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Report No: PAD3031

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 10.8 MILLION
(US$15 MILLION EQUIVALENT)

AND A MULTI-DONOR GRANT
IN THE AMOUNT OF
US$26 MILLION

TO THE

KINGDOM OF CAMBODIA

FOR A

CAMBODIA NUTRITION PROJECT

March 14, 2019

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

CURRENCY EQUIVALENTS

(Exchange Rate Effective February 28, 2019)

1 US$ =	4011.07 KHR
1 US$ =	0.7153 SDR
1 SDR =	1.3979 USD

FISCAL YEAR
January 1 – December 31

Regional Vice President:	Victoria Kwakwa
Country Director:	Ellen A. Goldstein
Senior Global Practice Director:	Timothy Grant Evans
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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
AOP	Annual Operational Plan
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BMI	Body Mass Index
BMZ	Germany's Federal Ministry for Economic Cooperation and Development
BoD	Burden of Disease
C/S	Commune/Sangkat (s)
C/S-SDG	Commune/Sangkat-Service Delivery Grant
CARD	Council for Agriculture and Rural Development
CCWC	Commune/Sangkat Committee for Women and Children
CCWC FP	Commune/Sangkat Committee for Women and Children Focal Person
CDHS	Cambodia Demographic and Health Survey
CET	Cost-effectiveness Threshold
CHW	Community Health Worker
CNP	Cambodia Nutrition Project
CPA	Comprehensive Package of Activities
CPF	Country Partnership Framework
CPWC	Commune Program for Women and Children
CSO	Civil Society Organization
D&D	Decentralization and Deconcentration
DA	Designated Account
DALY	Disability-Adjusted Life Year
DBF	Department of Budget and Finance
DFAT	Department of Foreign Affairs and Trade
D/K	District/Khan (s)
DLI	Disbursement-Linked Indicator
DPHI	Department of Planning and Health Information
DPT	Diphtheria-Pertussis-Tetanus
EA	Executing Agency
EEP	Eligible Expenditure Program
EMP	Environmental Management Plan
FAD	Financial and Administrative Division (of NCDDS)
FM	Financial Management
FMM	Financial Management Manual
FTIRM	Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality

FTRM-N	Fast Track Roadmap for Improving Nutrition
GDNT	General Department of National Treasury
GDP	Gross Domestic Product
GFF	Global Financing Facility in Support of Every Woman, Every Child
GIZ	German Agency for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit*)
GMP	Growth Monitoring and Promotion
GRS	Grievance Redress Service
IA	Implementing Agency
IYCF	Infant and Young Child Feeding
H-EQIP	Health Equity and Quality Improvement Project
HCMC	Health Center Management Committee
HEF	Health Equity Fund
HMIS	Health Management Information System
HNP	Health, Nutrition, and Population
HSP-3	Third Health Strategic Plan
HSSP2	Second Health Sector Support Program
I4C	Information for Citizens
IA	Implementing Agency
ISAF	Implementation of the Social Accountability Framework
ICER	Incremental Cost-Effectiveness Ratio
ICR	Implementation Completion and Results Report
ICT	Information and Communication Technology
IFR	Interim Financial Report
IMF	International Monetary Fund
IP3-III	Third Three-year Implementation Plan
IPF	Investment Project Financing
IPPF	Indigenous Peoples Planning Framework
ISAF	Implementation of the Social Accountability Framework
JAAP	Joint Accountability Action Plan
KfW	German Development Bank (*Kreditanstalt für Wiederaufbau*)
KOICA	Korean International Cooperation Agency
LiST	Lives Saved Tool
M&E	Monitoring and Evaluation
MC	Management Committee
MCHN	Maternal and Child Health and Nutrition
MDTF	Multi-Donor Trust Fund
MEF	Ministry of Economy and Finance
MIYCN	Maternal, Infant, and Young Child Nutrition

MOH	Ministry of Health
MOI	Ministry of Interior
MPA	Multiphase Programmatic Approach
MRD	Ministry of Rural Development
MUSEFO	Multisectoral Food and Nutrition Security in Cambodia Project
NBC	National Bank of Cambodia
NCD	Noncommunicable Disease
NCDD	National Committee for Subnational Democratic Development
NCDDS	National Committee for Subnational Democratic Development-Secretariat
NCHP	National Center for Health Promotion
NGO	Nongovernmental Organization
NIP	National Immunization Program
NIP-SP	National Immunization Program Strategic Plan
NMCHC	National Maternal and Child Health Center
NMR	Neonatal Mortality Rate
NNP	National Nutrition Program
NOURISH	Nutrition, Sanitation and Hygiene Project
NQEM	National Quality Enhancement Monitoring
NSFSN	National Strategy for Food Security and Nutrition
NSPPF	National Social Policy Protection Framework
NSSF	National Social Security Fund
OD	Operational Health District
OM	Operational Manual
OOP	Out-of-Pocket
PCA	Payment Certification Agency
PDO	Project Development Objective
PFM	Public Financial Management
PHD	Provincial Health Department
PMD	Preventive Medicine Department
PMRS	Patient Management and Registration System
PNC	Postnatal Care
PPSD	Project Procurement Strategy for Development
PRH	Provincial Referral Hospital
QAO	Quality Assurance Office
QEWG	Quality Enhancement Working Group
RGC	Royal Government of Cambodia
RMNCAH-N	Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition
SAM	Severe Acute Malnutrition
SBCC	Social and Behavior Change Communication

SCD	Systematic Country Diagnostic
SDG	Service Delivery Grant
SNA	Subnational Administration
SOA	Special Operating Agency
SOP	Standard Operating Procedure
STEP	Systematic Tracking of Exchanges in Procurement
SUN	Scaling Up Nutrition
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
TSA	Treasury Single Account
TWG-FSN&SP	Technical Working Group for Food Security, Nutrition, and Social Protection
TWG-Health	Technical Working Group for Health
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
VHSG	Village Health Support Group
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WRA	Women of Reproductive Age

TABLE OF CONTENTS

DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Cambodia	Cambodia Nutrition Project	
Project ID	**Financing Instrument**	**Environmental Assessment Category**
P162675	Investment Project Financing	B-Partial Assessment

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[✓] Disbursement-linked Indicators (DLIs)	[ ] Small State(s)
[ ] Financial Intermediaries (FI)	[ ] Fragile within a non-fragile Country
[ ] Project-Based Guarantee	[ ] Conflict
[ ] Deferred Drawdown	[ ] Responding to Natural or Man-made Disaster
[ ] Alternate Procurement Arrangements (APA)	

Expected Approval Date	Expected Closing Date
04-Apr-2019	30-Jun-2024

Bank/IFC Collaboration

No

Proposed Development Objective(s)

The PDO is to improve utilization and quality of priority maternal and child health and nutrition services for targeted groups in Cambodia.

Components

Component Name	Cost (US$, millions)
Component 1: Strengthening the delivery of priority health services	24.00
Component 2: Stimulating demand and accountability at the community level	10.80
Component 3: Ensuring an effective and sustainable response	18.20

Organizations

Borrower:	Kingdom of Cambodia
Implementing Agency:	Ministry of Health National Committee for Sub-National Democratic Development Secretariat

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	53.00
Total Financing	53.00
of which IBRD/IDA	15.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	15.00
IDA Credit	15.00

Non-World Bank Group Financing

Counterpart Funding	12.00
Borrower/Recipient	12.00
Trust Funds	26.00
Freestanding Tfs - Health, Nutrition & Population GP	2.00

Global Financing Facility	10.00
Integrating Donor-Financed Health Programs	5.00
Cambodia - Free-standing Trust Fund Program	9.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
National PBA	15.00	0.00	0.00	15.00
Total	**15.00**	**0.00**	**0.00**	**15.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2019	2020	2021	2022	2023	2024	2025
Annual	0.13	0.91	1.37	2.31	3.85	5.24	1.20
Cumulative	0.13	1.04	2.41	4.71	8.56	13.80	15.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?	
a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF	Yes
b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment	Yes
c. Include Indicators in results framework to monitor outcomes from actions identified in (b)	Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

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

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Performance Standards for Private Sector Activities OP/BP 4.03		✓
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09	✓	

Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10	✓	
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description

Institutional Arrangements (Sections I.A.1 and I.A.2 of Schedule 2 of the Financing Agreement). Obligation of the Recipient to maintain, throughout the period of implementation of the Project, Project implementation structures with composition, functions, staffing and resources satisfactory to the Association and as set out in the Project Operations Manual, including (a) a Steering Committee with terms of reference and composition acceptable to the Association to be responsible, inter alia, for providing overall policy direction, strategic guidance, and general oversight of the Project; and (b) Project coordination focal points in each NCDDS and MOH to be responsible, inter alia, for the overall Project coordination.

Sections and Description

Project Operations Manual, SDG Operational Manual, HEF Operational Manual, and C/S-SDG Operational Manual - Sections I.B and I.D.1 of Schedule 2 to the Financing Agreement). Obligation of the Recipient to ensure that the Project is carried out in accordance with the arrangements and procedures set out in the Project Operational Manuals (provided, however, that in the case of any conflict between the arrangements and procedures set out in the said manual and the provisions of this Agreement, the provisions of this Agreement shall prevail) and, except as the Association shall otherwise agree, shall not amend, abrogate or waive any provision of the said manuals.

The Recipient shall ensure that all SDGs, HEF Grants, and C/S-SDGs financed out of the proceeds of the Financing and the Grant are made and administered in accordance with the guidelines, procedures and criteria set forth in the SDG Operational Manual, HEF Operational Manual, and C/S-SDG Operational Manual and the additional terms and conditions set forth in Part D.

Sections and Description

Mid-term Review (Section II.B.of Schedule 2 to the Financing Agreement). Obligation of the recipient to prepare and furnish to the Association a mid-term report within 30 months after the Effective Date, in such detail as the Association shall reasonably request,documenting progress achieved in the carrying out of the Project during the period preceding the date of such report, taking into account the monitoring and evaluation activities performed pursuant to this Part A, and setting out the measures recommended to ensure the continued efficient carrying out of the Project and the achievement of its objectives during the period following such date; and review with the Association such mid-term report, on or about the date forty-five (45) days after its submission, and thereafter take all measures required to ensure the continued efficient implementation of the Project and the achievement of its

objectives, based on the conclusions and recommendations of the mid-term report and the Association's views on the matter.

Sections and Description
DLI Reporting and Verification (Sections I.E.1.(a) of Schedule 2 to the Financing Agreement). Obligation of the Recipient through MOH and NCDDS, shall, not later than September 30 of each year during the Project implementation period, furnish reports to the Association on the status of achievement of the relevant DLI Targets, in accordance with the Verification Protocols and procedures set out in the Project Operational Manuals and the DLI Manual.

Sections and Description
Annual Work Plan and Budget (Section I.C of Schedule 2 to the Financing Agreement). Obligation of the Recipient to prepare and furnish to the Association for its no-objection not later than December 15 of each year during the implementation of the Project (or such later date as the Association may agree), an Annual Work Plan and Budget ("AWPB") for the Project as approved by MOH and NCDDS respectively, containing all Project activities and Eligible Expenditures proposed to be included in the Project in the following FY, including the Financing's and the Grant's respective shares of financing of the Eligible Expenditures. Obligation of the recipient to ensure the Project is implemented in accordance with the AWPB accepted by the Association for the respective FY; provided, however, that in the event of any conflict between the AWPB and the provisions of this Agreement, the provisions of this Agreement shall prevail.

Sections and Description
Safeguards (Section I. F.1.(a) of Schedule 2 to the Financing Agreement. Obligation of the recipient to ensure that the Project is carried out with due regard to appropriate health, safety, social, and environmental practices and standards, and in accordance withthe Safeguards Instruments.

Conditions

Type	Description
Effectiveness	In accordance with Article IV 4.01 of the Financing Agreement: (a) The Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of this Agreement) have been fulfilled; (b) The Recipient through each of MOH and NCDDS has adopted its respective Project Operations Manual acceptable to the Association.
Disbursement	In accordance with Section III B.1. of the Financing Agreement: No withdrawal shall be made: (a) for payments made prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed SDR 715,000 may be made for payments made prior to this date but on or after September 1, 2018, for Eligible Expenditures subject to the requirements

	referred to in paragraph (e) below; (b) for payments under Category (1), unless and until the Recipient has adopted the SDG Operational Manual acceptable to the Association; (c) for payments under Category (2), unless and until the Recipient has adopted the HEF Operational Manual acceptable to the Association; (d) for payments under Category (3), unless and until the Recipient has adopted the C/S-SDG Operational Manual acceptable to the Association; or (e) for Eligible Expenditure Programs under Category (4), unless and until the Recipient has: (i) furnished evidence satisfactory to the Association in accordance with the Verification Protocol set forth in the Project Operational Manuals and the DLI Manual that the Recipient has achieved the respective DLI Targets set forth in Schedule 4 to this Agreement against which withdrawal is requested; (ii) complied with the additional instructions referred to in Section IV.A of this Schedule, including furnished to the Association the applicable interim unaudited financial reports documenting the incurrence of Eligible Expenditure Programs during the respective fiscal year up to the date against which withdrawal is requested; and (iii adopted the DLI Manual acceptable to the Association.

Note: With respect to the Systematic Operations Risk-Rating Tool, risk ratings are defined as follows: Low = low risk; moderate = moderate risk; substantial = substantial risk.

I. STRATEGIC CONTEXT

A. Country Context

1. Due to rapid and sustained growth, Cambodia has become one of the world's leaders in economic growth, poverty reduction, and shared prosperity. Cambodia has sustained an average growth rate of 7.6 percent over 1994–2015, ranking sixth in the world. Due to strong economic growth, gross national income per capita more than tripled from US$300 in 1994 to an estimated US$1,070 in 2015, the year in which Cambodia became a lower-middle-income economy.

2. In addition to strong economic growth, Cambodia has achieved dramatic poverty reduction. Poverty incidence below the national poverty line fell from 47.8 percent in 2007 to 13.5 percent in 2014. From 2004 to 2007, poverty reduction was driven by the movement of people out of agriculture and into the fast-growing garment and services sectors. Poverty reduction then became particularly dramatic during 2007–09, when poverty declined by 25 percentage points and 3.3 million people escaped poverty.

3. However, lagging progress on human capital outcomes poses a challenge to sustained future growth and regional competitiveness. The Human Capital Index reveals that a child born in Cambodia today will be 49 percent as productive when she grows up as she could be if she enjoyed complete education, good health, and a well-nourished childhood.[1] Lack of access to quality health services, especially in the more remote and rural areas and high levels of stunting among under-fives are significant remaining challenges to human capital. Quality in education is a concern, and when years of schooling are adjusted for quality of learning, learning gap is 2.7 years.

4. High vulnerability and the risk of impoverishing shocks contribute to lower household investments in longer-term human capital formation. According to the 2017 Systematic Country Diagnostic (SCD),[2] most Cambodians not in extreme poverty are either moderately poor or vulnerable according to international standards. Two-thirds of the population live under US$5.50 per day purchasing power parity. Vulnerability to financial and weather shocks is also a concern, and Cambodia ranks among the world's top ten countries in terms of out-of-pocket (OOP) health expenditure.

B. Sectoral and Institutional Context

Cambodia's Health and Nutrition Outcomes

5. Emerging from widespread poverty in the 1990s, Cambodia's health outcomes have improved rapidly (table 1) and surpassed several better-off countries. The country's progress and innovation in health service delivery contributed to achievement of most health-related Millennium Development Goals, including those for maternal and child mortality. Despite these improvements, maternal mortality remains unacceptably high; neonatal mortality has not declined proportionately to total child mortality and accounted for nearly half of all under-five deaths in 2014.

[1] World Bank. 2018. *Human Capital Index: Cambodia Country Brief*. Available online: https://databank.worldbank.org/data/download/hci/HCI_ 2pager_KHM.pdf.
[2] World Bank. 2017. *Cambodia Systematic Country Diagnostic*. Report No. 115189-KH Phnom Penh: World Bank.

Table 1. Human Development Indicators, Cambodia (2000–2014)

Indicator	2000	2014
Total population	12,152,354	15,270,790
Total fertility rate	3.8	2.7
Life expectancy	65.6	68.3
Under-five mortality rate (deaths per 1,000 live births)	83	35
Infant mortality rate (deaths per 1,000 live births)	80	29
Neonatal mortality rate (deaths per 1,000 live births)	37	18
Maternal mortality ratio (deaths per 100,000 live births)	437	170

Source: CDHS 2000 and 2014.

6. Meanwhile, Cambodia is facing demographic and epidemiological transitions: the country's burden of disease (BoD) is shifting from high communicable, maternal, neonatal, and nutritional diseases to a pattern in which noncommunicable diseases (NCDs) take a leading role, while simultaneous declining fertility is projected to yield rapid increases in the elderly population from 2030. In 1990, communicable diseases (including vaccine preventable diseases), maternal and neonatal disorders, and nutritional deficiencies accounted for 64 percent of BoD. In the following years, the share of NCDs in BoD increased steadily while the share of communicable diseases diminished. By 2016, NCDs (55 percent) accounted for a significantly higher share of BoD than communicable diseases (34 percent). Malaria and tuberculosis (TB) have declined significantly from 1990 to 2016, with malaria falling from 2,487 to 767 disability-adjusted life years (DALYs) lost per 100,000 and TB declining from 2,352 to 597 DALYs lost per 100,000.[3]

7. Despite progress on many fronts, maternal and child undernutrition remain significant public health challenges and threaten human capital formation (Table 2). Child stunting (low height-for-age) declined from 59 percent in 1996 to 32.5 percent in 2014. However, prevalence of child stunting remains 'high' according to the World Health Organization (WHO) public health thresholds. Child wasting (9.6 percent) is also considered 'high', particularly given the low levels of absolute poverty and food insecurity. Maternal undernutrition is common: 14 percent of women age 15–49 are underweight and nearly half (45 percent) of the women of reproductive age (WRA) suffer from anemia. Poor maternal health and nutrition during pregnancy (including maternal anemia and underweight) contribute to the high burden of children born with low birth weight (11 percent), the in utero origins of stunting (UNICEF 2016), and maternal and neonatal mortality.

Table 2. Prevalence of Undernutrition in Children (<5 years) and WRA (15–49) in Cambodia, 2014

	Status	Level of Public Health Significance
Stunting, % children 0–59 months	32.5	High
Wasting, % children 0–59 months	9.6	High
Anemia, [a, c] % children 6–59 months	55.5	Very high
Median urinary iodine concentration (ug/L), children 6–59 months	78.0	Mild deficiency
Thinness (BMI<18.5 kg/m^2), % WRA	14.0	
Anemia, [b, c] % WRA	45.4	Very high
Median urinary iodine concentration (ug/L), WRA	63.0	Mild deficiency

[3] Institute for Health Metrics and Evaluation. 2016. Global Burden of Disease Estimates. Available online: http://ghdx.healthdata.org/gbd-2016.

Source: CDHS 2014.
Note: BMI = Body mass index.
a. Only measured among children 6–59 months, defined as hemoglobin <11 g/dl. b. Defined as hemoglobin <12 g/dl in nonpregnant women and <11 g/dl in pregnant women. c. Recent analysis of micronutrient status indicates that only 8.1 percent of anemic women and 10.5 percent of anemic children are iron deficient, indicating that interventions beyond iron supplementation are necessary to reduce the burden of anemia in Cambodia.

8. The determinants and drivers of malnutrition are multiple, interacting, and multisectoral. Therefore, reducing the burden of child stunting and wasting in Cambodia will require interventions to (a) prevent the in-utero origins of growth faltering (through improvements in maternal health and nutritional status); (b) improve the immediate drivers of malnutrition (nutrient intake and disease); and (c) simultaneously address underlying drivers (food insecurity; poor care for women and children; low access to health services; and poor access to water, sanitation, and hygiene [WASH]) (see annex 2).

9. National averages mask persistent and growing disparities in reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) outcomes. Cambodia's rural, remote, indigenous, and socioeconomically challenged women and children remain disproportionately affected by poor health and nutritional status. The wealth gap in child mortality has remained unchanged since 2005 at roughly three times higher for poor and rural children compared to wealthy and urban children. Household wealth is one of the strongest determinants of NMR in mortality, followed by rural residence. Between 2000 and 2014, both absolute and relative inequality gaps in NMR by household wealth and place of residence increased.[4] Stunting prevalence in the poorest wealth quintile (42 percent) is more than double that of the richest (18 percent); improvements in stunting have been driven by rapid declines among the wealthy. Due to the rapid social and demographic transitions, Cambodia simultaneously faces new challenges to address the RMNCAH-N needs of vulnerable urban and migrant populations.

Health System Context: Governance, Service Delivery, and Financing

10. Improving reproductive health and reducing maternal, newborn, and child mortality and malnutrition is one of the four Ministry of Health (MOH) goals in the Third Health Strategic Plan (HSP-3) 2016–2020. Similarly, the HSP-3 also identifies RMNCAH-N (including immunization) as priority areas for action. Administratively, Cambodia's public health system is divided into national, provincial, and operational district (OD) levels. HSP-3 aims to "effectively manage and lead the entire health sector to ensure that quality health services are geographically and financially accessible and socio-culturally acceptable to all people in Cambodia" through both public and private services. At the central level, the National Maternal and Child Health Center (NMCHC) governs the areas of nutrition, reproductive health, maternal and infant health, and child health and immunization. The NMCHC ensures the strategic alignment of programmatic[5] and national priorities and provides coordination, training, and supervision for lower levels of the health system on RMNCAH-N activities.

[4] Hong, R., P. Ahn, F. Wieringa, et al. 2017. "The Unfinished Health Agenda: Neonatal Mortality in Cambodia." *PLoS ONE* 12 (3): e0173763.
[5] NMCHC programs have outlined priority actions and objectives in subsector strategies such as the National Strategy for Reproductive and Sexual Health in Cambodia 2017–2020; Fast Track Roadmap for Improving Nutrition (FTRM-N) 2014–2020; Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality (FTIRM) 2016–2020; and National Immunization Program Strategic Plan (NIP-SP) 2016–2020.

11. The Provincial Health Departments (PHDs) are responsible for RMNCAH-N service delivery. Each of the 25 provinces has a PHD and a provincial referral hospital (PRH). The PHD has responsibility for supervising ODs, including their district offices, referral hospitals, health centers, and health posts. Cambodia's Minimum Package of Activities (MPA) and a Comprehensive Package of Activities (CPA) outline clinical and service delivery guidelines for facilities at each level of public health facility, though provider adherence varies.

12. Investing in the quality of public service provision is a priority of the Royal Government of Cambodia (RGC), generally, and the MOH, specifically. Through strong political commitment and a willingness to innovate, Cambodia has set an example of how a low-income country can change the paradigm in financing and provision of health care services to accelerate progress on health outcomes. Significant improvements in service delivery have occurred over the past two decades. These include a dramatic increase in facility-based deliveries (10 percent in 2000 to 83 percent in 2014), uptake of antenatal care (ANC), and coverage of other maternal and child-health services, such as polio-3 vaccination (45 percent in 2000 to 80 percent in 2014). RGC initiatives and reforms to improve quality service delivery (the National Quality Enhancement Monitoring [NQEM] Process) and health financing have contributed to these improved outcomes (box 1).

13. Despite these notable achievements, Cambodia continues to face challenges in delivering quality RMNCAH-N services that meet the expectations of the population. Lagging RMNCAH-N outcomes in Cambodia are the result of multiple and interacting causes, including (a) variable and inequitable availability, accessibility, and quality of essential RMNCAH-N services; (b) fragmented and verticalized financing and service delivery for priority RMNCAH-N programs; (c) low community awareness and demand for preventive, promotive, and curative health services; and (d) limited coordination and accountability for improved RMNCAH-N outcomes at local and national levels.

14. Suboptimal access to, utilization, and quality of basic maternal health services is a driver of maternal and neonatal mortality. This is particularly true for Cambodia's rural and poor women, whose outcomes lag considerably, despite the inclusion of these services in the Health Equity Fund (HEF) benefits package, indicating the pressing need to improve the utilization and quality of these services. ANC services promote the health of the mother and her offspring: inadequate prenatal care (delayed initiation of ANC beyond the first trimester, too few [<4] contacts, and poor quality of ANC) is associated with increased risk of maternal and neonatal mortality.[6] Micronutrient supplementation during ANC is a marker of a quality ANC contact: it reduces the risk of maternal micronutrient deficiencies, promotes normal fetal growth and development, and reduces the risk of maternal mortality. In 2014, three-quarters of Cambodian women consumed micronutrient supplements in accordance with national guidelines,[7] but this was as low as 38 percent in Kratie and 63 percent in Preah Vihear/Stung Treng. NMR for mothers who did not receive any ANC services was 6.26 times higher than those receiving at least four ANC visits. Provinces with the lowest ANC visits were also the ones with the highest pre-term/low birthweight babies.[8]

[6] United Nations. Every Woman, Every Child: The Global Strategy for Women's, Children's and Adolescent's Health (2016-2030).
[7] The current national guideline is to consume at least 90 tablets of iron-folate beginning in the first trimester of pregnancy. However, given the low burden of iron deficiency anemia amid high maternal undernutrition, efforts are under way to revise the guidelines in accordance with Cambodia's burden of malnutrition.
[8] Hong et al. 2017.

Box 1. Cambodia's Health System Reforms: Progress and Partnership

Over the past two decades, Cambodia's MOH has endeavored to improve the health system, health outcomes, and health equity through transformational partnerships and innovations in health financing and health service delivery.

Cambodia's HEF system has dramatically improved access to health services for the poor. The HEF provides free health insurance to about 3 million poor people in Cambodia, having grown from a series of small nongovernmental organization (NGO)-run pilots in the early 2000s to a government-owned, nationwide social health protection and health financing mechanism. The HEF purchases services from public health facilities on an output basis, and reliable electronic reimbursements provide a major source of flexible revenue for frontline facilities.

In 2008, under the Second Health Sector Support Program (HSSP2), the MOH established special operating agencies (SOAs) which granted greater managerial authority and flexibility to PRHs and ODs in return for stronger accountability for performance. These arrangements were expanded and integrated into the NQEM Process. The NQEM now includes a suite of quality tools and improvement processes, including quarterly quality assessment of health facilities, that serve as the basis for a national performance-based financing system (service delivery grants [SDGs]). As of December 2018, the NQEM Process was implemented in about two-thirds of public health centers and referral hospitals, with a full national rollout envisaged in July 2019.

The Health Equity and Quality Improvement Project (H-EQIP) (2016–2021) is the current flagship project of the Cambodian MOH with co-financing from Australia's Department of Foreign Affairs and Trade (DFAT), German Development Bank (*Kreditanstalt für Wiederaufbau*, KfW), Korean International Cooperation Agency (KOICA), under the H-EQIP TF072541 and the World Bank. H-EQIP endeavors to expand, build, and strengthen performance-based instruments (such as HEFs and SDGs). H-EQIP has also established the implementation arrangements for these instruments and supports the underlying institutions (Payment Certification Agency [PCA]) and systems (public financial management [PFM], quality improvement) necessary to institutionalize these reforms. Key shifts in H-EQIP design from its immediate predecessor (HSSP2) focus on sustainability of financing and implementation for major health systems initiatives, through (a) mainstreaming implementation of project activities through RGC systems; (b) increasing funding flows to the subnational implementation level; (c) building domestic capacity to take over project implementation support, information systems, and monitoring roles; and (d) enhancing the use of output-based payments through HEFs and performance-based financing through SDGs and Disbursement-Linked Indicators (DLIs).

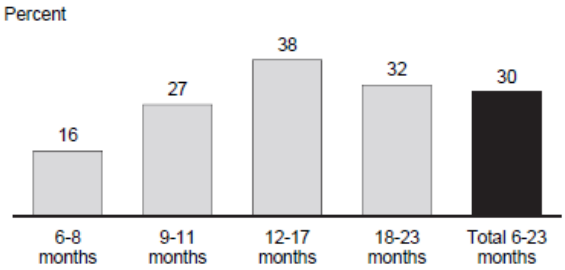
15. There is a need to further improve the availability and quality of infant and young child feeding (IYCF) counselling and the associated behaviors. Counselling is recommended during contacts covered by the HEF (ANC, delivery, postnatal care [PNC], well-child visits) but actual delivery of this service and quality therein remain variable. The early initiation of breastfeeding (within one hour of birth) is associated with increased likelihood of breastfeeding at four months and a decreased risk of neonatal mortality.[9] However, only 63 percent of children are breastfed within an hour of birth, with this share as low as 16 percent in Mondul Kiri/Ratanak Kiri. Improving the quantity and quality of complementary feeding[10] will

[9] The initiation, duration, and exclusivity of breastfeeding plays an important role in establishing the child's early life nutritional status and preventing infant mortality (See: Black, et al. 2008. "Maternal and Child Undernutrition: Global and Regional Exposures and Health Consequences." *Lancet* 371: 243–60). The WHO recommends the early initiation of breastfeeding within one hour of birth, exclusive consumption of breastmilk through six months of age, and continued breastfeeding through 24 months. WHO. 2017. *Protecting, Promoting, and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services*. Geneva: World Health Organization.

[10] Beyond the first 6 months of age, the frequency of feeding, the diversity of diet, and nutrient composition of complementary foods affects infants' and young children's nutritional status and has been strongly associated with stunting. See: Bhutta, Z. A.,

also be necessary to reduce stunting and wasting: it is not the timing of complementary food introduction[11] but rather the quantity and the composition of the diet which is of concern**.** Few infants and young children, particularly those between the ages of 12 and 23 months, consume a minimum acceptable diet (figure 1).[12] Minimum dietary diversity (consuming foods from at least four recommended food groups) is also low at 47.6 percent, with the lowest prevalence when children are introduced to complementary foods at age 6–8 months (18 percent).

Figure 1. Minimum Acceptable Diet among Children Age 6–23 Months, by Age Group - Cambodia, 2014



Source: CDHS 2014.

16. Vaccination is a core child health intervention: routine immunization drives contacts with the health system in the first year of life and contributes to a multisectoral package of interventions to reduce undernutrition.[13] However, in Cambodia only three-quarters (73 percent) of children receive all basic vaccinations by age 12 months, and coverage varies considerably by province (figure 2).[14] Linear growth faltering accumulates most rapidly in the period 6–24 months of age; during this time immunization visits can provide the entry point to provide growth monitoring and promotion (GMP) of optimal complementary feeding. The diphtheria-pertussis-tetanus (DPT) tetravalent vaccine is a part of Cambodia's routine vaccination schedule and administered in three doses between 6 weeks and 6 months of age. High dropout is observed between the first (DPT1) and third (DPT3) vaccine: 94 percent of children received DPT1 compared to only 84 percent for DPT3; DPT3 coverage is 72 percent in the lowest wealth quintile and 82 percent in rural areas. The result is numerous missed opportunities to provide IYCF

et al. 2013. "Evidence-Based Interventions for Improvement of Maternal and Child Nutrition: What Can Be Done and at What Cost?" *The Lancet* 382: 452–77.

[11] According to the 2014 CDHS, over 80 percent of children 6–8 months receive solid and semisolid foods.

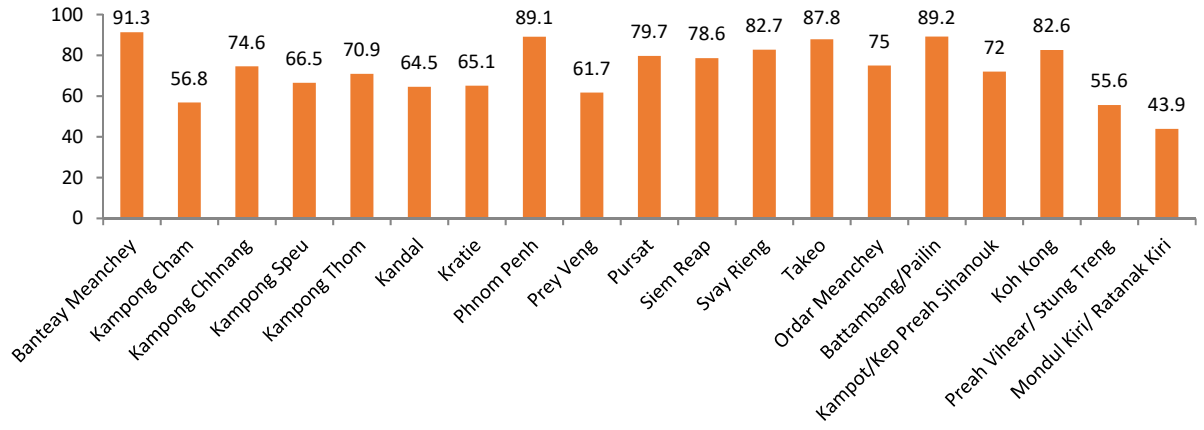
[12] Minimum acceptable diet is a composite indicator which represents the percent of children ages 6–23 months who received all the following the previous day: 1. Breast milk. If not breastfeeding, must receive two or more feedings of commercial infant formula; fresh, tinned, or powdered animal milk; or yogurt. 2. Minimum dietary diversity or foods from four or more of the following groups: (a) infant formula, milk other than breastmilk, cheeses or yogurt, or other milk products; (b) foods made from grains, roots, and tubers, including porridge and fortified baby food from grains; (c) vitamin A-rich fruits and vegetables (and red palm oil); (d) other fruits and vegetables; (e) eggs; (f) meat, poultry, fish, and shellfish (and organ meats); and (g) legumes and nuts. 3. The minimum number of recommended meals per day, according to age and breastfeeding status. For breastfed children, the minimum meal frequency is solid or semisolid food at least twice a day for infants 6–8 months per day least three times per day for children 9–23 months. For non-breastfed children, the minimum meal frequency is solid or semisolid food or milk at least four times a day for children 6–23 months.

[13] With a close link between infection and undernutrition, recent evidence suggests that it is unlikely that a single antigen will make a significant improvement in child nutrition and growth; rather, the suite of immunizations along with the package of nutrition-specific interventions that will contribute to better nutritional status. See: Prendergast, A. J. 2015. "Malnutrition and Vaccination in Developing Countries." *Philosophical Transactions of the Royal Society of London.* 370 (1671): 20140141.

[14] CDHS 2014.

counselling around the time of transition to complementary feeding. Moreover, only about half (59 percent) of children receive biannual deworming medication and 70 percent receive biannual vitamin A supplementation, services typically delivered through routine immunization contacts.

Figure 2. Share of Fully Immunized Children by Province, 2014



Source: CDHS 2014.

17. Supply-side bottlenecks contribute to variable availability and quality of RMNCAH-N services. These include low provider training and capacity; limited accountability for delivering nutrition and immunization services in adherence to Minimum Package of Activity guidelines; and insufficient availability of necessary equipment, commodities, and supplies. Though outlined in the Minimum Package of Activity and Comprehensive Package of Activity guidelines, interventions such as nutrition counselling during pregnancy, IYCF promotion, micronutrient supplementation in the first 1,000 days, and GMP are often left to provider discretion, and there remains a lack of clarity regarding the reimbursement of such services under the HEF. There are no administrative data collected on child growth and only ad hoc supervision of nutrition interventions.

18. Health outreach is a critical link between communities and services. However, a recent policy shift away from health outreach and toward fixed-site services at frontline health facilities has influenced the equity of health service delivery. The transition from external financing has been partially implicated in this shift (for example, outreach providers have historically received donor-funded per diem payments). Fixed-site immunizations now account for two-thirds of overall immunization coverage, but outreach services remain essential for those difficult to reach. Most parts of the country face challenges in delivering health outreach in accordance with the MOH guidelines. Without the commensurate investments in community demand creation and health promotion, the over-reliance on facility-based services disfavors hard-to-reach areas and accentuates inequities, further weakening the link between health centers and the communities they serve.

19. Thus, demand-side barriers for priority RMNCAH-N services and low community awareness must be addressed to achieve sustainable improvements in these outcomes. Among families and health providers, there is limited awareness of the importance of good maternal and child health and nutrition (MCHN) and the links with optimum linear growth and child development. Traditional health, nutrition,

and child care practices—particularly for ethnic minorities—create additional challenges. Eating down during pregnancy, feeding formula milk, and delayed care-seeking during child illness are relatively widespread and contribute to poor health and nutrition outcomes. A recent assessment of social and behavior change communication (SBCC) implementers in Cambodia found that health staff and health volunteers feel poorly equipped to stimulate this sort of demand-side change.[15] A recent HEF utilization study indicated that while there is growing use of HEF benefits for inpatient services, ID poor households have low consumption of outpatient, preventive, and promotive services and tend to pay OOP fees to use private sector facilities. Health center staff, HEF operators, and village volunteers consistently reported low knowledge of HEF benefits, poor quality of services in public facilities, and transportation/geographic access as the reasons for underutilization of HEF for outpatient services.[16]

20. Total health expenditure in Cambodia is on par with regional peers, but it is largely driven by OOP expenditures. Efforts have been made to increase the pro-poor nature of supply- and demand-side investments in health, but OOP expenditures continue to be high (60–70 percent): at an estimated 62 percent of total health expenditure and much higher than the average for low- and middle-income countries (40 percent). Overall macroeconomic growth (driving general government expenditure) and OOP spending, rather than increasing prioritization of health in the government budget, are driving increases in total health expenditure: government health expenditure as a share of gross domestic product (GDP) remained constant at 1.3–1.4 percent of GDP over 2010–2016.

21. Cambodia's priority RMNCAH-N programs are verticalized and heavily dependent on external financing and OOP expenditures. The NMCHC subprograms in immunization, reproductive health, and nutrition are largely donor dependent. The MOH FTRM-N describes an evidence-based package of high-impact priority interventions to address maternal and child undernutrition through the health sector (Table 3). However, it is underfinanced and relies on non-state mechanisms (primarily NGOs) for community-based service delivery. An optimistic conceptual budget for the FTRM-N identifies a US$17.8 million financing gap (43 percent) over five years to scale up the full package of nutrition-specific services. Similarly, though the RGC finances routine immunization, the MOH relies heavily on donor financing for high-risk communities. The National Immunization Program (NIP) has outlined five key objectives areas in its National Strategic Plan (2016–2020) (Table 4). Integration of the nutrition and routine immunization programs is sporadic at both the central and provider levels and offers considerable potential for gains in efficiency and effectiveness.

Table 3. MOH Priorities for NMCHC Programs

Priority Interventions in the FTRM-N (2014–2020)	Strategic Priorities in the Cambodia NIP-SP (2016–2020)
1. Nutrition counselling of pregnant women 2. Micronutrient supplementation of pregnant and lactating women 3. Treatment of severely wasted children 4. Micronutrient supplementation of young children for prevention and treatment strategies	1. *Service Delivery* - Increase immunization coverage nationwide, especially by reducing the number of high-risk communities and ensuring that geographic and wealth disparities in coverage are minimized. 2. *Cold chain* - Strengthen the immunization supply system by implementing recommended activities in

[15] World Bank, MOH, MRD, and iDE. Forthcoming. *From Prescribing to Empowering: A Foundational Assessment of Implementers' Capacities to Deliver Wash-Nutrition Behavior Change*. Phnom Penh: World Bank.
[16] World Bank. 2016. *Utilization and Impact of Health Equity Funds: Improving Entitled Benefits Uptake by the Poor*. Phnom Penh, Cambodia: World Bank.

5. Behavior change communication (BCC) focused on 1,000-day window of opportunity 6. Removing financial and human resource barriers to scale up efficient nutrition-specific interventions 7. Leverage support through other ministries and initiatives 8. Improve nutrition data in existing information systems	[effective vaccine management] EVM improvement plans. 3. *Community awareness and demand* - Increase community awareness of, and demand for, immunization. 4. *Surveillance* - Strengthen the quality of surveillance of all vaccine-preventable diseases, involving all key stakeholders. 5. *Management capacity* - Strengthen management capacity at all levels to support the immunization program.

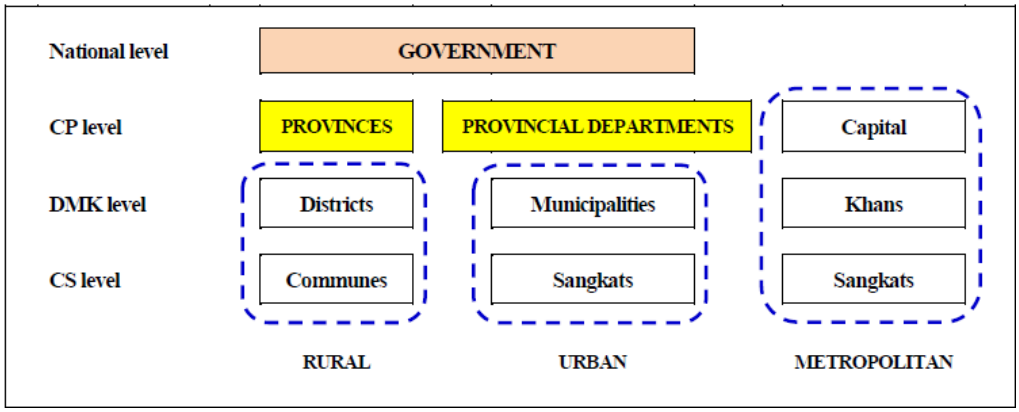
Source: MOH.

The Subnational Administration and its Role in Health Outcomes

22. Cambodia's subnational administration (SNA) system (figure 3) can be leveraged to improve health and nutrition outcomes. [17] Communes/Sangkats (C/S) are the lowest level of government and have the responsibility for identifying local needs through a C/S Development Plan process, which informs the preparation of the C/S Investment Program. Through their general mandate, C/S discretionary powers include social service provision and social protection. C/S are generally funded through the C/S Fund, an unconditional, mandatory, and steadily increasing grant from the central government budget. The C/S Fund includes a 'development' component (approximately one-third of the total fund) that finances projects outlined in the C/S Investment Program. While the general mandate of C/S covers a range of activities, C/S development funds have primarily been used for small infrastructure; social services, social protection, and local economic development are relatively underfinanced. However, the RGC is working to improve the transparency and responsiveness of local services through the Implementation of the Social Accountability Framework (ISAF) (see box 2) and has plans to improve the transparency and performance of C/S through a performance grant pilot.

[17] Cambodia has 25 provincial/capital administrations; 197 district, municipality, and khans administrations (in rural and urban areas, respectively); and 1,646 communes (rural) and sangkats (urban) (C/S) administrations. Provincial/capital administrations and district, municipality, and khans administrations are led by appointed governors and supported by a legislative wing of indirectly elected councilors, who are elected every five years through a body of electoral college made up of C/S councilors. C/S councilors elect village chiefs and councilors at the district and provincial levels. Each commune has, on average, ten villages, each with an appointed village chief.

Figure 3. Cambodia's SNA



Source: NCDD. 2017. *3 Year Implementation Plan, Phase III (2018–2020) of the National Program for Sub-National Democratic Development (IP3-III)*. Phnom Penh: NCDDS.

23. There are opportunities to leverage the C/S structure and function to improve MCHN. The C/S Committee for Women and Children (CCWC) was established in 2007 to provide advice and assistance in areas such as MCHN, water and sanitation, child protection, early childhood education, and vulnerabilities.[18] The CCWC includes a permanent member (or CCWC Focal Person [CCWC FP], often a female commune councilor) whose responsibilities include (a) preparing the annual work plan and budget of the Committee, (b) monitoring the implementation of activities and preparing activity reports for the Committee, (c) participating in collecting and analyzing information and data related to women and children issues, and (d) and coordinating and proposing the integration of women's and children's needs into the C/S Development Plan and C/S Investment Program and so on.

24. The MOH has identified C/S administrative units as a critical link in improving health outcomes. Through their general mandate functions, C/S can increase demand for and utilization of MCHN services and improve the management and accountability of health services to the citizens. The MOH's Community Participation Policy in Health (draft 2008) outlined key roles and responsibilities of all actors in the MOH and the SNA to improve health and nutrition. The MOH draft policy recommends the identification of two community health volunteers (locally known as Village Health Support Group (leaders), or VHSGs) per village to facilitate links between the community and the health centers and to coordinate and support

[18] Priority indicators for the CCWC FP include the following: Households with a pregnant woman who has not accessed ANC; Households with a pregnant woman who has not delivered her baby at a health facility; Households with children ages 12–23 months who have not received full immunization; Households with children under five years old who are wasted; Households without improved latrines; Households without access to safe drinking water; Households practicing positive discipline (nonviolence) to raise their children; Households with children who are at risk of family separation; Households with children who have been reintegrated from a residential care institution; Households with members who do not have birth certificates or certified birth certificates; Households with children ages three to five who are not attending any form of early childhood education; Households with primary school-age children whose caregivers have never met with school representatives to discuss issues regarding their children's education; Households with valid ID poor status; Households with persons/children with a disability who have not received any social services support or specialized services within the last 12 months. Source: Ministry of Interior. 2018. "Manual on Commune/Sangkat Social Service Implementation." Phnom Penh: Ministry of Interior.

Instruction No. 082 SNN/KCFF of August 08, 2007 on the Organization and Establishment of the Commune Sangkat Focal Point for Women and Children.

health center activities in the community. However, this policy is yet to be operationalized, largely due to the lack of consistent, scalable funding.

Box 2. ISAF in Cambodia

The ISAF in Cambodia aims to empower citizens, strengthen partnerships between SNAs and citizens, and leverage enhanced accountability of SNAs to improve local service delivery (in local government, health, and education). The ISAF is implemented through a partnership between the National Committee for Subnational Democratic Development-Secretariat (NCDDS) facilitating 'supply-side' service provider activities and civil society organizations (CSOs) mobilizing citizens around 'demand-side' activities.

The ISAF consists of three interlinked and mutually reinforcing actions, implemented in an annual cycle, and involving demand-side (civil society) and supply-side (state) actors:

1. Enhancing both service provider and citizen access to information about public service standards, performance, and budgets through Information for Citizens (I4C) materials such as posters with performance against minimum standards, budget, and spending from year to year
2. Parallel assessment of public services through self-evaluations by service providers and independent citizen-led monitoring and assessment, both using Community Scorecards
3. Creation and implementation of agreed Joint Accountability Action Plans (JAAPs) based on the priority actions identified and agreed between service providers and citizens to improve public service delivery

During Phase I (2016–2018), ISAF activities were rolled out to 75 percent (18 out of 24) of the provinces, 62 percent (98 out of 159) of the districts, and 56 percent (786 out of 1,409) of the rural communes across the country. Learning from Phase I indicates that the ISAF contributed to (a) enhanced transparency of key public services; (b) raised awareness of citizen rights and service standards; (c) strengthened citizen voice; (d) improved relations and trust between citizens and public officials and service providers; and (e) concrete improvements in local public service delivery.

ISAF Phase II (2019–2023) will aim to strengthen the engagement and ownership of line ministries in citizen monitoring and implementation of JAAPs, achieve full national coverage of communes, establish sustainable support networks for active citizenship, integrate social accountability practices into existing government systems, and expand the ISAF into new public services and urban areas.

Source: NCDDS. 2018. "ISAF Phase II (2019–2023) Implementation Plan." *Draft for Consultation.*

25. The absence of community health promotion and service delivery remains a fundamental bottleneck to improving health and nutrition outcomes.[19] Cambodia's community health and nutrition platform remains informal despite the availability of C/S financing, the presence of local implementation structures, and the MOH recognition of its importance. The CCWC FP often lacks the time, skills, support, and budget to carry out the prescribed responsibilities. Moreover, the health volunteers are disconnected from formal systems in health and C/S and do not have the resources or support to be fully effective.[20] Strengthening frontline primary health care is a priority to extend health information and services to the

[19] Globally, a well-functioning community-based health and nutrition platform has been recognized as a key approach to reducing stunting and improving maternal and child health. There is strong evidence that demand-side interventions with communities and households have been successful in improving determinants along the pathway to improved child nutrition practices and have even led to improvements in nutritional status and reductions in neonatal mortality. (References: Cruz, R. C. S., L. B. A. de Moura, and J. Neto. 2017. "Conditional Cash Transfers and the Creation of Equal Opportunities of Health for Children in Low and Middle-income Countries: A Literature Review." *International Journal for Equity in Health* 16: 161).

[20] World Bank, MOH, MRD, and iDE. Forthcoming. *From Prescribing to Empowering: A Foundational Assessment of Implementers' Capacities to Deliver Wash-Nutrition Behavior Change*. Phnom Penh: World Bank.

grassroots level and can further stimulate citizen voice, social accountability, social mobilization, and community surveillance for health and nutrition.[21]

Coordination, Stewardship, and Focus on Quality of Services

26. Stronger cross-sectoral collaboration and coordination at the national and subnational levels will also be critical for making progress on MCHN outcomes. Cambodia has the foundations of a comprehensive response to malnutrition: a national strategy, a cross-sectoral coordinating agency, and a high level of awareness across key stakeholders. Operationalization of coordinated actions, however, has been limited. The Council for Agriculture and Rural Development (CARD) is a coordinating and policy development unit chaired by the Deputy Prime Minister. CARD prepared the multisectoral National Strategy for Food Security and Nutrition (NSFSN) (2014–2018), the RGC's overarching framework to address nutrition and food security. Because it is not an implementing agency (IA), CARD faces challenges in securing sufficient financial, technical, and political resources to engage the implementing line ministries and the SNA[22] and hold them accountable for increasing resource allocations and scaling up priority interventions.

27. The passage of the National Social Policy Protection Framework (NSPPF) 2016–2025 constitutes a key shift in support for demand-side financing for health, with potential to positively influence RMNCAH-N outcomes. An interministerial initiative, the NSPPF outlines the country's direction toward universal health coverage (UHC) and includes (a) expansion of the HEF to non-poor informal workers and other groups, (b) the expansion of the National Social Security Fund (NSSF) and other prepaid insurance schemes, and (c) social assistance initiatives targeting pregnant women and young children.

C. Relevance to Higher Level Objectives

28. Improving MCHN is aligned with the priorities highlighted in Cambodia's national development framework, sector-specific strategies, and Cambodia's Sustainable Development Goal commitments. The Phase IV Rectangular Strategy for Growth, Employment, Equity, and Efficiency of the RGC (2018–2023) commits to translating Cambodia's peace and prosperity into investments in the Cambodian people and enhanced human capital. The strategy outlines a 'new transformation' to enable attainment of upper-middle-income country status, prioritizing investments in people through public health care and nutrition.[23] Project investments will contribute to strengthening service delivery quality by increasing the capacity, accountability, and efficiency of public services (in health and local government) at the frontline levels, thereby contributing to objectives set forth in the HSP-3, the Third Three-year Implementation Plan

[21] Community health platforms can be engaged on a variety of health promotion issues such as communicable and noncommunicable diseases, health security and infectious disease surveillance, reproductive health and family planning, and others.
[22] Key implementing agencies include the MOH; Ministry of Agriculture, Forestry, and Fisheries; MRD; Ministry of Education, Youth, and Sports; Ministry of Interior (MOI); Ministry of Planning; and Ministry of Industries and Handicrafts. The NCDD plays an important role in mobilizing implementation among SNAs.
[23] The strategy promotes "uplifting the quality, safety, and effectiveness of health services," "introducing interventions to enhance nutrition," and "establishing a multisectoral mechanism with participation from the community and sub-national administration in areas suffering from insufficient nutrition" as means of accelerating investments in people.

(IP3-III), the NSFSN, and the ISAF. Project activities will help accelerate Cambodia's achievement of the Sustainable Development Goals (namely, 2.2 to reduce all forms of malnutrition and 3.8 to achieve UHC).

29. Principles of investing in human capital—beginning in early life—as a driver of future prosperity and growth underpin the World Bank's twin goals and the strategic engagement in Cambodia. These principles are reflected in the proposed project activities. The SCD (Report No. 115189-KH) highlights three channels to sustain growth, reduce poverty, and boost shared prosperity in Cambodia; Pathway 2 promotes the acquisition of human assets to facilitate economic mobility and shared prosperity, particularly through investing in the early years of life. The forthcoming Country Partnership Framework (CPF) for Cambodia, covering 2019-2023 includes a prominent focus on improving service delivery quality and accountability, human capital, and equity; the project will make significant contributions toward these objectives and includes in its Results Framework the proposed CPF indicators on this priority area. The project anchors a portfolio response to malnutrition, and the CPF includes projects that finance nutrition-sensitive interventions in the WASH; agriculture; and education sectors (see box 3).Though the drivers of poor RMNCAH-N outcomes span across sectors, the project will focus primarily on a subset of health and nutrition-specific interventions delivered in health facilities and communities; however, the project will support cross-sectoral coordination and monitoring at the national, provincial, district, and community levels.

Box 3. A Multisectoral Approach to Improving Nutrition in Cambodia

The World Bank and its pooled fund partners are supporting the RGC in taking a multisectoral approach to improving maternal and child nutrition outcomes and human capital formation in the early years. This strategic approach is evident in a portfolio that supports the RGC in strengthening and consolidating nutrition governance, harmonizing and converging interventions, and scaling up subnational coordination mechanisms.

A 'portfolio' approach for this agenda is derived from an investment portfolio of four main projects: (a) this project (P162675); (b) the Cambodia Agricultural Sector Diversification Project (P163264); (c) the Cambodia Water Supply and Sanitation Improvement Project (P163876); and (d) the Cambodia Health Equity and Quality Improvement Project (H-EQIP) (P157291). Except for H-EQIP (FY16–21), the projects have fully aligned effectiveness periods from FY19 to FY23. Principles of social accountability supported through the Voice and Action: Social Accountability for Improved Service Delivery (P146160) Project (closing March 2019) will cut across all relevant portfolio projects. The projects in this portfolio approach aim to address the immediate and underlying causes of malnutrition in Cambodia and will have a strong focus on the rural, remote, and poor populations concentrated in the Northeastern provinces to improve equity of nutrition outcomes.

The health and WASH sectors are undertaking analytical work to provide national-level policy support and strengthen nutrition governance. The teams are providing technical assistance (TA) to CARD to revise the NSFSN and co-chair the sub-technical working group for WASH-Nutrition; pooled-fund partner Germany (with investments in this project as well as in H-EQIP) chairs the Technical Working Group for Food Security, Nutrition, and Social Protection (TWG-FSN&SP). CARD considers the IDA/pooled-fund support to line ministries for subnational implementation and coordination as key to operationalizing the revised NSFSN. The teams are supporting line ministries to develop harmonized SBCC strategies and implementation (the MOH Maternal, Infant, and Young Child Nutrition [MIYCN] Strategy and the Ministry of Rural Development [MRD] Nutrition-Sensitive WASH Strategy). The Cambodia Agriculture Sector Diversification Project will support producer alliances to improve farmer income and market availability of nutritious products. The teams are discussing support for an alliance to produce a locally made, micronutrient-rich fish-based complementary food for children age 6–23 months and pregnant women, while the Cambodia Nutrition Project (CNP) is to work on demand creation and consumption (working with United Nations Children's Fund [UNICEF], private sector, Ministry of Agriculture, Forestry and Fisheries, MOH, and Global Financing Facility in Support of Every Woman, Every Child [GFF]).

A multisectoral human-centered design implementer assessment provided insights into the design of community-level implementation of BCC, service delivery, and coordination. The result is growing consensus across the MOH, MRD, and National Committee for Subnational Democratic Development (NCDD) regarding the approach to the implementation of commune activities and the results-based financing of 'social' activities through the SNA (aligned with the C/S Fund). The teams are further leveraging the ISAF experience and learning to integrate community scorecards into the process of performance-based financing for communes and social accountability into support for line ministries. Further, the design of the community platform builds on the experience of the German Agency for International Cooperation (*Deutsche Gesellschaft für Internationale* Zusammenarbeit, GIZ) Multisectoral Food and Nutrition Security in Cambodia Project (MUSEFO) in working at the commune, district, and provincial levels for multisectoral nutrition coordination and will incorporate learning from the project experience.

30. The project is also aligned to the objectives and priority focus areas for the contributing partners: the GFF in support of Every Woman, Every Child, the One World No Hunger special initiative of the Germany's Federal Ministry for Economic Cooperation and Development (BMZ), Germany's contribution through the H-EQIP multi-donor trust fund (MDTF) for HEF promotion, and the Government of Australia's 2017 Foreign Policy White Paper, which recognizes the importance of good health and strong and resilient health systems to support productive societies and economic growth and investment in Integrating Donor-Financed Health Programs (see box 4 for details on contributing partners for this project).

Box 4: Pooling Partners for the CNP

The GFF in support of Every Woman, Every Child - US$10 million

The GFF is a broad financing partnership to assist countries in setting the trajectory to achieve the health-related Sustainable Development Goals by strengthening dialogue among key stakeholders under the Government's leadership. More specifically, the GFF objectives are to (a) support the identification of a clear set of priority RMNCAH-N results that all partners commit resources to achieving; (b) get more results from existing health resources and increase the total volume of financing for health; and (c) strengthen systems to track progress, learn, and course-correct for reductions in preventable maternal and child deaths and improved health and well-being for vulnerable women, children, and adolescents. Cambodia's engagement with the GFF was launched in December 2017 and has proceeded in parallel to the preparation of this project. In addition to co-financing the IDA project in Cambodia, the GFF aims to mobilize additional resources from partners, the private sector, and at the national level in support of the priority issues identified during the development of the RMNCAH-N Investment Case. Beginning with a May 2018 Investment Case Prioritization Workshop in Kep and continuing with the December 2018 Investment Case workshop in Phnom Penh, the RGC took a systematic and participatory approach to developing the Investment Case priorities. Identified priorities are reducing neonatal mortality, lowering teenage pregnancy, and addressing child undernutrition, focusing on closing equity gaps in seven priority provinces. A short list of 16 interventions (consolidated from 25)—including newborn care practices, coverage and access to quantity and quality ANC/PNC, nutrition counselling during ANC and promotion of early initiation, and exclusive breastfeeding and complementary feeding—was also selected for priority implementation. It is expected that the Investment Case will be finalized during the first quarter of 2019. It will outline the vision to 2030, a comprehensive Results Framework, and a plan to strengthen health information systems, improve efficiency of health resources, and achieve equity of outcomes for Cambodia's disadvantaged women, children, and adolescents.

Germany's Special Initiative One World, No Hunger through German KfW - US$9 million

BMZ special initiative One World, No Hunger represents the German development cooperation's commitment to support the Sustainable Development Goals to end hunger and malnutrition. The BMZ is investing roughly EUR 1.5 billion annually to support improve food and nutrition security globally, focusing on the rural poor. The One

World, No Hunger initiative is supporting over 17 partner countries that are struggling with food security and malnutrition. Germany is also supporting the Scaling Up Nutrition (SUN) Movement in Cambodia, chairing the Donor Network as well as co-chairing the TWG-FSN&SP. The KfW has received support from the BMZ to invest US$10 million from this global initiative as a pooled investment in this project.

Australia's Support through the Trust Fund for Integrating Donor Financed Health Programs (IDFHP) - US$5 million

Australian DFAT is the largest contributor to the MDTF on integrating externally financed health programs, which supports developing countries in sustaining progress on UHC while effectively managing the transition from and integration of externally financed health programs. Other contributors include the Bill & Melinda Gates Foundation, GAVI, and Global Fund. The investment supports policy-relevant analytical work and provides resources for targeted in-country TA, global/regional knowledge sharing activities, and co-financing of health system strengthening interventions that help improve outcomes for communicable diseases such as immunization, HIV, TB, malaria, and health security that are affected by both the epidemiological and health financing transitions. Australia's support currently covers 10 countries in the East Asia and Pacific region and is organized around three windows: HIV, TB, and malaria; immunization; and health security. Financial support to this project is from the immunization window and will co-finance (a) addressing of gaps and enhanced quality of routine immunization services and routine integrated outreach, (b) transport support for the HEF children's immunization visits, and (c) community-based demand creation for immunization services and monitoring of immunization coverage.

H-EQIP MDTF - US$2 million

The H-EQIP MDTF (with contributions from Australian Aid, Germany's KfW, and the Republic of Korea's KOICA) received an additional financing in December 2018, which included a sum of US$2 million to be invested through this project in HEF promotion activities.

II. PROJECT DESCRIPTION

A. Project Development Objective

PDO Statement

31. The Project Development Objective is to improve utilization and quality of priority maternal and child health and nutrition services for targeted groups in Cambodia.

32. The project will finance 'priority maternal and child health and nutrition services', a subset of interventions drawn from the MOH Investment Case for RMNCAH-N in Cambodia (Table 5).[24] These priority services are aimed at reducing neonatal mortality, improving maternal and child nutrition, and improving routine immunization coverage (referred to herein as 'priority RMNCAH-N outcomes'). The priority services were defined in accordance with the expectation of the RGC to converge on interventions with known effectiveness to increase sustainability and efficiency of RMNCAH-N financing. Targeted groups include pregnant and lactating women and children in the first 1,000 days of life as well as the targeted areas of Mondul Kiri, Ratanak Kiri, Kratie, Stung Treng, Preah Vihear, Kampong Chhnang, and Koh

[24] The interventions prioritized in the draft Investment Case are derived from the HSP-3, the FTRM-N, the NIP-SP, the FTIRM and the National Strategy for Reproductive and Sexual Health. The priorities were identified through multiple rounds of multistakeholder consultation conducted for Cambodia's participation in the GFF in support of Every Woman, Every Child and endorsed by the MOH. As the project will finance only a subset of Investment Case interventions, it will similarly constitute only a piece of the required Investment Case financing.

Kong provinces. These seven provinces were prioritized in the RMNCAH-N Investment Case due to their high burden (in absolute and relative terms) of lagging health outcomes, their relatively high deprivation using multidimensional poverty indicators, and their gaps in supply-side service readiness.

Table 4. Priority Services for Project Support

1. Increase coverage, access to, quality, and quantity of ANC, including maternal nutrition, particularly for rural and urban poor communities.
2. Expand the screening, management, and treatment of severe acute malnutrition (SAM) nationwide, including community-based screening, conduct systematic follow-up visits of children under treatment to ensure provision of adequate care at community level, detect medical issues, and prevent defaulting.
3. Increase coverage and access to quality delivery care.
4. Increase the availability of GMP in health facilities and communities.
5. Improve early and essential newborn care practices.
6. Increase the availability and quality of MIYCN promotion (including early initiation and exclusive breastfeeding and complementary feeding) in health facilities and communities.
7. Improve quality and quantity of PNC.
8. Increase delivery of integrated outreach services.
9. Improve quality of the management of sick newborn.
10. Improve routine immunization and fill gaps in coverage
11. Improve the management/prevention of low birth weight births.

PDO Level Indicators

33. The PDO indicators capture improvements in priority service coverage and the quality priority service provision through facility- and community-based approaches.

Table 5. Indicators by PDO Element

PDO Element	PDO Indicators (source)
To improve utilization of priority maternal and child health and nutrition services	(a) Percentage of children born in the last 24 months who were put to the breast within one hour of birth (Impact Evaluation) (b) Number of children under 12 months of age in target areas receiving DPT-HepB-Hib 3 in the last calendar year[25] (HMIS)
To improve quality of priority maternal and child health and nutrition services	(c) Percent of children age 6-23 months of age in target provinces who receive foods from 4 or more food groups, by gender (Impact Evaluation) (d) Percent of pregnant women in target areas receiving micronutrient supplementation in accordance with national guidelines (HMIS) (e) Number of health facilities in target areas scoring over 60 percent on their Maternal and Child Health and Nutrition Scorecards (project administrative data) (f) Number of Commune/Sangkats in target areas receiving Commune/Sangkat Service Delivery Grants (C/S-SDGs) for women and children (project administrative data)

[25] Penta-3 vaccine

34. PDO indicators were selected to capture utilization of services that have wide availability at health facility contacts (breastfeeding initiation during facility-based delivery and immunization through well-child visits/outreach). Service quality is defined as the extent to which the delivery of priority health services is translated into the priority health and nutrition outcomes. In addition to directly measuring changes in these outcomes (c), PDO indicators capture multiple elements of service quality in the Cambodian context. Indicator (d) specifically relates to adherence to clinical guidelines (and increased likelihood of improving nutritional status), while (e) and (f) capture the outcome and coverage, respectively, of the project's investments in performance-based financing for quality improvement. The MCHN Scorecard is aligned to Cambodia's NQEM process and measures and rewards specific, quantifiable aspects of service quality, including structural (inputs), process (encounter between patient and health care professional), and outcome (health and patient satisfaction) domains. Therefore, indicator (e) will monitor improvements in these quality domains at the health center level, while indicator (f) demonstrates enhanced coverage of quality assessment and improvement processes at the C/S level.

35. Data for PDO indicators will primarily be collected from administrative systems (the HMIS and project data). Project investments will support improvements in the scope, quality, and availability of administrative data to enhance results monitoring through the life of the project. As behavior change is important to the PDO but infrequently and poorly captured through administrative data systems, the team has proposed two PDO indicators that will be derived from survey data forming part of an impact evaluation to complement the Government's results monitoring arrangements (see Subcomponent 3.3). The impact evaluation will include facility, community, and household survey instruments and capture a suite of behavioral indicators and health/nutrition outcomes to better establish the project's impact pathways. The impact evaluation will also include indicators to monitor the underlying determinants of nutritional status (in WASH, agriculture, care, and others) and access to related services. The impact evaluation will be financed using TA resources available through the World Bank and its partners, outside the recipient-executed project resources and a baseline survey will be rolled out before the initiation of interventions in the field (data collection anticipated June–August 2019).

B. Project Components

36. The project aims to serve as an anchor for an enhanced and coordinated response to accelerate the country's human capital formation focusing on MCHN in the early years. The project brings together global evidence on effective interventions with Cambodia's priorities and employs three complementary approaches to deliver facility- and community-based health and nutrition interventions:

(a) **Build** upon existing government platforms. The project will use the existing MOH implementation arrangements for the HEF and SDG (for example, management, fund flow, performance instruments, and so on supported under the H-EQIP) to enhance supply-side delivery and quality of priority health and nutrition services in health facility and health outreach activities. It will use the C/S existing structures, cadres, and processes to deliver community-based interventions. For both the MOH and C/S activities, the project will focus on maximizing the impact of instruments and arrangements to achieve priority RMNCAH-N outcomes.

(b) **Link** beneficiaries with their service providers. The project will extend service provision beyond health facilities through enhanced integrated health outreach activities for pregnant

and lactating women (including adolescents) and children and a harmonized approach to community mobilization and service delivery for health and nutrition. In so doing, the project will aim to increase demand for priority services.

(c) **Strengthen** public sector performance, accountability, and systems to sustainably deliver priority health and nutrition services. The project will focus on capacity building from the central to the frontline levels in functional and technical aspects, work with C/S and health centers to sustainably mobilize resources for priority interventions, routinely monitor and improve program performance, and converge local actors across sectors.

37. The PDO will be achieved through three components: Component 1: Strengthening the Delivery of Priority Health Services; Component 2: Stimulating Demand and Accountability at the Community Level; and Component 3: Ensuring an Effective and Sustainable Response.

Component 1: Strengthening the Delivery of Priority Health Services (US$24 million)

38. Component 1 leverages the HEF and SDG systems—existing results-based health sector platforms—to improve the supply-side delivery of priority interventions. The component will aim to improve the accessibility, affordability, and quality of these priority services. The component has two subcomponents outlined in the following paragraphs.

39. **Subcomponent 1.1: Performance-based Service Delivery Grants (SDGs) to Improve Availability and Quality of Priority Services (US$18 million).** Subcomponent 1.1 will build on Cambodia's NQEM processes to accelerate improvements in health service quality across the continuum of care for women and children. A performance-based SDG payment will be provided to health facilities based upon performance on a MCHN Scorecard.[26] The MCHN Scorecard will focus on the 11 priority services, including reduction of gaps in routine immunization and improvements in integrated outreach.[27] The MCHN Scorecard will be based on the structure of the existing NQEM Tools (using structural, process, and outcome quality) and aim to encourage adherence to clinical best practice, patient awareness and satisfaction, and provider performance and accountability (including, for example, through adherence to ISAF supply-side guidelines). The MCHN Scorecard and its associated payment will be the main innovations to the existing SDG system. In addition to health facilities, the subcomponent will finance performance-based top-ups to SDG assessors to conduct the MCHN Scorecard assessments (at OD and PHD levels, as appropriate). With these exceptions, the subcomponent will remain fully integrated within the usual assessment and verification processes of the NQEMP (see annex 1 for implementation arrangements and fund flow). All existing SDG implementation arrangements related to quarterly assessment, scheduling of ex ante and ex post verification, payment modality, and management will be followed as per the NQEMP procedures and as described in the SDG manual. Annex 3 includes an overview of the existing SDG system

[26] Cambodian experience with thematic SDG expansion (for instance, with an Indigenous Peoples' Scorecard) has indicated that the preferred method of such additions is through supplementary instruments rather than integrating indicators and introducing a sub-score on the standard balance scorecard.
[27] Financing under the subcomponent is not intended to cover the full cost of RMNCAH-N service delivery. Rather, it will complement existing supply-side investments, fixed lump-sum grants, standard performance SDGs, HEF receipts, and other health facility revenues to provide an incentive to health providers to focus on priority services.

and proposal for the details on the MCHN Scorecard indicators, assessment process, and verification mechanisms.

40. The MCHN Scorecard will be gradually rolled out with the quarterly SDG process. In the first phase, the scorecard will be (a) applied only in health centers and (b) rolled out only in the seven priority provinces identified above. At the midterm review, expansion of the subcomponent will be initiated, with potential options including (a) developing and deploying a tool for referral hospitals in the target provinces, (b) providing nationwide expansion of the health center scorecard, and/or (c) incorporating measures of service utilization and facility-level outcomes into the MCHN Scorecard tool.

41. **Subcomponent 1.2: Expanding Health Equity Funds (HEFs) (US$6 million).** This subcomponent aims to enhance the equity of priority RMNCAH-N outcomes through an expansion of the scope of coverage for the current HEF system (details in annex 3). These expansions of service and population coverage will increase utilization of priority RMNCAH-N services among targeted vulnerable populations. All other existing HEF implementation arrangements related to use of HEF monitors, the Patient Management and Registration System (PMRS) software payment modality, and management will be followed. The project will support three areas of HEF benefit expansion (table 6).

Table 6. HEF Expansion

1. Definition of standard operating procedures (SOPs) for a well-child visit for children age 0–2 years	A revised SOP with clear reimbursement guidelines will form the basis of HEF reimbursements and will help stimulate the provision of integrated well-child services (namely immunization, micronutrient supplementation, deworming, GMP, and IYCF counselling).
2. Extension of HEF benefits to the children (age 0–2 years) of informal workers	The Ministry of Economy and Finance (MEF) and the NSSF have defined a process to expand HEF coverage to informal workers who are neither ID poor nor post-ID and have been registered by the NSSF. However, the current scheme does not cover children of the informal workers. Based upon the final decision and guidance provided by MEF, the subcomponent can finance HEF benefits for the children (age 0–2 years) of these informal workers.
3. Transport allowances for priority services	The component will finance transport costs for four ANC visits, delivery, and 10 child (age 0–2 years) health visits to health centers. Transport allowances will be limited to ID-poor and post-ID beneficiaries, who bear a disproportionate burden and face access barriers due to the cost of accessing these services. Initially, this transport allowance will also be limited to the seven priority provinces. The MOH and the MEF, in consultation with the funding partners of this project, will define an appropriate transport benefit amount (that is, in turn, based upon the distance from residence to the health center) to be financed under the project.

Component 2: Stimulating Demand and Accountability at the Community Level (US$10.8 million)

42. Component 2 will finance community-based interventions in the seven priority provinces to stimulate demand, increase utilization of facility-based priority services, and encourage the adoption of improved RMNCAH-N behaviors. Component objectives are to (a) strengthen the links between the subnational administration, the public health providers, and the citizens; (b) create demand and increase access to priority health and nutrition services; and (c) strengthen public sector commitment and accountability to improve the availability and quality of priority health and nutrition services ; and (d) use

performance-based grants to improve SNA delivery and sustainable financing of relevant social service activities linked with the project's priority services. The NCDDS of the MOI will implement Component 2, and C/S supply-side actors will deliver RMNCAH-N demand creation activities. Active engagement from the MOH to define the community level intervention package is necessary for the component's success and to avoid duplication of activities across components (described further in Component 3 and annex 1).

43. The component will aim to reduce fragmentation and increase the sustainability of community health and nutrition activities by operationalizing a standardized Commune Program for Women and Children (CPWC)[28] to serve as the community-based health and nutrition platform (with formal links between the SNA and MOH actors. The CPWC will be piloted as a community platform for health and nutrition promotion in the seven priority provinces. Under Component 3, the MOH will develop the package of activities for VHSGs to support this program. The package will include, at minimum, (a) social mapping for first 1,000 day households; (b) targeted health and nutrition SBCC through door-to-door home visits, community groups, and/or community-based GMP; (c) HEF promotion to increase service utilization among the poor; (d) community mobilization, including for SAM screening; and (e) health center management committee (HCMC) meetings, including integration of ISAF supply- and demand-side aspects, as relevant. In addition to these minimum activities, other commune- and village-level social activities may be incorporated as per NMCHC and C/S priorities (outlined in the Commune Development Program). The CPWC activities will be adapted, as relevant and necessary, to address the needs (activities, language, and so on) in indigenous communities where it will operate.

44. The CPWC will formalize the responsibilities and relationships between existing cadres using implementation arrangements based upon the 2008 draft Community Participation Policy in Health. This includes the Commune Council; CCWC FP; Commune Clerk and other permanent staff; Village Chief, Village Assistant, and Village Commune Council Focal Point (together, these would constitute the 'Village Team'); VHSGs; and others through the development of clear operational guidelines. Commune- and village-level actors will take on the CPWC administrative and management functions, while local health staff will provide regular frontline quality assurance and coaching as part of their activities under Subcomponent 1.1. A main innovation of the CPWC platform will be the regular engagement of the village volunteers and public sector provision of performance monitoring and incentives (financial and nonfinancial).

45. The component will channel financial support to C/S to implement the CPWC in the form of a performance-based grant. The component will finance a new initiative of performance-based grant to C/S to enable the scale-up of the CPWC's community-based health, nutrition, and HEF promotion activities (Subcomponent 2.1), alongside results-based (Subcomponent 2.2) and input-based (Subcomponent 2.3) investments in the underlying systems and capacities in districts, provinces, and NCDDS necessary to deliver such activities.

46. The project's will deliver a thematically focused (MCHN promotion) special grant as an entry point to design and implement performance-based financing for communes. The aim is to build systems for results-based planning, budgeting, social service implementation, monitoring, and fund flow arrangements for C/S. Aligned with the Government's plan for decentralization and deconcentration

[28] The name CPWC has been used to align with the mandate of the CCWC which extends beyond health and nutrition. If it is successful and feasible, it may be possible to expand the scope of CPWC activities beyond those proposed in the project.

(D&D), the new initiative will also provide the learning necessary for the NCDDS to expand this concept to the broader general mandate in the future.[29] Due to the nature of the activities and the flexibility of the associated planning, budgeting, and financing, the CPWC and C/S-SDG together will serve as mechanisms to promote bottom-up coordination to address multisectoral drivers of undernutrition. The sustainability of this platform will be based upon the commitment and direction of the MOH and NCDDS to subsume CPWC and/or related social activities within the commune structure and sustained through C/S funds.

47. **Subcomponent 2.1: Commune/Sangkat (C/S) Service Delivery Grants (C/S-SDGs) for Women and Children (US$6.9 million).** Subcomponent 2.1 has two main elements: (a) performance-based financing to C/S through a C/S-SDG to operationalize the CPWC and deliver a package of community-based priority RMNCAH-N and HEF promotion activities and (b) performance-based financing through C/S-SDG to District/Khan (D/K) to conduct C/S-SDG assessment.

48. **C/S-SDG.** Subcomponent 2.1 will finance C/S to deliver the CPWC package of health, nutrition, and HEF promotion activities using the performance-based C/S-SDG grant. The grant adapts the successful MOH SDG system and applies the principle to the SNA. C/S-SDG will provide discretionary support to communes over and above the C/S Fund to ensure the delivery of activities according to the CPWC guideline. The financing formula will be outlined in the C/S-SDG manual and based on quantity (commune size) and quality (performance on a C/S-SDG checklist). The full eligible expenditure list will be defined by the MEF in collaboration with the MOH and NCDDS and included in the C/S-SDG manual but will include activities such as (a) CPWC operational cost, (b) performance incentives to village volunteers, and (c) other activities as required to improve C/S-SDG scores. Commune performance on C/S-SDGs will be systematically assessed through semiannual assessment by a district assessment team.

49. **C/S-SDGs to D/K Administration.** These C/S-SDGs aim to strengthen the performance of D/K administration in conducting the C/S-SDG assessment process. The C/S-SDG assessment will build upon experience of OD assessment of health centers/referral hospitals under H-EQIP as well as the citizen monitoring using community scorecards under the ISAF.[30] D/K will conduct assessment of C/S, report on their own activities in a standardized D/K checklist, and submit the scores to the NCDDS. The checklist will include elements such as the regularity and timeliness of assessment, extent of discrepancies in the previous two rounds compared to independent verification scores, participation in oversight and coaching, and responsiveness on citizen feedback.

50. Following receipt of C/S-SDG scores and D/K reports, the NCDDS will certify C/S and D/K performance and request the MEF to electronically disburse C/S-SDG funds to commercial bank accounts at C/S level and D/K accounts. An independent agency will be contracted under Subcomponent 2.3 to conduct independent verification of the C/S and D/K scores. Annex 3 includes proposed C/S-SDG checklist indicators, assessment, and verification processes. The C/S-SDG assessment and verification processes will leverage the CPWC actors and mechanisms to integrate the transparency, community monitoring, and joint annual planning (between the community, commune, and health sector) as outlined in the ISAF.

[29] Appropriate revisions can be made to project operations manuals and implementation arrangements as and when such broader commune grants are rolled out.
[30] Additional mechanisms for social accountability will be considered for integration into the performance measurement system, including I4C disclosure and public disclosure of C/S-SDG scores.

51. **Subcomponent 2.2: Building Capacities, Monitoring, and Verifying C/S-SDG (US$1.65 million).** This subcomponent will support the activities necessary to activate and operationalize the C/S-SDG system, including (a) development of the C/S-SDG implementation guidelines and capacity building and coaching for the SNA to implement the program; (b) establishment of a system of timely payments to C/S and strengthening fiduciary oversight at the subnational level; and (c) timely conduct of six-monthly commune ex ante assessment.

52. The subcomponent will be financed using DLIs, a method of payment against delivery of results (a set of tracer indicators with annual targets linked to systems strengthening actions). The DLI approach reimburses the RGC against eligible expenditures referred to as Eligible Expenditure Programs (EEPs).[31] Once achievement of a DLI target is verified, funds are transferred to the MEF against the defined EEPs, which is the Government contribution to Component 1 (HEFs and SDGs) as set forth in the Operational Manual (OM). The DLI manual will outline the project EEPs, the procedures related to partial and overachievement, scalability of DLIs, discrepancies with external verification, and rollover. Table 7 provides the proposed DLIs for Subcomponent 2.2 (detailed annual DLI targets and verification protocol in annex 4).

Table 7. DLIs for Subcomponent 2.2

DLI	Focal Point	Name
A	NCDDS	Subnational capacity building and rollout of C/S-SDG system
B	NCDDS	Sustained timeliness of C/S-SDG payments and fiduciary oversight
C	NCDDS	C/S-SDG assessment and coaching in accordance with guidelines

53. **Subcomponent 2.3: Project Management, Monitoring, and Evaluation for the NCDDS (US$2.25 million).** Project management for Component 2 will be integrated into the responsible units and departments of the NCDDS. This subcomponent will support provision of technical and operational assistance for routine administration; procurement; financial management (FM); environmental and social safeguards management; cross-project coordination; and monitoring, evaluation, and reporting of Component 2 activities (including internal audits of NCDDS activities). The subcomponent will finance the procurement of a third-party entity to conduct ex post independent verification of C/S-SDG scores and procurement of comprehensive services from a firm to transition from a paper-based assessment system to an IT-based C/S-SDG system.

Component 3: Ensuring an Effective and Sustainable Response (US$18.2 million)

54. This component will finance (a) central-level actions needed to enhance the effectiveness and sustainability of project investments; (b) development and delivery of modernized SBCC campaigns; (c) comprehensive monitoring, evaluation, and adaptive learning; and (d) project management.

55. **Subcomponent 3.1 Strengthening the functional and technical capacities at national and subnational levels (US$6.45 million).** This subcomponent will support MOH national centers and departments to (a) create an enabling environment and (b) improve supply-side readiness, responsiveness, effectiveness, and delivery of priority interventions financed under Components 1 and 2.

[31] The DLI approach is currently used under the World Bank-financed health and higher education operations in Cambodia and is an MEF-preferred financing modality to support more sustainable improvements in service quality.

Table 8 provides the proposed DLIs for the subcomponent, and annex 4 provides the detailed breakdown of annual DLI targets and values specified for each DLI, and the DLI verification protocol. Additional details will be included in the OM.

56. Similar to Subcomponent 2.2, financing for Subcomponent 3.1 will be based on delivery of results tracked by DLIs. The DLIs will support the relevant units' contributions to effective program functioning on a performance basis. The DLI manual will detail the procedures related to partial and overachievement, scalability of DLIs, discrepancies with external verification, and rollover. When deciding on the amount to be disbursed based on DLI achievement, the following arrangements will be made. Since the results from external verification may vary from those reported by the project, a discrepancy of up to 5 percent between the internal and the external verification will be accepted as having achieved the target. Unless otherwise specified, in the case of partial achievement of a DLI target in a given year, a minimum value of 60 percent of the DLI target must be achieved to qualify for payment. In cases of achieving less than 100 percent but more than 59 percent, the disbursement will be 50 percent of the DLI value (rounded to the nearest whole number); the amount not disbursed can be rolled over to the following year and disbursed in case the level of achievement of the following year's target equals or exceeds the previous year's target (in case of cumulative targets). If targets are noncumulative, that is, they need to be attained in each year separately, then the amount not disbursed can be rolled over to the following year and be disbursed in case the target in the following year is overachieved by at least the same margin as it was underachieved in the previous year. If, by Year 4, all funds for Subcomponents 2.2 and 3.1 have not been disbursed due to nonachievement of DLIs, the remaining amount may be cancelled or reallocated through a restructuring.

57. DLI targets will be verified by a third-party mechanism (using World Bank-executed funds). Funds achieved through DLIs will be transferred to the MEF against the defined EEPs (the Government contribution to HEFs and SDGs under Component 1 of the project). The MEF will review and monitor the use of DLI funds following the RGC's SOP system, as set forth in the project OM, to support investments in attaining DLIs for future years and for consolidating the gains made by these DLI-related investments by the MEF. Clear guidelines on measuring the results will be agreed at the beginning of implementation and included in the project OM. If the annual DLI target for each year is not fully met by the end of the year, payment will be delayed until the result is fully achieved in a subsequent year. DLI performance will be assessed every six months during the joint project review missions. An annual DLI status report will be due every year by September 30 (starting with the year 0 report on September 30, 2019) and an additional optional semiannual report can be submitted by March 31 every year. These DLI status reports will be compiled by each IA and will be sent to the World Bank through the project director. Once achievement of a DLI target is verified, funds will be transferred to the MEF against the defined EEPs, which is the Government contribution to HEFs and SDGs.

Table 8. DLIs for Subcomponent 3.1

DLI	Focal Point	Name
D	National Nutrition Program (NNP)	Ongoing readiness and quality of priority nutrition services
E	Preventive Medicine Department (PMD)	Delivery of an integrated outreach package including priority MCHN services
F	NMCHC	Comprehensive coaching conducted for MCHN Scorecard
G	National Center for Health Promotion (NCHP)	Communications materials, training, and supervision delivered for VHSGs and HEF Promotion

DLI	Focal Point	Name
H	PCA	Sustainable institutional arrangements for HEF and SDG payment and certification
I	Quality Assurance Office (QAO)	MCHN service quality monitoring enhanced and mainstreamed in the MOH
J	Department of Budget and Finance (DBF)	Timeliness of MCHN-SDG and HEF payments ensured and continued FM capacity building for health centers
K	Department of Planning and Health Information (DPHI)	Regularity of MCHN data availability enhanced

58. **Subcomponent 3.2: Development of a Comprehensive Social and Behavior Change Communication (SBCC) Campaign (US$5.6 million).** The subcomponent will support the NMCHC, NNP, and NCHP to design and roll out modern, innovative, and effective SBCC campaigns. Delivery of interpersonal communications will be financed under Subcomponent 1.1 (for health facilities and outreach) and Subcomponent 2.1 (for community-level activities). Subcomponent 3.2 will use input financing to support (a) TA and formative research to develop messages and content; (b) development of materials (mass/social media production, printed goods, materials, supplies, and so on); and (c) support for operationalization (the development of training materials, operational guidelines, air time on television and radio stations, website maintenance, and so on). This subcomponent will also finance the development and delivery of technology-enhanced communications interventions (for example, app development and hardware rental and maintenance) to improve the quality and reach of SBCC interventions.

59. The component will finance the finalization and rollout of the MIYCN campaign (for which there has been ongoing strategic and technical support[32]), the development and rollout of HEF promotion and other health promotion activities in collaboration with relevant departments, and the overall CPWC (including HCMC meetings and VHSG materials). Mass/social media activities will be designed for national coverage, while the interpersonal communication activities will have a phased rollout beginning with the seven priority provinces. Implementation of the subcomponent activities will be aligned with the project's safeguards instruments and ensure inclusion of indigenous populations' language, barriers, and norms.

60. **Subcomponent 3.3: Monitoring, Evaluation, and Adaptive Learning (US$2.5 million).** The subcomponent will support the strengthening of monitoring and evaluation (M&E) systems for RMNCAH-N in Cambodia, including gender-disaggregated data collection, reporting, and analysis at subnational and national levels; strengthening of M&E human resources in the MOH; and updating of data systems to meet reporting needs. The subcomponent will finance operational research, field monitoring and supervision, domestic and international training, and updating information and communication technology (ICT) systems. The subcomponent will be supplemented by a World Bank-executed impact evaluation to assess the effectiveness of the project's interventions in improving health and nutrition

[32] With technical support from UNICEF, Helen Keller International, Alive & Thrive, and the World Bank, the NNP has conducted robust formative research into MIYCN behaviors, developed a comprehensive national strategy, and initiated the development of a multichannel and contextually relevant SBCC campaign. The World Bank WASH and health, nutrition, and population (HNP) teams have collaborated with the MRD and NNP to conduct an implementer assessment to support operationalization of the campaign.

outcomes. Implementation research questions will be jointly agreed between the MOH and NCDDS and pooled fund partners to complement the assessment of plausibility under the impact evaluation.

61. **Subcomponent 3.4: Project Management (MOH) (US$3.65 million).** Project management will be integrated into the responsible departments of the MOH. This subcomponent will finance the provision of technical and operational assistance for the day-to-day coordination, administration, procurement, FM, environmental and social safeguards management, and reporting of the project, including the carrying out of financial audits of the whole project. The subcomponent will also support capacity strengthening of responsible departments with the MOH to ensure continued ability of relevant departments to support project management, implementation, and coordination needs.

Project Cost and Financing

62. The total project cost is outlined in table 9. The RGC has requested an IDA Credit of US$15 million equivalent. Australian DFAT, German KfW, H-EQIP MDTF, and the GFF have committed a total amount of US$26 million equivalent as recipient-executed trust funds. The MEF confirmed that the government financing of the project will be maintained at 50 percent of investments in SDGs and HEFs, or 50 percent of component 1 financing (approximately US$12 million).

63. The Australian DFAT contribution, the H-EQIP MDTF contribution, and the contribution from GFF are child trust funds channeled to this project under existing administrative agreements. Preparation of the German KfW administrative agreement for the funding from the BMZ special initiative One World, No Hunger—which aims to combat malnutrition and support food security—is under way and will be completed before signing of the grant agreement. The Financing Agreement and the Grant Agreement will be tied by a cross-effectiveness condition to ensure harmonized execution. [33]

64. The project will use the Investment Project Financing (IPF) instrument with DLIs. Subcomponents 1.1, 1.2, 2.1, 2.3, 3.2, 3.3, and 3.4 will use traditional input-based financing while Subcomponents 2.2 and 3.1 will use DLIs (linked to the achievement of targeted results necessary to build/strengthen project systems) paid against the agreed EEPs. EEPs will be the Government contribution to HEF and SDG under Component 1. Even where traditional IPF is used, the majority of project financing is channeled through performance modalities: Component 1 will use performance-based financing at the health facility and district levels with a focus on quality and performance-based HEF payments, while Subcomponent 2.1 will provide performance-based payments to C/S.

[33] In the event that any part of the KfW co-financing does not materialize for any reason, the project will be restructured to promptly commence implementation of the activities and either additional resources will be sought through an IDA additional financing mechanism or the project will be scaled down through a restructuring to limit its scope to the available resources.

Table 9. Project Costs by Component and Financing Source (US$, millions)

Component	IDA	RGC	H-EQIP Child TF for HEF Promotion	IDFHP Child TF for Strengthening Routine Immunization	Child TF from GFF	Standalone TF from KfW	TF Total Share	Total
Component 1: Strengthening the Delivery of Priority Health Services (US$24 million)								
Subcomponent 1.1	4.500	9.00	0.50	1.00	1.500	1.50	*50%*	**18.00**
Subcomponent 1.2	1.500	3.00		0.50	0.500	0.50	*50%*	**6.00**
Component 2: Stimulating Demand and Accountability at the Community Level (US$10.8 million)								
Subcomponent 2.1	2.300		0.50	1.00	1.550	1.550	*67%*	**6.90**
Subcomponent 2.2	0.550			0.30	0.400	0.400	*67%*	**1.65**
Subcomponent 2.3	0.750			0.20	0.650	0.650	*67%*	**2.25**
Component 3: Ensuring an Effective and Sustainable Response (US$18.2 million)								
Subcomponent 3.1	2.150			1.00	1.650	1.650	*67%*	**6.45**
Subcomponent 3.2	1.200		1.00		2.200	1.200	*79%*	**5.60**
Subcomponent 3.3	0.833			0.40	0.633	0.633	*67%*	**2.50**
Subcomponent 3.4	1.217			0.60	0.917	0.917	*67%*	**3.65**
Total	**15.000**	**12.00**	**2.00**	**5.00**	**10.00**	**9.00**	*63.4%*	**53.00**

Note: IDFHP = Integrating Donor Financed Health Programs; TF = Trust fund.

C. Project Beneficiaries

65. Based upon the window of opportunity to achieve maximum impact on improving nutrition, immunization, and neonatal mortality, the primary beneficiaries will be WRA (especially pregnant and lactating women) and children under the age of two in Cambodia. Given the geographic focus and the support for HEF promotion, the project will specifically target the poor and underserved. While the project's systems and institutional strengthening activities will take place at the national level, implementation of community- and facility-level activities will be rolled out in a phased manner, covering subnational geographies as feasible within the financing envelope. The Investment Case for RMNCAH-N has identified seven target provinces in need of intensive support to improve service delivery and close equity gaps: Mondul Kiri, Ratanak Kiri, Kratie, Stung Treng, Preah Vihear, Kampong Chhnang, and Koh Kong. All districts in these provinces will roll out the MCNH Scorecard and will receive Component 2 financing. Table 10 describes the estimated project beneficiaries, including the secondary target population of all community members interacting with the first 1,000 days' beneficiaries.

Table 10. Annual Project Beneficiaries in Seven Prioritized Provinces

Age Groups	Male	Female	Total
Infants (0–1)	20,852	20,427	41,279
Children under five (0–5)	101,749	98,541	200,290
Women in reproductive age (15–49)	—	426,826	—
Total population (0–100)	829,107	847,724	1,676,831

D. Theory of Change and Results Chain

Figure 4. Project Theory of Change

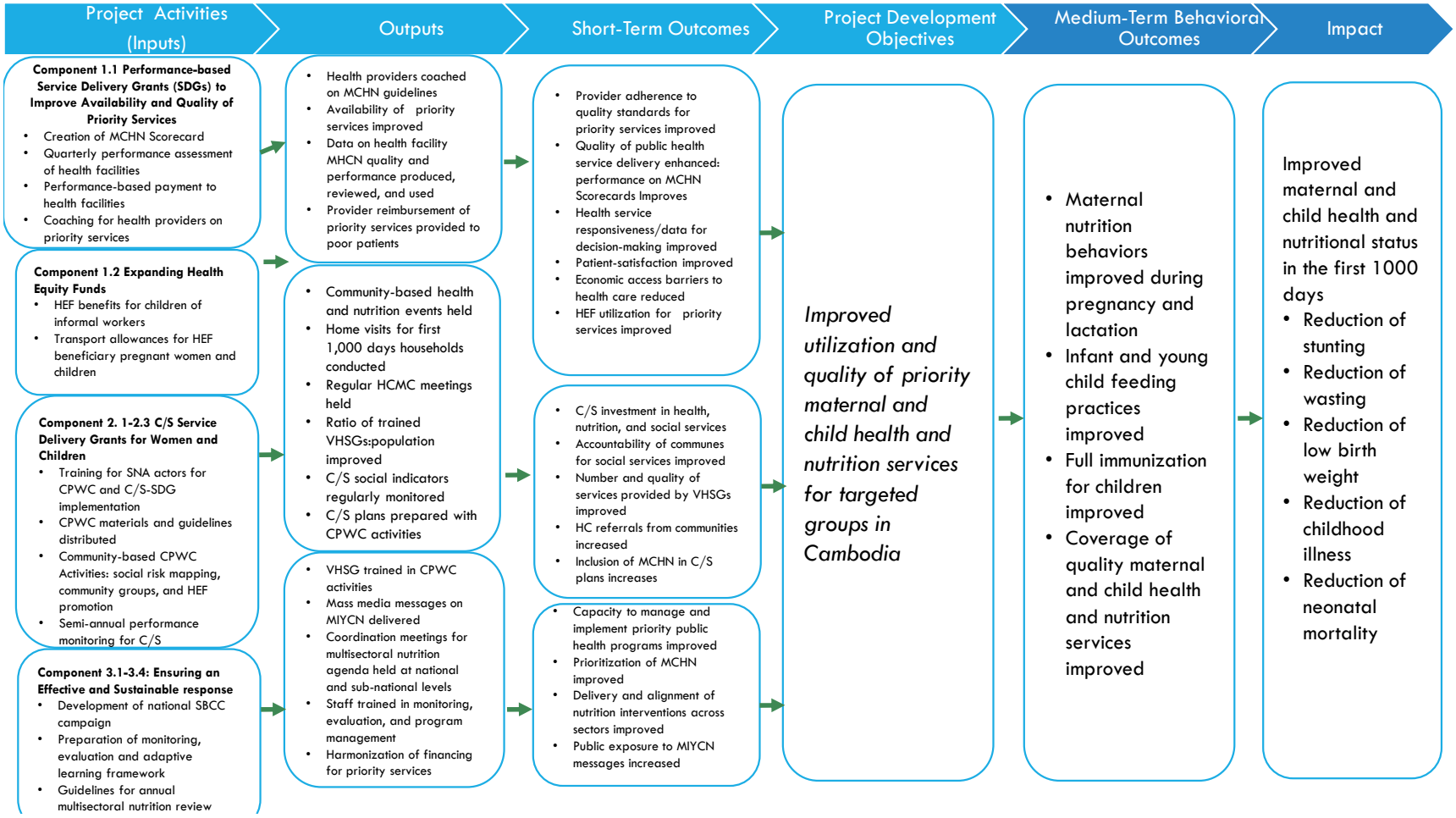


Table 11. Detailed Results Chain

Inputs and Activities	Outputs	Project Development Objectives		Medium-Term Behavioral Outcomes	Long-Term Impact
		Improved Quality of Priority Maternal and Child Health and Nutrition Services	***Improved Utilization of Priority Maternal and Child Health and Nutrition Services***		
Component 1: Strengthening the Delivery of Priority Health Services				Percent of infants/young children age 6–23 months in target areas receiving minimum dietary diversity Children 6–23 months consume a minimum acceptable diet (including diversity and frequency) Percent of children who start breastfeeding within one hour of birth (early initiation of breastfeeding) Percent of infants age 0–5 months who are exclusively breastfed	Improved MCHN status in the first 1,000 days and reduction of neonatal mortality
Subcomponent 1.1: Performance-based Service Delivery Grants (SDGs) to Improve Availability and Quality of Priority Services					
National Development of MCHN tools (revised vignettes, scorecards) to provide performance-based grants to health centers for priority services Standardization of coaching package for MCHN Quality Improvement standardization of package for interpersonal communication during nutrition contact points in health facilities (DLI 3) Quarterly review and verification of health center MCHN Scorecard scores Revision of guidelines for integrated outreach,	**National** Increased national program participation in MCHN Scorecard Coaching and Training Increased quarterly reports on MCHN Scorecard performance and service delivery bottlenecks prepared (DLI 8) Improved harmonization of development partner support for priority services **PHD/OD** Increased number of ODs conducting quarterly MCHN Scorecard assessment and coaching conducted for lower-level facilities **Health Center**	**National** Improved data for decision making and responsiveness of NMCHC programs to systems bottlenecks **Health Center** Increased number of health centers scoring over 60% on their MCHN Scorecard Increased number of health centers with adequate equipment, commodities, supplies to deliver priority services Increased availability of priority RMNCAH-N services in health centers	Increased number of children receiving regular growth monitoring, growth promotion, and IYCF promotion in the first two years of life Increased number of women receiving quality nutrition counselling during pregnancy, delivery, and post-partum period Increased number of women receiving micronutrient supplementation in accordance with national guidelines Increased number of children 6–59 months		

Inputs and Activities	Outputs	Project Development Objectives		Medium-Term Behavioral Outcomes	Long-Term Impact
		Improved Quality of Priority Maternal and Child Health and Nutrition Services	***Improved Utilization of Priority Maternal and Child Health and Nutrition Services***		
including pregnant or lactating adolescents (DLI 4) **PHD/OD** OD incentives for conducting MCHN Scorecard assessment	Increased number of health center staff receiving training and coaching on priority services Improved provider knowledge of the importance of maternal and child health, nutrition, and development in the first 1,000 days Improved provider adherence to clinical guidelines for priority services Increased discretionary resources for health centers to support delivery of priority services and integrated outreach	Enhanced quality of counselling provided during priority services in health centers Increased availability of priority RMNCAH-N services through integrated outreach	receiving vitamin A supplementation within previous 6 months Increased number of children under 12 months of age in target areas receiving Penta-3 vaccine	Percent of WRA who consume minimum dietary diversity Percent of pregnant women achieving optimum weight gain during the second and third trimesters of pregnancy Increased percent of children age 12–23 months fully immunized	
Subcomponent 1.2: Expanding Health Equity Funds (HEFs)					
National Development and dissemination of SOP for well-child visit Development and dissemination of guidelines	**National** Increased timeliness of HEF reimbursements to facilities **Health Facility** Increased reimbursement of health workers providing	**Health Facility** Increased provision of well-child visits to HEF and non-HEF beneficiaries **Beneficiary**	Decreased coverage gap between poor and non-poor for priority services Increased number of rural and remote women		

Inputs and Activities	Outputs	Project Development Objectives		Medium-Term Behavioral Outcomes	Long-Term Impact
		Improved Quality of Priority Maternal and Child Health and Nutrition Services	***Improved Utilization of Priority Maternal and Child Health and Nutrition Services***		
for transportation reimbursement for HEF beneficiaries Timely approval of health center HEF claims	comprehensive well-child visits for HEF beneficiaries Increased health center claims for well-child visits **Beneficiary** Increased receipt of transportation allowances among pregnant women and children in (select) ID poor 1 and 2 households receive transportation allowances for nutrition and immunization services	Reduced economic access barriers for poor and informal workers to consume preventive and promotive immunization and nutrition services Increased HEF utilization for priority services, especially among the poor and vulnerable households	consuming four or more ANC visits Increased social awareness around the importance of nutrition and immunization services among HEF beneficiary households Increased number mothers and secondary caregivers with knowledge of optimal nutrition, growth and development of children in the first two years		
Component 2: Stimulating Demand and Accountability at the Community Level					
Sub-Component 2.1: Commune/Sangkat (C/S) Service Delivery Grants (C/S-SDGs) for Women and Children					
National Development of comprehensive package of CPWC activities, training, innovative and evidence-based job aids, materials, guidelines for VHSGs, HCMC Development of C/S-SDG operations manual	**National** Decreased fragmentation of community-level health and nutrition activities Increased harmonization of donor financing for community health and nutrition activities **Commune**	**Commune** Increased number of community-based health and nutrition events conducted in priority areas Increased participation of community leaders in community-based	Improved community leader knowledge of the importance of good health and nutrition in the first 1,000 days Improved caregiver knowledge of appropriate maternal, infant, and young child care, nutrition, and		

Inputs and Activities	Outputs	Project Development Objectives		Medium-Term Behavioral Outcomes	Long-Term Impact
		Improved Quality of Priority Maternal and Child Health and Nutrition Services	***Improved Utilization of Priority Maternal and Child Health and Nutrition Services***		
Development of comprehensive training and support to community cadres for delivery of effective counselling and community-based interventions Development of terms of reference (TOR) and job descriptions to formalize the participation of VHSGs, VAs, and CCWC FP in the CPWC Facilities Plan HCMC meetings **Commune** Conduct community mobilization Convene community meetings **Village** Social mapping of 1,000 days HH	Improved ratio of community health worker (CHW): catchment population Increased number of regular HCMC meetings Improved joint accountability between the health center and the commune Improved responsivity of commune and health center planning to community needs Increased routine mobilization and monitoring for cross-sectoral nutrition results at the commune level **Village** Increased accountability of VHSG to perform health and nutrition counselling and HEF promotion activities	health and nutrition events Increased number of home visits for first 1,000 days households Increased delivery of integrated outreach according to guidelines Increased SAM screening and referral Increased delivery of nutrition-related services and messages by VHSGs Improved quality of nutrition-related services and messages (of appropriate type) by VHSGs Increased number of communes receiving C/S-SDG for women and children	health in the first 1,000 days Increased utilization of priority services *(see specific indicators, above)* Decreased coverage gap between poor and non-poor for priority services		

Inputs and Activities	Outputs	Project Development Objectives		Medium-Term Behavioral Outcomes	Long-Term Impact
		Improved Quality of Priority Maternal and Child Health and Nutrition Services	***Improved Utilization of Priority Maternal and Child Health and Nutrition Services***		
	Increased frequency and reliability of performance incentives provided to VHSGs Improved VHSG knowledge and motivation to deliver health and nutrition counselling, GMP, and other services in communities Increased HEF promotion in priority provinces	**Beneficiary** Improved knowledge of HEF entitlements Increased demand for and utilization of priority services in health centers and health facilities			
Subcomponent 2.2: Building Capacities, Monitoring, and Verifying C/S-SDG					
National Development of C/S-SDG operations manual Production of training and guidelines for operationalization of C/S-SDG Checklist Procurement of third party to conduct verification Development of standardized advocacy and training materials for subnational authorities	**National** Increased review of commune performance on C/S-SDG and verification discrepancies **District** Increased number of ODs conducting quarterly MCHN Scorecard assessment and coaching conducted for lower-level facilities Enhanced knowledge, capacity, and resources at district level to coordinate	Improved availability and efficiency of public sector resources for community health and nutrition activities Increased prioritization of nutrition at province, district, and commune levels, especially within commune investment plans and social spending	Increased coverage of cross-sectoral nutrition interventions at commune level Increased awareness among commune leaders, influencers, and households regarding importance of good maternal and child nutrition		

Inputs and Activities	Outputs	Project Development Objectives		Medium-Term Behavioral Outcomes	Long-Term Impact
		Improved Quality of Priority Maternal and Child Health and Nutrition Services	*Improved Utilization of Priority Maternal and Child Health and Nutrition Services*		
	multisectoral nutrition agenda **Commune** Improved knowledge and ability to plan/budget for health and nutrition-related activities at the commune level Improved PFM capacity at commune level Improved program management, negotiation, communication, and empowerment at the commune level, especially among CPWC Increased number of commune and village actors receiving performance-based incentives for conducting, monitoring, and supervising village-level health and nutrition activities	Increased resources available for nutrition-related support at commune level			

Inputs and Activities	Outputs	Project Development Objectives		Medium-Term Behavioral Outcomes	Long-Term Impact
		Improved Quality of Priority Maternal and Child Health and Nutrition Services	***Improved Utilization of Priority Maternal and Child Health and Nutrition Services***		
	Increased accountability and implementation fidelity due to ex post verification				
Subcomponent 2.3: Project Management, Monitoring, and Evaluation for the NCDDS					
Not applicable					
Component 3. Ensuring an Effective and Sustainable Response (Subcomponents 3.1–3.4)					
National Development of guideline for provincial annual review of multisectoral nutrition progress Development of national MIYCN SBCC campaign Preparation of M&E plan Engagement of TA agencies to provide additional M&E support	**National** Increased management capacity at national level to deliver consistent, reliable, and sustained national nutrition and immunization programs Increased availability of data from routine monitoring, spot checks, household surveys, and/or process evaluations Enhanced operationalization of multisectoral nutrition agenda Increased number in delivery of mass media messages on MIYCN **Provincial**	**National** Enhanced capacity of line ministries and SNAs to collect and use nutrition data for decision making Increased prioritization of MCHN at the province, district, and commune levels **Commune** Increased delivery of nutrition interventions across sectors aligned with the drivers of malnutrition **Health Facility** Improved identification and removal of	**Beneficiary** Improved caregiver knowledge of appropriate maternal, infant, and young child care, nutrition, and health in the first 1,000 days		

Inputs and Activities	Outputs	Project Development Objectives		Medium-Term Behavioral Outcomes	Long-Term Impact
		Improved Quality of Priority Maternal and Child Health and Nutrition Services	***Improved Utilization of Priority Maternal and Child Health and Nutrition Services***		
	Increased number of provinces conducting annual reviews of nutrition performance Increased advocacy with provincial governors, administrators (in Rural Development, Agriculture, Health, and others) on the importance of cross-sectoral coordination for nutrition **District/Health Facility** Increased number of staff trained to improve M&E capacity across line ministries and SNAs	implementation bottlenecks Improved service delivery responsiveness due to design modifications and adaptive learning **Beneficiary** Increased exposure to MIYCN messages			

E. Rationale for Bank Involvement and Role of Partners

66. The rationale for World Bank support on MCHN is strong. Reducing the intergenerational consequences of undernutrition will be central to increasing human capital formation, accelerating poverty reduction, and achieving sustainable development in Cambodia. Investing in early life health and nutrition is outlined as a key development priority in the SCD and the draft CPF. During the first 1,000 days between conception and two years of age conception, early life nutrition sets the trajectory for an individual's growth, cognition, and long-term health. Cambodia's Human Capital Index score reveals that Cambodia lags behind global and East Asia Pacific regional averages in terms of the share of children not stunted and adult survival.[34] Maternal and child undernutrition is a detriment to well-being and survival and remained among the top five risk factors for premature death and disability in 2015. Undernutrition slows growth and perpetuates poverty through direct losses in productivity due to poor health status, indirect economic losses from impaired cognition and schooling deficits, and economic losses due to increased health care costs. Recent estimates indicate that US$240–420 million are lost annually due to malnutrition. Moreover, early life stunting increases the risks of developing NCDs earlier in adulthood and increases future health expenditures. Recent estimates show that early life stunting has a cost to society as a whole; the penalty posed on national GDP resulting from reduced productivity due to stunting in early life can be as high at 10 percent.[35]

67. Use of mainstream government systems to provide support for nutrition-specific interventions is extremely limited in Cambodia, resulting in an inefficient and fragmented response. Cambodia became the 53rd member of the SUN Movement in July 2014 and has active civil society and donor networks. USAID, European Union, Germany, and World Bank are the main donors participating in the SUN Donor Network. The 2016 National Nutrition Report highlights 19 agencies (mostly national/international NGOs) supporting the FTRM activities with a total of US$14.7 million in support in Cambodia.[36] The Nutrition, Sanitation and Hygiene Project (NOURISH - USAID financed, implemented by Save the Children) is currently the largest nutrition investment, allocating over US$16 million over 5 years to be implemented in over 500 villages within Siem Reap, Battambang, and Pursat provinces. USAID also supported the largest investment in the nutrition-specific space, financing the Quality of Health Services project to provide institutional support to 450 of 585 health centers in nine provinces. Other United Nations (UN)/international NGO partners are most commonly engaged in activities such as BCC during the first 1,000 days (cooking demonstrations, community education sessions, mothers' groups, and so on) and screening and referral of SAM. Though UNICEF is a key technical partner to the NNP, shifting implementation financing has limited this support to a smaller scale. The European Union and IFAD are active in the agriculture and food security space, where nutrition is sometimes embedded as a subactivity within select projects.

68. The World Bank is well positioned to provide support to the RGC in scaling up investments in early life human capital formation. The project builds upon the successful experience of the H-EQIP project and supports the RGC in moving away from vertical, fragmented programs in RMNCAH-N and community health. The project will aim to mainstream a sustainable response to accelerate nutrition, immunization,

[34] World Bank. 2018. Human Capital Index. Available online: *http://www.worldbank.org/en/publication/human-capital*
[35] Galasso, E., Wagstaff, A. 2018. The Aggregate Income Losses from Childhood Stunting and the Returns to a Nutrition Intervention Aimed at Reducing Stunting. Policy Research Working Paper; No. 8536. World Bank, Washington, DC.
[36] However, with US$5.9 million to school feeding, there is effectively US$8.8 million nutrition activities.

and neonatal mortality outcomes using results-based modalities. By strengthening underlying government systems in health and the SNA—such as PFM, service delivery, information and management systems, and procurement—the project will enhance the efficiency of the use of existing public sector resources. It will also encourage other development partners to increase their use of government systems. The World Bank can leverage expertise from across the World Bank Group to support the project in areas such as health financing, WASH, agriculture, community and social development, PFM, and governance.

69. In taking a 'portfolio approach', the CNP may serve as an anchor for complementary World Bank IDA nutrition-sensitive investments in Cambodia. The current lending portfolio includes at least three relevant projects[37] that will be implemented during the proposed CNP time frame and may thereby provide opportunities for further addressing stunting. The project will support national and provincial coordination and—through the CPWC and C/S-SDG planning process—create the platform for subnational convergence (CPWC) for multisectoral actions to reduce malnutrition in Cambodia.

70. The project harmonizes a considerable share of RMNCAH-N financial and TA behind a discrete set of government-identified priorities. The project includes four pooling partners (Australian DFAT, H-EQIP, German KfW, and the GFF). Moreover, USAID and GIZ have complementary investments. UN agencies (such as UNICEF, Food and Agricultural Organization, United Nations Population Fund, WHO, and World Food Programme) and CSOs (Helen Keller International, Save the Children, and World Vision, among others) have provided technical and financial assistance that has supported key policies and strategies underlying this investment and will support complementary implementation and capacity building.

F. Lessons Learned and Reflected in the Project Design

71. The project is informed by global evidence on the return on investments in RMNCAH-N, alongside the World Bank's country-specific analytical and advisory work. Such analytical work includes (a) formative research on MIYCN barriers and motivators; (b) the behaviors, limitations, and motivators of frontline SBCC implementers in health centers and the community; and (c) HEF utilization, SDGs and quality of care, and other health system issues in the SDG Impact Evaluation. The project incorporates learning from World Bank financing in the health sector under HSSP2 and H-EQIP; World Bank support for social accountability through I-SAF; and the work of other partners such as the USAID-financed NOURISH, the GIZ-financed MUSEFO, and the KfW-financed voucher project. The core principles reflected in project design are the following:

(a) **Mainstream support for nutrition in the first 1,000 days in the RMNCAH-N continuum.** There is widespread consensus that effective maternal, newborn, and child care is driven by the basic principle of continuum of care, which includes provision of care starting from pregnancy until delivery and then to the newborn, infant, and young child, and that delivering effective primary health care interventions through the continuum of care is an

[37] The three relevant projects currently under way are the Cambodia Second Health Sector Support Program-Additional Financing 2, P150472; the Mekong Integrated Water Resources Management Project- Phase III, P148647; and the KH-Land Allocation for Social and Economic Development Project II, P150631. Currently, CNP and the Health project have convergence on all 7 provinces; CNP and the Water project have convergence on 8/11 communes in the first batch of 3 provinces in the Water project; and CNP and the Agriculture project have convergence on 6 of 7 provinces. Efforts will be made to identify further opportunities for alignment with these and other projects going forward.

integral component of health strategies in high-, middle-, and low-income settings.[38] Delivering nutrition services across this continuum of care, both at the facility and the community level, is an integral component of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and critical for achieving scale and sustainability of nutrition interventions.

(b) **Extend service provision to the community level.** The essence of community-based care lies in reaching the community where people live with the health services they need.[39] Community-based approaches for improving health outcomes are recognized as one of the most important avenues for improving health and nutrition and reducing child mortality, particularly in high-mortality settings with weak health systems, scarce resources, and facilities that are difficult for most of the population to access.[40] Research has long recognized that delivering quality RMNCAH-N interventions through community-based care can be beneficial for utilization and uptake of practices, as well as health outcomes. A growing number of countries and states (India) are implementing basic health and nutrition GMP services at the community level. Their lessons with using different modalities ranging from working with volunteers to providing different incentives and moving toward professionalization, financing modalities, addressing supply and demand simultaneously, and implementing supervision and coordination mechanisms and other lessons are being used to inform this project design.

CHW impact on health service utilization and coverage. Compared to clinic-based care alone, CHWs extend the capacity of the health system to improve health outcomes through increasing the volume of efficacious interventions delivered to underserved populations in an appropriate manner with sufficient quality to be effective.[41] In short, CHWs decrease both accessibility and acceptability barriers to increasing service utilization. When CHWs provide micronutrients through routine periodic contact with all families, the coverage rate is much higher than when provided through health facilities alone.[42] Using the care group model, coverage increases for high-impact interventions were more than double those in non-care group project areas.[43] Using community-based growth promotion, mothers are more likely to receive iron supplements during pregnancy and malaria pills, and children are more likely

[38] Khan A. M., Z. Lassi, Z. A. Bhutta. 2018. *Community-Oriented Primary Health Care for Improving Maternal, Newborn, and Child Health*. Vol. 1. Oxford University Press. https://doi.org/10.1093/acrefore/9780190632366.013.57; Aboubaker, S., S. Qazi, C. Wolfheim, A. Oyegoke, and R. Bahl. 2014. "Community Health Workers: A Crucial Role in Newborn Health Care and Survival." *Journal of Global Health*: 4 (2). https://doi.org/10.7189/jogh.04.020302.

[39] Khan, Lassi, and Bhutta 2018; Hart, R. H, M. A. Belsey, E. Tarimo, and World Health Organization. 1990. *Integrating Maternal and Child Health Services with Primary Health Care: Practical Considerations*. Geneva: World Health Organization. http://www.who.int/iris/handle/10665/39618.

[40] Perry H., M. Morrow, S. Borger, et al. 2015. "Care Groups: An Innovative Community-Based Strategy for Improving Maternal, Neonatal, and Child Health in Resource-Constrained Settings." *Global Health: Science and Practice* 3 (3): 358–69. *https://doi.org/10.9745/GHSP-D-15-00051*.

[41] Berman P. A., Davidson R. Gwatkin, and Susan E. Burger. 1987. "Community-Based Health Workers: Head Start or False Start towards Health for All?" *Social Science & Medicine* 25 (5): 443–59. https://doi.org/10.1016/0277-9536(87)90168-7.

[42] Perry, H., L. Crigler. 2014. *Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide and Case Studies for Program Managers and Policymakers*. Jhpiego Corporation.

[43] George, C. M., E. Vignola, J. Ricca, et al. 2015. "Evaluation of the Effectiveness of Care Groups in Expanding Population Coverage of Key Child Survival Interventions and Reducing Under-5 Mortality: A Comparative Analysis Using the Lives Saved Tool (LiST)." *BMC Public Health* 15 (1). https://doi.org/10.1186/s12889-015-2187-2.

to receive vitamin A and deworming medicine.[44] There is evidence that health-seeking behavior improves in communities implementing community-based interventions.[45]

CHW impact on health and nutrition behaviors and outcomes. There is ample evidence that, with adequate support, CHWs are capable of delivering efficacious health interventions with sufficient quality to improve lives.[46] CHWs have proven to be important catalysts for change for millions of mothers in various health behaviors that contribute to poor health and nutrition outcomes, including IYCF practices such as exclusive breastfeeding; care of children with illness or malnutrition; and hygiene and sanitation practices such as handwashing.[47] CHWs have also demonstrated success in diagnosing and treating children with serious diseases such as pneumonia, diarrhea, malaria, and malnutrition.[48] Service delivery through CHWs is associated with decreased incidence of childhood diseases such as diarrhea (53 percent) and pneumonia (50 percent) and other health-related outcomes, including under-five mortality, and child and maternal undernutrition.[49] A recent meta-analysis of community-based care interventions showed a 25 percent reduction in neonatal mortality in high mortality settings.[50] Home visits alone have been demonstrated to reduce

[44] Alderman, Harold, Biram Ndiaye, Sebastian Linnemayr, Abdoulaye Ka, Claudia Rokx, Khadidiatou Dieng, and Menno Mulder-Sibanda. 2009. "Effectiveness of a Community-Based Intervention to Improve Nutrition in Young Children in Senegal: A Difference in Difference Analysis." *Public Health Nutrition* 12 (05): 667. https://doi.org/10.1017/S1368980008002619. Griffiths, Marcia, and Joy Del Rosso. 2007. "Growth Monitoring and the Promotion of Healthy Young Child Growth: Evidence of Effectiveness and Potential to Prevent Malnutrition." The Manoff Group.

[45] Griffiths and Del Rosso 2007; Sharkey, Alyssa B., Sandrine Martin, Teresa Cerveau, Erica Wetzler, and Rocio Berzal. 2014. "Demand Generation and Social Mobilisation for Integrated Community Case Management (ICCM) and Child Health: Lessons Learned from Successful Programmes in Niger and Mozambique." *Journal of Global Health* 4 (2). https://doi.org/10.7189/jogh.04.020410; Lassi, Zohra S., Philippa F. Middleton, Zulfiqar A. Bhutta, and Caroline Crowther. 2016. "Strategies for Improving Health Care Seeking for Maternal and Newborn Illnesses in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis." *Global Health Action* 9 (1): 31408. https://doi.org/10.3402/gha.v9.31408; Khan, Lassi, and Bhutta. 2018.

[46] Berman, Gwatkin, and Burger 1987.

[47] Perry, Henry B., Rose Zulliger, and Michael M. Rogers. 2014. "Community Health Workers in Low-, Middle-, and High-Income Countries: An Overview of Their History, Recent Evolution, and Current Effectiveness." *Annual Review of Public Health* 35 (1): 399–421. https://doi.org/10.1146/annurev-publhealth-032013-182354.

[48] Perry, Zulliger, Rogers 2014; Singh, Prabhjot, and Jeffrey D Sachs. 2013. "1 Million Community Health Workers in Sub-Saharan Africa by 2015." *The Lancet*. https://doi.org/10.1016/S0140-6736(12)62002-9.

[49] Perry, Zulliger, and Rogers 2014.

[50] Prost, Audrey, David Sanders, Anthony Costello, Joanna Vogel, Abdullah H Baqui, Nirmala Nair, Magali Romedenne, Ketan Chitnis, Geoffrey Bisoborwa, and Tanya Doherty. 2018. "Strengthening the Capabilities of Families and Communities to Improve Child Health in Low and Middle Income Countries." *BMJ* 362: bmj.k2649. https://doi.org/10.1136/bmj.k2649; Austin, Anne, Ana Langer, Rehana A. Salam, Zohra S. Lassi, Jai K. Das, and Zulfiqar A. Bhutta. 2014. "Approaches to Improve the Quality of Maternal and Newborn Health Care: An Overview of the Evidence." *Reproductive Health* 11 (Suppl 2): S1. *https://doi.org/10.1186/1742-4755-11-S2-S1*.

neonatal mortality by 30–61 percent.[51] Use of community-based growth promotion has been demonstrated to reduce several measures of child undernutrition.[52] Furthermore, it is estimated that approximately 75–80 percent of all SAM cases can be effectively treated in the community.[53]

The proposed project will deliver RMNCAH-N care to communities based on their needs through a 'horizontal system' of services—integration of vertical services and programs with general preventive and curative services at the community level.[54] Community-based interventions are diverse and intersecting—each modality (that is, comprehensive, integrated packages) may combine multiple approaches (that is, discrete services), using the same package (that is, messages and training for promotion of health and nutrition behaviors). Despite gaps in research, several effective community-based primary health care approaches have been proven to have a positive impact on RMNCAH-N.[55]

(c) **Modernize SBCC and GMP.** Under the umbrella of what constitutes BCC falls an array of communication channels, including mass media (for example, radio, television), community mobilization and 'sensitization' campaigns (radio listening clubs, community theater), and interpersonal communication (house visits, visual/job aids). Health and nutrition education workshops and GMP are additional BCC channels commonly used. These all represent very different interventions—each with a unique rationale for use and target audience—and vastly differing levels of intensity. What is often casually referred to as 'behavior change' is, rather, a complex process on which programs aiming to improve health and nutrition outcomes depend. Community mobilization, home visits, and social marketing are vital in developing the links between facility-based and community-based care.[56] Furthermore,

[51] Bang, Abhay T., Rani A. Bang, Sanjay B. Baitule, M. Hanimi Reddy, and Mahesh D. Deshmukh. 1999. "Effect of Home-Based Neonatal Care and Management of Sepsis on Neonatal Mortality: Field Trial in Rural India." *The Lancet* 354 (9194): 1955–61. https://doi.org/10.1016/S0140-6736(99)03046-9; Baqui, Abdullah H, Shams El-Arifeen, Gary L Darmstadt, Saifuddin Ahmed, Emma K Williams, Habibur R Seraji, Ishtiaq Mannan, et al. 2008. "Effect of Community-Based Newborn-Care Intervention Package Implemented through Two Service-Delivery Strategies in Sylhet District, Bangladesh: A Cluster-Randomised Controlled Trial." *The Lancet* 371 (9628): 1936–44. https://doi.org/10.1016/S0140-6736(08)60835-1; Bhutta, Zulfiqar A., Tahmeed Ahmed, Robert E. Black, Simon Cousens, Kathryn Dewey, Elsa Giugliani, Batool A. Haider, et al. 2008. "What Works? Interventions for Maternal and Child Undernutrition and Survival." *The Lancet* 371 (9610): 417–40. https://doi.org/10.1016/S0140-6736(07)61693-6; Kumar V., S. Mohanty, A. Kumar, R. P. Misra, M. Santosham, S. Awasthi, et al. 2008. Effect of Community-Based Behaviour Change Management on Neonatal Mortality in Shivgarh, Uttar Pradesh, India: A Cluster-Randomised Controlled Trial. *Lancet* 372 (9644): 1151–62. http://dx.doi.org/10.1016/S0140-6736(08)61483-X. PMID: 18926277; Khan, Lassi, and Bhutta 2018.

[52] Alderman et al. 2009; Griffiths and Del Rosso 2007; Maybelle, Arole. 1988. "A Comprehensive Approach to Community Welfare: Growth Monitoring and the Role of Women in Jamkhed." *The Indian Journal of Pediatrics* 55: S100–S105; Cunningham, N. 1978. "The Under Fives Clinic - What Difference Does It Make?" *Journal of Tropical Pediatrics and Environmental Child Health* 24 (6): 237–334; Alderman, M. H., P. H. Wise, R. P. Ferguson, H. T. La verde, and A. J. D'souza. 1978. "Reduction of Young Child Malnutrition and Mortality in Rural Jamaica." *Journal of Tropical Pediatrics and Environmental Child Health* 24 (1): 7–11.

[53] Lenters, L., K. Wazny, and Z. Bhutta. 2016. "Management of Severe and Moderate Acute Malnutrition in Children." In *Disease Control Priorities (third edition): Volume 2, Reproductive, Maternal, Newborn, and Child Health*, edited by R. E. Black, R. Laxminarayan, N. Walker, and M. Temmerman. Washington, DC: World Bank.

[54] Khan, Lassi, and Bhutta 2018; Elzinga, G. 2005. "Vertical–Horizontal Synergy of the Health Workforce." *Bulletin of the World Health Organization* 83 (4). Retrieved from http://www.who.int/bulletin/volumes/83/4/editorial10405/en/; Mullan, Fitzhugh, and Leon Epstein. 2002. "Community-Oriented Primary Care: New Relevance in a Changing World." *American Journal of Public Health* 92 (11): 1748–55. https://doi.org/10.2105/AJPH.92.11.1748.

[55] Khan, Lassi, and Bhutta 2018.

[56] Khan, Lassi, and Bhutta 2018.

experience from Alive and Thrive—whose systematic approach encompasses advocacy and policy, interpersonal communication and social mobilization, and mass communication—underscores the importance of layering multiple strategies to bring about widespread change in social norms and beliefs.[57]

(d) **Focus on results.** Upgrading the skills of existing health workers is an integral part of effective scale-up. Improved supervision and monitoring, in addition to results-based performance incentives and contracts, have the potential to motivate existing health workers. There is increasing evidence that incentivizing results rather than financing inputs leads to enhanced service delivery and use. As a measurable and targeted strategy relying on baseline, target, and progress data at relevant levels, results-based approaches offer several advantages over traditional, input-based approaches, including an emphasis on achieving outputs and outcomes relatively quickly within a well-defined period; incentives for performance at key junctures in the service delivery chain; a mechanism for driving focus on priorities; and visibility to successes, shortfalls, and bottlenecks by which to enable midstream adjustments. Furthermore, approaches aiming to boost social accountability through, for example, community scorecards and health facility committees have demonstrated improvements in the coverage and quality of RMNCAH-N service, as well as satisfaction.[58]

The proposed project aims to improve social protection and quality of RMNCAH-N services by introducing performance-linked and results-based mechanisms at all levels of the health system: PHD, OD, and health facility. In addition, a DLI approach is envisaged at the central level to encourage establishment of appropriate institutional arrangements as well as system strengthening that will be key to implementing this operation. The model builds on experiences from Cambodia, Afghanistan, Argentina, and Rwanda that have shown positive results and will further strengthen the results-based focus of both HEFs and SDGs with a specific goal of improving the quality of RMNCAH-N service delivery and utilization of services by the poor.

(e) **Results-based community transfers.** The C/S-SDG program of results-based community transfers combines the experience from the MOH SDG program as well as village-level transfers for health and education in Indonesia. The community-driven development program *Program Nasional Pemberdayaan Masyarakat—Generasi Sehat dan Cerdas* or *PNPM Generasi* a demonstrated impact on reducing severe stunting by providing grants to poor communities to improve health and nutrition. The program empowered communities and strengthened the demand side by making village grants conditional on improved demand/utilization of health and education services. At the same time, the health and education sectors improved the supply side to respond adequately to increased demand.

(f) **Mainstreaming implementation arrangements.** The proposed project will build off H-EQIP experience and embed project management across the Government's RMNCAH-N program. It is the first project of its kind to be delivered through mainstream systems with an intensive

[57] Alive and Thrive. 2014. "Interpersonal Communication & Community Mobilization: Infant and Young Child Feeding at Scale."
[58] Prost et al. 2018.

focus on RMNCAH-N outcomes. The project will aim to improve the sustainability of the involved Government programs by directly financing these through the RGC's own fund flow mechanisms. It will leverage and further strengthen H-EQIP investments in transitioning key accountabilities and systems away from parallel implementation entities to relevant MOH departments and expand this approach to include the NCDDS and subnational authorities as well as ensure close collaboration and coordination with CARD.

(g) **Additional demand-side incentives for poor households.** Low HEF utilization for outpatient services indicates that the fee waiver may not be sufficient to offset the opportunity costs of preventive and promotive health care seeking. Evidence from the World Bank's cash transfer pilot in Siem Reap and from the KfW voucher scheme demonstrates that transportation allowances to poor households can increase consumption of MCHN services.

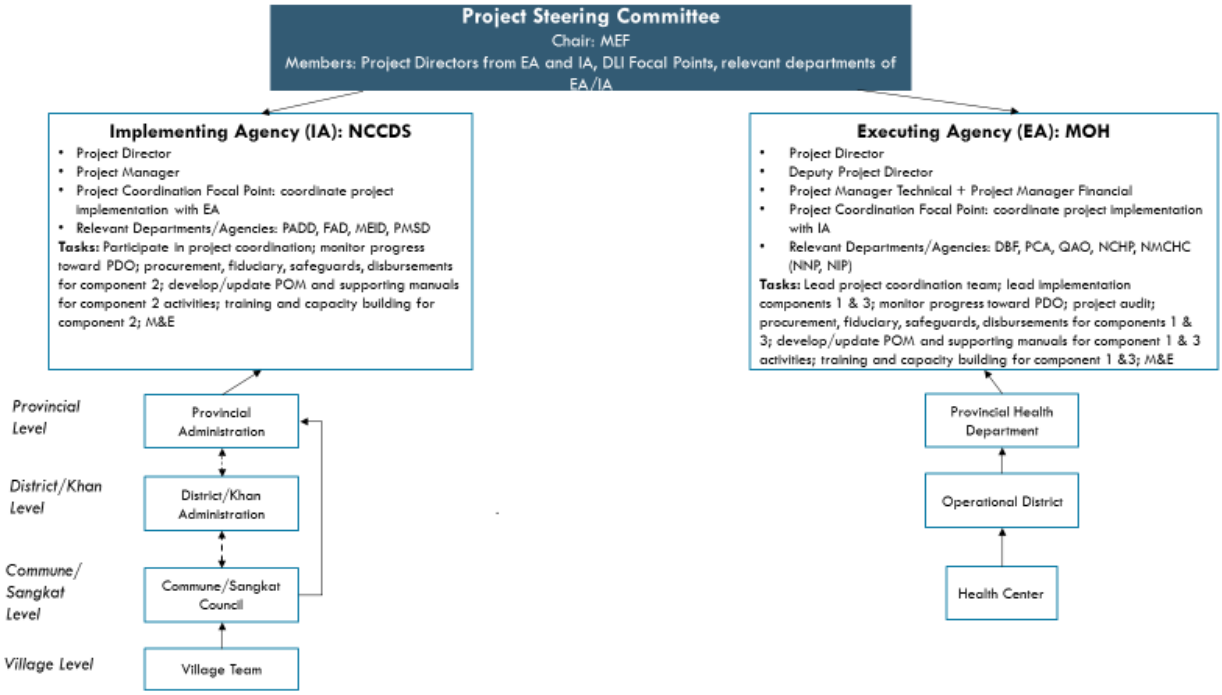
III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

72. The project will be implemented through two implementing agencies: the MOH, acting as executing agency (EA), and the NCDDS. The project will be prepared and implemented by the appropriate existing sector institutions in alignment with sector institutional mandates and using mainstream government (MOH and NCDDS) processes. The MOH will implement Components 1 and 3 through its technical departments, the national programs, and the PHDs, ODs, referral hospitals, and health centers. The NCDDS will implement Component 2 through its technical departments and the provincial, D/K, and C/S administrations. The institutional arrangements (Figure 5) are based on the implementation experience of H-EQIP, the World Bank's cash transfer pilot, the Rural Investment and Local Governance Project, experiences of pooling partners and other development partners in the country, and the PFM reforms under way in the country.

73. The MOH will appoint a project director below the minister to lead the project governance. Under the project director will be two project managers—a technical project manager and the Director General for Administration and Finance. The project will be implemented through the DBF and the NMCHC using mainstream MOH processes; it will not involve a parallel project implementation unit or secretariat. The NCDDS will also appoint a project director and a technical project manager to oversee Component 2 activities, and NCDDS' procurement and fiduciary departments will be used for this component. The project will include provisions to strengthen these departments' capacities and skills through additional consultants or advisers, as needed, to enhance departmental/program functions (rather than working only for specific project activities).

Figure 5. Project Implementation Arrangements



Note: Dotted lines indicate coordination relationships between subnational administrative levels.

74. Strategic direction and guidance will be provided by a high-level Project Steering Committee chaired by the MEF and including high-level representatives from each of the implementing agencies/departments and DLI focal points.

75. The EA and IA will nominate coordination focal points within the respective entity to coordinate activities that are in the shared domain of the MOH and NCDDS. Therefore, all activities which are not within the realm of the respective implementing agencies alone will be coordinated through a joint meeting mechanism. The coordination focal points will be responsible for coordinating project implementation support missions and consolidating all project reports created at the IA level, as and when needed. The focal points will convene relevant technical staff from the MOH and NCDDS as needed. The project will include support to the operating costs for project coordination under Subcomponent 2.3 for operating costs incurred at the NCDDS and under Subcomponent 3.4 for operating costs incurred at the MOH. The SBCC subcomponent will also finance the NCHP for supporting the SBCC needs of both the EA and IA.

76. An overview of project roles and responsibilities is found in annex 1. Relevant MOH/NCDDS departments/programs participating in the project implementation are listed in Table 1.1, and detailed roles, responsibilities, and procedures will be outlined in the project OM. Two volumes of the project OM will be drafted (first volume by the MOH and second volume by the NCDDS) and finalized within 30 days of effectiveness as a project covenant. The manual will be a living document and updated as necessary. Each volume will detail for the EA and IA, respectively, the following: the project management, institutional arrangements with clear roles and responsibilities, FM controls and procedures and fiduciary responsibilities, staff selection and management, results M&E, risk assessment and mitigations,

environmental and social safeguards monitoring and implementation, and any other specific reporting requirements imposed by the World Bank and RGC policies.

77. Based upon the H-EQIP experience, the project will establish a Management Committee (MC) consisting of all funding partners. The MC will have a rotating chair, usually chosen from among the non-World Bank partners. The MC will meet on a bimonthly basis (or as necessary) to exchange information, coordinate technical and financial assistance, conduct strategic decision making, and review implementation progress. Further, the MC members will conduct joint semiannual implementation support missions, including field visits, and will contribute to the preparation and finalization of the Aide Memoires.

78. A multisectoral project advisory group will also be formed that includes all relevant implementing agencies from the RGC-World Bank multisectoral nutrition portfolio, the project managers of CNP, DLI focal points, and CARD. The multisectoral advisory group will be convened on an annual basis to conduct joint review of the progress of the relevant nutrition-specific and nutrition-sensitive projects.

79. **Project's FM.** The MOH and NCDDS will adopt the institutional structure of the respective entity to carry out the project's FM and disbursement functions. The DBF of the MOH will manage the project's FM and disbursements for Components 1 and 3. The arrangement for the MOH is the same as the ongoing World Bank H-EQIP. The DBF staff capacity in managing project FM has steadily improved. To enable the DBF to have adequate staff to implement the project, the MOH will make efforts to provide enough government staff with relevant skills and qualification to the DBF. In the short term, FM consultants should be selected if the DBF staff become overloaded with project-related tasks.

80. The Finance Office of the Financial and Administrative Division (FAD) of the NCDDS will manage the project's FM and disbursements for Component 2. Staff of FAD have some experience from the previous World Bank-financed projects, though not extensively so. The arrangement for NCDDS requires adequate government FM staff (Finance Officer, Accountant, Cashier, and/or Assistant Accountant) to be appointed and committed to be responsible for the project's FM and disbursement for the NCDDS' part. An FM consultant can also be hired by FAD for capacity building, while day-to-day FM operations are expected to be performed by the staff of FAD from a sustainability perspective.

81. **Funds flow.** For MOH traditional input-based financing (components 1.1, 1.2, 3.2, 3.3, 3.4), a pooled Designated Account (DA) in US$ for IDA credit and TFs will be maintained at the NBC by MOH. The DA for MOH has a variable ceiling equal to six-months' projected cash requirement. MOH also maintains US$ denominated Counterpart Fund Bank Account at NBC to receive the government funds to co-finance certain project's expenditures. For DLI component 3.1, the reimbursement for achievement of DLI values will be transferred to RGC's bank account under the TSA. Fund flow diagrams for MOH are in Figure 1.1 and Figure 1.3 of annex 1.

82. For traditional input-based financing to NCDDS under component 2.1 and 2.3, fund flow will be through a pooled DA for IDA credit and TFs maintained at the NBC by NCDDS. The DA will be a pass-through account and administered by the NCDDS for project operations. The DA for the NCDDS has a fixed ceiling of US$200,000 for the first two years and then up to US$500,000 thereafter, subject to the World Bank Task Team Leader's approval. For DLI Subcomponent 2.2, the reimbursement for achievement of DLI

values will be transferred to the RGC's bank account under the TSA. Fund flow diagrams for Component 2 are found in Figure 1.2 and Figure 1.4 of annex 1.

83. **Accountabilities for financial reporting.** A common auditor will be appointed for the entire project and the payment of the auditor fees will be made from Subcomponent 3.4. The auditor will submit the report to the World Bank in two volumes (Volume 1 for the MOH and Volume 2 for the NCDDS) covering the project's operation. The audit will cover all sources of project funds for the MOH and NCDDS and is required to be submitted to the World Bank no later than 6 months after fiscal year-end.

84. The MOH is responsible for preparing a six-month unaudited interim financial report (IFR) for Components 1 and 3 and will submit the IFR to the World Bank no later than 45 days after semester end. The MOH is accountable for the audit of Components 1 and 3 and will ensure close collaboration with the MEF and the external auditors to ensure timely completion of the audit. The contents and the IFR format are in the Disbursement and Financial Information Letter.

85. The NCDDS is responsible for preparing a six-month unaudited IFR for Component 2 and will submit the IFR to the World Bank no later than 45 days after semester end. The NCDDS is accountable to ensure close collaboration with the MEF and the external auditors to ensure timely completion of the audit. The contents and the IFR format are in the Disbursement and Financial Information Letter.

B. Results Monitoring and Evaluation Arrangements

86. Progress toward the PDO will be monitored through reporting on the PDO-level and intermediate-level results indicators outlined in the project Results Framework. The MOH and NCDDS are responsible for collecting data and reporting on indicators outlined for their respective components. The MOH indicators will be drawn from data sources including the improved HMIS, national program reports, and project administrative data. The MOH indicator definitions, baselines, and targets are aligned with the RGC's HSP-3 and National Health Congress reports. The project will build/strengthen systems (including the MOH HMIS and MOI Commune Database) to support the regular collection and reporting of service provision, utilization, and quality information in both the MOH and NCDDS. Support will be provided for improved data collection, reporting, and analysis to disaggregate data by gender and report on the project target areas.

87. Additional types of data collection and monitoring will supplement the use of routine data: (a) rigorous monitoring and verification of the project's performance-based financing elements for (i) independent verification of MCHN SDGs (using the PCA) and C/S-SDGs (using a third-party agent) and (ii) independent verification of DLI targets achieved and disbursement formulas; (b) rapid, nimble evaluations to document implementation processes and effectiveness; and (c) an impact evaluation managed by the World Bank. The World Bank-executed impact evaluation will aim to assess the effectiveness of project interventions, as well as better establish the influence of nutrition-sensitive factors and program convergence on the priority outcomes.

88. The pooled fund partners will monitor implementation progress during semiannual implementation support missions and regular field visits. A midterm review of project performance will be carried out by the MOH, NCDDS, World Bank, and pooling partners after 24 months and no later than 30 months after project effectiveness, wherein, among other decisions, the scale-up plans for the MCHN

Scorecard will be decided based on emerging evidence and implementation experience. Throughout implementation, the EA and IA will be responsible for the following reporting:

(a) **The MOH** will submit annual progress reports to IDA and pooled fund partners to (i) describe implementation progress, (ii) highlight issues that need attention (including safeguards compliance and mitigation actions), and (iii) report on progress toward meeting the PDO and intermediate results indicator targets. The MOH will be responsible for producing an annual DLI achievement report for Subcomponent 3.1, detailing the performance of DLIs and submitting to the World Bank for review and approval, due on September 30 each year. An optional semiannual DLI report can also be submitted by March 31 each year. Final agreements on the status of DLI achievements will be documented in an Aide Memoire. At the end of the project, the MOH will prepare an end-of-the-project implementation report detailing achievement of project activities toward reaching the PDO and lessons learned from implementation of the CNP.

(b) **The NCDDS** will submit annual progress reports to IDA and pooled fund partners to (i) describe implementation progress, (ii) highlight issues that need attention (including safeguards compliance and mitigation actions), and (iii) report progress toward meeting the PDO and intermediate results indicator targets. The NCDDS will be responsible for producing an annual DLI achievement report for Subcomponent 2.2, detailing the performance of DLIs and submitting to the World Bank for review and approval, due on September 30 each year. An optional semiannual DLI report can also be submitted by March 31 each year. Final agreements on the status of DLI achievements will be documented in an Aide Memoire. At the end of the project, the NCDDS will prepare an end-of-the-project implementation report detailing achievement of project activities toward reaching the PDO and lessons learned from implementation of the CNP.

89. The RGC reports will feed into the World Bank Implementation Completion and Results Report (ICR). The World Bank will also complete an assessment of the project to evaluate the project and draw lessons to be part of its ICR.

C. Sustainability

90. **Financial sustainability.** The project financing reflects the RGC commitment to increase domestic financing for these important interventions for mothers and young children, using the proven mainstream instruments of HEF and SDG which have significant counterpart financing. These investments increase the overall public budget for health, including nutrition. External financing as a share of total health expenditure has been declining in Cambodia since 2011, nearly halved from 2002. From a starting point of low domestic investment in nutrition, the project represents a significant shift toward increasing the efficiency and sustainability of financing for nutrition by mainstreaming into public systems. The investments in the MCHN SDG top-ups are not meant to be sustained indefinitely but will provide a time-bound incentive for improving quality and delivery of priority identified services. The MCHN SDG activities and top-up can be mainstreamed into SDG processes (currently receiving approximately 75 percent RGC financing) beyond the life of the project. C/S continue to receive increased allocations through the C/S Fund (see annex 2). The CPWC activities can be sustained in the future through established processes and guidelines for C/S to increase social spending on these activities.

91. **Institutional sustainability.** There is strong political and financial commitment both from the RGC and the World Bank and pooled fund donors for this agenda. The growing understanding of the links between ill health and high stunting rates at young ages and the lifelong negative consequences and costs to society of these conditions has cemented the political commitment. The design leverages and builds on existing MOH and MOI institutional structures and cadres and does not require investments in new implementation agents. While the proposed expansion of the RMNCAH-N services is ambitious, the focus on decentralizing financing to the frontlines increases the absorptive capacity of the line ministries. Districts and C/S in the project's provinces have had experience with SDGs and hence are familiar with the basic tenets of results-based approaches.

92. **Technical sustainability.** All prioritized interventions are evidence based or would be tested to ensure effectiveness before scaling up. The project gives a major focus to training and capacity building at all levels, from parents, caregivers, and CHWs at the community level to health staff, district personnel, and national stakeholders. Strengthened decentralized capacity to oversee, monitor, and coordinate multisectoral activities will bolster district institutional capacity. Enhanced knowledge and awareness of optimum child health, growth, and development among mothers, caregivers, CHWs, health personnel, and the public at large are expected to lead to behavior change that will go beyond the life of the project.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis (if applicable)

Technical

93. The technical design for the project is aligned with the strategic directions outlined in Cambodia's national development, health, and nutrition strategies. The design is the result of review of the analytical work already undertaken by the MOH, World Bank, and other development partners in the country; implementation experience of the HEFs and SDGs in H-EQIP; and extensive consultations. The specific RMNCAH-N interventions and service delivery modalities supported in the project are the result of a two-day prioritization workshop supported by the GFF.

94. The proposed interventions to be funded under the project are in line with global evidence of what works and considers the specificities of the Cambodian context. In 2013, the Lancet identified 10 effective interventions that would reduce the burden of stunting by one-fifth if all delivered at 90 percent coverage. Implementing multisectoral nutrition-sensitive interventions that address the multidimensional causes of malnutrition simultaneously with nutrition-specific interventions is expected to reduce the remaining 80 percent. Reversal of stunting requires nutrition-specific interventions that focus on improving both child and maternal health.[59] To this end, the project aims to scale up and stimulate

[59] Maternal stature and nutrition are important predictors of intrauterine growth retardation and size at birth (Ozaltin E, Hill K, Subramanian SV. Association of maternal stature with offspring mortality, underweight and stunting in low- to middle-income countries. *JAMA* 2010;303:1507–16. doi: http://dx.doi.org/10.1001/jama.2010.450 PMID:20407060). Maternal birthweight not only affects the birthweight of the offspring but also extends to health later in life. For example, birthweight is inversely related with the risk of coronary heart disease and stroke. See, for instance: Barker, D.J. and Clark, P. "Fetal undernutrition and disease in later life." Rev *Reproduction*; 2(2):105-12.).

demand for the best-buy nutrition-specific interventions in high-burden areas, targeting children under two years and pregnant and lactating mothers.

95. It is well documented that prenatal care, with a focus on maternal nutritional counselling alongside health checkups, immunizations, and micronutrient supplements, is a prerequisite for any stunting intervention. Even if a child is born with a low birthweight or length, there is a compensatory period of up to two years of age when growth can catch up.[60] During the first six months after birth, exclusive breastfeeding is one of the most effective ways of reducing infant morbidity (which negatively affects growth) and mortality.[61] Therefore, some of the main interventions to be supported under the project include early initiation of breastfeeding and regular growth promotion. For infants 6–24 months, complementary feeding, growth promotion, and micronutrient interventions (for example, iron, vitamin A, iodine, and zinc supplementation) are critical.[62] These interventions have been found to be cost-effective.[63] Other interventions include administering anthelminthic drugs (deworming) to reduce the incidence of parasite and bacterial infections among pregnant women, infants, and children. Given the importance of WASH in the prevention of diarrheal morbidity and mortality, the project also includes an important focus on these underlying determinants of stunting.

Economic Analysis

96. The project's economic analysis, as detailed in annex 5, aligns with global evidence that investing in RMNCAH-N through primary health care services is highly cost-effective.[64] The project's health and nutrition gains will contribute to economic growth through multiple pathways. On a macro level, global evidence shows that countries that invest in human capital grow as much as 1.25 percent faster than countries that underinvest in these areas.[65] Timely investments in health and nutrition can reduce the economic losses attributable to these conditions (such as decreased school performance, labor productivity, and incomes and higher health care costs). For example, Bagriansky et al. (2014) estimated that the economic impact of malnutrition alone in Cambodia is over US$400 million annually, which accounts for roughly 2.5 percent of GDP.[66] Further, it is anticipated that the project's investments in quality improvement will have positive externalities by improving the quality of care of interventions delivered by the same providers but financed outside this project (for instance, through private practice).

[60] Victora C.G., M. de Onis,, P.C. Hallal, M. Blössner, R. Shrimpton. 2010. "Worldwide timing of growth faltering: revisiting implications for interventions." *Pediatrics*; 125: e473-e80.
[61] Victora C.G, R. Bahl, A.J. Barros, et al. 2016. "Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect." *Lancet;* 387:475-90.
[62] Complementary feeding can increase height by 1 centimeter up to the age of three years (Bhutta et al. 2008). Zinc supplementation and vitamin A can reduce diarrhea, and iron is known to reduce anemia and improve cognitive ability. See for example: Caulfield L., M. de Onis, M. Blossner, R.E. Black. 2004. "Undernutrition as an underlying cause of child deaths associated with diarrhea, pneumonia, malaria and measles." *American Journal of Clinical Nutrition*; 80(1): 193-8.
[63] Shekar, M., J. Kakietek, J. Dayton Eberwein, and D. Walters. 2016. *An Investment Framework for Nutrition*. Washington DC: World Bank Group.
[64] In fact, community management of severe malnutrition, family planning, ANC, and PNC are among the most cost-effective interventions in the Global Investment Framework for Reproductive, Maternal, Newborn, and Child Health. See: Black, R., R. Laxminarayan, M. Temmerman, and N. Walker (eds). 2016. "Disease Control Priorities, (Volume 2): Reproductive, Maternal, Newborn, and Child Health." The World Bank.
[65] World Bank. 2011. "The Changing Wealth of Nations: Measuring Sustainable Development in the New Millennium." IBRD, Washington, DC.
[66] Bagriansky, J., N. Champa, K. Pak, S. Whitney, and A. Laillou. 2014. "The Economic Consequences of Malnutrition in Cambodia, More than 400 million US dollar lost annually." *Asia Pacific Journal of Clinical Nutrition*. 23(4); 524-31.

In this sense, the project increases the efficiency and effectiveness of the Government's investments in health.

97. Project-financed interventions will increase the efficiency of health spending, therefore increasing value for money. The widespread use of results-based mechanisms will increase the likelihood of achieving the desired health outcomes through project investments; the project will further increase the efficiency of underlying investment in the health system (for instance in commodities, supplies, and so on) by linking these to providers delivering higher-quality care. Project investments reinforce accountability mechanisms and contribute to improvements in provider behavior and service delivery. Moreover, results-based financing fosters the use of data for decision making: the improved generation and use of information will increase efficiency of health spending through the timely identification and resolution of service delivery bottlenecks.

98. Geographic targeting under this project will contribute to improved efficiency of health spending and equity of health outcomes by targeting resources where they are most needed. Lower than average health service coverage rates[67] are contributing to poor health outcomes: under-five mortality rates were more than twice the national average, and stunting rates were almost 30 percent higher. Demand-side interventions like the expansion of the HEF and transport allowances will help address the geographic and financial barriers to accessing health services, which disproportionally affect the poor and residents of the project provinces.[68]

99. A single cost-effectiveness analysis was performed for the entire project, encompassing each component's contributions to the development objective and economic growth.[69] Using a 5 percent discount rate, the overall project envelope of US$54 million has a net present value of US$46.3 million (see Annex Table 1). These investments will be targeted toward 11 priority services in seven provinces, covering 339 C/S with an estimated population of 1.78 million people in 2019. Improvements in the coverage of PNC practices, treatment of malnutrition, and periconceptual interventions have the highest impact on averted deaths for children, while periconceptual interventions and $MgSO_4$ management of pre-eclampsia have a higher impact on averted maternal deaths. The incremental cost-effectiveness ratio (ICER) estimates the cost of averting one death over the life of the project as US$3,434. Investments under this project are deemed cost-effective. The economic benefit of the averted deaths under this project is US$528.3 million. Discounting the project's costs, the net economic benefit is US$482 million, and the benefit-cost ratio is 11.4 This means that every dollar invested in this project will yield an estimated benefit of US$11.4.

[67] For example, 71.6 percent of women in the seven targeted provinces received PNC within two days, compared to the national average of 90.3 percent. Also, immunization coverage rates in these provinces was more than 10 percent lower than the national average.

[68] Poverty is concentrated in the project provinces. Nationally, financial barriers to service utilization were reported by 79.2 percent of women in the lowest-income quintile, while 41.2 percent of women in the highest-income quintile reported having financial difficulties to access care. Similarly, more than half of the women in the lowest-income quintile reported significant geographic barriers to accessing care, while less than 15 percent of the women in the highest-income quintile had that problem.

[69] Cost-effectiveness analysis consists of the following steps: (a) assessing the project's costs, (b) establishing target coverage rates for the activities financed under this project, (c) estimating health gains derived from increases in the coverage rates, and (d) calculating and interpreting cost-effectiveness ratios.

Financial Analysis

100. Cambodia's fiscal outlook is positive and high rates of economic growth are projected to continue over the short and medium term. Despite continuous economic growth, Cambodia faces a fiscal deficit, and this is expected to widen.[70] Pressure to safeguard and increase public spending in the social sector is explained by Cambodia's relative underinvestment in social assistance, education, and health[71] and the growth-promoting potential of these investments. Compared to other countries in the region and countries in the same income bracket, Cambodia's public spending in the social sector is low. RMNCAH-N programs and services are heavily dependent on external financing. The NMCHC subprograms in immunization, reproductive health, and nutrition remain largely donor dependent, and nutrition is the least funded of all NMCHC programs. However, private for-profit organizations constitute the largest share of total RMNCAH-N spending.

101. Failing to invest in health and nutrition, as described in the previous section, has high economic costs and hinders growth, as investments in human development contribute to further accelerate economic growth. Mobilizing additional resources for health and nutrition is therefore critical and key to improve the efficiency, equity, and sustainability of Cambodia's current health financing structure. Reducing the reliance on OOP improves the equity and the efficiency of the health financing system. In addition, an increase in public spending in health promotes the sustainability of health and nutrition programs. The project's financing does not raise fiscal sustainability concerns. First, with a net present value of US$46.3 million, an average annual disbursement of US$9 million represents less than 2 percent of the actual spending of the MOH in 2018. Second, the project will not pay for capital investments and will not require significant increases in future operational spending and the continuation of the activities financed by the project will not require an exponential increase in public spending. Third, the project's financing will not represent a significant increase to the country's foreign debt.

B. Fiduciary

(i) Financial Management

102. **Planning and budgeting.** The project will follow government budgeting principles as outlined in the SOP/Financial Management Manual (FMM) for externally financed projects issued by Sub-Decree No. 74 dated May 22, 2012, and its subsequent amendments, if any. The MOH and NCDDS are each responsible for preparing their respective annual work plans and budget for submission to the MEF for approval and then for obtaining no-objection from the World Bank. There are Government funds to finance HEF and SDG and the sharing percentage is determined on an annual basis between the Government, the trust fund grant and the World Bank credit. The MOH will work with the MEF to ensure that the project's annual budget and the Government fund co-financed investments in HEF and SDG will be included in the RGC's annual budgets.

103. **Accounting policies and procedures and internal control.** The project will adopt a modified cash basis of accounting and adopts the RGC's chart of accounts. The MOH adopts the SOP/FMM and subsequent amendments; any amendments may be subject to the World Bank's review before adoption.

[70] Article IV recommendations include spending pressure containment and the introduction of a medium-term fiscal framework to promote the sustainability of fiscal policies.
[71] IMF (International Monetary Fund). 2017. *Staff Report*. IMF Country Report No. 17/325.

For the MOH, the existing QuickBooks accounting software will be used as the FM tool to manage financial transactions and producing timely and reliable financial reports. The existing supplementary FMM of H-EQIP is applicable for this project. There is a need to customize a new chart of accounts and other functions in QuickBooks to meet the specific reporting requirement of the project. Management of performance-based SDG and eligible expenditures for OD, referral hospitals, and health centers will be reflected in the SDG manual for the MOH.

104. The NCDDS adopts its Finance and Administration Manual of 2008 and any amendments subject to the World Bank's review before adoption. The NCDDS will adopt its own accounting software (Sage 50) to manage financial transactions and produce timely and reliable financial reports. There is a need to customize a new chart of accounts and other functions in Sage 50 to meet the specific reporting requirement of the project. Management of performance-based C/S-SDGs and eligible expenditures will be reflected in the C/S-SDG manual for the NCDDS.

105. **Government funds.** The MOH will make a request to the MEF for the Government funds to co-finance SDG and HEF in Component 1. The GDNT of the MEF will transfer the requested amount to the U.S. dollar denominated Government fund bank account at the NBC which is administered by the MOH. The first advance for the Government fund for the project will be equal to the first six-month budget forecast. The subsequent replenishment to the Government fund bank account will be done on a quarterly basis based on the amount in the IFR. The fund balance at the year-end will be carried over to the next fiscal year and will be deducted from the request for funds for the next fiscal year.

106. **External auditing arrangement.** An independent external auditing firm would be engaged by the MEF under the audit bundling contract to audit the project's annual financial statements in accordance with TOR acceptable to IDA. The costs of the external auditor will be financed under Subcomponent 3.4. The auditor will issue one volume of the audit report each for the MOH and NCDDS. The audit will include a review of controls and expenditures paid from performance-based SDG at the subnational level of the MOH and for the use of C/S-SDG by the SNA. The external audit will integrate a review of the post review procurement packages carried out by subnational-level entities at a percentage based on the auditor's risk assessment but not less than 10 percent of the total post review procurement packages. The audited financial statements for the MOH and NCDDS should be disclosed on the MOH's and NCDDS' website, respectively, once there is an acknowledgement from the World Bank. IDA will also make these available on its external website.

107. **Key FM risks.** The main risks are associated with (a) insufficient handling capacity of the current DBF's staff to handle more project-related FM, (b) weak FM capacity of health facilities and inexperienced C/S to manage the performance-based SDG funds, and (c) limited FM capacity of FAD of the NCDDS. Risk mitigating measures are (a) further enhancing capacity of the DBF's and FAD's staff in project FM, (b) providing one or more contracted finance assistants to support the project's operations under the DBF and providing an FM consultant for FM capacity building of FAD and C/S for the first three years of the project, and (c) more capacity building in FM for health facilities and C/S to manage SDG funds.

108. **Oversight and monitoring arrangements.** The FM performance is monitored by regular review of IFRs, discussion with FM team, and specific FM missions twice per year to reassess FM risks and performance. Time-bound action plans will be prepared for implementation to mitigate any identified control weaknesses and risks.

109. **Disbursement arrangements for all components.** The disbursement methods will be reimbursement, advances, special commitment, and direct payments. An E-disbursement is used. The minimum application size for reimbursements, special commitment, and direct payments would be equivalent to US$100,000. The project will have a disbursement deadline date of four months after the closing date of the project. The IDA Credit and trust fund proceeds will be disbursed against eligible expenditures as shown in table 12, which also includes the DLI subcomponents (2.2 and 3.1).

110. **EEP and disbursement arrangements for Subcomponents 2.2 and 3.1 - DLI-based approach.** The EEP will be used as the basis of expenditures when the DLIs have been met. After discussion with the MEF, the entire Government contribution to HEFs and SDGs under Component 1 of the project has been identified as the EEP.

111. The EEPs will be reported through the project's IFRs and will be audited as part of the project's annual financial statement audits. In the project's IFRs, there will be a note of the cumulative amounts of HEFs and SDGs that the Government has contributed under Component 1 and the cumulative amount used as EEPs for Subcomponents 2.2 and 3.1. The RGC must demonstrate that the amount of EEPs recorded in the IFRs exceeds the amount being requested from IDA for reimbursement of the DLI achieved.

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

Table 12. Allocations of Proceeds

Category	Amount of the IDA Financing Allocated (expressed in US$, millions)	Amount of the Trust Fund Financing Allocated (expressed in US$, millions)	Percentage of Expenditures to Be Financed[a] (inclusive of Taxes)
(1) SDGs under Part 1.1 of the Project	4.5	4.5	Up to 100% of the Financing's agreed share of the cost specified in the Disbursement and Financial Information Letter
(2) HEF Grants under Part 1.2 of the Project	1.5	1.5	Up to 100% of the Financing's agreed share of the cost specified in the Disbursement and Financial Information Letter
(3) C/S-SDGs under Part 2.1 of the Project	2.3	4.6	Up to 100% of the Financing's agreed share of the cost specified in the Disbursement and Financial Information Letter

Category	Amount of the IDA Financing Allocated (expressed in US$, millions)	Amount of the Trust Fund Financing Allocated (expressed in US$, millions)	Percentage of Expenditures to Be Financed[a] (inclusive of Taxes)
(4) Eligible Expenditure Programs under Parts 2.2 and 3.1 of the Project	2.7	5.4	Up to 100% of the Financing's agreed share of the cost specified in the Disbursement and Financial Information Letter
(5) Goods, works, non-consulting services, consulting services, Operating Costs, and Training under Parts 2.3, 3.2, 3.3, and 3.4 of the Project[b]	4.0	10.0	Up to 100% of the Financing's agreed share of the cost specified in the Disbursement and Financial Information Letter
TOTAL AMOUNT	15	26	

Note: a. The Association may further specify the financing percentage of each of the HEQIP Grant, IDFHP Grant, the GFF Grant, and the KfW Grant through the provisions of the Grant Agreement. b. Works and non-consulting services are eligible expenditures only for the IDA and counterpart financing; grant financing will not cover works and non-consulting services.

113. **Disbursement arrangements for traditional input-based financing.** Supporting documentation required for eligible expenditures paid from the DA is IFR for the MOH (Component 1, Subcomponents 3.2, 3.3, 3.4) and Statement of Expenditure for the NCDDS (Subcomponents 2.1 and 2.3). Direct payments will be documented by records. The frequency of reporting of expenditures paid from the DA shall be quarterly.

114. The project will provide retroactive financing for eligible expenses paid by the Government on or after September 1, 2018, for the maximum amount not exceeding SDR 715,000 (US$1 million equivalent) to be applicable to IDA financing only.

(ii) Procurement

115. **Applicable procurement rules and procedures.** All procurement activities financed under the project will be governed by the World Bank Procurement Regulation for IPF Borrowers, dated July 2016 and revised November 2017 and August 2018. Procurement under National Procedures will be carried out in accordance with the Government of the Kingdom of Cambodia's Updated Standard Operating Procedures and Procurement Manual for All Externally Financed Projects/Programs, promulgated through the Sub-decree 74 dated May 22, 2012, which is issued pursuant to Article 3 of the Government of the Kingdom of Cambodia's Law on Public Procurement dated January 14, 2012, subject to the additional provisions included in the Procurement Plan. Procurement activities at the subnational level carried out by C/S and budget entities will follow the provisions of the project OM, which will be agreed by the World Bank. Systematic Tracking of Exchanges in Procurement (STEP), which is a web-based tool for procurement planning and tracking, streamlining and Automation, and monitoring a reporting, will be applicable for this project. All applicable procurement rules and procedures and procurement documents will be elaborated and referred in the project OM that will be prepared by the borrower and acceptable to the World Bank.

116. **Procurement arrangements.** Detailed procurement arrangements, the first 18 months Procurement Plan, procurement risks and mitigation measures, and a summary of the Project Procurement Strategy for Development (PPSD) are included in annex 1. The agreed first 18 months Procurement Plan will be published on the World Bank's external website through STEP.

117. **Procurement oversight and monitoring arrangements.** The procurement supervision will be part of the semiannual project implementation support mission and procurement clinics/consultation will be provided based on the needs of the EA and IA. In addition to the prior review by the World Bank based on the prior thresholds, which are subject to change according to the result of risk assessment carried out during the project implementation, the World Bank will carry out the annual procurement ex post review on a sample of at least 10 percent of all post review contracts financed by the project. Furthermore, the external auditor engaged by the borrowers will be tasked to carry out the integrated FM audit and procurement ex post review of the procurement activities at the subnational levels. STEP will help the World Bank monitor the procurement progress and to take appropriate supportive actions in due course. The Government's Excel procurement tracking form will be used by executing agencies and implementing agencies in addition to STEP for the Government internal procurement monitoring.

118. **The project OM will detail procurement arrangements, including responsibilities of each ministry, and the procurement risk mitigation action plan.**

C. Safeguards

(i) Environmental Safeguards

119. The project has triggered OP/BP 4.01 - Environmental Assessment and OP/BP 4.09 - Pest Management. The project activities will be financed throughout the Kingdom of Cambodia. It is anticipated that most of the project support activities will be delivered at the community and health facility levels to improve nutritional status of women and children under the age of two years. The project will align to the existing performance-based SDG system to finance activities in Component 1, whereby eligible expenditures of the SDG allow for (a) purchasing drugs; (b) financing activities related to pesticides for vector-borne disease control such as malaria and dengue; and (c) minor works such as construction of toilets, installation of handwashing facilities, or repair of health center buildings in existing health facilities. There will be no new construction or expansion of existing health facilities.

120. The project support under Component 1 and Component 2 is also expected to increase utilization of immunization services both at health centers and during health outreach activities at the village level and would generate a small quantity of health care wastes such as spent vaccines vials and used syringes, which needs to be handled and disposed of properly. The MOH has developed the National Guidelines for Health Care Waste Management, which will guide any support related to this aspect provided by the Project. The project has been assigned as Category B under the World Bank's OP/BP 4.01 (Environmental Assessment) given that the impacts to the environment from these activities are expected to be minor (dust, noise, construction safety, minimal waste disposal, and so on) and site specific and can be readily managed by applying good environmental management practices. Through capacity building for C/S administrations, the NCDDS will encourage villagers to provide feedback to health facility staff about hygiene and sanitation and smoke from incineration through multiple means of reporting. In addition, an Environmental Management Plan (EMP), including specific environmental safeguard mitigation measures,

and a Pest Management Plan have been prepared to mitigate any potential impact. The EMP was disclosed in-country and on the World Bank's external website on January 18, 2019.

(ii) Social Safeguards

121. Due to limited public works, it is not anticipated that there will be any land acquisition or physical/economical displacement of households/individuals, and no involuntary resettlement will be involved. The project's priority provinces include areas with large concentrations of indigenous people (especially in Mondul Kiri, Ratanak Kiri, Kratie, Preah Vihear, Stung Treng, and Koh Kong), and as such the World Bank's Operational Policy on Indigenous Peoples (OP/BP 4.10) will be applied. As required by the policy, a process of free, prior, and informed consultation has been carried out. In December 2018, consultations were conducted in three provinces (Ratank Kiri, Mondul Kiri, and Kratie) that have sizable, diverse indigenous populations (that is, Stieng, Kraol, Phnong, Kreung, Jarai, Tampoeun). These consultations build upon the findings of the Social Assessment and consultations held under the implementation of the H-EQIP which focused on activities included in the project such as SDGs and HEFs. All such consultations have identified broad community support for the proposed activities under the project.

122. To ensure that the project design is culturally appropriate for indigenous people and that they obtain the full benefits from the project, an Indigenous Peoples Planning Framework (IPPF) has been prepared and disclosed in-country and on the World Bank's external website on January 18, 2019.

123. A national stakeholder consultation meeting to obtain feedback on both the IPPF and EMP (including Pest Management Plan) was held in Phnom Penh on October 18, 2018. Participants included representatives of NGOs, UN, and other development partner agencies; participating health centers; and referral hospitals.

Citizen Engagement

124. The project incorporates citizen engagement through multiple channels. Under Component 1, the MOH SDG system uses patient satisfaction as monitored through randomized beneficiary feedback calls as a means of monitoring heath facility performance. Under Component 2, the CCWCs will be supported to engage community members in the identification of activities and investments that will strengthen the nutritional status of women and children. This includes stimulating participation of women in planning, budgeting, implementation, and monitoring of activities. In addition to the top-down technical assessment of C/S by D/K assessors to empower subnational government to hold service providers accountable, a bottom-up assessment of C/S and health service providers will be conducted using methods aligned with the highly participatory ISAF community scorecards. The project will incentivize C/S and health centers to continue dissemination of service delivery and budget information to institutionalize mechanisms of transparency and accountability developed under the ISAF. VHSGs will play an instrumental role in engaging community members in the use and assessment of public services to improve their performance. The incentive systems built into SDG performance grants also include engagement of citizens in VHSGs and HCMCs, particularly in remote areas where indigenous people are living, and services must be more responsive to their unique social and cultural characteristics.

Climate

125. The operation was screened to identify and, if relevant, address any potential short- and long-term climate change and disaster risks. Options to address climate change include (a) support for improvement of service delivery at the health facilities and at the communities where schedules of health outreach activities and community activities can be flexible depending on local season and weather; (b) flexible use of SDG and HEF grants earned by health facilities under Component 1 for maintenance of health facility buildings in the case of damage by rain water, flood, and storm, for improving clean water availability; and (c) improvement of health care waste management practices in health facilities to reduce potential public health impact to nearby residents and health facilities staff from infection during flooding.

Gender

126. Cambodian women continue to face unacceptably high risks of maternal mortality, particularly women in rural and remote provinces. This high burden is due in part to low quality and utilization of essential MCHN services. In project areas, women suffer from higher poverty and lower access to and poorer quality services than elsewhere, leading to higher maternal and neonatal mortality and child stunting (table 13).

Table 13. Disparities in MCHN Outcomes in 7 Priority Provinces

	% receiving ANC from a skilled provider	% consuming iron tablets or syrup at least 90 days during pregnancy of last birth	% receiving two or more tetanus toxoid injections during last pregnancy	% births assisted by a skilled provider[a]	% children who started breastfeeding within 1 hour of birth[b]	% child (<5) stunting
Mondul Kiri/Ratanak Kiri	76.0	55.9	53.9	53.6	15.9	39.8
Kratie	72.8	38.5	50.3	51.9	64.0	38.4
Preah Vihear/Stung Treng	85.5	63.3	45.1	54.6	77.3	44.3
Kampong Chhnang	99.5	94.4	79.5	97.6	47.5	42.8
Preah Sihanouk/Koh Kong	97.6	74.5	56.8	97.5	76.6	33.4
National average	**95.3**	**75.5**	**62.4**	**89.0**	**62.6**	**32.4**

Source: CDHS 2014.
Note: a. Among all births in the five years preceding the survey. b. Among last-born children born in the two years preceding the survey.

127. The project targets women and children in seven high-burden provinces as the primary beneficiaries and aims to close gender gaps in women's endowments in health by removing supply-side and demand-side constraints in the availability, access, and utilization of priority MCHN services. These investments will aim to alleviate the burden of preventable maternal malnutrition, morbidity, and mortality. Project investments in performance-based grants for MCHN service readiness and quality (in health facilities, outreach, and communities) for 11 priority services, including ANC including nutrition, safe delivery, early and essential newborn care, and PNC. Further, the project will finance transportation

allowances and expanded HEF coverage for the poorest women and children to overcome financial and geographic access barriers to these services. In addition to directly benefitting women, these investments will further interrupt the intergenerational transmission of poor health endowments and nutritional status from mothers to children that is manifest in the high burden of stunting.

128. Micronutrient supplementation during pregnancy is a component of a quality ANC visit and intervention known to reduce post-partum hemorrhage, while skilled delivery helps reduce the risk of maternal mortality. The 2014 CDHS demonstrates large gaps in coverage of these essential maternal health and nutrition services in project provinces (table 13). Therefore, the project will monitor micronutrient supplementation during pregnancy, the number of women with skilled delivery, and the number of women receiving essential nutrition services in target provinces. While there is enhanced quality and reliability of survey-based data, the planned surveys do not align well with the project time frame. Therefore, the project will monitor coverage of these interventions using routine administrative systems to allow comparison of results between target areas and non-target areas.

129. Additionally, project analytical work is under way to identify the most appropriate community-based and facility-based service delivery modalities that can address the needs of working Cambodian women and interventions will be designed accordingly. Actions included in the project's IPPF will help mitigate risks experienced by ethnic minority women and children facing multiple and intersecting forms of exclusion. The design will incorporate findings from the H-EQIP gender study, such as the following: (a) emphasize and monitor the requirement to have at least one woman (midwife) in each assessment team and promote qualified women to be on assessment teams and (b) increase HEF transport allowance to reflect market cost in remote areas (also through other demand-side financing mechanisms with the same purpose).

Grievance Redress Mechanisms

130. For activities implemented under Component 1, community feedback and grievances can be communicated from the bottom up through MOH staff. The commune- and village-level community members can begin by contacting the staff of a health center, followed by the OD staff, provincial hospital staff, and then up to the national ministry staff. For Component 2 activities, community members may use the subnational government system to provide feedback or report grievances on activities led by commune and district administration by reporting through the commune, district, and provincial administrations and the NCDDS at the national level. Contact information for the MOH and NCDDS staff specifically responsible for the project will be provided on project documentation and in electronic communications to allow for direct feedback or grievance reporting by project staff. Any such feedback and grievances will be recorded in a spreadsheet or database to ensure issues are resolved and responses tracked.

131. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may also submit complaints to the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an

opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

V. KEY RISKS

132. The overall risk rating for the operation is Substantial, primarily due to the Substantial risk ratings related to political and governance, technical design, institutional capacity, and fiduciary.

133. Political and governance risks are Substantial. Governance issues need to be given due attention throughout the project and immediate concerns will need to be addressed for effective implementation of the project. Governance of the health sector has been constrained by (a) fragmentation of financing and programs and the limited ability of the Government to manage and coordinate many initiatives and (b) ineffective regulation of public and private service providers. Further, subnational governance risks are inherent in working with C/S administrations. The project will aim to mitigate these risks by (a) conducting a launch workshop to sensitize beneficiaries to the project and its proposed activities, (b) incorporating beneficiary feedback mechanisms into the SDG and C/S-SDG systems, and (c) supporting robust communications and awareness campaigns to further sensitize the public.

134. The overall risks associated with technical design are Substantial**.** The project complexity, involving two implementing agencies, will raise the implementation complexity but will be necessary to achieve the proposed development objectives. A nutrition operation working with a single ministry may not be sufficient to address the multisectoral determinants of stunting, though mitigated to some extent by the World Bank's 'portfolio' approach of working with multiple sectors through coordinated projects rather than through the same project. Component 1 activities build on established, proven MOH platforms which should enhance implementation feasibility and support a package of highly effective interventions. However, there are project risks should the MOH discontinue the HEF/SDGs beyond the life of the H-EQIP project (2016–2021) which may necessitate a restructuring. Implementation of a results-based C/S transfer will necessitate the building of a system of performance assessment and verification. The technical design of the project depends on the existing division of roles and responsibilities between the SNA and line ministry actors. Progress toward D&D and/or the amendment of the MOH OD arrangement would also require a project restructuring to revise the implementation arrangements of the project. Some of these risks are partially mitigated by the Government's growing familiarity with performance-based financing through SDGs and the use of DLIs, which are core features of the technical design of this project. Risks are further mitigated by (a) building off the successful experience of SDGs under H-EQIP; (b) drawing lessons from implementation of prior projects (the Rural Investment and Local Governance Project) which supported communes through 2010, the ongoing Livelihoods Enhancement and Association of the Poor project and the ISAF; and (c) building in considerable implementation support both within the project design and from the World Bank team.

135. Risks related to institutional capacity are Substantial. The multisectorality of nutrition across different types and levels of service delivery may undermine the sense of ownership and accountability in implementation. Strong leadership and good coordination will be key to mitigating this risk. Following the H-EQIP example of mainstreaming into government systems is a critical step to ensure sustainability; however, as faced under H-EQIP, there will be constraints of capacity, resourcing, and stakeholder

alignment. As part of project preparation, independent procurement and FM assessment (including PFM) were carried out to assess the risks and propose appropriate mitigation measures within the OM. Wherever appropriate, experience from H-EQIP and assessments done in this context will feed into the design and implementation arrangement of the project. The absence of a community-level platform for service delivery may be a key impediment, especially in the delivery of community-level interventions foreseen under Component 2. The project will aim to rely on permanent staff at the subnational levels to the extent possible to limit turnover and conflicts of interest and maximize the efficiency of investments in capacity building.

136. Fiduciary risk is considered Substantial. Currently, the MOH is implementing the World Bank-financed H-EQIP. Its subnational-level health facilities nationwide are implementing HEF and SDG. The DBF and Procurement Unit of the MOH performs the fiduciary function of H-EQIP. For procurement, there are significant delays under the current project (H-EQIP) given the limited capacity and staffing and inability to outsource a qualified procurement consultant and a coordination challenge among the concerned departments. The fiduciary risk of the project is rated Substantial owing to:

(a) Weak governance, particularly fiduciary performance and oversight in the public sector;

(b) Understaffed DBF and Procurement Unit. Despite significant improvements in their capacity and contributions in the first two years of H-EQIP, government staff in charge of the fiduciary function of the project are stretched by the multiple functions they handle and may not be able to effectively handle more work during the period of gradual capacity strengthening in project implementation;

(c) Limited timely availability of qualified procurement expertise;

(d) Limited fiduciary capacity of staff of health centers and referral hospitals, who require continued support to manage the SDGs and HEFs under H-EQIP;

(e) Limited involvement of the Internal Audit Department of the MOH with the project auditing; and

(f) Staff of the NCDDS' FAD having limited fiduciary capacity and C/S not having capacity and experience in FM in handling the performance-based SDG for women and children. C/S are themselves new to the concept of performance-based SDG.

137. The following factors will help reduce fiduciary risks: (a) continued capacity building of the DBF's and Procurement Unit's staff in fiduciary function through (i) hands-on supports from consultants, (ii) the World Bank's interaction and support to the fiduciary staff of the MOH and NCDDS, and (iii) short training courses organized by training institutions; (b) provision of consultants in FM and procurement in the short term to support the fiduciary function of the MOH and NCDDS and over the long term, ensure adequate government staff in the fiduciary function of the MOH and NCDDS to be responsible for externally financed projects; (c) continued capacity building for health facilities and initiation of FM capacity building and oversight for C/S to manage SDG funds; (d) conduct of integrated financial audit and procurement post review at the subnational level by an external auditor firm engaged by the Government; (e) provision in each procurement document for channels and contacts of both Government and the World Bank

through which interested parties can lodge their procurement complaints; and (f) applicability of conditions for use of national procurement procedures through the project Procurement Plan.

VI. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: Cambodia
Cambodia Nutrition Project

Project Development Objectives(s)

The PDO is to improve utilization and quality of priority maternal and child health and nutrition services for targeted groups in Cambodia.

Project Development Objective Indicators

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
To improve utilization of priority maternal and child health and nutrition services							
Percent of children born in the last 24 months who were put to the breast within one hour of birth (Percentage)		56.50	58.00	58.00	62.00	62.00	68.00
Number of children under 12 months of age in target areas receiving DPT-HepB-Hib 3 in the last calendar year (annual) (Number)		38,500.00	39,000.00	39,500.00	40,000.00	40,500.00	41,000.00
To improve quality of priority maternal and child health and nutrition services							
Percent of children 6-23 months of age in target provinces who receive foods from 4 or more food groups, by gender (Percentage)		40.00	45.00				50.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Female (Percentage)		40.00					50.00
Males (Percentage)		40.00					50.00
Percent of pregnant women in target areas receiving micronutrient supplementation in accordance with national guidelines (annual) (Percentage)		80.20	80.50	82.50	85.00	87.50	90.00
Number of health facilities in target areas scoring over 60 percent on their Maternal and Child Health and Nutrition Scorecards (annual) (Number)		0.00	10.00	60.00	70.00	80.00	90.00
Number of commune/sangkats in target areas receiving Commune/Sangkat Service Delivery Grants (C/S-SDGs) for women and children (annual) (Number)		0.00	0.00	70.00	145.00	210.00	271.00

Intermediate Results Indicators by Components

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Component 1: Strengthening the Delivery of Priority Health Services							
People who have received essential health, nutrition, and		0.00	211,000.00	422,500.00	634,500.00	847,000.00	1,060,000.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
population (HNP) services (CRI, Number)							
Number of children immunized (CRI, Number)		0.00	39,000.00	78,500.00	118,500.00	159,000.00	200,000.00
Number of deliveries attended by skilled health personnel (CRI, Number)		0.00	32,000.00	64,000.00	96,000.00	128,000.00	160,000.00
Number of women and children who have received basic nutrition services (CRI, Number)		0.00	140,000.00	280,000.00	420,000.00	560,000.00	700,000.00
Number of coaching sessions conducted in target areas with participation of NMCHC (cumulative) (Number)		0.00	12.00	24.00	36.00	48.00	60.00
Average health center staff score (%) on GMP vignettes in target areas (annual) (Percentage)		0.00	30.00	45.00	55.00	60.00	65.00
Number of integrated outreach sessions in target areas supported by the project (cumulative) (Number)		0.00	500.00	1,500.00	2,500.00	3,750.00	5,000.00
Percent of children 12-23 months in target areas fully immunized (Percentage)		63.04					75.00
Bottom 40% of households (Percentage)		56.30					68.00
Upper 60% of households (Percentage)		77.80					85.00
Utilization of outpatient HEF services in target areas in the		232,872.00	237,800.00	242,800.00	247,800.00	252,800.00	256,000.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
last calendar year (annual) (Number)							
Component 2. Stimulating Demand and Accountability at the Community Level							
Number of citizens in target areas providing feedback on commune services for women and children (cumulative) (Number)		0.00	0.00	7,000.00	14,000.00	21,000.00	28,000.00
Number of communes in target areas incorporating C/S-SDG beneficiary feedback in Commune Development Fund plan (annual) (Number)		0.00	0.00	56.00	112.00	168.00	225.00
Number of villages in target areas with active VHSGs trained according to guidelines (annual) (Number)		0.00	0.00	262.00	525.00	787.00	1,050.00
Number of VHSGs in target areas trained by the project to implement CPWC and HEF promotion (cumulative) (Number)		0.00	0.00	300.00	600.00	900.00	1,200.00
Number of VHSGs trained by the project to implement CPWC and HEF promotion-female (cumulative) (Number)		0.00	0.00	180.00	360.00	540.00	720.00
Number of community health and nutrition events for women and children convened in target areas (cumulative) (Number)		0.00	0.00	8,750.00	17,500.00	26,250.00	35,000.00

Indicator Name	DLI	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Number of mothers of children age 0-2 years participating in any CPWC event in the last calendar year (annual) (Number)		0.00	0.00	5,000.00	10,000.00	15,000.00	20,000.00
Percent of commune/sangkats in target areas receiving C/S-SDG payment within specified timelines (Percentage)		0.00	0.00	70.00	75.00	80.00	85.00
Component 3. Ensuring an Effective and Sustainable Response							
Number of public health providers trained in MIYCN package (cumulative) (Number)		0.00	50.00	100.00	150.00	200.00	250.00
Of which female (Number)		0.00	30.00	60.00	90.00	120.00	145.00
Percent of health facilities receiving MCHN scorecard SDG payment within specified timelines (Percentage)		0.00	60.00	65.00	70.00	75.00	80.00

Monitoring & Evaluation Plan: PDO Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Percent of children born in the last 24 months who were put to the breast within one hour of birth	Numerator: Children born in the last 24 months who were put to the breast within one hour of birth.	3 Rounds: baseline, midline and endline	Project Impact Evaluation	Household Survey	The World Bank

	Denominator: Children born in the last 24 months. Note: This indicator is based on historic recall. The denominator and numerator include living children and deceased children who were born within the past 24 months. Note: The baseline for this indicator is the weighted average from the CDHS 2014 for the project's 7 provinces. It will be updated as it is available from the project's impact evaluation.				
Number of children under 12 months of age in target areas receiving DPT-HepB-Hib 3 in the last calendar year (annual)	Annual number of children under 1 year of age in 7 target provinces receiving the third dose of DPT-HepB-Hib (Diphtheria/Tetanus/Pertussis, Hepatitis B, Haemophilus Influenzae Type b) from routine immunization delivered at health facilities and during outreach activities.	Annual	MOH-HMIS	Health Management Information System (HMIS)	MOH-HMIS

	Number was chosen rather than % due to the challenges with the denominator used to calculate the coverage (see below) For percent, the indicator would be calculated as follows Numerator: Number of children under 1 year of age receiving 3 doses of DPT-HepB-Hib) from routine immunization delivered at health facilities and during outreach activities Denominator: Total number of children under 1 year of age in 7 target provinces				
Percent of children 6-23 months of age in target provinces who receive foods from 4 or more food groups, by gender	Numerator: Children 6–23 months of age who received foods from ≥ 4 food groups during the previous day Denominator: Children 6-23 months of age Note: The baseline is based upon CDHS data for the 7 target provinces. True baseline will be updated as data are available from the	3 impact evaluation rounds: Baseline, midline, and endline	Project Impact Evaluation	Household Survey	The World Bank

	impact evaluation baseline.				
Female					
Males					
Percent of pregnant women in target areas receiving micronutrient supplementation in accordance with national guidelines (annual)	Percent of pregnant women in target areas receiving micronutrient supplementation according to the national guideline / Expected pregnancies x 100 Numerator: Number of women receiving recommended micronutrient supplementation during pregnancies according to the national guideline Denominator: Total number of expected pregnancies	Annually	MOH-HMIS	Routine Health Management Information System (HMIS) reporting	MOH-HMIS
Number of health facilities in target areas scoring over 60 percent on their Maternal and Child Health and Nutrition Scorecards (annual)	Count of the number of health facilities scoring 60% on a composite Health Facility (HF) Quality Index covering structural, process, and outcome domains included in the MCHN Scorecard. Based upon administrative data from	Semi-Annual	MOH-QAO in the MCHN Scorecard Report	Quarterly health facility assessment using the National Quality Enhancement Monitoring Process (NQEMP)	MOH-QAO

	the latest available round.				
Number of commune/sangkats in target areas receiving Commune/Sangkat Service Delivery Grants (C/S-SDGs) for women and children (annual)	Number of commune/sangkats receiving performance-based C/S-SDG according to the scores obtained from semi-annual performance assessment which will be assessed by certified district assessors.	Annual	C/S SDG reports	Semi-annual C/S SDG report will include number of C/S assessed and receiving grants	NCDDS

Monitoring & Evaluation Plan: Intermediate Results Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
People who have received essential health, nutrition, and population (HNP) services		Annual.	HMIS and NCDDS Administrative data	Cumulative sum of the annual sub-indicators	MOH and NCDDS
Number of children immunized		Cumulative sum of annual number of children in target areas receiving DPT3.	MOH-HMIS	Routine HMIS data collection	MOH-HMIS

Number of deliveries attended by skilled health personnel		Cumulative sum of the annual number of skilled deliveries reported through the MOH HMIS.	MOH-HMIS	Routine HMIS data collection	MOH-HMIS
Number of women and children who have received basic nutrition services		Cumulative sum of the following: Number of children 6-59 months receiving vitamin A supplementation in the previous 6 months (round 2) as reported in HMIS and number of mothers of children age 0-2	HMIS (Vitamin A supplementation) and project administrative data (CPWC coverage)	Sum of the following: Number of children 6-59 months receiving vitamin A supplementation in the previous 6 months (round 2) and number of mothers of children age 0-2 years participating in any CPWC event in the year.	MOH (HMIS) and NCDDS (CPWC administrative data)

		years participating in any CPWC event in the previous year.			
Number of coaching sessions conducted in target areas with participation of NMCHC (cumulative)	Cumulative Number of coaching sessions conducted in 7 target provinces as planned after each quarter NQEM assessment that include the NMCHC National Programs. The coaching session could be performed by the Operational District (OD) assessors or technical staff at the OD, referral hospital, provincial health department (PHD), provincial hospital, NGOs or development partners but also include at least one from NMCHC, NIP, or NNP.	Annual	MOH-NMCHC	NMCHC report	MOH-NMCHC
Average health center staff score (%) on GMP vignettes in target areas (annual)	The Average score that health providers in seven target provinces obtained on the GMP vignette during each quarterly quality	Annual	MOH-NMCHC	NMCHC Annual Report	MOH-NMCHC

	performed by OD assessors, as reported in the previous round. Numerator: Sum of the health center GMP vignette scores in the previous round for target areas Denominator: Number of health centers scored in the previous round in target areas				
Number of integrated outreach sessions in target areas supported by the project (cumulative)	Cumulative number of integrated outreach sessions in the 7 target provinces conducted according to the MOH integrated outreach guideline.	Annual	MCHN Scorecard Report	MOH-QAO	MOH-QAO
Percent of children 12-23 months in target areas fully immunized	Children are fully immunized when they received vaccines against tuberculosis (BCG), Hep B at birth, OPV 1-3, Inactivated Polio Vaccine (IPV), diphtheria, tetanus, pertussis, hepatitis B, haemophilus influenzae Type b (DPT-HepB-Hib 3), Pneumococcal Conjugate	Every 5 years	CDHS	Household survey	MOP

	Vaccine (PCV 1-3), Japanese encephalitis and measles and before the first birthday.				
Bottom 40% of households	This sub-indicator will be calculated as the percent of children 12-23 months of age who are fully immunized among the subset of households in the bottom 40 percent of the standard DHS household wealth index distribution.	Every 5 years	CDHS	Household survey	MOP
Upper 60% of households	This sub-indicator will be calculated as the percent of children 12-23 months of age who are fully immunized among the subset of households in the bottom 40 percent of the standard DHS household wealth index distribution.	Every 5 years	CDHS	Household survey	MOP
Utilization of outpatient HEF services in target areas in the last calendar year (annual)	Defined as total number of outpatient services (episodes) in health centers and referral hospital covered by HEF in target provinces, excluding delivery. The outpatient report generated by PMRS includes general	Annual	PMRS-MOH	Routine monthly PMRS submission from public health facilities	PCA-MOH

	consultation and delivery by health facility. This indicator includes only general outpatient consultation and is computed by subtracting total number of delivery from the total outpatient.				
Number of citizens in target areas providing feedback on commune services for women and children (cumulative)	Cumulative number of citizens providing beneficiary feedback through the C/S-SDG processes. This feedback could include specific suggestions or grievances, or general feedback such as satisfaction levels. The target for citizens submitting feedback is from a universe of 1.7 million beneficiaries residing in the seven provinces targeted by the project.	Reported annually	Aggregate from semi-annual C/S-SDG report	C/S-SDG Report	NCDDS
Number of communes in target areas incorporating C/S-SDG beneficiary feedback in Commune Development Fund plan (annual)	Cumulative number of communes with C/S-SDG beneficiary feedback included in the Commune Development Plan. The target of 225 communes is with reference to a total of 339 communes in the seven provinces targeted by the	Annual	C/S-SDG administrative data	C/S SDG report	NCDDS

	project.				
Number of villages in target areas with active VHSGs trained according to guidelines (annual)	Number of villages in 7 target provinces with the required number of trainned village health support group to support in: village mapping, community mobilization, convene health, nutrition, and HEF promotion sessions.	Annual	C/S-SDG administrative data	C/S-SDG Report	NCDDS
Number of VHSGs in target areas trained by the project to implement CPWC and HEF promotion (cumulative)	Number of VHSGs trained by the project to implement CPWC	Annual	Project data	NCHP Report	NCHP
Number of VHSGs trained by the project to implement CPWC and HEF promotion-female (cumulative)					
Number of community health and nutrition events for women and children convened in target areas (cumulative)	Cumulative number of community events for women and children convened under CPWC in 7 target provinces as defined in the operational guideline.	Annual	C/S-SDG Administrative data	C/S-SDG Report	NCDDS
Number of mothers of children age 0-2 years participating in any CPWC event in the last calendar year (annual)	Number of mothers of children age 0-2 years participating in any commune program for women and children (CPWC) event. Mothers will only be counted once for participation in the previous year.	Annual	Project Data	C/S-SDG Report	NCDDS

Percent of commune/sangkats in target areas receiving C/S-SDG payment within specified timelines	Numerator: Number of C/S receiving C/S-SDG payments within timeline specified in C/S-SDG guideline in the previous round Denominator: Total number of C/S receiving C/S-SDG payments in the previous round	Semi-annual	C/S-SDG report		
Number of public health providers trained in MIYCN package (cumulative)	Number of public health providers trained in social and behavior change communication to raise awareness to the community: mothers, care givers on proper practices for initiating breastfeeding within one hour of birth, and complementary feeding practices for infants and young children aged 6-23 months in target areas.	Annually	Project Data	NNP Annual Report	NNP
Of which female					
Percent of health facilities receiving MCHN scorecard SDG payment within specified timelines	Percentage of health facilities administering the MCHN scorecard receiving payment according to timeline specified in SDG operations manual. Numerator: Number of	Annual	DBF payment report	DBF SDG records	MOH

	health facilities administering the MCHN scorecard Denominator: Number of health facilities with payment received according to specified timeline				

ANNEX 1: Implementation Arrangements and Support Plan

COUNTRY: Cambodia
Cambodia Nutrition Project

1. The project will be implemented through the MOH and NCDDS, with the MOH acting as the EA and the NCDDS as IA for Component 2. The project aims to extend frontline primary health care to the community level and requires cross-sectoral collaboration between the MOH and the SNA to do so. Little progress has been made to operationalize a formal model of community health and nutrition promotion at the commune level, though the HSP-3 and RMNCAH-N sub-sector strategies acknowledge the need to engage subnational administration for community level activities. The MOH Community Participation Policy was approved in 2003 with an update drafted in 2008 to incorporate these aspects not approved. Therefore, the project is designed to clearly define the responsibilities of these line ministries, strengthen collaboration and coordination, and extend the reach of frontline health and nutrition promotion and services

2. Program governance will be through the project Steering Committee with TOR outlined in the OM. The MEF will chair the Steering Committee. Under the MOH project director will be two project managers—each respectively responsible for technical and financial implementation. The NCDDS will name a project director and a project manager for technical implementation.

3. The MOH and NCDDS and their relevant departments and technical staff will be the implementing agencies for project activities. The project implementation arrangements are based upon experience of H-EQIP and embed project management within the relevant technical departments and national programs. The project EA and IA and the subnational level procurement entity with possible support of individual procurement consultants will carry out procurement activities financed under their respective components and subcomponents themselves. The applicable procurement procedures are of the World Bank Procurement Regulation for IPF Borrowers, July 2016 and revised November 2017 and August 2018. Project management support for the MOH and NCDDS will support procurement and FM capacity building. The roles and responsibilities of key actors for project implementation are summarized in table 1.1

Table 1.1. Roles and Responsibilities for CNP Implementation

Steering Committee	The Steering Committee will deal with policy issues and legal and regulatory framework issues/decisions, provide strategic guidance, and support problem solving to project implementation. Meetings will be at least annually to discuss and decide on issues where policy, procedural, and/or interministerial cooperation are required. The Steering Committee will be the last resort for solving conflicts and complaints that cannot be resolved by technical implementing units. Chair: MEF with MOH and NCDDS project directors as members
MOH	Project EA. Lead project coordination team; lead implementation of Components 1 and 3; monitor progress toward PDO; finance project audit from Subcomponent 3.4 funds and contribute to completion of audit Volume 1; procurement, fiduciary, safeguards, disbursements for Components 1 and 3; develop/update OM Volume 1 and supporting manuals for Component 1 and 3 activities; training and capacity building for

	Components 1 and 3; Component 1 and 3 M&E; nominate coordination focal point to work with IA on collaboration issues.
MOH DBF	Responsible for (a) preparing financial aspects of project annual operating plan; (b) FM and disbursement of project funds ; (c) releasing project funds to implementing units; (d) FM capacity building of health facilities; (e) providing quarterly and annual FM reports, including disbursement rates of government and project funds; (f) producing timely quarterly financial monitoring reports; and (g) close collaboration with the external auditor for timely completion of the audit report.
NMCHC	Responsible for (a) prioritizing among service delivery modalities for priority interventions through facilities and communities in the CPWC package; (b) preparing technical aspects of annual operating plan with financial aspects being contributed by DBF; (c) leading the development of the MCHN Scorecard and MCHN Vignettes; (d) DLI F focal point; (g) supporting midyear review and joint annual review and project midterm and project completion reports for the MOH and pooled fund partners.
NNP	Contribute to development of the MCHN Scorecard and MCHN Vignettes; contribute to development of the CPWC guidelines and VHSG training materials; participate in training, coaching, field supervision of CPWC activities (along with the NCHP); DLI D focal point; technical lead on the development and implementation of MIYCN SBCC campaign, content, and materials under Component 3.
PMD	Prepare Integrated Outreach Guideline including priority MCHN services; DLI E focal point; focal point for monitoring MOH environmental and social safeguards implementation.
NIP	Contribute to development of the MCHN Scorecard, CPWC guidelines, and VHSG training materials; Participate in MCHN Scorecard reviews.
NCHP	Convene cross-sectoral Component 2 working group; lead development of guidelines for the CPWC with support from MOH national programs and the NCDDS; develop training materials, job aides for VHSGs, HCMC meetings to implement CPWC; conduct step down training to OD for CPWC; DLI G focal point.
MOH DPHI	Responsible for (a) periodical reporting on project-relevant data; (b) periodical updates to the HEF promotion and implementation guidelines including bundled packages; and (c) DLI K focal point.
PUs of MOH and NCDDs	Support any required procurement for their respective components which is being undertaken at the central level; contribute to building capacity at the field level to undertake small procurements using the SDG and HEF funds; ensure very small procurement activity under DLI funds follows the acceptable procurement procedures in DLI Manual.
Quality Assurance Office (QAO)	Prepare and update the SDG manual and guidelines for the MCHN Scorecard, together with the NMCHC and other concerned departments, as needed; incorporate revisions into SDG annual instruction; development and periodic update of NQEM tools and checklists; participate in development of MCHN Scorecard and MCHN Vignettes with the NMCHC; chair the Quality Enhancement Working Group (QEWG) with participation of DPs and technical units, ensuring monitoring of the SDGs; DLI I focal point.
PCA	Certify HEF and MCHN SDG payments; conduct ex post verification of MCHN SDG scores; train health centers/referral hospital on full PMRS and updated HEF guideline; DLI H focal point.
PHD	Supervision of ODs; coordination with health facilities to facilitate timely settlement of advances and timely payments flowing under the SDGs.

OD	Undertake quarterly performance and quality assessment of the health centers using the NQEM Tool and MCHN Scorecard; health center coaching to improve MCHN Scorecard quality; conduct VHSG training for CPWC.
Health centers	Frontline primary care services for patients including maternal and child health, nutrition, immunization, communicable and non-communicable diseases; conduct integrated health outreach activities to villages according to guidelines; participate in HCMC meetings and conduct quality assurance for VHSGs.
Health Posts	Support delivery of priority interventions in provinces with low density (including project provinces).
NCDDS	IA for Component 2, including FM, procurement, safeguards monitoring, M&E, and so on. Identify a coordination focal point to lead cross-sectoral coordination meetings; develop and revise OM Volume 2 for the NCDDS; prepare guideline for C/S-SDG; develop training and capacity building package for commune on C/S-SDG processes including FM readiness and accountability; compile and certify C/S-SDG scores; trigger request for payment to C/S; M&E and semiannual report of project progress for Component 2 activities.
Internal Audit Department (IAD) of MOH and Internal Audit Unit (IAU) of NCDDS	Involve in the project's operations to get capacity building on the project implementation and FM to enable the IAD and IAU to effectively provide services to the project management and ministers.
NCDDS Finance Office of FAD	Responsible for (a) jointly preparing annual work plan and budget for Component 2; (b) FM and disbursement of Component 2 project funds; (c) releasing Component 2 project funds to implementing units; (d) developing FM readiness certification and capacity building plan for C/S; (e) providing quarterly and annual FM reports, including disbursement rates of project funds; (f) producing timely quarterly financial monitoring reports; and (g) close collaboration with the external auditor for timely completion of Volume 2 (NCDDS) of the project audit report.
Provincial Administration	In 7 target provinces, chair an annual review of multisectoral nutrition progress; participate in C/S-SDG assessor pool and conduct training and coaching to build capacity of C/S to implement C/S-SDG; support districts to conduct C/S-SDG assessment; and review C/S-SDG scores and submit to the NCDDS for certification.
District Administration: Office of Planning Focal Point	In 7 target provinces, conduct training and coaching to build capacity of communes to implement C/S-SDG and certify commune readiness through exposure of chief, CCWC, and Village Team; participate in C/S assessor training and complete certification; conduct C/S-SDG assessment with support from provinces; and timely reporting of C/S scores to province.
C/S Council	In 7 target provinces, integrate planning and budgeting of C/S-SDG into standard commune investment plan processes and convene quarterly HCMC meetings
CCWC FP	In 7 target provinces, oversight and mentoring for the Village Team and VHSGs; maintenance of VHSG register; monitoring and supervision of commune- and village-level CPWC activities; focal point for monitoring C/S-SDG indicators; participate in commune investment plan and C/S-SDG planning; and support to the Commune Clerk to promote allocation of C/S-SDG funds to planned CPWC activities.
Commune Clerk	In 7 target provinces, frontline FM and accounting for C/S-SDG funds; management and supervision of VHSGs; consolidation of C/S-SDG indicators on semiannual basis and submission to C/S council; maintain VHSG register; and reporting on C/S-SDG funds and progress to the CCWC FP
HCMC	Coordination tool to promote mutual investment of the commune and the MOH to help ensure that CPWC activities take place as planned; joint annual review of C/S-SDG, CIP,

	and health center Annual Operational Plan (AOP); and support adoption of actions outlined in the ISAF JAAP for health centers.
Village Chief	In 7 target provinces, sensitize community on CPWC and C/S-SDG; motivate community to participate in CPWC activities; work as part of Village Team to support supervision of VHSGs and microplanning of village-level CPWC activities; and reporting on progress to the Commune Clerk.
Village Team	Includes Village Chief and Village Member/Assistant, as well as the Commune Council's focal point for the village. Support planning and management of CPWC activities at village level; reporting CPWC activities to the CCWC FP; and routine support for aggregate village data for semiannual C/S-SDG assessment.
VHSG	Conduct activities as per CPWC guidelines, including community mobilization, health and nutrition education, and HEF promotion activities; conduct village social mapping (number of pregnant women, children under 2 years, and so on) and maintain register; support Village Team in gathering village data for C/S-SDG checklist; and ensure nominated members participate in HCMC meetings and report back.

Donor Arrangements

4. The CNP design resulted from extensive rounds of consultations among the Government and development partners to develop a common understanding of the priority gaps in RMNCAH-N to be filled and the operational modalities required to do so. On this basis, four partners (Australian DFAT, H-EQIP, German KfW, and the GFF) will pool support to the project. Grant funds will be channeled to the project using multiple trust funds administered by the World Bank. Pooling partners will also contribute to a World Bank-executed pooled fund that will support project supervision costs as well as jointly prioritized TA.

5. Based upon the H-EQIP experience, the project will establish an MC consisting of all funding partners. The MC will have a rotating, non-World Bank chair. The MC will meet on a bimonthly basis (or as necessary) to exchange information, coordinate technical and financial assistance, conduct strategic decision making, and review implementation progress. Further, the MC members will conduct joint semiannual implementation support missions, including field visits, and will contribute to the preparation and finalization of the Aide Memoires.

6. Broader development partner coordination with the CNP will continue through existing mechanisms such as the P4H Social Health Protection platforms as well as through the RGC Technical Working Group for Health (TWG-Health) and the TWG-FSN&SP and relevant sub-technical working groups, which include membership from government and nongovernmental agencies, private organizations, and bilateral and multilateral organizations. The TWG-Health also serves as the coordination platform for the GFF.

Financial Management

7. **FM assessment**. An FM assessment was carried out in accordance with World Bank Directives and Policy: IPF for the MOH, NCDDS, and two selected C/S in Ratanak Kiri and Preah Vihear province. The MOH has an acceptable FM system and manual established under the H-EQIP; staff in the DBF who are involved in the H-EQIP's FM have been trained and FAD has some experience in the previous World Bank-financed project. Subject to satisfactory implementation of FM system enhancement actions, the project is

considered to have an acceptable FM arrangement and the FM risk is considered as Substantial after mitigating measures.

8. **Internal controls and internal audit.** The MOH adopts the SOP/FMM which contain sound internal control over FM, and the NCDDS adopts its Administration and Finance Manual of 2008 and its amendment is subject to the World Bank's review before adoption. Whenever undertaken as part of their normal internal audit work program, the IAD of the MOH and IAU of the NCDDS can receive capacity-building support to include the project activities in their samples selected and report on them in their normal internal audit report for the period. The IAD has adequate staff; while the IAU will need to have more staff for its operations. The IAD and IAU will report the results of such internal audit work undertaken on the project to the management of the ministries. Project management will include internal audit findings into the Project Progress Report to be submitted to the World Bank. The IAD and IAU can also be considered for involvement in capacity building and financial oversight efforts at the subnational level. The original supporting documents will be retained by the MOH, NCDDS, and subnational-level entities for a period of 10 years, according to the SOP.

Procurement

9. **Procurement capacity and risk assessment.** Key procurement risks and mitigation measures are identified in Table 1.2.

Table 1.2. Procurement Risk Assessment and Mitigation Measures

Risk Description	Description of Mitigation	Risk Owner
Possible coordination challenge among the EA, IA, and their line technical departments, provincial agencies, and district offices may delay the procurement processes.	1. The EA and IA need to ensure good coordination among themselves and respective departments and subnational-level entities. 2. Each EA and IA will assign focal persons for coordination purpose within the EA/IA and across the ministries and line departments. The coordinating roles and responsibilities of these persons will be included in OM.	EA and IA
Procurement of at least 9 consulting firms and NGO contracts separately in addition to about 18 individual consultant contracts under this project will consume a lot of time and effort for the EA, while the EA already faces capacity and understaffing constraint. Moreover, according to past experiences included in the Joint Country Portfolio Review Report, the procurement of consulting firms/NGOs took longer time than scheduled, given the complexities and time consuming nature of the government's internal evaluation and approval processes.	1. Procurement of firms/NGOs and individual consultants will strictly follow the agreed time frames in the procurement plan. 2. The EA/IA need to agree on the service standard that will be included in OM. 3. Sufficient delegation of authority will be provided to the members of Bid Evaluation Committee and Procurement Review Committee. 4. Procurement tracking and monitoring form in the SOP/Procurement Manual will be used in addition to STEP.	EA and IA

Risk Description	Description of Mitigation	Risk Owner
Possible delay in technical inputs. A challenge for the EA to prepare the most appropriate technical specifications for the new technologies and TORs for NGOs/firms.	TORs and specifications of key procurement packages will be finalized before project effectiveness. The World Bank team will provide support and samples of TORs to the EA and IA to strengthen technical specifications.	EA, IA, and World Bank
Qualified consulting firms/NGOs and other key individual consultants would not be available when needed.	Sufficient advertisement for expressions of interest and start of the selection sufficiently ahead of the need for the consultants.	EA and IA
Each EA/IA has limited qualified procurement staff and is not familiar with the World Bank Procurement Regulations for IPF Borrowers and STEP.	(a) Each EA and IA will hire at least one national procurement consultant to assist them in executing procurement activities and providing support on contract management and strengthening their capability. (b) The World Bank should provide more training on a need basis. (c) Each EA and IA will assign one focal person for implementation of STEP and monitoring the procurement tracking form.	All EA, IAs, and World Bank
Poor governance and misuse of funds in procurement.	In addition to the disclosure provisions of the SOP, the CNP EA and IA will establish a project website for the publication of procurement opportunities and contract award notices and for receiving possible complaints for this project. The MOH will administer this project website that can be accessed by the NCDDS. The NCDDS will also post all publications and receive complaints through its own website parallelly.	All EA, IAs, and World Bank

10. **Institutional arrangements for procurement**. Each EA and IA with the support of individual procurement consultants will carry out procurement activities financed under their respective components and subcomponents themselves. Procurement activities at the subnational level will be carried out by C/S and respective budget entities.

11. **Applicable procurement procedures.** All procurement activities financed under the project will be governed by the World Bank Procurement Regulation for IPF Borrowers, July 2016 and revised November 2017 and August 2018. Procurement under National Procedures will be carried out in accordance with the Government of the Kingdom of Cambodia's Updated Standard Operating Procedures and Procurement Manual for All Externally Financed Projects/Programs, promulgated through Sub-decree 74 dated May 22, 2012, which is issued pursuant to Article 3 of the Government of the Kingdom of Cambodia's Law on Public Procurement dated January 14, 2012, subject to the additional provisions that will be included in the Procurement Plan. Procurement activities at the subnational level carried out by

C/S and budget entities will follow the provisions of the OM which has been agreed by the World Bank. All applicable procurement rules and procedures and procurement documents will be elaborated and referred in the project OM prepared by the EA and IA and acceptable to the World Bank.

12. **Procurement scope under the project as identified in the PPSD.** An estimated budget of US$8 million would be spent for all procurement activities under this project. Out of this estimated budget, about US$6 million would finance all consulting services, US$1.6 million would finance goods (technical and laboratory equipment/tools, office equipment, vehicles, and so on), and the rest will finance minor repairing works (toilets, washbasins, and the like).

13. **Procurement Plan.** Based on the PPSD, a first 18 months' Procurement Plan for the project has been jointly prepared by EA and IAs, and agreed with the World Bank.

14. **Review threshold.** The procurement risk under this project is considered Substantial after applying the agreed risk mitigation measures. Thus the prior review thresholds by procurement types are as detailed in table 1.3.

Table 1.3. Prior Review Threshold Amounts by Procurement Type

Type of Procurement	Prior Review Threshold Amounts (US$, millions)
Works	10
Goods, information technology, and non-consulting services	2
Consultants: Firms	1
Consultants: Individuals	0.3

Table 1.4. Summary of Planned Procurement Packages for First 18 Months of Project

Description	Estimated Cost (US$, millions)	Procurement Method	Domestic Preference	Review by the World Bank	Comments
Procurement of Goods					
Production of MIYCN package for HCs; supply of demonstration of nutritious complementary foods for children 6–23 months through CPWC; Integrated Outreach Kits; production and supply of field monitoring/supervision materials; televisions for health centers; and vehicles for MOH and NCDDS.	0.57	Request for Bid, Request for Quotation, and UN	No	Post	Seven separate contracts
Procurement of Consultants					
Consultancy services for mass media production, digital media production, web videos, audio spots,	3.45	Quality- and Cost-Based Selection , Selection	No	Post	Thirteen separate contracts

Description	Estimated Cost (US$, millions)	Procurement Method	Domestic Preference	Review by the World Bank	Comments
print media, and merchandise for IYCF and MIYCN; HEF promotion; development of communication apps for MIYCN, immunization, and HEF promotion; development of interactive/innovative communication services; implementation research for 15 studies; independent verification firm; and integrated financial audit and procurement post review		Based on the Consultants' Qualifications, Quality-Based Selection, Consultant Direct Selection			
Individual consultants for supporting the project implementation	1.81	Individual consultant	No	Post	23 separate individual consultants

15. **Use of STEP.** Applicable to this project, STEP, which is a web-based tool, will be used for procurement planning and tracking, streamlining and automation, and monitoring and reporting.

16. **World Bank's review and implementation support.** The procurement supervision will be part of the semiannual project implementation support mission, and procurement clinics/consultation will be provided to EA/IA based on their needs. In addition to the prior review by the World Bank based on prior thresholds, which are subject to change according to the result of risk assessment carried out during project implementation, the World Bank will carry out the annual procurement ex post review on a sample of at least 10 percent of all post-review contracts financed by the project at the national level. An external auditor engaged by the borrower will be tasked to carry out the integrated FM audit and ex post review of the procurement activities at the subnational level. STEP will help the World Bank monitor the procurement progress and take appropriate supportive actions in due course. The Excel procurement tracking form of the Government will be used by EA and IA in addition to STEP for the government internal procurement monitoring.

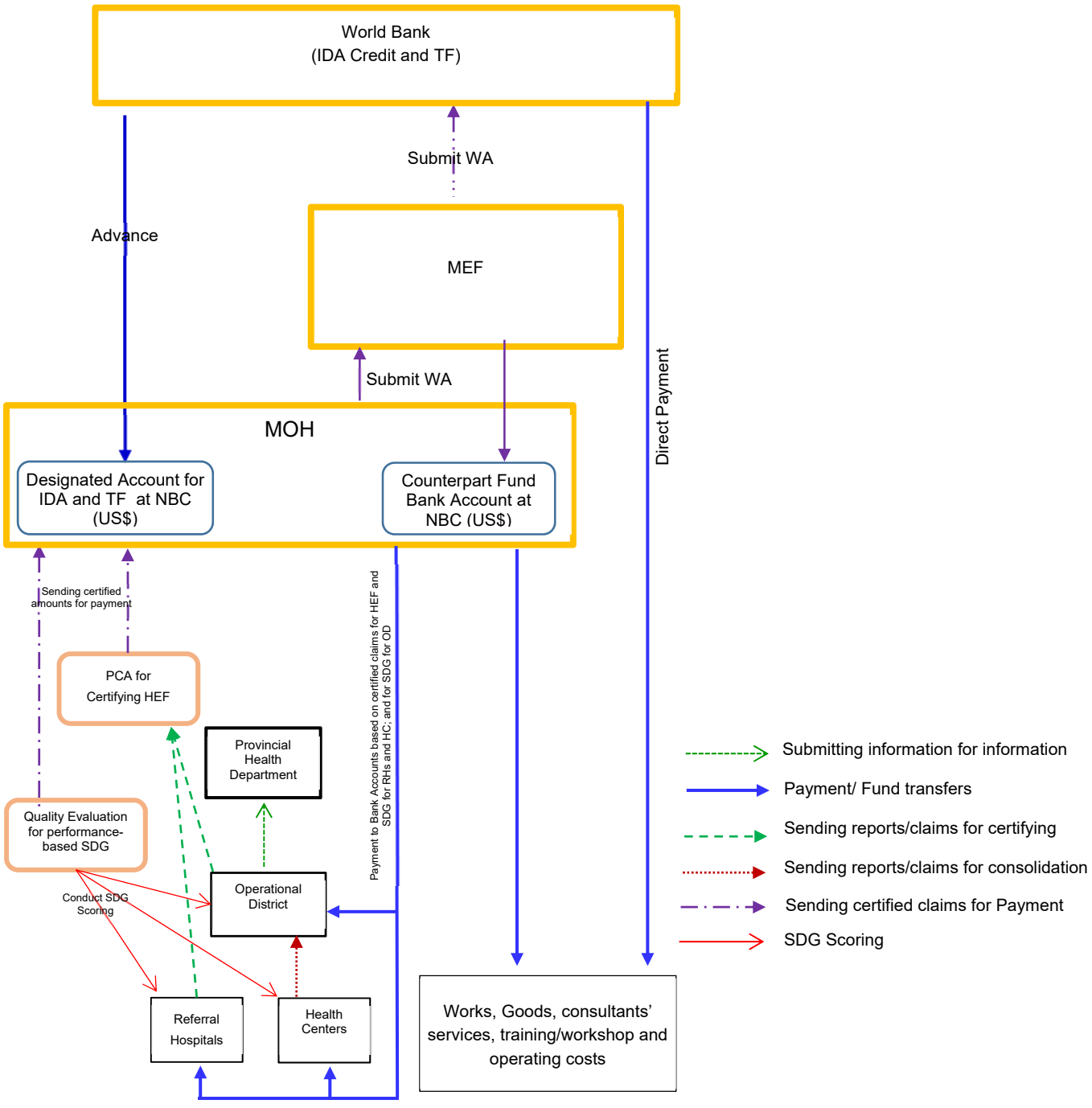
17. **The project implementation support** will comprise regular dialogue with the MOH and NCDDS and regular oversight for project activities and fiduciary requirements, complemented by six-monthly implementation support missions including the project's pooling partners. The implementation support plan is found in table 1.5.

Table 1.5. Project Implementation Support Plan

Time	Focus	Skills Needed	Resource Estimate (staff weeks/year)
First 12 months	Implementation support coordination	Task Team Leaders	12
	Overall technical support	Nutrition Specialist	12
	Overall technical support	Senior Health Specialist	6
	Overall technical support	Health Analysts	12
	Overall operational support	Senior Operations Officer	2
	FM and capacity building	FM Specialist	8
	Procurement	Procurement Specialist	4
	Safeguards and gender	Safeguards Specialists	4
12–48 months	Implementation support coordination	Task Team Leaders	8
	Overall technical support	Nutrition Specialist	8
	Overall technical support	Senior Health Specialist	4
	Overall technical support	Health Analysts	6
	Overall operational support	Senior Operations Officer	2
	FM	FM Specialist	4
	Procurement	Procurement Specialist	2
	Safeguards	Safeguards Specialists	4

Fund Flows

Figure 1.1. Fund Flow Diagram for Input-Based Traditional Financing to MOH (Subcomponents 1.1, 1.2, 3.2, 3.3, and 3.4).



Note: HC = Health center; RH = Referral hospital.

Figure 1.2. Fund Flow Diagram for Traditional Input-Based Financing to the NCDDS (Subcomponents 2.1 and 2.3)

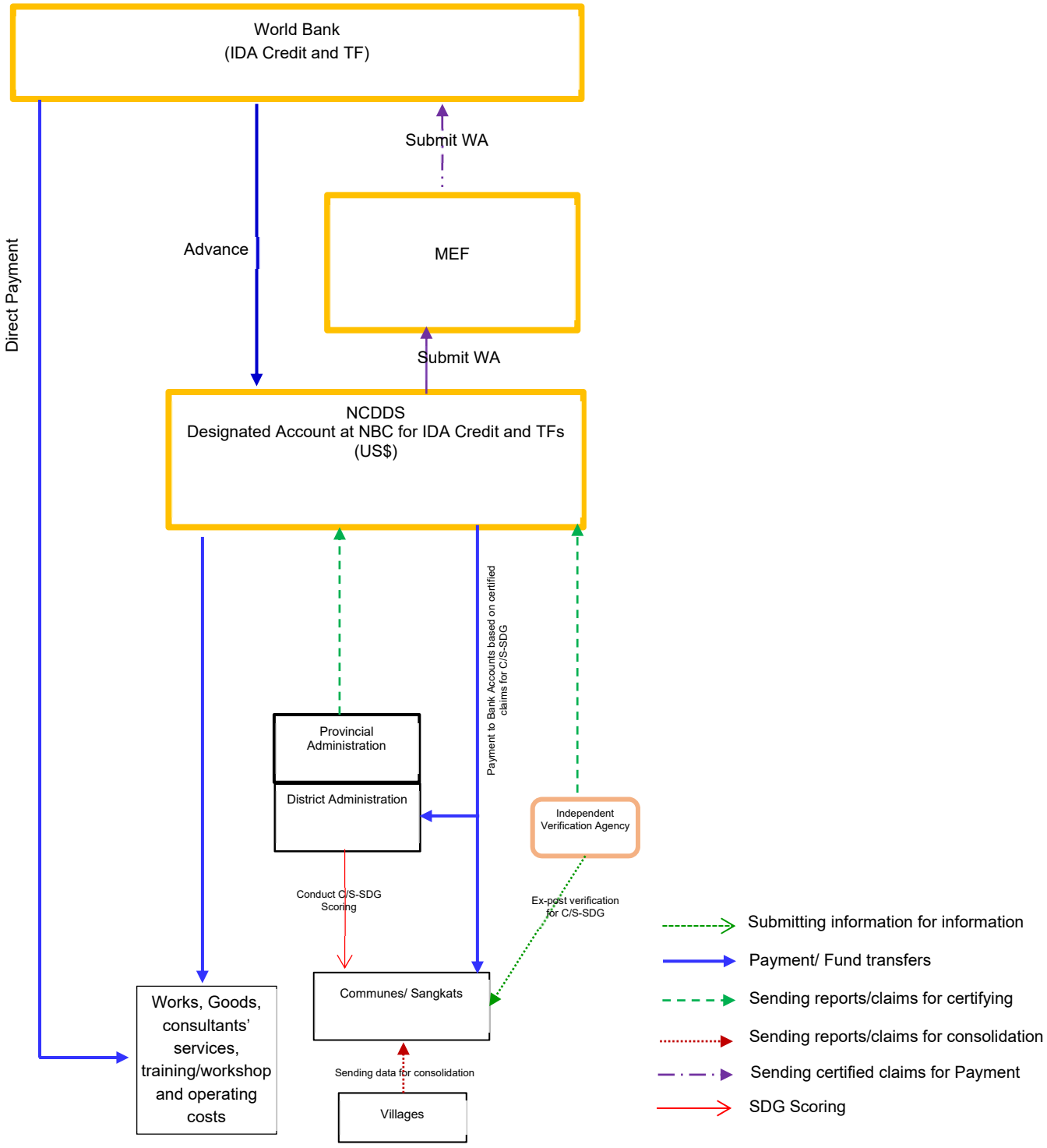


Figure 1.3. Proposed Fund Flow Diagram for DLI-based Financing (Subcomponent 3.1)

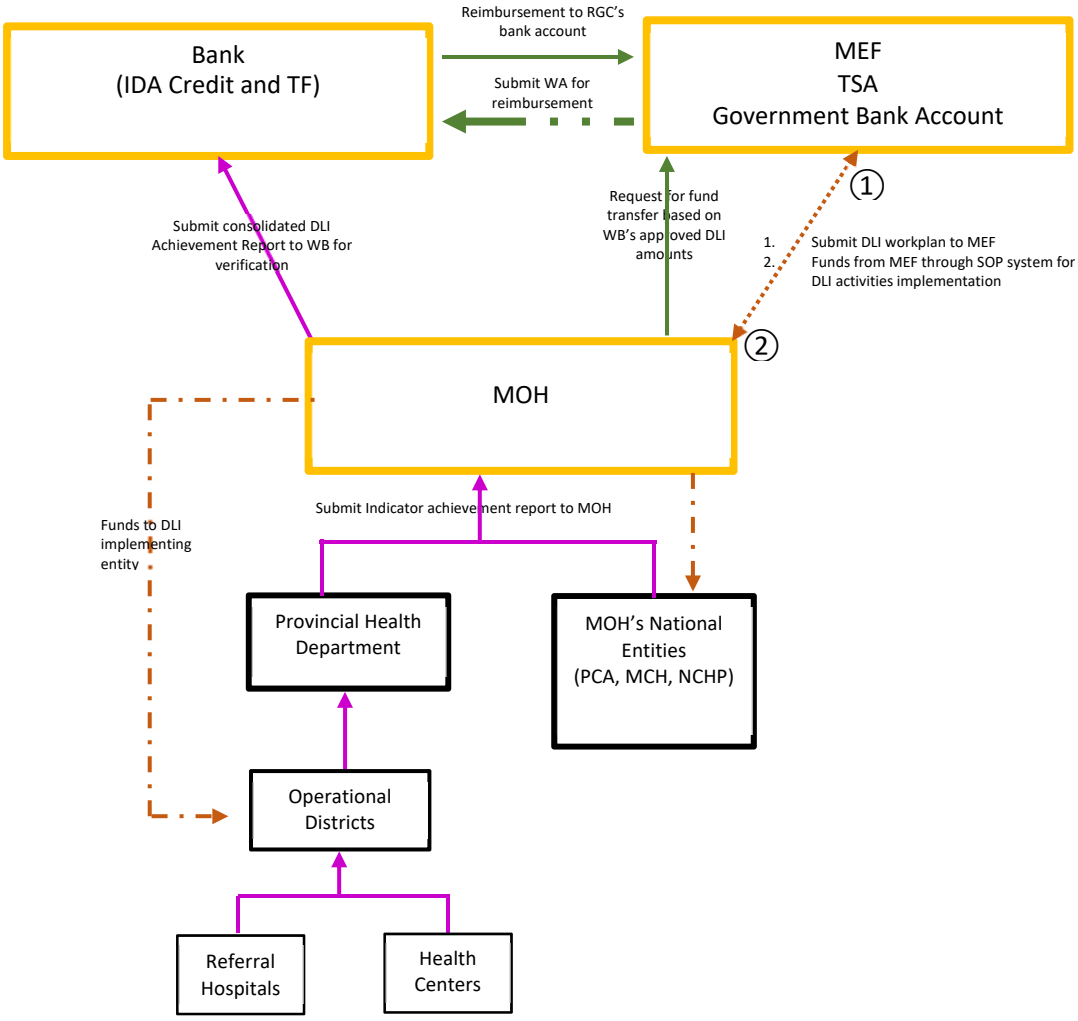
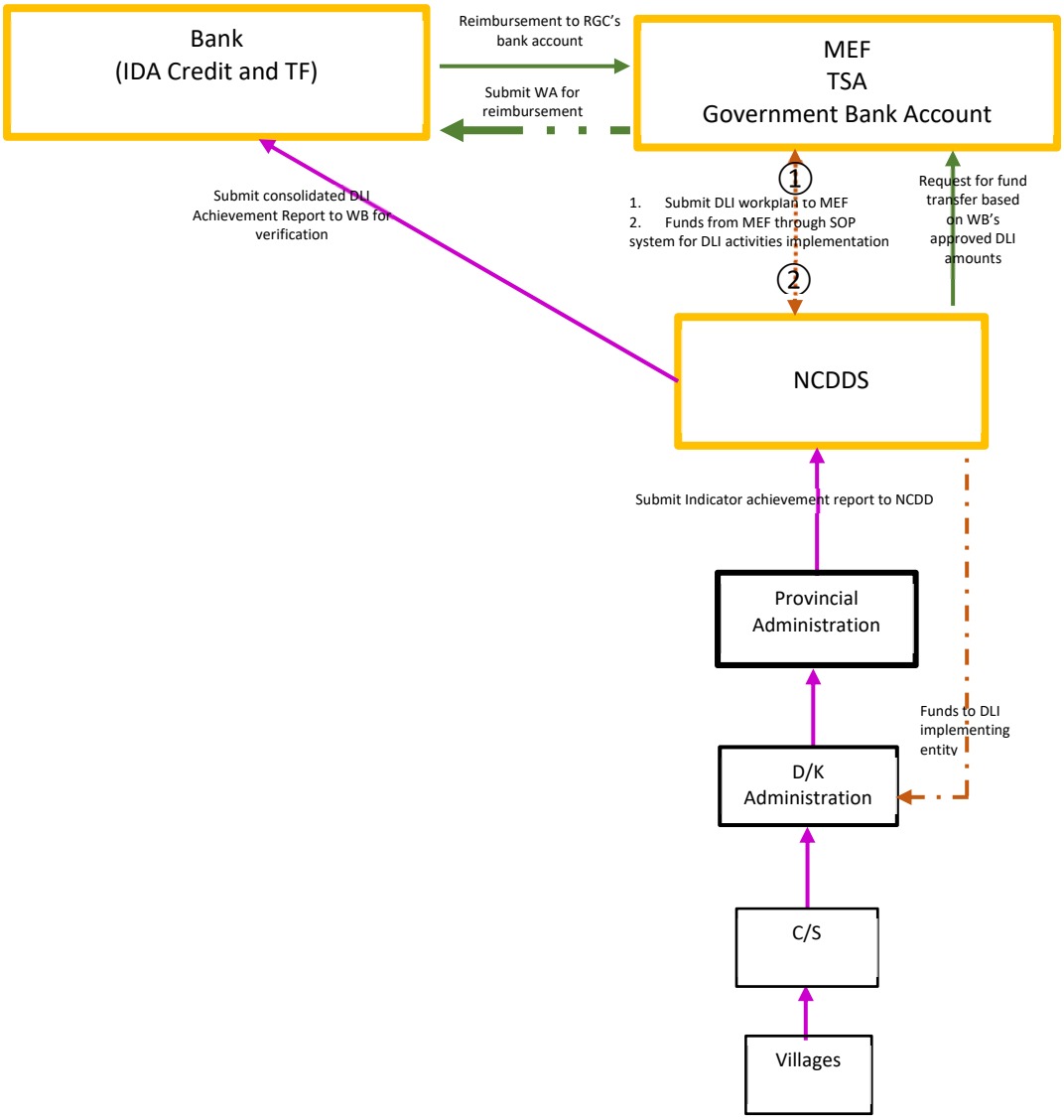


Figure 1.4. Proposed Fund Flow Diagram for DLI-based Financing (Subcomponent 2.2)

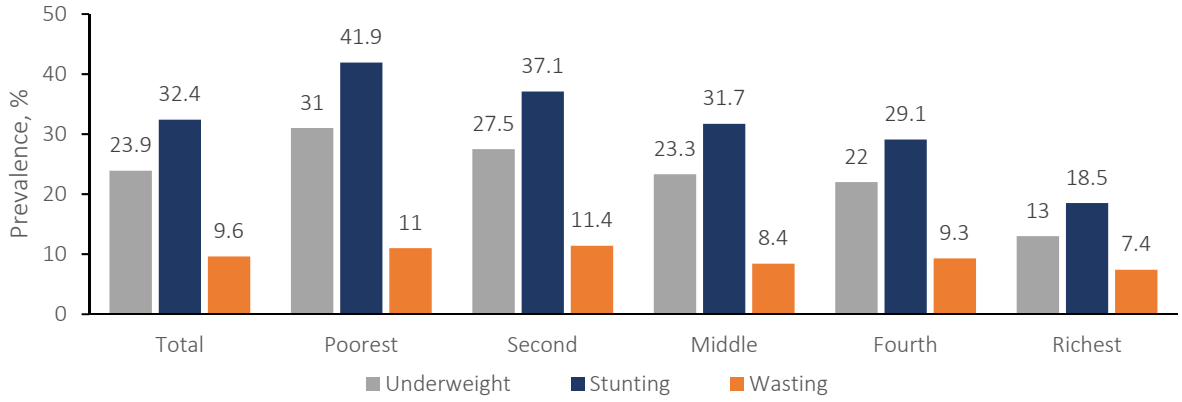


ANNEX 2: Detailed Sectoral Analysis

A. Nutrition Situation in Cambodia

1. **Overall, poor households are most vulnerable to undernutrition; however, the relatively high prevalence of maternal and child undernutrition among wealthy households indicates that economic status is not the sole contributing factor.** In Cambodia, wealthier households have better child nutrition outcomes than poorer households (figure 2.1). Stunting prevalence in the poorest wealth quintile (42 percent) is more than double that of the richest (18 percent). High household income alone does not necessarily lead to improved nutritional status; inappropriate health, hygiene, and nutrition-related behaviors and exposures which augment risk of disease and low nutrient intake are prevalent across socioeconomic groups.

Figure 2.1. Undernutrition in Children Under-Five by Wealth Quintile, 2014, Cambodia



Source: CDHS 2014.

2. **Place of residence is also a strong determinant of maternal and child undernutrition** (figures 2.2 and 2.3). Stunting among rural children remains significantly higher (34 percent) than among urban children (24 percent) (National Institute of Statistics 2015). The most recent small area estimates of malnutrition indicate that there is close, but imperfect, alignment between the geographic distributions of poverty and child stunting.

3. **Linear growth faltering and poor child nutritional status often begins during gestation and further accumulates as Cambodian children age**: 13 percent of children age 6–8 months are stunted compared to 40 percent of children age 36–47 months.

Figure 2.2. Geographic Distribution of Stunting and Wasting among Children (<5)

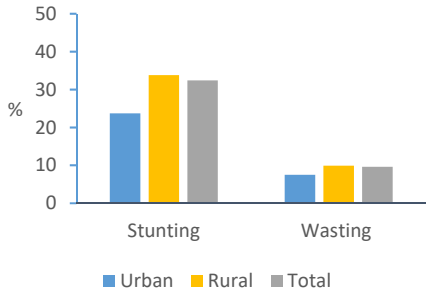
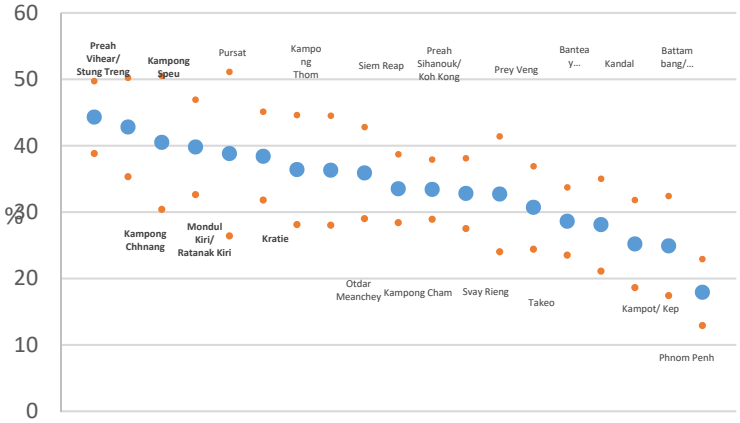


Figure 2.3. Stunting Prevalence by Province in Cambodia, Point Estimates and 95% Confidence Interval



Source: CDHS 2014.

4. Reducing the burden of child malnutrition in Cambodia will require progress on the immediate drivers of malnutrition (nutrient intake and disease) as well as the underlying drivers (food insecurity, poor care for women and children, low access to health services, and poor access to WASH).

5. **Nutrient intake.** Maternal nutrient intake during pregnancy and the adequacy of complementary feeding are main barriers to proper nutrient intake in the first 1,000 days**.** The Cambodian diet is generally monotonous and rice based, and there is little evidence that women enhance dietary practices to accommodate the needs of pregnancy.[72] Compared to other Southeast Asian countries in the region, breastfeeding practices[73] in Cambodia are high but show signs of deterioration, especially among urban and wealthy mothers. The quantity and quality of complementary foods[74] in Cambodia is poor. It is not the timing of complementary food introduction[75] but the composition of the foods which is of concern**.** Few infants and young children, particularly those between the ages of 12 and 23 months, consume a

[72] In fact, recent analysis indicates that based upon current levels of rice consumption, achieving requirements for fats and select B vitamins is not possible without exceeding acceptable levels of caloric intake.
[73] The initiation, duration, and exclusivity of infant and young child breastfeeding plays an important role in establishing the child's early life nutritional status and preventing infant mortality (Black et al. 2008). The WHO recommends the early initiation of breastfeeding within one hour of birth, exclusive consumption of breastmilk through six months of age, and continued breastfeeding through 24 months.
[74] Beyond the first 6 months of age, the frequency of feeding, the diversity of diet, and nutrient composition of complementary foods has an impact on infants' and young children's nutritional status and has been strongly associated with stunting. See: Bhutta et al. 2013.
[75] According to the 2014 CDHS, over 80 percent of children ages 6–8 months receive solid and semi-solid foods.

minimum acceptable diet.[76] Unsurprisingly, there is a near doubling in the prevalence of stunting around the timing of introduction of complementary foods: 16 percent of infants under 9–11 months are stunted compared with 34 percent of children age 18–23 months.

6. **Disease.** The prevalence of acute respiratory infection (ARI), fever, and diarrhea is 5.5 percent, 28 percent, and 13 percent, respectively. Diarrhea incidence is elevated in the lowest wealth quintile (16 percent) compared to the richest (11 percent). Care from a health provider was sought for about two-thirds of children with illness (68.8 percent for ARI, 60.6 percent for fever, and 55.5 percent for diarrhea). Only about a third (35.2 percent) of diarrhea is treated with oral rehydration therapy.

7. **Food insecurity.** Large increases in food availability (for example, national rice self-sufficiency) have been accompanied by only small improvements in food access (namely geographic and economic access to a diverse, nutrient rich diet). Severe food insecurity remains a challenge only in select subnational areas (largely poor and remote); rather the affordability of nutrient-dense foods poses a common challenge. Only 21 percent of households can afford a nutritious diet[77] and poor agricultural households are the most food insecure. The national average daily cost of the staple-adjusted nutritious diet[78] in Ratanak Kiri/Mondul Kiri (US$6.06) is nearly twice as high as the national average (US$3.62). Thus, 66 percent of households in the Northeast could not afford a nutritious diet.[79] Most agricultural households can meet their staple food (rice) needs but rely on income and foraging to obtain nutrient-dense foods. Geographic access to markets is not a widespread concern: most households can access a market within 30 minutes and these markets have, on average, 270 foods available.

8. **Care for women and children.** Gender parity in women's education and labor force participation has been nearly attained, but traditional gender norms pose tradeoffs between women's productive and reproductive roles. The composition of Cambodia's labor force is changing, with many women employed in the informal sector and/or engaged in migrant labor: 48 percent of the 1.8 million Cambodian migrant workers are female. Both informal and migrant workers lack social protections around maternity, workload burden, wage, and so on. In the absence of strong family, community, and social support, high levels of women's labor force participation places increasing constraints on the time available for care of young children. There is concern over the availability and quality of secondary caregivers (for example, grandmothers, neighbors) in providing for optimal care and child development: approximately one in ten

[76] Minimum acceptable diet is a composite indicator which represents the percentage of children age 6–23 months who receive all of the following the previous day: 1. Breast milk. If not breastfeeding, must receive two or more feedings of commercial infant formula; fresh, tinned, or powdered animal milk; or yogurt. 2. Foods from four or more of the following groups: (a) infant formula, milk other than breastmilk, cheeses or yogurt, or other milk products; (b) foods made from grains, roots, and tubers, including porridge and fortified baby food from grains; (c) vitamin A-rich fruits and vegetables (and red palm oil); (d) other fruits and vegetables; (e) eggs; (f) meat, poultry, fish, and shellfish (and organ meats); and (g) legumes and nuts. 3. The minimum number of recommended meals per day, according to age and breastfeeding status. For breastfed children, the minimum meal frequency is solid or semisolid food at least twice a day for infants 6–8 months per day least three times per day for children 9–23 months. For non-breastfed children, the minimum meal frequency is solid or semisolid food or milk at least four times a day for children 6–23 months.

[77] World Food Programme. 2017. *Fill the Nutrient Gap Summary Analysis*. Phnom Penh, WFP.

[78] The staple-adjusted nutritious diet is modeled using linear programming to identify the least-expensive nutritious diet for a household including nutritionally vulnerable individuals that is adjusted to include the main staples (rice and fish). It is not a true reflection of what people are eating nor designed to provide recommendations of what people should eat but is instead based upon identifying how the macro-/micro-nutrient needs of individuals within a household can be met at the lowest cost based upon the foods available in local markets and small adjustments for local preferences.

[79] World Food Programme 2017.

children in Cambodia are left in inadequate care. Women commonly report cessation of breastfeeding within 1–3 months to 'train' their children to bottle-feed upon their return to work.[80] Complementary foods most often consist of grains and young children are not often fed a variety of foods, particularly animal source foods. *Borbor*, a watery rice porridge, is often of insufficient nutrient density and children are not fed in sufficient quantity. Convenience plays an important role in the selection of complementary foods both for primary and secondary caregivers, with little evidence of caregiver willingness to invest the time and energy in the preparation of enriched porridge. Recent analyses show concerning trends with respect to unhealthy snack consumption among children in the early years, with potato chips, sunflower oil, and pork the most commonly consumed groups among infants ages 6–11 months.[81]

9. **Access to health and nutrition services.** Though progress has been made in reducing maternal and child mortality, significant barriers to effective coverage of essential RMNCAH-N services remain. According to the 2014 CDHS, only two-thirds (65 percent) of children receive all basic vaccinations by age 12 months. Over one-quarter of children age 12–23 months are not fully vaccinated, and many of these reside in 1,832 'high-risk communities'. Migrant workers and their families, indigenous populations, the urban and poor, and unofficially/remotely settled populations are most at risk. Only about half (59 percent) of children receive semiannual deworming medication and 70 percent receive semiannual vitamin A supplementation.[82]

10. **Health environment.** Low and unequal access to safe drinking water and sanitation and suboptimal hygiene practices increase risk of disease and impair nutrient absorption, ultimately leading to chronic and acute undernutrition among Cambodian children. In Cambodia, although impressive improvements were achieved in the last decades, access to water supply and sanitation remains below its regional peers: only 21 percent of the people enjoy piped water supply, 76 percent have access to an improved water source, and only 42 percent have access to improved sanitation. Inequalities in access to water supply and improved sanitation across income quintiles is pressing: access to piped water and improved sanitation in rural areas is four times higher for the 'better-off' quintile, compared to the poorest rural quintile. Recent studies indicated strong association between the lack of sanitation and stunting among under-five children. In Cambodia, a five-year old child living in an unhygienic environment (community where people practicing open defecation) is 2.0–3.6 cm shorter than a child of the same age living in a hygienic environment where everyone uses toilets.[83]

11. **Household income, poverty, and risk of shocks.** Over the last two decades, Cambodia has experienced impressive reduction in poverty, but there is high vulnerability such that small shocks can bring many of the near-poor households back into poverty. Despite an overall decline in health spending and catastrophic spending as a percentage of income in recent years due largely to rising incomes and the protection offered by the HEF system, an estimated 0.9 percent of Cambodian households fell into poverty

[80] NNP, iDE Global, UNICEF, and Helen Keller International. 2017. *The 1000-Day Feeding Journey of Infants and Young Children in Cambodia*. Phnom Penh.
[81] Skau, J. K., T. Bunthang, C. Chamnan, F. T. Wieringa, M. A. Dijkhuizen, N. Roos, and E. L. Ferguson. 2014. "The Use of Linear Programming to Determine Whether a Formulated Complementary Food Product Can Ensure Adequate Nutrients for 6- to 11-month-old Cambodian Infants." *Am J Clin Nutr* 99: 130–8.
[82] National Institute of Statistics. 2015. *Cambodia Demographic and Health Survey 2014*.
[83] Investing in the next generation: Growing tall and smart with toilets, World Bank Water and Sanitation Program research brief (2013).

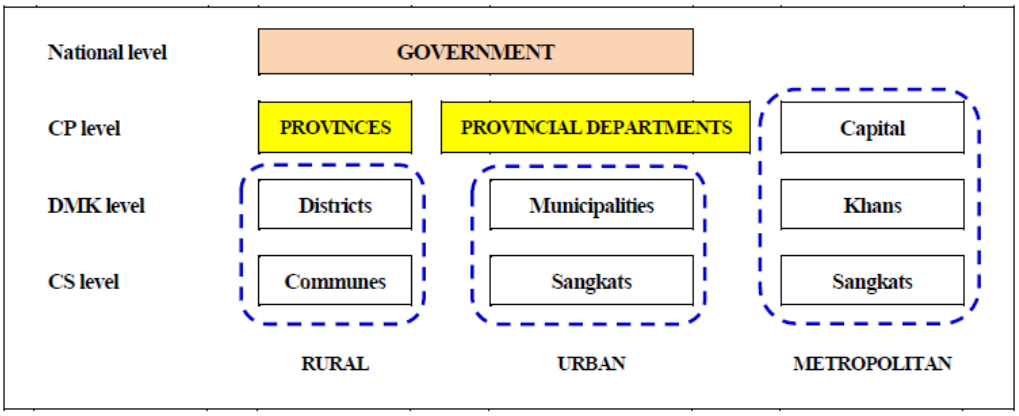
in 2014 because of health costs. Health spending remains a significant burden on the poor, with about 18 percent incurring debt because of health expenses.

B. The Cambodian SNA and Its Role in Health

12. Cambodia is on a steady path toward D&D. The RGC 10-Year National Program for Sub-National Democratic Development (2010–2019) supports implementation of the Law on Administrative Management of Capital, Provinces, Municipalities, Districts and Khans 2008 (Organic Law). The program outlines activities to progressively increase the capacities of the country's three-tiered SNA system (figure 2.4) to carry out their roles and functions. Cambodia has 25 provincial/capital administrations; 197 district, municipality, and khans (DM) administrations (in rural and urban areas, respectively); and 1,646 communes (rural) and sangkats (urban) (C/S) administrations.[84] Each commune has, on average, 10 villages, each with an appointed village chief.

13. The NCDD is a decision-making forum of 15 ministers that functions as the oversight board for the D&D reforms. The Deputy Prime Minister/Minister of Interior chairs the committee, which meets on a semiannual or trimestral basis to approve policies, regulations, plans, and budgets. The NCDDS is housed in the MOI.

Figure 2.4. Cambodia's SNA



Source: NCDD. 2017. *3 Year Implementation Plan, Phase III (2018–2020) of the National Program for Sub-National Democratic Development (IP3-III)*. Phnom Penh: NCDDS.

14. IP3-III (2018-2020) for the 10-year national program of D&D promotes a vision whereby "SNAs deliver better services and promote local development which will contribute to the improved welfare and quality of life of citizens in their jurisdiction." IP3-III priorities include operationalizing the SNA general mandate and improving citizen engagement at the C/S level (demand-side) and local service delivery (supply-side). The C/S 'general mandate' is the right of initiative to solve the most pressing problems and most pressing development needs in their communities, especially among those who are most vulnerable. It includes the C/S discretionary powers, including local infrastructure, addressing gaps in central

[84] Provincial/capital administrations and district, municipality, and khans administrations are led by appointed governors and supported by a legislative wing of indirectly elected councilors, who are elected every five years through a body of electoral college made up of C/S councilors.[84] C/S councilors elect village chiefs and councilors at the district and provincial levels.

government service delivery, solving community problems and conflict, promoting local economic development, partnering with civil society, providing social services and social protection, and addressing climate change.[85]

15. Decentralization at the C/S administrative level has proceeded more rapidly than that of the line ministries.[86] C/S has an independent governance structure, and C/S councils are elected through competitive multiparty elections and have the most accountability to the local people. Councils are also responsible for identifying local needs through a planning process and pass the information upwards, through the political structure.

16. C/S are generally funded using unconditional, mandatory, and steadily increasing grants from the central government budget, largely through the C/S Fund. The C/S Fund follows a formula-based allocation[87] and has both development and administrative components. The administrative component finances salaries and allowances of C/S chiefs, councilors, and village chiefs and covers operational expenses. Each C/S employs one staff (clerk) and provides incentives to, on average, seven councilors. The development component finances projects outlined in the C/S Investment Program. Projects are selected through a participatory process whereby citizens in each village identify their priorities.

17. C/S have faced challenges to deliver on their general mandate due to the amount and structure of their central transfer. The MEF allocates C/S Fund budget based on a percentage of the previous year's recurrent revenues (figure 2.5). The allocation has risen consistently from 2 percent of the previous year's revenues in 2003 and is expected to reach 3.2 percent in 2021. The total allocation for C/S increased from US$12 million in 2003 to US$93 million in 2017. However, due to civil servant salary and staffing increases, a majority of the C/S Fund is now used for 'administration' (figure 2.6). Only about one-third of the total allocation (averaging US$63,000 per C/S) is available for development activities.[88] Thus, despite remarkable increases in the total funding, the development investment per capita is relatively low (US$2.37 in 2017) and has plateaued since 2013.[89]

18. The commune investment plan process and the complex procurement procedures limit C/S investment in local social services/development projects. While the general mandate of C/S covers diverse issues and areas, C/S development funds have primarily been used for small infrastructure (namely road construction, though water supply and irrigation projects are also commonplace). Though it is not highly cost-efficient, the C/S Fund has started to resemble a rotating village road development fund, where a

[85] The SNA 'permissive functions' found in the Organic Law were extended in line with Article 29: "the council shall have roles to undertake activities necessary to achieve the purpose of establishing, promoting and sustaining democratic development and to perform functions and duties that have been assigned and delegated to it through this Law or in accordance with this Law." The 'general mandate' means that SNAs are allowed to do what they consider to be in the interest of the citizens as long as it is not prohibited by law or explicitly disallowed otherwise.
[86] The MOH has piloted decentralization of administration and finance functions in Phnom Penh, Battambang, and Kampot provinces; the MRD has decentralized functional transfer for rural water supply and rural sanitation in 15 districts across Tboung Khmum, Kampong Speu, and Kampong Chhnang.
[87] With population (35 percent), poverty (30 percent), and fixed (35 percent) elements.
[88] Until 2013, it was a legal requirement that the cost of administration not exceed one-third of all total funding. By 2017, the cost of administration reached 61 percent of total costs. This raises potential allocative efficiency issues, as the opportunity costs of high salaries is reduced development spending on capital projects and, by extension, reduced effectiveness of SNAs.
[89] World Bank. 2018. *Cambodia's Cross-Cutting Public Financial Management, Decentralization, and Public Administration Reforms: Achievements, Coordination, Challenges, and Next Steps*. Phnom Penh: World Bank.

different village each year is selected for road upgrade. Social services, social protection, and local economic development are relatively underfinanced.[90] IP3-III includes a proposal to increase accountability and compliance of SNAs using performance incentives linked to resource allocation (Outcome 2.3, IP3-3). Aligned with this outcome, the Government aims to use incentive-linked performance monitoring to improve local service delivery and has set a target of 2020 to pilot a performance grant system. The ISAF further aims to increase the accountability and transparency of the C/S planning and investment processes.

Figure 2.5. C/S Fund Allocation as a Percentage of the Previous Year's Budget (with projections from 2019 forward)

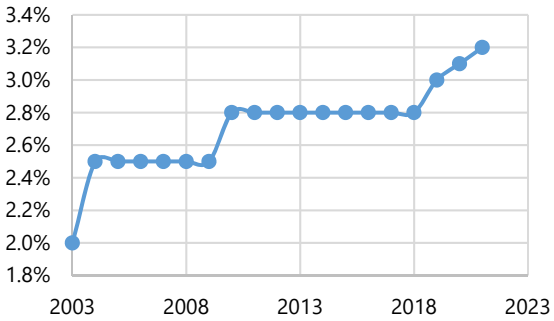
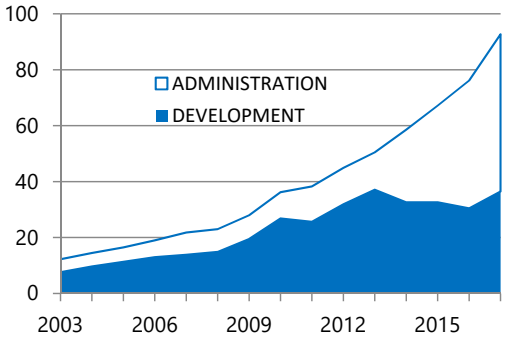


Figure 2.6. Total C/S Fund Levels, US$, millions



Source: World Bank. 2018. *Cambodia's Cross-Cutting Public Financial Management, Decentralization, and Public Administration Reforms: Achievements, Coordination, Challenges, and Next Steps*. Phnom Penh: World Bank.

C. A Multisectoral Portfolio Approach to Improve Nutrition in Cambodia

19. The causes of maternal and child undernutrition in Cambodia are multiple and interlinked. Therefore, interventions are needed across sectors to improve these underlying drivers. Coordinated interventions covering the same geographic area may yield synergies that will be more effective in accelerating stunting reductions. The interventions to achieve better nutrition outcomes are classified as nutrition specific and nutrition sensitive. Nutrition-specific interventions included SBCC, micronutrient interventions and deworming, and supplementary and therapeutic feeding. Nutrition-sensitive interventions can be found within women's education and empowerment, quality health services, agriculture, water and sanitation, and safety nets and response to shocks.

20. The ongoing revision of the NSFSN (2019–2023) outlines interventions across sectors that are required to tackle the existing and emerging nutrition and food security challenges in the country. Aligning with this strategy, and in consultation with the RGC, the World Bank teams have proposed a multisectoral portfolio approach in supporting nutrition results in Cambodia. A 'portfolio' approach for this agenda is derived from an investment portfolio of four main projects: (a) this project (P162675); (b) the Cambodia Agriculture Sector Diversification Project (P163264); (c) the Cambodia Water Supply and Sanitation Improvement Project (P163876); and (d) the Cambodia Health Equity and Quality Improvement Project (P157291). Except for H-EQIP (FY16-21), the projects have fully aligned effectiveness periods from FY19

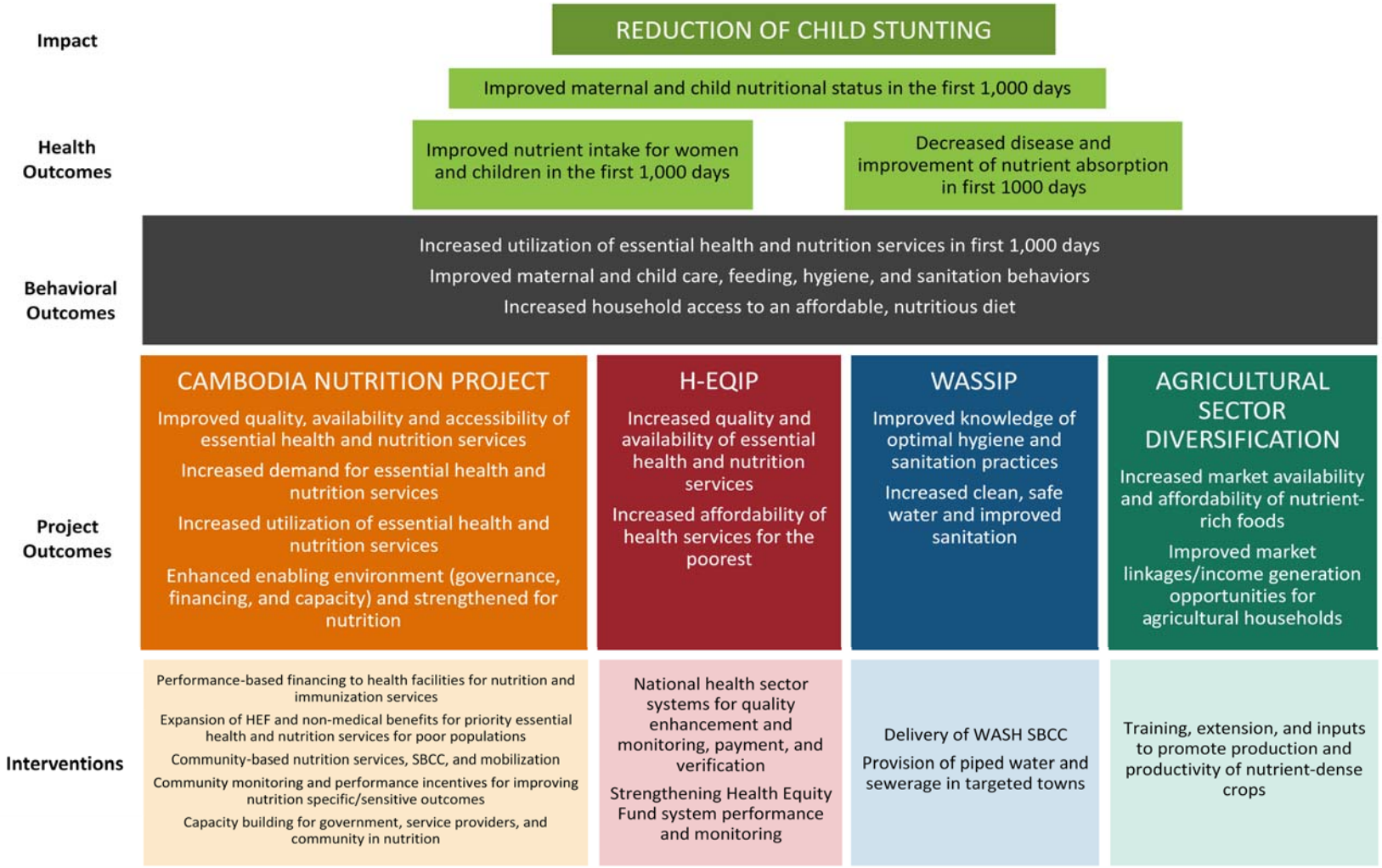
[90] World Bank. 2018. *Cambodia's Cross-Cutting Public Financial Management, Decentralization, and Public Administration Reforms: Achievements, Coordination, Challenges, and Next Steps*. Phnom Penh: World Bank.

to FY23. Principles of social accountability supported through the Voice and Action: Social Accountability for Improved Service Delivery Project (P146160) (closing March 2019) will cut across all relevant portfolio projects. The projects in this portfolio approach aim to address the immediate and underlying causes of malnutrition in Cambodia and will have a strong focus on the rural, remote, and poor populations concentrated in the Northeastern provinces to improve equity of nutrition outcomes.

21. Given the nature of the nutrition situation and the demand-driven approaches of the nutrition-sensitive projects,[91] the Cambodia portfolio will support the RGC in consolidating nutrition governance, harmonizing implementation across sectors, and scaling up subnational multisectoral nutrition coordination. Rather than focusing on converged service delivery to households, the portfolio will focus on creating an environment conducive to improved nutritional status, including through market approaches. This will include improving the quality of health and nutrition service delivery in health facilities and communities, increasing access to safe piped water in small towns, and improving the market availability of nutritious foods, such as complementary foods for infants and young children. Where services are converged at the community level, these four project teams have collaborated to harmonize content and implementation arrangements to the extent possible to maximize the synergistic effects of convergence. The conceptual framework for this portfolio approach is in figure 2.7.

[91] The investment in piped water supply under the Water Supply and Sanitation Improvement Project (WaSSIP) will focus on areas where piped water service is currently not available and where there is sufficient population density to ensure the viability of investment and sustainability of the operation. The first batch of locations of the piped water supply investment will be in three towns/districts covering approximately 11 communes in three provinces. The second batch of locations are being identified. The geographic convergence of the CNP with WaSSIP is estimated at 8 out of 11 WaSSIP communes, specifically those in Mondulkiri and Kampong Chhnang provinces.

Figure 2.7. A Multisectoral Portfolio Approach to Address Maternal and Child Undernutrition in Cambodia



ANNEX 3: Detailed Project Description

1. The project aims to anchor an enhanced and coordinated response to accelerate the country's human capital formation, focusing on facility- and community-based approaches to MCHN in the early years. The project brings together global evidence on effective interventions with Cambodia's priorities and employs four complementary strategies to mainstream a public sector response to accelerate lagging priority RMNCAH-N outcomes. The PDO will be achieved through three main components: Component 1: Strengthening the delivery of priority health services; Component 2: Stimulating demand and accountability at the community level; and Component 3: Ensuring an effective and sustainable response.

Component 1: Strengthening the Delivery of Priority Health Services (US$24 million)

2. Component 1 leverages institutionalized, results-based health sector platforms—namely HEFs and SDGs—to improve supply-side delivery of priority interventions. The component aims to improve the availability, accessibility, affordability, and quality of these priority services. The component has two subcomponents described in detail in the following paragraphs.

3. **Subcomponent 1.1: Performance-based Service Delivery Grants (SDGs) to Improve Availability and Quality of Priority Services (US$18 million).** Subcomponent 1.1 will leverage Cambodia's NQEM process to accelerate improvements in health service quality across the continuum of care for women and children. SDGs were introduced under the HSSP2 as a means of channeling financing to the frontlines and improving quality of service delivery, in addition to further streamlining the funds flow and reporting arrangements. The existing SDGs are of two types:

(a) **Fixed lump-sum grants** are allocated to all health centers and referral hospitals throughout the country in fixed amounts for operational expenditures in addition to operational budgets defined in their annual operating plans. The fixed lump-sum grants are intended to complement the facility operational budget to manage and implement direct spending for promoting quality and equity in patient care. Fixed lump-sum grants have been rolled out to all health centers and referral hospitals since 2016.

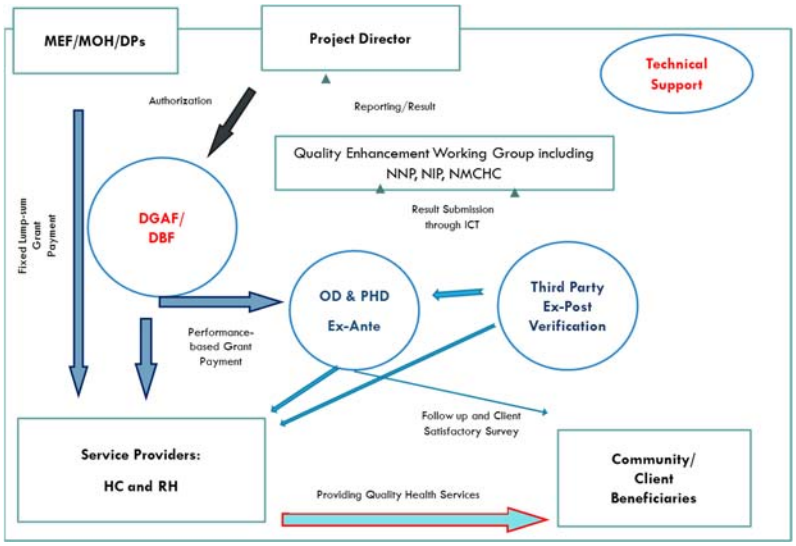
(b) **The performance-based SDGs** are intended to reward health facilities for quality performance and to reward the OD and PHD for conducting quality ex ante assessment. They are provided to health centers and referral hospitals based on their quality of care performance scores assessed using the NQEM Tools (known as a balance scorecard) and provided to ODs and PHDs based on their managerial performance scores assessed using the NQEM Tools, which are heavily weighted toward performance assessment of health center/referral hospital and coaching functions. Up to 80 percent of the performance-based SDGs can be spent for staff incentives. At least 20 percent of the performance-based SDGs are eligible for other eligible expenditures.

4. The SDG performance grant was rolled out to all SOA ODs in May 2016, which included 14 PHDs, 13 PRHs, 33 ODs, and 452 health centers. The second and third phases which will cover two-thirds of all facilities in the country will be rolled out between Q2 2017 and Q4 2018. The PCA provides the means to certify HEF payments to health centers and conduct ex post verification of health facilities' quality scores.

5. A performance-based SDG top-up payment will be provided to health centers based on the score from an MCHN Scorecard focusing on the 11 priority services. The tablet-based MCHN Scorecard and its associated top-up payment will be the main innovations to the existing SDG system. Subcomponent 1.1 will also finance additional performance-based top-ups to SDG assessors (at the OD and PHD levels, as appropriate) to allow them to carry out MCHN Scorecard assessments. All other existing SDG implementation arrangements related to quarterly assessment, scheduling of ex ante and ex post verification, payment modality, and management will be followed (see figure 3.1). Some small customizations (for example, expanding eligible expenditures under SDG performance grants to incorporate key activities to improve MCHN Scorecard performance; including the NMCHC programs in QEWG meetings for review and adoption of MCHN scores; and involving the NMCHC and other relevant programs—such as the PMD and the NCHP—in the development and delivery of coaching sessions) are likely to be needed to promote the links between MCHN Scorecard implementation and improvements in the priority health outcomes.

6. Details of the MCHN Scorecard indicators will be developed by the NMCHC with the QEWG, NNP, and NIP participation; included in the OM; and updated in the SDG guidelines, as needed. The relative weighting of the tool's three domains and the verification procedures (including sampling for ex post verification) will be developed in coordination with the QEWG. It is proposed that the MCHN Scorecard follows the same general format of the existing balance scorecard and include (a) structural quality elements connected to the availability of equipment, commodities, guidelines, innovative and evidence-based job aids, and records related to the 11 identified services; (b) process quality elements including the development/revision of vignettes; and (c) outcome quality measures. The MCHN Scorecard will include the delivery of facility-based services and will also be weighted heavily toward facilities' adherence to integrated outreach guidelines. The proposed MCHN Scorecard indicators are outlined in table 3.1. The specifics of the tool and associated performance grant levels will be detailed in a joint *Prakas* from the MEF and the MOH and the revised SDG manual. In the future, the SDG annual instruction will incorporate the MCHN Scorecard implementation and payment levels.

Figure 3.1. Existing SDG Implementation Arrangements to Be Adopted under the CNP



Source: Adapted from MOH SDG manual.

7. **The application of the MCHN Scorecard will be phased into the existing SDG system.** In the first phase, the scorecard will be (a) applied only in health centers and (b) rolled out only in the seven priority provinces identified earlier. As the system matures, additional opportunities will be explored to expand the complexity of the subcomponent, including (a) incorporating measures of service utilization and facility-level outcomes into the tool, (b) developing and deploying a tool for referral hospitals, and (c) expanding the MCHN health center scorecard nationwide. A summary of the MCHN SDG design elements is in table 3.2.

Table 3.1. Proposed MCNH Scorecard Indicators

Health Facility	Structural Measures	Process Measures	Outcome Measures
Health center	• Health center has cold chain system functioning • Health center management of drugs and medical consumables (including vaccines and nutrition commodities) • Health center has integrated outreach plan • Health center has a record of integrated outreach, including minimum number of services delivered, in frequency according to guideline • Health center conducts HEF promotion activities • Health center has MIYCN guideline/job aids/materials • Health center has functioning anthropometric equipment • Health center has (revised) pink card/yellow card • Absence of breastmilk substitute promotion materials • Health center adheres to Baby Friendly Hospital Initiative standards	Vignettes to be included in the MCHN Scorecard • Well-child visit • SAM (updated for new guidelines) • ANC (revise existing + add ANC 4, nutrition counselling) • PNCs 2, 3, 4 including nutrition counselling • MIYCN counselling • Safe delivery for health center • Early and essential newborn care • Kangaroo mother care • Integrated management of childhood illness	Additional 1–2 questions for client feedback survey (complexity to be explored) Over time could include facility utilization, such as • Number of ANC visits, • Number of children 0–24 months receive vaccination and growth monitoring visits, • Number of PNC 2 visits, • Number of PNC 4 visits, and • Number of outreach-based GMP/ANC/PNC/immunization.

Table 3.2. Summary of MCHN SDG Elements

Scope	Beginning with a phased rollout in seven priority provinces, expansion to higher level facilities (referral hospital, provincial hospital), and/or review of nationwide coverage at midterm review.
Tools	An MCHN Scorecard to be developed by the NMCHC with the QEWG, NNP, and NIP participation. The MCHN Scorecard to be applied at the health center level. The MCHN Scorecard may be adapted for primary care services provided at the referral hospital level over time. The MCHN Scorecard score will be based on structural, process, and outcome quality.

Assessment and verification	Standard NQEM processes to be followed: Quarterly scoring of facilities by ODs/PHDs. SDGs for OD assessor for additional work. Existing assessor time, duration of assessment, and workload will be considered. The NNP, NIP, and NMCHC to participate in QEWG meeting to review and adopt scores, monitor and support preparation of annual report. The PCA to conduct ex post verification (will receive Subcomponent 3.1 DLI funds); national programs contribute to QEWG review of discrepancies and identify actions to be taken.
Payment	An additional performance-based grant to health centers on top of standard SDG will be disbursed based on the score of the MCHN Scorecard assessment.
Eligible expenditures	Proposed clarifications for inclusion of outreach costs; HCMC, Midwifery Care Alliance Team/Pediatric Care Alliance team meetings in eligible expenditures
Coaching	NQEM processes will be followed. Coaching guidelines and modules to be developed by national programs under Component 3; focus on involving national programs in the coaching process and IT-enhanced coaching.
Management	The NMCHC to coordinate the development of tool; QAO to lead revision of SDG manual, guidelines, and annual instruction to incorporate MCHN Scorecard, training of assessor, and operationalization of MCHN Scorecard to be monitored (Component 3 DLIs).

8. **Subcomponent 1.2: Expanding Health Equity Funds (HEF) (US$6 million).** This subcomponent will support expansion of the HEF to improve utilization of priority RMNCAH-N services among targeted populations. The HEF system was introduced as an innovation to address vulnerability to high health expenditure as well as inequity in access and utilization of health services. The HEF exempts the poor from user fees in health facilities and purchases services from public health facilities on a pay-for-performance (output) basis. The HEF system has improved access to health services for the poor, leverages quality improvements, and provides major source of flexible revenue within the health system. HEF beneficiaries receive a predefined set of benefits. These include payment of service fees (including maternal and child health, nutrition, and immunization services) for the beneficiaries at public health facilities. Additional HEF benefits include transportation reimbursements, food allowances, and funeral support. As of December 2016, the HEF system had reached nationwide coverage to over 1,200 health facilities, including all health centers, district hospitals, referral hospitals, and one of the eight national hospitals.

9. This subcomponent aims to enhance the equity of priority RMNCAH-N outcomes through an expansion of the scope of coverage for the current HEF system. These expansions of service and population coverage will increase utilization of priority RMNCAH-N services among targeted vulnerable populations. The project will support three areas of HEF benefit expansion (table 3.3). The proposed revisions and expansions will require additional guidelines and training for the health facilities which will implement them, updates to the Payment Management and Registration System, and additional institutional support from the PCA and DPHI. These supportive actions will be financed under Subcomponent 3.1.

Table 3.3. HEF Expansion Supported under the Project

Definition of SOPs for a well-child visit for children age 0–2 years	A revised SOP with clear reimbursement guidelines will form the basis of HEF reimbursements and will help stimulate the provision of integrated well-child services (namely immunization, micronutrient supplementation, deworming, GMP, and IYCF counselling).

Extension of HEF benefits to children (age 0–2 years) of informal workers	The MEF and NSSF have defined a process to expand HEF coverage to informal workers who are neither ID poor nor post-ID and have been registered by the NSSF. However, the current scheme does not cover children of the informal workers. Based upon final MEF decision, the subcomponent can finance HEF benefits for the children (age 0–2 years) of these informal workers.
Transport allowances for priority services	The component will finance transport costs for four ANC visits, delivery, and 10 child (age 0–2 years) health visits to health centers. Transport allowances will be limited to ID-poor and post-ID beneficiaries, who bear a disproportionate burden and face access barriers due to the cost of accessing these services. Initially, this transport allowance will also be limited to the seven priority provinces. The MOH and MEF, in consultation with the funding partners of this project, will define an appropriate transport benefit amount (that is, in turn, based upon the distance from residence to the health center) to be financed under the project.

Component 2: Stimulating Demand and Accountability at the Community Level (US$10.8 million)

10. Component 2 will finance community-based interventions in the seven priority provinces to stimulate demand, increase utilization of facility-based priority services, and encourage the adoption of improved RMNCAH-N behaviors. Component objectives are to (a) create demand through regular, intensified community-mobilization and health, nutrition, and HEF promotion activities; (b) extend service provision to the community level to increase access to priority health and nutrition services; (c) strengthen the links between SNAs, public health providers, and citizens; and (d) use performance-based grants to improve SNA commitment and accountability to deliver and sustainably finance relevant social service activities linked with the project's priority services. The NCDDS of the MOI will implement Component 2, and C/S supply-side actors will deliver RMNCAH-N demand creation activities. Active engagement from the MOH to outline the community-based intervention package is necessary for the component's success and to avoid duplication of activities.

11. The component will aim to reduce fragmentation and increase the sustainability of community health and nutrition activities by (a) operationalizing a standardized CPWC[92] to serve as the community-based health and nutrition platform (with formal links between the SNA and the MOH actors) and (b) channeling financial support to C/S to implement the CPWC in the form of a performance-based grant. Due to the nature of the activities and the flexibility of the associated planning, budgeting, and financing, the CPWC and C/S-SDG together will serve as mechanisms to promote bottom coordination to address multisectoral drivers of undernutrition.

12. Specifically, the component will finance a new initiative of performance-based grant to C/S to enable the scale-up of the CPWC's community-based health, nutrition, and HEF promotion activities (Subcomponent 2.1), alongside results-based (Subcomponent 2.2) and input-based (Subcomponent 2.3) investments in the underlying systems and capacities necessary to deliver such activities.

13. The project will deliver a thematically focused (MCHN promotion) special grant as an entry point to design and implement performance-based financing for communes. The aim is to build systems for results-based planning, budgeting, social service implementation, monitoring and fund flow

[92] The name CPWC has been used to align with the mandate of the CCWC which extends beyond health and nutrition. If successful and feasible, it may be possible to expand the scope of CPWC activities beyond those proposed in the project.

arrangements for C/S. Aligned with the Government's plan for D&D, the new initiative will also provide the learning necessary for the NCDDS to expand this concept to the broader general mandate in the future.[93] The sustainability of this platform will be based upon the commitment and direction of the MOH and NCDDS to subsume the CPWC and/or related social activities within the commune structure and sustained through C/S funds.

14. **Subcomponent 2.1: Commune/Sangkat (C/S) Service Delivery Grants (C/S-SDGs) for Women and Children (US$6.9 million).** Subcomponent 2.1 has two main elements: (a) performance-based financing to C/S under a C/S-SDG to operationalize the CPWC and deliver a package of community-based priority RMNCAH-N activities and HEF promotion and (b) performance-based financing through C/S-SDG to D/K to conduct C/S-SDG assessment.

15. **Operationalization of CPWC activities and package.** The CPWC will be piloted as a community platform for health and nutrition promotion in the seven priority provinces. Under Component 3, the MOH will develop the CPWC package of activities. The package will include, at minimum, (a) social mapping for first 1,000 day households; (b) targeted health and nutrition SBCC through home visits, community groups, and/or community-based GMP; (c) HEF promotion to increase service utilization among the poor; (d) community mobilization; and (e) HCMC meetings, including integration of ISAF supply- and demand-side aspects, as relevant. In addition to these minimum activities, other commune- and village-level social activities may be incorporated as per NMCHC and C/S priorities (outlined in the Commune Development Program). The CPWC activities will be adapted, as relevant and necessary, to address the needs (activities, language, and so on) in indigenous communities where it will operate.

16. The CPWC will formalize the responsibilities and relationships between existing cadres using implementation arrangements based upon the 2008 draft Community Participation Policy in Health. This includes the Commune Council, CCWC FP; Village Chief, Village Assistant, and Village Commune Council Focal Point (together the 'Village Team'); VHSGs; and others through the development of clear operational guidelines (table 3.4). Commune and village-level actors will take on the CPWC administrative and management functions, while local health staff will provide regular frontline quality assurance and coaching. A main innovation of the CPWC platform will be the regular engagement of the village volunteers and public sector provision of performance monitoring and incentives (financial and non-financial). The proposed link between health, subnational authorities, and communities are outlined in Figure 3.2.

17. **C/S-SDGs.** Subcomponent 2.1 will finance C/S to deliver the CPWC package of health, nutrition, and HEF promotion activities through the performance-based C/S-SDG grant. The grant adapts the successful MOH SDG system and applies the principle to the SNA. C/S-SDG will provide discretionary support to communes over and above the C/S Fund to ensure the delivery of activities according to the CPWC guideline. The financing formula will be outlined in the C/S-SDG manual and based on quantity (commune size) and quality (performance on a C/S-SDG checklist). The full eligible expenditure list will be defined by the MEF in collaboration with the MOH and NCDDS and included in the C/S-SDG manual but will include activities such as (a) CPWC operational cost, (b) performance incentives to village volunteers,

[93] Appropriate revisions can be made to project operations manuals and implementation arrangements as and when such broader commune grants are rolled out.

and (c) other activities as required to improve C/S-SDG scores. Commune performance on C/S-SDGs will be systematically assessed through semiannual assessment by a district assessment team.

18. An eligible expenditure list will be created to govern the use of C/S-SDG funds. The eligible expenditure list will include performance-based incentives (financial and non-financial) for VHSG to carry out activities; operational costs of CPWC activities; performance-based salary top-ups to CPWC actors, as appropriate; and other activities as required to improve C/S-SDG performance (such as contract staff to support commune C/S-SDG accounting, patient transport allowances to health facilities). The full eligible expenditure list will be defined by the MEF and NCDDS and included in the C/S-SDG manual.

19. Commune performance on C/S-SDGs will be systematically assessed through semiannual scoring of a predefined checklist by a district assessor team. The first round of assessment for each C/S will be based upon a performance against a 'readiness' checklist (table 3.5) that will incorporate more process elements and have a higher start-up value than the checklist implemented in subsequent rounds (table 3.6).

20. The OM will outline measures to integrate C/S-SDG planning into the annual CIP process to ensure adequate public resources for the CPWC activities. The CCWC FP, the Commune Clerk, and other permanent staff will be mainly responsible for ensuring adequate budget allocation to support CPWC activities. Based on the implementers assessment, the CPWC will aim to leverage permanent administrative staff at the commune level to the extent possible; the CCWC demonstrated relatively weak capacity and low negotiation skills in the commune investment plan process and additional training will be needed to empower the CCWC in this area.

21. **C/S-SDGs to D/K Administration.** These C/S-SDGs aim to strengthen the performance of the D/K administration in conducting the C/S-SDG assessment process. The C/S-SDG assessment will build upon experience of OD assessment of health centers/referral hospitals under H-EQIP as well as the citizen monitoring using community scorecards under the ISAF.[94] D/K will conduct assessment of C/S, report on their own activities, and submit the scores against a D/K checklist to the NCDDS. The checklist will include elements such as the regularity and timeliness of assessment, extent of discrepancies in the previous two rounds compared to independent verification scores, participation in oversight and coaching, and responsiveness on citizen feedback. The assessor teams will undertake the six-monthly assessment of C/S. The assessment process will generally proceed as per figure 3.3. The C/S-SDG assessment and verification processes will leverage the CPWC actors and mechanisms to integrate the transparency, community monitoring, and joint action planning (between the community, commune, and health sector) aspects of the ISAF. The complete process will be detailed in the OM and the C/S-SDG guideline.

22. Following receipt of C/S-SDG scores and D/K reports, the NCDDS will certify C/S and D/K performance and request the MEF to electronically disburse C/S-SDG funds to commercial bank accounts at the C/S level and D/K accounts. An independent agency will be contracted under Subcomponent 2.3 to conduct independent verification of the C/S and D/K scores. The C/S-SDG assessment and verification processes will leverage the CPWC actors and mechanisms to integrate the transparency, community

[94] Additional mechanisms for social accountability will be considered for integration into the performance measurement system, including I4C disclosure and public disclosure of C/S-SDG scores.

monitoring, and joint annual planning (between the community, commune, and health sector) as outlined in the ISAF.

Figure 3.2. CPWC Implementation Arrangements

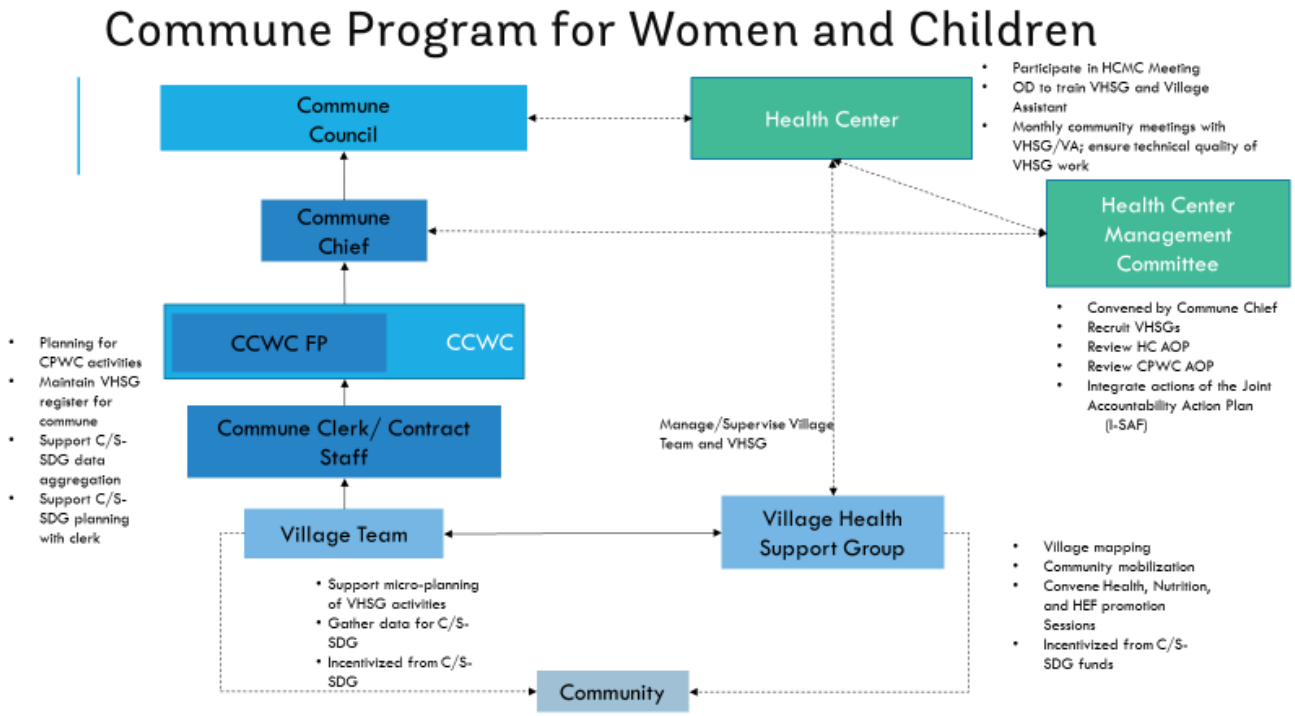


Figure 3.3. Proposed C/S-SDG Assessment Process

1. VHSG + Village Team collect village indicators
2. CCWC compiles indicators for commune and seeks approval from C/S council
3. D/K assessors (with support of province) assess the C/S based on checklist and report on own performance
4. District/Provincial administration sends C/S scores to NCDDS (these are subsequently verified by an independent entity on a sample basis)
5. NCDDS certifies C/S-SDG scores and sends request for payment (adjusted for ex post)
6. Electronic transfer to C/S commercial accounts

Table 3.4. Key Actors for the Implementation of the CPWC

Cadre/Group	Description	Form of Remuneration[a]
Village Volunteer: VHSG	• New TOR and recruitment criteria beyond existing VHSG; engaged at least part time to support the commune • Conduct village social mapping of first 1,000 days households • Community mobilization • Convene health, nutrition, and HEF promotion sessions as per CPWC package guidelines • Collect village data for C/S-SDG	Performance-based financial and non-financial; 100% C/S-SDG financed
Village Team: Village Chief, Village Assistant, and Commune Council Focal Point for Village	• Paid through C/S administration funds • Support microplanning of VHSG activities • Assist the CCWC/Commune Clerk with day-to-day supervision support for VHSG • Report on village data for C/S-SDG	Receive allowance from C/S Fund; may receive performance-based incentives from C/S-SDG
Commune Clerk and CCWC FP	• Administrative oversight and performance management for VHSG • Maintain VHSG register for commune • C/S-SDG data aggregation • C/S-SDG planning and allocation of budget to CPWC activities	Commune Clerk receives regular remuneration as a civil servant; CCWC FP receives allowance as commune councilor; both can receive performance-based incentives from C/S-SDG
Health Center: Chief and Midwife	• OD to train VHSG and Village Assistant • Monthly community meetings with VHSG/Village Team to ensure technical quality of VHSG work (CPWC and HEF promotion) • Participate in HCMC	Receive salary as regular or contract MOH staff; performance incentives from SDG; can be further supported for outreach or CPWC supportive supervision from C/S-SDG
HCMC	• Convened by Commune Chief • Review health center AOP • Recruit VHSGs • Review C/S-SDG AOP • Integrate aspects of JAAP process from the ISAF	Not applicable. Operational cost from C/S-SDG

Notes: a. Based on preliminary discussion. Final details to be outlined in project operations manual.

Table 3.5. Proposed Indicators for the C/S-SDG Readiness Checklist

C/S-SDG Readiness Checklist
• Key C/S-SDG actors trained (Commune Clerk, CCWC FP, and Village Assistant) in C/S-SDG processes (assessment process, FM) • C/S assessed for FM readiness • Has recruited, registered, and trained VHSG for the CPWC • Has required supplies and health promotion materials • Has completed community social risk mapping for 1,000 days households • Has conducted C/S-SDG sensitization of commune (Chief, Council, Village Chief, and Community)

Table 3.6. Proposed Indicators for the Standard C/S-SDG Checklist

Structural	Process	Outcome
• VHSG register is maintained • Has required CPWC supplies • Has completed community registers and social risk mapping • Has appropriately completed FM logs	• Has convened monthly community events for women and children aligned with CPWC guidelines • Has convened quarterly HCMC meetings • C/S adheres to FM procedures • Has conducted HEF promotion aligned with CPWC guidelines • Facilitates integrated outreach to villages according to schedule	• Percentage of birth registration • Percentage of pregnant women receiving ANC 4 • Percentage of institutional delivery • Percentage of full PNC • Percentage of children with immunization 'on track' • Percentage of children with regular GMP • Percentage of children stunted • Percentage of ID poor utilizing HEF benefits • Percentage of households with improved water • Percentage of households with improved sanitation • Third-party beneficiary feedback mechanism (incorporating ISAF as feasible)

23. **Subcomponent 2.2: Building Capacities, Monitoring, and Verifying C/S-SDG (US$1.65 million).** This subcomponent will support the activities necessary to activate and operationalize the C/S-SDG system, including (a) development of the C/S-SDG implementation guidelines and capacity building and coaching for the SNA to implement the program, (b) establishment of a system of timely payments to C/S and strengthening fiduciary oversight at the subnational level, and (c) conduct of six-monthly commune ex ante assessment by district assessors (details in annex 3). The C/S-SDG assessment and verification processes will leverage the CPWC actors and mechanisms to integrate the transparency, community monitoring, and joint annual planning (between the community, commune, and health sector) as outlined in the ISAF. Key design features for C/S-SDG are outlined in table 3.7.

Table 3.7. Key Design Features of C/S-SDG

Element	Description
Geographic Scope	Phased rollout in seven priority provinces
Tools	A C/S Readiness Checklist for Round 1. C/S Checklist for Women and Children in subsequent rounds
Assessment and Verification	Six-monthly performance assessment conducted by district administration with support from provincial administration Independent agency to conduct verification
Payment	C/S-SDGs will be disbursed to commune bank account based on the score of the assessment. The scores are measured on a scale of 0–100%.
Eligible Expenditures	Outlined in C/S-SDG manual; include performance incentives for VHSGs; performance incentives for commune/village level staff; operational costs for CPWC activities, HCMC meetings, patient transport costs to reach health center, and so on. Further refined in Operations Manual.
Coaching and Capacity Building	The NCDDS to lead on the development of coaching and capacity building for provinces, districts, and communes to support implementation of C/S-SDG performance financing processes and FM capacity building; the NCHP to lead on training and capacity building on the CPWC platform with support from the NMCHC
Social Accountability	Opportunities for community monitoring and joint annual planning (similar to the ISAF) to be integrated into guidelines

24. The subcomponent will be financed using DLIs, a method of payment against delivery of results (a set of tracer indicators with annual targets linked to systems strengthening actions). The DLI approach reimburses the RGC against eligible expenditures referred to as EEPs.[95] Once achievement of a DLI target is verified, funds are transferred to the MEF against the defined EEPs, which is the Government contribution to Component 1 (HEFs and SDGs) as set forth in the OM. The DLI manual will outline the project EEPs, the procedures related to partial and overachievement, scalability of DLIs, discrepancies with external verification, and rollover. Table 3.8 provides the proposed DLIs for Subcomponent 2.2 (detailed annual DLI targets and verification protocol in annex 4).

Table 3.8. DLIs for Component 2.2

DLI	Focal Point	Name
A	NCDDS	Subnational capacity building and rollout of C/S-SDG system
B	NCDDS	Sustained timeliness of C/S-SDG payments and fiduciary oversight
C	NCDDS	C/S-SDG assessment and coaching in accordance with guidelines

25. DLI A will finance the NCDDS to increase staffing for the C/S-SDG program, communicate with communes on the C/S-SDG program, and roll out C/S-SDG training. The NCDDS will also develop a comprehensive capacity-building program to train the SNA in C/S-SDG processes; planning, budgeting, monitoring, and reporting on relevant CPWC activities and expenditures. DLI milestones will set targets for the phased rollout of the C/S-SDG program in the seven priority provinces. The subcomponent will finance the development and implementation of training, job aids such as registries, counselling materials, and reporting templates. The training would include in addition to technical expertise, communication skills, empowerment, and leadership and mentoring skills as these were identified as important

[95] The DLI approach is currently used under the World Bank-financed health and higher education operations in Cambodia and is an MEF-preferred financing modality to support more sustainable improvements in service quality.

constraints in the implementers assessment. The capacity-building package will also include specific coaching and job aids for communes to perform oversight and management functions.

26. DLI B will support the NCDDS to strengthen the FM around the C/S-SDG process. This includes the development of an FM capacity-building and certification process, support for FM oversight at the subnational level, and improvement of the regularity of C/S-SDG payments to communes.

27. DLI C will support the NCDDS to train C/S-SDG assessors and for the NCDDS and the district administrations to conduct timely assessment of C/S. DLI milestones will encourage the timely and accurate conduct of assessment and reporting to the NCDDS. The assessment and verification procedures will be initially paper based, though the milestones will incentivize the adoption of an ICT-enabled system as feasible, based upon the H-EQIP experience with tablet-assisted assessment and verification. The NCDDS will be incentivized to complete timely review and certification of C/S-SDG scores to achieve DLI milestones.

28. **Subcomponent 2.3 Project Management, Monitoring, and Evaluation for the NCDDS (US$2.25 million).** Project management for Component 2 will be integrated into the responsible units and departments of the NCDDS. This subcomponent will support provision of technical and operational assistance for the routine administration, procurement, FM, environmental and social safeguards management, and M&E of Component 2 activities (including internal audits of NCDDS activities). The subcomponent will also support the procurement of a third-party entity to conduct ex post independent verification of C/S-SDG scores. Unlike the MOH, the NCDDS does not have an existing entity to conduct the ex post verification of C/S-SDG scores.

Component 3: Ensuring an Effective, Sustainable Response (US$18.2 million)

29. This component will finance (a) central-level actions needed to enhance the effectiveness and sustainability of project investments; (b) development and delivery of modernized SBCC campaigns; (c) comprehensive monitoring, evaluation, and adaptive learning; and (d) project management.

30. **Subcomponent 3.1: Strengthening the functional and technical capacities at national and subnational levels (US$6.45 million).** This subcomponent will support MOH national centers and departments to (a) create an enabling environment and (b) improve supply-side readiness, responsiveness, effectiveness, and delivery of priority interventions financed in Components 1 and 2. A detailed description is provided in annex 4.

31. **Subcomponent 3.2: Development of a Comprehensive SBCC Campaign (US$5.6 million).** The subcomponent will support the NMCHC to design and roll out modern, effective SBCC campaigns and associated content. The delivery of the campaign's interpersonal communication activities will be financed under Subcomponent 1.1 (for health facilities and outreach) and Subcomponent 2.1 (for community-level activities). Subcomponent 3.2 will be financed on an input basis and will support additional TA and formative research required to prepare content, develop materials (mass/social media, print, radio, and so on), and support delivery (the development and rollout of operational guidelines through training and/or coaching modalities). The priority will be to support relevant programs in the NMCHC to develop a campaign focused on MIYCN, for which there has been ongoing strategic and

technical support.[96] The subcomponent can further support the creation of SBCC materials for HEF promotion and other health promotion activities in collaboration with relevant departments. This subcomponent will also be able to finance the procurement and use of technology to improve the quality and reach of the SBCC. Mass/social media activities can be implemented with national coverage, while the interpersonal communication activities will have a phased rollout beginning with the seven priority provinces.

32. **Subcomponent 3.3: Monitoring, Evaluation, and Adaptive Learning (US$2.5 million).** The subcomponent will support the strengthening of M&E systems for RMNCAH-N in Cambodia, including gender-disaggregated data collection, reporting, and analysis at subnational and national levels; strengthening of M&E human resources in the MOH; and updating of data systems to meet reporting needs. The subcomponent will finance implementation research assessments to accompany development, piloting, revisions, and adaptation of project elements such as the CPWC, the MIYCN SBCC rollout, provider training methods, beneficiary feedback modalities, and so on. Adaptive learning questions will aim to complement the assessment of plausibility under the externally financed impact evaluation and will be defined based on jointly agreed priorities of the implementing agencies and the pooled fund partners. The process for selecting implementation research questions will be outlined in the OM. To support the implementation of the project's social safeguards instruments, the subcomponent will finance operational research to adapt the design of community platforms to the needs of targeted indigenous peoples'/ethnic minority groups. Subcomponent financing will further monitor the effectiveness of different approaches to enhance participation in community-level activities. The subcomponent will also complement the proposed financing of an impact evaluation external to the project.

33. **Subcomponent 3.4: Project Management (MOH) (US$3.6 million).** Project management will be integrated into the responsible departments of the MOH. This subcomponent will finance the provision of technical and operational assistance for the day-to-day coordination, administration, procurement, FM, environmental and social safeguards management, and M&E and reporting of the project, including the carrying out of financial audits of the whole project. The subcomponent will also support capacity strengthening of responsible departments with the MOH to ensure continued ability of relevant departments to support project management and implementation needs and support operational costs to deliver on the project's cross-sectoral coordination requirements.

[96] With technical support from UNICEF, Helen Keller International, Alive and Thrive, and the World Bank, the NNP has conducted robust formative research into MIYCN behaviors; developed a comprehensive national strategy; and initiated the development of a multi-channel and contextually relevant SBCC campaign. The World Bank WASH and HNP teams have collaborated with the MRD and the NNP to conduct an implementer assessment to support operationalization of the campaign.

ANNEX 4: Disbursement Linked Indicators and Verification

DLIs	Year 0	Year 1	Year 2	Year 3	Year 4
DLI A. Subnational capacity building and rollout of C/S-SDG system	**DLI Targets** 1. C/S-SDG checklists and readiness guidelines distributed to all C/S and D/K in target provinces 2. NCDDS is adequately staffed to carry out C/S-SDG implementation according to mutually agreed staffing plan 3. Plans for subnational capacity building and monitoring for C/S-SDG approved.	**DLI Targets** 1. Training on C/S-SDG processes rolled out as per year 1 plan	**DLI Targets** 1. Training on C/S-SDG processes rolled out as per year 2 plan	**DLI Targets** 1. Training on C/S-SDG processes rolled out as per year 3 plan	**DLI Targets** 1. Training on C/S-SDG processes rolled out as per year 4 plan
	DLI Value US$300,000	**DLI Value US$100,000**	**DLI Value US$100,000**	**DLI Value US$100,000**	**DLI Value US$100,000**
DLI B. Sustained timeliness of C/S-SDG payments and fiduciary oversight	**DLI Targets** 1. Plans for sub-national capacity building and monitoring of financial management (FM) are approved 2. NCDDS FM team receives training in its standard operating	**DLI Targets** 1. At least 60% of C/S-SDG payments are made within the prescribed time 2. Activities as per the year 1 FM capacity building and monitoring plan have been completed for	**DLI Targets** 1. At least 75% of C/S-SDG payments are made within the prescribed time 2. Activities as per the year 2 FM capacity building and monitoring plan have been completed for	**DLI Targets** 1. At least 80% of C/S-SDG payments are made within the prescribed time 2. Activities as per the year 3 FM capacity building and monitoring plan have been completed for	**DLI Targets** 1. At least 85% of C/S-SDG payments are made within the prescribed time 2. Activities as per the year 4 FM capacity building and monitoring plan have been completed for

DLIs	Year 0	Year 1	Year 2	Year 3	Year 4
	procedures and World Bank's Procurement Regulations	C/S-SDG FM readiness and roll out.	C/S-SDG FM readiness and roll out	C/S-SDG FM readiness and roll out	C/S-SDG FM readiness and roll out
	DLI Value US$100,000	**DLI Value US$100,000**	**DLI Value US$100,000**	**DLI Value US$100,000**	**DLI Value US$100,000**
DLI C. C/S-SDG assessment and coaching in accordance with guidelines	**DLI Targets** 1.Implementation guideline detailing C/S-SDG fund flow, rollout, process, and oversight arrangements is finalized and distributed among C/S, district, provincial, and central authorities 2. C/S-SDG assessor team trained and certified according to a plan agreed between NCDDS and the Association.	**DLI Targets** 1. At least 70% of target C/S receive timely C/S-SDG assessment 2. 2 additional assessors from every district and province in targeted areas trained and certified as assessors after undergoing the standard C/S-SDG program	**DLI Targets** 1. At least 80% of target C/S receive timely C/S-SDG assessment 2. ICT system is established and functional appropriately, with all assessor teams using tablet-assisted collection and submitting data through the ICT system 3. Actions taken as per C/S-SDG Operational Manual to address discrepancies in ex-ante and ex-post verification scores	**DLI Targets** 1. At least 85% of target C/S receive timely C/S-SDG assessment 2. Actions taken as per C/S-SDG Operational Manual to address discrepancies in ex-ante and ex-post verification scores	**DLI Targets** 1. At least 90% of target C/S receive timely C/S-SDG assessment 2. Actions taken as per C/S-SDG Operational Manual to address discrepancies in ex-ante and ex-post verification scores
	DLI Value US$90,000	**DLI Value US$80,000**	**DLI Value US$130,000**	**DLI Value US$80,000**	**DLI Value US$70,000**
DLI D. Ongoing readiness and quality of priority nutrition services	**DLI Targets** 1. The NNP of MOH is adequately staffed according to the MOH's relevant plan with full-time qualified personnel and	**DLI Targets** 1. Training and coaching package and implementation guidelines for comprehensive nutrition interventions	**DLI Targets** 1. At least 125 health centers in priority provinces have relevant staff trained in the comprehensive	**DLI Targets** 1. At least 150 health centers in priority provinces have relevant staff trained in the comprehensive	**DLI Targets** 1. At least 200 health centers have relevant staff trained in the comprehensive nutrition intervention package

DLIs	Year 0	Year 1	Year 2	Year 3	Year 4
	contractual staff to carry out Project functions 2. Comprehensive package of nutrition interventions defined 3. Supervision, training, and coaching plans for comprehensive nutrition interventions is agreed and budgeted	have been approved by MOH 2. At least 66 health centers in priority provinces have relevant staff trained in the comprehensive nutrition intervention package 3. Monitoring, supervision and coaching carried out according to Year 1 plan	nutrition intervention package 2. Monitoring, supervision and coaching carried out according to Year 2 plan	nutrition intervention package 2. Training and coaching modules and implementation guidelines updated 3. Monitoring, supervision and coaching carried out according to Year 3 plan	2. Monitoring, supervision, and coaching carried out according to Year 4 plan
	DLI Value US$200,000	**DLI Value US$250,000**	**DLI Value US$200,000**	**DLI Value US$200,000**	**DLI Value US$100,000**
DLI E. Delivery of an integrated outreach package including priority MCHN services	**DLI Targets** 1. Guidelines specifying integrated outreach package including minimum MCHN activities, frequency, and monitoring protocol for central and OD levels is adopted (the Guidelines) 2. Procurement for the integrated outreach portable kits initiated	**DLI Targets** 1. ODs in target provinces with health centers conducting integrated outreach according to the Guideline	**DLI Targets** 1. ODs in target provinces with health centers conducting integrated outreach according to the Guideline	**DLI Targets** 1. ODs in target provinces with health centers conducting integrated outreach according to the Guideline	**DLI Targets** 1. ODs in target provinces with health centers conducting integrated outreach according to the Guideline
	DLI Value US$120,000	**DLI Value US$120,000**	**DLI Value US$120,000**	**DLI Value US$120,000**	**DLI Value US$120,000**
DLI F. Comprehensive coaching conducted for MCHN Scorecard	**DLI Targets** 1.MCHN scorecard developed based on	**DLI Targets** 1.Comprehen-sive package of MCHN	**DLI Targets** 1.MCHN scorecard coaching conducted	**DLI Targets** 1.MCHN scorecard coaching conducted	**DLI Targets** 1.MCHN scorecard coaching conducted

DLIs	Year 0	Year 1	Year 2	Year 3	Year 4
	the criteria set out in the Verification Protocol 2.MCHN vignettes finalized based on criteria set out in the Verification Protocol 3.Annual plan for MCHN coaching developed, agreed, and budgeted	scorecard coaching modules developed and approved 2.MCHN scorecard coaching conducted according to year 1 plan	according to year 2 plan 2.ICT-enabled MCHN coaching introduced	according to year 3 plan	according to year 4 plan
	DLI Value US$150,000	**DLI Value US$200,000**	**DLI Value US$200,000**	**DLI Value US$100,000**	**DLI Value US$100,000**
DLI G. Communication materials, training, and supervision delivered for VHSGs and HEF Promotion	**DLI Targets** 1. Package of activities for the CPWC (including for HCMC and VHSG) is defined and implementation guidelines prepared 2. SBCC implementation plan and list/package of materials developed for VHSG, NMCHC, NNP, and HEF promotion is approved by Project director. 3. Capacity building and supervision plans for NCHP's support to HEF	**DLI Targets** 1. Training workshop conducted for VHSG as defined for year 1 in the Capacity Building and Supervision Plan 2. All SBCC materials as per the SBCC Implementation Plan and list/package of materials for year 1 for VHSG, NMCHC, NNP and HEF promotion are developed.	**DLI Targets** 1. Training workshop and supervision conducted for VHSG as defined for year 2 in the Capacity Building and Supervision plan 2. SBCC implementation plan for year 2 is completed	**DLI Targets** 1.Training workshop and supervision conducted for VHSG as defined for year 3 in the Capacity Building and Supervision plan 2.SBCC implementation plan for year 3 is completed	**DLI Targets** 1.NCHP undertakes supervision of community level activities and any remaining training programs defined for year 4 in the Capacity Building and Supervision plan 2.SBCC implementation plan for year 4 is completed

DLIs	Year 0	Year 1	Year 2	Year 3	Year 4
	promotion and support to CPWC (Capacity Building and Supervision Plans) aligned with C/S-SDG rollout is agreed and budgeted.				
	DLI Value US$200,000	**DLI Value US$250,000**	**DLI Value US$150,000**	**DLI Value US$150,000**	**DLI Value US$150,000**
DLI H. Sustainable institutional arrangements for HEF and SDG payment and certification	**DLI Targets** 1.PMRS updated to incorporate the expanded HEF package under Part 1.2 2.Training to implement MOH guidelines on HEF expansion is completed for all target provinces.	**DLI Targets** 1. Supervision conducted as per MOH's relevant plan to promote adherence to HEF expansion 2. Payment certification agent (PCA) carries out timely certification of MCHN scorecard scores as per MOH's relevant guideline 3.Full PMRS is rolled out in at least additional 40 health centers/ referral hospitals in target provinces	**DLI Targets** 1.Timely certification of MCHN Scorecard scores as per MOH's relevant guideline 2.Full PMRS is rolled out in at least additional 50 health centers/ referral hospitals in target provinces	**DLI Targets** 1.Timely certification of MCHN Scorecard scores as per MOH's relevant guideline 2.Full PMRS is rolled out and functional in all health centers/ referral hospitals in target provinces	**DLI Targets** 1.Timely certification of MCHN Scorecard scores as per MOH's relevant guideline
	DLI Value US$150,000	**DLI Value US$400,000**	**DLI Value US$350,000**	**DLI Value US$300,000**	**DLI Value US$100,000**
DLI I. MCHN service quality monitoring enhanced and	**DLI Targets** 1.MCHN scorecard manual and guideline finalized	**DLI Targets** 1.MCHN scorecard rolled out in at least 80	**DLI Targets** 1.MCHN scorecard rolled out in all health	**DLI Targets** 1.MCHN scorecard updated and scaled up in new provinces and	**DLI Targets** 1.MCHN scorecard implemented in new provinces and health

DLIs	Year 0	Year 1	Year 2	Year 3	Year 4
mainstreamed in the MOH	2. MCHN scorecard guidance integrated into SDG annual instruction for implementation 3.Protocol for reviewing MCNH scorecard developed and templates for quarterly and annual MCHN scorecard reports produced	health centers in target provinces 2.Quarterly joint review (quality assurance office (QAO) + NMCHC) of MCHN Scores and production of quarterly and annual MCHN scorecard reports	centers in target provinces 2.Quarterly joint review (QAO + NMCHC) of MCHN scores and production of quarterly and annual MCHN scorecard reports	health facilities as per mid-term review agreements for year 3. 2.Quarterly joint review (QAO + NMCHC) of MCHN scores and production of quarterly and annual reports	facilities as per mid-term review agreements for year 4. 2.Quarterly joint review (QAO + NMCHC) of MCHN scores and production of quarterly and annual reports
	DLI Value US$150,000	**DLI Value US$150,000**	**DLI Value US$150,000**	**DLI Value US$250,000**	**DLI Value US$200,000**
DLI J. Timeliness of MCHN-SDG and HEF payments ensured and continued FM capacity building for health centers	**DLI Targets** 1.Financial procedure guidelines and standards for HEF and SDG expansion finalized and distributed to OD, PHD, and MOH central staff 2. Sub-national FM capacity building plan approved by MOH	**DLI Targets** 1.At least 70% of MCHN-SDG and HEF payment are made within the prescribed time 2.Activities as per the FM capacity building plan have been completed for year 1	**DLI Targets** 1. At least 75% of MCHN-SDG and HEF payment are made within the prescribed time 2. Activities as per the FM capacity building plan have been completed for year 2	**DLI Targets** 1. At least 80% of MCHN-SDG and HEF payment are made within the prescribed time 2. Activities as per the FM capacity building plan have been completed for year 3	**DLI Targets** 1. At least 85% of MCHN-SDG and HEF payment are made within the prescribed time 2. Activities as per the FM capacity building plan have been completed for year 4
	DLI Value US$150,000	**DLI Value US$150,000**	**DLI Value US$150,000**	**DLI Value US$150,000**	**DLI Value US$150,000**
DLI K. Regularity of MCHN data availability enhanced	**DLI Targets** 1.Template for monthly, semi-annual and annual MCHN and	**DLI Targets** 1.Timely production of monthly, semi-annual and annual MCHN and	**DLI Targets** 1.Timely production of monthly, semi-annual and annual MCHN and	**DLI Targets** 1.Timely production of monthly, semi-annual and annual MCHN and	**DLI Targets** 1.Timely production of monthly, semi-annual and annual MCHN and

DLIs	Year 0	Year 1	Year 2	Year 3	Year 4
	HEF utilization report developed 2.Guideline/ notification on Part 1.2 HEF expansion issued to PHDs in priority provinces	HEF utilization reports in year 1	HEF utilization reports in year 2	HEF utilization reports in year 3	HEF utilization reports in year 4
	DLI Value US$100,000	**DLI Value US$50,000**	**DLI Value US$50,000**	**DLI Value US$50,000**	**DLI Value US$50,000**

Verification Protocol	
DLI A	**Subnational capacity building and rollout of C/S-SDG system**
Compliance Condition	C/S-SDG checklists, readiness guidelines, staffing plan, capacity building and monitoring plan are ready and approved by the project director NCDDS (for year 0). Training is achieved as per each year's capacity building and monitoring plan for subsequent years.
Means of Verification	Year 0: Availability of the prescribed documents in final form. Subsequent years: Review of training reports, sample check of officials trained
Compliance Verification Procedure	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	**NCDDS**
DLI B	**Sustained timeliness of C/S-SDG payments and fiduciary oversight**
Compliance Condition	Year 0: Availability of the prescribed documents including training records in final form. Subsequent years: Review of transaction dates during payment processing, training reports, sample check of officials trained
Means of Verification	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	NCDDS
DLI C	**C/S-SDG assessment and coaching in accordance with guidelines**
Compliance Condition	The required documents including C/S-SDG implementation guidelines, training plan, and oversight arrangements are ready (for year 0) in consultation with the 'Association' where Association refers to International Development Association/ The World Bank. Assessments are

	undertaken for all target C/S of which the specified share are undertaken on time, that is, within the specified timelines in the implementation guidelines as stipulated in the plan (for subsequent years). The two additional assessors are trained to allow for unexpected staff changes or other reasons for nonavailability and should be completed for all districts and provinces in target areas (that is, not just for partial rollout if the system is in a phased rollout). The implementation manual should be updated to specify actions to be undertaken to reduce discrepancies noticed between assessments and verification and with clear annual targets, and the year 2 to year 4 subindicators will be assessed based on the extent to which this plan was followed to reduce the discrepancy and evaluated based on achievement of annual targets specified in the plan.
Means of Verification	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	NCDDS and District Administration Planning Office
DLI D	**Ongoing readiness and quality of priority nutrition services**
Compliance Condition	Adequate staffing of the NNP will be determined and mutually agreed based on a capacity assessment undertaken before project effectiveness and based on the required functions and skillsets for the NNP. The package of comprehensive nutrition interventions is defined which encompasses FTRM interventions and the GFF priority nutrition interventions. All documents have been formally approved by the project director in year 0. In year 1, the NNP has developed a training and coaching package of materials aligned with the comprehensive nutrition package. For subsequent years, the NNP conducts training of health centers in numbers as outlined in DLI milestones and monitoring, supervision, and coaching as defined in the year 0 plan (subsequent years). The NNP revises the training and coaching modules in year 3 based upon experience and gaps in performance of the nutrition interventions in the MCHN Scorecard. The 'relevant' staff to be trained in each health centre will also be defined in this training plan to be developed for year 0.
Means of Verification	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	NNP
DLI E	**Delivery of an integrated outreach package including priority MCHN services**
Compliance Condition	Year 0 DLIs are based on the finalization of the guidelines for integrated outreach with clear definitions on what constitutes the minimum number of integrated outreach sessions for any village, which villages need such outreach and which ones do not, and what MCHN services must be delivered at a minimum to qualify as an integrated outreach session. The integrated outreach guideline is approved by the project director including, at minimum, immunization, GMP, ANC and PNC services along with the frequency of visits according to the distance, density, and difficulty to reach the catchment villages. The guideline specifies outreach requirements for both urban and rural areas. A package of essential equipment for portable outreach kits is defined and the procurement is initiated for all health centers in the seven target provinces to be equipped with the package. The 'initiation of procurement' will include having finalized technical specifications in consultation with the World Bank, finalization of bid documents and the publication of the relevant advertisement. Achievement values are shared between the PMD and ODs in a ratio specified in the DLI manual. This DLI is fully scalable across the seven target provinces, and a proportional value is payable for each OD which achieves the target in subsequent years.

Means of Verification	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	PMD
DLI F	**Comprehensive coaching conducted for MCHN Scorecard**
Compliance Condition	The NMCHC provides technical leadership to the MCHN Scorecard and vignettes development, which are approved by the project director. An annual coaching plan which includes costs and budgets is also approved by the project director (year 0) and fully achieved in each year (for subsequent years). Based on initial implementation experience, coaching becomes more structured and coaching modules are developed and approved by the project director (year 1). Subsequent coaching is undertaken as per this plan (subsequent years). In year 2, the MCHN coaching module is incorporated in the ICT system for SDGs.
Means of Verification	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	NMCHC
DLI G	**Communication materials, training, and supervision delivered for VHSGs and HEF Promotion**
Compliance Condition	The package of activities to be implemented through the implementation guidelines supporting the same are developed by the NCHP in consultation with the NMCHC, NNP, NIP and NCDDS. This package focuses on the priority Investment Case interventions. SBCC implementation plan is likewise prepared with the list/package of materials to be developed and their approximate quantities and costs. All documents and plans will need to be formally approved by the project director for compliance with year 0. Capacity building plan for all identified VHSGs to be trained will include the training themes, duration of training, competencies to be built, and other operational specifications. Supervision plan will define the content and frequency of CPWC supervision to be conducted by the NCHP as well as recommendations for OD and health center. From year 1, the NCHP delivers the training as per the plan submitted in year 1. In year 1, all SBCC materials as per list/package finalized in year 0, are developed, and the implementation plan is followed and on track.
Means of Verification	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	NCHP
DLI H	**Sustainable institutional arrangements for HEF and SDG payment and certification**
Compliance Condition	Appropriate revisions to PMRS carried out to facilitate HEF expansion and due training in the updated system provided to all target provinces (year 0). The PCA completes its assigned duties of SDG ex post verification including that for the MCHN Scorecard in target provinces.
Means of Verification	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	PCA

DLI I	**MCHN service quality monitoring enhanced and mainstreamed in the MOH**
Compliance Condition	The relevant documents (manual, guideline, annual instructions) are finalized following due consultative processes where needed and have been formally approved by the project director (year 0). The assessors are using the MCHN Scorecard in all health facilities where the MCHN Scorecard system is reported to have been rolled out and that this is in full compliance of the planned (subsequent years). QAO involves the NMCHC in the review of quarterly assessment scores and in validating these with post-verification results, as well as undertakes the analysis of data for the prescribed reports.
Means of Verification	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	QAO
DLI J	**Timeliness of MCHN-SDG and HEF payments ensured and continued FM capacity building for health centers**
Compliance Condition	Implementation plan for 'SDG and HEF' expansion under CNP detailing fund flow instruments, processes, World Bank and facility accounts (where needed), and standards for the HEF and SDG payments and health facility FM capacity building established, as well as a capacity building plan, especially in FM, is laid out (year 0). The payments to health facilities are being made within prescribed timelines and the capacity-building plan is achieved as per the year's plan (subsequent years).
Means of Verification	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	DBF
DLI K	**Regularity of MCHN data availability enhanced**
Compliance Condition	The reporting content, timing, and template is agreed upon between DPHI and the NMCHC/NNP (year 0) and the reports are generated and distributed as per this agreement in subsequent years.
Means of Verification	Independent verification consultant will review the documents and undertake field visits for sample checks, as per laid down procedure in the DLI manual
Responsible Department	DPHI

ANNEX 5: Economic and Financial Analysis

1. The project's economic analysis aligns with global evidence that investing in RMNCAH-N through primary health care services is highly cost-effective.[97] The project's health and nutrition gains will contribute to economic growth through multiple pathways. On a macro level, global evidence shows that countries that invest in human capital grow as much as 1.25 percent faster than countries that underinvest in these areas.[98] Timely investments in health and nutrition can reduce the economic losses attributable to these conditions (such as decreased school performance, labor productivity, and incomes and higher health care costs). For example, Bagriansky et al. (2014) estimated that the economic impact of malnutrition alone in Cambodia is over US$400 million annually, which accounts for roughly 2.5 percent of GDP.[99]

2. Three different types of interventions will contribute to health and nutrition gains: (a) supply-side interventions (for example, increase provision of quality ANC services); (b) demand-side interventions (for example, SBCC, promotion and expansion of HEF and transportation allowances); and (c) interventions to improve quality of care (for example, reduction of non-medically indicated C-sections). Supply-side interventions improve the availability of targeted services and strengthen providers' readiness to deliver them. This, in turn, increases the coverage of targeted services and therefore promotes better health outcomes. Demand-side interventions contribute to the improvement of health outcomes by promoting a higher utilization of health services. By addressing poor public knowledge and awareness related to health and nutrition (and promoting the utilization of HEFs more broadly), these demand-side interventions can have spillover effects and increase utilization of other health services not supported under the project; these spillover effects can influence the prevention and treatment of other health conditions, such as NCDs.

3. Interventions to improve quality of care achieve health gains by increasing utilization and effectiveness of health services: poor quality of care deters citizens from utilizing health services, and when citizens use health services, poor quality can significantly hinder the effectiveness therein. Several assessments[100]show that quality of care in Cambodia is low and in need of improvement. It is anticipated that the project's investments in quality improvement will have positive externalities by improving the quality of care of interventions delivered by the same providers but financed outside this project (for instance, through private practice). In this sense, the project increases the efficiency and effectiveness of the Government's investments in health.

[97] In fact, community management of severe malnutrition, family planning, ANC, and PNC are among the most cost-effective interventions in the Global Investment Framework for Reproductive, Maternal, Newborn, and Child Health. See: Black, R., R. Laxminarayan, M. Temmerman, and N. Walker. eds. 2016. *Disease Control Priorities, (Volume 2): Reproductive, Maternal, Newborn, and Child Health.* World Bank.

[98] World Bank. 2011. "The Changing Wealth of Nations: Measuring Sustainable Development in the New Millennium". IBRD, Washington, D.C.

[99] Bagriansky, J., N. Champa, K. Pak, S. Whitney, and A. Laillou. 2014. "The Economic Consequences of Malnutrition in Cambodia, More than 400 million US dollar lost annually." *Asia Pacific Journal of Clinical Nutrition*. 23(4); 524-31.

[100] Ith, P., A. Dawson, and C. Homer. 2012. "Quality of Maternity Care Practices of Skilled Birth Attendants in Cambodia." *International Journal of Evidence-Based Healthcare* 10 (1): 60–67.
WaterAid. 2015. "Towards Better and Safer Quality Health Care Services in Cambodia. A Situation Analysis of Water, Sanitation and Hygiene in Health Care Facilities."

4. Project-financed interventions will increase the efficiency of health spending, therefore increasing value for money. The widespread use of results-based mechanisms under the project will increase the likelihood of achieving the desired health outcomes through project investments; the project will further increase the efficiency of underlying investment in the health system (for instance in commodities, supplies, and so on) by linking these to providers delivering higher quality care. Project investments reinforce accountability mechanisms and contribute to improvements in provider behavior and service delivery. Moreover, results-based financing fosters the use of data for decision making: the improved generation and use of information will increase efficiency of health spending through the timely identification and resolution of service delivery bottlenecks.

5. Geographic targeting under this project will contribute to improved efficiency of health spending and equity of health outcomes by targeting resources where they are most needed. Lower-than-average health service coverage rates[101] are contributing to poor health outcomes: under-five mortality rates were more than twice the national average, and stunting rates were almost 30 percent higher. Demand-side interventions such as the expansion of the HEF and transport allowances will help address the geographic and financial barriers to accessing health services, which disproportionally affect the poor and residents of the project provinces.[102]

6. **Cost-effectiveness analysis.** A single cost-effectiveness analysis was performed for the entire project, encompassing each component's contributions to the development objective and economic growth.[103] Using a 5 percent discount rate, the overall project envelope of US$54 million has a net present value of US$46.3 million (table 5.1). These investments will be targeted toward 11 priority services in seven provinces, covering 339 C/S (table 5.2) with an estimated population of 1.78 million people in 2019.

Table 5.1. Discounted Project Costs (US$, millions)

Fiscal Year	Actual Cost	Present Value
2019	2.0	2.0
2020	9.0	8.6
2021	11.0	9.9
2022	12.0	10.2
2023	12.0	9.6
2024	8.0	6.0
Total	**54.0**	**46.3**

[101] For example, 71.6 percent of women in the seven targeted provinces received PNC within two days, compared to the national average of 90.3 percent. Also, immunization coverage rates in these provinces were more than 10 percent lower than the national average.

[102] Poverty is concentrated in project provinces. Nationally, financial barriers to service utilization were reported by 79.2 percent of women in lowest income quintile, while 41.2 percent of women in the highest income quintile reported having financial difficulties to access care. Similarly, more than half of the women in the lowest income quintile reported significant geographic barriers to accessing care, while less than 15 percent of the women in the highest income quintile had that problem.

[103] Cost-effectiveness analysis consists of the following steps: (a) assessing the project's costs, (b) establishing target coverage rates for the activities financed under this project, (c) estimating health gains derived from increases in the coverage rates, and (d) calculating and interpreting cost-effectiveness ratios.

Table 5.2. Project Coverage by Province

Provinces	Number of ODs	Number of Health Centers	Annual Facility Deliveries	Number of Communes	Number of Villages
Ratanak Kiri	2	17	5,130	50	249
Mondul Kiri	1	11	2,208	21	100
Kratie	2	29	7,986	52	249
Stung Treng	1	12	3,843	34	131
Kampong Chhnang	3	39	12,215	93	563
Koh Kong	2	12	2,453	31	119
Preah Vihear	1	23	5,607	58	236
Total	**12**	**143**	**39442**	**339**	**1647**

7. Preliminary findings from the costing of Cambodia's Investment Case for RMNCAH-N (prepared in support of the GFF), indicate a resource envelope of approximately US$42.8 million over five years to scale up the 11 priority interventions (both supply-side investments in seven priority provinces and operational shifts in service delivery and systems strengthening) (table 5.3).[104]

Table 5.3. Summary of Costs Estimated for 11 Priority Interventions in 7 Provinces

No.	Priority Interventions	2019	2020	2021	2022	2023	Total
1	Increase coverage, access to, quality, and quantity of ANC, particularly for rural and urban poor communities	$ 210,104.41	$ 218,736.28	$ 222,236.06	$ 225,791.84	$ 229,404.51	**$ 1,106,273.10**
2	Increase coverage and access to quality delivery care	$ 1,177,946.26	$ 1,221,412.11	$ 1,240,954.71	$ 1,260,809.98	$ 1,280,982.94	**$ 6,182,106.00**
3	Improve quality and quantity of PNC	$ 66,082.04	$ 69,799.29	$ 70,916.08	$ 72,050.73	$ 73,203.55	**$ 352,051.69**
4	Improve the quality and geographic coverage of EmONC	$ -	$ -	$ -	$ -	$ -	**$ -**
5	Reduce gaps in basic infrastructure, drugs and equipment in EmONC facilities	$ -	$ -	$ -	$ -	$ -	**$ -**
6	Improve early and essential newborn care practices	$ 5,691.22	$ 5,716.59	$ 5,808.05	$ 5,900.98	$ 5,995.40	**$ 29,112.24**
7	Improve quality of the management of sick newborn	$ 20,236.79	$ 21,490.33	$ 21,834.17	$ 22,183.52	$ 22,538.46	**$ 108,283.26**
8	Improve the prevention and management of low birth weight	$ 22,218.78	$ 23,294.56	$ 23,667.27	$ 24,045.95	$ 24,430.68	**$ 117,657.24**
9	Promotion of early initiation and exclusive breastfeeding and complementary feeding	$ 68,250.00	$ 68,250.00	$ 69,342.00	$ 70,451.47	$ 71,578.70	**$ 347,872.17**
10	Expand the screening management and treatment of severe acute malnutrition (SAM)	$ 197,400.00	$ 211,050.00	$ 214,426.80	$ 217,857.63	$ 221,343.35	**$ 1,062,077.78**
11	Provide SRH education and parental education to adolescents	$ -	$ -	$ -	$ -	$ -	**$ -**
12	Promote accessible and adolescent friendly sexual and reproductive health services	$ -	$ -	$ -	$ -	$ -	**$ -**
13	Increase the availability of growth monitoring and promotion in health facilities and communities	$ -	$ -	$ -	$ -	$ -	**$ -**
14	Increase the delivery of integrated outreach services	$ 107,135.28	$ 107,135.28	$ 108,849.44	$ 110,591.04	$ 112,360.49	**$ 546,071.53**
15	Increase quality, availability, and utilization of family planning services, especially long-term/permanent family planning methods & reduce traditional family planning	$ -	$ -	$ -	$ -	$ -	**$ -**
16	Improve immunization coverage in high risk communities	$ 328,680.00	$ 328,680.00	$ 328,680.00	$ 328,680.00	$ 328,680.00	**$ 1,643,400.00**
UC	Social and Behavior Change Communication	$ 800,000.00	$ 800,000.00	$ 800,000.00	$ 800,000.00	$ 800,000.00	**$ 4,000,000.00**
OS1	MCHN SDG Top UP	$ 432,000.00	$ 432,000.00	$ 432,000.00	$ 432,000.00	$ 432,000.00	**$ 2,160,000.00**
OS2	HEF Expansion for IC Priorities	$ 562,716.00	$ 562,716.00	$ 562,716.00	$ 562,716.00	$ 562,716.00	**$ 2,813,580.00**
OS3	Operationalizing Community Participation Policy and ISAF	$ 1,800,000.00	$ 1,800,000.00	$ 1,800,000.00	$ 1,800,000.00	$ 1,800,000.00	**$ 9,000,000.00**
OS4	Strengthen health worker skills and competencies	$ 874,440.00	$ 874,440.00	$ 874,440.00	$ 874,440.00	$ 874,440.00	**$ 874,440.00**
UC	Strengthening underlying health systems for delivery of IC priorities	$ 1,800,000.00	$ 1,800,000.00	$ 1,800,000.00	$ 1,800,000.00	$ 1,800,000.00	**$ 9,000,000.00**
Total		**$ 8,472,900.77**	**$ 8,544,720.44**	**$ 8,575,870.59**	**$ 8,607,519.14**	**$ 8,639,674.07**	**$ 42,840,685.01**

[104] Preliminary estimates indicate the total envelope for the 16 Investment Case priority interventions is US$51.8 million.

8. The health impact of the 11 priority interventions was calculated using baseline service coverage data from the CDHS 2014. When these figures were not available, baseline coverage was derived from default data for Cambodia from the OneHealth tool.[105] The Lives Saved Tool (LiST) was then used to translate improvements in service coverage into changes in health outcomes.[106] LiST estimates show that 13,481 lives can be saved (deaths averted) over the life of the project relative to a scenario of no project (table 5.4). Improvements in the coverage of PNC practices, treatment of malnutrition, and periconceptual interventions have the highest impact on averted deaths for children, while periconceptual interventions and $MgSO_4$ management of pre-eclampsia have the higher impact on averted maternal deaths.

Table 5.4. Number of Averted Deaths (LiST estimates)

Year	Averted Deaths		
	Children	Mothers	Total
2019	764	14	778
2020	1,261	29	1,290
2021	1,921	44	1,965
2022	2,583	60	2,643
2023	3,207	74	3,281
2024	3,447	77	3,524
Total	**13,183**	**298**	**13,481**

9. **Calculating and interpreting cost-effectiveness ratios.** The ICER is calculated as the incremental cost (defined as the difference in cost with and without an intervention) divided by the health impact of an intervention. In this case, health impact is measured in averted death units. Using the above estimates, the ICER for this project indicates that the cost of averting one death over the life of the project is US$3,434 (table 5.5).

Table 5.5. ICER Calculations

Year	Present Value (US$, millions)	Averted Deaths			ICER (US$ per life)
		Children	Mothers	Total	
2019	2	764	14	778	11,054
2020	8.6	1,261	29	1,290	7,674
2021	9.9	1,921	44	1,965	5,191
2022	10.2	2,583	60	2,643	3,632
2023	9.6	3,207	74	3,281	1,829
2024	6	3,447	77	3,524	1,703

[105] It should be noted, however, that while CDHS data allowed to estimate average coverage rates for the provinces targeted in this project, OneHealth data is nationally representative. Estimates using nationally representative coverage data underestimate the health impact of reaching coverage targets, given that baseline data are higher than for the selected provinces.

[106] LiST applies country-specific health and nutrition data to predict changes in child and maternal mortality rates using multi-cause models. The tool is appropriate to model the health impact of the interventions financed under this project provided it focuses primarily on RMNCAH-N interventions. Default effect sizes (based on the best available evidence for Cambodia) were used to estimate the impact of changes in coverage on mortality rates.

Year	Present Value (US$, millions)	Averted Deaths			ICER (US$ per life)
		Children	Mothers	Total	
Total	**46.3**	**13,183**	**298**	**13,481**	**3,434**

10. Based on cost-effectiveness threshold (CET) guidance from WHO (2011,[107] 2015[108]), investments under this project are deemed cost-effective (table 5.6). Using Cambodia's GDP per capita to calculate country-specific CET, the analysis shows that interventions with an ICER between US$1,267 and US$3,801 are cost-effective.

Table 5.6. Cost-effectiveness Thresholds

Threshold	Cost-Effectiveness
ICER < GDP per capita	Highly cost-effective
GDP per capita < ICER < 3 x (GDP per capita)	Cost-effective
ICER > 3* GDP per capita	Not cost-effective

11. Further, economic benefits of the project can be calculated based on the impact of health gains on the labor force. In this case, averted deaths can be translated to increased productive years. Assuming that averted deaths for children derive in their full participation in the labor force and taking an average age for maternal deaths of 32, based on the above GDP per capita figures, the economic benefit of the averted deaths under this project is US$528.3 million. Discounting the project's costs, the net economic benefit is US$482 million and the benefit-cost ratio is 11.4 This means that every dollar invested in this project will yield an estimated benefit of US$11.4.

12. It should be noted that health gains calculated using LiST do not yet take into account the impact of investments in quality of care nor does the analysis include the indirect positive externality of demand-side interventions on the services that are not targeted by the project. In other words, the coverage of services that are not targeted by this project was considered to stay constant throughout the life of the project. Thus, the above number should be an underestimation of the health gains that would be attained by higher rates of prevention and treatment of such services. Finally, the improvement in performance of health facilities would also improve the productivity of the underlying investments made by the RGC in the public health system. Further systematic analysis will be undertaken during the project and its proposed impact evaluation to bring out these economic gains with real data emanating from the project and the rest of the health system.

Financial Analysis

13. Cambodia's fiscal outlook is positive and high rates of economic growth are projected to continue over the short and medium term. GDP growth rates are forecasted to oscillate around 7 percent in the

[107] World Health Organization. 2011. *Commission on Macroeconomics in Health*. Geneva: World Health Organization.
[108] World Health Organization. 2015. *Cost-effectiveness Thresholds*.

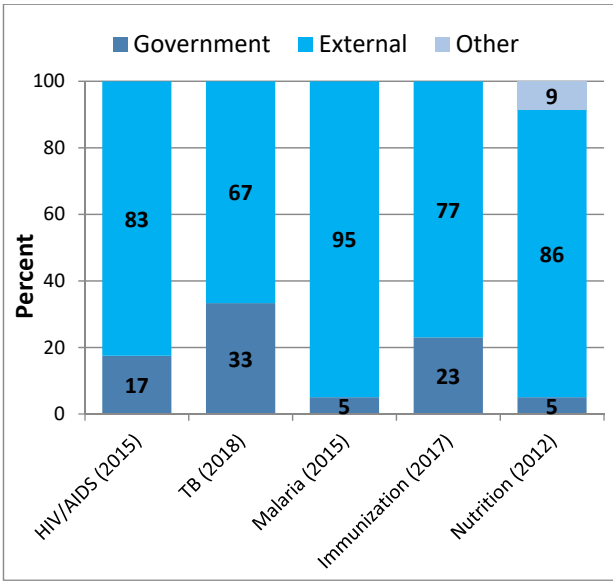
next two years and then decrease to 6 percent in 2022. Despite continuous economic growth, Cambodia faces a fiscal deficit, and this is expected to widen.[109]

14. Pressure to safeguard and increase public spending in the social sector is explained by Cambodia's relative underinvestment in social assistance, education and health,[110] and the growth promoting potential of these investments. Compared to other countries in the region and countries in the same income bracket, Cambodia's public spending in the social sector is low. In health, total health expenditure is relatively high (6–7 percent of GDP) but only 22 percent of total health expenditure is financed by the RGC.[111] The RGC allocates 6.6 percent of the Government's funding to the health sector, which amounts to US$16 per capita, one of the lowest government allocations to the health sector in the region. Increasing total health expenditure has largely been driven by macroeconomic growth and OOP expenditures, rather than shifting prioritization of health in the Government budget. Though efforts have been made to increase the pro-poor nature of supply- and demand-side investments in health, OOP expenditures continue to be high: at an estimated 62–74 percent, OOP as a share of total health expenditure is nearly double the average for low- and middle-income countries (39.4 percent). Relative prioritization of health within Cambodia's national budget has remained constant, with general government health expenditure as a share of GDP constant at 1.3–1.4 percent of GDP over 2010–2014.

15. RMNCAH-N programs and services are heavily dependent on external financing (figure 5.1). The NMCHC subprograms in immunization, reproductive health, and nutrition remain largely donor dependent, and nutrition is the least funded of all NMCHC programs (figure 5.2). However, private for-profit organizations constitute the largest share of total RMNCAH-N spending.

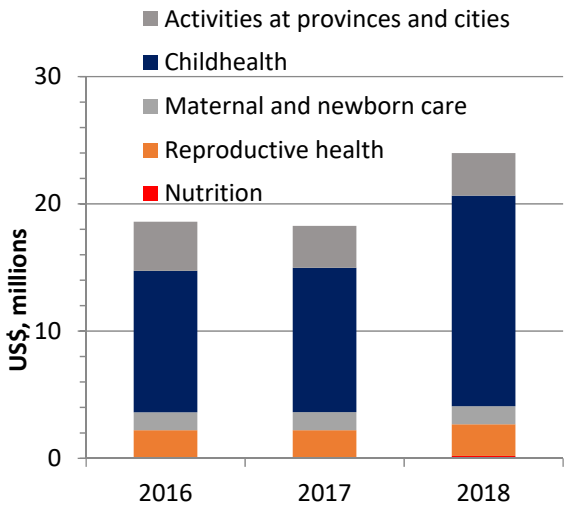
[109] Thus, Article IV recommendations include spending pressure containment and the introduction of a medium-term fiscal framework to promote the sustainability of fiscal policies.
[110] IMF. 2017. *Staff Report*. IMF Country Report No. 17/325.
[111] World Bank. Forthcoming. *Health Financing System Assessment*.

Figure 5.1. Health Spending by Program and Sources (latest available year)



Sources: UNAIDS, Global AIDS Monitoring Database 2018; WHO, World Malaria Report 2017; WHO, World Tuberculosis Report 2018; WHO/UNICEF, JRF, 2018.
Note: 'Other' includes OOP and Health Insurance.

Figure 5.2. Budget for Maternal and Child Health by Subprogram, 2016–2018 (US$, millions)



Source: General Department of Budget, MEF, Budget in Brief for Fiscal Year 2016, 2017, 2018.

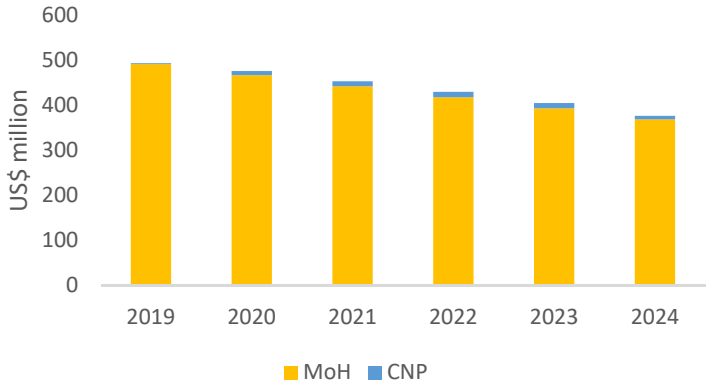
16. Failing to invest in health and nutrition, as described in the previous section, has high economic costs and hinders growth as investments in human development contribute to further accelerating economic growth. Mobilizing additional resources for health and nutrition is therefore critical and key to improve the efficiency, equity, and sustainability of Cambodia's current health financing structure. In the absence of major health financing reforms, economic growth will generate additional financing to the health sector. It is unlikely, however, that these resources will be sufficient to close the salient financing gap.[112] Furthermore, with limited revenue-generating capacity from existing pre-payment schemes, prioritizing Government spending for health and improving the efficiency of public spending constitute Cambodia's best options to mobilize additional resources for health and nutrition. Reducing the reliance on OOP improves the equity and the efficiency of the health financing system. In addition, an increase in public spending in health promotes the sustainability of health and nutrition programs.

17. **The project's financing does not raise fiscal sustainability concerns**. First, with a net present value of US$46.3 million, an average annual disbursement of US$9 million represents less than 2 percent of the actual spending of the MOH in 2018. If health spending increases at a similar pace as total Government spending (no prioritization of health), the project's funding will represent a marginal share of the health sector's budget throughout the project's life (see figure 5.3). Second, the project will not pay for capital investments. This means that the project will not require significant increases in future operational spending and the continuation of the activities financed by the project will not require an exponential increase in public spending. Third, the project's financing will not represent a significant

[112] To advance toward UHC, major investments in human resources for health and infrastructure are required.

increase to the country's foreign debt. It is worth mentioning that the last assessment conducted by the IMF concludes that the risk of debt distress in Cambodia is low, which suggests that small increases in borrowing (72 percent of the project envelop is grant financing) are unlikely to affect the sustainability of Cambodia's fiscal position.[113]

Figure 5.3. Forecasted Project and MOH Funding (net present value)



Source: Authors' own calculations.
Note: Calculations made using a 5 percent discount factor.

[113] IMF. 2017. *Staff Report*. IMF Country Report No. 17/325.