KINGDOM OF CAMBODIA
NATION RELIGION KING

Annual Project Progress Report

Health Equity and Quality Improvement

Project (H-EQIP)

January – December 2017

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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, with a total financing of US$175.2 million was approved by the World Bank Board of Executive Directors on May 19, 2016 and became effective on November 9, 2016. The project is financed by International Development Association (IDA) Credit of US$ 30.0 million equivalent to the RGC, RGC's counterpart financing of US$94.2 million, and a Multi-Donor Trust Fund (MDTF) with contributions from DFAT, KfW, and KOICA of US$50.0 million. 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

Component 1: Strengthening Health Service Delivery

This section describes progress made during this reporting period (January-December 2017) regarding the disbursement of SDG fixed lump-sum grants to health facilities. The section also describes the roll-out of performance-based grants to health facilities, ODs, and PHDs based on their quality of care performance scores, as evaluated by trained assessors and with third party cross-verification.

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

Fixed lump-sum grants: Based on the recommendations in 2016, the allocation of fixed lump-sum grants was increased for Health Centers (HCs) in 2017 based on the catchment size. Allocation was increased to 24 million KHR for HCs with catchment populations more than 10,000 and remained at 12 million KHR for HCs with catchment populations less than 10,000. Allocations were also increased for Referral Hospitals (RHs) according to their Complementary Package of Activity (CPA) level. Table 1. below described the revised fixed lump-sum amounts for 2017.

Table 1. Amount of fixed lump-sum grants by facility level

Health Facility	Allocation/ Health Facility/ Year in 2016 (in KHR and USD equivalent)	Allocation/ Health Facility/ Year in 2017 (in KHR and USD equivalent)
HCs	12 million Riels (3,000 USD)	24 million Riels for HC with pop > or = 10,000 (6,000 USD) and 12 million Riels for HC with pop <10,000 (3,000 USD)
RHs-CPA 1	100 million Riels (25,000 USD)	150million Riels (37,500 USD)
RHs-CPA 2	150 million Riels (37,500 USD)	200million Riels (50,000 USD)
RHs-CPA 3	200 million Riels (50,000 USD)	250 million Riels (62,500 USD)

The fixed lump-sum SDGs grants have been smoothly released to all health facilities and have been used to improve performance. There was some level of confusion among some facility staff regarding the use of funds, particularly related to the eligible expenditures, procurement procedures, and the process for fund withdrawal. This has been addressed through dissemination of the translated Khmer version of the SDG manual to all health facilities by April 2017 and with supervision support carried out by PHDs and ODs to help the facilities be in compliance with the prescription of the guidelines. Bookkeeping of accounts is in line with the requirements, as laid out in the SDG manual.

SDG assessment key development milestones:

- Dec 2016: Master training of NQEM team conducted.
- Jan 2017: Testing of NQEM tools completed and tools finalized
- May 2017: Training of PHD and OD assessors completed.
- May 2017: 1st round of ex-ante assessment initiated.
- Oct 2017: 2nd round of ex-ante assessment conducted.
- October 2017: ex-post verification firm recruited.
- December 2017: 1st ex-post verification of NQEM assessment performed

Performance-based grants: To reach national coverage, the NQEM process is planned to be introduced in three phases, starting with all Special Operating Agencies (SOAs) in phase I.

The second round of testing of the NQEM tool was completed in early January 2017, and the NQEM tool was updated and disseminated to all PHDs in late

January 2017. The cascade trainings for PHD and OD SDG assessors for SOA sites (Phase 1) was conducted from February to May 2017 (Table 2). The first round of Phase 1 ex-ante SDG assessments was launched in May 2017, followed by the second round, which was conducted in October 2017. A total of 452 health centers, 29 RH, and 13 PRHs in 34 ODs and 14 provinces were assessed in two rounds during this year using the relevant NQEM tools (CPA1, CPA2 and CPA3 tools). (Table 3). The first round of performance-based grants was disbursed in November 2017. A summary of Phase 1 SDG performance scores by health facility level is described in Table 4 below.

The percentage of health centers exceeding 60% score on the quality assessment of health facilities increase from 11% for round one to 70% for round two. The percentage of CPA1, CPA2, CPA3 facilities have a 60% quality score in previous quality assessments increase from 0% for round one to 17% for round two.

The average score assessment of HC increase from 45% for round one to 66% for round two, the average score assessment of RH increase from 27% for round one to 42% for round two, the average score assessment of PRH increase from 29% for round one to 44% for round two, the average score assessment of OD increase from 64% for round one to 42% for round two and the average score assessment of PHD increase from 29% for round one to 84% for round two.

The reduction in the variance in score on HC quality assessment (NQEMT) increase from 68% for round one conducted assessment in Q2 2017 to 73% for round two conducted assessment in Q4 2017.

The recruitment of the firm to develop an ICT-enabled tool for data collection and analysis of SDG performance assessments has experienced some delays. Procurement is at the evaluation of expressions of interest stage with the selection expected by early 2018.

The protocol for ex-post verification has been developed and is included as an annex to the PCA operational manual. A consulting firm, GFA, was recruited in October 2017 to conduct the SDG performance grant ex-post verification. The initial contract for the firm is for 18 months with the mandate that the firm will hand-over this function to the PCA once the agency is formally established and ready to take over the task. In November 2017, staff for conducting the ex-post SDG verification at the PCA were recruited, trained in their function, and certified as ex-post assessors. The first round of ex-post verification was conducted in December 2017 by GFA, and the transition of the ex-post verification function to the PCA is expected to begin in March 2018.

Table 2. No. of PHD and OD Assessors Trained (Phase 1-SOA entity)

Province/OD	OD	PHD Assessor trained	OD Assessor trained
Banteay Meanchey		**6**	**12**
	Poipet		6
	Preah Net Preah		6
Battambang		**6**	**0**
	Battambang		
	Sangkae		
	Maung Russei		
Kampong Cham		**6**	**25**
	Chamkar Leu		4
	Choeung Prey		4
	Prey Chhor		4
	Srey Santhor		
	Stueng Trang		5

	Batheay		4
	Koh Sotin		
	Kang Meas		4
Kampong Chhnang		**0**	**0**
	Kampong Chhnang		
	Boribo		
Kampong Speu		**0**	**0**
	Kampong Speu		
	Kong Pisey		
	Ou Dongk		
	Phnom Srouch		
Kampong Thom		**0**	**0**
	Kampong Thom		
Kandal		**0**	**0**
	Ang Snuol		
	Ksach Kandal		
	Muk Kam Poul		
	Leuk Deak		
Koh Kong		**6**	**8**
	Smach Mean Chey		4
	Srae Ambel		4
Mondul Kiri		**6**	**4**
	Sen Monorom		4
Phnom Penh		**0**	**0**
	Bassak		
	Dang Koa		
	Preaek Phnov		
Preah Vihear		**6**	**6**
	Tbeng Meanchey		6
Prey Veng		**6**	**12**
	Kamchay Mear		
	Pearaing		4
	Preah Sdach		4
	Svay Antor		
	Sithor Kandal		4
	Krong Prey Veng		
	Baphnom		
Pursat		**6**	**4**
	Bakan		4
	Sampov Meas		
	Kravanh		
	Krakor		
Ratanakiri		**6**	**8**
	Banlong		4
	Borkeo		4
Siem Reap		**6**	**24**
	Kralanh		6
	Siem Reap		6
	Sotr Nikum		6
	Angkor Chhum		6

Stung Treng		**6**	**6**
	Stung Treng		6
Svay Rieng		**0**	**0**
	Chi Phu		
	Romeas Hek		
	Svay Teap		
Takeo		**6**	**27**
	Ang Rokar		4
	Bati		4
	Daun Keo		6
	Kirivong		4
	Prey Kabass		5
	Koh Andeth		4
Oddar Meanchey		**6**	**12**
	Samraong		6
	Anlong Veng		6
Kep		**0**	**0**
	Kep		0
Pailin		**0**	**0**
	Pailin		0
Tbong Khmum		**6**	**14**
	Kroch Chhmar		
	Memut		6
	O Reang Ov		
	Ponhea Krek		4
	Dambae		4
	Total	84	162

Table 3. No. of HC and RH conducted ex-ante SDG assessment (Phase 1)

Province	OD	No. of HC assessed	No. of RH assessed
Banteay Meanchey	Mongkol Borei		1
	Poipet	16	1
	Preah Net Preah	15	2
Battambang	Battambang		1
Kampong Cham	Kampong Cham-Kg. Siem		1
	Chamkar Leu	12	1
	Choeung Prey	7	1
	Prey Chhor	11	1
	Stueng Trang	12	1
	Batheay	7	1
	Kang Meas	8	
Koh Kong	Smach Mean Chey	7	1
	Srae Ambel	6	1
Mondul Kiri	Sen Monorom	11	2
Preah Vihear	Tbeng Meanchey	28	1
Prey Veng	Krong Prey Veng		1
	Pearaing	9	1

	Preah Sdach	11	1
	Sithor Kandal	11	1
Pursat	Sampov Meas		1
	Bakan	11	1
Ratanakiri	Banlong	15	1
	Borkeo	10	1
Siem Reap	Siem Reap	29	1
	Kralanh	16	1
	Sotr Nikum	25	1
	Angkor Chhum	21	2
Stung Treng	Stung Treng	12	1
Takeo	Ang Rokar	12	1
	Bati	14	1
	Daun Keo	15	1
	Kirivong	13	1
	Prey Kabass	13	2
	Koh Andeth	11	1
Oddar Meanchey	Samraong	26	1
	Anlong Veng	11	1
Tbong Khmum	Memut	13	1
	Ponhea Krek	11	1
	Dambae	6	1
Total		**452**	**42**

Table 4. Summary of SDG performance scores by health facility level

Health facility level	Total number of facilities/offices nationwide	Number of facilities/offices assessed	Average SDG performance score (round 2 in Q4, 2017)	Number of facilities/ offices scoring above 60% (round 2 in Q4, 2017)
PRH	24	13	44%	17%
RH	84	29	42%	
HC	1190	452	66%	70%
PHD	25	14	84%	
OD	100	34	78%	

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

Fixed lump-sum grants are not eligible for PHDs and ODs.

Performance-based grants will be disbursed to PHDs and ODs based on their performance scores, assessed by the Quality Assurance Office (QAO) against self-reported activities on a scorecard. A total of 33 ODs and 14 PHDs in 14 provinces have been assessed during this period. The first round of performance-based grants for PHDs and ODs was disbursed in November 2017.

Component 2: Improving Financial Protection and Equity

This section describes progress made during this reporting period (January-December 2017) regarding the transition of the Health Equity Fund Implementer (HEFI) roles to a newly established Payment Certification Agency (PCA). The section also describes the transition of Health Equity Fund Operator (HEFO) roles to health facilities and progress toward recruitment of Health Equity Fund Promoters (HEF-Ps).

HEFI transition to PCA: the process for the establishment of the PCA is in progress. An Inter-Ministerial Working Group was established and consecutive meetings have been convened accordingly. The PCA Transition Manual was approved by the MOH in January 2017. The Sub-Decree for the establishment of the PCA as a Public Administrative Entity (PAE) were endorsed by the Council of Ministers on September 8, 2017, thereby formally establishing the agency as a legal institution (see progress of DLI accomplishment in component 3). The PCA Governing Board, Director, Deputy Director, and institutional structure were appointed in October 2017. The PCA Operational Manual was submitted to the Ministry of Economy and Finance (MEF) and is awaiting approval, expected in early 2018.

Key PCA establishment chronology:

- Jan 2017: Inter-Ministerial Working Group established and meetings convened.
- Jan 2017: PCA transition manual approved.
- Sep 2017: PCA Sub-decree signed.
- Oct 2017: PCA Director and Deputy appointed
- Nov 2017: Key staff for SDG ex-post verification at PCA on board and trained.

During the transition process, the certification of HEF payments continues to be performed by USAID/Social Health Protection Project implemented by URC. The transition of all HEF verification functions will take place in June 2018.

HEFO transition: HEF operational manuals have been developed, translated, and disseminated to all relevant PHDs and ODs for distribution to health facilities. HEF payments to health facilities continued to be on schedule with all health centers and referral hospitals reporting received HEF payments between March and July 2017 (see progress of DLI in component 3). Capacity to manage HEF benefits and record utilization in the PMRS system has improved in a majority of health facilities.

Health facilities continued to conduct HEF beneficiary screening for identified poor patients who possessed "Equity Card" pre-identification (ID-Poor) using the PMRS, as well as facilitated their access to services, and prepared and submitted HEF claims for verification to the HEFI/ URC. The MOH issued a formal instruction to allow health centers to resume payment for transportation allowances for delivery cases in January 2017, and a refresher training on PMRS and payments for food and transportation allowances was completed in February 2017 for referral hospital staff. Reimbursement payments for and food and transportation allowances were resumed between March and April, 2017. Advanced payments for non-medical allowances have been issued to all health facilities except for health centers.

In May 2017, the firm, Partnership for Better Health (PBH), was procured by the MDTF to resume post-identification of the poor (post-ID) at RHs, as an interim measure until the HEF-Promoters (HEF-Ps) are on board. This arrangement was initially scheduled to end in late November 2017, and was extended by one month until December 31, 2017 due to delays in the HEF-P procurement process. The post-identification questionnaire is under revision with support from USAID Social Health Protection Project (SHP) to be in consistent with the updates to the ID-poor system of the MoP. It is expected that training on the revised questionnaire will be conducted once the HEF-P is on board.

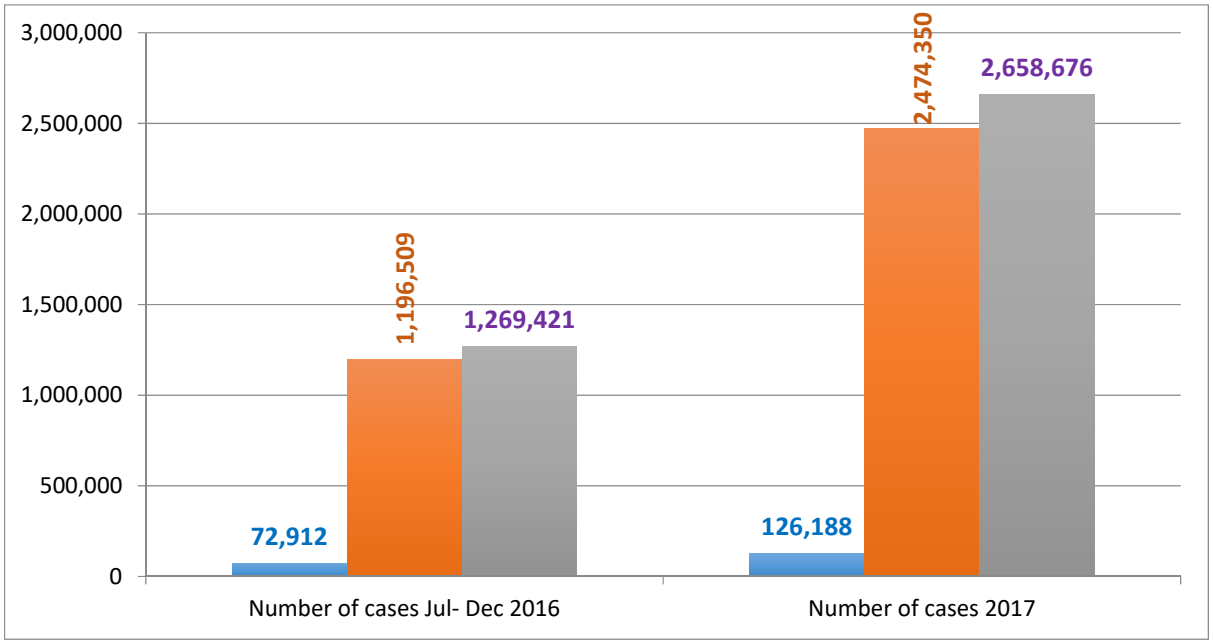
Recruitment of HEF-Ps is pending, raising concerns about the continuation of post-ID assessments after the end of the interim solution contract with PBH. Draft ToRs and the announcement to request for expressions of interests for the firms to carry out HEF-P functions have been approved. The bidding proposal, evaluation process, and procurement is expected to be completed as soon as possible, with the HEF-Ps expected to be on board by early next year.

HEF utilization: Following the decline of utilization experienced in the last reporting period, HEF utilization is now increasing with the reintroduction of non-medical benefit allowances and post-identification of HEF, and a drastic decline of exemption cases is noticed accordingly. Table 5 and Figure 1 below describe cumulative HEF utilization and disbursement in H-EQIP.

Table 5. Cumulative HEF utilization during H-EQIP

Medical Benefits	**Number of cases Jul- Dec 2016**	**Number of cases 2017**	**Disbursement (in USD) Jul-Dec 2016**	**Disbursement (in USD) 2017**
OPD	1,196,509	2,474,350	1,372,162	2,552,167
IPD	72,912	126,188	2,470,470	3,149,731
Total number of cases	1,269,421	2,658,676	3,842,632	8,346,444
Non-medical benefits	**Number of cases Jul- Dec 2016**	**Number of cases 2017**	**Disbursement (in USD) Jul-Dec 2016**	**Disbursement (in USD) 2017**
Transportation	-	164,639	-	944,272
Food allowance	-	109,620	-	713,185
Funeral cost	-	957	-	14,355
Total number of cases	-	275, 216	-	1,671,812

Figure 1. Cumulative HEF utilization for medical benefits



Financing of HEF: As new HCs were established, HEF has been expanded accordingly. The total number of HCs covered by HEF has risen to 1,161 in 2017, which is an increase from 1,149 HCs in 2016. The HEF is also expected to be expanded to five additional national hospitals in 2018.

The total expenditure for HEFs in 2017 is USD 10,043,494, of which USD 8,359,063 was for medical expenses and USD 1,684,431 was for non-medical benefits. The RGC national budget covered 59.18% of this cost with a total of USD 6,090,940.97, which roughly increased by 15% from 2016. The remaining 40.82% of HEF expenditure was covered by IDA and MDTF funding through H-EQIP.

Component 3: Ensuring Sustainable and Responsive Health Systems

Sub component 3.1: Health System Strengthening

This section reviews and discusses progress made in terms of updating achievements and disbursements against DLIs for year Zero and year 1 targets, as submitted in the DLI report and supplementary report in January and June 2017, respectively.

The total value of funds available through all DLIs for year Zero is US$3 million equivalent. A supplementary report on the status of achievement of remaining year Zero DLI targets (DLI 3, 4, 5 & 6) was submitted on time to the World Bank on January 31, 2017. The report has been verified and was endorsed by the H-EQIP MDTF Management Committee during the 2nd ISM in late March 2017, and an additional payment of US$1,350,000 was approved accordingly. The report confirmed that following achievements were made against year Zero targets, in addition to those confirmed from the July 2016 report:

- DLI 3 (C2 hospitals fully equipped to provide emergency obstetric care and neonatal care) has been **fully achieved**;
- DLI 4 (Health service quality monitoring in MOH enhanced) has been **fully achieved**;
- DLI 5 (Sustainable health purchasing arrangements) has been **partially achieved** and was expected to be fully achieved by the June 2017 report with the signing of the sub-decree for the establishment of the PCA
- DLI 6 (Timeliness of HEF and SDG payments) has been **fully achieved**.

The DLI report describing the status of achievement for remaining year 1 Targets was also submitted on time to the World Bank on July 31, 2017. The total value of funds available through all DLIs for year 1 is US$2.5 million equivalent. Upon review of the independent verification report, it was concluded that following achievements were confirmed for year 1 DLI targets:

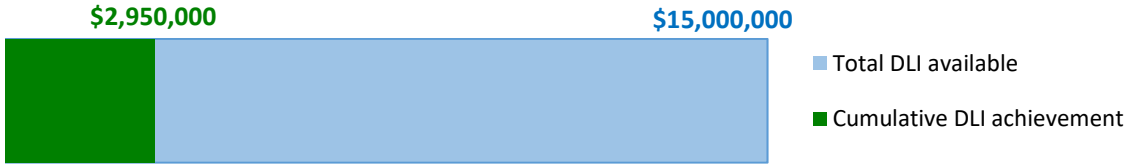
- DLI 3 (C2 hospitals fully equipped to provide emergency obstetric care and neonatal care) was **partially achieved;**
- DLI 6 (Timeliness of HEF and SDG payments improved) was **fully achieved**.

The total amount approved for year Zero targets in this period was US$1,350,000, and the total amount approved for year 1 DLI targets this period was US$600,000. Thus, the cumulative amount approved thus far for year Zero and year 1 DLIs is US$2,950,000 (Figure 2). The remaining DLI targets are in progress, except for DLI 2 on (Comprehensive in-service training program on MPA for health workers implemented by the MOH), which requires restructuring.

Two consecutive meetings were conducted with H-EQIP pooled fund partners, MEF, and all DLI focal points to clarify the process for planning and expenditure of DLI grants and to discuss the possibility of modification of DLI 2 and DLI 4 to better align with the current context. Modifications to these DLIs will be done as part of the project restructuring, which will be processed in conjunction

with the expected additional financing of the project. Workplans with proposed budgets for spending DLI funds have been developed and submitted to MEF, as suggested and agreed in the meeting, and financial guidelines for spending DLI funds have been developed and approved.

Figure 2. Cumulative value of DLIs achieved



Sub component 3.2: Health Infrastructure Improvement

Progress on planned infrastructure development and civil works financed by H-EQIP from January-December 2017 is as following:

Construction of 45 Health Centers: the land titles, size, and locations for the construction of HCs were examined. Based on the findings from the assessment carried out jointly by MOH and MDTF partners in 2016, with recommendations on how to best target funding for health infrastructure, the standard design for HCs was updated with the following modifications:

- two additional rooms included for pre and post-delivery
- improvements in water systems (including collection, storage, and flow of water)
- improvements in toilet facilities
- elevation of the ground floor by 2.5 to 2.8 meters to allow HCs use of the ground floor for staff rooms, pre/post-delivery rooms or other purposes.

Site visits and environmental and social impact screenings will be conducted in the next fiscal period.

Construction of 15 maternity and neonatal units for referral hospitals: the construction of 8 medium-sized and 7 large-sized maternity and neonatal units (depending on location and CPA level of the hospital) were proposed and are being taken into consideration in the budgeting plan. Site visits and environmental and social impact screenings will be conducted in the next fiscal period.

Construction of 2 Provincial Hospitals (Pailin and Oddar Meanchey): Preliminary surveys were conducted and it was determined that both hospitals require upgrades to CPA-2 level, including additional buildings and complete replacement of all supply/utility systems. It was confirmed that the planned upgrade of these two hospitals to CPA-3 level PRHs was therefore unnecessary. Site visits will be carried out in the coming quarter (see the procurement and environmental and social safeguard sections below).

Component 4: Contingent Emergency Response:

No reallocation of financing has been made.

V. Financial management performance

The supplementary financial management manual has been completed and approved and MOH finance staff of the Department of Budget and Finance (DBF) have been trained to apply the manual. The FM training for SDG and HEF financial processes was carried out nationwide in January 2017 by MOH's DBF staff. The setup and design of QuickBooks software was completed and quarterly interim unaudited financial reports (IFR) have been submitted on time.

VI. Project Procurement

Progress on procurement has faced significant delays in the 2nd year of project initiation. Twelve key individual consultants (procurement, FM, civil works, and quality assurance) were brought on board late this year, however, a few have resigned and the process for replacement has been taken accordingly. The procurement of HEF-Ps is at the expressions of interest stage and the selection of the consulting firm for the development of ICT system for the SDGs is at the evaluation of expressions of interest and shortlist stage.

Other procurement for civil works, including construction of HCs, construction of EmONC facilities, construction of provincial hospitals, and procurement of related equipment, medical tools, and furniture has not yet initiated.

VII. Environmental and social safeguards

Following a restructuring of H-EQIP Project Management, there was a handover of responsibility for implementing the Social and Environmental Safeguard aspects of the project from the MOH Human Services Department to the Preventive Medicine Department (PMD). The PMD is now responsible for implementing all safeguards aspects of H-EQIP, including the Resettlement Policy Framework (RPF), Indigenous People Planning Framework (IPPF) and Environmental Management Framework (EMF), and a meeting was conducted among relevant project focal points within the PMD to discuss and ensure that the safeguards roles and responsibilities of each focal point were well understood. The status of implemented activities in 2017 are as follows:

Environmental safeguards: As identified in the H-EQIP ISMs, compliance to environmental safeguards at some referral hospitals and health centers remain sub-optimal despite sufficient policy, regulations, and guidelines in place. The SDG quality scorecard related to healthcare waste management and infection prevention and control was reviewed to ensure compliance with existing policy and guidelines and additional indicators are planned to be added following the NQEMP Annual Review Workshop in December 2017.

Lessons learned from HSSP2 will be taken into account to ensure that the newly constructed health facilities have sufficient clean water supply. These include ensuring sufficient water pressure to the entire health facility, conducting water quality testing, and communicating results to health facilities in case of presence of Arsenic. The environmental safeguard screenings of civil works sites will be performed after the civil works priority plan is finalized.

Social safeguards: Meetings and field visits were conducted to several health facilities and communities to better understand the needs for improving and strengthening the social safeguards implementation in the project. This included the preparation of land acquisition, Indigenous Peoples Planning Framework (IPPF), and a gender assessment of the project.

The PMD conducted field visits to seven provinces with the largest population of Indigenous Peoples (IPs) between March and May 2017 to collect baseline data. A consultative workshop on IPs was

conducted from September 7-8, 2017 and the findings of the workshop were shared among representatives from 14 H-EQIP target provinces, Ministry of Interior, MOP, Ministry of Rural Development, CARE and GIZ. Following the workshop, each province prepared and submitted an individual action plan to the PMD for review. The consolidated draft of a project-wide Indigenous Peoples Plan (IPP) was submitted to World Bank for review for No Objection.

Gender assessment: A team from the WB and DFAT conducted a gender assessment of the project from July 25- August 5, 2017. The team met with relevant stakeholders and conducted field visits in Kratie and Mondulkiry provinces. The draft report on the assessment was shared with MOH and a workshop on the Draft Gender Assessment was conducted on November 24, 2017, chaired by H.E. Prof. Tan Vuoch Chheng. The workshop collected feedback from a range of stakeholders from the government, donor partners, and CSOs on the findings and recommendations of the report before finalization.

VIII. Project Monitoring

Implementation Support Missions (ISMs):

The Ministry of Health and H-EQIP pooled fund partners jointly conducted two ISMs during this year. The 2nd ISM was held from March 13-24, 2017 and the 3rd ISM was held from October 2-6, 2017. A summary of findings from the two missions is below.

- During the 2nd ISM, the team visited 8 HCs and 5 RHs in Kampot, Kampong Chhnang, Kampong Cham and Kampong Speu provinces and held meetings with several PHDs and ODs with the objective to review the overall progress and operational management of the project at the point of service delivery, including the current status of HEF transition since hand-over by HEFOs; the implementation of the lump-sum SDGs; the overall achievement against annual health targets and challenges at health facilities; and the status of environmental and social safeguards, with a particular focus on gender aspects. In general, it was found that fixed lump-sum grants were flowing smoothly to health facilities and were being used innovatively for quality improvements. Record keeping of accounts at the sub-national level did not pose significant challenges. Some clarification was needed on SDG lump sum eligible expenditure categories. Likewise, HEF payments were flowing regularly to health facilities and utilization rates were reported to be increasing following the reintroduction of non-medical benefit allowances.

  In terms of environmental and social safeguards, it was found that there were numerous challenges with waste management and water supply in the majority of facilities visited. Many incinerators were broken, out of service, or unavailable, and proper handling of medical waste posed an issue. Water quality was also reported to be an issue in many health facilities.

  With regard to gender, several good cases of promoting women's voices and participation in decision making at health centers were observed, such as health facilities using the SDG lump-sum grant to purchase post-delivery kits, which was attributed to the active participation of the predominantly female midwives in the decision-making process for the use of the grant. In general, common areas for improvement related to the gender balance of staff at health facilities, Hospital Management Committees, and Health Center Management Committees, as well as with targeting health facilities' attention to address gender-specific aspects.

- During the 3rd ISM, the team met with relevant PHDs and ODs and visited 19 HCs and 8 RHs in the 5 provinces of Banteay Mean Chey, Siem Reap, Stung Treng, Rotanakiry, and Kampong Thom. The objective of the mission was to review the overall progress and operational management of the project at the point of service delivery, including the implementation of the

HEF and SDGs, the roll-out of performance-based SDGs; the overall achievement against annual health targets and challenges at health facilities; and the status of environmental and social safeguards.

The mission found that the fixed lump-sum grants were flowing smoothly to all health facilities since July 2016 until the third quarter of 2017. Health facilities reported comfort in managing these funds and appreciated the supervision and support being given by ODs and PHDs and the grants enable them to provide better quality of care, particularly in terms of drug supply and medical materials, hygiene, infection control, waste management, and emergency transportation. Most facilities visited reported spending on drugs and medical consumables, however, clarification on eligible expenditures for the fixed lump sum grants was felt needed.

Of those Phase 1 facilities assessed for the NQEM process, most facilities visited accepted their quality scores and appreciated the immediate feedback and coaching provided which helped to identify areas for quality improvement. Many facilities had already taken action to address these areas such as procurement of segregated waste bins and soap for hand washing stations using the fixed lump sum grants. Most facilities had also recently received their first performance-based grants, although several facilities requested further guidance on how these grants should be spent and distributed amongst their teams.

In terms of the HEF, payments for HEFs had been on schedule with most (if not all) payments between March and July reported as received on time. Most hospitals reported that they can manage the HEF system well with the technical support of USAID/URC since the transfer of HEFO roles to the facilities. Many hospitals have chosen to contract ex-HEFO staff to assist with this function.

HEF utilization was reported to be increasing since non-medical benefits resumed in March/April, 2017 and the reintroduction of post-ID at PRHs, following a significant drop during the months when medical and non-medical allowances were unavailable and when new post-IDs had been discontinued. However low HEF utilization remained and a high rate of exemptions were observed in a few facilities and provinces, such as Stung Treng and Siem Reap PRH due to the absence of post-ID. Several HCs visited reported that they had not resumed payment of non-medical benefits for delivery and post-abortion care, citing that this was no longer allowed. Health facilities requested to simplify the process for checking which patients are eligible for HEF, as currently only the head of the household is listed and checking the PMRS can take time and often can only be done once the patient has left the facility. Facilities reported that communities are seeing more benefit to the ID Poor card with increasing quality of services provided.

Waste management continued to present an issue, with many incinerators not functioning, issues with flooding, and several facilities reported that staff had not been trained on infection control and waste management practices. Modest improvement was observed in some health facilities (HC and RHs), however, which were equipped with colored bins with plastic bags labeled according to respective medical waste categories.

Annex A. Key project events held in 2017

1) Second round of testing of the NQEM tools completed: January 2017
2) Cascade trainings for PHD and OD SDG assessors for SOA sites (Phase 1): February to May 2017
3) First round of Phase 1 ex-ante SDG assessments launched: May 2017
4) Second round of Phase 1 ex-ante SDG assessments launched: October 2017
5) PCA staff trained in ex-post verification function for SDGs and certified as ex-post assessors: November 2017
6) First round of ex-post verification conducted: December 2017
7) FM training for SDG and HEF financial processes carried out nationwide: January 2017
8) NQEMP Annual Review Workshop: December 2017
9) Field visits conducted to seven provinces by PMD to collect baseline data on Indigenous Peoples: March- May 2017
10) Consultative workshop on Indigenous Peoples: September 7-8, 2017
11) Gender assessment of H-EQIP conducted: July 25- August 5, 2017.
12) Workshop on the Draft Gender Assessment conducted: November 24, 2017
13) 2nd H-EQIP ISM: March 13-24, 2017
14) 3rd H-EQIP ISM: October 2-6, 2017

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	2017	End Target
Target	49		Baseline +10%	Baseline + 50%
Achievement		49	314	
Date	30-Apr-2016	10-Aug-2016	Q4, 2017	30-Jun-2021

Notes: *Out of 1,190 targeted HCs, 452 HCs were assessed in Q2 2017 for round 1 and 453 HCs were assessed in Q4, 2017 for round 2. Among those assessed, only 46 HCs (or 11%) exceeded 60% in score starting from 60.01%. for first round, and 314 HCs (or 70%) for second round.*
Source: *MOH assessment results.*

Reduction in the share of households that experienced impoverishing health spending during the year. (Percentage, Custom)				
Description	Baseline	2016	2017	End Target
Target	0.9		0.8	0.7
Achievement		0.9	0.9	
Date	30-Oct-2015	10-Aug-2016	05-Oct-2017	30-Jun-2021

Notes: *Baseline from Cambodia Socioeconomic Survey (CSES) 2014. Status will be updated once the CSES 2016 is released, expected in either December 2017 or January 2018 as informed by the National Institute of Statistic (NIS), Ministry of Planning*
Source: *NIS focal point.*

Reduction in OOP health expenditure as percentage of the total health expenditure. (Percentage, Custom)				
Description	Baseline	2016	2017	End Target
Target	62.30		59	55
Achievement		62.30	62.30	
Date	30-Oct-2015	10-Aug-2016	05-Oct-2017	30-Jun-2021

Notes: *Baseline from National Health Accounts (NHA) 2013, achievement from NHA 2014. Status will be updated one the NHA 2015 & 2016 is released expected in December 2017*

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	2017	End Target
Target	51%		55%	81%
Achievement		n/a	n/a	
Date	30-Oct-2015	10-Aug-2016		30-June-2021

Notes: *The national Health Congress (NHC) only recorded number of cases and not individual HEF users who utilized OPD services at HC and hospitals. This indicator will be replaced by "increase in number of outpatient service (episodes) covered by HEF" in the upcoming AF restructuring.*

Intermediate Results Indicators

Percentage of health centers having stock-outs of 14 essential medicines. (Percentage, Custom). This indicator was dropped.				
Description	Baseline	2016	2017	End Target
Target	4.73		<5	<5
Achievement		4.01	n/a	
Date	2014	30-Jul-2016		30-Jun-2021

Note: *The NHC reports did not include this indicator and despite all efforts made to obtain this data, it has not been possible. It has been agreed to drop this indicator. However, given the importance of monitoring this indicator, it will be monitored through the results of quality scorecards under the NQEM process which also report on drug availability*

Proportion of health centers with functioning health center management committees. (Text, Custom)				
Description	Baseline	2016	2017	End Target
Target	64%		Baseline + 5%	Baseline + 25%
Achievement		64%	75%	
Date	24-Mar-2017	31-Dec-2016	31-Dec-2017	30-Jun-2021

Notes: *This data is updated based on the 2018 NHC report, p. 137*

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	2017	End Target
Target	0.00		50%	70%
Achievement		n/a	100%	
Date	30-Oct-2015	10-Aug-2016	05-Oct-2017	30-Jun-2021

Notes: *Data excluded 13 PRHs that just completed the quality assessment in September 2017. All 452 HCs and 29 district RHs received payment by 12 September 2017.*
Source: *DBF focal person and a health center chief at the province*

Reduction in the variance in score on Health Center quality assessment. (Text, Custom)				
Description	Baseline	2016	2017	End Target
Target	53 percentage			43 percentage
Achievement	points	53%	73.07%	points
Date	30-Oct-2015	10-Aug-2016	Q4, 2017	30-Jun-2021

Notes: *Target for this indicator were set for year 3 & year 5 only. The difference between the highest and the lowest score in the second round of NQEM was 73.07% (the highest score was 97.88% and lowest score was 24.81% for round 2 in Q4, 2017).*
Source: *MOH assessment results*

Percentage CPA-1, CPA-2, and CPA-3 facilities having a 60% quality score in previous quality assessments. (Text, Custom)				
Description	Baseline	2016	2017	End Target
Target	not yet available		Baseline + 10%	Baseline + 50%
Achievements		0	16.67%	
Date	30-Oct-2015	10-Aug-2016	Q4, 2017	30-Jun-2021

Notes: *All 42 CPA1, CPA2 and CPA3 hospitals (including 29 district RHs and 13 PRHs) were assessed in Q2, 2017 for round 1 and Q4, 2017 for round 2. Among those assessed there are only 7 hospitals (or 17%) exceeded 60% quality score assessment for the second round in Q4, 2017.*
Source: *MOH assessment results.*

Outpatient Department (OPD) consultations (new cases only) per person per year. (Number, Custom)				
Description	Baseline	2016	2017	End Target
Target	0.59		0.75	0.95
Achievement		0.63	0.71	
Date	30-Oct-2015	31-Dec-2016	31-Dec-2017	30-Jun-2021

Notes: *OPD new cases per person/year is 0.71 in 2017 (from both public and private health facilities).*
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	2017	End Target
Target	0.00		2	25
Achievement		2	2	
Date	30-Jul-2016	10-Aug-2016	05-Oct-2017	30-Jun-2021

Notes: *2 courses are already updated and 5 others courses are under review.*
Source: *MOH submission letter to WB dated July 31, 2017 on DLI Report for Year 1.*

Percentage of health centers, hospitals and OD/PHD receiving HEF and SDG payments within specified timelines. (Percentage, Custom)				
Description	Baseline	2016	2017	End Target
Target	0		40.00	80
Achievement		n/a	100.00	
Date	30-Oct-2015		05-Oct-2017	30-Jun-2021

Source: *DBF focal person and MOH Submission letter to WB on DLIs Report for year 1, dated July 31, 2017.*

Percentage of HMIS reports submitted on time. (Percentage, Custom)				
Description	Baseline	2016	2017	End Target
Target	95%	--	95%	95%
Achievement		90.04%	95.10%	
Date	30-Oct-2015	31-Dec-2016	31-Dec-2017	30-Jun-2021

Note: *This data is taken from the 2018 National Health Congress Report (NHC). P130.*