

Mid Term Review of the Health Sector Reform Phase III Project

Cambodia

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Final

Report

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I.

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

Contents

ABBREVIATIONS AND ACRONYMS	4
EXECUTIVE SUMMARY.....	5
1 INTRODUCTION	12
1.1 The Mid Term Review.....	12
1.2 Introduction to the HSR3 project	12
1.3 Progress with implementation of HSR3 project to September 1999.....	15
2 REVIEW OF PROGRESS AGAINST OUTPUTS AND ACHIEVEMENTS OF HSR3 TO DATE	18
2.1 Progress and suggestions on Output 1.....	18
2.2 Progress and suggestions on Output 2.....	22
2.3 Progress and suggestions on Output 3	26
2.4 Progress and suggestions on Output 4	

28

2.5	Progress and suggestions on Output 5.....
30	

3 CONTRIBUTION TO THE IMMEDIATE OBJECTIVES OF THE PROJECT 32

4 INCREASING UTILISATION AND EQUITY OF ACCESS, AND THE CONTRIBUTION HSR3 CAN MAKE
34

4.1	How to improve utilisation and equity of access.....
34	

4.2	Role of the HSR3 project
37	

5 COMMENTS ON THE HSR3 PROJECT MANAGEMENT ARRANGEMENTS AND PROCESS

41

6 RECOMMENDATIONS
43

6.1	Priorities for HSR3 project.....
43	

6.2	Future support
44	

6.3	Revisions to the logframe.....
46	

Institute for Health Sector Development

2

December 1999

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

S

ANNEX 1: TERMS OF REFERENCE FOR THE MID, TERM REVIEW
48

ANNEX 2: SCHEDULE FOR MTR INDIVIDUAL MEETINGS.....
53

TIMETABLE FOR THE MID-TERM REVIEW
55

ANNEX 3 - ORIGINAL LOGICAL FRAMEWORK FOR HEALTH

SECTOR REFORM PHASE III PROJECT
60

ANNEX 4: HSR PHASE III PROJECT: PAST ACHIEVEMENTS AND
FUTURE ACTIVITIES.....
64

Institute for Health Sector Development

3

December 1999

I

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

Abbreviations and Acronyms

ADB
ADD CPA DFID DHDC GDP GTZ HC HETF H FA HIS HQ HSR3 HSRG JICA
MEDICAM MEF
MOEYS M PA MSF MTR NGO NIPH NORAD NPAR OD
PAR PHA PHD RO SAB SHS SWAp TA TB UNDP UNICEF UNV VSO WB WG
WHO

Asian Development Bank
Accelerated District Development Complementary
Package of Activities
Department for International Development (UK co-operation) District Health
Development Committees Gross Domestic Product
(German co-operation) Health Centres
Health Economics Task Force Health Financing
Advisor Health Information System Headquarters
Health Sector Reform Phase III Project Health Sector
Reform Group Japanese International Co-operation
Medical Cambodia (NGO health sector committee) Ministry of
Economy and Finance Ministry of Education, Youth and Sport
Minimum Package of Activities Medecins Sans Frontieres Mid Term
Review
Non Governmental Organisation National Institute for
Public Health Norwegian Co-operation
National Public Administrative Reform Operational
District Public Administrative Reform Provincial Health
Adviser Provincial Health Director Regional Office (of
WHO) Senior Advisory Board Strengthening Health
Systems Sector Wide Approach Technical Assistance
Tuberculosis
United Nations Development Programme UN Children's
Fund
United Nations Volunteers Voluntary Services

Executive Summary

This is the report of the Mid Term Review (MTR) of the Cambodian Health Sector Reform Phase III (HSR3) project. The project started in February 1998, and is due to end at the end of the year 2000. The project is executed by the Ministry of Health (MOH) and World Health Organisation (WHO), and funded by the UK Department for International Development (DFID), United Nations Development Programme (UNDP), Norwegian Co-operation (NORAD) and WHO. Total funding is \$ 6.8 million for the three years.

The MTR took place in Cambodia from 13 to 24 September 1999. A team of six (including members from the MOH and 3 of the funding agencies) reviewed the activities and achievements of the project, visited 3 provinces and interviewed officials from the health sector, key donors and development agencies, Non Governmental Organisations (NGOs) and other ministries. At the end, the team presented their findings to the Minister of Health, Secretaries of State, MOH officials and other key players in the sector. The team is very grateful to the MOH and the project team for their thorough arrangements for the mission and to all those consulted, for their frankness and willingness to discuss the issues.

The purpose of the MTR was to review progress against the outputs and objectives of the project and advise on priorities for the remainder of the project and any future support.

Progress against outputs

The immediate objective of HSR3 project is "To increase people's, and in particular poor people's, access to and utilisation of good quality essential health services whether subsidised by Government or paid for through public-private mix." This is to be achieved through five main outputs.

Output 1 is "Developed and strengthened capacity in the MOH to develop, support, manage and monitor Health Sector reform initiatives."

There has been good progress with establishing the structure for supporting policy development and monitoring in the MOH. The Health Sector Reform Group (HSRG) has been set up and seems to function well with active members from

relevant departments. It has established six working groups (WG) or task forces to tackle specific issues, and has a workplan of activities at central and provincial levels.

The main constraint on its performance has been the limited time available for members who, also hold other posts in the MOH. The MTR team felt this should be addressed by bringing a wider range of people into the HSRG and WG, including

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

able people drawn from national programmes and provinces, so that a wider range of people are involved and can share the workload.

The MTR team noted that HSRG is increasingly considering all reforms and sector performance issues, not just those seen as 'reforms', and strongly encourages this broad perspective.

Much effort has gone into developing a Monitoring and Evaluation Framework and Planning Guidelines. The team felt that more effort now needs to go towards supporting implementation in provinces and districts. This support can be tailored to the needs of different provinces. Increased contact with provinces will also be useful for reviewing their progress, so this experience can feed back into policy making.

It was not clear how this feedback to top levels of the MOH would take place. Whilst there is a Senior Advisory Board (SAB) established to approve project activities, it was not clear that this had appropriate representation to play a strategic role. There is a need to identify how the feedback into policy making will work. A review of the SAB's membership and role has been proposed by the MOH and would provide a good opportunity to address the issue.

Output 2 is "Implementation of district-based health care systems, according to the health coverage plan, in the five provinces directly supported by the project and in collaboration with UNICEF and other donor agencies in an additional five provinces."

The implementation of the district health system is making progress especially when taking into account the low starting point with very few services functioning. The construction of health facilities is supported by other agencies as is training of health staff, and while there has been progress with these there have been some delays in implementation. In the project provinces 59% of the health centres are in place and offering the Minimum Package of Activities (MPA), compared to only 29% for the country as a whole.

The HSR3 project has provided management support to assist this development, through provision of Provincial Health Advisers (PHAs). These are generally seen as useful by the provinces but it is important to ensure the province wants an Adviser and that the skills meet the needs of the province. The MTR team felt the provinces should have a stronger role in selecting and reviewing performance of their PHAs. The PHAs also provide a useful source of information for the centre on progress and implementation difficulties.

There are still some unresolved issues in implementing the coverage plan. One is integration - there is a policy of integration but there are not yet clear plans for how national vertical programmes will link with and support the development of basic services, except for the introduction of integrated supervision from districts to

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

encourage further work in this area. One area for review and co-ordination might be training as each programme tends to organise its own. The MOH will require the support of the funding agencies in introducing changes to the way national programmes operate.

Output 3 is "Alternative service delivery models implemented and evaluated for their impact on access and equity." This refers to efforts to develop new methods for service delivery in Phnom Penh. The project activities are being implemented through a contract which includes collection of baseline information and development, implementation and evaluation of two initiatives serving poor populations in the city. Because there was a delay in agreeing the project scope and finalising the contract, this component did not start until April 1999. As a consequence, the progress to date is limited: an urban task force has been set up; the baseline studies have been carried out; and some initial design work on the initiatives has started.

The MTR felt that the urban component had made a good start and that the baseline study had produced some useful information for health policy and planning. However it was too early to see progress against the output. The team felt that the project could not be expected to complete the testing and evaluation of models by the end of 2000; an extra year would be needed for this.

Output 4 is "Development and evaluation of health financing models in project supported provinces". There has been some activity in assisting health facilities to introduce user fees in line with the MOH Charter on financing. However there has been limited progress on evaluating the impact of charges or the success of the exemption mechanisms. This delay reflects the difficulty in recruiting a Health Financing Adviser, but the adviser is now in place and plans are developed for evaluation work and for enhancing MOH capacity in financing issues. The MTR

team felt that the efforts under this output should be focused on evaluation of the different types of financing initiatives and mechanisms for improving access by the poor, rather than on increasing the coverage of user fees. The evidence on impact will form the basis for reviewing the fee policy.

Output 5 is "Sector-wide approach to health development and investment adopted." The HSR3 project has assisted the MOH to understand the approach and to prepare a plan for its introduction. The plan that has been developed seems sensible and well thought through, if ambitious in timing. The stakeholder analysis indicated mixed views in MOH and in funding agencies on the readiness for such an approach. Despite this, the MTR team felt the preparations for a more coherent approach to sector development should be pursued. This would include development of sector policy in consultation with donors, NGOs and other key groups to develop a broad consensus on the directions of policy; development of mechanisms for budget support; and starting to introduce more shared planning and review exercises such as a joint sector review to replace the many project reviews.

Impact on project objectives

The project's immediate objective is to increase access and utilisation of services, particularly for poor people. The limited evidence there is suggests that utilisation of public services is relatively low. Meanwhile, the poor are spending large amounts of their income on health care, often using drug shops and private services (whose quality can be poor), but also paying unofficial charges in Government health facilities.

On the positive side, the data in the project provinces shows that the use of services in health centres offering MPA was significantly higher than in those which do not yet have the MPA, indicating that once better services are in place then use can increase - (although this data can also be questioned). Where services have support (financial and technical) from NGOs, their utilisation is often high. Also, it is an early stage to expect high utilisation nationally taking into account that less than one third of the primary care facilities are functioning properly (with MPA services, drugs and training), so many people still do not have geographic access to public health services.

The low use of public health services can be attributed to a number of factors, principally that the services are perceived to have uncertain quality and staff are often not present. The charges (formal and informal) are also a deterrent to use. Underlying this is the under-funding of services - both for operating costs and for staff salaries. Low salaries (around \$15 per month) means that staff are not motivated to offer quality care; and spend their time offering services for a fee

elsewhere. Managers feel unable to expect better performance or to send qualified staff to remote health facilities where they have little opportunity to earn incomes.

The HSR3 does not directly address these issues in terms of improving the funding of services, (apart from the urban component which is not yet operational). It has however addressed the constraints on improving health service performance in various ways, including:

- Work on monitoring budget releases, which has been used to pressurise the Ministry of Economy and Finance (MEF) to release more funds;
- Proposals for budget reforms in order to assure more funds actually reach the health facilities - some have been adopted (Accelerated District Development - ADD) and others will start in the next financial year;
- Development of policies and strategies for improving district performance (discussed below)
- Qualitative research on community perceptions and preferences (and further studies planned), which identifies the need for changes in some policies and strategies



- Support to introducing community committees and feedback committees at health facilities to improve contact between the facilities and the communities they serve
- Strengthening planning and management of services so that resources are used more efficiently and in line with priorities.
- Supporting the introduction of user fees intended both to replace under the table payments and to supplement salaries.
- Supporting MOH's role in contributing to the reform process in other sectors.

Overall the MTR team felt that the HSR3 project is making a contribution to improving the health system and that the health system will not become effective and sustainable without the development of systems and capacity (which the project supports). However, while the project can help to overcome the barriers

to increasing access and use of services, it cannot be expected to resolve the financing and system issues. The project was intended to complement other funding and activities in the health sector - including infrastructural developments, training programmes, NGO activities, Government funding and public administration reforms.

Future Directions

It is recognised that the project is working in a complex environment: the health sector is going through a complex and ambitious process of regeneration and reform, at a time of gradual but not consistently smooth improvement in the economic, social and political situation. Also, the Government is planning wider reforms which affect the pace of implementation and it is important for HSR3 to take these into account and work with them to improve health in Cambodia.

However, the health status of the population is still low whilst the high expenditure on health by families is a major cause of impoverishment and a major burden on poor households, which could have a negative impact on social development in Cambodia. There is an urgent need to review health policies and strategies in order to identify how to improve access to effective health services and reduce the waste of expenditure on poor quality provision.

The MOH policy is to develop cost effective public services which are readily accessible. It has recognised the problems facing the public health services and has started to define a package of measures to improve the situation. This includes:

- additional funding for recurrent costs to improve salary levels and running costs
- increasing local control over budget and staff, based on contracts with staff and with health providers which have funding linked to performance
- a strategy to ensure access to services for the poor
- more community involvement

- lesson learning through monitoring and evaluation

The MTR team felt that the HSR3 project should support the development of such a national framework for health sector support, which could also form the basis for a sectoral approach. The project can also support consensus building

with key players and civil society.

In particular the HSR3 project can support the MOH in thinking through the options for reforming staff terms and conditions in order to improve their motivation, deployment and performance. It is important that this work links closely with the National Public Administrative Reform (NPAR) programme in these areas, to ensure NPAR support initiatives taken in the health sector. Health has already been identified as a pilot for Public Administrative Reform (PAR), so it has the remit to start addressing PAR issues, and the MTR team encourages work in these areas. There is a balance to be achieved between maintaining consistency with broad civil service reform on issues such as remuneration reform, and moving ahead with improving the health sector even if there are delays in NPAR.

The project can also continue to play an important role in budget and financial management reforms. The MTR team was pleased to note close working between MOH and MEF and to hear that a joint committee on budget issues is being established. A key role in the short term will also be to support province and district level financial management so that they can show results in terms of improved performance from any increases in the budget they receive.

Recommendations

The main recommendations for project focus and direction have been covered above (under each output and future directions). In addition the team has some recommendations on project management and processes:

- Technical assistance should continue to shift from being WHO advisers based in WHO offices to being MOH advisers based in MOH.
- Ensure the next annual project review is short and avoid extensive preparations for it, and continue to have shared reviews and reports.
- Ensure there is discussion of the process of skills transfer and review of the extent it has occurred, by expatriate staff and their key counterparts in MOH and provinces.

The MTR team recommends an extension for 12 to 15 months, to be used for the project to achieve its outputs and reorient its work in line with the MTR recommendations. This should not require an increase in annual expenditure levels nor in the number of long term Technical Assistance (TA).

The major reasons for this recommendation are:

- the delayed start of some components;
- the project outputs and objectives are still relevant;
- the external environment, including elections in 1998 and slow progress on PAR, which have made progress more difficult in the MOH;
- various changes can be expected in the next 12 months including further work on PAR; progress in defining health policies; and further thinking on the nature of a Sector Wide Approach (SWAp). It will be easier to define the needs for future support once these issues are clearer.
- It would be preferable for HSRG and project staff to focus on implementing the project activities than to be distracted by planning a new phase of support.

The MOH suggested that the project should add support for the Health Information System (HIS) and social development to the project. The MTR team view is that there are already inputs in the project (under HSRG and TA) which can be used for HIS work. On social development, there is already encouraging work on how to implement this in MOH work and the project can consider how best to support integration of social development in MOH activities, within the existing funding levels. It is not recommended that the project should take over the human resources policy and planning work of another project, although this is an important area and the WHO should be able to assist MOH to identify needs for further support and potential funding.

If the recommendation for an extension is accepted, then it is proposed that the MOH and project team prepare a revised logframe, budget and short justification for the extension. It is recommended that the process of approving the extension should not impose a major workload on the project, so that they can focus on project-supported activities. A deadline of May 2000 is proposed for agreeing to the extension.

A further phase of support is likely to be required. Preparation for this can start in early 2001. It could be part of a sector programme or within a Programme Support framework.

The logframe should be revised by the MOH and project staff in line with the MTR. It is suggested that the logframe should include more quantified indicators or milestones, which could be reflected in HSRG workplans.

1Introduction

1.1 The Mid Term Review

This is the report from the Mid Term Review (MTR) of the Health Sector Reform Phase III (HSR3) Project. The HSR3 project started in February 1998 with a three year time scale. The project is executed by the Ministry of Health (MOH) and World Health Organisation (WHO). The project is co-funded by four agencies: the British Department for International Development (DFID); UNEP; WHO; and Norwegian Cooperation (NORAD).

The Mid Term Review was a joint review by the partners in the HSR3 project. It was carried out in Cambodia from 13 to 24 September 1999. The MTR team comprised representatives from MOH, DFID, WHO and NORAD as well as a consultant team leader and institutional expert. UNDP did not join the team but the Resident Representative and Program Officer met team members during the review and attended the final presentation. The objectives of the MTR were to review progress against the outputs of the project, assess impact on the objective, and recommend the way forward in terms of priorities and any future support. The terms of reference for the review are given in Annex 1.

i

The MTR team held meetings with those responsible for project implementation within the MOH and provinces and with the project advisers. There were field visits to three provinces (Takeo, Pursat and Kampot) which were very helpful to the team. A series of roundtable discussions were organised with key agencies on specific topics. The team also met advisers to other Government agencies (Ministry of Economy and Finance, Public Administrative Reform and Ministry of Education and Sports) and representatives of other agencies active in the health sector including the World Bank (WB), Japanese International Co-operation (JICA), Australian Aid (AusAid), UNICEF, MEDICAM, GTZ and Medicins Sans Frontieres (MSF). The team was therefore able to gather a wide range of views and reactions on the development of the health sector in general and the HSR3 project in particular. A list of those consulted is given in Annex 2.

The MTR team would like to record their thanks to all concerned for the careful preparation for the review and the participation in meetings and discussions. The high level participation in the review was particularly welcome and taken as an indicator of the importance which the MOH places on the HSR3 project.

1.2 Introduction to the HSR3 project

The HSR3 project is the third phase of support to the Cambodian Ministry of Health. The first two phases were called Strengthening Health Systems (SHS) Phase 1

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

(which ran from 1992 to 1994, funded by British aid, UNDP and WHO) and Phase 2 (from 1995 to 1997, funded by the same agencies and also by NORAD). Both phases were executed by WHO in close collaboration with the MOH.

The previous phases concentrated on developing capacity in the Ministry of Health to develop policies and plans for the health sector. At the time the first phase started the health sector in Cambodia, as other sectors, was emerging from a long period of civil war, disruption and genocide. The health system was decimated - only some 43 doctors were left in the country, only 20% of health facilities were in reasonable condition and the Ministry headquarters level was ill equipped and lacked staff with appropriate training. The SHS project was intended to provide support to the Government in identifying appropriate policies and systems to revive the health sector. Good progress has been made since 1992.

The project helped the MOH to develop policies for an affordable health system, which involved reforms to the structure of services. This is embodied in the Health Coverage Plan which identifies two main levels of health services - Health Centres (HC), serving a population of around 10,000 and offering a Minimum Package of Activities (MPA); and Referral Hospitals serving a population of around 100,000 and offering a Complementary Package of Activities (CPA); in addition there are some national level services. The services were to be managed by "Operational districts", each of which had one referral hospital and several health centres. This replaced the previous structure of commune clinics and district hospitals based on administrative districts. In effect it required a major rationalisation of service provision compared with restoration of the previous system (since there would only be 935 HCs rather than clinics in some 1600 communes and 65 referral hospitals rather than 167 administrative districts each with a district hospital). The intention was to develop an affordable public health system providing good quality services which was accessible to all of the population, particularly the poor.

Other donors and funding agencies have adopted the coverage plan approach and are supporting the construction and rehabilitation of facilities in line with the plan. Whilst there have been some delays in implementing the plan substantial progress has been made with about one third of the Health Centres in place' and offering the MPA. Provinces visited by the team indicated that the building programme for new health centres is proceeding more rapidly now so the infrastructure for providing basic health services is gradually being put in place.

Following the coverage plan the MOH produced the Health Financing Charter in 1996 which proposed to test the approach of charging user fees for services,

99% of which would be retained at facility level to improve services. The charter also proposed development of Management Committees and Feedback Committees at facility level to improve communication with the community. This was to address the widespread practice of unofficial charging by health staff, which had arisen in the context of their very low salaries.

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

The third phase of the project was intended to reinforce capacity for implementation of the sector policies and strengthen MOH capacity for policy development, management and monitoring.

The immediate objective of HSR3 project was "To increase people's, and in particular poor people's, access to and utilisation of good quality essential health services whether subsidised by Government or paid for through public-private mix." This was to be achieved through five main outputs (see the original project logical framework in Annex 3):

Output 1: Developed and strengthened capacity in the MOH to develop, support, manage and monitor Health Sector reform initiatives.

Output 2: Implementation of district-based health care systems, according to the health coverage plan, in the five provinces directly supported by the project and in collaboration with UNICEF and other donor agencies in an additional five provinces.

Output 3: Alternative service delivery models implemented and evaluated for their impact on access and equity.

Output 4: Development and evaluation of health financing models in project supported provinces

Output 5: Sector-wide approach to health development and investment adopted.

The project is intended to continue for three years. The MTR team was told that this was originally agreed to fit in with the UNDP funding cycle. The project has a shared project document which is in the UNDP format and has been applying UNDP reporting procedures.

The main inputs to the project are as follows:

- National level technical assistance: Team leader; Institutional Development Adviser; Financing Adviser; Budget Adviser; each for 3 person years.
- Provincial Health Advisers (PHA): for a total of 12 person years. In parallel, some provinces are supported by other agencies, including UNICEF.)

- Short term consultants
- Volunteers 4 from Voluntary Services Overseas (VSOs) and one United Nation Volunteer (U NV)
- "National execution funds" to support the Health Sector Reform Group (HSRG) within the MOH - covering modest salary supplements and funds for activities at national and provincial level.
- Training activities
- Operational costs and overheads

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

The HSR3 project is funded as follows:

Funding agency	Current HSR3 budget in US \$	Main areas of expenditure
DFID	4,265,180 (63%)	TA at national level; PHA; short term consultants; national execution funding for operational research; urban health contract; short term fellowships; project operating costs; WHO overheads
UNDID	1,207,594 (18%)	"National execution" funds & one PHA
NORAD	896,377 (13%)	2 Provincial Health advisers; funds for provincial level activities; WHO overheads
WHO	434,294 (6%)	PHA, management training, fellowships, local professional staff
Total	6,803,445 (100%)	

The project management is complex, with most of the funds channelled through WHO, apart from the "national execution funds" which are passed directly to the MOH and the funds for short term consultants, the team leader, some operational research and the urban contract which are funded directly by DFID.

1.3 Progress with implementation of HSR3 project to September 1999

The MTR focus is on achievement of outputs and the objectives/purpose of the project. This section briefly summarises progress in terms of inputs and activities as a context for reviewing progress against outputs.

The project formally started on 15th January 1998, although in practice it became active and the project document was signed in mid February 1998. Thus the MTR took place half way through the 3-year project life. However there were some delays in aspects of project:

- External TA: The team leader and Institutional Adviser were in place from the start but there were delays in appointing other key staff - the Budget Adviser only started full time in November 1998. The Financing Adviser started a year late in early 1999 (despite repeated efforts, it was difficult to recruit a suitable expert). There were delays in filling some other posts as well.
- Testing alternative delivery models in the Phnom Penh urban area - the activities related to Output 3 were to be implemented through a contract. Agreeing the project scope and design took longer than expected and there was then a lengthy contracting process, so the contractor only started work in April 1999, 5 months before the MTR.
- The National Execution funds for HSRG only became available in mid 1998.

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

- Some planned training activities were delayed.
- In addition there were delaying factors in the broader environment which affected progress in the health sector, particularly the coup in 1997 and the instability and particularly the disruption to loans from development banks that followed. Furthermore there were elections in 1998 and then it took more than four months to form a Government. Also public administrative reform (to address issues including civil service salaries) has been much slower than expected (as discussed further below).

As a result of these delays only 20% of the project funds were used during the first year. However, now that all the main inputs are in place, the project expects to have spent 57% of the budget by the end of 1999, two-thirds of the way through the project life.

The MTR was presented with a useful summary of the project's activities under each output - titled HSR Phase III Project Past Achievements and Future Activities (attached as Annex 4). The main activities and achievements under each output are set out below. It is difficult to assess whether the project has achieved as much as originally expected by this mid-term stage because the logframe did not give any time-bound indicators to show what might be expected by this stage. Also, it was difficult for the team to assess how much of the capacity building had taken place in Phase 2 and how much in phase 3. However, it is clear that the activities related to outputs 3, 4 and 5 (testing urban delivery models, evaluating financing reforms and SWAP development) are behind what would be expected if they had started more promptly.

Main activities and achievements under each output (from a MOH presentation)

Output	Activities and achievements by September 1999
Output 1- MOH Capacity Building	<ul style="list-style-type: none"> • HSRG and 5 working groups established • HSRG accounting system functioning & has attracted other funds • Tools developed to monitor health policies and performance • Operational research on equity and access started • Training in health economics and in management underway
Output 2 - District health systems implemented in 5 project provinces and 5 others	<ul style="list-style-type: none"> • Provincial and Operational District management teams established in all supported provinces • Planning manual developed and used • Integrated supervision checklists introduced • Continuing establishment of health centres with MPA • Provincial co-ordination meetings held to strengthen links between PHDs and MOH • Community participation established

Institute for Health Sector Development,

- 16

December 1999

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

Output 3 - alternative delivery strategies	<ul style="list-style-type: none"> • Urban Health Project Task Force established <ul style="list-style-type: none"> • Baseline survey underway with some results available • Design work on innovative strategies has started
Output 4 - develop and evaluate financing strategies	<ul style="list-style-type: none"> • Monitoring designed for financing schemes • Support provided for hospital financing schemes in 3 provinces • Evaluation of user fees impact is designed and agreed • Evaluation of exemption mechanisms designed
Output 5 - develop a SWAP	<ul style="list-style-type: none"> • Discussion and confirmation of interest in MOH • Plan for moving to a SWAP developed • Stakeholder analysis conducted • Study of effects of the project approach completed • Pipeline and policy analysis underway

Institute for Health Sector Development

-17-

December 1999

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

2 Review of progress against outputs and achievements of HSR3 to date

This chapter reviews achievements towards each of the outputs and suggests changes in emphasis where appropriate.

2.1 Progress and suggestions on Output 1

Output 1 is: **the achievement of developed and strengthened capacity in the MOH to develop, support, manage and monitor Health Sector Reform activities.**

The measurable indicators listed against this output are:

- existence of structures to support, manage and monitor reform initiatives;
- capacity of groups working on key reform issues;
- % of HSRG budget spent (note: no specified % given);
- development of evidence base for decision-making.

Structures to support health reforms

Against the first indicator, progress has been made. The HSRG is set up, as is the Senior Advisory Board (SAB) to which it reports, and the Working Groups which report to it. The membership of the HSRG includes relevant departments in the MOH organisation structure, and its members are reform enthusiasts and "doers". It is chaired by the Director General of Health, who is an appropriate senior official for this role.

Capacity of the HSRG has been developed through some training and orientation, and through the requirement to produce individual as well as group workplans. Its capacity is demonstrated in the range of activities planned, the types of activities undertaken and the procedures for using the funds it controls. The MTR team was pleased to see a range of provincial level activities as well as centrally managed work in the work plans.

The MTR also welcomed the way that the HSRG is increasingly looking at the health sector performance as a whole - rather than focusing on elements defined as Reforms. The MTR team felt that it is very important for HSRG to take this broad perspective. Thus, for example, the impact of the initiative of contracting health services which MOH is testing (with ADB support) is an important initiative to review alongside various other initiatives by NGOs and bilateral projects. Similarly the HSRG has started to widen the scope of the sector to include the private sector and can also consider issues such as the pharmaceutical sector and the links with community development work under the Ministry of Rural Development. In reviewing these areas, the HSRG should draw on all the available sources of information - not just those funded or collected under the HSRG auspices.

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

An indicator of success in strengthening MOH capacity is how the Ministry is perceived. Several sources outside and within the Government said that the MOH is a strong and capable ministry, with a vision and capacity to make decisions and lead reforms. There was also a recognition that the HSR project and its predecessors had contributed to this. However some commentators questioned how far there was actually capacity built in the MOH itself, as opposed to provided by the TA under the various project phases.

The team found it very difficult to assess the extent of capacity building, particularly how much had occurred in phase 2 rather than phase 3 of the project. However the conclusion was that the project was going in the right direction for developing further capacity in the MOH by the end of the project. It is important to ensure that skills transfer is maximised from the international TA and it seems that performance in this respect was mixed.

"National Execution" funding

The development of the "national execution" funding channel seems to be working well. The procedures are established and accounting arrangements in place. The first external audit was satisfactory. The team felt this had contributed to the increased ownership of the project by the MOH. The funding mechanism has attracted additional funding from another funding agency (\$38,080 from UNICEF in 1999), which can be seen as an indicator of its acceptance.

However the 1999 HSRG budget is currently underspent. This was due to underspending for central level activities - the provincial activities have been implemented in line with the plans. The major reason given for low implementation rates at central level is that of "time constraints". HSRG members all have departmental responsibilities as well as HSRG ones.

The project has identified that it has time-consuming procedures for release of funds for each activity to province level. The project is proposing to change this approach and the MTR team support this - it may be appropriate to give individual provinces an increasing amount of control over the funds as they demonstrate their capacity to use and account for the funds sensibly.

The "national execution" funding arrangement could provide a channel for other support to the health sector, including for example support for recurrent costs of services. However the MTR team felt that this using such a parallel funding mechanism was not desirable - in principle it would be better to use the Government funding channels rather than creating a parallel system with its own management and accounting arrangements. There are already several of these

funding channels at provincial and lower levels (e.g. for World Bank and ADB funds, for the AIDS programme) and it was not desirable to add more such channels. The MOH also

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

expressed a preference for having one shared system. However, for donors to be confident about using the Government channels will require a high degree of transparency and accountability, and clear signs that the funds are released and used for their intended purposes - which is not apparent at present.

Evidence based monitoring

The production of the evidence base for monitoring sector policy and performance has commenced, but is not yet complete. A list of health reform indicators has been published; there are 51 indicators relating to the areas of development, financial resources, access and utilisation, quality, and the improvement of health. Whilst there was not time for detailed technical review, the indicators look relevant and take into account 'demand side' issues as well as service provision, but there may be too many for regular use. The next step is to ensure the information is actually collected in affordable ways and there is a need for baseline information in some areas. This is ongoing work of the MOH with the project's support. It will then be important to use the information at national level for policy monitoring and at lower levels to improve services.

Other initiatives to improve monitoring of sector developments have been introduced, notably the meetings for provincial health directors (PHDs) on a regional basis. This was welcomed by the PHDs met and provides an opportunity for the MOH to gain direct feedback on progress and problems. However the team felt a concern that there was not a clear mechanism for the findings from monitoring and feedback to feed into decision making and policy revision in the MOH. Whilst the SAB could possibly take on this role, it was not in its original remit.

Constraints on capacity

The key constraints have been;

- time constraints of key staff working in the HSRG and the Working groups;
- the slow central approval system in the MEF for the release of budget funding;
- delays in the arrival of the Budget Adviser, and in the recruitment of the Health Financing Adviser;
- lack of funding for the Health Information System

- A future constraint is likely to be that of the capacity of staff in the provinces to handle the increased and more complex workload in the future.

Statements by the Minister of Economy and Finance indicate that the budget release system will become more liberal and flexible from the year 2000. However, the time constraints on staff remain. A future constraint is likely to be that of the capacity of staff in the provinces to handle the increased and more complex workload in the future.

Suggestions for increasing MOH capacity

Time constraints on senior staff could be relieved through management training for middle-level departmental staff, enabling them to undertake higher departmental responsibilities. There is evidence that the training is happening.

A further suggestion from the MTR team is to increase the number of people involved in the HSRG and its working groups so that the workload can be shared on a wider basis. This would also have the advantage of building capacity of a wider range of individuals in the MOH so it is not so dependent on a few key individuals in the MOH so that it is not dependent on a few key individuals. It is suggested that the extra members include some from vertical programmes and provincial health departments.

An increase in capacity would also enable the MOH to provide more support to provinces in implementation of health reforms and policies, and allow for more first hand monitoring of performance. There is a working group for 'Support to Provinces' under HSRG but the team felt that this work required greater emphasis to ensure that the policies were actually implemented and implementation difficulties were addressed. The Support to Provinces working group could be strengthened by including officials from the vertical programmes, and HSRG could encourage more attention to province level work (particularly for those provinces which do not have support from this or other projects).

Some training for MOH finance staff has taken place, and more is proposed for provincial staff in the future. However, because of new budget systems and an increased budget for 2000 onwards, accountability requirements will increase as will the requirement for planning skills and utilisation capacity. Only further training will provide these skills. The MTR team consider it an important role of the project to take steps to ensure the provinces and districts have the capacity to manage and account for funds. This is particularly key if the MOH wants to convince both Government and external funders to release more funds through the government funding channels.

The MTR stressed the importance of reviewing the effects of various policies and guidelines, and then incorporating the findings from such reviews in future policies and activities. While the project is focused on the former, there is not a clear mechanism for the latter and it may be helpful to identify clearly responsibility and mechanisms in the MOH for receiving such findings and reviewing the implications for policy. There could be a role for capable Provincial Health Directors (PHDs) in policy review and development.

The transfer of skills from international TA should be an explicit part of their workload. It is suggested that the role, outputs and deliverables from each TA should be discussed' with the MOH (and for PHAs, the province), including their

responsibility for skills transfer. There can then be regular review of their achievements, including the extent of skills transfer, and obstacles faced, and strategies can be agreed for the next period to ensure the expected results are achieved. The project has already developed a management capacity assessment tool for Provincial Health Departments, which could be a useful tool for starting this process in project provinces.

The team considered the case for increasing project support in areas raised by the MOH: the Health Information System (HIS) and Social Development. On HIS, the team noted that the project already supports a UN Volunteer to assist with database development, and suggests the work programme of this person be reviewed to ensure his efforts are focussed on assisting MOH to get a basic and reliable HIS database in place. Other than this, the team concluded that it is not appropriate to expand the project to meet gaps in funding of this sort - rather the HSRG can use some of its funding for priority activities, and the project can support MOH in seeking funding from other sources.

A similar issue arose with the support for human resources policy and development. While there is a case for further work in this area the MTR team did not see it as a role of the HSR3 project to take on this activity. WHO and the project can help to identify the requirements for support and seek funding.

As for Social Development Advice, the team welcomed the fact that there is an increasing interest and awareness of demand side and equity issues in MOH thinking and that this is reflected in the workplans under the project, which include various activities to research attitudes to and access to services. The MTR felt that a good start has been made on defining what is required and these efforts should continue. Once the work is planned it will be possible to identify how it should be implemented. The project has identified some capacity for this type of work in Cambodia, including at the University, in the NIPH and in private

firms; based on this, it was not evident that long term international TA was required in this area (as suggested by a short term consultant) and therefore additional funding for such inputs is not recommended. However the project should identify what inputs are required and can suggest changes in the mix of project inputs to achieve its purpose.

2.2 *Progress and suggestions on Output 2*

Output 2 is: Implementation of district-based health care systems, according to the health coverage plan, in the five provinces directly supported by the project and in collaboration with UNICEF and other donor agencies in an additional five provinces.

Implementation of the coverage plan

The provinces supported by the project have made substantial progress towards developing their health systems in line with the health coverage plan. The construction and rehabilitation of facilities is still under way as is training to support implementation. The coverage plan is widely accepted by government and NGOs as the guide for sector development. In the project provinces 59% of the health centres are providing the MPA services.

There are however some unresolved issues in implementation and aspects where the plan has been revised in the light of changing conditions. For example, there has been limited progress with reducing staff and service levels at some of the former district hospitals, as well as difficulties in getting qualified staff to work in rural health centres where the opportunities for income generation are limited. In some places this has been addressed by allowing the health centres to retain beds, supposedly for TB patients. In one district with very low density of population (Rattanakiri) the MOH has decided to vary the plan to build health posts servicing a smaller catchment population. These modifications demonstrate some flexibility to allow for local circumstances, but need to be monitored to ensure the services will be affordable.

There are not yet clear plans for how the national vertical programmes will link with and support the development of basic services. There is a policy of integration but the practical implications and transition mechanisms are not yet developed, with the exception of integrated supervision from districts to health facilities. A dialogue has started at national level and the team would encourage further work in this area to gradually make service provision more efficient and more convenient for service users; while also maintaining the successes of the national programmes. One area for review and co-ordination might be training as

each programme tends to organise its own with the result that health staff attend many courses (one study showed that staff from 6 rural health centres had attended 174 training courses during 1998'). Clearly the MOH will require the support of the funding agencies in introducing changes to the way such programmes operate.

Another issue in implementing the coverage plan is the referral hospital services and referral system. The MOH has recognised that the CPA for referral hospital services is not clearly defined yet, and has responded by setting up a task force under HSRG to work on this aspect. This indicates the capacity of the project to respond to priorities identified.

' Final report of 4 Rounds of Field Research - Health Providers and Health Seeking Behaviour, UNFPA, August 1999

Institute for Health Sector Development

- 23 -

December 1999

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

Strengthening planning and management capacity

There has been progress in establishing management and planning capacity at provincial and district levels. Provincial Management Teams are in place in all the provinces supported, and all the operational districts have a management team while 87% have District Technical Advisory Teams in place and functioning. There has also been substantial work on planning - all supported provinces and 53% of the ODs have plans.

The introduction of a new funding mechanism the Accelerated District Development (ADD) budget, has also led to some ODs having to plan, manage and account for funds. Their capacity to do so is indicated by a survey showing better performance in ADD districts than others (although the additional funding is also likely to be a factor).

An issue which arose was the variable performance across provinces. A key factor in this was the 'calibre of the Provincial Health Director. The MTR team understood that the MOH formally has power to change these key posts although it may be difficult in practice. If service delivery is to improve this may need to be addressed more often by the MOH.

The MTR team was also concerned that the focus on certain provinces which have PHAs and are typically nearer to the capital may lead to neglect of other more remote provinces. This view is reflected in the proposal to emphasise support to provinces in project activities.

Service utilisation

The key question is whether utilisation of district services has increased as a result of the efforts to implement the coverage plan, improve planning and management. There is evidence to suggest that the utilisation of services which offer the full MPA (defined to include having MPA drugs, supervision and training) is higher than in health centres which are not yet offering the MPA. For example, in Pursat province in 1998, the number of new cases per inhabitant per year at health centres with MPA was 0.31, compared to 0.17 in non-MPA health centres. Although the validity of the comparison can be questioned, this suggests that the MPA is attractive to patients.

However the data on utilisation overall, while not conclusive, does not show rising utilisation yet. There is not good baseline data on service utilisation based on the population. The facility statistics suggest there may be falling utilisation at some facilities although the increasing number of functional health facilities suggest that overall access to services has improved. The reliability of the data can be questioned, since the HIS is not fully installed and there are incentives for distortion of data (for example, drug supplies depend partly on numbers of patients reported). However there are various studies and surveys which provide useful information and the MTR team encourages the project to use all sources of information, not just those connected with the project.

it is evident that utilisation rates are quite low at some facilities - 5 to 10 new patients per day were indicated by the facility statistics in districts visited. Surveys show continued use of private services in preference to public and continued high private expenditure on health, with the most visited source of care being the pharmacy/drug shop.

The issue of utilisation and how it may be increased is discussed further in chapter 4. However it is important to note that there are several major reasons for the relatively low utilisation of services. Most important is the low level of salaries in the civil service. With salaries of \$10 to 15 per month, health staff have to find other ways of making their living and supporting their families. Anecdotal evidence shows that these include working in the private sector (often running a clinic from home); unofficial charging in the public sector; part time work to allow time for other activities such as farming; attending training courses and workshops. Recognising the low salaries, managers and supervisors do not feel they can put pressure on staff to work harder or longer hours. They too earn low salaries, have limited motivation and expectations, and both need and have developed their own survival strategies.

Another major factor is limited operational costs for services. The amount of the

government budget for health is low (\$2.20 per capita in 1999) and the amount actually released is lower still - \$1 per capita in 1998. Part of the problem is that provinces do not release all the funds provided to health. So the Accelerated District Development (ADD) budgets were established. Releases were low in 1998 (13% of the budget spent) but have improved in 1999 (26% spent by June). The HSR3 project has put substantial efforts into monitoring the release of budgets and lobbying for more to be released, with some success - the Ministry of Economy and Finance (MEF) acknowledged that pressure from project advisers and MOH had influenced the budget for health and the reforms planned for the 2000 budget.

Other factors also affect utilisation, including attitudes of staff in the public sector, the range and convenience of services offered, and the costs. The rapid and unregulated growth of the private sector has led to a proliferation of different providers, particularly in urban areas, as well as drug sellers and traditional healers in rural areas. Prospective patients balance the costs and perceived quality of different services and this often means they will not use public providers. The MOH has recognised the need for more qualitative and survey research on the factors which affect access and utilisation, and this is to be encouraged, particularly looking at the factors affecting service use by the poor.

Demand side issues and community participation

There has been an increasing emphasis in the supported provinces on developing community participation and consultation. This is a welcome development and the

MTR team felt that there was more potential for increasing the community's role - partly in service management and definition, but also in improving their own health. The administrative arrangements for this are complicated by the split responsibility between MOH and the Ministry of Rural Development in this area. But this has now been recognised and there has been an inter-sectoral working group on Primary Health Care. MOH has also decided to review different mechanisms for community participation and consensus building, and the MTR encourages this work as a basis for strengthening broader participation in policy definition and service implementation in future and to mobilise communities to improve their own health.

The role of PHAs

The main mechanism for support under the HSR3 project has been the appointment of Provincial Health Advisers (PHAs). (The Institutional Adviser also

has a role in this but establishment of structures at central level has taken up much of her time to date). The experience with PHAs has generally been seen as positive although their effectiveness has been variable. One key factor seems to be the extent to which the province health department, particularly the Director, wants this type of support and whether the PHA can respond to the particular situation in their province. The province has to request support but at present has little say in the person allocated as their adviser - in any future support it would be desirable for the province to have a clearer role in identifying requirements and selecting the PHA. In addition, the MTR team suggest that in order to encourage effective use of the PHAs and skills transfer, the Provincial health department should be involved in agreeing the goals and outputs expected from the PHA; participate in their regular performance appraisal; and agree on strategies to address any constraints on their effectiveness.

On a broader level, the scope for PHAs to improve services and, management is limited if there are very few resources available for the provincial health services. However, there were some indications that the presence of a PHA had helped some provinces to attract additional support from NGOs and other agencies. Also, the changes in the health service structure and increased decentralisation of management responsibility have implications for the role and activities of the provincial level. It is suggested that there is a need to review the role and functions of the Provincial Health Departments and hence the role and priorities of PHA support.

2.3 Progress and suggestions on Output 3

Output 3 is **to implement alternative service delivery models and evaluate their impact on access and equity**. The major activities involved here are conducting baseline surveys in Phnom Penh and then establishing two alternative service delivery models and evaluating their impact. This activity is being managed through a contractor working closely with the Phnom Penh Municipal Health department.

As noted in chapter 1, this part of the project only started activities in April 1999. To date it has established an Urban Health Project Task Force and carried out qualitative and quantitative baseline survey work. The project is currently working on the design of alternative service delivery models with health providers and communities.

It is thus too early to assess whether the project is improving access to services and equity. However it was noted that one of the alternative models is well targeted to improving utilisation by the poor, as it is focused in a squatter area

and will try to address the main constraints on utilisation found in the baseline survey. The second pilot - the Approved Provider Scheme - is not targeted in this way as it works with medical doctors whose patients are mainly people with more resources. However, it is an important initiative for the MOH to test how to work with the private sector, and it will be possible to increase the poverty focus of this initiative at a later stage, for example by introducing vouchers for the poor linked to approved providers. A decision can be made on how to develop this initiative after the analysis of the surveys under the project.

The MTR team felt however that the initial work was well planned and that appropriate mechanisms were in place for consulting with relevant groups, including through the Urban Health Project Task Force and participation in the Municipal Coordinating Committee. There have also been some discussions with the DFID and UNDP supported urban poverty project. There were views expressed that the project could be better integrated with other urban initiatives and it is suggested that the links are reviewed to ensure co-ordinated approaches to urban issues and lesson learning from other urban poverty work.

The baseline survey has produced interesting information which should prove useful in informing MOH policy and assessment of access to services (as well as a basis for evaluating the initiatives). For example, it has information that few of the poor know there are meant to be exemptions in public health services, and that unofficial user charges still exist. As noted in the discussion of output 1 above, it is important to have a mechanism for feeding back such material to top policy makers and incorporating the implications in future thinking. There has already been a dissemination workshop in September 1999 to feedback the findings from the survey to policy makers and others, and the findings will be circulated. They can also be presented and discussed in the SAB and project Task Force meetings.

The team felt that the development of urban health initiatives had made a good start and would need longer than the remaining 15 months of the current project to introduce and then test and evaluate alternative service delivery models. A longer period of 2.5 to 3 years (in total) is more appropriate, as was originally envisaged for this component. It would be useful to have a review mid way to ensure the project is

on course and will provide useful lessons. There should be scope for review and flexibility in the design although the activity is contracted out.

2.4 Progress and suggestions on Output 4

Output 4 is **Development and evaluation of health financing models in project supported provinces**. The main activities so far have been the provision of support by the Health Economics Task Force (HETF) to facilities seeking to introduce user fees; the design of a monitoring format for health facilities to record income and expenditure; the design of an approach to evaluating user fees and exemption mechanisms. Training for members of HETF has also been planned.

User fee models

There has been an increase in the numbers of facilities with user fee schemes approved by the MOH - there are now 73 facilities with approved schemes. Approval indicates that the schemes follow the MOH Financing Charter in terms of processes for management and accounting and use of the revenue. In addition the MTR team understood that there are other health facilities with formal user fees that have not applied for approval from MOH.

The HETF has been active, with support from the HSR3 project (HSRG funds) to assist hospitals and districts with preparing their financing schemes. This involvement is welcomed as an example of how the centre can support implementation of policies.

The Financing Charter includes many aspects of international best practice in establishing and managing user fees, including retention of most fee income at facility level; publicising fee rates; proper planning and accounting for revenue; and involving the community in management. However, the team felt concern that the current norms set by MOH for revenue use (49% for staff, 50% for operating costs, 1 % return to MOH) may not be achieving the aims of formalising unofficial fees. Since only half the revenue collected is used for salary increments which are then shared among all staff, and utilisation is often low, the revenue from fees is small. For staff to maintain their income it seems likely that they will continue to ask for additional payments.

This issue has been addressed at Takeo Hospital where the management has taken a strict line on unofficial charging. This has been possible because the staff receive a salary supplement provided by an NGO, so that they are not reliant on fees to supplement their official salaries and they are also concerned to stay at the hospital. Furthermore, as the quality of services is well respected and services trust of the

community, the services are well utilised so that significant amounts are raised

form user fees.

At other facilities where utilisation is low but staff numbers are high, the scope for raising a significant salary supplement from formal fees is limited. For example, a study of rural health centres indicated that each staff member on average would see 1.5 patients per day²; the amount of fee revenue from this level of activity is clearly limited. This emphasises the continued importance of pushing for government to allocate funds for health care and to release the allocation, and for external support to improve services. It also suggests the need to avoid excessive staffing levels in underused facilities and to restore quality before expecting much revenue to be raised from fees.

The issue of exemptions is also a concern. There is little incentive for a facility to offer exemptions since this reduces their revenue. The evidence available also suggests that those getting exemptions are mainly not the poorest in the community. This emphasises the need for proper evaluation and review of the policy with a view to finding ways to make exemptions more effective; using other mechanisms to assure access for the poorest; or abolishing fees in situations where the negative impact and administrative costs outweigh the benefits.

Evaluation of financing models

Evaluation would demonstrate the extent to which these concerns are valid. There has however been little evaluation to date, although, it was the stated objective of the Charter to review and evaluate schemes systematically. This is partly due to the late arrival of the Health Financing Adviser. Another constraint was the capacity of the HETF members; this is now being addressed through training fellowships and the plans for in-country training.

An overall plan for evaluation has been developed and seems appropriate, though further work could be done to identify how best to collect information and how far existing surveys can be used to study demand and exemption issues. Initial qualitative work has been carried out in one study, with the results due soon. There is also some data available from the 1998 Health Survey and the Urban baseline survey.

The MTR team felt that the emphasis of the HSRG/HETF and HSR3 project work should be to focus on the evaluation of fees and exemptions, and respond to the findings, rather than on promoting introduction of more fee schemes in more facilities.

² See previous footnote for reference.

2.5 Progress and suggestions on Output 5

Output 5 is adoption of a Sector-wide approach (SWAp) to health development and investment.

The SWAp development process

The MOH with the project has identified a 'step by step process' for developing a SWAp and has started implementing activities towards this end. The activities originally defined have been revised and expanded to allow for more consultation and development of common management arrangements. The process for developing the SWAp looks appropriate and well thought out.

The HSRG has established a SWAp working group to lead the process but this only been working since the end of 1998, with delays due to political events including elections in 1998. Given this delay the proposed timescale (to have a SWAp in place for 2001) looks optimistic to the MTR team, given experience in other countries.

However, there is an understanding that a SWAp is a process and that some elements such as shared review or monitoring of the sector could start before other aspects such as pooled sector investment. This was discussed during the MTR. MOH would welcome fewer separate reviews and evaluation exercises. Joint reviews across various partners and projects could start in the coming year as a pre-cursor to more formal SWAp arrangements. In terms of planning support to the sector, the UN agencies are currently in the process of developing a joint framework (UNDAF) but other agencies (e.g. World Bank) are developing their own strategies.

Commitment to a SWAp

There is a risk that a SWAp will be seen as an imposition from the donors, so the project has taken steps to ensure that the MOH clearly understands the concept, advantages and disadvantages of SWAps before deciding to move forward or meeting with the donor agencies. The first activity in the SWAp plan was therefore to assure interest of the MOH in such an approach and the Ministry supported the proposal to work further on the SWAp. There was evidence of support and understanding of the approach at high levels in the MOH.

The extent of commitment will need to be confirmed as the process develops. There may be barriers and resistance within the MOH to developing a SWAp as there are advantages to keeping inputs separate and not transparent to all. For example, it has proved difficult to "merge" the ADB project monitoring arrangements with the HSRG process.

A stakeholder analysis was conducted which indicated mixed views within the

MOH and among the donors about the readiness for a SWAp with clear common management arrangements. From the donor and development agency side there are

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Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

concerns, particularly about the capacity of government systems to handle any pooled or budget support funds effectively.

The MOH established a co-ordinating committee in 1991, involving MOH, MEDICAM, donors/funding agencies and NGOs both at national level (CoCom) and relevant agencies at provincial level (ProCoCom). One idea which had been discussed in CoCom was to "have a trust fund". This may be seen as an important building block towards a SWAp. CoCom was perceived to have been a well functioning forum, but in the opinion of some it has lost some of its effectiveness (with a decline in input from some of the major donors).

In the coming year it will be critically important for health sector donors and NGOs to engage with the MOH in its efforts to develop policies and processes which could form the basis for a SWAp - even if the SWAp does not initially involve all funding agencies providing pooled or budget support. The benefits of agreeing on sector policies and priorities should be apparent to all agencies in the sector, as they should lead to more efficient use of external support and avoidance of duplication.

The mechanisms for consulting and involving different partners will need to be defined so that consensus is developed. The MTR supports the proposal to review the terms of reference of CoCom in order to strengthen its role in donor co-ordination and as a link to civil society. In addition there will be a need to define the links between CoCom, the SWAp working group and HSRG. There may also need to be specific consultation procedures to involve donors or agencies which are not present in Phnom Penh for routine monthly CoCom meetings.

In addition it is suggested that MOH should collaborate with the Ministry of Education, Youth and Sport (MOEYS) and MEF on policy issues and new approaches to sector development, to

ensure compatibility of approaches and sharing of experience across sectors. WHO participation in the newly formed Donor Working Group on Social Sector Performance will also assist this.

3 Contribution to the immediate objectives of the project

The immediate objective of the HSR3 project is to increase utilisation, particularly by the poor, of good quality health services. It is difficult to show a direct impact on service access from a project of this nature which works indirectly on capacity building and policy development. The exception to this is the urban component which involves direct service delivery, (but it is too early to see impact from this component).

However, the MTR team concluded that the HSR3 project has the potential to make a contribution to improving access to good quality services, particularly for poor people. There are various mechanisms by which it has contributed and is contributing:

- by helping to **define appropriate and realistic policies**, drawing on international expertise and taking into account experience and changing conditions in Cambodia, such as planned work to assist policy development on the private sector
- By strengthening **capacity to manage implementation** of policies at central and provincial level, so that services are made more accessible, for example by helping with provincial planning and financial management.
- By supporting **monitoring and fieldwork** that provides the evidence for determining policy, plans and regulations in order to achieve the objective; for example, developing the regional meetings with provincial health directors as a forum for feedback, and modifying the coverage plan to take into account different provinces' conditions.
- By helping to **address the barriers to successful implementation** and achievement of objectives - for example, work to increase the amount of the health budget actually released and development of budget reforms which allow more efficient use of resources
- By **testing and reviewing innovative** strategies such as urban health reforms and health financing initiatives.

The project thus is relevant for achieving the objective, although it will not achieve it in isolation of other changes in policy and increases in funding. The MTR recommendations are intended to increase the relevance, appropriateness and impact of the project towards meeting its objective.

Constraints on greater achievement and assumptions not met

The HSR3 project will not have the intended impact of improving equity of access to quality services without critical issues being addressed. These critical issues include: more funding, better skills, better motivation of staff; and more health facilities with appropriate qualified staff in the unserved areas. It is also critical that

4 Increasing utilisation and equity of access, and the contribution HSR3 can make

4.1 How to improve utilisation and equity of access

The immediate objective of the project is "to increase access to and utilisation of effective health services, whether paid for by Government or public private mix". How can the MOH achieve this and what can the HSR3 project do?

At present people often use private services - usually either drug shops/ pharmacies or private clinics, which are run on a for profit basis and are mostly considered to provide poor quality care, including inappropriate treatment, which can at times actually be harmful to patients (e.g. unnecessary drips; incomplete courses of treatment). There are some NGO services which are reported to be better quality. The quality of Government services appears to be variable; some have NGO support which helps by developing the clinical skills and by funding.

The amounts spent on health services by households (private and public) are extremely high. Average expenditure is some \$20 on health per capita, with the average cost of inpatient care estimated as \$55 and an outpatient episode at \$ 15. One study indicated the poorest households were spending 28% of their income on health care. As a result, health is a major cause of debt and impoverishment to households.

The government's main strategies to improve access and utilisation of quality services are:

- expansion of the public health services to provide basic health services through a network of Health Centres and Referral hospitals. This involves rationalisation of existing services and construction of new facilities in line with the Coverage Plan; training of staff to provide the services agreed for each level; provision of drugs and improved supervision;

- testing an approach of formalising user fees and establishing exemptions for those unable to pay
- continued national programmes with integration into facility based services.
- Regulation of the private sector and testing alternative delivery strategies such as contracting out; social marketing; and urban health schemes

The evidence suggests that utilisation levels in many public facilities are disappointing, as discussed in chapter 2. This applies to national programmes as well - for example, recent surveys of immunisation rates in the community indicate that actual immunisation rates are much lower than reported immunisation rates (25 to 35% in surveys versus 75% reported by staff). There are various reasons why utilisation is not rising and the MOH has recognised the need for further research on this. Reasons include:

the facilities are offering services people want to use and can afford. The HSR project was never intended to provide all these inputs - rather it was a project offering central and provincial level support which was intended to complement other major areas of support to the health sector, including major construction and training programmes from ADB, World Bank and GTZ and the vertical disease-focussed programmes.

These major programmes have helped to address some of the constraints facing the sector. But there are still major constraints inhibiting development of good quality and accessible services which are attractive to the population. As discussed above, there is a major problem due to the low levels of salaries and consequently low motivation and low output of staff. On the other hand there is evidence to suggest that where the pay issue is addressed, and combined with effective management, then performance improves and utilisation rises - as for example in the various NGO supported services; one example is Takeo Hospital.

One of the assumptions underlying the HSR3 project was that staff would work to deliver the services in line with MOH policies. There was an assumption that the Public Administration Reform programme, which has been under discussion for years, would deliver results in terms of improving motivation and hence performance. However, this assumption has not yet been met.

The other major constraint is in recurrent budgets, due to the low level of Government budgets and limited release of funds, combined with reported 'diversion' of some funds intended for the health sector. The project has been influential in seeking to address this problem, both with the ADD initiative and for

the next budget year (2000), the decision that budgets will go directly to provincial health departments rather than being controlled and allocated by the Provincial Governor. The project should continue its active role in budget reform and improving financial management in order to address this key constraint on sector performance.

Another constraint on improving performance has been in the use of external support. There was less external support than expected for skills training and the HIS. Thus although manpower plans have been developed, some of the major gaps identified by those plans have not been met. There is also an issue of uneven distribution of external support - the team was told that NGOs tend to choose which provinces they work in, so some provinces have lots of support while others have very little. The development of a SWAp should help to improve the allocation of external support so it matches national priorities more than donor or NGO preferences. It is an important role for the project and HSRG to assist with facilitating these moves to improve equity in allocation of external resources, as well as efficiency of resource use.

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Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

The vision for the sector can be summarised in the diagram set out below:

Present Health Service

Public: Under reorganisation according to Health Coverage Plan

Reorganisation based on accessibility and population

23 provinces will have 67 Operational Districts (each with referral hospital), 935 Health Centres & 8 national hospitals

Phnom Penh has its own Health Coverage Plan

Utilisation of Health Centres is falling, not increasing Rural

population still have access problems

Perception of public service is low

Mistrust of pricing system (fees plus "add-ons")

Exemption system (from fees) not consistent

Many people prefer to use private system, even though costly, unregulated and variable quality

MOH still experimenting with Health Financing schemes

Do rural poor know about health sector reforms and re-organisation?

Low budget @ USD1.00 per capita

Private: Growing since 1996, unregulated for price and quality

Many for profit providers give expensive poor quality care leading to high health expense

Undermines public service by attracting staff and customers

Process

Public

1. Get extra recurrent expenditure (donors) plus higher budget & full and timely budget access from RGC 2.

Improve clinical skills

3. Better internal management and distribution of staff and funds
4. User fee system that contributes, but exemptions that reach the poor
5. Individual staff contracts that reward and motivate
6. Operational Districts and Health Centres become Budget Management Centres with management control
7. Budgets provided through "internal contracts" between OD/HC and MOH/donors with resources linked to outputs and performance
8. Social Development strategy for each OD to ensure access by the poor
9. Ongoing monitoring and evaluation and effective central level contract management

Private

1. Effective legislation that provides for self-regulation and professionalism
 2. Test innovative service delivery strategies and mechanisms
- Public: Deliver priority health service through ODs with referral hospitals and HCs Have basic resources (buildings, equipment, staff, recurrent funding) Have realistic and appropriate health service product Internal management of quality following "best practice", motivated staff Operational control and authority over budget and staff Funding linked to output and performance Demand for product, taking into account the size and strength of the private sector Community participate in service development/ management and in improving their own health

Private: Self-regulated for price and quality through professional association(s) Possibly public/private co-operation to improve access for the poor

Affordable Health Service



Institute for Health Sector Development

December 1999

-36

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

- low salaries so staff are not motivated and attend for only a few hours (if at all)
- staff have got used to private practice income and do not want to attract patients to public services
- insufficient running costs so services are not attractive
- lack of trust in staff capability at HC level, with insufficient trained staff in rural facilities
- services in private sector meet preferences for injections etc
- exemptions rates are low and not reaching the poorest
- formal fees may be additional to informal fees
- possibly also diversion of resources to private use (e.g. sale of drugs)

MOH has outlined a proposal to strengthen district health services which includes:

- additional funding for recurrent costs to improve salary levels and running costs
- increasing local control over budget and staff, using contractual arrangements with staff and with health providers with funding linked to performance
- a strategy to ensure access to services for the poor
- lesson learning through monitoring and evaluation.

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

This proposal would provide a framework for support to the health sector. It already incorporates some of the elements of existing strategies and projects, including implementation of the coverage plan and trials of contractual arrangements with salary increments as a means to improve performance. Elements of this 'package' are already in place in the various donor and NGO projects. A standard approach for support to the sector would have the advantage of developing a more consistent approach that is more geographically equitable. If a clear framework can be agreed this could be the start of a provincial SWAp including budget support. It is envisaged that the approach would start in selected provinces or districts and be phased in.

This approach provides for transitional support to improve remuneration and running costs. It takes into account discussions in MEF and NPAR which suggested that Public Administrative Reform would take some years to lead to substantial pay rises in the health sector. Experience in Takeo and elsewhere have shown that performance can be improved with salary supplements plus other key inputs to strengthen management and build up trust in the community. Donors recognise this, but tend to provide support in indirect ways which often distort behaviour e.g. training or allowances, some of which do not reach the intended beneficiaries.

The MOH has started to cost such an approach, based on the package of district services - the MPA at health centre level and CPA (which is still being defined in detail) at hospital level. Preliminary cost estimates for district services (excluding national programme, some management and central costs) are about \$4 per capita, in the short term as services improve. This estimate is based on increasing health workers salaries to \$45 to 90 per month, and a modest rise in surgical activity. Assuming utilisation and the amount of surgery will rise with better quality and performance, costs can be expected to rise to around \$6 per capita. If the Government's commitment to increase the health budget to 2% of the Gross Domestic Product (GDP) by the year 2003 is realised, this estimate should be affordable in the medium term within the context of Cambodia's plans for budget increase to the health sector, although in the intervening period extra

finance would be required.

4.2 Role of the HSR3 project

The MTR team recognised the benefits such an approach could bring to the performance of the sector and that it could form the basis for a sector wide approach. However it raises major issues:

- how to link with PAR so that health (as a pilot ministry for PAR) can take a lead in this process particularly concerning payment of salary supplements and increasing local control over staff, 'but maintains consistency with broader plans for civil service reform

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

- how to change civil servants employment terms so there is effective performance and discipline for non-performance
- whilst the approach to block budgets linked to outputs has been agreed by MEF, how to manage and specify these in practice
- how to channel and manage external funds for budget support at district level and ensure accountability acceptable to funders
- how to strengthen management and performance and develop community confidence in services
- how to protect the poor
- the role and influence of the private sector and policy on this

The MOH and project team are aware of these issues but have not adequately addressed them yet. Any proposal for funding would need to do so.

If the MOH 'is developing such initiatives to improve sector performance then the HSR3 project should be able to assist. The project's role should be to help define the institutional and funding framework for such a development, but not to fund its implementation.

Addressing these issues is consistent with the issues and recommendations made in earlier chapters of this report. In particular it is consistent with the need for the HSR3 project to be involved in tackling key barriers to increasing utilisation, particularly through PAR/improving pay and management; budget reforms and financial management; and concentrating on evaluation and improving mechanisms for access for the poorest.

Funding mechanisms

The work will include identifying options for funding arrangements. It would be desirable to have all funds through the government budget system rather than a proliferation of parallel arrangements at district and province level. This may require substantial work to develop and strengthen financial management and accountability at local level. As discussed earlier, the project can assist in this and help to demonstrate the capacity of the system. The MTR team's view is that the identification of funding channels should start from Government's system and use this as far as is possible. But the review of capacity may indicate that in the short term some special arrangements are required to enable donors to feel confident about providing support. HSRG can play a leading role in this area, with the budget adviser, to identify options and to arrange for capacity strengthening in provinces (especially those known to be weak and those not covered by advisers). There may also be benefit in setting up a forum for discussion with potential funding agencies to define what their requirements would be (e.g. a CoCom working group).

Improving staff performance

The other key area is to identify how best to improve the motivation and performance of staff. The MOH is keen to address staff motivation in order to make their services effective. It is important to ensure that any health sector plans are consistent with NPAR thinking but there is also a balance to be struck with the risk of delays while waiting for NPAR to develop its plans. The team felt that the MOH should facilitate and contribute to civil service reform by: helping to identify potential measures; contributing to the development of reforms; agreeing proposals with the National PAR programme; and implementing reforms in the health sector. This approach should ensure NPAR involvement and approval while providing opportunities for health to take forward measures to address the major issues of staff motivation and deployment.

Recently there have been encouraging developments in the PAR programme. Preliminary studies (a civil service census and a functional review) are starting in the near future; there is a structure of committees and sectoral PAR groups including one with senior and appropriate representation in the MOH; there are efforts to plan the approach and support for civil service reform; and targets for reducing the size of the civil service have been agreed with the IMF. MOH is named as one of the pilot ministries. It therefore seems to be an appropriate time for MOH to make proposals to NPAR on how to take forward civil service reform.

Various options could be considered:

- The approach commonly used in Cambodia tends to be provision of a salary supplement combined with an NGO to support improving performance at service level (e.g. 'contracting in', Takeo Hospital).
- Other options being tested are contracting out provision (with funding for salary supplements) and allowances related to specific activities (e.g. immunisation).
- The MOH is considering contracts between service providers and districts and for staff ('contracting within') in the public health service as a mechanism to manage performance
- There could also be other options such as taking the health staff out of the main civil service and creating a health authority or parastatal which has different terms of employment and salaries than the regular civil service.
- Delegation of management authority over staff and the capacity to use any savings from staff rationalisation would offer another approach.
- Mechanisms to pay extra to those working in remote areas or to provide other rewards for such postings would be another option for improving deployment.

The MTR team felt that this is an area where the HSR3 project can provide technical support to MOH in thinking through these options and analysing the consequences and hence address the barriers to developing effective services.

The project can also support the MOH in developing policies and strategies which have a broad consensus at different levels. Consensus building is an important investment for the whole reform process. This may mean modification of policies in order to gain this wider acceptance. There are already some, initiatives in this direction in the MOH plans, including the plans to develop a policy framework and sector programme in consultation with donors under the SWAp. There are also plans to work at community level in implementing the recently agreed Primary Health Care policy. The collaboration with the Ministry of Rural Development and other agencies at the village level, such as women's organisations and temples, should be encouraged. It is suggested that there is scope for broader involvement of civil society and public debate of the sector policies and that this will be instrumental in getting policies accepted and implemented.

5Comments on the HSR3 Project management arrangements and process

As described in chapter 1, the project has a complex organisational set-up. It is coexecuted by MOH and WHO and co-financed by DFID, UNDP, NORAD and WHO. In addition DFID has an "executing" function. The team leader is recruited and paid directly by DFID, but seconded to WHO. The other national level TA are recruited by DFID but employed and paid by WHO. DFID also recruits and pays short term consultants directly and has contracted OPTIONS as executing agency for the Urban component of the project. The intention of the project design is that flexibility and national ownership is maximised, accountability is assured and the comparative advantage of the partners is exploited.

The organisational set-up has provided a flexible framework for project execution and been pragmatic about using strengths of the different funding bodies. Where WHO is slow and does not provide the conditions that are needed, DFID has been able to fill the gap. This has been particularly useful for recruitment of short-term consultants as WHO consultant fees are so low that it is difficult to attract professionals with adequate background and experience. NORAD funds have been channelled through WHO HQ and Regional Office (RO). Some of these funds are for activities at province level and it would be appropriate for these to be channelled through the HSRG account in the MOH. WHO systems have to be used to release these funds adding steps to the flow of funds. UNDP channels the funds for "national execution" directly to the HSRG account in the MOH while the funding for a PHA are managed by WHO regionally.

It may not be wise to make fundamental changes during the ongoing project phase. However, if a next phase is considered, there is scope for simplifying the organisational set-up without losing flexibility. MOH may, for instance, recruit consultants or contract out directly with funds provided by the funding agencies. This would also enhance MOH ownership/leadership.

The partnership between these various organisations may be considered a strategic alliance. The planning process has been joint between MOH and its partners (with the exception of NORAD). It has given WHO the opportunity to play the role as an impartial adviser in Cambodia (fulfilling its intended mandate). The MOH and other partners in health in the country look towards WHO for policy advice. However, since WHO has had limited capacity to provide technical backstopping for the project, DFID has provided some technical advice on reform issues and health financing, particularly in terms of global experience. As DFID has broad experience in these areas, this may be considered to be making full use of the comparative advantages of these organisations.

During project planning, joint meetings between the partners were held to identify common approaches for monitoring, evaluation and reporting procedures. The project planning and reporting documents are required to fit UNDP's reporting system. Reviews have been joint, but there is still a need to ensure that these are not excessive in order to meet all the different donors' requirements. Clear assignment of roles concerning reviews and reports should have been made prior to the start of activities.

It was especially positive for the partnership in this project that NORAD participated in the MTR. Although UNDP did not participate fully in the MTR, it was consulted. The documentation and the MTR process itself has provided a opportunity for the partners to assess progress and relevance in depth. The following annual review (if needed) should therefore be a very short and simple check on progress. There should be no need for preparation of extensive documentation.

Several of the partner organisations have recently experienced considerable internal changes. WHO/HQ has undertaken a major reorganisation and staff have been reallocated. The staff previously responsible for systems development have been transferred to other departments. WHO/RO has a new Regional Director as well as Head of division for health service development. The WHO Representative in the country office is new as well as the UNDP Country Representative. DFID has recently established a regional health advisor position in Bangkok and has changed its policy with the 1997 White Paper. Cambodia itself has had elections and since last year a new Health Minister has been in place. The MOH senior management has also undergone major changes. Such changes may potentially result in improved performance and organisational environment. However, in the course of changes, project implementation is vulnerable. The project leadership and some key people in the MOH have in this situation provided continuity and protection to the project.

A major change in ownership and leadership seems to have taken place between the last phase and HSR3. This is commendable. HSR is now seen as a MOH programme of reform and not a project. This is partially facilitated by introducing different arrangements (e.g. the HSRG account in the MOH). There is still a concern that advisers and some documents are seen as WHO rather than MOH. The advisers are referred to as WHO advisers and although all the advisers have offices in the MOH and use them some of the time, the project's main base seems to be in WHO premises. The MTR team feels strongly that the advisers should have their base in the MOH and be seen as MOH advisers rather than WHO advisers.

6 Recommendations

6.1 *Priorities for HSR3 project*

The earlier chapters have indicated the views of the MTR team on 'the directions and emphasis for the HSR3 project. The MTR team view is that the project is moving in the right direction and can be expected to make good progress on achieving its outputs if it has a slightly longer implementation period. The main recommendations and suggestions for the direction of effort can be summarised under the types of support the project offers, as follows:

a) helping to **define realistic and appropriate policies**

- support for policy development involving the donor community in preparation for agreement on sector policies, including strengthening C6Com and participating in other mechanisms for inter-agency and cross sector working
- developing effective methods for consensus building and community participation
- HSRG to take a wide view of the sector, covering issues such as private sector, pharmaceuticals, contracting (ADB project) experience
- Increase emphasis on demand side issues to understand how best to reach the population, particularly the poor, and hence to reduce their high spending on health
- Identifying an effective 'feedback loop' to bring findings from experience and surveys back to top levels in the MOH so they can be incorporated in policy making. This could include a role for PHDs in policy work.

a) strengthening **capacity to manage implementation** of policies at central and provincial level, so that services are made more accessible

- more support from the centre to province level, tailored to each province's needs
- provide training and inspection/support to improve financial management capacity and demonstrate capacity to handle funds at province and OD level
- involve a larger number of people in the HSRG and its working groups, including officials from the national programmes and more junior staff
- continue assessing capacity and training needs at province and OD levels

a) supporting **monitoring and fieldwork** that provides the evidence for

- determining policy, plans and regulations in order to achieve the objective
 - evaluation and research on exemptions and on access for the poor to services

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

- collection and analysis of the most important monitoring indicators from the framework
- a) helping to **address the barriers to successful implementation** and achievement of objectives
- continue work to increase the amount of the health budget and the amounts actually released and development of budget reforms
 - support PAR in health, for example reviewing different options for addressing staff performance issues
 - support definition of a framework for support to the sector, including recurrent support
 - Encourage joint donor reviews and planning (as initial steps towards a SWAp)
- a) **testing and reviewing innovative** strategies
- continue with the urban health pilot schemes
 - support development and review of new approaches for reaching the poor and excluded
 - more emphasis on evaluating health financing initiatives of different types - not just the approved schemes (rather than on developing more schemes).
- a) **the process of the HSR3 project**
- TA to shift from being WHO advisers in WHO to being MOH advisers based in MOH
 - Ensure the next annual review is short and avoid extensive preparations for it
 - Given the delayed start of some components and the scope of the project, a longer timescale is required, see below.

6.2 Future support

Extension of HSR3 - for one year to 15 months.

The issue of whether to extend the project for how long, or whether to identify a new phase of support was discussed extensively in the MTR team. The options considered were ending central level support on policy and health systems in

December 2000; a 12 to 15 month extension; a 2 year extension (proposed by the project); or a new phase of support.

The team concluded that a 12 to 15 month extension would be the most appropriate for the following reasons:

- the project is not expected to achieve the outputs by the end of year 2000, as originally planned, partly because of late start of some elements,

Mid Term Review of the Health Sector Reform Phase III Project, Cambodia

particularly urban and financing evaluation; in addition the political uncertainty in 1998 and the low salaries which have slowed down progress; and there has been little progress on PAR.

- An additional 12 to 15 months should be sufficient time to make substantial progress with testing alternative delivery strategies; with reviewing financing policy and with identifying policy and mechanisms as a basis for a SWAp.
- the team considers the outputs are still relevant and appropriate to conditions in Cambodia, although with some refinement of direction and activities as discussed through this report.
- during the next year there are likely to be developments which will help to define future directions for assistance, particularly a more intensive effort on PAR; definition of a framework for support to the health sector in partnership with donor agencies; and definition of policy towards the private sector; the team therefore felt that the MOH will be in a better position to define the nature and purpose of future support in a year's time rather than starting to define needs for support for next 5 years now.
- in addition, the team concluded that the project would be better to focus on existing project activities than to divert attention to preparation of a new phase of support.

In recommending an extension, the MTR team felt that the MOH with the project team should identify how best to meet its objectives and outputs and hence the inputs required, taking into account the MTR recommendations and suggestions. Additional resources will be required but the team recommends that this should **not** be at a higher level of resources on an annual basis than the current budget, and in particular the number of long term international TA should **not** be increased for the extension. Within this framework, the MOH and project should review the needs for TA and whether the existing mix is appropriate or whether alternative skills are needed.

It is therefore recommended that, once the idea of an extension is agreed, the MOH with the project team should prepare a short proposal for the extension, setting out the priorities for work, the inputs proposed and budget for the extra period, and a revised logframe which includes timebound targets and indicators.

In order to facilitate smooth implementation and efficient use of time during the remaining project period, all donors and MOH should agree on schedule and scope of reviews to the end of project, and on the process for planning for a subsequent phase. In addition the process of agreeing an extension should avoid imposing a heavy workload of documentation and appraisals on the project and MOH.

Future support after 2001

The team felt it likely that there would be a need for further support to the central and provincial level after the extension to HSR3 (i.e. from early 2002). However, it was considered too early for MOH to define its priorities for support at this stage. In addition it is not clear yet whether it will be appropriate to develop an integrated programme of support as a component of a sector approach, which would be desirable if a SWAp is being developed. If not, the support could be established as a sub-sector programme within a framework (rather than being confined to a project cycle). It is proposed that the MOH should start to identify its requirements for future support in early 2001.

Suggested timescale

A possible timetable for completing the MTR and taking forward its recommendations:

- Funding agencies discuss and agree whether to support an extension in principle - by 15 January 2000.
- MOH with the project team to prepare a short proposal and budget for the extension and a revised logical framework which includes time bound indicators/milestones, quantified where possible. To be ready by 15 February 2000.
- Aim that the funding agencies should agree on the extension by May 2000. The MTR team recommends a simple process of approval in order not to distract much time and attention from the work of the project.
- Assuming the extension is agreed, then review the case for further central support and needs of MOH in order to define the next phase of support, starting in early 2001. This would allow a year for design and appraisal by the agencies concerned, so the new programme will be ready for funding from early 2002.

6.3 Revisions to the log frame

The MTR team proposed that there should be detailed review of the logframe by the MOH and the project as part of the review of this report and preparation for the extension.

In reviewing the logframe the MTR recommends that inclusion of targets for indicators be considered. There are currently no measurable indicators in the logframe by which progress towards output may be gauged. Although there may have been good reasons for this at the time of design (i.e. a reform project with heavy policy implications; the uncertain Cambodian environment of the time), the situation is now changing. Not only has the country remained fairly stable for the last year, but the project has commenced and some progress has been made.

The HSRG is established and working, as are its 6 Working Groups and Task Forces. Both subscribe to a "workplan culture" in which schedules of future activities are periodically listed. As the work of the HSRG is geared to the achievement of Output 1, and that of the Task Forces towards the achievement of its constituent sub-outputs, so each of their respective workplans already includes timebound and quantified indicators. It is therefore recommended that the HSRG identifies quantified targets for project indicators and the means to measure them, drawing on the existing workplans. The MTR team proposed that there should be detailed review of the logframe by the MOH and the project as part of the review of this report and preparation for the extension.

Annex 1: Terms of Reference for the Mid Term Review

Background

The first phase of the Strengthening Health Systems (SHS) began in 1992 with the objective of strengthening the capacity of the Cambodian Ministry of Health to plan and manage basic health services. An independent evaluation concluded that the project had made a considerable impact and should continue. Phase 2 consolidated the gains of Phase 1 and helped to implement the new policies including a rationalised health coverage plan for provinces and districts and developing alternative health financing schemes. The third phase aims at increasing poor peoples access to and utilisation of good quality essential health services, whether public or private. The project assists in the implementation and evaluation of various new policies thereby increasing Cambodian capacity to plan

and manage the health sector.

The situation in Cambodia has changed since the project was initially designed. There is now peace and at the recent Consultative Group meeting in Tokyo the Royal Government of Cambodia made commitments to increase expenditure on health. There is the possibility of a structural adjustment credit tied to actions to address the many issues raised in the Public Expenditure Review. For example, it is now widely acknowledged that civil service reform is a major priority. More widely, there is a growing consensus amongst donors that we need to try to integrate our assistance more closely into government systems in all the countries that we work. The Ministry of Health, with support from the project, needs to position itself so as to take advantage of these new opportunities.

The review team will carry out a series of interviews with key Ministry of Health officials, other relevant ministries including the Ministry of Economy and Finance, project staff, donors, UN agencies, NGOs/IOs and the private sector. They will visit at least two provinces supported by Provincial health advisers (PHAs) and at least one province that has not received project support and has not received similar support at the Provincial Health Department/Operational District level.

Objectives

The mid term review will be a joint partner review of the progress of Health Sector Reform phase III project (HSR 3). The review team will assess progress on achieving each of the outputs of the project and the review the status and appropriateness of defined project activities. They will assess the impact of these in achieving the project purpose i.e. increase peoples especially poor peoples access to and utilisation of good quality essential health services. The review team should provide guidance on priorities for the remainder of the project, and (if appropriate) outline a process for designing a new phase of support. Based upon this, they will review the project logframe (immediate objectives, outputs, activities) with suggestions for modification as appropriate.