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Report Number: ICRR0024137

1. Project Data

Project ID	Project Name	
P157291	Health Equity and Quality Improvement	
Country	**Practice Area(Lead)**	
Cambodia	Health, Nutrition & Population	
L/C/TF Number(s)	**Closing Date (Original)**	**Total Project Cost (USD)**
IDA-58130,IDA-67720,TF-A2562,TF-A3114,TF-A9492	30-Jun-2021	98,973,405.67
Bank Approval Date	**Closing Date (Actual)**	
19-May-2016	31-May-2023	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	81,000,000.00	57,000,000.00
Revised Commitment	99,637,726.85	55,587,876.72
Actual	99,212,024.49	55,587,876.72

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Project Objectives and Components

a. Objectives

According to the Financing Agreement (p. 5), the project's objective was “to improve access to quality health services for targeted population groups with protection against impoverishment due to the cost of health services in the Kingdom of Cambodia." At an additional financing (AF) in 2018, an objective was added, such that the objectives were "to improve access to quality health services for the targeted population groups, with protection against impoverishment due to the cost of health services in the Kingdom of Cambodia, and to provide immediate and effective response in case of an eligible crisis or emergency" (Project Paper, October

10, 2018, p. 15). As the added objective, reflecting a contingency emergency response component (CERC) that was eventually triggered, represented an expansion of the project's scope, it does not warrant the use of a split rating methodology for purposes of this Review.

However, as one outcome target was revised downward at a 2022 restructuring, a split rating will be performed for the objective relevant to that indicator. At that time of that restructuring, US$90.46 million, or 91.2 percent of total Bank financing, had been disbursed.

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

Yes

Date of Board Approval

21-Jun-2022

c. Will a split evaluation be undertaken?

Yes

d. Components

The project was approved with four components:

1. **Strengthening Health Service Delivery** (appraisal: US$74.2 million; actual: US$120.1 million) was to expand existing service delivery grants (SDGs, supplementary payments made to service providers in underperforming locations for achievement of annual performance targets) into a mechanism for providing performance-based financing to various levels of the Cambodian primary and secondary health system based on achievement of results. The project was to provide SDGs to outpatient health centers to help finance minimum packages of activities, with the amount of the grants based on quantity and quality of services provided, including utilization by the poor and vulnerable. It was also to provide SDGs to hospitals, with amounts determined quarterly based on structural measures (infrastructure, staff, financing, equipment), process measures (technical and interpersonal processes and actions, as reflected in transactions between patients, providers, and staff), and patients' health outcomes. Finally, it was to provide SDGs to operational districts (ODs) and provincial health departments (PHDs), with payments based on their key supervisory processes and health system outputs, including timely completion of quality checklists for health facilities in their jurisdiction, contribution to capacity-building activities for in-service and pre-service training, drug stock-outs in health facilities, health management information system (HMIS) reports submitted, and quarterly review meetings and system functionality. For all recipients of SDGs, verification of performance was to be performed by an independent payment certification agency.

At a restructuring in 2018, US$6 million in AF was provided under this component to support delivery of services for long-term family planning, hypertension and diabetes screening and treatment, and cervical cancer screening and treatment

2. **Improving Financial Protection and Equit**y (appraisal: US$70 million; actual: US$97.0 million) was to support and expand the existing health equity fund (HEF) system, in which a third-party payer purchases

health care for the identified poor from a public health care provider, with claims verified by an international agency. Prior to the project, HEFs had successfully reduced catastrophic spending, increased use of health services by the poor, and provided a reliable source of financing to health facilities. This component aimed to finance an agreed share of the direct benefit costs of HEFs, while providing incentives for the transfer of verification functions to a national verification agency and for strengthening of Health Equity Fund Promoters (HEFPs), patient advocates who would raise awareness and promote HEF utilization (as recent studies had shown that lack of understanding of how HEFs work was one of the main barriers to utilization).

3. **Ensuring Sustainable and Responsive Health System**s (appraisal: US$30 million; actual: US$37.3 million) was to support activities to improve supply-side readiness and strengthen the institutions that would be implementing project activities. These activities were to include implementation of comprehensive pre-service and in-service training programs for health workers, equipping of health facilities to meet minimum standards for the provision of obstetric and neonatal care, carrying out of enhanced health service quality monitoring, improved timeliness of SDG and HEF payments, and establishment of sustainable health service purchasing arrangements. Financing for these activities was to be provided based on results tracked by six disbursement-linked indicators (DLIs). This component was also to finance civil works according to priorities established by the Ministry of Health (MOH) in its 2016-2020 civil works plan, prioritizing access issues, attention to remote areas, concerns around patient safety, and improvement of maternal and neonatal survival. Finally, the component was to support day-to-day project coordination, administration, procurement, financial management (FM), environmental and social safeguards management, and monitoring and evaluation (M&E), all of which was managed by responsible departments of the MOH. A technical assistance grant from the Japan Policy and Human Resources Development (PHRD) Trust Fund, administered by the Bank, was to provide complementary financing under this component for strengthening M&E.

4. **Contingent Emergency Response component (CERC)** (appraisal: US$0; actual: US$13.8 million) was to allow for the realization of financing, in accordance with the International Development Association (IDA) Immediate Response Mechanism (IRM), to provide an immediate response to an eligible crisis or emergency, as needed.

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Cost and financing: The project was initially financed by a US$30 million IDA Credit and a US$50 million Bank-administered multi-donor trust fund (MDTF) financed by Australia, Germany, and South Korea, proportionally co-financing the project's first three components. The Japan PHRD Trust Fund in the amount of US$1 million supported M&E strengthening under the third component. The government was to provide US$92.4 million, bringing total planned financing to US$174.2 million. The CERC, if triggered, was to be financed entirely by IDA under the IDA IRM.

There were two AFs: US$6 million at a 2018 restructuring, to expand service delivery for long-term family planning, hypertension and diabetes screening and treatment, and cervical cancer screening and treatment; and US$14 million at an August 2020 restructuring to fill financing gaps caused by the COVID-19 pandemic, including the activation of the CERC on March 27, 2020, bringing total planned Bank/MDTF financing to US$101 million and total planned project financing to US$196.2 million.

The actual Bank contribution was US$99.21 million, and the actual government contribution was US$170.12 million, bringing total actual project costs/financing to US$269.33 million. Exchange rate fluctuations accounted for the difference between planned and actual Bank financing.

Borrower contribution: The Borrower contributed US$170.12 million, significantly exceeding the originally planned US$94.2 million.

Dates: The project was approved on May 19, 2016, became effective on September 15, 2016, underwent a mid-term review in May of 2019, and closed on May 31, 2023, almost two years later than its originally planned closing on June 30, 2021. It was restructured six times:

- October 2018: AF of US$6 million, adjustment of some intermediate results indicators, and introduction of three new DLIs.
- June 2019: Reallocation of funds among expenditure categories.
- June 2020: Extension of the PHRF Grant closing date from June 30, 2020, to June 30, 2021.
- September 2020: AF of US$14 million to reflect activation of the CERC, reallocation of some funds among components, adjustment of some intermediate results indicators, and extension of the IDA Credit's closing date from June 30, 2021, to June 30, 2022.
- June 2021: Extension of the MDTF Grant closing date from June 20, 2021, to June 30, 2022.
- June 2022: Downward revision of the target for one outcome indicator, revision of targets for some intermediate results indicator and DLI targets, and extension of the IDA Credit and MDTF Grant closing dates from June 20, 2022, to May 31, 2023.

3. Relevance of Objectives

Rationale

The objectives were highly relevant to country context. Cambodia had made steady and significant progress in health outcomes over the decade prior to project appraisal. Maternal mortality, under-five mortality, and the total fertility date dropped significantly from 2005 to 2014. Despite these gains, however, inequities in health outcomes persisted by socioeconomic status, geographic areas, and urban versus rural populations. Non-communicable diseases were a growing burden due to an aging population and lifestyle challenges. Public financing for health had increased steadily since 2008, but it still accounted for only 20 percent of health expenditure. Out-of-pocket (OOP) payments were an important source of debt and impoverishment for the poor. Heath sector reforms inaugurated in the 1990s had improved physical infrastructure, implemented innovations in health financing and access to services, and decentralized some aspects of health management and administration to the district level. HEFs and SDGs had expanded, with tangible benefits in coverage of the poor and service quality. However, shortcomings remained. There were design, management, and implementation bottlenecks that prevented full utilization of the HEF scheme, the quality of health services was suboptimal, and recent Bank studies had found that beneficiaries were still incurring high OOP payments because of the perceived poor quality of care in some public facilities, even when those beneficiaries were covered by an HEF. Cambodia also faced major challenges with the skills

and competencies of its health workforce, and the absence of a well-coordinated M&E mechanism hampered effective monitoring of health sector performance and evidence-based decision making.

The objectives were also highly relevant to government strategy. Cambodia's Health Strategic Plan (HSP-3, 2016-2020), which was in draft form at the time of project preparation, contained priorities to increase equitable access to effective and efficient health services and reduce impacts on human health due to major public health concerns. The country's broader development agenda, expressed in the National Strategic Development Plan (NSDP, 2014-2018) and Rectangular Strategy 3, called for "expanded coverage, strengthened quality, and increased affordability of health care services." The project remained relevant to HSP-4 (2012-2030) which challenges the health sector to use resources more effectively and efficiently and to accelerate progress toward universal health coverage, and to the key priority of the NSDP for 2019-2023 to "enhance public health and nutrition of the people to support sustainable human resource development, economic growth, and social development."

This project built logically on the previous Bank-financed Second Health Sector Support Program (P102284, US$124.03 million, 2008-2016), which had supported the government's 2008-2015 health strategic plan, especially by co-financing refinement and scaleup of HEFs and SDGs. Health was identified by stakeholders as one of the top development priorities during consultations to inform the Bank's Cambodia Country Engagement Note (FY2016-17), which was under preparation at the time of this project's appraisal. Social health protection for the poor and other vulnerable groups emerged as a key theme in those discussions. The project's objectives were directly aligned with the Country Partnership Framework in place during most of the project's implementation period and at closing (FY19-24), which contained a focus area to foster human development and an objective to expand access to quality health services. That objective focused on improvements in health centers and hospitals, increased utilization of health services (particularly for the disadvantaged), and reduction of household health spending. The project retained relevance throughout implementation by triggering the CERC, enabling it to finance priority equipment to respond to health care challenges posed by the COVID-19 pandemic.

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Improve access to health services for targeted population groups (original outcome target)

Rationale

The theory of change for this objective held that financing construction of health facilities, coupled with support for expansion of the health equity funds, would provide more people in poor, remote, and difficult-to-access communities with financial coverage for health care, enabling access to care. (According to the ICR, pp. 7 and 19, the poor were defined by the Ministry of Planning through surveys conducted with the

Department of Local Administration of the Ministry of the Interior. Persons with disabilities were also covered as defined by law. This pre-identification of household eligibility occurs every three years, subject to random verification by an individual's community.) Critically, the theory of change for this objective was intertwined with that for the second (quality) objective, as demand-side factors were key in the Cambodian context; people needed to be convinced that the public health care financed by HEFs was of sufficient quality to be worth accessing. Improvements in quality would result from improved accountability and efficiency of health spending at all levels, incentivized by the SDGs, and through project-supported training of medical personnel and improvements in the quality of that training at the university level. Critical assumptions included that: (a) SDGs would be used effectively, and quality performance would monitored regularly to ensure quality improvements; (b) payments under the HEF and SDGs would be timely; (c) eligible beneficiaries would be aware of the HEF, how to secure eligibility, and improvements in access to and quality of health facilities; (d) the institutional structures and accountability needed to implement the performance-based grant scheme and monitor quality improvements would remain in place.

Outputs and intermediate outcomes

The project financed the construction of 45 health centers, 15 maternity and obstetric wards, and two provincial referral hospitals in remote, difficult-to-access areas. It equipped an additional ten hospitals to meet comprehensive standards for emergency obstetric and neonatal care.

Coverage of the HEF increased from 9.4 percent of the population in 2014 to 12.4 percent in 2021 (ICR, p. 15). The institutional mechanisms for the HEF were strengthened, as HEF claim verification was transferred to an independent, country-owned claim verification agency established in 2019. Health care providers receiving HEF funds were granted more autonomy over their use, so that individual health centers could address their own specific long-standing and ongoing needs.

51 new ODs were enabled to provide cervical cancer screening and treatment services, and 15 new ODs were enabled to provide hypertension and diabetes screening and treatment services.

The number of outpatient department consultations (new cases) per person per year remained essentially constant, at 0.59 in 2015 and 0.60 in 2023, not reaching the original target of 0.95 but meeting the revised target of 0.60.

24 ODs reported an increase of over 10 percent in current long-term family planning service users over the preceding 12 months, exceeding the target of 20 ODs (DLI 9).

The number of women screened for cervical cancer with visual inspection with acetic acid (VIA), a simple, inexpensive, and safe method recommended for use in resource-limited settings, increased from 37,267 women in 2018 to 123,990 women in 2023, almost reaching the original target of 130,000 women and exceeding the revised target of 73,000 women.

100 percent of health centers, hospitals, and ODs/PHDs received HEF and SDG payments within specified timelines, exceeding the target of 80 percent (DLI 6).

11.741 million people received essential health, nutrition, and population services, exceeding the target of 7.992 million people. Of these, 0.969 million were women, exceeding the target of 0.497 million women. 1.97

million children were immunized, exceeding the target of 1.01 million children. 8.08 million women and children received basic nutrition services, exceeding the target of 5.92 million women and children. 1.70 million deliveries were attended by skilled health personnel, exceeding the target of 0.998 million deliveries.

Outcomes

The number of outpatient services (episodes) covered by HEF increased from 2.474 million in 2018 to 2.871 million in 2023, achieving about two-thirds of intended progress toward the original target of 3.1 million services.

Rating
Modest

OBJECTIVE 1 REVISION 1

Revised Objective
Improve access to health services for targeted population groups (revised outcome target)

Revised Rationale
The target was revised downward in 2022 in response to the COVID-19 pandemic. The number of outpatient services (episodes) covered by HEF increased from 2.474 million in 2018 to 2.871 million in 2023, exceeding the revised target of 2.85 million services. The project's impact evaluation (summarized in the ICR, Annex 10) reported that outpatient utilization in public health facilities was six percent higher in project-supported ODs than in control districts, though the ICR did not indicate whether this difference was statistically significant.

Revised Rating
Substantial

OBJECTIVE 2

Objective
Improve access to quality health services for targeted population groups

Rationale
As noted above, the theory of change for this objective was closely related to that for the first objective, as investment in quality of health service delivery (supply side) was expected to produce an increase in the demand for those services. Quality refers to infrastructure, managerial capacity, and clinical competency achieved at PHDs and ODs, hospitals, and health centers, as measured by National Quality Enhancement Monitoring Tools. For PHD and OD offices, performance was measured against activities comprising key supervisory and coaching processes and health system outputs. Hospitals and health centers' quality performance was measured against a Balance Scorecard comprising structural quality, process, and outcomes. Investments in pre-service training programs for medical and nursing professionals (DLI 1), in-

service training programs (DLI 2), full equipping of CPA-2 hospitals* to provide emergency obstetric care and neonatal care (DLI 3), enhancement of health service quality monitoring by MOH (DLI 4), carrying out of HEF purchasing arrangements by a payment certification agency (DLI 5), improved timeliness of HEF and SDG payments (DLI 6), support for ODs to provide quality cervical cancer screening and treatment services (DLI 7), support for ODs to provide quality hypertension and diabetes screening and treatment services (DLI 8), and support for ODs to provide quality long-term family planning services (DLI 9) were explicitly intended to support improvements in quality of services.

*Cambodian referral hospitals are rated CPA-1, CPA-2, or CPA-3, referring to the level of comprehensive package of activities they are able to provide. A CPA-1 hospital performs no major surgeries but can provide basic obstetric services. A CPA-2 hospital can deliver emergency care and major surgeries. A CPA-3 hospital is larger than a CPA-2 facility and provides a wider range of more highly specialized services.

Outputs and intermediate outcomes

SDGs were expanded to include not only ODs and referral hospitals but also PHDs and health centers, increasing fund flows to the subnational implementation level. A performance-based element was introduced in SDGs to reward health facilities for quality performance on predefined criteria through a set of standardized, independently verified supervision checklists. Additional funding was therefore provided to health facilities based directly on their quality performance scores, assessed quarterly by the MOH Quality Assurance Office. Between May 2017 and March 2022, 18 rounds of quality assessments were rolled out in three phases, covering 1,253 health centers, 94 referral hospitals, and provincial referral hospitals.

100 percent of health center, CPA-1, CPA-2, and CPA-3 facilities received payments based on performance including quality scores within 90 days from the end of each quarter, exceeding the target of 70 percent of facilities receiving payment within 90 days.

The variance in score on health center quality assessments measuring improvement in patient satisfaction as one part of quality declined from 53 percentage points in 2015 to 38.34 percentage points in 2022, exceeding the target of reduction to a variance of 43 percentage points.

98.3 percent of CPA-1, CPA-2, and CPA-3 facilities had a 60 percent or higher quality score on their last quality assessment, exceeding the target of 50 percent of facilities.

25 University of Health Sciences courses adopted competency-based curricula employing trained faculty and using skills laboratories, meeting the target of 25 courses (DLI 1). 74 faculty were trained on how to use the integrated skills laboratories, exceeding the target of 69 faculty. 996 medical and nursing students were trained based on the new curriculum, exceeding the target of 875 students.

The percentage of health centers with functioning health center management committees increased from 64 percent in 2017 to 87.8 percent in 2023, exceeding the target of 80 percent.

Outcomes

The number of health centers achieving a score of 60 percent on a quality assessment of health facilities increased from 49 in 2018 to 1,181 in 2023, far exceeding the target of 700 health centers. Overall, between the first and last rounds of assessment, the average scores on quality assessments increased from 45 percent to 81 percent for health centers, from 27 percent to 80 percent for referral hospitals, and from 29 percent to 86 percent for provincial referral hospitals. The project's impact evaluation noted that the SDGs improved health service quality through provision of necessary supplies, investments in repairs and maintenance, improved monitoring and supervision, and increased motivation and morale among health care workers and administrators.

Rating
High

OBJECTIVE 3

Objective
Protect against impoverishment due to the cost of health services

Rationale
The theory of change for this objective held that increased utilization of health services by HEF beneficiaries, who were, by definition, members of poor, remote, and difficult-to-access communities, would reduce OOP expenditures as a percentage of health expenditure and reduce the share of households experiencing impoverishment from health spending.

The outputs and intermediate outcomes for this objective are reflected under objectives 1 and 2, above.

Outcomes

The percentage of households that experience impoverishing health spending during the previous year decreased from 1.29 percent in 2015 to 0.74 percent in 2023, almost achieving the target of 0.70 percent.

According to MOH data, OOP health expenditure as a percentage of total health expenditure declined from 62.3 percent in 2015 to 60.4 percent in 2023, not reaching the target of a reduction to 55 percent. However, the ICR (p. 15) reported on World Health Organization data (Global Health Expenditure database) indicating that OOP as a share of current health expenditure reached 54.9 percent in 2021 (the latest year available), reaching the project target. A 2023 report, "Analysis of Financial Risk Protection in Cambodia's Health System using Cambodia Socioeconomic Survey Data 2009-2021," found that the decline from 2019 through 2021 in catastrophic health expenditure was higher for the poor (covered by HEF) than the non-poor, with a decline of 6.6 percentage points for HEF beneficiaries and 4.8 percentage points for non-HEF cardholders. Similarly, that study found that OOP for health care decrease by 37 percent for HEF beneficiaries between 2014 and 2021, but only by 7 percent for non-beneficiaries.

The project's impact evaluation (summarized in the ICR, Annex 10) found evidence of the project's specific impact on financial protection for households. Household impoverishment due to health care spending was 3.4 percentage points lower (statistically significant) in project-supported ODs than in other areas. Similarly,

the impact evaluation found that OOP health expenditures, while still high, were overall lower for households in project-supported ODs. The impact evaluation attributed these results to high knowledge of HEF benefits in project ODs relative to control districts.

Rating
Substantial

OBJECTIVE 4

Objective
Provide immediate and effective response in case of an eligible crisis or emergency

Rationale
The theory of change for this output-oriented objective is straightforward: in the event of an eligible emergency, the project would respond. That was the case when the CERC was activated in response to the COVID-19 emergency. The project upgraded, renovated, and equipped Cambodia's national reference laboratory to achieve a biosafety level 2+, it equipped and upgraded two regional laboratories, and it trained staff. It also financed the purchase of equipment to treat COVID-19 patients, including 80 ambulances, 110 ventilators, 31 mobile x-ray machines, 370 patient monitors, laboratory reagents, COVID-19 test kids, and other equipment and consumables for laboratories.

The number of hospitals equipped with ventilators for treatment of severe COVID-19 cases increased from 2 hospitals in 2020 to 30 hospitals in 2022, exceeding the target of 27 hospitals.

Rating
Substantial

OVERALL EFFICACY

Rationale
Under the original outcome targets, achievement of the general access objective is rated Modest, and achievement of the quality objective is rated High. The emergency response objective was Substantially achieved. Overall efficacy under the original outcome targets is therefore rated Substantial.

Overall Efficacy Rating

Substantial

OVERALL EFFICACY REVISION 1

Overall Efficacy Revision 1 Rationale

Under the revised outcome targets, achievement of the general access objective is rated Substantial, and achievement of the quality objective is rated High. The emergency response objective was Substantially achieved. Overall efficacy under the revised outcome targets is therefore rated Substantial.

Overall Efficacy Revision 1 Rating

Substantial

5. Efficiency

The PAD (Annex 6) stated that investments under the project would improve efficiency, equity, and financial protection and that the project was therefore economically and financially justified. It presented an exhaustive economic analysis, describing in detail the numerous positive health and economic impacts of improved health care quality and health system strengthening. The return on these investments was not quantified, however. The ex-ante analysis used the expected increase in utilization of the public health facilities and the associated decrease in OOP expenditures to find a large net present value. The underlying assumptions were (a) a robust expansion of the HEF base and public health care utilization, and (b) a moderate increase in the unit cost of the public health facilities. The analysis found that the shift from the private to the public health facilities would reduce OOP expenditures by a larger amount than the cost to be incurred by the public sector. The gain was estimated at US$739 million over the five years of the project. As the project cost was US$174 million (including US$94.5 million from the government), this implied an expected rate of return of 33 percent.

The PAD (p. 17) also stated that the project would help tackle inefficiencies by introducing financial incentives to increase utilization of essential interventions (interventions such as immunization, family planning, and nutrition interventions that have high benefit-cost ratios and large positive externalities) and improve quality of health services; by simplifying implementation arrangements of HEFs and SDG and reducing their administrative costs; and by strengthening public financial management. In addition, by improving and further promoting HEFs, by reducing geographical inequities in access to services, by improving technical and perceived quality of care in public facilities, and by expanding eligibility of HEFs to other vulnerable groups, the project was envisioned to encourage more poor, disadvantaged, and vulnerable groups to use free services provided by government health facilities. In addition to improving health outcomes and addressing inequities in health service utilization, this was estimated to reduce total OOP spending of these population groups by up to US$739 million.

The ICR rightly noticed that an expected massive switch to the public sector for HEF beneficiaries did not materialize. The utilization of public health care did, indeed, decline overall (from 23.5 to 15.3 percent, a relative decline of 35 percent). However, this decline was concentrated among the population not covered by the HEF (–40.7 percent). HEF beneficiaries also reduced their relative utilization of public health services, but significantly less than among non-HEF beneficiaries (–22.1 percent). However, the savings in OOP expenditures were substantial, as the ICR's analysis found a rate of return of this project of 10.96 percent. The ICR noted that this economic analysis excluded positive externalities of the project, such as improved productivity of health workers, greater availability of the population for productive tasks, and financial stability that reduces medical indebtedness.

The ICR (p. 17) also pointed to important elements of implementation efficiency, including project administration through regular government structures, reducing the need for a separate and potentially costly project implementation unit. However, there were also sources of moderate implementation inefficiency. For example, as noted in the ICR (p. 22), despite assurances from the government, there was a gap in continuity of HEF benefit payments between the closing of HSSP-2 and this project's effectiveness. That gap led to lack of availability of medical and non-medical allowances, resulting in a temporary but significant drop in the number of HEF patients and an increase in exemptions as well as user fees. In addition, there were delays in the construction of the two provincial referral hospitals financed by the project and contractual issues that led to extensions in the project's closing date (ICR, p. 23). These issues were mainly due to delays in recruiting a firm to carry out hospital design, which meant that designs and drawings were not available until early 2020; subsequently, pandemic-related restrictions delayed hospital construction. Procurement was also rated unsatisfactory for a brief period in 2018 due to slow progress in procurement, high turnover of procurement staff, and delays in assigning new staff (ICR, p. 25; see also Section 10b).

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal	✓	33.00	100.00 ☐ Not Applicable
ICR Estimate	✓	10.96	100.00 ☐ Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

With High relevance, Substantial efficacy, and Substantial efficiency, Outcome under the original outcome targets is rated Satisfactory. IEG notes that the modest rating for the access objective could result in an Outcome rating of Moderately Satisfactory under the original outcome targets, but that two-thirds achievement of intended progress on the primary outcome indicator (under the original targets) is considered here as an overall minor rather than moderate shortcoming, leading to a fully Satisfactory Outcome rating.

With High relevance, solidly Substantial efficacy, and Substantial efficiency under the revised outcome targets, Outcome under the revised outcome targets is also rated Satisfactory.

Overall Outcome is therefore rated Satisfactory, indicating that there were minor shortcomings in the project's preparation, implementation, and achievement.

a. Outcome Rating

Satisfactory

7. Risk to Development Outcome

The risk to achieved outcomes is minimal, thanks largely to the transfer of functions previously executed by an external party to government structures (ICR, p. 18). Complemented by technical assistance provided by trust funds and the Bank's implementation support, this implementation model helped to build domestic capacity for project implementation and information systems management and to create a strong culture of M&E. This was the first Bank-financed project in Cambodia to be implemented without a stand-alone project implementation unit. In addition, the Payment Certification Agency (PCA, an autonomous public administrative entity), was established in 2017 as an independent HEF claim verification agency. The PCA has the mandate to independently verify the benefits provided to the HEF beneficiaries. This function was previously carried out by an external non-governmental organization. Furthermore, management of HEF implementation has been successfully transferred from Health Equity Fund Operators to hospitals and health centers, with OD and PHD support. Finally, sustainability was supported by the design and implementation of comprehensive pre-service and in-service training programs for health care workers. This included an innovative reward scheme through DLIs to strengthen the faculty of medicine and to improve the knowledge of new generations of clinicians.

The government's ICR (p. 50) noted some sustainability concerns related to the PCA, specifically in terms of office space and predictability of its funding mechanism. The government also noted the importance of supporting HEF promotion staff to ensure adequate monitoring of utilization trend and targeted increases in outreach activities, and it indicated that MOH staff will require additional and ongoing training to ensure understanding of performance-based incentives.

There is firm financial commitment from the government. The total project cost was estimated (after revision) to be US$269.3 million, out of which the government contributed US$170.1 million (63 percent), significantly higher than the 50 percent share of project costs promised by the government at appraisal. This represents a strong indication of ownership and demand-driven intervention to ensure sustainability. In addition, a follow-on project, H-EQIP II, was approved in March of 2022 (P173368, 2022-2027, US$113 million) with an objective to improve equitable utilization of quality health services. This project will build on successful rollout of the HEF, strengthen the PCA as the national entity for health insurance claim verification, and continue to channel performance-based financing to health facilities through SDGs. Donor partners also remain committed to supporting the government's health sector priorities.

8. Assessment of Bank Performance

a. Quality-at-Entry

The project was a continuation of previous Bank engagement in the health sector: the Health Sector Support Project (HSSP, P070542, US$28.84 million, 2002-11), which focused on basic health infrastructure and training, and (b) HSSP-2 (P102284, US$124.03 million, 2008-2016), which added support for health system strengthening, including HEFs and SDGs. Project preparation was informed by

a range of analytical work on utilization of HEFs, quality of care, and other health system issues in the country. Lessons learned from previous projects stressed the suitability of financing a part of the broader government program, the need to incentivize focus on results, and pathways for mainstreaming implementation arrangements within existing government structures. As a result, the project's implementing agency was the MOH, acting through its technical departments and national programs, as well as the PHDs, ODs, referral hospitals, provincial referral hospitals, and health centers. A public financial management (PFM) assessment was conducted during preparation, confirming that the Ministry of Economy and Finance, MOH, and other implementing agencies had acceptable PFM arrangements in place. Another lesson learned from HSSP-2 focused on the need to strengthen implementing agency capacity and skills; as a result, MOH Department of Planning and Health Information and Department of Budget and Finance staff were supported with consultants and advisors to strengthen procurement and other functions. The PAD contained detailed information on the project's implementation arrangements (Annex 3) and implementation support plan (Annex 4), as well as a high-quality sector analysis (Annex 5).

Arrangements for collaboration with development partners were clearly specified for both MDTF pooling partners and for other partners (Germany, Japan, United Nations agencies) who planned to provide independent technical assistance under a sector-wide approach; the PAD (Annex 7) carefully mapped current and anticipated partner investments in the project's component areas. These arrangements included provisions for pooled resource management and joint supervision, program review, and reporting. A Joint Partnership Interface Group had served as the focal point for consultation and decision making under HSSP-2, and that forum continued as a coordinating mechanism under this project.

Overall project risk was rated Substantial at appraisal, with the most significant risks identified as fiduciary (PAD, p. 16). Misappropriations had been documented in a recent program financed by the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and a 2011 Integrated Fiduciary Assessment Review had concluded that more competitive procurement and international price benchmarking could have saved the country more than US$50 million (one-third of government health spending) annually. Mitigation measures to address fiduciary risk included reducing the scope for capital expenditures by health facilities under the HEF and SDG mechanisms, supporting implementation of a national PFM reform program within the MOH, and establishment of a payment certification agency to support independent verification of facility performance for the performance-based grants. Substantial risks were also identified related to governance and design/institutional capacity, addressed through independent procurement and financial management assessments; the PAD did not specify specific mitigation measures related to these risks.

Quality-at-Entry Rating

Satisfactory

b. Quality of supervision

The Bank team worked closely with the government and other partners throughout implementation to adjust project design and financing to emerging priorities, including those resulting from the COVID-19 pandemic. The results framework was adjusted through six restructurings to maintain relevance as project components were revised. Supervision missions were timely and regular, and Implementation Status and Results Reports were thorough and candid. Implementation benefited from two Programmatic Advisory

Services and Analytics tasks, one to support the project's mainstreaming of implementation functions within the government system, and the other on just-in-time implementation support and on generating knowledge and analytics on new areas of engagement in the health sector. The Bank team was proactive in seeking a solution to challenges related to construction of a provincial referral hospital in Pailin (see Section 10b).

Quality of Supervision Rating

Satisfactory

Overall Bank Performance Rating

Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The project's results framework was aligned with that of the government's HSP-3 in terms of indicator definition, baselines, and targets. Data collection and monitoring was to be carried out through regular government systems (MOH departments). Data sources were to include routine data through the national HMIS, as well as periodic surveys such as the Cambodia Demographic and Health Surveys and Cambodia Socioeconomic Surveys. Independent mechanisms were established to verify results under the project's first and second components and achievement of DLI targets. Quality aspects were to be ensured through development of standardized supervisory checklists and institutionalization of Level 2 quality assessment in the MOH Quality Assurance Office. (Level 2 assessments had recently been introduced in Cambodia, going beyond Level 1 assessments of facility infrastructure, supplies, and staffing to include also measures of process of care quality and provider competency.) The Bank was to conduct a rapid performance assessment to verify DLI results reported in MOH annual reporting, and these results were to be discussed as part of a Joint Annual Review conducted with all MDTF partners.

b. M&E Implementation

M&E implementation proceeded as planned. Indicators and targets were adjusted appropriately. The M&E function was strengthened considerably through capacity building provided by the project, and with the development and nationwide rollout of a National Quality Enhancement Monitoring Tool (NQEMT) in 2019 and the establishment of the PCA, which assumed responsibility for quality assessments and HEF reimbursements to health facilities. The planned Level 2 assessment was not carried out, given that the NQEMT was carried out routinely. A comprehensive quantitative and qualitative impact evaluation of SDGs reviewed their implementation, outcomes, impact, challenges, and impact on health-seeking behaviors; some of its findings are reported in Section 4.

c. M&E Utilization

M&E was central to project implementation, given the extent of performance-based and output-based financing. Monitoring of DLI compliance was required for Bank disbursements, and monitoring of quality improvements and HEF services was required for financing of health facilities through SDGs and HEF reimbursements, respectively.

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

The project was classified as category B and triggered the Environmental Assessment (OP/BP 4.01) and Pest Management (OP 4.09) safeguard policies, mainly due to the financing of construction and rehabilitation of selected health facilities. Potential impacts named were site-specific impacts from civil works, impacts from incremental health care waste from the SDGs, and impacts from the use of pesticides for dengue vector control, which could all be mitigated through the preparation and implementation of an Environmental Management Plan. Following consultation, the final Environmental and Social Management Framework was disclosed in April 2016.

The project was particularly sensitive to indigenous populations, especially in the provinces of Mondulkiri and Ratanakiri. The project was designed to accommodate cultural differences and customs by promoting local participation in project design. For example, a participatory social assessment reviewed barriers for ethnic women and children to receive proper health services. As explained in the ICR (p. 24), the project also conducted over 50 focus group discussions to identify gender imbalances in health care provision. A comprehensive review of land acquisition conducted by MOH confirmed that almost all construction sites were on state land. A Resettlement Policy Framework, including screening criteria and relevant protocols, was also prepared and disclosed.

Despite all policies and regulations in place, safeguards compliance was occasionally weak, particularly with regard to health care waste management (HCWM) and infection control criteria. As explained in the ICR (p. 24), the Bank recommended that HCWM and infection control indicators in the SDG quality scorecard be reviewed. Safeguards requirements were included in construction contracts for all health facilities, but field visits identified issues in the implementation of the Environmental Code of Practices. The ICR explained that actions to address these limitations were discussed at the project's mid-term review, but progress was affected by insufficient site visits affected by lack of funds, irregular submissions of contractors' reports, and insufficient training of contractors in social and environmental safeguards. However, despite these shortcomings, the ratings for Environmental Assessment and Implementation were either Satisfactory or Moderately Satisfactory throughout the project's lifetime.

b. Fiduciary Compliance

Financial management: An FM assessment carried out during project preparation assessed FM risk as High due to limited experience of MOH staff with Bank-financed operations, inadequate capacity of health

facility staff and budget entities at the provincial level to implement program-based budgeting, delays in the release of funds due to funds availability and cumbersome procedures, and inadequate documentation of government policies and procedures. Mitigation measures were put in place, including supplementary manuals, the provision of hands-on support, adoption of new accounting software, and risk-based internal audits. During implementation, FM was consistently rated either Satisfactory or Moderately Satisfactory. Toward completion, FM reviews noted some weaknesses, including delays in documenting expenditures, settling outstanding advances, and updating monthly financial reporting and transactions in the accounting system. While all actions were eventually completed, the Bank identified ineligible expenditures in the amount of US$238,619. These expenditures were related to construction of the PRH in Pailin, which was not completed by the project closing date, as the contractor did not successfully address an issue of soil stabilization that caused cracks, and then did not follow the testing method recommended by the Bank for soil compaction. The Bank declared that payments that had been made to the construction firm and supervising engineer were not eligible for financing. At the time of the ICR, the Bank was in communication with the Ministry of Economy and Finance to follow up on refund to the Bank.

Procurement: The MOH procurement unit was responsible for all procurement activities at the national level, and the subnational entities (health centers, referral hospitals, ODs, and PHDs) were to carry out their own procurement. A procurement assessment carried out during preparation assessed risk as High due to limited capacity and oversight at the central and subnational levels due to staff not being familiar with externally financed procurement and having limited English proficiency, the dispersed nature of project implementation (with activities at the subnational level implemented all over the country), delays in procurement cycle management due to slow technical inputs for procurement start-up, and governance-associated factors. Mitigation measures included providing high prior threshold reviews, contracting of a procurement consultant, training for procurement staff at all levels, and adopting a communication strategy to inform stakeholders about the project to increase awareness. During implementation, procurement was rated Satisfactory or Moderately Satisfactory, except for a brief period in 2018 when the rating was Unsatisfactory due to slow progress, high turnover of staff, and delays in assigning new staff. Initial procurement reviews noted delays in preparing work plans for each DLI, but there was considerable improvement by mid-2019. All procurement packages in the project's procurement plan, including for the CERC, were completed by mid-2021.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	

Bank Performance	Satisfactory	Satisfactory
Quality of M&E	Substantial	Substantial
Quality of ICR	---	Substantial

12. Lessons

The ICR (pp. 28-29) and project team (in conversation with IEG) offered a series of insightful lessons:

Long-standing engagement in a country and sector can allow lessons and learning from previous support to be adapted and re-implemented. In this case, the Bank had engagement in Cambodia that went beyond the project. Its presence in the sector-wide dialogue was strong and well-coordinated with an ample coalition of development partners and fluid conversations with the government.

Building and strengthening capacity ultimately pays off. Multiple examples of this lesson are evident across its design and implementation. Implementation through existing government structures reduced overhead costs while consolidating relevant official departments. The project was carefully designed to gradually transfer competencies (for example, HEF monitoring, previously outsourced to non-governmental organizations, to government structures), thus ensuring sustainability, while also closely supervising processes to guarantee transparency and good governance. The establishment of the PCA was another success story, implemented with the support of both MOH and the Ministry of Economy and Finance. The Bank team started these transitions early in project preparation and invested time in learning from other experiences in the region through study visits. However, from the interview with the project team, it transpires that, although there were more gains than losses in this approach, the Bank does lose some control over project implementation. It also means having to share government officials with other organizations implementing projects through the government and, consequently, less dedicated bandwidth.

There is a sometimes difficult balance between equity and quality in a health system. The project aimed to increase utilization of public health facilities by increasing quality (SDGs) and also reducing financial barriers to access (HEFs). However, upsurges in utilization rates may overwhelm the health system, distorting supply chains and over-stretching human resources, for example, thus deteriorating quality, paradoxically. Recognition of and planning for these potential negative externalities is needed.

Improvements in health services quality do not translate automatically into higher utilization of the public health system. The project team shared that addressing rooted perceptions takes time, and there are elements that are hard to address that play a fundamental role in demand. Waiting times and distances associated with public health facilities cannot compete with the much larger network of the private and informal sector. In addition, in the relatively unregulated health sector of Cambodia, buying drugs over the counter without prescriptions saves time for clients.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a concise and clear description of the project. It efficiently detailed the various restructurings the project went through and the rationale driving them. The ICR was schematic and visual, providing easy access to the key strengths and weaknesses of the project. It was results-oriented, with high-quality data, providing additional data to support project indicators in assessing achievement of the objectives, particularly for the financial protection objective. The ICR provided an in-depth and candid analysis of project shortcomings, particularly regarding efficiency. Considerable effort was put into the efficiency analysis as well. Its lessons were insightful and comprehensive, although these were complemented even further with observations and analysis directly from the project team.

a. Quality of ICR Rating
Substantial