KINGDOM OF CAMBODIA
NATION RELIGION KING

Annual Project Progress Report

Health Equity and Quality Improvement Project (H-EQIP)

July – December 2016

Table of Contents

I. Introduction

The Health Equity and Quality Improvement Project (H-EQIP) builds upon the innovations and achievements supported and scaled up in the Health Sector Support Project (HSSP) 2002-2008 and the Second Health Sector Support Program (HSSP2) 2009-2016. In particular, it consolidates and scales up proven and potentially transformative interventions such as the Health Equity Funds (HEFs) and Service Delivery Grants (SDGs). The key evolutionary shifts in project design and implementation include: (i) mainstreaming implementation of project activities through Royal Government of Cambodia (RGC) systems; (ii) increasing funding flows to the decentralized, implementation level; (iii) building domestic capacity to take over project implementation support and monitoring roles; and (iv) strengthening the results-based-focus of the project through the use of output-based payments through the HEF, performance-based financing through the SDGs, and the use of Disbursement Linked Indicators (DLIs). Through these initiatives, H-EQIP accelerates overall reforms in the health sector, improves social health protection for the poor and vulnerable groups and expands access to and coverage of health care services, while strengthening their quality and affordability, and creating sustainable government institutions for health care management.

II. Project Overview

The H-EQIP was approved by the World Bank Board of Executive Directors on May 19, 2016 and became effective on November 9, 2016, with a total financing of US$175.2 million. The project is financed by an International Development Association (IDA) Credit of US$ 30.0 million equivalent to the RGC, RGC's counterpart financing of US$94.2 million, and a Multi-Donor Trust Fund (MDTF) grant of US$50.0 million with contributions from DFAT, KfW, and KOICA. In addition, the Japan Policy and Human Resources Development Trust Fund finances activities to support the strengthening of health sector monitoring and evaluation through complementary financing of US$1.0 million equivalent.

III. Project Development Objective

The Project Development Objective (PDO) of H-EQIP is to improve access to quality health services for targeted population groups with protection against impoverishment due to the cost of health services in the Kingdom of Cambodia.

The project beneficiaries are the population of Cambodia, particularly the poor and vulnerable, and health care providers working in the public health sector.

IV. Implementation Progress Details

A launch ceremony for H-EQIP was held on September 19, 2016 at the InterContinental Hotel in Phnom Penh, chaired by H.E. Mam Bunheng, Minister of Health. The event was led by H.E. Prof. Eng Huot (Secretary of State, MOH), H.E. Oum Samol (Undersecretary of State, MOH), H.E. Youk Sambath (Director General for Administration and Finance, MOH), H.E. Meach Sophanna (Undersecretary of State, Ministry of Interior), Dr. Lo Veasnakiry (Director, Department of Planning and Health Information, MOH) on behalf of the RGC. Representatives of Provincial Health Departments (PHDs), Referral Hospitals (RH) and Operational Districts (ODs) participated in the event. H.E. Ms. Angela Concoran (Ambassador of Australia to Cambodia), H.E. Dr. Ingo Karsten (Ambassador designate of Germany to Cambodia), Ms. Inguna Dobraja (WB Country Manager), Mr. Jeong Yun Gil (KOICA Country Director), and Dr. Toomas Palu (WB Global Practice Manager for Health, Nutrition and Population) represented the development partners.

A technical workshop preceded the event, which was facilitated by MOH officials and provided an overview of the H-EQIP, introduced the contents of different project manuals, and discussed other implementation issues including environmental and social safeguards, financial management (FM) and procurement.

Component 1: Strengthening Health Service Delivery

Service Delivery Grants (SDGs) were introduced as part of HSSP2 to provide supplementary funds to Special Operating Agencies (SOAs) in addition to their budgetary funds from the MOH, strengthen internal health service delivery contracting, and promote decentralization. Under H-EQIP, the SDGs were redesigned to strengthen their focus on results, expanding into a mechanism for providing performance-based financing to different levels of the Cambodian primary and secondary health system based on achievement of results, as measured through a national quality enhancement monitoring process. The new SDGs consist of two grants: (i) fixed lump-sum grants, which are allocated based on a flat, fixed basis for all health centers (HCs) and referral hospitals (RHs) throughout the country to augment the availability of funds for operational expenditures; and (ii) performance-based grants, which are co-financed by RGC, IDA, and the MDTF over the H-EQIP life-span. Performance-based grants are provided to HCs, RHs, Operational District Offices (ODOs) and Provincial Health Department Offices (PHDs) based on their quality of care performance scores, as evaluated by trained assessors and with third party cross-verification.

The national quality enhancement monitoring tools focus on structure, process, and outcomes. The key design features of the tools focus on: (i) improving quality through the measurement of financial management, hygiene and infection control, technical capacity through the use of clinical vignettes, skill observations, and client interviews conducted by certified assessors from PHDs and ODs (ex-ante verification); (ii) strengthening the management and supervision of PHD and OD offices; (iii) using third party ex-post verification mechanisms; (iv) using modern information communication technology (ICT) including tablets to facilitate data collection, compilation and analysis; and (v) measuring the effects of the quality enhancement program through an impact evaluation. The following describes the progress of implementation under Component 1 from July to December 2016.

Sub-components 1.1 and 1.2. Service Delivery Grants for Health Centers and Referral Hospitals

Fixed lump-sum grant: the RGC introduced Fixed Lump-sum Grants (FLG) for the first time to the health sector budget in 2016. These grants were allocated and disbursed directly to all HCs and RHs/Provincial Hospitals (PHs) throughout the country to newly opened facility bank accounts. Grants were disbursed in fixed amounts for operational expenditures in addition to existing operational budgets, as defined in health facility annual operational plans (AOPs).

Performance-based grant: in preparation for the roll-out of performance-based grants, a number of key activities in relation to the SDG performance assessment were undertaken in this period. The English version of the SDG operational manual was approved at the end of 2016, the technical committee responsible for the development of the National Quality Enhancement Monitoring (NQEM) tools was established, and many meetings were convened for developing the NQEM tools, cascade training of assessors, and national scale-up plan. The first draft of the NQEM tools were first piloted in June 2016 and the training of master trainers was conducted in December 2016. The second round of testing of the NQEM tools was planned to be conducted in early 2017, followed by the introduction of performance assessments.

Sub-component 1.3. Service Delivery Grants for PHD and OD:

Fixed lump-sum grants are not eligible for PHDs and ODs. As the performance-based assessment had not yet been rolled-out, there was no disbursement for the performance-based grant to PHDs and ODs in this period.

Component 2: Improving Financial Protection and Equity

Under this component, H-EQIP continues to support and expand the HEFs for the poor. Under HSSP2 2009-2016, the HEF was scaled up to reach nationwide coverage in July 2015, with approximately 3 million poor people registered in the Patient Management Registration System (PMRS). Duing HSSP2, the HEF was implemented and monitored by a Health Equity Fund Implementer (HEFI) and Health Equity Fund Operators (HEFOs), respectively.

The HEFI was an international organization that conducted field monitoring and independently verified health care benefits provided to identified poor patients. Its roles included conducting household interviews, bedside monitoring, and document reviews to ensure that the benefits reported were the actual benefits provided to poor patients and no falsified claims were made.

HEFOs were NGOs and CSOs contracted to perform specific roles at the facility level, including facilitating and monitoring HEF beneficiaries' access to services, reimbursing transportation and food allowances for caretakers, conducting post-identification interviews, and administering HEF payments to health facilities at the end of each month.

Under H-EQIP, the HEF system was redesigned to ensure sustainability of the scheme and sustain progress toward a national health insurance scheme for the poor. In H-EQIP, the roles and responsibilities of the HEFI and HEFOs were transferred to a to-be-established Payment Certification Agency (PCA), PHs/RHs, and newly introduced Health Equity Fund Promoters (HEF-Ps), respectively.

The HEF operational manual in both English and Khmer was prepared by the Bureau of Health Financing of DPHI. In terms of the PCA, a working group was established on the creation of the PCA and formal establishment of the entity is pending (see DLI 5 achievement below). The roles and responsibilities of HEFOs were successfully transferred to PHs/RHs under the support of a USAID funded project implemented by University Research Company, LLC., beginning with a pilot testing in five ODs and one PRH in Takeo province in April, 2016. Following this, comprehensive trainings on key operational functions of HEF, including the use and management of the PMRS were conducted for all public health facilities nationwide in May 2016. Procurement of HEF-Ps was delayed while the Project was not yet effective and remains pending.

In terms of HEF implementation during this period, the MOH reimbursed HEF benefit payments for health facilities from July to November 2016 using the national budget, which were retroactively reimbursed by H-EQIP once the Project became effective in November 2016. Reimbursements of food and transportation allowances for caretakers were temporarily discontinued from July 2016, following the discontinuation of HEFO services at the end of June 2016. Refresher trainings for facility staff on the PMRS and resumption of payment of these allowances were planned to be conducted in 2017. Cumulative HEF utilization during H-EQIP is summarized in the table below.

Table 1. Cumulative HEF utilization during H-EQIP

Medical Benefits	Number of cases July- Dec 2016	Disbursement (in USD) July-Dec 2016

OPD	1,196,509	1,372,162
IPD	72,912	2,470,470
Total number of cases	1,269,421	3,842,632

Component 3: Ensuring Sustainable and Responsive Health Systems

Sub component 3.1: Health System Strengthening

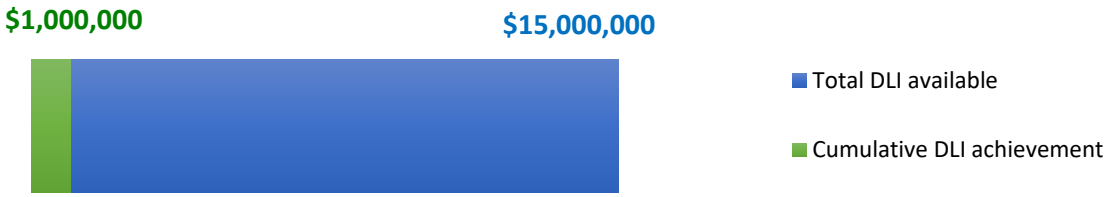
This sub-component supports a program of activities designed to improve supply side readiness and strengthen the institutions that implement project activities. The activities are implemented through a results-based financing mechanism and tracked by Disbursement Linked Indicators (DLIs)-- a set of tracer indicators that are disbursed against based on the delivery of results. H-EQIP has a total of 6 DLIs. This section describes the progress and accomplishments toward year Zero DLI targets.

The DLI report describing the status of achievement for year Zero targets was submitted on time to the World Bank on July 29, 2016 for review and validation. The current status of DLI achievements for year Zero includes:

- DLI 1 "Comprehensive pre-service training in foundational courses for medical and nursing professionals implemented by UHS" was **confirmed as fully achieved**.
- The DLI 2 "Comprehensive in-service training program on Minimum Package of Activities (MPA) for health workers implemented by the MOH" achieved less than 60% as only 4 out of 13 MPA modules were reviewed and updated.
- DLI 3 "C2 hospitals fully equipped to provide emergency obstetric care and neonatal care" was **confirmed as partially achieved**. A costed plan for the EmONC improvement plan 2010-2015 is still required.
- DLI 4 "Health service quality monitoring in the MOH enhanced" achieved less than 60% and requires further field testing of supervisory checklists and hiring additional skilled staff to meet the benchmark of ten staff.
- DLI 5 "Sustainable health purchasing arrangements established by the RGC" is less than 60% achieved, awaiting finalization and adoption of PCA operational manual and formal establishment of PCA.
- DLI 6 "Timeliness of HEF and SDG payments improved" is less than 60% achieved but will most likely be fully achieved by January 2017, as HEF and SDG financial procedure guidelines are awaiting submission to the WB for approval, and a dissemination plan to staff at OD, PHD, and central level is in place.

The total value of funds available through all DLIs for year Zero is US$3 million equivalent. The total value of DLIs earned in this period is US$1 million equivalent (US$800,000 for full achievement of DLI 1 target and US$200,000 for partial achievement of DLI 3 target). Please see the Year Zero DLI report for detailed progress of DLI achievement.

Figure 1. Cumulative value of DLIs achieved



Sub component 3.2: Health Infrastructure Improvement:

MOH is in the process of selecting civil works engineer consultants to develop/update the designs and drawings of health facilities to be financed under H-EQIP. This includes plans to build 45 HCs, 15 maternity and neonatal units at RHs, and 2 PRHs in Pailin and Oddar Meanchey, following the priorities identified in the MOH civil works plan 2016-2020 and based on access issues, attention to remote areas, and concerns around patient safety and improving maternal and neonatal survival.

Based on the identification of sites for civil works, an assessment was carried out jointly by MOH and MDTF partners in June 2016 to recommend how to best target funding for health infrastructure, given the limited funds available under H-EQIP. The assessment generated recommendations for improvements to health facility designs to fit with actual building needs of HCs and RHs as well as improvements in the quality of construction based on lessons learned from construction of health facilities under HSSP2.

Component 4: Contingent Emergency Response:

No reallocation of financing has been made.

V. Financial management performance

The development of the supplementary FM manual is in progress. A two-day training on project FM and QuickBooks was conducted for the DBF staff in October 2016 by the World Bank FM Specialist. Other key FM activities for the kick-start of the project have faced delays, including registration of the Client Connection, opening of the Designated Account, and design of the chart of accounts and QuickBooks accounting software. Recruitment of additional FM consultants to provide capacity building support at the sub-national levels is pending.

VI. Project Procurement

Introductory training on the applicable procurement guidelines, standard operating procedures/ project management, procurement procedures, and STEP (Systematic Tracking of Exchanges in Procurement) was conducted for the procurement staff of MOH by the World Bank. The Word Bank's procurement specialist also provided further detailed training on the procedures of each applicable procurement method to MOH procurement staff in late 2016. An FM consultant has been

selected to support the project. Other key procurement processes required for project start-up, including selection of HEF promoters, ICT firm for SDGs, Master trainers for SDGs, and other MOH consultants have faced delays and have not yet been initiated during this initial stage of the project.

VII. Environmental and social safeguards

The project environmental and social safeguards instruments, including the Environmental Management Framework (EMF), Resettlement Policy Framework (RPF), and Indigenous People's Policy Framework (IPPF) were prepared in both English and Khmer to be followed and complied with during H-EQIP implementation. These documents were presented along with other project documents during the project launch workshop on September 19, 2016 to relevant MOH departments, PHDs, ODs and RHs. A staff member from the Preventive Medicine Department (PMD) was assigned to be the project focal point for safeguards, and a checklist was developed for conducting a health needs assessment in seven provinces with a high concentration of indigenous populations by the PMD, with support from the World Bank team.

VIII. Project Monitoring

Implementation Support Mission (ISM):

The first ISM was jointly conducted by the Ministry of Health and H-EQIP pooled fund partners from September 19-23, 2016. Field visits were conducted to one CPA2 RH and one HC in Angkor Chey OD, Kampot Province, and one CPA1 RH and the CPA3 Provincial Referral Hospital in Ang Roka OD, Takeo Province. The purpose of the visits was to: (i) review utilization of fixed lump-sum grants at SOAs and non-SOAs, and (ii) assess the overall progress and preparedness for HEF transition at the point of service delivery. The following is a summary of key findings observed from the field visits in addition to findings and recommendation addressed in the relevant sections above.

1) **Active use of SDG fixed lump sum grants**: all facilities visited had received fixed lump sum grants into bank accounts for at least the first and second quarters of 2016, and had begun to actively use these funds. Spending of the grants was done for items that has been pending for a long time, based on established priority lists at the facilities, such as for small building renovations and essential or emergency services. Most of the facilities visited felt confident in their abilities to manage their accounts. Further training on accounting for existing health facility staff would be useful to further boost capacity and clarify any confusion on eligible expenditures and use of bank accounts.

2) **Transfer of HEFO functions to hospitals**: with the support provided from PHDs and from USAID through URC, most facilities visited felt confident in their abilities to administer the HEF system. HEF payments have been received for the month of June, 2016 but July and August 2016 payments were still pending, causing some strains at the facility level and raising concerns about the potential of reduced patient confidence in the HEF system. It was recommended that a refresher training be conducted on the disbursement of food and transportation allowances for all facilities, prior to the resuming of these benefits. The mission also raised a concern over the high number of exemption cases being used by health facilities in the absence of the post-ID mechanism.

3) The differences in capacity between SOAs and non-SOA was observed in terms of taking on the new functions associated with the SDG fixed lump-sum grants and transfer of HEFO roles

to hospitals and health facilities between SOAs and non-SOAs, stressing the need for continued support and guidance on these functions at the facility level.

4) **Medical waste management practices** were raised as a lingering concern, including proper disposal of sharps and use and repair of incinerators. Efforts to improve medical waste management practice should be made and emphasized during project implementation.

Annex A. Key project events held in 2016

1) Launch ceremony for H-EQIP and technical workshop: September 19, 2016
2) NQEM tools piloted: June 2016
3) Training of master trainers for SDG performance-based assessment: December 2016
4) Pilot testing for transfer of HEFO to RH/PRH, Takeo province: April, 2016
5) Trainings on key operational functions of HEF, including on PMRS conducted by HEFI/URC: May, 2016
6) Training on project FM and QuickBooks for the DBF staff conducted by WB FM Specialist: October 2016
7) First H-EQIP ISM: September 19-23, 2016.

Annex B. Results Framework
Project Development Objective Indicators

Increase in number of health centers exceeding 60% score on the quality assessment of health facilities. (Number, Custom)			
Description	Baseline	2016	End Target
Target	49.00	--	Baseline + 50%
Achievement		49.00	
Date	30-Apr-2016	10-Aug-2016	30-Jun-2021

End target +50% of baseline

Reduction in the share of households that experienced impoverishing health spending during the year. (Percentage, Custom)			
Description	Baseline	2016	End Target
Target	0.9	--	0.7
Achievement		0.9	
Date	30-Oct-2015	10-Aug-2016	30-Jun-2021

Reduction in OOP health expenditure as percentage of the total health expenditure. (Percentage, Custom)			
Description	Baseline	2016	End Target
Target	59.70	--	55
Achievement		--	
Date	30-Oct-2015	10-Aug-2016	30-Jun-2021

Increase in the utilization of health services by HEF beneficiaries. (Percentage, Custom). To be changed to "Increase in the number of outpatient services (episodes) covered by HEF"			
Description	Baseline	2016	End Target
Target	51.00	--	81.00
Achievement		--	
Date	30-Oct-2015	10-Aug-2016	30-June-2021

Intermediate Results Indicators

Percentage of health centers having stock-outs of 14 essential medicines. (Percentage, Custom). This indicator was dropped.			
Description	Baseline	2016	End Target
Target	4.73	--	<5
Achievement		4.01	
Date	2014	30-Jul-2016	30-Jun-2021

End target is <5

Proportion of health centers with functioning health center management committees. (Text, Custom)			
Description	Baseline	2016	End Target
Target		--	Baseline + 25%
Achievement	64%	64%	
Date	31-Dec-2016	31-Dec-2016	30-Jun-2021

Baseline to be collected in Year 1. End target +25% of baseline

Percentage of health center, CPA-1, CPA-2, and CPA-3 facilities that receive payments based on performance that includes quality scores within 90 days of the end of the quarter. (Percentage, Custom)			
Description	Baseline	2016	End Target
Target	0.00	--	70.00
Achievement		--	
Date	30-Oct-2015	10-Aug-2016	30-Jun-2021

Reduction in the variance in score on Health Center quality assessment. (Text, Custom)			
Description	Baseline	2016	End Target
Target	53	--	43
Achievement		53	
Date	30-Oct-2015	10-Aug-2016	30-Jun-2021

Baseline: based on 2015 L2 assessment: 53 percentage points

Percentage CPA-1, CPA-2, and CPA-3 facilities having a 60% quality score in previous quality assessments. (Text, Custom)			
Description	Baseline	2016	End Target
Target	18	--	Baseline + 50%
Achievements		18	
Date	30-Apr-2016	10-Aug-2016	30-Jun-2021

End target +50% of baseline.

Outpatient Department (OPD) consultations (new cases only) per person per year. (Number, Custom)			
Description	Baseline	2016	End Target
Target	0.59	--	0.95
Achievement		0.63	
Date	30-Oct-2015	31-Dec-2016	30-Jun-2021

Source: This data is from the 2018 National Health Congress Report (NHC) p 11.

Number of University of Health Sciences courses that adopt competency-based curricula with trained faculty and use of skills laboratory (DLI 1). (Number, Custom)			
Description	Baseline	2016	End Target
Target	0.00	--	25
Achievement		2	
Date	30-Jul-2016	10-Aug-2016	30-Jun-2021

Percentage of health centers, hospitals and OD/PHD receiving HEF and SDG payments within specified timelines. (Percentage, Custom)			
Description	Baseline	2016	End Target
Target	0	--	80
Achievement		--	
Date	30-Oct-2015		30-Jun-2021

Percentage of HMIS reports submitted on time. (Percentage, Custom)			
Description	Baseline	2016	End Target
Target	95.00	--	95.00
Achievement		90.04	
Date	30-Oct-2015	31-Dec-2016	30-Jun-2021

Note: This data is taken from the National Health Congress Report (NHC).