



# **GAVI Health System Strengthening Support Evaluation**

RFP-0006-08

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## **Cambodia Case Study**

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### Submitted by

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## Acronyms and Abbreviations

AoP	Annual Operational Plan
ANC	Ante Natal Care
ART	Antiretroviral Therapy
CDC	Communicable Disease Control (Department)
CDHS	Cambodia Demographic and Health Survey
CPA	Complementary Package of Activities
CPR	Contraceptive Prevalence Rate
CRDB	Cambodia Rehabilitation and Development Board
CSES	Cambodia Socio-Economic Survey
DBF	Department of Budget and Finance
DPHI	Department of Planning and Health Information
DTP	Diphtheria, Tetanus, Pertussis (whooping cough)
EmOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunisation
FFS	Fee for Service
GNP	Gross National Product
HEF	Health Equity Fund
HIS	Health Information System
HSP	Health Strategic Plan
HSR	Health Sector Review
HSS	Health System Strengthening
HSSP	Health Sector Support Programme
HSSC	Health Systems Strengthening in Cambodia (USAID)
ICSC	Immunization Coordination Sub Committee
IHP	International Health Partnership
IP(D)	In Patient (Department)
IRC	Independent Review Committee
JAPR	Joint Annual Performance Review
JPA	Joint Partnership Agreement
M&E	Monitoring and Evaluation

MCH	Maternal and Child Health
MBPI	Merit Based Pay Initiative
MDG	Millennium Development Goal
MLM	Middle Level Management
MoH	Ministry of Health
MPA	Minimum Package of Activities
MTEF	Medium Term Expenditure Framework
NGO	Non Government Organization
OD	Operational District
OP(D)	Out Patient (Department)
PBA	Programme based Approach
PHD	Provincial Health Department
PIU/PMU	Project Implementation Unit/Project Management Unit
PLHA	Person Living with HIV/AIDS
PMG	Priority Mission Group
RMNCH	Reproductive Maternal Neonatal and Child Health
SOE	Special Operating Agency
SWiM	Sector Wide Management
TB	Tuberculosis
TWG-H	Technical Working Group – Health
U5MR	Under 5 Mortality Rate

## Summary of key findings, conclusions and recommendations

This summary of the Cambodia case study answers the first two GAVI HSS evaluation questions, namely:

- What has been the experience at country level with GAVI HSS in terms of each of the following aspects: design, implementation, monitoring, integration (harmonisation and alignment), management and outputs/outcomes;
- What have been the main strengths and weaknesses of GAVI HSS at the country level, and what are the specific areas that require further improvement?

It also highlights some key issues related to how well the Cambodia HSS intervention fits with GAVI's principles and values.

The Cambodia case study was carried out between the end of April and early June 2009 led by Mark Pearson with support from a national consultant Sok Pun. The approach included a series of meetings with key stakeholders using structured questionnaires and teleconferences with stakeholders at regional and global levels. The available literature was reviewed; the 2008 Annual Performance Review (MoH, 2009) and an independent review of the HSS support (Biacabe 2009) commissioned by UNPFA and GAVI proved to be particularly useful. Field visits were carried out by the national consultant to two operational districts (ODs) in which the programme was operating and a feedback session with key stakeholders was held on June 11<sup>th</sup> during which many of the conclusions here were discussed.

It is important to note that many of the findings reflect the early stage in the development of the HSS approach and both Government and GAVI have been going through a learning process. As such the findings reflected here often focus heavily on teething problems and the upfront costs involved in getting a large programme like GAVI HSS up and running. Without suggesting that future progress is guaranteed, many of the costs have now been borne and the benefits should now begin to flow.

Cambodia received support for one year in Round 1 and, after a follow on proposal was rejected, support for a further 8 years – in line with Government’s new Health Strategic Plan - in Round 5. The Cambodian experience has, in general, been a positive one; both in terms of consistency with GAVI principles and, at a very early stage, delivery of outputs. GAVI HSS is particularly valued for its flexibility and the organisation has taken major steps to harmonise its support with the most aligned form of donor support in country. Nonetheless, there are some suggestions that the programme may not fully realise its potential and there are a number of lessons to learn.

### Consistency with GAVI Principles

A first conclusion is that it is simply impossible for GAVI HSS programmes to adhere to all of the principles it sets itself<sup>1</sup>. Some are inconsistent – for example a programme cannot always be both innovative and country owned or both additional and fully aligned. The key question should, therefore, not be whether the programme adheres to the principles but whether the programmes guided by the principles adopt an approach most relevant to the country circumstances. The following paragraphs outline the team’s assessment of how the approach fared against the individual principles.

The approach adopted by Cambodia enjoys significant **country ownership**.

Although the proposal was drafted with support from an external consultant it strongly reflected Government priorities. For example, the choice of ODs resulted from a series of criteria developed by Government. In many donor programmes in Cambodia, by contrast, location is suggested by donors. Government’s ongoing interest is reflected through a number of assessments (funded by the programme) which have been made to assess progress – the most recent in Sihanoukville at the end of May 2009 - which have resulted in modifications to the approach. Following approval of the proposal, significant changes were made which further reinforced Government ownership. However, this does raise questions as to whether, and on what basis, significant changes to programmes can be made post approval without consulting with GAVI and the Independent Review Committee (IRC).

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<sup>1</sup> Note – the list of principles has changed over time with the inclusion of new ones e.g. additionality and the modification of existing ones e.g. catalytic has become innovative and catalytic. In some cases there is no shared understanding of what the principle means

GAVI support is **well aligned** with Government priorities - this is clearly spelled out in key policy and planning documents. There is a robust and gradually strengthening approach to improving harmonisation in country which GAVI needs to continue to be aware of. GAVI is **reasonably well harmonised** with other forms of donor support. To all intents and purposes GAVI HSS is a discrete donor within the Health Sector Support Programme (HSSP 2) – a joint donor programme operated through a secretariat involving some 7 donors some of which provide pooled funding - and its activities are reflected in the various Annual Operational Plans (making the support “on plan” if not “on budget”). There is a dedicated GAVI HSS bank account but it uses HSSP financial management guidelines. The Annual Performance Review (APR) is an additional, and quite burdensome, requirement which is not aligned with the Government planning cycle. By harmonising with HSSP 2 GAVI should become aligned with Government systems as HSSP 2 becomes more fully integrated into Government systems (planning and monitoring and evaluation are practically there, financial management and procurement functions are due to be transferred to Government in the next couple of years). In practice, given that the national treasury only channels resources to provincial treasuries (and not through line Ministries) the only way to be fully aligned is through general budget support. The World Bank, in fact, plans to provide this form of support by 2014. A key question for GAVI is whether it should be aiming to become a pooled donor and whether this might be feasible by 2015 if not by 2012. The 2012 evaluation might look for evidence of clear thinking and possibly action on this issue.

GAVI needs to retain its flexibility to respond to new challenges. The implications of the current decentralisation law are not known and any approach adopted will need to take account of the changing environment. To do this it will probably need to take a more active role in quarterly HSSP review missions, Joint Annual Plan Appraisal and the Joint Annual Performance Reviews. To do this it may need to actually attend such meetings or delegate such roles to IRC member or staff at regional level.

**Transactions costs** incurred to date were felt to have been high leading some respondents to question whether the effort was worth it given the level of funding and availability of funding from other sources. This improved somewhat given the approval of phase 2 (the third proposal) which covered an 8 year period.

The approach is extremely **results oriented** and particularly so after the shift in emphasis away from capitation based support for the MPA package – as envisaged in the approved proposal - to a fee for service type approach in which providers are paid a set fee for delivering certain, specified services (such as a out patient consultation or an ante natal care visit) which accounts for over a third of the programme spend. The need to achieve results appears to have been a key driver of Government interest in the approach. However, these results are not fully captured in current reporting systems.

GAVI support was **catalytic**. HSSP has faced a slow and painful transition between its phases and flexible GAVI support (also not requiring counterpart Government funds) has been able to pilot new approaches or at least accelerate the implementation of existing ideas. One respondent likened the GAVI HSS support to a nimble “monkey” against HSSP’s “elephant”. Specifically, GAVI HSS enabled Government to introduce an approach – internal contracting – that it had wanted to do for some time, and had been discussed with a number of donors, but never had the means to do so. The approach also brought interest from UNPFA (with financial support from Ausaid to broaden the approach to cover a larger share of the MPA package). However, in a fast moving policy environment, pilots are learnt from and are adapted. Having stimulated reforms, the GAVI models will soon run the risk of being left behind as the Special Operating Agency (SoA)/Service Delivery Grant (SDG) model of contracting moves forward with support from HSSP 2. The challenge is to see how the GAVI HSS model will adapt to this and be aligned with the overall national policy.

Processes were seen as being **reasonably inclusive** and though efforts were made to bring in civil society the short notice of meetings and the lack of discussion documents hindered more effective consultation in the design process and there has been little role in the implementation phase.

The picture is mixed on **predictability**. Many of those interviewed liked the GAVI approach in principle, as it set out a clear unambiguous budget based on objective, verifiable criteria (per capita GNP). The problem in Cambodia is that between the first, and ultimately successful, third GAVI HSS proposal, Cambodia’s GNP per capita figure rose above the point at which per capita allocations dropped from \$5 to \$2.5. This upset many in-country stakeholders who felt that the different proposals had not been appraised in a consistent manner and that they had been led

to believe an earlier second proposal would be approved at the higher rate. There appears to be some truth in this – the first proposal was the only one supported without reservation yet the second similar proposal – prepared to secure funds before the change in GNP status - was rejected. This probably also reflected the learning process GAVI was also undergoing but also seems to have been the result of some miscommunication within the GAVI secretariat. In short, the allocation approach is fine, in principle, but some elements of the design need to be revisited. These might include the sharpness of the transition (should support be halved once a particular income level is reached or should the decline be gradual? Or should a country be assigned to one group of the other and not change irrespective of changes in per capita income?).

The fact that the perceived lack of impact was given as one of the reasons for rejection added to the frustration, given that activities were delayed for a considerable period of time as funds were mislaid and needed to be re-transferred to the correct bank account. Although quite simple in nature, such details do require close attention at the early stage of implementation as they can result in serious delays and frustration.

The reduction in per capita funding had further effects as the lower than expected allocation resulted in a skewing the direction of the programme as service related performance based components were protected as the budget declined whereas broader HSS components at provincial and central levels were cut. This might have further reinforced the vertical orientation of the programme.

In terms of **progress to date**, the programme is delivering some good results in terms of service delivery outputs – the independent Biacabe review found “**excellent quantitative performance in the area of Reproductive, Maternal and Child Health**” although there are some questions about the quality of the data (especially given the strong financial incentives now present to exaggerate outputs) and the quality of the services. Progress is not consistent between and within ODs or between interventions. It is less easy to assess the progress in terms of the more upstream activities such as financial management training and on management systems and governance. The review found that the GAVI support had encouraged more supervision from the provincial level but not necessarily better supervision; had not embedded integrated monitoring and supervision; and the training in financial

management and IMCI had helped reduce other constraints. However, the lack of midwives remained a serious pressing concern, suggesting GAVI was providing necessary but not sufficient support. This also raises the important question of whether GAVI should be focusing more on upstream HSS interventions (thus focusing on broader health systems strengthening) or on more downstream service related interventions (thus focusing more on immunisation results). The Cambodia programme generally focuses on the latter. There is a risk however, that as the benefits from downstream interventions are easier to identify, more attention will be placed here. This is fine, but it does raise the question as to how the important, but difficult to assess, upstream interventions will be covered

It is fairly clear given the level of GAVI support that complementary support will be needed if serious attempts are to be made to strengthen health systems. GAVI support at less than \$1 per head is far less than the \$5-7 per head provided under the previous contracting-in approach. Expectations of impact need to be in line with the resources provided.

Though it is extremely difficult to measure impact and attribute improvements in service delivery to upstream components they do have a crucial role in providing sustainable improvements in access to services. GAVI needs to ensure a reasonable balance between more upstream and downstream components (and reconsider whether the latter really fulfils the aim of supporting HSS). A number of respondents referred to the programme as a successful vertical programme

In terms of design, the approach attempted to complement support provided by other donors notably the Global Fund. However, in terms of implementation there is little evidence that approaches for example to supervision, were any more integrated than they had been previously. It is perhaps unrealistic to think that such behaviours – much of it a product of the way donors have provided support over many years – would change overnight. The 2012 evaluation might be a reasonable timeframe within which to see some progress.

Given that a) the support is focused on lower performing ODs, b) the needs of better-off groups are already better catered for, and c) a remote area allowance has been introduced the approach should, in principle, be pro-poor and, therefore, help reduce **inequality**. E.g. half of the 10 GAVI supported ODs achieved 80% DPT3 coverage according to the 2008 APR, versus

none in 2006. However, continued progress in this area could be impaired by lack of progress on other measures aimed at addressing access barriers e.g. the scale up of health equity funds.

The activities supported by GAVI appear to have been **additional** and would not have been carried out, at least according to the programme timetable, otherwise.

Many of the activities involve substantial recurrent costs. Financial and technical **sustainability** will depend heavily on the willingness of Government and/or other development partners to take on the recurrent cost burden (as the support is front loaded). At the same time, as noted above, GAVI HSS support in per capita terms is less than in many other donor supported ODs. This might suggest that the problem is less one of sustainability (compared to those other ODs) but more one that the level of support will be insufficient to deliver an identifiable impact and that this is an attempt to support HSS on the cheap.

## Broader issues raised

**The degree of GAVI involvement in decision making:** The shift away from an approach which aimed to support the whole MPA package through a capitation based approach to one that supported elements of the MPA package and neglected others represented a shift away from a truly system wide approach to one that remained rather more vertical in nature. The decision to do this appears to have been based largely on concerns about affordability and the practicality of introducing capitation based approaches. There may be some justification in the former. The GAVI HSS support per OD was well below the levels of support provided in recent years through contracting approaches (which were in the range of \$5-7 per head) and did not benefit from the ongoing technical support enjoyed by contracting districts. This being the case, the logical choice would have been to reduce the range of services covered or to have retained the focus on the full MPA package but implemented it in rather less ODs. In practice this can be quite hard given that the 10 ODs had been “promised” support and this would have been difficult to withdraw. It is less clear why capitation is so impractical. Given adequate data it is fairly simple to allocate resources to different ODs (HSSP 2 is doing this for service delivery grants). How the money is then allocated within ODs is an issue but is simply part of the resource allocation process.

**The need to see GAVI support in the context of overall sector reform:** In the short term, the GAVI approach may have served to entrench fragmentation by encouraging the use of multiple funding channels to support some parts of the MPA package (and not others). Also by failing to address issues related to referral and by reducing the scope for ensuring the continuum of care, the HSS proposal may have further contributed to a lack of programme coherence. To be fair, the expansion of Health Equity Funds which would have reduced some of the financial barriers to timely referral has been restricted by the transition between HSSP 1 and 2. Taking a charitable view, the course of action adopted could be seen as a logical response to an overambitious initial HSS proposal. As resources increase, however, one might expect the full MPA to be covered and for the model in the 10ODs to be harmonised with those in the HSSP 2 ODs. A less charitable view would see this as little more than another vertical programme – albeit a rather successful one - with relatively little to distinguish it from other forms of GAVI support such as ISS (even if the mechanisms for deciding how rewards are shared and the

beneficiaries of the payments differs). It would be reasonable for GAVI to seek clarification on which way Government intends to move forward and to have seen some evidence of this by 2012. The 2012 evaluation might focus particularly on the extent to which activities which are not supported directly have suffered.

**The need for clarity on what this is for?** A key underlying question which underpins much of this discussion remains “**what is health systems strengthening**”. Some respondents suggested, for example, that the fee for service is, in fact a performance system itself and also a reflection of the health system the Government would like to see. Others felt it served only to fragment and undermine the health system. Similarly some respondents’ questioned whether helping underperforming ODs to catch up was really HSS.

**The need to explore ways to engage more effectively in policy dialogue:** GAVI should try and remain “lean and mean” but consider how its involvement at the country level can be timed to better effect i.e. to coincide with the JAR rather than through independent visits. It should also consider the possibility of staff at regional level or IRC members getting involved in other key policy fora e.g. quarterly HSSP 2 monitoring reviews or for in country partners to do this more actively on GAVI’s behalf.

**The need for realism:** The Cambodia experience raises questions as to how realistic it is to expect the HSS approach to be designed and implemented using SWAp processes and led by Planning Departments.

Issues of **quality assurance** and **community participation** remain weak and need more attention.

Key **contextual factors** against which the findings of this case study should be viewed include the fact that, unlike some other settings, GAVI funding was not that significant in overall financing terms. As such it perhaps did not get the necessary attention that it might have elsewhere. A number of partners suggested that they would ideally have provided more support had they not faced other competing priorities. This raises the question as to whether there is a need for ongoing technical support in some settings if the full benefits are not to be realised.

Key areas to focus on in the **2012 evaluation** might include:

- A clear vision for how GAVI plans to take forward the harmonisation agenda. Will it join the pool? When, under what conditions?
- the extent to which Government has developed a clear vision for how GAVI HSS ODs will be aligned with approaches in other districts - possibly including a shift towards a more integrated approach focused on the MPA package as a whole - as originally envisaged. One would expect this to result in a sustained and balanced increase in utilisation of essential services (as defined in the MPA and CPA packages);
- the extent to which the more upstream investments – which have less direct impacts - are leading to changes in behaviour . This might involve tracking studies to see if those who have been receiving capacity building training are actually using that training as planned.

## 1 Scope, Approach and Methodology

### 1.1 Background

This report contains the findings of the case study conducted in Cambodia between April and June 2009 as part of the GAVI HSS Evaluation Study. This is one of 11 In-depth case studies that have been conducted in the following countries, all of them recipients of GAVI HSS grants: Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. An additional 10 countries were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etcetera) are publicly available documents that can be requested from HLSP. To keep this report short these broader methodological issues are not be discussed here. A summarised description of the study approach is at **Annex 1**.

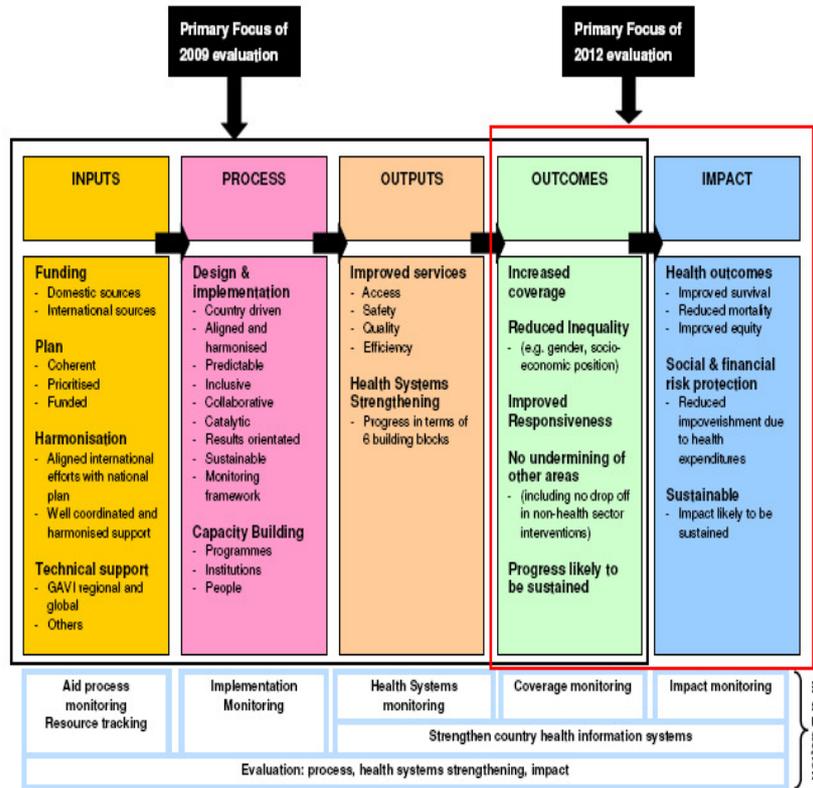
## 1.2 Brief conceptual framework of the Evaluation

This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.)
3. To enhance the quality of the 2012 evaluation.

It is important to note that in view of the short time elapsed since the first HSS applications were approved in 2006 that this evaluation - the first one ever conducted on the GAVI HSS component - will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

Figure 1: The conceptual framework - logical progression from inputs to impact



The priority evaluation questions are summarised in Box 1 below.

### Box 1 Examples of Questions for the HSS Evaluation Study

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the “right” bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

### 1.3 Approach to the Country Case studies

All 11 in-depth review countries at least one country was carried out by the HLSP country lead consultant helped by one or more national consultants or national research institutions depending on the circumstances.<sup>2</sup> In the case of 6 countries (DRC, Ethiopia, Kyrgyzstan, Nepal, Vietnam and Zambia) the HSS evaluation team were able to count on the support and previous work of another study team conducting the so called GAVI HSS Tracking Study in those countries. The Tracking Study - led JSI/InDevelop-IPM - covers very similar areas (albeit from a different angle) to those of this HSS Evaluation study, so attempts were made to achieve synergies between the two studies.

In Cambodia, as in other countries, the country case studies were triggered by a letter from the Executive Secretary of the GAVI Alliance Secretariat addressed to the Minister of Health and

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<sup>2</sup> The main circumstances that determined the kind of support required by the HLSP Country Lead consultants included the size of the country, the size and complexity of the HSS grants, whether the grants were targeting any specific geographical areas, etcetera.

copied to the main stakeholders involved in follow up or implementation of GAVI grants at national or regional level, including the so-called “Focal Points” based at either the World Health Organisation (WHO) or UNICEF.

Once the letters had been sent the Country Lead Consultants began the process of documentation (see list of documents reviewed in **Annex 2**), they approached potential country researchers to work with them and they began preparing the country visits with country and regional stakeholders. In the case of Cambodia the country visits took place between 29<sup>th</sup> April and 8<sup>th</sup> May and 8<sup>th</sup> June and 12<sup>th</sup> June. A list of people met for this evaluation is included in **Annex 3**. Most meetings took place in Phnom Penh. The local consultant carried field visits to 2 ODs and a number of discussions took place by phone notably with regional WHO contacts and the GAVI country contact

At the end of the visit a feedback session was arranged with key stakeholders. Agenda is attached as **Annex 4**.

#### **1.4 Acknowledgements**

We would like to thank the Ministry of Health in Cambodia for facilitating this study and for those stakeholders who generously gave their time to contribute.

## 2 The Cambodia Country Context

A sustained period of war and internal conflict left Cambodia's economy and social fabric in tatters. Political stability since 1993 has created the basis for sustained development. Despite rapid economic growth, poverty remains widespread and Cambodia is still only ranked 131 out of 177 countries on the human development index. The 2004 Cambodia Socio Economic Survey (CSES) estimated that around 35% of the population lives below the poverty line with 90% of the poor living in rural areas.

### 2.1 Health situation, priorities and programmes

Although significant improvements have been made, access to health services remains low. Regional and social inequity are major concerns and though child mortality rates have come down, maternal mortality has actually increased – a clear sign of a defective health system. 37% of children were stunted in 2005 and malnutrition continues to be major contributor to early childhood mortality. Child survival indicators have shown consistent progress over the last decade. After a setback in 2002, immunization services have seen a rapid improvement though there is a high dependence on outreach to reach immunization targets (80%).

**Table 1: Progress against key health indicators**

Indicator	CHDS 2000	CHDS 2005
Life expectancy at birth (years)	56	61
Birth rate, crude (per 1,000 people)	31	30
Death rate, crude (per 1,000 people)	11	11
Fertility rate, total (births per woman)	4.3	3.9
Mortality rate, infant (per 1,000 live births)	109	66
Mortality rate, child (per 1,000 live births)	21	19
Mortality rate, under-5 (per 1,000 live births)	127	83
Mortality ratio, maternal (per 100,000 live births)	437	472

## 2.2 Current Situation – Ongoing Health Reforms

Key systems weaknesses include:

- The failure to channel resources to the periphery and resulting effects on equity and access;
- the lack of incentives to promote good performance – notably the effects of low salaries on health worker productivity;
- weak management of key resources – especially human resources and drugs;
- lack of clarity on the role of the state and institutional arrangements which result in duplication and fragmentation of efforts.

Key reforms are set out in Health Strategic Plan 2. Key elements include:

- Focusing efforts on the delivery of key services as spelt out in the Minimum and Complementary (MPA and CPA) packages (Cambodia's version of an essential health package);
- a shift from external to internal contracting supported by performance management agreements as a means of delivering these services;
- expansion of health equity funds (HEFs) to reduce financial barriers to access;
- development of Annual Operation Plan (AoP) processes;
- efforts to improve aid effectiveness through harmonisation and alignment;
- decentralisation of services;
- improving health worker productivity through a range of incentives schemes including the Merit Based Pay Initiative (MBPI) and Priority Mission Groups (PMGs).

For more detail see **Annex 5**.

HSS is being supported through a number of programmes including the Health Sector Support Programme (HSSP) 2, the USAID HSSC and the Global Fund. For further details see **Annex 6**. Efforts were made during the design stage to ensure complementarity between the approaches

### 2.3 Barriers to greater immunisation coverage

Several challenges remain to obtain full coverage and sustainability of immunisation services.

These include:

- Inequities in coverage - families with low educational status tend to have lower coverage rates;
- financial barriers and low quality of care;
- high dependence on out reach services;
- limitations and large inequities in human resources availability quality, remuneration and motivation.

Delays to referral include: poor knowledge of dangers signs, home deliveries attended by non - skilled staff unable to identify and refer promptly complications, distance and transport costs to hospitals, lack of community awareness and readiness for Emergency Obstetric Care (EmOC).

### 2.4 Coordinating bodies in the Health Sector the International Health Partnership

Cambodia has a long history in promoting harmonisation and alignment. The Government and development partners signed a Declaration on Harmonization and Alignment in 2004 (as an OECD/DAC pilot country), and further developed this in 2006 with a 5-year Action Plan on Harmonization, Alignment, and Results. Government's Action Plan for Harmonisation and Alignment<sup>3</sup> calls for:

- The development of sector plans and prioritized results based programmes and a sector medium term expenditure framework (MTEF);
- the preparation and implementation of a capacity development plan to fill identified capacity gaps (and donor support for Merit based Pay Initiative/Priority Mission Group MBPI/PMG) schemes as part of this);
- reducing the number of parallel Project Implementation /Management Units (PIU/PMUs);
- increases the proportion of development assistance delivered through sector/thematic programmes and other Program Based Approaches (PBAs).

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<sup>3</sup> [http://www.aidharmonization.org/download/256119/Cambodia-twg\\_updated\\_h-a-r\\_action\\_plan\\_eng.pdf](http://www.aidharmonization.org/download/256119/Cambodia-twg_updated_h-a-r_action_plan_eng.pdf)

- reducing the number of separate duplicative donor missions and diagnostic reviews and studies
- transparent and comprehensive reporting of information to CDC/CRDB on aid flows (including contributions to NGOs) in a timely fashion, to enable integration into budget cycle.

As part of this effort Government established Technical Working Groups in 18 sectors or technical areas. The **TWG for Health** (TWGH) built on an already-established Coordinating Committee. It meets monthly and brings together around 80 government, donor and civil society representatives under the chairmanship of the Minister of Health, co-chaired by a donor. Health partners and government also meet regularly to facilitate harmonization – in the case of the latter through the **Health Sector Steering Committee** made up of senior ministry officials

A sub-group of the TWGH, the TWGH Secretariat, meets monthly, and is also chaired by the Minister or his designate, and co-chaired by the lead donor (WHO). The Secretariat is coordinated by the MoH Department of International Cooperation which was established in 2007 to facilitate collaboration between MoH and development partners and acts as the Country Health Sector Team for the IHP. Although no compact has been signed – as in other International Health Partnership (IHP) countries – there is a Joint Partnership Arrangement (JPA), signed December 18th, 2008 (a formal agreement signed by the 7 HSSP2 partners and MoH).

The **International Health Partnership (IHP)**, launched in September 2007, aims to coordinate the efforts of donors, ensuring they fall behind national priorities and free the Ministry of Health to focus on its core business of providing better healthcare to Cambodians. Cambodia was one of the original signatories to the IHP Global Compact in September 2007. IHP seed money provided to Cambodia has been used to develop reports and action plans and an 18-month workplan for IHP-related activities has been developed. An IHP Core Group of 4 senior staff, drawn from among the MoH members of the TWGH Secretariat will take forward these activities.

**Key challenges** remaining include the need for improved predictability of aid, further strengthening national institutions in health such as those responsible for financial management

and procurement, and better aligning external aid to national priorities given the vertical nature of the funding provided by many of the major aid donors.

During 2009 the Government has also introduced a Joint Annual Plan Appraisal which is expected to better link annual plans with expected funding, both from Government and donors. (As part of this process donors were able to give some direction as to which of the Governments 68 priorities they favoured)

Nonetheless approaches to health systems strengthening remains extremely fragmented, with different approaches and levels of funding being adopted in different ODs.

### 3 GAVI HSS Support to Cambodia

#### 3.1 Introduction

Cambodia was amongst the first countries to apply for GAVI HSS funding. It was the only country to receive unqualified approval during the first round, although only one years funding was granted at that point as Cambodia was in the process of completing a successor to its Health Sector Strategic Plan 2003-7. A second proposal, largely based on the first proposal, and submitted in 2007 was rejected on the grounds that there was too little consultation with the NGO/civil society sector, too little evidence of impact from the first tranche of support and because the budget exceeded Cambodia's entitlement (given the Cambodia's GNP per capita figure had, during the intervening period exceeded the \$365 per capita threshold which reduced the per capital allocation from \$5 per new born to \$2.5). A third proposal submitted during the fifth round was subsequently approved.

#### 3.2 Broad Overview of the Proposals

Following the invitation by GAVI to develop a HSS proposal, the Ministry of Health convened a **Working Group for HSS** comprising representatives of the Department of Planning, National Immunization Program, Department of Finance, Ministry of Finance, WHO, UNICEF and PATH. The terms of reference of the working group were to oversee development of the proposal, conduct national and sub national consultations and communicate findings and final draft proposal to the MOH and to GAVI. The Working Group was chaired by the Deputy Director General for Health, with operational aspects of the proposal development being managed through the Department of Health Planning and Information (DHPI).

The proposal involved:

- The establishment of performance management agreements to increase coverage of a range of maternal and child health (MCH) services. The original intention was that this would cover the full MPA package. The programme also included a performance management agreement for a team of 5 ODs staff (paid \$80 each) and for one Provincial Health Department (PHD) staff member (the one responsible for the expanded programme on immunisation (EP)I) who would complement the Global Fund support to the PHD team to strengthen monitoring and supervision of ODs and health centres;

- communication strategies to increase utilisation through a village-based health information network to support accurate birth and death reporting and strengthening of Health Centre Management Committees and Village Health Support Groups;
- integrating immunisation by consolidating the effective fixed site strategy and through instituting Coverage Improvement Planning in areas of poor immunisation coverage.

The programme focused on 10 ODs – based on a range of criteria<sup>4</sup> - with 137 health centres covering a population of just under 2.2m; around 15% of the total population.

The initial plan was to scale up the approach to cover 20 ODs between 2008-10 but this was dropped as the allocation was reduced.

Cambodia received some \$1.8m through its first proposal (covering a period of 1 year). The proposal was submitted on November 3rd 2006 – formal approval was sent on March 1st 2007. The successful Phase 2 proposal for a further \$8.5m covering an 8 year period<sup>5</sup> was submitted to the GAVI Alliance Secretariat on March 7<sup>th</sup> 2008. Approval was recommended by the Independent Review Committee (IRC) on 25th April 2008. The GAVI Alliance and Fund Boards approved the HSS proposal on 26th June and formal approval was sent on August 14th 2008. The amounts and timeframe are shown in Table 2 below:

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<sup>4</sup> ODs were selected on the basis of: Immunization coverage levels, with preference to those ODs with lower coverage; MPA level staffing at health centres (or commitment to obtain); Referral Hospital (District Hospital) at CPA 2 level in order to provide emergency obstetric care and other key referral support for maternal and child health; Existing or planned Equity Funds to support referral services for poor people at Referral Hospitals; OD under direct management of Provincial Health Department (not contracted to third party); OD is in a PHD receiving GFATM HSS support

<sup>5</sup> Despite the IRC recommendation that an eight year proposal was not realistic since it felt envisaged activities and costs may change over time as well as priorities

**Table 2 Financial Flows under GAVI HSS in Cambodia**

YEAR	2007	2008	2009	2010	2011	2012	2013	2014	2015	TOTAL
Approvals \$m	1.85	0.34	1.51	1.46	1.23	1.12	1.03	0.94	0.84	
Grant	HSS1									1.85
Grant		HSS2	HSS2	HSS2	HSS2	HSS2	HSS2	HSS2	HSS2	8.47
Received in Country	\$1.85m 11/4	\$0.38m 20/7								
Expenditure	\$0.15m	\$1.38m								

A total of \$1,527,069 was spent in 2007 and 2008 leaving a balance of \$660,450.

Although significant in absolute terms, this represents a rather minor share of total aid flows for the sector in Cambodia which currently runs at over \$100m per annum (CRDB database). USAID, for instance, is currently spending around \$30m per annum in Cambodia and around \$20m per annum is being provided through the HSSP 2 pooled fund. The Global Fund disbursed over \$37m in 2008 and has disbursed a total of \$111m in Cambodia so far.

Table 3 below shows actual expenditure in 2008 and also the relative importance in financial terms of the different components.

**Table 3 GAVI HSS Expenditure by Component in 2008**

	Major Components	Expenditure by end 2008
<b>Objective 1 SERVICE DELIVERY</b>	Health Centre Service Delivery Contracts	597,914
	District Management Contracts	59,200
	Coverage Improvement Planning	192,971
	Demand Side Strategy	52,537
<b>Objective 2 SYSTEMS</b>	Finance Systems	5,953
	Planning Systems	43,393
	Supervision	
	Research	0
<b>Objective 3 Capacity Building</b>	Training workshops for middle level management (MLM) and OD staff in each 5	92,118
	Child Survival	12,579
	IMCI	212,688
	RMNCH Training and Quality Improvement (Co Financing Ausaid UNFPA)	0
	Private Sector	0
<b>Support Functions</b>	Project Management, M&E and Technical Support and Miscellaneous.	257,696
	<b>Total</b>	<b>1,527,049</b>

### Governance Arrangements

The approach is not, as set out in the GAVI principles, led by the Planning Department and managed through existing SWAp processes. Rather the approach is spearheaded by the Deputy Director General for Health who is also the EPI manager. A GAVI HSS working group comprising the National Immunisation Programme (NIP), DPHI, CDC and the Department for Budget and Finance (DBF) meets quarterly to assess progress. The **Technical Working Group for Health** receives information updates on progress with GAVI HSS but is not a forum for discussion of decision making. The recently established **Health Systems Strengthening Task Force** (one of four task forces established to support the JAPR process) is supposed to carry out

detailed reviews of the AoPs in addition to other activities. Whilst the MCH Task Force has been particularly active, the HSS Task Force covers a rather diverse range of areas and still has to get going but offers a promising forum for actively promoting and monitoring progress on HSS.

### **Technical Support**

MoH sought \$ 30,000 to prepare the GAVI HSS proposal but ultimately used only \$ 23,000. Further external consultancy support was not required as it was able to draw on support from in country partners such as WHO, PATH and UNICEF. As part of the programme, ongoing technical support is being provided by one full time project officer plus six weeks of international technical assistance. Whilst no specific requests were made for greater ongoing support it is fairly evident that the demands of supporting the programme are onerous and that the other partners have little capacity to provide significant ongoing support. This raises the question as to whether it might not make sense to provide funding to support programme implementation – as well as for project preparation.

## 4 Analysis of Progress against Key GAVI Principles

### 4.1 Country Driven

The approach seems to be clearly Government led. Although a consultant was used to do a large share of proposal drafting, it appears very evident that Government was giving clear direction on the content of the proposal. In contrast to many donor programmes in the country where donors suggest approaches and geographical areas to work, the selection criteria for the ODs covered were determined solely by Government. There are some question marks as to whether other country stakeholders such as civil society and NGOs played a sufficient role (see **section 3.5** below).

### 4.2 Alignment with National Plans and Systems

The current Health Strategic Plan (HSP 2) emphasises the need to improve access to a range of priority activities, amongst which immunisation is extremely prominent. A large share of GAVI HSS support has been allocated to activities which directly support increased access to the MPA package (although subsequent revisions have meant that the support is only focused on parts of the MPA package – although still those recognised as key priorities in HSP 2). This has to be viewed as a highly positive move against the overall context in which current donor support in Cambodia is very poorly aligned to national priorities (Lane 2007) and where the vast share of donor support goes to HIV/AIDS rather than the Minimum Package of Activities as a whole. The emphasis on supporting decentralised management systems is likely to be supportive of the yet to be defined, policy on decentralisation.

The approach is reasonably well aligned with Government systems. GAVI HSS uses a dedicated HSS account but uses financial management procedures developed as part of the HSSP 2 programme. Under HSSP 2 some planning and M&E functions have been handed over from the HSSP Secretariat to the Ministry – financial management and procurement are expected to follow. Thus by 2012 GAVI HSS should be much more closely aligned with Government systems through its links to HSSP2.

GAVI HSS is not aligned in terms of how it provides support for staff at PHD level as it does not use the national process which is in place to recruit staff under the MBPI scheme. The JAPR

process also places an additional burden on Government although the period covered by the JAPR (calendar year) is consistent with GAVI requirements. The use of compulsory GAVI indicators also causes a degree of misalignment with only 4 of the 6 indicators used representing core HSP 2 indicators (see M&E section).

The approach is reasonably well aligned with Government planning cycles. The decision to award only one year of funding during Round 1 was done with the explicit purpose of aligning GAVI support with the Government planning cycle. The subsequent approved 8- year HSS budget is fully consistent with the 2008-2015 planning cycle. GAVI activities are fully incorporated into the AoPs.

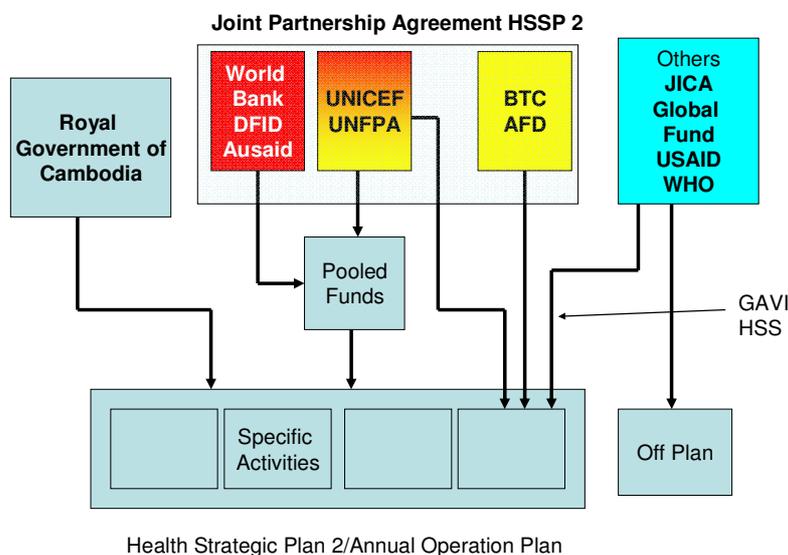
### 4.3 Harmonisation

Current aid arrangements are set out in the schematic below. There is no hard and fast rule as to who is actually a member of the SWIM (Sector wide Management) in Cambodia as all are invited to the TWG-H meetings. There are currently five donors providing pooled funding to Government through HSSP 2 – World Bank, DFID (UK), Ausaid (Australia), UNICEF and UNFPA<sup>6</sup>. BTC (Belgium) and AFD (France) provide discrete funding through HSSP to particular activities. The seven HSSP 2 donors have signed a (non-legally binding) Joint Partnership Agreement with Government setting out their mutual responsibilities. Other donors provide support for activities within the HSP 2 and this support is captured in the Annual Operational Plans<sup>7</sup>. Although much of the Global Fund and USAID funding goes to NGOs, the MoH is making increasing efforts to capture such spending in the Annual Operational Plan (through capturing the activities and expenditure of the implementing agencies). To all intents and purposes GAVI is currently a discrete donor providing support to HSP 2.

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<sup>6</sup> Some provide a mix of pooled and earmarked support. UNFPA and UNICEF, for example, provide some pooled funding and some discrete funding – reflecting their ongoing programmes commitments. It is envisaged that a larger share of their support will be channelled through the pool when new 5 year programmes are negotiated in coming years (although the fact that some of their support is not from their regular budget but is earmarked for particular activities means they will probably need to continue to use both routes. (Although not particularly relevant for the GAVI HSS evaluation this is another importance message for development partners – that the modalities they use for supporting multilaterals can serve to hamper harmonisation at the country level)

<sup>7</sup> Government is trying to capture all spending even that made for example by USAID and Global Funds which is channelled outside the Government system through NGOs but should be picked up in AoPs at OD and PHD level.

**Figure 1: Current Situation - Aid Modalities and Flows for Health in Cambodia**

Possible future options for GAVI to consider include:

- Signing the Joint Partnership Agreement
- Providing pooled funding through the HSSP 2 pool
- Dropping its Annual Progress Report (APR) requirement and relying instead on the Joint Annual Progress Report
- Participating (or delegating some of the above for a partner to do it on their behalf given workload of Secretariat staff) in key meetings. In order of priority these would include:
  - HSSP 2 mid term review – due in 2010
  - Joint Annual Performance Review (JAPR) and associated supervision missions
  - quarterly HSSP progress reviews<sup>8</sup>;
  - Joint Annual Plan Appraisal process

Whilst GAVI wants to remain a “lean and mean” organisation and there is no suggestion they should have in country presence it may be worth considering the case for having for increasing support for staff at regional level who, alongside Geneva based staff, could increase GAVI’s role

<sup>8</sup> These meetings are chaired by Government and involve pooling partner and serves as the principal forum for dialogue on all supervision issues relating to the use of pooled funds.

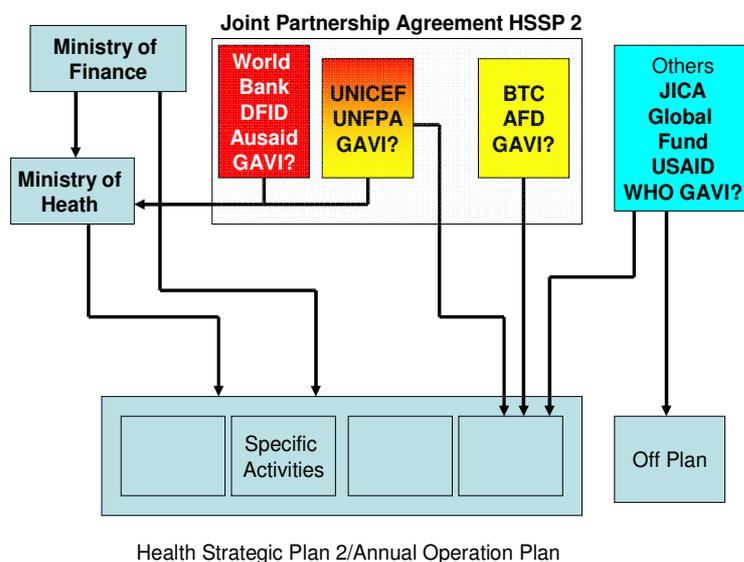
in dialogue at the country level.

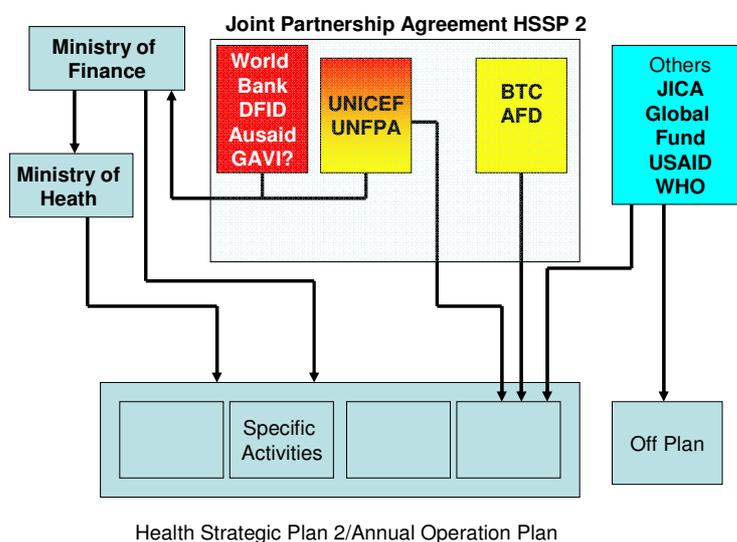
By the time of the 2012 evaluation, it is envisaged that the externally managed HSSP 2 pool will have disappeared with funds being channelled directly through the Ministry of Health. The questions for GAVI are whether it should aim to pool (the most harmonised approach), provide discrete funding but sign the JPA or continue providing discrete funds outside the JPA or even a combination of the two. A second question would relate to the role of the APR. Presumably it would not be needed if funds are pooled but may still be required under the other scenarios

**Figure 2: Future Option for Channelling GAVI Support in Cambodia**

**Options for Channelling of GAVI Funds - 2012**

Full alignment would imply that funds are pooled through the Ministry of Finance. This may be an option by 2015. GAVI would need to be clear it is confident with the fiduciary arrangements in place and of the effectiveness of mechanisms such as the JAPR to assess the value for money from its investments.



**Figure 3: Options for Channelling of GAVI Funds – a further option by 2015**

#### 4.4 Predictability of Funding

Predictability is now extremely high. Cambodia knows how much money it will get for the next 8 years (subject to the availability of funds by GAVI). Most of the uncertainty is pre approval – i.e. whether Cambodia will get the money rather than how much).

**Initial teething problems** resulted in late access to funds which delayed initial activities. It appears that GAVI transferred funds to MoH but not to the account that MoH expected. Other than that funding appears to have flowed smoothly.

**Uncertainty over funding decision:** Cambodia felt, rightly or wrongly that approval of the second proposal was, in effect, a given. Rejection may have reflected a degree of complacency on the part of Government and the development of more rigorous appraisal criteria by GAVI as it learned from its experience. Both are understandable, however, it does highlight the need for clear and consistent messages on approval criteria and reasons for rejection. Whilst, quite rightly, GAVI does not want to be prescriptive, sometimes Government actually want to be told “we will not fund X” or at least to have further guidance on their priorities.

**Impact of \$365 pc capita GNP threshold:** Of particular relevance here is the impact of the \$365 per capita threshold and the tension created between strict alignment with budget cycles and predictability in funding levels. Having only seen year one of a five year programme funded Cambodia submitted a similar proposal only to find the amount of the budget halved given its increasing GNP per capita level. Given the current fall out from the global financial crises and expected contraction in the Cambodian economy it may well be that the GAVI decision point was the only point in time at which per capita income actually exceeded \$365!

Having already agreed to run the approach in ten ODs, the service delivery components of the third proposal were protected, meaning that the central components of the programme – those arguably more related to broader HSS but also more subject to governance issues and where there are more challenges in measuring impact - were cut back. Thus although the rules of the game were clear beforehand, the unintended result was a distortion in the approach adopted. This raises the question as to whether or not some uncertainty might be removed by removing the possibility of transition above and below an arbitrary line which is in any case subject to much uncertainty. Alternatively, a more gradual approach might be warranted; does a country with pc GNP of \$366 really “need” only half as much as one with \$364. In short, the principle of a clear objective formula is well appreciated; however, it is recommended GAVI reconsider some of the design elements involved.

#### **4.5 Inclusive and Collaborative Processes**

GAVI preparation funds were used to make field visits and hold two regional consultative workshops (in the north west - Battambang - and south east - Kampong Cham) plus a national consultative workshop. Further consultations were conducted through a National Consultative Workshop as well as by the Immunization Coordination Sub Committee (ICSC) and Technical Working Group for Health (TWGH). In general those interviewed felt that efforts had been made to make the approach more inclusive whilst accepting that the tight timeframes in place made this extremely challenging. In part this was stimulated by feedback from the second proposal which required more NGO/civil society involvement. However, it is far from clear that the second proposal had any less civil society involvement than the first. Equally, it is far from clear that Government saw the benefits of carrying out a broader exercise or whether it just did it as a GAVI requirement and whether such approaches are now embedded in the system. Some respondents questioned how meaningful the consultation had been. In practice, they were often

given little notice or advance documents with which to prepare adequately. Biacabe reports that “community participation and social mobilisation, particularly through Health Centre Management Committees” had not been strengthened as planned.

#### 4.6 Catalytic Effects of GAVI HSS Funding

It is fairly clear that there is little consensus at least at the country level as to what is meant by catalytic. This review – taking it to mean that the GAVI support encourages others to do things they would not otherwise have done – considers that the support to have been catalytic in a number of respects:

- **Internal contracting:** Government has wanted to introduce internal contracting for a long period of time but, until GAVI funding became available, it had not had the opportunity to take it forward. The GAVI HSS funds gave Government a chance to pilot the approach and learn lessons from it which have been applied to subsequent efforts in this area. This was successfully carried out but in a fast changing policy environment it has now, in effect, been overtaken by events. The key question now is whether and how the GAVI HSS approach should be aligned with the HSSP 2 internal contracting model (which itself was built on lessons from the GAVI pilots. Should it adopt the HSSP 2 model including performance framework? Should the GAVI HSS ODs be passed on to HSSP when they reach Special Operating Agency (SOA) readiness and GAVI funds be redirected to other deserving ODs?).
- **Financial Management procedures:** The GAVI financial management procedures were also seen by the World Bank as part of this peer review process as providing an important starting point in setting up the financial procedures and manual for the proposed provincial block grant funding system. The decentralisation of GAVI HSS support to the Provincial banking system was also a forerunner of the service delivery grant system
- **Coordination of support at OD level:** GAVI was also instrumental in bringing in UNFPA (with AusAID funding) support to complement its HSS efforts. As a result UNFPA agreed, in July 2008, to provide additional support amounting to some \$3.7m to expand coverage to help develop a more comprehensive approach towards MCH and MDG 4. In practice, it has provided support to the Performance Based Agreement in nine ODs (as one of the GAVI ODs already received support from AFD as well as support activities in the AoPs of 5 ODs).

Three additional indicators have been added and providers are paid an additional \$1 for each new birth spacing user, \$1 for post natal care and \$0.25 for each current birth spacing user. This support began in the third quarter of 2008.

#### 4.7 Results-oriented Approach

GAVI HSS in Cambodia has adopted a rather extreme result based approach based on a fee for service approach, with providers paid according to the schedule set out in Box 1 (below). Although the initial proposal talked about providing capitation-based funding in support of the MPA package, in practice overall a third of GAVI funding is for specific components of the MPA package on a fee for service basis as set out in **Box 1** below.

##### **Box 2 GAVI HSS – Fee for Service Schedule**

OPD Consultation: \$ 0.50\* subsequently revised from any consultation to a consultation for a child aged <5)

ANC: \$1

Hepatitis B birth dose: \$1

DPT- Hep3 immunisation: \$1

Measles immunisation: \$1.

The key question here is although this is clearly a payment system favoured by Government it is not clear whether this approach strengthens the overall system or fragments it. In the case of Cambodia a whole series of Government and donor funded financial incentives are being used - the concern is that this involves large transactions costs and pulls health workers in different directions and away from important services which do not benefit from specific incentives.

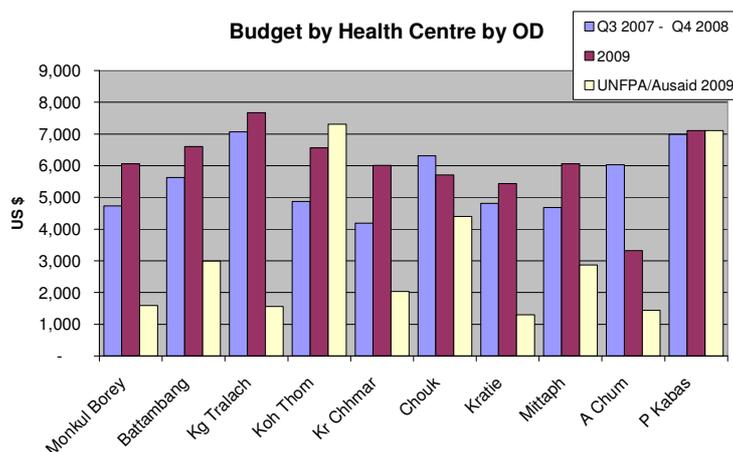
Following a rapid assessment and two workshops conducted in 2008, decisions were taken to change the OPD indicator to U5 rather than general consultations, to introduce a remote area allowance of \$30 per staff member in areas of low population density, (low consultation rates and where distances are high) and to harmonise the various approaches with the AoP process.

This decision was taken by Government apparently without GAVI approval and apparently with misgivings from a number of development partners. It is possible to look at the issue from two points of view. One is that this was a sensible prioritisation based on the limited availability of

resources. This being the case, the aim would be to focus on the more important elements of the MPA package with coverage scaled up as more funds might be available – a “prioritised, fragmented but coordinated approach”. There is some truth to this. GAVI funds were not huge - >\$1 per person per annum under the first proposals and half that for the second proposal compared to \$5-7 per head under external contracting.

The chart bellows shows that the performance contracts are typically worth up to \$7000 per facility. This equates to around \$0.5 per head which given that the external contracting experiments in Cambodia attracted support of almost 10 times this amount, must raise the question of whether or not it is sufficient to make a major difference?

**Chart 1**



However, against this, one could argue that if resources were short the approach could have focused on a smaller number of ODs to show that an integrated approach could work. In practice, the approach, as it stands, favours the delivery of some services over others with little justification as to why certain services were chosen. If heavy emphasis is to be placed on FFS approaches it will be important to focus attention on:

- The choice of indicators – and the need for a possible balance between quantitative and qualitative indicators;
- the need to ensure data quality. The Biacabe report found evidence of late data entry as well as suspicious patterns in the data;
- the need to set appropriate targets – high enough to be challenging without being

demoralising and based on quality underlying data (e.g. including the denominators for the target group). There is a need for flexibility. Staff in low performing HCs felt the PHD staff had set targets too high. Mobility of patients is also an issue and they may attend facilities outside their immediate catchment area, especially if quality is perceived to be good.

- the need for balance – i.e. to ensure that important services e.g. nutrition which do not receive funding are not neglected;
- the use of HSS indicators as far as possible.

Government plans to review the approach in 2009 with a view to possibly returning to a capitation/MPA wide package approach.

#### **4.8 Sustainability**

It is worth pointing out that sustainability is the only principle which is out of the control of GAVI and the Ministry of Health. Much of the support will have significant ongoing recurrent implications. This being the case sustainability will depend upon a number of factors including the identification of secure funding sources. The fact that GAVI funding is incorporated into the Annual Operational Plan suggests that it has become a feature of the system and identified as such as a valid case for support (under the “No AoP, no budget” mantra). Ultimately financial sustainability will depend heavily on Cambodia's future economic and fiscal prospects as well as likely flows from development agencies. The strong Government ownership would tend to suggest a fair likelihood that such programmes might enjoy priority calls over limited public resources and that expanding the programme might even be a priority use of additional funds. The presence of donor co-financing (the Ausaid commitment is for at least 2 years) and the increasing government contributions to health care costs (including for traditional vaccines) provide some grounds for confidence though no guarantees of future sustainability. There is also a possibility (albeit an extremely slim one) that GAVI itself might not have funds available to meet its commitments during the programme itself.

A key question, however, is whether simply buying outputs does anything to develop the long term capacity of the system to deliver sustainable benefits. A key concern is that the fee for service approach might develop important, but ultimately superficial and non sustainable, benefits. Continued tracking of outputs will be necessary to address this. A tail off in any

increases by the time of the 2012 evaluation might be evidence of this.

#### 4.9 Monitoring

APR preparation is led by the National Immunisation Programme with inputs from the Department of Budget and Financing and Department of Planning and Health Information. Data was derived from the health information system, financial statements from DBF, from contracts signed between PHDs and ODs, feedback from mid year and annual reviews and from the interim report of the independent evaluation. The draft APR was presented at the ICC/ICSC on May 5<sup>th</sup>, the TWG-H on 7<sup>th</sup> May and approved by the Health Sector Steering Committee on 11<sup>th</sup> May. As this fell in the holiday season it was not possible to get the necessary signatures in time to meet the 15<sup>th</sup> May deadline. The APR provides a lot of data (proposed budget and activities for 2009 and 2010, detailed data on progress in the 10 GAVI HSS supported ODs) which although useful, goes well beyond that strictly required by GAVI. It would be helpful if GAVI could respond to this clarifying that that whilst it represents good practice, the MoH is welcome, but not obliged, to provide such information in future.

The GAVI monitoring indicators are by and large taken from national systems. HSP 2 includes a total **27 core indicators**, which are assessed through the Joint Annual Performance Review. For annual operational plan monitoring there are **additional 69 indicators** for sub-sectoral monitoring.

Government is compelled to use three GAVI HSS outcome indicators; DPT3 coverage, % of districts achieving > 80% coverage and U5MR. Of these the U5MR is one of nine key outcome indicators set out in HSP 2. DPT3 coverage is an additional, but not a core indicator whilst there is no reference in HSP 2 to equity in coverage. Cambodia has drawn 3 further indicators from its core JAPR list (which, as can be seen, does include a number of HSS related indicators.

**27 Core Indicators - JAPR**

- C1. % of population with access to full MPA
- C2. Bed Occupancy Rate
- C3. Average Length of Stay
- C4. % of essential drugs (15 items listed) at health centres that faced stock-outs
- C5. % client satisfied with quality of public services
- C6. Consultations (new cases) per person per year:
- C7. % of currently married women using modern contraceptive method
- C8. **2 or more ANC health personnel consultation**
- C9. % of HIV+ pregnant women receiving ART for PMTCT
- C10. **% births delivery by trained health personnel**
- C11. % of deliveries by C-section
- C12. **% of children under one year immunized against measles**
- C13. % PLHAs on ART alive after a 12-month treatment.
- C14. Case detection rate of smear (+) pulmonary TB (%)
- C15. TB cure rate (%)
- C16. # of malaria cases treated at public health facilities per 1,000 pop
- C17. Dengue hemorrhagic fever case fatality rate
- C18. Incidence of diabetes reported from public health facilities
- C19. Incidence of cervical cancer reported from public health facilities
- C20. Percentage of population with head trauma due to road traffic accident received treatment
- C21. # of mental health cases reported in public sector
- C22. Share of provincial budget spent on PHDO, ODO, RH, HC
- C23. # cases covered by SHP schemes
- C24. # of HC with staffing level recommended by MPA Guidelines
- C25. % external funds for health included in 3YRP
- C26. % of private entities licensed: policlinics, consultation cabinets, pharmacies
- C27. # of functioning Health Center Management Committee

In broad terms, the APR reported significant progress in terms of immunisation coverage in most areas with 321,000 children received DPT3 vaccinations, the highest ever, an 11% increase in measles coverage and a 9% increase in DPT Hep B coverage. Of particular interest are the findings that::

- The proportion of children vaccinated at health facilities (rather than through more vertical outreach programmes) has increased from 21% to 41% at trial sites;
- that five of the GAVI HSS supported districts achieved >80% DPT3 coverage compared to none in 2006 reflecting a degree of catch up.

The APR reported more effective delivery of funds to primary health care level but provided no evidence to this effect. The external audit of GAVI HSS funds has been delayed and is expected shortly.

The use of indicators does raise a number of questions. Firstly, it is not clear why national figures are used when most of the resources are focused in ten ODs (In practice, the 2009 APR provides considerable detail on progress in the ten ODs – over and above what was agreed in the proposal). Secondly, the use of targets for 2015 without the use of intermediate targets makes it difficult to assess whether progress is on track. It is not clear whether linear progress might be expected or that progress might accelerate once capacity is built up. Thirdly, there is no use of HSS indicators. Concerns were also expressed that health system indicators were too complicated, such as full MPA and 24 hour opening and had no baselines. The Ministry is giving further attention to these areas and whilst they may not be perfect it would be strange not to use HSS indicators to assess progress in an HSS programme. There are concerns that the data is only providing a partial picture. Drop out rates are a concern and although rates appeared to have dropped there is a concern that FFS may create incentives for single attendance and not necessary completion of a full course suggesting a possible case for adjusting the payments criteria to pay only for full courses. Work by JICA in Kroach Chmar OD for example found significant drop out rates between first and subsequent ANC and PNC visits. Equally although the number of ANC attendance rose shortly the number of attendances in the first trimester remained lower. Increased emphasis will also need to be placed on the quality of the data (the APR reports that only “very few” ODs have conducted spot checks on data quality). Finally, as recommended in the independent review, there is an over emphasis on quantitative indicators given ongoing concerns about service quality

#### **4.10 Overview of results/assessment of progress**

Cambodia and its development partners are to be commended on its efforts to assess progress whether through stakeholder meetings or through external reviews. Of particular note are the

UNFPA and GAVI funded independent reviews carried out by Dr Sophie Biacabe and a JICA funded review

Progress against outputs is described in the 2009 APR submitted on June 2<sup>nd</sup> 2009. Key extracts are at **Annex 7**. Overall the APR provides a detailed overview of progress against outputs<sup>9</sup>. For the more upstream activities this gives little indication of likely results (i.e. it shows the training took place but gives little idea of how the training is likely to change behaviour).

### Key Findings from Independent Evaluation

The Biacabe report - based on field visits to 16 health centres in the first quarter of 2009 found **“excellent quantitative performance in the area of Reproductive, Maternal and Child Health”**. With hepatitis B immunisation at birth, DPT-HepB3 and measles immunisation targets were reached or surpassed in most ODs. It also found that:

- Utilisation of services, for both adults and children under 5 years had increased in all sites;
- Ante Natal Care coverage increased dramatically: performance targets were exceeded for Ante Natal Care in all ODs. Increase in deliveries at health facility and Post Natal Care in most sites.

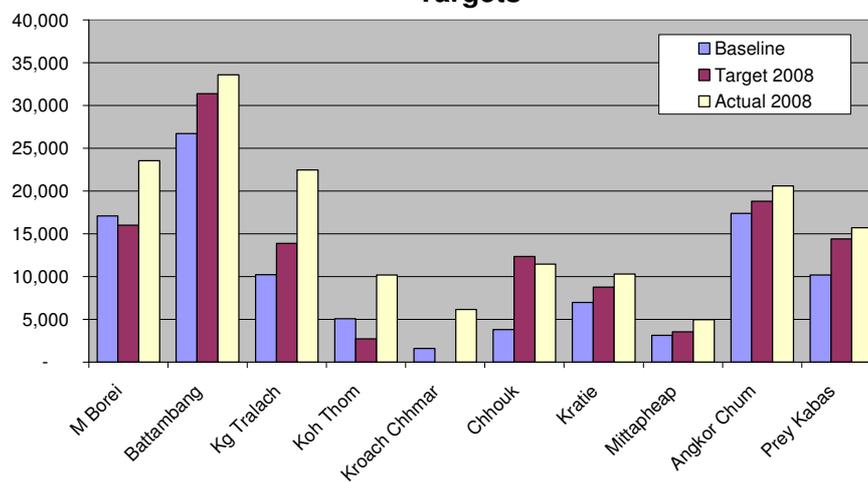
The following tables show overall results for the key services and progress across ODs for a selected intervention – ante natal care visits

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<sup>9</sup> The APR does not attempt to assess the % achievement as requested by GAVI – our view is that this is reasonable

**Table 4: Performance against Targets and Baseline in Selected HCs**

	Baseline	Target 2008	Actual 2008
Consultation	914440	n/a	978643
ANC	102111	n/a	158852
HepB birth dose	16387	26426	27185
Measles	40464	44126	43881
DTP HepB3	42706	45070	45484
BS New case	14501	n/a	17002
Total BS	268279	n/a	271017
PNC	22721	n/a	34603

**Chart 2****ANC Cases: Performance against Baseline and Targets**

The report did find that progress against birth-spacing targets, especially for new acceptors, was rather disappointing with only four ODs able to perform as expected. It will also be important to track coverage of important services not covered under the present arrangements e.g. nutrition. There is little evidence that utilisation of such services actually declined but it is a concern.

The review found a generally high level of satisfaction in terms of availability of services, quality and cost. However, there were concerns about quality of services notably in terms of hygiene and clinical skilled which fell below MoH standards in 2/3 of the facilities visited.

However it found that the approach has done little to improve the continuum of care. Referral systems do not work well and need to be strengthened. Financial accessibility is also a major concern as most health centres covered do not have a Health Equity Fund. Technical capacity building in IMCI, EPI and BS was provided and though the results were reasonable, the lack of skilled staff – particularly secondary midwives – remained a pressing concern. The number of supervision visits was found to have increased but the quality of the supervision was questionable with a continuing focus on administrative box ticking and reporting rather than the provision of clinical skills. Planning and financial management capacity of OD managers and, to a lesser degree health centre staff, was thought to have improved through training provided by DPHI and DBF.

Data quality audits have tended to suggest data quality in Cambodia is quite high. Whilst this might be the case there are still shortcomings. The FFS focus of the approach is likely to present further challenges by creating strong financial incentives to inflate figures. Proposed measures for spot checks do not yet appear to have been instituted.

There was very little change in management practices at the field level in spite of the efforts of the HSS management team. Comprehensive interdepartmental management had not been instituted and the approach remain vertical and largely project based – reinforced in part by the FFS emphasis of the approach.

Although the GAVI HSS clearly supplements health worker salaries, it was still felt that whilst the approach was necessary it was still not sufficient to provide health workers with a living wage which would mean they no longer had to resort to rent seeking activities to supplement

their incomes.

The review found it far from clear that GAVI HSS was working on general Health System strengthening. The NIP is seen as the leader in managing what is still considered as a vertical programme. The UNFPA/AusAid support to RMCH continuum of care is often seen as a complementary, but largely, separate intervention and the link between child and maternal health has not yet become a reality at the peripheral level. In many ways this is perhaps inevitable and is an outcome of years of donor practice which has encouraged such approaches

### **Box 3 Key Findings from OD visits: National Consultant**

#### *MPA Planning, Supervision and Financial Management System Development*

GAVI support has contributed significantly to improving Annual Operational Plan development, implementation, management and reporting by using the MoH system and structure due to the fact that health centers have enough budget and clear outputs. GAVI support also revitalizes and strengthens monitoring and supervision systems such as quarterly target reviews and spot checks even though these approaches were not fully implemented. Data quality was still a challenge and integrated monitoring visits from central departments were irregular and few. However, the Performance-Based Management Agreement sharply improved quality of HC planning and reporting, and data quality improvement required active participation from all levels.

#### *MPA Capacity Building*

Health centers staff responded that they had received skill-based training and coaching leading to improve their performances. In addition, the training was delivered through MOH systems and curricula. The training topics are about immunization, maternal and child health, TB and planning.

#### *Implementation of Health Service Delivery Strategy Based On Priorities Identified In Local Area Health Center Plan*

Health service delivery outputs at health center level were significantly improved in many areas including the improvement of staff attitude, working hours, lateness, client follow-up, and outreach to villages where health center service utilization is low. Service delivery-based incentives was seen as the best approach to delivery a quality MPA package if monitoring and

supervision also focused on quality of services. All health center staff did not think about capitation; while explaining capitation, health center staff expressed concerned that population coverage from national estimations was always higher than local statistics, especially for children. Furthermore, more than half of the health center staff interviewed said that they were happy with the current level of incentives and that it could be replaced by health center financing and government salary increases or other NGOs support in the future. However, health center staff also asked for support to other bottleneck barriers such as transportation for service providers (motorbikes) and transportation cost for clients, health center building/renovation and community volunteer support. In particular, the majority of the health centers visited had a low level of community participation including Village Health Support Group. This needs to be strengthened especially when Special Operating Agency was implementing. Both provincial health departments asked GAVI support or GAVI approach like to scale up to more ODs within the provinces.

### **Progress in reducing inequality**

Given that the better off tend to have better immunisation coverage and the fact that support is focused in worse performing and poorer ODs, support is likely to be focused on the least well off groups (though this has yet to be verified). Remote area allowances of \$30 per staff member (agreed by OD) are likely to benefit harder to reach areas which will presumably also disproportionately benefit poorer groups. At the same time the disappointing rate of scale up of health equity funds which address a key barrier to access may undermine to a degree, progress in improving equitable access. Use fees continue to be charged for basic health services. In the ODs visited by Biacabe only one OD provided delivery free of charge. Only one HC had a functional HEF.

GAVI support may be too small to have much of an effect. GAVI HSS ODs receive much less support than ODs in other areas. The average additional income for a staff member from the GAVI HSS FFS payments was \$50 per head but varied from \$25 to \$80. This, in turn is different from the incentives paid as part of other performance based incentive schemes – much higher than those paid by BTC and HSSP in Takeo (\$27-28) but much lower than those paid by HSSP in Kampong Cham (\$75).

Wide income differences also remain between different health centres within GAVI HSS ODs. Key

factors include population density, remoteness and number of staff in the health centre team.

#### **4.11 The Counterfactual and Additionality**

It appears likely that GAVI support was additional as few, if any, other donors would have been able to take on the activities supported through GAVI HSS.

## Annex 1 Summary of Methodology

In February 2009, HLSP Ltd was awarded the contract to undertake the 2009 GAVI Health Systems Strengthening Support (HSSS) Evaluation.

There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

The GAVI HSS evaluation will develop **five In-depth country case studies**. These are structured in such a way that independent consultants teamed with local consultants will spend time in countries documenting country experiences. We anticipate up to two visits to each in-depth country between the period of May and June 2009 will be undertaken. The first visit will focus largely on interviewing key country stakeholders to map key areas of interest, information and to gather initial data. This visit may also include engaging / commissioning a local research institution to conduct further research into particular districts/ activities. During the second visit, we anticipate any outstanding stakeholder interviews being conducted, and the data collated and subsequently presented to all key stakeholders. We will explore with national stakeholders the opportunity and appropriateness of conducting an end-of-mission 'validation workshop' to provide countries with feedback on the in-depth case studies, and seek validation/confirmation of their findings and conclusions

Specific issues to be addressed as part of the country case studies include the following:

## Priority Questions for the Evaluation

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)?
- If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the “right” bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed?
- Do they measure the right things?
- Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes?
- How realistic is it to try and attribute improved outputs and outcomes to GAVI support?
- What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?

Qualitative and quantitative information will be collected and analyzed, both retrospectively as well as prospectively. Typically the period covered will be from the time the GAVI HSS application process commenced in country, then through the implementation process and it will also cover the monitoring and evaluation of the project to date.

In addition, the five in-depth case studies will be **complemented by the addition of on-going GAVI HSS Tracking Studies** currently being conducted by the JSI-InDevelop-IPM research group in a further six countries. Additional data collection will be undertaken by the HSSS Evaluation to bring these studies to the same point as the five in-depth case studies. Finally, the HSSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to **develop a database of HSS countries**.

All these sources of information put together will aim to answer the five study questions outlined above.

## **Annex 2 List of Documents Reviewed**

Assessment of Performance Based Block Grant to Health Centres Documentation of Lessons Learnt Cambodia March 2009 Dr Sophie Biacabe

CRDB Database

Annual Progress Report 2008 and 2009 (MoH)

Performance-Based Financing of Maternal and Child Health Services: Financial and Behavioural Impacts at the Field Level in Kompong Cham Province: A Brief Review Paper (Second Draft) February 2009, Phnom Penh, Kingdom Of Cambodia

JICA Project for Improving Maternal and Child Health Services in Rural Areas In Cambodia Health Strategic Plan 2 MOH

Report No: 42249-Kh Program Appraisal Document on a Proposed Credit in the Amount of SDR18.5 Million (Us\$30.0 Million Equivalent) to the Kingdom Of Cambodia for a Second Health Sector Support Program, May 27, 2008

### Annex 3 List of People Consulted

Shoko Sato - JICA

Diane Northway – HLSP (Financial Management Project)

Andrew Cornish - Ausaid

John Grundy – Independent Consultant

Professor Sann Chan Soeung – Deputy Director General, Head of EPI, MoH

Dr Chea Sokhim – EPI Programme

Myo Min and Kout Thavary – Department of Budget and Finance, MoH

Toomas Palu – World Bank

Veng Ky – HSSP 2 Project

Alice Livesay - UNFPA

Jean Marion Aitken and Lizzie Smith (by phone) - DFID

Paul Weelen and Ben Lane

Medicam – Sin Sumony - WHO

Dr Mondol Dr Kiry – Department of Planning and Health Information, MoH

Viorica Berdaga and colleagues– UNICEF

Kate Crawford and colleagues - USAID

People consulted during field visit by national consultant:

NO	NAME	TITLE	INSTITUTION
<b>1. Kampong Cham Province-May 24-26, 2009</b>			
1	Dr. Gnoun Sim An	Director of Provincial Health Department	Kampong Cham Health Department
2	Dr. Taing Bunsreng	PMTCT Focal Point and MCH/PEV Assistant	Kampong Cham Health Department
3	Dr. Ma Sokhorn	Vice Chief of Operational District in Charge of Health Centers	Kroch Chmar Operational District
4	Mr. Soeung Sinat	Chief of Health Center	Peus Pii Health Center
5	Mr. Mark Sophear	Staff In Charge of PEV	Peus Pii Health Center
6	Mr, Veng Heang	Chief of Health Center	Chum Nik Health Center

7	Mrs. Leang Sokha	Staff In Charge of MCH	Chum Nik Health Center
8	Mr. Tolors Rovy	Staff In Charge of PEV	Chum Nik Health Center
9	Mrs. Khat Borin	Chief of Health Center	Arak Thnaot Health Center
<b>2. Bantey Meanchey Province- May 31-June 2, 2009</b>			
10	Dr. Chhum Vannarith	Provincial Health Director	Bantey Meanchey Health Department
11	Dr. Tes Simon	Chief of Operational District	Mongkul Borei Operational District
12	Mr. Pol Sarom	Vice Chief of Health Center	Russey Krok I Health Center
13	Mr. Norng Sitha	Staff In Charge of Consultation	Russey Krok I Health Center
14	Mr. An In	Staff In Charge of PEV	Russey Krok I Health Center
15	Mr. Phan Bunny	Chief of Health Center	Seur Health Center
16	Mrs. Pov Sotheary	Staff In Charge of MCH	Seur Health Center
17	Mr. Phal Ly	Staff In Charge of PEV	Seur Health Center
18	Mr. Kragh Udom	Chief of Health Center	Phnom Touch Health Center
19	Mrs. Chhourn Kim Sourn	Staff In Charge of Pharmacy and PMTCT	Phnom Touch Health Center
20	Mr. Chhim Kosal	Staff In Charge of PEV	Phnom Touch Health Center

## **Annex 4 Agenda for Feedback Meeting**

### **AGENDA**

GAVI HSS Feedback Meeting, 2:30 PM at DBF, MOH

YYYYYYYYYYYYYYYYYYYY

GAVI-HSS

Welcomes and introduction by Prof. Sann Chan Soeung, Deputy Director General for Health and GAVI-HSS Manager

HLSP Ltd Presentation of preliminary findings by Mark Pearson, Consultant from HLSP Ltd.

Discussion

HLSP Ltd. Wrap-up by Mark Pearson

Close the meeting

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## Annex 5 Overview of Health Reform Efforts

Health sector reform processes were initiated in 1996. The Health Coverage Plan mapped out a systems focusing on the Operational District (covering a population of around 100000) based on a network of primary health care centres staffed by nurses and midwives covering a population of around 10,000 complemented by secondary level referral hospitals. The first Health Sector Strategic Plan 2003-2007 has recently been followed by a second Health Strategic Plan 2008-15 which allows for an initial consolidation period to take stock of the various initiatives currently in place. The key strategic priorities of HSP are shown in **Box 4** below

### Box 4 Key Strategic Priorities – Health Strategic Plan 2 – 2008-2015

#### **Population health problems and essential services: (1) Reduce maternal, new born and child morbidity and mortality with increase reproductive health**

To improve the nutritional status of women and children

To improve access to quality reproductive health information and services

To improve access to essential maternal and newborn health services and better family care practices

To ensure universal access to essential child health services and better family care practices

#### **(2) Reduce morbidity and mortality of HIV/AIDS, Malaria, TB, and other communicable diseases**

To reduce the HIV prevalence rate

To increase survival of People Living with HIV/AIDS

To achieve a high Case Detection Rate and to maintain a high Cure Rate for pulmonary TB smear positive cases.

To reduce malaria related mortality and morbidity rate among the general population

To reduce burden of other communicable diseases

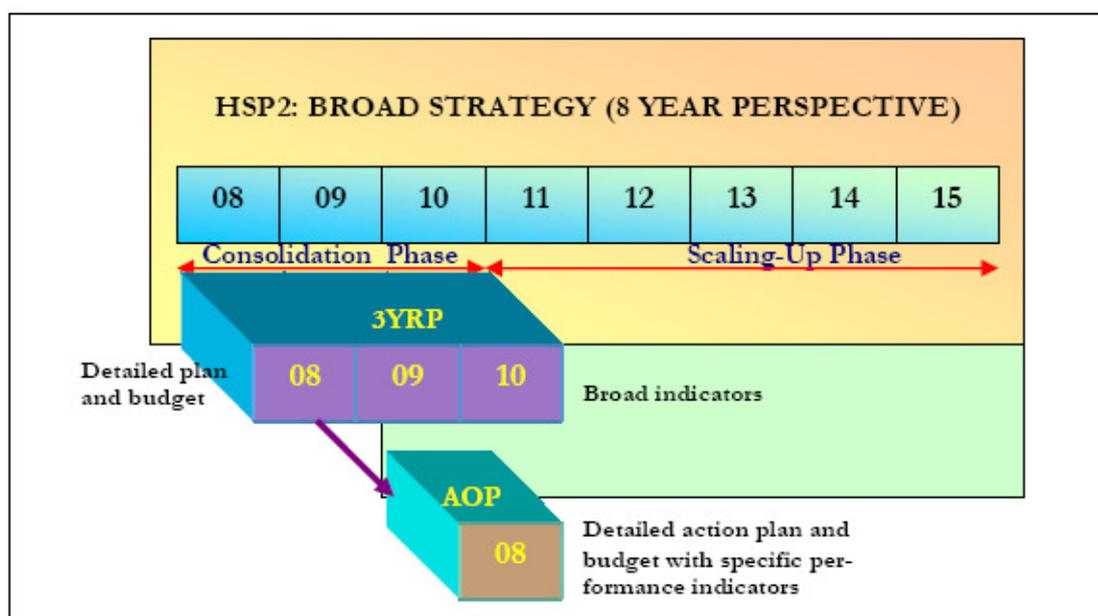
#### **(3) Reduce the burden of non-communicable diseases and other health problems**

##### **Objectives**

To reduce risk behaviours leading to non-communicable diseases (KAP): diabetes, cardiovascular diseases, cancer, mental health, substance abuse, accidents and injuries, eye care, oral health , etc

2. To improve access to treatment and rehabilitation for NCD: diabetes, cardiovascular diseases, cancer, mental health, substance abuse, accidents and injuries, eye care, oral health, etc
3. To ensure Essential Public Health Functions: environmental health:, food safety, disaster management and preparedness

The schematic below shows how the various planning processes combine.



### Shift to from external to internal contracting

Over the last decade Cambodia has relied heavily on a contracting model for the delivery of health services. In recent years this has involved contracting with international NGOs under the ADB and WB supported HSSP 1 project to manage Government health services in 11 Operational Districts in 2008. The contracts and financing of these NGOs are linked to their achieving defined performance targets. This model has worked relatively well and has achieved significant benefits especially in remote areas where capacity is limited. However the MOH's policy in line with RGC's Service Delivery Policy (May 2006), is to gradually increase reliance on its own internal capacity to manage health services. Under such arrangements Special Operating Agencies meeting certain technical and managerial readiness criteria will be given a degree of autonomy to deliver services as they set fit Operational guidelines and mechanisms that will ensure accountability and secure resources – effectively PHDs will commission services

from SOAs on the basis of contracts. As part of HSSP 2 Service Delivery Grants - based on a resource allocation formula that takes into account population as well as other factors - will channel incremental funds to the district and health centre levels for the purpose of scaling-up delivery of an integrated package of essential preventive and curative care. This process is expected to strengthen Government systems for financing and managing service delivery at the sub-national level. Implementation of SDGs and internal contracting will be phased starting in selected provinces and ODs with previous NGO contracting arrangements. In provinces and operational districts where capacity constraints do not allow to transit from NGO contracting to internal contracting, transitional arrangements (to December 2009) have been agreed with the Government to continue to engage currently contracted NGOs to ensure continuity of service.

### **Development of AoP processes**

Government is continuing to develop and refine its approach to the Annual Operating Plan. This is ultimately intended to be the single plan and budget upon which decisions about priorities and the allocation of resources can be based. AOPs will include resources from several sources, including Government budget, DP and NGO resources, as well as user fees.

### **Decentralisation**

There is considerable uncertainty about what form decentralisation will take once it is implemented following the forthcoming elections. It seems highly likely that funds will flow into provincial baskets as it is far from clear that there will be any earmarking of resources to specific sectors such as health. This being the case it is far from clear, which, if any scope the Ministry might have to influence resource allocations decisions other than through the development of tools and guidelines.

### **Human resource development – MPBI**

The MBPI scheme - approved through Government sub-decree No 29, April 2008 - is a Government led performance-based employment incentives programme which attempts to address the low salary and performance within the public sector. Its aim is to improve governance in priority ministries and reduce corruption risk through ensuring better salary structures and meritocratic civil service management principles. The approach is focused on back office staff i.e. those without direct service delivery roles and is intended to be awarded on merit on the basis of demonstrated capability and commitment based on performance evaluations. MoH is a lead sector – the Department of Budget and Finance is currently in the process of identifying who will benefit from this scheme. A number of donors have signed up to an agreement to abide by MPBI principles – in the case of the Global Fund where salary

supplements are most out of line with MPBI rates the transition will take place over a couple of years

**MPA as essential package**

The aim is to increasingly ensure resource are put to priority uses as set out in the Minimum Package of Activities – a range of cost effective services than are to be provided at lower level facilities and should provide the basis for performance contracts

## Annex 6 Other approaches aimed at strengthening health systems

The GAVI HSS proposal has been designed to complement and build upon major initiatives now under implementation. These include the GFATM Health Systems project support to the Department of Planning and Health Information and selected Provincial Health Departments, as well as HSSP supported OD Contracting and Equity Funds.

The Global Fund project focuses on supporting capacities strengthening for the integrated planning, monitoring and evaluation cycle at the Provincial and Central Levels. Districts selected for GAVI support will be in GFATM supported provinces. Synergies between projects will be strengthened through integrated monitoring and supervision for both projects carried out by teams from PHDs, as well as through management training at the central level designed to support MPA Management Training Module for ODs and HCs. The GFATM project includes long term Technical Assistance for health planning, to be provided through WHO. This TA will also be called upon to support coordination of GFATM and GAVI project activities and provide support as required by DPHI at relevant levels.

### HSSP 2 – Key Components

- (a) **Strengthening Health Service Delivery** through (i) the provision of Service Delivery Grants and contracting for health services at provincial level and below; and (ii) strengthening health services management supervision and public health functions at provincial and district level; and (iii) investments for the improvement, replacement, and extension of the health service delivery network.
- (b) **Improving Health Financing** which will support (a) health protection for the poor through the consolidation of health equity funds under common management and oversight arrangements and expansion of health equity fund coverage; and (ii) supporting the development of health financing policies and institutional reforms.
- (c) **Strengthening Human Resources** will focus on (i) strengthening pre- and in-service training and supporting enrolment where shortfalls exist; (ii) strengthening human resource management in the Ministry of Health; and (iii) support the Merit Based Performance Incentive scheme for health managers and key technical staff participating in the implementation of the HSP2 at central and provincial level.

**(d) Strengthening Health System Stewardship Functions** by supporting (i) development of policy packages identified, strengthening the institutional capacity (in particular meeting the demands from Decentralization and Deconcentration); (ii) private sector regulation and partnerships; (iii) supporting governance and stewardship functions of the national programs and centres overseeing the three HSP2 strategic programs; and (iv) strengthening community participation.

The Health Sector Support project (HSSP) provides support at all levels of the health system, however it is at the OD level where its OD Contracting support has been achieving some of the most important results. Thus far MoH has signed performance contracts for external management of 11 Operational Districts. The GAVI HSS MPA Performance Agreements refine the contracting concept by focusing on capitation based payment for delivery of a specific package of services. Through their introduction in non-contracting districts, the GAVI HSS MPA Performance Agreements will significantly increase the number of facilities and clients benefiting from this type of arrangement.

Equity Funds have been another important and innovative Cambodian contribution to health systems strengthening. Working within the context of the user fee system with exemptions for the poor, the EF's provide payment to facilities for services that would otherwise be subject to user fee exemptions. In doing so they protect access of the poor to health services while at the same time providing demand based incentives to facilities. EF's focus on services at Referral Hospitals and as such provide an important complement to the GAVI HSS Health Center support, in particular with regards to the HC referral function. The GAVI HSS OD's will therefore be selected to ensure an overlap with HSSP funded EF Districts, although non EF OD's will also be included.

The Global Fund (Round 5) HSS proposal focuses on the development of integrated planning, monitoring and evaluation at Provincial and Central levels. The GAVI HSS programme is located in provinces receiving Global Fund support with a view to achieving synergies

#### **Global Fund – Round 5 Health System Strengthening proposal**

- Strengthen and develop Sector Wide Management (SWiM) through harmonization of GFATM supported programs, other National Programs, and Health Partners' activities, through alignment of these with the Health Sector Strategic Plan 2003-2007(HSP) and the National Strategic Development Plan.

- Strengthen the implementation of the Ministry of Health's existing operational planning, monitoring and evaluation processes and mechanisms at the central, provincial and district levels.
- Strengthen technical planning capacities for managers at central, provincial and district levels, including consolidation and development of analysis and program budget preparation skills.
- Strengthen the MoH process for forecasting and assessing the needs for drugs, vaccines and medical supplies
- Strengthening the procurement process to ensure the timely provision of the required quantities of drugs, vaccines and medical supplies to all health service providers which meet agreed quality standards
- Procurement of drugs, vaccines and medical supplies.
- Strengthen the storage and distribution functions of the MoH to ensure the timely distribution of the correct quantities of drugs, vaccines and medical supplies to service delivery points.

**USAID Health Systems Strengthening in Cambodia (HSSC).** The objective is to strengthen the capacity of the Ministry of Health (MOH) in Cambodia to plan, manage, and implement programs addressing HIV/AIDs, tuberculosis, and family health in seven provinces. The approach remains extremely fragmented

#### **Fragmentation of Donor Support**

Amongst the 76 operational districts (ODs) in Cambodia, 28 ODs (36%) receive health staff incentives for MCH services through the RBF scheme financed by different funding sources. Eleven receive the incentives through the RBF supported by NGOs operating under the Contracting, 10 through the one funded by the health system strengthening (HSS) support of the Global Alliance for Vaccine and Immunization (GAVI) and seven through the ones supported by bilateral donors operating under the contracting. In 18 ODs, the direct budget transfer in line with the HSSP-II is conducted by the United Nations Population Fund (UNFPA), although this fund transfer is not operating in the form of the PBF. In Kompong Cham Province, including the Ministry of Health (MOH) disbursement for facility-based deliveries, all ODs applied any form(s) of PBF targeting MCH, which were classified into six distinct prototypes. Source: JICA study

Table 1 below shows the different approaches to incentives for different services within ODs

Table 1: Summary of the different MCH related PBF schemes applied in 10 ODs in Kompong Cham as per February 2009

ODs	Partner(s)	Targeted MCH services					Scheme descriptions
		ANC	Delivery	PNC	EPI	BS	
Kompong Cham	MOH	×	○	×	×	×	MOH disburses US\$15 per health centre delivery.
Chamkar Leu	BTC	○	○	○	○	○	Quantity of these services and other HC performances (e.g. staff friendliness) are scored. BTC disburses 1,200,000 riels (US\$292)/HC/month X (actual score/full score).
	RHAC	○	○	○	×	×	RHAC disburses US\$7 plus transportation costs for delivery if mothers complete 4 ANC, delivery at HC and a PNC.
	MOH	×	○	×	×	×	MOH disburses US\$15 per health centre delivery.
Kroch Chmar	GAVI-HSS	○	×	×	○	×	GAVI-HSS disburses US\$1 for each ANC visit, EPI dose and medical consultation visit.
	AusAID/UNFPA	×	×	○	×	○	AusAID/UNFPA disburse US\$1 for each PNC and BS visits.
	MOH	×	○	×	×	×	MOH disburses US\$15 per health centre delivery.
Srey Sentor	RHAC	○	○	○	×	×	See Chamkar Leu.
	MOH	×	○	×	×	×	MOH disburses US\$15 per health centre delivery.
Choeng Prey	BTC	○	○	○	○	○	See Chamkar Leu.
	MOH	×	○	×	×	×	MOH disburses US\$15 per health centre delivery.
Prey Chhor	BTC	○	○	○	○	○	See Chamkar Leu.
	RHAC	○	○	○	×	×	See Chamkar Leu.
	MOH	×	○	×	×	×	MOH disburses US\$15 per health centre delivery.
Memut	SCA	○	○	×	○	○	Quantity of these services and other HC performances components are scored. SCA disburses total disbursement amount /HC/month X (actual score/full score).
	MOH	×	○	×	×	×	MOH disburses US\$15 per health centre delivery.
Ponhea Krek	SCA	○	○	×	○	○	See Memut.
	MOH	×	○	×	×	×	MOH disburses US\$15 per health centre delivery.
Tbong Khmum*	RHAC	○	○	○	×	×	See Chamkar Leu.
	MOH	×	○	×	×	×	MOH disburses US\$15 per health centre delivery.
Oreang Ov	RHAC	○	○	○	×	×	See Chamkar Leu.
	MOH	×	○	×	×	×	MOH disburses US\$15 per health centre delivery.

\*UNFPA provides Tbong Khmum OD with funds through the HSSP scheme as a lump sum budget supplementation, not in the form of the PBF.

Source: JICA study

## Annex 7 Key Highlights – 2008 Annual Performance Review

Major Activities in 2008	Planned Activity for reporting year	Report on progress (% achievement)	Available GAVI HSS resources for the reporting year (2008)	Expenditure of GAVI HSS in reporting year (2008)	Carried forward (balance into 2009)	Explanation of differences in activities and expenditures from original application or previously approved adjustment and detail of achievements
<b>Objective 1 SERVICE DELIVERY</b>						
<b>Activity 1.1: HEALTH CENTRE SERVICE DELIVERY CONTRACTS</b>	Establish and Implement Health Centre MPA Annual Operational Plans & Performance Agreements (using supply and demand side approaches) (MCH)	139 health centre contracts have been signed and have been implemented for a package of MCH primary care services. In 2008 the package of services in all districts was extended to include family planning, post natal care and referral through co financing by UNFPA/AusAID	595,761	597,914	-2,153	<p><b>Main achievements</b> - (1) acceleration of concept of internal contracting as a management methodology (2) Improved performance in immunization and maternal and child health indicators from baseline (see following M &amp; E table for details) (3) co financing of strategy by UNFPA and AusAID.(4) Reported higher motivation of health centre staff (5) Expanded opening hours by most health centers.</p> <p><b>Differences:</b> (1) MOH decided on fee for service system of contracts instead of capitation based model of funding. This was due to the fact the model was not sufficiently developed and the MOH considered the fee for service system would be easier to manage. This is under review (2) remote area allowances have been introduced for remote area staff to compensate for lower consultation numbers (3) Contracts have been extended</p>

						to include more MCH services (birth spacing, referral, post natal care) as a result of UNFPA/AusAID co financing
<b>Activity 1.2: DISTRICT MANAGEMENT CONTRACTS</b>	Establish and Implement Annual Operational Plans & Performance Based Management Agreements for ODS and Provinces (MCH)	10 management contracts have been signed with 10 Operational Districts. As from the last quarter of 2008, contracts are integrated for MCH including GAVI and UNFPA/AusAID financing.	48,000	59,200	-11,200	<b>Main Achievements:</b> Improved health outcome indicators as outlined in M & E framework <b>Main Differences:</b> (1) In 2008, there was not enough emphasis and financial support for District and provincial management system. (2) The ending of Global Fund management support in 2008 means that GAVI HSS and Govt. will need to fill this gap.
<b>Activity 1.3: COVERAGE IMPROVEMENT PLANNING</b>	Integration of Immunization Coverage Improvement Planning into MPA Planning Systems (MCH) (gradual scale down of CIP))	This micro-planning program for improving coverage in harder to reach areas has been implemented in 2 quarters of 2008 in the catchment areas of 187 health centers (out of 1000 health centers in Cambodia.	230,271	192,971	37,300	<b>Main Achievements:</b> In 2008, Cambodia vaccinated the highest number of DPT3 in its history - 321,111

<p><b>Activity 1.4: DEMAND SIDE STRATEGY</b></p>	<p>Implement, Evaluate and Fixed Site Strategy (MCH) (including demand side activities )</p>	<p>This strategy (with support for social mobilization and meetings with local authorities and volunteers) was implemented in 191 health centers (56 health districts) in 2008. 41% of vaccinations are now provided at health facilities at these sites.</p>	<p>75,137</p>	<p>52,537</p>	<p>22,600</p>	<p><b>Main Achievements:</b> The numbers of children being vaccinated at health centers is increasing, reflecting grater demand for health services. At baseline, it was estimated that 21% of children were vaccinated at facilities, but this has now increased to 41% at trial sites</p>
<p><b>Objective 2 SYSTEMS</b></p>						

<p><b>Activity 2.1: FINANCE SYSTEMS</b></p>	<p>Develop MPA Financial Management Systems &amp; health financing guidelines</p>	<p>Financial management guidelines for decentralized management of operational funds have been implemented in all 10 operational districts. Provinces and Districts in the 10 HSS areas have been trained in use of the guidelines. Supervision has been conducted for financial management in 5 ODs, and joint supervision with the monitoring team on two occasions in each of the 10 ODs. Objectives now are to facilitate improvements to the financial management system. This will mean increasing the financial management capacity of the OD staff. This will also require strengthening of supervision of health centers, districts and provinces.</p>	<p>17,529</p>	<p>5,953</p>	<p>11,576</p>	<p><b>Main Achievement:</b> The financial management guidelines and management system means that finances are reaching facilities on time. This is without doubt a major contributing factor to improved performance.</p>
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<p><b>Activity 2.2: PLANNING SYSTEMS</b></p>	<p>Strengthening of AOP planning systems and implementation of MPA Planning guidelines</p>	<p>No of 6 training courses in Planning Procedure in AOP for 296 for OD/HCs staff in 10 ODs.</p>	<p>99,575</p>	<p>43,393</p>	<p>56,182</p>	<p>Achievements: All GAVI HSS programs and activities have been integrated within the AOPs of 10 operation Districts. The supervision conducted for evaluation of planning process according to the MoH-Manual On Planning. Most PHDs and ODs have prepared and implemented all planning steps according to MoH guideline on planning. But still HCs and RHs have not yet prepared their own quarterly report by themselves unless having initiative from ODs. However, only few ODs have conducted spot check for quality of data, the rest have not yet pay attention on DQA. Post training follow-up at OD/HC has to continue till the year of 2009. For technical support from OD planning team to RH and HC has not yet conducted regularly due to the time constraint.</p>
<p>Activity 2.3: SUPERVISION</p>	<p>Strengthening of integrated supportive supervision programs from central to PHD, and OD to HC level</p>	<p>No of 2 integrated supervision visits conducted by central level to Provinces (Costs included in project management)</p>				<p>Two integrated supervision visits conducted by Program Monitoring Team(NIP, DBF, DPHI and CDC,DPM)</p>

Activity RESEARCH	2:4: Conduct Health Systems Operational Research Programs	No activity	0	0		No activity
<b>Objective 3 Capacity Building</b>						
<b>Activity MLM</b>	<b>3.1:</b> Conduct capacity building programs for Middle Level Management	Training workshops middle level management (250 HC staff and OD staff in each 5 days training)	55,000	41,525	13,475	No of 250 HCs has received training on management course in 5 days at PHD level.
		Outreach guidelines review ( as part of MPA): Consultative workshop with national programs and key implementaters and supporters	17,750	17,643	107	Outreach guidelines has reviewed and distributed.
		National Communication Strategy MPA/EPI: Production/Airing/printing and communication workshop	50,000	32,950	17,050	The National Communication Strategy on MPA/EPI will continue to conduct in 2009.
		Document Publication: 1- Printing revised planning manual / financial system manual / MPA Guideline	20,000	0	20,000	Document already finalized and approved and will print in 2009.

<p><b>Activity 3.2: CHILD SURVIVAL</b></p>	<p>Strengthen systems for child survival scorecard monitoring (include in 3.3)</p>	<p>No of monitoring visits conducted</p>	<p>13,400</p>	<p>12,579</p>	<p>821</p>	<p>Monitoring activities was conducted according to schedule.</p>
<p><b>Activity 3.3: IMCI</b></p>	<p>Conduct capacity Building &amp; supportive supervision programs for IMCI and immunization</p>	<p>IMCI Clinical Training IMCI Facilitators Training IMCI Follow up Training/ IMCI Monitoring Strengthen the facilitating supervision of OD level Strengthen monitoring and spot-checking form national level IMCI planning workshop to introduce IMCI related activities in planning cycle of OD IMCI Workshop-IMCI Annual Review Meeting 2008. Child Survival Scorecard Monitoring Immunization Training (10 OD TOT training Cold Chain/Vaccine Management/IIP and training of HC staff)</p>	<p>278,581</p>	<p>212,688</p>	<p>65,893</p>	<p>Monitoring activities was conducted according to schedule in 2008.</p>

<b>Activity 3.4 : RMNCH Training and Quality Improvement (co financing AusAID UNFPA)</b>		(activity through UNFPA)	0	0		
<b>Activity 3.5 : Private Sector</b>	Implement, Evaluate and Scale Up Public / Private Collaboration (immunization with potential integration with MCH)	The private sector collaboration strategy is being implemented in 14 private clinics		0		
<b>Support Functions</b>						
<b>Project Management, M&amp;E and Technical Support and Miscellaneous.</b>	Office support, evaluation workshops, transportation, technical support	1 full time project officer employed. International TA 6 weeks. 2 national workshops conducted mid -year and end of year evaluations	324,473	130,337	194,136	1 full time project officer has employed. International TA for 6 weeks also employed. 2 national workshops conducted at mid-year and the end of the year.
	Other logistics	vehicle 2 units, 10 motorcycle, fuel, maintenance system for cold chain	95,900	127,359	-31,459	Due to the price increased during the time of purchasing.
<b>Total Budget for 2008</b>			1,921,377	1,527,049	394,327	
<b>Q4/08 Remaining Fund</b>			266,123	0	266,123	
<b>Total Fund Balance as at 31 Dec/08</b>			2,187,500	1,527,049	660,451	