TECHNICAL ASSISTANCE TO CAMBODIA
FOR THE SECOND BASIC HEALTH SERVICES PROJECT
(FINANCED FROM THE JAPAN SPECIAL FUND)

The attached Report is circulated for the information of the Board. The
President approved the technical assistance on 3 May 2001.

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TECHNICAL ASSISTANCE
(Financed from the Japan Special Fund)

TO THE

KINGDOM OF CAMBODIA

FOR PREPARING THE

SECOND BASIC HEALTH SERVICES PROJECT

May 2001
CURRENCY EQUIVALENTS  
(as of 15 April 2001)

<table>
<thead>
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<th>Currency Unit</th>
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<td>$0.00026</td>
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<td>$1.00</td>
<td>KR3850</td>
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ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<td>BHSP</td>
<td>Basic Health Services Project</td>
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<td>HRD</td>
<td>human resource development</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>nongovernment organization</td>
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<tr>
<td>PCU</td>
<td>project coordination unit</td>
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<tr>
<td>TA</td>
<td>technical assistance</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
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NOTES

(i) The fiscal year (FY) of the Government ends on 31 December.
(ii) In this report, "$" refers to US dollars.
I. INTRODUCTION

1. The Asian Development Bank’s (ADB’s) country operational strategy for Cambodia identifies these key challenges for the country: improving the quality of human resources, removing inequities in access to health care, improving the quality of health services, and reducing poverty. During the Country Programming Mission in 2000, the Government requested project preparatory technical assistance (TA) for the Second Basic Health Services Project. A Fact-Finding Mission visited Cambodia from 15 to 25 January 2001 and reached an understanding with the Government on the TA objectives, scope, cost estimates, terms of reference, and implementation arrangements. The Mission held consultations with the concerned Government ministries, nongovernment organizations (NGOs), potential beneficiaries, and various multilateral and bilateral organizations. The TA is included in the Country Assistance Plan for 2001.

II. BACKGROUND AND RATIONALE

2. Health indicators of Cambodia are still among the worst in the Asia and Pacific region. Any sustainable achievements in economic growth and poverty reduction will require substantial attention to improvements of health status. Presently, average life expectancy at birth is estimated at only 56.4 years, or 54.4 years for males and 58.3 years for females. The infant mortality rate is estimated to be 95 per 1,000 live births, and the child mortality rate is 125 and the maternal mortality rate 473 per 100,000 live births. Rates of malnutrition are second highest in East Asia, with 56 percent of children under five affected by chronic malnutrition.

3. Communicable diseases remain the main causes of mortality and morbidity. The rural poor and particularly young children and women of reproductive age are the most vulnerable groups of the population. Tuberculosis (TB) and malaria are the major causes of morbidity and mortality for the adult population. Cambodia is one of the 22 high-burden countries for TB (64 percent of the population or 7 million are infected). Malaria, which infects an estimated 80,000 people annually, resists common drug. The prevalence of HIV is the highest in Asia, has reached epidemic proportions, with about 4 percent of the adult population (age 15 to 49) infected.

4. Many factors contribute to poor health: the limited coverage and poor quality of basic health services, limited access to safe water supply and sanitation, low level of education, and high fertility rates. Many years of war and political upheaval have left Cambodia with a limited health infrastructure, particularly in rural areas. While there are sufficient paramedical staff, their training is inadequate and the quality of care remains low. As salaries in the public sector are very low (about $8-$15 per month at current exchange rates) health workers have low morale and most engage in some form of private practice. Poor-quality management at the district level, the result of appointing managers on the basis of political connections rather than demonstrated ability, often exacerbates the low morale of the workers. All these issues have resulted in a primary health care system that has not delivered an adequate level of services. For example, a 1998 demographic and health survey found that, nationwide, only 39 percent of children 12-23 months of age were fully immunized.

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1 The TA first appeared in ADB Business Opportunities in February 2001.
2 Human immunodeficiency virus.
5. In the near and immediate future, the Ministry of Health (MOH) will need to focus on these critical issues to expand and sustain future progress in health:

(i) improving efficiency, effectiveness, and pro-poor targeting of health services, particularly services by public providers;

(ii) improving people’s, particularly poor people’s, use of and benefit from available health services; and

(iii) orienting the health system and focusing resources on health issues of the poor, including HIV/AIDS, malaria, reproductive health and TB.

6. Despite severe financial and institutional constraints, the MOH has made impressive strides in strengthening the health system. It developed a national health policy and strategy that includes major financial reforms (budgetary reforms, introduction of user fees) and a national system of primary health care coverage. Although still high, infant mortality rates declined by 16 percent between 1990 and 1998. Immunization coverage expanded significantly over the last decade. Poliomyelitis was eradicated. MOH has also made substantial progress in other critical areas of public health, including TB and malaria control, HIV/AIDS prevention and introduction of modern birth spacing. Progress was achieved only recently and in such a short time that, in most cases its entire impact may not have been captured in the available survey data. Most commendably, MOH has remained open to change and has piloted several innovative approaches for increasing the coverage and quality of health services.

7. The Government’s health policy has two main instruments: (i) provision of government infrastructure for health care in rural areas, and (ii) centrally financed and managed vertical programs for major public health interventions. The extension of health services follows a health coverage plan to establish 927 health centers that will provide a defined minimum package of activities, comprising a basic set of preventive, curative, and promotive activities; and 67 referral hospitals with a defined complementary package of activities, comprising emergency medical and surgical interventions.

8. The health infrastructure is organized into 73 operational districts rather than administrative districts based on the criteria of population and accessibility of services. The Government developed precise budget allocation rules, instituted formal user fees and introduced innovations to improve access to the budget. The Government also introduced several pilot initiatives to improve the quality of health services for the poor, which includes contracting out health services to them (para. 11). To improve the access of the poor to health services, NGOs and some international agencies are piloting and planning equity funds.

9. After the period of rapid expansion and innovation in the last decade, the Government is now keen to consolidate the gains and apply the lessons learned from various pilot initiatives. There is a need to carefully assess the effectiveness, affordability, and sustainability of these pilots.

10. Several international agencies are supporting the Government in reconstructing and developing the health sector. Official development assistance accounts for more than half of the consolidated public funding to the sector. Some major supporters are ADB, Department for International Development (DFID), Japan International Cooperation Agency (JICA), German

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3 Acquired immunodeficiency syndrome.
Agency for Technical Cooperation (GTZ), World Bank, World Health Organization (WHO), and other agencies of the United Nations. International support—investment for developing infrastructure and technical assistance for developing policies and processes—has played a critical role in developing the sector. MOH is actively considering the approach of sector wide management (SWM) in planning and financing health services. SWM will be based on an overall health sector strategy and a master plan for the next five years, supported by all interested international agencies. The health sector strategy is expected to be developed and agreed upon by mid-2001 and the master plan is likely to be finalized by end-2001. ADB, together with other involved international agencies, will support the development of SWM.

11. ADB has been one of the lead funding agencies in the sector and is financing the Basic Health Services Project that aims to strengthen community-based health services in five provinces. Implementation was rated as highly satisfactory. The Project is pilot-testing an innovative approach of providing basic health services through contracts with NGOs and private sector groups. Service delivery in two districts has been contracted out to two NGOs; other NGOs have been contracted to manage the operations of three other districts. The impact of the pilot and lessons learned in implementing need to be comprehensively assessed so that the government can use these approaches on a wider scale.

12. The current project ends in June 2002. However, additional support will be required to consolidate the gains of the interventions and fully meet the development objectives. The Government has requested ADB to support the next project before the end of the current project so as to maintain the momentum of the various activities.

III. THE TECHNICAL ASSISTANCE

A. Objective

13. The main objective of the TA is to prepare a detailed project feasibility report for the Government and ADB to consider. The proposed project will cover 27 operational districts in five provinces that are currently included in the ongoing Basic Health Services Project. The tentative ADB assistance is $35 million. In each operational district, the proposed project will pursue the following objectives:

(i) improve the health status of poor communities, households, and individuals; and

(ii) increase the use of essential health services that can reduce cases of avoidable morbidity and mortality, particularly those due to poverty and economic disadvantage.

14. The TA aims to assemble the information and provide an analytical base to enable the Government and ADB to appraise the proposed Second Basic Health Services Project. The output of the TA will consist of (i) a report on the evaluation of pilot models for providing health services at eight operational districts; and (ii) a project implementation plan and a feasibility report on the Second Basic Health Services Project.

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4 Loan 1447-CAM: Basic Health Services Project, for $20 million, approved on 20 June 1996.
B. Scope

15. The TA will have two components:

1. Evaluation of Pilot Models for Providing Health Services

16. This component will support MOH in conducting a comprehensive evaluation of the impact of the contracting-in and contracting-out pilot approaches on districtwide performance, use of services, and health benefits. The findings should support concrete and practical recommendations of features and specifications to be incorporated in the design of the proposed Second Basic Health Services Project as well as in any future initiatives that may pursue MOH to further improve the efficiency of operational districts.

17. The evaluation will comprise a repeat household survey in all contracted (5) and control (4) districts, and a repeat health facility survey in all contracted and control districts, following the methodology of the baseline survey. The consultants will make a comparative analysis of efficiency and equity levels associated with changes in health coverage indicators and service use over time in the different districts. The study will also analyze cost-effectiveness by relating improvements in health coverage to costs for achieving the same in various districts.

2. Project Preparation

18. This component will help prepare a detailed project proposal for the Government and ADB to consider. The consultants will analyze the financing needs, strategies, and investment options to meet the proposed objectives (para. 14). The project proposal will include the necessary inputs, costs, and implementation arrangements, as well as the justification and risks. The TA will also analyze the potential poverty impact of the Project and will recommend a strategy to effectively benefit the disadvantaged groups, including girls, the poor, and ethnic minorities.

C. Cost Estimates and Financing Plan

19. The total cost of the TA is estimated at $850,000 of which $700,000 will be financed by ADB on a grant basis from the Japan Special Fund, funded by the Government of Japan. The grant will cover the entire foreign exchange cost of $555,000 and the local currency cost of $145,000. The Government was advised that approval of the TA does not commit ADB to financing the ensuing Project. ADB financing will cover consulting services, production of reports, organization of workshops, studies and field surveys, and administrative and support services. The Government contribution will be in kind and will comprise counterpart staff, office accommodation, meeting rooms, office support, and translation services. Government financing is estimated at $150,000 the cost estimates and financing plan are in Appendix 1.

D. Implementation Arrangements

20. The Executing Agency for the TA will be MOH. The TA will be implemented over 12 months starting May 2001. The project preparation component will start in September 2001 and will be completed within six months. In March 2001, a tripartite meeting of the Government, ADB, and consulting team will discuss the proposed feasibility report and the future time frame for project processing.
21. A team of three international consultants, providing services for 10 person-months, will be recruited for component 1. In addition, a local agency will assist the consultants in undertaking households and facilities surveys. Component 2 will be carried out by a team comprising five international and two domestic consultants (28 person-months). Component 1 will be implemented through individual consultants, while Component 2 will be implemented through a firm. Any procurement under the TA will be conducted in accordance with ADB’s Guidelines for Procurement. The consultants will be engaged in accordance with ADB’s Guidelines on the Use of Consultants following a simplified technical procedure and other arrangements satisfactory to ADB for engaging consultants. The terms of reference for the consultants are in Appendix 2.

22. The project coordination unit (PCU) of MOH for ADB and World Bank projects will support the day-to-day operations of the TA. The Government will provide the international consultant with a qualified counterpart team of four staff to assist the consultants in all aspects of the work, including liaising with concerned agencies. The counterpart staff will have the same areas of expertise as the international consultants. This team of counterpart staff will ultimately become the core of the project implementation unit. The TA team will be provided suitable office space within PCU.

23. A steering committee (SC), chaired by the secretary of the state MOH, will be established to provide overall guidance and ensure coordination with other concerned ministries, such as the Ministry of Economy and Finance and the Ministry of Planning. The SC will include representatives from the concerned divisions/departments of MOH, such as the Department of Health Planning and Information, Department of Human Resources Development, Department of Budget and Finance, and related ministries. The PCU manager will be the member-secretary of the SC. The TA will be implemented in a participatory way by closely involving all stakeholders, including rural communities, interested NGOs and international agencies and health care providers. ADB staff, the consulting team, and interested international agencies will hold intensive consultations to discuss the TA findings and to generate cofinancing interest at the earliest stages of project processing.

24. The TA is scheduled to be implemented from May 2001 to March 2002. Component 1 will start in May 2001, and component 2 will start in September 2001. Work on the two components is planned to be staggered to ensure feedback from evaluation of alternative models of service delivery into project preparation. The TA team leader for component 2 will submit a draft inception report to ADB and MOH within one month from the start of the TA, an interim report three months thereafter, and a final draft report by March 2002.

IV. THE PRESIDENT’S DECISION

25. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance, on a grant basis, to the Royal Government of Cambodia in an amount not exceeding the equivalent of $700,000 for the purpose of preparing the Second Basic Health Services Project, and hereby reports such action to the Board.
# COST ESTIMATES AND FINANCING PLAN

($)

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<sup>a</sup> ADB = Asian Development Bank, JSF= Japan Special Fund.
<sup>b</sup> Includes two computers, software, printer, fax and photocopy machines and office furniture.
<sup>c</sup> Includes cost of travel and per diem for two government observers invited for contract negotiations.

Source: Staff estimates.

(Reference in text: page 4, para. 19)
OUTLINE TERMS OF REFERENCE OF THE CONSULTANTS

A. Component 1: Evaluation of Pilot Models

1. Team Leader (international, 5.0 person-months)

   1. The consultant will be a public health expert with experience in organizing household and facilities surveys. With the help of the other team members, the team leader in component 1 will:

   (i) direct and supervise the activities of the health survey researchers in carrying out repeat household and health facility surveys in the contracted and control districts under the Basic Health Services Project (BHSP), ensuring that the methodology used is comparable with that in the baseline survey and that fieldwork is in accordance with the sample design and is reliable;
   
   (ii) oversee the activities of the data entry clerks in editing and recording survey data to ensure quality of data entry;
   
   (iii) with the assistance of the health survey researcher and health economist, analyze the findings of the household and health facility surveys, comparing them with the baseline survey and quantifying changes in the individual districts and across the three groupings of contracted in, contracted out, and control;
   
   (iv) direct and supervise the activities of the health economist in determining cost inputs in the control and contracted districts during the pilot period and analyzing such inputs in relation to measured changes in health coverage over the same period;
   
   (v) prepare a comprehensive report on the effectiveness of the pilots experiment;
   
   (vi) study other ongoing innovative projects, such as “new deal” project in Sotnikum District, the inputs of Swiss Red Cross in strengthening Takeo Provincial Hospital contracting and proposed “boosting” strategy, to identify elements that need to be added to future contracting arrangements with NGOs.
   
   (vii) prepare a Powerpoint presentation that can be used by the Ministry of Health (MOH) to present the study findings;
   
   (viii) assist MOH in conducting a workshop to present these findings to the concerned MOH, and aid and other agencies in Cambodia;
   
   (ix) develop a detailed report on recommendations for contracting activities in the future, including those for the next ADB loan project; and
   
   (x) facilitate the approval and implementation of the recommendations in the health sector strategy being developed by MOH.

2. Health Survey Researcher (International, 3.0 person-months)

   2. The consultant will:

   (i) train domestic supervisors and interviewers in using the household survey instrument and sampling methodology;
   
   (ii) train the health facility surveyors in using the health facility survey instrument and methodology;
   
   (iii) develop a work plan and timetable for the household and health facility surveys, and identify logistical requirements (lodging, transport for the team, etc.);
   
   (iv) in collaboration with the domestic supervisor, arrange transportation, meals, and lodging for the interviewers at each field site;

(Reference in text: page 5, para. 21)
(v) oversee the selection of samples for the household survey to ensure strict adherence to the sampling methodology;
(vi) direct and supervise the domestic supervisors in collecting household data daily, and in checking quality and editing completed questionnaires;
(vii) direct and supervise the activities of the health facility surveyor and review completed survey forms for completeness and consistency; make periodic spot checks;
(viii) ensure timely delivery of completed survey forms to the team leader for data entry; and
(ix) be responsible for other tasks assigned by the team leader.

3. **Health Economist (international, 2.0 person-months)**

3. The consultant will

(i) identify and estimate all government resources supplied to the control and contracted districts since 1 January 1999;
(ii) identify and estimate any other resources supplied to those districts during that period if such resources directly or indirectly supported the delivery of basic health services;
(iii) identify and estimate the household expenditure for the use of basic health services, for both public and private sector services;
(iv) develop a methodology for relating these cost inputs to health service coverage as measured in the analysis of the baseline and follow-up household and health facility surveys; and
(v) prepare a detailed report describing the relative costs and cost-benefit of three models of health service delivery tested under the pilot: control (direct government service delivery), contracting NGOs or and contracting out health services to them.

B. **Component 2: Project Preparation**

1. **Health Systems Management Expert/Team Leader (international, 6.0 person-months)**

4. The consultant will have extensive background in preparing health projects in developing countries, preferably in Southeast Asia. The team leader will have the following responsibilities:

(i) be responsible for the collective work of the consulting team and for timely preparation of all formal written reports the inception report, periodic progress reports, draft final report, and final report;
(ii) with the assistance of other team members, undertake a comprehensive review of the BHSP (as described in para. 2);
(iii) summarize lessons learned from the BHSP;
(iv) identify various alternative approaches/project designs that can help achieve the proposed objectives;
(v) suggest the most cost-effective project design and prepare a project brief outlining the main components, subcomponents, and activities for the project;
(vi) prepare the overall project framework;
(vii) reach an agreement with MOH on the project brief and the proposed logical framework;
(viii) with the assistance of other consultants, prepare a detailed project proposal and be responsible for issues related to project management, health systems management, and contracting arrangements with nongovernment organizations (NGOs);
(ix) carefully assess the assumptions underlying the Project, identify risks that may hamper its implementation, and suggest measures that will minimize such risks;
(x) together with counterparts, identify potential innovative activities (with implementation details)—for example, equity fund for assisting the poor, or any other health financing scheme in rural areas;
(xi) develop a system for benefit monitoring and evaluation of the Project including (a) identifying baseline data requirements and key performance indicators; (b) procedures for collecting, compiling, and analyzing monitoring data; (c) responsibilities of staff involved in monitoring and evaluation; (d) staff training and equipment needs at each level of the monitoring system; and (e) reporting requirements and formats
(xii) work with NGOs and aid agencies working in rural health to get feedback and inputs on the project design; and
(xiii) explore the potential for cofinancing and for NGOs to get involved in implementing selected project components.

2. Medical Equipment Expert (international, 3.5 person-months)

5. The consultant will

(i) review the usefulness and appropriateness of the equipment supplied to health centers and referral hospitals under the BHSP;
(ii) identify the list of equipment, with detailed specifications, that will need to be procured to meet the proposed project objectives;
(iii) assist in identifying pre-installation activities (including preparation of sites and training of staff) for the different inputs to be supplied; and
(iv) prepare plans for effective procurement (including guidelines), delivery, maintenance, and storage;
(v) suggest bidding packages for procuring equipment; and
(vi) prepare bidding documents for procuring packages with cost estimates of more than $200,000.

3. Human Resource Development (HRD)/Training Expert (International, 3.5 person-months)

6. The consultant will

(i) assess the supply of and demand for human resources for health in the project area in the next 10 years;
(ii) consider the available alternatives for meeting the human resource needs and propose the most appropriate option;
(iii) assess the HRD inputs in the BHSP and Basic Skills Project for their effectiveness;
(iv) assess the present capacity for preservice and in-service training;
(v) prepare the HRD component/subcomponent of the Project;
(vi) suggest training curricula, prototype training materials, and trainers competencies for different training activities;
(vii) identify potential training facilities/resources and trainers that can be used in project-related training; and
(viii) develop cost estimates for the different training activities.

4. **Health Economist/Health Financing Expert (international, 3.5 person-months)**

7. The consultant will

(i) assist the team leader in analyzing the cost estimates and unit costs of the BHSP;
(ii) prepare detailed cost estimates for the project components using COSTAB and be responsible for the final project budget;
(iii) disaggregate the cost tables into investments and recurrent costs, local currency and foreign currency related costs, and source of funding;
(iv) undertake economic analysis to explore project viability and justification – estimate the rate of returns of the Project;
(v) estimate the resources required to sustain the implemented activities beyond the project period and assess the potential for financial sustainability;
(vi) assess the Government’s capacity to meet counterpart financing needs, both at the central and provincial levels;
(vii) undertake distributional analysis of project benefits and poverty analysis in accordance with ADB guidelines; and
(viii) quantify the potential impact of project activities in terms of beneficiaries and benefits.

5. **Health Facilities Expert/Architect (international, 1.5 person-months)**

8. The consultant must have experience in designing and supervising the construction of rural health facilities. She/he will

(i) review the existing designs of rural health facilities and the designs used in the BHSP for their usefulness, effectiveness, and cost;
(ii) based on the review, design health centers and referral hospitals including appropriate documentation, specifications, and schedule of rates;
(iii) assist the team leader in organizing a survey of all facilities proposed to be upgraded/constructed to assess the investment needs;
(iv) check the findings of the survey of all facilities for the project and confirm the extent of work; determine the most successful way to implement the refurbishment contracts;
(v) prepare packages of construction based on the project brief as agreed upon with the government;
(vi) finalize design and documentation for the packages; the documents will be used for bidding, contracting, supervising, and administering implementation; and
(vii) help develop guidelines for proper building maintenance and estimate maintenance costs that need to be budgeted to maintain the physical conditions of rural health facilities.

6. **Project Management and Organization Expert (domestic, 5.0 person-months)**

9. The consultant will have a background and experience in project management, institutional development, and setting up management information systems for the health sector. The consultant will assist the team leader in reviewing the management structure of the BHSP,
assist in developing the management framework for implementing the Project, and identify staffing norms, and staff qualifications, responsibilities, and duties of project personnel at different levels.

7. **Human Resources Development/Training Expert (domestic, 5.0 person-months)**

10. The consultant will work closely with the international HRD expert and assist in reviewing the HRD inputs in the BHSP and identifying the inputs for the proposed project. The consultant will prepare the HRD plan for the Project and will assist in costing the inputs.