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Report No: PAD4341

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON

A PROPOSED CREDIT IN THE AMOUNT OF EURO 48.6 MILLION
(US$55 MILLION EQUIVALENT)

AND

A GRANT FROM THE GLOBAL FINANCING FACILITY IN SUPPORT OF EVERY WOMAN AND EVERY CHILD IN THE AMOUNT OF US$15 MILLION EQUIVALENT

AND

A GRANT FROM THE AUSTRALIA-WORLD BANK PARTNERSHIP FOR PROMOTING INCLUSION, SUSTAINABILITY AND EQUALITY IN CAMBODIA SINGLE DONOR TRUST FUND IN THE AMOUNT OF US$19 MILLION EQUIVALENT

TO THE
KINGDOM OF CAMBODIA

FOR A

HEALTH EQUITY AND QUALITY IMPROVEMENT PROJECT - PHASE 2

February 15, 2022

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

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CURRENCY EQUIVALENTS

(Exchange Rate Effective December 31, 2021)

Currency Unit =	Cambodian Riel (KHR)
KHR 4,066.03 =	US$1
US$1 =	EUR 0.8835
US$1 =	AUD 1.38

FISCAL YEAR
January 1 - December 31

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care	**JICA**	Japan International Cooperation Agency
ACM	Asbestos Containing Material	**KfW**	German Development Bank (*Kreditanstalt für Wiederaufbau)*
AOP	Annual Operational Plan	**KOFIH**	Korea Foundation for International Healthcare
BETF	Bank Executed Trust Fund	**KOICA**	Korean International Cooperation Agency
CCS&T	Cervical Cancer Screening and Treatment	**MCH**	Maternal and Child Health
CERC	Contingent Emergency Response Component	**M&E**	Monitoring and Evaluation
CHE	Current Health Expenditure	**MDG**	Millennium Development Goal
CNP	Cambodia Nutrition Project	**MDTF**	Multi-Donor Trust Fund
COVID-19	Coronavirus Disease-19	**MEF**	Ministry of Economy and Finance
CPA	Complementary Package of Activities	**MOH**	Ministry of Health
CPF	Country Partnership Framework	**MOP**	Ministry of Planning
DA	Designated Account	**MPA**	Minimum Package of Activities
DALY	Disability Adjusted Life Year	**MTR**	Midterm Review
DBF	Department of Budget and Finance	**NAPA**	National Adaptation Program of Action
D&D	Decentralization and De-concentration	**NBC**	National Bank of Cambodia
DFAT	Australia's Department of Foreign Affairs and Trade	**NBTC**	National Blood Transfusion Center
DHS&T	Diabetes and Hypertension Screening and Treatment	**NCD**	Non-Communicable Disease
DLI	Disbursement Linked Indicator	**NCDDS**	National Committee for Sub-national Democratic Development Secretariate
DP	Development Partner	**NGO**	Non-Governmental Organization
DPHI	Department of Planning and Health Information	**NQEMP**	National Quality Enhancement Monitoring Process
EMR	Electronic Medical Record	**NQEMT**	National Quality Enhancement Monitoring Tool
ESCP	Environmental and Social Commitment Plan	**NSDP**	National Strategic Development Plan
ESF	Environmental and Social Framework	**NSPC**	National Social Protection Council
ESMF	Environmental and Social Management Framework	**NSSF**	National Social Security Funds
ESRS	Environmental and Social Review Summary	**OD**	Operational District
ESS	Environmental and Social Standards	**OD-IDPoor**	On-demand-IDPoor
FHI360	Family Health International's 360	**OOP**	Out of Pocket
FM	Financial Management	**OPD**	Outpatient Department
GAP	Gender Action Plan	**PBC**	Performance-Based Condition

GBV	Gender-Based Violence	**PCA**	Payment Certification Agency
GDP	Gross Domestic Product	**PDO**	Project Development Objective
GESI	Gender Equality and Social Inclusion	**PFM**	Public Financial Management
GFF	Global Financing Facility	**PF Partner**	Pooled Fund Partners
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit	**PH**	Provincial Hospital
GMAG	Gender Mainstreaming Action Group	**PHD**	Provincial Health Department
GMAP	Gender Mainstreaming Policy and Strategic Plan	**PMD**	Preventive Medicine Department
GNI	Gross National Income	**PMRS**	Patient Management and Registration System
GRS	Grievance Redress Service	**PNC**	Postnatal Care
HC	Health Center	**POM**	Project Operational Manual
HCMC	Health Center Management Committee	**PPSD**	Project Procurement Strategy for Development
HCW	Health Care Waste	**QAO**	Quality Assurance Office
HCWM	Health Care Waste Management	**QEWG**	Quality Enhancement Working Group
HEF	Health Equity Fund	**QIWG**	Quality Improvement Working Group
HEIS	Hands-on Enhanced Implementation Support	**RGC**	Royal Government of Cambodia
H-EQIP	Health Equity and Quality Improvement Project	**RH**	Referral Hospital
H-EQIP II	Health Equity and Quality Improvement Project-Phase 2	**SDG**	Service Delivery Grant
HF	Health Facility	**SDTF**	Single Donor Trust Fund
HMIS	Health Management Information System	**SEP**	Stakeholder Engagement Plan
HSP-4	Fourth Health Strategic Plan (2021-2030)	**UHC**	Universal Health Coverage
IAD	Internal Audit Department	**UNFPA**	United Nations Population Fund
ICT	Information Communication Technology	**UNICEF**	United Nations Children's Fund
IEC	Information, Education, and Communication	**USAID**	United States Agency for International Development
IPC	Infection Prevention and Control	**VAC**	Violence Against Children
IPD	Inpatient Department	**VHSG**	Village Health Support Group
IPF	Investment Project Financing	**WBG**	World Bank Group
ISAF	Implementation of Social Accountability Framework	**WHO**	World Health Organization

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DATASHEET

BASIC INFORMATION

Country(ies)	Project Name	
Cambodia	Health Equity and Quality Improvement Project - Phase 2	
Project ID	Financing Instrument	Environmental and Social Risk Classification
P173368	Investment Project Financing	Substantial

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[√] Contingent Emergency Response Component (CERC)
[ ] Series of Projects (SOP)	[ ] Fragile State(s)
[√] Performance-Based Conditions (PBCs)	[ ] 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)	[ ] Hands-on Enhanced Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
10-Mar-2022	31-Dec-2027

Bank/IFC Collaboration
No

Proposed Development Objective(s)

The PDO is to improve equitable utilization of quality health services in Cambodia, especially for the poor and vulnerable populations, and to provide immediate and effective response in case of an Eligible Crisis or Emergency in the Kingdom of Cambodia.

Components

Component Name	Cost (US$, millions)
Component 1: Improving Financial Protection and Utilization of Health Equity Fund	112.00
Component 2: Strengthening Quality and Capacity of Health Service Delivery	183.30
Component 3: Project Management, Monitoring & Evaluation, Gender Equality and Social Inclusion	3.70
Component 4: Contingent Emergency Response	0.00

Organizations

Borrower:	Kingdom of Cambodia
Implementing Agency:	Ministry of Health

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	299.00
Total Financing	275.00
of which IBRD/IDA	55.00
Financing Gap	24.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	55.00
IDA Credit	55.00

Non-World Bank Group Financing

Counterpart Funding	186.00
Borrower/Recipient	186.00
Trust Funds	34.00
Global Financing Facility	15.00

Miscellaneous 1	19.00

IDA Resources (in US$, Millions)

	Credit Amount	Grant Amount	Guarantee Amount	Total Amount
Cambodia	55.00	0.00	0.00	55.00
National PBA	55.00	0.00	0.00	55.00
Total	**55.00**	**0.00**	**0.00**	**55.00**

Expected Disbursements (in US$, Millions)

WB Fiscal Year	2022	2023	2024	2025	2026	2027	2028
Annual	0.00	7.00	9.00	9.00	11.00	11.00	8.00
Cumulative	0.00	7.00	16.00	25.00	36.00	47.00	55.00

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

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial

7. Environment and Social	Substantial
8. Stakeholders	Moderate
9. Other	Moderate
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

Environmental and Social Standards Relevance Given its Context at the Time of Appraisal

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Relevant
Cultural Heritage	Not Currently Relevant
Financial Intermediaries	Not Currently Relevant

NOTE: For further information regarding the World Bank's due diligence assessment of the Project's potential environmental and social risks and impacts, please refer to the Project's Appraisal Environmental and Social Review Summary (ESRS).

Legal Covenants

Sections and Description
Institutional Arrangements
Financing Agreement: Schedule 2, Section I.A and Grant Agreement: Schedule 2, Section I
Recurrent, Continuous

The Recipient shall maintain, throughout the Project implementation period, (i) a Project steering committee, (ii) a Project implementation team appointed with a Project director and two Project managers, and (iii) a Quality Improvement Working Group; all with composition, functions, staffing and resources satisfactory to the Association and set out in the Project Operational Manual.

The Recipient shall recruit an environmental consultant and a social development consultant; all with experience, qualifications, and terms of reference satisfactory to the Association not later than 90 days after Effective Date

Sections and Description
Project Operational Manual
Financing Agreement: Schedule 2, Section I.B and Grant Agreement: Schedule 2, Section I
Recurrent, Continuous

The Recipient shall carry out the Project in accordance with the Project Operational Manual, and not amend, abrogate or waive any provisions of the manual unless the Association agrees otherwise in writing.

Sections and Description
Annual Operational Plans
Financing Agreement: Schedule 2, Section I.C and Grant Agreement: Schedule 2, Section I
Recurrent, Annual

The Recipient shall prepare and furnish to the Association no later than November 30 of each year, an annual operational plan containing relevant Project activities and expenditures proposed to be included in the Project in the following fiscal year, in a manner and substance satisfactory to the Association, except for the first annual operational plan, which shall be furnished not later than one (1) month after the Effective Date, and thereafter implement the activities under the Project during the relevant fiscal year in accordance with such plan.

Sections and Description
SDGs and HEF Grants
Financing Agreement: Schedule 2, Section I.D and Grant Agreement: Schedule 2, Section I
Recurrent, Continuous

The Recipient shall provide the SDGs and HEF Grants in accordance with the SDG Operational Manual and HEF Operational Manual, which are part of the Project Operational Manual.

Sections and Description
Environmental and Social Standards
Financing Agreement: Schedule 2, Section I.F and Grant Agreement: Schedule 2, Section I
Recurrent, Continuous

The Recipient shall (i) ensure that the Project is carried out in accordance with the Environmental and Social Standards and the ESCP (including the management tools and instruments referred to therein) in a manner acceptable to the Association, and (ii) not amend, repeal, suspend or waive the ESCP, or any provision thereof, unless the Association agrees otherwise, and report on their status of implementation as part of the project reports.

Sections and Description
PBC Monitoring and Reporting
Financing Agreement: Schedule 2, Section I.E and Grant Agreement: Schedule 2, Section I
Recurrent, Continuous/ Due date: July 31 and January 31 of Year 1, January 31 of Years 2-4, and July 31 of Year 5
The Recipient shall furnish reports to the Association on the status of achievement of the relevant PBC Targets.

Sections and Description

Contingent Emergency Response
Financing Agreement: Schedule 2, Section I.G

In case of an Eligible Crisis or Emergency
The Recipient shall (i) adopt a CERC Manual for implementation of Part 4 of the Project and prepare and adopt an Emergency Action Plan; both in form and substance acceptable to the Association and ensure that the activities under the said part are carried out in accordance with such manual and plan and all relevant safeguard instruments; and (iii) not amend, suspend, abrogate, repeal or waive any provisions of the manual unless the Association agrees otherwise in writing.

Sections and Description
Mid-term Review
Financing Agreement: Schedule 2, Section II.B and Grant Agreement: Schedule 2, Section I
Once, by December 31, 2024

The Recipient shall carry out with the Association a mid-term review, and not less than 60 days prior to the commencement of the mid-term review, prepare and furnish to the Association a mid-term report in such details that the Association shall reasonably request.

Sections and Description
Co-financing Deadline
Financing Agreement: Article IV
The deadline for the effectiveness of the grant agreement between the Recipient and the Association, acting as administrator of the Cambodia Health Equity and Quality Improvement Program Multi Donor Trust Fund for the Project is December 31, 2022.

Conditions

Type	Financing source	Description
Effectiveness	Trust Funds	Financing Agreement: Article V (i) The Grant Agreement has been executed and delivered and all conditions precedent to its effectiveness have been fulfilled; and (ii) The Project Operational Manual has been duly adopted by the Recipient. Grant Agreement for the grants funded by Multi-Donor Trust Fund for the Global Financing Facility in Support of Every Woman and Every Child and Australia-World Bank Partnership for Promoting Inclusion, Sustainability and Equality in Cambodia Single Donor Trust Fund: Article IV (i) The execution and delivery of the Grant Agreement has been duly authorized by all necessary actions and delivered on behalf of

		the Recipient (ii) The Financing Agreement has been executed and delivered and all conditions precedent to its effectiveness have been fulfilled; and (iii) The Project Operational Manual has been duly adopted by the Recipient.
Type Disbursement	Financing source IBRD/IDA	Description Financing Agreement: Section III.B.1(c) The Recipient may not withdraw the proceeds of the Financing as allocated for Emergency Expenditures, unless and until: (i) (A) the Recipient has determined that an Eligible Crisis or Emergency has occurred, and has furnished to the Association a request to withdraw Financing amounts under Category (5); and (B) the Association has agreed with such determination, accepted said request and notified the Recipient thereof; and (ii) the Recipient has adopted the CERC Manual and Emergency Action Plan, in form and substance acceptable to the Association.
Type Disbursement	Financing source Trust Funds	Description Financing Agreement: Section III.B.1(b)/ Grant Agreement: Schedule 2, Section II.B.1(b) (i) The Recipient may not withdraw the proceeds of the Financing/Grant as allocated for PBC Expenditures, unless and until the Recipient has: (ii) furnished evidence satisfactory to the Association that the Recipient has achieved the respective PBC Targets; and (iii) complied with the Disbursement and Financial Information Letter, including furnished to the Association the applicable interim unaudited financial reports documenting the incurrence of PBC Expenditures during the respective PBC period up.

I. STRATEGIC CONTEXT

A. Country Context

1. **Over the past two decades, Cambodia has undergone significant economic transition, reaching lower-middle-income status in 2015 with its per capita gross national income (GNI) reaching US$1,060.**[1] With a total population of approximately 16 million in 2021, the economy was growing rapidly, driven by agriculture, ready-made garments, tourism, and, more recently, construction. The annual average growth rate of 7.6 percent between 1995 and 2019 ranked Cambodia among the top seven fastest-growing economies in the world during this period. As a result, Cambodia's GNI per capita (Atlas method, current US dollars) increased from US$250 in 1995 to US$1,530 in 2019. Nevertheless, the country's external competitiveness eroded, partly caused by rapidly rising wages—made worse by a dollarized economy—and exacerbated by challenges in doing business and investment climate reforms. With an aspiration to become an upper-middle-income country by 2030, Cambodia needs to diversify its growth drivers while strengthening the existing ones.

2. **The continuous high economic growth has led to dramatically reduced monetary poverty. Poverty rates continue to vary considerably by area of residence and region.** Nearly 1 in 5 Cambodians live in poverty. About 17.8 percent of the population lived below the national poverty line in 2019/20. Poverty rates vary considerably by area of residence and region. Poverty is twice as prevalent in rural areas than in urban areas (22.8 vs. 9.6 percent). About 80 percent of the poor live in rural areas, making poverty largely a rural phenomenon in Cambodia. Around 2.4 million people remain near-poor, but Cambodia has few social safety nets or social assistance to mitigate the negative welfare impacts of shocks on vulnerable households. Further, although labor income was the main driver of poverty reduction, most of the poor have low-paying jobs, signaling that low skills and productivity remain a big challenge.

3. **Although the coronavirus disease-19 (COVID-19) pandemic has caused sharp decelerations in Cambodia's main engines of growth, Cambodia's economy has gradually recovered after contracting by 3.1 percent in 2020.** In 2020, the three most affected sectors (tourism, manufacturing exports, and construction) contributed to more than 70.0 percent of growth and 39.4 percent of total paid employment in 2019. Cambodia's growth model—characterized by a narrow export base with a high degree of concentration of products and markets—exhibited weaknesses years even before the pandemic hit.

4. **The growth projection for 2021 reaches 2.2 percent, despite strong export performance supported by improved external demand conditions.** While relying on social distancing measures to quell the current outbreak, the Government has also stepped up its vaccination program, and coverage is now the second highest in Southeast Asia. However, risks of further disruptions remain, given the removal of quarantine requirements for fully vaccinated travelers and the limited capacity for intensive care in the health system. The experience with and continued vulnerability to disasters because of floods and droughts and those caused by climate change could have a negative impact on its economy. For example, during the 20-year period, from 1987 to 2007, a succession of droughts and floods resulted in significant loss of life and considerable economic cost. With a coastal region on the Gulf of Thailand, Cambodia is one of the more disaster-prone countries in Southeast Asia, affected by floods and droughts on a seasonal basis. Furthermore, high credit growth and concentration of

[1] GNI per capita, Atlas method (current US dollars).

domestic credit in the construction and real estate sector remain key risks to Cambodia's financial stability.

5. **The country's persistently slow progress on human capital development also poses a substantial risk to economic development.** A Cambodian girl born today will only be 49 percent as productive when she grows up as if she had received a complete education and was in full health.[2] The lack of access to quality education and health services, especially in remote and rural areas, and high levels of stunting among under-five children are significant remaining challenges hindering human capital development. The country's Human Development Index is lower than the average for the East Asia and Pacific region and slightly higher than the average for lower-middle-income countries.

6. **Despite considerable progress in improving gender equality and women's empowerment, Cambodia's Gender Development Index indicates medium-to-low equality between women and men (0.919 in 2018).** The Gender Inequality Index was only at 0.474 in 2019, ranking Cambodia at 114 out of the 162 countries. Despite women's significant contribution to the economy, social norms still hinder their assuming leadership positions. In the health sector alone, for example, less than 15 percent of leadership roles in the Ministry of Health (MOH) are occupied by women, even though women make up over half of the health workforce. There is also a gender gap in trained health professionals. While some enabling legislation and policies exist, they are inadequately implemented due to limited political will and institutional weaknesses. Furthermore, gender-based violence (GBV) remains a serious issue.

7. **The ongoing decentralization and de-concentration (D&D) reforms in the country have profound implications for the way in which health services are financed, managed, and delivered.** These D&D reforms in the health sector were accelerated by the launch of Sub-decree 193 on 'Decentralization of Health Management Functions and Service Delivery to the Capital and Province Administration' in December 2019. This sub-decree shifts the responsibility of health service delivery implementation and management away from the central ministries to the provincial- and district-level authorities. This shift will require a transformation of the central ministries including the MOH, to take on more of a stewardship role with a focus on policy making, setting monitoring standards, and providing technical support to sub-national levels. The sub-national levels—provincial- and district-level authorities—are to carry out planning and budgeting, financial management (FM), health service administration, human resource management, procurement, and civil works. This reform process is an opportunity to strengthen community participation and social accountability for health in the country and promote gender equality and social inclusion (GESI) across the health sector but will require substantial new skills at the sub-national level.

B. Sectoral and Institutional Context

Health Outcomes

8. **Alongside the sustained economic growth, Cambodia has seen steady improvements in health outcomes in recent decades achieving most of the health-related Millennium Development Goals (MDGs)**. Life expectancy at birth rose from 58 years in 2000 to 70 years in 2020. Maternal and infant mortality have significantly improved. The maternal mortality ratio decreased from 351 deaths per 100,000 live births in 2005

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[2] World Bank Group. 2020. 2020. *Human Capital Index: Cambodia Country Brief.* https://databank.worldbank.orsg/data/download/hci/HCI_2pager_KHM.pdf. *Retrieved on November 5, 2020.*

to 160 in 2017. Childhood immunization coverage has expanded with 81 percent of children ages 12–23 months immunized against measles in 2016 compared to 52 percent in 2002, which has contributed to a steep decline in infant and under-five mortality rates, dropping from 78.1 deaths in 2000 to 22.8 deaths in 2019 per 1,000 live births and 106.3 deaths in 2000 to 26.6 deaths in 2019 per 1,000 live births, respectively.[3]

9. **Notwithstanding these achievements, access to quality health care remains problematic, particularly for the poor and vulnerable groups, and has deteriorated further due to COVID-19.** Nearly 32 percent of under-five children are stunted[4] which is associated with an increased risk of communicable and non-communicable diseases (NCDs) in adulthood. The adolescent pregnancy rate is 12 percent and neonatal mortality rate at 18 deaths per 1,000 live births— both considered high compared to other countries in the region and indicating unfinished MDGs agenda. Also, inequalities persist in health service utilization and outcome by socioeconomic status, geographic region, between urban and rural population as well as by ethnic minority and indigenous people who are concentrated in the five north-east provinces of Mondul Kiri, Ratanak Kiri, Preah Vihear, Stung Treng, and Kratie. All these five provinces have large numbers of ethnic minorities and indigenous people whose mother-tongue is not Khmer, and who tend to marry earlier and have more children. Female literacy rates are also below the national average in each of these provinces (Census, 2019). Regressive social determinants along with poor health coverage are factors that lead to low utilization and poor health outcomes. Despite the national share of fully immunized children increasing from 39.9 percent in 2000 to 73.4 percent in 2014 and institutional delivery rates from 9.9 percent to 83.2 percent (table 1), socioeconomic and regional disparities remain with two-fold differences in full immunization rates and institutional delivery rates and four-fold differences in the rates of appropriate treatment for diarrhea across regions. The childhood immunization and institutional delivery rates also highlights critical disparities across income levels in essential health services.

Table 1. Utilization of Key Health Services

	National Estimates For		**Regional Differences 2014 estimates for**		**Wealth Quintile**	
	2000	**2014**	**(Region) with lowest utilization**	**(Region) with highest utilization**	**Poorest**	**Richest**
Percentage of children 12-23 months who had received all 8 basic vaccinations	39.9	73.4	56.8 (Kampong Cham)	91.3 (Banteay Meanchey)	60.9	90.5
Percentage of children with diarrhea who were treated appropriately	19.9	35.2	20.2 (Kratie)	77.2 (Kampong Chhnang)	39.8	26.7
Modern contraceptive prevalence rate among married women	18.8	38.8	27.6 (Kampong Cham)	51.0 (Banteay Meanchey)	39.6	34.6
At least 4 antenatal visits during pregnancy	8.9	75.6				
Institutional delivery	9.9	83.2	46.3 (Kratie)	95.9 (Phnom Penh)	68.4	95.9

[3] Estimates developed by the United Nations Inter-Agency Group for Child Mortality Estimation (United Nations Children's Fund [UNICEF], World Health Organization (WHO), World Bank, and United Nations Department of Economic and Social Affairs [UNDESA] Population Division). https://data.worldbank.org/indicator/SH.DYN.MORT.MA.

[4] Short for age indicating chronic undernutrition. Estimates developed by the United Nations Inter-Agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, and UN DESA Population Division).

Source: 2000 and 2014 Cambodia Demographic and Health Surveys.
Note: a. Percentage of children born in the five (or three) years preceding the survey with diarrhea in the two weeks preceding the survey who received either oral rehydration solution or recommended home fluids.

10. **Although Cambodia has successfully contained local transmission of COVID-19, the capacity of the public health sector to respond to larger outbreaks and maintain routine health services is a cause for concern, and the disruption of essential health services is evident.** Based on a preliminary analysis of routine Health Management Information System (HMIS) data, Cambodia has experienced persistent disruptions in the utilization of essential health services during the pandemic. Most significant disruptions were seen in inpatient and outpatient consultations, especially for children under five, antenatal visits, postnatal visits, and measles vaccination (table 2). Cambodia risks losing its hard-earned gains in maternal and under-five survival if the decreases in utilization of essential health services due to patients fear of COVID-19 are not mitigated while ensuring that vulnerable populations are specially protected.

Table 2. Percentage Change in Quarterly Utilization of Essential Health Services during the COVID-19 Pandemic Compared to Quarterly Utilization Seen in the Same Quarter(s) Pre-Pandemic

		Changes in Quarterly visits/Users/Vaccine Uptake (in percent)												
		OPD Visits	OPD Visits Children<5	IPD Visits	IPD Visits Children < 5	Deliveries	PNC2 visits	PNC4 visits	ANC2 visits	ANC4 visits	Current Users of Modern FP	DPHT-HepB3	MR9	M18-Measles
2020	Q2	-10	-23	-33	-55	5	0	25	1	-2	-2	15	4	3
2020	Q3	-7	-14	-26	-48	7	-3	-3	-2	-9	0	16	3	-7
2020	Q4	-3	-5	-11	-25	5	-8	-8	-11	-12	-1	2	-9	-12
2021	Q1	-8	-7	-17	-22	-5	-20	-11	-10	-15	-3	8	4	-5
2021	Q2	-25	-33	-54	-70	-8	-25	-9	-16	-22	-5	4	-4	-14

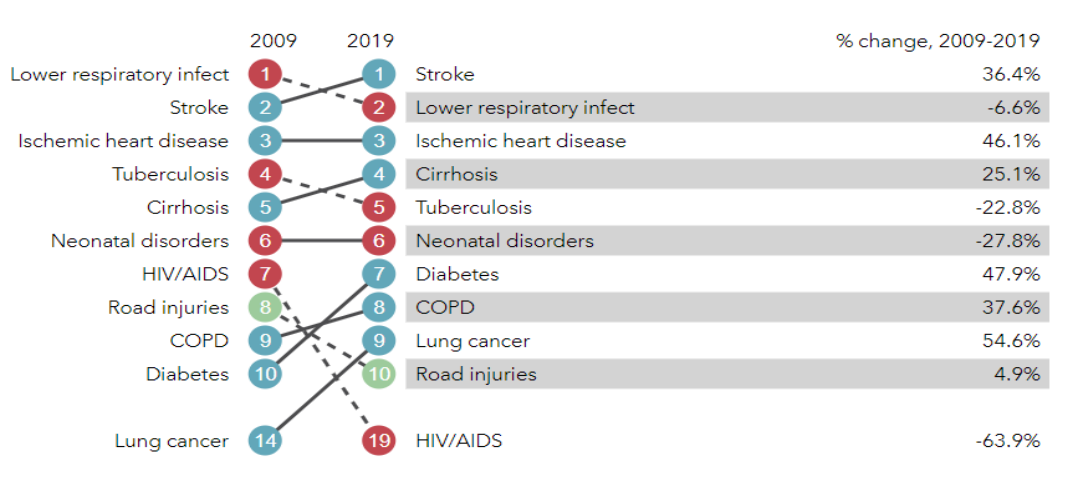
Source: HMIS, with collaboration from Department of Planning and Health Information (DPHI) colleagues who provided the World Bank task team with monthly data, from January 2019 to June 2021. Data analysis by task team.
Note: ANC = Antenatal Care; DPHT-HepB3 = third dose of Diphtheria-Pertussis-Hepatitis-Tetanus-Hepatitis B vaccination; FP = Family Planning; IPD= Inpatient Department; M18= second dose of measles vaccination at 18 months; MR9 = first dose of measles vaccination at 9 months; OPD = Outpatient Department; PNC = Postnatal Care.
Discussions for more robust support on monitoring disruptions to essential services are currently under way, and the project document will be updated once the new analysis is completed.

11. **Cambodia is undergoing an epidemiological transition resulting in the double burden of communicable diseases and NCDs, with the latter accounting for a larger and increasing share.** Between 2009 and -2019, the share of NCDs increasing significantly, with diabetes and ischemic health diseases increased by almost 50 percent, while the share of communicable diseases and injuries decreased relatively (figure 1).[5] Furthermore, the share of deaths attributed to NCDs increased from 33 percent in 2000 to a high 64 percent in 2018.[6] Stroke and ischaemic heart disease are among the top killers, and cancer is becoming increasingly an important cause of mortality. It has been estimated that the annual health care costs and productivity losses related to NCDs in

[5] Institute of Health Metrics and Evaluation. 2019. *Country Profile of Cambodia. Global Burden of Disease.*
[6] WHO. 2018. *Noncommunicable Diseases Country Profiles.* Geneva: WHO.

Cambodia amounts to US$1.5 billion (6.6 percent of gross domestic product [GDP]).[7] The financial burden on households is also considerable in 2014, households with at least one member with an NCD were three times more likely to incur catastrophic health expenditures compared to other households.[8] The long-term health care cost of NCDs, loss of income, and added care burden on women as the primary care-giver in the family mean that NCDs have a disproportionate impact on the vulnerable, make household poverty worse, and undermine poverty reduction efforts. Despite the societal and individual impact of NCDs, as well as the rising prevalence, spending on NCDs accounted for only 21 percent of total health expenditure in 2016 despite accounting for 60 percent of the total burden of disease. Investment in NCD control in Cambodia is far from sufficient to address the burden of disease and the economic impact on society and financial burden on households.

Figure 1. Top 10 Causes of Total Number of Deaths in 2019 and Percent Change 2009–2019, All Ages Combined



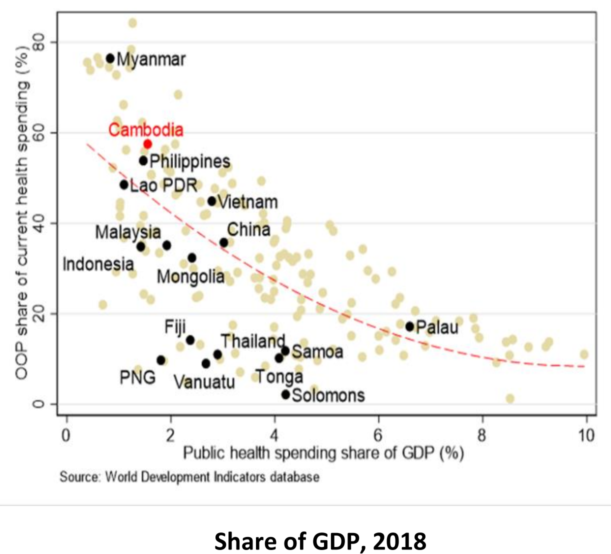
Source: Institute for Health Metrics and Evaluation (IHME), University of Washington, 2021. Available from http://www.healthdata.org/

[7] Kulikov, A., et al. 2019 *Prevention and Control of Noncommunicable Diseases in Cambodia: The Case for Investment.* Manila: WHO Western Pacific Regional Office.
[8] Jacobs, B, R. de Groot, and A. Fernandes Antunes. 2016. “Financial Access to Health Care for Older People in Cambodia: 10-Year Trends (2004- 2014) and Determinants of Catastrophic Health Expenses.” *International Journal for Equity in Health* 15: 94.

Health Financing

12. **Out of-pocket (OOP) expenditure remains high in Cambodia.** Impressive progress has been made in providing financing protections for health services including the Health Equity Funds (HEF) for the Poor, voucher systems, and social health insurance schemes for the formal sectors. In addition, the national budget for health has increased significantly over time, increased from US$199.3 million in 2012 to US$365 million in 2019, constituting an 83 percent increase.[9] Despite this noteworthy increase, government spending remains low in relative terms, accounting for only 23.8 percent of current health expenditure (CHE) and roughly 1.5 percent of GDP. In 2017, CHE was approximately US$1.3 billion, corresponding to 6.1 percent of GDP and US$82 per capita. Donors accounted for only 16.6 percent of CHE in 2016, a slight increase since 2010.[10] OOP expenditures still make up 60 percent of total health expenditures (figure 2), which is a serious impediment to the country's progress towards universal health coverage (UHC). Nearly 80 percent of OOP expenditure was spent on private clinics or emergency care. High OOP places a considerable financial burden on households, with 15.3 percent of households experiencing catastrophic health expenditure (more than 10 percent of total household expenditure) in 2014.[11] Approximately 3.7 percent of households were pushed into poverty due to high health spending in 2017.[12] More specifically women-headed households were at higher risk, with 18.4 percent, exceeding the 10.0 percent threshold for catastrophic spending, compared to 14.8 percent of male-headed households.[13]

Figure 2. OOP versus Public Health Expenditure as



Share of GDP, 2018

13. **The RGC has established HEF as one of the social health insurance schemes to reduce financial barriers to health service utilization by the poor.** Introduced in 2000 through a non-governmental organization (NGO)-run pilot, this program is now a government-owned, nationwide social health protection and health financing scheme managed by the MOH,[14] covering 21.3 percent of the total population in 2020. A recent study that used

[9] MOH, WHO. 2019. *Cambodia National Health Accounts (2012-2016): Health Expenditure Report.* Manila: WHO Regional Office for the Western Pacific.
[10] Additionally, there has been a considerable injection of funds to respond to COVID-19 in 2020.
[11] WHO. *2019 Global Monitoring Report on Financial Protection in Health*.
[12] Using the poverty line based on US$ 1.9 per capita per day. Source: World Bank. 2020. *Cambodia Health Financing Systems Assessment.*
[13] CSES 2017.
[14] HEF was scaled up nationally to cover all sub-national public health facilities (HFs) by 2015 and to all national level health facilities by 2018.

HEF rollout data between 2004 and 2013,[15] showed that the program was associated with a significant increase in care seeking in both hospitals and health centers (HCs): inpatient cases increased by 47.9 percent, outpatient cases increased by 24.1 percent, and deliveries increased by 31.4 percent in hospitals and by 5.3 percent in HCs. In 2019, annual outpatient service utilization for the HEF beneficiaries was 1.07 per capita while it was 0.67 for the general population.

14. **While overall utilization has increased, there are persistent implementation bottlenecks resulting in poor HEF utilization in approximately 39 operational districts (ODs) in 14 provinces (see annex 4)**. In addition to low awareness of HEF, supply side barriers include poor geographical access to services, related transportation costs, and gaps in the availability of drugs in public HCs. Poor attitudes and interpersonal skills of some health staff also discourage HEF utilization by marginalized populations including people with disability; old people and non-Khmer speakers; and those who break traditional norms, such as, girls and women who become pregnant outside marriage, and people with a non-conforming sexual and gender identities.

15. **The National Social Security Fund (NSSF) is another major health insurance provider in the country managed by the Ministry of Labour and Vocational Training**. The NSSF covers civil servants (around 4.3 percent of the total population) and workers in the formal sector (11 percent of the total population) but not their dependents. In 2018, the NSSF started a program to expand the coverage to the informal sector, but slow progress has been made. The three NSSF schemes plus HEF for the poor cover approximately 39.5 percent of the total population[16] but leave the majority of the informal sector and the near poor without any financial protection who have to pay out of pocket for health services. In addition, the tariffs, benefit package, and service coverage for the NSSF are all much better than that for HEF, resulting in favouring the NSSF over HEF beneficiaries at the point of care, which indicate the suboptimal financial protection of HEF compared with the NSSF schemes. The higher reimbursement rate under the NSSF may discourage from providing the same quality of services to the HEF beneficiaries. There is potential for significant quality improvement and efficiency gains by (a) harmonizing financial incentives and performance assessments of health providers, (b) quality monitoring and payment certification by a single agency across these two major programs, and (c) pooling the risk to provide a higher level of risk protection. A joint effort by the Ministry of Economy and Finance (MEF) and line ministries in 2015, led to the development of a National Social Protection Framework, which includes social health protection and health insurance. The Cambodian Social Health Insurance Program will benefit from harmonization of incentives for health providers across major social health insurance schemes. The National Social Protection Council (NSPC) has developed a long-term vision of establishing universal health insurance coverage, consolidating the four existing health insurance schemes with the NSSF as the single operator. A roadmap to achieve this vision is under development.

Service Delivery

16. **Cambodia has a well-established public health service delivery system including those at national,**

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[15] Annear, P.L., J.T. Lee, Khim, Ir, E. Moscoe, T Jordanwood, T. Bossert, M. Nachtnebel, and V.Lo. 2019. "Protecting the Poor? Impact of the National Health Equity Fund on Utilization of Government Health Services in Cambodia, 2006 -2013." *BMJ Global Health 4(6).*
[16] Annual Health Congress Report 2021.

provincial, OD, [17] **and community levels,** providing both outpatient and inpatient curative care.[18] In the public health sector, each OD has HCs serving about 10,000 to 20,000 people and providing first line health services (minimum package of activities [MPA][19]) and at least one referral hospital (RH) providing second-line health services (complementary package of activities [CPA][20]). The CPA is classified into three categories, namely CPA-1, CPA-2, and CPA-3, based on the number and composition of staff, number of beds, standard drug kit, standard medical equipment, and clinical activities performed. CPA-1 hospitals have 40–60 beds, provide no surgical services and have no blood bank, often because of their proximity to provincial or national hospitals. CPA-2 hospitals (60–100 beds) provide surgical services, and CPA-3 (100–250 beds) is reserved for provincial and national hospitals that have a wide range of specialized health services. In 2020, there were 103 ODs with 1,376 public HFs including nine national hospitals in large cities, 24 provincial and 94 RHs, and 1,250 HCs (including 1,182 HCs without beds and 68 HCs with beds). Each province (24) and the one municipality (Phnom Penh) have a health department.

17. **These public HFs face the challenges of capacity constraints and low utilization, especially for outpatient services**. People visit private practitioners and clinics more for curative care and visit public sector for preventive activities such as immunization or communicable disease testing and treatment for tuberculosis and human immunodeficiency virus/AIDS. Only 16 percent of ill or injured patients currently seek care first in the public sector, while 43 percent sought care for their last concern at private providers.[21] The National Health Account report, jointly produced by the MOH and WHO, revealed that 80 percent of the OOP expenditure was for outpatient services in private clinics. The sub-optimal condition of facilities; outdated equipment; unstable supply of drugs; unfriendly attitude of some health workers; and limited-service capacity (for example, no NCD services provided in most of HCs) are the identified contributing factors to underutilization of public service providers.

18. **The service delivery system in Cambodia is not set up to enable an effective response to tackle rising NCDs.** The current system is better suited for addressing maternal and child health (MCH) conditions, vaccinations, and communicable diseases, but it does not provide effective services and less well suited for the treatment and management of NCDs, which requires stronger emphasis on health promotion and continuum of care of those with chronic illness. In 2016, 43 percent of Cambodians ages 18–69 never had their blood pressure checked, while 72 percent previously diagnosed with high blood pressure were not on medication. Currently, Cambodia has limited public HFs that provide NCDs prevention or treatment services. To date, of the 1,250 HCs in the country, only about 200 HCs have received training on NCD screening and case management, with the support of the Health Equity and Quality Improvement Project (H-EQIP)[22] and a few other development partners (DPs). According to the WHO Cambodia office, the overall NCD screening rate in the country is around 1 percent of the target population. Continuum of care and ongoing management of NCDs barely exist throughout the

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[17] The operational health district is the lowest organizational level in the Cambodian health system, providing services through HCs and a single RH.
[18] Asia Pacific Observatory on Health Systems and Policies. 2015. "The Kingdom of Cambodia Health System Review." *Health Systems in Transition* 5 (2) WHO Regional Office for the Western Pacific
[19] MPA is the package of services that should be provided by HCs.
[20] The services that should be provided at the different levels of hospitals have been defined in a CPA (except for national hospitals). A CPA-1 hospital is a small district hospital without major surgical services; a CPA-2 hospital is a larger district hospital with major surgical services; and a CPA-3 hospital is the equivalent of a provincial hospital (PH), which acts as a secondary referral facility.
[21] Cambodia Socio-Economic Survey 2014. Phnom Penh: National Institute of Statistics, Ministry of Planning; 2015
[22] World Bank. 2016. Cambodia - Health Equity and Quality Improvement Project. Washington, DC: World Bank Group. *https://hubs.worldbank.org/docs/imagebank/Pages/docProfile.aspx?nodeid=26343868.*

country. Overall, there is an imminent need to build a new service model to provide more comprehensive service, including response to NCDs.

19. **Furthermore, community engagement for health promotions and for increasing social accountability of quality health care needs to be an integral component of service delivery and needs to be strengthened to prevent disruptions of essential health services, raise awareness of risk factors, and support HCs in screening and case management.** The MOH's Community Participation Policy in Health outlined key roles and responsibilities of all actors in the MOH and the sub-national authorities to improve health outcomes. Village health support group (VHSG) - two community health volunteers per village facilitate links between the community and HCs and are expected to coordinate and support HC activities in the community. The Health Center Management Committee (HCMC) is the administrative link between HCs and commune councils - the lowest level of the sub-national administration. The HCMC is chaired by the Chief of Commune Council, and its members are important village figures who play a key role in mobilizing communities. The HCMCs, VHSGs, and HCs are supposed to meet bi-monthly to identify local health related issues and report to their respective HCs. The close collaboration of HCs and VHSGs is critical in monitoring the utilization of essential health services of the target population and to follow up with patients to ensure the continuum of services. Moreover, the Government's roll-out of the Implementation of Social Accountability Framework (ISAF) and the enhanced space created by D&D for community engagement in monitoring public services including health service provision, presents an opportunity to strengthen the community health structures created by the MOH to both promote healthy behaviors and participate in the governance of local health services.

Health Information System

20. **Cambodia recognizes the health information system as one of the seven strategic areas in its Fourth Health Strategic Plan (HSP-4)**. Further investments are needed to ensure data interoperability and robust use of data for decision-making to improve the country's health information system. The major data systems—HMIS, Patient Management and Registration System (PMRS), and National Quality Enhancement Monitoring Process (NQEMP)—are not interoperable. The use of data to inform policy and decision making remains limited both at central and sub-national levels due to limited capacity and human resources. Neither the HMIS nor PMRS systematically report data disaggregated by sex or other key population groups such as age, disability, or indigenous status. Furthermore, there are gaps in the reporting of gender-specific data, such as the provision of services and referral of GBV survivors. The National Digital Health Strategy (2021-2030) has been drafted and is going through stakeholder consultation.

Gender Equality and Social Inclusion (GESI)

21. **The Royal Government of Cambodia (RGC) has made specific commitments to promote gender equality and equitable development through its institutions, policies, and practices**. Various gender assessments conducted under H-EQIP and the findings of the GESI study conducted in preparation for the proposed Health Equity and Quality Improvement Project-Phase 2 (H-EQIP II) design, have identified shortcomings in the institutional capacity of the MOH to implement the Government's GESI commitments. This includes lack of routine collection of health data disaggregated by sex and other markers of inequity such as ethnicity, disability; and geographical location, to inform analysis of gender and intersecting equity gaps and subsequent responses to address these inequities and respond to the needs of vulnerable populations. In addition, there is limited understanding of and leadership on the intersection of GESI and health and lack of women and diversity in leadership positions, with women making up 52 percent of the health workforce but only 16 percent of

management positions based on data from 2017. Another key bottleneck is the lack of resources and capacity of the Gender Mainstreaming Action Group (GMAG) to implement the MOH's Gender Mainstreaming Policy and Strategic Plan (GMAP), and the lack of knowledge on GESI across the MOH, provide technical guidance to executing departments on the intersection of GESI and health, and monitor performance for accountability.[23]

Cambodia's Health Equity and Quality Improvement Projects

22. **H-EQIP is the RGC's flagship health project aiming to support RGC in advancing UHC in Cambodia**. Over the past five to six years, the RGC has successfully institutionalized home-grown innovations and consolidated lessons learned in the provision of services through H-EQIP. Co-financed by IDA, Australia's Department of Foreign Affairs and Trade (DFAT), *Kreditanstalt für Wiederaufbau* (KfW), and Korean International Cooperation Agency (KOICA), H-EQIP (July 2016 -June 2022) supported a move from donor-led systems to an RGC-led-results-oriented funding approach and leveraged the effective partnership with DPs. It has improved the provision of health services by strengthening a nationwide network of HFs and consolidating social health insurance schemes for the poor (HEF). H-EQIP has strengthened and empowered the Quality Assurance Office (QAO) to develop the NQEMP and implement quarterly quality assessments in all public HFs at the subnational level, using service delivery grants (SDGs) to reward improvements in the quality of care. In addition, the project has supported the RGC in establishing the Payment Certification Agency (PCA), which has become a functional validation agency for HEF and SDGs.

23. **With the Global Financing Facility (GFF)[24] as a new partner joining H-EQIP's Pooled Fund Partners (PF Partners), H-EQIP II aims to sustain the reform initiated under H-EQIP and continue to support the RGC in advancing UHC in Cambodia**. The proposed H-EQIP II is designed to build on the achievements of H-EQIP while adding new interventions and innovations to address the challenges faced during H-EQIP implementation and align with the priorities of the RGC in advancing UHC. Thus, H-EQIP II will continue to build on the successful nation-wide roll-out of HEF, strengthen PCA as the national entity for health insurance claim verification, and continue to channel performance-based financing to HFs through SDGs to improve quality of services. New interventions and innovations have been designed to be implemented under H-EQIP II, including (a) Building capacity to mainstream GESI; (b) Improving the service delivery system from a largely MCH service-focused model to providing more comprehensive services, including NCDs, with strong community engagement and health promotion and prevention;(c) Rolling out the second phase of the National Quality Enhancement Monitoring Tools (NQEMTs-II) system to further improve SDGs' implementation for quality and equitable service delivery; (d) Expanding the HEF benefit package, and updating the reimbursement rate schedule to improve financial protection of HEF; (e) Increasing HEF awareness and utilization through an ISAF and community engagement to address barriers to health care utilization; (f) Rolling out a full PMRS to improve data availability and efficient and effective HEF claim validation; (g) Supporting the Government's digital health strategy by enhancing interoperability and developing new system for patient tracking and NQEMTs; and (h) Establishing an adaptive learning agenda to facilitate knowledge generation and mutual learning to support the implementation of

[23] USAID (United States Agency for International Development). 2016. *Cambodia Gender Assessment from September 2016.*

[24] The Global Financing Facility for Women, Children and Adolescents (GFF) is a country-led multi-stakeholder partnership housed at the World Bank committed to ensuring all women, children and adolescents can survive and thrive. In order to support GFF partnership countries in the face of the global pandemic, GFF is supporting investments to maintain essential health and nutrition services at community and primary care levels, enhance service quality and resilience and/or contribute to health systems redesign and innovation in light of COVID-19.

innovation and reform.

24. **H-EQIP II is also being designed in a different macroeconomic context in which H-EQIP was developed.** While the preparation of H-EQIP enjoyed a booming economy and the Government's fiscal revenue growth, H-EQIP II preparation is constrained by limited fiscal space due to the impact of the COVID-19 pandemic. The COVID-19 pandemic has also brought added challenges including disruptions of the health system's ability to provide quality essential health care services, especially to vulnerable populations of women, children, and adolescents. Given the current context of the COVID-19 pandemic and the fact that major policies and strategic directions are still in the process of development, it was agreed among the RGC, PF Partners, and World Bank that a mid-term review (MTR) will provide a window for possible adjustments as necessary to ensure continued alignment with the RGC's priorities and to accommodate progress made in realizing the H-EQIP II's ambitions.

C. Relevance to Higher Level Objectives

25. **The proposed H-EQIP II is aligned with and will contribute to the realization of the vision and objectives of the National Strategic Development Plan (NSDP) 2019- 2023 of Cambodia, health sector strategies and policies, and the social health protection framework to support the achievement of UHC**. The NSDP sets out a vision for implementing the fourth phase of the Rectangular Strategy for Growth, Employment, Equity, and Efficiency.[25] One of the key policy priorities of the NSDP is to "enhance public health and nutrition of the people to support sustainable human resource development, economic growth, and social development." The proposed operation will also contribute to the Cambodia Climate Change Strategic Plan (2014-2023), which aims to improve capacities, knowledge, and awareness for climate change responses.

26. **The proposed project will contribute to achieving goals, objectives, and targets of the Health Sector Strategic Plan of the MOH,** which guides health sector stakeholders to effectively and efficiently use their available resources to translate health strategies into action to accelerate progress toward UHC. HSP-4 (2021-2030) is currently undergoing stakeholder discussions in its draft form and is expected to be finalized by the first quarter of 2022. The consultation version indicates a clear alignment of H-EQIP II activities with the Government's health sector priorities moving forward. The project also supports the National Social Protection Policy Framework (2016 -2025), which is a long-term roadmap to build an efficient and financially sustainable social protection system serving as a policy tool for reducing and preventing poverty, vulnerability, and inequality. The policy framework also contributes to the strengthening and broadening of human resource development and stimulating national economic growth. The National Social Protection Policy Framework includes a strong focus on social health protection, including human capital development; welfare for vulnerable people[26] and health insurance.

27. **The proposed project's activities are also closely linked with the twin goals of the World Bank Group (WBG)**: reduce extreme poverty and enhance shared prosperity, World Bank's Health, Nutrition and Population Global Practice's focus to assist clients to accelerate progress toward UHC, and the Country Partnership

[25] RGC. 2019. *Rectangular Strategy for Growth, Employment, Equity and Efficiency. Fourth Phase.* Phnom Penh, RGC.

[26] According to the National Social Protection Policy Framework, vulnerable people include (a) those living below the poverty line; (b) those who live close to the poverty line with high vulnerability to crisis; and (c) infants, children, pregnant women, families with food insecurity, people with disabilities and the elderly.

Framework (CPF) for FY19-23[27] for Cambodia (Report no.136500-KH). The framework supports Cambodia's progression to the next stage of its development and reflects the evolution of the WBG's engagement in the country. The CPF reflects the RGC's priorities and will address the country's challenges of limited economic diversification, rapidly increasing urbanization, human capital deficiencies, and infrastructure gaps. The CPF comprises three focus areas, and this proposed project falls under the second focus area on fostering human development and is aligned directly with the third objective of the second focus area, which is expanding access to quality health services. The proposed project will also support aspects of the CPF's critical cross-cutting theme which underpins reforms in all three focus areas—strengthening governance, institutions, and citizen engagement — and aligns with the World Bank Gender Equality Strategy.

II. PROJECT DESCRIPTION

28. **The proposed H-EQIP II will build on lessons learned from H-EQIP to support the RGC in advancing UHC** over a five-year period from July 2022 to December 2027 with a continued focus on improving financial protection and access to services for the poor and vulnerable, enhancing the quality and inclusiveness of health services, and strengthening the health service delivery system through planned activities from July 2022 to June 2027 with the second half of 2027 focusing on verification of performance-based conditions (PBCs) and evaluation and dissemination of lessons learned.

29. **The project will further strengthen the focus on results by expanding SDGs to finance more health programs and using an investment project financing (IPF) with PBCs**. PBCs are a set of indicators, that, as part of the project's Result Framework, aim at measuring performance against key actions and interventions. This performance-focused financing approach would promote timely achievements of PBC targets.[28] Achievements of the PBC targets will be verified by the government and submitted to the World Bank for validation.

A. Project Development Objective

PDO Statement

30. **The project development objective (PDO)** is to improve equitable utilization of quality[29] health services in Cambodia, especially for the poor and vulnerable populations, and to provide immediate and effective

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[27] World Bank.2019. *Cambodia - Country Partnership Framework for the Period of FY2019-2023 (English).* Washington, DC: World Bank Group. *http://documents.worldbank.org/curated/en/872721559440966260/Cambodia-Country-Partnership-Framework-for-the-Period-of-FY2019-2023.*

[28] This performance-focused financing instrument will define annual targets and target values. PBCs will be associated with specific financing levels, called PBC values, which will be made available to the respective implementing entities to carry out project activities upon achievements of the PBC targets. Specific cash advance is provided to implement PBC-related activities, such as training or monitoring activities, in case the payment by a banking system is possible. After completing the activities, the advance will be liquidated with all supporting documents for expenditures. The project will provide advances, based on cost estimation of specific activities to be carried out to reach agreed targets. In cases where the set targets are not met, and the incurred expenditures are paid from the Designated Account (DA), the proportionate allocation linked to the PBCs will need to be refunded to the World Bank. The instructions on advance, verification criteria, measuring of results, and presentation of the paid eligible expenditures for PBCs will be described in the Project Operational Manual (POM).

[29] Quality health services are defined as services provided according to the national clinical protocols, guidelines and the national healthcare accreditation standards being rolled out in all public HFs at the subnational level under the H-EQIP II.

response in case of an Eligible Crisis or Emergency in the Kingdom of Cambodia.

31. **The RGC has developed and rolled out a national On Demand identification of poor (IDPoor) system** to identify the poor population. It consists of standard and robust procedures executed by the commune council offices at the community level, and the Ministry of Planning (MOP) at the national and sub-national levels. It identifies poor and vulnerable households who will be issued an IDPoor card and are eligible for social assistance programs, cash transfers, HEF, and other targeted services.

PDO Level Indicators

32. **The achievement of PDO will be monitored and assessed through the following PDO-level indicators:**

(a) **Improved equitable utilization of health services:**

- Outpatient visits by HEF beneficiaries in low utilization ODs, disaggregated by sex (PBC 1)
  - Supplement: Outpatient visits by HEF beneficiaries in selected provinces with the highest multidimensional poverty
- Percentage of HEF beneficiaries in all HCs with Full PMRS being introduced in year 1, 2 and 3, used the outpatient services paid by HEF, disaggregated by sex

(b) **Improved quality of health services utilized:**

- Number of HFs exceeding 60 percent score on the April-May round of the semi-annual national quality assessment
- Hypertension screening rate by sex
- Number of HFs with Full PMRS introduced routinely collect & report sex, age & geographical location disaggregated data, gender-specific health data (e.g. GBV), & other markers of disadvantage[30]

B. Project Components

COMPONENT 1: Improving Financial Protection and Utilization of Health Equity Fund (US$112.00 million total; US$20.44 million from IDA; US$12.64 million from PF Partners; US$70.00 million from the RGC; US$8.92 million financing gap)

33. **The strategic objective of this component is to support the RGC's vision of building a universal health insurance scheme in Cambodia as an important step in achieving UHC by 2030.** With co-financing from the RGC, this component will continue to support HEF to (a) cover the cost of health services for the poor, including those most vulnerable to the impacts of climate change and natural disasters; (b) optimize and expand the HEF benefit package and update the reimbursement rate schedule of HEF claims; (c) support increased utilization of HEF through addressing barriers to awareness, social inclusion and gender equality; and (d) expand the coverage of full PMRS to all the remaining HCs and RHs. This component will also support building financial sustainability, improving capacity, and expanding functions of the PCA as the single agency to certify claims for all health insurance schemes in Cambodia and validate public services for MOH and other sectors. Moreover, this component will also support the RGC in strengthening social health protection through policy dialog and technical

[30] Note that this indicator contributes to both elements of the PDO.

assistance, including the generation and translation of evidence, and capacity building activities.

<u>Subcomponent1.1: Financing the HEF (US$105 million total; US$17.04 million from IDA; US$ 10.53 million from PF Partners; US$70.00 million from the RGC, and US$7.43 million financing gap)</u>

34. **As of the end of December 2020, 3.33 million people benefited from HEF**. The program covered poor and vulnerable groups accounting for 21.3 percent of Cambodia's total population, providing them with access to all public HFs from primary to tertiary levels in the country. There are two types of HEF expenditure: medical benefits and non-medical benefits. Medical benefit expenditures are HEF reimbursement to the HFs for the health service provided to IDPoor card holders. Non-medical benefits pay for indirect costs related to health services received by the HEF beneficiaries, such as transportation costs, food for caregivers, and funeral allowances. Both medical and non-medical benefit expenditures are certified by the PCA. Funds will be disbursed directly to the HFs monthly after the PCA's certification. During H-EQIP, the DPs provided US$6 million each year to HEF for the payments to HFs, and the RGC covered the rest of the annual costs. Total HEF costs in 2020 were US$22 million, of which DPs paid US$6 million (27 percent) and RGC paid US$16 million (73 percent).

35. **H-EQIP II will increase PF Partners' contribution to the HEF program from US$6 million per year under H-EQIP to US$7 million per year.** The funds are provided to HFs to cover the cost of providing health services to HEF beneficiaries. Transportation costs have been identified as a major demand side barrier leading to low HEF utilization. The added funds will be used to increase payment for transportation, in particularly for (a) those from ethnic minorities, (b) indigenous people, (c) people living in remote and hard-to-reach areas, (d) people with disability, and (e) those accessing specialized outpatient services at RHs. In addition, the added funds will be used to cover the increased costs associated with the expanded benefit package and the updated reimbursement rate schedule which include services such as paraclinical tests and imaging services and so on to support diagnosis. The RGC will continue to cover the rest of the annual cost of the HEF program, and its contribution is expected to be around US$70 million for five years of project lifespan. HEF will help ensure that the vulnerable can access quality health care on time even if income falls or crops fail, because of climate change and natural disasters. This will be especially vital for the treatment of climate-sensitive conditions including malnutrition, NCDs, and vector-borne-and water borne diseases.

<u>Subcomponent1.2: Enhancing HEF Management and Utilization (US$1.00 million total; US$0.49 million from IDA; US$0.30 million from PF Partners; and US$0.21 million financing gap)</u>

36. **This subcomponent aims to improve the impact of HEF by enhancing HEF utilization, monitoring, and management**. DPHI of the MOH oversees the management and implementation of HEF throughout the country. The Provincial Health Departments (PHDs) and ODs have the responsibility to ensure quality service provision to the HEF beneficiaries at HFs and ensure the utilization of HEF by IDPoor cardholders. This subcomponent will focus on optimizing and updating the benefit package and reimbursement rate schedule of HEF; thus, increasing the utilization of HEF by the beneficiaries.

37. **A specific PBC will be designed with yearly targets that links to the tasks and progress in enhancing management, monitoring, and utilization of HEF. This will include** (a) optimizing and updating the benefit package and updating the fee schedule to incentivize health staff for providing services appropriately; (b) updating the treatment guidelines linked to the updated benefit packages; (c) updating the HEF operational manual with new activities and functions, such as the requirement for HCs to work with the HCMC and commune council members who work on the On-demand-IDPoor (OD-IDPoor) system for raising awareness about

healthcare benefits for IDPoor card holders, and for PHDs/RHs to routinely conduct Health Financing Steering Committee meeting to address issues related to HEF implementation and low utilization; (d) supporting HFs and ODs to improve utilization of HEF in low utilization areas including awareness raising in communities; and (e) monitoring, analyzing, and reporting utilization of HEF on a regular basis and conducting data review on utilization of essential health services.

PBCs	Indicators	Total PBC Value (US$, millions)
PBC 1	Improved HEF management	1.0

Subcomponent 1.3: Enhancing Roles and Responsibilities of PCA (US$6.00 million total; US$2.91 million from IDA; US$1.81 million from PF Partners; and US$1.28 million financing gap)

38. **This subcomponent will strengthen the capacity of the PCA for its expanded role in Cambodia's social health protection schemes and for the additional tasks under H-EQIP II**. Established in September 2017, the PCA is one of the key achievements of the ongoing H-EQIP. It has made significant improvements in the efficiency of paying for health services and is now an essential element in building universal health insurance coverage in Cambodia. The PCA acts as a neutral, semi-independent agency to monitor, verify, and certify HEF claims, and conduct quality ex-post verification for SDGs. Claims for the HEF payments are submitted by HFs to the PCA. The PCA validates the payments and sends them to the MOH for reimbursements. The payments are processed directly to HFs' bank accounts monthly. The PCA uses its own PMRS to administer the system. In the Government's vision of building universal health insurance coverage, the PCA will take on an expanded role as the single validation and certification agency of public services, including service provided by the health and other sectors. Building on H-EQIP, the PCA will carry out some new activities as specified in table 3, including validation for claims of the NSSF schemes.

39. **Specific activities to be financed through a PBC include**: (a) ex-post verification on ex-ante assessment scores for the NQEMTs-II system; (b) verification and certification of the HEF and NSSF claims and recommendation for reimbursements; (c) verification of NCDs performance against targets and indicators; (d) rolling out the full PMRS to all remaining 800 HCs and all remining 20 RHs in the first three years (see details in table 5) and (e) carrying out other new functions as needed. The Korea Foundation for International Healthcare (KOFIH) will finance the construction of a new office building for the PCA.

Table 3. Existing and Expanded Functions of PCA

Existing Functions	Expanded Functions
1. Independently verify claims for HEF reimbursement and certify and submit verification reports to the MOH. 2. Verify the quality performance scores of HFs assessed by PHD/OD assessors on randomized basis and report to the Quality Enhancement Working Group (QEWG) for review, adoption, and submission to the project director for disbursement of SDG performance-based grants to HFs. 3. Develop and maintain the PMRS which includes specific tools for managing HEF reimbursement.	1. Single validation agency for public services in Cambodia 2. Verify and certify claims for the NSSF schemes. 3. Verify HFs performance in providing NCD services for performance based NCD SDGs payment. 4. Advise relevant ministries on HEF and SDGs management and optimizing benefit packages, quality standards, and tariffs.

PBCs	Indicators	Total PBC Value (US$, millions)
PBC 2	Expanded PCA functions and service coverage	6.0

COMPONENT 2: Strengthening Quality and Capacity of Health Service Delivery (US$183.3 million total; US$32.77 million from IDA; US$20.24 million from PF Partners; US$116 million from the RGC; and US$14.29 million financing gap)

40. **Building on the progress in H-EQIP, this component in H-EQIP II will focus on strengthening the health service delivery system in Cambodia,** particularly at the sub-national level PHs/RHs and HCs and communities with enhanced efforts in improving service quality, expanding service capacity and coverage, shifting the service delivery model from an MCH focused model to providing more comprehensive services, and strengthening community- based essential service provision. This component will continue using SDGs, both fixed lump-sum grants and performance-based grants, to provide financing to HFs. It will also provide funds to PHDs/ODs and key MOH agencies through PBCs in building up internal health service performance targets and promoting enhanced responsibility and accountability at sub-national levels.

Subcomponent 2.1: Implementing New NQEMTs-II Nation-Wide (US$133.8 million total; US$11.60 million from IDA; US$7.14 million from PF Partners; US$110 million from the RGC; and US$5.06 million financing gap)

41. **Under H-EQIP, the fixed lump-sum grants and the performance-based grants[31] have contributed to significant improvements in the quality of healthcare services at public HFs through the deployment of NQEMTs -** a scorecard-based quality enhancement mechanism which has become a core institutional establishment in Cambodia's health sector**.** After more than five years of implementation, most of the RHs and HCs have achieved high scores on NQEMTs under H-EQIP. So, the Government is ready to bring NQEMTs to the next level, which is to roll out the national accreditation standards to continue enhancing the quality of services (NQEMTs-II).

42. **This subcomponent will finance the implementation of the second phase of NQEMT (NQEMT-II)[32] to drive continued quality improvement at the public HFs**. NQEMTs-II will comprise (a) the national accreditation standards (thereafter called the national health care quality standards), which have been developed by the MOH Quality Improvement Working Group (QIWG) with the support of USAID/ Enhancing of Quality Health Activities (EQHA) and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and accredited by the International Society for Quality in Health Care External Evaluation Association (see box 1) and (b) the knowledge tests and competency tests, which will comprise existing and newly developed clinical vignettes and new competencies.

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[31] SDGs are key Government supply-side instruments which are allocated to all government health HFs at the subnational level and comprise fixed lump-sum grants and performance-based grants. Introduced in 2016, fixed lump-sum grants are allocated to HFs as fixed amounts for operational expenditures as an addition to operational budgets defined in their annual operational plans (AOPs). Performance-based grants are allocated based on the HFs' quality performance scores that are assessed regularly through an IT-enabled National Quality Enhancement Monitoring program.

[32] The RGC will use the new National Accreditation Standards, including Cambodia Hospital Accreditation Standards and Cambodia Primary Health Care Facility Accreditation Standards, as the NQEMTs-II system during H-EQIP II as it aims to upgrade the system and bring quality enhancement to a new level. This is aligned with the MOH's direction in improving the quality of healthcare service using the health care accreditation mechanism.

The MOH will roll out the whole set of NQEMTs-II, which consists of 116 indicators for HCs and 365 indicators for PPHs/RHs in all public HFs at subnational level from the start of NQEMTs-II implementation. An additional scorecard to measure performance on community engagement activities will also be used to assess the support from the community and VHSGs in assisting HCs to enhance awareness and use of essential health services. A potential GESI scorecard will be developed based on the GESI-related indicators included in the national accreditation standards being assessed as part of NQEMTs-II, and in line with the planned operational guideline on GESI standards for health service delivery under PBC 7. In addition, the indicators also include readiness of the health service providers on the detection, control, and treatment of climate-sensitive conditions including both infectious diseases and NCDs.

BOX-1. National Health Care Service Accreditation Standards under NQEMTs-II of H-EQIP II

NQEMTs-II for PH/RH has 365 Standards, Divided into 11 Groups					NQEMTs-II for HC has 116 Standards, Divided into 9 Groups				
Standards Group	**Critical**	**Core**	**Stretch**	**Total**	**Standards Group**	**Critical**	**Core**	**Stretch**	**Total**
Patient and family rights and responsibilities	5	15	0	20	Leadership and management	9	18	5	32
Leadership and management	7	19	1	27	Quality improvement, patient safety, and risk management standards	2	4	3	9
Quality improvement, patient safety, and risk management	1	8	5	14	Medication management	6	1	0	7
Infection prevention and control	16	17	2	35	Human resource management and development	5	6	0	11
Human resources	7	24	0	31	Infection prevention and control	12	1	2	15
Patient care services	34	24	1	59	Laboratory services	6	2	0	8
Medication management	20	7	0	27	Patient care services	11	3	0	14
Diagnostic services	31	18	5	54	Community engagement	1	7	1	9
Support services	9	15	3	27	Environmental safety and security	5	4	2	11
Environmental safety and security	9	24	1	34					
Health information management	5	32	0	37					
Total	**144**	**203**	**18**	**365**	**Total**	**57**	**46**	**13**	**116**

43. **The process of conducting NQEMTs under H-EQIP, including ex-ante assessment carried out by certified PHD and OD assessors, cross-province ex-ante assessments carried out by assessor teams from a different province, and ex-post verification carried out by certified PCA staff, will be maintained.** However, the frequency of this assessment will be reduced to a semi-annual basis as NQEMTs-II for both PH/RH and HC levels are much more comprehensive requiring more time for HFs to develop quality improvement plans and implement them.

Implementation of NQEMTs-II will include strengthening accountability of HFs in implementing NQEMTs-II through mandatory implementation of self-assessments to routinely measure the improvement of health care quality, including health provider's knowledge regarding services to GBV survivors and preventing climate-related diseases such as dengue, diarrhea, respiratory infection, tuberculosis, and household water treatment. Disbursement of the quarterly fixed lump-sum grants will be conditioned on HFs completing the mandatory self-assessment. The self-assessment report will be submitted for review by assessor teams of the respective PHDs and ODs before the ex-ante assessment is conducted to verify the performance of self-assessment and measure progress on quality improvement of every HF. A quality improvement coordinator will be appointed by each PH/RH and OD to coordinate with different units of PH/RH and HCs within each OD for preparing and implementing activities defined in the semi-annual quality improvement plan.

44. **The performance-based SDG linked to the quality enhancement score of each HF will be disbursed semi-annually to support HFs in implementing NQEMTs-II**. This subcomponent will also provide performance-based SDGs to assessor teams from PHDs and ODs based on their respective scorecards for providing routine guidance, monitoring, coaching, and assessment of quality improvement of CPA and MPA services against NQEMTs-II.

45. **Every PHD and OD will prepare a roster of technical experts, which will comprise experts from hospitals and PHD/OD program managers to coach HFs**. After conducting an ex-ante assessment, the technical experts will provide technical coaching to HF staff using respective coaching protocols developed as part of the development of clinical vignettes. By the middle of each NQEMP round, the assessor team will conduct a review meeting with HFs to (a) discuss progress on implementation of actions defined in the semi-annual quality improvement plans and (b) provide a short technical training to HFs. The QEWG, established under H-EQIP, has been reviewing the results of ex-ante assessments and ex-post verification from the past round and has discussed and validated these results. This task will be mainstreamed into the functions of the QIWG.

46. **This subcomponent, through a PBC, will also support the QAO to lead the nationwide implementation of NQEMTs-II.** This will include (a) development and updating of the assessment tools, (b) providing training to PHs/RHs and HCs on conducting semi-annual self-assessments of quality improvement, (c) providing training to PHD/OD assessor teams, and (d) carrying out supervision. The development, maintenance and management of NQEMTs-II information and communication technology (ICT) system is included in project management under subcomponent 3.1.

PBCs	Indicators	Total PBC Value (US$, millions)
PBC 3	Enhanced quality of health service as defined in the NQEMTs-II by MOH	3.80

Subcomponent 2.2: Building Comprehensive Service Provision with Expanded NCD Services and Strong Community Engagements (US$25.50 million total; US$9.49 million from IDA; US$5.87 million from PF Partners; US$6.00 million from the RGC; and US$4.14 million financing gap)

47. **This subcomponent seeks to expand and enhance service delivery in Cambodia from a largely MCH service-focused model to providing comprehensive services including NCDs with stronger focus on community engagement, health promotion and prevention, and people-centered care.** This enhanced service model emphasizes stronger accountability of health providers to provide life-long health services to the residents in

their catchment area, focusing on more coordination vertically and horizontally among health service providers providing continuum of care. Activities under this subcomponent include the following:

(a) Establishment of electronic registration at HCs and communities to register key population groups such as pregnant women, newborn, children under three years, and those with NCDs (diabetes, hypertension, and cervical screening)
(b) Defining the essential service package for these key population groups based on their conditions
(c) Establishment of a service alliance between VHSG, HC, and RH, which will play a role as family health doctor that is accountable for health maintenance and disease treatment of these key population groups
(d) Establishment of a dual referral mechanism within this alliance to ensure effective communications between each level and rapid assessment of cases to refer patients for timely and appropriate care. Referrals from community to HC and from HC to RH level are often an obstacle for accessing health care, especially in remote areas and, in general, during the monsoon season. Strengthening referrals from community to HC and HC to RH level will increase utilization of essential health services
(e) Rolling out the NCD services to the remaining HCs (910 HCs), except for the HCs in three provinces covered by KOFIH (Battambang, Pursat, and Pailin); rolling out of cervical cancer screening to 500 new HCs, strengthening the capacity of existing 196 HCs and 236 HCs; and support for establishment of NCD clinics and services for treating cervical lesion in all remaining 57 and 39 PHs/RHs; respectively. Devices and training for providing NCD services and using the PMRS will be provided to HFs to build the capacity for NCD screening and case management
(f) Development of a patient tracking ICT system to support HCs and communities in monitoring and managing essential services for target populations starting from NCDs and MCH services
(g) Piloting and establishment of a community engagement model in selected provinces to build strong collaboration between HCs and communities with a strong continuum of care from HC to the community including registration of target population groups, provision of health education on healthy lifestyles, ensuring provision of MCH services and immunization, and follow-up and referring of target populations for NCD screening and treatment.

48. **Maximizing NCD services utilization will depend on the combination of enhanced readiness of HFs to deliver NCD screening, treatment, and management coupled with strong community engagement through the HCMCs and VHSGs to build awareness and demand for services**. Leveraging the established institutional mechanism of collaboration among community and HCs, the HCMC will play a critical role in carrying out community engagement activities under H-EQIP II. Through regular HCMC meetings, the social accountability and the governance role of the commune council extends to health care provision in the local communities. The communes including VHSGs and HCs, work together to ensure provision of essential health services (see box 2). A community engagement SDGs will be introduced and provided to the HCMC to support community engagement activities such as health promotion and health education; capacity building of VHSG groups; incentives to VHSGs for supporting health service provisions including referring residents and patients to HCs for screening, MCH services, NCD treatments, and immunizations; and assisting of HCs to carry out outreach services particularly under public health emergencies such as the COVID-19 pandemic. The VHSGs are important carriers of these health-related community engagement activities; thus, regular training and appropriate incentives will be provided to support these community volunteers. The operational details will be defined in the Project Operational Manual (POM). While NCD services are intended to be expanded at the HC level nationwide in the first year of project implementation, introduction of the community engagement model will be rolled out only in selected provinces not supported by Cambodia Nutrition Project (CNP, P162675) taking into account the available

financing resources and the impact evaluation study in CNP[33] provinces. Priority will be given to remote and less developed provinces. Subject to additional financing at the MTR, the model will be rolled out to the rest of the provinces.

Box-2. Addressing Disruption of Health Services: The preliminary analysis of routine HMIS data shows that Cambodia has experienced persistent disruptions in the utilization of essential health and nutrition services during the pandemic with the most significant disruption experienced by vulnerable women, children, and adolescents for the essential services. The service delivery strengthening efforts supported by H-EQIP II will aim to avert the impacts of the pandemic on the continuity of essential service provision through: (i) enhancing the accountability of primary health care system to provide continuum of health care to the community in their catchment areas including during special situation like COVID pandemic through establishing electronic registration at HCs and communities for the target population groups, defining essential service package and working closely with community; (ii) strengthening community-based institutions and actors including the Health Center Management Committees (HCMC) and the frontline community health volunteers (Village Health Support Groups) to be active partners in health service provision and utilization at the community level; (iii) building strong collaboration between the health centers and the communities to jointly monitor, follow-up and referring target population for essential services and to carry out health promotion activities, facilitated by the electronic registration and patient tracking system; (iv) improving referral of patients from village to Health Center and from health centers to referral hospital; (iv) improving the capacity of MOH and sub-national Operational Districts to routinely monitor, review, and manage changes in demand and utilization for health services and the Health Equity Fund (HEF). Strengthen health system to address the disruption of care and to ensure essential health service provision is aligned with the focus of Essential Health Services (EHS) grant of GFF, one of the pooled fund partners of H-EQIP II.

49. **The mechanism of financing of this subcomponent will be switched from disbursement linked indicators (DLIs) under H-EQIP to performance-based SDGs** to be disbursed to HCs directly for screening and diagnosis as well as for community engagement. The NCD SDGs will provide funding to HCs to support hypertension and diabetes screening and will be rolled out nation-wide. The PCA will be responsible for verifying the performance /service delivery indicators of HFs for NCD screening and case management which will serve as the basis for allocation of the NCD SDGs.[34] This community engagement SDGs will be disbursed to the HCs together with the NCD SDGs. The performance assessment for these SDGs will be linked with achievement of a set of indicators including establishment of registers, regular meetings between HCs and VHSGs, achievement of screening targets, and implementation of health promotion activities. The assessment will be carried out together with the QAO's NQEMTs assessment.

50. **To enable the rollout of NCD services at such a large scale and strengthen the capacity and accountability of subnational health authorities and HFs, planning, and implementation of NCD services will be decentralized to become the responsibilities of PHDs, ODs, and HC/HCMC** for planning and implementation of activities while the Preventive Medicine Department (PMD) will assume the role of overall management of the national NCD programs. The project will provide financing to the PMD and subnational level PHDs/ODs through

[33] World Bank. 2019. I Washington, DC.: World Bank Group. http://documents.worldbank.org/curated/en/598441554688835540/Cambodia-Nutrition-Project
[34] The CNP aims to provide MCH SDGs to support MCH services at HCs.

PBC for purchasing small NCD devices/equipment/consumables and providing training to HFs to enable the provision of NCDs services. Based on the lessons learned from the current H-EQIP, a cascade training model will be adopted, that is, the PMD will provide training to PHs/RHs and training of trainers to PHDs and ODs, and PHDs and ODs will then provide training to HCs and supply the equipment and consumable to the PHs/RHs and HCs, respectively. Training on ICT systems on how to use this system for recording, and monitoring patients' referral and follow-up, data analysis, and reporting for OD/PHD and HFs will be conducted jointly with these trainings.

51. **Reducing NCD risk factors.** In addition to support for expansion of service coverage and building on existing national health promotion capacity and programs, the project will support formulating a National NCD Prevention and Health Promotion Action Plan to address the risk factors, which will be led by the PMD of the MOH. A community-based health promotion program for prevention of NCDs will be developed to create awareness of NCDs, its impact on pregnant women and their babies, and its risk factors in the community. Health promotion activities will also raise awareness of the health impacts of climate change and build capacity of communities to implement climate change mitigation and adaptation actions, such as steps to help maximize the intake of nutrients from climate-vulnerable food sources, especially for women and children. A national multimedia campaign package targeting mass populations, including school students on healthy diet and physical activity, will be developed, and distributed through social media. Healthy lifestyle champions/leaders will be identified to promote and advocate for positive healthy behavior.

52. **The proposed project will seek synergy with World Bank's ISAF Project and CNP on community engagement**. ISAF data regarding community feedback on quality of health service will be provided to the service providers and ODs to support service improvement. The community engagement platform created under ISAF will be used to raise awareness of HEF benefits, and increase utilization of healthcare services, particularly among the HEF beneficiaries, as well as to carry out health promotion activities together with VHSGs and communes. The community engagement component for MCH and nutrition services under CNP will be expanded to also include health promotion and referrals for NCD services in the CNP provinces with the community engagement component. The CNP and H-EQIP II will also build synergy in streamlining the SDGs payment to HCs for MCH SDGs and NCD SDGs.

PBCs	Indicators	Total PBC Value (US$, millions)
PBC 4	Rolling out of NCD services and cervical cancer screening — national level	2.00
PBC 5	Rolling out of NCD services and cervical cancer screening — sub-national level	4.70

Subcomponent 2.3: Building Service Capacity of Referral Hospitals (US$24.00 million total; US$11.68 million from IDA; US$7.23 million from PF Partners; and US$5.09 million financing gap)

53. **The suboptimal service capacity in the CPA hospitals, including infrastructure, equipment, and health workforce,** has resulted in patients' increasingly seeking care in the private sector, leading to high OOP health expenses. **H-EQIP II will support RGC's goal to build the service capacity in RHs by providing investments to address the service capacity gaps in selected CPA-1, 2, 3 hospitals** including renovation, refurbishment, and expansion of hospital buildings, procurement of equipment for providing quality/new services and supporting the implementation of national digital health strategy. Climate resilient designs such as energy-efficient ventilation and air conditioning systems, water and energy efficiency measures, energy efficient improvements, and appliances, and equipment (solar panels and so on) will be incorporated and applied during implementation.

H-EQIP II will not finance construction of new hospitals. Prioritization will be based on improving equitable access, attention to remote areas and vulnerable groups (such as GBV survivors and people with disabilities), concerns around patient safety and infection prevention and control (IPC), and improvement of maternal and neonatal survival, and NCD services. Technical support for the establishment of public private partnerships between PHs/RHs and private sector for proper maintenance of medical equipment will be provided under the financing of the Bank Executed Trust Fund (BETF) to complement this subcomponent.

54. **Digital health.** The National Digital Health Strategy 2021-2030 of Cambodia sets out the vision and objectives of building a robust digital health system. It aims to build an overarching design and a national Electronic Medical Record (EMR) system to automatically provide required information to different platforms. This subcomponent will support the implementation of RGC's National Digital Health Strategy focusing on four dimensions:

(a) Supporting an EMR system that communicates with PMRS and HMIS;

(b) Improving/building key systems supporting project implementation including (i) developing a patient tracking and management system; to support essential service provision; (ii) developing NQEMP Phase II digital platform; and (iii) inclusion of sex-disaggregated data and other key identity variables such as age, disability, indigenous status, and inclusion of data on services to and referral of GBV survivors;

(c) Supporting the design and implementation of enhancing interoperability between key systems; and

(d) Supporting capacity building at the national and sub-national levels, as needed.

COMPONENT 3: Project Management, Monitoring and Evaluation, Gender Equality and Social Inclusion (US$3.7 million total; US$1.79 million from IDA, US$1.12 million from PF Partners; and US$0.79 million financing gap).

55. **This component will finance activities related to project implementation management, mutual learning, capacity building, and monitoring and evaluation (M&E).** In addition, this component will also support activities to improve GESI.

Subcomponent 3.1: Project Management, Capacity building, and M&E (US$3.2 million total; US$1.55 million from IDA; US$0.97 million from PF Partners; and US$0.68 million financing gap)

56. **This subcomponent will support project management costs related to operations, capacity building and training, audit, and implementation of safeguards activities.** Key activities include (a) operating expenses for project management, reporting, and supervision; (b) support for procurement activities, FM, and environmental and social sustainability activities; (c) learning and knowledge exchange; and (d) M&E.

57. **In particular, the subcomponent will strengthen the capacity of the Department of Budget and Finance (DBF)** to (a) ensure timely disbursement of SDGs and HEF payments to HFs and improve the project's FM performance, (b) provide on-site training to HFs to build FM capacity at the sub-national level, and (c) provide capacity building to enable the sub-national level to carry out procurement as needed. PBC 6 is designed to support FM capacity building for the DBF and sub-national level. This subcomponent will also support strengthening the capacity of the environmental and social management group in the PMD to guide, monitor, and ensure that all project activities are implemented in full compliance with mitigation measures identified in

the project Environmental and Social Commitment Plan (ESCP), Stakeholder Engagement Plan (SEP), and Environmental and Social Management Framework (ESMF) action points and ensure timely reporting of project implementation progress.

PBCs	Indicators	Total PBC Value (US$, millions)
PBC 6	Timely processing of project funds and improved capacity of sub-national HFs in applying relevant financial management system	0.60

58. **Project M&E:** The current HMIS in Cambodia has a number of core components including (i) **PMRS**; (ii) a core **HMIS;** which is web-based at the central, provincial and OD levels and paper-based at the HC level and report on key service indicators on a monthly basis; and (iii) **NQEMP**, which is used to monitor quality of services in HFs and generates quality scores for allocating performance-based SDGs to facilities as indicated earlier. **There is a need for better integration of health service data systems to reduce inefficiencies and allow more timely monitoring by managers.** The project will support (a) capacity-building activities such as contracting consultants, workshops, and trainings as needed, to improve data monitoring and use; (b) generation of semi-annual and annual reports and performance reviews on health service delivery (focused on essential health services including NCDs) and health service utilization at the national and province level to strengthen data-driven decision-making; (c) generation of citizen engagement reports in collaboration with the ISAF platform; and (d) ensuring of GESI-sensitive and GBV data collection, reporting and use.

Adaptive Learning

59. **Given the system strengthening focus and the large-scale implementation of H-EQIP II, knowledge generation, mutual learning, and adaptation will be of particular importance.** A learning network and knowledge exchange platform will be established in H-EQIP II from the start of project implementation. The semi-annual implementation review and support mission will serve as the regular platform to facilitate mutual learning between the project provinces. A project implementation workshop and knowledge-sharing workshop will be organized during the semi-annual implementation support mission. Policy dialog workshop/theme seminars, and study visits will also be organized as needed. A learning and knowledge-exchange agenda and annual workplan will be developed to lay out the learning events to be organized and operational research to be conducted throughout the project based on specific technical areas where the project faces challenges and areas of innovations. The learning agenda annual workplan will be an integrated component of the project 's Annual Operational Plan (AOP).

60. **As part of the learning, the project will also aim to generate lessons and evidence from project implementation, to learn from other countries in the regions or those with similar context to enhance project implementation and inform key** dialogue for **policy reform.** It will include implementation research to understand the local contextual factors at play and what works and can be adapted and scaled-up, impact evaluation of innovations, and case studies on best practices that can be disseminated. These activities will be financed by the BETF.

Subcomponent 3.2: Gender Equality and Social Inclusion (US$0.50 million total; US$0.24 million from IDA; US$0.15million from PF Partners; and US$0.11 million financing gap)

61. **This subcomponent will support developing the MOH's capacity in realizing the RGC commitment of closing gender and equity gaps in health coverage, quality of care, and outcomes through**: (a) providing capacity

building supports for GMAG to fulfill its mandate of mainstreaming gender across the whole health sector; (b) strengthening know-how, attitudes, and skills on GESI and health across the MOH departments and sub-national institutions including capacity to undertake GESI analysis to develop gender responsive plans and budgets using sex and other GESI- disaggregated data; and (c) producing tangible and practical outputs such as operational guidelines on GESI standards for health service delivery to help translate the RGC policies on gender equality and equitable development into decision-making and practice. The project will also support a MOH's Women in Leadership Development Program, which aims to respond to the capacity-building challenges women face in progressing to management positions. These are steps toward building policy commitment to gender equality and strengthening women's voice and participation in decision-making in the sector and leadership on GESI and health.[35]

62. **This subcomponent will support the collection and processing of timely and reliable health data disaggregated by sex, location, and other markers of inequality and vulnerability to promote GESI efforts and evidence-based decision-making in the framework of UHC.** Moreover, the health information systems will be strengthened to ensure that GESI-disaggregated data are captured routinely to allow for measurement of health outcomes of different population groups and improved operational planning and policy decision-making. This will be done through a PBC with DPHI. It will include an assessment of GESI-disaggregated data and gender-specific data gaps and an agreed action plan to close the gaps that will be supported through the project.

63. **Furthermore, this subcomponent will strengthen the health system's capacity to collect data on GBV.** While another Bank-financed operation, namely 'Strengthening Pre-Service Education System for Health Professionals Project'[36] introduces training requirements on GBV into curricula for undergraduate students in health training institutes to improve the capacity of health workers to identify, care for and refer GBV survivors, H-EQIP II will provide assistance to collect and analyze data on services provided to GBV survivors and referral to health and non-health service providers as well as inclusion of reporting and data on GBV in the digital health system, ensuring the data remains secure and confidential. The project will support the MOH to engage with other GBV service providers to build consensus and harmonize GBV definitions and streamline data collection across service providers[37] to improve survivor-centered care, reduce revictimization caused by the recounting of the incident and improve evidence for policy and planning.

64. **Once sex-disaggregated data are routinely collected and disclosed, qualitative and quantitative evidence on gender and equity gaps in health service utilization will inform an evidence-based policy roundtable on GESI and progress made toward UHC and who is left behind, as well as an evidence informed policy roundtable on a gender equal and inclusive workforce.** These two policy streams of work will support MOH in the sustainability of project support to strengthening GESI in the health system.

65. **Aligned with the D&D, the new governance arrangements--the capacity building support for the mainstreaming of GESI into health management and service delivery will extend to sub-national authorities through the structures being established under the D&D reforms.** This will synergize and support the National

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[35] Vong, S., B.Ros,R. Morgan,*and S. Theobald. 2019."Why are Fewer Women Rising to the Top ? A Life History Gender Analysis of Cambodia's Health Workforce." "BMC Health Services Research* 19: 595. https://doi.org/10.1186/s12913-019-4424-3
[36] World Bank. 2020. Cambodia - Strengthening Pre-Service Education System for Health Professionals Project (English). Washington, D.C: World Bank Group. http://documents.worldbank.org/curated/en/668861591063363140/Cambodia-Strengthening-Pre-Service-Education-System-for-Health-Professionals-Project.
[37] Currently, only the number of forensic exams provided is collected at the National Maternal and Child Health Center.

Committee for Sub-national Democratic Development Secretariat (NCDDS) intentions to strengthen the gender and inclusive capacity of sub-national authorities, their leadership, the responsiveness of service delivery to the local context, and accountability to citizens. The GESI PBC will also support implementation of the H-EQIP II Gender Action Plan (GAP) which will be developed. By demonstrating how GESI contributes to improving the core business of the health system, it is anticipated that demand for GESI and health analytics and advice at national and sub-national levels will increase.

PBCs	Indicators	Total PBC Value (US$, millions)
PBC 7	Implementation of Gender Equality and Social Inclusion Action Plan	0.50

COMPONENT 4: Contingent Emergency Response (US$0)

66. **The objective of the contingent emergency response component (CERC), with a provisional zero allocation, is to allow for the reallocation of financing to provide an immediate response to an eligible crisis or emergency[38] as needed.** The RGC can request the World Bank to urgently activate CERC and reallocate any undisbursed balance to support the implementation of the RGC's emergency plan. Detailed procedures and rules on activation and implementation of CERC will be summarized in the CERC Manual.

C. Project Financing

67. **The proposed project has an estimated cost of US$299 million, which will be covered by an IDA credit of US$55 million, contributions from the GFF and DFAT in an amount of US$34 million,** a contribution from the KfW in the amount of EUR16 million (or US$17.92 million equivalent), a contribution from the Government of Korea through the KOICA of US$9.5 million, and funds from the RGC in the amount of US$186 million**.** KfW and KOICA have already confirmed their respective contributions which will be channeled through a new Cambodia Health Equity and Quality Improvement Program Multi-Donor Trust Fund (MDTF). However, the funding from this trust fund was not available by the negotiations, thus the contribution from KfW and KOICA was presented as financing gap during the negotiations (see table 4). The MDTF funds are expected to be available by the end of May 2022. A co-financing deadline is introduced in the Financing Agreement to ensure that the MDTF funds will be made available by December 31, 2022 as the latest. In the unlikely event that the co-financing MDTF grant does not materialize as expected, the project will be restructured to appropriately scale down the scope and adjust the PBCs to reflect a lower level of achievement.

Table 4. Project Financing by Funding Sources (US$ equivalent, millions)

Component/Activities	IDA	DFAT	GFF	RGC (Agreed)	Financing Gap (MDTF)	Total
Component 1	**20.44**	**7.06**	**5.58**	**70.00**	**8.92**	**112.00**
Subcomponent 1.1	17.04	5.88	4.65	70.0	7.43	105.00

[38] An Eligible Crisis or Emergency may include (a) cyclone, (b) earthquake, (c) storm, (d) storm surge and strong waves, (e) tornado, (f) tsunami, (g) volcanic eruption, (h) flood, (i) landslides, (j) forest fires, (k) drought, (l) severe weather, (m) extreme temperature, (n) high winds, (o) dam break, (p)Public health emergency, and (q) any natural disaster or man-made crisis.

Component/Activities	IDA	DFAT	GFF	RGC (Agreed)	Financing Gap (MDTF)	Total
Subcomponent 1.2	0.49	0.17	0.13	0.00	0.21	1.00
Subcomponent 1.3	2.91	1.01	0.8	0.00	1.28	6.00
Component 2	**32.77**	**11.32**	**8.92**	**116**	**14.29**	**183.30**
Subcomponent 2. 1	**11.60**	**4.00**	**3.14**	**110.00**	**5.06**	133.50
Subcomponent 2.2	9.49	3.28	2.59	6.00	4.14	25.50
Subcomponent 2.3	11.68	4.04	3.19	0.00	5.09	24.00
Component 3	**1.79**	**0.62**	**0.5**	**0.00**	**0.79**	**3.70**
Subcomponent 3.1	1.55	0.54	0.43	0.00	0.68	3.20
Subcomponent 3.2	0.24	0.08	0.07	0.00	0.11	0.50
Component 4	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Contingent Emergency Response (CERC)	0.00	0 .00	0.00	0.00	0.00	0.00
Total	**55.00**	**19.00**	**15.00**	**186.00**	**24.00**	**299.00**

Note: MDTF = Multi-Donor Trust Fund.

D. Project Beneficiaries

68. **The project beneficiaries are the entire population of Cambodia, particularly the poor and vulnerable, and the health care providers working in the public health sector.** Given the support for increased HEF utilization, the project target will have stronger focus on the poor and underserved, including the socially marginalized population. While the majority of the project's systems and institutional strengthening activities will take place at the national and provincial levels, supporting community- and facility-level activities will also be prioritized, benefiting subnational entities as feasible, including communes and VHSGs.

E. Results Chain

69. **The assumption underpinning the project's theory of change is that improved equitable utilization of quality services coupled with improved management and accountability will substantively improve health outcomes and accelerate the country's progress toward UHC (figure 3).** More specifically, the following outputs are a prerequisite to the project achieving its PDO:

(a) Increased utilization of health services by the HEF beneficiaries
(b) Improved accountability and efficiency of health spending
(c) Improved availability of key essential health services in communities, HCs, and hospitals
(d) Improved supervision, management, and accountability
(e) Improved health worker knowledge, attitudes, and practices
(f) Gender responsive and inclusive health governance, management, and service delivery.

70. **Some critical assumptions in the causal chain above include the following**: (a) HEF and SDGs payment transfers and quality assessments will be conducted on time; (b) Government is fully committed to robustly testing and improving implementation of the new phase of quality improvement program—(NQEMTs-II), which

will further build on progress in quality improvement; (c) there is improving quality of care in public HFs and further removing financial barriers to seeking care among the poor and vulnerable (HEF implementation), improving health service utilization by the poor; and (d) improving health systems management and accountability will accelerate UHC progress in Cambodia.

Figure 3: Project Theory of Change

Problem Statement: Inequitable utilization of health services, weak quality of care coupled with challenges in governance and accountability adversely impacts health outcomes and progress towards universal health coverage in Cambodia.

Inputs and Activities	Outputs		Outcomes	Impact
Improved equitable utilization of health services				
1. Financing medical and non-medical benefits for the poor (HEF) 2. Community and facility level support to improve HEF awareness and utilization	**PDI1/ PBC1:** Outpatient visits by HEF beneficiaries in low utilization ODs (**PDI 1s:** Increased outpatient visits by Health Equity Fund beneficiaries in provinces with high multidimensional poverty) **PDI2:** Improved percentage of HEF beneficiaries who used OPD services paid by HEF		Improved equitable utilization of health services by poor and vulnerable populations	Improved equitable utilization of quality health services in Cambodia, especially for the poor and vulnerable populations.
3. HEF benefit package optimized to match the cost of the services 4. Monitoring, reporting and analyzing HEF utilization on a regular basis 5. Strengthen PCA capacity in HEF claim verification and SDG Ex-post verification 6. Capacity building for new functions such as reviewing claims from NSSF	**PBC1:** Improved HEF management **PBC2:** Functions and service coverage of PCA expanded	Improved accountability and efficiency of health spending		
Strengthened quality and capacity of health service delivery				
1. Biannual administration of National Quality Enhancement Monitoring Program (NQEMP) 2. Performance-based grants to health facilities, PHDs and ODs 3. Enhanced digital tools for supervision and performance	**PDI3/ PBC3:** Number of HFs exceeding 60 percent score on the second round of semi-annual national quality assessment **PBC3:** Increased number of HFs exceeding 60 percent score on the second round of semi-annual national quality assessment	-Improved supervision, management and accountability -Improved health worker knowledge, attitude and practice	Improved quality and inclusivity of health service delivery	
4. Lump-sum grants to facilities 5. Building an enhanced primary health care model centered on community engagement, including training of VHSGs and strengthening the referral network 6. Screening and treatment of NCDs 7. Building service capacity of referral hospitals	**PBC4/5:** NCD services and cervical cancer screening rolled out at national and subnational levels **PDI4/ PBC5:** Increased hypertension screening rate	Improved availability of key health services including NCDs in communities, PHCs and hospitals		
Implementation management, institutional capacity building including in GESI and M&E				
1. Technical assistance for PFM, procurement, safeguards, operating costs 2. Digital health monitoring and reporting system to improve interoperability of major data systems 3. Capacity building to improve data monitoring and use	**PBC6:** Timely processing of project funds and improved capacity of sub-national HFs in applying relevant financial management system -Improved data management and use -Data reviews conducted on the utilization of essential health services including NCDs	-Improved performance of critical MOH staff -Improved management and accountability -Improved data-driven decision-making		
4. Capacity building on mainstreaming GESI into health systems	**PDI5:** Increased number of HFs with Full PMRS being introduced routinely collect and report sex, age and geographical location disaggregated data, gender specific health data (e.g. GBV), and other markers of disadvantage such as indigenous status **PBC7**: Implementation of Gender Equality and Social Inclusion Action Plan	Gender responsive and inclusive health governance, management and service delivery		

Note: PDI = PDO indicator; PHC = primary health care

F. Rationale for Bank Involvement and Role of Partners

71. **Through engagements in Cambodia and globally, the World Bank has extensive knowledge and adapted learning experiences of implementing health systems reforms**. The World Bank brings deep global knowledge and experience of (a) expanding service coverage in countries undergoing an epidemiological transition and facing a double burden of communicable and non-communicable disease, (b) scaling up health financing reforms to pave the way for UHC, (c) improving the quality of health service delivery, and (d) improving health information systems and public financial management (PFM) for better health systems governance and management. This evidence-based global knowledge is the World Bank's strongest value-added in addition to providing significant financing.

72. **The proposed project builds on more than two decades of engagement by the World Bank on improving health systems performance including Communicable Disease Control and Health System Strengthening, Health Sector Support Program 1 and 2, and the ongoing H-EQIP**. In particular, a previous World Bank-supported project (Cambodia Second Health Sector Support Program [HSSP2, P102284])[39] supported scaling up of HEF to all public HFs at the sub-national level by 2015, and the ongoing H-EQIP has been supporting institutionalization and streamlining of the scheme within the national system and scaling it up to all national public hospitals by 2018. The project design will also draw upon findings from ongoing analytical studies under the programmatic Advisory Services and Analytics, including the impact evaluation of H-EQIP and the Health Financing Systems Assessment. Complementary to the technical inputs from the World Bank, the project will also benefit from the technical and financial inputs from the PF Partners—DFAT, KfW, KOICA, and GFF — in addition to close collaboration with the USAID, WHO, Family Health International's 360 (FHI360), and other DPs and civil society organizations.

G. Lessons Learned and Reflected in the Project Design

73. **The key evolutionary shifts that were introduced through H-EQIP and which have consolidated into the H-EQIP II's design and implementation are:** (a) strengthening the social health protection system and increasing focus on the decentralized, implementation level; (b) strengthening the results-based focus of the project through the predominant use of output-based payments through HEF, performance-based financing through SDGs, and the use of PBCs; and (c) mainstreaming the implementation of project activities into the RGC systems and strengthening domestic capacity to take over project implementation support, monitoring, and PFM roles.

74. **The project design incorporates the experiences of previous and ongoing World Bank/PF partners health projects in Cambodia including HSSP2, H-EQIP, CNP, and the Integration of Social Accountability into National and Subnational Systems[40] as well as the World Bank operations in other countries.** The ongoing CNP provides valuable lessons on working with communes and sangkats (urban communes) in supporting service provision. Collaboration with the ISAF Project will be explored to disseminate feedback from the community collected through ISAF to HFs and health authorities for them to take actions for improvement. The design is also

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[39] World Bank. 2008. Cambodia - Second Health Sector Support Program (English). Washington, DC: World Bank Group. http://documents.worldbank.org/curated/en/192201468216606460/Cambodia-Second-Health-Sector-Support-Program
[40] World Bank. 2020. Cambodia - Integration of Social Accountability into National and Subnational Systems Project: Additional Financing. Washington, D.C.: World Bank Group. https://imagebank2.worldbank.org/search/31794054

informed by several analytical and advisory works financed by the BETF, including utilization of HEFs, impact of the pandemic on disruption of essential health services, gender and social inclusion, capacity gap analysis of RHs, PFM, and the SDGs impact evaluation, which provides detailed quantitative and qualitative results of health service utilization and users' views. The project design has also drawn experiences and lessons from a number of analytical works done by other DPs.

75. **Sustaining the focus on results of H-EQIP, H-EQIP II emphasizes performance-based financing into the core of its design.** Two performance-based financing mechanisms have been integrated into the Cambodian health system: (a) SDGs are a mechanism for rewarding objectively assessed improvements in quality of care and provide additional and more flexible financing to HFs for operational costs and (b) DLIs are used to transfer funds to relevant departments in the MOH when they achieve agreed targets. H-EQIP II will expand the use of SDGs to more health programs and will use PBCs, the similar result-based financing instrument as DLIs, to incentivize achievement of results.

76. **H-EQIP II incorporates lessons from H-EQIP, which grafted the GAP onto the project during implementation but struggled to achieve the necessary ownership to have any impact.** Challenges in implementing GAP were compounded by weakness of the RGC's capacity on gender and lack of earmarked project resources. In response to this, H-EQIP II has a PBC to strengthen the capacity of the RGC's institutional structures for mainstreaming GESI in the health sector at national and sub-national levels, strengthen women in leadership, and produce practical outputs to translate GESI policies into decision-making and practice.

77. **H-EQIP II will continue to focus on consolidating the roles of the QAO and PCA and mainstream implementation by using the RGC's systems and staff and building on lessons learned from HSSP2 and H-EQIP as well as the D&D reforms that are now being implemented across the country.** The expanded use of SDG and specially designed PBCs will disburse funds directly to the sub-national levels, providing incentives and support for management strengthening, increased autonomy, and direct supervision at sub-national levels.

III. IMPLEMENTATION ARRANGEMENTS

A. Institutional and Implementation Arrangements

78. **Overall institutional arrangements are based on the lessons learned from H-EQIP and aligned with the ongoing D&D reforms which decentralizes and delegates health service management functions to the subnational administration.** The PHDs, ODs and HFs will play important roles in the implementation of H-EQIP II under oversight from the provincial and district governors. PHDs and ODs will report the implementation progress of project activities through monthly meetings at provincial and district governor offices and seek their collaboration and support, as required, to improve project implementation progress.

79. **A Project Steering Committee will be established at the national level to provide policy guidance and overall direction for the project (figure 4).** The committee will also review and endorse the annual workplan for the adaptive learning agenda and will advise on areas for policy study/policy dialog and knowledge exchange. The World Bank project implementation support missions will meet with the committee by the end of each mission. Provincial health directors and provincial governors will participate in this meeting, as required. The committee at the national level, chaired by the Health Minister, will consist of representatives from MEF, MOH, NCDDS, NSPC, MOP, and NSSF.

80. **The MOH is the implementing agency of the project and will oversee day-to-day operations.** The Honorable Minister of Health will appoint a project Director to oversee the project implementation (figure 4). Two project managers, one technical and another administration and finance, will be appointed to assist the project director in carrying out the day-to-day operations. The project will be implemented through the technical departments of the MOH; national centers; PCA; and national hospitals, PHDs, ODs, PHs/RHs, and HCs using the mainstreamed MOH structure and will not involve a parallel project implementation unit or secretariat. The MOH's technical departments and the national centers participating in this project implementation will be the (a) Hospital Services Department and QAO, (b) PMD, (c) DPHI, (d) Department of Food and Drugs, (e) GMAG, (f) National Maternal and Child Health Center, (G) National Blood Transfusion Center (NBTC), and (H) DBF. FM, procurement, social and environment, and gender and social inclusion capacity improvement at both the national and subnational levels will be provided through training and on-site hands-on support, where appropriate.

81. **The project will engage and work closely with the MEF, NSPC, NSSF, NCDDS, and sub-national administration to review progress on project implementation, support policy reform, and build capacities.**

82. To reduce fragmentation, simplify the process, strengthen ownership and sustainability, and bring management in line with the decentralization process of the health sector, the following changes will be introduced to the implementation arrangements under H-EQIP II.

- The reviews on quality scores of the NEQMTs, which under H-EQIP are being carried out by the QEWG, will be streamlined and to be performed by the QIWG.

- Post-identification of the poor, which is being carried out by two contracted NGOs under H-EQIP to identify the patients who missed the Pre-IDPoor update rounds and fell into poverty in between the update rounds, will be dropped and instead will use the OD-IDPoor system, which is being carried out by commune/sangkat council under the technical support and supervision of the MOP/Provincial Department of Planning. The OD-IDPoor system has been rolled out to every commune since April 2021 to replace the Pre-IDPoor system. Patients who present at the PHs/RHs and report that they are not able to pay user fees are advised to request ID-Poor cards from the commune/sangkat council through the village chiefs.

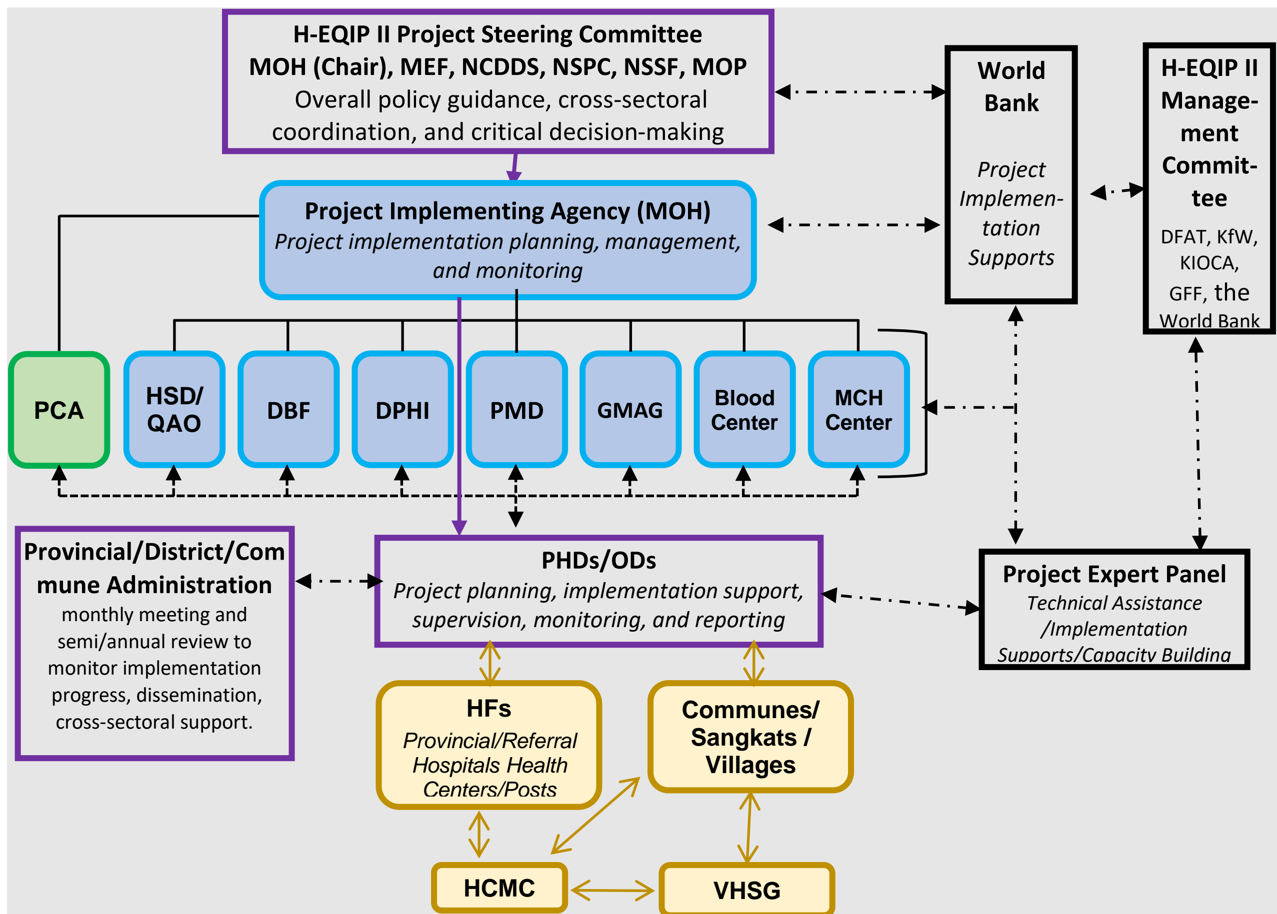
- HFs will work in close collaboration and with active support from local administration networks (commune councils and village chiefs), the HCMC, and other forums to improve community awareness about activities financed by H-EQIP II; raise awareness on the benefits of IDPoor cards and provide health education messages on healthy lifestyles, the need for screening and having proper treatment on cervical cancer and diabetes and hypertension, and awareness raising on healthcare benefits of ID-Poor cards. The project will also coordinate closely with the CNP and other DP supported projects to avoid overlapping and to synergize with each other.

- An experts' panel, consisting of both international and national experts and/or institutions will be established. The international experts with the domestic experts in each core technical areas will be teamed up, for example, NCD intervention, quality improvement, accreditation, and so on to enhance the domestic capacity to support research and learning and provide continuous support to the RGC and frontline implementers. The panel of experts will lead on providing technical assistance, implementation support and supervision, conducting studies and implementation research and producing knowledge products in their respective areas as part of the overall learning network.

83. An adaptive learning agenda and platform will be established to facilitate knowledge generation and mutual learning during the implementation.

84. **The POM will be developed and adopted by the project effectiveness and will serve as the guiding document for project implementation**. The POM will include an updated SDG operational manual; an updated HEF operational manual; chapters detailing implementation arrangements, the PBC verification protocols, the project fiduciary, environment, and social, and M&E requirements; and relevant Prakas. In addition, AOPs for project implementation will be developed and submitted to the World Bank for 'no-objection' by November 30 each year, except for the first AOP which is due no later than one month after the Financing Agreement's effectiveness. The AOPs will lay out the project implementation activities, targets to be achieved' and budgets for each fiscal year and specify the funding allocation for each of the components; the sources of funding; and shares of funding from IDA credit, grant from PF Partners, and RGC counterpart funds.

Figure 4: Project Implementation Arrangements



Note: ◄·-·► Dotted line indicates consultative/advisory role

85. **Donor arrangements**. H-EQIP II is developed under the collaborative efforts of PF Partners including DFAT, KfW, KOICA, and GFF, with the shared goal of supporting the RGC's development agenda in the health sector. DFAT, KfW, and KOICA will co-finance the project through existing or newly established trust funds

administered by the World Bank. In addition to periodic implementation support, BETF components of each trust fund will finance adaptive learning, technical assistance, capacity building and analytics that are closely linked to the successful achievement of project objectives. In addition, USAID through FHI360 and EQHA will continue to provide technical support to 20 hospitals (comprising 13 public hospitals and 7 private hospitals) for implementing the accreditation requirements and providing technical support to the MOH for the development of accreditation standards. The KOFIH will finance the construction of the PCA office building, the enhancement of the PMRS and claims review system, the rollout of the full PMRS, and the establishment of NCD and Cervical Cancer Screening and Treatment (CCS&T) services in three provinces (Pursat, Battambang, and Pailin). Agreement on the harmonized arrangements for pooled Technical assistance, including pooled resource management, decisions on activities, joint supervision, and project review and reporting, have been agreed on by the contributing partners and these will be spelled out in the administrative agreements to be signed by the World Bank and each partner. The Management Committee —a partner forum for consultation and decision making on issues arising in the project—which was established under H-EQIP will be maintained. Building on the strengths of this collaboration between DPs, this forum will serve as a coordinating mechanism for donors, including PF Partners for H-EQIP- II and partners with their own development programs. Independent technical assistance will also be provided from GIZ, Japan International Cooperation Agency (JICA), and United Nations agencies to fully complement the activities under the project and close coordination will be ensured through regular meetings of pooled and non-pooled technical assistance partners.

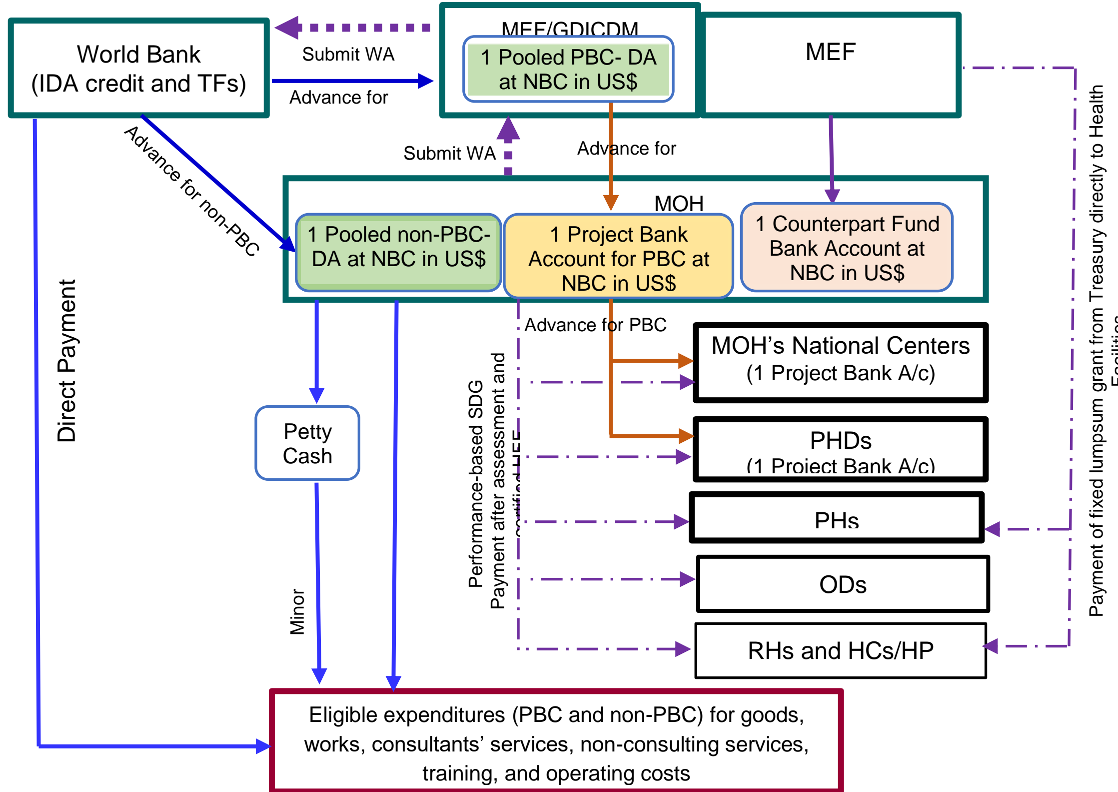
86. **Fund flows and accountabilities for financial reporting**. One Designated Account (DA) for non-PBC parts (non-PBC-DA-01) and another DA for PBC parts (PBC-DA-02) in US dollars will be opened at the National Bank of Cambodia (NBC) and administered by the MOH for non-PBC-DA and by the MEF for PBC-DA to receive advances from IDA and trust funds to pay for all eligible project expenditures (Figure 5). The MOH will manage a project bank account in US dollars at the NBC to get funds from the MEF’s PBC-DA to implement the PBC parts and a counterpart fund bank account in US dollars at the NBC to co-finance the project in accordance with the agreed shared percentage specified in the Disbursement and Financial Information Letter (DFIL). Given that many expenditures will be paid by the PCA and sub-national-level entities in implementing the PBC parts, each PCA and PHD will manage a bank account in US dollars at the acceptable commercial bank and maintain a corresponding accounting system. The total expenditures pertaining to each PBC will be monitored in the accounting software (QuickBooks) to determine the eligibility of each PBC’s total expenditure which should not exceed the value of each PBC. A six-month interim unaudited financial report, which will include the two DAs, project bank account, counterpart fund bank account, and all sources of funds, and provide financial information by components, subcomponents, disbursement category and each PBC’s expenditures, will be furnished to the World Bank no later than 45 days after the end of each calendar semester, starting from the first semester following the project’s first disbursement.

87. **HEF FM arrangements.** The HEF payments to HFs for certified services provided to beneficiaries are recognized as expenditure upon payment from the project. The RGC allows 40 percent of the HEF payment to cover operating costs of HFs; however, this 40 percent amount should be prioritized for expenses to increase health care benefits awareness and for regular health financing steering committee meetings for PHs/RHs. The reimbursement of the HEF to HCs is subject to HCMC working with VHSG in raising awareness of the healthcare benefits of IDPoor cards. The HCMC also works closely with the commune council to explain healthcare benefits when they distribute IDPoor cards. Similarly, reimbursement of the HEF payment to PHs/RHs is subject to them conducting health financing steering committee meetings routinely for reviewing HEF implementation and addressing community concerns and issues encountered with the HEF patients. The PCA will check and verify that this condition is met before certifying the HEF invoices and payments.

88. **Performance-based SDG FM arrangements.** Payments made by the MOH to PHDs, PHs, ODs, RHs, and HCs for the certified performance assessment are recognized as expenditure upon payment. PHDs, PHs, ODs, RHs, and HCs will maintain an Excel-based manual accounting system and supporting documents for all expenditures and paid from the SDG funds in accordance with the SDG operational manual. At the HC level, SDG performance-based grants will finance screening of new cases for Diabetes and hypertension, and cervical cancer in the population groups targeted. These SDG performance-based grants' utilization will be aligned with the mechanism applied for user fee incomes. It is compulsory for HCs to use 39 percent of incomes from SDG performance-based grants[41] for the HCMC to work closely with village chiefs and VHSGs; support community engagement activities, including community education on healthy lifestyles, community mobilization, follow-up for NCD screening and treatment; and purchase medicines and consumables for treating NCD, as required.

89. **Fixed lump-sum SDG FM arrangements.** Fixed lumpsum grants are paid directly from the treasury to HFs. During the implementation of H-EQIP II, disbursement of fixed lump-sum grants is conditional to quality self-assessment in the previous immediate semester's round that was conducted by HFs. The project recognizes both receipts and expenditures upon payment from the treasury to HFs. The accounting maintained by HFs is the same as performance-based SDGs.

Figure 5: Project Fund Flow Diagram



Note: GDICDM = General Department of International Cooperation and Debt Management; TFs = Trust Funds.

[41] According to the national policy on user fees in the health sector, user fees generated by the public HFs are distributed as follows: at least 39 percent to spend on operating HFs, 1 percent to pay to the national treasury, and up to 60 percent to distribute as bonuses for staff.

90. **FM capacity building for HFs at sub-national level.** HFs (PHs, RHs, and HCs/health posts) receive funds from various sources such as user fees, HEF, NSSF, fixed lumpsum grant, performance-based grant, and reimbursement from activities implemented by other NGOs and DPs. Currently, disaggregated recording of funds is executed manually in the form of separate and combined cash books. This has led to resource constraints within HFs to manage various books and inconsistent recordings while most of them do not have accounting/FM skills. Under the implementation of H-EQIP, the two SDG funds (fixed lumpsum grant and performance-based grant) are managed and recorded in one manual Excel-based system which has complete control over accounting and produces a complete statement of receipts, expenditures, and fund balance of the SDG funds. The cascade trainings on FM for SDG funds to use the manual Excel-based system in all HFs at the sub-national level was provided by the OD/PHD accountants who were trained as trainers. Trained experts will provide on-the-job support to all HFs to equip them with higher knowledge in applying the manual Excel-based system. Due to limited understanding of how to apply the Excel-based system, the commitment/unavailability of most trainers, especially the negative impact of the COVID-19 pandemic, which limits travel, meetings, and hands-on support to HFs, has not been sufficiently provided. In the proposed project, more scope for capacity building on FM to the sub-national HFs and other technical assistance support will be derived from an ongoing PFM assessment.

B. Results Monitoring and Evaluation Arrangements

91. **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 indicators will be drawn from data sources including HMIS, PMRS, national programs, the periodic Cambodia Demographic and Health Surveys, Cambodia socioeconomic survey, and project administration data. The indicator definitions, baselines, and targets are aligned with the RGC’s HSP-4, and National Health Congress reports. Project financing will also support strengthening the various national data systems including HMIS, PMRS (for HEF patient level data) and NQEMTs (for quality of services data) as described in project Components 1 and 2.

92. **The project indicators have been selected based on (a) their importance in achieving project goals and (b) the availability and feasibility to monitor on a regular basis through routine data.**[42] Project progress will be monitored and evaluated through rigorous mechanisms: (a) third-party verification of SDG and HEF outputs and outcomes by PCA and (b) verification of PBC targets and robust validation - as part of Bank’s due diligence - before disbursements against PBC expenditures.

93. **The PF Partners will monitor implementation progress during semi-annual implementation support missions, regular project reporting and field visits.** Data related to project implementation progress will be made available for review and discussion during every implementation support mission. An MTR of project performance will be carried out by the MOH, World Bank, and PF Partners by no later than December 31, 2024. At MTR, the project priorities will be revisited, renegotiated, and necessary adjustments will be introduced to ensure alignments with the RGC priorities throughout project implementation and taking into consideration the progress in project implementation.

94. **The MOH will submit annual progress reports to IDA and PF Partners no later than sixty days after the end of each calendar semester.** The annual progress report should: (a) describe implementation progress, (b)

[42] Note that DPHI is also supported to produce routine data disaggregated by sex and location as a minimum with the scope to extend this disaggregation to other markers of social vulnerability as the project progresses.

highlight issues that need attention (including safeguards compliance and mitigation actions), and (c) report on progress toward meeting the PDO and intermediate results indicator targets. The MOH will be responsible for checking the achieved results by PBC implementers, producing PBC achievement reports, detailing the performance of PBCs, and submitting the reports to the World Bank for review and validation prior to disbursements. 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 project.

C. Sustainability

95. **Financial sustainability**. Between 2021 and 2020, the RGC's financing for health increased by 102 percent. Under the ongoing H-EQIP, with a view to its commitment to financial sustainability, the RGC committed to supporting 50 percent of the costs of HEFs and SDGs from the national budget at the start of the project. In fact, the RGC's support to HEF in 2020 amounted to 73 percent of the total HEF costs. The RGC's contribution under HEF, over the five-year life of H-EQIP-II, is expected to be around US$90 million. Anticipated overall support from the RGC to the project amounts to 68 percent, which indicates the continued progress toward financial sustainability.

96. **Technical and institutional sustainability**. H-EQIP- II will build on successes in H-EQIP and further expand in a few aspects. Component 1 will strengthen and expand the role of the PCA (the establishment of which was a key achievement under H-EQIP), which certifies HEF claims and verifies SDGs claims and is governed by a Board chaired by the MEF. Component 2 will continue strengthening the QAO and the health service delivery system, with a particular focus on the subnational level, including continued improvement to the quality of health service by rolling out national healthcare standards in HFs, in line with the RGC's plans. Component 2 will also contribute to the National Digital Health Strategy (2021-2030) by, among other aspects, enhancing the PMRS and developing the EMR system in Cambodia. Component 3 aims to strengthen the gender and social inclusive capacity of the MOH and sub-national authorities through capacity building and supporting the MOH to operationalize the gender mainstream action plan for the health sector. By aligning with the RGC's policies and strategies, H-EQIP-2 is better placed to contribute to the sustainability of the activities supported.

IV. PROJECT APPRAISAL SUMMARY

A. Technical, Economic and Financial Analysis

97. **The proposed project will contribute to Cambodia's development** by (a) improving health service utilization, quality, and outcomes; (b) financing pro-poor service-fee exemption, which will promote equity and shared prosperity; (c) improving labor force productivity; (d) increasing efficiencies in health systems; (e) ensuring that health system shocks, such as the COVID-19 pandemic do not result in reduced access to and utilization of essential services for vulnerable populations of women, children and adolescents; and (f) building human capital.

98. **The project is pro-poor.** H-EQIP II will finance fee-exemptions, transport cost reimbursements, and food-allowances for poor households which will reduce demand-side barriers to health service utilization by the poor. The pro-poor approach of achieving UHC will be realized by focusing public financing on (a) primary and secondary levels of care; and (b) essential health packages that address both financial inequities in public sector spending and the current unequal distribution of essential health services.

99. **The project will improve the quality of health services.** An estimated 22,000 deaths annually in Cambodia are **attributed** to conditions amenable to medical care, out of which 65 percent occur because of the poor quality of health care as opposed to non-utilization.[43] Improvements in the quality of health care not only reduce deaths due to poor quality of health care but also improve demand for health services in the public sector by improving technical and perceived quality of care and improving labor productivity.

100. **The project will finance high-impact and highly cost-effective health services**. Based on exhaustive evidence from low and middle-income countries,[44] key services included in the MPA and CPA, including the quality enhancement bonus are cost-effective, and the project will finance further optimization of the HEF benefit packages to improve its effectiveness and efficiency. The proposed project will also expand access to essential NCD services as Cambodia has been undergoing an epidemiological transition. A recent investment case in NCD control estimated that the overall economic losses due to NCDs amount to US$ 1.5 billion (6.6 percent of GDP in 2018) in Cambodia.[45] As is the case for other essential health services, many NCD preventive and curative services are highly cost-effective. A recent cost-effectiveness exercise led by the Lancet Non-Communicable Disease and Injuries Poverty Commission found at least 27 health-sector NCD and injuries interventions that are highly cost-effective[46] and prioritize the poor and vulnerable groups.[47]

101. **The project activities will improve efficiency of health spending.** The HEF-financed health services for the poor and improved allocative efficiency of health financing by targeting financing where it is most needed and impactful. As discussed before, HEF has improved utilization of health services by the poor. Additionally, the results-focused approach in SDGs, HEFs, and PBCs improve accountability and allocative and technical efficiency by defining the key outputs from health providers and managers, improving health worker and management motivation, and engendering a data-driven approach to improving health service access and quality. Finally, the PFM and M&E support, further investments in the PCA and QAO, and financing of a digital health system will improve health systems management and data-driven decision-making, thereby improving efficiency of health spending in the country.

Rationale for Public Sector Provisioning/Financing

102. **Public sector engagement in this project is justified because of various positive and negative externalities and spillovers in health.** Improving access to quality health services, financial risk protection, and health systems would not only improve health outcomes but would also ensure inclusive growth and accelerated human capital development in the country. Additionally, there is a strong equity argument for public financing

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[43] Kruk, M.E., A.D. Gage,N.T. Joseph,G. Danaei, S.García-Saisó, and J.A. Salomon. 2018." Mortality due to Low-Quality Health Systems in the Universal Health Coverage Era: A systematic Analysis of Amenable Deaths in 137 Countries." *The Lancet 392*(10160):2203-2212.
[44] Horton, S., H. Gelband,D. Jamison, C. Levin, R. Nugent and D. Watkins,2017. "Ranking 93 Health Interventions for Low-and Middle-Income Countries by Cost-Effectiveness." PloS one 12(8):0182951.
[45] United Nations Interagency Task Force on the Prevention and Control of NCDs, WHO Regional Office for the Western Pacific, United Nations Development Program. 2019. *Prevention and Control of Noncommunicable Diseases in Cambodia: The Case for Investment*. WHO: Manila, Philippines.
[46] (With cost-effectiveness ratios close to those of the essential Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition services)
[47] Bukhman, G., A. O. Mocumbi, R. Atun, A. E. Becker, Z. Bhutta, A. Binagwaho, et al.2020. "The Lancet NCDI Poverty Commission: Bridging a Gap in Universal Health Coverage for the Poorest Billion." *The Lancet* 396 (10256): 991-1044. *https://doi.org/10.1016/S0140-6736(20)31907-3*.

as the project focuses on improving access to quality health services for the poor.

Benefit-Cost and Cost-Effectiveness Analysis Results

103. **The return-on-investment analysis shows that the project interventions would generate significant health and economic benefits with positive returns on investment.** For every dollar spent on the project, the investment is expected to yield US$3.95 in returns. The net present value of investments is US$ 795 million, with an internal rate of return at 7.42 percent. The investments are estimated to avert 7,700 deaths or 398,000 disability adjusted life years (DALYs) during the project period because of its focus on improving access, utilization, and quality of care, with its expanded access to NCD services. With cost-effectiveness ratio at less than half of the country's GDP per capita (US$1,513 in 2020) at US$679 per DALY averted, the project investments are also considered highly cost-effective[48] (see annex 3 for more details).

B. Fiduciary

(i) Financial Management

104. **The FM assessment of the proposed project was carried out in accordance with the Bank Policy and Directive: Investment Project Financing.** The overall FM arrangements are considered adequate and meet the World Bank's minimum FM requirements under the above referred policy and directive. The project's FM arrangements will be embedded into the existing structure of the MOH, as arranged under the ongoing H-EQIP. The DBF will have overall responsibility for the project FM, including disbursements against planned activities. The DBF has considerable experience in managing ongoing World Bank-funded projects. Key FM risks of the project include (a) sub-national HFs' weak FM capacity to manage the SDG funds; (b) understaffing in the DBF stretching its ability to manage the RGC's budget and many projects' funds; and (c) the MOH's Internal Audit Department (IAD) not having the adequate resources to carry out the internal audit of the project with the frequency and scope needed. The residual FM risk is rated Substantial. The agreed mitigating measures include (a) continued application of the QuickBooks accounting software, (b) hiring of two FM consultants to support the FM operations at the DBF and FM capacity building of HFs, (c) reinforcing of capacity building in FM at the sub-national HFs with one PBC on financial reporting of HFs in accordance with the SDG manual, and (d) provision of capacity building to the MOH IAD.

105. **Planning and budgeting.** The project will follow the RGC's budgeting principles as outlined in the Standard Operating Procedure on FM for externally financed projects issued by Sub-Decree No. 181 ANK/BK dated December 2, 2019. The project will prepare the AOPs for implementing activities leading to the achievement of the PDO covering all sources of funds covering the PBC and non-PBC parts. IDA Credit, all trust funds, and RGC's counterpart funds provide a joint co-financing at agreed shared percentages to the project's expenditures. During the preparation of the AOP, the World Bank will provide technical support to the MOH's teams in preparing the activities plan for the PBC and non-PBC parts before submitting it to the MEF for approval. The AOP should be submitted to the MEF for approval and then to the World Bank for 'no objection'.

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[48] Choosing interventions that are cost-effective [Internet]. Geneva: World Health Organization; 2014. Available from: http://www.who.int/choice/en/

106. **FM staffing**. By adopting the current FM staffing arrangement under H-EQIP, the MOH will assign adequate FM staff within the DBF for a full-functioning FM to carry out the day-to-day FM and disbursement tasks and ensure that the internal controls and policies are adhered to. To support the FM staff during their busy schedule for some routine works, two FM consultants will be engaged to provide operations support to the DBF and capacity building in FM for the sub-national-level HFs. One or two FM assistants can also be engaged to provide routine support to the DBF.

107. **Accounting policies and procedures and internal controls.** The MEF will manage the PBC-DA for the advances from the World Bank. The MEF will ensure timely and sufficient funds to be transferred to the MOH to implement the PBC-related activities in accordance with the approved AOP. The MEF will also provide a monthly bank statement and other bank related documents to the MOH to account for all financial transactions in the PBC-DA and in the MOH's accounting system for the whole project. The project will adopt a cash basis of accounting and the RGC's chart of accounts. The MOH maintains the QuickBooks accounting software, which is currently being used in H-EQIP and will remain as the FM tool to manage financial transactions and produce timely and reliable financial reports covering all the project's activities (expenditures for the PBC and non-PBC expenditures) and all sources of funds within the project. Each PCA and PHD will maintain QuickBooks accounting software to ensure timely submission of financial reports to the MOH for consolidation. The existing H-EQIP-supplementary FM guidelines and procedures will be updated to provide clear controls and procedures pertaining to expenditures for the PBC and non-PBC parts and be applied in the project, together with the enhanced involvement of the IAD to build capacity of the internal auditors and carry out internal auditing of the project. The project recognizes the SDG funds as expenditures upon payment and each HF will maintain a simple accounting system to manage and account for the SDG funds. The original supporting documents for the whole project are maintained by the DBF, PCA, PHDs, ODs and HFs for all expenditures paid by them.

108. **External auditing.** The project's financial statements will be audited annually by an external auditing company acceptable to the World Bank. The selection of the auditor is carried out by the MEF under the audit bundling contract arrangement. The audit will cover all sources of funds within the project and includes a review of the expenditures for all project activities, including the PBC-related expenditures and the SDG funds to be managed by HFs. Each audit will cover one calendar year and the audit report for each year shall be submitted to the World Bank not later than six months after the end of each calendar year. The audited financial statements will be subject to public disclosure in accordance with the World Bank's Policy on Access to Information.

109. **Disbursement arrangements**. The advance to the two DAs has a variable ceiling amounting to two-quarter cash projection which is approved by the World Bank's task team leader. The disbursement methods will be (a) reimbursements, (b) advances, (c) special commitments, and (d) direct payments. Supporting documentation required for eligible expenditures paid from the DAs is the interim unaudited financial report and the frequency of reporting of expenditure paid by DA is quarterly and yearly for DA for non-PBC part and DA for PBC part, respectively. The minimum application amount for reimbursements, special commitments, and direct payments would be equivalent to US$200,000. The project will have a disbursement deadline date of four months after the closing date of the project. The details are in the Disbursement and Financial Information Letter. Expenditures paid from the PBC-DA for implementing the PBC parts are provisional until the PBC targets are confirmed by the World Bank as being achieved.

110. **Disbursement for Component 4 (CERC)**. No withdrawal can be made under Component 4 until the RGC has (a) determined that an eligible crisis or emergency has occurred and has furnished to the Association a request to withdraw Credit amounts under Component 4 and the Association has agreed with such

determination, accepted said request and notified the Recipient thereof; and (b) the Recipient has adopted the CERC Manual and Emergency Action Plan, in form and substance acceptable to the Association.

111. **Retroactive financing.** The project will not provide retroactive financing.

112. **A risk-based FM support will be provided to the project** in the form of implementation support missions to review the adequacy of the FM arrangements, FM performance, and capacity-building strengthening and implementation of the auditor's recommendations.

(ii) Procurement

113. **Procurement under the project will be carried out in accordance with World Bank's Procurement Regulations for IPF Borrowers dated November 2020, and provisions stipulated in the Financing Agreement.** The approaches to national markets (National Procurement and Request for Quotations) will be carried out in accordance with the Kingdom of Cambodia's Updated Standard Operating Procedures and Procurement Manual for All Externally Financed Projects/Programs (Procurement Manual), promulgated through the Sub-Decree No. 181 ANK/BK, dated December 2, 2019, subject to the additional provisions included in the Procurement Plan. The World Bank planning and tracking system, Systematic Tracking of Exchanges in Procurement, will be used to prepare, clear, and update Procurement Plans and conduct all procurement transactions for the project.

114. **The MOH will be the implementing agency for the Project**. Procurement activities will be undertaken by the Procurement Unit of MOH. The World Bank has carried out capacity assessment and procurement risk assessment. Based on the assessment, the overall procurement risk assessment is rated Substantial. Key procurement risks preliminarily identified include (i) due to COVID-19 pandemic, project implementation could be delayed because the travel restriction and social distancing policies; (ii) limited resources and capacity of the procurement unit; (iii) possible delay of technical inputs for procurement; and (iv) governance risks. The proposed risk mitigation measures include (i) using the virtual technological solutions, such as audio/video conferences, and/or permit bids to be submitted by electronic means, e.g. scanned and attached to an email and PRC members under the special condition can join in the bid opening in person; (ii) at least one full time government procurement officer to be assigned for the Project and hiring procurement consultants to support the Project; (iii) putting in place an effective procurement monitoring system to ensure an effective internal procurement review process through sufficient delegation of authority to the members of all procurement committees and in compliance with the internally agreed service standard; and (iv) assigning focal person for effective coordination within the technical departments and across the ministries.

115. **The Borrower has prepared a Project Procurement Strategy for Development (PPSD) to inform fit-for-purpose procurement arrangements in the Procurement Plan**. It is expected that there will be some large civil works packages and large medical equipment for hospital packages required under MOH and therefore the International competitive market approach will be used for large procurement packages and selection of consultants. The involving international competition will be carried out in accordance with the Procurement Regulations for IPF Borrowers. National market approaches will be carried in accordance with the Kingdom of Cambodia's Updated Standard Operating Procedures and Procurement Manual for All Externally Financed Projects/Programs ('Procurement Manual'), promulgated through the Sub-Decree No. 181 ANK/BK, dated December 2, 2019, subject to the additional provisions included in the Procurement Plan.

116. Based on the findings and recommendations of the PPSD, the initial 18-month Procurement Plan has

been prepared. The Procurement Plan will be entered in STEP and updated annually (or as needed) by MOH to accommodate changes during project implementation and add new procurement activities as needed for the Project. The Procurement Plan and any updates or modifications shall be subject to World Bank's prior review and no objection. The World Bank will carry out procurement post reviews on an annual basis with an initial sampling rate of 20 percent, which will be adjusted periodically during project implementation based on the performance of the project. The detailed Procurement Plan is available in a separate project document.

C. Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

D. Climate Change

117. **Cambodia is highly vulnerable to current and future impacts of climate change and is considered one of the more disaster-prone countries in Southeast Asia.** In the 2021 Global Climate Risk Index, out of 180 countries, Cambodia ranked 14th most at risk based on data from 2000 to 2019. First, Cambodia has extremely high exposure to flooding. In terms of the proportion of the population affected, Cambodia is one of the world's most flood-exposed countries in the world. One study suggests that around 4 million people, or 25percent of the population, are affected when an extreme river flood strikes. Another study estimated that the increase in the population exposed to flood by 2050 is 19 percent. Second, Cambodia's coastal zones are known to be exposed to cyclones and tsunami-induced storm surges. Known risks include the action of sea-level rise to enhance the damage caused by cyclone-induced storm surges and the possibility of increased windspeed and precipitation intensity. Without adaptation, sea-level rise is likely to increase the overall risk faced by agricultural communities in the country's southwestern region. Last, Cambodia already experiences some of the highest temperatures in the world, with an estimated national average of 64 days per year when the maximum temperature exceeds 35°C. There is sufficient existing data to infer that Cambodia also faces a transition to a state of permanent heat stress because of temperatures regularly surpassing the levels safe for humans and biodiversity.

118. **The poor and the vulnerable, who are the main beneficiaries of the project, suffer the most from the negative impacts of climate change and natural disasters**. Cambodia is a predominantly agrarian country, with 80 percent of the population living in rural areas and many farmers relying on rainfed agriculture. Climate change pressures, such as increased incidence of extreme rainfall and flood, as well as higher temperatures, represent environmental drivers of vector-borne and water-borne diseases. Disease transmission is known to be sensitive to temperature, as demonstrated by research into dengue fever incidence in Cambodia. Higher average, maximum, and minimum temperatures all correlate with greater dengue incidence. Cambodia is also exposed to water-related diseases, such as diarrheal diseases, typhoid fever, leptospirosis, melioidosis, viral hepatitis, and schistosomiasis. Disease transmission is known to worsen during and after flood events in Cambodia, demonstrated for example in the spread of diarrheal disease. Diarrheal disease is a significant health risk to children in Cambodia and represents around 6 percent of all under-five deaths in Cambodia. Apart from altering transmission and occurrence of infectious diseases, climate change also directly and indirectly increases the incidence of NCDs. The impacts of climate change on NCDs can be directly through heat wave, sea-level rise or indirectly through reduced crop yields and food provisions and degraded water supplies and quality. Impacts on

human health are not only physical but also psychological. Moreover, extreme weather events, such as heavy rainfall, floods and heat waves, hamper health service delivery by making areas inaccessible; suspending outreach campaigns; and making it difficult for community members, particularly the elderly and those with preexisting conditions, to reach HFs. It is evident that the poor and the vulnerable are disproportionately affected by diseases and health service interruptions. Weak adaptive capacity, economic inequality, poor infrastructure, and limited institutions exacerbate the country's vulnerability to climate variability and change.

119. **The RGC clearly recognizes the negative impacts of climate change to the country and is fully committed to global efforts to address climate change, both at the national and international levels.** The Government's National Adaptation Program of Action (NAPA)[49] surveys conducted in seven provinces show that malaria transmissions are most common in agricultural fields and forests, particularly during the wet season. In addition to NAPA, the country already has several policies in place to help the health sector cope with these rising impacts the National Strategic Plan for Climate Change Adaptation and Disaster Risk Reduction in the Health Sector 2019–2023. The project design is fully aligned with the Government's priorities in this area.

120. **The project has been screened for short and long-term climate change and disaster risks, while the risk for project implementation is moderate, the risk to the population served by the project is substantial.** Given Cambodia's climate vulnerability, the project intends to implement measures to help the health system adapt to and mitigate the impacts of climate change both during the project and in the longer term. Specifically, the project will implement the following climate adaptation and mitigation activities under the specific project components to address climate vulnerability and enhance health system resilience to climate change.

COMPONENT 1: Improving Financial Protection and Utilization of Health Equity Fund (IDA US$20.44 million)

121. **Subcomponent 1.1: Financing the HEF (IDA US$17.04 million).** This subcomponent will cover the cost of health services for the poor who are the most vulnerable to the impacts of climate change and natural disasters. Financing transportation costs through this subcomponent will directly help reduce health service access disruptions due to climate disasters. This will ensure climate vulnerable populations including ethnic minorities, indigenous people, people living in remote and hard-to-reach areas, and those with disabilities access to quality health care on time, when needed. The HEF funds will help cover transportation costs for people during prolonged climate-induced crises, including when incomes fall, or crops fail. Consequently, this will allow them to have a faster recovery with less financial and physical barriers to health services. This will be especially vital for treatment of climate-sensitive conditions including malnutrition; NCDs; and vector-borne and water-borne diseases such as diarrheal diseases, malaria, and dengue fever.

122. **Subcomponent 1.2: Enhancing HEF Management and Utilization (IDA US$0.49 million**). This subcomponent will support HFs and ODs for improving utilization of HEF in low utilization areas including awareness raising in **communities** on measures to prepare for and respond to climate-related shocks, such as floods, increased heat, lower crop yields and nutrient levels, and stressed water resources. Health staff will explain the links between these changes and risks to health and advise on how these risks can be managed. An estimated US$12,000 is expected to directly support climate awareness raising and capacity building.

COMPONENT 2: Strengthening Quality and Capacity of Health Service Delivery (IDA US$32.77 million)

[49] The country also has the Cambodia National Adaptation Plan Financing Framework and Implementation Plan, August 2017

123. **Subcomponent 2.1: Implementing New NQEMTs-II nation-wide (IDA US$11.6 million).** This subcomponent will finance the implementation of NQEMTs-II to drive continued quality improvements at public HFs. The implementation of NQEMTs-II will improve the quality of health services through mandatory implementation of routine self-assessments by HFs and external, ex-ante assessments. HFs will receive semi-annual performance-based payments based on the results of the assessments. The HF quality self-assessment tool will help mainstream climate-informed health services at public HFs by including specific questions on provider knowledge of (a) preparedness and response to climate shocks, particularly floods; (b) measures to detect, control, and treat climate related infectious diseases such dengue, malaria, diarrhea, respiratory infection, tuberculosis; and (c) management of conditions such as NCDs, malnutrition and mental illness upon the onset of extreme weather events. Results of these assessments will feed directly into in-service training for health staff so that they can improve their skills in managing health problems generated by climate change. Estimated US$500,000 will contribute to the self-assessment that will contribute to enhancing the climate-related questions.

124. **Subcomponent 2.2: Building Comprehensive Service Provision with Expanded NCD Services and Strong Community Engagements (IDA US$9.49 million)**. The subcomponent will support reducing NCDs risk factors by formulating a National NCD Prevention and Health Promotion Program and supporting VHSGs that will conduct promotion and awareness raising activities. The national NCD Prevention and Health Promotion Program will include a specific component to raise community awareness on climate change and its impact on diseases and build the capacity of communities to implement climate change mitigation and adaptation actions, such as measures to prepare and respond to climate shocks; steps to prevent the spread of climate related diseases; and steps to help maximize the intake of nutrients from climate-vulnerable food sources, especially for women and children. Building these capacities will contribute to the health system's long-term ability to adapt and respond to the impacts of climate change and support the system to adapt quickly and identify and serve people at risk. This, as a result, will contribute to a more effective, agile and climate-resilient health system, with the ability to serve more people, including those groups that are climate vulnerable. An estimated US$26,000 for implementing health promotion activities is expected to directly support the climate change community awareness and capacity building.

125. **Subcomponent 2.3: Building Service Capacity of Referral Hospitals (IDA US$11.68 million).** This subcomponent will build the service capacity in RHs to address the service capacity gaps in selected hospitals, including renovation, refurbishment, and expansion of hospital buildings as well as procurement of equipment for providing new services. Low-carbon infrastructure and equipment including such as energy efficient ventilation and air conditioning systems, water and energy efficiency measures, energy-efficient improvements and appliances, LED[50] lights/ equipment, and solar panels will be incorporated and applied during the implementation. Civil works will also include climate-resilient siting, design, and construction measures to minimize risks of flooding and other natural disaster damages. Procurement conditions will be used to ensure that energy-efficient equipment is purchased, and energy-efficient measures are incorporated in the design. The project will also finance solar panels for facilities, wherever applicable to equip facilities with energy- and water-efficient systems for buildings. While specific sub-projects to be financed under this subcomponent will be determined once the National Health Infrastructure Development Plan is formulated, approximately US$7.5 million is expected to be allocated for civil works, US$3.4 million for equipment, and US$1 million towards the Digital Health Strategy. Of these investments, about US$2,900,000 of expenditures is likely to support climate mitigation and adaptation

[50] LED = Light-Emitting Diode.

measures.

E. Environmental and Social

126. **The overall environmental and social risk is classified as Substantial**. The proposed project aims to improve equitable utilization of quality health care for the poor through strategic and efficient delivery of health services in Cambodia. Toward this aim, the project will enhance access to quality health services and financial protection for the poor and vulnerable through, among other measures, support for improving HEF utilization. The project will thus cover all public national, provincial, and referral hospitals and all HCs. The nationwide scope of the project means that the project also supports HFs located in the north-east provinces of Cambodia, where there is high concentration of indigenous peoples, who have marginalized access to public services, including health services.

127. **In addition to health services enhancement and expansion for the poor and the vulnerable, the proposed project will support upgrading of RHs, including renovation or construction of additional hospital wards and upgrading of blood depots/banks at the provincial and regional hospitals, and NBTC**. Seven of the ten World Bank's Environmental and Social Standards (ESS) have been screened as relevant. ESS6 on Biodiversity Conservation and Sustainable Management of Living Natural Resources, ESS8 on Cultural Heritage, and ESS9 on Financial Intermediaries are considered not relevant.

128. **The social risk is classified as Substantial.** While the project is expected to provide positive benefits for the Cambodian population, particularly poor and vulnerable groups, many of them continue to have limited access to quality health services. There are potential social risks that while providing health services, the project may exclude or discriminate vulnerable and marginalized groups (including vulnerable women who are GBV survivors, the poor, people with disabilities and indigenous peoples), whose access to health services is already constrained due to social, economic, cultural, and environmental barriers (that is, language, culture, and distance). A social assessment undertaken during project preparation has pointed to some constraints on the part of disadvantaged and vulnerable groups in accessing health services, particularly indigenous groups. These constraints include insufficient access to information about benefits and services, high transportation costs and some cultural barriers. The project is being proactive in addressing these risks by introducing various activities to mitigate these social risks. It is of vital importance that vulnerable groups have access to project benefits, and that they can use the benefits of HEF. Therefore, robust stakeholder engagement and information sharing is essential. Measures to mitigate these social risks are built into the project's Component 1, aimed at increasing the demand for the HEF services, including by enhancing communication of the HEF services to vulnerable and marginalized groups. Furthermore, the project has prepared an SEP, which will guide consultations and outreach activities throughout project implementation. The SEP is also the main document to guide engagement with indigenous groups, as this has been mainstreamed into project preparation and implementation, rather than preparing a stand-along Indigenous Peoples Framework/Plan.

129. **Other potential social risks are tied to the construction/upgrading of HFs, and the provision of health services at the community level, which may result in risks associated with labor management, including use of child labor in construction and indentured labor in the supply of construction materials, safety of workers/community workers, and the spread of COVID-19 in the community.** There are also potential risks related to community health and safety due to poor waste management in HFs, and risks related to GBV and violence against children (VAC) due to the influx of labor for construction activities. Sexual exploitation and abuse/sexual harassment risk is rated low, taking into account various factors including the sectoral context such

as the existence of a code of conduct spelling out standards of behavior for health staff, as well as minimal labor influx because of the project activities, which will be conducted in the existing HFs in remote or solitary locations . These risks are being managed through the ESMF prepared for the project, which will guide the preparation of future 'Environmental and Social Management Plans' or 'Environmental and Social Codes of Practice' where appropriate. While project activities are expected to be confined to the existing HFs, there could be a risk of land acquisition impacts, though this risk is assessed as minimal. Nevertheless, a Resettlement Policy Framework has been prepared for the project. The project will work closely with VHSGs, who are volunteers, and this could lead to labor risks around sexual harassment and discrimination. The Labor Management Procedures, which have been prepared for the project as part of the ESMF, take these risks into account. Capacity and commitment of the MOH needs to be strengthened for successful management of risks and impacts.

130. **The environmental risk is classified as Substantial**. In addition to limited experience of the MOH to meet the Environmental and Social Framework (ESF) requirement, the project may have risks and impacts related to major construction and hazardous health care waste (HCW) and HFs' potential environmental impacts and risks are related to construction works and the operation of hospitals and blood depots. Construction-related impacts may include traffic related accidents, dust, noise, vibration, air emissions, and generation of construction wastes, electronic waste, and potential asbestos containing material (ACM) that may be present at facilities undergoing rehabilitation. These impacts are temporary, predictable, and reversible and mitigatory measures are readily available and reliable. These potential impacts will be managed through the application of good engineering designs and practices for construction by incorporating environmental mitigation measures in the technical design and tender documents. The project may also require disposal of old medical equipment and/or supplies from refurbishment of health care facilities. Project-supported rehabilitation activities will be used to dispose of such waste, including ACM, in a technically sound manner, depending on the type of equipment and so on. Construction of additional hospital wards will be located within the existing hospital perimeter.

131. **The operation of hospitals, and blood depots, are likely to generate large volumes of hazardous and infectious HCW, including COVID-19-related wastes, and non-hazardous sanitary liquid and solid wastes.** These potential environmental and health risks are well-defined and can be readily addressed through WBG Environmental, Health, and Safety Guidelines and the existing comprehensive guidelines on HCW Management and IPC prepared by the MOH. The guidelines incorporate best HCW management practices and are intended for practical application at HFs with limited available financial and technical resources. However, gaps exist in implementation at the RH levels. This includes an uneven application of the guidelines and insufficient resources and capacity to properly handle and dispose of HCWs. In addition, under the ongoing H-EQIP, selected HFs have their own waste incineration facilities installed onsite. Due diligence of the existing incinerators will be conducted to examine their technical adequacy, process capacity, performance record, and operators' capacity. In case any gaps are discovered, corrective measures should be recommended.

132. **The MOH has experience with implementing World Bank-financed project requirements regarding safeguards policies**. The current rating of environmental safeguard compliance for H-EQIP is Moderately Satisfactory. However, capacity to manage impacts and risks consistent with the relevant ESS is still limited. Also, even though the MOH has sufficient policy, regulations, and guidelines on Health Care Waste Management (HCWM), the compliance at RHs and healthcare centers remains weak.

133. **The MOH has prepared an ESMF, which built on lessons learned from the past and ongoing H-EQIP and**

Cambodia COVID-19 Emergency Response Project (Cambodia COVID-19 ERP)[51] and lays out effective and practical processes; implementation arrangements, including the budget requirements to assess the environmental risks and impacts, and measures and plans to mitigate the potential environmental risks and impacts at the individual facility level. The environment section of the proposed ESMF will include (a) gap analysis between the requirements of the national HCWM guidelines and applicable ESS; (b) distinct options/procedures/Environmental Code of Practices for managing HCWs by each of the five levels of HFs (national, provincial referral, district referral, HCs and health posts); (c) process for carrying out performance assessment or environmental audit of the existing HCW and non-hazardous waste treatment and disposal practices such as on-site incinerators and other facilities at selected HFs to identify specific interventions needed to improve their performance and compliance with the national guidelines and relevant requirements of the applicable ESS; (d) summary findings and recommendations of the institutional capacity assessment; and (e) budget provision for implementation. The Environmental and Social Review Summary were disclosed on the World Bank's external website on December 20, 2021. The ESCP and SEP were disclosed publicly in-country[52] and on the World Bank's external website on November 12, 2021, and December 20, 2021 respectively, and the updated ESMF were disclosed publicly in-country[52] and on the World Bank's external website on December 17, 2021.

V. GENDER CONSIDERATION

134. **Gender equality and inclusive development to protect vulnerable populations at risk of being left behind is critical for achieving UHC**. The Cambodia H-EQIP aims to address the gaps in GESI in access to and utilization of health services and increase the inclusiveness and equity of the health system in Cambodia. Various gender assessments conducted under H-EQIP I and the findings of the GESI study conducted in preparation of the H-EQIP II design identified two fundamental gaps in the institutional capacity of the health system to translate gender equality policy into decision-making and actions. These gaps impede the Government from closing the gender and equity gaps in health coverage and access to services, quality of care, and health outcomes. The first fundamental gap is the lack of routine collection of sex and other disaggregated health data to enable analysis of gender and intersecting equity gaps and inform the design of targeted responses. The second gap is the weak institutional capacity of the MOH in leading the implementation of the MOH's GMAP. The lack of systematic gender and equity-related disaggregated data at the national and subnational levels further undermines the capacity of the MOH in addressing gender gaps(see Figure 6).

135. **The lack of systematic collection of national sex-disaggregated data and data on other markers of inequality and vulnerability is a key gap within the health sector.**[53] DPHI of the MOH leads and oversees the health information system in the country. The current health information system in Cambodia has two core systems, PMRS and HMIS. The PMRS is an individual-based data collection system used by the PCA to manage a variety of patient and finance tracking functions for the HEF program including patient registration; tracking from admission to discharge; invoice submission and management; non-medical expense management (food, transport, and funerals); and invoice approval. This system has information on the sex of the patient but does not have information on indigenous status and disability[54] and only collects data for the HEF beneficiaries. The full

[51] World Bank. 2020. Cambodia - COVID-19 Emergency Response Project (English). Washington, DC: World Bank Group. http://documents.worldbank.org/curated/en/737031585950801934/Cambodia-COVID-19-Emergency-Response-Project
[52] MOH *http://hismohcambodia.org/public/announcements.php?pid=32*
[53] GESI disaggregated data are used to refer to sex, age and geographical location disaggregated data and other markers of disadvantage such as indigenous status, and disability.
[54] This area will be explored and discussed further with the MOH to assess culturally appropriate and sensitive data to ask and collect

PMRS also has not yet been rolled out to all HFs; particularly only about 15percent of total HCs have installed this system. The HMIS is web-based at the central level but paper-based at the facility level. HFs collect data on health service utilization using paper-based registers onsite, and report aggregate data for each of the indicators to the MOH on a monthly basis. It produces a large volume of data routinely but does not provide regular disaggregated GESI-data. This systematic lack of collection of GESI-data inhibits the accurate measurement and monitoring of gender gaps and equity and inclusiveness in access to quality health services. It inhibits the MOH's capacity to assess how gender inequality intersects with other social determinants of health that affect access to services and health outcomes. GESI-responsive data are also critical to inform the design of policy and service delivery measures, such as HEF, to narrow inequitable access to health services and higher order UHC ambitions [55]. Access to sex-disaggregated data, such as the screening rates of various NCDs in men and women or the geographical inequalities in use of essential health services, will help policymakers find more effective solutions toward inclusive and equitable health services.

136. **The project will support the strengthening of information systems to ensure that GESI-disaggregated data are captured comprehensively**. Funds will be provided to DPHI through PBC1 linked to the achievement of the PBC targets including (a) an assessment of gaps in existing information systems (both PMRS and HMIS) in collecting and reporting GESI-disaggregated data and gender specific-data and development of an agreed action plan to close the gaps; (b) actions taken according to the action plan to update/enable the existing HMIS/PMRS and the paper-based data collection at grassroots level to systematically collect and produce GESI specific-data at the national and provincial level; (c) ensuring of the design/development of the new health information systems (such as an EMR system, and NCD patient tracking system) to build in the functions to routinely collect and report GESI specific-data (for example, GBV administrative data and care referral monitoring and so on); and (d) supporting of evidence-based decision-making and service provision. In addition, the project will finance the rolling out of the PMRS to all HCs in Cambodia in the first two years through PBC2 for the PCA. This will enable individual-based electronic data collection at all HCs. The progress of the interventions will be monitored through the achievement of PBC1 and PBC2, both are part of the Results Framework.

137. **Strengthening the information collection and management for responding to violence against women is also critical.** Specific programs and services financed by the RGC and DPs have been strengthening the capacity of health facilities to provide services to GBV survivors; however, the definition of GBV and GBV services are not standardized, and the collection of data is fragmented. As part of the broader mapping of the existing GESI-disaggregated and gender-specific data collected through routine health information systems, the added value of H-EQIP II with regard to GBV will be through the strengthening of GBV administrative data collection and inclusion of reporting and data on GBV in the digital health system. The project will provide assistance to the MOH to collect and analyze data on services provided to GBV survivors and referral to health and non-health service providers[56]. Second, to ensure that GBV data are secure, confidential, and harmonized across providers, the project will support the MOH to engage with other GBV service providers to build consensus to harmonize GBV definitions and streamline data collection across service providers[57]. Project support will contribute to improve survivor-centered care, reduce revictimization caused by the recounting of the incident, and improve evidence for policy

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[55] United Nations Resolution 2017 states that "Sustainable Development Goal indicators should be disaggregated, where relevant, by income, sex, age, race, indigenous status, migratory status, disability and geographic location, or other characteristics, in accordance with the Fundamental Principles of Official Statistics." https://undocs.org/A/RES/71/313

[56] World Bank. 2019. *Gender Based Violence Institutional Mapping Report, Cambodia.*

[57] Currently, only the number of forensic exams provided is collected at the National Maternal and Child Health Center.

and planning.

138. **The RGC has made commitments to promote gender equality and equitable development through its institutions, policies, and practices**. Across the government, since 2005, GMAG have been established within sectors with the primary responsibility of preparing GMAPs. For the health sector, the GMAG established the same year[58] relies on 34 task team members across various departments of the MOH with a variety of other full-time responsibilities and levels of seniority within their departments.[59] However, the implementation of the GMAP has faced difficulties given its lack of clearly set targets, roadmap and indicators, lack of resources and lack of capacity of the GMAG of the MOH to lead this agenda, as well as the broader lack of knowledge on GESI across the MOH.

139. **The project will focus on strengthening the capacity and performance of the RGC's institutional structures for mainstreaming gender equality in the health sector**. Through a GESI-capacity-building-focused PBC7 and coupled with technical assistance, the project will support the implementation of the MOH's GMAP through capacity building of the MOH by:

(a) Developing a clear roadmap for each year of the project through GESI action plans and setting annual targets[60] for GMAGs to fulfill their mandate of mainstreaming gender across the whole health sector including by helping technical departments of the MOH incorporate GESI targets in their annual workplan;
(b) Providing training to project implementing agencies and managers of national and sub-national institutions on know-how, attitudes, and skills on GESI and health including capacity to undertake GESI analysis using sex and other GESI disaggregated data to develop plans and budgets;
(c) Producing tangible and practical outputs such as operational guidelines on GESI standards for health service delivery, and helping the MOH update its policy on GESI; and
(d) Supporting a Women in Leadership Development Program, which aims to respond to the capacity building and cultural challenges women face in progressing to management positions.[61]

140. These are steps toward building policy commitment to gender equality and strengthening women's voice and participation in decision-making in the health sector and leadership on GESI and health. The progress of the project intervention will be measured by PBC7 through the implementation of annual GESI action plans. This is significant, as it is the first time that GMAGs will be incentivized to achieve their targets through PBC. As one of the legal covenants, the Government will develop an AOP for the whole project and submit this to the World Bank and PF Partners for approval annually before the start of implementation. The annual GESI action plan will be an integral component of the project AOP of H-EQIP II.

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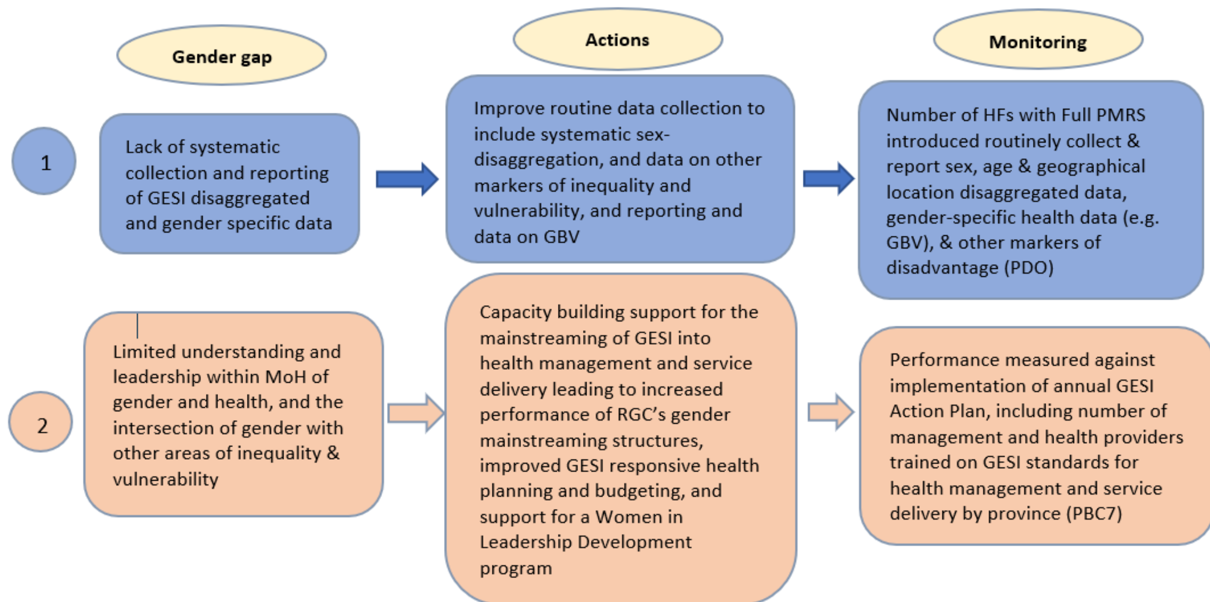
[58] Latest update on the establishment of GMAG-MOH dates from April 30, 2019.
[59] The GMAG is led by a Chair at the Secretary of State or Under Secretary of State level or Vice Chair at the Director General or Deputy Director Gender level.
[60] Targets will be developed collaboratively through discussions with the MOH and GMAG. Building on the lessons learned from H-EQIP, the project will develop the GMAG's capacity and increase ownership so that the GMAG can set its own targets that it will achieve.
[61] Voong, S., B. Ros,R. Morgan,and S. Theobald. 2019. "Why Are Fewer Women Rising to the Top? A Life History Gender Analysis of Cambodia's health workforce". *BMC Health Services Research 19: 595.*
https://doi.org/10.1186/s12913-019-4424-3.

Figure 6: Theory of Change for Closing Gender Gaps



VI. CITIZEN ENGAGEMENT

141. **A grievance redress mechanism (GRM) will be established to receive, record, and address the complaints from the communities and individuals who believe that they are adversely affected by the H-EQIP II project implementation.** This has been included in the ESCP which the government has committed to implement during the project implementation. The project implementation core group of MOH will be responsible to establish the mechanism which will collect the complaints, make a record systematically and inform the relevant department to take actions to address the complaints within certain timeframe. In the case the complaint requires a long- term action/solution, MOH will contact the community or individual who submitted the complaint and provide information on the action plan and estimated timeframe. An indicator "percentage of complaints received to the project Grievance Redress Mechanism (GRM) addressed within 60 days of initial complaint being recorded" has been included in the result framework to monitor the implementation of this process. The indicator will be monitored and reported twice a year based on MOH's semi-annual project progress report.

VII. GRIEVANCE REDRESS SERVICES

142. **Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level grievance redress mechanisms or the World Bank'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 World Bank's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of World Bank 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 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.

VIII. KEY RISKS

143. **The overall residual risk rating for the operation is Substantial**, primarily due to the substantial risk ratings related to institutional capacity for implementation, fiduciary, and environmental and social. The risk descriptions and mitigation measures for such risks are summarized in the following paragraphs.

144. **Institutional capacity for implementation and sustainability risks are Substantial**. The technical and institutional capacity risks to the proposed operation stem partially from the comprehensiveness and complexity of the project design aimed to support, to the extent possible, the RGC's health sector reforms and development needs. The level of ambition proposed in the RGC program, such as rolling out the comprehensive accreditation standards as a major measure to enhance service quality of all HFs in the country also poses high requirements on a strong institutional framework, new incentive mechanism and robust technical and implementation capacity. However, the existing issues with institutional fragmentation, stakeholder alignment, and resource constraints, as well as the weak capacity at the sub-national levels, pose substantial implementation challenges. In addition, even though the RGC at both the central and provincial levels has gained experience in using the World Bank's IPF+ DLI lending instrument throughout H-EQIP, the use of the IPF+PBC instrument will require further learning to understand the intricacies. To respond to such challenges, first, the project will provide significant capacity building to support both the national and subnational agencies, as well as the public HFs to adjust to their new roles in the shift to the decentralization of health service management as well as to leading or implementing new activities. For example, the project will continue building the capacity of the QAO and PCA. Second, the governance structure and implementation arrangement of H-EQIP II has been designed to enhance strong leadership and effective coordination (see figure 4). Having learned from the H-EQIP implementation, the project also continues to mainstream the H-EQIP interventions into the RGC's systems to ensure sustainability. Finally, the project will provide intensified operational technical assistance and implementation support to the Government such as assisting in the development of action plans, AOPs, technical guidelines, implementation pathways through adaptive learning agenda and networks.

145. **Fiduciary risks are Substantial**. The fiduciary function of the proposed project will be performed by the DBF for FM and the Procurement Unit of the MOH for procurement. While the MOH's DBF and Procurement Unit have developed the fiduciary capacity under the current World Bank-financed health projects, the units are facing shortage of staff and increasing workloads. Furthermore, the capacity of HFs at the sub-national levels to manage SDGs has been built up through H-EQIP implementation; however, the capacity is still weak, especially considering the increased direct fund flow to these facilities and the added SDGs. The Excel-based accounting system will need modification based on experience gained from implementation. Small-scale procurement activities have been decentralized to the subnational levels, and this trend to decentralize more fiduciary functions is expected to continue along with the implementation and expansion of D&D reforms. Enhanced fiduciary capacity building for the subnational levels is provided to PHDs, ODs and HFs in FM and procurement. As a mitigation measure, strong fiduciary capacity building will be provided under H-EQIP II including a PBC. In addition, the World Bank team will work closely with the RGC in developing capacity-building and training plans for the sub-national actors and supporting the capacity-building activities. Additional hands (either government staff or consultants) with the right skills will need to be engaged to ensure timely implementation of the new operations.

146. **The environmental risk is Substantial** for two main reasons: (a) risks and impacts related to the refurbishment, renovation, and expansion of healthcare facilities and hazardous HCW and (b) the limited experience of the implementing agency to meet ESF requirements. To mitigate such environmental risks, H-EQIP II will be applying the World Bank's ESF in a pro-active way to minimize the environment risks associated with the project. Moreover, the World Bank team will work closely with the RGC in mitigating negative potential impacts from the project through the application of good engineering designs and practices for construction by incorporating environmental mitigation measures in the technical design and tender documents.

147. **The social risk is Substantial.** Potential social risks associated with the proposed project include possible exclusion of vulnerable and marginalized groups, including vulnerable women who are victims of GBV, the poor, people with disabilities and indigenous peoples, whose access to health services is already constrained due to social, economic, cultural, and environmental barriers (that is, language, culture, and distance). Other potential social risks are tied to construction/upgrading of HFs, which may result in risks associated with labor management, including the use of child labor in construction and indentured labor in the supply of construction materials, safety of workers, and the spread of COVID-19 in the community. There are also potential risks related to community health and safety due to poor waste management by HFs and risks related to GBV and VAC due to the influx of labor from construction activities. To mitigate such potential social risks, first, the MOH's institutional capacity will be strengthened through intensive technical assistance for successful management of risks and impacts. Second, vulnerable groups have access to project benefits, and they can make use of the benefits of HEF. Therefore, the project will ensure robust stakeholder engagement and information sharing. Part of the measures to mitigate these social risks are also built into the project's Component 1 such as enhancing communication of the HEF services to vulnerable and marginalized groups. Finally, the project has prepared an SEP which will guide consultations and outreach activities throughout project implementation.

148. **Other risk includes data protection and privacy and is moderate**. HEF may handle a large volume of personal data. Personally identifiable information and sensitive data are likely to be collected and used in identifying the beneficiaries— under circumstances where measures to ensure the legitimate, appropriate, and proportionate use and processing of that data may not feature in national law or data governance regulations or be routinely collected and managed in health information systems. To guard against abuse of that data, the project will incorporate good international practices for dealing with such data in such circumstances. Such measures may include, by way of example, data minimization (collecting only data that are necessary for the purpose); data accuracy (correct or erase data that are not necessary or are inaccurate), use limitations (data are only used for legitimate and related purposes), data retention (retain data only for as long as they are necessary), informing data subjects of use and processing of data, and allowing data subjects the opportunity to correct information about them, and so on. In practical terms, the project will ensure that these principles apply through, among other aspects, assessments of existing or development of new data governance mechanisms and data standards for emergency and routine health care, data sharing protocols, rules or regulations, revision of relevant regulations, training, sharing of global experience, unique identifiers for health system clients, and strengthening of health information systems.

Table 5. PBCs Disbursement and Verification Protocol
COUNTRY: Cambodia

PBC 1	Year 1 Target (Jul. 2022-Dec. 2023)	Year 2 Target (Jan.-Dec. 2024)	Year 3 Target (Jan.-Dec. 2025)	Year 4 Target (Jan.-Dec. 2026)	Year 5 Target (Jan.- Jun 2027)
Improved HEF Management Implementing entity: DPHI (US$1.0 million)	(a) Semi-annual workshop to review HEF utilization conducted and semi-annual HEF utilization analysis reports, including findings from the rapid survey, completed according to the defined template by end of February and end of August (PBC Value: US$240,000) *(time bound).* (b) updated HEF benefit package and service reimbursement rates approved (PBC Value: US$60,000). (c) Action plan agreed before June 30, 2023 on routine collection of gender and other GESI-related disaggregated data and gender specific data. (US$30,000).	(a) Semi-annual workshop to review HEF utilization conducted and semi-annual HEF utilization analysis reports, including findings from the rapid survey, completed according to the defined template by end of February and end of August (PBC Value: US$160,000) *(time bound).* (b) HMIS/DHIS2/PMRS routinely produces GBV data according to the action plan (US$40,000).	(a) Semi-annual workshop to review HEF utilization conducted and semi-annual HEF utilization analysis reports, including findings from the rapid survey, completed according to the defined template by end of February and end of August (PBC Value: US$160,000) *(time bound).* (b) HMIS/DHIS2/PMRS routinely produce gender and other GESI-disaggregated data, and gender specific data according to the action plan (PBC Value: US$60,000).	(a) Semi-annual workshop to review HEF utilization conducted and semi-annual HEF utilization analysis reports, including findings from the rapid survey, completed according to the defined template by end of February and end of August (PBC Value: US$160,000) *(time bound).*	(a) Semi-annual workshop to review HEF utilization conducted and semi-annual HEF utilization analysis reports, including findings from the rapid survey, completed according to the defined template by end of August (PBC Value: US$90,000) *(time bound)*
PBC value	US$330,000	US$200,000	US$220,000	US$160,000	US$90,000
Eligible Expenditures/activities	• Contracting of qualified consultants • Expenditures associated with training, workshops and field supervision including vehicles • Expenditure for printing and dissemination of materials • Purchasing of office equipment and office supplies for project activities				

PBC 2	Year 1 Target (Jul. 2022-Dec.2023)	Year 2 Target (Jan.-Dec.2024)	Year 3 Target (Jan.-Dec.2025)	Year 4 Target (Jan.-Dec.2026)	Year 5 Target (Jan.- Jun.2027)
Expanded PCA Functions and Service Coverage Implementing entity: PCA (US$6.0 million) *(time bound except for target c for year 1-3)*	(a) Two rounds of ex-post verification conducted for NQEMTs-II, and verification report prepared and shared with QIWG within 45 days (Formula: US$250,000 per round, PBC Value: US$500,000). (b) Three rounds of validation of NCD services provision conducted and report submitted within 45 days (Formula: US$360,000 for the first round and US$310,000 per round afterwards; PBC Value: US$980,000). (c) Full PMRS rolled out to 350 HCs in low utilization ODs and 10 RHs (in low utilization ODs first) (Formula: US$1,500 per each HC; and US$5,000 per each RH; PBC Value: US$575,000).	(a) Two rounds of ex-post verification conducted for NQEMTs-II, and verification report prepared and shared with QIWG within 45 days (Formula: US$150,000 per round; PBC Value: US$300,000). (b) Two rounds of validation of NCD services provision conducted and report submitted within 45 days (Formula: US$310,000 per round; PBC Value: US$620,000). (c) Full PMRS rolled out to 300 HCs and 10 RHs (both in low utilization ODs first) (Formula: US$1,500 per each HC; US$5,000 per each RH; PBC Value: US$500,000).	(a) Two rounds of ex-post verification conducted for NQEMTs-II, and verification report prepared and shared with QIWG within 45 days (Formula: US$150,000 per round; PBC Value: US$300,000). (b) Two rounds of validation of NCD services provision conducted and report submitted within 45 days (Formula: US$310,000 per round; PBC Value: US$620,000). (c) Full PMRS rolled out to 150 HCs (Formula: US$1,500 per each HC; PBC Value: US$225,000)	(a)Two rounds of ex-post verification conducted for NQEMTs-II, and verification report prepared and shared with QIWG within 45 days (Formula: US$150,000 per round; PBC Value: US$300,000). (d) Two rounds of validation of NCD services provision conducted and report submitted within 45 days (Formula: US$310,000 per round; PBC Value: US$620,000).	(a) One round of ex-post verification conducted for NQEMTs-II, and verification report prepared and shared with QIWG within 45 days (Formula: US$150,000 per round; PBC Value: US$150,000). (b) One round of validation of NCD services provision conducted and report submitted within 45 days (Formula: US$310,000 per round; PBC Value: US$310,000).
PBC value	**US$2,055,000**	**US$1,420,000**	**US$1,145,000**	**US$920,000**	**US$460,000**
Eligible Expenditures/activities	• Contracting of qualified consultants • Expenditures associated with workshops, training, and on-site training, and installation of the PMRS and field visits and supervisions/monitoring including vehicles • Expenditure for PCA staff capacity development • Purchase of related office equipment and office supplies • Expenditure for improvement, management, and maintenance of the PMRS				

PBC 3	Year 1 Target (Jul.2022-Dec.2023)	Year 2 Target (Jan.-Dec.2024)	Year 3 Target (Jan.-Dec.2025)	Year 4 Target (Jan.-Dec.2026)	Year 5 Target (Jan.-Jun.2027)
Enhanced Quality of Health Service as defined in NQEMTs-II by MOH Implementing entity: QAO/HSD (US$3.8 million)	(a) NQEMTs-II training provided according to the AOP (PBC Value: US$850,000). (b) At least 200 HFs reached 30% score in one round (Formula: US$256,250 per round; PBC Value: US$256,250). (c) 20 new clinical vignettes and their respective coaching protocols developed and applied in NQEMTs-II. (Formula: US$7,500 per clinical vignette; PBC Value US$150,000)	(a) At least 300 HFs reached 40% score in round 1 and 45% score in score in round 2 (Formula: US$256,250 per round; PBC Value: US$512,500). (b) Less than 20 percent of HFs which ex-post verification and ex-ante assessment scores differed more than 10.5 percent point. (PBC Value: US$150,000) *(time bound).*	(a) At least 400 HFs reached 50% score in round 1 and 55% score in round 2 (Formula: US$256,250 per round; PBC Value US$512,500); (b) Less than 18 percent of HFs which ex-post verification and ex-ante assessment scores differed more than 10.5 percent point. (PBC Value: US$150,000) *(time bound).* (c) 20 new clinical vignettes and their respective coaching protocols developed and applied in NQEMTs-II. (Formula: US$7,500 per clinical vignette; PBC Value US$150,000).	(a) At least 550 HFs reached 60% score in round 1 and 65% score in round 2 (Formula: US$256,250 per round; PBC Value US$512,500). (b) Less than 16 percent of HFs which ex-post verification and ex-ante assessment scores differed more than 10.5 percent point. (PBC Value: US$150,000) *(time bound).*	(a) At least 700 HFs reached 70% score in round 1 (Formula: US$256,250 per round; PBC Value US$256,250). (b) Less than 15 percent of HFs which ex-post verification and ex-ante assessment scores differed more than 10.5 percent point. (PBC Value: US$150,000) *(time bound).*
PBC Value	US$1,256,250	US$662,500	US$812,500	US$662,500	US$406,250
Eligible Expenditures/activities	• Contracting of qualified consultants • Procurement of office equipment, office supplies, and tablets for assessors, and competency equipment • Expenditure associated with development and testing clinical vignettes and their respective coaching protocols and competencies • Expenditure associated with conducting training, workshops, field visits and supervision/monitoring including printing costs and Vehicles for field supervision and coaching.				

PBC 4	Year 1 Target (Jul.2022-Dec. 2023)	Year 2 Target (Jan.-Dec. 2024)	Year 3 Target (Jan.-Dec. 2025)	Year 4 Target (Jan.-Dec. 2026)	Year 5 Target .2027)
Rolling out of NCD Services and Cervical Cancer Screening -National Implementing entity: PMD (US$2 million)	(a) Supervision, coaching, and annual reviews conducted according to the AOP. (PBC Value: US$250,000) *(time bound).* (b) A national Health Promotion Program developed, and health promotion IEC materials developed, distributed to HFs and schools and disseminated to the general population through social media. (PBC Value: US$180,000). (c) National standard operation procedures for implementing NCD and cervical cancer screening and management updated (PBC Value: US$50,000). (d) All PHDs and ODs completed the training of trainer (TOT) training on NCD and cervical cancer as well as the NCD ICT training according to the AOP and received certificates (Formula: US$1,200 per each PHD/OD; PBC Value: US$240,000). (e) All remaining 53 RHs and 61 RHs received training on cervical cancer and NCD services, respectively (Formula: US$1,000 per RH per training; PBC Value:US$230,000).	(a) Supervision, coaching, and semi-annual reviews conducted according to the AOP (PBC Value: US$200,000) *(time bound).* (b) Health promotion activities completed according to the AOP. (PBC Value: US$100,000).	(a) Supervision, coaching, and semi-annual reviews conducted according to the AOP (PBC Value: US$200,000) *(time bound).* (b) Health promotion activities completed according to the AOP (PBC Value: US$100,000).	(a) Supervision, coaching, and semi-annual reviews conducted according to the AOP (PBC Value: US$200,000) *(time bound).* (b) Health promotion activities completed according to the AOP (PBC Value: US$100,000).	*(a)* Supervision, coaching, and semi-annual reviews conducted according to the AOP (PBC Value: US$100,000) *(time bound)*. (b) Health promotion activities completed according to the AOP (PBC Value: US$50,000).
PBC Value	US$950,000	US$300,000	US$300,000	US$300,000	US$150,000
Eligible Expenditures/activities	• Contracting of qualified consultants to assist the PMD in rolling out NCD and cervical cancer services • Expenditure associated with training, workshops, semi/annual reviews, reporting, and supervisions /monitoring including vehicles • Maintenance of ICT system including contracting of qualified consultant • Expenditure associated with development, printing, and dissemination of IEC materials • Procurement of office equipment and office supplies for implementing project activities				

PBC 5	Year 1 Target (Jul.2022-Dec.2023)	Year 2 Target (Jan.-Dec.2024)	Year 3 Target (Jan.-Dec.2025)	Year 4 Target (Jan.-Dec.2026)	Year 5 Target (Jan.- Jun.2027)
Rolling out of NCD Services and Cervical Cancer Screening - Subnational Level Implementing entities: PHD and OD (US$4.70 million) (*scalable, non-time bound)*	(a) At least 12% of the target population screened for hypertension and diabetes (Formula: US$12,800 per OD; US$1,300 per HC; PBC Value: US$2,676,100). (b) At least 12% of the target population screened for cervical cancer (Formula: US$9,000 per OD; US$500 per HC; PBC Value: US$1,100,000).	(a) At least 24% of the target population screened for hypertension and diabetes (Formula: US$300 per OD; US$100 per HC; PBC Value: US$141,500). (b) At least 24% of the target population screened for cervical cancer (Formula: US$300 per OD; US$120 per HC; PBC Value: US$115,200).	(a) At least 35% of the target population screened for hypertension and diabetes (Formula: US$300 per OD; US$100 per HC; PBC Value: US$141,500); (b) At least 35% of the target population screened for cervical cancer (Formula: US$300 per OD; US$120 per HC; PBC Value: US$115,200).	(a) At least 45% of the target population screened for hypertension and diabetes (Formula: US$300 per OD; US$100 per HC; PBC Value: US$141,500). (b) At least 45% of the target population screened for cervical cancer (Formula: US$300 per OD; US$120 per HC; PBC Value: US$115,200).	(a) At least 50% of the target population screened for hypertension and diabetes (Formula: US$200 per OD; US$60 per HC; PBC Value: US$87,000). (b) At least 50% of the target population screened for cervical cancer (Formula: US$200 per OD; US$60 per HC; PBC Value: US$66,800).
PBC Value	US$3,776,100	US$256,700	US$256,700	US$256,700	US$153,800
Eligible Expenditures/activities	• Expenses associated with training, workshops, meetings, supportive supervision, monitoring, and reporting • Procurement of equipment and consumables • Printing training and IEC materials, and dissemination • Procurement of office equipment and office supplies for implementing project activities.				

PBC 6	Year 1 Target (Jul.2022-Dec.2023)	Year 2 Target (Jan.-Dec.2024)	Year 3 Target (Jan.-Dec.2025)	Year 4 Target (Jan.-Dec.2026)	Year 5 Target (Jan.- Jun.2027)
Timely processing of project funds and improved capacity of sub-national HFs in applying relevant financial management system Implementing entity: DBF (US$0.6 million)	(a) HEF and SDG payments processed within 5 working days (PBC Value: US$45,000) *(time bound).* (b) 22% of the HFs (300 HFs) can produce timely financial report as stipulated in the SDG manual (Formula: US$325 per HF for on-site training; PBC Value: US$98,000).	(a) HEF and SDG payments processed within 5 working days (PBC Value: US$30,000) *(time bound).* (b) 50% of the HFs (380 additional HFs) can produce timely financial report as stipulated in the SDG manual (Formula: US$325 per HF for on-site training; PBC Value: US$124,000).	(a) HEF and SDG payments processed within 5 working days (PBC Value: US$30,000) *(time bound).* (b) 79% of the HFs (400 additional HFs) can produce timely financial report as stipulated in the SDG Manual (Formula: US$325 per HF for on-site training; PBC Value: US$130,000).	(a) HEF and SDG payments processed within 5 working days (PBC Value: US$30,000) *(time bound).* (b) 100% of the HFs (293 additional HFs) can produce timely financial report as stipulated in the SDG Manual (Formula: US$325 per HF for on-site training; PBC Value: US$96,000).	(a) HEF and SDG payments processed within 5 working days. (PBC Value: US$17,000) *(time bound).*
PBC Value	US$143,000	US$154,000	US$160,000	US$126,000	US$17,000
Eligible Expenditures/activities	• Expenses for necessary training supplies, small equipment, refreshment, printing, rental; and materials • Expenses for on-site capacity building/training. • One qualified FM consultant to support the DBF for improving FM capacity at subnational level for 4 years and one qualified FM consultant to support the DBF's operations and for improving FM capacity at subnational level for 5 years.				

PBC 7	Year 1 Target (Jul. 2022-Dec.2023)	Year 2 Target (Jan.-Dec. 2024)	Year 3 Target (Jan.-Dec. 2025)	Year 4 Target (Jan.-Dec.2026)	Year 5 Target (Jan.- Jun.2027)
Implementation of Gender Equality and Social Inclusion Action Plan Implementing entity: GMAG (US$0.5 million) *(scalable, non-time bound)*	GESI Action Annual Plan agreed and at least 60% of actions implemented (Formula: US$1,670 per each 1%)	GESI Action Annual Plan agreed and at least 70% of actions implemented (Formula: US$1,430 per each 1%)	GESI Action Annual Plan agreed and at least 70% of actions implemented (Formula: US$1,720 per each 1%)	GESI Action Annual Plan agreed and at least 80% of actions implemented (Formula: US$1,880 per each 1%)	Evidence informed policy roundtables held on (a) GESI and progress made toward UHC and who is left behind and (b) on a gender equal and inclusive workforce *(time bound)*
PBC Values	US$100,000	US$100,000	US$120,000	US$150,000	US$30,000
Eligible Expenditures/activities	• Contracting of qualified consultants (national/international) to assist GMAG • Expenditure associated with training, workshops, and related materials • Expenditure associated with assessments				

IX. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY: Cambodia
Health Equity and Quality Improvement Project - Phase 2

Project Development Objectives(s)

The PDO is to improve equitable utilization of quality health services in Cambodia, especially for the poor and vulnerable populations, and to provide immediate and effective response in case of an Eligible Crisis or Emergency in the Kingdom of Cambodia.

Project Development Objective Indicators

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Improved equitable utilization of health services							
1. Outpatient visits by HEF beneficiaries in low utilization ODs (Text)	PBC 1	0.44	0.49	0.54	0.62	0.70	0.78
1.1. Outpatient visits by HEF beneficiaries in select provinces with highest multidimensional poverty (Text)		0.59	0.64	0.69	0.77	0.85	0.93
1.2. Outpatient visits by female HEF beneficiaries in low utilization ODs (Text)		Full-year utilization of female beneficiaries in project year 3 for these ODs will be the baseline, to be reported at the end of year 3 after the full PMRS has been rolled out nationwide.				Baseline plus 0.08 per capita per year	Baseline plus 0.16 per capita per year

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
1.3. Outpatient visits by male HEF beneficiaries in low utilization ODs (Text)		Full-year utilization of male beneficiaries in project year 3 will be the baseline, to be reported at the end of year 3 after the full PMRS has been rolled out nationwide.				Baseline plus 0.08 per capita per year	Baseline plus 0.16 per capita per year
2.1. Percentage of HEF beneficiaries in all HCs with Full PMRS being introduced in year 1, used the outpatient service paid by HEF (Text)		Full-year utilization of project year 2 will be the baseline to be reported in the end of year 2.			5 percentage point increase from baseline	10 percentage point increase from baseline	15 percentage point increase from baseline
2.1.1. Percentage of female HEF beneficiaries, in all HC with Full PMRS being introduced in year 1, used the outpatient service paid by HEF (Text)		Full-year utilization of female beneficiaries in project year 2 will be the baseline to be reported at the end of year 2.			5 percentage point increase from baseline	10 percentage point increase from baseline	15 percentage point increase from baseline
2.1.2. Percentage of male HEF beneficiaries, in all HC with Full PMRS being introduced in year 1, used the outpatient service paid by HEF (Text)		Full-year utilization of male beneficiaries in project year 2 will be the baseline to be reported at the end of year 2.			5 percentage point increase from baseline	10 percentage point increase from baseline	15 percentage point increase from baseline
2.2. Percentage of HEF beneficiaries in all HCs with Full PMRS being introduced in year 2, used the outpatient service paid by HEF (Text)		Full year utilization of project year 3 will be the baseline to be reported in the end of year 3.				5 percentage point increase from baseline	10 percentage point increase from baseline
2.2.1 Percentage of female HEF beneficiaries, in all HC		Full-year utilization for female beneficiaries in				5 percentage point increase from baseline	10 percentage point increase from baseline

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
with Full PMRS being introduced in year 2, used the outpatient service paid by HEF (Text)		project year 3 will be the baseline to be reported at the end of year 3.					
2.2.2. Percentage of male HEF beneficiaries in all HCs with Full PMRS being introduced in year 2, used the outpatient service paid by HEF (Text)		Full-year utilization for male beneficiaries in project year 3 will be the baseline to be reported at the end of year 3.				5 percentage point increase from baseline	10 percentage point increase from baseline
2.3. Percentage of HEF beneficiaries in all HCs with Full PMRS being introduced in year 3, used the outpatient service paid by HEF (Text)		Full year utilization of project year 3 will be the baseline to be reported in the end of year 4.					5 percentage point increase from baseline
2.3.1. Percentage of female HEF beneficiaries in all HCs with Full PMRS being introduced in year 3, used the outpatient service paid by HEF (Text)		Full-year utilization of female beneficiaries in project year 3 will be the baseline to be reported in the end of year 4					5 percentage point increase from baseline
2.3.2. Percentage of male HEF beneficiaries, in all HC with Full PMRS being introduced in year 3, used the outpatient service paid by HEF (Text)		Full-year utilization of male beneficiaries in project year 3 will be the baseline to be reported at the end of year 4					5 percentage point increase from baseline
Improved quality of health services utilized							
3. Number of HFs exceeding 60 percent score in the April-May round of semi-annual national	PBC 3	0.00	0.00	150.00	350.00	550.00	700.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
quality assessment (Number)							
4. Hypertension screening rate (Percentage)	PBC 5	0.00	5.00	17.00	30.00	40.00	50.00
4.1. Hypertension screening rate among women (Percentage)		0.00	5.00	17.00	30.00	40.00	50.00
4.2. Hypertension screening rate among men (Percentage)		0.00	5.00	17.00	30.00	40.00	50.00
5. Number of HFs with Full PMRS introduced routinely collect & report sex, age & geographical location disaggregated data, gender-specific health data (e.g. GBV), & other markers of disadvantage (Number)		0.00	210.00	520.00	810.00	820.00	820.00

Intermediate Results Indicators by Components

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
Component 1: Improving Financial Protection and Utilization of Health Equity Fund							
1. Percentage of HEF claims verified by PCA within six working days (Text)	PBC 2	N/A	100%	100%	100%	100%	100%
2. Percentage of NSSF invoice		0.00	100.00	100.00	100.00	100.00	100.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
verified by PCA within six working days (Percentage)							
3. Total number of HEF utilization (Outpatient and Inpatient visits) (Number)		3,277,126.00	3,408,211.00	3,539,296.00	3,670,381.00	3,801,466.00	3,932,551.00
Component 2: Strengthening Quality and Capacity of Health Service Delivery							
4. Percent of HFs for which ex-post verification score is more than or equal to 10.5 percent point lower than ex-ante assessment score (Text)		0.00	0.00	less than 20%	less than 18%	less than 16%	Less than 15%
5. Cervical cancer screening rate of target population (Percentage)		0.00	5.00	17.00	30.00	40.00	50.00
6. Number of HCs with established electronic rosters for target population (Number)		0.00	50.00	150.00	250.00	400.00	500.00
7. Number of diabetes patients managed by HCs according to the national protocol (Number)		0.00	0.00	300.00	500.00	600.00	700.00
7.1. Number of female diabetes patients managed by HCs according to the national protocol (Number)		0.00	0.00	178.00	292.00	345.00	395.00
7.2. Number of male diabetes patients managed by HCs according to the national protocol (Number)		0.00	0.00	122.00	208.00	255.00	305.00
8. Percentage of hypertension cases managed by public health facilities according to national protocol (Percentage)		0.00	50.00	55.00	60.00	65.00	70.00

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
8.1. Percentage of hypertension cases managed by public health facilities according to the national protocol among women (Percentage)		0.00	50.00	55.00	60.00	65.00	70.00
8.2. Percentage of hypertension cases managed by public health facilities according to the national protocol among men (Percentage)		0.00	50.00	55.00	60.00	65.00	70.00
People who have received essential health, nutrition, and population (HNP) services (CRI, Number)		0.00	2,137,959.00	4,297,121.00	6,477,489.00	8,679,061.00	10,910,837.00
Number of children immunized (CRI, Number)		0.00	323,183.00	648,151.00	974,905.00	1,303,445.00	1,633,770.00
Number of women and children who have received basic nutrition services (CRI, Number)		0.00	1,503,782.00	3,025,164.00	4,564,147.00	6,120,729.00	7,694,912.00
Number of deliveries attended by skilled health personnel (CRI, Number)		0.00	310,994.00	623,806.00	938,437.00	1,254,887.00	1,573,155.00
Component 3: Project Management, Monitoring & Evaluation, Gender Equality and Social Inclusion							
10. Percentage of HFs producing timely financial report as stipulated in the SDG Manual (Percentage)	PBC 6	0.00	15.00	40.00	70.00	100.00	100.00
11. Number of management and health providers trained		0.00	100 managers and technical staff from the	100 additional managers and technical staff from	150 additional managers and technical staff from	150 additional managers and technical staff from	150 additional managers and technical staff from

Indicator Name	PBC	Baseline	Intermediate Targets				End Target
			1	2	3	4	
on GESI standards for health management and service delivery by province and sex. (Text)			central level to participate in training modules.	central and subnational levels to participate in training modules.	central and subnational levels to participate in training modules.	central level and subnational levels trained.	central level and subnational levels trained and Women in leadership development program conducted for at least 50 women.
12. Number of data reviews conducted on the utilization of essential health services including NCDs (Number)	PBC 4	0.00	2.00	2.00	2.00	2.00	2.00
13. Percentage of complaints received to the project Grievance Redress Mechanism (GRM) addressed within 60 days (Percentage)		0.00	50.00	55.00	60.00	65.00	70.00

Monitoring & Evaluation Plan: PDO Indicators					
Indicator Name	**Definition/Description**	**Frequency**	**Datasource**	**Methodology for Data Collection**	**Responsibility for Data Collection**
1. Outpatient visits by HEF beneficiaries in low utilization ODs	Outpatient visits by HEF beneficiaries in ODs with OPD utilization lower than 0.7 per capita per year in the baseline year 2020. Numerator: Total	Semi-annual	PMRS/ Full PMRS	Routine Data collection and reporting	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting

	Outpatient visits by HEF beneficiaries in ODs with OPD utilization lower than 0.7 per capita per year in the baseline year 2020. Denominator: Total HEF Beneficiaries in ODs with OPD utilization lower than 0.7 per capita per year in the baseline year 2020. (Please see Annex 4 for a list of these ODs and utilization rates)				
1.1. Outpatient visits by HEF beneficiaries in select provinces with highest multidimensional poverty	Outpatient visits per capita per year by HEF beneficiaries in five provinces with lowest multidimensional poverty index at baseline (Mondul Kiri, Ratanak Kiri, Kratie, Preah Vihear and Stung Treng)	Semi-annual	PMRS/ Full PMRS	Routine data collection and reporting	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting
1.2. Outpatient visits by female HEF beneficiaries in low utilization ODs	Outpatient visits by female HEF beneficiaries in low utilization ODs, as defined in the main indicator	Semi-annual	Full PMRS	Routine data collection and reporting	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data

					analysis and reporting
1.3. Outpatient visits by male HEF beneficiaries in low utilization ODs	Outpatient visits by male HEF beneficiaries in low utilization ODs as defined in the main indicator	Semi-annual	Full PMRS	Routine data collection and reporting	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting
2.1. Percentage of HEF beneficiaries in all HCs with Full PMRS being introduced in year 1, used the outpatient service paid by HEF	This is an indicator to track improvements in awareness and utilization of HEF benefits by HEF beneficiaries. The Project year is from July to June Numerator: Number of HEF beneficiaries who used OPD services reimbursed by HEF in all HCs with Full PMRS being introduced from July 2022-June 2023,year Denominator: Total number of HEF beneficiaries covered by HEF in the 200 HCs with Full PMRS being introduced from July 2022-June 2023.	Annual	Full PMRS	Routine data for HEF utilization and HEF beneficiaries from PCA will be used.	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting
2.1.1. Percentage of female HEF beneficiaries, in all HC with Full PMRS being introduced in year 1, used the	As defined in the parent indicator	Annual	Full PMRS	Routine data for HEF utilization and HEF beneficiaries from PCA	PCA will report the HEF utilization to DPHI or allow DPHI's access to

outpatient service paid by HEF				will be used	the database for conducting data analysis and reporting
2.1.2. Percentage of male HEF beneficiaries, in all HC with Full PMRS being introduced in year 1, used the outpatient service paid by HEF	As defined in the parent indicator	Annual	Full PMRS	Routine data for HEF utilization and HEF beneficiaries from PCA will be used	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting
2.2. Percentage of HEF beneficiaries in all HCs with Full PMRS being introduced in year 2, used the outpatient service paid by HEF	This is an indicator to track improvements in awareness and utilization of HEF benefits by HEF beneficiaries. The project year is from July to June Numerator: Number of HEF beneficiaries who used OPD services reimbursed by HEF in all HCs with Full PMRS being introduced from July 2023-June 2024 Denominator: Total number of HEF beneficiaries covered by HEF in all HCs with Full PMRS being introduced from July 2023-June 2024.	Annual	Full PMRS	Routine data for HEF utilization and HEF beneficiaries from PCA will be used	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting

2.2.1 Percentage of female HEF beneficiaries, in all HC with Full PMRS being introduced in year 2, used the outpatient service paid by HEF	As defined in the parent indicator	Annual	Full PMRS	Routine data for HEF utilization and HEF beneficiaries from PCA will be used	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting
2.2.2. Percentage of male HEF beneficiaries in all HCs with Full PMRS being introduced in year 2, used the outpatient service paid by HEF	As defined in the parent indicator	Annual	Full PMRS	Routine data for HEF utilization and HEF beneficiaries from PCA will be used	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting
2.3. Percentage of HEF beneficiaries in all HCs with Full PMRS being introduced in year 3, used the outpatient service paid by HEF	This is an indicator to track improvements in awareness and utilization of HEF benefits by HEF beneficiaries. The project year is from July to June Numerator: Number of HEF beneficiaries who used OPD services reimbursed by HEF in all HCs with Full PMRS being introduced from July 2024-June 2025 Denominator: Total number of HEF beneficiaries covered by HEF in the 300 HCs with Full PMRS being introduced	Annual	Full PMRS	Routine data for HEF utilization and HEF beneficiaries from PCA will be used	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting

	July 2024-June 2025.				
2.3.1. Percentage of female HEF beneficiaries in all HCs with Full PMRS being introduced in year 3, used the outpatient service paid by HEF	As defined in the parent indicator	Annual	Full PMRS	Routine data for HEF utilization and HEF beneficiaries from PCA will be used	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting
2.3.2. Percentage of male HEF beneficiaries, in all HC with Full PMRS being introduced in year 3, used the outpatient service paid by HEF	As defined in the parent indicator	Annual	Full PMRS	Routine data for HEF utilization and HEF beneficiaries from PCA will be used	PCA will report the HEF utilization to DPHI or allow DPHI's access to the database for conducting data analysis and reporting
3. Number of HFs exceeding 60 percent score in the April-May round of semi-annual national quality assessment	This is an indicator to track the improved quality of HFs and is assessed by the NQEMTs-II.	Annual	NQEMTs-II ICT system	Health centers and hospitals are assessed on a semi-annual basis against NQEMTs-II. The assessment is conducted by ex-ante assessors, who report the results to QAO.	QAO
4. Hypertension screening rate	Numerator: number of target population screened for hypertension Denominator: total number of the target population	Semi-annual	NCD patient tracking system	reporting from NCD patient tracking ICT system	PMD

	(residents that are ≥40 years old) for hypertension screening.				
4.1. Hypertension screening rate among women	Numerator: number of target female population screened for hypertension Denominator: total number of target female population (residents that are ≥40 years old) for hypertension screening.	Semi-annual	NCD patient tracking system	reporting from NCD patient tracking ICT system	PMD
4.2. Hypertension screening rate among men	Numerator: number of target male population screened for hypertension Denominator: total number of target male population(residents that are ≥40 years old) for hypertension screening	Semi-annual	NCD patient tracking system	reporting from NCD patient tracking ICT system	PMD
5. Number of HFs with Full PMRS introduced routinely collect & report sex, age & geographical location disaggregated data, gender-specific health data (e.g. GBV), & other markers of disadvantage	Full indicator name: Number of HFs with Full PMRS being introduced routinely collect and report sex, age and geographical location disaggregated data, gender-specific health data (e.g. GBV), and other markers of disadvantage such as indigenous status	Semi-annual	MOH report/HMIS/ full PMRS	DPHI collects and reports data in collaboration with other agencies	DPHI

	The indicator will require an assessment in year 1 to look at the full package of data and include the GBV collection of data. The assessment will be done in collaboration with the various agencies within the MOH that will provide exact definitions, criteria for the target groups and provide DPHI (department in charge of collecting the data) the formula to incorporate the indicators in the system. Year one will also see the roll-out of the indicators that are included in the CNP project (covering only 7 provinces) to the remaining provinces. The remaining GESI data around disability and indigenous status will require consultations and collaboration with other ministries that are responsible for defining these indicators. PCA/DPHI will roll out full				

	PMRS to all remaining health centers in the first three years (200 HCs in year 1, 300 HCs in year 2, and 300HCs in year 3). DPHI will complete aggregation and finalization of all required information necessary in each year for the HCs/HFs with full PMRS rolled out. Year 4 will see the roll-out of the full sex-disaggregated data and GESI indicators as agreed with the Government and the Bank.				

Monitoring & Evaluation Plan: Intermediate Results Indicators

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
1. Percentage of HEF claims verified by PCA within six working days	This is an indicator to track the timeliness of claims verified by the PCA. Numerator: number of claims submitted to PCA	Monthly	PMRS	PMRS report	PCA

	verified and certified by PCA within six working days Denominator: total number of claims submitted to PCA.				
2. Percentage of NSSF invoice verified by PCA within six working days	Number of cases claimed by HFs for reimbursement by NSSF being verified by PCA within 6 days	monthly	PMRS	PMRS report	PCA
3. Total number of HEF utilization (Outpatient and Inpatient visits)	Total number of IPD and OPD cases utilized by HEF beneficiaries.	Semi-annual	Full PMRS	total number of OPD and IPD cases by HEF beneficiaries recorded in the full PMRS	PCA will report HEF utilization to DPHI for conducting data analysis and reporting
4. Percent of HFs for which ex-post verification score is more than or equal to 10.5 percent point lower than ex-ante assessment score	Numerator: total number of HFs being verified by the ex-post assessors having ex-post verification score less than 10.5 percent point against the ex-ante scores Denominator: total number of HFs being verified by ex-post assessors.	Semi-annual	NQEMT-2 ICT system	Result of the ex-post verification conducted by PCA comparing the ex-ante score against the ex-post score.	QAO/PCA
5. Cervical cancer screening rate of target population	Numerator: number target population screened for cervical cancer screening Denominator: total number of the target population	Semi-annual	NCD patient tracking	Report from NCD patient tracking system	PMD/DPHI

	(women aged 30-49) for cervical cancer screening.				
6. Number of HCs with established electronic rosters for target population	Number of health centers with electronic rosters for target population including ANC, PNC, Immunization, and NCD.	Semi-annual	NCD patient tracking	Routine data	PMD
7. Number of diabetes patients managed by HCs according to the national protocol	Number of diabetes patients managed by HCs according to the treatment protocol.	Semi-annual	NCD Patient Tracking	Routine Data	PMD
7.1. Number of female diabetes patients managed by HCs according to the national protocol	Number of female diabetes patients managed by HCs according to the treatment protocol	Semi-annual	NCD Patient Tracking	Routine Data	PMD
7.2. Number of male diabetes patients managed by HCs according to the national protocol	Number of male diabetes patients managed by HCs according to the treatment protocol.	Semi-annual	NCD Patient Tracking	Routine Data	PMD
8. Percentage of hypertension cases managed by public health facilities according to national protocol	Numerator: number of hypertension cases treated by public health facilities according to the national protocol Denominator: total number of people diagnosed with hypertension by public health facilities recommended for treatment	Semi-annual	NCD patient tracking system	NCD tracking system will track these patients. The patients managed according to the national protocol will be defined based on the Government protocol for managing hypertensive patients.	PMD
8.1. Percentage of hypertension cases managed by public health facilities	Numerator: number of hypertension cases among	Semi-annual	NCD patient tracking	NCD tracking system will track these	PMD

according to the national protocol among women	women treated by public health facilities according to the national protocol Denominator: total number of women diagnosed with hypertension by public health facilities recommended for treatment		system	patients. The patients managed according to the national protocol will be defined based on the Government protocol for managing hypertensive patients.	
8.2. Percentage of hypertension cases managed by public health facilities according to the national protocol among men	Numerator: number of hypertension cases among men treated by public health facilities according to the national protocol \ Denominator: total number of men diagnosed with hypertension by public health facilities recommended for treatment	Semi-annual	NCD patient tracking system	NCD tracking system will track these patients. The patients managed according to the national protocols will be defined based on the Government protocols for managing hypertensive patients.	PMD
People who have received essential health, nutrition, and population (HNP) services		Semi-annual	HMIS	Routine data: Sum of (a) number of children who received HepB within 24 hours, (b) number of deliveries attended by skilled health personnel at public health facilities, and (c) number of women and children	DPHI

				who have received basic nutrition services.	
Number of children immunized		Semi-annual	HMIS	Routine data; Cumulative number of newborns vaccinated with HepB within 24 hours of birth-as a proxy indicator	DPHI
Number of women and children who have received basic nutrition services		Semi-annual	HMIS	Routine data: Cumulative numb er of children aged 6-59 months received Vitamin A supplementation in second round, and cumulative number of pregnant women received 90 tablets iron/folic acid	DPHI
Number of deliveries attended by skilled health personnel		Semi-annual	HMIS	Routine data: Cumulative number of deliveries attended by skilled health personnel at public health facilities.	DPHI
10. Percentage of HFs producing timely financial report as stipulated in the SDG Manual	DBF, with support from ODs' and PHDs' Accountants to provide hand-holding/on-	Annual	DBF report from ODs	DBF will collect the table prepared by ODs showing the timeline of	DBF

	site training/coaching to HFs in producing timely financial reports according to the SDG Manual			monthly financial reports prepared by health facilities	
11. Number of management and health providers trained on GESI standards for health management and service delivery by province and sex.	Number of management and health providers trained on GESI standards for health management and service delivery by province and sex. Please note that this indicator is also linked with PBC 7. As the portal only allows for one PBC to be linked with one indicator, we have linked PBC 7 on GESI with the main GESI indicator (PDI 5).	Annual	GMAG	reporting by GMAG supported by training sign-in sheet, hotel bill and etc	GMAG and DPHI
12. Number of data reviews conducted on the utilization of essential health services including NCDs	Number of routine reviews conducted by DPHI and PMD to review the utilization of essential health services (ANC, PNC, delivery at health facilities, family planning, and immunization) including NCDs.	Semi-annual	DPHI Reports	Routine reporting	DPHI
13. Percentage of complaints received to the project Grievance Redress Mechanism (GRM) addressed within 60 days	Numerator: total number of complaints addressed within 60 days	Semi-annual	MOH admin data/semi-annual	Routine monitoring	MOH

	Denominator: total number of complaints received within last 6 months		project program report		

Performance-Based Conditions Matrix

PBC 1	Improved HEF Management			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	1,000,000.00	0.36
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Nil			
Year 1: Commencing on July 1, 2022 and ending on December 31, 2023	(a) Semi-annual workshop to review HEF utilization conducted and semi-annual HEF utilization analysis reports, including findings from the rapid survey, completed according to the defined template by end of February and end of August (PBC Value: US$240,000) (time bound). (b) Updated HEF benefit package and service reimbursement rates approved (PBC Value: US$60,000). (c) Action plan agreed before June 30, 2023 on routine collection of gender and other GESI-related disaggregated data and gender specific data. (US$30,000).		330,000.00	As noted in value cell
Year 2: Commencing January 1, 2024 and ending on	(a) Semi-annual workshop to review HEF utilization conducted and semi-annual HEF		200,000.00	As noted in value cell

December 31, 2024	utilization analysis reports, including findings from the rapid survey, completed according to the defined template by end of February and end of August (PBC Value: US$160,000) (time bound). (b) HMIS/DHIS2/PMRS routinely produces GBV data according to the action plan (US$40,000)		
Year 3: Commencing January 1, 2025 and ending on December 31, 2025	(a) Semi-annual workshop to review HEF utilization conducted and semi-annual HEF utilization analysis reports, including findings from the rapid survey, completed according to the defined template by end of February and end of August (PBC Value: US$160,000) (time bound). (b) HMIS/DHIS2/PMRS routinely produce gender and other GESI-disaggregated data, and gender specific data according to the action plan (PBC Value: US$60,000).	220,000.00	As noted in value cell
Year 4: Commencing January 1, 2025 and ending on December 31, 2026	(a) Semi-annual workshop to review HEF utilization conducted and semi-annual HEF utilization analysis reports, including findings from the rapid survey, completed according to the defined template by end of February and end of August (PBC Value: US$160,000) (time bound).	160,000.00	As noted in value cell
Year 5: Commencing January 1, 2027 and ending on June 30, 2027	(a) Semi-annual workshop to review HEF utilization conducted and semi-annual HEF utilization analysis reports, including findings from the rapid survey, completed according to the defined template by end of August (PBC Value: US$90,000) (time bound).	90,000.00	As noted in value cell

PBC 2	Expanded PCA Functions and Service Coverage (time bound except for target c for year 1-3)			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	6,000,000.00	2.18
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Nil			
Year 1: Commencing on July 1, 2022 and ending on December 31, 2023	(a) Two rounds of ex-post verification conducted for NQEMTs-II, and verification report prepared and shared with QIWG within 45 days (Formula: US$250,000 per round, PBC Value: US$500, 000). (b) Three rounds of validation of NCD services provision conducted and report submitted within 45 days (Formula: US$ 360,000 for the first round and US$310,000 per round afterwards; PBC Value: US$980,000). (c) Full PMRS rolled out to 350 HCs in low utilization ODs and 10 RHs (in low utilization ODs first) (Formula: US$1,500 per each HC; and US$5,000 per each RH; PBC Value: US$575,000).		2,055,000.00	As noted in value cell
Year 2: Commencing January 1, 2024 and ending on December 31, 2024	(a) Two rounds of ex-post verification conducted for NQEMTs-II, and verification report prepared and shared with QIWG within 45 days (Formula: US$150,000 per round; PBC Value: US$300,000). (b) Two rounds of validation of NCD services provision conducted and report submitted within 45 days (Formula: US$310,000 per round; PBC Value: US$620,000). (c) Full PMRS rolled out to 300 HCs and 10 RHs (both in low utilization ODs		1,420,000.00	As noted in value cell

	first) (Formula: US$1,500 per each HC; US$5,000 per each RH; PBC Value: US$500,000).		
Year 3: Commencing January 1, 2025 and ending on December 31, 2025	(a) Two rounds of ex-post verification conducted for NQEMTs-II, and verification report prepared and shared with QIWG within 45 days (Formula: US$150,000 per round; PBC Value: US$300,000). (b) Two rounds of validation of NCD services provision conducted and report submitted within 45 days (Formula: US$310,000 per round; PBC Value: US$620,000). (c) Full PMRS rolled out to 150 HCs (Formula: US$1,500 per each HC; PBC Value: US$225,000)	1,145,000.00	As noted in value cell
Year 4: Commencing January 1, 2025 and ending on December 31, 2026	(a) Two rounds of ex-post verification conducted for NQEMTs-II, and verification report prepared and shared with QIWG within 45 days (Formula: US$150,000 per round; PBC Value: US$300,000). (b) Two rounds of validation of NCD services provision conducted and report submitted within 45 days (Formula: US$310,000 per round; PBC Value: US$620,000).	920,000.00	As noted in value cell
Year 5: Commencing January 1, 2027 and ending on June 30, 2027	(a) One round of ex-post verification conducted for NQEMTs-II, and verification report prepared and shared with QIWG within 45 days (Formula: US$150,000 per round; PBC Value: US$150,000). (b) One rounds of validation of NCD services provision conducted and report submitted within 45 days (Formula: US$310,000 per round; PBC Value: US$310,000).	460,000.00	As noted in value cell

PBC 3	Enhanced Quality of Health Service as defined in NQEMTs-II by MOH			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	3,800,000.00	1.38
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Nil			
Year 1: Commencing on July 1, 2022 and ending on December 31, 2023	(a) NQEMTs-II training provided according to the AOP (PBC Value: US$850,000). (b) At least 200 HFs reached 30% score in one round (Formula: US$256,250 per round; PBC Value: US$256,250). (c) 20 new clinical vignettes and their respective coaching protocols developed and applied in NQEMTs-II. (Formula: US$7,500 per clinical vignette; PBC Value US$150,000)		1,256,250.00	As noted in value cell
Year 2: Commencing January 1, 2024 and ending on December 31, 2024	(a) At least 300 HFs reached 40% score in round 1 and 45% score in round 2 (Formula: US$256,250 per round; PBC Value: US$512,500). (b)Less than 20 percent of HFs which ex-post verification and ex-ante assessment scores differed more than 10.5 percent point. (PBC Value: US$150,000)(time bound).		662,500.00	As noted in value cell
Year 3: Commencing January 1, 2025 and ending on December 31, 2025	(a) At least 400 HFs reached 50% score in round 1 and 55% score in round 2 (Formula: US$256,250 per round; PBC Value US$512,500); (b)Less than 18 percent of HFs which ex-post verification and ex-ante assessment scores differed more than 10.5 percent point. (PBC Value: US$150,000)		812,500.00	As noted in value cell

	(time bound).(c) 20 new clinical vignettes and their respective coaching protocols developed and applied in NQEMTs-II. (Formula: US$7,500 per clinical vignette; PBC Value US$150,000).			
Year 4: Commencing January 1, 2025 and ending on December 31, 2026	(a)At least 550 HFs reached 60% score in round 1 and 65% score in round 2 (Formula: US$256,250 per round; PBC Value US$512,500). (b)Less than 16 percent of HFs which ex-post verification and ex-ante assessment scores differed more than 10.5 percent point. (PBC Value: US$150,000) (time bound).		662,500.00	As noted in value cell
Year 5: Commencing January 1, 2027 and ending on June 30, 2027	(a) At least 700 HFs reached 70% score in round 1 (Formula: US$256,250 per round; PBC Value US$256,250).(b) Less than 15 percent of HFs which ex-post verification and ex-ante assessment scores differed more than 10.5 percent point. (PBC Value: US$150,000) (time bound).		406,250.00	As noted in value cell
PBC 4	Rolling out of NCD Services and Cervical Cancer Screening—National			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	2,000,000.00	0.73
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Nil			
Year 1: Commencing on July 1, 2022 and ending on	(a) Supervision, coaching, and annual reviews conducted according to AOP. (PBC Value: US$250,000) (time bound). (b) A national Health		950,000.00	As noted in value cell

December 31, 2023	Promotion Program developed, and health promotion IEC materials developed, distributed to HFs and schools and disseminated to the general population through social media. (PBC Value: US$180,000).(c)National standard operation procedures for implementing NCD and cervical cancer screening and management updated (PBC Value: US$50,000). (d) All PHDs and ODs completed the training of trainer (TOT) training on NCD and cervical cancer as well as the NCD ICT training according to the AOP and received certificates (Formula: US$1,200 per each PHD/OD; PBC Value: US$240,000). (e) All remaining 53 RHs and 61 RHs received training on cervical cancer and NCD services, respectively (Formula: US$1,000 per RH per training; PBC Value:US$230,000).		
Year 2: Commencing January 1, 2024 and ending on December 31, 2024	(a) Supervision, coaching, and semi-annual reviews conducted according to the AOP (PBC Value: US$200,000) (time bound). (b)Health promotion activities completed according to the AOP. (PBC Value: US$100,000).	300,000.00	As noted in value cell
Year 3: Commencing January 1, 2025 and ending on December 31, 2025	(a) Supervision, coaching, and semi-annual reviews conducted according to the AOP(PBC Value: US$200,000) (time bound).(b)Health promotion activities completed according to the AOP (PBC Value: US$100,000).	300,000.00	As noted in value cell
Year 4: Commencing January 1, 2025 and ending on	(a) Supervision, coaching, and semi-annual reviews conducted according to the AOP (PBC	300,000.00	As noted in value cell

December 31, 2026	Value: US$200,000) (time bound).(b)Health promotion activities completed according to the AOP(PBC Value: US$100,000).			
Year 5: Commencing January 1, 2027 and ending on June 30, 2027	(a) Supervision, coaching, and semi-annual reviews conducted according to the AOP (PBC Value: US$100,000) (time bound). (b)Health promotion activities completed according to the AOP (PBC Value: US$50,000).		150,000.00	As noted in value cell

PBC 5	Rolling out of NCD Services and Cervical Cancer Screening – Subnational Level (scalable, non-time bound)			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	4,700,000.00	1.71
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Nil			
Year 1: Commencing on July 1, 2022 and ending on December 31, 2023	(a) At least 12% of the target population screened for hypertension and diabetes (Formula: US$12,800 per OD; US$1,300 per HC; PBC Value: US$2,676,100). (b) At least 12% of the target population screened for cervical cancer (Formula: US$9,000 per OD; US$500 per HC; PBC Value: US$1,100,000		3,776,100.00	As noted in value cell
Year 2: Commencing January 1, 2024 and ending on December 31, 2024	(a) At least 24% of the target population screened for hypertension and diabetes (Formula: US$300 per OD; US$100 per HC; PBC Value: US$141,500). (b)At least 24% of the target population screened for cervical cancer (Formula: US$300 per OD; US$120 per HC; PBC Value:		256,700.00	As noted in value cell

	US$115,200).		
Year 3: Commencing January 1, 2025 and ending on December 31, 2025	(a) At least 35% of the target population screened for hypertension and diabetes (Formula: US$300 per OD; US$100 per HC; PBC Value: US$141,500); (b)At least 35% of the target population screened for cervical cancer (Formula: US$300 per OD; US$120 per HC; PBC Value: US$115,200	256,700.00	As noted in value cell
Year 4: Commencing January 1, 2025 and ending on December 31, 2026	(a) At least 45% of the target population screened for hypertension and diabetes (Formula: US$300 per OD; US$100 per HC; PBC Value: US$141,500). (b)At least 45% of the target population screened for cervical cancer (Formula: US$300 per OD; US$120 per HC; PBC Value: US$115,200).	256,700.00	As noted in value cell
Year 5: Commencing January 1, 2027 and ending on June 30, 2027	(a) At least 50% of the target population screened for hypertension and diabetes (Formula: US$200 per OD; US$60 per HC; PBC Value: US$87,000). (b) At least 50% of the target population screened for cervical cancer (Formula: US$200 per OD; US$60 per HC; PBC Value: US$66,800).	153,800.00	As noted in value cell

PBC 6	Timely processing of project funds and improved capacity of sub-national HFs in applying relevant financial management system			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	600,000.00	0.22
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Nil			
Year 1: Commencing on July 1, 2022 and ending on December 31, 2023	(a) HEF and SDG payments processed within 5 working days (PBC Value: US$45,000) (time bound).(b) 22% of the HFs (300HFs) can produce timely financial report as stipulated in the SDG manual (Formula: US$325 per HF for on-site training; PBC Value: US$98,000).		143,000.00	As noted in value cell
Year 2: Commencing January 1, 2024 and ending on December 31, 2024	(a) HEF and SDG payments processed within 5 working days (PBC Value: US$30,000) (time bound)(b) 50% of the HFs (380 additional HFs) can produce timely financial report as stipulated in the SDG manual (Formula: US$325 per HF for on-site training; PBC Value: US$124,000).		154,000.00	As noted in value cell
Year 3: Commencing January 1, 2025 and ending on December 31, 2025	(a) HEF and SDG payments processed within 5 working days (PBC Value: US$30,000) (time bound).(b) 79% of the HFs (400 additional HFs) can produce timely financial report as stipulated in the SDG Manual (Formula: US$325 per HF for on-site training; PBC Value: US$130,000).		160,000.00	As noted in value cell
Year 4: Commencing January	(a) HEF and SDG payments processed within 5		126,000.00	As noted in value cell

1, 2025 and ending on December 31, 2026	working days (PBC Value: US$30,000) (time bound). (b) 100% of the HFs (293 additional HFs) can produce timely financial report as stipulated in the SDG Manual (Formula: US$325 per HF for on-site training; PBC Value: US$96,000).			
Year 5: Commencing January 1, 2027 and ending on June 30, 2027	(a) HEF and SDG payments processed within 5 working days. (PBC Value: US$17,000) (time bound).		17,000.00	As noted in value cell

PBC 7	Implementation of Gender Equality and Social Inclusion Action Plan (scalable, non-time bound)			
Type of PBC	**Scalability**	**Unit of Measure**	**Total Allocated Amount (USD)**	**As % of Total Financing Amount**
Process	Yes	Text	500,000.00	0.18
Period	**Value**		**Allocated Amount (USD)**	**Formula**
Baseline	Nil			
Year 1: Commencing on July 1, 2022 and ending on December 31, 2023	GESI Action Annual Plan agreed and at least 60% of actions implemented (Formula: US$1,670 per each 1%)		100,000.00	As noted in value cell
Year 2: Commencing January 1, 2024 and ending on December 31, 2024	GESI Action Annual Plan agreed and at least 70% of actions implemented (Formula: US$1,430 per each 1%)		100,000.00	As noted in value cell
Year 3: Commencing January 1, 2025 and ending on December 31, 2025	GESI Action Annual Plan agreed and at least 70% of actions implemented (Formula: US$1,720 per each 1%)		120,000.00	As noted in value cell
Year 4: Commencing January 1, 2025 and ending on	GESI Action Annual Plan agreed and at least 80% of actions implemented (Formula: US$1,880 per		150,000.00	As noted in value cell

December 31, 2026	each 1%)		
Year 5: Commencing January 1, 2027 and ending on June 30, 2027	Evidence informed policy roundtables held on (a) GESI and progress made toward UHC and who is left behind and (b) on a gender equal and inclusive workforce (time bound)	30,000.00	As noted in value cell

Verification Protocol Table: Performance-Based Conditions	
PBC 1	Improved HEF Management
Description	This PBC will finance DPHI's expenditures for (a) updating HEF benefit package and service reimbursement rates; (b) conducting semi-annual review on HEF utilization and producing semi-annual HEF utilization analysis reports; (c) preparing Action Plan for routine collection of gender and other GESI related disaggregated data, and gender specific data; (d) routinely producing gender and other GESI disaggregated data, and gender specific data, and gender-based violence data from HMIS/DHIS2/PMRS; Target (a) across 5 years is time bound. Target (b) and target (c) across all years are not time bound.
Data source/ Agency	1. Consultation report for updating HEF benefit package and service reimbursement rates 2. Official documents to prove that the new HEF benefit package and new service reimbursement schedule have been developed and adopted 3. Semi-annual workshop invitation, participant sign-in sheet, venue renting invoice, 4. Semi-annual HEF analysis reports produced and submitted to the Association by end of February and end of August 5. GESI implementation action plan, progress on GESI implementation action plan, and gender-based violent data
Verification Entity	Result verification working group/verification agency. Verification procedures will be defined in the POM
Procedure	Desk review of reports submitted with supporting documents/evidence. Randomly sampled follow-up call and site-visit to be conducted as necessary to validate the reported achievement.

PBC 2	Expanded PCA Functions and Service Coverage (time bound except for target c for year 1-3)
Description	This PBC will finance PCA's expenditures for (a) conducting timely verification of HEF claim, quality ex-post verification validating diabetes, hypertension and cervical cancer screening and case management. (b) strengthening and expanding its capacity as needed to carry out the tasks defined above. (c) rolling out the full PMRS to remining 800 HCs and 20 RHs. This PBC is time bound except for target (c) year 1, year 2, and year 3. The disbursement will be made when each target is validated as fully achieved except scalability applied to target (c) in Year 1, Year 2, and Year 3 based on unit cost.
Data source/ Agency	1. Meeting invitation/notification, meeting participant sign in sheet, meeting venue renting invoice, certificate issued 2. Documents proven that supervision, coaching, semi/annual reviews conducted 3. Documents proven contracting of consultants 4. Reports of claim validation, diabetes and hypertension screening and treatment (DHS&T) and CCS&T screening and case management reports 5. Reports of ex-post verification of NQEMTs-II 6. Document proven the roll-out of full PMRS to HCs and RHs
Verification Entity	Result verification working group/verification agency. Verification procedures will be defined in the POM
Procedure	Desk review of reports submitted with supporting documents/evidence. Randomly sampled follow-up call and site-visit to be conducted as necessary to validate the reported achievement.

PBC 3	Enhanced Quality of Health Service as defined in NQEMTs-II by MOH
Description	This PBC will finance QAO's expenditures for (a) building PHD and OD assessor teams to conduct NQEMTs-II;(b) building the capacity of HCs and PHs/RHs to improve quality of healthcare service delivery; (c) developing 40 new clinical vignettes and their respective coaching protocols, and knowledge tests to be added in implementation of NQEMTs-II for improving knowledge and competency of health facility staff; and (d) conducting supervisions as necessary to improve the implementation of NQEMTs-II as well as the performance of health facilities. Target (a) of year 1 is time bound; Target (b) of year 2-5 is time bound; target (b) of year 1 and target (c) in year 3 are scalable; target (a) of year 2-5 is not timebound, which means MOH can continue to implement in the following years, but the disbursement will be made only when the target has been achieved.
Data source/ Agency	1. Statement of PBC achievement approved by the Project Director 2. NQEMTs-II data generated from the NQEMTs-II ICT system 3. Report of ex-post verification 4. Document proving approval of the new clinical vignettes and their respective coaching protocols.

Verification Entity	Result verification working group/verification agency. Verification procedures will be defined in the POM
Procedure	Desk review of reports submitted with supporting documents/evidence. Randomly sampled follow-up call and site-visit to be conducted as necessary to validate the reported achievement.

PBC 4	Rolling out of NCD Services and Cervical Cancer Screening—National
Description	This PBC will finance PMD's expenditures for (a) updating National standard operation procedures for implementing DHS&T and CCS&T management; (b) providing TOT to PHDs and ODs in 22 provinces for providing cascade training to HC staff; (c) training all remaining 53 RHs and 61 RHs for diagnosing and treating severe/complicated diabetes, hypertension and cervical lesion cases; (d) performing supportive supervision and coaching and conducting programs' semi/annual reviews; and (e) preparing and implementing the national Health Promotion Program. Target (a) of year 1-5 is time bound; target (b) of year 1-5 & target (c) of year 2 are not timebound, which means MOH can continue to implement in the following years, but the disbursement will only be made when the target has been achieved; target (c) &(d) of year 1 are scalable.
Data source/ Agency	1. Meeting invitation/notification, meeting participant sign in sheet, meeting venue renting invoice, certificate issued 2. Documents proven that supervision, coaching, semi/annual reviews conducted 3. Documents proven that the national plan or standard operation procedures developed and adopted 4. Documents proven the National Health Promotion Program developed and health promotion activities completed every year according to the annual operational plan.
Verification Entity	Result verification working group/verification agency. Verification procedures will be defined in the POM
Procedure	Desk review of reports submitted with supporting documents/evidence. Randomly sampled follow-up call and site-visit to be conducted as necessary to validate the reported achievement.

PBC 5	Rolling out of NCD Services and Cervical Cancer Screening – Subnational Level (scalable, non-time bound)
Description	This PBC will finance PHDs and ODs' expenditures for rolling out DHS&T and CCS&T to 810 new HCs and 500 new HCs respectively and ensure the achievement of NCD screening targets. The expenditures include (a)training HC staff to provide DHS&T and SSC&T services; (b) procure and providing equipment and consumables to health facilities and NCD clinics; (c) conducting supportive supervision, review workshops, monitoring and reporting. This PBC is scalable and non-time bound means partial disbursement is allowed based on the formula and linking with partial achievement. If the target for certain year is not achieved in that year, MOH can continue implementing in the following years, but the disbursement will only be

	made when the target has been achieved.
Data source/ Agency	1. Supporting evidence to confirm training has been provided. Such as official meeting invitation/notification, meeting participant sign in sheet, meeting venue renting invoice, certificate issued 2. Documents proven that supervision, coaching, semi/annual reviews conducted 3. Documents proven procurement/distribution of equipment, consumables, and other supplies according to the items and qualities defined in Annual Operational Plan 4. Validation report of achievement of screening targets
Verification Entity	Result verification working group/verification agency. Verification procedures will be defined in the POM
Procedure	Desk review of reports submitted with supporting documents/evidence. Randomly sampled follow-up call and site-visit to be conducted to validate the reported achievement.

PBC 6	Timely processing of project funds and improved capacity of sub-national HFs in applying relevant financial management system
Description	This PBC will finance the necessary project expenditures required for (a) DBF to ensure timely payment of HEF grant and performance-based SDG to sub-national HFs, ODs and PHDs; and (b) DBF, with support from ODs' and PHDs' Accountants to provide handholding/on-site training/coaching to Health Facilities in producing timely financial reports according to the SDG Manual. Target (a) of year 1-5 is time bound; target (b) of year 1-5 is scalable.
Data source/ Agency	1. Payment record in accounting system of DBF; 2. A table prepared by OD showing a timeline of which Desk review of reports submitted with supporting documents/evidence. 3.documetn proven the monthly financial reports are produced by Health Facilities; 4,Documents proven that on-site training/supervision/coaching conducted.
Verification Entity	Result verification working group/verification agency. Verification procedures will be defined in the POM
Procedure	(a) DBF will extract timeline of payment dates (the length of time for payment from the receipt of PCA-certified invoice) and provide it to IVA who will check to see if the payment is within 5 working days from the receipt of certified invoices. Randomly sampled follow-up call and site-visit to be conducted to validate the reported achievement (b) DBF will collect the table prepared by OD showing the timeline of monthly financial reports prepared by HFs and provide it to IVA. IVA will review the table to see if the monthly financial reports are produced no later than the deadline stated in the SDG manual. IVA can request for a copy of monthly financial reports, on a sample basis, for review and verification.

PBC 7	Implementation of Gender Equality and Social Inclusion Action Plan (scalable, non-time bound)
Description	This indicator is to measure the implementation of Gender Equality and Social Inclusion Action Plan each year according to the annual operational plan. The annual workplan will be developed and agreed by the Pooled Fund partners. This PBC (except for target for year 5) is scalable and not time bound. Target for Year 5 is time bound and non-scalable.
Data source/ Agency	1. GMAG will be responsible to monitor, collect and report on the data 2. Report developed according to the agreed template; 3. Documents proven training provided such as official training invitation, participant sign-in sheet, record of certificate issued 4. Documents proven policy roundtable conducted such as official invitation, participant sign-in sheet, venue renting invoice, policy report, presentations and etc. 5. Documents proven the annual operational plan developed every year and the activities defined in the plan completed according to the annual operational plan.
Verification Entity	Result verification working group/verification agency. Verification procedures will be defined in the POM
Procedure	Desk review of reports submitted with supporting documents/evidence. Randomly sampled follow-up call and site-visit to be conducted to validate the reported achievement.

ANNEX 1: Project Implementation and Support Arrangements

COUNTRY: Kingdom of Cambodia
Health Equity and Quality Improvement Project Phase 2 (H-EQIP II)

Strategy and Approach for Implementation Support

1. As with the H-EQIP support, the World Bank team will include task team leader(s) (a senior health specialist and/or senior economist), an operations officer, and procurement and FM specialists based in-country, along with locally based safeguard specialists. Further operational and fiduciary management support will be provided from the region, as and when required. Expertise from the Health, Nutrition, and Population Global Practice, as well as from other practices will be drawn upon, particularly with respect to DLIs, health service delivery, digital health, and PFM.
2. In addition to the IDA credit, the World Bank-executed part of the MDTF-BE will be used to conduct analytical work and contract technical assistance that would contribute to meeting the PDO. This will be provided as complementary support to the ongoing Cambodia Health Programmatic Analytical and Advisory Activities, which has as its objective to generate evidence and engage in policy dialogue with the RGC, contribute to developing and implementing policies for improved access to health services by the poor, and strengthen the RGC's capacity to move towards UHC. The MDTF-BE will finance costs associated with carrying out the analytical work and World Bank operational and supervisory work including fiduciary assessments, oversight, and supervision of recipient managed activities, task-level M&E, and RGC and donor relationship management.
3. A portion of training and knowledge sharing will be provided by the World Bank from its own resources, with additional resources being sought for relevant support as and when the need arises. The team will also draw upon the in-country expertise of various DPs (DPs-bilateral, multilateral, including United Nations agencies) as well as NGOs and international firms operating in Cambodia.
4. The World Bank will provide formal implementation support on a semi-annual basis jointly with those contributing to the MDTF. The DPs and World Bank will jointly approve the annual operational plans and the agreed share of financing (disbursement percentages) for these expenditures between the IDA credit, MDTF grant, and the RGC counterpart funds. The long history of donor harmonization/ coordination in Cambodia will continue under this project, taking a collaborative approach and drawing upon the expertise of each of the DPs. This includes identifying additional technical assistance needs and resources available among the DPs, with a view to continuously explore the possibility of leveraging support from different resources, including partners who are not co-financing H-EQIP II, and enhance efficiency in coordination.

Implementation Support Plan

5. Table 1.1 provides an overview of the anticipated needs during the implementation period. Areas are tentatively identified as specified in tables 1.2.

Table 1.1. Implementation Support Plan

Time	*Focus*	*Skills Needed*	*Resource Estimate*	*Partner Role*
Initial 12 months	• Health financing • PFM in health • Health system strengthening (training) • Digital health • FM • Procurement • Community engagement and social accountability • Environmental safeguards • Social safeguards • GESI	• Health economics • PFM • Health, nutrition, and population • Training • Operations • Digital health • FM • Procurement • Social sector specialist • M&E • Environment specialist • Social safeguards specialist • GESI specialist	US$200,000	• DFAT • KfW • KOICA • ADB • USAID • GIZ • JICA • WHO • UNICEF • UNFPA
12–60 months	• Health financing • PFM in health • Health system strengthening (training) • MNCH, nutrition • Digital Health • FM • Procurement • Citizen engagement and social accountability • Environmental safeguards Social safeguards • GESI	• Health economics • PFM • Health, Nutrition, and population • Training • Operations • Digital Health • FM • Procurement • Social sector specialist • M&E • Environment specialist • Social safeguards specialist • GESI specialist	US$300,000	• DFAT • KfW • KOICA • USAID • GIZ • JICA • WHO • UNICEF • UNFPA

Note: MNCH = Maternal, Newborn, and Child Health; UNFPA = United Nations Population Fund.

Table 1.2. Skills Mix Required (five years)

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
Task team leaders	160	10	DC based and in-country
Health financing	20	10	In country and Washington DC
Performance-based	20	10	Regional and Washington DC
Health, nutrition, and population	25	10	In country and Washington DC
Operations	160	10	In-country and Washington DC
Quality of health service	20	5	Regional
Digital health	80	10	Washington DC and in-country
PFM	20	5	In-country and regional
Social safeguards	10	0	In-country
Gender equality	40	5	In-country and regional
Environment specialist	20	0	In-country
FM	40	5	In-country and regional
Procurement	25	0	In-country
Social development	10	0	In-country

ANNEX 2: Project Costing Table

Component/Activities	Modality	IDA	DFAT	GFF	RGC	Financing Gap (MDTF)	Total
Component 1: Improving Financial Protection and Utilization of Health Equity Fund		**20.44**	**7.06**	**5.58**	**70**	**8.92**	**112.00**
Subcomponent 1.1: Financing the HEF	Out-put Based	17.04	5.88	4.65	70	7.43	105.00
Subcomponent 1.2: Enhancing HEF Management and Utilization (DPHI)	PBC	0.49	0.17	0.13	0.00	0.21	1.00
Subcomponent 1.3: Enhancing Roles and Responsibilities of PCA	PBC	2.91	1.01	0.8	0.00	1.28	6.00
Component 2: Strengthening Quality and Capacity of Health Service Delivery		**32.77**	**11.32**	**8.92**	**116**	**14.29**	**183.30**
Subcomponent 2.1: Implementing New NQEMTs-II Nation-Wide	**SDGs+PBC**	**11.60**	**4.00**	**3.14**	**110.00**	**5.06**	**133.80**
Fixed lump-sum grants	SDGs	0.00	0.00	0.00	93.00	0.00	93.00
Performance-based SDGs	SDGs	9.75	3.36	2.64	17.00	4.25	37.00
QAO	PBC	1.85	0.64	0.5	0.00	0.81	3.80
Subcomponent 2.2: Building comprehensive service provision with Expanded NCD Services and strong community engagements	SDGs+PBC	9.49	3.28	2.59	6.00	4.14	25.50
NCD SDG and community engagement SDG	SDGs	6.23	2.15	1.7	6.00	2.72	18.80
Management and supervision	PBC	3.26	1.13	0.89	0.00	1.42	6.70
Subcomponent 2.3: Building Service Capacity for Referral Hospitals	IPF	**11.68**	**4.04**	**3.19**	**0.00**	**5.09**	**24.00**
Component 3: Project Management, Monitoring and Evaluation, Gender Equality and Social Inclusion		**1.79**	**0.62**	**0.50**	**0.00**	**0.79**	**3.70**
Subcomponent 3.1: Project Management, Capacity Building and M&E	IPF+PBC	**1.55**	**0.54**	**0.43**	**0.00**	**0.68**	**3.20**
Project Management, adaptive learning & M&E	IPF	1.26	0.44	0.35	0.00	0.55	2.60
DBF	PBC	0.29	0.1	0.08	0.00	0.13	0.60
Subcomponent 3.2: Gender Equality and Social Inclusion	PBC	**0.24**	**0.08**	**0.07**	**0.00**	**0.11**	**0.50**
Component 4: Contingent Emergency Response (CERC)		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Total		**55.00**	**19.00**	**15.00**	**186.00**	**24.00**	**299.00**

ANNEX 3: Detailed Economic Analysis

1. This section will elaborate on the summary economic analysis presented in section IV of the Project Appraisal Document. The analysis will gauge economic rationale of project investments from access, equity, and efficiency perspective, and estimate the cost-effectiveness ratio of the project investments.

Economic Rationale

2. As noted in section IV, the proposed project will contribute to Cambodia's development by (a) improving health service utilization, quality, and outcomes; (b) promoting equity and shared prosperity by financing pro-poor service-fee exemption; (c) increasing efficiency of the health system; (d) improving labor productivity; and (e) building human capital.

3. The project will improve access to health services through two key interventions:

(a) **HEF finances essential package of health services** at the primary and secondary levels for the poorest 20 percent population of the country and provides the beneficiaries with transport costs and food-allowance. As documented by Annear et al.[62] introduction of HEF significantly improved utilization of health services in public HFs. Inpatient cases increased by 47.9 percent, outpatient cases by 24.1 percent, and deliveries increased by 31.4 percent in hospitals. The number of consultations in HCs increased by 15.6 percent and deliveries by 5.3 percent.

(b) **Expansion of NCD services.** The country is going through an epidemiological transition, with NCDs now responsible for 64 percent of all deaths in the country. The project invests in expanding access to key NCD services including diabetes, hypertension and cervical cancer screening, and diabetes management at the community level and front-line facilities. The project's focus on expanding access to NCD services is highly timely and is expected to reduce NCD morbidity and mortality burden in the country.

4. This project will improve equity through following mechanisms:

(a) The project financing will disproportionately benefit the poor by providing high-quality care (including for NCDs) at lower levels of the health system. As estimated by Asante et al.[63] (figure 3.1), the distribution of health service use across wealth quintiles in Cambodia is relatively pro-poor for government HFs and the reverse for private facilities. Nearly 33 percent of total HC visits are by the poorest population quintile, and the bottom two quintiles use close to 60 percent of all public hospital inpatient services.

(i) The project finances services and quality improvements at lower levels of the health

[62] Annear, P.L., J. T. Lee, K. Khim, P. Ir, E. Moscoe, T. Jordanwood, T., Bossert, M. Nachtnebe, and V. Lo2019. "Protecting the Poor? Impact of the National Health Equity fund on Utilization of Government Health Services in Cambodia, 2006-2013." *BMJ Global Health 4(6).*

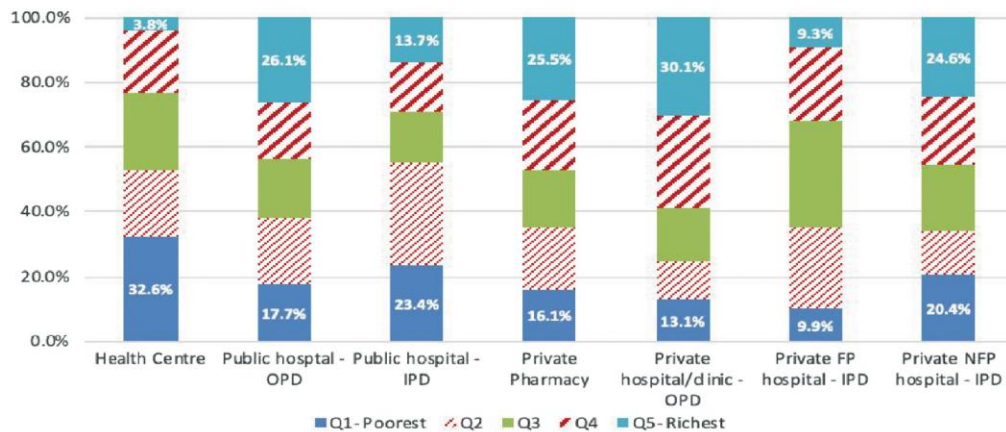
[63] Asante, Augustine D., Por Ir, Bart Jacobs, Limwattananon Supon, Marco Liverani, Andrew Hayen, Stephen Jan, and Virginia Wiseman.2019. "Who Benefits from Healthcare Spending in Cambodia? Evidence for a Universal Health Coverage Policy." *Health Policy and Planning* 34(1):i4–i13. https://doi.org/10.1093/heapol/czz011

system that the poor are more likely to use. In addition to HEF financing for services provided in government HCs and secondary hospitals, the project also finances operational financing and quality improvement mechanism for these frontline facilities.

(ii) The project will contribute to alleviating the disproportionate economic burden that NCD care places on the poor. NCDs are chronic and potentially debilitating diseases that can lead to loss of income due to disability or death of a household member. Additionally, NCD management can be costly and related expenditures could have a catastrophic impact on the economic prospects of the poor and vulnerable. The project would improve equity by promoting healthy lifestyle and facilitating early detection and management of NCDs at the level of care that is most accessible to the poor and vulnerable.

(b) Through capacity-building activities to mainstream Gender Equity and Social Inclusion in the country's health system, the project will contribute to establishing a gender response and inclusive health system governance, management, and service delivery.

Figure 3.1 Utilization of Health Services by Wealth Quintile and Facility Type in Cambodia[63]



5. The project will improve efficiency of health spending through several channels:

(a) HEF-financed health services for the poor improves allocative efficiency of health financing by targeting financing where most needed and impactful.
(b) The results-focused approach in SDGs, HEFs, and PBCs improve allocative and technical efficiency by defining key outputs from health providers and managers, improving health worker and management motivation, and engendering a data-driven approach to improving health service access and quality.
(c) The focused investments in the PCA and QAO will further improve health systems management, thereby also improving efficiency of HEF and SDG spending.
(d) PFM capacity building at the sub-national level and the project investment in M&E, including in the digital health strategy, will also further improve health system management and data-driven decision-making and will be important to improve efficiency of health spending in the country.

Measuring Project Costs and Benefits

6. The proposed project supports a complex set of interventions that will affect the health sector for years to come. The project's impact has been assessed by examining both the benefits it will generate and the costs it will involve over the project duration. Throughout the analysis, the counterfactual is a scenario without the project investments and activities, and a health system perspective was adopted.

7. All project costs (IDA, trust fund, and Government co-financing) were incorporated. However, potential reduced costs to the health system from reduced morbidity and mortality due to project interventions were not considered. This will likely result in an underestimate of the project impact. A base case discount rate (r) of 3 percent was applied, and additional scenarios of 0 and 5 percent discount rates were also considered. A 6.10 percent annual GDP growth rate —the average annual growth rate for the past 10 years—is also assumed.[64]

8. Effectiveness of three key project interventions (reduction in mortality/ DALYs averted) were quantified: (a) expansion of NCD services, (b) improvements in quality of care because of SDGs, and (3) Improvements in access to health services by the poor because of continued investments in HEF.

(a) **Estimating effectiveness of NCD services expansion.** Based on literature review, cervical cancer screening[65] and diabetes management[66] were found to have measurable impact on health outcomes and were included to estimate project health benefits. For hypertension, impact on cardiovascular disease mortality is estimated as follows: (i) overall impact of hypertension screening on health outcomes is inconclusive in the literature[67] and the key reason seems to be non-adherence to diagnosis and treatment and (ii) the team reviewed the literature further to estimate the expected project impact explicitly considering effective adherence to diagnosis and treatment in low-and middle-income countries.[68] and the impact on cardiovascular disease mortality in the select cases where blood pressure has been effectively controlled.[69] As the targets are included and defined in the Results Framework, impact is estimated for (i) cervical cancer screening among women ages 30—49 in target provinces[70] during the project period, (ii) ensuring diabetes patients managed by HCs

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[64] Source: https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=KH

[65] Source: Landy R, F. Pesola, A. Castañón, and P. Sasieni.2016. "Impact of Cervical Screening on Cervical Cancer Mortality: Estimation Using Stage-Specific Results from a Nested Case-Control Study. Br J Cancer115(9):1140 1146. doi: 10.1038/bjc.2016.290. Epub 2016 Sep 15. PMID: 27632376; PMCID: PMC5117785.

[66] Kung, Fang-Ping Ching-Fang Tsai Chin-Li Lu Li-Chung, Huang, and Chieh-Hsiang Lu.2020. "Diabetes Pay-for-Performance Program Can Reduce All-Cause Mortality in Patients with Newly Diagnosed Type 2 Diabetes Mellitus." *Medicine*99(7): p e19139 doi: 10.1097/MD.0000000000019139

[67] Schmidt BM, S. Durao, I. Toews, C. M. Bavuma, A. Hohlfeld, E. Nury, J. J, Meerpohl, T. Kredo. 2020. "Screening Strategies for Hypertension." *Cochrane Database Syst Rev.* 5(5):CD013212. doi: 10.1002/14651858.CD013212.pub2. PMID: 32378196; PMCID: PMC7203601.

[68] Burnier, M. and B. M. Egan,2019. "Adherence in Hypertension: A Review of Prevalence, Risk Factors, Impact, and Management." *Circulation Research* 124(7):1124 -1140.

[69] Ettehad, D., C. A. Emdin, A. Kiran, S. G. Anderson,T. Callender, J. Emberson, J. Chalmers, A. Rodgers, and K. Rahimi.2016. "Blood Pressure Lowering for Prevention of Cardiovascular Disease and Death: A Systematic Review and Meta-Analysis." *The Lancet* 387(10022):957- 967.

[70] All except Battambang, Pursat and Pailin

according to the guidelines, and (ii) hypertension screening among those over 40 years of age in target provinces, with hypertension case management targets as defined in the Results Framework as well.[71]

(b) **Estimating effectiveness of SDGs**. SDGs combined with NQEMP have resulted in impressive improvements in structural process and clinical quality of care in the country. An estimated 22,000 deaths annually in Cambodia are attributed to conditions amenable to medical care, out of which 65 percent occur because of poor quality of health care as opposed to non-utilization (Kruk et al. 2018).[72] Improvements in quality of health care not only reduce deaths due to poor quality health care, but also improve demand for health services in the public sector by improve technical and perceived quality of care and improve labor productivity. For estimating the health impact of SDGs and NQEMP, several rounds of NQEMP data were first used to estimate weighted average improvements in quality of care in HCs and hospitals because of SDGs and NQEMP. The team then used the global burden of disease data, combined with the Kruk et al. disaggregated estimates of deaths that could be prevented by improvements in quality to estimate the total number of deaths that could have been averted by continued investments in SDGs and NQEM system.

(c) **Estimating HEF effectiveness.** Estimating health benefits from overall reports of improved HEF utilization presents a challenge. Some of the increased utilization by the HEF beneficiaries may be due to a substitution effect where the poor are now seeking care from public facilities rather than private facilities (and this pathway holds based on literature). This pathway could likely result in reduction of OOP expenditures for health for the poor, but not perhaps, improvements in health outcomes. The second pathway, where some of the increased utilization is because of improved care-seeking for health services by the poor, will result in improved health outcomes. To estimate the relative increase in care-seeking through this second pathway, the team looked at increased health seeking behavior among households in the poorest wealth quintile and found an encouraging increase in health seeking behavior from Cambodia Demographic and Health Survey. In addition to evidence presented by Annear et al. (2019), Flores et al[73]. also found some impact of HEF in improving overall health service utilization. Given that there are no explicit studies that look at the population level health outcome impact of HEF, the team draws from the literature to understand the potential impact of providing social health insurance to the poorest quintile and focuses explicitly on improvements in under-five survival just in the poorest quintile. The team estimates the number of under-five deaths in the poorest quintile during the project period without HEF[74] and assumes that those covered by HEF (27 percent of this population) will benefit from the under-five survival impact of social health insurance for the poor seen in the literature.[75]

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[71] All except Battambang, Pursat and Pailin

[72]Kruk, M.E., A.D. Gage., N. T. Joseph, G. Danaei, S. García-Saisó, and J. A. Salomon,2018. "Mortality due to Low-Quality Health Systems in the Universal Health Coverage Era: A Systematic Analysis of Amenable Deaths in 137 Countries." *The Lancet*, *392*(10160):2203 – 2212.

[73] Flores, G., Ir, P., Men, C.R., O'Donnell, O. and Van Doorslaer, E., 2013. "Financial protection of patients through compensation of providers: the impact of Health Equity Funds in Cambodia". Journal of Health Economics, 32(6), pp.1180-1193.

[74] Sources: Demographic and Health Survey data to estimate proportion of all under-five deaths that occur in the poorest quintile, and United Nation Inter-Agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, and UN DESA Population Division) data for estimates of under-five deaths.

[75] Impact estimated from: Currie, J., and J. Gruber. (1996). "Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women." *Journal of Political Economy104*(6): 1263–1296. http://www.jstor.org/stable/2138939

9. **Estimating benefits from increased lifetime earnings due to project impact.** The economic benefits were calculated based on the deaths averted. The project benefits are estimated in this analysis as the present value of the increase in future earnings/income flow of beneficiaries for ages 15-64. Sex-specific labor force participation rates are used (WDI 2020)[76]. The benefits for adults start accruing at the average age of death without the intervention and end at 64 years. The economic benefits for children accrue at 18 years and end at 64.

10. This analysis likely underestimates the impact of project on health outcomes in the country as (a) the DALYs averted included only estimated years of life lost (mortality) and not years lived with disability (morbidity); (b) the health impact of investments in the M&E system, learning agenda, PCA, QAO and GESI are hard to quantify given the limited literature on the impact of these efficiency and equity-improving interventions and hence are not included; and (c) the health impact of continued investments in HEF are only estimated for the poorest quintile (only 27 percent of the poorest quintile Cambodians use HEF compared to 17 percent of those in second wealth quintile.[77]

Results of benefit-cost and cost-effectiveness analysis

11. The return-on-investment analysis shows that the project interventions would generate significant health and economic benefits with positive returns on investment. For every dollar spent on the project, the investment is expected to yield US$3.95 in returns. The net present value of investments is US$ 795 million, with an internal rate of return at 7.42 percent. The investments are estimated to avert 7,700 deaths or 398,000 DALYs during the project period because of its focus on improving access, utilization, and quality of care, with its expanded access to NCD services. With cost-effectiveness ratio at less than half of the country's GDP per capita (US$1,513 in 2020) at US$679 per DALY averted, the project investments are also considered highly cost-effective.[78]

Table 3.1. Cost-Effectiveness of the Project Investments

	R= 3%	R= 0%	R=5%
Costs (US$, millions)	270	296	254
Effectiveness			
Deaths averted	7,700	8,400	7,200
DALYs averted	398,000	435,000	375,000
Cost-Effectiveness Ratios			
Cost (US$) per death averted	35,300	35,200	35,300
Cost (US$) per DALY averted	679	680	678
Benefit-Cost Ratios	3.95	13.3	2.00
Net present value (US$ millions)	795	3,650	254
Internal rate of return (%)	7.42		

[76] World Development Indicator, World Bank Group, https://datatopics.worldbank.org/world-development-indicators/
[77] National Institute of Statistics (Cambodia). Cambodia Socio-Economic Survey 2017.
[78] Bertram, Melanie Y., and Tessa Tan Torres Edejer. 2014. "Choosing Interventions that are Cost-Effective (Internet). *International Journal of Health Policy and Management* 10: 670–672. WHO, Geneva. http://www.who.int/choice/en/.

ANNEX 4: List of ODs with Low Outpatient Service

Lower than 0.7 Visits Per Capita Per Year (2020)

#	Province	OD	Total OPD Cases	Total Population	Total Identified Poor	OPD visits Per Capita Per Year
1	Kampong Speu	Kampong Speu	5,464	332,498	46,267	0.12
2	Phnom Penh	Chaktomouk	4,043	358,079	32,003	0.13
3	Phnom Penh	Por Senchey	5,356	252,565	27,667	0.19
4	Kampong Speu	Phnom Srouch	3,160	117,794	12,668	0.25
5	Preah Sihanouk	Preah Sihanouk	13,241	221,360	49,575	0.27
6	Steung Treng	Steung Treng	12,671	150,929	46,076	0.28
7	Kampong Speu	Kong Pisey	12,803	309,050	43,442	0.29
8	Kampong Speu	Ou Dongk	6,220	140,122	20,950	0.30
9	Phnom Penh	Bassak	13,567	344,029	43,492	0.31
10	Svay Rieng	Svay Teap	7,182	161,812	22,853	0.31
11	Phnom Penh	Mekong	7,567	294,748	23,539	0.32
12	Svay Rieng	Svay Rieng	11,941	219,362	35,441	0.34
13	Svay Rieng	Chi Phu	3,953	107,530	11,304	0.35
14	Kampong Cham	Kampong Cham - Kg. Siem	9,073	165,177	25,291	0.36
15	Phnom Penh	Dang Koa	4,495	166,007	11,585	0.39
16	Banteay Meanchey	Malai	5,540	54,485	13,915	0.40
17	Kandal	Takhmao	11,513	229,602	27,865	0.41
18	Kampot	Chhouk	16,993	324,307	39,402	0.43
19	Koh Kong	Srae Ambel	10,559	68,192	22,737	0.46
20	Koh Kong	Smach Mean Chey	12,140	68,483	24,763	0.49
21	Ratanakiri	Banlong	21,416	153,480	43,440	0.49
22	Kratie	Kratie	28,876	181,249	58,461	0.49
23	Phnom Penh	Preaek Phnov	7,681	64,239	15,394	0.50
24	Kampong Cham	Kang Meas	9,339	106,883	18,585	0.50
25	Prey Veng	Mesang	10,871	128,517	21,588	0.50
26	Kandal	Saang	7,235	185,802	13,888	0.52
27	Takeo	Bati	12,356	217,039	23,631	0.52
28	Phnom Penh	Sen Sok	6,701	174,364	12,205	0.55
29	Kampong Cham	Srey Santhor-Srey Santhor OD	10,587	115,487	18,593	0.57
30	Svay Rieng	Romeas Hek	15,500	145,031	26,750	0.58
31	Kampot	Kampot-Kampot	14,012	159,828	24,142	0.58
32	Mondolkiri	Sen Monorom	18,044	90,815	30,338	0.59
33	Kampong Chhnang	Kampong Chhnang	25,851	250,100	42,955	0.60

#	Province	OD	Total OPD Cases	Total Population	Total Identified Poor	OPD visits Per Capita Per Year
34	Kampot	Kampong Trach	14,287	188,309	23,676	0.60
35	Kampong Cham	Choeung Prey-Choeung Prey	10,723	**101,575**	17,756	0.60
36	Kratie	Chhlong-Chhlong OD	26,647	138,070	42,914	0.62
37	Kampong Thom	Kampong Thom-Kampong Thom OD	50,273	322,312	79,320	0.63
38	Kandal	Ksach Kandal-Ksach Kandal OD	11,151	149,884	17,163	0.65
39	Pursat	Kravanh-Kravanh OD	15,513	96,113	23,082	0.67
	Total		494,544	7,055,228	1,134,716	0.44

ANNEX 5: Map of Cambodia