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AGENCE BELGE
DE DÉVELOPPEMENT

ANNUAL REPORT 2010

PROVISION OF BASIC HEALTH SERVICES IN THE PROVINCES OF SIEM REAP, OTDAR MEANCHEY & KAMPONG CHAM
KAM0200711

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1 Project form

<table>
<tr><td>Funded by</td><td>Directorate General for Development Cooperation, Belgium
Ministry of Health, Kingdom of Cambodia
HSSP2 Pooled Fund Partners (AUSAID, DFID,UNFPA, UNICEF,WB)</td></tr>
<tr><td>General objective</td><td>The general objective of the Consolidation Phase is identical to the goals of the National Health Sector Strategic Plan 2008 – 2015 (HSP2):
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.</td></tr>
<tr><td>Specific objective</td><td>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.</td></tr>
<tr><td>Expected results</td><td><u>Result 1:</u> Increased access to good quality health services for the poorest population.
<u>Result 2:</u> Increased capacity in eight Operational Districts and two Referral Hospitals to provide better quality health services to the people in the respective catchment areas.
<u>Result 3:</u> 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.
<u>Result 4:</u> Evidence based policy making through systematic and sustainable documentation and analysis of relevant information at various levels.</td></tr>
<tr><td>Executing agencies Consolid. Phase</td><td>- Partially in National Execution: Ministry of Health, 2nd Health Sector Support Program (HSSP2) secretariat
- Partially in Own Management: for the Health Equity Fund Component</td></tr>
<tr><td>Partnership</td><td>HSSP2 Partners: MOH and AFD, AUSAID, BTC, DFID, UNICEF, UNFPA, WB</td></tr>
<tr><td>In participation with</td><td>Local NGOs</td></tr>
<tr><td>Project location</td><td>Provinces of Siem Reap, Otdar Meanchey and the 3 Operational Districts (Chamkar Leu, Cheung Prey, Prey Chhor) and the Provincial Referral Hospital of Kampong Cham province, and the Central MOH departments</td></tr>
<tr><td>Project start</td><td>July 01, 2004, start of Consolidation Phase on January 01, 2009</td></tr>
<tr><td>Duration</td><td>7 ½ years</td></tr>
<tr><td>Budget in Million €</td><td><table><tr><td></td><td>1st Phase</td><td>Cons. Phase</td><td>Total</td></tr><tr><td>Total</td><td>13.5</td><td>5.6</td><td>19.1</td></tr><tr><td>Belgian contribution</td><td>4.8</td><td>3.0</td><td>7.8</td></tr><tr><td>Cambod. contribution</td><td>8.7</td><td>0.5</td><td>9.2</td></tr><tr><td>HSSP2 pooled fund</td><td>N/A</td><td>2.1</td><td>2.1</td></tr></table></td></tr>
<tr><td>Direct Beneficiaries</td><td>1) ±1,6 Million persons being the population of the 8 focal districts
2) Health staff in the three Provincial Health Departments, eight Operational District Offices, nine Referral Hospitals (including the three Provincial Referral Hospitals) and more 100 Health Centres</td></tr>
<tr><td>Indirect Beneficiaries</td><td>1) Population of the neighboring provinces utilizing the health facilities of the three supported provinces;
2) Population of Cambodia through the project's contributions to policy development and strategic planning at national level</td></tr>
<tr><td>Key persons</td><td>Prof. Eng Huot, Chairman of Project Steering Committee, HSSP2 Program Director, Secretary of State MOH
Dr. Lo Veasna Kiri, Grant Authorizing Officer, Director of DPHI, MOH
Dr. Char Men Chhuor, Coordinator of the HSSP2 secretariat, Dep. DG, MOH
Mrs. Isabelle Austin, Chairlady of the JPIG, Dep. Repr.. UNICEF Cambodia</td></tr>
<tr><td>Sector(s)</td><td>Health</td></tr>
</table>

2 Summary

2.1 Analysis of the intervention

Intervention logic	Efficiency	Effectiveness	Sustainability
Specific objective	B	B	A
Result 1	B	A	A
Result 2	B	B	Not required
Result 3	C	C	Not required
Result 4	Not started	Not started	D

Budget	Expenditure 2004-2006	Expenditure 2007	Expenditure 2008	Expenditure 2009	Expenditure 2010	Total expenditure (31/12/2010)	Balance of the budget	Exec. rate
7,787,335	2,184,292	1,345,550	1,104,308	1,222,994	513,201	6,370,344	1,416,991	82%

2.2 Key points

2010 Project achievements should be regarded as satisfactory resulting in increased utilization of the public health services by the Cambodian population and more specifically by the poorer quintiles.
Result 1 activities assured that HEF continued to function without interruption, a new improved monitoring system was established looking at the quality of services offered. Together this contributed to a further increase in HEF supported poor patients of 32%, from of 58,409 in 2009 to 77,152 in 2010.
Activities under result 2, capacity building for Service Delivery Grants, the performance incentives and their improved management did contribute to the 2010 increase in utilization and coverage of the health services in the project area. The number of deliveries at public health facilities, the number of hospitalisation and the number of outpatient consultation increased respectively 23%, 13% and 27%.
This increased utilization can be linked directly to improved accessibility and satisfaction with quality of health services. Both are major aspects of the PBHS2 project specific objective.
With regards to result 3, capacity building for the provincial health departments in the field of contracting, only little progress was made, mainly because of the limited availability of counterparts of the provincial health Departments.
Activities for result 4 “Evidence based Policy Making” will only start in 2011 aiming at properly documenting and disseminating the project experiences.

During 2010 no major national political, economical or environmental events took place which influenced importantly the progress of the project.

The government decision to abolish MBPI and the delays with the new temporary incentive mechanism “Priority Operational Cost” have contributed significantly to the limited commitment of central and PHD level back office staff. As a result essential activities such as monitoring, assessments, instrument developments, logistic support have been seriously delayed with an important impact on PHD and MOH activities in general and on the progress of SDG systems in particular. This issue can be considered as a major reason for the poor achievement under Result 3 and does equally impacts achievements of result 2. At the end of the 2010 the administrative arrangements were not yet finalised and no POCs had been paid yet.

Poor regulation of “Dual Practice”, although not new, remains an important factor

obstructing the development of the public hospitals and health services and also delaying the development of a strong private health sector. With Dual Practice we mean the practice that public health staff, nurses, doctors and other health professionals also work in, own or co-own a private health practice, clinic or pharmacy. As dual practice is not regulated it creates a very important conflict of interest in which the public and the private is competing for the same clients using the same human and other resources. Several staff are paying much more attention to their private practice to the detriment of the hospital and HC patients. This does often result in delayed treatment, unhappy patients, catastrophic health expenditure and sometimes even in death.

In 2010 the HSSP2 secr. managed to recruit only 3 technical assistants of the 6 required. Lack of competent capacity building technical assistants reduced the effectiveness of result 2 & 3 capacity building activities, and more so with regards to quality improvement. The project management proposes to stop recruitment of new technical assistants in 2011 as the project has come too close to the end, unless in case of unplanned departures.

In 2010 the MOH has started with the preparation of the Midterm Review of the 2nd National Strategic Health Plan (HSP2), this will coincide with the MTR of the HSSP2 and end of the PBHS2 project. This does provide the opportunity to include some of the project experiences as evidence for the HSP2 MTR. Documentation and required evaluations are planned under Result 4. The backstopping mission proposed to conduct these activities in own-management modality in order to avoid delays.

Since the start of the 2nd phase of the PBHS in 2009 almost all decisions are taken in consultation with the MOH and the other HSSP2 health partners.
HSSP2 partnership provides several communication and joint decision mechanisms such as the technical leads, the monthly JPIG meeting, monthly operational support group meetings and joint quarterly meetings and 6-monthly joint review missions.
In 2010 HSSP2 has made special efforts to increase collaboration with other Health Partners. As a result most of its technical discussions are now organized in forums with other health partners. WHO is invited to and present at almost all JPIG meetings. This further improves harmonization and alignment in the sector but does also add to the burden of frequent meetings.
Once a quarter the MOH provides an update on the HEF, the SDG/ SOA or the HSSP2 situation and plans during the TWGH meeting which is attended by MOH authorities and departments, Development Partners in Health and other relevant Ministries.
The Development Health Partners (AFD, GIZ, GRET, URC, WB, WHO) have also intensified their collaboration around Social Health Protection. URC has agreed in principal to take over the HEFI responsibilities of BTC for the 8 HEF schemes including the BTC HEFI staff, an important aspect for the sustainability of the HEFs.

The PBHS does not target specifically gender or environmental aspect however in the context of HSP2 and the national health priorities Result 1 and Result 2 pay particular attention to women and children, with a strong focus on maternal health. The project's Maternal Health Vouchers do obviously target women. In 2010 women use the HEF support more than men with 58% of the supported persons being female.

The procurement of the new HEF Operator contracts by the HSSP2 secr. is planned to be completed by 18th February 2011 with the signing of the contracts. The planning looks realistic and the HEFI team will support the HSSP secr. and closely follow up.

Budget execution versus the financial planning of version quarter 1 was 76.8% in total, 89.9% in own management and 61%in national execution. The low execution rate in national execution is due to a mistake in the financial planning caused by a communication problem and delays with the approval of the MOH AOP 2010. The project team used to high an amount in the project financial plan 2010 version Q1.

The sustainability risk can now be regarded as very low. HSSP2 pooled fund and the counterpart fund have already taken over funding responsibilities of the SDG, the POC, the HEF direct costs and have committed to take over the HEF indirect costs at the end of the project. In the absence of a Cambodian National Social Health Protection Agency URC has agreed to take over the HEF implementer role of BTC if so requested by the MOH.

During 2011 the project will continue HEF Implementer and capacity building activities. New SDG monitoring tools and a revised SDG manual will require intensified capacity building of SOAs and PHDs.
As recommended by the back stopping mission result 4 activities will focus on documenting the experiences of the project in the wider context of the HSSP2 midterm review (MTR) and the HSP2 MTR which will both take place in 2011. The project will support some specific studies in the field of health financing which will contribute to the revision of the MOH health Financing Strategies.
The risk exists that the 2011 budget execution rate in national execution is low. This will depend mostly on the expenditure by the provincial health departments. This risk level should be regarded as moderate to high. Technical Assistants will try to follow up closely the implementation of planned activities by PHDs.
Coming closer to the end of the project some staff will start looking for other job opportunities. Unplanned departure of or HEFI financial staff would create serious problems for the functioning and the closing of the project. The risk level is moderate.

2.3 Lessons learned and recommendations

Decisions	Source	Who	Time	Status
HEFO procurement changes from own management back to National Execution	4.2.3	JLCB	Q1 2011	Ongoing
To repeat several TA recruitment rounds in 2010	4.4.4	HSSP2 secretariat	2010	Done with limited result
To revise the SOA/SDG manual	4.4.4	MOH & consultant	Q2 2011	Ongoing
To develop and finalize the monitoring instruments	4.4.4	MOH & consultant	Q2 2011	Ongoing
In order to assure an uninterrupted continuity after the end of PBHS it was decided that POC for Siem Reap, Otdar Meanchey and Kampong Cham provinces will be paid from Pooled Fund and not from BTC discrete funds	4.5.3	HSSP2 secretariat	Q2 2011	ongoing
Develop an improved Hospitalisation Appropriateness Assessment Tool	4.3.5	BTC Health Advisor	Q2-Q3 2011	Open
To introduce a new HEF monitoring system harmonised with URC	4.3.3	BTC Health Advisor	Q4-2011	Done
Make concrete arrangements with MOH and URC to take over HEFI responsibilities and BTC HEFI staff	4.3.3	BTC Health Advisor	Q2-Q3 2011	Open

Recommendation	Source	Who	Deadline
To follow up with MOH to have POC incentives paid asap and monitor the impact of POC on the commitment of the selected PHD staff	4.2.2	BTC Health Advisor through JPIG	Q2 2011
To increase the frequency and improve the quality of the PHD monitoring by the MOH central level	4.5.3	BTC Health Advisor through JPIG	Q2-2011

To request the MOH to develop an assessment plan identifying responsible departments and required resources and do one round of all types of assessments in all SOAs and PHDs in 2011	4.5.4	BTC Health Advisor through JPIG	Q4 2011
Not to recruit any new TA in 2011 unless new departures	4.2.3	BTC Health Advisor	Not applicable
To review the financial management control responsibilities of the HEFI	4.3.4	HEFI manager	Q3-2011
Advise the MOH to establish an active official Health Financing sub TWGH		BTC Health Advisor through JPIG	Q2-2011
Result 4 to focus on the documentation of project experiences and support some specific evaluation and consultancies in the field of Social Health protection and Health Financing	4.6.3	BTC Health Advisor	Q4 2011
To decide to implement the different evaluations an consultancies in own management rather than in National Execution to avoid major delays.	4.2.2	JLCB	Q4 2011
The steering Committee to decide whether to conduct the end of project household survey or not.		JLCB	Q1 2011

Lessons Learned	Public	Capitalisation in the Project Cycle
National Execution is not an appropriate modality for Capacity Building through Technical Assistant Teams and their logistic support	BTC HQ, BTC Representation, Health Partners, partner department	Identification and formulation
The present SWAP HSSP2 partnership allows BTC, although proportionally a small funder, to actively participate in policy discussion forums	BTC HQ, BTC Representation, Health Partners, partner department	Planning, Identification and formulation
Having the project function at both field and central level creates an opportunity to provide field experiences in the central level policy discussions.	BTC HQ, BTC Representation, Health Partners, partner department	Planning, Identification and formulation
Need for a performance incentive system to improve remuneration of back office staff involved in monitoring, contracting and other specific intensive task	BTC HQ, BTC representation, Development Partners, MOH	Identification, Formulation

3 Evolution of the context

During 2010 no major national political, economical or environmental events took place which influenced importantly the progress of the project.

In July 2010 the Council of Ministers decided to replace the previously cancelled Merit Based Payment Initiative (MBPI) by a new temporary incentive scheme called the Priority Operational Cost (POC). POC incentives can be paid to civil servants involved in priority activities. This is a temporary scheme and is to be financed wholly by donors and NGOs without any government contribution. All other incentives schemes have become illegal. Development of POC operational guidelines and contracts involved a lot of donor discussion (sectoral and intersectoral). PBHS2 which planned and budgeted to pay MBPI had already agreed in the March 2010 JLCB to contribute to POC in the eventuality that it would be approved. However based on a request of the MOH it was agreed with HSSP2 to have all POC in the HSSP2 areas, including the BTC areas, paid for from the Pooled Fund in order to assure automatic continuity after December 2011. At Sector level HEF forum. At the end of the 2010 the administrative arrangements were not yet finalised and no POCs had been paid yet. Several civil servants, also at central and PHD level, blame their low motivation on the low salary and absence of incentives. Low motivation of this back office staff influences project progress in all the areas but most particularly with regards to SDG monitoring and capacity buidling.

A consultative HEF forum with high level stakeholders (MOH, partners, MEF, Council of Administrative Reform, HP) took place on March 2010. Awaiting the approval of SHP Masterplan by the Council of Ministers the meeting did not progress on the establishment of an institutional home for HEF and CBHI coordination. Such an institutional home, possibly a semi autonomous national agency for HEF/CBHI should also take over some of the HEFI roles. As a result MOH did decide not to scale up further the HEF during the period 2010-2011. MOH hopes that the Council of Ministers decides soon on the Institutional Home but has little impact on that process. As a result PBHS will have to hand over its HEFI roles to URC as there is no other alternative.
The MOH would also like to come up with a standard HEF/CBHI model Forum which would be applied for further HEF scaling up.
MOH would like to integrate HEF and CBHI and expand HEF services to health center level. It has requested newly contracted HEFO NGOs to prepare proposals for such integration and expansion. Funding for this is not yet assured as donors are not convinced of the effectiveness and efficiency and no evidence is available yet.

MOH has delayed with the development and revision of several Special Operating Agency (SOA) / Service Delivery Grant (SDG) tools and instruments. They include:

- SOA/SDG monitoring tool for the different levels
- revision of the SDG allocation per SOA
- SDG manual including important aspects on the use of the grants

The non availability of these instruments have delayed the finalization of the SDG contracts and hence some aspect of PBHS2 capacity building.

PBHS2 has assisted the MOH Department of Health Information and Planning with

the development of a database for the Annual Operational Planning. This database allows bottom up approach with aggregation at each of the higher levels. It also allows to generate reports with different dimensions (locality, period, program, activity, donor, etc) which does facilitate the review of the AOPs by MOH and donors.

At donor coordination level, HSSP2 made special efforts to increase collaboration with other Health Partners (HP). As a result most of its technical discussions are now organized in forums with other health partners. WHO is invited to and present at almost all JPIG meetings. This further improves harmonization in the sector but does add to the burden of frequent meetings.

4 Analysis of the intervention

4.1 Institutional anchoring and execution modalities

Institutional anchoring: At central MOH level but with offices in the field -- "Very appropriate"

The first phase of PBHS was mainly in co-management mode with the co-directors at the level of the Provincial Health Department which was de facto the institutional home of the project.
For the second phase of the project (PBHS2) BTC has joined the second phase of the Health Sector Support Program (HSSP2), a partnership of the MOH and 7 development partners (AFD, AUSAID, BTC, DFID, UNFPA, UNICEF, WB) which agreed to support a number of priority activities of the 2nd Cambodian Health strategic Plan (HSP2). In that context they use a common set of procedures and regulations to plan, budget, coordinate, implement, monitor and audit their support. These are not 100% government procedures but they have been developed in collaboration between the World Bank and the Ministry of Economy and Finance and are equally used for partner supported projects and programs in other sectors. These procedures assure a good level of harmonization and alignment without losing too much transparency or accountability. The HSSP2 is regarded as a pre-SWAP.
5 of the partners contribute to a Pooled Fund for the totality or part of their funding. AFD and BTC provide their support through a Discrete (separate) Fund. The Pooled Fund and the Discrete Funds are managed by the HSSP2 secretariat which is a kind of project management unit but completely controlled by the MOH. This makes the central level of the Ministry of Health the institutional home for the second phase of the project PBHS2.
This arrangement assures a very good level of alignment and harmonization for the project. Sustainability of the main project results (HEF and SDG) is guaranteed already as the Pooled Fund and increasingly the MOH counterpart fund have gradually taken over the funding responsibilities for HEF Direct Costs, for SDGs and for POC.
This arrangement also permits BTC to participate actively in the health strategy and policy discussions at National level.
The project offices of the HEFI and capacity building TA teams are still at the PHDs. The teams spent a lot of their time in the field. Their feedback allows the BTC Health Advisor to contribute field experience based advice in the different national level meetings and policy discussions. Those inputs are much appreciated by the other partners.
The institutional home for the component HEF should preferably be outside the MOH to assure a split between provider and payer, avoiding possible conflicts of interest.

Execution modality: Mostly in National Execution with HEFI team activities and monitoring in own management – "Appropriate"

Activities related to result 2,3 and 4 have been budgeted and implemented in National Execution by the MOH/HSSP2 secr.
The Capacity Building has two main components, one being the activities organised by the PHD and SOAs such as review meeting, trainings, small workshops, local

study tours and some goods required for the capacity building, the other one being the local technical assistants and their logistic support. For the first component National Execution is an appropriate modality has it assures full alignment and harmonization, although sometimes a bit too inflexible when adaptation needs to be made during the year against the Annual Operational Plan. For the second component National Execution modality is not appropriate at all, it has delayed recruitment and complicates the logistic support by slow, time consuming and rigid procedures. This makes it difficult to respond timely to the capacity building needs of their counterparts.

Apart from technical assistance the activities for Result 1 have been mainly implemented in own management. From 2011 onwards the HEF operator contracts will come under National Execution procured and managed by the HSSP2 secr..
It will be important to keep the real HEFI tasks such as monitoring, HEF evaluations, meetings with communities, adhoc meetings to follow up on problems, etc. in own management in order to avoid big delays and blocking procedures.

In agreement with the MOH Department of Planning and Health Information the backstopping mission proposed to implement the studies contributing to the HSP2 Midterm Review and the documentation of the project in own management rather than in national execution modality. For the good reason that organizing consultancies via the HSSP2 secr. takes very long.

4.2 Specific objective

4.2.1 Indicators

Specific objective: 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.					Progress: B
Indicators	**E**	**G**	**Baseline**	**Progress year N**	**Comments**
Increased access to quality care in eight Operational Districts in three Provinces.		X	See results Household Survey 2008 regarded as baseline	Follow up survey planned by TFF in Q4 2011	This set of indicators cannot be measured on yearly basis Health Service Utilization and coverage data show important increases
Three Provincial Health Departments, eight Operational Districts and two Provincial Referral Hospitals able to implement health policies in areas of health financing and health contracting.	X		Scores of Quality and Capacity Assessments PHD KC: 60% PHD SR: 70% PHD OMC: 68% SOA OD PC: 73% SOA OD CP: 56% SOA OD CL: 61% SOA OD SR: 76% SOA OD Stn: 75% SOA OD AC: 71% SOA OD Krl: 76% SOA OD Sam: NA SOA PRH KC: 81% SOA PRH SR: 84% SOA PRH OMC: 76%	Not assessed in 2010	HSSP2 development partners requested the MOH several times to conduct all the specified assessments yearly
Health policies and strategies are developed and adjusted taking into consideration provincial level experiences and operational needs.			Not available, not assessed	Not yet assessed	Activities yet to start Definition of present Indicator does not allow quantification

4.2.2 Analysis of progress made

<u>Relation between activities and results</u>

Result 1, 2 and 3 have the potential to really improve accessibility to and quality of the health services provided by public health centers and hospitals.

In 2010, progress with regards to result 1 and 2, show that utilization of health services by both HEF beneficiaries and non HEF beneficiaries has increased considerably. Under Result 1, Health Equity Funds functioning was maintained and further improved. As a result the number of poor patients supported increased by 32% from 58,409 to 77,152.

Activities under result 2, Service Delivery Grants, their performance incentives and their improved management will probably have contributed to the 2010 increase in utilization and coverage of the health services in the project area. The number of deliveries at public health facilities, the number of hospitalisation and the number of outpatient consultation increased respectively 23%, 13% and 27%. This increased utilization is directly linked to improved accessibility and satisfaction with quality of services.

With regards to result 3 only little progress was made, mainly because of the limited availability of counterparts of the provincial health Departments.

Result 4 “Evidence based Policy Making is not expected to influence the achievement of the specific objective in the short term. Moreover activities will start in 2011 to assure dissemination of the project experiences.

Sensitive factors

The government decision to abolish MBPI and the delays with the new temporary incentive mechanism “Priority Operational Cost” has contributed significantly to the limited commitment of central and PHD level back office staff. As a result the essential activities such as monitoring, assessments, instrument developments, logistic support have been seriously delayed with an important impact on the progress of SDG systems and PHD and MOH activities in general.

Dual practice although not new remains an important factor obstructing the development of the public hospitals and health services but also delaying the development of a strong private health sector. With Dual Practice we mean the practice that public health staff, nurses, doctors and other health professionals also work in, own or co-own a private health practice, clinic or pharmacy. As dual practice is not regulated it creates a very important conflict of interest in which the public and the private is competing for the same clients using the same human and other resources. Several staff are paying much more attention to their private practice to the detriment of the hospital and HC patients. This does often result in delayed treatment, unhappy patients, catastrophic health expenditure and sometimes even in death.

In 2010 the MOH has started with the preparation of the Midterm Review of the 2nd National Strategic Health Plan (HSP2), this will coincide with the MTR of the HSSP2 and closure of the PBHS2 project. This does provide the opportunity to include some of the project experiences as evidence for the HSP2 MTR. Documentation and required evaluations are planned under Result 4. The backstopping mission proposed to conduct these activities in to own-management modality in order to avoid delays.

Unexpected results
None

“Harmo” dynamics
Since the start of the 2nd phase of the PBHS in 2009 almost all decisions are taken in consultation with the MOH and the other health partners.
HSSP2 partnership provide several communication and joint decision mechanisms such as the technical leads, the monthly JPIG meeting, monthly operational support group meetings and joint quarterly meetings and 6-monthly joint review missions.
In 2010 HSSP2 made special efforts to increase collaboration with other Health Partners. As a result most of its technical discussions are now organized in forums with other health partners. WHO is invited to and present at almost all JPIG meetings. This further improves harmonization in the sector but does add to the burden of frequent meetings.
Outside the HSSP2 but with participation of HSSP2, the Health Development Partners in Cambodia meet monthly to communicate on specific health sector issues, to present their project, activities, result and problems and to discuss common approaches and concrete collaboration.

The Technical Working Group Health meets monthly. It brings together MOH authorities and departments, Development partners in Health and other relevant Ministries with the aim to communicate and discuss specific health sector issues, to present plans, budgets, progress, result and problems of departments, programs and projects. TWGH is a forum for information sharing, not so much for decision making. Once a quarter the MOH provides an update on the HEF, the SDG/ SOA or the HSSP2 situation and plans during the TWGH meeting.

In the context of the MTR of the HSP2 the Health Partners have revived the technical sub groups to provide inputs and coordination of their support to the HSP2 MTR. The monthly HP meeting and the TWGH will regularly review and discuss planning, contributions, TOR, and progress of the MTR.

The Development Health Partners (AFD, GIZ, GRET, URC, WB, WHO) have also intensified their collaboration around Social Health Protection. URC has agreed in principal to take over the HEFI responsibilities of BTC for the 8 HEF schemes including the BTC HEFI staff, an important aspect for the sustainability of the HEFs.

Gender and Environmental integration

In the context of HSP2 and the national health priorities Result 1 and Result 2 pay specific attention to women and children with a strong focus on maternal health. The project's Maternal Health Vouchers do obviously target women. In 2010 women use the HEF support more than men, 58% of the persons supported are female.

The hospital and health centre quality assessments (Result 2) do look specifically at hospital hygiene and waste management aspects. They are indicators which are considered in the score for the SDG performance incentives.

4.2.3 Risks and Assumptions

From the risks identified in the TFF only the following remain and require some reflection:

- The risk that some of operational districts or provincial hospitals would not achieve minimal standards and would therefore not qualify to become SOA and receive SDGs is now nil. Because all 3 provincial hospitals and 8 operational districts have already become SOAs.
- The risk that the HSSP2 secr. could have problems to recruit the required technical assistants did materialize. Today this should however not be regarded as a risk anymore as the project has come too close to the end and the management proposes not to employ any new staff anymore unless in case of unplanned departures.
- The risk that exchange rates and inflation would diminish the budget in USD the operational currency is now very low. The present planning is now based on an USD-Euro exchange rate of 1.26 lower than the TFF one which was 1.50 and lower than the current one which is around 1.37. The financial planning does not foresee a shortfall. This was partially due to the Pooled fund taking over the funding of certain activities and the low execution rate the provinces.
- The sustainability risk can now be regarded as weak. HSSP2 pooled fund and the counterpart fund have already taken over funding responsibilities of the

SDG, the POC, the HEF direct costs and have committed to take over the HEF indirect costs at the end of the project. And in the absence of a Cambodian National Social Health Protection Agency URC has agreed to take over the HEF implementer role of BTC if so requested by the MOH.

Other Risks identified during implementation:

- In July 2010 the Council of Ministers decided to replace the previously cancelled Merit Based Payment Initiative (MBPI) by a new temporary incentive scheme called the Priority Operational Cost (POC). Several civil servants, also at central and PHD level, blame their low motivation on the low salary and absence of incentives. Low motivation of this back office staff influences project progress in all the areas but most particularly with regards to SDG monitoring and capacity building. At the end of the 2010 the administrative arrangements were not yet finalised and no POCs had been paid yet.
  POC incentives to selected PHD staff involved in contracting and monitoring might start in Q2 2011. The level of risk for further delays is moderate.
- The procurement of the new HEF Operator contracts by the HSSP2 secr. is planned to be completed by 18th February 2011 with the signing of the contracts. The planning looks realistic and the HEFI team will support the HSSP secr. and closely follow up on timely progress.
- Unplanned departure of technical assistants or HEFI financial staff would create serious problems for the functioning and the closing of the project. The risk level is moderate. The BTC Health Advisor should openly discuss individual staff plans during their appraisals.
- The risk exists that the 2011 budget execution rate in National execution will be low. This will depend mostly on the expenditure by the provincial health departments. This risk level should be regarded as moderate to high. Technical Assistants will try to follow up closely the implementation of planned activities by PHDs.

4.2.4 Quality criteria

	Score	Comments
Effectiveness	B	HEF are functioning well and have further increased utilization, all SOAs have been receiving their SDG throughout the year and managed them acceptably well resulting in increased health services utilization. Good achievements for result 1 & 2 have contributed to an increased accessibility and improved quality of services, both important aspect of the specific objective.
Efficiency	B	In the absence of a real cost-effectiveness evaluation, but with an effectiveness scored satisfactory and project expenses and unit costs lower than planned in TFF we can assume that it’s efficiency is also satisfactory.
Sustainability	A	all arrangements are in place to guarantee that funding and technical support for the health strategies supported by the project will continue after the end of the project.
Relevance	A	All project supported strategies and its activities are priorities of the 2nd National Health Strategic Plan which have a clear logic of contributing to the General Objective of the Project and the HSP2.

4.2.5 Impact

The stated positive relation between the specific objective and the general objective of the project which is similar to the goal of the MOH “*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”* remains valid. We can still

assume that better accessibility to improved quality health care does contribute positively to reduce morbidity and mortality.
This TFF did not specify indicators for the global objective. Measuring morbidity and mortality is quite complicated and can only be done by surveys or censuses, at bigger intervals and for bigger catchment areas. Comparing results of the Cambodian Demographic Health Survey of 2005 and 2010 could possibly allow to say something about the impact of the first phase of the PBHS project but certainly not of the 2nd phase.

4.2.6 Lessons learned and recommendations

Decisions	Source	Who	Time	Status
HEFO procurement changes from own management back to National Execution	4.2.3	JLCB	Q1 2011	Ongoing

Recommendation	Source	Who	Deadline
To follow up with MOH to have POC incentives paid asap and monitor the impact of POC on the commitment of the selected PHD staff	4.2.2	BTC Health Advisor through JPIG	Q2 2011
Not to recruit any new TA in 2011 unless new departures	4.2.3	BTC Health Advisor	Not applicable
To decide to implement the different evaluations an consultancies in own management rather than in National Execution to avoid major delays.	4.2.2	JLCB	Q4 2011
The steering Committee to decide whether to conduct the end of project household survey or not.		JLCB	Q1 2011

Lessons Learned	Public	Capitalisation in the Project Cycle
National Execution is not an appropriate modality for Capacity Building through Technical Assistant Teams and their logistic support	BTC HQ, BTC Representation, Health Partners, partner department	Identification and formulation
The present SWAP HSSP2 partnership allows BTC, although proportionally a small funder, to actively participate in policy discussion forums	BTC HQ, BTC Representation, Health Partners, partner department	Planning, Identification and formulation
Having the project function at both field and central level creates an opportunity to provide field experiences in the central level policy discussions.	BTC HQ, BTC Representation, Health Partners, partner department	Planning, Identification and formulation

4.3 Result 1

4.3.1 Indicators

Result: Increased access to good quality health services for the poorest population.					Progress: A
Indicators	**E**	**G**	**Baseline**	**Progress year N**	**Comments**
Number of patients (in-patients and out-patients) supported by the nine Health Equity Funds.		X	2009 Data Inpatients: 24,222 Outpatients: 31,481 Deliveries: 2,706	2010 Data IPD (2010): 26,774 Outpatients: 48,425 Deliveries: 1,953	Change IPD (2010): +11% Outpatients: + 54% Deliveries: - 28% (see below for explanations)
Uninterrupted funding for the nine Health Equity Funds, beyond December 2011			Not yet applicable	Continued funding committed by other HSSP2 partners	
Quality of health care at hospitals with a Health Equity Fund.			No organized comprehensive baseline hospital quality assessment was done although the MOH was asked several times to organize this in the context of SDG. Several individual assessment gave the following results: PRH KC (2008): 81% PRH SR (2008): 84% PRH OMC (2007): 76% RH PC (2007): 52% RH CP (2009): 52% RH CL (2009): 75% RH KR : RH STK: RH AC (2010): 74% RH AV:	In 2010 Angkor Chum RH was the only hospital where a Quality Assessment was conducted. This was their first assessment they received a 74% score.	The MOH Department of Hospital Services is responsible for organizing the Quality Assessments. Due to internal reasons very few assessments took place in 2009 and 2010.

4.3.2 Evaluation of activities

Activities	**Progress:**				**Comments** (only if the value is -)
	++	+	+/-	-	
1. Continued funding of nine Health Equity Funds in a co-financing arrangement with the Ministry of Health multi-donor funded Health Sector Support Programme (HSSP2)		X			
2. Continued management and oversight of the nine co-funded Health Equity Funds (Health Equity Fund Implementer).		X			
3. Strengthening the capacity of the three Provincial Health Departments to monitor and evaluate Health Equity Funds.				X	Counterparts at PHD not really identified. But monitoring role will continue to be assured by Central level and other HEFI organization.

4.3.3 Analysis of progress made

Relation between activities and results

Activity 1 and 2 are directly linked to access for the poor. They can however been disaggregated in multiple sub-activities which are all contributing to the increased

access and the improved quality of care. They include contracting NGOs as HEFO, financial control, following up payments by the HSSP2 secretariat, arranging monitoring, assuring the required equipment for the HEFOs, backstopping and capacity building of the HEFOs, organizing twice yearly dissemination workshops, organizing evaluations, etc.

Activity 3 does not have an immediate impact on the result at present but is a necessity with a view on long term sustainability and decentralization.

These activities do not directly contribute to the quality assessments by the MOH as these assessments have mainly been planned in the context of other instruments (SDG and SOA).

Sensitive factors

Delays with the replenishment of the pooled fund advances for the Direct Benefits have been a chronic problem mainly due to delays within the HSSP2 secretariat and also because of changing procedures which are not always well understood. So far this has mostly led to delays with the reimbursement of the hospitals not so much with reimbursements to patients for transport and food. The HEFI manager needs to follow up very frequently with the HSSP2 secr. to push the payments through.

The HEFI team was expanded with one new staff. This person assists the manager with financial control of the HEF operators. This has allowed to improve the quality of the financial controls and also to diminish the delays with the introduction of funding requests.

The abolishment of the MBPI and the delays with the POC payments have certainly contributed to the diminished involvement of the PHD staff (capacity building) and the Central level staff (hospital assessments).

One of the HEF operator NGOs, AHRDHE who is the operator in the operational districts of Chamkar Leu and Prey Chhor did mismanage funds for direct benefits (Pooled Funds) and administrative costs OD (BTC project funds). The director of the NGO had used the Pooled Fund advance and the BTC advance payment for other purposes than then HEF. This problem was only detected through a not routine evaluation by the HEFI Technical Assistant. The HEFI financial management team made an in depth control and quantified and documented the mismanagement. We continue to work with AHRDHE until the new NGO will be contracted by 1st March 2011, but under very close supervision of the HEFI financial management team and a new monitoring system. Stopping the contract would automatically have resulted in interruption of the HEF and thus limited accessibility for the poor. In the meantime and as a result of intense follow up and pressure the mismanaged amounts has been recuperated completely.

The project did have to wait long for the advice requested from L&A BTC HQ on the new procurement of the HEF operator contracts mainly with regards to the implication of a change in modality. This resulted in an important delay with the procurement.

Unexpected results

The decrease in number of deliveries supported by the HEF (maternal Health Vouchers) is partially due to

- Competition with the maternal voucher scheme from RHAC

- Delays with the replenishments by the HSSP2 secr.
- Poor implementation by the HEF operator AHRDHE in Chamkar Leu and Prey Chhor OD

“Harmo” dynamics

The Development Health Partners (AFD, GIZ, GRET, URC, WB, WHO) have further intensified their collaboration around Social health Protection. They have regular technical meetings to exchange results, problems and plans and to discuss collaboration. The BTC Health Advisor is the technical lead for this component representing JPIG in the different meetings and communications.
Often these meetings are followed by meetings of MOH and Health Partners to seek clarifications and jointly propose activities.

Once a quarter during the monthly TWGH the MOH provides an update on the HEF situation and plans for the bigger health partner community allowing for some exchanges but not really for decision making.

A consultative HEF forum with high level stakeholders (MOH, partners, MEF, Council of Administrative Reform, HP) took place in March 2010. Awaiting the approval of SHP Masterplan by the Council of Ministers the meeting did not progress on the establishment of an institutional home for HEF and CBHI coordination. Such an institutional home, possibly a semi autonomous national agency for HEF/CBHI should also take over some of the HEFI roles. As a result MOH did decide not to scale up further the HEF during the period 2010-2011. MOH hopes that the Council of Ministers decides soon on the Institutional Home but has little impact on this process. As a result PBHS will probably have to hand over its HEFI roles to URC as there is no other alternative.

In the meantime the two main HEFIs, URC and BTC collaborate very closely in the development of instruments (database, monitoring system, reporting system, etc.) and their implementation. URC has agreed in principal to take over the HEFI responsibilities of BTC for the 8 HEF schemes including the BTC HEFI staff.

The HSSP2 Pooled Fund partners, including the MOH, are committed to continue the funding of the 8 HEF after the end of the PBHS project.

Gender and Environmental integration

The HEF database does allow producing all reports disaggregated by gender. This teaches us that women use the HEF support more than men, 58% of the persons supported are female. The Maternal Health Vouchers do obviously target women.

4.3.4 Risks and Assumptions

The TFF does not identify any specific risks for this result.

Departure of HEFI TA before the end of the project remains a moderate risk which could however have a significant impact on the functioning during the last months and the closing of the project. An official agreement with URC to take over those staff would diminish this risk. I will also be important to assure an interesting challenging working environment interesting until the end possibly by involving staff in the documentation of the project experiences.

The fund mismanagement by AHRDHE is described above under unexpected results. This problem is solved and close supervision of their financial management should

prevent further mismanagement until the end of their contract on 28th February 2011.

The procurement of the new HEF Operator contracts by the HSSP2 secr. is planned to be completed by 18th February 2011 with the signing of the contracts. The planning looks realistic and the HEFI team will support the HSSP secr. and closely follow up on timely progress.

From 1st March newly contracted HEF operators will start their operator activities in an arrangement new to BTC HEFI, namely that the HEFI has no directly contracted the HEFO. The multiparty MOU will therefore have to describe clearly all responsibilities and relationship. Close follow up during the first months should allow to intervention quickly in case problems appear.

4.3.5 Quality criteria

	Score	Comments
Effectiveness	A	HEF are functioning well supporting an increasing number of poor patients.
Efficiency	B	The administrative cost continues to decrease over time. It is however necessary to follow up on the problem of unnecessary hospitalisations. This will require improving the present assessment instrument.
Sustainability	A	Most conditions to assure continuation of the HEF after the end of the project seem to be in place.

4.3.6 Budget execution

Activities for this result were mainly executed in own management. In 2010 the expenditure for this result was 185,500 Euro, 87.5 % from what was planned. There were no major problems. The difference between plan and execution is mainly due to a change of implementation mode from own-management to National Execution for 2011 effecting a advance payment.

4.3.7 Lessons learned and recommendations

Decisions	Source	Who	Time	Status
HEFO procurement changes from own management back to National Execution	4.3.4	JLCB	Q1 2011	Ongoing
Not to allow AHRDHE participate in the tender for new HEFO contracts	4.3.4	BTC Health Advisor	Q4 2010	Done
Develop an improved Hospitalisation Appropriateness Assessment Tool	4.3.5	BTC Health Advisor	Q2-Q3 2011	Open
To introduce a new HEF monitoring system harmonised with URC	4.3.3	BTC Health Advisor	Q4-2011	Done
Make concrete arrangements with MOH and URC to take over HEFI responsibilities and BTC HEFI staff	4.3.3	BTC Health Advisor	Q2-Q3 2011	Open

Recommendation	Source	Who	Deadline
To request RHAC to include transport cost for the poor in their Maternal Health Voucher scheme since the BTC Maternal Health Voucher scheme was stopped	4.3.3	MOH	Q2-2011

To make the necessary revision to the Multi Party MOU in the context of the changed contractual relationship between HEFI and HEFO	4.3.4	HSSP2 secr.	Q1-2011
To review the financial management control responsibilities of the HEFI	4.3.4	HEFI manager	Q3-2011
Advise the MOH to establish an active official Health Financing sub TWGH		BTC Health Advisor	Q2-2011

Lessons Learned	Public	Capitalisation in the Project Cycle
To make having a functioning board of directors a requirement for future HEFO NGOs	MOH, department of Planning and Health Information and HSSP2	Not applicable

4.4 Result 2

4.4.1 Indicators

Result: 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.					Progress: B
Indicators	**E**	**G**	**Baseline**	**Progress year N**	**Comments**
Number of Operational Districts and Provincial Referral Hospitals eligible to implement service delivery contracts (converted into SOA and receiving SDGs).	X		6	Not assessed	Assessments repetitively requested by HSSP2 to MOH
Number of Operational Districts and Provincial Referral Hospitals implementing service delivery contracts that are meeting service delivery targets (including quality of care targets).	X		Not assessed	Not assessed	Assessments repetitively requested by HSSP2 to MOH

4.4.2 Evaluation of activities

Activities	**Progress:**				**Commentaires** (only if the value is -)
	++	+	+/-	-	
1. Support the Ministry of Health and the Provincial Health Departments in assessing the capacity and readiness of eight Operational Districts and two Provincial Referral Hospitals to implement service delivery contracts.				X	The MOH and PHD responsibility for assessments is not well defined. Moreover they are mostly unavailable for this type of task and not motivated in the absence of MBPI and POC.
2. Transitional support to Operational Districts and Provincial Referral Hospitals that are expected to start implementation of service delivery contracts in 2009.					Only relevant in 2009
3. Intensive capacity development for Operational Districts that do not yet meet the criteria and required standards to start implementation of service delivery contracts.		X			
4. Support capacity development for Operational Districts and Provincial Referral Hospitals that have been contracted to deliver health services.		X			

4.4.3 Analysis of progress made

<u>Relation between activities and results</u>

Activity 1 did not take place because of organizational problems at MOH and PHD level. Quality and Capacity Assessments could however contribute substantially to result 2 it would allow to measure the situation, identify clearly the problems which should be the basis for improvement plans and measuring achievements.
In the second year of the consolidation phase activities 3 and 4 should be regarded has one activity as all ODs (8) and PRH (3) are now SOAs. This capacity building remains very relevant and does contribute to achieving result 2. The capacity building provided was mainly in the field of planning and budgeting, financial management, contract development, performance incentive monitoring and scoring, and Health

Information System. For those aspects of capacity building achievements should be regarded as satisfactory.
Capacity building in the field of Quality Improvement did not take place because no Quality Improvement TA could be recruited. This leaves an important gap in the capacity building required for achieving result 2.

Sensitive factors
Monitoring is regarded has a very important aspect in performance contracting which has received too little attention of the MOH and PHD. Important delays with establishment of teams, developments of tools make that only some provinces have received central level monitoring.

PHDs are reluctant to take up their responsibilities as contract commissioners and have not yet done any proper monitoring.

Many SOA managers do not take their managers role serious and provide SDG incentives equally to strong and poor performers.

The SDG manual specifies the need of yearly assessments in the context of baseline information and for measuring performance. They include quality assessment of health centers and hospitals, and management capacity assessments of OD offices and PHDs. Although requested several times by HSSP2, the MOH has not yet developed a proper plan for those assessments neither identified the departments responsible.

Absence and delays of incentives for back office staff (see previous discussions on MBPI and POC) are contributing factors for the above raised problems.

The HSSP2 secr. has not been able to recruit the required number local technical assistants needed for the capacity building. This is partially because of the market but also because of the conditions offered by the HSSP2 secr..

Unexpected results
The 2010 health service output and coverage data of most SOAs and PRH do show some important increases for several indicators, surprising given the number of problems. The number of deliveries at public health facilities, the number of hospitalisation and the number of outpatient consultation increased respectively 23%, 13% and 27%.These data are coming from the Health information System and do however still need to be validated.

"Harmo" dynamics

HSSP2 partners are the main stakeholders for SDG and SOA approaches. JPIG collaborates very intensively internally and with the MOH. The BTC Health Advisor is a technical lead alternate to the WB for this component representing JPIG in the different meetings and communications.

Once a quarter during the monthly TWGH the MOH provides an update on the SOA/SDG situation and plans for all departments and the bigger health partner community allowing for some exchanges but not really for decision making.

MOH and government intention for SDG and SOA after HSSP2 are not yet clear.

Gender and Environmental integration
The hospital and health centre quality assessments do look specifically at hospital hygiene and waste management aspects. They are indicators which are considered in the score for the SDG performance incentives.

4.4.4 Risks and Assumptions

The TFF identified already local technical assistant recruitment difficulties by the HSSP2 secr. as a possible implementation risk. Until now the secr. was only able to recruit three of the six new persons required, while five TA from the first phase did continue. Two TA did resign. As a result the capacity building team has only 6 TA form the 11 required. It leaves an important gap mainly for the quality improvement capacity building aspect. The current risk level can be regarded as high. No proper measures have been identified. The MOH will be conducting an assessment of the capacity building which should come up with recommendations. This assessment should take place during Q2 2011.

The SDG manual contains several procedures and regulations which are not relevant and/or clear. The manual needs to be revised. The MOH with support of a consultant has started the revision work. The BTC Health advisor and the capacity building team will contribute to this revision work.

The monitoring instruments for central level, PHD level and SOA internal level are not yet finalised. The MOH with support of a consultant will complete the development of these tools. The BTC Health advisor and the capacity building team will contribute to this revision work.

4.4.5 Quality criteria

	Score	Comments
Effectiveness	B	Limited by shortage of TA, the inadequate competencies of some of the TA and the limited availability of the counterparts
Efficiency	B	As a result of the above mentioned reasons
Sustainability	Not applicable	the required capacity should have been achieved at the end of the project

4.4.6 Budget execution

The activities under result 2, 3 and 4 have been planned and budgeted completely under National Execution by the HSSP2 secretariat. Because of completely different budget categories neither the budget nor the execution can be disaggregated by the TFF results.

In line with the HSSP2 Joint Partnership Agreement the BTC discrete fund financial plan in National Execution is prepared by the different implementation units of the MOH and is integrated in the Annual Operational Plan of the MOH.
Due a communication problem and delays with the approval of the MOH AOP 2010

the project team used to high an amount in the project financial plan 2010 version Q1. Together with low execution rates of the provinces this was the main reason for the low execution rate of 61%.

4.4.7 Lessons learned and recommendations

Decisions	Source	Who	Time	Status
To repeat several TA recruitment rounds in 2010	4.4.4	HSSP2 secretariat	2010	Done with limited result
To revise the SDG manual	4.4.4	MOH & consultant	Q2 2011	Ongoing
To develop and finalize the monitoring instruments	4.4.4	MOH & consultant	Q2 2011	Ongoing

Recommendation	Source	Who	Deadline
Not to recruit any new TA in 2011 unless new departures	4.4.4	BTC Health Advisor	Not applicable
Request the MOH to develop an assessment plan identifying responsible departments and required resources and do one round of all types of assessments in all SOA and PHDs in 2011	4.3.4	BTC Health Advisor through JPIG	Q4 2011

Lessons Learned	Public	Capitalisation in the Project Cycle
National Execution Mode is not adapted for Capacity building through a team of TA. This should be done either in co-management or in own management to allow the necessary flexibility and avoid limitations by procedures	BTC HQ, BTC Representation, Health Partners	Identification and formulation

4.5 Result 3

4.5.1 Indicators

Result: 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.					Progress: C
Indicators	**E**	**G**	**Baseline**	**Progress year N**	**Comments**
Number of Provincial Health Departments that successfully manage service delivery contracts.			Score KC: 60% Score SR: 70% Score OMC: 68%	Not assessed Not assessed Not assessed	Assessments repetitively requested by HSSP2 to MOH
Number of Provincial Health Departments that successfully support Operational Districts and Referral Hospitals implementing service delivery contracts.			Not available	Not measured	Measurement criteria for indicator not well defined
Number of Provincial Health Departments with staffing plans that are based on functional analysis			Not available	0	No functional analysis took place
Number of Provincial Health Departments able to critically analyse information and provide meaningful feedback to the national level on the provincial level implementation of health policy.			Not available	Not measured	Measurement criteria for indicator not defined

4.5.2 Evaluation of activities

Activities	**Progress:**				**Commentaires** (only if the value is -)
	++	+	+/-	-	
1. Transitional support to Provincial Health Department staff until the introduction of service delivery contracts and MBPIs.					Only in 2009
2. Replace current incentives for Siem Reap and Otdar Meanchey Provincial Health Departments with MBPI, conform the existing legal framework.				X	Cancelled by government and alternative POC system not yet functional
3. Support capacity development for the three Provincial Health Departments.			X		
4. Encourage and support the analysis and documentation of contracting, health financing and other initiatives at provincial level and ensure results are communicated to Ministry of Health and Health Partners at national level			X		

4.5.3 Analysis of progress made

<u>Relation between activities and results</u>

Activity 1 has become redundant and was only planned for a period of 2009.
Activity 2 is related to the MBPI incentive scheme which has been cancelled by the government and has been replaced by another temporary scheme called Priority Operational Cost (POC). In February 2011 no POC incentives have been paid yet.

This absence of incentives is an important demotivator for PHD staff and often an excuse for limited involvement.
Activity three and four could be very useful but is severely limited through the unavailability of PHD staff. Until now capacity building to PHDs was mainly limited to specific events, annual operational planning, reporting and review and contract writing.

Sensitive factors
In the current settings, no incentives and unclear framework, PHDs are reluctant to take up their responsibilities as contract commissioners. As a result they have not yet developed real SOA support teams at PHD level and they have done almost no monitoring. Their involvement in contract negotiations and follow up of logistical and financial support for SOA remains abstract.

Monitoring is regarded has a very important aspect in performance contracting which has received too little attention of the MOH and PHD. Important delays with establishment of teams, developments of tools make that only in some provinces PHDs have received central level monitoring themselves.

The HSSP2 secr. has not been able to recruit the required number of local technical assistants needed for the capacity building. This is partially because of the market but also because of the conditions offered by the HSSP2 secr..

Unexpected results
The 2010 health service output and coverage data of the three provinces do show some important increases for several indicators. These data are coming from the Health information System and do however still need to be validated.

"Harmo" dynamics
same as paragraph 4.4.3

Gender and Environmental integration
Not very relevant

4.5.4 Risks and Assumptions

The TFF identified already local technical assistant recruitment difficulties by the HSSP2 secr. as a possible implementation risk. Until now the secr. was only able to recruit three of the six new persons required, while five TA from the first phase did continue. Two TA did resign. As a result the capacity building team has only 6 TA form the 11 required. For PHD level support, the capacity building gap is mainly for contract management for the provinces of Siem Reap and Otdar Meanchey. The current risk level can be regarded as high. No proper measures have been identified. The MOH will be conducting an assessment of the capacity building which should come up with recommendations. This assessment should take place during Q2 2011. (see above for more details)

POC incentives to selected PHD staff involved in contracting and monitoring might start in Q2 2011. It is assumed that POC might positively influence PHD commitment

towards their SDG/ SOA commissioner role. This assumption will need to be evaluated once POC incentives are paid.

The monitoring instruments for central level, PHD level and SOA internal level are not yet finalised. The MOH with support of a consultant will complete the development of these tools. The BTC Health advisor and the capacity building team will contribute to this revision work.

4.5.5 Quality criteria

	Score	Comments
Effectiveness	C	Mainly as a result of the low commitment of the PHD staff and the unavailability
Efficiency	C	Efficiency is automatically low when effectiveness is low
Sustainability	Not applicable	Capacity Building should be limited in time

4.5.6 Budget execution

Same as paragraph 4.4.6

4.5.7 Lessons learned and recommendations

Decisions	Source	Who	Time	Status
In order to assure an uninterrupted continuity after the end of PBHS it was decided that POC for Siem Reap, Otdar Meanchey and Kampong Cham provinces will be paid from Pooled Fund and not from BTC discrete funds	4.5.3	BTC Health Advisor	Q2 2011	ongoing

Recommendation	Source	Who	Deadline
To request MOH to increase the frequency and improve the quality of the PHD monitoring by the MOH central level	4.5.3	BTC Health Advisor through JPIG	Q2-2011
To request the MOH to develop an assessment plan identifying responsible departments and required resources and do one round of all types of assessments in all SOA and PHDs in 2011	4.5.4	BTC Health Advisor through JPIG	Q4 2011
To follow up with MOH to have POC incentives paid asap and monitor the impact of POC on the commitment of the selected PHD staff	4.5.3	BTC Health Advisor through JPIG	Q2 2011
Not to recruit any new TA in 2011 unless new departures	4.5.4	BTC Health Advisor	Not applicable

Lessons Learned	Public	Capitalisation in the Project Cycle
Need for a performance incentive system to improve remuneration of back office staff involved in monitoring, contracting and other specific intensive task	BTC HQ, BTC representation, Development Partners, MOH	Identification, Formulation

4.6 Result 4

4.6.1 Indicators

Result: Evidence based policy making through systematic and sustainable documentation and analysis of relevant information at various levels.					Progress: D
Indicators	**E**	**G**	**Baseline**	**Progress year N**	**Comments**
Evidence of results of data analysis at provincial and national level made available to the policy level in a systematic manner.			Not available	Not assessed	Activity not yet started and proposal to revise approach
Functioning thematic groups at provincial and national level, in particular concerning health financing and contracting and including all stakeholders.			Not available	Not assessed	Activity not yet started and proposal to revise approach

4.6.2 Evaluation of activities

Activities	**Progress:**				**Commentaires** (only if the value is -)
	++	+	+/-	-	
1. Support the Ministry of Health in the analysis of data and information that is routinely collected and readily available.				X	Not yet started
2. Support the Ministry of Health in identifying additional data needs and in formulating appropriate ways to gather this data.				X	Not yet started
3. Ensure that relevant information is properly documented and is communicated to policy makers and the health partners.				X	Not yet started

4.6.3 Analysis of progress made

Relation between activities and results
Relevant but activities have not started

Sensitive factors
Decision makers have limited time to consult with the technical level.

The DPHI team has to little extra capacity to follow up on Evidence Based policy making as a specific issue.

Unexpected results
The back stopping mission recommends focusing this result towards documenting the experiences of the project. This should be done in the wider context of the HSSP2 midterm review (MTR) and the HSP2 MTR. The project will support some specific studies in the field of health financing which will contribute to the revision of the MOH Health Financing Strategies.

"Harmo" dynamics
In the context of the MTR of the HSP2 the Health Partners have revived the technical

sub groups to provide inputs and coordination of their support tot the HSP2 MTR. The monthly HP meeting and the Technical Working Group Health will regularly review and discuss planning, contributions, TOR, and progress of the MTR.

Gender and Environmental integration

The HSP2 MTR will pay extra attention to gender in the different components and will also have a specific evaluation which will look at gender in the MOH and the health sector.

4.6.4 Risks and Assumptions

Several consultancy contracts need to be procured. The quality of the evaluation and the policy advice will depend on the timely availability and the correct selection of competent and experienced consultants.

4.6.5 Quality criteria

	Score	**Comments**
Effectiveness	Not applicable	Not yet started
Efficiency	Not applicable	Not yet started
Sustainability	Not applicable	Not yet started

4.6.6 Budget execution

Same as paragraph 4.4.6

4.6.7 Lessons learned and recommendations

Decisions	Source	Who	Time	Status
None				

Recommendation	Source	Who	Deadline
To focus on the documentation of project experiences and support some specific evaluation and consultancies in the field of Social Health protection and Health Financing	4.6.3	BTC Health Advisor	Q4 2011
To decide to implement the different evaluations an consultancies in own management rather than in National Execution to avoid major delays.	4.6.3	JLCB	Q4 2011
The steering Committee to decide whether to conduct the end of project household survey or not.		JLCB	not applicable

Lessons Learned	Public	Capitalisation in the Project Cycle
None		

5 Beneficiaries

1) The population utilizing the health facilities of the three supported provinces supported by the project, they are the population of the 8 focal districts (±1,6 Million persons) as well as the population of the neighboring districts and provinces utilizing those health facilities.
   In line with the Cambodian Decentralization & Deconcentration agenda provincial, district and commune councils district have been established. They are responsible to follow up and influence results and development of the public health sector and other sectors. This is a very new process which still needs a lot of strengthening. In the future this approach should allow the communities to participate in the decision making process. At health center level health center management committees allow the communities to have a say in the management of the Health center, at least in theory. In reality these committees function more as communication/information tools than as a decision making tools. At present provincial and district hospitals do not have boards enabling the communities to follow up on their results and use of resources and to participate in their management decision.
   From the Health Information System we learned that during 2010 hospitals and health centers assured 54,825 hospitalizations which represents a 13% increase in comparison with 2009; 1,378,503 outpatient consultations (27% increase); and 27,399 deliveries (23% increase). These are major increases which show clearly an increased uptake of public health services by the target population. Most probably this does somehow reflect improved accessibility and satisfaction with those services. Our project did not organize any specific promotion activities for the hospitals or health centers.

2) In 2010 in PBHS2 supported areas there were 506,174 Pre-Identified persons (64,966 Households) who were eligible for HEF support in case of sickness or for preventive care at hospitals and health centers. The Pre-Identified Households have an Equity Access Card which entitles them to certain services for the poor, including health. The Pre-Identification, the distribution of the EAC cards and the EAC cards themselves serve as important opportunities for promotion of hospital and health center services although often this opportunity is not used to its full potential. After 2 years some cards were not yet distributed. An important proportion of the poor and very poor was missed by the Pre-Identification exercises by the Ministry of Planning which took place in 2008-2009. They still could receive support by the HEFs if found eligible through a Post Identification process at the hospital when requiring services.
   In 2010 the MOP started a new round of Pre-Identification covering rural areas of all provinces. In Siem Reap Province the new Pre-Identification has been completed. Otdar Meanchey and Kampong Cham provinces will be covered in 2011. This will allow having a valid dataset at the moment of handing over HEFI responsibilities at the end of the project.
   Twice yearly HEF consultative workshops are conducted at operational district level. During these meetings local authorities, village health volunteers, district health authorities and the HEF operator meet to look at progress, problems and discuss proposals and solutions. The poor households themselves have

however only limited direct representation in these HEF workshops.
During and after hospitalization the HEF operators follow up on the problems of the patients with regards to Hospital services and HEF. The HEF operator does feedback possible complaints to the hospital management and also monitors that corrective action is taken. Since the end of 2010 this system has been strengthened by independent monitors who interview monthly a sample of HEF patients at their homes after having received care and support.
The HEF operator are responsible for the promotion activities in the villages, this is mainly done through meetings held at health center level.
An important share of the above mentioned increase of utilization of the health facilities was due to an increased utilization by HEF beneficiaries. A total of 77,152 poor persons did receive HEF support during 2010 an increase of 32% over 2009, they include 26,744 hospitalizations (11% increase), 48,425.outpatient consultations (54% increase). These are major increases which show clearly an increased uptake of public health services by the lowest socio-economic quintiles of the population. Most probably this does somehow reflect improved accessibility and satisfaction with those services.

3) The number of Public Health staff in the PBHS supported areas, the three Provincial Health Departments, eight Operational District Offices, 11 Referral Hospitals (including the three Provincial Referral Hospitals) and 138 health centers totals 1,543 persons. Most of these staff and especially those of the operational district level and the provincial hospitals benefited from PBHS2 capacity building support and HSSP2 Pooled Fund SDGs incentives and extra userfee income from the HEF. Since April 2009 the PHD staff did not receive project or merit based payment incentives. Although the POC decree was officialised in July 2010 no POC incentives were paid during the year. This absence of incentives seems to be one of the major causes of the low performance of back office staff. The Annual Operational Planning is a bottom up process which allows HC, hospital and back office staff to participate in the planning of activities for the next year. This process needs to be strengthened certainly at the lower levels. Consultative workshops are organized to enable participation of field level staff in the policy making process. Cultural context and hierarchical relationship do however often limit active participation certainly during public forums.

4) As partner of HSSP2, BTC-PBHS project is an active member of several health policy/strategy/planning and budget discussion platforms and forums. The PBHS field experience contributes to assure that policy advice considers the field reality and that it is more field oriented. In 2010 our inputs contributed to annual operational budget and planning as well as strategic decisions with regards to POC, SDG, monitoring of services and HEF and other Social Health Protection activities. Those decisions did influence quality of services and utilization in the whole of Cambodia.

6 Follow-up of the decisions taken by the JLCB

The only strategical decision taken by the JLCB in 2010 was to reverse the implementation modality for the HEF operator contracts for 2011 from Direct Management back to National Execution. This was done in the context of a now strengthened procurement unit of the HSSP2 Secretariat which does assure more timely procurement. It was also done with the objective of increased harmonization. Another major advantage of having HEFO contracts procured by the HSSP2 secretariat, based on the Standard Operating Procedures, is that it will facilitate the transfer of those contracts to HSSP2 Pooled Funding after the end of the PBHS2 project. This change will contribute to an uninterrupted continuation of the functioning of the HEF.
This decision was followed upon and implemented although with some minor delays. The new HEF are expected to be signed on 18th of February 2011.

7 Annexes

7.1 Logical framework

No changes since TFF, see original

7.2 M&E activities

7.2.1 2010 SEMI ANNUAL PERFORMANCE MONITORING REPORT

7.2.2 2010 ANNUAL PERFORMANCE MONITORING REPORT

Will be provided when available (expected in May 2011)

7.2.3 HSSP2 AUDIT REPORTS

7.2.4 JPIG Retreat report

7.2.5 Maternal Health Voucher Evaluation Report

7.2.6 Backstopping Mission Dr. Karel Gyselinck

7.2.7 Belgian audit

7.3 “Budget versus current (y – m)” Report

7.4 Operational planning Q1-2011