KINGDOM OF CAMBODIA
Nation Religion King

MINISTRY OF HEALTH
No. ...

Phnom Penh, ...

Dr Julian Lob-Levyt
Executive Secretary
GAVI Geneva

Subject: Submission of the Second GAVI Health System Strengthening Proposal

Dear Dr. Lob-Levyt

On behalf of the Ministry of Health, I would like to submit our second Health System Strengthening proposal (2008 - 2015).

As the second proposal was not successful, we are now submit the third proposal (2008 - 2015) which had been developed taking into consideration of the ongoing development of second Health Strategic Plan (2008 - 2015) and lessons learnt from the current implementation of GAV/HSS1. We have taken the opportunity to consult more widely with our national and international partners, and especially with the potential co-financers, AusAID and UNFPA. This proposal has been adopted by the Health Sector Steering Committee.

I look forward to our continued international health collaboration, and would like to thank you once again for the contribution of GAVI to the health and well being of the population of Cambodia,

Yours Sincerely,

H.E. Nuth Sokhom
Minister of Health

cc: H.E. Keat Chhon, Senior Minister, Minister of Economy and Finance

Health Sector Support Project, Ministry of Health, No. 151-153, Kampuchea Krom Street, Phnom Penh, CAMBODIA
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Application Form for: CAMBODIA (February 21)

GAVI Alliance Health System Strengthening (HSS) Applications

March 2008

An electronic version of this document is available on the GAVI Alliance website (www.gavialliance.org) and provided on CD. Email submissions are highly recommended, including scanned documents containing the required signatures. Please send the completed application to:

Dr Craig Burgess
Senior Programme Officer, HSS
GAVI Alliance Secretariat
c/o UNICEF, Palais des Nations
1211 Geneva 10, Switzerland
Email: cburgess@gavialliance.org

Please ensure that the application has been received by the GAVI Secretariat on or before the day of the deadline. Proposals received after that date will not be taken into consideration for that review round. GAVI will not be responsible for delays or non-delivery of proposals by courier services.

All documents and attachments should be in English or French. All required information should be included in this application form. No separate proposal documents will be accepted by the GAVI Secretariat. The GAVI Secretariat is unable to return submitted documents and attachments to countries. Unless otherwise specified, documents may be shared with the GAVI Alliance partners, collaborators and the general public.

Please direct all enquiries to:
Dr Craig Burgess (cburgess@gavialliance.org) or representatives of a GAVI partner agency.

Abbreviations and Acronyms

To the applicant

- *Please ensure that all abbreviations and acronyms presented in the application and supporting documents are included here.*

AFD	Agence Francaise de Developpement
AusAID	Australian Agency for International Development
CPA	Complementary Package of Activity (Referral Hospital essential services)
CSS	Child Survival Strategy
DHS	Demographic and Health Survey
DPHI	Department of Health Planning and Information
EPI	Expanded Program of Immunization
GAVI	Global Alliance for Vaccines and Immunization
GNI	Gross National Income
HCMC	Health Centre Management Committee
HC	Health Centre
HSS	Health System Strengthening
HSSP	Health Sector Support Project (World Bank, ADB, DFID)
IRGC	Royal Kingdom of Cambodia
IMCI	Integrated Management of Childhood Illness
IRC	Independent Review Committee
JAPR	Joint Annual Performance Review
MCH	Maternal and Child Health
MOH	Ministry of Health
MPA	Minimum Package of Activity (health centre essential services)
MBPI	Merit Based Performance Initiative
MDG	Millennium Development Goal
MTEF	Medium Term Expenditure Framework
MYP	Multi Year Plan
NIP	National Immunization Program
NSDP	National Strategic Development Plan
OD	Operational Health District
PBMA	Performance Based Management Agreement
PATH	Program Appropriate Technology in Health
PMG	Priority Mission Group
PHD	Provincial Health Department
RGC	Royal Government of Cambodia
RMCNH	Reproductive Maternal Neo Natal and Child Health
TWGH	Technical Working Group
WHO	World Health Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHSG	Village Health Support Group

Executive Summary

Country and Health System Background

Cambodia is currently ranked 131 out of 177 countries on the human development index. Although Cambodia is a rapidly urbanizing nation, 80% of the population of 14 million remains rurally based. Population density and accessibility varies greatly from the larger population centres of the central plain to the highly dispersed and remote populations of the mountainous and forested regions bordering Thailand, Laos and Vietnam. Administratively, Cambodia is divided into provinces (24), health districts (77), communes (1100) and villages (13200). The most recent poverty estimates for Cambodia based on the Cambodia Socio-Economic Survey 2004 indicate that 35% of the population lives below the poverty line[1]. 90% of the poor live in rural areas. A Health Sector Reform process was initiated in 1996, with a focus on the development of the Operational District (Pop.100,000) as the focus for health management and organization, supported by a secondary level referral hospital (with a defined complementary package of services) and a network of primary care health centres staffed by nurses and midwives (1 HC per 10,000). This reform was mapped out in a "Health Coverage Plan" and resulted in nationwide implementation from 1996. The system of joint health sector review and development of the first Health Sector Strategic Plan, 2003-2007, has been followed recently by a Second Health Sector Review (2003–2007) and the formulation of the Health Sector Strategic Plan, 2008–2015. Associated health system developments have included the development of contracting models of health service provision, mostly through NGOs, the beginning of health financing schemes, and the rapid expansion of a private medical sector.

Health System Barriers

To strengthen the quality of health services delivery, Cambodia is implementing an essential package of health services for all Health Centres in the public health system. The "minimum package of activity" (MPA) integrates essential activities for preventive and primary health care, especially for mothers and children. A key element of this package is immunization. Cambodia has made impressive gains in immunization between the years 2000 and 2005, with rapid improvements in coverage (from 39% to 66% fully immunized child status). Other child health indicators have improved, including exclusive breastfeeding rates, reduced under nutrition rates, and increasing service provision coverage of IMCI. Infant mortality has declined from 93/1000 to 66/1000 between two Demographic Health Surveys in 2000 and 2005. However, there remain several important challenges to the sustainability and reach of immunization, and reproductive, maternal and child health (RMCNH) services in Cambodia that have been identified in nation-wide population based surveys, research studies, sector reviews and national plans. These include the following:

Human Resource Barriers: There are large inequities in human resource distribution across Cambodia, with medical doctors and other trained professionals concentrated in the cities and towns. Of those remaining in rural areas (particularly the category of "primary midwife") there are ongoing concerns regarding the quality and distribution of this cadre of staff. The second major HR concern is low rates of retention and motivation of rural health staff, related in turn to very low rates of remuneration, resulting in reduced operational mobility of the workforce and the phenomenon of ""double job holding" in private and public medical sectors.

Service Delivery Barriers: There are large inequities in immunization and reproductive, maternal and child health access across the country. DHS surveys clearly demonstrate that coverage is correlated with income levels, location and educational status. Supply side factors are attributable to these inequities, most often related to lack of sufficient numbers and quality of human resources leading to discontinuities in service provision of RMCNH and a lack of function of RMCNH referral systems. The lack of any change in maternal mortality rates between 2000 and 2005 is

[1] Royal Government of Cambodia, 2005. *National Strategic Development Plan 2006-10*, p. xvi.

demonstrable evidence of this discontinuity of RMCNH care. On the demand side, very low utilization rates for facilities are often related to financial barriers. One third of Cambodians are simply too poor to pay for health services. Secondly, as demonstrated by strong correlation between health coverage and educational and income status, it is apparent that knowledge and behaviour of the population, providers and local authorities in relation to modern health services is also a factor in limiting access.

Health Management Barriers: The most persistent and intractable system barrier to supply of health services is inadequate or untimely *financial disbursement* for basic health service operations at the primary level of care. This barrier de-motivates the health workforce, and limits health worker mobility for health outreach and the scope and quality of basic health service provision. Limits to middle level financial management capacity is also a constraint to the potential scale up of health financing schemes, which have already proved effective in the Cambodian setting in improving access for the poorest, particularly for hospital services. Linked to limits in financial management capacity, is the limited capacity for *decentralized health planning and management*, particularly in health centres and operational districts. Consequences of this limitation include *fragmentation of health services management and services* along "project" or "program" lines. This leads to inefficiencies and gaps in service provision. The fragmentation extends to provincial and central level, where a range of international projects and national programs are often managed and funded separately with distinct project administrations, reporting systems and financial flows.

The removal of these barriers has the potential to deliver the highest sustainable impact on immunization and RMCNH coverage and quality, by directly addressing major constraints – namely, an underpaid workforce, fragmented management and service delivery, and inequitable demand and access to services by socially and economically marginalized sub population groups for a continuum of RMCNH care.[4]

GAVI HSS 1 in Cambodia

This is the third GAVI HSS submission in the last 18 months. In 2006, Cambodia was awarded a grant of 1 year in line with the closure of Health Sector Plan (2003 – 2007). The goal of the HSS proposal was to enhance MCH services and child survival through four main activities – (1) Health management (2) Technical capacity building (3) Implementation of health plans (4) Strengthening of logistics systems. Underlying these activities were central HSS strategies of performance based contracts, promotion of an MCH continuum of care and implementation of demand side communication strategies. A second submission was developed in May 2007 for an extension of 3 years, but was rejected by the IRC principally on the grounds of lack of a health sector plan, no demonstration of NGO involvement, and the wrong GNI figure. (Please refer to Section 1, which gives a detailed overview of the HSS proposal development process, including consultation, review and endorsement linked to these proposal developments as well as to the consultations associated with the development of the new Health Sector Plan 2008 – 2015)

The Internal Contracts System has been developed for 10 provinces, 10 operational districts (10/77), with a range of 9 – 22 health centres in each district. The 10 Districts (pop. 785,766) represents 15% of the national population. The following factors were taken into account in district selection: absence of significant levels of external support, lower immunization coverage and delivery by trained staff, presence where possible of an Equity Fund at District level in order to support a continuity of RMCNH care from primary to secondary level, and finally, presence of Global Fund or bilateral HSS support at provincial level in order to support complementarities in approach.[5] Due to administrative and management issues,[6] the program did not commence until October 2007. A HSS Rapid Assessment was conducted in order to support this submission and its main conclusions were as follows:

[4] Specifically, lower income quintiles, families with lower educational status, remote area populations.
[5] Refer to Annex 8 for list of Cambodia ODs and HSS ODs for baseline indicators
[6] Please refer to the barrier analysis, implementation arrangements and HSS rapid assessment (annex 8) for explanation of management challenges

As of February 2008, all health centres and districts in the 10 ODS have signed performance contracts for a range of annual targets including immunization, ante natal care and general consultations. Reported strengths of the existing program (refer to Annex 8 HSS Rapid Assessment) include increased motivation of rural health workforce, relatively seamless flow of financing for basic health operations, and in most cases, improved immunization and ANC coverage. Weaknesses identified by managers and implementers include lack of management capacity for planning and management at the decentralized level, lack of remote area equity in the fee for service model, and lack of clarity on data quality auditing and mechanisms for community partnerships. Fragmentation of management still remains an issue at all levels, particularly central and provincial levels.

Design modifications for HSS 2 are based on four factors (1) Lessons learned from early implementation (2) Development of Health Sector Strategic Plan and (3) The decision by AusAID – UNFPA to invest in co financing of the MOH HSS Strategy (4) Comments from IRC panel on the last unsuccessful submission in March 2007.

HSS Goal, Objectives and Activities

The Goal of HSS 2, is, by 2015, to contribute to reduction of maternal, new born and child morbidity and mortality to MDG Targets through improved decentralized health systems and human resource management, and enhanced access by the population for a continuum of RMCNH Care (including immunization).The expected outcomes of the program is an increase in DPT 3 immunization coverage nationally from a baseline of 78% in 2005 to 90% in 2015, and increases in deliveries of trained staff from 44% in 2005 to 90% in 2015.[7] These two outcomes will also be complemented by improvements to other selected maternal health and child survival indicators. These outcomes will be achieved through (1) internal contracting linked to strengthened annual operational planning processes (focussing on both supply and demand side barriers to health services access) (2) development of decentralized health management systems (planning, financing, referral systems) and (3) improved quality of human resources through targeted human resource development programs (IMCI, Child Survival, Emergency Obstetric Care and Health Management & Planning)

Program implementation will be divided into the two phases of Health Sector Plan 2 (HSP 2). In the consolidation phase, the 10 ODs will implement the internal contracting systems and associated health system developments (planning, financial management, referral systems) and then shift to national scale up through a range of other sources including that of the World Bank and other health partners from 2009 – 2010.[8]

The central strategy of the HSS program is the internal contracting model initiated in HSS 1 that acts as a performance based reinforcement for the Annual Operating Planning system (AOP) of the Ministry of Health. The AOP is to be the basis for internal contracting – there will be no separate indicators or reporting. Parallel systems are avoided via reliance on this strengthening of existing AOP implementation processes and structures.

The MOH, through linked support of GAVI HSS and AusAID UNFPA, will support enhancement and implementation of innovative output based block grant system for reproductive, maternal and child health in 10 Operational Districts (GAVI - HSS) (2008 onward). Specific areas for child and reproductive health support will include supporting elements of Annual Operational Plans in GAVI - HSS provinces and operational districts. This support includes:

- PHD/OD outreach and supervision; (GAVI HSS & UNFPA)
- Immunization contacts, ANC and general consultations (GAVI HSS)

[7] References for EPI Target Baseline DHS Survey 2005, Target cMYP. For Deliveries by trained staff, targets from the Health Sector Plan 2

[8] The Health Sector Support Program 2 (World Bank and others) will use a similar but more comprehensive model of internal contracting referred to as "Provincial Block Grants".

- Delivery contacts (Government funded)
- Referral costs, community based distribution of contraceptives, maternal death audits, birth preparedness and maternal waiting homes (UNFPA)
- Capacity building, training and roll-out of new protocols and systems guidelines (all partners)
- Community participation (all partners)

Objective 1 SERVICE DELIVERY By 2015 in 100% of HSS Targeted Districts, the coverage of RMCNH care will reach National MDG Targets,[9] as a result of service priorities and demand side strategies identified and implemented through the OD Annual Operational Plan (AOP) supported by MPA Performance Based Contract

Activity and Outputs: The principal activity to support the attainment of this objective will be the strengthening of an internal contracting system established through HSS 1. The HSS program, with management and implementing agencies, will implement comprehensive MPA annual operational plans linked to the performance contracts. The contracts will specify roles and responsibilities of implementers and agencies, main activities, method of financial disbursal and expected outputs for a cluster of Reproductive, Maternal and Child Health Services including 5 immunization contacts. Building on lessons learned from HSS 1, and the outcomes of an in depth contracting evaluation in mid 2008, the contracts will be amended in order to accommodate the expected AusAID-UNFPA complementary investment as well as the methodology of performance payment (options include fee for services, base payments and bonus payments, remote area allowances. This is based on lessons learned from HSS 1) (see Activity 1.1 for details) The principal of advance payments to Provincial Health Departments will be continued according to new Dept. Budgeting and Finance Guidelines established through HSS 1, which have demonstrated that timely advance disbursal of finance for basic health operations in Cambodia is feasible through contracting mechanisms. Financing by GAVI HSS will be complemented by AusAID through UNFPA using the same financial mechanisms. Contractual outcomes and activities will be linked to coordinated service implementation based on the Operational District Annual Operational Plan (AOP).

These supply side strategies will be complemented by demand side initiatives including support for a fixed facility and community participation to assist health providers and community structures to educate and mobilize the population to access health services at the fixed site, as well as in the community. The expected output of this activity includes enhancement of a continuum of RMCNH care (as specified in the performance contract) including increased consultation rates, improved ante natal care contacts, increased delivery rate by trained staff, increased numbers of post natal contacts, and improved immunization coverage and referral systems.

Objective 2 MANAGEMENT SYSTEMS By 2015, 100% of HSS targeted ODS will implement co-financed and co-ordinated OD service management contracts according to MOH national planning, management, health financing and financial management policy and standards.

Activity and Outputs: The experience of HSS 1 has demonstrated the need to strengthen planning and financial management systems at all levels but particularly at the health centre and OD level. The HSS program will develop micro-planning capacity at health centre and OD level, in order to guide implementers and managers on the provision of the package of MPA services for at risk or underserved populations. This addresses the fundamental equity gap identified in research studies and barrier assessments in Cambodia. This will build on the experience of immunization coverage improvement planning which has demonstrated that *micro-planning systems* have been effective in reaching very high coverage levels.[10] At the Provincial and District level, capacity building

[9] National Strategic Development Plan 2006 – 2010 Government of Cambodia (MDG Targets)

[10] Improving Immunization Coverage through Budgeted Micro-plans and Sub-national Performance Agreements: Early Experience from Cambodia SC Soeung Asia Pacific Journal of Public Health 2006; 18(1): 29–38.

programs will be conducted in financial management in order to consolidate the introduction of new *financial management* guidelines, and to ensure that the existing financial flow to health centres is maintained and appropriately accounted for. The experience to date of annual financial release to Provincial Health Departments for HSS has demonstrated the feasibility of timely release of operational funds to the delivery level (see section 7 for details). In relation to *health information*, a system of data quality auditing to verify contractual outcomes will be introduced in Cambodia, once again building on lessons learned from HSS 1 and various pilots of Data Quality Audit (DQA) systems in immunization and at provincial level (see section 4). Secondly, through the technical support of UNFPA, a system of maternal death audits will be introduced in OD HSS Districts. Finally at Central and Provincial Levels, multi departmental monitoring teams (reinforced by comprehensive management agreements) will be strengthened to provide oversight to the internal contracting system, and report to the HSS management team on a quarterly basis the outputs of the HSS program and the performance of OD contractors (link to Objective 3). The expected outcome of this program is improved RMCNH coverage (as above) resulting from development and implementation of system guidelines for decentralized planning and financial management, DQA and maternal death audit, and the establishment of a multi program and departmental strategy for management and supervision (through MOH, GAVI and AusAID HSS support)

These management systems interventions address the fundamental barrier to health system performance in Cambodia of fragmented "program or project" based implementation and the lack of adequate systems and capacity for decentralized planning and financial management.

Objective 3 QUALITY IMPROVEMENT & CAPACITY BUILDING By 2015, 100% of HSS Targeted ODs will meet MPA policy & standards through implementation of MPA capacity building and supportive supervision programs (IMCI, Child Survival NIP, RH, systems)

The HSS program proposes to implement a comprehensive MPA Capacity Building programs (IMCI, NIP, RH, immunization, management systems) The expected output of this activity is that by 2015, the number of facilities implementing full MPA will have increased from 429 in 2007 to 960 in 2015. A particular focus of the capacity building program will be the reinforcement of continuum of RMCNH care through wherever feasible conducting training and follow up supervision in an integrated manner (link to Objective 2). The development of the Child Survival Provincial Committee,[11] steered through the Child Survival Committee centrally, and the associated monitoring program for the child survival scorecard, will be reinforced by IMCI capacity building programs and follow up supervision. UNFPA Country Office Fund and with support from AusAID, will balance the child health investment through conducting of capacity building programs for a range of reproductive and maternal health activities including EMOC, birth spacing and maternal care, community based distribution programme of contraceptives, supervision and outreach activities. Finally, a program of management systems capacity development will be implemented for OD and health centre managers (micro-planning, health financing, financial management, DQA & maternal death audit, supervision and community participation). It is envisaged that capacity building will be conducted through training as well as through management strengthening initiatives such as annual and quarterly reviews at District and Province, quarterly meetings with commune councils, and monthly meetings with health centres, backed up by programs of integrated multi program coordinated contracts monitoring (commenced through HSS 1 and identified as a key strategy in the Health Sector Plan 2008 – 2015). *Quality improvement* for facilities and service delivery will be enhanced through a range of activities and programs. Firstly, through AusAID - UNFPA support, facilities will be assessed for quality of Emergency Obstetric and Neonatal Care services (EmONC) and provides recommendations for further quality improvement. The quality of child health care (including immunization) through a systematic process of clinical and facilitators training, followed up by a program of IMCI and child survival scorecard monitoring. This objective

http://www.apjph.org.my/vol18_1/improvingimmunization.html This strategy also involves co financing with NGos and other partners

[11] MOH 2006 Child Survival Strategy see Annex 12

and associated activities address the identified health system gap of lack of quality of health service providers in rural areas, and the requirement for both a technical and management systems response to the challenge of decentralized health management.

Complementarities, Alignment and Sustainability

The HSS program is fully aligned with the central gap analysis, policies, strategies and timing of the Health Sector Strategic Plan 2 (2008 – 2015). HSS 1 anticipated and to some degree provided impetus for "internal contracting" as being a focal strategy for health system development in HSP 2. The emphasis on decentralized health management systems is in keeping with the focus of HSP 2 on governance strategy, and of the broader RGC institutional and social development initiative of decentralization and de-concentration. Finally, the emphasis on reproductive and maternal and child health is in keeping with two of the three main program areas of HSP 2. HSS 2 will further align with MOH planning process by focussing on consolidating systems development in the 10 ODs up until 2010 (HSP 2 "Consolidation Phase"), after which the GAVI HSS program will be integrated with a sector wide approach program proposed by the MOH in collaboration with other major partners including the World Bank, AusAID, DFID and AFD.[12] A key feature of the approach will be the development of Provincial and District "Block Grants", with pooled government and donor funding reinforced by strengthened annual planning and internal contracting mechanisms.

In terms of complementarities, from 2008, AusAID and UNFPA will link with GAVI HSS in the same ODs (using the same internal contract and financial management system) to support RMCNH components of the AOP (please refer to Annex 14 Draft UNFPA proposal). The same financial systems of the World Bank / MOH "Health Sector Support Project" (HSSP) will be utilized. HSSP is the forerunner to the sector wide program proposed for 2010.[13] Parallel to these developments, the roles of NGOs in supporting internal contracting models are currently being developed, with the Health Sector Plan 2 proposing to transition NGOs roles from management to support (see section 1.4.1 for details on NGO roles). The HSS program will also utilize the public private collaboration system for immunization already adopted by the MOH to potentially extend the collaboration to a wider range of MCH services.[14]

The GAVI HSS proposal has been designed to complement and build upon the *GFATM HSS* project now under implementation. The Global Fund project focuses on supporting capacities strengthening for the integrated planning, monitoring and evaluation cycle at the Provincial and Central Levels. Synergies between projects will be strengthened through integrated monitoring and supervision for both programs carried out by teams from PHDs. An important lesson learned from HSS 1 is to develop a single management TOR for both GAVI and GFATM investments in management strengthening, to prevent fragmentation of management activity that is pursuant to "project based" financing and TOR.

Sustainability is inherent in the complementariness and alignment outlined above. The GAVI HSS investment, although having been catalytic in advancing the decentralization agenda through early implementation of "internal contracting", will essentially merge within a wider HSS strategy led by the MOH in collaboration with a much larger range of national and international investors (see section 7 and also the figure at the end of this summary). GAVI finance will focus on the existing 10 ODs in the "consolidation phase" of HSP 2 (2008 – 2010) after which the program will be evaluated and then merged within the "scale up" phase of HSP 2 (2010 – 2015) through the World Bank and other sources utilizing the HSP 2 proposed Provincial Block Grant System.

[12] Agence Francaise de Develeoppement proposes to develop a comprehensive internal contracting model in Takeo Province. Consultations are currently underway with MOH and AusAID to ensure there is a well aligned and harmonized approach to development of the internal contracting systems (ie same contractual model, same financial management systems etc).

[13] Please refer to Activity 3. 4 for details of the AusAID UNFPA maternal health package.

[14] MOH Policy Public Private Collaboration for Immunization MOH 2007

HSS Implementation Arrangements

A HSS manager (Deputy Director General for Health) and Director (Secretary of State for Health) will take primary responsibility for HSS program development, technically supported by a multi departmental HSS program monitoring team managed by the Department of Health Planning and Information (see Health Sector Support Plan). As outlined above, comprehensive management agreements with Provinces and Districts (incorporating management finance from all project sources including GAVI & GFATM) will facilitate more integrated multi departmental technical and management responses to health system strengthening initiatives. Finance from both GAVI and AusAID will be managed through the office of the Health Sector Support Project (HSSP) at the MOH, utilizing current Dept. of Finance mechanisms and guidelines, thereby enabling the potential transition of GAVI funding into the sector wide funding mechanisms by 2010 (HSSP is the designated proposed SWaP mechanism for the health sector (See Annex 6 for details). At the District level and in Health Centres, the program will be managed through the District Health Team, utilizing the Annual Operational Planning System, existing monitoring and evaluation systems and internal contracts as the principal implementation mechanisms for HSS. The costs of the program are a total of $ 8,465, 508 for the planning cycle years of 2008 – 2015. GAVI HSS costs per OD Contracts are on average $77,000 per annum (excluding UNFPA funds) or .40 cents per capita.

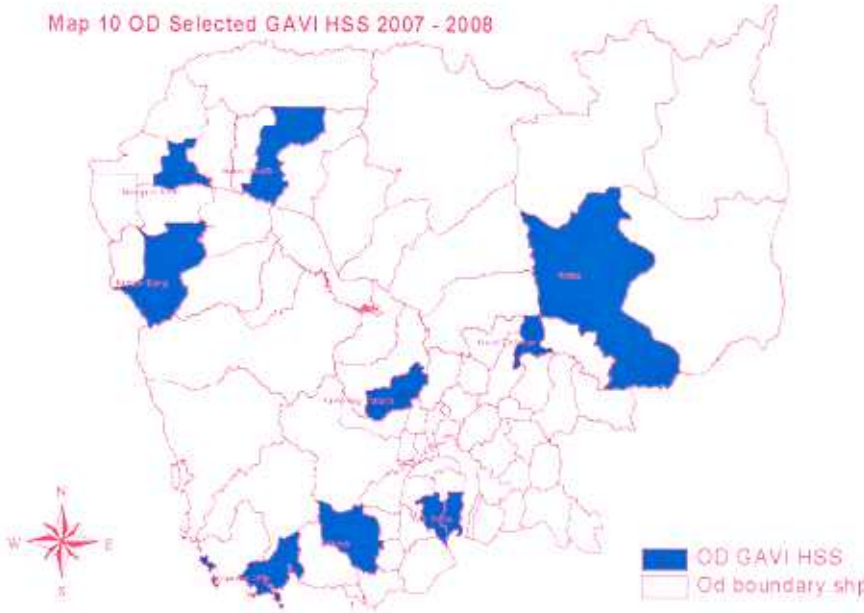
Conclusions - Impact on Immunization Coverage, and Reproductive, Maternal and Child Health Outcomes

In the coming years, the National Immunization Program is proposing major initiatives including neo natal measles and tetanus elimination, and the introduction of new vaccines (Hib, JE). This will require a rigorous and comprehensive delivery system with equitable reach of coverage in order to reach elimination targets and also in order for the most disadvantaged populations to access life saving and disability preventing new vaccines. The main challenges for Cambodia in terms of EPI and RMCNH coverage are this equitable and sustainable demand for, and access to, a basic package of life saving maternal and child health services including immunization. Prospects for sustaining improved immunization and RMCNH coverage are higher through system interventions as described above, because they address the fundamental constraints to sustaining high coverage – namely, an underpaid workforce, a "projectized" system characterized by inadequate and fragmented financial and planning systems, and sub population groups marginalized from RMCNH service by social and economic constraints. The MOH HSS program proposes to directly address these constraints through a decentralized health system strategy based on internal contracting, multi-program management and planning, demand creation and the promotion of a continuum of RMCNH service care. This essentially means decentralizing financial flow, knowledge and accountability to District level and below – a proven strategy in many country settings and the proven strategy of previous experiments with health contracting through NGOs in Cambodia.[15] [16]

[15] MOH HSSP 1 Cambodia Health Services Contracting Review 2007

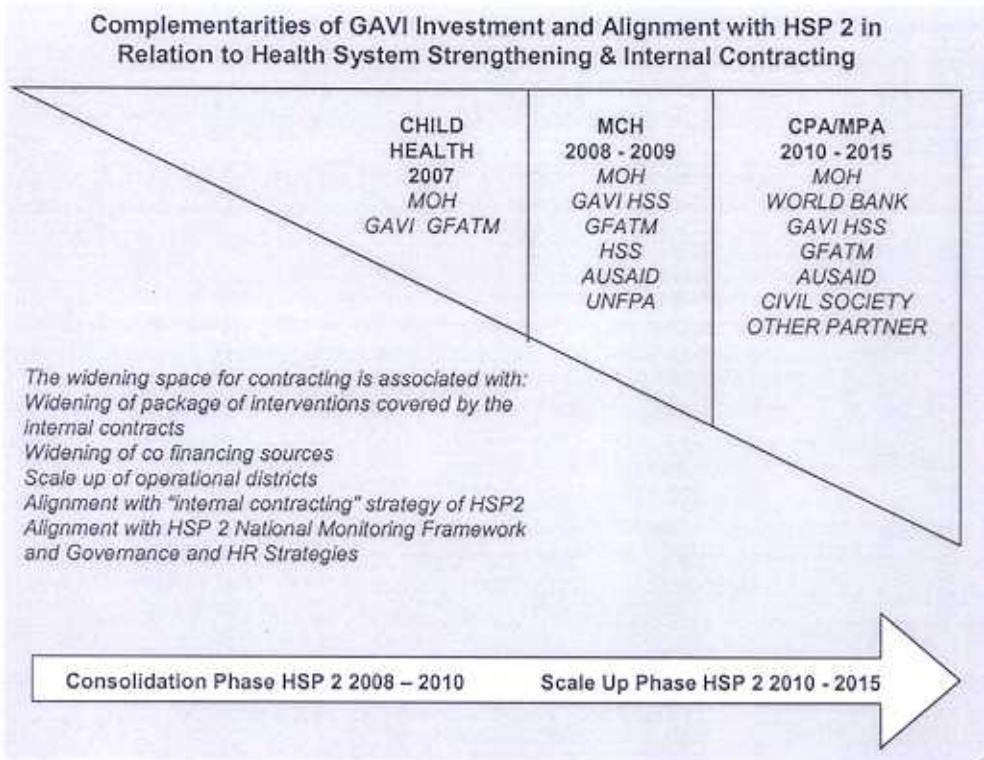
[16] Schwartz J, Bhushan I, Improving Immunization Equity through a Public Private Partnership in Cambodia Bulletin of the World Health Organization 2004 82; 661 – 667

Figure Map of HSS Districts



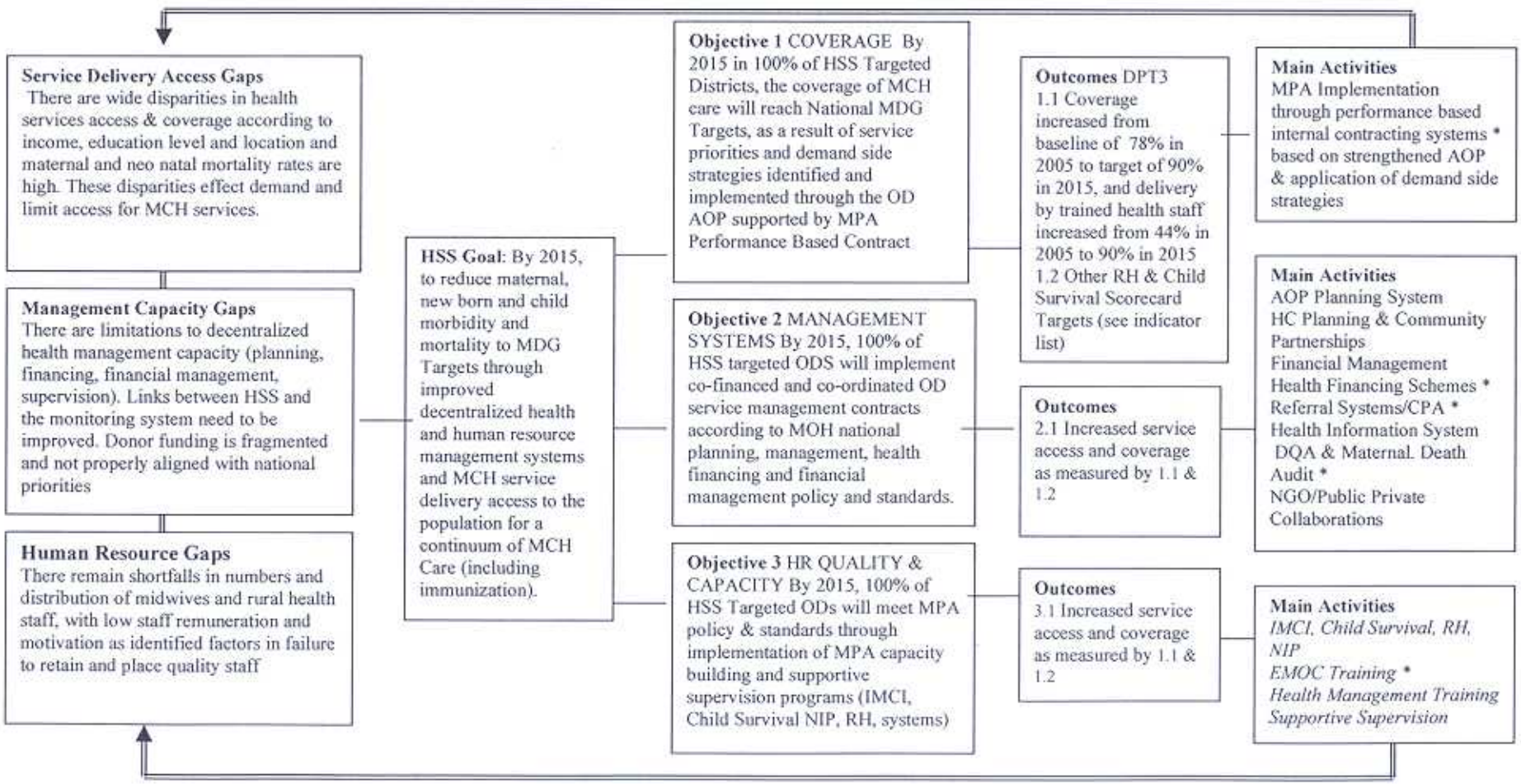
The Internal Contracts System has been developed for 10 provinces, 10 operational districts (10/77), with a range of 9 – 22 health centres in each district. (Total Health centres = 137) The 10 Districts (pop. 785,766) represents 15% of the national population.

Figure Complementarities and Alignment of GAVI HSS



* Activities supported through UNFPA and others

HSS Framework Summary



Section 1: Application Development Process

1.1: The HSCC (or country equivalent)

Name of HSCC (or equivalent):

(1) Health Sector Steering Committee (HSSC)

HSCC operational since:

(1) Health Sector Steering Committee has been operational since 2004, when it was established by MOH decree.

Organisational structure (e.g., sub-committee, stand-alone):

The HSSC is chaired by The Minister of Health, and includes 11 other senior members of the Ministry of Health (Secretaries of State, Directors General) and the Ministry of Economics and Finance and Ministry of Planning. This is a Government only body with final authority over MoH policy and planning (including the Health Sector Plan and Annual Operational Planning). Donor coordination is managed through a separate body – the Technical Working Group for Health which is operational at Central and provincial level.

Frequency of meetings:[17]

The HSSC meets on an as needs basis.

Overall role and function:

The overall role of the HSSC is to "generally give an oversight and direction in the health sector" Specific functions include the following:

- Guide the implementation of the health sector strategic plan
- Ensure necessary inputs from other ministries
- Guide multi sector activities
- Give direction to government wide reforms
- Articulate key policy direction
- Coordinate external aid to the health sector

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

Process of Proposal Development

The Ministry of Health convened a Working Group for HSS comprising representatives of the Department of Planning, the Child Survival Management Committee, CDC, National Immunization Program, Department of Finance, Ministry of Economics and Finance, and WHO

[17] Minutes from HSCC meetings related to HSS should be attached as supporting documentation, together with the minutes of the HSCC meeting when the application was endorsed. The minutes should be signed by the HSCC Chair. The minutes of the meeting endorsing this GAVI HSS application should be signed by all members of the HSCC.

and UNICEF (as observers). The terms of reference of the working group were to oversee development of the proposal, conduct national and sub national consultations and communicate findings and final draft proposal to the MOH and to GAVI. The Working Group was chaired by the Deputy Director General for Health, with operational aspects of the proposal development being managed through the Department of Planning and Health Information (DPHI). In depth consultations were undertaken at facility level and with Provincial and OD managers through conducting of an interim evaluation study of HSS 1. Findings were then tabled at a National Workshop on February the 6th, at which implementers, managers and NGOs provided their input on strengths, weaknesses and recommendations for HSS 2. Proposal review was conducted through this National Consultative Workshop, as well as through HSS partners meeting and by the Technical Working Group for Health (minutes attached). After clearance by the Health Sector Steering Committee, endorsement was provided by the Minister of Health and Minister for Economy and Finance.

Who led the drafting of the application and was any technical assistance provided?

This was led by the HSS working group in collaboration with WHO / UNICEF and technical assistance for drafting was provided by a short term consultant through the Ministry of Health

Give a brief time line of activities, meetings and reviews that led to the proposal submission?

This is the third GAVI HSS application developed by Cambodia in the last 18 months, so, in reality, this is the third in depth consultation for development of HSS strategy, taking also into account the extensive national consultations undertaken for development of HSP 2 and the health sector review.

Who was involved in reviewing the application, and what was the process that was adopted?

1. I January 2008, the HSS Working group convened 3 teams comprising representatives from the National Immunization Program, Department of Planning and Health Information and Dept. of Budgeting and Finance. A questionnaire was designed by the HSS Working Group, focussing on data analysis, strengths and weaknesses of the program and recommendations for managers and implementers for HSS 2. Data was collected from the field and analysed to form an Interim Evaluation of HSS 1.
2. At a national workshop on February 5, with participants from NGOs, health partners, ODs Provinces and Health Centres recommendations were obtained from provinces, ODs and NGOs on implementation of internal contracting in each district and recommendations for future implementation.
3. On February 7 and 8,a health partners meetings were conducted for the purpose of gaining input on design and implementation of HSS, particularly with respect to alignment with national strategy.
4. Members of the HSS Working Group, in collaboration with MOH and with support of the drafting consultant, undertook individual consultations with participating Operational Districts and Provincial Health Departments, DPHI, Dept. Budget and Finance, NIP, WHO, UNICEF, UNFPA, HSSP secretariat, World Bank, USAID, JICA, AusAID, Medicam Steering Committee and RHAC (National NGO) in order to disseminate information on existing design and gain input for the future of HSS.
5. Representatives of the GAVI Secretariat, USAID and JICA also conducted a mission to Cambodia during the proposal development period, and provide technical advice on the existing draft. Recommendations were then built into the proposal design.
6. For review, the members of the HSS working group undertook an internal review. The District and Provincial Workshop reviewed the framework (with participation of the NGOs and Health Partners please refer to Annex 6 for list of participants).
7. On the 9th February, the Deputy Director General circulated a request for proposal review

to development partners. These review comments were summarized with actions proposed for correcting them (Refer to Annex 13 for details of their comments and follow up actions). This was then circulated back to all development partners on February 14Th.

8. The Technical Working Group for Health (peak development partner co-ordination committee) reviewed the proposal on February 15th. The Deputy Director General once again presented the HSS framework. After further questions and clarifications from development partners, the Chair of the meeting (Secretary of State) and co chair (WHO Representative) recommended to proceed with the March 5 submission.

Who approved and endorsed the application before submission to the GAVI Secretariat?

1. HSSC
2. Minister of Economy and Finance H. E Keat Chuon
3. Minister of Health H.E Nuth Sokhom

To the applicant

- *Please describe overleaf the roles and responsibilities of key partners in the development of the GAVI HSS application (Table 1.3).*

Note: Please ensure that all key partners are included; the Ministry of Health; Ministry of Finance; Immunisation Program; bilateral and multilateral partners; relevant coordinating committees; NGOs and civil society; and private sector contributors. If there has been no involvement of civil society or the private sector in the development of the GAVI HSS application, please explain this below (1.4).

1.3: Roles and responsibilities of key partners (HSCC members and others)

**** Important note on roles and responsibilities in proposal development in Cambodian context:**

The *Health Sector Steering Committee* of Cambodia is represented by Government only. Please refer to minutes of HSSC meeting for this committee membership and comment.

The *Technical Working Group for Health* (TWGH) is the peak committee for providing donor coordination advice to government. Please refer to TWGH minutes for this committee membership and comment.

MEDICAM is the peak NGO (National NGO) representative body of Cambodia. Please refer to MEDICAM steering committee minutes for this committee membership and comment.

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
Title / Post	**Organisation**	**HSCC member**	**Roles and Responsibilities related to GAVI HSS**
H.E Professor Eng Huot Secretary of State	MOH, Member of GAVI Board	Yes	Strategic direction for program development
Professor Sann Chan Soeung Deputy Director General for Health	MOH	Yes	Overall management of the program development Chair of HSS Working Group Oversight of proposal development and HSS 1 Implementation

Dr Lo Veasna Kiry Director	MOH, Dept. Planning & Health Information	No	Vice-chair of HSS Working Group Provided technical input on strategic directions of HSP 2, and how the GAVI HSS can align with it. HSS Working Group Member Chair of HSS Monitoring Team
Ms Khout Thavary Deputy Director	MOH, Dept. Budget & Finance *Email	Yes	Responsible for Financial Monitoring Financial Management Costing Overseeing development and implementation of financial management guidelines HSS Working Group Member
Dr Loun Mondol , Vice-chief of Planning Bureau Dr. Ly Vichea Ravuth, Vice-chief of Planning Bureau	Policy, Planning & Health sector Reform Bureau MOH, Dept. Planning	No	Team leader for evaluation in Kampong Cham and Kraties province interim evaluation HSS Working Group Member
Dr Hong Rathmony Deputy Director	MOH, CDC Dept.	No	Input on IMCI and child survival scorecard development
Dr Svay Sarath, Mr Ork Vichit	MOH, National Immunization Program	No	Immunization program input as well as Team Leaders for HSS Rapid Assessments HSS Working Group Member
Dr Paul Weelen Health System Development Adviser	WHO	No	Technical assistance on health system development and proposal review HSS Working Group Member (observer)
Dr Benjamin Lane Health Planning Advisor	WHO	No	Technical assistance in health system development and proposal review HSS Working Group Member (observer)
Dr Kohei Toda Immunization Advisor	WHO	No	Technical assistance on immunization
Dr Thor Rasoka MCH Program Officer	UNICEF	No	Maternal and Child Health including community participation. HSS Working Group Member (observer)
Ms Thazin Oo Head of Health Section	UNICEF	No	Technical advice on HSS including community participation and concept of Community Partnership Fund.
John Grundy Consultant	University of Melbourne	No	HSS Proposal drafting in collaboration with HSS TWG
Medicam Dr Sin Somuny Executive Secretary	MEDICAM National NGO Umbrella Organization of health NGOs	No	Advice on NGO roles in HSS and internal contracting (see minutes)
Technical Working Group for Health	Sector coordination structure	Cross membership with HSSC	Advice on strategic Directions
Dr Var Chivorn Maggie Huff-Rouselle	Reproductive Health Association of Cambodia (RHAC)	No	Provided insights on the potential role of NGOs in relation to the internal contracting model.
Provincial and OD Budget Management Centers and Health Center Management Team	PHD managers OD Managers HC Managers NGOs	No	Management and implementation

Health Sector Steering Committee	Inter-ministerial top management: MoH, MEF, MoP	No	Strategic direction Recommendation of endorsement to MOH
Lia Burns Peter Lindenmayer Australian Embassy Phnom Penh	AusAID Cambodia	No	Advice on long term AusAID strategy in relation to HSS and connections with GAVI
Shoko Sato Tomohiko Sugishita Hiromi Obara	JICA JICA JICA	No	HSS working Group (observer) Assisted facilitate communications with secretariat of Technical Working Group for Health Advice on role of Institutional development and health system research in relation to HSS Advice on budget flow through HSS, and outline of preliminary findings of JICA HSS study in Kroch Chmar District
Dr Toomas Palu Ms L Nareth	WORLD BANK		Advice on links to Health Sector Support Program Peer Review
Dwyane Shuey	WHO	No	Peer Review
Dr Sokun	UNFPA	No	Advice on UNFPA current and future engagement with the HSSP 2 and complementary support on reproductive and maternal health in GAVI supported locations.
Ms Diana Chang Blanc Regional Immunization Specialist	UNICEF	No	Peer Review
USAID	Kate Crawford	No	Advice on civil society relationships to HSS Peer Review
URC	Tapley Jordanwood	No	Advice on quality improvement and links to HSS
ADF	Luize Guimaraes	No	Advice on potential links between ADF proposal for internal contracting in Takeo province, and the links to HSSP 2.
University of Melbourne Head of Health Systems Strengthening Unit	Dr Kris Hort	No	Peer Review
PHD Directors Vice Directors	(see attached List Annex 6)	No	Rapid Assessment of Implementation and Recommendations for the next submission
Selected NGOs	(see attached List Annex 6)	No	Rapid Assessment of Implementation and Recommendations for the next submission (see list of NGOs in workshop attendance)

To the applicant

- *If the HSCC wishes to make any additional comments or recommendations on the GAVI HSS application to the GAVI Secretariat and Independent Review Committee, please do so below.*
- *Please explain if there has been no involvement of civil society or the private sector, and state if they are expected to have a service provision or advocacy role in GAVI HSS implementation.*

The principal methods for coordination in the 10 ODS will be joint planning through the annual operational planning system (including annual review) backed up by the Provincial Technical Working Group for Health (this is the provincial level donor coordination mechanism in Cambodia).

NGO Roles in Proposal Development

NGOs have been involved in the development and implementation of the HSS Strategy in the following ways:

During the proposal development, NGOs have been consulted in the field and in central level consultative workshops on proposal design and on NGO roles in implementation of HSS contracts. The leadership of MEDICAM (the umbrella organization of Health NGOs in Cambodia) has been consulted in particular on the potential role of NGOs in the health sector as it transitions to health sector development through internal contracting. NGOs are directly involved in implementation of HSS through participation in the development and implementation of annual operational plans. Furthermore, this HSS strategy mirrors and supports the implementation of HSP2, which had extensive NGO participation in the development stages. NGOs participated in the review of HSS 1 activities in the National Workshop on February 5 in Phnom Penh, and were invited to provide their viewpoint of NGO roles in relation to HSS and internal contracting (see HSS Rapid Assessment for details). A specific meeting was conducted with the steering committee of health NGOs in Cambodia in order to elicit their view on a strategic alliance with HSS (refer to minutes Annex 6). Both the academic and NGO sector was involved in proposal drafting and review.

1.4.2 Role of Private Sector

The Private Sector has not been involved substantially in the development of this proposal. However, HSP 2 identifies public private collaborations as a strategic component of the Governance Strategy. Some national programs (including immunization) have developed successful models of public private collaborations for improved coverage and quality of health programs in the private sector. It is proposed that HSS 2, in line with the focus on public private collaborations of HSP 2, will focus on strengthening implementation of public private sector collaborations in the consolidation phase of the health sector plan.

A recent survey has indicated that of 123 private health facilities of Cambodia, over 80 were providing immunization services.[19] It was also found that the services were of dubious quality with some questionable immunization practices relating to cold chain management, vaccine schedule and waste management. In response, the NIP has developed a private public collaboration policy and system.[20] There is also a strong focus in HSP 2 on strengthening of public private collaborations.

It should be noted that in a rural setting "private sector" also means health centre staff working in private settings during part of the day due to low civil servant remuneration. Internal contracting to a certain extent would address the necessity for such coping mechanisms.

Co financing of this strategy through other sources will be allocated to monitoring and supervision and operational research in order to problem solve aspects of the private collaboration as well as identifying opportunities of broadening the collaboration to encompass maternal and child health programming in the private sector. For full clarification of public/private collaboration, please refer to the broader policy intent expressed in HSP 2 (Page 16 Policy 13 "Promote effective public and private partnerships in service provision based on policy, regulation and legislations.")

[19] Research Study on Immunization Private Sector Practice NIP PATH Cambodia 2006

[20] MOH NIP 2007 Policy and Guidelines on Public Private Sector collaboration for immunization MOH Phnom Penh 2006

1.4: Additional comments on the GAVI HSS application development process

1.4.1 Role of NGOs

Roles in Implementation

Role of NGOs: In the traditional contractual context, NGOs have been accustomed in many instances to adopting the role of the contracting manager. In the HSP 2 transition, contracting is becoming internal to Government. This will require a transition in NGO role from management of services to technical support for district health services implementation. This involves a "move from substitution to technical assistance, including in contractual arrangements with NGOs" (HSP 2).

In consultations between the MOH and Health Sector Plan 2, the draft HSP 2 was amended to emphasise the need to strengthen delivery of NGO assistance in line with HSP2 priorities. However, it is important to ensure their independence and complementarities in addressing the health of the marginalized groups, implementing pilots and innovative approaches, and engaging in policy dialogue (HSP 2).

In terms of implementation, since 2002, the National Immunization Program, through the technical facilitation of UNICEF, has developed an effective Government civil society partnership to improve immunization coverage in Cambodia. [18] Lessons learned from this experience will be applied for HSS. Chief amongst these lessons is the need for careful district mapping of NGO activity, co planning of delivery and a systematic approach to consultation and information. This strategy will be decentralized to the Province and District in HSS, in order to maximise the benefits of government civil society coordination for RMCNH.

Throughout this application, reviewers will observe the following roles that are currently being adopted or planned be NGOs in Cambodia, particularly given the rise of civil society generally (in particular National NGOs), the development of health financing and the transition to "demand side feedback mechanisms" to strengthen quality of public service delivery. Listed below are some of the described functions of NGOs in HSS:

- Assisting the National Immunization program to gap fill immunization coverage by NGOs in underserved areas (with technical support from UNICEF)
- Assisting with community level data quality auditing
- Monitoring and evaluation
- Quality assessment
- Poverty assessments for health financing schemes
- Demand side research.

NGOs funded through USAID in particular but also other agencies propose a role of civil society in providing management support at the peripheral level in Cambodia in areas such as planning, budgeting, development of community based insurance schemes, quality improvement and community outreach. A third party role for NGOs in quality assessment and monitoring and evaluation is also proposed in some locations.

In consultations undertaken with the steering committee of MEDICAM and the MOH generally in relation to HSS, it was agreed that the civil society function in strengthening health governance, and not only be seen as a "gap filler" or "social mobilizer".

[18] Please refer to Pages 4,7,10,11.12,28,36,42 of the cMYP (annex 2) for more details on NGO roles. The contact for discussing NGO roles and mapping in immunization is through MEDICAM or UNICEF (achum@unicef.org)

1.4.3 Response to Independent Review Committee Comments

In this section, the opportunity is taken to articulate the response to the reviewers comments from the unsuccessful October 2007 HSS submission.

(a) Re-budget according to $2.5 $ per child recommendation

The budget has been reformatted to $2.5 per child. The reduction of budget has resulted in the need to focus on the 10 ODs in the consolidation phase of Health Sector Plan 2, rather bthan scale up through GAVI resources as proposed originally in HSS 1.

(b) Harmonize with Health Sector Plan

The Final Draft HSP 2 is annexed (See Annex 1). Gap analysis, objectives and indicators and management procedures have been aligned and harmonized as closely as possible to HSP 2

© Reformulation of objectives according to logical framework

Refer to framework following the executive summary. This aligns as closely as possible to HSP 2. Indicators are aligned as close as possible to the draft M & E framework for HSP 2.

(d) Reassess targets

These are now aligned as closely as possible to HSP 2.

(e)Ensure specific consultation with and participation in review by NGOs (especially in proposed districts).

Refer to 1.4.1 above as well as section 6 and section 7.

(f)Description of additional NGO involvement is needed in implementation (not only operations research)

Refer to 1.4.1 above as well as to section 6 and section 7.

(g)Provide a map of proposed health districts to be covered

Refer to maps at the end of the executive summary.

(h)Ensure all necessary signatures in line with GAVI HSS proposal guidelines.

Annexed with minutes.

(i)Ensure reporting is initiated at District Level

Health Contracting is with Districts. District accountability is built into the design and into HSP 2 and GAVI HSS 1 as "internal contracting." The Annual Operational Planning System of the MOH is District based (please refer to HSP 2 which has Chapter 6 devoted to M & E and the AOP system, much of which is focussed on the district).

(j) Clarify how the HSSP project at MOH would be part of the existing financial management system and not as a separate project

Refer to section 7 implementation arrangements, which describes the role of The Health Sector Support Program as a transitional mechanism towards sector wide approach implementation in

Cambodia. Please also refer to Ministerial minutes in Annex 6, which clearly articulates the role of the Health Sector Support Program as a transitional SWAp mechanism.

(k)Describe how the community based insurance (EF) and GFATM HSS would facilitate influence or overlap with HSS.

This is now described in section 7. HSP 2 describes in some detail health financing issues and strategy 2008 – 2015. Refer to Chapter 4 of HSP 2 which describes in more details the role of equity funds in poverty alleviation and the effective functioning of a continuum of maternal and child health care, of which immunization is a key component.

GFATM and GAVI are co financing management strengthening programs (supportive supervision) at provincial level. The proposal for GAVI funding to support development of integrated central supervision teams for contracts monitoring is also consistent with the GFATM HSS fund proposal to strengthen development partner coordination mechanism at central level. It is now proposed that GAVI and GFATM jointly fund a comprehensive management strategy for monitoring at central and provincial level.

(k) Wait evaluation and health sector plan before submitting next proposal.

The Health Sector Plan is appended as Annex 1 HSS Rapid Assessment as Annex 8.

1.4.3 Response to Main Review Comments during HSS 2 proposal development

On the 9th of February, the Deputy Director General circulated the final draft proposal to all development partners and agencies for review and comments. Please refer to Annex 13 which provides a summary of all comments received, corrections requested and actions taken to improve proposal quality.

Section 2: Country Background Information

2.1: Current socio-demographic and economic country information[21]

Information	Value	Information	Value
Population [22]	14,363,519	GNI per capita	$US 430 [23]
Annual Birth Cohort	385421	Under five mortality rate	83 / 1000 [24]
Surviving Infants	360,369	Infant mortality rate	66 / 1000
Percentage of GNI allocated to Health[25]	10.14%	Percentage of Government expenditure on Health	11.29%

[21] If the application identifies activities that are to be undertaken at a sub-national level, sub-national data will need to be provided where it is available. This will be in addition to the national data requested.
22 Ministry of Planning Statistics 2005
[23] The World Bank The Little Green Data Book 2007 on line
[24] IMR and U5MR DHS 2005
[25] MTEF 2004

* Surviving infants = Infants surviving the first 12 months of life

To the applicant

- *Please provide a brief summary of your country's Health Sector Plan (or equivalent), including the key objectives of the plan, the key strengths and weaknesses that have been identified through health sector analyses, and the priority areas for future development (Table 2.2).*

2.2: Overview of the National Health Sector Strategic Plan

2.2.1 Health Strategic Plan 2008 - 2015

The Health Sector Strategic Plan 2008 – 2015 (HSP 2) is the second from Cambodia, and follows on from the first developed for 2003 – 2007. The HSP 2 incorporates the strategic directions of the National Strategic Development Plan (see below and Annex 4) and the findings of the Health Sector Review (see Annex 5). The structure of the health system and the background to its development is outlined in Chapter 1 of the HSP 2. 3 Year Rolling Plans are also implemented by the MOH as essential medium term processes to implement the HSP 2. These are in turn linked to the Annual Operational Plans of the MOH, Provinces and Districts.

2.2.2 Key Objectives of Health Sector Strategic Plan

The Goals of the Health Sector Plan are divided into these three program areas and are as follows:

- HSP Goal 1 Reduce maternal, new born and child morbidity and mortality with increase in reproductive health
- HSP Goal 2 Reduce morbidity and mortality of HIV / AIDS, Malaria and TB and other communicable diseases
- HSP Goal 3 Reduce the burden of non communicable diseases and other health problems.

Component objectives are described on page 21 and measurable outcomes on page 20 of HSP 2.

2.2.3 Key Strengths and Weaknesses

Key strengths and weaknesses in the Cambodian Health Sector were analyzed in a Health Sector Review undertaken in 2007 (see Annex 5) in support of the development of HSP 2. These findings are summarized in HSP 2.

Health Outcomes: Cambodian health has improved considerably from very low post conflict levels. Infant and child mortality has declined significantly. Under 5 child mortality for example has declined from 124 to 83 per 1000 live births between 2000 and 2005. However, maternal mortality has not declined in this period and remains a major concern.

Poverty and Equity: A striking feature of Cambodian health system development is the large differences in health access and outcomes between socio economic groups. Specifically, there are wide differences in health outcomes between rural and urban populations, and between more and less educated populations. The basic problem is low utilization of both minimum package of services for primary care (MPA) and complementary package of services for referral hospital care (CPA). (pg 10) Demand creation is an area of priority and urgency for MCH.

About one third of the population is too poor to pay for health care in the public or private sectors. Cambodian financing of health care is dominated by out of pocket expenditures. The total health expenditure was $37 dollar per capita, of which 68% (US $ 25) was out of pocket. 35% of the population lives under the poverty line of US $ .46 - .63 per day, and health expenditures can tip others above this figure into poverty (Pg 10 – 11). Relatively low shares of government budgets reach facilities, mostly due to financial management constraints (Pg 11). The Salaries of staff are highly dependent on health equity funds and contracting mechanisms.

However, there are encouraging signs of development in the health sector in relation to tackling the problem of inequities in health outcomes and access. These include increasing government health budget allocations, and the development of health equity funds to cover the needs of the poorest populations.

Human Resources for Health: There are continuing challenges of shortfalls in numbers and distribution of midwives, levels of competency of rural health staff and a need for a more multi skilled cadre of health staff. There are also large imbalances in remuneration between public and private sectors. Despite these challenges, contracting of health services and their management have demonstrated that a combination of better pay for staff with merit based remuneration provides a better way forward for major reform of district and facility organizational management.

Governance: Donor funding remains fragmented and not properly aligned with stated national priorities. Non aligned funding flows disrupt the effectiveness of health sector governance. However, policy progress has been made, with strong conviction amongst government and development partners to the principles of the Paris Declaration, with national and international mechanisms in place to improve donor harmonization during the course of HSP 2.

2.2.4 Priority Areas for Future Development

Major Policy Directions for HSP 2 2008 – 2015 are outlined in more detail on page 15 – 16 and include the following:

- Strengthening sector wide governance through implementation of SWAP.
- Implementation of decentralized management and service delivery
- Scaling up access and coverage of health services through packages of interventions that have both a supply and demand side intervention e.g. expansion of contracting, health equity funds, and health insurance (for details on MCH please see Chapter 4 of HSP 2)
- Implementation of pro poor financing schemes
- Increasing competency and skills of the health workforce, and promotion of quality standards and standard clinical guidelines
- Strengthening investment in health information and research.
- Promotion of effective public and private partnerships

In terms of aid effectiveness, the HSP 2 recommends integration of Global Health Initiatives into existing processes of cooperation in Cambodia, in order to reduce transaction costs and avoid distortion of program priorities (page 35). Other main policy directions confront the major weaknesses in the Cambodian health system relating to inequities in health service accessibility, human resource distribution and quality, and decentralized management. These include:

- Establishment of contractual arrangements with block grants to provinces and districts (page 28)
- Reductions of financial barriers through scaling up of health equity funds and CBHI (page 29)
- Scaling up of consolidated packages of essential preventive and curative health services including MCH (page 26)
- Establishment of multi departmental Health Service Delivery Monitoring and Supervision Team at Central MOH to support PHDs and lower levels (page 26)
- Improve management of facility managed salary supplementation from HEF, quarterly block grants and contracting (page 32)
- Development of a common monitoring and evaluation framework that allows development partners to reduce "dedicated" forms of monitoring (page 35)
- Strengthening annual operational planning and program based budgeting as a basis for annual performance agreements between central and operational levels (page 36) (see Chapter 5 for details on Planning and Budgeting process)

An *operational framework* describes the three program areas of MCH, CDC and NCD that are cross cut by 5 strategies structured around the key functions of the health system – finance, human resource , governance, health information system and health service delivery. Policy requirements for each strategic area will be detailed (see Chapter 3 on Health Strategy for detail on operational frameworks). The *approach to implementation* will be based on a ""two phase strategy". In the *"consolidation phase"* of 2008 - 2010, institutional and systemic constraints to scale up will be addressed. In the second phase of 2011 to 2015, key health system strengthening interventions will be rolled out to all provinces while being subject to rigorous monitoring.

2.2.5 The National Strategic Development Plan of the RGC 2006 – 2010:
The NSDP outlines the main strategic directions for social and economic development in Cambodia, including setting of targets for achievement of Millennium Development goals (including targets for maternal and child mortality reduction and immunization). The NSDP incorporates the National Poverty Reduction Strategy and the Socio Economic Development Plan. The NSDP is a "living document "that is updated annually based on sector developments. Key strategies of the NSDP include the following: (1) Factor poverty reduction and gender concerns in all activities (2) pursue reforms in all sectors, however painful they may be in the short term (3) focus on well tried, low cost activities with quick and high returns at the grassroots to have profound effect on the poverty situation (4) target most needy and least served areas and (5) Stress institutional and human resource capacity building in all sectors

2.2.6 Multi Year Plan for Immunization 2008 – 2015

System barriers to immunization performance are outlined on page 6 of the cMYP, which include weaknesses in decentralized management, demand side barriers with high risk populations and a very high dependence on health outreach services to populations in order to sustain coverage.

Milestones between 2008 and 2015 outlined in the cMYP (see page 6)) include neo natal tetanus elimination by 2009, measles elimination by 2012 and reduction of hepatitis B carriage in newborns to 2% by 2012.Also of significance for 2010 – 2015 for the NIP, is the current consideration given to the likely introduction of Hemophylus Influenza B and Japanese Encephalitis vaccines into the routine program in 2009 and 2010, as well as ongoing programs for measles, hepatitis B and neo natal tetanus elimination.

Health Sector Plan 2 notes the improvement of immunization coverage in the last planning cycle, and the role of new technologies such as immunization as part of it for its impact upon the disease profiles of the Kingdom, and for its capacity to generate an increase in user demand.

Section 3: Situation Analysis / Needs Assessment

3.1: Recent health system assessments[26]

Title of the assessment	Participating agencies	Areas / themes covered	Dates
Health Strategic Plan 2008 - 2015	MOH, Civil Society and Health Partners	(1) Introduction to Sector (2) Goals & Objectives (3) Health Strategy (4) Implementing Strategy (5) Implementation and M & E	2008 - 2015
Health Sector Review 2003 - 2007	MOH and Health Partners with technical assistance of HLSP	(1) Population Health Status (2) Policy development & implementation (3) Resources for Health (4) Experimentation in Systems Development	2003 - 2007
Joint Annual Performance Review 2007	Ministry of Health, Sub national health authorities and International Health Partners	(1) Current situation, (2) Constraints and priorities, (3) Indicators and targets for 2008	2007
Situation Analysis NIP MYP 2008 - 2015	NIP, MOH, International health partners	Immunization and health system barriers to immunization performance, costed national plan	2006 -2010
National Child Survival Strategy	MOH and International partners	Situation analysis child survival, Key strategies include transition to integrated Child Survival Scorecard Monitoring with 12 priority indicators including immunization	2008 - 2015
Final Draft Cambodia Contracting Review	MOH / Health Sector Support project / Conseil Sante	Situation Analysis of Health Contracting including access, utilization, management and costs, Recommendations for the Future, including transition to internal contracting model.	Feb 2007
Demographic Health Survey	Ministry of Planning, Ministry of Health	National Survey – Morbidity and Mortality Rates, Health Seeking Behaviours, Program Coverage MCH. Demonstrated declining child mortality and unchanged maternal mortality.	2005
Midwifery Review	Ministry of Health	The Midwifery Review demonstrated that the levels of competency amongst primary midwives are inadequate. In addition, placing primary midwives in rural areas has failed to address broader health needs, in particular those of children. Rural areas need a more multi-skilled staff cadre, such as a secondary nurse/midwife.	2006
SWIM Review	Ministry of Health	Donor funding remains fragmented and not properly aligned with stated national priorities, despite efforts under the SWiM process. Fragmented donor financing support – a key to the financial	2006

[26] Within the last 3 years.

		challenges – also constitutes a major problem. Non-aligned financial flows from donors disrupt the health sector governance model.	

To the applicant

- *Please provide information on the major health system barriers to improving immunisation coverage that have been identified in recent assessments listed above. (Table 3.2)*
- *Please provide information on those barriers that are being adequately addressed with existing resources (Table 3.3).*
- *Please provide information on those barriers that are not being adequately addressed and that require additional support through GAVI HSS (Table 3.4).*

3.2: Major barriers to improving immunisation coverage identified in recent assessments

Service Accessibility Barriers

In terms of service accessibility barriers, there are significant regional balances in health facility utilization. The main determinants of variations of program coverage are related to socio economic factors (see below). The basic problem is low utilization of both minimum package of services for primary care (MPA) and complementary package of services for referral hospital care (CPA) (pg 10). Demand creation is an area of priority and urgency for RMCNH programs, but this problem may persist in the absence of health financing initiatives, given the significant percentage of the population living below the poverty line. *Low utilization* is due to financial barriers which will be addressed in part by this proposal through linking of GAVI investments with NGO supported community based health insurance and hospital equity funds. *Low demand*, on the other hand, is the result of low quality which will be addressed by the internal contracting model and human resource quality improvement (IMCI and RMCNH).

A major constraint is sustaining social mobilization finance support for fixed site utilization. Health volunteers and local authorities often lead the effort to mobilize the population, but there are no operational budgets to cover the operational costs of this effort. Health education and communication with local authorities is critical to raise awareness of the population of the services that facilities provide. But currently, there is no government budget source to finance village based social mobilization of health education (NIP MYP 2008)

A striking feature of Cambodian health system development is the large differences in health access and outcomes between specific socio economic groups. About one third of the population is too poor to pay for health care in the public or private sectors. (HSP 2) There is lower coverage and lower demand in high risk groups and children of families with low educational status (53% of children with parents that have no primary school entry are fully immunized, compared with 83% of children whose parents have entered secondary school). Many of the high risk areas of Cambodia for vaccine preventable disease include remote areas, urban slums and ethnic minorities. (DHS 2005, NIP 2008).

The under-five mortality is almost three times as high in the poorest compared to the richest socioeconomic groups: 127 versus 43 per 1,000 live births and infant mortality in the poorest 20% of children is 101 compared to 34 per 1,000 live births in the richest group. Although the mortality rates have improved since 2000, the gap between the richest and poorest quintiles has actually increased to almost 3 times as high in 2005, up from 2 times as high in 2000. (Child Survival Strategy 2007)

Health Management Barriers

Financing and Financial Management: Cambodian financing of health care is dominated by out of pocket expenditures. The total health expenditure was $37 dollar per capita, of which 68% (US $ 25) was out of pocket. 35% of the population lives under the poverty line of US $ .46 - .63 per day, and health expenditures can tip others above this figure into poverty (HSP 2 Pg 10 – 11). Relatively low shares of government budgets reach facilities, mostly due to financial management constraints (HSP 2 Pg 11). Health workers are highly reliant on a reliable cash flow to health centres in order to immunize children, 80% of whom are vaccinated during village health outreach sessions (cMYP). The Salaries of staff are highly dependent on health equity funds and contracting mechanisms and NGO supplements. This is clearly non sustainable in the longer term, which provides the main rationale for promotion of utilization of the facilities by communities, and through developing a more consistent flow of finance from a range of sources to reach the health centers in a timely and reliable manner. The significant successes of hospital health equity funds in raising utilization rates post introduction has provided further strong evidence of the impact of financial barriers on accessibility. The extension of theses schemes to the community level may also impact on health centre utilization, thereby enhancing access of the population to a continuum of care (although immunization services are technically "free", most health centers operate user fee schemes for maternal and child health consultations in Cambodia). The reported increase of motivation of health staff post introduction of HSS 1 has demonstrated the important linkages between financial management barriers (ie interrupted flow of finance to health centers) and human resource management (see Annex 8 Rapid Assessment of HSS 1).

Harmonization and Alignment: Donor funding remains fragmented and not properly aligned with stated national priorities.(health Sector Review 2007). Non aligned funding flows disrupt the effectiveness of health sector governance.(HSP2). There is mostly a projectized approach in donor operations. The Royal Government of Cambodia's Harmonization, Alignment and Results Action Plan calls for concrete action to consolidate linkages between aid programs (HSP 2 Governance Strategy)

Health Planning & Management: Staff lack capacity for management of information for planning purposes. Staff are good at collecting data but not at analyzing it and using it to develop a good plan. (NIP MYP 2008). The HSS Rapid Assessment has indicated that there are persisting problems with planning and financial management capacity at the District level and at health centres. In many instances, health centres do not have a plan at all, and what plans do exist, are usually program specific such as coverage improvement planning for immunization or TB Dots (see Annex 8 Rapid Assessment HSS 1).

Human Resource Barriers

There is a continuing challenge of shortfalls in numbers and distribution of midwives, and a continuing challenge of mal-distributions of staff between urban and rural areas. Levels of competency of rural health staff (especially primary midwives) are a concern, and there is a need for a more multi skilled cadre of health staff. (HSP 2). There are large imbalances in remuneration between public and private sectors, and there is unclear documentation of the numbers of health staff working in the private sector. Experiences from the studies of contracting demonstrate that results can improve strongly once a constructive approach to remuneration of health staff is found and implemented (HSP 2).

Unresolved issues related to human resources in Cambodia include staff motivation, quality of performance, productivity and distribution by geographical area. Persistent low wages have continuously undermined all efforts to improve human resources management and performance in the public sector. Since 1996, there has been a 10% decrease in the number of midwives and 5% decrease in the Ministry of Health (MOH) workforce. In 2005, it was estimated that 78% of health centres had staff with updated midwifery skills (Child Survival Strategy 2007). There are 146 health centers that do not have a midwife and 532 health centers that do not have the benefit of the services of a secondary midwife.(JAPR 2007) It is therefore critical to provide human resource to

these health centers to ensure that quality MCH services could be available to women in these localities (JICA Draft Report Strengthening MCH Service performance in Cambodia).

The HSS 1 Rapid Assessment has indicated that in some areas absence of a midwife is still a major barrier to access. A recent Midwifery Review has indicated that 51% of health centres remain without a secondary midwife and current competency levels are below 70% for all competencies observed.

3.3: Barriers that are being adequately addressed with existing resources

3.3.1 Background

Health system reconstruction accelerated in the late 1990s following a process of health sector reform that developed a network of national institutions, Provincial Health Departments (24), operational health districts (77) and primary care health centres (977). Despite this, the system is still in the early stages of reconstruction. This is compounded by the comparatively low level of social and economic development. Given the level of social and economic development and the recent history of health sector reconstruction, it cannot be said that there are any barriers that are being adequately addressed with existing resources. What can be observed however is the recent progress Cambodia has made in addressing some of these barriers which are outlined below.

3.3.2 Physical infrastructure Barriers

28 referral hospitals are now offering higher levels of medical and surgical care according to a specific health system classification and 32 of the 77 OD hospitals now have blood banks. (JAPR 2005) Numbers of Hospitals with Complementary Package of Service Capability Level 2 is 27 in 2006, and the number with level 3 status (specialization) is 17 in 2006 (Joint Monitoring Indicators of the Technical Working Group for Health 2006).

439 Health Centers now are providing full "minimum package of activity" (MPA) , up from 294 in 2004. Stock-outs of essential drugs at health centres have fallen to 3.51% and 943 health centers out of a total of 966 (in the health coverage plan) now are equipped with refrigerators (JAPR 2005). Although it is still the case that there are districts without adequate physical infrastructure (See Annex 8 Rapid Assessment Case Study from Kroch Chmar), it remains the case that Cambodia has made significant steps since the introduction of the health coverage plan in 1996 in extending the reach of facilities across the country.

3.3.3 Health Planning Systems and Health Sector Reform

The MOH developed a new planning system in 2002 and drafted the National Health Sector Strategic Plan. Under the new planning system, health systems at all levels, including national health programs, share common strategic areas, planning formats, and planning tools and follow the same annual and three-year planning cycle. An important feature of the new planning system is that objective setting and activity development are undertaken prior to budgeting, to ensure that there is a match between identified activities and resources required to implement them. Although it remains the case that planning capacity is limited at district and health centre level, it is nonetheless a significant achievement to introduce an integrated planning system encompassing all management and delivery levels into a single comprehensive framework.[27]

3.3.4 Health Financing and Financial Management

The absolute level of financing in the health system is probably adequate to meet population health needs (37$ per capita). The problem is that the majority of spending is in the private sector (68%) through out of pocket expenditures, and that much of this private sector care is of doubtful quality. The Government budget has increased with strategic targets, with allocations based on need and the poorer populations receiving higher per capita allocations. Yet a relatively low share is reaching the facilities due to financial management constraints (page 13 HSP 2). The interim evaluation of HSS 1 in Cambodia has indicated there is improved financial flow associated with internal

[27] MOH Planning Manual 2002 MOH Phnom Penh

contracting mechanisms. However, the same evaluation indicated that further investment is required in financial management capacity building for district accountants and health centre managers. In recent years, the introduction of health equity funds for insurance cover for poor populations has ready to a steady rise in hospital utilization.

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

3.4.1 Service Accessibility Barriers (Demand and Supply Side)

The Health Sector Review, HSP 2 and Demographic Health Survey 2005 are quite clear in articulating the point that the main inequities in health care provision are driven by socio economic factors (income, education level) and regional location. These inequities are specific to immunization coverage, with immunization coverage being associated with education level of the mother and location.

Also the HSP 2 and Health Sector Review describe, although utilization has improved, it has improved from a very low base. Furthermore, the persistently high maternal mortality rates are indicative of fundamental inequities in the health system, along with providing incontestable evidence of low utilization of primary care and referral facilities by women, and a breakdown in the continuum of maternal and child care. This is attributable to a range of factors including knowledge and behaviour of population and providers, and costs and perceived quality of services.

Additionally, the high dependence of immunization services on health outreach strategy to reach targets is indicative of high dependence on less sustainable supply driven program strategies. Supply side factors are also implicated in service accessibility services, particularly in relation to barriers 3.4.2 (Health Management) and 3.4.3 (Health Human Resources), both of which are described in more detail below.

Assistance is required from national and international partnerships in order to address both the demand and supply side factors effecting accessibility of the population to health services, particularly for promoting accessibility to a continuum of MCH care for vulnerable groups in rural areas. Assistance is required for scale up and system integration of immunization initiatives such as the fixed site strategy, coverage improvement planning and public / private sector collaboration for immunization. This will assist with the sustaining and consolidation of immunization strategy development through stimulation of higher levels of supply and demand for an RMCNH package of services as defined by HSP 2.

Findings from the HSS Rapid Assessment have confirmed that specific HR and demand side strategies are required for remote area providers and populations over and above the activities currently undertaken in HSS 1. It is these particular issues of demand and supply side services at the health centre level that will addressed in HSS 2 through internal contracting (linked to needs identified in an annual operational plan), backed up by a demand side strategy for improved access to health services by vulnerable populations

3.4.2 Decentralized Health Management Barriers (Governance)

The fundamental management barriers relate to middle level capacity for coordinated planning, supportive supervision, financial management and management of health financing initiatives. Given the trends to decentralization, public and private collaborations (including with civil society) and performance based management (including "internal contracting"), the pressures on managers to widen their decision making powers will grow. Additionally, although the national immunization program has been successful in raising coverage levels with vertical program and campaign strategies, there is ongoing concern regarding the long term sustainability of these supply side approaches. The emergence of integrated clinical and community management strategy for the sick child (IMCI), the child survival strategy scorecard M & E approach, and MPA and RMCNH "packages of services" in HSP 2, all point to the need for enhanced service delivery accessibility through more coordinated management, planning, evaluation and delivery systems.

Significant levels of management support and systems developments are required for this more decentralized and coordinated health management era. This will require national and international partnerships in order to reform and consolidate health planning, financial management, health financing and human resource management systems (including "internal contracting" model of GAVI HSS 1 and HSP 2). This has been confirmed by the HSS Rapid Assessment, which has again identified the constraints of limited planning and financial management capacity at District level and below in terms of overall management performance.

3.4.3 Human Resource Barriers (Numbers, Skill, Motivation)

Numbers, competency and motivations of health staff are consistently mentioned by health system assessments as being critical to securing equity of access of the population to a continuum of reproductive, maternal and child health care services (RMCNH). Additionally, recent social developments including the growth of the private sector, urbanization and decentralization are all influencing a changing picture for health human resources management. HSP 2 takes this into account by prioritizing skill development, public private collaborations and enhanced remuneration of health staff as priority human resource investments for enhancing equity of access.

Internal contracting has been prioritized in HSP 2 as a primary management strategy for health sector development. GAVI HSS 1 provided impetus for this health strategic direction through design and implementation of health system internal contracts in 10 operational districts in 2007. Internal contracting incorporates enhanced remuneration and improved decentralized management of human resources. More assistance is required by the MOH GAVI HSS program to consolidate the internal contracting system between 2008 and 2010 (in partnership with AusAID – UNFPA), prior to scale up with the MOH and other development partners from 2010.

In tandem with the extension of internal contracting, more assistance is required from GAVI to consolidate the gains of IMCI, reproductive health and child survival strategy development and implementation in support of the overall HSP 2 direction of the extension of the continuum of RMCNH care to the less accessible populations of rural Cambodia.

Although the HSS Rapid Assessment has confirmed that decentralized financial management and internal contracting has reportedly raised health workforce motivation, this is not yet the case for health staff in the more remote locations in health centre catchments where consultation rates are lower and distances are greater. Flaws and limitations in contract formulation in HSS 1 (specifically sole emphasis on a fee for service model) has meant that remote health staff and populations are not equitably compensated for the higher implementation costs of remote area access. In HSS 2, this gap in contracts management and design will be addressed by a mid 2008 contracts amendment, which is likely to focus on a concept of base payment and coverage bonus, or a weighted fee for service for remote area work (see Annex 8 for details of limitations of contractual model and recommendations for amendments).

3.4.4 Summary - Prioritization of Health System Barriers

Three main barriers have been prioritized for the HSS program. These are:

1. Inequities in service coverage relating to supply and demand side factors,
2. Fragmented project or program based health management systems and
3. Limitations in human resource quality, distribution and motivation.

These barriers have been prioritized according to the following criteria: *Firstly,* the barriers have significant gaps in coverage and investment, as demonstrated by inequities in health program coverage and human resource distribution across the country.[28] *Secondly,* addressing these barriers can be overcome by proven and affordable health system interventions that directly

[28] The Demographic Health Survey Cambodia 2005 provides the clearest evidence of the social and economic determinants of health service access. http://www.measuredhs.com/pubs/pub_details.cfm?ID=624&srchTp=

address these barriers – such as health contracting, supportive supervision, integrated planning and quality improvement through human resource capacity building. *Thirdly*, these barriers are prioritized in the Health Sector Plan 2 (HSP 2) 2008 – 2015, particularly in reference to the governance strategy, key program areas (RMCNH), the sector wide approach, and the identification of "internal contracting" as a preferred strategy for increasing health workforce motivation and performance. *Fourthly*, the removal of these barriers has the potential to deliver the highest impact on immunization and RMCNH coverage and quality, by directly addressing major constraints – namely, an underpaid workforce, fragmented management and service delivery, and inequitable demand and access to services by socially and economically marginalized sub population groups.[29]

This prioritization of barriers assisted in the prioritization of district selection. Factors affecting district selection included the following:

- Absence of significant levels of external support
- Lower immunization coverage and delivery by trained staff
- Presence of an Equity Fund at District level in order to support a continuity of RMCNH care from primary to secondary level
- Presence of Global Fund HSS support at provincial level in order to support complementarities in approach

The Internal Contracts System has been developed for 10 provinces, 10 operational districts (10/76) and 140 health centres.[30]

[29] Specifically, lower income quintiles, families with lower educational status, remote area populations.
[30] See Annex 8 List of ODs and criteria for selection

Section 4: Goals and Objectives of GAVI HSS Support

To the applicant

- *Please describe the goals of GAVI HSS support below (Table 4.1).*
- *Please describe (and number) the objectives of GAVI HSS support (Table 4.2). Please ensure that the chosen objectives are specific, measurable, achievable, realistic and time-bound.*

4.1: Goals of GAVI HSS support

The Goal of HSS 2, is, by 2015, to contribute to reduction of maternal, new born and child morbidity and mortality to MDG Targets through improved decentralized health systems and human resource management, and enhanced access by the population for a continuum of RMCNH Care (including immunization).

This goal is aligned to two of the three program areas of HSP 2 (MCH, CDC) and cross cutting system strategies health service delivery, health care financing, human resources, health information systems and health governance.

4.2: Objectives of GAVI HSS Support

The HSS program proposes three objectives in order to achieve the above stated goal:

Objective 1: SERVICE DELIVERY STRENGTHENING (COVERAGE) By 2015 in 100% of HSS Targeted Districts, the coverage of RMCNH care at health facilities and in the community will reach National MDG Targets, as a result of service priorities and demand side strategies identified and implemented through the Operational District Annual Operational Plans (OP) and contracts.

Objective 2: DEVELOPING MANAGEMENT SYSTEMS By 2015, 100% of HSS targeted ODS will implement co-financed and co-ordinated OD service management contracts according to national planning, management, health financing and financial management policy and standards.

Objective 3: QUALITY IMPROVEMENT & HUMAN RESOURCE CAPACITY BUILDING By 2015, 100% of HSS Targeted ODs will meet MPA policy & standards through implementation of MPA capacity building and supportive supervision programs (IMCI, Child Survival NIP, RH, systems training)

The three objectives directly address the three previously identified health system gaps impeding sustained progress in immunization coverage and maternal and child health improvement, namely:

(1) Reduced accessibility of sub populations to basic health services (related to supply and demand side factors)
(2) Limited capacity for decentralized health management in a health system that is gradually decentralizing and diversifying (planning, financing, financial management, private sector development and widening of health partner support) and
(3) Limitations in human resource competencies and motivation, which affects the quality and distribution of the health workforce in less accessible areas.

Section 5: GAVI HSS Activities and Implementation Schedule

Structure of Design

The structure of the design (identified gaps, objectives and activities) are aligned according to the framework below.

Main health outcomes will be generated through improved service delivery coverage enhanced by internal contracting and strengthened annual planning processes (objective 1), reinforced by health systems development initiatives (objective 2) and capacity building programs (objective 3).

GAPS		OBJECTIVES		ACTIVITIES
SERVICE GAPS	⇨	SERVICE DELIVERY COVERAGE OBJECTIVES (RMCNH)	⇨	*Implementation of performance based internal contracting systems for RMCNH * based on Annual Operational Plan & application of demand side strategies*
MANAGEMENT GAPS	⇨	SYSTEM OBJECTIVES	⇨	*Strengthening District Planning Systems* *Financial Management Systems ** *Referral Systems/CPA ** *Data Quality Audit and Maternal Death Audit ** *Linking to Health Finance Schemes* *NGO/Public Private Collaborations*
HR CAPACITY GAPS	⇨	HR CAPACITY OBJECTIVES	⇨	*IMCI, Child Survival, RH, NIP* *EMOC Training ** *Health Management Training* *Supportive Supervision*

* *Support through AusAID UNFPA & MOH*

Overall Strategic Approach to Implementation

The central strategy of the HSS program is the internal contracting model initiated in HSS 1 that acts as a performance based reinforcement for the Annual Operating Planning system (AOP) of the Ministry of Health. The AOP is to be the basis for internal contracting – there will be no separate indicators or reporting. Parallel systems are avoided via reliance on this strengthening of existing AOP implementation processes and structures.

The MOH, through linked support of GAVI HSS and AusAID UNFPA, will support enhancement and implementation of innovative output based block grant system for reproductive, maternal and child health in 10 Operational Districts (GAVI - HSS) (2008 onward). Specific areas for child and reproductive health support will include supporting elements of Annual Operational Plans in GAVI - HSS provinces and operational districts. This support includes:

- PHD/OD outreach and supervision; (GAVI HSS & UNFPA)
- Immunization contacts, ANC and general consultations (GAVI HSS)
- Delivery contacts (Government funded)
- Referral costs, community based distribution of contraceptives, maternal death audits, birth preparedness and maternal waiting homes (UNFPA)

- Capacity building, training and roll-out of new protocols and systems guidelines (all partners)
- Community participation (all partners)

Objective 1: STRENGTHENING MPA SERVICES (SUPPLY & DEMAND) By 2015 in 100% of HSS Targeted Districts, the coverage of RMCNH care at health facilities and in the community will reach National MDG Targets, as a result of service priorities and demand side strategies identified and implemented through the Operational District Annual Operational Plans (AOP) and performance agreements.

This objective focuses on the coordinated and complementary implementation and financing of basic health services (minimum package of activity) through the mechanisms of annual operational planning and internal health contracting. This objective links closely to the service delivery and governance strategies of HSP 2 through an RMCNH and performance based management focus. This objective is complemented by system developments in Objective 2, and capacity building investments under objective 3.

Activity 1.1: SERVICE DELIVERY CONTRACTS Establish and Implement Health Centre Annual Operational Plans & Performance Agreements (using supply and demand side approaches) (MCH)

LINK TO HSP 2: Develop "internal contracting" as the center of a comprehensive approach to HSD contracting (Page 28, Page 59) and Service Delivery Strategy in HSP 2, in particular the RMCNH package of services as outlined on page 42. LINKS TO HSP 2 and CMYP Good Governance Strategy (including Effective Planning Systems and CMYP Coverage Improvement Planning) RESPONSIBILITY: HSS Inter Departmental Monitoring Team. OD and PHD Management Teams, Health centres, DPHI

This is the central activity of the GAVI HSS Program, and incorporates two key components. These are (1) the Annual Operational Planning System (AOP) of the MOH and (2) the performance based contract system. The AOP system of the MOH is the focal point for resource allocation and monitoring and evaluation of all inputs, including those of GAVI HSS. This activity will support co financing of AOPs and Districts by the MOH and a range of partners including GAVI HSS and AusAID-UNFPA for RMCNH services including immunization. Activities are based on needs and are costed, and are inclusive of all service delivery activities within the minimum package of activities as defined by the MOH, as well as of the RMCNH focus of GAVI – AusAID funding. The AOP role and system including planning cycle is described on page 52 of the HSP 2 Final Draft, and the essential reproductive, maternal, newborn and child health package of services on page 40. The GAVI HSS program will assist to co finance the AOPs with the MOH, AusAID - UNFPA and NGOs, as well as strengthen the planning and supportive supervision system as described in Activity 2.2 (Strengthening of District and Health centre Planning Systems).

The AOP will be reinforced by the system of performance based contracts as described in GAVI HSS 1 (see page 19 Annex 7). Please also refer to Annex 8 which provides an English translation of the current contracts in operation. Each Health Center in GAVI HSS supported ODs has been implementing MPA Performance Contracts that are designed to provide strong incentives for increasing coverage of key maternal and child health services, including immunization. The contents of the performance contracts are as follows:

- Objectives
- Roles and Functions of Operational Districts
- Roles and Functions of Health Centres
- Implementation and Monitoring
- Population based targets for 5 priority RMCNH indicators
- Allocation of finance based on MPA, CIP and Fixed site activity

The contents of the HSS 2 internal contract service delivery package of MOH - GAVI HSS and its links to the UNFPA AusAID program are described in the figure on the left. AusAID agrees to partner with UNFPA to link their existing Reproductive and Maternal Child Health Program with the GAVI block grant system to add the reproductive and maternal health elements to the performance grant package, and to finance implementation of an EMONC assessment. The MOH will finance deliveries and general operations through the Annual Operational Plan. The HSS Rapid Assessment provides more details of District financing of basic health services. Service delivery activities and targets will be developed through the Annual Operational Planning process, but with an emphasis on fixed site utilization, MCH continuum of care and other demand side strategies (see activity 1.4 below) [31]

Based on feedback from managers and implementers during consultations for HSS 2, and on a more in depth health system evaluation in May 2008, contracts amendment (identified in the recent HSS Rapid Assessment) are likely to include the following:

- Higher fee for service for remote areas to reflect higher costs of reaching populations
- baseline payments for facilities to ensure start up funding for operations and bonus payments based on reaching coverage targets
- Additional 3-4 indicators will be added to the latter stages of HSS 1 and for HSS 2 to reflect the emphasis on a wider RMCNH package withy technical support through UNFPA. These are (a) Referrals, (b) Post Natal Visits, and (3) Birth Spacing Acceptor.[32]
- Inclusion of a data quality audit system (through collaboration with DPHI) to be managed through Provincial Health Departments in order to verify contractual outcomes.

It is proposed that from 2008 to 2010, GAVI HSS will co finance the MCH package of services in the 10 ODs using the internal contract and AOP system. From 2010, it is proposed that GAVI, along with other development partners, will co finance the comprehensive Provincial and District Block Grants that are likely to encompass the full range of health services. Based on evaluation outcomes of GAVI in 2010, the program will be reviewed and then integrated within the broader Health Sector Support program of the MOH (this is also the intent of the AusAID UNFPA program).

EXPECTED OUTPUTS

- No/% of Health Centres with Performance Based Contracts for RMCNH
- % Staff covered by incentive schemes *(draft National M & E Framework)* *
- No. of Health Sector Plan 2 Policy Package Approved *(draft National M & E Framework)* *
- No/% of Health Centres with Annual Operational Plan

[31] See Annex 8 for details of AOP financing and NGO co financing (by OD)

[32] The original HSS list with additions for HSS 2 is described in the M & E section of this application. Given the decision by AusAID – UNFPA and the MOH to co-financing of a broader package of MCH indicators, an Deliveries are funded through an alternative financing window and system – in HSS 2, it is proposed to research integration of this financial channel into the OD block grants.

Activity 1.2: MANAGEMENT CONTRACTS Establish and Implement Annual Operational Plans & Performance Based Management Agreements for ODS and Provinces (MCH)

LINK TO HSP 2: Develop "internal contracting" as the center of a comprehensive approach to HSD contracting (Page 28, Page 59)

RESPONSIBILITY: Operational Districts and Health Centres, support by Provincial Health Management Teams.

For each of the 10 Operational Districts, Performance Agreements are provided for a team of 5 OD staff, whose responsibilities will include finance and planning through the OD Budget Management Center, as well as integrated monitoring and supervision of MPA implementation by HCs and compliance with MPA Performance Agreements. Each team will include one immunization specialist and one maternal and child health specialist.

At the PHD level, GFATM supported management teams are complemented by inclusion of an additional GAVI HSS supported Performance Agreement for each PHD covering the addition of an immunization specialist to strengthen monitoring and supervision of ODs and HCs in GAVI supported districts. Lessons learned from early implementation indicate the following:

- "Comprehensive" management contracts are required for the PHD and Central level. There should be no "separate Global Fund and GAVI agreements.
- More emphasis should be placed on data quality auditing. There is more risk of data inflation now that the contract scheme is introduced, so this will require more investment by managers in operating health information data quality checks.

In GAVI HSS 2, the contracting system, in line with HSP 2, is likely to move to a system of ""consolidated annual planning, budgeting and funding for public facilities, with quarterly capitation based block grants paid to facilities through ODs and pooling of funds at appropriate level" (HSP 2)

The additional support for MPA contracts through AusAID with technical assistance from UNFPA will allow the widening of the package of services to those proposed in HSP 2 for RMCNH services up to 2010. This will reduce the risk of "selective incentivization" by ensuring adequate financing and technical support for a full range of primary care RMCNH services, including health financing costs for emergency referral to the secondary level of care. HSS 2 performance contracts will therefore be amended to reflect the wider range of investment.

Following evaluation in 2010 and during the mid term review of HSP 2, it is expected that the contracts will be further widened (through MOH, World Bank and other sources) to be inclusive of the full minimum package of services incorporating the three program areas of HSP 2. An evaluation in 2010 - 2011 (in line with mid term review of HSP 2) will then provide the HSS evidence base for transitioning to GAVI co financing of MPA contracts through the Provincial Block Grant System as described in HSP 2.

This activity addresses the HSS program goal and objective by addressing the fundamental gap in human resource management, which is inadequate remuneration and motivation of the rural health workforce. This activity supports development of the HSP 2 Governance Strategy, through strengthening of annual operational planning for MPA at the most peripheral level of the health system, and through the strengthening of the HSP 2 health sector development strategy of "internal contracting", initiated through GAVI support in HSS 1.

EXPECTED OUTPUTS

- No/% of ODs and PHDs with Performance Based Contracts for RMCNH
- No/% of ODs/PHDS with Annual Operational Plan
- No. of Health Sector Plan 2 Policy Package Approved *(draft National M & E Framework)* *

Activity 1.3: COVERAGE IMPROVEMENT PLANNING Integration of Immunization Coverage Improvement Planning into MPA Planning Systems (RMCNH)

LINKS TO HSP 2 and CMYP Good Governance Strategy (including Effective Planning Systems and cMYP Coverage Improvement Planning)

RESPONSIBILITY: HSS Inter Departmental Monitoring Team

In the last 3 years, the NIP has implemented a strategy known as Coverage Improvement Planning (CIP) in order to raise immunization coverage rates in areas of the country with high numbers of un-immunized or low immunization coverage. [33] [34]This strategy is based on the "Reaching Every District" Strategy of WHO. At the end of the third quarter of each year, the NIP management team and GAVI partners identify areas of the country with low immunization coverage. Consultations are also undertaken with NGOs to ensure that there is no overlap of resources and there is consistency in strategy approach and implementation. The CIP strategy and resources are then targeted to the lower performance and under resourced areas.

Key elements of the planning process include mapping of catchment areas, identification of villages with high numbers of un-immunized, identification of problems of non access and the solutions to improving it, and finally the description of activities and costs at village level to reach these populations. One of the limitations of the process is that planning is restricted to immunization. It is logical to assume that if there are large numbers of un-immunized children in these areas, then the same population of women and children are also not likely to be accessing other services in the MPA. This provides the rationale for linking immunization planning closer with health system planning.

In 2008 in the 10 HSS OD, lessons learned from immunization coverage improvement planning will be linked to health systems developments in the area of strengthening of health planning systems for MPA (see Activity 2.2) while at the same time assisting to secure national coverage rates while health system strengthening activities are scaled up.

This activity addresses the HSS program goal and objective by addressing the fundamental gap in supply of services to less accessible populations. It will also support development of the HSP 2 Governance Strategy, through strengthening of annual operational planning for MPA at the most peripheral level of the health system where most of the RMCNH health gains can be made.

OUTPUTS

- Updated Planning Guidelines of Health Centres based on integrated micro-planning
- No. of Health Sector Plan 2 Policy Package Approved *(draft National M & E Framework)* *

Activity 1.4: DEMAND SIDE STRATEGY Implement, Evaluate and Scale Up Fixed Site Strategy (RMCNH) (supported by NIP in collaboration with National MCH centre and DPHI)

LINKS TO HSP 2: Emphasis in HSP 2 of continuum of Reproductive Maternal Neo Natal and Child Health (RMCNH) care and on demand side strategy

RESPONSIBILITY: HSS Inter Departmental Monitoring Team

The aim of this strategy is to improve immunization coverage through increased health centre utilization. There are 13,000 villages in Cambodia, and each village is visited monthly by a mobile health worker in order to maintain coverage rates. This comes at a cost to the program in terms of transport, reduced staff at health centres in opening hours and a higher vaccine wastage rate. The fixed facility strategy responds to some of these problems by attracting the population to use immunization services at the facility, instead of waiting in the village for the service to come to them. The communication interventions are simple and effective, and involve application of such strategies as a monthly meeting at the health centre between Village Health Support Group, health

[33] GAVI Evaluation of ISS Phase 1 case Study Cambodia
[34] NIP / MOH Guidelines for Fixed Site, Guidelines for Coverage Improvement Planning

staff and village chiefs, closure of outreach within accessible areas and the sending of an invitation slip from local authorities to the mothers who fail to come to the health centre.

A trial of 100 health centres across Cambodia in 2006 has demonstrated that immunization coverage can be maintained and even improved, while at the same time also achieving improvements in other indicators such as reduced vaccine wastage, increased consultation rates for MCH services and increased user fees. Health workers report that the advantages of this strategy include the ability to provide a wider range of services, 7 days opening for immunization and savings in both human and financial resources due to reduced dependence on outreach.

This strategy has the potential for wider strengthening of the health system, through closer integration of immunization with other health services at the health centre. The transition from "immunization fixed site" to "MPA fixed site" will require a consolidation of the trial in 2007. Joint monitoring of the strategy between the Planning Department and the NIP will assist this transition, and enable lessons learned on this strategy to be a vital input to policy developments on MPA and for the health sector review and planning development in 2007.

Main activities in 2008 to 2010 will be to strengthen the fixed site in the 10 HSS through targeted support for demand side strategy and review of guidelines for strengthening health facility utilization for MPA. This activity addresses the HSS program goal and objective by addressing the fundamental gap in demand for fixed facility utilization identified in HSP 2, and through improved access to a continuum of care for RMCNH services at facilities. In order to reduce the risk that populations that are less accessible may be disadvantaged by this strategy, the fixed site strategy will be implemented within the context of the wider AOP to ensure there is adequate outreach to more difficult to access communities.

OUTPUTS

- No. of Health Sector Plan 2 Policy Package Approved *(draft National M & E Framework)* *
- Increased utilization of the fixed facility for consultations and immunization

Objective 2: DEVELOPING MPA MANAGEMENT SYSTEMS By 2015, 100% of HSS targeted ODS will implement co-financed and co-ordinated OD service management contracts according to national planning, management, health financing and financial management policy and standards.

This objective has a focus on systems development, and links closely with service implementation through AOPs and Internal Contracts as expressed in activities under Objective 1.

Activity 2.1: FINANCIAL MANAGEMENT SYSTEMS Develop MPA Financial Management Systems & health financing guidelines

LINK TO HSP 2 Increase government budget and improve efficiency of government resource allocation for health Page 29, Health Sector Governance Strategy, Policy Statement 4 "Implement pro-poor health financing systems in combination with other forms of social assistance mechanisms to promote equitable access to priority services, especially by the poor and by those who need them most" Page 15

RESPONSIBILITY: Dept. Budget & Finance and DPHI

In line with overall strategic direction of the Royal Government of Cambodia towards decentralization and de-concentration, and the HSP 2 governance strategy, the GAVI HSS 1 program, through the Department of Budget and Financing, has designed financial management guidelines for district level and below (see Annex 9). The GAVI HSS current operational manual will be an important starting point for developing the manual for the provincial grants but additional or adjusted features may be needed when the HSS is expanded to the Provincial Block Grants.

Staff at provincial level has been trained in use of the guidelines by the Dept. Budget and Financing in the 10 HSS Operational Districts. "The Operational Manual will be reviewed and updated to harmonize with Operational Manual for the proposed Provincial Block Grants under the

HSSP2 once it will become available to ensure consistency of financial management, performance management, monitoring and other operational arrangements.

This activity will closely link to initiatives in health financing through MOH – AusAID UNFPA. As outlined earlier, one third of the Cambodian population does not have the capacity to pay for health services. This complementary investment will address the demand side barrier at the primary level of care through community based insurance, and through the secondary level of care through the now increasingly established and efficacious hospital equity funds. In the absence of such initiatives, a continuum of RMCNH care cannot be guaranteed for the least accessible populations in Cambodia due to the financial barrier of fee for service and travel and accommodation costs. These two activities (financial management and health financing) address a fundamental health system gap in aid and management effectiveness. Firstly, it will assist the program to achieve the HSS objective and goal by enhancing resource allocation and flow to the peripheral level, and secondly, will stimulate improved access to fixed facility care for a continuum of RMCNH care through reduction of financial barriers for the poorest members of the Cambodian population. In the absence of successful implementation of these two initiatives in the coming HSP 2 planning cycle, sustainable gains in immunization and related RMCNH services are highly unlikely.

OUTPUTS

- % of approved budget reaching health facilities *(draft National M & E Framework)* *
- Government health expenditure per capita *(draft National M & E Framework)* *
- Developed and implemented financial management guidelines for HSS internal contracting (completed)
- No. of Health Sector Plan 2 Policy Package Approved *(draft National M & E Framework)* *

Activity 2.2: HEALTH PLANNING SYSTEMS Strengthen OD and Health Centre Planning Systems

LINK TO HSP 2 Links to Governance Strategy and Decentralization and De-concentration Strategy of RGC, also refer to Ch 6 Implementation and Monitoring, which provides an overview of the AOP process.

RESPONSIBILITY: DPHI, Department of Prevention

Since 2002, the MOH, through the Dept. Health Planning and Information, has developed comprehensive annual operational guidelines for each level of the health system in Cambodia. Up to this time, although there have been improvements to planning systems at central, provincial and to a lesser extent District level, the service delivery level at the health centre has received less attention and guidance on health planning.

The National Immunization Program, through campaign strategy, coverage improvement planning and the fixed facility strategy, has developed planning techniques that have proved to be successful in reaching down to the village level with high coverage rates, as well as demonstrating some success with facilitating higher utilization of health centres.

Based on some of the lessons learned from immunization, more detailed planning guidelines will be developed for health centre level. Guidance will be provided on mapping of missed populations, the design of activities to reach these populations, incorporation of strategies for facilitating fixed facility utilization and the social mobilization investments needed to promote the utilization of services for a continuum of MCH care.

The Department of Prevention will also collaborate with DPHI to implement new guidelines for MPA services (currently drafted). Guidelines will clarify management structures, the role of annual operational plans, package of services to be delivered based on HSP 2, health information

HSSP2 once it will become available to ensure consistency of financial management, performance management, monitoring and other operational arrangements.

This activity will closely link to initiatives in health financing through MOH – AusAID UNFPA. As outlined earlier, one third of the Cambodian population does not have the capacity to pay for health services. This complementary investment will address the demand side barrier at the primary level of care through community based insurance, and through the secondary level of care through the now increasingly established and efficacious hospital equity funds. In the absence of such initiatives, a continuum of RMCNH care cannot be guaranteed for the least accessible populations in Cambodia due to the financial barrier of fee for service and travel and accommodation costs. These two activities (financial management and health financing) address a fundamental health system gap in aid and management effectiveness. Firstly, it will assist the program to achieve the HSS objective and goal by enhancing resource allocation and flow to the peripheral level, and secondly, will stimulate improved access to fixed facility care for a continuum of RMCNH care through reduction of financial barriers for the poorest members of the Cambodian population. In the absence of successful implementation of these two initiatives in the coming HSP 2 planning cycle, sustainable gains in immunization and related RMCNH services are highly unlikely.

OUTPUTS

- % of approved budget reaching health facilities *(draft National M & E Framework)* *
- Government health expenditure per capita *(draft National M & E Framework)* *
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The Department of Prevention will also collaborate with DPHI to implement new guidelines for MPA services (currently drafted). Guidelines will clarify management structures, the role of annual operational plans, package of services to be delivered based on HSP 2, health information

reporting, the role of the community (Village Health Support Groups), outreach services, fixed facility approach, and health financing guidelines (user fees and CBHI). Priority activities will be:[35]

- Assessment of current implementation of MPA at Health Centers;
- Review of existing Health Outreach guidelines and their impact at facilities level, consolidation of Health Outreach into general MPA guidelines;
- Integration of MPA guidelines dissemination into health management capacity building program for OD and health centre managers (link to Objective 3)

These system developments will assist to achieve the program goal of improved MCH coverage and reduced mortality, through identification of missed or inaccessible populations, and the refinement of guidelines and management and planning strategies for increasing utilization of health facilities and programs by these populations.

Activity 2.3: INTER DEPARTMENTAL MONITORING Strengthening of integrated supportive supervision programs from central to PHD, and OD to HC level

LINKS TO HSP 2 and CMYP Good Governance Strategy

RESPONSIBILITY: Interdepartmental Monitoring Team, PHD Management Team
One of the main barriers to effective public health management, as has been reinforced by the recent HSS 1 Rapid Appraisal, is the fragmentation of management by various monitoring funding sources from bilateral and global health initiative sources. As a part of HSS 1, it was proposed that a multi departmental monitoring team be established in order to oversee system development and monitor contract implementation. Experience from HSS 1 is demonstrating that it takes time from moving from a "project" or "program orientation" towards a coordinated "system approach" to health system monitoring. To date, participation in the monitoring team has come from NIP, DPHI, Dept. Budget and Finance and the office of HSSP but not yet from MCH or CDC Departments.

Between 2008 and 2010, in line with HSP 2, it is proposed that quarterly multi departmental monitoring team visits be conducted to the 10 HSS ODs, in order to identify strengths and weaknesses of the program, and make recommendations for problem solving implementation and contract amendments. Main technical issues will then be discussed in the HSS working group and then referred for decision making to the HSS Management Team (chaired by Secretary of State).

At the Provincial level, a similar process will be facilitated through national leadership and adequate financing of inter program monitoring by the PHD management team.

One of the main bottlenecks to coordinated management is project financing of management initiatives. In 2008 and 2009, in line with the trend to sector wide approach, strategies will be developed to pool project financing for health management activities in order to reduce inefficiencies of duplication of funding and to minimize the risk of fragmentation of management along project lines.

Activity 2:4: OPERATIONS RESEARCH Development and Implementation of Health System Operational Research Programs

LINKS TO HSP 2 and CMYP Good Governance Strategy

RESPONSIBILITY: HSS Working Group, MOH, National Institute of Public Health, GAVI Partners

Please refer to section 6 for details of operational research programs.

[35] These activities were intended to be implemented in the first quarter of HSS 1, but have not as yet been implemented due to DPHI focus on development of HSP 2.

Objective 3: SERVICE QUALITY & HUMAN RESOURCE CAPACITY By 2015, 100% of HSS Targeted ODs will meet MPA policy & standards through implementation of MPA capacity building and supportive supervision programs (IMCI, Child Survival NIP, RH, systems training)

Activity 3.1: SYSTEMS CAPACITY BUILDING Conduct capacity building programs for Middle Level Management (Planning & Financial management & Supportive Supervision)

The objective of this activity is to improve the quality of planning, financial and management systems at health centre and OD level. The lead activity for the HSS program and management systems development will be *health planning*. District and health centre plans will serve as the focal point for input of GAVI resources through the annual operational plans of operational districts and health centres.

The approach will be to adopt an integrated approach to health management systems – that is, health systems development, and monitoring programs will be implemented together within a package of health management support for MPA services.

The first area of activity will include strengthening of *financial management and annual planning process implementation* and will include:

- Develop Financial Management Manual for OD / HC (completed in 2007)
- Revise and simplify OD and HC Planning Manual reference to program based budgeting and use of health information at the HC and OD
- Technical support and Monitoring the implementation of financial management tool and revised planning manual of OD and HC and planning implementation (currently underway)
- Strengthen OD capacity in quarterly and annual review and plan preparation (currently underway)
- OD planning team in appraisal AOP and consolidation plan

A health management training module will be developed in mid 2008 incorporating planning, financial management and MPA guidelines. The focus will be on District and Health Center level planning, health information systems and financial management. This will consist of 5-day Workshops for management staff from each facility and District. The training will be based upon updated and simplified manuals for planning, health information systems and financial management, which are to be completed during the third Quarter of HSS1, and will be implemented in the first year of HSS 2 in the 10 HSS ODs.

EXPECTED OUTPUTS

- Management & Training Modules developed for Health centre and OD MPA Management
- Numbers of Managers trained in MPA Management
- %/No of facilities with MPA standards

Activity 3.2: CHILD SURVIVAL MONITORING Strengthen systems for child survival scorecard monitoring

The recent development of a child survival strategy in Cambodia provides the opportunity for sustaining immunization gains through integration with a wider package of RMCNH services. The identification of a set of "child survival scorecard indicators" positions 2 immunization indicators within a wider group of 11 RMCNH interventions that includes micronutrient supply, delivery by trained staff and promotion of breast feeding. This strategy is being technically advised by a Child Survival Management Committee, consisting of key stakeholders in child survival strategy implementation.

This strategy builds on the program to expand the IMCI strategy to the 960 health centres of Cambodia. Currently 322 health centres out of 960 have an IMCI trained staff member. MPA services are now provided at 429 health centers. The expansion of the IMCI strategy and support for child survival scorecard monitoring is crucial to upgrading the quality of services at health centres and in the community. The sustaining of facility based immunization services is dependent upon improvements to facility based quality of care, such as IMCI treatment capacity of health workers, 24 hours opening, and availability of lighting and transport at the facility.

This activity will support the implementation of the child survival strategy through establishment of a Provincial Health Committee for scorecard monitoring, through co monitoring with the HSS inter departmental monitoring team, and inclusion of scorecard monitoring within the annual operational planning processes of the 10 ODs.

EXPECTED OUTCOMES AND OUTPUTS

- Improved coverage of child survival scorecard interventions and outcomes
- Establishment of Provincial Child Survival Management Committee
- HSS Interdepartmental Monitoring with membership of the Child Survival Management Committee

Activity 3.3: IMCI Conduct capacity Building & supportive supervision programs for IMCI and immunization and MCH

It is proposed to extend the IMCI strategy to the 960 health centres of Cambodia. Currently * health centres out of 960 have an IMCI trained staff member. MPA services are now provided at 429 health centers. The expansion of the IMCI strategy and support for child survival scorecard monitoring is crucial to upgrading the quality of services at health centres and in the community.[36] The sustaining of facility based immunization services is dependent upon improvements to facility based quality of care, such as IMCI treatment capacity of health workers and 24 hours opening.

Immunization training is also a critical component to improve quality of services at the health centre. The HSS program proposes to link immunization training more closely with IMCI capacity building and implementation, in order to promote rates of opportunistic immunization at the health centre (during sick child or well child checks) and to promote closer linkages of immunization and IMCI capacity building programs.

In 2007 5 of the 10 HSS ODs have undertaken the IMCI training as part of the HSS 1 program. In the remaining 5 OD, orientation programs have commenced, with co financing through ADB. It is proposed that in HSS 2, this program will be extended to the other 5 HSS ODS, and will comprise the following activities:

- Clinical Training in IMCI for health centre staff
- Facilitators Training IMCI for OD staff
- Follow up Training/IMCI Monitoring for OD staff
- Community Training IMCI
- Immunization Training (vaccine management, immunization in practice)

EXPECTED OUTPUTS

- Increased Numbers of health staff trained in IMCI
- Increased numbers of staff trained in immunization in practice
- All health centres in 10 ODs have an IMCI trained staff member.
- Increase in consultations for children under 5 years *(draft National M & E Framework)* *

[36] Child Survival Strategy MOH 2006 & Joint Annual Performance Review MOH 2006

Activity 3.4: RMNCH Reproductive Maternal Neo Natal and Child Health (RMCNH) Training and Quality Improvement [37]

This activity is being supported in the 10 ODs through AusAID with the technical assistance of UNFPA, using the same performance contract, financial management, HIS and AOP systems as GAVI HSS.

Key Activities to be supported by AusAID in 2008 are as follows:

Comprehensive Emergency Obstetric and Neonatal Care Assessment (2008-2009): This assessment will provide critical information on availability, utilization and quality of Emergency Obstetric and Neonatal Care services (EmONC), and provide recommendations for further improvement of EmONC in the country. (The corresponding EmONC improvement plan will be developed and implemented 2009 onwards.)

AusAID UNFPA will support enhancement and implementation of innovative output based block grant system for reproductive, maternal and child health in 10 Operational Districts (GAVI - HSS) (2008 onward). Specific areas for reproductive health support will include supporting elements of Annual Operational Plans in GAVI - HSS provinces and operational districts.

This support includes:

- PHD/OD outreach and supervision;
- referral costs;
- community based distribution of contraceptives;
- maternal death audits;
- capacity building, training and roll-out of new protocols and contraceptive methods;
- birth preparedness and maternal waiting homes (in remote locations.)

EXPECTED OUTPUTS

- Strengthened capacity of government institutions to provide high quality reproductive health services.
- Increased access to high quality, comprehensive, client – oriented and gender sensitive reproductive health information and services for rural poor and vulnerable groups.

Activity 3.5 PUBLIC PRIVATE SECTOR COLLABORATION Implement, Evaluate and Scale Up Public / Private Collaboration (immunization with potential integration with MCH)

LINKS TO HSP 2 Governance Strategy "Public Private Collaborations" *(Supported by NIP)*

A recent survey has indicated that of 123 private health facilities of Cambodia, over 80 were providing immunization services.[38] It was also found that the services were of dubious quality with some questionable immunization practices relating to cold chain management, vaccine schedule and waste management. In response, the NIP has developed a private public collaboration policy and system. There is also a strong focus in HSP 2 on strengthening of public private collaborations.

Financing of this strategy through HSS and other sources will be allocated to monitoring and supervision and operational research in order to problem solve aspects of the private collaboration as well as identifying opportunities of broadening the collaboration to encompass maternal and child health programming in the private sector.

[37] Information sourced from UNFPA proposal to AusAID

[38] Research Study on Immunization Private Sector Practice NIP PATH Cambodia 2006. See also Policy on Private Public Collaborations for Immunization MOH Phnom Penh 2006

For full clarification of public/private collaboration, please refer to the broader policy intent expressed in HSP 2 (Page 16 Policy 13 "Promote effective public and private partnerships in service provision based on policy, regulation and legislations.")

EXPECTED OUTPUT

- Immunization numbers reported by private sector to public sector
- No. of private facilities accredited by MOH to provide immunization
- No. of Health Sector Plan 2 Policy Package Approved *(draft National M & E Framework)* *

To the applicant

- *Please identify below how you intend to sustain, both technically and financially, the impact achieved with GAVI HSS support (5.1) when GAVI HSS resources are no longer available.*

5.1: Sustainability of GAVI HSS support

5.1.1 POLICY SUSTAINABILITY To some extent, GAVI HSS has already achieved a major sustainability objective through inclusion of the model of "internal contracting" as the primary health sector development contracting approach for 2008 – 2015, as stated in HSP 2 policy and strategy.

5.1.2 DEVELOPMENT PARTNER COORDINATION The commitment of AusAID to link with GAVI HSS for at least a two year period increases the likelihood that the GAVI investment will be sustained over a longer period through co financing from AusAID and other bilateral and multilateral donors. The role of GFTAM in co financing with GAVI monitoring systems at provincial level is also an important expression of sustaining the GAVI investment through co financing. Please refer to page 27 of Cambodia GAVI HSS 1 which outlines the mechanisms by which the Global Fund collaborates with GAVI investment in Cambodia.

5.1.3 ALIGNMENT STRATEGY The role of GAVI HSS in supporting core features of HSP 2 (namely, contracting, MPA systems development and MPA capacity building) ensures that there will be a high level of complementarity to the GAVI Investment. The Health Sector Support Programme 2 (HSSP 2), estimated to be valued at $100 M, commencing from late 2009, will also adopt an internal contracting model, based on a likely system of quarterly Provincial and District "Block Grants" (as also expressed in HSP 2). The GAVI HSS program has provided some impetus for this strategic direction through implementation of internal contracting in 10 districts in 2007. This means that absorption of the GAVI HSS program into the sector wide strategy from 2010 (including the Provincial Block Grant System) will be facilitated in turn by the World Bank and other partners investment. The HSP 2 proposes that Global Health Initiative investments be integrated "into existing processes of co-operation in Cambodia to reduce transaction costs and avoid distortion of program priorities" (Page 35). This alignment of GAVI HSS with broader sector strategy will minimize the risk that it will become an isolated "project"" investment The likely transition to a sector wide approach strategy from 2010, as facilitated through the above mentioned Health Sector Support Program (World Bank, AusAID, DFID, ADF), will mean that the GAVI HSS program from that point on will be embedded within a common strategy, M & E framework and financial management systems along with other international investors including possibly the Global Fund. This trend will also be assisted by the fact that Cambodia has been selected as one of the 12 priority countries for the new International Health Partnership. In the transition process to HSSP 2 (2009 – 2010) both ADF in Takeo Province and AusAID in GAVI HSS ODs have expressed the intent to fully align with MOH contractual and financial management processes.

5.1.4 CIVIL SOCIETY PARTICIPATION Civil society is highly active in the health sector Cambodia. Previously, the Government, through the World Bank and other partners, has directly contracted health services to NGOs. As the health system has developed and decentralized, the Royal Government of Cambodia, through HSP 2, has made the strategic decision to transition from management by NGOs to contracted management by government employees through Provincial, District and Health Centre Health management structures. Clearly, this is more sustainable in the longer term, given the heavy dependence by NGOs on international financing and technical advisors. On the other hand, national NGOs such as RHAC, RACHA and MEDICAM have emerged, and there is now an opportunity for both national and international NGOs to transition their role from management to technical support. Given that internal contracting is new, this transition in role may take time. However, the transition is likely to assist and sustain this health system development through Health NGO functions such as co financing, technical support for decentralized health governance, quality assessment, health care financing, health systems

research, assessment of demand side feedback mechanisms, private sector collaborations, and social mobilization. In GAVI HSS 2, there will be opportunities to explore the potential role of NGOs in being potential co signatories of contracts, as well as through integrating the above mentioned activities and financing within the AOP of the District.

5.1.5 DEMAND SIDE SUSTAINABILITY The service delivery strategy of HSP 2 and GAVI HSS has inbuilt sustainability features, due to the focus on (a) a continuum of MCH care (b) removal of demand side barriers through health financing schemes and social mobilization techniques (c) extension of public private collaborations. Please refer to Page 28 of GAVI Cambodia HSS 1 which provides an outline of the role of equity funds in particular in relation to poverty alleviation and health system strengthening. The HSP 2 also articulates the role of health financing in poverty alleviation. Also please refer to the HSP introduction on the role of the private sector in Cambodia. This clearly illustrates that the private sector is the primary source for health consultations in Cambodia, and that no health public health strategy can be sustained without some level of collaboration with this sector.

5.1.6 GOVERNMENT FINANCIAL SUSTAINABILITY (a) HSP 2 points out that Government financing of health systems has increased in recent years, and that trends in the direction of decentralization will strengthen the pro poor direction of health financing, including allocation of government budget to support equity funds. (b) Additionally, the government decree in 2007 to finance midwife supported deliveries to the value of $15 US per delivery highlights the political and financial commitment of government to strengthening health services for women and children. (c) The Annual Operational Plan of the Ministry of Health for 2008 indicates that there has been a 31% increase in the total health budget request for 2008 when compared to 2007 ($137,005,850 in 2008 compared to $104,841, 076 for 2007). (d) For the first time in 2007, the Royal Government of Cambodia funded traditional vaccine supply to the value of over $947,434 without development partner support. (e) In 2008, following support from the Ministry of Health, the Ministry of Economy and finance reintroduced health outreach program funding after a break of two years (value $1.1 M). There has been a 4.6% reduction in planned development partner funding for the year 2008 when compared to 2007.(f) Analysis of the AOP of the 10 HSS districts indicates that there are high levels of co financing by Government and in some cases by NGOS, once again minimizing the risk of GAVI HSS becoming an isolated investment (see HSS Rapid Assessment for analysis of OD HSS finances). (g) The HSS budget will be scaled down gradually from 2010 (see section 8). This will enable time to phase in financing from Government and other development partners through the Provincial Block Grant System.

5.1.7 SUSTAINING OF BASIC HEALTH SERVICES THROUGH HEALTH SYSTEMS DEVELOPMENT Evidence from the HSS Rapid Assessment and JICA study (see Annex 8) indicates that the HSS strategy has developed, through internal contracting and financial management guidelines, a process whereby a significant health system barrier can be overcome. The design and operation of a system for timely financing of basic health operations increases the potential for sustaining the gains of health investments.

5.2: Major Activities and Implementation Schedule

Major Activities	2007 (GAVI 1)				2008 (GAVI 2 Q3)				2009				2010				2011 - 2015
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	2011 - 2015
HSS GOAL: The Goal of HSS 2, is, by 2015, to contribute to reduction of maternal, new born and child morbidity and mortality to MDG Targets through improved decentralized health systems and human resource management, and enhanced access by the population for a continuum of MCH Care (including immunization).																	
MOH GAVI HSS INCEPTION AND INTRODUCTION OF INTERNAL CONTRACTING	XXXX				XXXXXXX												
CONSOLIDATION PHASE OF HSP 2 INCLUDING GAVI AUSAID – UNFPA AND NGO CO FINANCING OF MPA CONTRACTS					XXXX				XXXXXXXXXXX				XXXXXXXXXXX				
SCALE UP OF INTERNAL CONTRACTING THROUGH SWAP MECHANISM WITH WORLD BANK AND BLATERAL CO FINANCING																	XXXXXXXXXXXXXXXX
Objective 1: STRENGTHENING MPA SERVICES (SUPPLY & DEMAND) By 2015 in 100% of HSS Targeted Districts, the coverage of MCH care at health facilities and in the community will reach National MDG Targets, as a result of service priorities and demand side strategies identified and implemented through the OD Annual Operational Plans and Performance Agreements. LINKS TO HSP 2 GOAL 1: Reduce maternal, newborn and child morbidity and mortality with increased reproductive health. Also with Goal 1 Objectives 1 – 4 of HSP 2, Strategic Component (SC) 1.1 MCH Service Delivery Package, SC 5 Internal Contracting, SC 3 HRD Strategy Staff Remuneration & performance incentives, Key MCH Components & Interventions (page 42 HSP 2)																
Activity 1.1: HEALTH CENTRE SERVICE DELIVERY CONTRACTS Establish and Implement Health Centre MPA Annual Operational Plans & Performance Agreements (using supply and demand side approaches)	10 OD (CHILD HEALTH) GAVI				10 OD (MCH) GAVI AUSAID/UNFPA				10 OD (MCH) GAVI AUSAID/UNFPA				10 OD (MCH) GAVI AUSAID/UNFPA				10 OD (MPA) for GAVI finance & national scale up through other sources (WB, BILATERAL)
Activity 1.2: PHD & OD MANAGEMENT CONTRACTS Establish and Implement Annual Operational Plans & Performance Based Management Agreements for ODS and Provinces	10 OD				10 OD GAVI AUSAID/UNFPA				10 OD GAVI AUSAID/UNFPA				10 OD GAVI AUSAID/UNFPA				10 OD for GAVI finance & scale up through other sources (WB, BILATERAL)

Major Activities	2007 (GAVI 1)	2008 (GAVI 2 Q3)	2009	2010	2011 - 2015
Activity 1.3: COVERAGE IMPROVEMENT PLANNING Integration of Immunization Coverage Improvement Planning into MPA Planning Systems	XX	XX XX	XX XX	XX XX	Evaluate and redesign
Activity 1.4: DEMAND SIDE STRATEGY Implement, Evaluate and Scale Up Fixed Site Strategy (MCH)	XX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	Evaluate and redesign
Objective 2: DEVELOPING MPA MANAGEMENT SYSTEMS By 2015, 100% of HSS targeted ODS will implement co-financed and co-ordinated OD service management contracts according to national planning, management, health financing and financial management policy and standards. LINKS TO HSP 2 Strategic Components (SC), SC 1.3 Health Service Delivery Monitoring & Supervision Team, SC 3 Social Protection Measures SC 1 Health Financing Strategy, SC 5 Internal Contracting, SC 1 Harmonization & Alignment (integration of Global Health Initiatives into existing system processes), HSP 2 CH 5 Implementation and M & E Framework, Planning Process and Schedules (page 55), SC3 Governance Strategy (operational research)					
Activity 2.1: FINANCE SYSTEMS Develop MPA Financial Management Systems & health financing guidelines	XXXXXX				Evaluate and redesign
Activity 2.2: PLANNING SYSTEMS Strengthening of AOP planning systems and implementation of MPA Planning guidelines (including referral systems)		XXXXXX			Evaluate and redesign
Activity 2.3: SUPERVISION SYSTEMS Monitoring support for development & implementation of planning and finance systems (including strengthening of integrated supportive supervision programs from central to PHD, and OD to HC level)	XX	XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXXX	XXXXXXXXXXXXXXX
Activity 2:4:OPERATION RESEARCH Conduct Health Systems Operational Research Programs		X X	X X	X X	XXXXXXXXXXXXXX

Major Activities	2007 (GAVI 1)	2008 (GAVI 2 Q3)	2009	2010	2011 - 2015
Objective 3 : HUMAN RESOURCE QUALITY IMPROVEMENT & CAPACITY BUILDING By 2015, 100% of HSS Targeted ODs will meet MPA policy & standards through implementation of MPA capacity building and supportive supervision programs (IMCI, Child Survival NIP, RH, systems training) LINKS TO HSP 2 Strategic Components (SC), SC 1 HRD strategy Technical Skills and Competence, Key MCH Components Page 41, SC 3 Governance Strategy (systems capacity building)					
Activity 3.1: MLM Conduct capacity building programs for Middle Level Management (Planning & Financial management & Supportive Supervision)	XXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	Evaluate and reassess capacity building needs
Activity 3.2: CHILD SURVIVAL Strengthen systems for child survival scorecard monitoring	XXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	Evaluate and reassess capacity building needs
Activity 3.3: IMCI Conduct capacity Building & supportive supervision programs for IMCI and immunization	XXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	Evaluate and reassess capacity building needs
Activity 3.4 : RMCNH Training and Quality Improvement (co financing AusAID UNFPA)	XXXXX	XXXXXXXXXX			AusAID has expressed intention to integrate with the wider SWAP Health Sector Support Program from 2010
Activity 3.5 PRIVATE SECTOR Implement, Evaluate and Scale Up Public / Private Collaboration (immunization with potential integration with MCH)	XXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	Co financed activity but relating to HSS strategy and Governance strategy of HSP 2

Section 6: Monitoring, Evaluation and Operational Research

To the applicant

- *All applications must include the three main GAVI HSS impact / outcome indicators:*

i) National DTP3 coverage (%)
ii) Number / % of districts achieving ≥ 80% DTP3 coverage[39]
iii) Under five mortality rate (per 1000)

- *Please list up to three more impact / outcome indicators that can be used to assess the impact of GAVI HSS on improving immunisation and other child and maternal health services.*

Note: It is strongly suggested that the chosen indicators are linked with proposal objectives and not necessarily with activities.

- *For all indicators, please give a data source, the baseline value of the indicator and date, and a target level and date. Some indicators may have more than one data source (Table 6.1).*

Note: The chosen indicators should be drawn from those used for monitoring the National Health Sector Plan (or equivalent) and ideally be measured already (i.e. not an extra burden to measure). They do not have to be GAVI HSS specific. Examples of additional impact and outcome indicators are given in the tables below. It is recommended that when activities are implemented primarily at sub-national level that indicators are monitored, to the extent possible, at sub-nationally as well.

To the applicant

- *Please list up to 6 output indicators based on the selected activities in section 5. (Table 6.2).*

- *For all indicators, please give a data source, the baseline value of the indicator and date, a target level and date, as well as a numerator and denominator. Some indicators may have more than one data source (Table 6.1).*

Note: Examples of output indicators that could be used, with the related numerator, denominator (if applicable) and data source are shown below. Existing sources of information should be used to collect the information on the selected indicators wherever possible. In some countries there may be a need to carry out health facility surveys, household surveys, or establish demographic surveillance. If extra funds are required for these activities, they should be included.

[39] If number of districts is provided than the total number of districts in the country must also be provided.

6.1: Impact and Outcome Indicators

Indicator	Data Source	Baseline Value[40]	Source[41]	Date of Baseline	Target	Date for Target
1. National DPT – HEPB 3 coverage (%)	MOH/MOP	78.3%	DHS 2005	2005	90%	2015
2. Number / % of districts achieving ≥80% DTP3 coverage	MOH/MOP	18/76	NIP	2006	76/100%	2015
3. Under five mortality rate (per 1000)	MOH/MOP	83/1000	DHS 2005	2005	65/1000	2015
4. Measles Coverage	MOH/MOP	76.9%	DHS 2005	2005	90%	2015
5. % pregnant women who have at least 2 ANC visit from a trained health professional	NMCHC/DPHI	60%	NSRH 2005	2005	90% [42]	2015
6. Proportion of deliveries attended by trained health staff	MOH/MOP	44%	DHS 2005	2005	90%	2015

Please Note: These indicators only relate to the indicators required to be reported to GAVI. The other three main maternal health indicators within the internal contracts (contraceptive prevalence rate, post natal care rates and referrals) will be reported through the health information system as part of the overall M & E system.

TARGET SOURCES

Indicators 1, 4 NIP Multi Year Plan 2006 – 2010

Indicator 2 Joint Report Form 2006 NIP/WHO/UNICEF

Indicator 3 Draft HSP 2

Indicators 5, 6, 7 Draft HSP 2

6.2: Output Indicators

[40] If baseline data is not available indicate whether baseline data collection is planned and when

[41] Important for easy accessing and cross referencing

[42] This target will be reviewed an annual basis given that a 5% rise from 2005 would be required each year to reach the target.

Indicator	Numerator	Denominator	Data Source	Baseline Value[40] 2006	Source	Date of Baseline	Target	Date for Target
1. % of OD that have reached performance targets specified in the OD Contracts	No of OD that have reached contractual targets at the end of each year.	No of OD that have signed OD Contract (10 in 2007)	DPHI	0%	DPHI	2006	77 (100%)	2015
2. % of facilities implementing full MPA * [43]	No of facilities (health centres) implementing MPA	No of facilities (health centres) in Cambodia	DPHI	48% (470 out of 972)	DPHI	2006	100% (972)	2015
3. Number of new case of general consultation per inhabitant per year for children under the age of 5 *	Consultations	Total number of inhabitants	DPHI	1	DPHI	2006	1.5	2015
4. No. of Health Sector Plan 2 Policy Package Approved *	Number of guidelines and policies developed and adopted by MOH for scale up	-	DPHI	0	DPHI	2006	5 [44]	2015
5. % immunization provided at the fixed site	Total number of immunizations provided at facilities (health centres or hospitals)	Total number of immunizations provided	Surveys	20-25%	(1) KAP Study on Immunization NIP/PATH 2003 (2) Health Coverage Survey PATH/NIP 2005	2003 - 2004	40% in target HSS districts	2010
6. % of approved budget reaching health facilities *	Total budget dispersed	Total budget planned	OD Accountant	Not available	Not available			2010

[43] * These indicators are part of the draft M & E Framework

[44] Potentially – Decentralized Financial Management Guidelines, Micro-planning Guidelines, Guidelines for strengthening Fixed Site, Model Internal Contracts, MCH Public private Collaborations Policy MCH - EPI

To the applicant

- *Please describe how the data will be collected, analyzed and used. Existing data collection and analysis methods should be used wherever possible. Please indicate how data will be used at local levels and ways of sharing with other stakeholders in the last column (Table 6.3).*

6.3: Data collection, analysis and use

Indicator	Data collection	Data analysis	Use of data
Impact and outcome			
1. National DTP3 coverage (%)	National DPT-Hep B 3 Data will be collected at local level by health centre staff through routine data collection mechanisms and then aggregated at District, Provincial and National level (integrated within National HIS System)	(1) At the Health Centre level, data will be analysed according to immunization contacts (all antigens). This data will also be analysed according to area (areas of high contact and low contact) (2) At the District level data will be collected from Health centres on a monthly basis (3) Districts report aggregated data to Provinces and provinces to the National level on a quarterly basis.	(1) At the Health centre level, the data will be used to identify areas of low population contact and guide local area strategies for improving contacts with these populations. This information will also be used to guide capitation based performance payments (more contacts more payments) (2) At the district level, the data will be used to assess areas in the district of lower coverage, in order to guide implementation and monitoring strategies in support of higher coverage. The data will also be used to guide performance based targets based on coverage rates achieved by the OD. (3) The same applies to the Provincial level. (4) Nationally the data will be used for national rates and to assess HSS impact. (5) data will be shred with stakeholders at the local level through health centre management committees and at District / Provincial

			level through the Provincial Working Group for Health (comprises national and international staff) At the national level, data will be disseminated through existing annual program reviews, the Technical Working Group for Health and annual program reviews of national programs.
2. Number / % of districts achieving ≥80% DTP3 coverage	Collected through national aggregated data HIS	Analyzed through national aggregated data HIS	Used to measure progress towards disease elimination goals in the NIP MYP as well as to assess GAVI HSS impact.
3. Under five mortality rate (per 1000)	The Demographic and Health Survey conducts 5 yearly national assessments of child mortality that are statistically relevant and are published internationally. Details of methodology are provided in the annex to this application (DHS 2005)	Details of methodology are provided in the annex to this application (DHS 2005)	This information is used to track Cambodia's progress towards achievement of MDG Goal 4. A follow up survey will be conducted in 2010.
4. Measles Coverage	As for DPT3. However, additional data will be collected on reporting of suspected measles cases.	As for DPT3. However, reports will also be analysed for location and numbers fo reported measles cases.	As for DPT3, as well as providing additional data in support of Cambodia measles elimination targets.
5. % pregnant women who have at least 2 ANC visit from a trained health professional	Data will be collected at local level by health centre staff through routine data collection mechanisms and then aggregated at District, Provincial and National level (integrated within National HIS System)	(1) At the Health Centre level, data will be analysed according to consultations contacts as measured against the annual targets based in the AOP and internal contracts. This data will also be analysed according to area (areas of high	As for Impact Indicator 1

		contact and low contact) (2) At the District level data will be collected from Health centres on a monthly basis (3) Districts report aggregated data to Provinces and provinces to the National level on a quarterly basis.	
6. Proportion of deliveries attended by trained birth attendant	Data will be collected at local level by health centre staff through routine data collection mechanisms and then aggregated at District, Provincial and National level (integrated within National HIS System)	(1) At the Health Centre level, data will be analysed according to delivery contacts as measured against the annual targets based in the AOP and internal contracts. This data will also be analysed according to area (areas of high contact and low contact) (2) At the District level data will be collected from Health centres on a monthly basis (3) Districts report aggregated data to Provinces and provinces to the National level on a quarterly basis.	As for Impact Indicator 1
Output			
1. No. of OD that have reached performance targets specified in OD Contracts	Collected by Implementation monitoring team DPHI	Analyzed by DPHI and included in Annual Reports	Evaluation of expansion of performance based management systems.
2. No. of facilities implementing full MPA	Collected through routine HIS system of MOH	Analysed according to set criteria for what constitutes "full MPA" services	Assess the extent to which GAVI HSS inputs have developed the capacity of health centres to provide services according to agreed criteria
3. Consultations per inhabitant per year for children under the age of 5	Collected through routine HIS system of MOH	Analysed according to number of contacts under the age of 5 divided by the population catchment	As for Impact Indicator 1

4. No. of Health Sector Plan 2 Policy Package Approved	Collected through Integrated Inter Departmental Monitoring Team Supervision	Analysed according to numbers of policies developed in the consolidation phase of HSP 2 through development in the 10 HSS ODs supported through GAVI, MOH and AusAID (eg financial guidelines developed, planning system updated for health centres, referral system guidelines , internal contract design etc)	Assess the extent to which the HSS program has been developmental in innovating health system policy development
5. % immunization provided at the fixed site	Collected at health centre level by recording site of vaccination (fixed or outreach)	Analysed according to total number of vaccinations provided at the fixed site divided by the total of all vaccinations provided.	This indicator will be used to assess the impact of communication strategies in increasing the demand fo the population for use of the health centre
6. % of budget disbursement at OD annually compared to AoP budget planned	Collected at OD level through analysis of OD accounting records	Analysed according to the amount of budget disbursed per quarter divided to the total amount of budget planned in the annual operational plan of the district.	This indicator will be used to assess (1) effectiveness of financial management guidelines and capacity building in improving budget disbursal and (2) government co financing of performance based management agreements

To the applicant

- *Please indicate if the M&E system needs to be strengthened to measure the listed indicators and if so describe which indicators specifically need strengthening. (Table 6.4).*
- *Please indicate if the GAVI HSS application includes elements of operational research that address some of the health systems barriers to better inform the decision making processes or health outcome. (Table 6.5).*

6.4: Strengthening M&E system

The fundamental approach to M & E will be through strengthening of existing systems of annual operational planning processes, which are inclusive of central and provincial annual reviews, systems of appraisal and feedback, monitoring implementation of AOPs through quarterly reviews and the building into annual plans of the draft M & E framework and child survival scorecard indicators. [45]. This means of this strengthening will be through programs of integrated management systems capacity building and supportive supervision from inter departmental and inter program teams (see Governance Strategy of HSP 2).

(1) DATA QUALITY AUDITS Traditionally, Cambodia has demonstrated very high data quality in terms of the accuracy of data collection. An international data quality audit conducted by GAVI in 2004 demonstrated a 98% accuracy of health centre data with national data in terms of immunization information. The recent DHS survey in 2005 demonstrated only 2-3% difference between national HIS data and national survey data (immunization).

One of the probable reasons for the high level of data accuracy is the fact that government agencies and international organizations/NGOs have a tradition of supporting village based "data quality audits" or "spot checks" to validate immunization data. More broadly, the development of contracting models in Cambodia over the last 8 years has necessitated the development of more rigorous methods for validating contractual outcomes. The Health Partners meeting conducted on April 6 argued for a much stronger role in future for the monitoring of contractual outcomes by independent agencies. The review of contracting in Cambodia suggests that this could be a role taken up by NGOs (representing a shift in role from contractual managing to contractual monitoring and technical assistance). This is feasible, given the successful role of NGOs to date in assisting local authorities to independently evaluate poverty status of local populations as a test of eligibility for community based health insurance enrolment.

Early implementation of GAVI HSS contracts has indicated that there is concern that data "inflation" may be more likely given the transition to a contractual system of payments. Operational District and provinces have recommended for HSS 2 a stronger emphasis on District and provincial roles in Data Quality Auditing.

In summary, quality of M & E in the MOH/GAVI HSS program will be strengthened in the following ways: (1). Operational support for data quality audits at village level to validate contractual outcomes applying methodologies already successfully applied by the NIP and UNICEF ("Post activity assessment").

(2) HEALTH PLANNING CAPACITY BUILDING One of the main critiques of the health planning system from the various health sector reviews is that, although health managers and workers have a very good track record with data collection and data quality, it remains the case that this information is not often used effectively and analytically to guide implementation at the OD and

[45] See Health Sector Plan 2 Chapter on Implementation, Monitoring and Evaluation Framework (Annex 1) and Child Survival Strategy for details on the Child Survival Scorecard (Annex 13).

facility level. The MOH/GAVI program will apply two strategies in order to improve this capacity. (a) The application of performance based management agreements will enable the MOH, PHDs, ODS and facilities to prioritize indicators and use health information as a strategy to raise health service performance. (b) The DPHI has developed a new planning system in 2002, and only recently has the planning system been extended to the health facility level. The MOH will take the opportunity GAVI has provided to development planning (AOP) and financial management system review and capacity development programs (through training and supportive supervision) in order to improve the performance of health managers and workers in using local health data for management purposes (reaching hard to reach, identifying populations with low coverage/consultation rates)

(3) CHILD SURVIVAL SCORECARD MONITORING The MOH and Health Partners have launched a Child Survival Strategy 2006 – 2010 in April 2007. The cornerstone of the strategy is the scaling up of a set of child survival "scorecard indicators" by the year 2010, with the longer term goal of reaching 2015 MDG targets for infant and child mortality reduction (see table below). The MOH/GAVI HSS program, in collaboration with the CDC MOH will implement a program of support for strengthening the monitoring of child survival scorecard interventions at the district level nationally, commencing first in districts supported by performance based management agreements.

(4) OTHER INDICATORS THAT WILL NEED STRENGTHENING In terms of impact indicators, 5 out of the six are measurable at the District level through routine HIS systems, backed up by data quality audits. As stated above, Cambodia has an excellent track record in data quality and data quality management, as evidenced by the close correlation between DHS and HIS data (2-3% margins). However, 2 of the output indicators mentioned above will require additional data collection management and analysis by District managers (indicator 5 "fixed site" and indicator 6 ""budget disbursement"). Investing effort in improving M & E in relation to these indicators will further MOH management objectives of improving budget flow and health centre utilization.

(5) COORDINATED AND SUPPORTIVE SUPERVISION Managers at central and provincial level in consultations for this proposal have pointed out the need for a coordinated supervision and monitoring system. HSP 2 also expresses the intent to strengthen multi-departmental systems for supervision. At the Provincial level, it is proposed to develop a single management contractual system for the Global Fund and GAVI Investments. Additionally, managers have indicated the need for strengthening of data quality auditing by managers as a result of the introduction of capitation based contractual systems. Additionally, the trend to sector wide approach and multi donor funded "Provincial Block Grants" provides additional rationale for strengthening coordinated management of coordinated grants. This being the case, GAVI HSS 2 through the HSS management system, and, The GAVI HSS program will strengthen the monitoring and management capacity and systems of the MOH through joint supervision and monitoring between departments (HSS Monitoring Teams) of HSS contracts (see implementation arrangements for details on the functioning and structure of the MOH monitoring team) using pooled funding mechanisms where possible.

(6) LINKING M & E SYSTEMS TO FEEDBACK MECHANISMS IN THE AOP SYSTEM Managers at all levels will be encouraged to adopt a reflective approach based on the data and feedback received - how can we improve matters, what are lessons learned, what needs to be fixed, who will do it, when, how, where, etc.? The principle mechanism for this feedback is the AOP system that will be reinforced by GAVI HSS through the system of planning appraisal and annual and quarterly program review (see AOP chapter in the health sector plan for details). The system of quarterly interdepartmental monitoring of contracts will also reinforce the feedback mechanisms for M & E, through monitoring and DQA checks of contractual targets and outcomes.

6.5: Operational Research

In its health governance strategy, HSP 2 outlines a health system research agenda to support policy development that includes the following:

- Contracting for service delivery (covering both internal and external contracting)
- Decentralization and de-concentration in the health sector
- Health Equity Funds and social health insurance
- Staff management, including dual employment, and staff remuneration, including performance incentives, merit based pay, facilities based salary supplementation, per diems, and contract work
- Health management information systems and disease surveillance

HSS 2 will set aside an annual research fund in implement a program of health system research in support of health systems service research, policy development and evaluation. The HSS health systems agenda will be under the direction of the HSS Technical Working Group chaired by the Deputy Director General for Health.

Specific areas of research will include:

- Research, development and evaluation of decentralized financial management
- In depth evaluation of models of internal contracting within the 10 ODs (incorporating human resource motivation)
- Assessment of demand side feedback mechanisms on the quality of service delivery
- Emergency Obstetric and Neonatal Care (EmONC) Assessments by UNFPA financed by AusAID co financing

Research dissemination will occur through routine dissemination mechanisms of the MOH (Annual Review and quarterly reviews) and through publications and the NGO network MEDICAM (monthly newsletter and website).

Research Partners

Key research partners will include Cambodia's *National Institute of Public Health*, GAVI in country partners and selected NGOs for demand side research and quality assessment. Significant health systems research co financing is anticipated through the Health Sector Support program funded through the *World Bank* and others (including DFID) from mid 2009.

JICA is currently conducting health systems research in HSS ODs, focussing on provider and community behaviour change. *UNFPA* will conduct research on quality assessment of facilities for emergency obstetric and neonatal care (EmONC) with financial support from AusAID.

AusAID: A particular focus of Australia's re-engagement to the Health sector is through a Partnerships approach which aims to support Health Partners and Cambodian and international institutions to foster partnerships and institutional linkages. In recognition of the well established relationship between the National Institute of Public Health (NIPH) and the University of New South Wales (UNSW), AusAID proposes to support the continued partnership between UNSW and NIPH. A key element of the partnership will be to promote research capability within the NIPH to enable it to play a key role in promoting research on issues related to health, development and human rights; health policy and systems issues. Further exploration will be made in relation to how these future activities could support health systems research through the GAVI/MoH HSS proposal.

Section 7: Implementation Arrangements

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	Annual operational plans and processes of the Ministry of Health will form the basis for planning HSS inputs as well as providing the focus for coordination of all other government and non government inputs, including implementation of HSS strengthening activities and monitoring of outcomes. A HSS Project Monitoring Team has been established at central level and is now operational. Membership includes the Dept. of Planning, Dept. of Finance and NIP. This team is chaired by the Dept. Planning. The Project Monitoring team reviews and appraise all funding requests from Provinces. This strategy is line with HSP strategy to develop multi departmental monitoring teams to support health system development. The recommendations will be passed to a HSS project Manager located in the office of the Health Sector Support Program (HSSP) for funding decision making and disbursal. The Health Sector Support is a Joint program supported by ADB, World Bank DIFID and other partners. This program is currently in the design phase of a 100 M $ extension. HSS Project management is overseen by the Health Sector Support Program Director (Secretary of State H.E. Prof.Eng Huot)) and a HSS Manager (Deputy Director General for Health Prof.Sann Chan Soeung) This management will make decisions on HSS resource allocations based on the HSS annual plan. This needs to be done in the overall context of the AOP. Functions will also involve executing budget and performing financial management (budget request and cash disbursement mechanism, financial expenditure etc). The HSS management will also promote co ordination with other programs acting within the scope of HSS. At provincial level, Provincial Health Departments through PHD Budget Management Center (4 members of PHD Senior Management: 3 are planning team supported by Global Funds HSS and other 01 will be supported by GAVI-HSS) and Operational District Health Office through OD Budget Management Center (5 OD management team will be supported by GAVI-HSS) will primarily carry out management roles. The Health Centre Management Team will be the implementing agencies accountable for performance at the health centre level, working within the framework of the internal contracts and strategic and annual operational plans. The rationale for this management approach is to link the institutional macro-planning capacity of the Department of Planning with the proven institutional track record of the NIP in supporting successful program implementation at district level and below. As outlined in Health Sector Plan 2, inter departmental monitoring Teams, Chaired by DPHI Director DR Lo Veasna Kiry will facilitate quarterly monitoring visits to HSS ODs to monitor program progress. Information will be disseminated through normal AOP processes including quarterly and annual program reviews, with lessons learned built into subsequent AOPs. Management arrangements are essentially the same as proposed by the MOH and endorsed by GAVI in 2006 in the HSS 1 proposal. One internal contracted staff member has been hired by the MOH and is based in DPHI. There is no GAVI PSU or secretariat.

Role of HSCC (or equivalent) in implementation of GAVI HSS and M&E	The Heath Sector Steering Committee has the overall responsibility for endorsing the strategic direction of this project, as well as linking it to health sector planning strategic directions.
Mechanism for coordinating GAVI HSS with other system activities and programs	(1) The Implementation Monitoring Team, comprising membership of Dept Planning, Dept Finance, NIP and other National Programs will take primary responsibility for ensuring that GAVI HSS is coordinated with other systems and programs, particularly through the Annual Operatining Planning processes (AOP) of the MOH (2) The Technical Working Group for Health and the Immunization Co ordination Sub Committee are the sector and immunization specific forums for ensuring that programs such as GAVI HSS are well coordinated with systems and programs supported by other partners.(3) Refer to annex 7 which provides details on management responsibilities for implementation through the internal contracting system. (4) The Health Sector Strategic Plan 2 provides the overall strategic framework in which to locate the GAVI HSS investment. (5) The multi donor Health Sector Support program (World Bank, DFID, ADB, UNFPA,) is the principle MOH coordination mechanism for development partner funding. GAVI HSS and AusAID will use the same processes.

Additional notes on Management of GAVI HSS Support

No new HSS "project" structures will be developed or have been developed as part of this program. Structures follow the MOH System. The main functional management innovation mentioned in HSP 2 (aside from internal contracting) is the development of inter departmental monitoring for which terms of reference have been developed.This is the point of interaction between programs and departments led by the DPHI and reporting to the HSS Manager and HSS Director.

AusAID/UNFPA will utilize the same management and financial management systems as GAVI HSS. Reporting will be through Health information System and planning through the Annual Operational Planning System.

Internal contract signatories include the Secretary of State, (HSS Director), PHD Director, OD Director and Health centre Manager. These authorities are accountable for outputs. This reflects the flow of authority, financing and accountability in the Cambodian Health System.

The HSS approach is dependent on a new way of managing the health system – this is through shifting towards inter-departmental and inter-program management and monitoring from the current emphasis on verticalized program or project approaches. The emphasis on inter departmental monitoring, internal contracting and the AOP system in HSP 2, and the transition to sector wide "Provincial Block Grants" from 2009 – 2010 indicate that this new way of managing will become an increasing requirement of the health system. The main point to consider, based on the experience of HSS 1, is that this transition will require strengthened communication, research and evaluation and lessons learned from implementation in order for it to become an established system and style of management.

7.2: Roles and responsibilities of key partners (HSCC members and others)

Title / Post	Organisation	HSCC member yes/no	Roles and responsibilities of this partner in the GAVI HSS application development
Title / Post	**Organisation**	**HSCC member**	**Roles and Responsibilities related to GAVI HSS**
H.E Professor Eng Huot Secretary of State	MOH, Member of GAVI Board	Yes	Strategic direction for program development HSS program Director Facilitation of Technical Assistance
Professor Sann Chan Soeung Deputy Director General for Health	MOH	Yes	Overall management of the program development Chair of HSS Working Group Oversight of proposal development and HSS 1 Implementation Facilitation of Technical Assistance Oversight of Operational Research
Dr Lo Veasna Kiry Director	MOH, Dept. Planning & Health Information	No	Vice-chair of HSS Working Group Provided technical input on strategic directions of HSP 2, and how the GAVI HSS can align with it. HSS Working Group Member Chair of HSS Monitoring Team Facilitation of Technical Assistance Oversight of Operational Research
Ms Khout Thavary Deputy Director Mr. Myo Minn	MOH, Dept. Budget & Finance *Email MOH Consultant	Yes	Responsible for Financial Monitoring Financial Management Costing Overseeing development and implementation of financial management guidelines Leads financial Management capacity Building HSS Working Group Member
Dr Loun Mondol , Vice-chief of Planning Bureau Dr. Ly Vichea Ravuth, Vice-chief of Planning Bureau	Policy, Planning & Health sector Reform Bureau MOH, Dept. Planning	No	AOP Review and appraisal HSS Working Group Member HSS monitoring Team Member
Dr Hong Rathmony Deputy Director	MOH, CDC Dept.	No	Manager of IMCI and child survival scorecard development Leads IMCI capacity Building
Dr Svay Sarath, Mr Ork Vichit	MOH, National Immunization Program	No	Immunization capacity building HSS Working Group Member and Monitoring Team Members Leads Immunization Capacity Building
Dr Paul Weelen Health System Development Adviser	WHO	No	Technical assistance health system strengthening HSS Working Group Member
Dr Benjamin Lane Health Planning Advisor	WHO	No	Technical assistance in health planning HSS Working Group Member
Dr Kohei Toda Immunization Advisor	WHO	No	Technical assistance on immunization
Dr Thor Rasoka MCH Program Officer	UNICEF	No	Adviser on Maternal and Child Health

			including community participation. HSS Working Group Member
Ms Thazin Oo	UNICEF	No	Technical advice on HSS including community participation.
Medicam	Umbrella of NGOs network active in health sector	No	Liaison with MOH (through steering committee) regarding co financing of HSS and technical support for district implementation. Member of HSS Working Group.
Technical Working Group for Health/ICC	Sector coordination structure	Cross membership with HSSC	Advice on strategic Directions and donor coordination for HSS and immunization
Provincial and OD Budget Management Centers and Health Center Management Team	PHD managers OD Managers HC Managers NGOs	No	Management and implementation
Health Sector Steering Committee	Inter-ministerial top management: MoH, MEF, MoP		Strategic direction Recommendation on policy to Minister
NIPH	Dr Ung Sam An	No	Potential collaborations on health systems research.
PHD Directors Vice Directors, OD Directors and Health Centre Managers	(see attached List Annex 6)	No	Signatories to Internal Contracts and overall responsibility for outputs and funds management of HSS
Ms Lia Burns	AusAID		Partner coordination for implementation of HSS in the 10 ODs through UNFPA
Dr. Sok Sokun	UNFPA		Technical support on reproductive and maternal health component of HSS contracts in the 10 ODs
Dr Shoko Sato	JICA		Liaison with Technical Working Group for Health on GAVI information dissemination through TWGH. Dissemination of JICA Health Systems Research
ADF	ADF		Linking of internal contracting model in Takeo Province to GAVI HSS (5 ODs)
USAID / URC	USAID / URC		Dissemination of health system research findings to HSS Working Group.
Selected NGOs	(see attached List Annex 6)	No	Technical support, quality assessment, advocacy for HSS implementation in selected districts through Annual Operational Planning System and Technical Working Group for Health

To the applicant

- *Please give the financial management arrangements for GAVI HSS support. GAVI encourages funds to be managed 'on-budget'. Please describe how this will be achieved (Table 7.3).*
- *Please describe any procurement mechanisms that will be used for GAVI HSS (Table 7.4).*

7.3: Financial management of GAVI HSS support

As part of HSS 1, a financial management manual has been developed to ""maintain effective and efficient of financial management especially in provincial level of PHD, OD and HCs. According to the manual, the HSS accounting system will be follow and abide by the "Financial Policies & Procedures Manual" of HSSP Project which was approved by Ministry of Economy and Finance in May 2007.[46] (see Annex 9). The World Bank has commented in the peer review that The GAVI HSS current financial operational manual will be an important starting point for developing the manual for the provincial grants but additional or adjusted features may be needed when transitioning to the full Provincial Block Grant System.

In support of the Royal Government of Cambodia and MOH trend towards decentralization, annual HSS grants have been decentralized to the Provincial level into the Provincial Banking system. This initiative of the Dept. Budget and Finance through GAVI HSS to decentralize financial management to provinces is the likely design approach for Health Sector Support Program 2, utilizing a Provincial Block Grant System (see HSP 2 for more details on the Provincial Block Grant Strategy). This strategy is designed to directly address the chronic health system barrier in Cambodia of irregular and non timely disbursal of funds to districts and the primary level of care, as well as being a lead activity in support of MOH governance objectives more broadly in terms of health system decentralization and de-concentration.

Monitoring activity through the HSS Rapid Assessment and through a JICA study indicates that funds are reaching the primary level of care in a timely manner(see Annex 8)

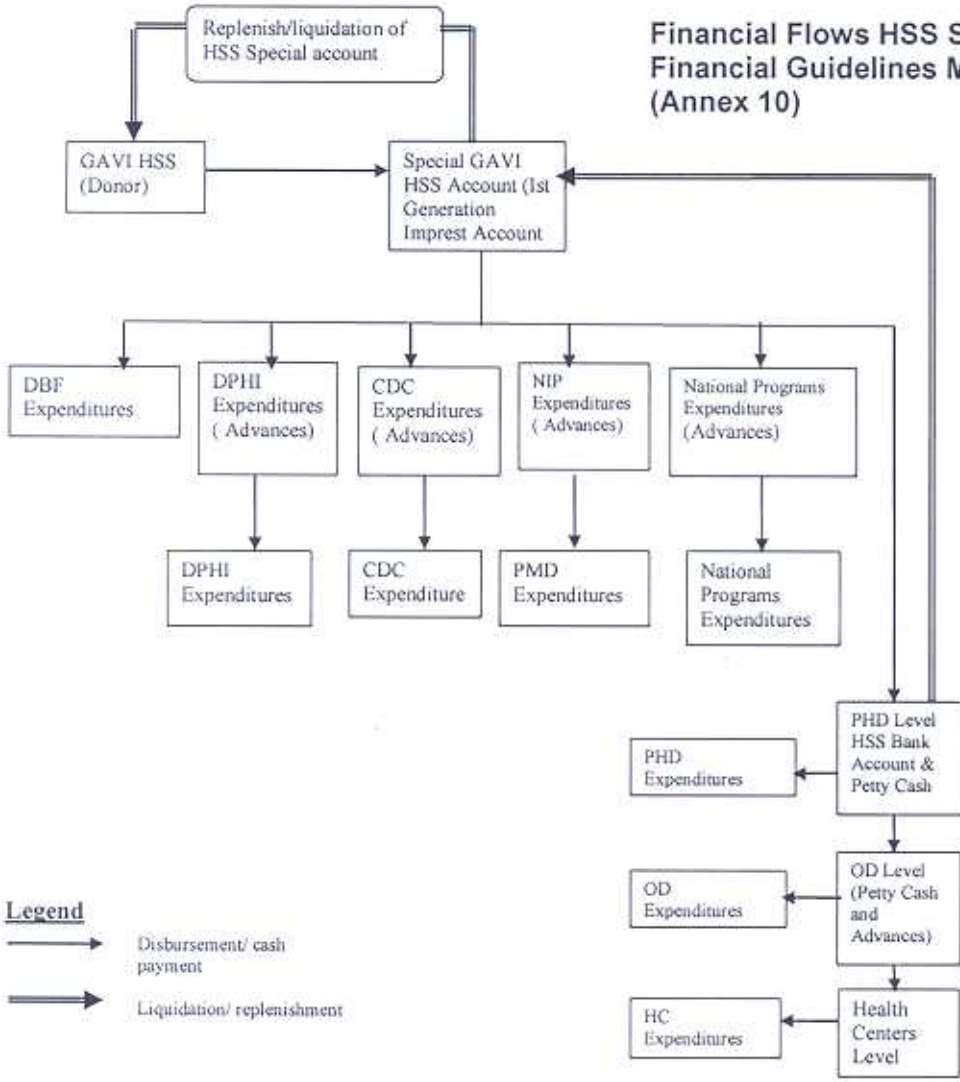
[46] The HSSP project is the transitional step to the sector wide program in Cambodia. See annex 6 for details.

Mechanism / procedure	Description
Mechanism for channelling GAVI HSS funds into the country.	HSS funds will be channelled into the country to a HSS account (refer to annex for details).
Mechanism for channelling GAVI HSS funds from central level to the periphery.	At the central level, to facilitate the grant disbursement, the MOH shall maintain a separate dollar special deposit account (HSS Account) for project at the National Bank of Cambodia under the name of "Health System Strengthening Project". [47] At the project related provincial level, the respective "Provincial Health Departments" (PHD) shall maintain separate dollar bank account for project at the provincial ACLEDA bank The GAVI fund shall disburse to HSS bank account at central level. The project expenditures for central level departments and National Programs shall be paid directly from HSS bank account at central level. For the provincial level, the initial advance will be transferred from HSS Bank account to PHD's ACLEDA Bank account base on annual requirement of each PHD's proposal. The initial advance for province level will follow revolving funds procedure based on performance assessment (10% quarterly). To date, annual HSS allocations have been disbursed to all Provinces. Districts on a monthly basis. the process is as follows: • Funds disbursal is through guidelines developed by Dept of Finance. • Yearly advance, 90% up front payment to PHDs • Monthly Advance to ODs • Payment to health centres based is monthly on service delivery result The HSS Rapid Assessment indicates the system is currently functional (ie – service delivery funds are reaching the delivery level on a timely basis and based on payment for services provided) (See Annex 8 HSS Rapid Assessment)
Mechanism (and responsibility) for budget use and approval	Responsibility for budget approval is with the HSS Manager centrally, the PHD Director at Provincial Level and the OD Director at District level. Please refer to the HSS Financial Management Guidelines at Annex 9 for more detail.

[47] This is the multi donor shared funding mechanism (World Bank, DFID, Govt. France, ADB, GAVI, AusAID)

Mechanism for disbursement of GAVI HSS funds	The advance will be paid to the PHD and OD office according to the "Performance Based Management Agreement" (MPA Service) between PHD and OD and OD and Health Centre. Refer to Financial Management Guidelines (annex 9) and Performance Management Agreements and MPA Contracts (annex 8) for details.
Auditing procedures	Auditing Procedure *External Audit (Post Audit)* Annual audit will be conducted during 4th quarter of 2008 for 1st year (from 4th Quarter/2007 to 3rd Quarter 2008) GAVI HSS project by external independent auditor. GAVI HSS has provided for Externally Auditing fees. • For the first year of GAVI HSS program, the separate external auditor will be hired with separate Term of References. (use HSSP Procurement mechanism to select external auditor). • Starting from second year of program, use the same external auditor of HSSP (use same Term of Reference of HSSP auditor but separate auditor' report will be produced) For the entire project and central level, the audit will be conducted with DBF's financial data and information.. For the provincial level, the audit will be conducted at each PHD office. *Internal control for Financial Accounts* Quarterly Financial Report will produce by DBF (GAVI HSS central level). It includes entire program financial status, reconciliation of 1st generation imprest account, 2nd generation imprest account, all advances and petty cash balance. PHD will manage OD's financial report including OD and HC expenditures. DBF will manage PHD's financial report including PHD, OD and HC expenditures. DBF will manage and report entire project financial status including central level and provincial level. DBF will report to Donor (annually and as and when require). And report to HSSP (and other necessary entities) by quarterly. Every quarter DBF will check all financial report from all PHD. If unsatisfactory financial reports are found by DBF, DBF staff will go and check at PHD and OD office or call the PHD and OD staff to come to DBF.

Financial Flows HSS Sourced From Financial Guidelines Manual HSS (Annex 10)



7.4: Procurement mechanisms

Procurements will be applied rules and procedures of the Ministry of Health and Ministry of Economy & Finance.

In HSS 2, due to the halving of budgets associated with the drop in GNI, there will not be large procurements as was the case with HSS 1.

Procurement procedures will follow according to Health Sector Support Program 1 Guidelines (as referred to below) after which the procurement guidelines will be amended according to Health Sector Support Program 2 (commencing from 2009 – 2010).

Reference Document is: "The Royal Government of Cambodia Externally Assisted project procurement Manual Goods, Works, Services." August 2005

To the applicant

- *Please describe arrangements for reporting on the progress in implementing and using GAVI HSS funds, including the responsible entity for preparing the APR. (Table 7.5)*

Note: The GAVI Annual Progress Report, due annually on 15 May, should demonstrate: proof of appropriate accountability for use of GAVI HSS funds, financial audit and proper procurement (in line with national regulations or via UNICEF); efficient and effective disbursement (from national to sub-national levels; in the context of a SWAp mechanism, if applicable); and evidence on progress on whether expected annual output targets and longer term outcome targets are being achieved.

7.5: Reporting arrangements

IIn terms of Health centre and District reporting, there are no changes to AOP reporting systems. There are no specific "GAVI" reports for HSS, only specific research studies or inter departmental monitoring reports (such as the HSS rapid assessment appended. All reporting is through existing MOH Health Information System and Annual Operational Planning Systems (please refer to Health Sector Plan Chapter on Monitoring and Evaluation for details). The reports generated by the interdepartmental monitoring team will principally use existing HIS and planning data for analysis and the internal contacts as a point of reference for monitoring.

In terms of "financial reporting" the OD shall report to Provincial (PHD) level on a quarterly basis including all health centres financial reports. The Provincial level shall consolidate PHD, OD and Health centres financial reports and report to central level (HSS Project Management Team) in quarterly basis. The central level (HSS Project Management Team) shall report to MOH and GAVI on annual basis for entire project financial report (including central level department's expenditure, National Programs expenditure and reporting from sub national level) (Source financial management guidelines HSS MOH). This reporting mechanism will also be applied by the central units and National Programs that receive HSS support.

To the applicant

- *Some countries will require technical assistance to implement GAVI HSS support. Please identify what technical assistance will be required during the life of GAVI HSS support, as well as the anticipated source of technical assistance if known (Table 7.6).*

7.6: Technical assistance requirements

In the Health Sector Plan 2, several strategies are defined that are of relevance to technical systems and support for health systems strengthening. These are as follows:

Role of NGOs: In the traditional contractual context, NGOs have been accustomed in many instances to adopting the role of the contracting manager. In the HSP 2 transition, contracting is becoming internal to Government. This will require a transition in NGO role to that of technical support for district health services implementation - "Move from substitution to technical assistance, including in contractual arrangements with NGOs." (HSP 2) NGOs provide technical support for management, budgeting, community outreach, quality assessment and M & E, mostly at the district level and below. Given the trend towards decentralization in Cambodia, the role of civil society in technical support for district health systems strengthening (governance) is likely to develop further.

Role of Development Partners: The role of development partners is to technical assist national priorities in identified gap areas. "The role of Donors is to provide technical assistance, to support national health priorities and to fill the gap in funding between resources currently available and those needed to achieve health goals. Harmonization and alignment, in particular along defined contracting arrangements will be needed for an effective donor support."....." Agree on how to improve partnership in support of HSP2 including driven Technical Assistance and its financing and integration of the Global Health Initiatives into existing processes of co-operation in Cambodia to reduce transaction costs and avoid distortion of program priorities." (HSP 2) ADF is currently discussing with the MOH a TOR for health systems strengthening technical assistance at central level which could support the overall direction of the HSS program funded from a range of sources (AusAID, UNFPA, AFD, MOH).

Role of Government: The principle technical support role of government is through implementation of capacity building programs backed up by programs of multi departmental supportive supervision - "Conduct monitoring and supportive supervision of facilities by Operational Districts through integrated technical teams drawn from Provincial Health Departments, relevant central Departments, National Programs and other institutions." (HSP 2)

Role of Research Institutes: (refer to section on operational research). The MOH proposes to establish Public Health and Policy research units within MoH in collaboration with Cambodian and international public sector and international research institutions.

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)
1. Health Systems Development with a focus on health contracting	12 months first year Reassess subsequently	2008 - 2010	MOH GAVI / WHO / ADF
2. Financial Management	4 months per year and then reassess for 2011 - 2015	2008 - 2015	MOH GAVI / WHO

3. Health Systems / Service Operations Research (refer to research agenda in HSP 2 and in section on operations research)	3 month per year	2008 - 2015	National Institute of Public Health or established MOH Institute
4. Mid Term Health Sector Review	3 months	2011	WHO co financing
5. Contracting System Evaluation	1 month per year	2008 - 2010	MOH - GAVI
6. Emergency Obstetric and Neonatal Care (EmONC) Assessments	6 months	2008-2009	UNFPA through AusAID
7. Capacity Building and Supportive Supervision Programs as described in Activities section (IMCI, Reproductive Health, Immunization, Management Systems, Emergency Obstetric Care).	Continuous	2008 - 2015	CDC NIP UNFPA WHO
8. Health System Research Capacity Building Program at National Institute of Public Health (complementary support through AusAID)	TBD	2008 - 2009	AusAID
9. Peripheral Health Management Support, including management capacity development for community based insurance, community outreach and district and health centre management (including planning and budgeting	Continuous	2008 - 2015	Civil Society programs supported through USAID-supported programs when there is geographic overlap
10. Third party quality assessment and M & E	Continuous	2008 - 2015	Civil Society programs supported through USAID-supported programs when there is geographic overlap

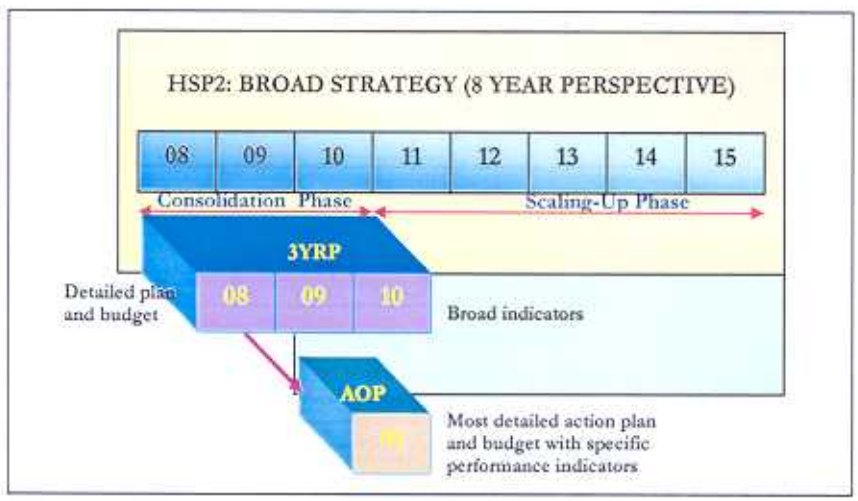
Section 8: Costs and Funding for GAVI HSS

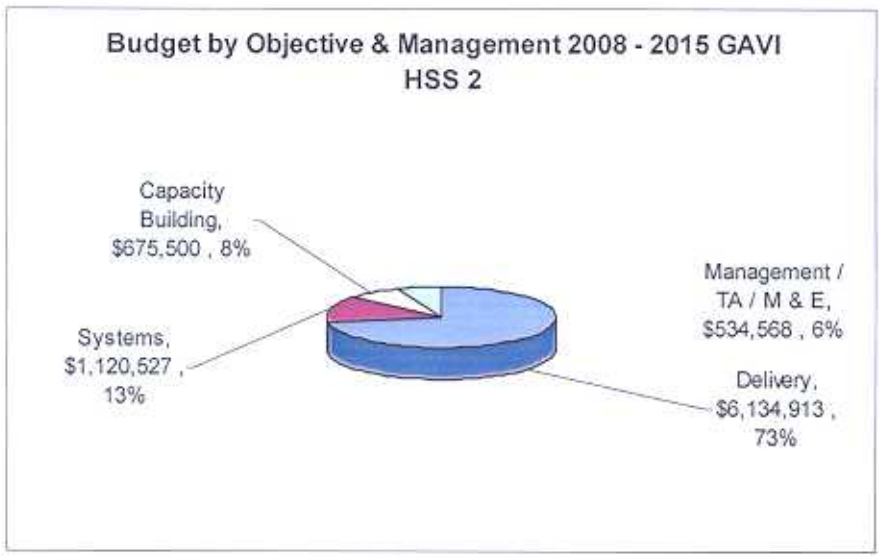
8.1: Cost of implementing GAVI HSS activities

The costing of GAVI HSS follows the same time frame and planning cycle as Health Sector Plan 2. A Three Year Rolling Plan (3YRP) is a medium term planning framework. The plan is built upon broader strategy of the HSP2 that sets longer-term goals and objectives. 3YRP is intended to inform resource allocation/re-allocation for coming three years and guide resource commitments by the Government and health partners and finally to coordinate the aid program to the health sector through sector wide consultation and mandate for forward allocations via the Joint Annual Review Program.

The costing of GAVI HSS 2 inputs will therefore follow the same principles for planning as outlined in HSP 2. Detailed costing is outlined for the years 2008 – 2010, after which the GVI HSS input will be reassessed according to the development of the Provincial Block Grants System from 2010. The exact modality of GAVI HSS funding from 2010 will be reassessed in that year based on lessons learned from implementation experience in the 10 co financed HSS ODs up to that time.

The figure extracted from the draft Health Sector Plan 2 outlines the longer term perspective for costing of HSS. GAVI HSS Costing corresponds to this long term perspective (see Table following)





	Year 1 HSS 2	Year 2 HSS 2	Year 3 HSS 2	Year 4 HSS 2	Year 5 HSS 2	Year 6 HSS 2	Year 7 HSS 2	Year 8 HSS 2	
Activity costs	2008	2009	2010	2011	2012	2013	2014	2015	GRAND Total
Objective 1 SERVICE DELIVERY									
Activity 1.1: HEALTH CENTRE SERVICE DELIVERY CONTRACTS Establish and Implement Health Centre MPA Annual Operational Plans & Performance Agreements (using supply and demand side approaches) (MCH)	$ 163,137	$ 770,051	$ 770,051	$ 693,046	$ 616,041	$ 539,035	$ 462,030	$ 385,025	$ 4,398,416
Activity 1.2: PHD & OD MANAGEMENT CONTRACTS Establish and Implement Annual Operational Plans & Performance Based Management Agreements for ODS and Provinces (MCH)	$ 33,374	$ 136,220	$ 136,220	$ 136,220	$ 136,220	$ 136,220	$ 136,220	$ 136,220	$ 986,914
Activity 1.3: COVERAGE IMPROVEMENT PLANNING Integration of Immunization Coverage Improvement Planning into MPA Planning Systems (MCH) (gradual scale down of CIP))	$ 33,667	$ 134,667	$ 100,000	$ 80,000	$ 70,000	$ 60,000	$ 50,000	$ 31,300	$ 559,633
Activity 1.4: DEMAND SIDE STRATEGY Implement, Evaluate and Fixed Site Strategy (MCH) (including demand side activities)	$ 6,250	$ 25,000	$ 25,000	$ 25,000	$ 25,000	$ 25,000	$ 25,000	$ 25,000	$ 522,000
Sub Total	$ 236,428	$ 1,065,937	$ 1,031,271	$ 934,266	$ 847,261	$ 760,255	$ 673,250	$ 577,545	$ 6,126,213
Objective 2 SYSTEMS									
Activity 2.1: FINANCE SYSTEMS Develop MPA Financial Management Systems & health financing guidelines	$ 10,000	$ 30,000	$ 20,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 110,000
Activity 2.2: PLANNING SYSTEMS Strengthening of AOP planning systems and implementation of MPA Planning guidelines	$ -	$ 45,000	$ 45,000	$ 45,000	$ 45,000	$ 45,000	$ 45,000	$ 45,000	$ 315,000
Activity 2.3: SUPERVISION Strengthening of integrated supportive supervision programs from central to PHD, and OD to HC level	$ 17,095	$ 69,776	$ 69,776	$ 69,776	$ 69,776	$ 69,776	$ 69,776	$ 69,776	$ 505,527
Activity 2.4: RESEARCH Conduct Health Systems Operational Research Programs	$ 30,000	$ 30,000	$ 30,000	$ 20,000	$ 20,000	$ 20,000	$ 20,000	$ 20,000	$ 190,000
Sub Total	$ 57,095	$ 174,776	$ 164,776	$ 144,776	$ 144,776	$ 144,776	$ 144,776	$ 144,776	$ 1,120,527
Objective 3 Capacity Building									
Activity 3.1: MLM Conduct capacity building programs for Middle Level Management	$ -	$ 46,000	$ 46,000	$ 46,000	$ 46,000	$ 46,000	$ 46,000	$ 46,000	$ 322,000
Activity 3.2: CHILD SURVIVAL Strengthen systems for child survival scorecard monitoring (include in 3.3)	$ 2,500	$ 10,000	$ 10,000	$ -	$ -	$ -	$ -	$ -	$ 22,500
Activity 3.3: IMCI Conduct capacity Building & supportive supervision programs for IMCI and immunization	$ 15,000	$ 104,000	$ 104,000	$ -	$ -	$ -	$ -	$ -	$ 223,000
Activity 3.4 : RMNCH Training and Quality Improvement (co financing AusAID UNFPA)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Activity 3.5 : PRIVATE SECTOR Implement, Evaluate and Scale Up Public / Private Collaboration (immunization with potential integration with MCH) (co financing)	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 10,000	$ 80,000
Sub Total	$ 27,500	$ 170,000	$ 170,000	$ 56,000	$ 56,000	$ 56,000	$ 56,000	$ 56,000	$ 647,500
SUB TOTAL 3 Objectives	$321,023	$1,410,713	$1,366,047	$1,135,042	$1,048,037	$961,031	$874,026	$778,321	
Management costs (include office support, computor printer)	$ 5,100	$ 20,400	$ 20,400	$ 20,400	$ 20,400	$ 20,400	$ 20,400	$ 20,954	$ 148,454
M&E support costs	$ 1,605	$ 28,214	$ 27,321	$ 22,701	$ 20,961	$ 19,221	$ 17,481	$ 15,586	$ 153,069
Technical Assistant (TA)	$ 10,000	$ 50,000	$ 50,000	$ 50,000	$ 31,441	$ 28,831	$ 26,221	$ 23,251	$ 269,744
Sub Total	$ 16,705	$ 98,614	$ 97,721	$ 93,101	$ 72,802	$ 68,452	$ 64,101	$ 59,771	$ 571,267
TOTAL COSTS	$ 337,728	$ 1,509,328	$ 1,463,768	$ 1,228,142	$ 1,120,838	$ 1,029,483	$ 938,128	$ 838,093	$ 8,465,508
AVAILABLE GAVI HSS FUND	$ 987,043	$ 1,010,070	$ 1,032,260	$ 1,052,865	$ 1,071,540	$ 1,088,545	$ 1,104,205	$ 1,118,980	$ 8,465,508

OD costings 2008 - 2010 based on costings by OD in HSS 1

CIP 20 ODs

CIP 15 ODs

Budget Notes: In 2009 – 2010, following proposed introduction of Provincial Block Grants, there will be a gradual scaling down of GAVI HSS investment in service delivery contracts and gradual scale up of government and other investors. Activity 3.4 will be supported by AusAID and UNFPA in the same 10 ODs up to 2010.

8.2 Fiduciary and Program Risk Management Strategy

The main financial and program risks, and the risk responses to date, are outlined below:

RISK 1 THAT OPERATIONAL DISTRICTS AND HEALTH CENTRES HAVE LACK OF EXPERIENCE IN MANAGING AND ACCOUNTING FOR OPERATIONAL BUDGETS

RISK RESPONSE: *Capacity Building* It is true that Cambodia has had a chronic problem with delayed or absent finance for the operation of basic health services. This being the case, there is less experience at the delivery and middle level in disbursal and accounting of funds. To date the HSS 1 program, through the Dept. of Budget & Finance, has undertaken a training program in the financial management for Provincial level accountants, with the expectation that this guidance would extend to the lower levels (OD and Health Centre). It is now apparent that a more systematic training program will be required for OD accountants and health centre managers in HSS 2, in order to develop a more financial management capacity at the sub provincial level.

RISK 2 THAT ALTHOUGH THERE MAY BE SUCCESSFUL INITIATIVES FOR ADVANCES OF FINANCE AND ITS APPLICATION FOR BASIC OPERATIONS, THERE MAY BE STILL BE LACK OF CONFIDENCE OF FINANCIAL MANAGERS DUE TO LACK OF ADEQUATE ACCOUNTING SYSTEMS

RISK REPSPONSE: *Systems and Guideline Development* This is the rationale for development of the financial management guidelines and systems. The main issue now is to successfully orientate sub provincial managers and accountants to the guidelines and systems, and back up this training with supportive supervision and auditing systems. The World Bank has confirmed that these financial guidelines are in broad alignment will proposed Health Sector Support Program (2009 – 2013) approaches currently in the design phase. The systems are also consistent with HSP 2 directions towards financial decentralization.

RISK 3 THERE IS A RISK THAT THE GAVI HSS INITIATIVE WILL BE AN ISOLATED INVESTMENT, WITHOUT DEMONSTRABLE COMMITMENT FROM GOVERNMENT OR INTERNATIONAL INVESTORS, RENDERING THE GAVI INVESTMENT NON SUSTAINABLE IN THE LONGER TERM

RISK RESPONSE: *Co financing* AusAID has committed to linking with GAVI HSS in the same 10 ODs up to 2010 for a wider package of MCH services (maternal health components). GFATM HSS is co financing provincial management strengthening. At meetings with the World Bank, it has been confirmed that the HSS program as it stands is in broad alignment with Health Sector Support Program of World Bank (value 100 M $ from 2010) with the strategies of the Health Sector Plan 2. The transition to Provincial Block Grants in 2010 therefore further mitigates the risk that GAVI HSS will become an isolated "project" investment. The decision by the Government to fund midwifery supported deliveries on a fee for service basis of $15 per delivery is also demonstrable evidence of government co financing.

RISK 4 THERE IS A RISK THAT GAVI HSS FUNDS AND ACTIVITIES WILL BECOME "PROJECTIZED" AND NOT BE INTEGRATED WITHIN THE OVERALL MANAGEMENT SYSTEMS OF MOH

RISK RESPONSE: *Annual operational planning and Inter Departmental Supervision* Cambodia developed an integrated planning system in 2002 incorporating programs of annual quarterly review, planning formats and cycles, costing guidelines and M & E systems. There is still a risk however that the contract system will become "parallel", leading to the development of parallel financial management systems along project lines. This risk will be managed in several ways. Firstly, contract M & Systems and targets will be linked to targets in the AOP system. Secondly, all HSS investments including proposed budgets and activities will be integrated within the annual operational planning system. Thirdly, integration of the GAVI HSS program within the "Provincial

Block Grant" system from 2010 will minimize the risk that financial management procedures and systems will be in any way distinct from an overall operating system. The HSS program is a pathfinder program in financial decentralization, and it has been verified with the World Bank through consultation, and with the MOH through consultation and specific references in HSP2, that the GAVI HSS approach is well aligned with sector trends, and is hence at significantly lower risk of becoming an isolated system.

RISK 5 THERE IS A RISK THAT THE DEVELOPMENT OF INTERNAL CONTRACTING AND DECENTRALIZED HEALTH MANAGEMENT SYSTEMS ARE HIGHLY EXPOSED TO PROGRAM FAILURE DUE TO WEAKNESSES IN M & E SYSTEMS AND LIMITS TO HEALTH SYSTEM RESEARCH CAPACITY

RISK RESPSONSE *National M & E Framework, Interdepartmental HSS strategy, Health System Research Capacity Building* This risk will be managed in the following ways. Firstly, GAVI HSS program indicators are by and large derived from the draft M & E framework of HSP 2. The same systems for M & E will be applied using the AOP systems and cycles (please refer to relevant chapter in HSP 2). Secondly, the innovation of HSS 1 has been to promote the development of an interdepartmental strategy for M & E. This is required given that the contracting model is based on an integrated package of services, and hence requires an integrated method of management to oversee it. Clearly, given that the MOH has a long tradition of vertical program management from central level, the transition to inter departmental and inter program management will take some time. The institutional strengthening strategy for HSS for the time being is therefore focused on the following:

- HSP 2 strategy for strengthening of interdepartmental monitoring at central level
- At provincial level, GAVI and GFATM co financing of a Provincial Health management strengthening through inter program supervision and a comprehensive management TOR.
- Step by step decentralization of monitoring of internal contracts to PHD
- Building health systems research capacity for evidence based policy development (see research strategy and agenda in relevant section of this proposal) with possible co financing from World Bank and AusAID

RISK 6 THERE IS A SIGNIFICANT RISK THAT HSS INCENTIVES WILL NOT ALIGN WITH THE MANY OTHER INCENTIVE SCHEMES BEING TRIALLED, AND THAT THIS BRINGS INTO QUESTION THE SUSTAINABILITY OF THE HSS INITIATIVE

The principal mechanisms for alignment are the Annual operational planning systems of the MOH, the national M & E framework and the system of Technical Working Groups for Health (TWGH) at National and Provincial level. This is the current system identified in HSP 2 for aligning and harmonizing investments. In HSS 2, it is proposed to contract outcomes and activities of the AOP. However, in reality, a comprehensive approach to this problem can only occur when the proposed Provincial Block Grants are introduced. There is a strong case for strengthening human resource planning and management at the Provincial Level, but this is probably beyond the scope of the existing GAVI investment.

To the applicant

- *Please calculate the amount of funds available per year from GAVI for the proposed GAVI HSS activities, based on the annual number of births and GNI per capita[1] as follows (Table 8.2):*

- *If GNI < $365 per capita, country is eligible to receive up to $5 per capita*
- *If GNI > $365 per capita, country is eligible to receive up to $2.5 per capita*

Note: The following example assumes the birth cohort in the year of GAVI application is 100,000, and gives the total fund allocations if the GNI < $365 per capita and if the GNI > $365 per capita.

8.2: Calculation of GAVI HSS country allocation

	Allocation per year (US$)								
GAVI HSS	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL FUNDS
Allocation	2008	2009	2010	2011	2012	2013	2014	2015	
Birth cohort	394817	404028	412904	421146	428616	435418	441682	447592	
Allocation per newborn	$2.5	$2.5	$2.5	$2.5	$2.5	$2.5	$2.5	$2.5	
Annual allocation	$987,043	$1,010,070	$1,032,260	$1,052,865	$1,071,540	$1,088,545	$1,104,205	$1,118,980	$8,465,508

Source and date of GNI and birth cohort information:

GNI: World Bank

Birth cohort: Ministry of Planning Statistics MOH

Total Other: .....

To the applicant:

Note: Table 8.3 is not a compulsory table.

- *Please endeavour to identify the total amount of all expected health system strengthening related spending in the country during the life of the GAVI HSS application (Table 8.3).*

Note: Please specify the contributions from the Government, GAVI and the main funding partners or agencies. If there are more than four main contributors, please insert more rows. Please indicate the names of the partners in the table, and group together all remaining expected contributions. Please indicate the source of the data (Public Expenditure Review, MTEF, donor reports etc).

8.3: Sources of all expected funding for health systems strengthening activities

In the 10 ODs, based on the existing contract model, the Government will fund $15 per delivery by a trained midwife at the health centre. GAVI HSS funds in the contract will finance immunization contacts and ANC and consultations. AusAID through UNFPA will support birth spacing acceptors, post natal care and health referrals. This will be packaged within a single comprehensive MCH Contract. Please refer to Annex 10, which provides a forecast of AOP budgets for each district and the level of NGO co financing.

The information below is sourced from the 4th Annual Operational Health Plan of the Ministry of Health 2008, and refers to total public and development partners health system funding levels in US $ for 2008.

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL FUNDS
	2008	2009	2010	2011	2012	2013	2014	2015	
GAVI	$987,043	$987,043	$1,010,070	$1,032,260	$1,052,865	$1,071,540	$1,088,545	$1,104,205	$8,465,508
Government	$137,005,850								
AusAID	TBD								
World Bank	$11.157,077								
ADB	$7,354,219								
UNFPA	$1,795,350								
DFID	$2,998,111								
Bilateral	$1,296,998								
GFATM	$10,800,142								
NGO	$4,938,563								
User Fee	$29,535								
Others	$4,572,775								
TOTAL FUNDING	**$198,144,716**	$2,928,869	$3,121,792	$1,979,839	$2,017,251	$2,051,231	$2,082,330	$2,111,287	

Section 9: Endorsement of the Application

To the applicant:

- *Representatives of the Ministry of Health and Ministry of Finance, and the Chair of the Health Sector Coordinating Committee (HSCC), or equivalent, should sign the GAVI HSS application.*
- *All HSCC members should sign the minutes of the meeting where the GAVI HSS application was endorsed. This should be submitted with the application (numbered and listed in Annex 1).*
- *Please give the name and contact details of the person for GAVI to contact if there are queries.*

Note: The signature of HSCC members represents their agreement with the information and plans provided in this application, as well as their support for the implementation of the plans. It does not imply any financial or legal commitment on the part of the partner agency or individual.

9.1: Government endorsement

The Royal Government of Cambodia commits itself to providing immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Ministry of Health:

NAME : H.E Nuth Sokhom

Title / Post: Minister of Health

Signature:

Date: 27/02/08

Ministry of Economics and Finance:

NAME: H. E Keat Chhon

Title / Post: Minister of Economics and Finance

Signature:

Date: 29 FEB. 2008

9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on Wednesday February 20th, 2008. The signed minutes are attached as Annex 10

Chair of HSCC (or equivalent):

Name: H.E Nuth Sokhom

Post / Organisation:

Signature: 27/02/08

Date:

9.3: Person to contact in case of enquiries:

Name: Professor Sann Chan Soeung

Title: Deputy Director General for Health

Tel No: 855 12 933344

Address: Ministry of Health Cambodia, 151 – 151 – 153 Kampuchea Krom Blvd., Phnom Penh Cambodia

Fax No.

Email: sanns@nip.everyday.com.kh

ANNEX 1 Documents Submitted in Support of the GAVI HSS Application

To the applicant:

- *Please number and list in the table below all the documents submitted with this application.*

Note: All supporting documentation should be available in English or French, as electronic copies wherever possible. Only documents specifically referred to in the application should be submitted.

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
National Health Sector Strategic Plan (or equivalent)	Yes	2008 - 2015	1
cMYP[48]	Yes	2008 - 2015	2
MTEF[49]			3
National Strategic Development Plan (This is inclusive of poverty reduction strategy	Yes	2006 - 2010	4
Health Sector Review	Yes	2003 - 2007	5
HSCC minutes, signed by Chair of HSCC (and all associated minutes of consultation meetings)	Yes	2007	6
Cambodia GAVI HSS Proposal 1	Yes	Oct 2007 – Oct 2008	7
Rapid Assessment HSS	Yes	2008	8
Financial Management Guidelines Dept. Finance	Yes	2007 -	9
Action Plan with Budget 2007 - 2008	Yes	2007- 08	10
Child Survival Strategy	Yes	2006 - 2010	12
Summary of Review Comments and Action Taken	Yes		13
Draft UNFPA Proposal HSS	Yes	2008 - 2009	14

[48] If available – and if not, the National Immunisation Plan plus Financial Sustainability Plan
[49] if available please forward the pages relevant to Health Systems Strengthening and this GAVI HSS application

ធនាគារជាតិ នៃ កម្ពុជា
NATIONAL BANK OF CAMBODIA
នាយកដ្ឋានប្រតិបត្តិការ

លេខគណនី
Account № 0102-35.1212-A347

គំរូហត្ថលេខា
Specimen of Signature

- ឈ្មោះគណនី [illegible]
  Account name Health System Strengthening Project
- ប្រភេទគណនី [illegible]
  Type of account
- ឈ្មោះអង្គភាពម្ចាស់គណនី ក្រសួងសុខាភិបាល
  Organization's name
- អាសយដ្ឋាន [illegible] ទូរស័ព្ទ [illegible]
  Address Telephone

ម្ចាស់គណនី Account holder -នាមត្រកូល [illegible] Name -ឋានៈ [illegible] Position - Category		គំរូត្រា Seal
អ្នកមានសិទ្ធិ Authorized Person -នាមត្រកូល [illegible] Name -ឋានៈ [illegible] Position - Category		
អ្នកមានសិទ្ធិ Authorized Person -នាមត្រកូល [illegible] Name -ឋានៈ [illegible] Position - Category		
អ្នកមានសិទ្ធិ Authorized Person -នាមត្រកូល [illegible] Name -ឋានៈ [illegible] Position - Category		
អ្នកមានសិទ្ធិ Authorized Person -នាមត្រកូល Name -ឋានៈ Position - Category		

អ្នកមានសិទ្ធិ Authorized Person -នាមត្រកូល .... Name -ឋានៈ .... Position - Category		
អ្នកមានសិទ្ធិ Authorized Person -នាមត្រកូល .... Name -ឋានៈ .... Position - Category		
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អ្នកមានសិទ្ធិ Authorized Person -នាមត្រកូល .... Name -ឋានៈ .... Position - Category		

សំគាល់:រាល់ប្រតិបត្តិការលើគណនីត្រូវមាន
Note: All operations on the A/c must have

☐ ហត្ថលេខាតែមួយរបស់ប្រភេទ..........ឬ..........
Single signature of category..........or..........

☐ ហត្ថលេខា ២ របស់ប្រភេទ..........និង..........
Double signature of categories...... and......

គំរូហត្ថលេខានេះមានប្រសិទ្ធភាពចាប់ពីថ្ងៃទី.........ខែ.........ឆ្នាំ...... 24 MAY 2007
This Specimen of Signature is valid from / /

ភ្នំពេញ, ថ្ងៃទី: 24 MAY 2007 ខែ..........ឆ្នាំ..........

នាយកដ្ឋានប្រតិបត្តិការ

គាំ_គណ្ណា