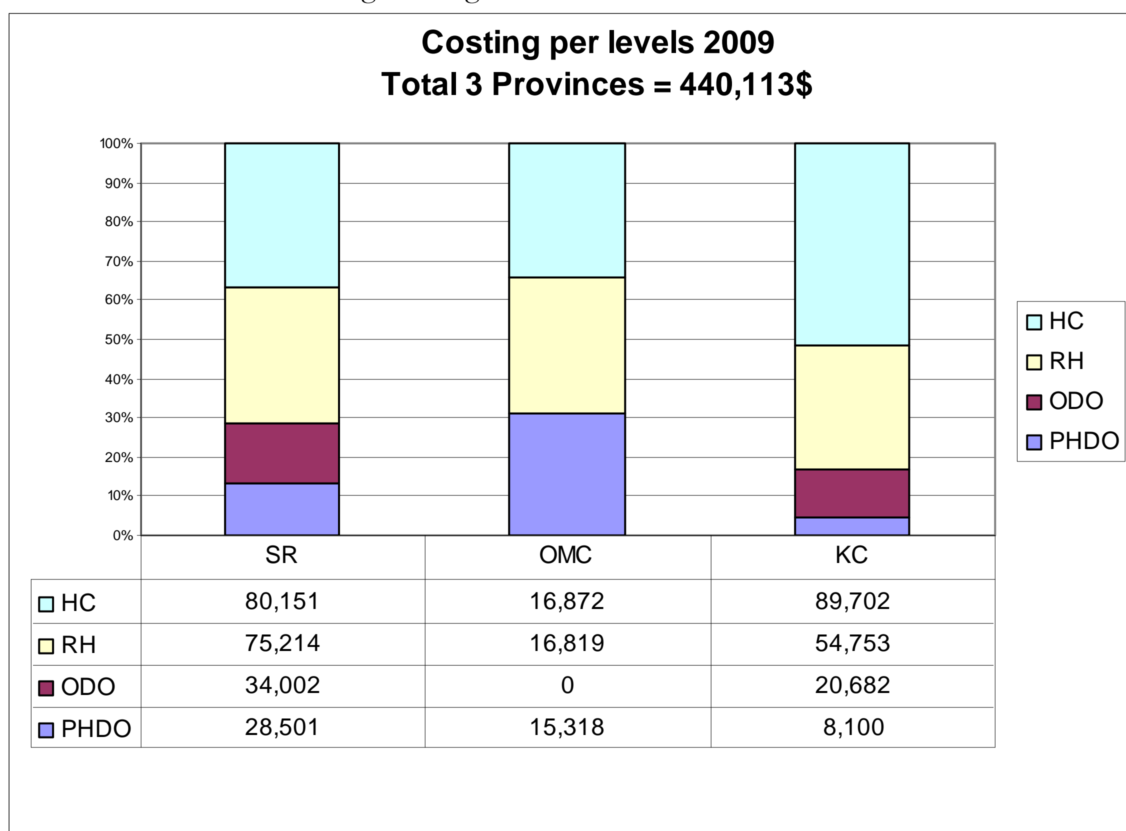
Covered:	Siem Reap	Otdar Meanchey	Kampong Cham	Total
Prov. Health Dpt Office	1	1	1	**3**
Operational District Office	4		3	**7**
Prov. Referral Hospital	1 CPA3	1 CPA2	1 CPA3	**3**
District Referral Hospital	2 CPA2	1CPA1	2 CPA2 and 1 CPA1	**6**
Health Centre	41	14	42	**97**
Total Health Staff	604	263	697	**1,564**

<u>Other Contract Initiatives in the project area:</u>

- GAVI contract: from October 2007, all health centers of Angkor Chum OD (as units) with also one OD staff and one PHD staff (as individuals) were put under a GAVI/HSS contract scheme focusing on MCH services. However, due to overlapping with PMG scheme, only 9 out of total 15 health centers of Angkor Chum have been under GAVI and 6 under PMG.
- PMG contract (individuals), a CAR initiative was declared for:
    - End of 2007:
        - In Siem Reap: 59 staff of 10 health centers of which 6 health centers in Angkor Chum OD and 4 in Siem Reap OD and it also includes 2 PHD staff and 2 OD staff.

- In Otdar Meanchey: 26 staff in 4 HCs and 1 health post with also 1 OD/PHD staff.
    - End of 2008:
        - In Siem Reap: 86 staff of 16 health centers of which 9 health centers in Angkor Chum OD and 7 health centers in Siem Reap OD (before 4 health centers) and it also includes 2 PHD staff and 2 OD staff.
        - In Otdar Meanchey: 57 staff (Including 26 staff of 2007) were declared as PMG. Among these staff 2 are the PHD staff and 55 from 10 HCs.
    - End 2009:
        - In Siem Reap: PBHS incentive was stopped at the end of February of the year for the three new HCs of Siem Reap OD who have been receiving PMG from November of 2008. The total number of PMG staff remained the same as in 2008 at 86 for 16 health centers of Angkor Chum and Siem Reap ODs including 2 PHD staff and 2 OD staff .
        - In Otdar Meanchey: PBHS incentive was stopped at the end of first quarter of the year for the 6 new HCs of Otdar Meanchey PHD who have been receiving PMG from November of 2008. The same number of 57 health staff at the end of 2008 continued to receive PMG.
        - All PMG stopped countrywide at 31st October 2009.
- Units under GAVI contracting and PMG have no more access to PBHS bonus.
- Either with GAVI/HSS or with PMG, the PHD monitoring/supervision system developed with PBHS remains and results are feed backed for action taking as appropriate.
- Even before the government letter on termination on incentive schemes was issued in December 2009, it was decided that PMG and GAVI schemes in Siem Reap and Otdar Meanchey would be replaced by SDG system. The SDG system will be officially activated from 1st January 2010 for all SOAs of Siem Reap and Otdar Meanchey provinces.

Figure 1: 2009 Annual Contracting Costing



	SR	OMC	KC
HC	80,151	16,872	89,702
RH	75,214	16,819	54,753
ODO	34,002	0	20,682
PHDO	28,501	15,318	8,100

For SR and OMC provinces, this is a decrease of 36% as compared to 2008. This is due to the reduction of 30 health centers with GAVI/PMG from PBHS bonus scheme (17 health centers with PMG and 9 health centers with GAVI) and the expenditure per capita of both provinces was 0.24$/year. Expenditure as per province was as follows:

- 37% for Siem Reap province less than previous year
- 31% for Otdar Meanchey less than previous year

Kampong Cham province the expense for contract in year 2009 was ($173,236) comparing to the amount of ($280,499) spend in year 2008. The major reasons for the reduction are:

- PBHS contracting for PHDO covered only Q1, 2009
- PBHS contracting for 2 ODs and PRH covered only for Q1 and Q2, 2009
- Only one OD(Prey Chhor) the PBHS contract continue until the end of 2009.

b. To provide financial and technical support for the capacity building of OD, PRHs, RHs and HCs in order develop, establish and implement SOA and to benefit from SDG funding

Process:

Provision of Financial and technical support to conduct management capacity assessment for ODO and quality assessments for service delivery levels (HC, RH, PRH).

- Management Capacity Assessment OD offices

The assessment was conducted from Jun to July 2008 by external consultant hired by BTC with assistance from BTC local experts using checklist developed by MOH in year 2006 with specific focus on area of Planning, Monitoring/Supervision, Human resource allocation/management, Training (technical supports), Essential Drug management, Financial Management and Coordination Capacity of OD offices

Table 3: Results Management capacity assessment broken down by ODs

	Kg Cham	Prey Chor	Cheung Prey	Chomkar Leu	Srey Santhor	Tbong Khmum	Kroch Chmar	O'Reang Av	Ponhea Krek	Memot	Siem Reap	Sotnikum	Angkor Chum	Kralanh	Samrong OD/OMC
Planning	54%	79%	50%	42%	71%	92%	38%	33%	29%	80%	92%	79%	63%	79%	54%
Monitoring & Supervision	77%	90%	48%	55%	77%	77%	52%	51%	26%	61%	90%	83%	81%	84%	77%
HR Allocation & Management	59%	61%	55%	58%	47%	36%	47%	53%	58%	61%	67%	76%	27%	55%	67%
Technical Support	39%	32%	38%	66%	48%	52%	38%	28%	84%	57%	78%	78%	88%	95%	76%
Essential Drugs Management	70%	100%	80%	90%	70%	90%	60%	90%	60%	100%	80%	80%	80%	80%	90%
Financial Management	64%	82%	75%	72%	50%	68%	61%	71%	68%	54%	54%	61%	61%	75%	54%
Total	62%	73%	56%	61%	61%	71%	49%	52%	51%	65%	76%	75%	71%	76%	70%

Table 2 shows results of OD capacity assessment for 15 ODs from the 3 provinces. Since Samrong OD is a single OD of Otdar Meanchey province thus it regards the result of PHD by taken out the subject of coordination. From the financial capacity assessment conducted by FMIP the OD, PHD and Provincial Hospital of Otdar Meanchey were assessed separately. From the above table (among the 8 ODs supported by the project) minimum

score was 56% seen in Cheung Prey and Maximum score was 76% seen in Siem Reap and Kralanh ODs.

- Quality Assessment for HC

As RACHA is planning to expand their activities to cover all 4 ODs in Siem Reap, therefore, Project coordinated with RACHA to financially and technically support the health facility quality assessment for all health centers in Sotnikum OD and Siem Reap OD.

In Kampong Cham Province there are 21 staffs, from the 3 project ODs, Memut OD and PHD, had been attending 1 week training to be HC assessor conducted by MOH supported by PBHS-KC since Jun 2008.
Similar situation to Siem Reap, in Kampong Cham RACH is operating their community project in 5 ODs within these all 3 ODs of the project are covered. For the reason that RACH is based on HC level and having already budget to conduct HC assessment therefore the project coordinate with PHD and RHAC to have the assessment done.

Table 4: Results of HC quality Assessment of the 8 project supported ODs

Province	OD	2009	
		HC	Score
Kampong Cham	Chamkar Leu OD	13	67
Kampong Cham	Prey Chhor OD	15	70
Kampong Cham	Cheung Prey OD	14	63
Siem Reap	Siem Reap OD	16	54
Siem Reap	Sotnikum OD	23	45
Siem Reap	Angkor Chum OD	16	50
Siem Reap	Kralanh OD	10	38
Otdar Meanchey	Samrong OD	16	60

Table 4 shows result of HC assessment of the 8 ODs supported by the project. Apart from SR province, the 3 OD in KC and One in OMC receiving score more than 60.
Results from the 4 ODs of Siem Reap province ranged from 38 to 54. The results indicate that in-depth analysis and certain improvement action need to be in place.

- Quality Assessment of Provincial and District Referral Hospitals

The quality assessment for district and provincial hospital was started since year 2006. The project collaborate with MOH, URC and Center of Hope to assess SR,OMC,KC and the 3 district hospitals in Kampong Cham in year 2006, 2007 and 2008. In year 2009, the hospital assessment seemed to be pending. There was some inappropriateness of using the same assessment tool for district and provincial hospital by the same time it was the period that several new schemes had been started such as MBPI, SOA, SDG. Therefore the assessment plan for year 2009 had been partially postponed.

Table 5: Results of Hospital Assessment

Hospital	2006	2007	2008	2009
Otdar Meanchey PRH	52%	76%		
Kampong Cham PRH	63%	74%	81%	
Siem Reap PRH	42%	67%	84%	
Chamkar Leu RH		53%		80%
Prey Chhor RH		52%		
Cheung Prey RH		48%		75%
Angkor Chum RH				
Kralanh RH				
Sotnikum RH				

Table 5 shows results of PRH and RH assessment for which only 2 hospitals had been done in year 2009. By the way the figure shows that the score of hospitals assessed increasing sharply from year 2006 to year 2009.

General Results:

- The administrative and financial management capacities were assessed for all ODs, PRHs in the project area
- Updated SOA/SDG sheets provide details on the status of the different implementation units.
- 3 years rolling planned have been developed for the 3 provinces and their ODs and PRH
- AOP of 8 ODs have been developed with aggregation process from bottom up approach (Planning from HC→ RH→ OD→ PHD)
- Business plan for 11 SOA have been developed and submitted to MOH
- The Service Delivery Contracts for Kampong Cham and OMC ODs and PRHs were ready before the end of 2009 while those for Siem Reap ODs and PRH were almost finalized.
- While the basic principles of the SDG incentive mechanisms were developed and agreed by all implementation units they still required finalization.

c. To provide technical and financial support for the capacity building to PHDs in order to become qualified for MBPI status and for assuring the commissioner role.

Process:

The PHD management capacity assessments were conducted by the same time to the OD capacity assessments during Jun-July 2008 by external consultant financed by the project.

Table 4: Results of PHD capacity assessment of the 3 PHDs

	KC	**SR**	**OMC**	**Average**
Planning	62%	62%	54%	59%
Monitoring & Supervision	66%	72%	77%	72%
HR Allocation & Management	56%	63%	67%	62%
Technical Support	65%	71%	76%	71%
Essential Drugs Management	64%	73%	90%	76%
Financial Management	53%	75%	54%	61%
Coordination	58%	92%	75%	75%
Total	60%	70%	68%	**66%**

Table 4 estimates the management capacity of the 3 PHDs in percentage comparing to the standard of 100% which defined as satisfactory level. On average the level of management capacity from the 3 PHDs was 66% this means that there is still rather large space needed to be improved.

- Financial Management Capacity Assessment of PHD, OD and PRH:

In addition to management capacity and quality assessments the financial management capacity assessment were conducted in Jun-July-Aug 2009 by FMIP (Financial Management Improvement Plan) Team and Team from department of Budget and Finance of MOH. The following summaries the finding of assessment at 3 PHD, 8 ODs and 3 PRHs of the project supported area.

1- **Human Resource Capacity Management**
Government accounting staff at OD/RH is not ready to assume full responsibility for existing SOA financial management needs. Many staff lack accounting qualifications, having learned on-the-job. Financial units are often below authorized strength.

2- **Planning and Budgeting**
Budget preparation at PHD level remains very mechanical with line item budgeting based on historic expenditure controlled by MEF and not linked with AOP priority policies and activities. OD/PRH ownership of its budget should be strengthened as currently the PHD controls the budgeting process in each of the locations assessed and the OD/PRHs have little responsibility for budget management.

3- **Funds Flow**
MEF controls the availability of cash funds and procurement of goods and supplies to the PHDs and ODs impacting on ability to deliver planned activities. Most of the financial transactions and flows of funds at the PHD, OD, hospitals and health centres are made in cash. Most cash transfers from PHD to OD and HCs are made in arrears resulting in no petty cash advances available for working capital purposes.HCs and hospitals must use their user fee income to finance ongoing activities until cash reimbursement from government budget is received. ODs rely on credit suppliers or personal financing until cash reimbursement received.
Despite local bank facilities being available at all ODs and hospitals cash transfers and transactions remain the norm. User fee income collected from patients is not deposited in a bank account but retained on the premises until used.

4- **Accounting and Reporting**
The lack of a computerized and inclusive Financial Management Information System (FMIS) for MOH, PHDs and ODs/RH/HC means that the manual accounting processes will continue to be prone to errors, and subject to delay in report preparation. The lack of written standard financial procedures for the government budget results in inconsistent accounting practices according to interpretation and understanding of individuals

5- **Internal Controls**
The dependence on cash payments to cover transfers from PHD to OD/PRH and from OD to HCs and to suppliers represents a substantial risk in financial management terms. Cash-based payments are known to be prone to higher corruption and to informal payments. The lack of completeness checks through poor use of pre-numbered stationery and incomplete cash records represents a high risk to potential leakage of funds
The lack of expenditure coding at the time of voucher preparation provides an opportunity to misclassify expenditure.

6- **Internal Audit**
It was observed that of the ODs and PRHs, assessed under this report the Internal Audit Department had undertaken missions to PHDs and the referral hospital at Kampong Cham but had not been to any of the ODs proposed as SOAs. In addition none of the entities which reported missions from the IAD had received a mission report.

- Capacity building through on the job training, discussion workshops, meetings and daily back stopping

Apart from capacity and quality assessment, project TA were working closely with the PHD, ODs and Provincial Hospital management teams of the 3 provinces concentrating on the development of

3 years rolling plans, Annual Operation Plan, SOA business plans and Institutional development plans for MBPI.
Dr. Him Phannary, the senior Technical Assistant responsible for Contract Management developed a database system for yearly AOP development and review. This database has been adopted by the DPHI for nationwide use. This long awaited AOP database should make the AOP process much easier and more standardised. It will also allow for automatic aggregation and disaggregation which will simplify the work of all levels and allow for better reviews. DPHI has requested project support (see component 4) to roll out training for the use of this database for all provinces and ODs.;

General Results:

- The administrative and financial management capacities were assessed for all three PHDs
- 3 years rolling planned have been developed for the 3 provinces
- The MBPI request, the Operational Development Plan and other related documents for Kampong Cham province were ready before 1 April. 8 of their staff started receiving MBPI incentives with effect from 1st July.
- For Siem Reap and Otdar Meanchey the MBPI request, the Operational Development Plan and other related documents were ready in May. Their request together with a supplementary request for 12 positions for Kampong Cham was introduced to the Council of Ministers by the end of August. The MBPI scheme was however canceled before these requests were approved.
- Development of the AOP database

Other Challenges

- With the MBPI scheme abolished PHD staff feel even less committed to take up the new commissioner role. A new motivation mechanism needs to be developed in order to get PHD staff involved in the SOA/SDG exercise. With absent of MBPI, roles of commissioner needed to be reconsidered
- Complex new procedures, not very clear guidelines, a communication gap between MOH-PHD and Capacity builder agencies, and the limited availability of PHD and OD staff have all contributed to the delayed start up of SOA and SDG.
- The performance monitoring system, essential in any contracting system is not yet developed and no monitoring by PHD or central level has taken place in 2009.
- The evaluation of training achievements focuses only reaching the number of planned training, and number of staff trained with complete disregard for quality.
- Fragmented structure to bring together the main three core functions of health financing unit, planning unit and contract management unit to work on the development of internal contracting system, integrated AOP plans from all SOAs and provide feedback on the various SOA documents such as AOPs, business plans, TORs, budgeting, etc.

Capacity Building constraints:

- Important shortage of Capacity Building TA in general (3/9) but worse for SR-OMC area (1/5) hampers the progress of the capacity building
- Constraints of the National Execution Approach on TA logistical support
  - Delays of office supplies, project equipments and BTC office operational cost
  - Delays of DSA for TAs
  - Some three months TAs could not travel because vehicle were grounded
- Availability of operational capacity building budgets of PHD and ODs:
  - All ODs and PRHs units who attended workshops/meetings/coaching were not receiving operational expenses such as DSA, accommodation and transports

- Not integrated well with PHD AOP 2009 caused difficulty for the release of fund for operational activities
- PHD and TA collaboration:
  - Limited involvement in the discussion of the selection of core functions for the MBPI positions at PHD level
  - Limited involvement in the development of the organizational development plan for MBPI/PHDs

Figure 2: MPBH/SOA starting plan and Real start up

Figure 3 shows the 6 months delay of starting SOA for 6 institutions and 3 months delay for MBPI for KC PHD

Discussion and Perspective

To transform the PBHS performance contracting into effective and efficient public health internal contracting system, PHD, OD and Project team is challenging the following issues:

- Financial transparency on different financial inputs is not yet systematic, but should be improved with the health financing unit. For example, expenditure by funding source was not yet clearly communicated with all health partners.
- PHD and ODs still need to strengthen its key functions. Expectation is foreseen in the starting of MBPI and SOA
- MBPI is cancelled by the government, alternative solution need to find to support PHD to play the role of commissioner.
- As GAVI and PMG are stopped, it is good that lessons learnt should be obtained for strengthening the internal contracting system in the future
- Path-finding towards financial sustainability, the SDG is reduced every year by 10% which will be covered by revenue from other sources.

Several important related aspects need attention to avoid/reduce negative interference:

- questionable private-public practices
- insufficient supplies
- budget shortage in Siem Reap, Otdar Meanchey and Kg Cham e.g. 2 months shortage of patient food
- staff shortage
- New initiatives, innovative ideas or intervention which is aimed to improve the identified gaps.
- Clinic quality aspect remains left behind

5.3. *Evidence based Policy Making*

The fourth project component aims to strengthen the capacity of the Department of Planning and Health Information (DPHI) of the Ministry of Health Evidence with regards to Evidence based policy making. The TFF put its implementation for 100% in National Execution. The project planned to provide International Technical Assistance and financial resources for specific trainings focusing on the three following aspects:

1) assuring that data and documentation is routinely collected, readily available and properly analysed;
2) identifying additional data needs and in formulating appropriate ways to gather this data;
3) ensuring that relevant information is properly documented and is communicated to policy makers and the health partners.

Priority subjects targeted were to be the new and innovative measures in support of health system strengthening, such as health financing strategies, newly developed mechanisms for staff incentives (MBPI and PMGs), and the introduction of service delivery contracts, SOAs and SDGs.

Although discussed at several occasions with the DPHI and WHO no concrete plans or activities were accomplished during 2009.

At present the DPHI has proposed the following two activities for project support during 2010:

- Nationwide training on the utilization of the newly developed database for AOP development and review (this long awaited database has been developed by Dr. Him Phannary, the senior Technical Assistant responsible for Contract Management);
- Consultancy support for the development of a Hospital Financing Policy which could be integrated in the new health Financing Charter.

Both activities do not reflect in the AOP 2010. The DPHI plans to update its AOP in order to implement them. The project considered their funding already in its internal financial planning 2010.

This component needs to be discussed and developed further with the DPHI in the coming months. But most probably only part of the 223,850 Euro planned in the TFF will be absorbed by this component.

6. UTILIZATION AND COVERAGE RESULTS

This chapter provides health service output data of the project area and provinces. We assume that different project strategies and activities did and do impact positively the results. However as most project strategies are implemented in the same areas and started more or less simultaneously it is rather difficult for most changes to attribute them to a specific strategy.

6.1. *Health Centers*

Utilization of health center services steadily increased since year 2004. Number of consultation per person per year was 0.7 in both Siem Reap and Kampong Cham and 0.61 in Otdar Meanchey. At the 3 provinces the figures is higher than national average which is 0.58 for year 2009. The number of delivery assisted by trained health personnel increasing three times from year 2004 to year 2009.

Table 4: HC 5 major indicator results (2004-2009) at 3 provinces

Province	5 main Indicators of HC performance	2004	2005	2006	2007	2008	2009	*Incr. % 2004/ 2009*	*Incr. % 2008/ 2009*
SR	# New consultation at HC/inhab./year	*0.46*	0.53	0.69	0.60	0.56	0.70	*52%*	*25%*
SR	% of deliveries by trained health staff	*31*	35	45	42	67	76	*145%*	*13%*
SR	% of pregnant women who receive at least 2 ANC consultations	*48*	57	61	76	98	104	*117%*	*7%*
SR	% of fully immunized by children	*79*	81	86	89	84	88	*11%*	*5%*
SR	% of children <1year who receive measles	*84*	83	89	90	84	90	*7%*	*7%*
OMC	# New consultation at HC/inhab./year	0.31	0.43	0.6	0.62	0.58	0.61	97%	5%
OMC	% of deliveries by trained health staff	14.00	19	30	43	51	58	*314%*	*14%*
OMC	% of pregnant women who receive at least 2 ANC consultations	47.00	60.00	82.00	96.00	98	94	*100%*	*-4%*
OMC	% of fully immunized by children	93.00	88.00	90.00	95.00	94	75	*-19%*	*-20%*
OMC	% of children <1year who receive measles	90.00	89.00	96.00	97.00	93	77	*-14%*	*-17%*
KC	# New consultation at HC/inhab./year	0.42	0.52	0.66	0.58	0.53	0.70	*67%*	*32%*
KC	% of deliveries by trained health staff	27	28	37	47	54.5	64	*137%*	*17%*
KC	% of pregnant women who receive at least 2 ANC consultations	0.49	0.51	0.58	0.63	0.66	0.80	*63%*	*21%*
KC	% of fully immunized by children	81	86	90	90	95	95	*17%*	*0%*
KC	% of children <1year who receive measles	0.87	0.89	0.90	0.90	0.95	0.95	*9%*	*0%*

Table 1 shows the results of 5 major indicators at HC level of the 3 provinces.

- The vaccination coverage for children is steadily increased since year 2004 and about to reach the ceiling for Kampong Cham province. By the same time the figure for Otdar Meanchey still being low but this may due to important changes in the denominators used for the calculation.
- Percentage of delivery assisted by trained health staff, which was quite low in year 2004 continue to improve. The figure increased sharply in year 2008 and 2009 after the introduction of the government institutional delivery incentives.

For reference, the nationwide figures for 2005, 2006, 2007, 2008 (only draft figures) and 2009

Indicator	**2005**	**2006**	***2007*** *(draft)*	***2008*** *Draft*	***2009***
"New consultation at HC/inhab/year"	0.45	0.53	0.42	0.54	0.58
"% Delivery by trained health staff	29.6%	36%	42%	58%	63%
"% of pregnant women with at least 2 ANC"	49%	60%	64%	81%	83%
"% of children < 1 received measles"	77%	78%	Not avail.	91%	92%

6.2. Referral Hospitals

Siem Reap Provincial Hospital (CPA3)

Figure 3

The number of hospitalizations of Siem Reap provincial hospital remains very high and more or less the same as last year decreasing its volume of activity esp. The activity level of the department of Internal Medicine continued to diminish. Pediatric care is remains unavailable. Gyn/Ob remains active. HEF patients represent 32% of all admitted patients.

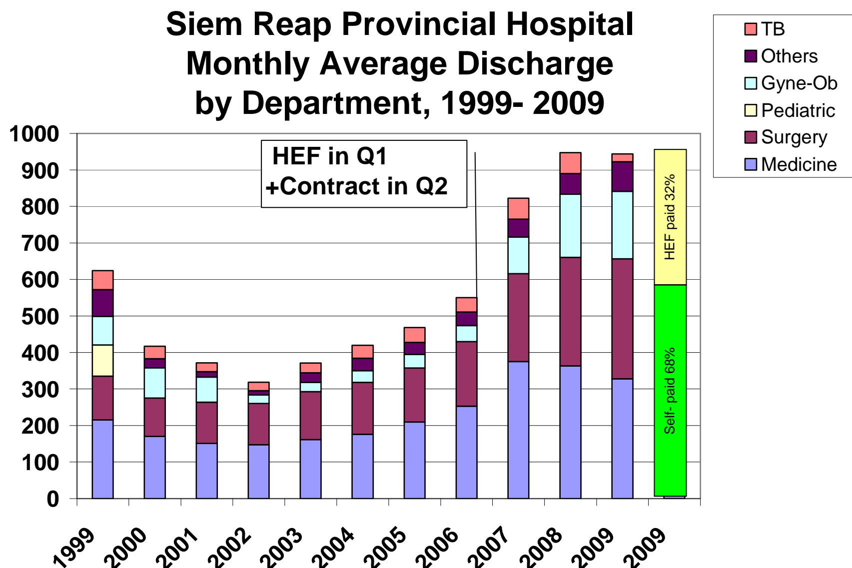
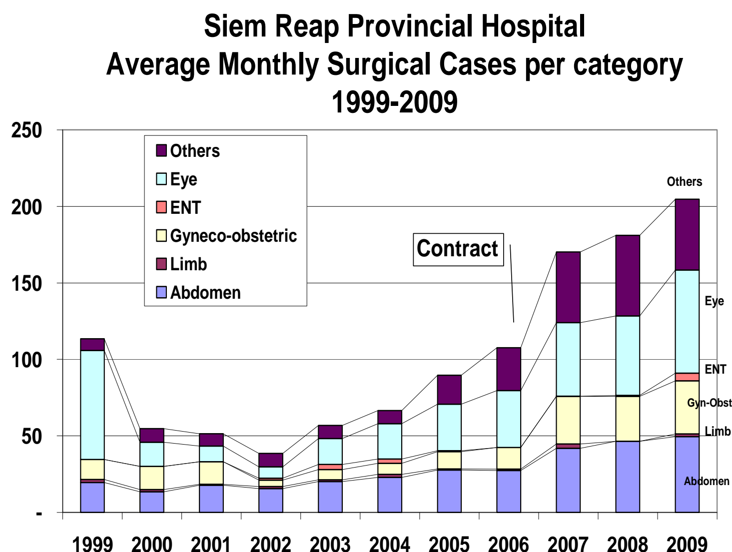


Figure 4

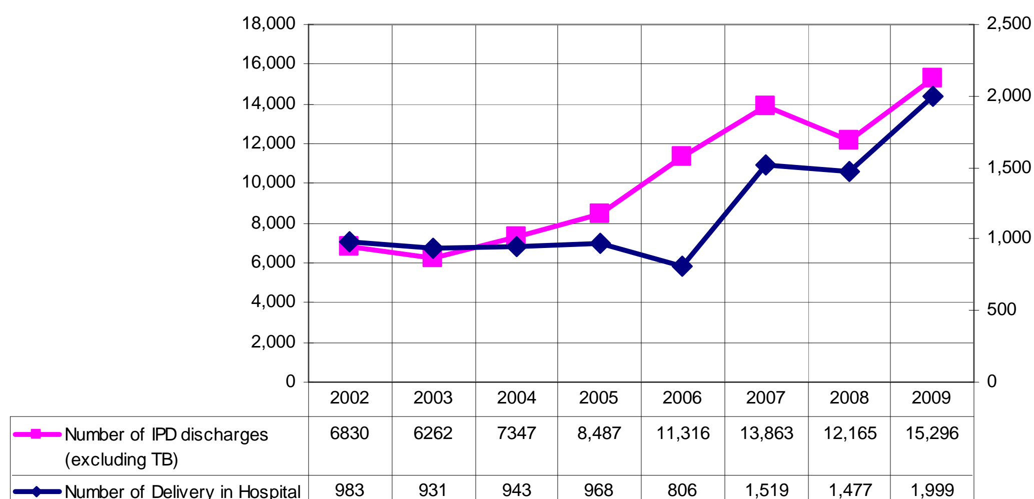
The continued increasing trend in surgical activities from 2003 and 2009 even more active.

In 2009 the proportion of planned surgery increased substantially showing that the surgical department is building up a good reputation and is not only used for emergencies. Most orthopedic and "limb" cases are caused by traffic accidents only few by land mines.



Kampong Cham Provincial Hospital (CPA3)

Figure 5: Number of IPD discharges and Number of Delivery in Kampong Cham PRH



	2002	2003	2004	2005	2006	2007	2008	2009
Number of IPD discharges (excluding TB)	6830	6262	7347	8,487	11,316	13,863	12,165	15,296
Number of Delivery in Hospital	983	931	943	968	806	1,519	1,477	1,999

Number of IPD and Number of Delivery in Provincial Hospital increasing remarkably since year 2005. There was a drop in year 2008 compared to year 2007, this may due to the extra number of dengue outbreak occurred in 2007. The number of delivery in hospital started to increase since year 2007 on the same time of the introduction of government incentive for delivery in health facility, to year 2008 the figure seemed to be stable which may caused by the situation of facilities for which some building was broken down for the new constructions.

Figure 6: Number of IPD discharge KC and SR Provincial Hospitals

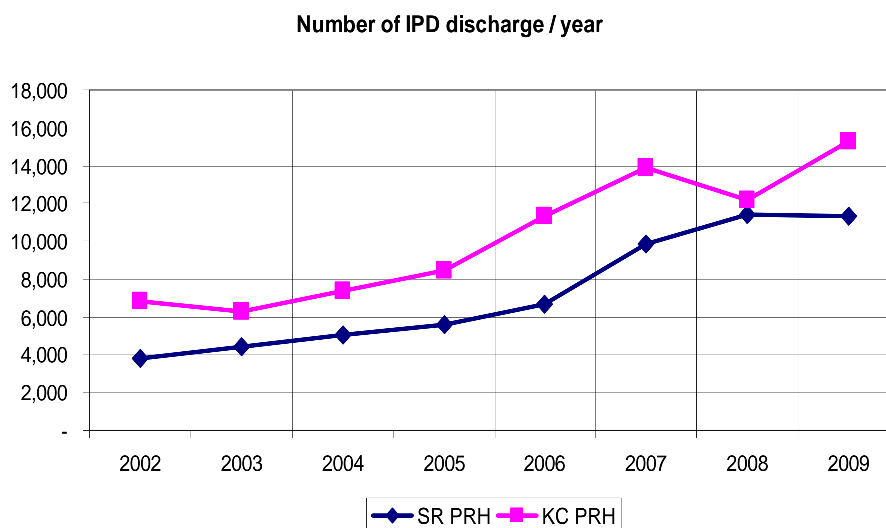
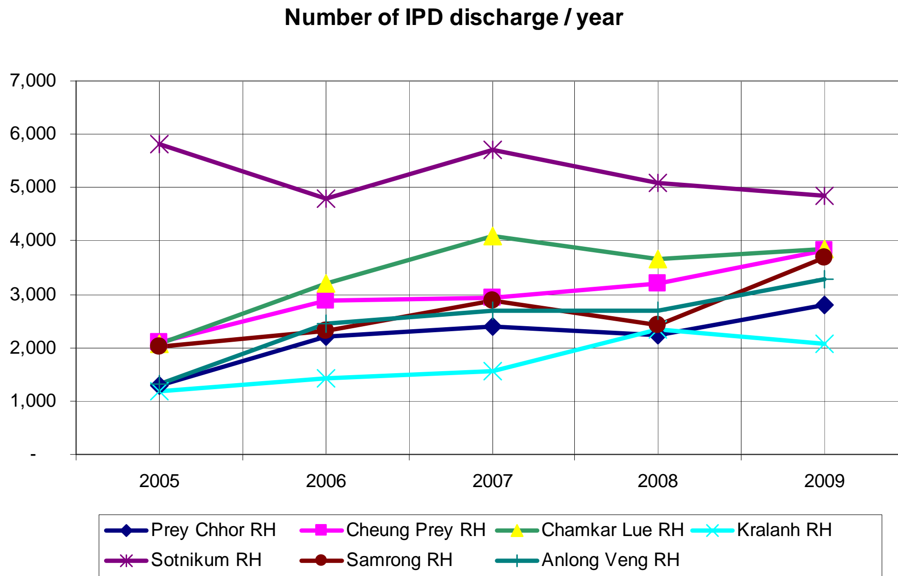


Figure 4 shows similar trend of increasing number of IPD discharge in both provincial hospital starting from year 2005.

District Referral Hospitals

Figure 7: Number of IPD discharge at District hospital



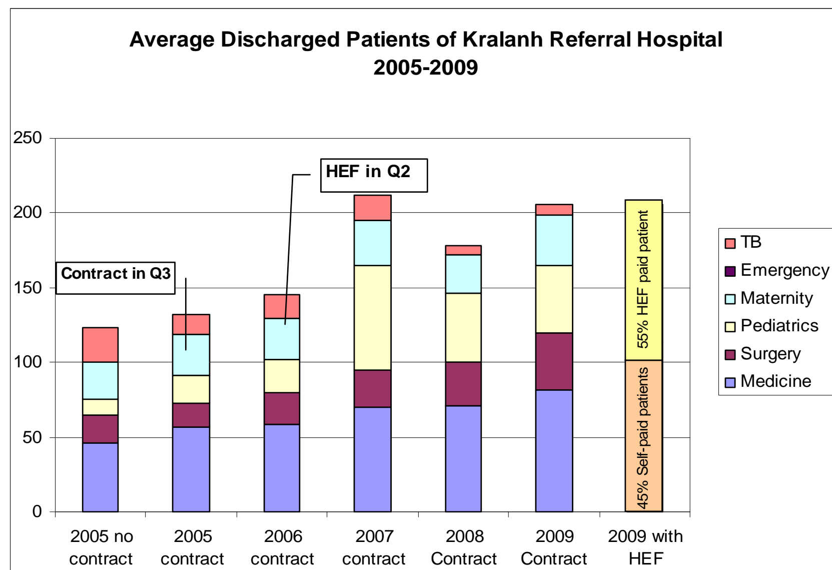
For most RH the number of IPD patients continue to increase. Except Sotnikum RH and Kralanh where the number of inpatients diminished.

Kralanh Referral Hospital (CPA2)

Figure 8:

The graph shows an increase in IPD services The number of self-paying patients increased but the proportion of HEF patients increased further up to 55% of all IPD.

The number of surgical cases increased and also more emergency cases were operated locally in the hospital due to the presence of one well trained surgeon.



Sotnikum Referral Hospital (CPA2)

Figure 9:

The declining trend which started in 2004 continues seems to slow down. Comparatively Sotnikum continues to treat more inpatients than other RH.

The number of HEF patients has increased to 66% of all admitted patients.

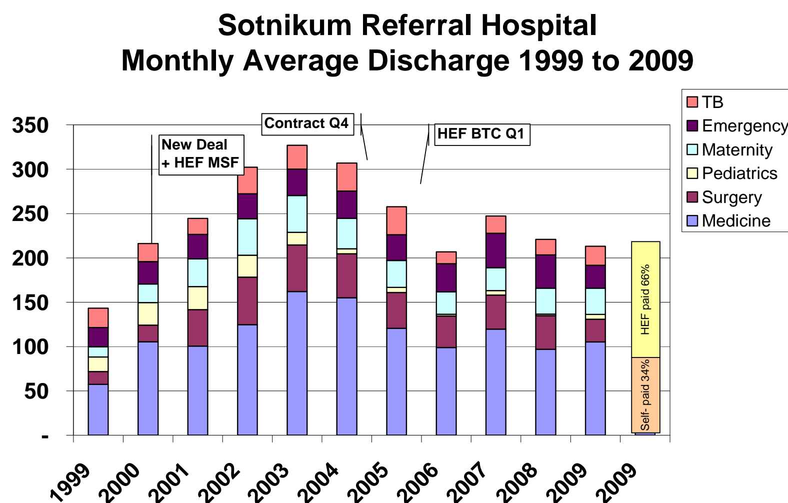
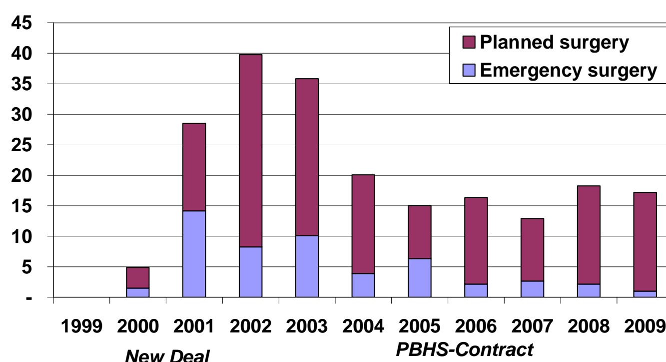


Figure 10:

The graph shows a continuous decrease in surgical activity from 2002 to 2007, especially the planned surgery.

After an increase in 2008 the average monthly number of surgical cases decreases slighthly to 17.

As the number of surgical emergencies became very low, the CPA2 RH mandate to provide emergency surgery remains challenged.



Samrong Provincial Referral Hospital (CPA2)

Figure 11

The graph shows a steady increase in utilisation over the past 4 years since 2004 and in 2007 it passes over the level attained in 2002 when a Cuban medical team was coaching the hospital. Contrary to the 2008 decrease after the 2007 dengue year, 2009 sees a strong increase and across all departments.
HEF patients represent 49% of all admitted patients.

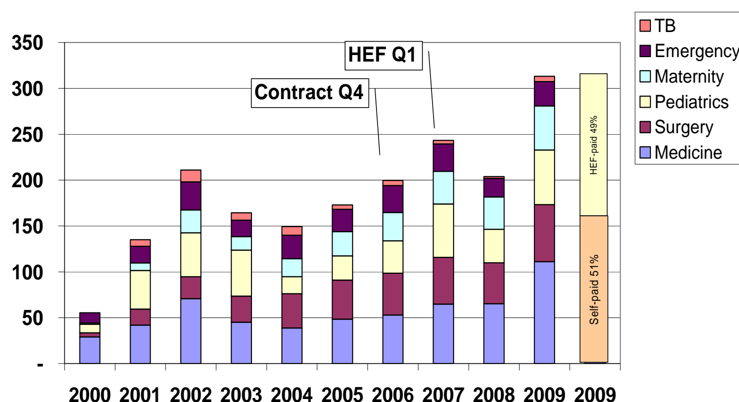
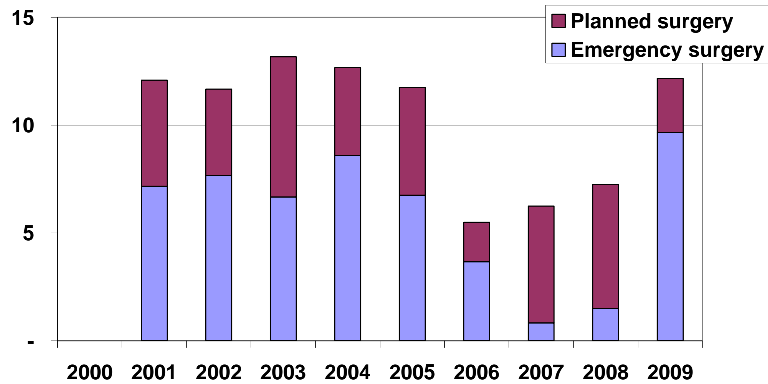


Figure 12

With the nomination of a new director-surgeon from 27 Jan 2009, we see a strong increase in surgical activity at Samrong Hospital after a three years of low activities. Furthermore, and very importantly emergency surgery has remarkably. For 2009, the activity of planned surgery services is much decreasing. Most emergency cases were appendicitis and C-section.



Anlong Veng RH (CPA1)

Figure 13

Some additional increase in IPD activity is assessed in 2007 and the increase continues mainly from self-paying patients. HEF patients represent 40%.

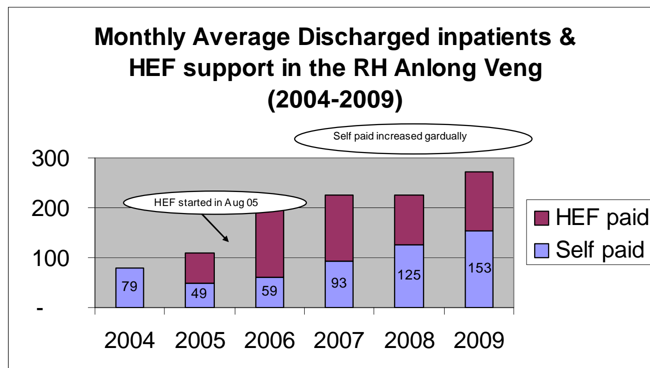
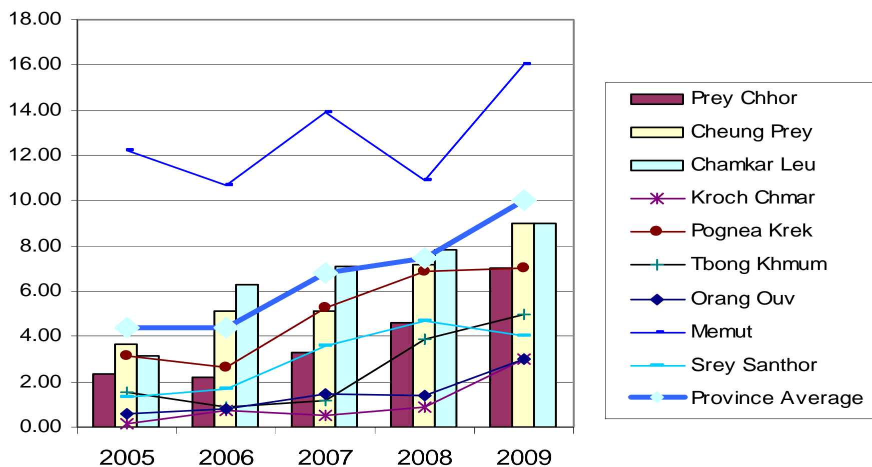


Figure 14: Percentage of delivery at 9 District RHs in Kampong Cham Provinces



The provincial average percentage of delivery in district referral hospitals increased by 41% from year 2005 to 2009. The trend of increasing shown from all the 9 district RHs of the province.

Utilization of services of Referral Hospitals

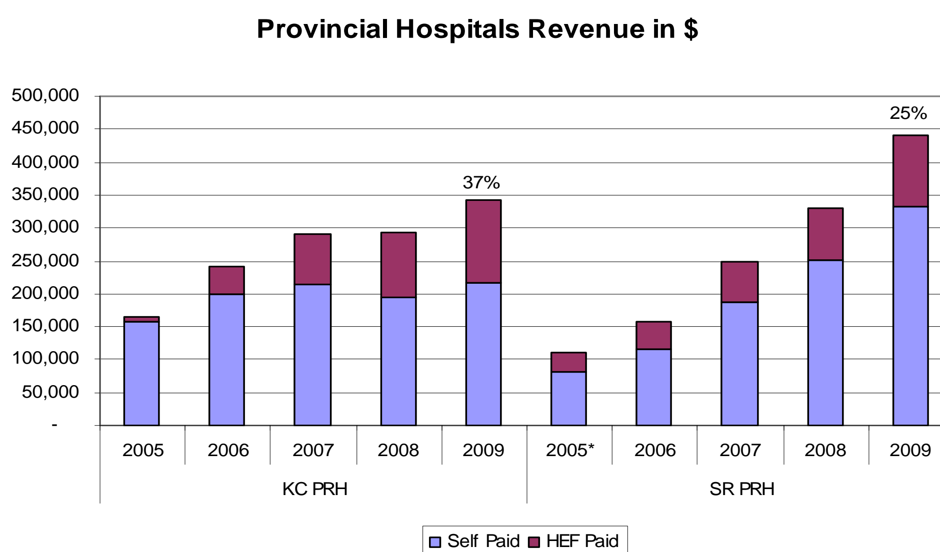
- In general, except for Sotnikum we continue to see a further increase of utilization or a stabilization of already high utilization. We understand this to be the impact of a comprehensive approach combining the following strategies:
  - HEF
  - Performance Incentive contracts
  - Monitoring
  - Improved management structures
  - Introduction/revival of some services (surgery and obstetrics at Siem Reap RH, paediatrics at Kralanh RH, …)
  - Some behavioural changes
- Sotnikum Referral Hospital seems to regain activity in surgical services esp. surgical program cases but in overall admissions decrease, and with a much higher rate of HEF-paid patients compared to 2008. Also the HEF-paid patients for the Chronic Disease Out patient Clinic, is an important source of revenue for Sotnikum hospital. See below the gradually decrease of self-paid user-fee.
- The number of surgical cases and especially the number of emergency surgery at Samrong RH increased sharply in 2009, relevant to their CPA2 status and very important as they are the only hospital providing surgery in the province.
- None of the three supported District RHs in KC are providing surgery; this is not regarded as essential as they are very close to the Provincial Hospital or for Cheung Prey to the Phnom Penh hospitals.

7. HEALTH FINANCING RESULTS

7.1. Revenue by institution and source

Provincial Hospitals (CPA3)

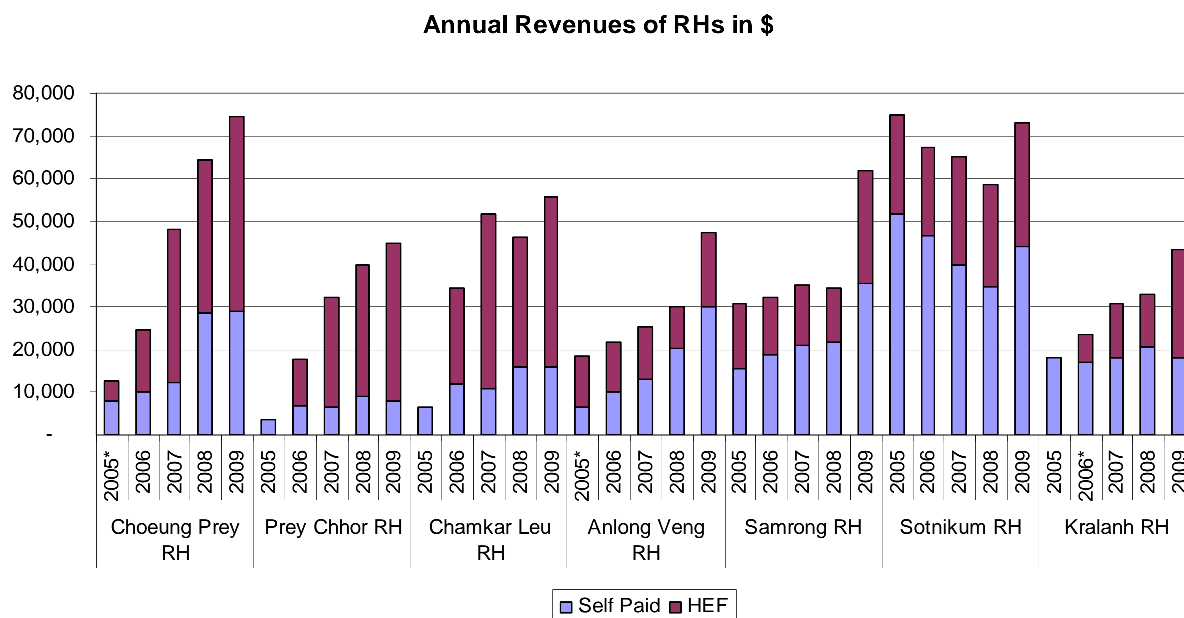
Table 5: Annual revenue of Provincial Hospitals



Compared to year 2008, the total income increased by 16% for KC and 34% for SR. Apart from IPD, the higher incomes of SR provincial hospital is contributed from the general OPD services, a service which is not yet well developed at KC.

District Hospitals (CPA2 & CPA1)

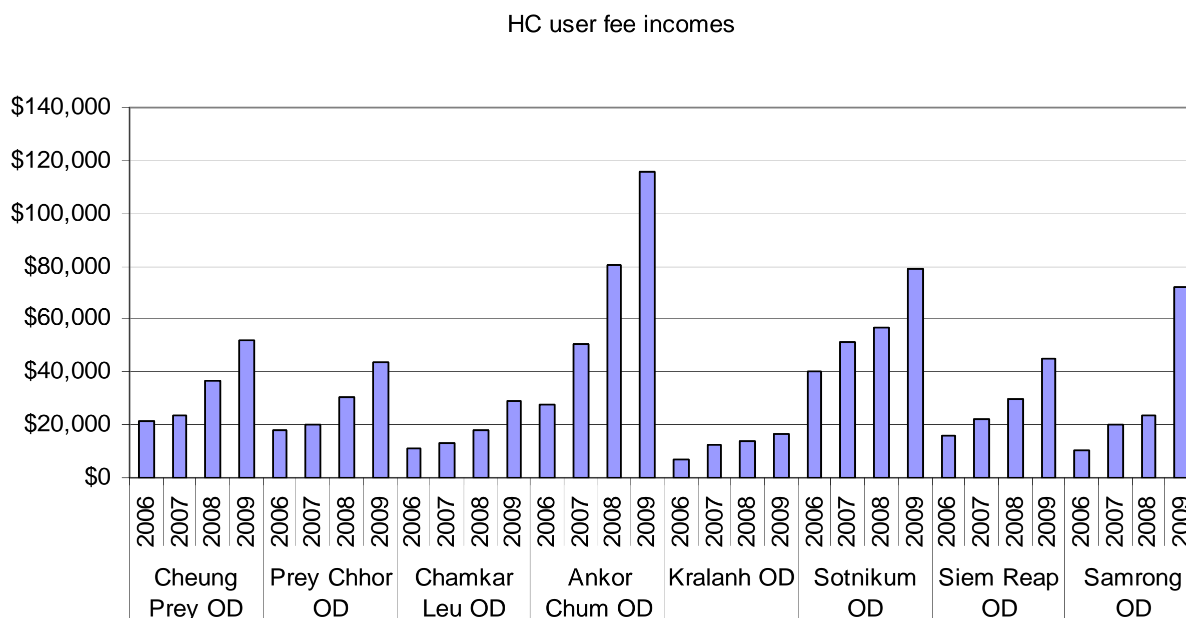
Table 6: Annual Revenue of District Hospitals



Similar to the trend of number of patients, district hospital revenue has increased everywhere. The biggest increases are seen at Samrong PRH and Along Veng CPA1 RH. It is important to note that the revenue of Cheung Prey RH is higher than others this is due to their very active OPD. In other RH OPD services remain poorly organized and neglectible

HC user fee incomes (MPA)

Figure 15: Revenue at HC level per OD



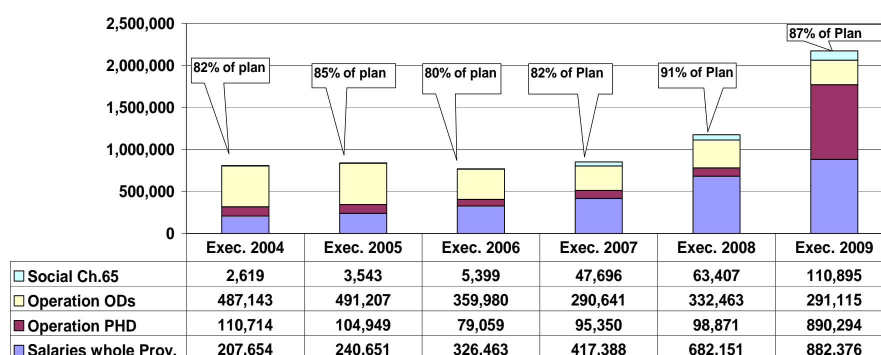
This graph shows a general jump in user fee (UF) revenue at health center level in all OD.

This is not consistent with the stabilized "New Consultation utilization rate".
Possible explanations are:

- UF in 2006 were under reported.
- UF in 2007 and 2008 are better reported (indicator in the bonus calculation + HFU)
- Several HCs increase their UF rates (without clear notification from ODOs to PHD).
- Samrong OD seems to increase much higher probably due to additional income from active CBHI.
- The highest UF incomes of Ankor Chum OD probably due to the strict discipline on private services and a small increase in HC tariffs

7.2. National Budget (exclusive CMS supplies)

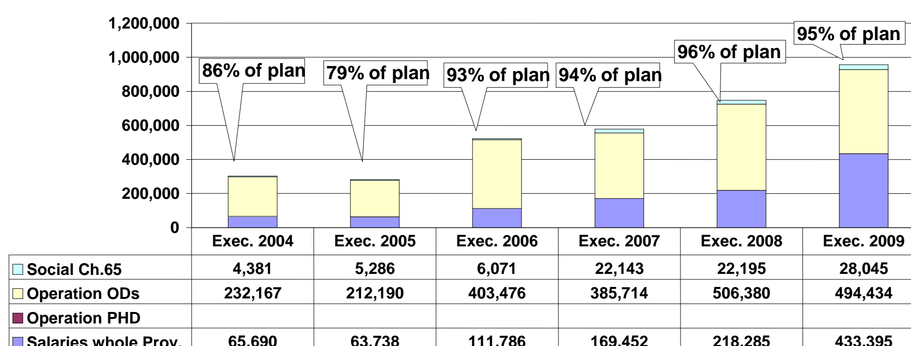
Siem Reap province



	Exec. 2004	Exec. 2005	Exec. 2006	Exec. 2007	Exec. 2008	Exec. 2009
Social Ch.65	2,619	3,543	5,399	47,696	63,407	110,895
Operation ODs	487,143	491,207	359,980	290,641	332,463	291,115
Operation PHD	110,714	104,949	79,059	95,350	98,871	890,294
Salaries whole Prov.	207,654	240,651	326,463	417,388	682,151	882,376

Siem Reap 2009: the execution (access) is better implemented than last year in term of budget amount but reaching only 87%. Salaries and related increase by 29% and Operational spending at OD level decrease by 12%. In 2009, this represents a total of US$2.37/cap/year of which US$0.32 goes to operation costs at OD level which is less than 2008.

Otdar Meanchey province

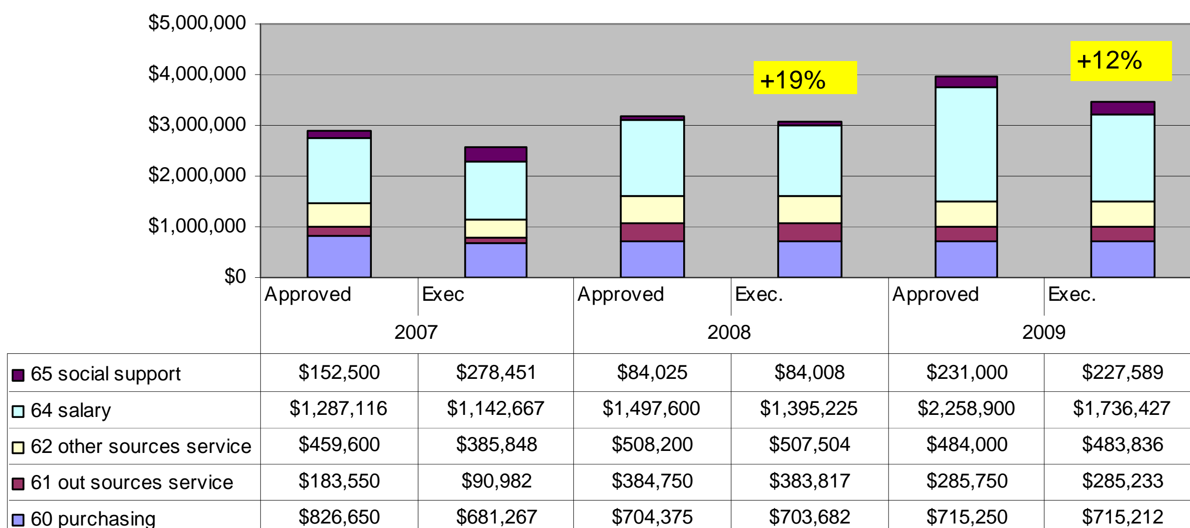


	Exec. 2004	Exec. 2005	Exec. 2006	Exec. 2007	Exec. 2008	Exec. 2009
Social Ch.65	4,381	5,286	6,071	22,143	22,195	28,045
Operation ODs	232,167	212,190	403,476	385,714	506,380	494,434
Operation PHD						
Salaries whole Prov.	65,690	63,738	111,786	169,452	218,285	433,395

OMC 2009: (PHD = OD) the execution (access) was steadily performed with a 99% increase in salaries including delivery incentive/PMG) and the operational spending with no increase or even decrease. For 2009, this represents a total of US$ 4.75/cap/year of which US$2,51 goes to Operations.

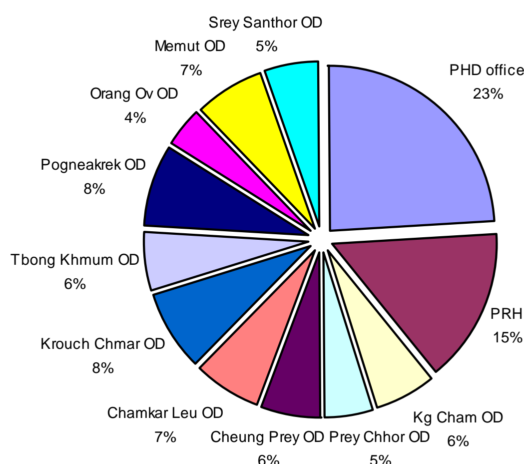
Kampong Cham Province

Table 7: Overall government budget excluding CMS drug



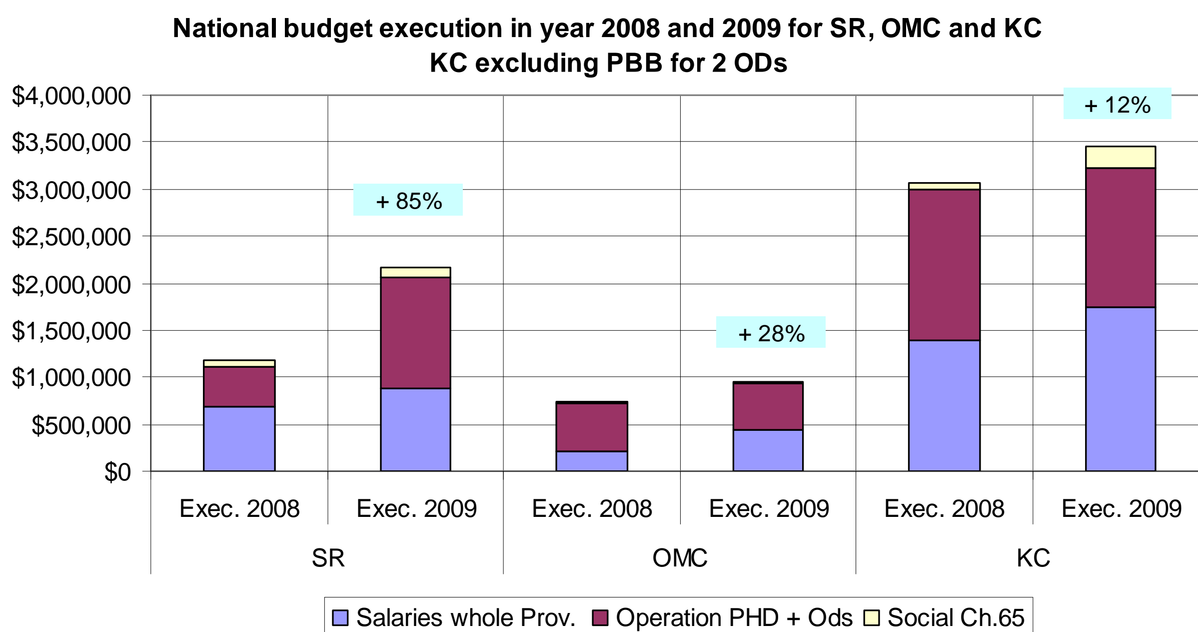
	Approved 2007	Exec 2007	Approved 2008	Exec. 2008	Approved 2009	Exec. 2009
65 social support	$152,500	$278,451	$84,025	$84,008	$231,000	$227,589
64 salary	$1,287,116	$1,142,667	$1,497,600	$1,395,225	$2,258,900	$1,736,427
62 other sources service	$459,600	$385,848	$508,200	$507,504	$484,000	$483,836
61 out sources service	$183,550	$90,982	$384,750	$383,817	$285,750	$285,233
60 purchasing	$826,650	$681,267	$704,375	$703,682	$715,250	$715,212

Overall budget execution in year 2009 increased by 12% compared to the execution in year 2008. There was a big increasing (171%) for chapter 65. Chapter 60 increased 2%.
The salary (chapter 64) increased by 24%, by the way the total execution of this chapter presenting only 64% of the approved budget, this mainly due to PMG budget ($175,000) which was approved and had not been executed.
Contrarily there were 26% and 5% decreased for chapter 61 and 62, these due to the reduction of maintenance budget (61), and mission budget (62).



At each OD the running cost presented about 5 to 8 % of the total expenditure of the province while 23% were used by PHD office and 15% used by PRH. High percentage of PHD office may account for mission and training cost while PRH may be used for patient food and staff duty allowance. Including in the graph, running cost for Memut and Ponhea Krek ODs accounted only to chapter 65 (PBB).

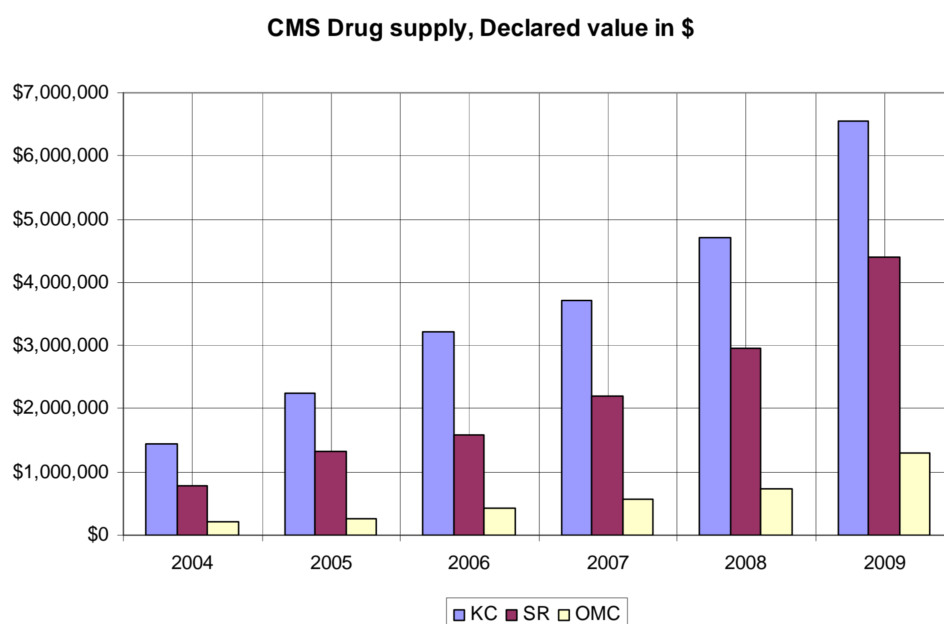
National budget execution of the 3 province 2008-2009



This graph shows increased government health expenditures for all three provinces. Siem Reap has seen a very important increase in budget availability and expenditure of 85 % and mainly for operational costs for PHD. In Otdar Meanchey and Kampong Cham the increase were 28% and 12% respectively and were mainly for salary increases.

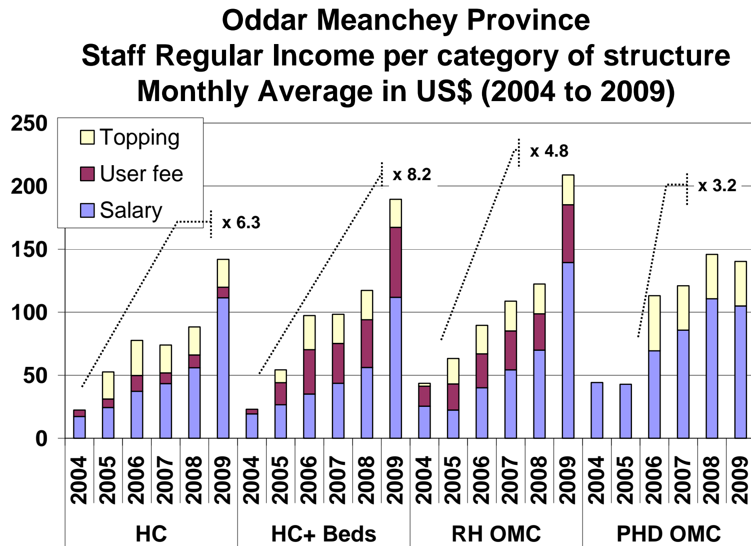
7.3. CMS Drug Supply

Figure 16



From 2004 to 2009, the declared value of supplies increased by 464% for the 3 provinces. The pharmacists observed much better supply of drugs than in 2008 but still did not meet the needs esp. the active provincial hospitals. Active hospitals and HCs can not acquired enough drugs even when using 39% of their user fee incomes. Therefore, other operational costs have to be reduced to the disadvantage of hygiene, administration, …

7.4. Staff Income

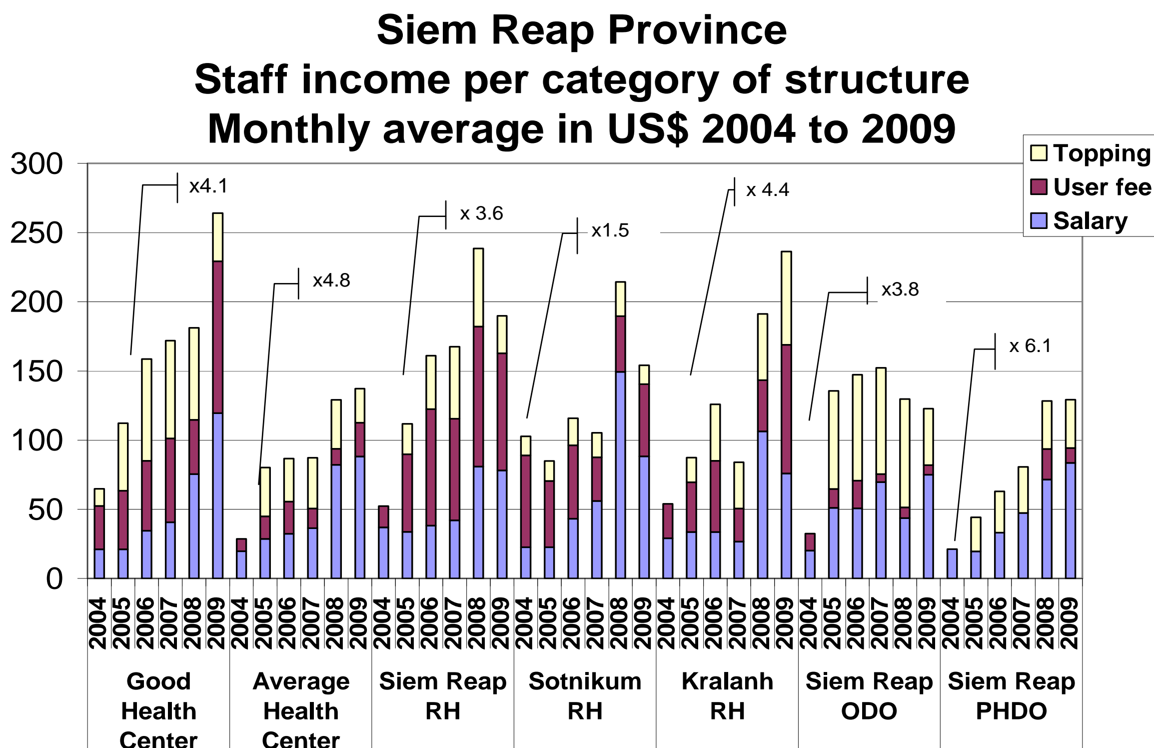


Oddar Meanchey: the staff income increased substantially from 2004 to 2009 to reach:

- Over $120 at HC with a stable user fee share
- and >$200 at RH
- and >120 at PHDO

Note: The decrease at the PHDO level due to a total cut of guard duty fee for PHDO staff since beginning of 2008.
HC/RH: UF + HEF +CBHI + govt. salary + guard duty fee + topping up

Figure 17



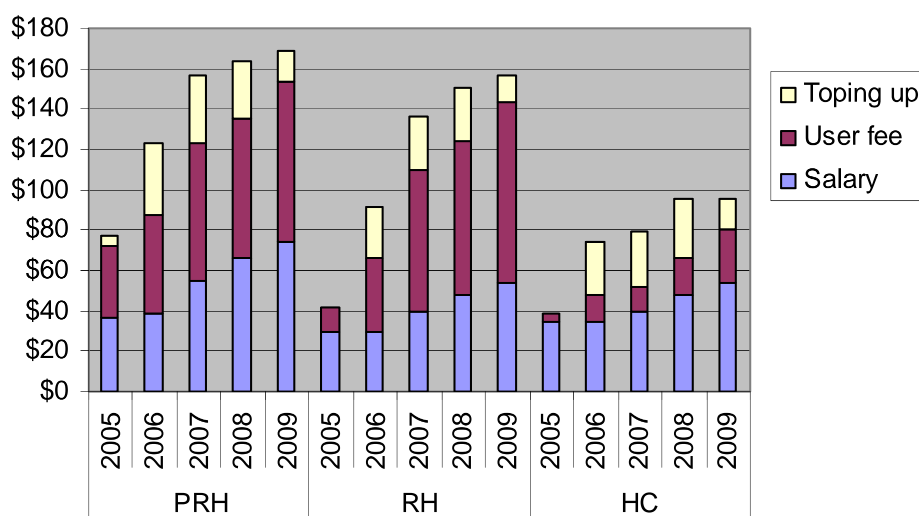
Siem Reap: The staff regular income at HC level is also around 140$ for average performance HC and more than 250$ for good performing HCs.

Here they reported increase in user-fee revenue reflect in the staff income, especially at Siem Reap RH making almost half of the total. This year toping up from BTC was only 6 months.

ODO is high and very much dependant on the external topping but also a small proportion coming from 5% of total user fees of RH and HCs. Except, Siem Reap OD received only from user fee of HCs. The topping up for Siem Reap, Sotnikum and Angkor Chum ODs was only for 6 months.

Data from the PHDO either contribute to explain the reduced mobilization of its workforce and/or is incomplete (other toppings by vertical projects, …). In 2009, like in 2008, the PHD also shares 5% of PRH user fee income as it is now under direct control of PHD.

In general, government salary increases with delivery incentive for midwives in all levels and some staff receiving PMG incentives through their salary payment roll.



The average monthly incomes of health staff vary from 96$ at HC, to 156 $ at Rh and 165$ at provincial hospital. Compared to year 2008 there was small increased which accounts to about 10% for salaries, 16 to 18 % for user fee at Provincial and District hospital and 49% at HC level. To the contrary the performance incentives decreased by 50% due to the 6 months gap between the PBHS performance incentives and the SDGs caused by delays

7.5. Staffing

The staff shortages which continued from 2008 to 2009, mainly in Siem Reap province (table below) have been partly addressed by receiving additional primary midwives whom were trained by RTC Battambang with financial support from PBHS-SROM/BTC.
At Kampong Cham province the 30 primary midwives trained by RTC with PBHS-KC fund were graduated in mid 2009. Currently they are at work in the 3 ODs according to the assignment agreed prior to the training. The recruitment application for these midwives had been submitted to MoH by PHD but is delayed and still the official nomination is not yet issued.

	National standard by population	Kampong Cham 2006*	Kampong Cham 2008	Kampong Cham 2009	SR 2009	OMC 2009
Medical Doctors (MD or MA)	1/3,800	1/9,725	1/10,112	1/10,108	1/8,113	1/5,071
Expected Number		454	455	458	241	47
Available		177	171	172	113	35
Shortage		277	284	124	128	12
Nurses (Secondary or Primary)	1/1,750	1/2,446	1/2,501	1/2,470	1/2,990	1/1,345
Expected Number		985	989	993	524	101
Available		705	692	704	354	132
Shortage		280	297	289	219	-33
Midwives (secondary or primary)	1/4,700	1/6008	1/6,094	1/5,757	1/5,269	1/4,437
Expected Number		367	368	370	195	38
Available		287	284	302	174	40
Shortage		80	84	68	36	-7
Total population		**1,724,327**	**1,730,976**	**1,738,592**	**16,756**	**77,484**

Siem Reap Province Health Staff Movement

	End of 2008	Out*	New	End of 2009	%
Specialist	**6**	**0**	**0**	**6**	1%
Doctor	**70**	**0**	**7**	**77**	9%
Medical As	**33**	**3**	**0**	**30**	4%
Pharmacis	**12**	**0**	**3**	**15**	2%
Pharm. As	**5**	**0**	**0**	**5**	1%
Dentist	**1**	**0**	**2**	**3**	0%
II Nurse	**213**	**2**	**0**	**211**	25%
I Nurse	**150**	**15**	**8**	**143**	17%
II Midwife	**104**	**2**	**0**	**102**	12%
I Midwife	**57**	**0**	**15**	**72**	9%
II Lab. Tec	**5**	**0**	**0**	**5**	1%
I Lab. Tech	**8**	**0**	**0**	**8**	1%
Kinesi	**4**	**0**	**3**	**7**	1%
IT Speciali	**5**	**0**	**0**	**5**	1%
Other skill	**1**	**0**	**1**	**2**	0%
Driver	**4**	**0**	**0**	**4**	0%
Worker	**2**	**0**	**0**	**2**	0%
Total	**680**	**22**	**39**	**697**	83%
Floating/Contract				**141**	17%
Grand Total				**838**	100%
Staff per 1,000 inhabitant				0.91	

Otdar Meanchey Province Health Staff Movement

	End of 2008	Out*	New	End of 2009	%
Specialist	**0**	**0**	**0**	**0**	0%
Doctor	**18**	**2**	**0**	**16**	5%
Medical As	**20**	**1**	**0**	**19**	6%
Pharmacis	**3**	**0**	**0**	**3**	1%
Pharm. As	**1**	**1**	**0**	**0**	0%
Dentist	**1**	**0**	**0**	**1**	0%
II Nurse	**73**	**0**	**0**	**73**	24%
I Nurse	**60**	**1**	**0**	**59**	19%
II Midwife	**15**	**0**	**1**	**16**	5%
I Midwife	**14**	**0**	**10**	**24**	8%
II Lab. Tec	**1**	**0**	**0**	**1**	0%
I Lab. Tech	**0**	**0**	**0**	**0**	0%
Kinesi	**0**	**0**	**0**	**0**	0%
IT Speciali	**0**	**0**	**0**	**0**	0%
Other skill	**9**	**0**	**1**	**10**	3%
Driver	**0**	**0**	**0**	**0**	0%
Worker	**0**	**0**	**1**	**1**	0%
Total	**215**	**5**	**13**	**223**	74%
Floating/Contract				**80**	26%
Grand Total				**303**	100%
Staff per 1,000 inhabitant				1.71	

In Siem Reap province, the number of government staff has been increased officially from 680 in 2008 to 697 in total including those who have been attending training and leave without pay. This amount of staff shows a trend towards less qualified nurses and midwifes. The ratio of staff per 1,000 inhabitants is more than 2 times less in Siem Reap than in Otdar Meanchey. While the main shortages in Siem Reap are on doctors, nurses and midwifes, Otdar Meanchey is short only of midwifes and seems to have nurses in excess, with also a relatively high number of floating staff (often nurse/midwife-assistants).

8. PROJECT ADMINISTRATION/MANAGEMENT ISSUES

8.1. Staffing

During the first three months of 2009 all first phase administrative and technical staff ended their contracts with KAM0200711 and KAM0300911. Most of the TA and one senior financial management officer were re-employed by the consolidation phase. All project staff, other than the

BTC Health Advisor and the HEFI manager, were to be employed and contracted by the HSSP2 secretariat. Early in 2009 it was also decided that the HSSP2 secretariat would only use Pooled Funds, and not BTC funding as initially planned, for their administrative staff. All staff recruited through HSSP2 secretariat were given one year consultant contracts. Contract negotiation took very long and resulted in several months delay before staff received their first salary payment.

End of contract:

- Mr. Kong Mon, the financial officer for KAM0200711 finished his employment contract at the end of January 2009 and was recruited by the BETT project. BETT agreed to have Mr. Mony part time available for the KAM0200711 financial management until the end of March 2009.
- Mr. Tep Chenda, recruited as Senior Administrator and Specialist in procurement and contract management for both first phase projects finished his employment contract at the end of January 2009.
- Ms. Khoun Lina, the KAM0200711 Office Administrator finished her employment contract at the end of February 2009.
- Mrs. Ngin Samey Office Administrator in PBHS-KC finished her employment contract at the end of March 2009.
- Mr. Than Vuth, the Project Officer in Siem Reap office. finished his employment at the end of March 2009 but continued working in April for specific project closing task on a one-month consultancy basis contact.
- All technical assistants of both projects KAM0200711 and KAM0300911 ended their contract on 31st March.
-

New recruitments:

- After finishing his employment as senior financial officer with KAM0300911 on 31st March, Mr. Pich Vichet was immediately re-employed but as HEFI manager on a BTC contract. He did however continue to be responsible for general financial management of the project as well as some administrative work. He was also responsible for the financial closing of KAM0300911. The work load of Mr. Vichet remained very heavy throughout 2009.
- 5 of the 6 first phase Technical Assistants were re-recruited by the HSSP2 secretariat, 2 based in Siem Reap-Otdar Meanchey and 3 in Kampong Cham
- Ms. San Sophorn was recruited by the HSSP2 secretariat as new TA-office administrator based in KC, she started her duties on 01 Augusts 2009. She provides logistic on administrative support to Technical Assistant and BTC Health Advisor and also assures reception and secretariat work.

Challenges:

- The HSSP2 secretariat organized several recruitment rounds (with public announcements) but was not able to recruit new TA staff during 2009. As a result all the following essential capacity building TA and one driver position remained open:
  - 2 TA-Financial Management Capacity Building
  - 2 Quality Improvement
  - 1 Contract Management
  - 1 Driver in KC-Office
- Payment of travel expenses by the HSSP2 secretariat was only possible after September resulting in important payment delays and the necessity to pay through co-management. This was not very motivating for the staff. Even after October payments of perdiem continue to be delayed.

8.2. Logistics and New Equipment

- Based on the Technical and Financial File and the decision of the Steering Committee Meeting of 20th March 2009 the titles and ownership 4 of the 7 project cars were handed over to the HSSP2 Secretariat but for use by the project TA and HEFI office, the other three cars were donated to the provinces.
  - The four vehicles received their New “State” number plates on November 20, 2009.
  - Payment of vehicle running costs (fuel and maintenance) by the HSSP2 secretariat was only possible since Thursday 26 November 2009 resulting in important payment delays and the necessity to pay through co-management.
  - Because of delays with the insurance of vehicles. The vehicles were parked for two months. As a result no transport was available till July 16, 2009.
- HSSP2 secretariat procured the following items for use by the TA:
  - 8 Laptop Computers
  - 3 Desktop Computers
  - 6 B&W small laser printers
  - 2 Color A3 desk jet printers
  - 3 Motorbikes
- Office/IT equipment and furniture of the first phase was hande over to the respective PHDs put at the disposition of the project TA team and HEFI. The Office administrator follows up on their use and keeps an inventory in communication with the PHDs.
- The contracts and payment responsibilities for office phone/fax and internet in the 2 PBHS2 offices (Siem Reap and Kampong Cham) were transferred to HSSP2 Secretariat and was effective from 01st May 2009.
- Utilities water, electricity of SR/KC-office are now being paid for by PHD of Siem Reap and Kampong Cham.
- Office cleaning sourced out to cleaner in Siem Reap Office paid by HEFI-own management account.
- Office cleaning in Kampong Cham Office paid by Project Office by cash advance.
- No petty cash (through National Execution) was available during 2009.

8.3. Challenges

- Very poor quality laptops (very slow, incompatibilities between different software and possibly extra RAM installed by shop)
- Several payments (fuel, office materials, office cleaning, car maintenance, computer maintenance, etc.) were paid for several months through co-management.
- The proposed 1,000 USD advance (replacing petty cash), to be managed through our Office Administrator, is too small an amount, certainly in the present context were replenishment require her to travel to Phnom Penh and a long procedure. This advance will need to pay for travel allowances for 16 persons, who main task require field visits, as well as for office stationary, office cleaning, fuel for motorbikes, and small maintenance.

8.4. Office Space

The PMU office spaces of the first phase in Kampong Cham and Siem Reap continue to be used as office space for the Capacity Building team and the HEFI. In both provinces the PHD/PRH have taken over some of the rooms for their officers. While in Otdar Meanchey, where TA are only part time available, office space is shared.

9. PROJECT FINANCIAL REPORT AND PLANNING

During 2009 KAM0200711 applied three financial management modalities:

1. Implemented in Co-management:
   - All first phase activities planned in co-management were implemented during the first four months
   - During the first three months all Consolidation phase activities initially planned in National Execution were reverted back to co-management.
   - Even after first April an important but decreasing number of activities planned in National Execution continued to be implemented in co-management because of delays with HSSP2 secretariat implementation. This was done in agreement with the secretariat and was for essential expenses, such as fuel, travel allowances, stationary, cleaning materials, office utilities. Gradually the HSSP2 secretariat took over all payment responsibilities.
2. Implemented in National Execution (NEX):
   Starting from 1st April the HSSP2 secretariat took over payment responsibilities for the different items. Because of the no-availability of petty cash or advance in NEX, the project continued to use co-management petty cash for small expenses as mentioned above till the end of the year.
3. Implemented in Own-management:
   On top of the items initially planned in own-management (international technical assistant, monitoring, backstopping) the SC decided to change, with effect of 1st April 2009, the implementation modality of almost all the HEF Implementation items from NEX to Own-management.

End 2008, before the confirmation of the project extension, a comprehensive financial plan 2009 was developed by the three provincial health departments in collaboration with the project technical assistants and guided by the budget proposed in the TFF. This financial planning was initially not integrated in the version of Annual Operational Plan approved by the MOH.

Because of the different budget categories used by HSSP2 and the TFF or FIT it is impossible to follow up the NEX expenditure by the implementation units (HSSP2 secretariat and provinces) by BTC budget categories and project component.

Through JPIG, the BTC Health Advisor receives regularly the quarterly Interim Financial Reports (IFR) and quarterly Audit reports, although with some delays. These reports are discussed and corrected through the Joint Quarterly Meetings.

On May 06, 2009 a first transfer was made to the HSSP2 secretariat BTC Discrete Account for the amount of **USD 465,876**. So far only one transfer was made as no further replenishments were requested by the secretariat. At the end of 2009 the balance on the co-management account was **USD 16,618**; this amount will be transferred to the HSSP2 secretariat BTC Discrete account to be used in NEX.

Expenses vs Financial Planning for Year 2009

For the year 2009, the expenditure in Own-management is Euro 366,720 compared to financial plan Euro 376,970, a budget execution rate of 97%. The expenditure in Co-management (mixture of co-management and NEX modality) is Euro 856,270 compared to financial plan Euro 809,110 giving a budget execution rate of 106%. It should however be observed that this expenditure considers the total amount of USD 358,760 transferred to HSSP2 BTC discrete account as NEX expenditure and this because of BTC procedures. In reality the NEX expenditure was only USD 345,780 leaving a

positive balance of USD 12,980 on the HSSP2 BTC discrete account. This amount has been transferred to 2010 budget.

The total expenditure for year 2009 is Euro 1,222,990 which gives an execution rate of 103%. The reference financial planning is the version of Q2-2009 which was updated at the moment of the budget revision K02.

Table 1:

Expenses vs Financial Planning in 2009

Figure in Euro '000

Description	Budget (K02)	Planning 2009	Expenses 2009	% Realization 2009
A Enhance Health Sector Development by supporting Provincial plans in Siem Reap and Ot	**3,430.58**	**85.00**	**88.83**	**105%**
01 Strengthened Consumer Rights in communities	879.67	51.50	51.52	100%
02 Enhanced Behaviour Change & Communications	118.91	-	-	0%
03 Strengthened quality of delivery of health services through contracting	1,350.98	25.10	26.63	106%
04 Increased number of quality improvement initiatives	535.49	5.60	6.54	117%
05 Improved staff skills through capacity building	337.74	1.60	2.33	145%
06 Strengthened Institutions capacity to manage, plan, regulate, finance, monitor and evaluate	207.79	1.20	1.82	152%
B Strengthen monitoring & evaluation capacity of health system	**111.94**	**0.30**	**0.28**	**92%**
01 Enhanced monitoring & evaluation capacity	111.94	0.30	0.28	92%
C To consolidate the results of the current health projects in Cambodia in order to	**2,069.09**	**881.59**	**958.90**	**109%**
01 Increased access to good quality health services for the poorest population.	701.18	333.47	430.21	129%
02 Increased capacity in 8 ODs & 2 Provincial Referral Hospitals to provide better quality health	773.88	418.20	147.34	35%
03 Increased capacity of 3 PHDs to manage service delivery contracts & to support ODs & Refe	370.18	108.58	22.57	21%
04 Evidence based policy making through systematic & sustainable documentation & analysis c	223.85	21.35	0.02	0%
05 National Execution (NEX); transfer to HSSP2 - BTC Discrete Account	-	-	358.76	0%
Z General means	**2,175.73**	**219.18**	**174.99**	**80%**
01 General means	1,244.81	21.90	19.88	91%
02 Staff 'Consolidation Phase'	616.76	155.63	142.64	92%
03 Procurement 'Consolidation Phase'	4.96	-	-	0%
04 Operational costs 'Consolidation Phase'	218.20	39.15	12.47	32%
05 Audit, M&E 'Consolidation Phase'	91.00	2.50	-	0%
REGIE	**2,147.95**	**376.97**	**366.72**	**97%**
COG	**5,639.39**	**809.11**	**856.27**	**106%**
TOTAL	**7,787.34**	**1,186.08**	**1,222.99**	**103%**

Budget Revision

(See Annex III for detail of proposed budget change)

The project is proposing a budget revision of **Euro 156,177** from National Execution to Own Management, as well as some other smaller changes between first phase budget lines.
The main reasons necessitating this revision are that the expected expenses are higher than those initially planned in the TFF:

1. Negative balances from first phase budgetlines are brought to zero using positive balances of first phase budgetlines.
2. Remaining positive balances on first phase budgetlines are transferred to "Phase 2" budgetlines.
3. Budgetline C_01_04 to be increased by Euro 96,033. The HEFO costs for the three years will be slightly higher than planned in 2008, ±10% or ±20,000 Euro. The cost of the Direct Benefit for the one month of April 2009, being Euro 74,941 which were initially budgeted on Pooled Funding 2009 but paid for from this budgetline (Belgian Contribution) because of delays.

4. Budgetline C_01_05 increased by Euro 12,768 to plan for a new staff (21 months) of HEFI office, and a three months extension period while closing the project will increase the cost of HEFI manager (3 months).
5. Budgetline C_01_06 increased by Euro 7,376 to plan for year 2010 HEF review workshop and a final handover workshop of HEF activities in year 2011.
6. Budgetline Z_02_01 increased by Euro 40,000 because of a three months extension period while closing the project will increase the cost for International Technical Assistance from Euro 450,000 to Euro 490,000.

Financial Planning for Year 2010 and beyond

(See Annex IV for detail)

The project prepared a provisional financial planning for the period 2010-2012, until the end of the project. This planning is based on planned activities and amounts of the TFF but adapted to the present situation and known needs. The project also proposes a three-month extension period in 2012 for smooth closing of the project combined with result dissemination. The financial planning 2010 for COG (=NEX) is Euro 300,810 and is substantially higher than the amount approved in the AOP 2010 being Euro 206,435 (US$268,366/1.3) (see table 3). The project expects that more activities under "Evidence based policy making" will take place during the second half of 2010. This will require changes in the DPHI AOP, possibly during the mid year review. The 2011 COG budget for 2011 is estimated at Euro 350,000 hoping that he implementation units will be allowed to plan for higher amounts (for capacity building) than for AOP 2010.

But even with the above increases this would still leave an important balance of Euro 341,630 by 31st March 2012.

Table 2:

Financial Planning for Year 2010 and beyond

Figure in Euro '000

Phase of Project	FinMet	Budget after 2nd SC	Expenses up to 2009	Planning			Est. Total Expenses	Est. End Project Balance	Est. % Exec.
				2010	2011	2012			
PBHS1 + PBHS2	REGIE	2,304.13	1,345.24	403.02	476.50	58.25	2,283.01	21.12	99%
	COG	5,483.21	4,511.90	300.81	350.00	-	5,162.71	320.51	94%
	TOTAL	7,787.34	5,857.14	703.83	826.50	58.25	7,445.71	341.63	95%
PBHS1	REGIE	979.50	979.50	-	-	-	979.50	-	100%
	COG	3,763.63	3,763.63	-	-	-	3,763.63	-	100%
	TOTAL	4,743.13	4,743.13	-	-	-	4,743.13	-	100%
PBHS2	REGIE	1,324.62	365.74	403.02	476.50	58.25	1,303.51	21.12	98%
	NEX	1,719.58	748.27	300.81	350.00	-	1,399.08	320.51	81%
	TOTAL	3,044.21	1,114.00	703.83	826.50	58.25	2,702.58	341.63	88%

AOP 2010 Approved by JPIG

Table 3:

Cambodia: Second Health Sector Support Program
BTC Discrete Donor (in US$)
JPIG Approval of 2010 AOPs

IU Name	IU Type	Reviewer	HSSP request?	Program Requested						Program Approved						Diff.
				P1	P2	P3	P4	NP	Total	P1	P2	P3	P4	NP	Total	Request vs Approve
HSSP Secretariat	Central	WB	Yes	-	-	-	-	130,000	130,000	-	-	-	-	140,000	140,000	(10,000)
Kampong Cham	PHD	BTC	Yes	-	-	-	55,000	-	55,000	-	-	-	55,000	-	55,000	-
Oddar Meanchey	PHD	BTC	Yes	-	-	-	16,066	-	16,066	-	-	-	16,066	-	16,066	-
Siem Reap	PHD	BTC	Yes	-	-	-	52,100	-	52,100	-	-	-	57,300	-	57,300	(5,200)
Total				-	-	-	123,166	130,000	253,166	-	-	-	128,366	140,000	268,366	(15,200)

Challenges:

- Because of the HSSP2 budget caps the provinces cannot plan and budget for the BTC discrete funds required for training even when these funds are available.
- delayed payment of office running costs because petty cash arrangements
- delayed payment of travel allowances of local TA consultants because petty cash arrangements
- For every advance (petty cash) of 1,000 USD, at least twice a month, the Office Administrator will need to travel to Phnom Penh for reimbursement and claiming of new advance.

10. CONCLUSIONS

2009 has clearly been a starting up or transition year. HSSP2 introduced several new financing and implementation instruments and multiple new management guidelines and procedures. Some of those were even not yet finalized at the start of the program. Many of the implementation units did not have a clear understanding of the regulations and held up expenditure. During the year it also became clear that certain procedures do not allow for payments essential to activities such as long term training or outreach activities. SDG, SOAs and MBPIs have started with a lot of delays and in fewer places than planned.

As a result HSSP2 cumulative expenditure was only 11.15 Million USD or 41.54% of the total annual available budget of 26.85 Million USD.

The total PBHS2 expenditure was 5,857 Million Euro or 75% of the 7,787 Million Euro planned. HSSP2 reports BTC expenditure in National Execution as 345,779 USD. BTC however does regard the total amount transferred to HSSP2 secretariat BTC Discrete Account during 2009 being 467,864 USD as expenditure rather than the 345,779 USD reported by HSSP2 secretariat.

PBHS2, being fully integrated in HSSP2 and partially implemented in National Execution, was equally confronted with these new procedures. For the HSSP2 secretariat which was already overstretched PBHS2 represented an extra burden because of the special arrangements and additional workload.
Throughout 2009 it became clear that National Execution is not the ideal modality for managing a capacity building team of technical assistants which requires flexibility to adapt to changing situation throughout the year. The initial rather complex set-up of a BTC HEF implementer being funded

through the HSSP2 secretariat using BTC funds was revised. It was decided to use own-management rather than NEX for the functioning of the HEFI office.

Because of the recruitment problems under NEX, the capacity building team remained limited to 5 TAs, only a fraction of the 11 staff required. NEX procedures also complicated and delayed the provision of logistic support for the capacity building. All this had an important impact on capacity building progress.

The combination of lengthy and hefty approval mechanisms, new non-routine procedures, delayed responses from central level departments and HSSP2 (secretariat and JPIG), as well as the shortage of capacity building TA made that no SOA, SDG or MBPI were established in the PBHS2 project areas during 2009. Performance incentive for public health staff were severely delayed and 5 ODs and 2 PRHs did not receive performance incentives after 30th June 2009.

Notwithstanding all those changes and complications all 8 HEFs continued to function uninterrupted throughout 2009, although often with their funding severely stretched and the HEFI manager forced to apply unorthodox procedures. In 2009 the HEFs supported 24,551 hospitalization, 2,712 deliveries and 41,481 outpatient consultations for poor patients. This important increase is largely attributed to the effect of the pre-identification.

Despite 2009 being a transition year the supported Provinces, ODs and PRHs achieved good and sometimes even impressive health service results and coverage rates.
Important gains were made for most health output indicators. In general numbers and rates increased for hospitalizations, outpatient consultations, deliveries by trained personnel, deliveries in HC and RH, the numbers of surgeries and emergency surgeries. Vaccination coverage rates remained high. In some places results were really impressive. Only in Sotnikum and Kralanh RH did the number of hospitalizations diminish. The vaccination coverage rates in Otdar Meanchey went down but this is caused by an important change in the denominators used.

Higher user-fee revenues, often with substantial contribution from self-paid user fees, together with substantial increased government salaries and allowances resulted in a further increase in staff income at most levels.

Beside this general positive appreciation, several aspects of the presented results deserve additional comments:

- The synergy between the government delivery incentives and the voucher system for maternal health services continue to contribute to an accelerated increased number of deliveries at HC level in KC.
- A very laudable increase or better reporting in HC user-fees revenues gives a reassuring picture of the financing at this level.
- The proportion of HEF supported inpatients continued to increase from 52% in 2008 to 55% in 2009 in Kampong Cham, from 43% in 2008 to 45% in 2009 in Otdar Meanchey and from 27% in 2008 to 40% in 2009 in Siem Reap. For most hospitals HEFB represent the major part of their clientele and obviously also of their userfee income. In 2009 no assessments of admission criteria and hospitalization indications were done. It will be important to conduct some assessments during 2010 in order to limit the number of unnecessary hospitalizations.
- This year again the high utilization is confronted with and limited by the inadequate and delayed mobilization of government resources:
    - CMS Drug Supply: while the declared value of the yearly supply kept on rising substantially, the quantities of received drugs did not increase in proportion. Although recognizing improved drug supplies throughout 2009 the better functioning hospitals and HCs continue to face important shortage of drugs.

- Staffing: the main shortages assessed in 2006 have not yet been improved in 2009. The numbers of doctors, nurses have not really changed. Shortages of midwives at HC level have been partially addressed in the project area through the training of 50 extra primary midwives by the project.

- Dual practice (in public and private) by government health staff creates huge conflicts of interest which will certainly impede further sustainable development of hospitals and health centers.

In 2009 the project assessed the presently used HEF post- and pre-identification tools and continued its evaluation of the Maternal Health Vouchers. The findings of the identification assessment have been shared in a workshop and through the report "Assessment of HEF beneficiary identification in three operational health districts in Kampong Cham" (for summary see annex 7).

The findings of the Maternal Health Vouchers evaluation have been published in the "BMJ, Pregnancy and Childbirth" as an article with the title "Using targeted vouchers and health equity funds to improve access to skilled birth attendants for poor women: a case study in three rural health districts in Cambodia" (for abstract see annex 8).

The 11 SOAs (8 ODs and 3 PRH) hope that they will start receiving their Service Delivery Grant with effect of 1st January 2010. PBHS2 will need to strengthen its capacity building certainly in the field of financial management and quality improvement. Hence the HSSP2 secretariat will need to look at alternative ways of recruitment and attracting candidates and possibly at other training approaches. In order to allow PHDs, ODs, and PRHs to budget for the required trainings and operational costs for capacity building using the HSSP2/BTC available funds it will be necessary to consider this in the setting of the provincial caps during the planning process for 2011.

An important weakness remains the absence of an external validation of the HIS provided figures. In 2009 little or no monitoring was done by PHDs and central level. Given that bonuses and incentives in the context of SDG are linked to the reported achieved results it has becomes crucial to establish and implement robust internal and external monitoring system soon.

It will be important for PHD teams to increase their involvement with SDG and SOA developments and to take their role as commissioner more seriously. The recently canceled MPBI scheme and the linked performance agreement, which tried to commit PHD teams to these responsibilities, will need to be replaced urgently by another motivation instrument.

In 2009 the AOP process has been given a strong new impetus, mainly because of the new compulsory linkage between AOP planning and HSSP2 funding. The PBHS2 has been assisting the DPHI with the development of a long awaited AOP database system. This system aims to simplify the work for the different planning levels and will allow for automatic aggregation and disaggregation and also facilitate the review process. In 2010 the DPHI plans to roll out the database system to all provinces. The DPHI has requested the project to support the training of PHD teams on the use of this database system.

In 2009 the HSSP2 Pooled Fund and related Cambodian Government counterpart funding did contribute substantial funding to the so-called "PBHS2 activities", through Service Delivery Grants and for HEF direct benefit expenses. Their contribution will increase further in 2010 and 2011. While funding arrangements for those strategies after the closing of PBHS2 still need to be agreed, the present understandings and funding trends are quite promising for the sustainability of Internal Contracting and HEFs.

11. ISSUES FOR DECISION

- Approval of 2009 activity and expenditure report (see annex 2)
- Approval of 2010 action/budget plan (see annex 4).
- Request revision of DPHI AOP 2010 to accommodate for nationwide AOP database training
- Approval of Budget revision (see annex 3)
- Approval that Co-management balance of 16,618 USD at end 2009 be transferred to NEX
- Decision on use of estimated NEX balance, HSSP2 provincial cap mechanism to provide for absorption of earmarked discrete fund for those provinces. Because of the HSSP2 budget caps the provinces cannot plan and budget for the BTC discrete funds required for training even when these funds are available. This should be corrected for 2011 AOP.
- Approval process for report on the first phase of KAM0200711 project
- Approval to plan for three-month project closing period (final report, dissemination of follow up survey and end evaluation of project, production of grey paper publication with project results)
- Approve in principal the use of MBPI earmarked funds for new mechanism for PHD staff targeted performance incentives linked to their commissioner role if agreed by MOH and JPIG
- Decision to keep Steering Committee for total length of project (2 more meetings in 2011 and 2012)
- Agree on content and format 2010 annual report
- Agree that the planned “Final follow up Household Survey” and “End of Project Evaluation” needs to be discussed with HSSP2 (MOH and HSSP2) and DPHI in order to avoid overlap and improve complimentarily with other HSSP2 or MOH evaluation exercises
- Agree to employ supplementary Project Financial Assistant to HEFI office in order to assure proper financial control of direct benefit expenditures financed by Pooled Fund and Counterpart Funds.

12. ISSUES FOR DISCUSSION

- Strengthen the functioning of the Capacity Building team:
  - Recruitment of the urgently required staffs by the HSSP2 secretariat, offer more interesting conditions
  - Renew present contracts timely
  - Improve logistic support (salaries, DSA, transport, stationary, etc.) for capacity building team by HSSP2 secretariat through more flexible arrangement and timely payments
  - PHD, ODs and PRHs to plan budget in AOP 2011 using BTC discrete fund for their operational costs for capacity building exercises
- Transmission of final fund balances of KAM0300911 to PHD Kampong Cham for the completion of HC & RH rehabilitation works and for repairs to the project offices handed over to the PHD.
- Many technical issues on SDG/SOA/HEF/ incentives, capacity building and monitoring will be no longer discussed in the SC but through other channels (MOH/JPIG/HP)

13. ANNEXES

Annex 1. Financial Plan 2009

Annex 2. Expenditure Report 2009

Annex 3. Budget Revision

Annex 4. Financial Plan 2010 and Beyond

Annex 5. IFR Q4 2009 BTC Extracts

Annex 6. Organizational Chart Functional Relations

Annex 7. Assessment of HEF beneficiary identification in three operational health districts in Kampong Cham

Annex 8. Research HEF Voucher Articles

Annex 9. Summary Project Sheet

Annex 1. Financial Plan 2009

ANNEX I:

Provision of Basic Health Services in the province of Siem Reap, Otdar Meanchey and Kampong Cham

KAM0200711 - Rev.- Q2-2009 Financial Planning (after 1st SC Meeting)

Figure in Euro '000

Description	FinMet	Budget	Expenses up to 2008	Balance Year Ended 2008	Year 2009					Balance Year Ended 2009
					Q1	Q2	Q3	Q4	Total	
A Enhance Health Sector Development by supporting Provincial plans in Siem Re		**3,430.58**	**3,297.99**	**132.58**	**85.00**	**-**	**-**	**-**	**85.00**	**47.58**
01 Strengthened Consumer Rights in communities		879.67	817.57	62.10	51.50	-	-	-	51.50	10.60
01 TA - Social/BCC - Local	COG	47.26	47.17	0.09	-	-	-	-	-	0.09
02 TA Equity/Finance - International	REGIE	19.95	19.95	-	-	-	-	-	-	-
03 Identification of the poor	COG	58.55	58.58	(0.03)	-	-	-	-	-	(0.03)
04 Social support activities for poor	COG	26.23	26.27	(0.04)	-	-	-	-	-	(0.04)
05 Equity Fund - Medical Fees	COG	719.53	657.45	62.08	51.50	-	-	-	51.50	10.58
06 Equity Fund - Operation Fees	COG	8.15	8.15	-	-	-	-	-	-	-
02 Enhanced Behaviour Change & Communications		118.91	118.18	0.73	-	-	-	-	-	0.73
01 TA - Social/BCC - Local	COG	45.73	45.01	0.72	-	-	-	-	-	0.72
02 BCC contracted out campaigns	COG	70.91	70.90	0.01	-	-	-	-	-	0.01
03 School Health Education	COG	2.27	2.27	-	-	-	-	-	-	-
03 Strengthened quality of delivery of health services through contracting		1,350.98	1,326.95	24.02	25.10	-	-	-	25.10	(1.08)
01 Project director OM & project director SR (2)	COG	65.26	65.42	(0.16)	-	-	-	-	-	(0.16)
02 Project Directors OD SR (3)	COG	31.42	30.61	0.81	0.70	-	-	-	0.70	0.11
03 Output related bonus system HC	COG	597.66	584.78	12.88	7.50	-	-	-	7.50	5.38
04 Output related bonus system RH	COG	348.35	346.13	2.22	10.60	-	-	-	10.60	(8.38)
05 Output related bonus system DHTAT	COG	124.25	121.19	3.06	2.90	-	-	-	2.90	0.16
06 Output related bonus system PHTAT	COG	100.98	97.83	3.14	2.50	-	-	-	2.50	0.64
07 Promotion of Family Based Care for AIDS patients	COG	55.66	55.15	0.51	-	-	-	-	-	0.51
08 School health inspection program	COG	0.97	0.97	-	-	-	-	-	-	-
09 Health Support	COG	26.43	24.87	1.56	0.90	-	-	-	0.90	0.66
04 Increased number of quality improvement initiatives		535.49	509.04	26.45	5.60	-	-	-	5.60	20.85
01 TA - Quality improvement - Local	COG	24.04	24.07	(0.03)	-	-	-	-	-	(0.03)
02 Micro interventions	COG	97.85	93.85	4.00	0.50	-	-	-	0.50	3.50
03 Quality standard and seal	COG	0.00	-	-	-	-	-	-	-	-
04 Quality Improvement Plans at RH	COG	154.69	153.53	1.16	0.80	-	-	-	0.80	0.36
05 Infra structural works at PRH Siem Reap	COG	258.91	237.59	21.32	4.30	-	-	-	4.30	17.02
05 Improved staff skills through capacity building		337.74	329.05	8.69	1.60	-	-	-	1.60	7.09
01 TA - Surgeon - International expert	REGIE	165.66	160.35	5.31	-	-	-	-	-	5.31
02 Contracted in training / workshop	COG	26.03	24.83	1.20	1.60	-	-	-	1.60	(0.40)
03 Contracted in training for teachers	COG	0.49	0.49	-	-	-	-	-	-	-
04 Contracted out training	COG	95.51	94.57	0.94	-	-	-	-	-	0.94
05 Training activities	COG	50.05	48.81	1.24	-	-	-	-	-	1.24
06 Strengthened Institutions capacity to manage, plan, regulate, finance, monitor and		207.79	197.20	10.59	1.20	-	-	-	1.20	9.39
01 TA - Social/Planning/Finance/PHA - Local	COG	74.38	72.87	1.51	0.30	-	-	-	0.30	1.21
02 TA - Finance/Planning - International	REGIE	24.90	22.85	2.05	-	-	-	-	-	2.05
03 Supervision / on-the job-training	COG	11.57	10.74	0.83	0.10	-	-	-	0.10	0.73
04 Stakeholder internal HMIS auditing	COG	40.51	38.38	2.13	0.80	-	-	-	0.80	1.33
05 Central level interventions	COG	56.43	52.36	4.07	-	-	-	-	-	4.07
B Strengthen monitoring & evaluation capacity of health system		**111.94**	**107.52**	**4.42**	**0.30**	**-**	**-**	**-**	**0.30**	**4.12**
01 Enhanced monitoring & evaluation capacity		111.94	107.52	4.42	0.30	-	-	-	0.30	4.12
01 TA - Social/Planning/Finance - Local	COG	9.28	9.29	(0.01)	-	-	-	-	-	(0.01)
02 TA - M & E - International	REGIE	28.76	29.22	(0.46)	0.30	-	-	-	0.30	(0.76)
03 External HMIS auditing	COG	0.45	0.45	-	-	-	-	-	-	-
04 External monitoring Quality Seal	COG	0.00	-	-	-	-	-	-	-	-
05 Surveys	COG	63.78	59.47	4.31	-	-	-	-	-	4.31
06 Steering committee expenses	COG	9.67	9.09	0.58	-	-	-	-	-	0.58
C To consolidate the results of the current health projects in Cambodia in order		**2,069.09**	**-**	**2,069.09**	**171.90**	**333.30**	**190.95**	**185.45**	**881.59**	**1,187.50**
01 Increased access to good quality health services for the poorest population.		701.18	-	701.18	72.60	110.04	87.18	63.65	333.47	367.71
01 Continued funding of 9 HEF in a cofinancing arrangement with the MOH multi-	COG	0.00	-	-	64.20	-	-	-	64.20	(64.20)
02 Continued management & oversight of the 9 co-dunded HEF	COG	0.00	-	-	2.60	-	-	-	2.60	(2.60)
03 Strengthening the capacity of the 3 PHD to monitor & evaluate HEF	COG	74.70	-	74.70	5.80	8.70	6.00	6.00	26.50	48.20
04 Continued funding of 9 HEF in a cofinancing arrangement with the MoH multi-d	REGIE	570.70	-	570.70	-	96.41	71.59	49.41	217.42	353.28
05 02 Continued management & oversight of the 9 co-funded HEF	REGIE	52.86	-	52.86	-	4.20	5.55	4.20	13.95	38.91
06 Strengthening the capacity of the 3 PHD to monitor & evaluate HEF	REGIE	2.92	-	2.92	-	0.73	4.04	4.04	8.80	(5.88)
02 Increased capacity in 8 ODs & 2 Provincial Referral Hospitals to provide better qu		773.88	-	773.88	81.10	193.13	72.29	71.68	418.20	355.68
01 Support the MoH & PHDs in assessing the capacity & readiness of 8 ODs & 2	COG	26.25	-	26.25	0.70	4.75	-	-	5.45	20.80
02 Transitional support to ODs & Hospitals that are expected to start implementati	COG	140.40	-	140.40	60.80	115.69	-	-	176.49	(36.09)
03 Intensive capacity development for ODs that do not yet meet the criteria/standa	COG	334.80	-	334.80	7.20	53.69	53.69	53.08	167.66	167.14
04 Support capacity development for ODs & Hospitals that have been contracted	COG	272.43	-	272.43	12.40	19.00	18.60	18.60	68.60	203.83
03 Increased capacity of 3 PHDs to manage service delivery contracts & to support		370.18	-	370.18	18.20	30.13	30.13	30.13	108.58	261.61
01 Transitional support to PHD staff until the introduction of service delivery contra	COG	12.60	-	12.60	9.60	-	-	-	9.60	3.00
02 Replace current incentives for Siem Reap and Otdar Meanchey PHDs with MB	COG	172.00	-	172.00	-	18.00	18.00	18.00	54.00	118.00
03 Support capacity development for the 3 PHDs	COG	152.58	-	152.58	8.60	12.13	12.13	12.13	44.98	107.61
04 Encourage & support the analysis & documentation of contracting, health finan	COG	33.00	-	33.00	-	-	-	-	-	33.00
04 Evidence based policy making through systematic & sustainable documentation &		223.85	-	223.85	-	-	1.35	20.00	21.35	202.50
01 Support the MoH in the analysis of data & information that is routinely collected	COG	180.10	-	180.10	-	-	1.35	20.00	21.35	158.75
02 Support the MoH in identifying additional data needs & in formulating appropria	COG	12.50	-	12.50	-	-	-	-	-	12.50
03 Ensure that relevant information is properly documented & is communicated to	COG	31.25	-	31.25	-	-	-	-	-	31.25
Z General means		**2,175.73**	**1,228.64**	**947.09**	**45.90**	**59.22**	**58.22**	**55.85**	**219.18**	**727.91**
01 General means		1,244.81	1,228.64	16.17	18.40	3.50	-	-	21.90	(5.73)
01 Secretary (2)	COG	109.33	97.03	12.30	11.50	3.50	-	-	15.00	(2.70)
02 Office Assistant / Drivers (2)	COG	17.53	16.56	0.97	0.70	-	-	-	0.70	0.27
03 Government Salaries & allowances	COG	0.00	-	-	-	-	-	-	-	-
04 Team Leader - Co-Director - International expert	REGIE	741.20	746.15	(4.95)	0.70	-	-	-	0.70	(5.65)
05 Assistant Team Leader - national expert	COG	90.60	86.59	4.01	-	-	-	-	-	4.01
06 Local staff missions costs	COG	12.72	11.90	0.82	0.40	-	-	-	0.40	0.42
07 National air tickets	COG	3.10	1.81	1.29	0.10	-	-	-	0.10	1.19
08 Office equipment	COG	41.28	41.28	-	-	-	-	-	-	-
09 Office running costs	COG	37.26	36.68	0.58	3.60	-	-	-	3.60	(3.02)
10 Vehicle running costs	COG	80.39	80.87	(0.48)	1.30	-	-	-	1.30	(1.78)
11 Office furniture/supplies	COG	22.37	21.53	0.84	-	-	-	-	-	0.84
12 Moto running costs	COG	6.86	6.07	0.79	0.10	-	-	-	0.10	0.69
13 Government Running Costs	COG	0.00	-	-	-	-	-	-	-	-
14 Government Social Interventions	COG	0.00	-	-	-	-	-	-	-	-
15 Vehicle purchase (Co-director, Assistant Co-dir, 2 TA)	COG	74.78	74.78	-	-	-	-	-	-	-
16 Moto purchase (one per supervisor)	COG	7.39	7.39	-	-	-	-	-	-	-
02 Staff 'Consolidation Phase'		616.76	-	616.76	23.90	43.87	43.87	44.00	155.63	461.13
01 Technical assistantce	REGIE	450.00	-	450.00	20.80	37.50	37.50	37.50	133.30	316.70
02 Administration and Finance Staff	COG	99.64	-	99.64	0.40	2.00	2.00	2.00	6.39	93.26
03 Technical Staff	COG	59.94	-	59.94	1.90	3.84	3.84	3.84	13.42	46.52
04 Other Staff Costs	COG	7.18	-	7.18	0.80	0.53	0.53	0.67	2.53	4.65
03 Procurement 'Consolidation Phase'		4.96	-	4.96	-	-	-	-	-	4.96
01 Office Equipment	COG	0.61	-	0.61	-	-	-	-	-	0.61
02 Computer Equipment	COG	4.35	-	4.35	-	-	-	-	-	4.35
04 Operational costs 'Consolidation Phase'		218.20	-	218.20	3.60	11.85	11.85	11.85	39.15	179.05
01 Vehicle Running and Maintenance	COG	119.88	-	119.88	1.70	9.99	9.99	9.99	31.67	88.21
02 Telephone, E-mail	COG	14.40	-	14.40	0.70	1.20	1.20	1.20	4.30	10.10
03 Office Materials	COG	6.12	-	6.12	0.40	0.51	0.51	0.51	1.93	4.19
04 Consultancy Fees	COG	76.00	-	76.00	-	-	-	-	-	76.00
05 Financial Costs	COG	1.80	-	1.80	0.80	0.15	0.15	0.15	1.25	0.55
05 Audit, M&E 'Consolidation Phase'		91.00	-	91.00	-	-	2.50	-	2.50	88.50
01 Monitoring and Evaluation	REGIE	83.50	-	83.50	-	-	-	-	-	83.50
02 Backstopping	REGIE	7.50	-	7.50	-	-	2.50	-	2.50	5.00
	REGIE	**2,147.95**	**978.52**	**1,169.43**	**21.80**	**138.84**	**121.18**	**95.15**	**376.97**	**792.46**
	COG	**5,639.39**	**3,655.63**	**1,983.75**	**281.30**	**253.68**	**127.98**	**146.15**	**809.11**	**1,174.64**
	TOTAL	**7,787.34**	**4,634.15**	**3,153.18**	**303.10**	**392.52**	**249.16**	**241.30**	**1,186.08**	**1,967.10**

Annex 2. Expenditure Report 2009

ANNEX II:

Provision of Basic Health Services in the province of Siem Reap, Otdar Meanchey and Kampong Cham

KAM0200711 - Budget Execution For Year 2009

Figure in Euro '000

Description	FinMet	Budget	Expenses up to 2008	Balance Year Ended 2008	Year 2009					Expenses up to 2009	Balance Year Ended 2009	% Exec. Vs Budget
					Q1	Q2	Q3	Q4	Total			
A Enhance Health Sector Development by supporting Provincial plans in Siem Reap and Otdar Mea		**3,430.58**	**3,297.99**	**132.59**	**84.95**	**3.88**	**-**	**-**	**88.83**	**3,386.82**	**43.76**	**99%**
01 Strengthened Consumer Rights in communities		879.67	817.57	62.10	51.52	-	-	-	51.52	869.09	10.58	99%
01 TA - Social/BCC - Local	COG	47.26	47.17	0.09	-	-	-	-	-	47.17	0.09	100%
02 TA Equity/Finance - International	REGIE	19.95	19.95	-	-	-	-	-	-	19.95	-	100%
03 Identification of the poor	COG	58.55	58.58	(0.03)	-	-	-	-	-	58.58	(0.03)	100%
04 Social support activities for poor	COG	26.23	26.27	(0.04)	-	-	-	-	-	26.27	(0.04)	100%
05 Equity Fund - Medical Fees	COG	719.53	657.45	62.08	51.52	-	-	-	51.52	708.97	10.56	99%
06 Equity Fund - Operation Fees	COG	8.15	8.15	-	-	-	-	-	-	8.15	-	100%
02 Enhanced Behaviour Change & Communications		118.91	118.18	0.73	-	-	-	-	-	118.18	0.73	99%
01 TA - Social/BCC - Local	COG	45.73	45.01	0.72	-	-	-	-	-	45.01	0.72	98%
02 BCC contracted out campaigns	COG	70.91	70.90	0.01	-	-	-	-	-	70.90	0.01	100%
03 School Health Education	COG	2.27	2.27	-	-	-	-	-	-	2.27	-	100%
03 Strengthened quality of delivery of health services through contracting		1,350.98	1,326.95	24.03	25.10	1.53	-	-	26.63	1,353.58	(2.60)	100%
01 Project director OM & project director SR (2)	COG	65.26	65.42	(0.16)	-	1.53	-	-	1.53	66.95	(1.69)	103%
02 Project Directors OD SR (3)	COG	31.42	30.61	0.81	0.70	-	-	-	0.70	31.31	0.11	100%
03 Output related bonus system HC	COG	597.66	584.78	12.88	7.46	-	-	-	7.46	592.24	5.42	99%
04 Output related bonus system RH	COG	348.35	346.13	2.22	10.58	-	-	-	10.58	356.71	(8.36)	102%
05 Output related bonus system DHTAT	COG	124.25	121.19	3.06	2.94	-	-	-	2.94	124.13	0.12	100%
06 Output related bonus system PHTAT	COG	100.98	97.83	3.15	2.55	-	-	-	2.55	100.38	0.60	99%
07 Promotion of Family Based Care for AIDS patients	COG	55.66	55.15	0.51	-	-	-	-	-	55.15	0.51	99%
08 School health inspection program	COG	0.97	0.97	-	-	-	-	-	-	0.97	-	100%
09 Health Support	COG	26.43	24.87	1.56	0.87	-	-	-	0.87	25.74	0.69	97%
04 Increased number of quality improvement initiatives		535.49	509.04	26.45	5.56	0.98	-	-	6.54	515.58	19.91	96%
01 TA - Quality improvement - Local	COG	24.04	24.07	(0.03)	-	-	-	-	-	24.07	(0.03)	100%
02 Micro interventions	COG	97.85	93.85	4.00	0.49	-	-	-	0.49	94.34	3.51	96%
03 Quality standard and seal	COG	0.00	-	-	-	-	-	-	-	-	-	0%
04 Quality Improvement Plans at RH	COG	154.69	153.53	1.16	0.80	0.98	-	-	1.77	155.30	(0.61)	100%
05 Infra structural works at PRH Siem Reap	COG	258.91	237.59	21.32	4.28	-	-	-	4.28	241.87	17.04	93%
05 Improved staff skills through capacity building		337.74	329.05	8.69	1.57	0.76	-	-	2.33	331.38	6.36	98%
01 TA - Surgeon - International expert	REGIE	165.66	160.35	5.31	-	-	-	-	-	160.35	5.31	97%
02 Contracted in training / workshop	COG	26.03	24.83	1.20	1.57	-	-	-	1.57	26.40	(0.37)	101%
03 Contracted in training for teachers	COG	0.49	0.49	-	-	-	-	-	-	0.49	-	100%
04 Contracted out training	COG	95.51	94.57	0.94	-	-	-	-	-	94.57	0.94	99%
05 Training activities	COG	50.05	48.81	1.24	-	0.76	-	-	0.76	49.57	0.48	99%
06 Strengthened Institutions capacity to manage, plan, regulate, finance, monitor and evaluate		207.79	197.20	10.59	1.20	0.62	-	-	1.82	199.02	8.77	96%
01 TA - Social/Planning/Finance/PHA - Local	COG	74.38	72.87	1.51	0.34	-	-	-	0.34	73.21	1.17	98%
02 TA - Finance/Planning - International	REGIE	24.90	22.85	2.05	-	-	-	-	-	22.85	2.05	92%
03 Supervision / on-the job-training	COG	11.57	10.74	0.83	0.09	-	-	-	0.09	10.83	0.74	94%
04 Stakeholder internal HMIS auditing	COG	40.51	38.38	2.13	0.78	0.62	-	-	1.39	39.77	0.74	98%
05 Central level interventions	COG	56.43	52.36	4.07	-	-	-	-	-	52.36	4.07	93%
B Strengthen monitoring & evaluation capacity of health system		**111.94**	**107.52**	**4.42**	**0.28**	**-**	**-**	**-**	**0.28**	**107.80**	**4.14**	**96%**
01 Enhanced monitoring & evaluation capacity		111.94	107.52	4.42	0.28	-	-	-	0.28	107.80	4.14	96%
01 TA - Social/Planning/Finance - Local	COG	9.28	9.29	(0.01)	-	-	-	-	-	9.29	(0.01)	100%
02 TA - M & E - International	REGIE	28.76	29.22	(0.46)	0.28	-	-	-	0.28	29.50	(0.74)	103%
03 External HMIS auditing	COG	0.45	0.45	-	-	-	-	-	-	0.45	-	100%
04 External monitoring Quality Seal	COG	0.00	-	-	-	-	-	-	-	-	-	?%
05 Surveys	COG	63.78	59.47	4.31	-	-	-	-	-	59.47	4.31	93%
06 Steering committee expenses	COG	9.67	9.09	0.58	-	-	-	-	-	9.09	0.58	94%
C To consolidate the results of the current health projects in Cambodia in order to increase		**2,069.09**	**-**	**2,069.09**	**171.89**	**559.21**	**134.67**	**93.13**	**958.90**	**958.90**	**1,110.19**	**46%**
01 Increased access to good quality health services for the poorest population.		701.18	-	701.18	72.54	130.42	134.65	92.60	430.21	430.21	270.97	61%
01 Continued funding of 9 HEF in a cofinancing arrangement with the MOH multi-donor funded HSSP	COG	0.00	-	-	64.16	74.86	52.85	-	191.86	191.86	(191.86)	?%
02 Continued management & oversight of the 9 co-dunded HEF	COG	0.00	-	-	2.61	0.08	-	-	2.69	2.69	(2.69)	?%
03 Strengthening the capacity of the 3 PHD to monitor & evaluate HEF	COG	74.70	-	74.70	5.78	0.50	-	0.39	6.67	6.67	68.03	9%
04 Continued funding of 9 HEF in a cofinancing arrangement with the MoH multi-donor funded HSSP2	REGIE	570.70	-	570.70	-	49.38	77.67	86.58	213.63	213.63	357.07	37%
05 02 Continued management & oversight of the 9 co-funded HEF	REGIE	52.86	-	52.86	-	5.59	2.85	2.61	11.06	11.06	41.80	21%
06 Strengthening the capacity of the 3 PHD to monitor & evaluate HEF	REGIE	2.92	-	2.92	-	-	1.28	3.01	4.30	4.30	(1.38)	147%
02 Increased capacity in 8 ODs & 2 Provincial Referral Hospitals to provide better quality health services		773.88	-	773.88	81.10	66.16	0.02	0.06	147.34	147.34	626.54	19%
01 Support the MoH & PHDs in assessing the capacity & readiness of 8 ODs & 2 Hospitals to impleme	COG	26.25	-	26.25	0.68	8.08	-	-	8.76	8.76	17.49	33%
02 Transitional support to ODs & Hospitals that are expected to start implementation of service deliver	COG	140.40	-	140.40	60.76	42.23	-	-	102.99	102.99	37.41	73%
03 Intensive capacity development for ODs that do not yet meet the criteria/standards to implement se	COG	334.80	-	334.80	7.23	15.61	-	0.06	22.90	22.90	311.90	7%
04 Support capacity development for ODs & Hospitals that have been contracted to deliver health serv	COG	272.43	-	272.43	12.44	0.24	0.02	-	12.70	12.70	259.73	5%
03 Increased capacity of 3 PHDs to manage service delivery contracts & to support ODs & Referal Hospi		370.18	-	370.18	18.25	3.85	-	0.48	22.57	22.57	347.61	6%
01 Transitional support to PHD staff until the introduction of service delivery contracts & MBPIs.	COG	12.60	-	12.60	9.63	3.68	-	-	13.31	13.31	(0.71)	106%
02 Replace current incentives for Siem Reap and Otdar Meanchey PHDs with MBPI, conform the exist	COG	172.00	-	172.00	-	-	-	-	-	-	172.00	0%
03 Support capacity development for the 3 PHDs	COG	152.58	-	152.58	8.62	0.17	-	0.48	9.26	9.26	143.32	6%
04 Encourage & support the analysis & documentation of contracting, health financing & other initiative	COG	33.00	-	33.00	-	-	-	-	-	-	33.00	0%
04 Evidence based policy making through systematic & sustainable documentation & analysis of relevant		223.85	-	223.85	-	0.02	-	-	0.02	0.02	223.83	0%
01 Support the MoH in the analysis of data & information that is routinely collected & available	COG	180.10	-	180.10	-	-	-	-	-	-	180.10	0%
02 Support the MoH in identifying additional data needs & in formulating appropriate ways to gather thi	COG	12.50	-	12.50	-	0.02	-	-	0.02	0.02	12.48	0%
03 Ensure that relevant information is properly documented & is communicated to policy makers & the	COG	31.25	-	31.25	-	-	-	-	-	-	31.25	0%
05 National Execution (NEX); transfer to HSSP2 - BTC Discrete Account		-	-	-	-	358.76	-	-	358.76	358.76	(358.76)	?%
01 National Execution (NEX); transfer to HSSP2 - BTC Discrete Account	COG	-		-	-	358.76			358.76	358.76	(358.76)	?%
Z General means		**2,175.73**	**1,228.64**	**947.09**	**45.87**	**57.62**	**37.26**	**34.23**	**174.99**	**1,403.63**	**772.10**	**65%**
01 General means		1,244.81	1,228.64	16.17	18.44	1.44	-	-	19.88	1,248.52	(3.71)	100%
01 Secretary (2)	COG	109.33	97.03	12.30	11.51	0.04	-	-	11.55	108.58	0.75	99%
02 Office Assistant / Drivers (2)	COG	17.53	16.56	0.97	0.68	0.09	-	-	0.77	17.33	0.20	99%
03 Government Salaries & allowances	COG	0.00	-	-	-	-	-	-	-	-	-	?%
04 Team Leader - Co-Director - International expert	REGIE	741.20	746.15	(4.95)	0.71	-	-	-	0.71	746.86	(5.66)	101%
05 Assistant Team Leader - national expert	COG	90.60	86.59	4.01	-	-	-	-	-	86.59	4.01	96%
06 Local staff missions costs	COG	12.72	11.90	0.82	0.42	0.09	-	-	0.51	12.41	0.31	98%
07 National air tickets	COG	3.10	1.81	1.29	0.13	-	-	-	0.13	1.94	1.17	62%
08 Office equipment	COG	41.28	41.28	-	-	-	-	-	-	41.28	-	100%
09 Office running costs	COG	37.26	36.68	0.58	3.64	0.04	-	-	3.67	40.35	(3.09)	108%
10 Vehicle running costs	COG	80.39	80.87	(0.48)	1.27	0.44	-	-	1.71	82.58	(2.19)	103%
11 Office furniture/supplies	COG	22.37	21.53	0.84	-	0.68	-	-	0.68	22.21	0.16	99%
12 Moto running costs	COG	6.86	6.07	0.79	0.10	0.06	-	-	0.16	6.23	0.63	91%
13 Government Running Costs	COG	0.00	-	-	-	-	-	-	-	-	-	?%
14 Government Social Interventions	COG	0.00	-	-	-	-	-	-	-	-	-	?%
15 Vehicle purchase (Co-director, Assistant Co-dir, 2 TA)	COG	74.78	74.78	-	-	-	-	-	-	74.78	-	100%
16 Moto purchase (one per supervisor)	COG	7.39	7.39	-	-	-	-	-	-	7.39	-	100%
02 Staff 'Consolidation Phase'		616.76	-	616.76	23.88	52.82	34.57	31.37	142.64	142.64	474.12	23%
01 Technical assistantce	REGIE	450.00	-	450.00	20.78	51.78	34.38	29.81	136.75	136.75	313.25	30%
02 Administration and Finance Staff	COG	99.64	-	99.64	0.42	0.07	-	0.09	0.58	0.58	99.06	1%
03 Technical Staff	COG	59.94	-	59.94	1.85	0.07	-	1.33	3.25	3.25	56.69	5%
04 Other Staff Costs	COG	7.18	-	7.18	0.83	0.90	0.19	0.15	2.06	2.06	5.12	29%
03 Procurement 'Consolidation Phase'		4.96	-	4.96	-	-	-	-	-	-	4.96	0%
01 Office Equipment	COG	0.61	-	0.61	-	-	-	-	-	-	0.61	0%
02 Computer Equipment	COG	4.35	-	4.35	-	-	-	-	-	-	4.35	0%
04 Operational costs 'Consolidation Phase'		218.20	-	218.20	3.56	3.37	2.69	2.86	12.47	12.47	205.73	6%
01 Vehicle Running and Maintenance	COG	119.88	-	119.88	1.68	1.09	1.72	1.62	6.12	6.12	113.76	5%
02 Telephone, E-mail	COG	14.40	-	14.40	0.72	1.14	0.19	0.03	2.07	2.07	12.33	14%
03 Office Materials	COG	6.12	-	6.12	0.37	0.96	0.78	1.17	3.27	3.27	2.85	53%
04 Consultancy Fees	COG	76.00	-	76.00	-	0.00	-	-	0.00	0.00	76.00	0%
05 Financial Costs	COG	1.80	-	1.80	0.79	0.18	-	0.04	1.01	1.01	0.79	56%
05 Audit, M&E 'Consolidation Phase'		91.00	-	91.00	-	-	-	-	-	-	91.00	0%
01 Monitoring and Evaluation	REGIE	83.50	-	83.50	-	-	-	-	-	-	83.50	0%
02 Backstopping	REGIE	7.50	-	7.50	-	-	-	-	-	-	7.50	0%
	REGIE	**2,147.95**	**978.52**	**1,169.43**	**21.76**	**106.76**	**116.18**	**122.01**	**366.72**	**1,345.24**	**802.71**	**63%**
	COG	**5,639.39**	**3,655.63**	**1,983.76**	**281.23**	**513.94**	**55.75**	**5.35**	**856.27**	**4,511.90**	**1,127.49**	**80%**
	TOTAL	**7,787.34**	**4,634.15**	**3,153.19**	**302.99**	**620.70**	**171.93**	**127.37**	**1,222.99**	**5,857.14**	**1,930.20**	**75%**

Annex 3. Budget Revision

ANNEX III:

Provision of Basic Health Services in the province of Siem Reap, Otdar Meanchey and Kampong Cham

KAM0200711 - Explanation and Justification for the Budget Change (Propose for 2nd SC Meeting)

Figure in Euro '000

Description	FinMet	Budget after 1st SC (K02)	Expenses up to 2009	Budget Balance Before Budget Change	Amount Change	Comments	Expect Balance after Budget Change	New Budget Propose for 2nd SC
A Enhance Health Sector Development by supp		**3,430.58**	**3,386.82**	**43.76**	**(43.76)**	**Decreased by 43,761€**	**-**	**3,386.82**
01 Strengthened Consumer Rights in communitie		879.67	869.09	10.58	(10.58)	**Decreased by 10,581€**	-	869.09
01 TA - Social/BCC - Local	COG	47.26	47.17	0.09	(0.09)	Decreased by 90€ transferred to budget line (C_05_01)	-	47.17
02 TA Equity/Finance - International	REGIE	19.95	19.95	-	-	None	-	19.95
03 Identification of the poor	COG	58.55	58.58	(0.03)	0.03	Increased by 30€ transferred from budget line (C_05_01)	-	58.58
04 Social support activities for poor	COG	26.23	26.27	(0.04)	0.04	Increased by 40€ transferred from budget line (C_05_01)	-	26.27
05 Equity Fund - Medical Fees	COG	719.53	708.97	10.56	(10.56)	Decreased by 10,561€ transferred to budget line (C_05_01)	-	708.97
06 Equity Fund - Operation Fees	COG	8.15	8.15	-	-	None	-	8.15
02 Enhanced Behaviour Change & Communicatio		118.91	118.18	0.73	(0.73)	**Decreased by 730€**	-	118.18
01 TA - Social/BCC - Local	COG	45.73	45.01	0.72	(0.72)	Decreased by 720€ transferred to budget line (C_05_01)	-	45.01
02 BCC contracted out campaigns	COG	70.91	70.90	0.01	(0.01)	Decreased by 10€ transferred to budget line (C_05_01)	-	70.90
03 School Health Education	COG	2.27	2.27	-	-	None	-	2.27
03 Strengthened quality of delivery of health servi		1,350.98	1,353.58	(2.60)	2.60	**Increased by 2,596€**	-	1,353.58
01 Project director OM & project director SR (2	COG	65.26	66.95	(1.69)	1.69	Increased by 1,689€ transferred from budget line (C_05_01)	-	66.95
02 Project Directors OD SR (3)	COG	31.42	31.31	0.11	(0.11)	Decreased by 109€ transferred to budget line (C_05_01)	-	31.31
03 Output related bonus system HC	COG	597.66	592.24	5.42	(5.42)	Decreased by 5,424€ transferred to budget line (C_05_01)	-	592.24
04 Output related bonus system RH	COG	348.35	356.71	(8.36)	8.36	Increased by 8,363€ transferred from budget line (C_05_01)	-	356.71
05 Output related bonus system DHTAT	COG	124.25	124.13	0.12	(0.12)	Decreased by 118€ transferred to budget line (C_05_01)	-	124.13
06 Output related bonus system PHTAT	COG	100.98	100.38	0.60	(0.60)	Decreased by 604€ transferred to budget line (C_05_01)	-	100.38
07 Promotion of Family Based Care for AIDS p	COG	55.66	55.15	0.51	(0.51)	Decreased by 510€ transferred to budget line (C_05_01)	-	55.15
08 School health inspection program	COG	0.97	0.97	-	-	None	-	0.97
09 Health Support	COG	26.43	25.74	0.69	(0.69)	Decreased by 691€ transferred to budget line (C_05_01)	-	25.74
04 Increased number of quality improvement initia		535.49	515.58	19.91	(19.91)	**Decreased by 19,912€**	-	515.58
01 TA - Quality improvement - Local	COG	24.04	24.07	(0.03)	0.03	Increased by 30€ transferred from budget line (C_05_01)	-	24.07
02 Micro interventions	COG	97.85	94.34	3.51	(3.51)	Decreased by 3,511€ transferred to budget line (C_05_01)	-	94.34
03 Quality standard and seal	COG	0.00	-	-	-	None	-	-
04 Quality Improvement Plans at RH	COG	154.69	155.30	(0.61)	0.61	Increased by 610€ transferred from budget line (C_05_01)	-	155.30
05 Infra structural works at PRH Siem Reap	COG	258.91	241.87	17.04	(17.04)	Decreased by 17,041€ transferred to budget line (C_05_01)	-	241.87
05 Improved staff skills through capacity building		337.74	331.38	6.36	(6.36)	**Decreased by 6,364€**	-	331.38
01 TA - Surgeon - International expert	REGIE	165.66	160.35	5.31	(5.31)	Decreased by 5,310€ transferred to budget lines (Z_01_04) & (C_01_04)	-	160.35
02 Contracted in training / workshop	COG	26.03	26.40	(0.37)	0.37	Increased by 370€ transferred from budget line (C_05_01)	-	26.40
03 Contracted in training for teachers	COG	0.49	0.49	-	-	None	-	0.49
04 Contracted out training	COG	95.51	94.57	0.94	(0.94)	Decreased by 940€ transferred to budget line (C_05_01)	-	94.57
05 Training activities	COG	50.05	49.57	0.48	(0.48)	Decreased by 484€ transferred to budget line (C_05_01)	-	49.57
06 Strengthened Institutions capacity to manage,		207.79	199.02	8.77	(8.77)	**Decreased by 8,770€**	-	199.02
01 TA - Social/Planning/Finance/PHA - Local	COG	74.38	73.21	1.17	(1.17)	Decreased by 1,173€ transferred to budget line (C_05_01)	-	73.21
02 TA - Finance/Planning - International	REGIE	24.90	22.85	2.05	(2.05)	Decreased by 2,050€ transferred to budget lines (B_01_02) & (Z_01_04)	-	22.85
03 Supervision / on-the job-training	COG	11.57	10.83	0.74	(0.74)	Decreased by 739€ transferred to budget line (C_05_01)	-	10.83
04 Stakeholder internal HMIS auditing	COG	40.51	39.77	0.74	(0.74)	Decreased by 738€ transferred to budget line (C_05_01)	-	39.77
05 Central level interventions	COG	56.43	52.36	4.07	(4.07)	Decreased by 4,070€ transferred to budget line (C_05_01)	-	52.36
B Strengthen monitoring & evaluation capacity		**111.94**	**107.80**	**4.14**	**(4.14)**	**Decreased by 4,143€**	**-**	**107.80**
01 Enhanced monitoring & evaluation capacity		111.94	107.80	4.14	(4.14)	**Decreased by 4,143€**	-	107.80
01 TA - Social/Planning/Finance - Local	COG	9.28	9.29	(0.01)	0.01	Increased by 10€ transferred from budget line (C_05_01)	-	9.29
02 TA - M & E - International	REGIE	28.76	29.50	(0.74)	0.74	Increased by 737€ transferred from budget line (A_06_02)	-	29.50
03 External HMIS auditing	COG	0.45	0.45	-	-	None	-	0.45
04 External monitoring Quality Seal	COG	0.00	-	-	-	None	-	-
05 Surveys	COG	63.78	59.47	4.31	(4.31)	Decreased by 4,310€ transferred to budget line (C_05_01)	-	59.47
06 Steering committee expenses	COG	9.67	9.09	0.58	(0.58)	Decreased by 580€ transferred to budget line (C_05_01)	-	9.09
C To consolidate the results of the current		**2,069.09**	**958.90**	**1,110.19**	**375.76**	**Increased by 365,758€**	**1,485.95**	**2,444.85**
01 Increased access to good quality health servi		701.18	430.21	270.97	243.67	**Increased by 243,665€**	514.64	944.85
01 Continued funding of 9 HEF in a cofinancing	COG	0.00	191.86	(191.86)	191.86	Increased by 191,864€ transferred from budget line (C_05_01)	-	191.86
02 Continued management & oversight of the 9	COG	0.00	2.69	(2.69)	2.69	Increased by 2,688€ transferred from budget line (C_05_01)	-	2.69
03 Strengthening the capacity of the 3 PHD to	COG	74.70	6.67	68.03	(68.03)	Decreased by 68,031€ transferred to budget line (C_05_01)	-	6.67
04 Continued funding of 9 HEF in a cofinancing	REGIE	570.70	213.63	357.07	**97.00**	Increased by 97,000€ (0.967€ + 96,033€) transferred from budget lines (A_05_01) & (C_05_01) respectively	454.07	667.70
05 02 Continued management & oversight of th	REGIE	52.86	11.06	41.80	**12.77**	Increased by 12,768€ transferred from budget line (C_05_01)	54.57	65.63
06 Strengthening the capacity of the 3 PHD to	REGIE	2.92	4.30	(1.38)	**7.38**	Increased by 7,376€ transferred from budget line (C_05_01)	6.00	10.30
02 Increased capacity in 8 ODs & 2 Provincial Re		773.88	147.34	626.54	(626.54)	**Decreased by 626,537€**	-	147.34
01 Support the MoH & PHDs in assessing the	COG	26.25	8.76	17.49	(17.49)	Decreased by 17,493€ transferred to budget line (C_05_01)	-	8.76
02 Transitional support to ODs & Hospitals that	COG	140.40	102.99	37.41	(37.41)	Decreased by 37,409€ transferred to budget line (C_05_01)	-	102.99
03 Intensive capacity development for ODs tha	COG	334.80	22.90	311.90	(311.90)	Decreased by 311,904€ transferred to budget line (C_05_01)	-	22.90
04 Support capacity development for ODs & H	COG	272.43	12.70	259.73	(259.73)	Decreased by 259,731€ transferred to budget line (C_05_01)	-	12.70
03 Increased capacity of 3 PHDs to manage serv		370.18	22.57	347.61	(347.61)	**Decreased by 347,614€**	-	22.57
01 Transitional support to PHD staff until the in	COG	12.60	13.31	(0.71)	0.71	Increased by 705€ transferred from budget line (C_05_01)	-	13.31
02 Replace current incentives for Siem Reap a	COG	172.00	-	172.00	(172.00)	Decreased by 172,000€ transferred to budget line (C_05_01)	-	-
03 Support capacity development for the 3 PH	COG	152.58	9.26	143.32	(143.32)	Decreased by 143,319€ transferred to budget line (C_05_01)	-	9.26
04 Encourage & support the analysis & docum	COG	33.00	-	33.00	(33.00)	Decreased by 33,000€ transferred to budget line (C_05_01)	-	-
04 Evidence based policy making through system		223.85	0.02	223.83	(223.83)	**Decreased by 223,830€**	-	0.02
01 Support the MoH in the analysis of data & in	COG	180.10	-	180.10	(180.10)	Decreased by 180,100€ transferred to budget line (C_05_01)	-	-
02 Support the MoH in identifying additional da	COG	12.50	0.02	12.48	(12.48)	Decreased by 12,480€ transferred to budget line (C_05_01)	-	0.02
03 Ensure that relevant information is properly	COG	31.25	-	31.25	(31.25)	Decreased by 31,250€ transferred to budget line (C_05_01)	-	-
05 National Execution (NEX); transfer to HSSP2 - BTC Dis		-	358.76	(358.76)	1,330.07	Increased by 1,330,074€	971.31	1,330.07
01 National Execution (NEX); transfer to HSSP	COG	-	358.76	(358.76)	1,330.07	Increased by 1,330,074€ after transferred from/to other budget lines in NEX and in Regie	971.31	1,330.07
Z General means		2,175.73	1,403.63	772.10	(327.85)	**Decreased by 327,854€**	444.25	1,847.88
01 General means		1,244.81	1,248.52	(3.71)	3.71	**Increased by 3,707€**	-	1,248.52
01 Secretary (2)	COG	109.33	108.58	0.75	(0.75)	Decreased by 753€ transferred to budget line (C_05_01)	-	108.58
02 Office Assistant / Drivers (2)	COG	17.53	17.33	0.20	(0.20)	Decreased by 203€ transferred to budget line (C_05_01)	-	17.33
03 Government Salaries & allowances	COG	0.00	-	-	-	None	-	-
04 Team Leader - Co-Director - International e	REGIE	741.20	746.86	(5.66)	5.66	Increased by 5,656€ transferred from budget lines (A_05_01 & A_06_02)	-	746.86
05 Assistant Team Leader - national expert	COG	90.60	86.59	4.01	(4.01)	Decreased by 4,010€ transferred to budget line (C_05_01)	-	86.59
06 Local staff missions costs	COG	12.72	12.41	0.31	(0.31)	Decreased by 312€ transferred to budget line (C_05_01)	-	12.41
07 National air tickets	COG	3.10	1.94	1.17	(1.17)	Decreased by 1,165€ transferred to budget line (C_05_01)	-	1.94
08 Office equipment	COG	41.28	41.28	-	-	None	-	41.28
09 Office running costs	COG	37.26	40.35	(3.09)	3.09	Increased by 3,094€ transferred from budget line (C_05_01)	-	40.35
10 Vehicle running costs	COG	80.39	82.58	(2.19)	2.19	Increased by 2,187€ transferred from budget line (C_05_01)	-	82.58
11 Office furniture/supplies	COG	22.37	22.21	0.16	(0.16)	Decreased by 161€ transferred to budget line (C_05_01)	-	22.21
12 Moto running costs	COG	6.86	6.23	0.63	(0.63)	Decreased by 626€ transferred to budget line (C_05_01)	-	6.23
13 Government Running Costs	COG	0.00	-	-	-	None	-	-
14 Government Social Interventions	COG	0.00	-	-	-	None	-	-
15 Vehicle purchase (Co-director, Assistant Co	COG	74.78	74.78	-	-	None	-	74.78
16 Moto purchase (one per supervisor)	COG	7.39	7.39	-	-	None	-	7.39
02 Staff 'Consolidation Phase'		616.76	142.64	474.12	(120.87)	**Decreased by 120,870€**	353.25	495.89
01 Technical assistantce	REGIE	450.00	136.75	313.25	40.00	Increased by 40,000€ transferred from budget line (C_05_01)	353.25	490.00
02 Administration and Finance Staff	COG	99.64	0.58	99.06	(99.06)	Decreased by 99,060€ transferred to budget line (C_05_01)	-	0.58
03 Technical Staff	COG	59.94	3.25	56.69	(56.69)	Decreased by 56,691€ transferred to budget line (C_05_01)	-	3.25
04 Other Staff Costs	COG	7.18	2.06	5.12	(5.12)	Decreased by 5,119€ transferred to budget line (C_05_01)	-	2.06
03 Procurement 'Consolidation Phase'		4.96	-	4.96	(4.96)	**Decreased by 4,960€**	-	-
01 Office Equipment	COG	0.61	-	0.61	(0.61)	Decreased by 610€ transferred to budget line (C_05_01)	-	-
02 Computer Equipment	COG	4.35	-	4.35	(4.35)	Decreased by 4,350€ transferred to budget line (C_05_01)	-	-
04 Operational costs 'Consolidation Phase'		218.20	12.47	205.73	(205.73)	**Decreased by 205,731€**	-	12.47
01 Vehicle Running and Maintenance	COG	119.88	6.12	113.76	(113.76)	Decreased by 113,764€ transferred to budget line (C_05_01)	-	6.12
02 Telephone, E-mail	COG	14.40	2.07	12.33	(12.33)	Decreased by 12,334€ transferred to budget line (C_05_01)	-	2.07
03 Office Materials	COG	6.12	3.27	2.85	(2.85)	Decreased by 2,847€ transferred to budget line (C_05_01)	-	3.27
04 Consultancy Fees	COG	76.00	0.00	76.00	(76.00)	Decreased by 75,998€ transferred to budget line (C_05_01)	-	0.00
05 Financial Costs	COG	1.80	1.01	0.79	(0.79)	Decreased by 788€ transferred to budget line (C_05_01)	-	1.01
05 Audit, M&E 'Consolidation Phase'		91.00	-	91.00	-	No Change	91.00	91.00
01 Monitoring and Evaluation	REGIE	83.50	-	83.50		None	83.50	83.50
02 Backstopping	REGIE	7.50	-	7.50		None	7.50	7.50
	REGIE	**2,147.95**	**1,345.24**	**802.71**	**156.18**	**Increased by 156,177€**	**958.89**	**2,304.13**
	COG	**5,639.39**	**4,511.90**	**1,127.49**	**(156.18)**	**Decreased by 156,177€**	**971.31**	**5,483.21**
	TOTAL	**7,787.34**	**5,857.14**	**1,930.20**	**-**	**No Change**	**1,930.20**	**7,787.34**

Annex 4. Financial Plan 2010 and Beyond

ANNEX IV:
Provision of Basic Health Services in the province of Siem Reap, Otdar Meanchey and Kampong Cham
KAM0200711 - Financial Planning For Year 2010 to 2012

Figure in Euro '000

Description	FinMet	Budget after 2nd SC	Expenses up to 2009	Balance Beginning Year 2010	Year 2010 Q1	Q2	Q3	Q4	Total	Year 2011	Year 2012	Est. End Project Balance	Est. % Exec.
A Enhance Health Sector Development by supporting Provincial plans in Siem Reap and Otdar Meanchey		**3,386.82**	**3,386.82**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**100%**
01 Strengthened Consumer Rights in communities		869.09	869.09	-	-	-	-	-	-	-	-	-	100%
01 TA - Social/BCC - Local	COG	47.17	47.17	-	-	-	-	-	-	-		-	100%
02 TA Equity/Finance - International	REGIE	19.95	19.95	-	-	-	-	-	-	-		-	100%
03 Identification of the poor	COG	58.58	58.58	-	-	-	-	-	-	-		-	100%
04 Social support activities for poor	COG	26.27	26.27	-	-	-	-	-	-	-		-	100%
05 Equity Fund - Medical Fees	COG	708.97	708.97	-	-	-	-	-	-	-	-	-	100%
06 Equity Fund - Operation Fees	COG	8.15	8.15	-	-	-	-	-	-	-	-	-	100%
02 Enhanced Behaviour Change & Communications		118.18	118.18	-	-	-	-	-	-	-	-	-	100%
01 TA - Social/BCC - Local	COG	45.01	45.01	-	-	-	-	-	-	-	-	-	100%
02 BCC contracted out campaigns	COG	70.90	70.90	-	-	-	-	-	-	-	-	-	100%
03 School Health Education	COG	2.27	2.27	-	-	-	-	-	-	-	-	-	100%
03 Strengthened quality of delivery of health services through contracting		1,353.58	1,353.58	-	-	-	-	-	-	-	-	-	100%
01 Project director OM & project director SR (2)	COG	66.95	66.95	-	-	-	-	-	-	-	-	-	100%
02 Project Directors OD SR (3)	COG	31.31	31.31	-	-	-	-	-	-	-	-	-	100%
03 Output related bonus system HC	COG	592.24	592.24	-	-	-	-	-	-	-	-	-	100%
04 Output related bonus system RH	COG	356.71	356.71	-	-	-	-	-	-	-	-	-	100%
05 Output related bonus system DHTAT	COG	124.13	124.13	-	-	-	-	-	-	-	-	-	100%
06 Output related bonus system PHTAT	COG	100.38	100.38	-	-	-	-	-	-	-	-	-	100%
07 Promotion of Family Based Care for AIDS patients	COG	55.15	55.15	-	-	-	-	-	-	-	-	-	100%
08 School health inspection program	COG	0.97	0.97	-	-	-	-	-	-	-	-	-	100%
09 Health Support	COG	25.74	25.74	-	-	-	-	-	-	-	-	-	100%
04 Increased number of quality improvement initiatives		515.58	515.58	-	-	-	-	-	-	-	-	-	100%
01 TA - Quality improvement - Local	COG	24.07	24.07	-	-	-	-	-	-	-	-	-	100%
02 Micro interventions	COG	94.34	94.34	-	-	-	-	-	-	-	-	-	100%
03 Quality standard and seal	COG	0.00	-	-	-	-	-	-	-	-	-	-	0%
04 Quality Improvement Plans at RH	COG	155.30	155.30	-	-	-	-	-	-	-	-	-	100%
05 Infra structural works at PRH Siem Reap	COG	241.87	241.87	-	-	-	-	-	-	-	-	-	100%
05 Improved staff skills through capacity building		331.38	331.38	-	-	-	-	-	-	-	-	-	100%
01 TA - Surgeon - International expert	REGIE	160.35	160.35	-	-	-	-	-	-	-	-	-	100%
02 Contracted in training / workshop	COG	26.40	26.40	-	-	-	-	-	-	-	-	-	100%
03 Contracted in training for teachers	COG	0.49	0.49	-	-	-	-	-	-	-	-	-	100%
04 Contracted out training	COG	94.57	94.57	-	-	-	-	-	-	-	-	-	100%
05 Training activities	COG	49.57	49.57	-	-	-	-	-	-	-	-	-	100%
06 Strengthened Institutions capacity to manage, plan, regulate, finance, monitor and evaluate		199.02	199.02	-	-	-	-	-	-	-	-	-	100%
01 TA - Social/Planning/Finance/PHA - Local	COG	73.21	73.21	-	-	-	-	-	-	-	-	-	100%
02 TA - Finance/Planning - International	REGIE	22.85	22.85	-	-	-	-	-	-	-	-	-	100%
03 Supervision / on-the job-training	COG	10.83	10.83	-	-	-	-	-	-	-	-	-	100%
04 Stakeholder internal HMIS auditing	COG	39.77	39.77	-	-	-	-	-	-	-	-	-	100%
05 Central level interventions	COG	52.36	52.36	-	-	-	-	-	-	-	-	-	100%
B Strengthen monitoring & evaluation capacity of health system		**107.80**	**107.80**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**100%**
01 Enhanced monitoring & evaluation capacity		107.80	107.80	-	-	-	-	-	-	-	-	-	100%
01 TA - Social/Planning/Finance - Local	COG	9.29	9.29	-	-	-	-	-	-	-	-	-	100%
02 TA - M & E - International	REGIE	29.50	29.50	-	-	-	-	-	-	-	-	-	100%
03 External HMIS auditing	COG	0.45	0.45	-	-	-	-	-	-	-	-	-	100%
04 External monitoring Quality Seal	COG	0.00	-	-	-	-	-	-	-	-	-	-	?%
05 Surveys	COG	59.47	59.47	-	-	-	-	-	-	-	-	-	100%
06 Steering committee expenses	COG	9.09	9.09	-	-	-	-	-	-	-	-	-	100%
C To consolidate the results of the current health projects in Cambodia in order to increase access to		**2,444.85**	**958.90**	**1,485.95**	**134.32**	**122.64**	**145.44**	**145.44**	**547.83**	**596.00**	**8.25**	**333.88**	**86%**
01 Increased access to good quality health services for the poorest population		944.85	430.21	514.64	80.52	55.50	55.50	55.50	247.02	246.00	8.25	13.37	99%
01 Continued funding of 9 HEF in a cofinancing arrangement with the MOH multi-donor funded HSSP2	COG	191.86	191.86	-	-	-	-	-	-	-		-	?%
02 Continued management & oversight of the 9 co-dunded HEF	COG	2.69	2.69	-	-	-	-	-	-	-		-	?%
03 Strengthening the capacity of the 3 PHD to monitor & evaluate HEF	COG	6.67	6.67	-	-	-	-	-	-	-		-	100%
04 Continued funding of 9 HEF in a cofinancing arrangement with the MoH multi-donor funded HSSP2	REGIE	667.70	213.63	454.07	70.70	50.00	50.00	50.00	220.70	220.00	-	13.37	98%
05 02 Continued management & oversight of the 9 co-funded HEF	REGIE	65.63	11.06	54.57	7.82	5.50	5.50	5.50	24.32	22.00	8.25	-	100%
06 Strengthening the capacity of the 3 PHD to monitor & evaluate HEF	REGIE	10.30	4.30	6.00	2.00	-	-	-	2.00	4.00		-	100%
02 Increased capacity in 8 ODs & 2 Provincial Referral Hospitals to provide better quality health services		147.34	147.34	-	-	-	-	-	-	-	-	-	100%
01 Support the MoH & PHDs in assessing the capacity & readiness of 8 ODs & 2 Hospitals to implement service	COG	8.76	8.76	-	-	-	-	-	-	-	-	-	100%
02 Transitional support to ODs & Hospitals that are expected to start implementation of service delivery contracts	COG	102.99	102.99	-	-	-	-	-	-	-	-	-	100%
03 Intensive capacity development for ODs that do not yet meet the criteria/standards to implement service delive	COG	22.90	22.90	-	-	-	-	-	-	-	-	-	100%
04 Support capacity development for ODs & Hospitals that have been contracted to deliver health services	COG	12.70	12.70	-	-	-	-	-	-	-	-	-	100%
03 Increased capacity of 3 PHDs to manage service delivery contracts & to support ODs & Referal Hospitals		22.57	22.57	-	-	-	-	-	-	-	-	-	100%
01 Transitional support to PHD staff until the introduction of service delivery contracts & MBPIs.	COG	13.31	13.31	-	-	-	-	-	-	-	-	-	100%
02 Replace current incentives for Siem Reap and Otdar Meanchey PHDs with MBPI, conform the existing legal fr	COG	0.00	-	-	-	-	-	-	-	-	-	-	?%
03 Support capacity development for the 3 PHDs	COG	9.26	9.26	-	-	-	-	-	-	-	-	-	100%
04 Encourage & support the analysis & documentation of contracting, health financing & other initiatives at provin	COG	0.00	-	-	-	-	-	-	-	-	-	-	?%
04 Evidence based policy making through systematic & sustainable documentation & analysis of relevant informatio		0.02	0.02	0.00	-	-	-	-	-	-	-	-	100%
01 Support the MoH in the analysis of data & information that is routinely collected & available	COG	0.00	-	-	-	-	-	-	-	-	-	-	?%
02 Support the MoH in identifying additional data needs & in formulating appropriate ways to gather this data	COG	0.02	0.02	(0.00)	-	-	-	-	-	-	-	-	100%
03 Ensure that relevant information is properly documented & is communicated to policy makers & the health par	COG	0.00	-	-	-	-	-	-	-	-	-	-	?%
05 National Execution (NEX); transfer to HSSP2 - BTC Discrete Account		1,330.07	358.76	971.31	53.80	67.14	89.94	89.94	300.81	350.00	-	320.51	?%
01 National Execution (NEX); transfer to HSSP2 - BTC Discrete Account	COG	1,330.07	358.76	971.31	53.80	67.14	89.94	89.94	300.81	350.00		320.51	?%
Z General means		**1,847.88**	**1,403.63**	**444.25**	**39.00**	**40.00**	**37.50**	**39.50**	**156.00**	**230.50**	**50.00**	**7.75**	**100%**
01 General means		1,248.52	1,248.52	-	-	-	-	-	-	-	-	-	100%
01 Secretary (2)	COG	108.58	108.58	-	-	-	-	-	-	-		-	100%
02 Office Assistant / Drivers (2)	COG	17.33	17.33	-	-	-	-	-	-	-		-	100%
03 Government Salaries & allowances	COG	0.00	-	-	-	-	-	-	-	-		-	?%
04 Team Leader - Co-Director - International expert	REGIE	746.86	746.86	-	-	-	-	-	-	-		-	100%
05 Assistant Team Leader - national expert	COG	86.59	86.59	-	-	-	-	-	-	-		-	100%
06 Local staff missions costs	COG	12.41	12.41	-	-	-	-	-	-	-		-	100%
07 National air tickets	COG	1.94	1.94	-	-	-	-	-	-	-		-	100%
08 Office equipment	COG	41.28	41.28	-	-	-	-	-	-	-		-	100%
09 Office running costs	COG	40.35	40.35	-	-	-	-	-	-	-		-	100%
10 Vehicle running costs	COG	82.58	82.58	-	-	-	-	-	-	-		-	100%
11 Office furniture/supplies	COG	22.21	22.21	-	-	-	-	-	-	-		-	100%
12 Moto running costs	COG	6.23	6.23	-	-	-	-	-	-	-		-	100%
13 Government Running Costs	COG	0.00	-	-	-	-	-	-	-	-		-	?%
14 Government Social Interventions	COG	0.00	-	-	-	-	-	-	-	-		-	?%
15 Vehicle purchase (Co-director, Assistant Co-dir, 2 TA)	COG	74.78	74.78	-	-	-	-	-	-	-		-	100%
16 Moto purchase (one per supervisor)	COG	7.39	7.39	-	-	-	-	-	-	-		-	100%
02 Staff 'Consolidation Phase'		495.89	142.64	353.25	37.50	37.50	37.50	37.50	150.00	150.00	50.00	3.25	99%
01 Technical assistantce	REGIE	490.00	136.75	353.25	37.50	37.50	37.50	37.50	150.00	150.00	50.00	3.25	99%
02 Administration and Finance Staff	COG	0.58	0.58	-	-	-	-	-	-	-		-	100%
03 Technical Staff	COG	3.25	3.25	-	-	-	-	-	-	-		-	100%
04 Other Staff Costs	COG	2.06	2.06	-	-	-	-	-	-	-		-	100%
03 Procurement 'Consolidation Phase'		0.00	-	-	-	-	-	-	-	-	-	-	?%
01 Office Equipment	COG	0.00	-	-	-	-	-	-	-	-		-	?%
02 Computer Equipment	COG	0.00	-	-	-	-	-	-	-	-		-	?%
04 Operational costs 'Consolidation Phase'		12.47	12.47	-	-	-	-	-	-	-	-	-	100%
01 Vehicle Running and Maintenance	COG	6.12	6.12	-	-	-	-	-	-	-		-	100%
02 Telephone, E-mail	COG	2.07	2.07	-	-	-	-	-	-	-		-	100%
03 Office Materials	COG	3.27	3.27	-	-	-	-	-	-	-		-	100%
04 Consultancy Fees	COG	0.00	0.00	-	-	-	-	-	-	-		-	100%
05 Financial Costs	COG	1.01	1.01	-	-	-	-	-	-	-		-	100%
05 Audit, M&E 'Consolidation Phase'		91.00	-	91.00	1.50	2.50	-	2.00	6.00	80.50	-	4.50	95%
01 Monitoring and Evaluation	REGIE	83.50	-	83.50	-	-	-	-	-	79.00		4.50	95%
02 Backstopping	REGIE	7.50	-	7.50	1.50	2.50	-	2.00	6.00	1.50		-	100%
PBHS1 + PBHS2	**REGIE**	**2,304.13**	**1,345.24**	**958.89**	**119.52**	**95.50**	**93.00**	**95.00**	**403.02**	**476.50**	**58.25**	**21.12**	**99%**
	COG	**5,483.21**	**4,511.90**	**971.31**	**53.80**	**67.14**	**89.94**	**89.94**	**300.81**	**350.00**	**-**	**320.51**	**94%**
	TOTAL	**7,787.34**	**5,857.14**	**1,930.20**	**173.32**	**162.64**	**182.94**	**184.94**	**703.83**	**826.50**	**58.25**	**341.63**	**96%**
PBHS1	**REGIE**	**979.50**	**979.50**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**100%**
	COG	**3,763.63**	**3,763.63**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**100%**
	TOTAL	**4,743.13**	**4,743.13**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**100%**
PBHS2	**REGIE**	**1,324.62**	**365.74**	**958.89**	**119.52**	**95.50**	**93.00**	**95.00**	**403.02**	**476.50**	**58.25**	**21.12**	**98%**
	NEX	**1,719.58**	**748.27**	**971.31**	**53.80**	**67.14**	**89.94**	**89.94**	**300.81**	**350.00**	**-**	**320.51**	**81%**
	TOTAL	**3,044.21**	**1,114.00**	**1,930.20**	**173.32**	**162.64**	**182.94**	**184.94**	**703.83**	**826.50**	**58.25**	**341.63**	**89%**

Annex 5. IFR Q4 2009 BTC Extracts

Cambodia: Second Health Sector Support Program
Projected Cash Requirement for the Next Two Quarters

Annex B4.2

BTC Discrete Donors (in US$)

In US$

	Funds Received to date	Funds Expended to date	Balance Fund to date	Budget plan for Quarter 1, 2010	Budget plan for Quarter 2, 2010	Budget plan for Total	Commitment amounts to be paid during the next quarter	Total Funds Required
	a	b	c = a - b	d	e	f =d+e	g	h = f+g-c
1. Service Delivery Grants		-						
2. HEF Grants (direct benefit cost)		-	-	-	-	-		-
3. MBPI and related payment	-	-	-	2,305	2,305	4,609		(4,609)
4. Others	-	-				-		-
Goods	116,469	4,050	112,419	2,500	2,500	5,000		107,419
Works	-	-	-			-		-
Services	116,469	66,210	50,259	23,750	23,750	47,500		2,759
Operating Costs	118,457	268,054	(149,597)	10,960	10,960	21,920		(171,517)
Training	116,469	7,465	109,004	27,578	27,578	55,156	-	53,848
TOTAL	**467,864**	**345,779**	**122,085**	**67,093**	**67,093**	**134,185**	**-**	**(12,100)**

Cambodia: Second Health Sector Support Program
Statement of Payments by Location

Annex B2.2

BTC Discrete Donor (in US$)

Quarter ended 31 December 2009

	Total	Used of funds for the Quarter, By location: KCM	OMC	SIR	HSSP
Payments					
I. By category					
1. Service Delivery Grants	-				
2. HEF Grants (direct benefit cost)	-				
3. MBPI & related payment	-				
4. Others	-				
Goods	**4,050**				4,050
Work	-				
Services	**29,960**				29,960
Operating Costs	**263,709**	100,601	31,401	128,832	2,875
Training	**5,461**	4,120	1,341		
Total	**303,180**	**104,721**	**32,742**	**128,832**	**36,885**
II. By method of payments					
Payments through petty cash	-				
Payments through cash advance	-				-
Payments through bank	-				
Direct payment	**303,180**	104,721	32,742	128,832	36,885
Total	**303,180**	**104,721**	**32,742**	**128,832**	**36,885**
	Ok				

AOP 2009	**1,518,638**	431,550	126,380	515,894	444,814
Cumulative expenses as of Q3, 2009	**42,599**	2,029			40,570
Cumulative expenses to date	**345,779**	106,750	32,742	128,832	77,455
% Actual Vs Budget	**22.77%**	**24.74%**	**25.91%**	**24.97%**	**17.41%**

Cambodia: Second Health Sector Support Program | **Annex B3.3**

Statement of Payments by Program Activities linked to Annual Operational Plan

BTC Discrete Donor (in US$)

Quarter ended 31 December 2009

Program Activities	Actual			Budget		Variance	
	Current Quarter	Year to date	Cumulative to date	Current Quarter	Current year	Current Quarter	Current year
Program 1: Reduce maternal, new born and child morbidity and mortality with improved reproductive health							
Program 2: Reduce morbidity and mortality of HIV/AIDS, Malaria, TB, and other communicable diseases							
Program 3: Reduce risk behaviors leading to non-communicable diseases (KAP): diabetes, cardiovascular diseases, cancer, mental							
Program 4: Health System Strengthening	303,179	345,779	345,779	23,000	1,410,388	(280,179)	1,064,609
Non program				-	108,249	-	108,249
Total	**303,179**	**345,779**	**345,779**	**23,000**	**1,518,637**	**(280,179)**	**1,172,858**
	ok	ok	ok				

Cambodia: Second Health Sector Support Program | **Annex B2.6**

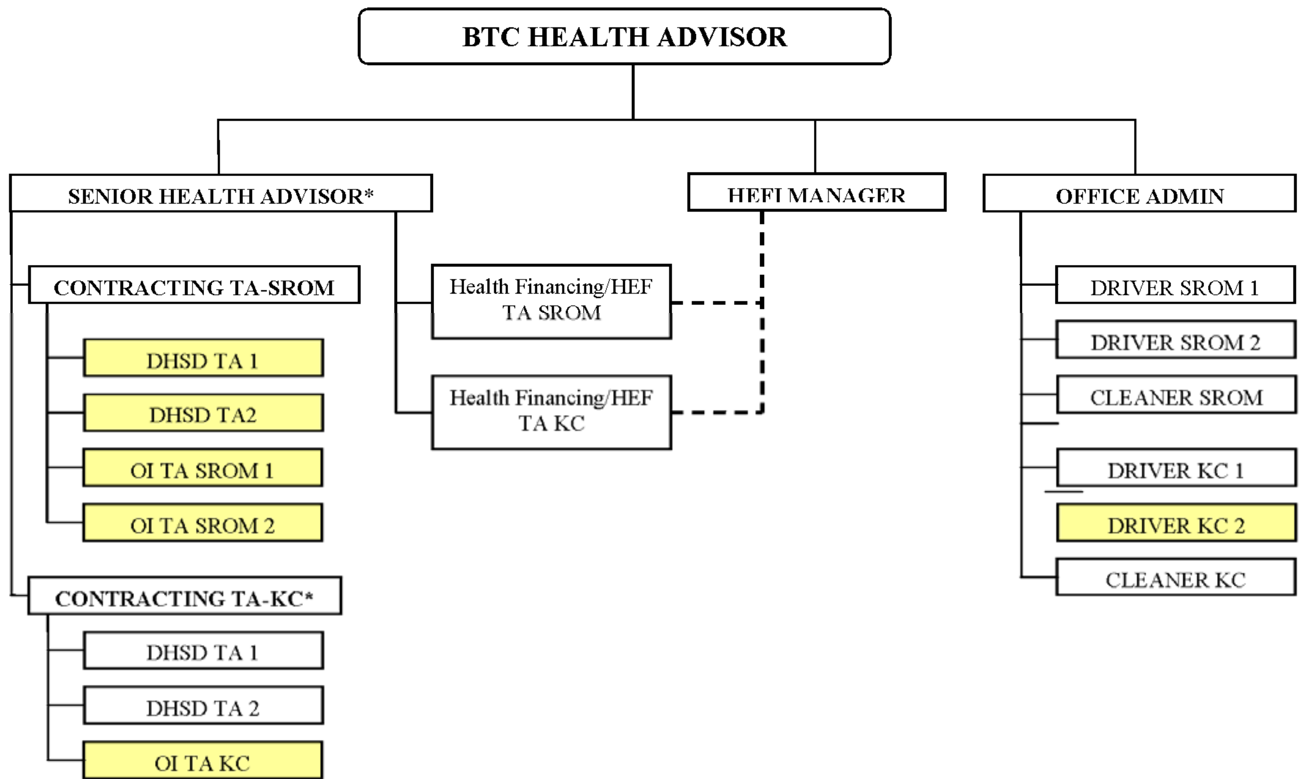
Statement of Receipts and Payments

BTC Discrete Donors (in US$)

Quarter ended 31 December 2009

		Actual			Budget		Variance	
		Current Quarter	Year to date	Cumulative to date	Current Quarter	Current year	Current Quarter	Current year
Receipts								
Designated Account			465,876	465,876	465,876	1,518,638	465,876	1,052,762
Direct Payment		-	-	-				
Other (Interest Income)		344	1,988	1,988				
Total receipts	(a)	**344**	**467,864**	**467,864**	**465,876**	**1,518,638**	**465,876**	**1,052,762**
Payments by category								
1. Service Delivery Grants								
2. HEF grants (direct benefit cost)		-			-	508,898	-	508,898
3. MBPI and related payment		-						
4. Others								
Goods		4,050	4,050	4,050	-	21,730	(4,050)	17,680
Works		-						
Services		29,960	66,210	66,210	22,000	211,478	(7,960)	145,268
Operating Costs		263,709	268,054	268,054	1,000	673,982	(262,709)	405,928
Training		5,461	7,465	7,465	-	102,550	(5,461)	95,085
Total payments	(b)	**303,180**	**345,779**	**345,779**	**23,000**	**1,518,638**	**(280,180)**	**1,172,859**
Excess/(deficit) receipts over payments	c = a - b	**(302,836)**	**122,085**	**122,085**				
Opening funds balance								
Cash at Bank								
		-						
BTC		370,651						
Advance payments								
BTC		54,270						
Petty Cash								
BTC								
Total opening funds balance	(d)	**424,921**	**-**	**-**				
Closing funds balance	e = c + d	**122,085**	**122,085**	**122,085**				
Represented by:								
Cash at Bank								
BTC		3,840	3,840	3,840				
Advance payments								
BTC		118,245	118,245	118,245				
Petty Cash								
BTC								
Total	f	**122,085.00**	**122,085**	**122,085**				
		ok	ok	ok				

Annex 6. Organizational Chart Functional Relations



- (*): functions are held by the same person
- Full Line: hierarchical relationship
- dashed line: functional relationship
- Yellow boxes are open positions being recruited
- DHSD TA: District Health System Development technical Assistant; QI TA: Quality Improvement technical Assistant; KC: Kampong Cham; SROM: Siem Reap and Otdar Meanchey; HEF(I): Health Equity Funds (Implementer)

Annex 7. Assessment of HEF beneficiary identification in three operational health districts in Kampong Cham

Provision of Basic Health Services-Kampong Cham
(PBHS-KC)

Assessment of HEF beneficiary identification in three operational health districts in Kampong Cham

Final

REPORT

December 2009

By Ir Por

1

Summary

The MOH and BTC started HEF in Cheung Prey, Chamkar Leu and Prey Chhor ODs, respectively in November, December 2005 and January 2006. The implementation of these schemes was entrusted to two local NGOs as HEFOs. From the beginning until October 2008, HEFBs were identified exclusively through Post-ID. Since October 2008, HEFBs have been identified through both Pre-ID and Post-ID. Even with Pre-ID, about half of the HEFBs were identified through Post-ID, raising a concern about the reliability of the current HEFB identification. Therefore, the MOH and BTC commissioned a study in October 2009 to assess the reliability of the Pre-ID and Post-ID, identify reasons behind the high proportion of Post-ID HEFB inpatients, and make recommendations for further improvement of HEFB identification.

We used a combination of data collection methods, including key informant interviews, a rapid Post-ID assessment at hospital, and household survey, for which 600 households (300 cardholders and 300 non-cardholders) were randomly selected.

The results of key informant interviews show that several potentially poor households could not be reached for interviews and photography because they were not at home during the pre-identification and some VRGs did not receive enough questionnaires and were reluctant to interview households living far away. Some VRGs had low technical capacity and were not motivated enough to do their job, which could lead to technical and professional mistakes through out the process of pre-identification. The Post-ID assessment did not find any major problem, except some inclusion errors in Prey Chhor. But many patients are familiar with Post-ID questionnaire and can falsify their answers to conform to the HEF eligibility criteria, suggesting a risk of inclusion errors made by Post-ID. The results from household survey show a large proportion of potentially poor households without an EAC. The under-coverage rate estimated by Post-ID, Pre-ID and interviewers' assessment was 27%, 17% and 25% (47%, 44% and 33% if adjusted number of non-cardholders) respectively. We also found mismatching between the SES and HEF eligibility cut-off points of Post-ID and Pre-ID tools. Self-assessed household living condition suggests that 75% of the survey households had their living condition changed over the last year (13% got better and 52% got worse). There were some newly formed and migrated families. Besides exclusion errors, the Pre-ID conducted one year ago might have also included several non-poor households into HEF programme.

Despite some limitations in methods, we can conclude that the reasons for the high proportion of Post-ID HEFB inpatients were diverse. The important ones are poverty dynamic, mismatching between Post-ID and Pre-ID tools, exclusion errors made by the Pre-ID conducted one year ago and inclusion errors made by the Post-ID at the hospitals. The main causes of the Pre-ID exclusion errors were the population mobility for work and technical and professional mistakes of the VRGs, while the main cause for the Post-ID inclusion errors was technical and professional mistakes of the HEFOs. Although we cannot appreciate the extent to which each of the above factors contributed to the problem, our findings are useful for further improvement of HEFB identification and shed light to further research on this area. Several recommendations to improve the current HEFB identification at policy and operational levels are made. It is to note that if all HEFBs are genuinely poor, certain proportion of HEFBs identified through Post-ID in the presence of Pre-ID may not be necessarily bad, but indicating the complementarity of both methods.

Ir *et al. BMC Pregnancy and Childbirth* 2010, **10**:1
http://www.biomedcentral.com/1471-2393/10/1

BMC Pregnancy & Childbirth

RESEARCH ARTICLE Open Access

Using targeted vouchers and health equity funds to improve access to skilled birth attendants for poor women: a case study in three rural health districts in Cambodia

Por Ir[1,2*], Dirk Horemans[3], Narin Souk[4], Wim Van Damme[2]

Abstract

Background: In many developing countries, the maternal mortality ratio remains high with huge poor-rich inequalities. Programmes aimed at improving maternal health and preventing maternal mortality often fail to reach poor women. Vouchers in health and Health Equity Funds (HEFs) constitute a financial mechanism to improve access to priority health services for the poor. We assess their effectiveness in improving access to skilled birth attendants for poor women in three rural health districts in Cambodia and draw lessons for further improvement and scaling-up.

Methods: Data on utilisation of voucher and HEF schemes and on deliveries in public health facilities between 2006 and 2008 were extracted from the available database, reports and the routine health information system. Qualitative data were collected through focus group discussions and key informant interviews. We examined the trend of facility deliveries between 2006 and 2008 in the three health districts and compared this with the situation in other rural districts without voucher and HEF schemes. An operational analysis of the voucher scheme was carried out to assess its effectiveness at different stages of operation.

Results: Facility deliveries increased sharply from 16.3% of the expected number of births in 2006 to 44.9% in 2008 after the introduction of voucher and HEF schemes, not only for voucher and HEF beneficiaries, but also for self-paid deliveries. The increase was much more substantial than in comparable districts lacking voucher and HEF schemes. In 2008, voucher and HEF beneficiaries accounted for 40.6% of the expected number of births among the poor. We also outline several limitations of the voucher scheme.

Conclusions: Vouchers plus HEFs, if carefully designed and implemented, have a strong potential for reducing financial barriers and hence improving access to skilled birth attendants for poor women. To achieve their full potential, vouchers and HEFs require other interventions to ensure the supply of sufficient quality maternity services and to address other non-financial barriers to demand. If these conditions are met, voucher and HEF schemes can be further scaled up under close monitoring and evaluation.

Background

The Millennium Development Goal 5 (MDG5) aims to reduce the maternal mortality ratio by three quarters between 1990 and 2015 [1]. However, progress towards this goal has been disappointing. The maternal mortality in many countries, especially in Sub-Saharan Africa and Asia, remains high with huge poor-rich inequalities [2,3]. Targeting effective maternal health interventions to the most vulnerable, especially the rural poor populations, is considered essential to achieve MDG5 [3]. However, there are few examples of successful maternal health interventions aimed at the poor [4].

Effective strategies to reduce maternal mortality are well known nowadays. Ensuring access to skilled birth attendants and emergency obstetric care are two priority interventions fundamental to the prevention of

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Annex 9. Summary Project Sheet

BASIC HEALTH SERVICES

Provision of Basic Health Services in the provinces of Siem Reap, Otdar Meanchey and Kampong Cham

Funded by	Belgian Government Cambodian Government Pooled Fund Health Sector Support Program 2			
Implementation	National Execution by the MOH Own-management by BTC HEF office			
Location	Siem Reap, Otdar Meanchey and Kampong Cham provinces and in capital Phnom Penh			
Duration	**2004-2008 & 2009-2013**			
BUDGET		**1st Phase**	**Cons. Phase**	**Total**
(IN MILLION EURO)	**Total**	13.5	5.6	19.1
	Belgian contribution	4.8	3.0	7.8
	Cambodian contribution	8.7	0.5	9.2
	HSSP2 pooled fund	N/A	2.1	2.1

CONTEXT

Decades of war and genocide had ravaged the Cambodian health system. Since the early nineties the country has known a period of relative stability during which its health system has known a rapid development with major reforms. Although these major improvements and progresses the health situation remains one of the worst in the South East Asian region. At present the MOH with the support of many partners continues to improve the Health System based on its Strategy for Health 2003-2007.

Extremely low salaries not motivated and poorly qualified health personnel are recognized as major causes for the poor quality of the public health services. As a result the population has little confidence in public hospitals and health centers. This is in combination with extreme poverty, of a big part of the population, makes that health centres and hospitals are severely underutilized. The project aims to increase the utilization of the health centers and hospitals, especially for the poor and for women and children, through improving the quality of their services, through health education activities and through improving the financial accessibility for the poor.

OBJECTIVES

The consolidation phase of the project has adopted the general objective of the 2nd Cambodian National Health Strategic Plan (2008-2015) "To reduce morbidity and mortality, in particular maternal, new born and child morbidity and mortality and morbidity and mortality due to communicable diseases, and to reduce the burden of non-communicable diseases and other health problems". The specific objective is "To consolidate the results of the current health projects in Cambodia supported by the Belgian Cooperation in order to increase access to quality care through capacity development in three provinces and through policy strengthening at central level within the framework of national health policies, public administrative reform and financial management reform". The project will achieve this objective through supporting the Ministry of Health and different provincial health institutions in their efforts to implement specific reform strategies. The project focuses its support to three provinces, their respective Provincial Health Departments (PHD) and Provincial Referral Hospitals (PRH) and 8 Operational Health District (OD). A component "Evidence and Information for Policy Making" will assure communication of the lessons learned to the central policy formulating level.

RESULTS ACHIEVED SO FAR

During the first phase of the project which finished on 31st Dec. 2008 the project introduced, supported and implemented 1) Health Equity Funds in 8 RH and several HCs which financed 56,070 hospitalisations, 76,105 outpatient consultations and 3,678 deliveries of very poor persons, 2) performance incentive contracts with the health institutions covering almost 1700 personnel, 3) a major training component on clinical and managerial skills, 4) several Behavioural Change Communication initiatives, 5) Quality Assessments of RH & HC and major rehabilitation and equipping of RH & HC and construction of 6 new HCs and a hospital pharmacy, and 6) Institutional Capacity Building and Health Policy Strengthening at Provincial and Central Level contributing to the government's decision to adopt HEF and performance incentive mechanisms. The Mid Term Review of the project concluded that the project was very successful especially with regards to service utilization by the poor and by pregnant mothers, increased staff motivation and their improved behaviour , but that further support was required to assure ownership and sustainability. Based on strong recommendations of the Mid Term Review, Cambodia and Belgium decided to support a 3-year consolidation phase. The consolidation phase has adopted National Execution has major implementation mode. BTC became one of the seven partners in the multi-donor funded Health Sector Support Program 2009-2013 (HSSP2) as such assuring full harmonization with other major health partners and aligning with government procedures and the Health Sector Strategic Plan 2008-2015. This approach also guarantees sustainability as financial and managerial responsibilities are progressively handed over to government and other partners. 2009 should be regarded as a transition year. Performance incentive schemes to Health Districts and Provincial Hospitals were replaced by a Government developed/owned mechanisms called the Special Operating Agency. SOA status provides bigger autonomy and allows benefiting from the Service Delivery Grants which fund the performance incentives. In 2009 the HEF supported 23,942 hospitalisations, 35,850 outpatient consultations and 2,712 deliveries.

CONTACT

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