ICR Review

Operations Evaluation Department

Report Number: ICRR11601

1. Project Data:		Date Posted: 09/12/2003		
PROJ ID:	P004034		Appraisal	Actual
Project Name:	Disease Control And Health Development Project	Project Costs (US$M)	35.6	29.09
Country:	Cambodia	Loan/Credit (US$M)	30.4	27.09
Sector(s):	Board: HE - Health (91%), Central government administration (9%)	Cofinancing (US$M)		
L/C Number:	CN005; CP997			
		Board Approval (FY)		97
Partners involved :		Closing Date	03/31/2002	12/31/2002

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2. Project Objectives and Components

a. Objectives

The project supported the Government of Cambodia in pursuing two of its principal health objectives :
(1) to reduce death and sickness from preventable diseases, especially malaria, TB, and HIV /AIDS; and
(2) to rehabilitate the health system infrastructure so as to deliver basic health services and disease control programs more effectively down to the community level.

b. Components

The project had two main components:
(1) National Disease Control Programs (US$13 million, 42% of base cost) organized into three sub-components for: (i) TB control ($3 million); (ii) malaria control ($3.5 million) and (iii) HIV/AIDS control ($6.5 million). This component financed drugs and laboratory supplies, impregnated bednets, training, logistical support, and technical assistance .
(2) Health Service Strengthening (US$18.1 million, 58% of base cost), including: upgrading and construction of referral hospitals and health centers in 10 out of 24 provinces; provision of equipment, transportation and drugs; limited in-service training; and operational support.

c. Comments on Project Cost, Financing and Dates

Eleven provinces were ultimately covered, as one of the original 10 provinces split. A parallel ADB project financed health facility construction and rehabilitation in five provinces and shared a Project Coordination Unit (PCU). An amendment of the Agreement allowed construction of 16 operational district offices and training of operational theater nurses for the upgraded full referral hospitals. The project closing date was extended by nine months. Shifts in the dollar-SDR exchange rate reduced the value of the credit to $27.3 million, 99% of which was disbursed. Government financed only $1.37 million (4.8% of project costs), of a planned $5.2 million.

3. Achievement of Relevant Objectives:

There were many concurrent activities in HIV, malaria, TB, and health services sponsored by other donors . Thus, although the following *outputs* can be attributed to the project, the *outcomes* cannot be attributed to the project alone. However, the Bank project was the only one to finance national implementation of these components *by the Cambodians.*

- **Basic health outcomes :** The project built and equipped 170 new health centers and rehabilitated 26 (98% and 46% of plan); 22 referral hospitals were renovated (85% of plan). 16 provincial offices, 8 blood transfusion centers, 11 pharmacies and 5 STD clinics were also constructed. In-service training was provided for 36 medical doctors and 50 nurses, health center staff were trained and regularly supervised . Between 1998 and 2002, under-five mortality decreased from 117/1000 to 89/1000.
- **HIV/AIDS:** Key activities financed by the project included outreach to sex workers, implementation of the 100% condom program in brothels, and national implementation of HIV sentinel and behavioral surveillance . Consistent condom use rose between 1997-99 among the military from 54.2% to 69.7% and among police from 53.8% to 74.9%. The share of sex workers using condoms rose from 42% to 78%. Estimated adult (19-45) HIV prevalence has declined from 3.8% in 1998 to 2.9% in 2000 (ICR) to 2.7% in 2002 (UNAIDS), which can be accounted for by increased AIDS mortality and a posited (based on behavior change evidence) decline in the

number of new HIV infections of unknown magnitude.

- **Malaria:** Nearly 1,000 health staff and 250 military health personnel received clinical training in malaria; 475 technicians and 375 military technicians were trained in laboratory methods; 775 health center staff were trained in dipstick diagnosis and national treatment guidelines. Total cases declined by 35% between 1997-2001, malaria incidence declined from 15/1000 to 9.6/1000 and the case fatality rate was reduced by 51%.
- **TB:** DOTS (Directly Observed Treatment, short course), which was only implemented at the level of referral hospitals in 1999, was extended to 49% of all planned health centers (946) as of 2002. The cure rate has remained over the target of 85% and the relapse rate less than 5%. However, the case detection rate is believed to be low, on the order of 41%-57%. The number of TB cases treated has increased steadily, in part due to an expansion of the health system (capturing a larger % of those affected) and partly due to the increase in AIDS morbidity, for which TB is a major opportunistic infection. This growth in number of cases treated was anticipated in the SAR.

4. Significant Outcomes/Impacts:

Prior to the project, international NGOs and donors were active in the health sector. They kept the government informed, but there was little capacity in the government and very few capable national NGOs.

- **The greatest contribution of the project was in terms of institutional development and capacity building.** Enormous strides were made in terms of planning, budgeting, and elaboration of specific implementation strategies in all three national disease programs. Health management agreements were set up in all 11 provinces and -- though they encountered problems at first -- have become the basis for a realignment of the health system in which the national centers are responsible for technical direction and strategy and the provinces manage implementation. This was supported by technical assistance to the national programs, adequate finance for field supervision in the provinces, and large-scale training of health center staff in an expanded health system to diagnose and treat malaria and TB. What once were vertical disease control programs have been largely (though not completely) integrated into a decentralized health system.
- **The National AIDS Office was elevated to the level of a major disease control program --NCHADS--within the Ministry of Health.** Substantial capacity building in management and technical areas coupled with effective leadership created an entity that could spearhead the national response, moving Cambodia's HIV/AIDS prevention and control program from "a collection of small and scattered donor-supported pilot schemes to a cohesive national program" (ICR, pp. 6-7) integrated in the health sector with complete national ownership.
- **The project financed several pilot projects from which much was learned** -- the 100% Condom Use program in Sihanoukville and the social marketing of impregnated hammock nets. The former is being adapted for national replication, while the hammock net project stimulated sufficient demand for commerciallly available hammock nets so that the program will focus in the future on social marketing of insecticide treatment.
- **The project's substantial investment in monitoring and evaluation** -- HIV sero-surveillance and behavioral surveillance, baseline and final household surveys, TB prevalence survey, TB drug resistance surveillance, evaluation of the HIV/AIDS outreach program--**provided a foundation for and commitment to evidence-based decision-making.**
- **The capacity of national NGOs was built through a contract with the Khmer HIV/AIDS Alliance (KHANA) to implement the small grant component.**

5. Significant Shortcomings (including non-compliance with safeguard policies):

- **The project design did not anticipate the need for extensive training of MOH and MEF staff in Bank financial management and procurement procedures,** which added to significant delays in project implementation. However, once this was rectified (and once the second-generation special accounts were established in provinces), implementation accelerated and virtually all funds were disbursed with only a 9-month extension of the project. An attempt to expedite procurement through UNICEF in fact resulted in extensive delays, a development that probably could not have been foreseen.
- **The nationwide baseline survey in 1997 neglected to collect indicators of HIV knowledge and of ownership and use of bednets.** T**he questions on health care utilization in the nationwide final survey in 2002 are not comparable with the questions in the baseline** (so it was not possible to confidently calculate changes in access to health care), and the final survey again failed to ask about bednets.
- **NCHADS had very little influence on the types of NGO-implemented interventions financed through KHANA and there was no obvious prioritization.** The NGO activities financed through KHANA were not evaluated, with the exception of home-based care interventions, which received a supplemental grant.
- **While there were attempts to promote financial sustainability in some features of the project (adoption of user fees for some health services, social marketing of hammock nets), the functioning of the health system and national programs relies heavily on external finance (e.g. many supervision and training activities ground to a halt during the gap in funding between this project and the Health Sector Support (HSSP) project),** and the low salaries of civil servants results in low morale, motivation, and efficiency. Sustainability of the benefits from the project's civil works depends on adequate finance for maintenance and recurrent costs.

6. Ratings:	ICR	OED Review	Reason for Disagreement /Comments

Outcome:	Satisfactory	Satisfactory	
Institutional Dev .:	High	High	
Sustainability :	Likely	Likely	The benefits will likely be sustained over the next few years only because of the follow-on HSSP project and substantial grants from the Global Fund for HIV/AIDS, TB, and malaria. Cost recovery policies that now allow retention by facilities and recent increases in the salaries of some government health cadres are likely to enhance sustainability.
Bank Performance :	Satisfactory	Satisfactory	Quality of project design was highly satisfactory, but failure to recognize the need for training in Bank procedures resulted in substantial delays in implementation. Supervision was satisfactory and displayed flexibility in the sub-contracting of the civil works to the Social Fund and the HIV/AIDS small grants to Khana.
Borrower Perf .:	Satisfactory	Satisfactory	
Quality of ICR :		Satisfactory	

NOTE: ICR rating values flagged with ' * ' don't comply with OP/BP 13.55, but are listed for completeness.

7. Lessons of Broad Applicability:

- With adequate investment in institutional capacity, sufficient political commitment, and flexible implementation arrangements, relatively complex projects can be successfully implemented in difficult settings .
- The emphasis on monitoring, evaluation, and operational research in this project reinforced an evidence -based approach to public health policy in Cambodia. However, baseline surveys must take into account all of the major indicators for the project and endpoint surveys must be timely and assure comparably worded questions to ensure that changes in outcomes are measurable .
- In countries with few previous Bank projects and low capacity, extensive training of local staff in procurement and financial management procedures should be planned in the project's design and Bank supervision should be intense. Use of external consultants at the launch of the project was not sufficient to compensate for low national capacity in these areas .
- Health management agreements between provinces and the national government can be successful tools for decentralizing the management of the health system provided that there is adequate training, local participation in the planning process, and attention to the timely flow of funds .
- The shared PCU between the Bank and ADB health projects improved donor cooperation and efficiency .

8. Assessment Recommended? ● Yes ○ No

Why? This was the first health project in Cambodia, the first fully decentralized project in that country, and had a major HIV/AIDS component of interest to the OED evaluation of the Bank's HIV /AIDS assistance. A PPAR mission was concluded shortly before the ICR was drafted .

9. Comments on Quality of ICR:

The ICR makes a convincing argument for the assigned ratings and key contributions of the project by mobilizing substantial evidence, thanks to the numerous data collection activities undertaken during the project . Moreover, it usefully highlights the issue of attribution of the outcomes of the national disease programs by presenting project expenditures in the context of the spending of other international donors and government, which is not often attempted in ICRs. It would have been useful to cite the source of the spending estimates, even if imprecise (for example, if from a document or a personal communication). The ICR might also have offered more explanation of the reasons behind the lack of counterpart funding, given the assertions of high political commitment; there are discrepancies in the amount of counterpart funding ($1.37 million in the text, $2 million in the annex) and appraisal costs ($34.9 million in one annex and $35.6 in another). Finally, it isn't clear why the author used data on changes in sexual behavior from 1997-99 (before most of the AIDS component was implemented), when data are available through 2001.