CAMBODIA HEALTH SECTOR SUPPORT PROGRAMME: MONITORING AND EVALUATION AND SOCIAL ASSESSMENT ISSUES

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List of acronyms

ADB  Asian Development Bank
ADD  Accelerated Development Districts
AIDS  Acquired Immuno-Deficiency Syndrome
APS  Approved Provider Scheme
ARI  Acute Respiratory Infection

BSS  Behavioural Sentinel Survey
CCC  Co-ordinating Committee for Cambodia
CDC  Communicable Disease Control
CDRI  Cambodian Development Resource Institute
CFR  Case Fatality Rate
CoCom  Co-ordinating Committee (of the Ministry of Health)
CPA  Complementary Package of Activities
CRC  Cambodian Red Cross
CSES  Cambodia Socio-Economic Survey

DBF  Department of Budget and Finance (MoH)
DFID  Department for International Development (UK)
DG-H  Directorate General for Health (MoH)
DHS  Demographic and Health Survey
DOTS  Directly-Observed Treatment Short course (TB)
DPHI  Department of Planning and Health Information (MoH)

EPI  Expanded Programme of Immunisation

FC  (health facility) Feedback Committee

GDP  Gross Domestic Product

HC  Health Centre
HCMC  Health Centre Management Committee
HFA  Height-For-Age
HIS  Health Information System
HISB  Health Information System Bureau
HIV  Human Immuno-deficiency Virus
HMIS  Health Management Information System
HSRG  Health Sector Reform Group
HSSP  Health Sector Support Programme

IBN  Impregnated Bed Nets
IHS  Institute for Health Sector Development
INGO  International Non-Governmental Organisation
ICSW  Indirect Commercial Sex Worker
ISC  Integrated Supervisory Checklists

JHSR  Joint Health Sector Review

M&E  Monitoring and Evaluation
MEF  Ministry of Economy and Finance
MMR  Maternal Mortality Rate
MoH  Ministry of Health
MoP  Ministry of Planning
MPA  Minimum Package of Activities
MTEF  Medium-Term Expenditure Framework

n.a.  not available
NCHADS  National Centre for HIV/AIDS, Dermatology and STDs
NGO  Non-Governmental Organisation
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<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>NHS</td>
<td>National Health Survey</td>
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<td>NIS</td>
<td>National Institute of Statistics</td>
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<td>NIPH</td>
<td>National Institute for Public Health</td>
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<td>NLI</td>
<td>National Level Indicators</td>
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<td>NPAR</td>
<td>National Programme of Administrative Reform / National Public Administration Reform</td>
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<td>OD</td>
<td>Operational District</td>
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<td>ODA</td>
<td>Overseas Development Assistance</td>
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<td>p.a.</td>
<td>per annum</td>
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<td>PAD</td>
<td>Project Appraisal Document</td>
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<td>PAP</td>
<td>Priority Action Programme</td>
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<td>p.c.</td>
<td>per capita</td>
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<td>PEM</td>
<td>Protein-Energy Malnutrition</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PMU</td>
<td>Project Management Unit</td>
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<td>PHD</td>
<td>Provincial Health Department</td>
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<td>ProCoCom</td>
<td>Provincial Coordinating Committee(s)</td>
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<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
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<td>RGC</td>
<td>Royal Government of Cambodia (1994-)</td>
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<td>RH</td>
<td>Referral Hospital</td>
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<td>SEDP</td>
<td>Socio-Economic Development Plan</td>
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<td>SESC</td>
<td>Socio-Economic Survey of Cambodia</td>
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<td>STD</td>
<td>Sexually-Transmitted Disease</td>
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<td>SWAp</td>
<td>Sector Wide Approach</td>
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<td>SWIM</td>
<td>Sector-Wide Management</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WFA</td>
<td>Weight-for-Age</td>
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<td>WFH</td>
<td>Weight-for-Height</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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**Currencies**

US$1 = c. 3,900 Cambodian riel  
UK£1 = US$ 1.42
Monitoring and evaluation and social assessment issues in the Cambodia Health Sector Support Programme (HSSP)

1. Background on the HSSP

DFID, the World Bank and the ADB have all been involved in programmes of support to the health sector in Cambodia. All three are now planning new phases of support. Following discussions, most recently in Phnom Penh, Manila and Bangkok, it has been agreed that the three donors will co-ordinate their support into a $92m programme of support – the Health Sector Support Programme (HSSP) - which the Government (RGC) will co-finance with a commitment of $8m. The precise form of co-ordination between the three international agency partners and the Ministry of Health (MoH) has however yet to be finalised.

A World Bank pre-appraisal mission visited Cambodia between the 5\textsuperscript{th} and 21\textsuperscript{st} November 2001. DFID funded three of the members of this team, including the monitoring and evaluation (M&E) advisor, the social assessment specialist and a maternal mortality specialist. This report covers the findings on monitoring and evaluation and social assessment.

At the end of the pre-appraisal mission a draft Aide Memoire was presented to the Ministry of Health and all partners in Phnom Penh. This Aide Memoire laid out three main components of the proposed HSSP:

- **Improving the provision of health services, especially for low income groups.** The Programme aims to increase the accessibility and affordability of primary health care and first referral services, including the Minimum Package of Activities (MPA) to be delivered by health centres, and the Complementary Package of Activities (CPA) to be delivered by referral hospitals. In order to ensure the accessibility and affordability of both packages, HSSP will finance: civil works; medical equipment; development and piloting of a maintenance system; pharmaceuticals; a quality assurance programme; training and fellowships; development and piloting of innovative financing schemes; development and piloting of arrangements to protect the poor; and monitoring of access and affordability of services for the poor.

- **The Health Sector Reform and Improvement component** aims to: i) strengthen MoH management responsibilities, ii) strengthen health administration at decentralised levels and iii) develop human resources.

- **Support to technical programmes addressing public health priorities**, including TB, malaria and dengue, HIV/AIDS and STDs, nutrition and safe motherhood.

The draft Aide Memoire was discussed by representatives of the WB, DFID and ADB on 22\textsuperscript{nd} November in Bangkok. Many issues were raised concerning the development and planning of the Programme over the coming months. While many issues were settled, several key points remain unresolved. Outstanding issues include the overall depth and breadth of coverage in terms of provinces and/or operational districts.

Finally, the three DFID-financed consultants met with the DFID SE Asia Region Population and Health Advisor (Delna Ghandhi) on 23\textsuperscript{rd} November and discussed
possible DFID inputs, especially in relation to social appraisal, monitoring and evaluation, and maternal mortality reduction.

This document discusses the findings from the initial (World Bank) pre-appraisal. Regarding monitoring and evaluation arrangements, section 2 provides a preliminary set of observations and recommendations. Further analysis is recommended to obtain feedback on the viability of the proposed M&E arrangements, and to cost them properly. Most critically, much of the detail of the M&E systems to be put in place cannot be specified until key project design decisions (e.g. what components will be national in scope and which will be developed in selected provinces; the number and identity of these provinces; etc.) have been made.

In the area of social assessment, section 3 and annex 3 give a social appraisal and recommends two further steps during project design: to look at how to tackle barriers to access to health promotion and health care for ethnic minorities, and how to develop mechanisms to improve access to health care for the poor.
2. Issues arising from the assessment of M&E requirements

2.1 Introduction
The draft World Bank Project Appraisal Document (PAD) provided a sound initial framework for project M&E needs. However, it could benefit from greater specification and some modification; and from a description of who will have overall responsibility for M&E. It also requires revision in the light of the revised proposal for HSSP activities as contained in the subsequent drafts of the Aide Memoire.

2.2 General principles
The integration of accurate, relevant and timely data into evidence-based management and policy change is crucial to health sector reform. M&E in the context of HSSP must be addressed both as an aspect of project management required to ensure success, and as a project objective (increased M&E capacity, allowing key stakeholders in the sector to design and implement policies and programmes on the basis of evidence). These perspectives overlap, and project M&E and health sector M&E should be integrated as far as possible.

As the Sector-Wide Management (SWIM) process is still at a very early stage of development, there is not yet a clearly defined RGC health sector M&E plan to which HSSP M&E might be related. A member of the SWIM Core Group will be included in the HSSP Steering Group: one aspect of this individual’s role should be to oversee the integration of HSSP M&E indicators and arrangements with those emerging under the SWIM process. Thus, while this document makes recommendations about what might constitute appropriate M&E arrangements for HSSP, it is important that there is scope to revise the indicator framework and schedule of M&E activities at a later date in response to the publication of the health Master Plan.

One of the key aspects of current and planned health sector reforms is experimentation with different contract-based relationships between institutions in the sector (i.e. contracting-in and –out and “boosting”). The MoH needs good M&E information to set targets and write contracts, and to determine whether contracted parties have succeeded or failed in delivering services as agreed.

2.3 Summary assessment of existing M&E capacity

A) General comments and priorities / priorities for HSSP
Capacity in various aspects of health sector monitoring has been much improved over recent years, with many of the building blocks for a national health information system in place. Improvements since 1990 include the introduction of:

- the Health Information System, with standardised monthly data collection forms completed by health facilities and aggregated at higher levels;
- a National Level Indicators (NLI) framework;
- the Tableau de Bord for internal performance monitoring and planning;
- reporting / health information systems specific to National Programmes;
- a supervision system including an MoH personnel database; a programme of supervision; supervision checklists for National Programmes; a financial reporting system; and an annual Health Centre Assessment.
- A number of major quantitative studies of health status and / or health service utilisation (e.g. NIPH 1998, NIS et al 2001 and chapter 5 in MoP 1999).
However, further improvement is required to meet data collection and analysis requirements, either of the HSSP or the MoH. There is a need to bring together the various strands of monitoring and ensure that it is used in decision-making on priorities and resource allocation at lower levels. The HSSP should therefore:

- Build up capacity to collate, analyse and use information more effectively at all levels (central, Provincial and OD). DPHI should help PHDs to train facility staff in using information in management meetings and annual planning. Higher levels in the hierarchy should be more proactive, providing feedback on both the quality of information supplied and what this information suggests about performance.

- At a later stage, efforts should be made to consolidate the various strands of monitoring. Options include i) computerisation; ii) strengthening information sharing at each level; iii) reducing the volume of information collected, when it appears that certain indicators are largely unused; and / or iv) combining information onto fewer forms to reduce duplication. Efforts should focus initially on the first two approaches: the latter two are more disruptive, and should only be attempted if it is clear that the benefits will outweigh the costs.

- Explore the potential for scanner-readable forms for rapid collation of HIS data.

- Expand MoH M&E to encompass surveillance of health service delivery outside the public sector.

- Use information regarding health system activities and outcomes to accountability and governance structures (e.g. by providing community bodies and NGOs with the information they need in order to hold health providers to account).

**B) M&E capacity at the central level**

A key constraint is the small size of the Department for Planning and Health Information, which contains good staff, but not enough of them. The current decision to recruit the acting Director of DPHI to lead on World Bank HSSP preparation has an obvious impact on the capacity of the Planning Department, and as such will need to be carefully managed. Regardless of the number of staff who are seconded to other duties related to the HSSP, the Programme will need to make a significant contribution to developing M&E capacity within the DPHI. This will involve both supplementing salaries and providing suitable training and supervision.  

The National Institute for Public Health (NIPH) has received considerable external support in recent years. However, while NIPH staff now have the technical and many of the managerial skills required to carry out health studies and develop health information systems, there is some feeling amongst donors that the NIPH is too isolated from the rest of the MoH and currently lacking in senior leadership.  

A key role of central MoH institutions – particularly the DPHI and NIPH, but also line departments – will be to assist Provinces to develop the M&E capacity they require in order to assume greater powers of planning, budgeting and managing contracts.

**C) M&E capacity at sub-national levels**

M&E capacity below the level of the central MoH was hard to gauge. From observations in Pursat, it would seem that the various forms are completed without too much difficulty. While there is scope for reductions, the burden of data collection does not appear to be as heavy as it is in many other countries. More importantly, there are unrealised opportunities for the information that is collected to be used at each level before it is passed upwards. Computerisation of HIS collection and
analysis, as piloted in Kompong Thom, may help to make it possible for higher levels in the HIS hierarchy to directly disaggregate data right down to facility level.

Since the introduction of the current MoH HIS in 1994 there have been concerns that routine HIS / HMIS monitoring data may be inflated at the point of collection, as there is an incentive for staff to over-report treatment on utilisation and essential drugs reporting forms in order to obtain surpluses which can be sold for profit. To check on this, the HISB carried out an Essential Health Costing Analysis. This survey found no evidence of the inflation of HIS data, although this may reflect the fact that all those facilities visited were all in receipt of some form of donor support: inflation may be occurring in facilities that have less resources and less supervision.

D) Recommendations re: linking M&E capacity building and decision-making

It is recommended that HSSP:

- **Consolidate and improve M&E capacity at the central level.** DPHI should concentrate upon routine monitoring and some issue-specific, management-focussed evaluations; better integration of information into decision-making; and development of M&E / HMIS capacity at Provincial levels. Periodic evaluations of HSSP should be external and independent: NIPH, together with the HSSP Programme Co-ordinator, will schedule and commission these evaluations, including writing the ToR, with DPHI consulted.

In terms of the reporting and validation functions for which DPHI would take lead responsibility, interviews suggest that there are two alternative models currently favoured. The first would involve building up an M&E Unit within DPHI and increasing its influence upon policy. The alternative arrangement is to create a cross-departmental M&E task force, with DPHI as the secretariat, but with representation from other departments. This arrangement has the potential to internalise awareness of the importance of M&E in key operational departments. However, this potential must be balanced against the problems observed in other cross-departmental bodies: departments tend to send junior staff, or no staff, to meetings, which are as a result largely ineffective. It is therefore recommended that a much strengthened M&E unit is created within DPHI, but that quarterly review meetings are held which senior staff of other departments must attend.

Extremely low salaries are a major impediment to improving performance. Annex 3 therefore provides a rough budget for salary support as part of a package to improve M&E capacity at the central level. However, to be effective in improving performance, salary supplements must be linked with improved HR management procedures (e.g. clarified job descriptions and performance assessment). Salary supplement arrangements should ideally be developed as part of a consistent MoH-wide set of scales and associated practices, designed so as to be consistent with planned national-level reforms.

- **Support the development of M&E capacity at the PHD level.** PHDs should be helped to make more use of information collected from facilities; to provide feedback; and to organise more pro-active M&E activities (e.g. reviews of particular aspects of the provincial health system). Active scrutiny of routinely collected information should be supplemented with quarterly field audits, and use both the routine and audit information in planning and budgeting. Draft guidelines and reporting forms for field audits already exist. To help PHDs to assume these M&E roles will require support to staff in the PHD Office of Planning and Health Information in each of the 23 Provinces: HSSP should support DPHI so that it can take the lead in building capacity at PHD level.
2.4 Indicators and methods of data collection

A) Sector impact indicators

Considerable work has already been done in Cambodia on sector-level health indicators. The Health Sector Performance Report framework, using the framework of National Level Indicators (NLI) finalised in November 1999, contains 51 quantitative and 15 qualitative indicators grouped under the headings of i) overall level of national development; ii) health financing; iii) increasing access and utilisation; iv) improving quality; v) improving health outcomes.

Ideally, HSSP indicators should fit as closely as possible with the NLI structure. However, this structure itself is likely to be revised somewhat with production of the sector Master Plan, currently scheduled for October 2002. Many of the NLI indicators relate to important process or output goals: training of health staff, the level of public funds committed to health, and so on – which can be obtained from analysis of managerial and financial information collected within MoH. However, many of the sector-level outcome / impact indicators identified within the NLI framework can only be collected through episodic national sample surveys. Thus for many of the higher-level sector indicators contained in the NLI (e.g. contraceptive use and antenatal and postnatal practices; fertility, infant and child mortality rates), the only truly reliable national measures to date are those collected through the census in 1998, the NHS in 1998, and the Demographic and Health Survey (DHS) in 2000. Of these estimates, those in the DHS are generally considered the most reliable.

There is a case for HSSP M&E to include funding towards one or more future rounds of the DHS, although donors have different opinions on how soon the second and third DSHs should be carried out (UNFPA favours one in 2004, but other donors have yet to be convinced). The DHS is an expensive exercise and it may not be worth conducting another within 5 years of the first survey, when outcome indicators are slow to change. However, there remains a good case for HSSP contributing at least some funding towards one DHS. For the donors involved in HSSP, one conducted towards the end of the programme (c. 2009) would be more valuable.

B) Component indicators: process, output and outcome

The Aide Memoire provides a structure of components, sub-components and activities. While this structure is likely to change as programme preparation proceeds (especially if ADB programming is incorporated), suggested indicators for key activities and notes on how the more complex indicators might be measured are given in Annex 1. In particular, this addresses the question of how to rapidly but accurately identify the poor in order to monitor the impact of changes on the poor.

2.5 Independent sector monitoring and HSSP evaluation

Joint (Government-donor) sector-wide reviews of progress are a crucial part of the process of moving towards a more sectoral approach to health funding and development. These annual sector performance reviews should provide an overall picture of both i) health outputs and outcomes and ii) intermediate process indicators. The overlap between the programme and the broader process of sector reform and sector-wide management is a crucial consideration in this context. While there should be an annual series of meetings and a short annual report relating specifically to review HSSP implementation, these should draw on the findings of the sector review (which should be funded and supervised by a partnership including both HSSP and
non-HSSP actors), rather than involve further rounds of comprehensive data collection and analysis.

This annual sector review should be carried out by independent organisations, ideally in a consortium which combined extensive international experience of conducting sector reviews with good knowledge of Cambodia. A formal review of the annual sector performance document would then occur between RGC, donors and NGOs, using the findings to inform the next round of annual planning and budgeting.

It is necessary to identify a suitable institution to take on responsibility for contracting and managing these reviews and subsequently incorporating findings into polices and plans. Various options for the management of the sector reviews were proposed during the course of the mission. It seems that the best option is to create a new tripartite body, with representation from the government, NGOs, and major donors in the sector. More work will be required to learn from other international examples, and to reach an agreement between stakeholders regarding what might be suitable in the Cambodian context.

There will remain a need to evaluate the performance of HSSP itself on a periodic basis, involving detailed examination of the specific components of the health sector supported by HSSP, as well as an assessment of the overall level and quality of influence exercised by HSSP on sector policy formulation and implementation. ToR for the HSSP review would be drawn up by the HSSP Steering Group, in consultation with the DPHI M&E Unit and NIPH. In discussion with DFID it was proposed that three such evaluations should occur (an initial evaluation in year 2, a mid-term review in year 4, and a final evaluation in year 6), although it may be possible to reduce the number to two. It is recommended that the issue of whether to have two or three HSSP evaluations is left open for the moment, with a review of the issues and a decision on the need for an evaluation scheduled for 18 months into the programme.

2.6 Linking sector monitoring to other development goals

It is desirable to link monitoring of progress in the health sector with a framework for monitoring national poverty reduction. Unfortunately however work on a national poverty monitoring system is not progressing, largely because it is dependent upon resolution of problems in the management of the PRSP process. The MoH and partners should remain open to involvement in the development of PRSP analysis, policy and monitoring arrangements as and when these might arise. More generally, it is likely that there will be research studies not specifically focussed upon the health sector which nonetheless provides opportunities for the collection of health care and health status data, and for relating this data to other aspects of socio-economic development. HSSP should be aware of, and where possible actively involved in, these studies, and build them into its M&E plan.

2.7 Summary of key recommendations

It is recommended that HSSP undertake the following interventions with regard to M&E / HMIS:

In the pre-implementation / programme preparation phase:

- Evaluate the pilot computerisation of HIS / HMIS systems at the OD and PHD levels currently in place in Kompong Thom; if findings are positive, conduct a feasibility study and draft a budget for scaling up the pilot under HSSP;
- Conduct a review of DPHI institutional and HR development needs with regard to M&E; provide material, salary, training and HR management inputs required to strengthen this M&E capacity.
Review with MoH and partners the institutional development and HR inputs required to develop the M&E capacity of PHDs; identify and cost options; and begin to implement it.

Assist the MoH in compiling baseline data for key indicators listed in this document (many of which are already available in existing documents).

Start to develop the capacity of public health service managers to monitor and evaluate the performance of parties contracted to deliver health services.

_During the first one-two years of programme implementation:_

- Build the capacity of central MoH to collate and compare in a more systematic manner findings on the outcomes of pilots and experiments (contracting, boosting, etc).
- Work with the MoH and other partners to organise annual sector reviews, and integrate the findings into annual planning and budgeting and policy-making.
- After eighteen months of programme implementation, hold a workshop to review evidence and impressions of progress to date, and to decide on whether an evaluation of HSSP is called for at the end of year 2.

_In subsequent years of programme implementation:_

- Expand the use of information to improve health sector governance, providing the public with information on health system financing, activities and outcomes in order to hold health providers (public and potentially also private) to account.
- Build up incentives and capacity for lower levels of the public health service (PHD and OD, maybe later HC) to analyse and use information in decision-making on priorities and resource allocation, rather than, as at present, focus primarily on channelling it up to the central level. More feedback (from MoH to PHDs and ODs, and from PHDs to ODs and facilities) on quality of data submitted would increase the motivation to improve collection and use.
- Consider the costs and benefits of consolidating the various strands of HIS / HMIS monitoring by reducing the volume of information collected, when it appears that certain indicators are largely unused in analysis; and / or by combining information onto fewer forms to reduce duplication.
- Schedule, contract and manage two HSSP evaluations: one mid-term review falling in either year three or year four (depending on whether an evaluation was held in year 2), and a final evaluation in year six.
- Negotiate with MoH and other sector partners about the timing and funding of a DHS; work on integrating sampling, interview forms and analysis so as to make possible analysis of health behaviour and outcomes by socio-economic status.

Finally, it should be reiterated that these recommendations are provisional. It would be misguided to make final decisions on the form of M&E arrangements when the sector Master Plan is not completed and when many key design issues for HSSP – most notably the decision on how many provinces are to be supported, and how – have yet to be made. More work will be needed to refine this plan once more decisions have been made on the shape of the HSSP programme.
3. Issues Arising From The Social Assessment

During the pre-appraisal mission, a Social Assessment was carried out. In accordance with WB directive 4.20, the Assessment focused on ethnic minority issues in relation to health, but also discussed other issues, notably gender and poverty, covered in a DFID Social Appraisal. The Social Assessment was written after a review of documents and consultation with key members of the Ministry of Health and donors. In addition, a field trip to Rattanakiri included visits to health posts, health centres and the referral hospital, as well as providing insights into the situation of ethnic minority Hill Tribes and enabling discussion with NGOs on their situation. The Social Assessment submitted to the Team Leader is attached as Annex 3.

The DFID consultants met with Delna Ghandhi on 23 November and discussed possible DFID inputs especially in relation to social appraisal, monitoring and evaluation and maternal mortality reduction. A number of recommendations arising from the Social Assessment work are outlined below:

1) Rattanakiri and Mondalakiri should be considered for contracting out of health services. These remote provinces are home to Hill Tribes and there are particular problems related to access. At present it is widely reported by MoH staff, donors and NGOs working in those provinces that service provision is particularly poor and that there appears to be little accountability.

2) Equity funds, and other means of assuring affordability and access by the poor to health services, are an important part of component 1, as outlined in the draft Aide Memoire and PAD. A number of arrangements to increase equitable access to health services for the poor have been piloted in Cambodia. However, the type of mechanisms to increase access and their management within HSSP are yet to be considered in detail. A WB consultant economist will be in Cambodia in February 2002 to work on equity issues. The success of arrangements put in place to protect the poor will depend partly on an understanding of the social-economic mechanisms operating at the local level in Cambodia. Therefore, as a matter of urgency, a social development consultant should be recruited to examine issues relating to access to health services, poverty and equity funds (draft ToR attached at annex 4). Ideally the consultant will have worked with the economist specialising in equity issues.

3) After discussions between WB, ADB and DFID representatives in Bangkok, it has become clear that a social development consultant is required to examine issues relating to ethnicity and access to health services. The findings of the consultant should be fed into the Programme design as a means of ensuring that measures to reduce or eliminate ethnicity as a barrier to health service utilisation are rigorously addressed. One output of this consultancy would be recommendations concerning culturally sensitive health promotion strategies. Ideally, the consultant will have experience of Cambodia and a medical anthropology background. Draft ToR are attached at annex 5.

4) As the Programme implementation gets underway, initiatives around demand creation should be developed using operational research that draws on the approach of medical anthropology and focuses on qualitative studies. This work should increase the understanding of health seeking behaviour in order
to design appropriate messages and interventions for IEC and BCC. This approach has been outlined in the Social Assessment and has been discussed with the WB team in Phnom Penh and with Delna Ghandhi in Bangkok.

Precise ToR should be drawn up after the design of the HSSP has been completed and implementation has started. The ToR should define a focused piece of work that addresses user/customer perspectives on the actual HSSP service delivery. In order to avoid duplication, the study should start with a careful review of existing literature relating to health seeking behaviour.

The study should be undertaken by a consultant with experience in the application of operational research findings to demand creation strategies. S/he should lead a team of Cambodian researchers working over a period of three months.

The research team should report to the MoH, possibly through the National Center for Health Promotion (NCHP). Results should be disseminated and used to inform a national strategy for demand creation through a range of IEC and BCC activities. Collaboration with the NCHP would build the operational capacity of an organisation that has already benefited from support from AusAid, but remains weak. However, once HSSP implementation is underway it may be easier to identify other Cambodian based collaborators with expertise in IEC and BCC.
4. ANNEXES

Annex 1 Detailed analysis and recommendations for M&E in HSSP

A1.1 Introduction

The starting point for identifying monitoring and evaluation (M&E) requirements for HSSP was the draft World Bank Project Appraisal Document (PAD). Annex 1 (Project Design Summary) to the PAD provided the initial framework for project M&E needs, listing indicators, information sources and M&E activities relevant to each sector goal, project objective and component and sub-component output. This framework appears essentially sound. However, it could benefit from greater specification and some modification; and from a description of who will have overall responsibility for M&E. It also requires revision in the light of the revised proposal for HSSP activities as contained in the end-of-mission draft Aide Memoire.

The M&E advisor met with RGC, donor and NGO staff, and, together with the Institutional Development specialist, visited Pursat province to examine health management systems in two Health Centres (H Cs), one Operational District (OD), and a number of units (including the Bureau of Planning and Health Information (BPHI) within the Provincial Health Directorate (PHD). An initial 2-page summary of M&E issues was supplied to the mission Team Leader.

A1.2 An M&E system for the HSSP: general principles

A) Strategies for linking M&E for HSSP to M&E for sector development

The integration of accurate, relevant and timely data into evidence-based management and policy change is crucial to health sector reform. M&E in the context of HSSP must be addressed both as an aspect of project management required to ensure success (monitoring performance against plans, identifying problems and issues to be addressed, learning lessons and incorporating these into subsequent planning and implementation); and as a project objective (increased M&E capacity allowing key stakeholders in the Cambodian health system to design and implement policies and programmes on the basis of evidence).

These perspectives overlap. To the extent that good M&E arrangements are a means to attain project ends, they must provide information on:

- Progress towards the specific goals of the allocated, projectised components of HSSP. This is particularly important in the first 3 years (when a major part of HSSP funding will support specified components) and with regard to the specific areas of HSS focus, namely infectious disease control, coverage and quality of primary health care, nutrition, and maternal mortality; but it will continue to be important in the latter half of the programme too, as some specific components will be funded for all six years.

- The contribution of HSSP to the attainment of sector-wide improvements in capacity, outputs and outcomes (particularly important in the last three years, when it is envisaged that an increasing proportion of total annual HSSP funding will be disbursed without allocation to specific activities).

As far as possible, these two functions (project M&E and health sector performance M&E) should be integrated. Apart from the benefits in terms of capacity building, the

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1 Given that this framework will have to be revised, it may be worth cross-referencing it with the evaluation framework presented for the proposed implementation of the boosting strategy (MoH 2001 pp. 29-31): the indicators chosen in the two logframes are quite similar, but the boosting strategy goes into more detail on sources of information and frequency of evaluation,
inclusion of HSSP M&E within a strengthened MoH Health Management Information System (HMIS) provides a basis for comparison with components or provinces which do not receive allocated support from HSS, and thus a better basis for evaluating the impact of activities receiving allocated HSS funding.

The Sector-Wide Management (SWIM) process is still at a very early stage of development (most notably, the sector Master Plan has yet to be produced). This means that there is not yet a clearly defined RGC health sector M&E plan with which HSSP M&E systems might be related. There is however a set of National Level Indicators (NLI), which will presumably form the basis of any SWIM M&E system. As discussed during meetings in Bangkok, a member of the SWIM Core Group should be included in the HSSP Steering Group in order to link HSSP implementation to the SWIM process. One aspect of this individual’s role should be to oversee the integration of HSSP indicators and M&E arrangements with those emerging under the SWIM process. Thus, while this document will make recommendations about what might constitute appropriate M&E arrangements for HSSP, it is important that there is scope to revise the indicator framework and schedule of M&E activities at a later date in response to the publication of the health Master Plan.

One of the key aspects of recent health sector reforms, and one which will continue to be a major focus under HSSP, is experimentation with different forms of contract-based relationships between institutions providing, financing and managing health care delivery. These include contracting-in and –out (which involve private (NGO or, possibly, private for-profit organisations) contracted to manage public health facilities and staff) and “boosting” (in which the MoH acts as purchaser of health services from PHDs and ODs). In this context the role of M&E becomes slightly different from that it would assume in conventional public health services. Information under contracting and boosting arrangements is important because it informs the setting of targets and writing of contracts, and in determining whether contracted parties have succeeded or failed in delivering services as agreed (see MoH 2001: 23-28 on M&E for the boosting strategy).

A1.3 Summary assessment of existing M&E capacity

A) General comments and directions/priorities for HSSP

Accurate information is a prerequisite for planning systemic changes intended to remedy the inefficiencies and inequities in the health system. Capacity in various aspects of health sector monitoring has been much improved over recent years, and there is presently is a considerable volume of information available on certain components of the health system, or on health status and health services within particular areas. There are also many of the building blocks for a national health information system. Improvements in information on the health sector since 1990 include:

- The Health Information System: health facilities complete standardised monthly data collection forms; these are aggregated into monthly reports at the Operational District (OD) level, which are then passed to Provincial Health Directorates (PHDs), where they are in turn aggregated into a monthly provincial report which is submitted to the Department for Planning and Health Information in the central MoH.
- A National Level Indicators (NLI) framework: key national indicators which are reviewed annually to monitor priority aspects of health sector performance;
- The introduction of the Tableau de Bord, a data collection tool used at the facility level for internal performance monitoring and planning;
• reporting / health information systems specific to National Programmes: special forms used by facilities to report cases and treatments for the vertical programmes.

• A supervision system including an MoH personnel database; a programme of supervision between levels of the MoH, with forms (Integrated Supervisory Checklists, or ISCs) for each level; checklists for supervising National Programmes' operation (e.g. the MCH / EPI checklist); a financial reporting system, with forms completed at facility, OD and PHD level and submitted to the Department for Finance and Budgets in MoH; and (from 1998) an annual Health Centre Assessment exercise.

• A number of major quantitative studies of health status and / or health service utilisation. These include the 1998 National Health Survey (NHS), the Demographic and Health Survey (DHS), and the analysis of health differentials by household expenditure in the 1999 Cambodia Poverty Assessment (based on the data collected in the 1997 Socio-economic Survey of Cambodia (SESC)).

However, further improvement is required to meet data collection and analysis requirements, either of the HSSP or the MoH. As in many countries, the various component health information systems are not particularly well integrated (JHSR 2001 Paper 2: 22). There is thus a need to bring together the various strands of monitoring: financial reporting through the Finance Department, utilisation information through the DPHI, etc. Secondly, “there remains…a general lack of understanding of the real purpose of the HIS, supervision and reporting. This leads to people just collecting and accepting the data, rather than using the data as the basis for action or further investigation” (MoH / WHO 2001: 18). Current health information systems / health management information systems focus on channelling information up to the central level (where it is often unaanalysed and only marginally influential upon decision-making), missing out on opportunities for it to be used in decision-making on priorities and resource allocation at lower levels. The alert system used by CDC to report and respond to disease outbreaks is particularly in need of change.

The HSSP should therefore:

• Aim to build up capacity to collate, analyse and use information more effectively at all levels (central, Provincial and OD). Information collection at the facility level and information processing at OD and PHD levels should be informed by the principle “use it before you pass it on”: DPHI should help PHDs to train facility staff in using information in monthly management meetings and annual planning. Higher levels in the administrative hierarchy, meanwhile, should be more proactive, providing feedback on both the quality of information supplied and what this information suggests about facility, OD and PHD performance.

• At a later stage, efforts should be made to consolidate the various strands of monitoring (HIS through DPHI; financial reporting through DBF; vertical programmes (EPI, TB, malaria etc.) through relevant national programme offices; etc.). Options (alternative or complimentary) may include i) computerisation; ii) strengthening information sharing at each level (OD, PHD, MoH) between units handling different information flows (eg. between Finance and Planning Units); iii) reducing the volume of information collected, when it appears that certain indicators are largely unused in analysis; and / or iv) combining information onto fewer forms to reduce duplication. Efforts should focus initially on the first two approaches, which involve adding value to established health information collection and reporting systems: the latter two, which involve changing or
merging forms, are more disruptive, and should only be attempted if there is compelling evidence that the benefits will outweigh the costs.

- For some routine reporting it is worth exploring the potential for scanner-readable forms which would allow rapid collation of routine HIS data. This might be one way to avoid the drop-out in detail that currently exists (e.g. when HC data is totalled at the OD level, so that the PHD cannot distinguish between the performance and problems of different HCs).

- Expand the focus of health sector M&E to encompass surveillance of health service delivery outside the public sector, in order to provide a comprehensive picture of sector-wide change.

- Link the collection, analysis and interpretation of information regarding health system activities and outcomes to governance (e.g. by providing Health Centre Management Committees (HCMCs), Feedback Committees (FBCs) and NGOs with the information they need in order to hold health providers (public but also potentially private) to account). HSSP could examine the feasibility and potential cost-benefit ratio from providing training and / or some remuneration to these civil society organisations in order to improve their ability to exercise effective oversight of health facilities.

B) M&E capacity at the central level

At the central level, a key constraint is the small size of the Department for Planning and Health Information (DPHI) and, within this department, the Health Information System Bureau (HISB). WHO advisors have worked with DPHI, which contains good staff, but not enough of them. The current decision by the Ministry to recruit the acting Director of DPHI to lead on World Bank HSSP preparation has an obvious impact on the capacity of the Planning Department, and as such will need to be carefully managed. The proposal that someone of the acting Director's ability should lead on programme preparation makes good sense. However, there is a risk that this will leave DPHI further under-resourced at a time when it needs to increase its capacity to perform sector planning, monitoring and HIS management functions.

Regardless of the number of staff who are seconded to other duties related to HSSP preparation and management, the Programme will need to make a significant contribution to developing M&E capacity within the DPHI. This will involve both supplementing salaries and providing suitable training (see Annex 2). Dr Sao Sovanratnak, who heads the HIS Bureau within the DPHI, has identified short-term training inputs needed to increase the capacity of the Department to perform an M&E function, but has yet to find a suitable training institution to meet these needs (Thai and Filipino institutions approached to date having offered only very expensive, overseas training).

The National Institute for Public Health (NIPH) has received considerable support in recent years from GTZ, and has been responsible for developing the National Level Indicators for health sector performance; the National Health Survey (NHS) in 1998; the Demand for health care study (also 1998); and NIPH staff have also been involved in piloting computerisation of HIS systems in Kompong Thom. However, while NIPH staff now have the technical and many of the managerial skills required to carry out health studies and develop health information systems, there is some feeling amongst donor observers that the NIPH is somewhat isolated from the rest of the MoH. It is also rather lacking in senior leadership, as the Director is on long-term study leave.
A key role of central MoH institutions – particularly the DPHI and NIPH, but also line departments – will be to assist Provinces to develop the M&E capacity they require in order to assume greater powers of planning and budgeting.

C) M&E capacity at sub-national levels

M&E capacity below the level of the central MoH was hard to gauge from a brief visit. From seeing two HCs, one OD and the PHD in Pursat, it would seem that the various forms are completed without too much difficulty. While there is scope for reducing it further, the burden of information collection does not appear to be as excessively heavy as it is in many other countries\(^2\). More importantly, there are unrealised opportunities for the information that is collected to be used before it is passed up to the next level in the hierarchy.

Since the introduction of the current MoH HIS in 1994 there have been concerns that routine HIS / HMIS monitoring data may be inflated at the point of collection. As supplies to health facilities are based in part on utilisation, there is an incentive for staff in HCs and hospitals to over-report treatment on utilisation (HIS) and essential drugs reporting forms, allowing staff to sell the excess drugs supplied. To check on this, the HISB has carried out an Essential Health Costing Analysis\(^3\). This survey found no evidence of the inflation of HIS data, whether in facilities that were contracted out, those in which services were contracted in, or those control sites which functioned under normal, direct MoH management. This may, however, reflect the fact that all those facilities visited were all in receipt of some form of donor support: inflation may be occurring in facilities that have less resources and less supervision.

GTZ / NIPH has supported the computerisation of HIS collection and analysis in Kompong Thom\(^4\). The primary benefit obtained is that it is possible for higher levels in the HIS hierarchy to directly disaggregate data right down to HC level: in other words, the DPHI in Phnom Penh can break down by OD or HC information supplied by a given province, and PHD staff can compare and contrast patterns in different HCs using the information they receive from ODs.

D) Recommendations re: linking M&E capacity development and decision-making

It is recommended that HSSP:

- **Consolidate and improve M&E capacity at the central level.** DPHI should concentrate upon routine monitoring and some issue-specific, management-focussed evaluations; better integration of information into decision-making; and development of M&E / HMIS capacity at Provincial and OD levels. Periodic evaluations of HSSP should be external and independent: NIPH, together with the HSSP Programme Co-ordinator, will schedule and commission these evaluations, including writing the ToR, with DPHI consulted.

In terms of the reporting and validation functions for which DPHI would take lead responsibility, interviews during the course of the mission suggest that there are two alternative models are currently favoured by MoH and donor staff. The first would involve building up an M&E Unit within DPHI (through

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\(^2\) In one Health Centre staff estimated that five of the eight staff each spent one morning per month compiling a report from the patient record book. In the second HC the head of the HC estimated that he spent a day per month compiling reports, while the other staff would also spend some time on the task.

\(^3\) Over a two-month period, HISB staff visited a randomly selected sample of 15% of those who had visited one of 30 health facilities in 4 provinces, and 15% of outreach contacts over the space of a month. These individuals were asked if they had indeed received the treatment reported in the HIS.

\(^4\) Data from health facilities is entered into a bilingual (Khmer and English) Access programme at the OD level. Denominator data (village populations) common to the calculation of the majority of the ratios used as HIS indicators is entered and an automatic multiplier is applied to account for annual population growth. The monthly data is sent on a floppy disc to the PHD for analysis and aggregation.
recruitment and training), and increasing its influence upon policy (by institutionalising regular meetings with the Minister, D-Gs and donors in which it would report on sector progress and emergent issues). The alternative arrangement is to create a cross-departmental body (an M&E task force), in which DPHI provides the secretariat, but staff from other departments (e.g. CDC, Finance, etc.) are also represented. WHO favours this latter model, proposing a cross-departmental M&E/Support Team for managing the monitoring of boosting. (Large, more episodic evaluation activities are to be assigned to NIPH under this arrangement.)

The attraction of a cross-departmental structure is that it has the potential to internalise awareness of the importance of M&E and learning in key operational departments, rather than have M&E relegated to a specific unit. If line departments are involved in identifying indicators and helping to develop monitoring frameworks, it is argued, they are more likely to enforce compliance with monitoring and evaluation requirements. However, this potential must be balanced against the problems observed in other cross-departmental bodies, in the MoH and elsewhere in government structures. As key personnel are under severe time pressure they tend to send junior staff, or no staff, to inter-departmental meetings in their stead, with the result that meetings are largely ineffective. Given these problems with the cross-departmental task force approach, it is therefore recommended that a much strengthened M&E unit is created within DPHI, but that quarterly review meetings are held which senior staff of other departments must attend.

It is recognised that extremely low salaries are a major impediment to improving performance, in the MoH as throughout the public sector in Cambodia. The draft budget for M&E activities in Annex 2 provides a rough estimate of the costs of salary support as part of a package to improve M&E capacity at the central level. On the basis of other initiatives in Cambodia (including that of “boosting” within the health sector), it is clear that salary supplements are a necessary but not sufficient condition for improved performance: to be effective supplements will have to be linked with improved HR management procedures (in terms of clarified job descriptions and performance assessment, for example). These systems should be designed with reference to accumulated experience gained to date with regard to improving performance through salaries and HR management in Cambodia. Salary supplement arrangements should obviously not be developed for the M&E positions in isolation, but as part of a consistent and coherent HSSP-wide (ideally Ministry-wide) set of salary supplementation scales and associated practices. Finally, health sector salary supplements and their linkages to performance appraisal should be designed so as to be consistent with planned national-level reforms. If these national plans, developed as part of a package of civil service reforms, are too underdeveloped to provide a point of reference for those designing HSSP arrangements during the pre-implementation phase, there should be a clear requirement within HSSP-specific arrangements for these arrangements to be replaced by national arrangements as and when these emerge.

- *Support the development of M&E capacity at the PHD level.* PHDs should be helped to make more use of information collected from facilities; to provide feedback; and to organise more pro-active M&E activities (e.g. reviews of particular aspects of the provincial health system, monitoring of health behaviour and private sector provision, or small-scale outcome evaluations). In monitoring the performance of ODs, the PHD should supplement active scrutiny of routine information with quarterly field audits covering each OD and
a randomly selected 2 HCs within each OD, and use both the routine and audit information in quarterly and annual planning and budgeting. Draft guidelines and reporting forms for these field audits already exist in the MoH5.

For the PHDs to take on these M&E responsibilities would involve providing salary and other support to 2 PHD staff in the PHD Office of Planning and Health Information in each of the 23 Provinces. It will also require considerable support at the central level to enable DPHI to assist in developing M&E capacity at Provincial level. Ideally the capacity of the centre to provide support to M&E at the provincial levels would be improved before attempts were made to develop PHD capacity: in practice, national and sub-national capacity building will have to proceed simultaneously.

A1.4 Indicators and methods of data collection

A) Sector impact indicators

Considerable work has already been done in Cambodia on sector-level health indicators. A framework of National Level Indicators (NLI) was finalised in November 1999, and provided the basis for the first Annual Health Sector Report a year later. The Health Sector Performance Report framework, using the NLI, contains 51 quantitative and 15 qualitative indicators grouped under the headings of i) overall level of national development; ii) health financing; iii) increasing access and utilisation; iv) improving quality; v) improving health outcomes.

Ideally, HSSP indicators should fit as closely as possible with the NLI structure. However, this structure itself is likely to be revised somewhat with production of the sector Master Plan (see DPHI 2000: 8), currently scheduled for October 2002. Many of the NLI indicators relate to important process or output goals: training of health staff, the level of public funds committed to health, and so on – which can be obtained from analysis of managerial and financial information collected within MoH. However, many of the sector-level outcome / impact indicators identified within the NLI framework can only be collected through episodic national sample surveys: the system for reporting essential statistics (births and deaths) is not regarded as adequate to the calculation of (for example) infant mortality rates. Thus for many of the higher-level sector indicators contained in the NLI (e.g. outcome KAP / behavioural change indicators such as contraceptive use and antenatal and postnatal practices, and impact indicators such as fertility, infant and child mortality rates), the only truly reliable national measures to date are those which were collected through the census in 1998, the National Health Survey (NHS) in 1998, and the Demographic and Health Survey (DHS) in 2000. Of these estimates, those in the DHS are generally considered the most reliable (see NIS et al 2001).

There is a case for the M&E component of HSSP to include funding towards one or more future rounds of the DHS, both as a way to assess the impact of HSSP, but more generally, and more importantly, as a contribution to sectoral understanding and sectoral planning. UNFPA, among others, favours conducting another DHS in 2004; however, many of the donors who funded the previous exercise and who have been approached to fund the proposed 2004 exercise (e.g. UNICEF and USAID) have declined. The DHS is undoubtedly an extremely expensive exercise (the 1998 survey cost c. $800,000) and it may not be sensible to conduct another within a mere 5 years of the first survey, when outcome / impact indicators are relatively slow to change. However, there remains a good case for HSSP contributing at least some funding towards one DHS. From the perspective of the donors involved in HSSP, if only one DHS can be funded, a DHS conducted in 2004 would be useful, but one

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5 See MoH 2001 pp. 25-6 on PHD M&E responsibilities.
conducted towards the end of the programme (on present formulations, 2009) would be more valuable. Accordingly, funding for one DHS has been included in the sketch budget for M&E activities (see Annex 2).

B) Component indicators: process, output and outcome

The Aide Memoire provides a structure of components, sub-components and activities. While this structure is likely to change as programme preparation proceeds (especially if ADB programming is incorporated along with World Bank and DFID programming), suggested indicators for key activities and notes on how the more complex indicators might be measured are given in Annex 1. In particular, this addresses the question of how to rapidly but accurately identify the poor in order to monitor the impact of HSSP-funded activities (and health reforms more generally) specifically on the poor.

A1.5 Independent sector monitoring function and HSSP evaluation

The organisation of joint (Government-donor) sector-wide reviews of progress is a crucial part of the process of moving towards a more sectoral approach to health sector funding and development. These annual sector performance reviews should provide an overall picture of both i) health outputs (coverage, quality of care etc.) and outcomes (morbidity, mortality, etc.), and ii) intermediate process indicators (level and allocation of resources, status of policy development, planning and management arrangements, etc.). Annual joint reviews of the health sector conducted in other countries may provide models (Dubbeldam and Bijlmakers 1999: 38). In Cambodia, the first Annual Health Sector Report (2000) produced by DPHI provided a first step in this direction: however, a sector-wide review could and should contain more disaggregation and analysis. The Joint Health Sector Review (in 2000) provided this kind of analysis, but appears to have been conceived as a one-off exercise related specifically to the development of the SWIM. Future exercises of this kind should also be fully integrated: although the Main Findings section is well-written, the document as a whole still reads as four papers.

It is in organising the annual sector performance review that issues regarding the overlap between the programme and the broader process of sector reform and sector-wide management – that is, the relationship of HSSP to SWIM – are most important. The SWIM process should involve an annual joint sector review examining all aspects of reform progress: and HSSP should support this as part of support to the SWIM. Given the desire to move towards sectoral management, and given that the HSSP will account for the single largest and most comprehensive programme of external assistance to the sector, it is recommended that the sector review is also used as the information base for the annual review of HSSP. In other words, while there should be an annual series of meetings and a short annual report relating specifically to HSSP implementation, these should draw on the findings of the sector review, rather than involve further rounds of data collection and analysis. Conducting a very “light” separate HSSP review that relied primarily on the findings of the sector review would reduce the burden on MoH; provide a better base for judging the relevance and relative effectiveness of HSSP-funded activities by setting the achievements and problems of the HSSP in the context of the whole sector; and will provide an opportunity to compare HSSP-supported Districts and Provinces with those not included in HSSP, providing controls and benchmarking.

In order to ensure that other donors do not perceive a HSSP-funded annual sector review as an appropriation of a common document, it is essential that other donors are encouraged to contribute to both the funding and the oversight / steering of this annual review process. This is important both to ensure that all major actors in the
sector are involved in the analysis and recommendations, and to reduce the burden of the reviews upon ADB, WB and DFID.

This annual sector review should be carried out by independent organisations. In other countries national research institutes or university departments (see SPM 1998 on Zambia) or a team of external and local consultants (as in Bangladesh or Ghana: see Walford 2001) have been contracted to provide sector reviews. In Cambodia this task might be given to CDRI (although they have no particular background in the health sector) or Crossroads. Alternatively, an international consultancy or evaluation NGO could be contracted. The ideal would be to commission a consortium which combined an organisation which had extensive international experience of conducting sector reviews with an organisation possessing good knowledge of Cambodia.

A formal review of the annual sector performance document would then occur between RGC (MoH, MoEF), donors and NGOs, which would discuss the findings and come to decisions on how they should be reflected in the next round of annual planning and budgeting. Such an arrangement should ensure that all stakeholders are represented in the annual review process, without needing to include them all in the sector review mission itself.

It is necessary to identify a suitable institution to take on responsibility for contracting and managing these reviews and subsequently disseminating the findings and incorporating them into MoH policy-making and planning. Various options for the management of the sector reviews were proposed by different stakeholders during the course of the mission. These suggestions included:

- DPHI, or the HSSP-supported M&E Unit within the Department
- NIPH (which is likely to be contracted for evaluation of the boosting strategy: MoH 2001: 24);
- the MoH Directorate-General of Inspection;
- CoCom, or possibly the sub-CoCom for NHIS with a revised, expanded mandate; or
- some tripartite government-donor-civil society body. It would be desirable to have some Cambodian civil society representation in the management of the sector review. This is hard at present, as there are no national-level health consumer bodies. One possibility is a steering committee with representation from MoH, WHO, one of the other major health sector donors (ideally one of the HSSP donors) and MediCam.

None of these proposed structures is ideal. As mentioned previously, under current arrangements DPHI lacks the capacity to assume the role of managing sector reviews. NIPH is seen as somewhat remote from the remainder of the Ministry, which may impede its ability to manage a high-profile oversight function. While the management of the review would seem to fit quite well with the formal definition of the competency of the D-G of Inspection, it was not possible during the course of the mission to assess its actual capacity of this body. CoCom, meanwhile, may be too large, and its effectiveness at any one time too dependent upon particular actors (in a membership that is subject to change), to provide a reliable long-term review sector management function.

It thus seems that it will be necessary to create a new body, with representation from the government, NGOs, and major donors in the sector (defined in terms of both financial contribution, e.g. the HSSP donors, and special status and technical competency, e.g. WHO). More work will be required to learn from other international
examples, and to reach an agreement between stakeholders regarding what might be suitable in the Cambodian context.

There will remain a need to assess the performance of HSSP itself on a periodic basis. ToR for the HSSP review would be drawn up by the HSSP Steering Group, in consultation with the DPHI M&E Unit and NIPH, and, through CoCom, actively informing other sector stakeholders (other donors and MediCam) of the review process and findings. These HSSP evaluations would involve detailed examination of the specific components of the health sector supported by HSSP, as well as an assessment of the overall level and quality of influence exercised by HSSP on sector policy formulation and implementation. They should include special surveys to collect information on information which is hard to collect during routine monitoring, particularly higher-order (outcome or impact) indicators.

In discussion with DFID it was proposed that three such evaluations should occur. If it was possible to reduce the number of evaluations to two (mid-term review and final evaluation), this would reduce the burden on the MoH (which would otherwise be dealing with a HSSP survey mission every other year), and reflect the fact that hopefully much of the basic sector information can be collected during the annual sector review. However, the programme is undoubtedly complex, and may benefit from a third evaluation (in which case the sequence would be an initial evaluation of progress in year 2, a mid-term review in year 4, and a final evaluation in year 6). It is recommended that the issue of whether to have two or three HSSP evaluations is left open for the moment, with a review of the issues and a decision on the need for an evaluation scheduled for 18 months into the programme. To keep options open, three evaluations are included in the budget, costed at $100,000 each: should only two evaluations be held, the balance can be reallocated to other activities within the M&E envelope. Regardless of whether two or three HSSP evaluations were held, each should be timed to coincide or follow shortly after the annual sector reviews so as to make the most of the existing information base, and to focus on specific issues which the sector review can identify as meriting further attention.

**A1.6 Linking health sector monitoring to other development goals**

The two-way links between ill health and the lack of affordable quality health care on the one hand and poverty, vulnerability and slow economic growth have been explored in some detail. In Cambodia it is particularly important to note that households spend an unusually high amount on out-of-pocket health costs: an expensive and ineffective health system contributes to indebtedness and loss of land, driving households in poverty and vulnerability. At the national level, this retards economic growth and the structural changes that economic growth makes possible.

It is desirable to link monitoring of progress in the health sector with any framework that may be developed for monitoring national poverty reduction. Unfortunately the PRSP development process in Cambodia currently appears to be stalled, and no work has yet been done on developing a PRSP-focussed poverty monitoring system. The MoH, HSSP Steering Group and partners should remain open to involvement in the development of PRSP analysis, policy and monitoring arrangements. It may be productive to approach this through links with CDRI and

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6 There is a potential contradiction between the plans presented here and those implicit in the draft costings for component 2 ("Annex 1: Summary of estimated targeted expenditures of the capacity-building / HR development component of the HSSP") prepared by the Planning and Capacity Building Specialist on the mission. This Annex provides $20,000 p.a. for support to a joint annual health sector review (Y1, Y2, Y4, Y5), and $40,000 for one joint mid-term health sector review (Y3). It is not clear whether these reviews are intended to also serve as HSSP annual reviews (given the reference to a mid-term review). It is also not clear whether these estimated targeted expenditures are officially part of the current proposal, as they were not submitted along with the Aide Memoire. For consistency, these two items are included in the preliminary costing of M&E activities presented in Annex 1 below.

7 NGO Forum 2001; conversation with DFID Governance Advisor, Phnom Penh.
Oxfam, both of whom have been involved in tracing the causal links between household expenditure on health care, distress sales of land, and resultant poverty. More generally, it is likely that there will be research studies not specifically focussed upon the health sector which nonetheless provides opportunities for the collection of health care and health status data, and for relating this data to data on other aspects of socio-economic development. HSSP should be aware of, and where possible actively involved in, these studies, and build them into its M&E plan (once the planning of HSSP is sufficiently advanced for this to make sense).

A1.7 Summary of key recommendations

It is recommended that HSSP undertake the following interventions with regard to M&E / HMIS:

In the pre-implementation / programme preparation phase:

- Conduct an evaluation of the pilot computerisation of HIS / HMIS systems at the OD and PHD levels currently in place in Kompong Thom, and if these findings are positive conduct a feasibility study and draft a budget for scaling up the pilot under HSSP. The feasibility study should be used as the opportunity to explore what institutional arrangements and inputs would be necessary to strengthen information sharing at each level (OD, PHD, MoH) between units handling different information flows (eg. between Finance and Planning Units); and to begin work on expanding the focus of HMIS arrangements to encompass surveillance of health service delivery outside the public sector, in order to provide an accurate picture of sector-wide change;

- Conduct a review of DPHI institutional and HR development needs with regard to M&E; provide material inputs required to strengthen DPHI M&E capacity; establish arrangements for salary supplementation for c. 10 DPHI M&E / HMIS staff; and source and contract a provider of short-term training for these staff.

- Review with MoH and partners the institutional development and HR inputs required to develop the M&E capacity of PHDs; cost this programme; and begin to implement it. This may require: reviewing the feasibility of paying salary supplements; the identification and contracting of suitable training institutions; the contracting of suitable long-term TA inputs; and the procurement of basic material inputs required to improve the collation and analysis of HIS / HMIS data.

- Assist the MoH in compiling baseline data for key indicators listed in this document. Many of these are presented in the first Annual Health Sector Report (2000). Others can be compiled from research compiled since then: for example, the DHS, and the final evaluation of the ADB-supported contracting-in and contracting-out pilots.

- Start work on developing the capacity of public health service managers at all levels to monitor and evaluate the performance of parties contracted to deliver health services under boosting arrangements (MoH 2001: 8-9, 23-28;), including regular field audits.

During the first one-two years of programme implementation:

- Build the capacity of central MoH to pull together findings on the outcomes of the various on-going pilots and experiments (contracting in and out, boosting,
etc.), to improve the ability for MoH and its partners to compare emerging evidence from different approaches in a more systematic manner.

- Work with the MoH and other partners to organise annual sector reviews, and integrate the findings into i) annual planning and budgeting and ii) policy-making.

- After eighteen months of programme implementation, hold a workshop to review evidence and impressions of progress to date, and to decide on whether an evaluation of HSSP is called for at the end of year 2. If it is decided that an evaluation is necessary at this time, to draw up ToR for this evaluation.

In subsequent years of programme implementation:

- Expand the use of information to improve health sector governance, providing the public with information on health system financing, activities and outcomes in order to hold health providers (public and potentially also private) to account. This would start at the local level with increasing the provision of relevant information to Health Centre Management Committees (HCMCs), Feedback Committees (FBCs) and NGOs.

- Build up incentives and capacity for lower levels of the public health service (PHD and OD, maybe later HC) to analyse and use information in decision-making on priorities and resource allocation, rather than, as at present, focus primarily on channelling it up to the central level. Tools such as the Tableau de Bord should provide a starting point. More feedback (from MoH to PHDs and ODs, and from PHDs to ODs and facilities) on quality of data submitted would increase the motivation to improve collection and use.

- Consider the costs and benefits of consolidating the various strands of monitoring (HIS through DPHI; financial reporting through DBF; vertical programmes (EPI, TB, malaria etc.) through relevant national programme offices; etc.) by reducing the volume of information collected, when it appears that certain indicators are largely unused in analysis; and / or by combining information onto fewer forms to reduce duplication. Changing or merging forms is likely to be disruptive in the short term, and should only be attempted if there is compelling evidence that the benefits will outweigh the costs.

- Schedule, contract and manage two HSSP evaluations: one mid-term review falling in either year three or year four (depending on whether an evaluation was held in year 2), and a final evaluation (including recommendations on whether to consider programme extension) in year six.

- Negotiate with MoH and other sector partners about the timing and funding of a DHS; work on proactively integrating sampling, interview forms and analysis so as to integrate with, for example, LSMS data.

Finally, it should be reiterated that these recommendations are provisional. It would be misguided to make final decisions on the form of M&E arrangements when the sector Master Plan is not completed and when many key design issues for HSSP – most notably the decision on how many provinces are to be supported, and how – have yet to be made. More work will be needed to refine this plan once more decisions have been made on the shape of the HSSP programme.
A1.8 Key references on monitoring and evaluation

n.a. 2001 Cambodia Joint Health Sector Review. Particularly Paper 2 (Health systems and services) pp. 22-3.


NGO Forum 2001 Rapid Assessment of the PRSP Process in Cambodia: Two Banks, Two Processes, Two Documents. Prepared by the NGO Forum on Cambodia on behalf of the Asian NGO Coalition (ANGOC) for the East Asia-Pacific Regional NGO Working Group on the World Bank: September 2001:


Rohan 1999 *no title (review of national health information system)* WHO.


Annex 2: Suggested indicators for monitoring HSSP components

As discussed in section 2, these indicators are based on the existing draft outline of HSSP. The indicators will need to be reviewed as the programme evolves.

A.2.1 Indicators for Component 1: Improving the provision of health services, especially for low income groups.

The objective of this component is to improve the accessibility and affordability of primary health care and first referral services (MPA via health centres, CPA by referral hospitals). To achieve this objective, HSSP will fund activities under several sub-component headings.

- civil works and medical equipment; development and piloting of a maintenance system. The revision of MPA and CPA packages will require revised standard designs and equipment lists for HCs and RHs. These standard designs will then provide the basis for indicators of programme and sector progress in regard to health infrastructure (i.e. number of HCs and RHs rehabilitated, extended or newly-built to standard design criteria and equipped as required for MPA / CPA criteria; percentage of HCs and RHs in HSSP-supported provinces that meet these criteria). The civil works specialist on the WB-DFID mission has recommended facilities mapping and a general health facilities survey to be carried out in HSSP-supported provinces prior to the start of the programme. Given the importance of the private sector in the provision of health services in Cambodia, this mapping exercise should include private as well as public facilities. While the problems with quality of care in the private sector are acknowledged, it is important to be able to distinguish “access to private care only” from “no access to local modern health services", and to be able to pick up when low utilisation of public facilities is not due to lack of effective demand for modern medicine but due to problems with the public health system.

Apart from providing a planning tool, this facility mapping and health survey will provide a baseline for monitoring progress. Process indicators will include the number of Maintenance and Repair Units and equipment maintenance and repair workshops created and fully staffed (central and provincial levels).

- Pharmaceuticals. The draft Aide Memoire currently specifies only pre-implementation, programme preparation activities with regard to the pharmaceutical sub-sector. Realistically, however, it seems likely that some of these objectives will not be completed by the start of the programme. Process indicators for these activities – which, if not completed by the start of the programme, should be early priorities for the HSSP - will include i) completion of an analysis of the drug procurement, stock management and distribution system; ii) completion of a feasibility study of alternative solutions to problems identified; action plan agreed and then implemented; iii) separate indicators for aspects of the upgrading of the national drug laboratory (indicators for physical facilities, equipment, staff, management capacity and financing); iv) completion of a feasibility study of drug revolving funds and equity funds; and v) development of pre-payment arrangements (see below under innovative financing arrangements). Output indicators will include increased availability of MPA and CPA drugs in HCs and RHs respectively.

The draft programme document does not yet specify outcome indicators for the pharmaceuticals sub-sector. Such measures – such as % of prescriptions conforming to diagnostic guidelines, % of patients complying fully with
prescriptions (e.g. size and timing of dose, completing the course of treatment) - might be derived from health staff and patient surveys, the former to assess whether training resulted in improved prescription practices and the latter to judge whether patients followed the advice given. Surveys of prescription practices would have to distinguish between public health staff (in HCs and RHs), private practitioners and pharmacists. They would also have to distinguish between facilities provided with different kinds of training and management support. Such surveys would entail quite complex questionnaire design, interviewer training and sampling in order to obtain an accurate picture of how people actually prescribe and use drugs (rather than against what health providers might say they would do when presented with a given set of symptoms), and in order to establish what the correct course of treatment for a given patient should have been, against which to score the prescribed course of treatment for accuracy. It is also hard to obtain the cooperation of private providers and pharmacists, who are likely to refuse to have their prescription practices subjected to examination (note the reluctance of these actors to participate in the Approved Providers Scheme (APS) attempted under the Urban Health Project: see Walford et al 2001).

It is therefore likely that it would only be feasible to obtain these kind of indicators (on the prevalence of correct prescription and subsequent patient compliance) with regard to a few common ailments for which M&E staff can fairly easily identify what constitutes correct prescription on the basis of a few simple diagnostic indicators. It would be useful to complement survey data with data obtained from directly observing treatment. Both methods do entail a fairly intensive M&E commitment: it would probably only be possible to obtain indicative rather than statistically representative sampling from a few case study facilities. This would nonetheless give a reasonable insight into whether public sector training, supervision or other management interventions, private sector regulation, and / or public health education succeeded in making an impact upon provider and patient behaviour.

- Development and piloting of innovative financing schemes – including development and piloting of arrangements to protect the poor and monitor access and affordability of services for the poor.

Over recent years several approaches have been piloted to address the need to generate income for the public health system and increase the effectiveness with which this revenue is used, while sustaining and improving the ability of the poor to obtain access to and afford health services. All of these approaches have involved a combination of increased core financing (reducing the incentive for facility staff to charge the poor informal fees) and improved management (to ensure adherence to formal user fee and exemption policies, so that those fees which are charged are progressive rather than regressive in impact). These initiatives include OD-level contracting-out and contracting-in pilots; “boosting” efforts; and the development of equity funds intended to reconcile exemptions for the poor with health facilities’ needs for cost recovery (addressing the observed failure of exemptions policies in the absence of these arrangements for reimbursement).

Central to the design of the HSSP is an awareness of the mutually-reinforcing links between poor health, expensive and ineffective health care, and poverty. It is therefore essential that initiatives which improve the accessibility and quality of health care do so in a pro-poor manner. This will include: increasing physical accessibility of health services (through construction of health facilities, or transport improvements, or outreach services); increasing the affordability of health services, and decreasing the burden of health spending on the household economies of poor households; increasing the effectiveness of health services
used by the poor. The HSSP M&E system will need to monitor progress in achieving more pro-poor services and more appropriate health care use by the poor.

The main difficulty is finding a suitable method by which to identify the poor in order to monitor their utilisation of, expenditure on and satisfaction with health services, and to evaluate their health status. Such a method of identifying the poor must be:

- accurate (that is, it must include the great majority of the poor and exclude the great majority of the non-poor);
- flexible enough to pick up local particularities in the manifestation of poverty while establishing an objective, universal standard for the meaning of poverty throughout all 23 provinces (so it does not include those deemed poor in Kandal, who would be deemed non-poor in Koh Kong);
- verifiable by the observer – that is, not subject to opportunistic responses by households who may believe that their identification as poor may bring benefits and answer accordingly;
- and, above all, relatively quick and simple to use, so that utilisation, expenditure, satisfaction and health outcomes amongst the poor can be assessed periodically without a prohibitive cost in time and money.

Such a method is not easy to come by, but ideas can be drawn from studies to date. The most valuable information on health service utilisation by the poor as compared to the non-poor comes from the 1999 MoP/World Bank Cambodia Poverty Assessment. In this research, however, the identification of the poor was derived from a national sample survey (the second (1997) Socio-Economic Survey of Cambodia, or SESC) involving a lengthy household expenditure questionnaire. Such an expenditure-based method of identifying the poor will be too cumbersome and expensive for the HSSP to undertake on its own: while it is highly likely that donors will fund subsequent SESCs, it is understood that there are at present no firm plans for these. Furthermore, assuming that an SESC is conducted every 4 or 5 years, this will provide only one point of reference during the HSSP period. Depending on when HSSP starts and when the next SESC is conducted, it is likely that the baseline data will have to be the 1997 data analysed in the 1999 Poverty Assessment. And as analysis of SESC data tends to take two years from the year in which it is collected, any future SESC-based insights into health care and health status amongst the poor will lag.

Alternative methods exist for identifying the poor in order to compare their experiences with those of the non-poor. These include the method used to track service utilisation by the poor in the ADB-financed piloting of contracting arrangements. This involved developing an index of 8 key housing characteristics or household assets (see Box 1), in which the weight assigned to the presence of a given indicator was the natural log of the inverse proportion of households that possessed this asset: in other words, the fewer households had a given asset, the higher its value. A frequency distribution of total household scores was used to define socio-economic status quartiles (Keller and Schwartz 2001: 13, 10).

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9 Note that there is also a need to identify the poor on a routine, operational basis in order to target exemptions from user fees (and the allocation of equity fund payments to cover user fees). Compared to the process used to identify the poor in monitoring the pro-poor distribution of expenditure, utilisation, satisfaction and outcomes, the criteria and method used in this operational definition of poverty will of necessity be less accurate and above all less geographically uniform. Equity funds will use community definitions of who is and is not poor: this will vary between communities, whereas HSSP monitoring requires a more objective definition of poverty.
Box 1: Housing characteristics / assets used in ADB socio-economic status (SES) scoring

- Roof of permanent material (brick, cement, metal or a combination of these)
- Bicycle
- Radio
- Motorcycle
- Television
- Oxcart
- Boat with outboard motor
- At least one cow or water buffalo

If this approach is used, there are several options available regarding the selection of household characteristics or assets used to construct the household wealth scores and thus the quintiles. Firstly, HSSP monitoring could simply use the 8 characteristics used in the ADB study. Assuming that HSSP works in the 12 ODs in which ADB studied performance, using the ADB criteria would have the advantage of enabling comparison between status at various stages during the HSSP with status in 1997 and 2001 (the dates of ADB surveys). Alternatively, HSSP could develop its own list of criteria. Ideally, these would be criteria which correlate closely with household poverty status as identified by p.c. expenditure from the SESC II, with the weightings given to each criterion in the construction of a total household SES score derived upon a multiple regression with poverty status rather than from simple prevalence in the population. The Poverty Assessment conducted a multiple regression analysis with this in mind (Mop / WB 1999: 15-17). The advantage of this method would be that it might provide a basis for comparison between findings on the relationships between health and poverty in the SESC (1997 and any future date) with survey findings on this topic obtained from annual HSSP / health sector reviews. Unfortunately the characteristics that emerge from the SESC 1997 / Poverty Assessment analysis as highly correlated with poverty (e.g. floor area per household member, distance to drinking water source) are somewhat time-consuming to collect and/or calculate, being more suitable to an in-depth, core-and-module household expenditure survey.

On the basis of the information collected during the course of the mission, it seems that using the ADB criteria may be as good a method as any. However, given that monitoring and evaluating the poor’s access to, expenditure on and outcomes from health care is central to the HSSP, this may be an issue that the partners in the HSSP wish to examine in more detail. Such a feasibility / options study should be conducted as early as possible and completed before the start of the HSSP. It would need to involve a re-analysis of the SESC data, exploring the possibility and value of a regression which uses only indicators pre-selected for ease of observation or measurement; and would have to update the analysis contained here with regard to progress made (if any) in planning national poverty monitoring as part of the PRSP or other sector plans. It would require a researcher with a strong background in poverty analysis (quantitative analytical skills essential, understanding of qualitative methods desirable).

The intention is to devise a relatively simple and low-cost method that enables comparison of utilisation rates and health spending amongst the poor and non-poor. It could also consider looking at perceptions of services. A sample survey could be conducted as part of the annual sector review process. This annual sector review would be funded by HSSP, along with other donors. For those
activities which are developed only in selected provinces rather than nationwide, this annual sector review would allow comparison of performance in HSSP and non-HSSP-affected areas. These annual findings on health care use by the poor can be checked against the more episodic findings on utilisation by per capita expenditure quintile, derived from SESC data (should an SESC be conducted during the HSSP period - which is reasonably likely - and should the results be available in time - which is less certain). If sample sizes are sufficiently large and sample provinces are selected to contain large numbers of ethnic minority (Cham, Vietnamese, Khmer Loeu) populations, it should also be feasible to disaggregate utilisation and expenditure data by ethnicity.

What this asset-poverty approach to identifying and surveying the poor on an annual basis will not enable is accurate and relatively precise calculation of the affordability of services, that is, health spending as a proportion of total household spending. This will have to wait for household expenditure data collected during the next SESC sample survey. More intensive methods (both qualitative and quantitative) will also be required to explore in detail the sequence of causal links between health spending and vulnerability to falling (deeper) into poverty.

It is essential that HSSP supports the expansion and refinement of arrangements to ensure the poor can afford access to health services. At present, most attention has centred upon the formation of local equity funds, which pay for health services of those officially recognised as poor. Basic output indicators for progress in this sub-component will include number of operational equity funds. However, equity funds require quite complex arrangements in order to be effective, and will need to be monitored closely to ensure that they do serve the poor rather than the non-poor, and to ensure that they do not create perverse incentives (i.e. encouraging over-utilisation). The key indicators (all related, specifying similar in different ways) will obviously be numbers of those poor- and non-poor households using health services which have costs paid (partially / fully) by equity funds, % of all households receiving support from equity funds which are poor cf non-poor and % of those poor households which use health services which receive support from equity funds. All of these get at the questions of whether it is indeed the poor who benefit from equity funds paying for their healthcare. These indicators should be disaggregated geographically (certainly by province and preferably by OD if sample size is large enough to allow this, although this is unlikely: see below); by type of facility (OD and RH); and by type of equity fund arrangement, in the event that more than one model is followed, by HSSP and / or other actors.

There is also the possibility that arrangements other than equity funds (e.g. village credit schemes which provide loans to meet healthcare costs) will be piloted or eventually mainstreamed within HSSP as a means of reconciling the financial sustainability of health facilities with the need to ensure affordability for the poor. A basic output indicator for judging the performance of such schemes would, as for equity funds, be the number of operational village credit schemes offering loans for health purposes, or the total population in the catchment areas served by such schemes. Indicators of sustainability would be rates of repayment; indicators of effectiveness or impact would once again involve reviewing lists of who received loans for healthcare and calculating the % of recipients who are poor and the % of poor seeking health care who received a loan.

Hopefully it will be possible to obtain this information from the yearly sample survey conducted as part of the annual sector review, as described above. However, sample size for the annual national survey may not be large enough for...
this purpose, depending on how widespread equity funds become: it may be the case that the number of facilities with operational equity funds grows slowly and the number of households in the annual sample survey which use facilities which have operational equity fund arrangements is too small to be yield statistically meaningful results. In this case it may be necessary to carry out a few case study surveys in a number of selected ODs (preferably using the same asset / housing characteristic-based method of identifying the poor as is used in the annual national surveys) specifically to test access to equity funds by poor and non-poor.

With regard to other indicators of equity fund performance, Annex F makes clear that there are still many “open issues” yet to be decided regarding the form(s) of equity fund that will be promoted through HSSP. These issues include the scope of costs to be exempted under equity fund payments (which could include one or more of HC fees, referrals, obstetric services, or drug costs); population coverage; criteria for exemption; caps on benefits; and reimbursement rates (total or partial). These design issues will to a large degree determine the precise indicators to be used in monitoring and evaluating equity funds. Whichever model or models are adopted, however, other key issues in monitoring the performance of equity funds will include deriving suitable indicators for quality of care provided to the poor under exemptions covered by equity funds; and monitoring the hoped-for but more intangible governance-related benefits (in terms of equity fund managers providing collective and informed representation of the interests of poor patients).

These indicators (especially the last of these) might be approached by facility-based rather than household-based surveys. This would make them feasible as a task for episodic but nonetheless routinised MoHM&E. Responsibility for assessment of quality of care and governance benefits arising from equity fund operation could potentially be incorporated either within the health centre assessment exercise or the Health Economics task force’s monitoring of user fee schemes. Given that most of the key performance issues are related to a review of equity fund accounts, it seems better to assign responsibility to the health economics task force.

A2.2 Indicators for Component 2: Health Sector Reform and Efficiency Improvement

The draft Aide Memoire identifies three areas of focus under this component (strengthening MoH management responsibilities; strengthening health administration at decentralised levels; and developing human resources), with five sets of activity. The definition of the five activities differs somewhat between the main text and Annex G. For the purposes of this document, the main text is taken as definitive, and material in Annex G is drawn upon when it relates to activities mentioned in the main text.

Partly because interventions under this component are related more to process and output indicators (policy reform and capacity building) rather than health outcomes, and partly because this component is most directly dependent upon future progress in developing the SWIM Masterplan, it is hard to specify at this stage indicators for activities under this component. This difficulty in specifying indicators for this component is apparent in the Aide Memoire. The following list of proposed indicators is thus somewhat tentative, depending upon decisions made in further rounds of project design in the pre-programme phase.

- **Implementation of sector reform measures.** Indicators (spanning project preparation and project implementation phases) might include: SWIM Sector
Strategy, Masterplan and MTEF completed according to current schedule (the “Roadmap”); Cambodian legal firm (with translators) contracted to assist in development of legislative programme and drafting of new laws; completion of discrete parts of this legislative programme; functional analysis of national and sub-national MoH institutions conducted; regular and effective CoCom and ProCoCom meetings held to provide policy debate, donor coordination and solutions to HSSP implementation problems; and the joint annual health sector review conducted as planned.

- **Improvement of central, PHD and OD performance of key management functions.** Indicators of improved capacity to plan and manage would include: MTEF produced annually and used to manage spending and planning guidelines revised and tested during 2002 (pre-implementation). Simultaneous progressive decentralisation of planning and integration of planning with budgeting would be monitored by: provincial planning workshops financed; and modified planning cycle developed and adopted. At the Province level, the revised Management Capacity Assessment Framework provides the basis for monitoring improvements in PHD management capacity (see MoH 2001: 24).

- **Personnel planning and management.** Indicators would include: functional analysis of national and sub-national MoH institutions conducted; number of provincial workforce plans produced; national Health Workforce Plan 2004-13 produced; reforms mandated under national Programme for Administrative Reform (NPAR) implemented in MoH. Outcome indicators are not currently specified in the draft Aide Memoire, but would include the percentage of HC or RH staff with suitable qualifications for their position, or the percentage of facilities meeting a minimum level of staffing (number and training of staff).

### A2.3 Indicators for Component 3: Support to technical programmes addressing public health priorities

- **Tuberculosis (TB).** Agreed M&E indicators for this component, as listed in Annex H to the draft Aide Memoire, include process indicators (% of HCs applying Directly-Observed Treatment Short-Course (DOTS); % of these DOTS-compliant HCs and TB units that have correct TB (DOTS) drugs); output / performance indicators (detection rate; cure rate); and outcome indicators (incidence rate of smear-positive pulmonary form per 100,000 new cases p.a.; TB death rate).

- **Malaria and dengue.** Agreed M&E indicators for the malaria control component, as listed in Annex I to the draft Aide Memoire, include process indicators (number of beds and hammock nets distributed p.a.; number of bed and hammock nets re-impregnated p.a.; number of supervision visits made with reports and remedial action); output / performance indicators (% of labs achieving 80%++ adherence to lab standards; % of suspected cases examined microscopically or with dipstick; % of malaria cases receiving standardised free treatment within 24 hours of onset of symptoms; % of target villages provided with sufficient IBN and re-impregnation kits; % of pregnant women and children under 5 benefiting from community and personal protective measures); and outcome indicators (new confirmed cases p.a.; malaria death rate or malaria case-fatality rate (CFR); number of outbreaks p.a.).

- Discussions during the mission established that HSSP would finance WHO execution of a programme of support to dengue control. WHO and RGC will develop a contract to be submitted to the WB for non-objection. This contract will specify activities to be supported, implementation timetable and cost. It will also include specific M&E indicators (WB-DFID 2001: 39). These will need to be incorporated into the HSSP indicator framework.
HIV/AIDS and STDs. Recent sentinel surveillance data indicates a stabilisation of the epidemic, but some observers have noted gaps in coverage and differences in sampling between surveys. The pre-appraisal mission has recommended in the draft Aide Memoire (Annex J) that these issues are addressed in forthcoming surveys. This implies that the definition of outcome indicators (as defined by the groups for whom HIV prevalence rates are tracked in sentinel surveys) may change from those currently employed. The basic monitoring methodology (sentinel surveillance) is well-established.

The draft Aide Memoire also notes that the results of the analysis of evidence could result in changes to national HIV/AIDS/STD policy. Thus, while the Aide Memoire provides a general recommendation that the national HIV/AIDS programme focus on i) creating capacity and strengthening collaboration with other programmes at lower levels and ii) integration of HIV/AIDS/STD activities into HC and RH services, it does not identify specific activities under this sub-component of HSSP, and accordingly does not at this stage identify specific process or output indicators for HSSP M&E. These will need to be developed as the HIV/AIDS sub-component of HSSP is further specified during the programme preparation period in 2002, hopefully informed by the review of evidence issues recommended in the Aide Memoire.

Nutrition. Annex K of the Aide Memoire recommends HSSP support to the development of an “operational entity” ensuring the implementation of the nutrition components included in the MPA (plus one activity – nutritional counselling – which is not currently included in the MPA).

For monitoring protein-energy malnutrition (PEM) outcomes, Annex K recommends using weight-for-age (WFA) rather than the measure proposed in the original PAD, namely weight-for-height (WFH) – a measure of wasting - on the grounds that height is hard to record accurately. This is true, but I would note from personal experience conducting small-scale anthropometric surveys in rural Cambodia that obtaining accurate data on age is also problematic and age-based indicators (either WFA or height-for-age (a measure of stunting)) may be biased in the direction of overestimating the prevalence of malnutrition10.

On the basis of MPA-based nutrition activities identified for support in Annex K, other outcome indicators would presumably include anemia and severe anemia prevalence rates for pregnant women and children aged 6-24 months; and vitamin A deficiency (VAD) rates for post-partum women and children aged 6-59 months. For iodine deficiency, the output indicator of % of households using iodised salt would seem to be the preferred measure. Technical definitions for the identification of anemia, VAD and iodised salt, and the methodology used for this identification, can be found in the DHS (NIS et al 2001 pp. 178-186). These indicators would be recorded once and possibly twice during the course of the HSSP through successive rounds of the DHS. The timing of the DHS will determine whether a separate, HSSP-specific nutritional survey will be required to provide end-of-programme performance data.

Safer motherhood. Annex L proposes an innovative approach to capacity development which attempts to combine efforts to foster demand and thus increase the number of attended births to a level at which it can develop and sustain midwife skills. Output indicators would include number of “Quality Maternities” established; number of trained / retrained midwives; number of births attended by a trained midwife (total; as % of all births; mean births attended p.a. per midwife); number of facilities providing safe abortion services; number of HCs

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with trained midwives in post (disaggregated by province and distinguishing between accessible and inaccessible ODs, as defined by a given travel time or distance from the provincial town); and the cesarean section rate as a proportion of maternal indications (see WB-DFID 2001: 48 on refining the definition of this indicator). The key outcome indicator would obviously be the maternal mortality rate (MMR), to be collected through DHS and HSSP-funded surveys.

A2.4 Other process indicators

In addition to these component-specific indicators, there are a few basic administrative indicators of HSSP progress which must also be monitored. These include disbursement rates (a measure of MoH absorptive capacity, in terms of human resources, political will and financial and procurement systems) and the proportion of HSS funds allocated to specific activities of the proportion unallocated (a measure of progress against the planned goal of switching HSSP funding over time to one of unallocated sector support).
Annex 3: Preliminary costing of support to M&E under HSSP

This costing provides a broadly indicative figure for the sums required for some key M&E activities under HSSP. It is hard to be more precise at this stage as i) it is not known exactly what these activities will be until more detailed project design (e.g. regarding number of provinces) provides a basis for detailed delineation of M&E options ii) some of the sector M&E activities – e.g. the annual sector reviews and the DHS – may attract co-financing from other donors; and iii) while preliminary costings have been prepared for component 2 of the HSSP, it is not clear how definitive this is as a budget framework for this component, and no costings have yet been provided for components 1 and 3. This creates the possibility of some M&E-type activities costed here are also being located and budgeted under other headings, albeit to different sums (e.g. joint annual health sector reviews ($20,000 each year) and joint mid-term sector review ($40,000) are already included in the draft costings for component 2, under “development of the framework for health sector reform”).

*A draft figure has been included to cover salary supplements for M&E unit staff in the DPHI. The US$150 is based on current UN rates for senior MOH staff, as described in a recent review for DFID on salary supplements and incentive payments to government workers. It should be noted that rates paid through the World Bank/ADB agreement are higher.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Cost in US $</th>
</tr>
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<tbody>
<tr>
<td><strong>A) Building HIS / HMIS / sector M&amp;E capacity within MoH</strong></td>
<td></td>
</tr>
<tr>
<td><strong>A1 Support to develop MoH M&amp;E Unit within DPHI</strong></td>
<td></td>
</tr>
<tr>
<td>i) Salary sup. plus</td>
<td>$150 salary p.m.</td>
</tr>
<tr>
<td>other costs*</td>
<td>10 Staff for 72 months</td>
</tr>
<tr>
<td>ii) Training:</td>
<td>$4,000 per staff member per course</td>
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<tr>
<td>10 Staff each attend 2 short courses</td>
<td></td>
</tr>
<tr>
<td>iii) TA and other costs</td>
<td></td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
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<tr>
<td><strong>A2 Support to develop Provincial M&amp;E units within HIS Bureaus</strong></td>
<td></td>
</tr>
<tr>
<td>i) Training:</td>
<td>$4,000 per staff member per course</td>
</tr>
<tr>
<td>2 Staff each on 2 short courses in 23 provinces</td>
<td></td>
</tr>
<tr>
<td>ii) TA</td>
<td>700 average TA costs per day (salary + reimbursible)</td>
</tr>
<tr>
<td>72 days (12 p.a. over 6 years) in 23 provinces</td>
<td></td>
</tr>
<tr>
<td>iii) Office</td>
<td>2000 per province</td>
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<tr>
<td>Equipment</td>
<td>23 Provinces</td>
</tr>
<tr>
<td>iv) Operating costs</td>
<td>$10,000 per province p.a. in 23 Provinces for 6 years</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>B) Reviews, evaluations and studies</strong></td>
<td></td>
</tr>
<tr>
<td><strong>B1 Support to annual sector / SWIM review (co-financed with other donors) and brief annual HSSP implementation progress review</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$50,000 50% financing of annual sector review for 6 years</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
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<tr>
<td><strong>B2 3 HSSP evaluations</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$100,000 for each of 3 evaluations: Y2, Y4 (MTR), Y6 (final)</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>B3 Support to other studies</strong></td>
<td></td>
</tr>
<tr>
<td>including surveys and HSSP reviews</td>
<td>$500,000</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>B4 1 DHS</strong></td>
<td></td>
</tr>
<tr>
<td>assuming other donors co-fund half total costs</td>
<td>$400,000</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
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</table>
Annex 4: Social Assessment for the Cambodia HSSP

A4.1 Background

Cambodia is the poorest country in South East Asia, and according to the UN Human Poverty Index, ranks 73rd out of 78 developing countries. About 40% of households live below the poverty line and about one third of Cambodians do not have enough to eat. 84% of the total population of 11.4 million people is rural. 90% of the poor are live in rural areas, but there are also significant numbers of urban poor. Such poverty is linked to the recent tragic history of civil war and genocide, the long terms effects of which Cambodians are struggling to alleviate. Between 1975 and 1979, during the Pol Pot regime national infrastructure was destroyed, millions of people, especially the educated, killed and health services were totally destroyed. From 1995 the Ministry of Health has made great strides in developing a new public health care delivery structure organised by 'operational districts' based on size and geographical access. However, levels of access to health services, particularly by the poor and other disadvantaged groups such as ethnic minority Hill Tribes, remain low. This Health Sector Support Project will further develop the on-going process of health sector reform, taking special care that provision is made for the poor and disadvantaged ethnic minority groups who face a range of difficulties in accessing public health services. In addition, the project will allow for the development of specific programmes that tackle the main health problems facing the Cambodian population as a whole, but impacting more on the poor.

Cambodia suffers from a range of health problems that reduce the quality of its human capital. The principal health problems relate closely to the socio-economic environment and are those associated with widespread poverty, poor sanitation and under-nutrition. Respiratory infections, diarrhoea, dengue fever and vaccine preventable diseases are the main causes of death. TB, HIV/AIDS and malaria are also widespread. Infant mortality is the worst in Asia at 115 per 1,000 live births and maternal mortality is also high at 650 per 100,000 live births. High levels of mortality and morbidity impact negatively on economic development and contribute impede measures to reduce poverty. Hence, poor health and poverty are linked at all levels from the household to the national.

A4.2 Stakeholders: interests and participation

The primary stakeholders of the Health Sector Support Project are the beneficiaries – customers of the health services who will benefit from the improved accessibility and quality of services. In addition, the Project is designed, through the better regulation of user fees and equity schemes, to identify and meet the special needs of poorer people and those from disadvantaged minority ethnic groups, who experience difficulties in accessing public health services. Other key stakeholders are the Ministry of Health staff working at all levels who will benefit from the planned programme of upgrading health facilities and training. These initiatives will lead to greater job satisfaction as the quality of services provided increases. Other stakeholders are those working in the health sector, including policy makers and donors (the World Bank, DFID, ADB, USAID, GTZ, the Japanese government, WHO, as well as international NGOs) are others with important interests in the project, and who have much to gain from its success. Other key ministries notably the Ministry of Economy and Finance will play an important part in the development of the project design and implementation and monitoring. Cambodian and international researchers and academics are a further stakeholder group with interests in the gaining experience in international best practice for health sector reform and as well as specific programme developments in fields such as TB, malaria and HIV control.
A4.3 Indigenous Peoples

The World Bank is concerned that projects do not adversely affect ‘indigenous peoples’. The term ‘indigenous peoples’ is used by the Bank to denote ‘indigenous ethnic minorities’, ‘tribal groups’ and ‘scheduled tribes’. The focus of concern is on ‘social groups with a social and cultural identity that makes them vulnerable to being disadvantaged in the development process’ (OD4.20).

The Khmer make up almost 90% of the population of Cambodia and are indigenous to the area. Significant non-Khmer groups include Vietnamese, the Cham, Lao, Chinese, Westerners and indigenous ethnic minority groups living in the remote border areas.

Of the ethnic minority groups, the Cham are the largest. They are Cambodian Muslims and account for 50% of the total non-Khmer population in Cambodia. The Cham are descendents of the medieval Hindu Kingdom of Champa, now in Vietnam. They became Muslim in the seventeenth century, adopting the faith from Malays settled in southern Cambodia. The Cham were targeted by the Khmer Rouge to adopt Khmer names and give up Islam. Much of the Cham population was killed or exiled and many mosques destroyed. However, currently the Cham enjoy freedom of worship and appear not to be especially socially or economically disadvantaged.

Groups of Vietnamese and Chinese are represented mainly in urban areas. Reflecting the often difficult political relations between the governments of Vietnam and Cambodia, tension exists between the Vietnamese and the host Khmer community. Following the 1998 elections there were violent anti-Vietnamese elections demonstrations in Phnom Penh. Some ethnic Vietnamese are Cambodian citizens, while others are foreign residents. Chinese traders have been in Cambodia for centuries. Technically the Chinese community are foreign residents, although in practice many have Cambodian passports.

There are no clear indications that the Cham, Vietnamese or Chinese populations are greatly disadvantaged in terms of accessing health services. However, in accessing public health services some or all these groups they may face discrimination and language difficulties. The National Center for Health Promotion reports that ‘most Vietnamese and Chinese speak Khmer’. More information on issues of access to health services for ethnic minority groups is required.

Highlanders

There are 15 groups of ‘hill tribes’ also referred to as ‘highlanders’ or the Khmer Loeu. They make up about 0.95% of the Cambodian population. Highlanders are distributed throughout the country, but concentrated in the northeast. They form a majority in the provinces of Mondulkiri and Ratanakiri.

The highlanders of the north-eastern provinces of Kratie, Mondalkiri, Ratanakiri and Strung Treng are probably the most disadvantaged Cambodian population. They live in isolated areas, characterised by poor road infrastructure and poor communication facilities. These remote forest areas are increasingly exploited by loggers, settlers from the lowlands and others motivated by commercial interests. Livelihoods based on traditional swidden farming and forest harvesting practices are being destroyed, as rights to land are lost to mining and logging concerns and to plantations of rubber, coffee and cashew nuts. Consequently, rapid social change is being imposed on the highlanders. Education levels are low among highland groups and they are poorly represented within the health sector.

In terms of health, the highland groups are highly vulnerable to disease. Malaria rates are higher in the north-east than in other parts of the country, and the disease
is a major source of mortality in the area. There are also more reported cases of diarrohea, acute respiratory infections and obstetric complications in the north-east than in the country as a whole. In such sparsely populated, isolated provinces, there are particular difficulties in accessing health centers and hospitals in times of obstetric emergency. By Cambodian standards, levels of HIV infection are low in the north-east. This may be because the area is isolated. On the other hand, experience from other parts of the world demonstrates that rapid social change and poverty make communities vulnerable to HIV. There are particular challenges to health providers in getting HIV prevention messages to highlander groups who do not understand Khmer.

In Ratanakiri, which has the biggest population of Highlanders, the government aims to build 17 Health Posts to serve isolated communities. These health posts offer basic health care and field visits to two health posts suggest varied levels of use from between two and 20 customers per day. Varied arrangements for exemptions for the poor appear to be in place. However, even the health posts are too far for many people from the surrounding villages to reach. An additional barrier to use occurs when the health post is staffed and located in the village of one ethnic minority group, but is designed to serve the needs of several ethnic minorities. The Seila programme, under the UNDP, carries out community development activities in ethnic minority villages and may influence villages to relocate so that they can be better served by government agencies including the MoH. Sometimes whole villages relocate to the roadsides where health posts tend to be situated. One strong reason for relocation is that occupation on land adjacent to the road better enables indigenous communities to retain their land and the counter the steady incursion of settlers from the lowlands who tend to first occupy roadside plots. Clearly the delivery of health services to these vulnerable communities is part of the complex process of social change. NGOs active in Ratanakiri, such as Health Unlimited and the Non-Timber Forest Products group, stress the need to carefully plan and think through the likely consequences of health interventions, if the Highlanders are to benefit and not be harmed by attempts to deliver health services.

A4.4 Gender and Access

During the war and genocide men died in greater numbers than women, and in 1979, women made up two thirds of the adult population. Women were forced to take the lead in farming and in state-run industries. During the 1980s women were active in all sectors of society, but lost ground in the 1990s. Currently, as in most other countries, Cambodian women are poorly represented in high levels of politics and administration. Nationally, women fill 13% of the professional and managerial positions. In terms of literacy, there are significant differences between men and women. 79% of men are literate, while 55% of women are literate (NIS / World Bank 1997, NIS 1999). The differential can be partly accounted for by traditional attitudes to female literacy (see Ledgerwood 1990), and in part by the recent militaristic history of Cambodia (many men upon joining an armed force learnt to read and write as part of their basic training).

Within the home, gender relations may still be affected by the psycho-social disruption caused by decades of war, genocide and instability. Domestic violence against women is reported to be widespread. The level of communication between spouses is reportedly limited in scope. Low levels of decision making by women concerning contraceptive use and health seeking behaviour are also reported by the 2000 DHS.

Similarly, the large size and level of organisation of the Cambodian sex industry points to the powerlessness of Cambodian women and girls, many of whom are
coerced or sold into the industry. Sex workers are especially vulnerable to HIV infection with estimated rates of between 30% to 60%. Some groups of men, such as the military and police, are also vulnerable to HIV, largely because they are frequent clients of sex workers. In turn, they pass HIV onto their wives. Data from a 1998 study of women using health services in larger cities indicated that HIV infection rates were 4.5%. There is a clear danger that HIV will move into the general population and that rates in rural areas will rise to match those in urban centres.

The life expectancy at birth for Cambodian men is 50.3, and for Cambodian women 58.6. Yet, maternal mortality is a significant problem in Cambodia, with issues of physical access and cost of services significant barriers to care for many women. Gender differentials in general health and nutrition have not been identified. There are no data that permit an understanding of the similarities or differences in health seeking behaviour of men and women. While there are no indications that gender is a significant barrier to accessing public health in Cambodia, the decision making process regarding choice of treatment, particularly where it involves the use of scarce household resources, probably does not lie with individual women. More information on the household level decision making process could be usefully fed into the project design with the aim of better identifying barriers to access by gender or income level.

A4.5 Poverty and Access

The WB/DFID/ADB programme will take into account and make provision for the needs of following groups of potential health service customers:

- Disadvantaged ethnic minorities (highlanders)
- The 40% of Cambodian households classified as ‘poor’ who are distributed throughout the country in both rural and urban areas.

Access to health care remains a major problem throughout Cambodia, but particularly for disadvantaged ethnic groups and the poor. Facilities destroyed in the Pol Pot era are still being rebuilt, and those which exist may be physically inaccessible to many people. Staff shortages affect many hospitals and health centres and the quality of care provided may be found wanting by customers. Although public health care is officially free, user fees, either formal or informal, are in practice collected and the cost of care is a significant barrier to access for many people, particularly the poor. Among the poor there are high levels of non-treatment and of self medication.

A4.6 Health Seeking Behaviour

Health seeking behaviour is determined by a number of inter-related factors. Individuals and families make decisions on treatment options based on:

- Their understanding of the cause of illness
- The cost of alternative sources of treatment relative to income levels
- Access to various health providers (including physical access and cultural factors)
- Perceptions of the quality of the competing service providers in their area.

In Cambodia, the recent history of political instability impacts on households and families and effects on the psycho-social well being of Cambodians of all backgrounds. Psychological stresses often manifest as physical symptoms, which require the ‘quick fix’ of pharmaceutical products. There appears to be little or no
research on the complex issue of somatization (physical manifestation) of psychological stress and its effects on health seeking behaviour in Cambodia. However, there are data to demonstrate that Cambodians are prepared to pay a higher percentage of their income for health care than families in many other low-income countries. Household contributions to health average $100 per year, 10 times the per capita level of the government contributions. Out of pocket expenditure on health in Cambodia is very high. WHO estimates that per capita health expenditure is $20. Studies have also shown that the poor may sell land or go into debt in order to raise funds for medical expenses, particularly when faced with an acute or life threatening condition, which then becomes a catastrophe. It is clear that there is a high demand for health services, and particularly drugs. The preference for drips and injections provided by the private sector and perceived to be a more direct and therefore more powerful mode of consumption, is well known to the MoH and the donor community in Cambodia. Various studies of health seeking behaviour have also revealed many of the reasons that public health services are unpopular, and that private providers are preferred by most consumers of health care.

Nevertheless, the demand for routine out-patients’ services appears to be less robust. The number of new outpatient consultations in all health facilities by the total population was 0.35 per capita in 1996, below the WHO international standard and well below the regional average (The World Bank, 1999, Cambodia Public Expenditure Review). All income groups show a preference for private health care.

Within the Cambodian context, public health providers appear to be unattractive to many potential customers for a number of reasons. A Briefing Paper presented to the Annual Donor Mission (1999) reports an overall decrease in utilisation of public services between 1995 and 1998. Several factors are cited to account for this decrease:

- Public services are expensive, as unpredictable informal charges are levied, thus creating uncertainty about ability to pay;
- Surveys have shown that self medication is the first health seeking behaviour in Cambodia;
- The private sector including private pharmacies, has developed rapidly in the last few years;
- Private services are perceived to be of higher quality.

The design of the WB/DFID/ADB project will address some of these barriers to accessing public health services directly in the following ways: 1) The improved physical distribution of hospitals and health centres at provincial and operational district levels is to be tackled through a programme of building and rehabilitation of facilities. In remote provinces, such as Ratanakiri, the development of the network of health posts that serve isolated communities is planned. A better distribution of public health facilities is a basic requirement for improved access. 2) The introduction of formal user charges has already reduced the level of payment required of facility customers particularly at health centre level. This system when applied and expanded through the project, and combined with equity schemes for the poor, should increase financial access. The issue of informal user charges is linked to the low salaries of US$15 per month received by employees of the MoH. In areas where formal and more transparent charges have been introduced, leading to a reduction in costs to the consumer, utilisation rates have risen, sometimes by as much as 50%. But the introduction of formal charges does not solve the problem of poor people who cannot afford even cheaper services. A single outpatient visit to a health centre can take up one third of all non-food expenditure for a year for those in the poorest
quintile (MoP / World Bank 1999). Since 1997 a number of pilot initiatives, including equity funds and exemption schemes, have attempted to improve access to the poor. These are reviewed in detail in the Aide Memoir. However, there are no easy solutions and the findings of ‘The Impact of User fees on Access, Equity and Health Provider Practices in Cambodia’ (2001) should be carefully considered. The evaluation found that:

- Health centres with user fee schemes are increasing equitable access for the poor to primary health care. However, user fees in referral and national hospitals often act as barriers to the poor.
- Paying for health care, particularly secondary or tertiary care, is still a major cause of destitution amongst the poorest sections of the community.
- There is a major failure of exemption schemes in hospitals to protect the poor. However, exemptions are provided more readily at health centres.
- There is a systematic conflict between a viable exemption scheme and a viable salary incentive scheme.

Another report, ‘Medical Practitioners and Traditional Healers: A Study in Health Seeking Behaviour in Kampong Chhnang’ (2000) makes three recommendations aimed at increasing demand for public health services:

1. A credit scheme that would prevent the poor becoming landless as a result of dealing with catastrophic illness. However, the success of such an initiative would depend on adopting the best practices of the micro-credit sector of the Cambodian NGO sector. Even if applied well, a credit scheme would be unlikely to benefit the poorest.
2. The introduction of instalment payments at public health facilities, to follow the model already applied in the private sector.
3. The formation of a consumer health protection organization, should be considered. Ideally this would be operated by an independent NGO, which could advocate for higher quality service and receive and mediate complaints about service and charges in both public and private sectors.

Demand creation

The creation of demand for public health services is not solely linked to financial issues. A report on ‘The Impact of User fees on Access, Equity and Health Provider Practices in Cambodia’ found that:

‘People at community level in Cambodia generally have low levels of awareness of public health services. There is a need to stimulate demand by informing present and potential customers about the availability of public health services, including fee levels and exemptions. In particular demand creation must target isolated rural communities, the poor and the illiterate and aim to promote appropriate health and health seeking behaviour.’ (Wilkinson, Holloway and Fallavier, 2001, vi)

At present most people prefer private health providers over the public health system. They are paying for drugs and services that may often be unnecessary or even harmful. There is a need to disseminate information that will enable people to make better choices concerning their health care. In addition, health information and promotion strategies are required to inform people, particularly the poor, about the price and quality of public health services. Carefully targeted information, education and communication (IEC) campaigns should be integrated into the project and linked to the development of behavioural change communication strategies (BCC). The challenge of demand creation for public health services is great and cannot be met
by IEC and BCC approaches, however well thought out, alone. Health seeking behaviour is the result of the complex interaction of inter-related factors, and increased information is but one factor influencing behavioural change.

There may be linguistic barriers to access to information, let alone services. This project will review the needs of ethnic minorities in relation to health promotion materials and will take into account the needs of disadvantaged Highlander ethnic minority groups, and those of the Vietnamese, Chinese and Cham communities in Cambodia.

At present, although the National Centre for Health Promotion (NCHP) is charged with health promotion within the MoH, in practice each health project, programme or NGO produces its own health promotion materials. There are few data available on the effectiveness or impact of these materials. Furthermore, the poor may be unable to benefit from the messages received through health promotion. For example, it may be impossible for the poor to follow up information received about particular services if there is no money available to pay for them, and no information concerning exemptions.

A4.7 Community Participation

There are differing views as whether Cambodian villagers have a tradition of community solidarity on which they can draw. One group of researchers argues that Cambodian peasants have always been individualistic and link this trait to the abundance of agricultural land. Others however, point to the traditional role of the pagoda in promoting social cohesion and to the contemporary flowering of self-help groups and local NGOs as evidence that the concept of social cohesion and community organisation. (Ministry of Planning, 1999).

The National Center for Health Promotion sees its role as facilitating communication between the community and health centers, with the aim of improving community participation. In practice community participation appears to depend on the functioning of a number of committees including Health Center Management Committees, Feedback Committees and Village Health Committees. It is hoped that these committees will improve the flow of information, provide great accountability and allow greater protection for the poor through the operation of mechanisms for exemptions for health service fees. However, there are varied reports from the pilot schemes for increasing equity as to the effectiveness of the village level committees in operating in different provinces. At present, the NCHP has very limited capacity to develop the important area of community participation.

A4.8 Gaps in information

The results of a range of useful studies relating to health seeking behaviour and demand creation are available to those working within the Cambodian health sector. This social assessment condenses many of these findings, but also identifies gaps in knowledge concerning:

- Psycho-social issues relating to illness and health seeking behaviour
- The rationale, from user and provider perspectives, of the demand and prescription of pharmaceuticals
- Health seeking behaviour by gender
- The provision of health promotion to ethnic minority groups
A4.9 Recommendations for further social assessment work

A well designed study that focuses on the gaps identified above is recommended. Additional operational research should draw on the approach of medical anthropology and should focus on qualitative studies that increase the understanding of health seeking behaviour. In order to avoid duplication, the study should start with a careful review of existing literature relating to health seeking behaviour.

The study should be undertaken by an international consultant, working with a team of Cambodian researchers over a period of three to six months. The research team should report to the MoH, possibly through the NCHP. Results should be disseminated and used to inform a national strategy for demand creation through a range of IEC and BCC activities. Collaboration with the NCHP would build the operational capacity of an organisation that has already benefited from support from Aus Aid, but remains weak.

A4.10 Key Documents consulted


‘Review of Health Sector Reform, Cambodia’ (2001) DFID/WHO


Thomas D (1999) ‘Cambodia Health Sector Reform Phase III Project: Social Development Priorities in Health Sector Reform. DFID


World Bank 1999 Cambodia Poverty Assessment.
Annex 5: Terms Of Reference: Preparation of the Cambodia HSSP -
Mechanisms to improve equity in access to services and protect the poor

Draft – 10 January 2002

Background

DFID with the World Bank, Asian Development Bank and the Government of Cambodia are preparing to implement a joint programme, The Health Sector Support Programme (HSSP). The HSSP has three main components:

1) ‘Improving the provision of health services especially for low income groups’ aims at increasing the accessibility and affordability of primary health care and first referral services including the Minimum Package of activities to be delivered by health centres and the Complementary Package of Activities to be delivered by referral hospitals. In order to ensure the accessibility and affordability of both packages the following will be financed: civil works; medical equipment; development and piloting of a maintenance system; pharmaceuticals; a quality assurance programme; training and fellowships; development and piloting of innovative financing schemes; development and piloting of arrangements to protect the poor; monitoring of access and affordability of services for the poor.

2) The Health Sector Reform and Improvement component aims to: (i) strengthening the MoH management responsibilities, (ii) strengthening health administration at decentralised levels, (iii) development human resources.

3) Support to technical programmes addressing public health priorities. The programmes include: TB, malaria and dengue, HIV/AIDS and STDs, nutrition and safe motherhood.

A number of activities for increasing accessibility by the poor are being considered. These include: equity funds that pay fees for identified poor patients; pre-payment arrangements, including provisions to pay premiums of low income groups from equity funds; lending money to the poor to pay the contribution to cost recovery in public health services or the cost of services rendered by private health sector. Another component planned that will contribute to protecting the is an exemption programme associated with the cost recovery scheme: the poor will be exempted from paying for immunizations, ante-natal and post-natal care, impregnated bed-nets and hammock-nets care and contraceptives.

A social development consultant is required to review the options for ensuring accessibility of services to the poor, and to make recommendations concerning the design and management of pro-poor schemes, including equity funds, within HSSP.

Key tasks

Review of work on: a) the relationship of income/poverty to access to health services and, b) the performance of equity funds, exemption schemes and other mechanisms piloted in Cambodia with a view of improving access by low income groups to health services.

Review in detail the various criteria and measures used to define and identify poor individuals and households in Cambodia. Identify the strengths and weaknesses of these measures.
Analyse the structure of Khmer village politics and assess the ways that village level political processes/community participation may exclude or protect the poor. A number of questions should be addressed:

- What existing village level social mechanisms could be developed through the HSS to alleviate the effects of catastrophic illness (including emergency obstetric and hospital-based care) on low-income households?

- What existing village level social mechanisms could be developed to improve access to poor families for primary health care?

- To what extent could these social mechanisms be applied in HSSP-supported provinces throughout Cambodia?

- What similar social mechanisms, in terms of access to health care, could be developed in poor urban neighbourhoods?

Assess the range of possible arrangements for managing schemes to improve access for the poor by a) community based committees; b) NGOs or c) health centre/Hospital staff, or d) a combination of these.

Output
A report containing the following sections:
- Review of the strengths and weaknesses of various arrangements to increase affordability and accessibility of services to the poor that have been considered, piloted or are operating in Cambodia;
- recommendations for the design and management of schemes to increase accessibility and affordability of services for the poor through the HSS.
- Recommendations on any further work required in planning and pre-project stages.

This report may be integrated with the report of the economist working on this issue, to come up with shared recommendations on how HSSP should address the issue.

Skills required
An experienced social scientist with specialist skills in the analysis of poverty in relation to health, ideally in relation to Cambodia or SE Asia. In addition, international experience of mechanisms to improve access to the poor would be desirable.

Alternatively, an international expert working with a local/regional expert could undertake the assignment.

Timetable
The consultant will spend three weeks in Cambodia, ideally as part of the February WB-led mission.
Annex 6: Terms Of Reference: Preparation of the Cambodia HSSP - Ethnicity And Access To Health Services

Draft – 10 January 2002

Background
DFID with the World Bank, Asian Development Bank and the government of the Kingdom of Cambodia are preparing to implement a joint programme, The Health Sector Support Programme (HSSP). The HSSP has three main components:

1) ‘Improving the provision of health services especially for low income groups’ aims at increasing the accessibility and affordability of primary health care and first referral services including the Minimum Package of activities to be delivered by health centres and the Complementary Package of Activities to be delivered by referral hospitals. In order to ensure the accessibility and affordability of both packages the following will be financed: civil works; medical equipment; development and piloting of a maintenance system; pharmaceuticals; a quality assurance programme; training and fellowships; development and piloting of innovative financing schemes; development and piloting of arrangements to protect the poor; monitoring of access and affordability of services for the poor.

2) The Health Sector Reform and Improvement component aims to: (i) strengthening the MoH management responsibilities, (ii) strengthening health administration at decentralised levels, (iii) development human resources.

3) Support to technical programmes addressing public health priorities.
The programmes include: TB, malaria and dengue, HIV/AIDS and STDs, nutrition and safe motherhood.

The HSSP is concerned that Cambodian minority groups should not be disadvantaged, on the grounds of ethnicity, in accessing health services. In particular, the World Bank is concerned that projects do not adversely affect ‘indigenous peoples’. The term ‘indigenous peoples’ is used by the Bank to denote ‘indigenous ethnic minorities’, ‘tribal groups’ and ‘scheduled tribes’. The focus of concern is on ‘social groups with a social and cultural identity that makes them vulnerable to be being disadvantaged in the development process’ (OD4.20). Therefore, a consultant is required to examine issues of ethnicity and access to health services.

The Khmer make up almost 90% of the population of Cambodia and are indigenous to the area. Significant non-Khmer groups include Vietnamese, the Cham, Lao, Chinese, Westerners and indigenous ethnic minority groups living in the remote border areas.

Of the ethnic minority groups, the Cham are the largest. They are Cambodian Muslims and account for 50% of the total non-Khmer population in Cambodia. The Cham are descendents of the medieval Hindu Kingdom of Champa, now in Vietnam. They became Muslim in the seventeenth century, adopting the faith from Malays settled in southern Cambodia. The Cham were targeted by the Khmer Rouge to adopt Khmer names and give up Islam. Much of the Cham population was killed or exiled and many mosques destroyed. However, currently the Cham enjoy freedom of worship and appear not to be especially socially or economically disadvantaged.

Groups of Vietnamese and Chinese are represented mainly in urban areas. Reflecting the often difficult political relations between the governments of Vietnam
and Cambodia, tension exists between the Vietnamese and the host Khmer community. Following the 1998 elections there were violent anti-Vietnamese elections demonstrations in Phnom Penh. Some ethnic Vietnamese are Cambodian citizens, while others are foreign residents. Chinese traders have been in Cambodia for centuries. Technically the Chinese community are foreign residents, although in practice many have Cambodian passports.

There are no clear indications that the Cham, Vietnamese or Chinese populations are greatly disadvantaged in terms of accessing health services. However, in accessing public health services some or all these groups they may face discrimination and language difficulties. The National Center for Health Promotion reports that ‘most Vietnamese and Chinese speak Khmer’. More information on issues of access to health services for ethnic minority groups is required.

There are 15 groups of ‘hill tribes’ also referred to as ‘highlanders’ or the Khmer Loeu. They make up about 0.95% of the Cambodian population. Highlanders are distributed throughout the country, but concentrated in the northeast. They form a majority in the provinces of Mondulkiri and Ratanakiri. The highlanders of the north-eastern provinces of Kratie, Mondalkiri, Ratanakiri and Strung Treng are probably the most disadvantaged Cambodian population. They live in isolated areas, characterised by poor road infrastructure and poor communication facilities. These remote forest areas are increasingly exploited by loggers, settlers from the lowlands and others motivated by commercial interests. Livelihoods based on traditional swidden farming and forest harvesting practices are being destroyed, as rights to land are lost to mining and logging concerns and to plantations of rubber, coffee and cashew nuts. Consequently, rapid social change is being imposed on the highlanders. Education levels are low among highland groups and they are poorly represented within the health sector.

In terms of health, the highland groups are highly vulnerable to disease. Malaria rates are higher in the north-east than in other parts of the country, and the disease is a major source of mortality in the area. There are also more reported cases of diarrhoea, acute respiratory infections and obstetric complications in the north-east than in the country as a whole. In such sparsely populated, isolated provinces, there are particular difficulties in accessing health centers and hospitals in times of obstetric emergency. By Cambodian standards, levels of HIV infection are low in the north-east. This may be because the area is isolated. On the other hand, experience from other parts of the world demonstrates that rapid social change and poverty make communities vulnerable to HIV. There are particular challenges to health providers in getting HIV prevention messages to highlander groups who do not understand Khmer.

**Key tasks**
Review the social-economic status of the various ethnic groups of Cambodia, in relation to health. The review should include the following groups: Highlanders (often referred to as ‘Hill Tribes’), the Cham, Vietnamese and Chinese communities.

For each of the above groups, assess how their ethnicity may affect access to health services in relation to the following interrelated factors:

- Poverty/income/land holdings/indebtedness
- Physical access to health facilities
• Language barriers/relationship to majority Khmer health providers

• Cultural/religious factors

Identify barriers to access to good quality health care, including health promotion and preventive services.

Identify and assess options and make recommendations on practical measures which would overcome these barriers, to be fed into the health sector master plan and the HSSP.

Skills required
A social scientist with training in medical anthropology and a good knowledge of Cambodia. Ideally the consultant would have experience of the application of research findings to the culturally appropriate development of health service delivery.

Output
A report containing the following sections:
- Review of the barriers to health care of Cambodian ethnic minorities. This would include language and cultural barriers specific to particular groups, as well as barriers connected to affordability and accessibility that impact to some extent on the poor regardless of ethnicity.
- Identification and assessment of options for interventions and measures to address these barriers, including assessing their feasibility and potential impact.
- Recommendations for practical measures to address and overcome these barriers, through initiatives that can be included within the HSSP and health master plan.

Timetable
One month in country and one week for report writing. Ideally, this work should be carried out by mid 2002, so that the recommendations can be incorporated into the Programme design.