Local Development through Decentralized Heath Services

End of Project Report
February 2016

LDDHS
Funded by DFAT
Implemented by NCDDS in partnership with UNCDF

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Authorship

This end of project report for LDDHS has been developed in alignment to the conditions of the UN National Implementation Modality (NIM). The report provides an overview of the implementation of the LDDHS project being generated in the first instance by the implementing partner - the National Committee for Democratic Development (NCDD) of the the Royal Government of Cambodia. The views expressed in this document are those of the author(s) and do not necessarily represent those of the United Nations, including UNCDF, their member states, or their partners.

Executive Summary

Decentralised function re-assignment is a core program area of the 10-year National Program for Sub-National Democratic Development (NP-SNDD) and its Implementation plans;

* *IP3-1:2011-2014*
* *IP3-2:2015-2017*

Under this framework the Secretariat of National Committee for Deconcentration and Decentralization (NCDD-S) and Ministry of Health (MoH) requested assistance from UNCDF in designing and implementing a test project to decentralize local health service delivery via functional re-assignments.

The Government of Australia, through its Department of Foreign Affairs and Trade (DFAT) agreed to provide funding for the demonstration and testing of functional transfer modalities through a Third Party Cost Sharing Agreement which was signed in November 2013. UNCDF and NCDD-S signed a project document (Local Development through Decentralized Health Services, LDDHS) on 11th December 2013.

The project was implemented in two phases. The first phase (January 2014 to May 2014) was to complete inception activities and the preparation of a detailed action plan for the test transfer of primary heath care functions to sub national administrations. Phase 2 (June 2014 to December 2015) demonstrated the testing of decentralized local health service delivery through functional re-assignment.

Achievements during LDDHS Phase 1 could be summarized as following:

* *Agreement between NCDD-S, Ministry of Health (MoH) and Ministry of Economy and Finance (MEF) to establish a Joint Technical Working Group (JTWG) to oversee implementation of LDDHS through NCDDS*
* *Decision on establishment of JTWG and its working arrangements signed on 4th April 2014;*
* *Agreement amongst JTWG members on roles and responsibilities of different stakeholders for implementation of LDDHS;*
* *Identification of five target administrative Districts in Battambang and Pursat provinces;*
* *A participatory situation review leading to preparation of District-level action plans for joint action (sub-national administrations and Health Operational Districts) to strengthen local health services;*
* *An expert review of financing options for LDDHS, leading to design of a Performance Based Grant (PBG) funding mechanism, fund flows and financial management arrangements;*
* *Identification of suitable arrangements for baseline survey and performance measurement;*
* *Identification of priority capacity development needs;*
* *Development of Phase 2 Action Plans.*

LDDHS implementation (Phase 1) clearly produced positive results. However, due to complex and long bureaucratic procedures, a few activities were postponed. Examples include; (i) the procurement of a performance baseline survey, (ii) organization of LDDHS board meeting, (iii) approval of Phase 2 work plan and budget, and (iv) PBG agreements with the five target districts.

Project achievements during implementation (Phase 2) are summarized as follows;

Development of legal instrument's

* *NCDD decision on selection of LDDHS five target districts with endorsement of MoH was officially signed by DPM and Minister of Interior on 11 September 2014;*

* *Prakas on function delegation of health sector to target district administrations was adopted by MoH and signed by MoH Minister on 10 October 2014;*

* *Joint decision (MOU) of work plan and budget for PBG implementation was signed by NCDD-S, MoH, and respective districts on 7 October 2014;*

* *NCDD-S guidelines for pilot program implementation and PBG execution procedures for piloting health service in target districts signed by NCDD-S on the 12 December 2014;*

* *Several official correspondences between NCDD-S, MEF and the target districts on commercial bank account opening and PGB cash flow.*

Baseline survey and reporting
Major documentation that has been generated by the LDDHS project include; (i) the performance baseline survey, (ii) quarterly progress reports, financial reports, and (iii) this end-of-project report and end-line performance survey (post project).

Capacity development
The project has provided training to all stakeholders which has consisted of; workshops and "*on the job*" training and coaching. Workshops delivered by LDDHS covered; (i) project implementation, (ii) review of functions, and (iii) district-wide local health service delivery planning and budgeting.

Capacity has also been built through dedicated training that included; (i) LDDHS PBG financial management, (ii) revision of PBG district 2015 plans and budgets, (iii) minimum package of service related activities and (iv) roles and responsibilities of District Administration for primary health care.

The project generated results in the context of improved local health service delivery being verified through sub national health statistics. These statistics recorded at all 30 health centers indicate improvements in terms of; (i) increased access to health services, in particular for maternal care, (ii) medical staff attended births, (iii) vaccinations, (iv) heath centre visits and (v) in patient care.

These achievements. which are related to functional reassignment, clearly illustrate that district administrations are able to effectively and efficiently manage access and maintenance related functions that delivery primary health care for their constituents. Further the success of the LDDHS demonstration provides a sound evidence base for the roll out of this exercise country wide.

The LDDHS project board composed of high-level officials of NCDDS, MOH, Ministry or Economy and Finance (MoEF) and UNCDF BKK Office. Direct implementation and management of LDDHS was carried by the Executive Vice Chair of NCDD-S and Undersecretary of State of Ministry of Interior, and a dedicated inter-ministry joint technical working group (JTWG) established within the framework of the LDDHS.

The JTWG composed of 14 members including three from MoH, four from MoEF, and seven from NCDD-S. The function of the JTWG was to provide LDDHS with policy advice, guidance and to facilitate M&E as well as gather lessons & experiences from this pilot for further policy level decision-making related to primary health care service delivery, associated functional re-assignment and dedicated resource transfers.

The JTWG was an active implementing partner at national level, providing support and backstopping via regular field monitoring activities at implementation sites. The JTWG was technically supported by a full-time project advisor and short-term international consultants.

Despite all positive results in terms of enhancing capacities and verifying the ability of district administrations to manage and deliver primary health care services significant challenges remain to enable a country wide roll-out.

Challenges

* *Successes and lessons learned from the implementation of LDDHS and its PBG in the five target districts are crucial for the formulation relevant policies and implementation of function re-assignments However, this transfer will potentially freeze without further support;*

* *The population-based health coverage policy has resulted in the establishment of 80 heath sector operational districts (ODs) that serve 120 administrative districts (ADs). This miss match results in some districts having to share the services provided by the ODs, creating issues related to budget and operations. It is essential that this issue is resolved so that the ODs become part of the administrative territory, which will require the establishment of additional ODs or OD inclusion within the ADs.*

* *Due to this short life of LDDHS, a comprehensive assessment on the allignment of the ODs and ADs, their working relationship and split of service delivery accountability has not been conducted.*

The RGC has annually increased its health budget and already introduced a "*bottom-up*" planning and budget process resulting in the 3-year Rolling Plan (3YRP) and Annual Operational Plan (AOP) at HC and OD levels. Nonetheless, resource allocations to the DAs to enable function transfers require to be incorporated within the DA budget (recurrent and capital).

The LDDHS PBG has established a "*bench mark*" in terms of budget allocations to aid the effective transfer of primary health care service delivery. However, the MoEF and MoH need to use such findings in to the annual budgeting processes to acomplish country wide function re-assignment.

Recommendations

To further the process of function re-assignment (primary health care) NCDD-S will continue to retain the existing JTWG as permanent working group to gather and institutionalize the process. To do this effectively, the following recommendations are generated from LDDHS:

* *Since relevant policy and implementation guidelines on conditional grants have not been formulated. The TWG should continue to institutionalize the lessons learned from LDDHS into NCDD-S policy formulation process, in particular, the conditional grant regulations;*

* *For LDDHS lessons learned and experiences to become valuable inputs into relevant policy formulation the NCDD Sub-Committee on Functions and Resources should be re-activated ;*

* *MoH D&D working group should convince its MoH senior management to institutionalize their role with accompanying resources;*

* *MoEF should utilize inputs from LDDHS lessons and experiences and its PBG implementation for formulation of policy and regulations on conditional grant transfers in this near future.*

Abbreviations

AOP	Annual Operational Plan
AWP	Annual Work Plan
AusAid	Agency for International Development
CS/ Councils	Commune / Sangkat Councils
CIP	Commune Investment Plan
CSO	Civil Society Organization
C/S	Commune / Sangkat (Lowest Level of Local Government)
CCWC	Commune Council Committee for Women and Children Affairs
CD	Capacity Development
DA	District Administration (Level of Local Government)
D&D	Deconcentration and Decentralisation Reform Policy (RGC)
DFAT	Department of Foreign Affairs and Trade - Australian Government
DPs	Development Partners
HC	District Health Center
HCMC	District Health Center Management Committee
HP	Health Post (Commune Located)
HSSP2	Health Sector Support Project (Phase 2)
IP3-2	3 Year NCDD Impmentation Plan for D&D Refrom ((Phase 2)
JTWG	Joint Technical Working Group (LDDHS Function Re-Assignment)
LDDHS	Local Development through Decentralised Health Services
MoH	Ministry of Health (RGC)
MoEd	Ministry of Education
MoEF	Ministry of Economy and Finance (RGC)
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
NCDD-S	National Committee for Sub National Democratic Development Secretariat
NIM	National Implementation Modality (UN Systems Project Management)
OD	Public Health Services Operating District
ODA	Offical Development Assistance
PADD	Policy Analysis and Development Division NCDD
PBG	Performance Based Grant
PFAs	Public Finance Administration Units (Sub National Government)
PHD	Provincial Health Services Department
MPA	Minimum Package of Activities (Primary Health Care)
RGC	Royal Government of Cambodia
SNAs	Sub National Administrations
TA	Technical Assistance
VHSG	Village Health Support Group
UNCDF	United Nations Capital Development Fund
3YRP	3-Year Rolling Plan (Capital Investments)

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Implementing the Financing for Development agenda

Blending ODA and Diaspora

The LDDHS project has been able to promote the use of blended financing to support local governments deliver improved local health services. In the District of Kandieng , Pursat Province.

LDDHS performance based grants have been blended with diaspora from an eminent US based expatriate to build a new fully equipped district health centre. Applying the blended financing options the citizens of Kandeing now have full access to quality public health services.

1.0 About this report

This End-of-Project Report provides a succinct account of the achievements, lessons learned, and forward pathways that address specific challenges from the implementation of the Project on Promoting Local Development through Decentralized Health Service Delivery (LDDHS). This report provides a consolidation of various reports from the five LDDHS targeted districts in Battambang and Pursat Provinces, and the periodic project progress reports. This document was generated in a participatory manner through organization of discussions with all levels of stakeholders, in particular the district administrations, health operation districts (OD), health centers, health center management committees (commune chiefs and councils) and LDDHS JTWG. A draft report was initially discussed at a provincial workshops and finalized at the national final (reflection) workshop with the representatives of the above institutions.

The project is pleased to share this document with all interested parties, in particular the funding agency – DFAT. NCDD-S and UNCDF are open to discuss the implementation, lessons learned & experiences, and challenges as part of the governments efforts to promote functional re-assignment under the 10-year national program for sub-national democratic development (NP-SNDD).

This report is structured as following:

* Background and Context: *This section provides the importance and rationale to align local health service delivery with decentralization & de concentration reform through function reassignment to district administrations;*
* Overview of LDDHS Objective: *Highlights the expected outcome and outputs to assess results of LDDHS implementation. This report highlights why a demonstration on decentralized local health service delivery (LDDHS) is critical to implement the findings of the function reviews and illustrate the commitment of the Royal Government of Cambodia (RGC) to the decentralization process;*
* End-Project Results: *provides the achievements against all four expected outputs of LDDHS as contained within the pro-doc;*
* PBG Implementation and Results: *One key objective of LDDHS relates to improved service delivery via the district health centers in the five target areas. This section provides first-hand results of LDDHS-PBG implementation by the five target districts while an post project implementation survey is being carried out;*
* Overall Coordination and Management: *Explains the oversight, monitoring and reporting of the LDDHS project by NCDD;*
* Summary of Expenditures: *while detailed expenditures are reported separately, this section captures, in summary, of the financial management systems, and resources received and expended;*
* Lessons Learned & Outstanding Challenges: *Key learning points and challenges are explained in this section;*
* Recommendation Pathways: *A pathway based upon a set of verified recommendations and key actions is presented.*

2.0 Background and context

2.1 Brief situation overview of the sector

Although there have been major improvements in the delivery of primary health services through the Commune Health Centers, supported by the government and multi-donor partnership HSSP2, key issues emerging from the NCCD-led local consultation and planning exercises include:

- *The level of support provided for local health service delivery varies greatly according to funding arrangements in the locality, with the allocation of funds, the amount raised from service fees and the support provided by NGO projects all being significant factors;*
- *The community health structures, (the Village Health Support Groups - VHSG and Village Health Volunteers) and the Commune Health Centre Management Committees (HCMCs) , that provide the dual function of local accountability and extending public health activities from the health center to the community, are weak except in areas where NGO projects continue to provide financial support;*
- *Village-level structures for health care are fragmentary and do not conform to any single service goal or standard, with different thematic programs (e.g. malaria, HIV) being organized through separate village level structures funded by NGOs;*

Furthermore, due to budget constraints, the Health Operational District Structures (ODs) as well as technical line offices of the Ministry of Health (MoH) face great difficulty in supporting community health functions performed by VHSG or health center staff. This activity has been previously fully supported by external projects and NGOs. It is, therefore, important that these community health structures can receive budget to enable sustainable operations and to establish an understanding of the community health needs to become more effective in the context of local service delivery planning and budget formulation practices.

2.2 Objective of LDDHS project

The National Committee for Sub-National Democratic Development (NCDD) is the implementing authority for the 10-year National Programme for Sub-National Democratic Development (NP-SNDD). Through its Secretariat (NCDD-S) NCDD is responsible for both decentralized policy formulation and programme coordination.

To support NCDD's effort to implement the results of the government wide functional reassignment exercises, UNCDF signed an agreement with NCDD-S in December 2013 to initiate a pilot project called Local Development through Decentralized Health Service Delivery (LDDHS). The pilot project was designed to design and demonstrate financial mechanisms (performance based grants) and identify suitable budget allocations to pave the way for the transfer of basic functions (access related) for the local delivery of primary health care services . LDDHS designed and tested innovations in five district administrations selected by MoH and NCDDS. The overall objective of the pilot was to improve the responsiveness, accountability and budget execution efficiency of District administrations resulting in improved provision for primary health care services. The project did not examine or exercise any activity related to the quality and type (medical) of service delivery.

2.3 LDDHS expected outcome and outputs

In alignment to the above mentioned objective the expected outcome was to design, through demonstration, novel and suitable solutions to enhance local planning and budget mechanisms to accommodate the transfer of selected public services and their local delivery from National institutions. LDDHS introduced new mechanisms that tested and promoted the improved efficiency of budget execution supporting the pilot transfer of primary health care functions to sub national administrations. LDDHS specifically designed a performance based grant applying conditions of administrative compliance , effective budget management, and public accountability.

The LDDHS pilot project delivered four major outputs: -

* *A detailed functional reassignment action plan, combining five District sub-plans, for demonstrating the transfer of an initial set of primary health care functions to sub-national authorities (SNAs), as agreed between NCDDS and MoH;*
* *Introducing performance based grants to demonstrate the transfer of an initial set of primary health care functions in five Districts;*
* *New capacities and competencies for local public health administration developed within five district administrations;*
* *Formulation of a policy and budget plan for the country wide roll-out of transfer of primary health care functions to Sub National Administrations (SNAs).*

3.0 LDDHS Results

3.1 Output 1: Detailed local plans for primary health care services

3.1.1 Formation of the LDDHS Joint Technical Working Group

According to the letter of H.E Secretary of State of Ministry of Interior and Chairperson of NCDD-S issued 28th of February 2014 to the MoH and MoEF a Joint Technical Working Group (JTWG) to test out the initial function transfers was established. Both ministries responded positively to enable the establishment of the JTWG. The Inter-ministerial JTWG was subsequently established with fourteen members, three from MoH, four from MoEF, and seven from the Secretariat of NCDD.

3.1.2 Selection of target districts

Following the formulation of the JTWG, five target districts in two provinces were selected: -

Battambang Province	Pursat Province
Mong Russey District	Bakan District
Rokha Kiri District	Kandieng District
Koh Krolor District	

Table 3.1: LDDHS Target Districts

Qualifications/Criteria for the above district's selections included:

Administrative and Health Services Territorial Alignments

A territorial mis-alignment is present between the sub national administrative boundaries and the health services (operational boundaries) resulting in inhomogeneity in terms of sub national budget distribution and execution. In this regard, due to different territorial arrangements of health operation areas and local government administrative districts, planning and budget implications will need be reconciled to enable the country wide roll out of primary health care functions.

In the context of the LDDHS project that attempted to examine this issue; Rokha Kiri, Mong Russey, Bakan, and Koh Krolor districts provide alignment i.e. one health operational area for each district. Kandeang district illustrates the misalignments with the administrative district receiving health services from a health operation area that provides services to an additional three administrative districts.

Concentration of Support

To ensure that it was easy to provide technical support from provincial and national levels (linking to NCDD structures), criteria relating to geographical positioning (clustering) was considered. To support clustering of the pilot, Rokha Kiri, Mong Russey, and Koh Krolor districts in Battambang province as well as Bakan and Kondeang districts in Pursat province were found to be most suitable options to support this qualification by the JTWG.

Commitment from district administrations and other stakeholders

From the field assessment conducted by the JTWG members during March-April 2014, district and commune administrations as well as health centers, health operation area officers and other stakeholders from the five districts tabulated (*table 3.1*) showed high levels of commitment and made pre-cursory preparations for the LDDHS project. The NCDD decision note (in Khmer) on five target district' selections with endorsement of Ministry of Health was officially signed on 11 September 2014, providing an MoU between the project and the pilot district administrations.

3.1.3 District's health service delivery improvement plans

NCCD advisors based in each target province facilitated the development of the LDDHS district action plans forging partnerships between district administrations, health centers, respective commune councils, and sub national line offices of the MoH. The draft action plans were discussed and agreed upon during the LDDHS Battambong workshop held between the 9-10 of April 2014. As a workshop output, all of the district action plans were translated into English, and utilized as the input for the Action Plan related to the second phase of LDDHS project. The LDDHS phase II work plan was submitted to NCDD-S and DFAT at the end of April 2014 and was approved at the end of May 2014.

3.1.4 Baseline performance based grant survey

To assess the level of success of the LDDHS Performance Based Grant, a baseline assessment was conducted in the five districts, focusing upon a set of relevant indicators of service delivery access (e.g. physical condition of health facilities; coverage of outreach activities etc.) The assessment also allowed for the identification of key points at which the processes of financing and administrating local service delivery could be improved. Moreover, indicators on stakeholder capacity (e.g. work and budget plan preparation for primary health care functions at district level) have also been captured by the survey. This assessment was implemented by academia that consisted of the health specialist lecturer and the student groups of the University of Battambang.

Although the procurement for this activity was delayed the developed PBG criteria (which examined administrative compliance, budget planning and execution and democratic accountability) was captured as base line data during the survey. This information was subsequently updated at the end of the project cycle.

3.2 Output 2: Demonstration of the transfer of primary public health functions

3.2.1 Function review and delegation of local health service delivery

The functional review of the health sector (local health service delivery functions) was completed in 2013 by a technical working group. The members composed senior officials from MoH, MoEF, NCDD Secretariat, facilitated by an international health consultants from the HSSP2 program, NCDD-S and UNICEF.

In the first phase of LDDHS discussions finalized the scope of function reassignments relating to the delivery of primary health care services for testing and demonstration purposes. The outcome of workshop in Battambang Province on 9-10 April 2014 proposed that function transfers be limited to service provision and access and include: -

* *Health centre maintenance (including hygiene, electricity, water, etc.);*
* *Providing motivation and support to community health mechanisms run by the HCMCs and VHSG';*
* *Motivating health center staff ;*
* *Promote and include other services such as community health service outreach and 24-hr standby services;*
* *Strengthening monitoring, control, and evaluation mechanisms on health center service delivery, and community health support mechanism.*

A Prakas covering the functional delegation of primary health care to target district administrations (Khmer) was signed by the Minister of Health on 10 October 2014.

3.2.2 Capacity development

Various interlinking capacity development activities were delivered through the organization of workshops, backstop stopping meetings with target districts by JTWG members and the LDDHS project team in partnership with NCDD. Capacity development activities conducted within the LDHHS project are tabulated below.

LDDHS CD Event	Venue	Participants	Date
Review of Functions, primary health care Sub-Functions	Plenary and group discussion in Battambang, using outdoor assessment exercises in all target districts	District and commune administration, , OD and HC representatives, NCDD advisors, JTWG members (MoH, MoEF abd NCDDS)	9-10 April 2014
Training on LDDHS PBG Financial Management	Preah Sihanouk Province	Representatives of target districts councils, NCDDS Finance Advisor, JTWG members and LDDHS Project Advisors	16-17 October 2014
Training on LDDHS financial and accounting systems	Mong Reusey District, Battambang province	Representatives of three target districts administration and councils, PFAs, NCDD Provincial Finance Advisors, District Advisors, Operational District Deputy Director, Health Center Chiefs,	8 December 2014
Refresher's Training on LDDHS financial and accounting system, and revision of PBG district 2015 plan and budget	In Pursat for its two target districts, and in Mong Russey District for all three Battambang target districts	District and commune administration (governor, selected council members, and finance officiers), advisors, OD and HC representatives, PFA, JTWG members and LDDHS Project advisors	19-21 January 2015

Table 3.2: LDDHS Activities

LDDHS CD Event	Venue	Participants	Date
Training on Minimum Package of Activities and Roles and Responsibilities of District Administrations and LDDHS stakeholders	Mong Russey District for all three Battambang target districts	District and commune administration (governor, selected council members, and SNA Officera who were responsible for LDDHS project), advisors, OD and HC representatives, PFA, JTWG members and LDDHS Project advisors	27-28 April 2015
Training on Minimum Package of Activities and Roles and Responsibilities of District Administration and LDDHS stakeholders	In Pursat for its two target districts,	District and commune administration (governor, selected council members, and DA Officer who is responsible for LDDHS project), advisors, OD and HC representatives, PFA, JTWG members and LDDHS Project advisors	29-30 April 2015

Table 3.2: LDDHS Activities

3.4 Output 3: National policy and planned transfer of health functions

In principle, LDDHS pioneered the functional transfer process of local health service delivery in five target districts. In essence it is considered, post project, by policy makers that local health service delivery can be coordinated, managed and budgeted by both national and sub-national administration based on a split of responsibilities and accountability. Administratively, local governments (in this context district administrations) have proved their ability manage primary health care service delivery whist the technical and quality aspects and national health programs be handled by sector ministry's line offices.

To enable the implementation of the LDDHS demonstrations a number of legal instruments and policy guidelines were developed and implemented within the framework of the project as listed below.

* *NCDDS decision on establishment of the inter-ministerial JTWG and its working procedures to implement LDDHS signed on 4th April 2014;*
* *NCDD decision on selection of LDDHS five target districts with endorsement of Ministry of Health was officially signed by DPM and Minister of Interior on the 11 September 2014;*
* *Prakas on functional delegation of primary health care provision to target district administrations was adopted by MoH and signed by MoH Minister on 10 October 2014;*
* *Joint decision (MOU) of work plan and budget for PBG implementation signed by NCDD-S, Ministry of Health, and respective districts on 7 October 2014.*

The application of these instruments established a conducive environment for the demonstration of the pilots to test the functional transfer of primary health care services to district administrations. Based upon the results of the LDDHS project the proven tools that include PBGs and PFM training can be utilized to replicate the transfer exercise country wide as a scale up policy action internal to government.

Furthermore, the LDDHS had to facilitate the numerous official correspondences between NCDDS, MEF and the target districts related to the opening of commercial bank accounts and PGB cash flows. In addition the LDDHS project assisted NCDD-S to generate detailed guidelines for pilot program implementation and PBG execution procedures.

These guidelines were tested throughout the initiation, distribution and monitoring of the LDDHS PBG Implementation and will be adopted by NCDD, MoH and MEF to facilitate the national roll out of primary health care functions. The guidelines are presented in four chapters:-

* *Chapter 1: the Legal Aspect and Concerned Stakeholder's Roles and Responsibilities;*
* *Chapter 2: Planning and Budgeting Local Health Service Delivery;*
* *Chapter 3: Implementation of Local Health Service Delivery;*
* *Chapter 4: M&E of Local Health Service Delivery Program Implementation.*

4 PBG Implementation and Results

4.1 PBG Allocations & Transfers

The PBG for primary health care functional transfers was designed to provide additional vertical transfers from National to District budgets to; (1) test out new vertical transfer mechanisms, (2) provide a cost estimate for primary health care functional transfers, (3) to provide additional resources to enable local governments take up new mandated responsibilities and (4) introduce administrative performance measurements to induce higher levels of democratic accountability.

The PBGs were developed to effectively demonstrate the transfer of primary health care service provision. The MOU's outlined the conditions, criteria for the allocation, the amount of allocated budget , expenditure conditions, and resource flows to the district based on performance and outcome measurement. Budget allocations being detailed below.

District	Health Centre	Vilages	Communes > 5km from HC	Villages using the HC	Budget (US$)
Mong Russey	9	92	36	13,404	39,234.76
Koh Krolor	2	51	24	14,491	15,435.09
Rokha Kiri	2	31	21	23,358	14,804.14
Bakan	10	153	62	14,556	50,655.29
Kandeang	5	110	31	13,024	29,870.71
Total	16	437	174	78,833	150,000.00

Table 3.3: LDDHS PBG Budget

To support direct fiscal transfers, to be later incorporated within the treasury system, NCDD-S issued an official letter to MoEF in September 2014. The request to test out a new vertical transfer mechanism (on principal consent) from MoEF was approved on 2 October 2014. Based upon this approval NCDD-S issued instruction letters to all five districts to open LDDHS PBG bank accounts at the local branches of the ACLEDA commercial bank.

The first tranche of PBG funds were successfully transferred to the five districts in the 3rd week of December 2014 while the second was distributed based upon performance assessment of the utilisation initial tranche in July 2015. PBG amounts and transfers detailed are shown in the following table:

District	Tranche 1 (US$)	Tranche 2 (US$)	Total PDG (US$)
Mong Russey	13,078.25	26,156.51	39,234.76
Koh Krolor	5,145.04	10,290.06	15,435.09
Rokha Kiri	4,934.71	9,869.43	14,804.14
Bakan	16,885.10	33,770.19	50,655.29
Kandeang	9,956.90	19,913.81	29,870.71
Total	50,000.00	100,000.00	150,000.00

Table 3.4: LDDHS PBG Budget by Tranche

4.2 PBG Implementation Mechanisms

The LDDHS PBG is a innovative grant mechanism that has been demonstrated in five target districts being specifically earmarked for the transfer of primary health service delivery to district authorities. The grants represent the actual cost of the transfer of service functions to enable district authorities maintain and improve primary health care service delivery (limited to access and availability of services). The PBG were not designed to maintain or improve service quality but placed focus on the incluisve and continual access to primary health services for poor rural communities.

Through joined up planning that involved district administrations, health operational districts and citizens individual local government service delivery plans were formulated and budgeted.

The performance criteria for the grants, which was utilized to determine the distribution of the second grant was purposely developed by UNCDF as previously described through a dedicated consultant mission. The performance criteria did not over-burden and were not too strenuous for adoption by the district administrations and in the main provided a systematic check of administrative compliance in the context of budget management, execution, and reporting. It should be noted that the performance aspects of the grant aligned to the general rules and conditions of the NCDD district development fund.

To ensure the testing of function transfers, the five district administrations worked with their respective heath sector OD partners, HCMCs (comprising of HC chief, commune chief) and commune council representatives) to effectively plan and prioritize activities and budget expenditure to improve service delivery. The entire planning exercises for was facilitated by NCDD-S in coordination with the deputy governor and assigned district councilors.

The plans were reviewed by JTWG and signed by NCDD-S chairperson, MoH, Vice Provincial Governor and respective District Governors (at LDDHS Board meeting on 7th October 2014). The district working groups have since transformed to become the LDDHS PBG implementation working groups.

To enable transparent PBG financial management, each target district established internal teams that approved, certified and accounted for the draw-down of the PBG in alignment to NCDD-S guidelines. The teams were chaired and directed by the Governor with Deputy Governors as alternate approving officers. The certifying team generally composed of Deputy Governor with District Director of Administration being the alternate certifying officer. The Chief of the District Fffice of Administration and Finance managed the process. The PBG transfer mechanism also tested the use of treasury deposits into district administration accounts held at the ACLEDA being disbursed through double-signatory cheque and petty cash systems.

Since the PBGs provided first earmarked transfers to provide discretionary authority to the district administration and were handled through private bank system, NCDD-S Finance Office involved the NCDD-S provincial advisory team, in particular the NCDD-S Finance Advisor. The team desiminated and trained on the PBG financial and accounting guidelines and supported monitoring and reporting.

4.3 PBG implementation cases

The LDDHS project supported the innovative testing of functional transfers based on the functional reassignment studies conducted within the framework of IP3. It should be noted that it was the time ever that DAs received earmarked funds to finance the transfer of new service delivery functions. Specifically, the target districts had to plan and budget the PBG to implement the identified sub-functions detailed under MoH's Prakas dated 10 October 2014. The following cases illustrate the success of the demonstrations and of the new fiscal transfer system that have been introduced to support functional transfers within the D&D framework.

4.3.1 Maintaining health centers including hygiene, electricity, water

Health center facility improvements were rated as a high priority by all health centers and their HCMC. Therefore, all five districts have utilized a large proportion of their PBG to implement the health center maintenance sub-function. This becomes a definitive output for LDDHS as local government entities are introducing "*maintenance budgeting*" for asset management and public service delivery. The PBG financial transfer mechanisms have also introduced specific earmarking for "*asset maintenance*", bringing in a new criteria and domain for sub national budget formulation.

Concretely, each target district has positively responded to the priorities submitted by their respective health center and its partner commune(s) through the HCMC mechanism. These asset upgrade and maintence based priorities included renovation of electrical supply systems, installation of solar electricity, installing clean water filtration system, HC toilet's repair and replacement, construction of new medical waste incinerators, HC waste landfill and the setting up or repair of plumbing systems.

Kandeang District

5 Summary of district maintenance activities:

5.1 Maintenance

Bakan	Kandeang	Rokha Kiri	Koh Krolor	Mong Russey
Purchased furniture to 11 Health Departments	Connected electricity to 3 HCs (at Sya, Kanchor and Sresdock)	Electricity connections and monthly bill payments for all 2 HCs and 1 health post in the district	Repaired toilet and 3 bathrooms with 100% completion.	Prepared 1 electricity system, connected the electricity network & paid electricity for 8 HCs.
Repaired and constructed waiting rooms (4mX8m) at the HC of Rohal Teul, and Tra Paing Chong, extended waiting area at Bat Kandol.	Repaired the electricity network (in 4 HCs including Kandeang, Watpor, Sresdock and Koh Chum).	Clean water connection for all 2 HCs and 1 health post Toilet constructions and repairs for all 3 HCs and health post	Repaired kitchen	Four HCs received water buckets and stand holders & improved water system at 3 HCs
Repaired bathroom, constructed toilet (1.5mX2m) at the Rohal Teul.	Buy one Honda generator (3KW) for Raing Teul HC.	Provision of 4 beds to all 3 HCs & health post (1 for Prey Tralath, 2 for Prek Chhek and 1 for Roung)	Repaired bedroom for staff and delivery room	Repaired the toilets for 4 HCs and 2 HCs had made a concrete road to the toilet.
Repaired incinerator for Tra Paing Chong and Boeung Kandol HC.	Repaired clean water pipes for all 7 HCs, but added the sinks and water tank for the Sresdok.		Paid for electricity for two months to Koh Kralor HC.	1 HC had repaired the Ceiling
Constructed incinerator for Rohal Teul and Svay Donkeo HCs.	Repaired the culvert for rain water stock at the Raing Teul HC.		Repaired 5 bathrooms and toilets	1 HC repaired the wall tile for delivery room
Constructed large incinerator Oh Tapoung HC.	Made concrete floor for 4 HCs with 444m² in Kandeang, Sresdaok, Watpor and Kanchor.		Paid electricity bill for 2 months.	1 HC had repaired the roof of the building
Provided electrical components and installation to 11 HCs	Constructed 3 new Rubbish burn ovens for Kandeang, Kohchum and Sredok HCs.			Repaired incinerators for 4 HCs
Connected the electricity for Rohal teul HC.	Repaired 5 toilets for Kandeang, Sresdok, Watpor, Kohchum and RaingTeul HCs.			5 HCs had received the bed for the patients
Provided the Monthly Supplement Salary to cleaners in 11 HCs				One HC had fixed the metal fan for security purposed.
Provided the fuel for ambulance from Ta Lourm HC to the provincial Hospital daily service				Completed the yard for 3 HCs, and completed with laterite make concrete floor for 2 HCs

Kanchor Health Centre - Tonle Sap

Kanchor Health Center services the remote Kanchor Commune located along Pursat River close to Tonle Sap Lake. The administrative territory has a population of approximately 9,500 people.

The Kanchor HC was established in 2013 and comprised of a very small staff of three persons, two of which were female. Until 2014, primary health care service delivery by the HC was limited mainly due to lack of electricity and the remoteness of the centre creating travel inconvenience for HC female staff and villagers.

In 2014, the HC was provided with solar power however, the system lacked capacity to provide an adequate electrification solution. This limited working hours of the HC to the day and also affected staff attendance levels.

The PBG was introduced in early 2015 to connect on-grid electricity and upgrade access and waiting areas. These improvements translated into improved security for the staff and end users. Today as a direct result of the PBG, Kanchor HC is open 24/7. With on-grid electricity. The HC has now pumped water improving sanitation. With these effective and efficient small scale interventions service delivery has considerably increased in particular for attended child delivery services.

5.2 Providing motivation to community health mechanisms

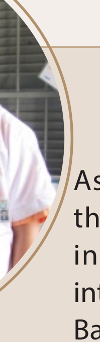
The reactivation of community health mechanisms that were formally supported by NGOs has been key priority of the district administrations and the HCMCs. As a value added component of the project the RBG injected funds for HCMC to conduct meetings and cover the travelling cost for VHSG members to provide community level support, raise awareness and follow-up community's outpatient visits (including pregnant & newly delivered women, TB, other outpatients). Over are summaries of projects outputs under this sub-function:

Bakan	Kandeang	Rokha Kiri	Koh Krolor	Mong Russey
Provision of incentives to VHSG to gather children for monthly vaccination program	Organization of VHSG bi-monthly meetings	Organization of bi-monthly HCMC and VHSG meetings to discuss challenges, utilization of budget,	Organization of monthly VHSG meetings including VHSG training (12 times)	Organization of HCMC every 2 months to discuss and solve problems of HC service delivery,
Provision of incentives to VHSG to convince potential TB patients for check-ups at Health Center	Provision of incentives for dissemination of relevant information to community and community feedback and concerns to health centers	Citizens pilot feedback, solution to improve HC's performance & development of VHSG work plan 5 VHSG trainings on birth & birth spacing, malaria, TB and sanitation & hygiene	Organization of HCMC quarterly meetings and training (20 HCMC members received training)	Community's feedback and preparation of VHSG work plan

5.2.1 LDDHS PBG for health center and VHSG staff in Bakan District

As summarized in the above table, with the application of the PBG new mothers and families in Bakan were able to receive relevant information and attend follow-up post natal checks. This process also allowed HCs and the associated OD to correctly update their database on pregnant women, vaccinated children, and malnourished children in their service delivery coverage area.

Through community network strengthening PBG grants provided through the LDDHS project helped pregnant women received maternal and pregnancy care on an a regular monthly basis and confidently used HC'maternity services as opposed to using traditional methods of care. Below are some validated improvements of primary health service provision recorded in the LDDHS pilot districts after the transfer of functions and provision of earmarked grants.



Bakan- Pursat Province

As a result of the LDDHS pilot intervention and introduction of the in Bakan that provided PBGs to 11 health centres key achievements have been made to validate the function transfer of primary health care to district administrations.

* *The number of vaccinated children increased from 2,955 in 2014 to 3,197 in 2015;*
* *Number of TB patients received treatments increased from 3/HC/month in 2014 to 6/HC/month;*
* *Number of active VHSG increased from 3 to 10 VHSG covering all communes in the District by 2015.*

5.2.2 Motivating health center staffs

To facilitate function transfer of primary health care services to local government the motivation of HC staffs is fundamental to improve service delivery. Prior to incentive focussed support being provided to health center's personnel in the five target districts, service delivery at those health centers was poor as staff did not attend work resulting in no evening and night health service coverage. This resulted in many complaints being raised by villagers often citing no access or no service provision as the HCs suffered early closures due to the lack of security, inadequate facilities, but most importantly for absenteeism of HC staff.

The LDDHS earmarked PBG supported the real transfer (underpinned by financial resources) of discretionary authority to the district administrations. Notably priorities for HC staff incentives took a slightly different form when compared to the initial concept raised in the project document and LDDHS Anual Work Plan (AWP).

Bakan	Kandeang	Rokha Kiri	Koh Krolor	Mong Russey
Provided incentive to HC staff, for 31 24-hr security guards in all 11 HCs budget cost US$45/ month	Provision of food allowances for staff at all 7 HCs for 24-hour shifts	Provision of travel and food allowances for HC staff to conduct community outreach activities (7 times for Preak Chhek, 14 times for Prey Tralat)	Provision of night-shift payment to doctors, HC staffs, contracted staffs.	Provision of travel and food allowances to HC staff local vaccination activities
Organization of specialized computer training course for 22 LDDHS concerned staff		Provision of food allowances for staff at 2 HCs for 24-hour shifts	Provision of office stationery to HC personnel, in particular contracted staff to serve better at HCs	Provision of food allowances to HC staff at all 9 HCs for 24-hour shifts
			Provision of incentives to HC and OD staff to conduct community service outreach and cross-district missions	

Through LDDHS PBG incentive schemes for VHSG, HCMC and HC personnel provided by the district administrations, health service access has been improved, in particular for poor women and children living in very remote areas. At health centers, there were also, on standby, health physicians during the night shifts and guards to provide security protection for in-patients and health center personnel. With these changes in place, people now have 24/7 access to local health services and for emergency purposes. The exercise has also indicated the level of financing for staff and maintenance that will be required per HC to ensure 24/7 coverage. Thus, results provided by this activity have assisted NCDD to verify and validate adequate operational budgets to be provided to the district authorities for the cost of this function transfer.

Koh Krolor Health Centre - Battambang

Due the improved motivation of HC staff induced by the LDDHS earmarked grants faciliated 24 / 7 coverage at all 9 HCs. LDDHS has contributed to enhancing primary health service delivery in Mong Russey District which has witnssed improved public health care indicators :

* *BRG vaccinations have increased reaching 2,822 in 2015;*
* *Hepatitis B vaccinations increased from 1,494 in 2014 to 1,880 in 2015;*
* *Vaccination to children for measles increased from 2,221 in 2014 to 2,357 in 2015;*
* *Outpatient visits at all nine health centers increased from 81,901 in 2014 to 91,999 in 2015;*
* *Attended deliveries increased from 2,280 in 2014 to 2,301 in 2015;*
* *Pregnancy checks (2-times) increased from 2,239 in 2014 to 3,001 in 2015;*
* *Pregnancy checks (4-times) increased from 2,373 in 2014 to 2,621 in 2015;*
* *All pregnancy checks increased from 14,166 in 2014 to 15,342 in 2015;*

5.2.3 Health service outreach and 24-hr standby services

To improve local service delivery the LDDHS project developed unique incentive schemes for VHSG, HCMC and HC staffs using the PBG. As a direct result health centers were able to conduct health outreach service delivery activities. These included the organization of individual village based monthly health awareness raising activities. Using funds from the PBG the HC physicians conducted these campaigns with support from VHSG members. Meetings and local health campaigns included birth spacing/family planning program, dissemination of information on available services offered at respective health centers, pregnancy checks, vaccination injections and other health related services were all delivered as funding was made available. The results of direct funding underpins the notion that effective and efficient public service delivery at the sub national level is highly dependent upon the predictability of earmarked fisical transfers.

The PBG mechanism secured direct funding for public service delivery. The results of the pilot initiatives underpins the rationale that earmarked finance can contribute to improving public service delivery.

Bakan	Kandeang	Rokha Kiri	Koh Krolor	Mong Russey
Organizations of individual HC monthly service delivery outreach & health awareness raising activities.		Traditional midwives assisted to support HC attended deliveries at the HCs	Organizations of individual village monthly health service delivery outreach & health awareness raising activities.	Provision of incentives to OD for provision technical backstopping to all nine health centers
As for remote HCs such as Rohat Toeul and Meteak, these activities were conducted quarterly		Ambulance and staff 24-hour stand-by	Organization of local health public forums (3 times in 2015)	

Mobg Russey - Battambang Province

Using the innovative LDDHS PBG mechanism the Koh Krolor district administration has invested budget to provide improved access to primary health care resulting in:-

* *In-patient care increased by 38% and with 527 patients staying at the HCs in 2015;*
* *Pregnancy checks, birth deliveries, 9-type vaccinations, knowledge on nutrition on other related matters increased;*
* *Local public forum on health has convinced people to increasingly utilize the two health centers for health consultations.*

5.2.4 Strengthening service delivery monitoring, control, and evaluation

As increased finances were made available to the district authorities through the LDDHS PBGs, local governments were required to strengthen their oversight of primary health care service provision and citizen perceptions satisfaction. Using a nominal portion of the earmarked PBG the pilot local governments undertook regular M&E exercises, arranged district council meetings, and local forums on service delivery of the HC's. The government – citizen interactions provided mechanism to improve service delivery after the initial function transfer.

These M&E arrangements have further allowed district administrations to report on improvements related to local health service provision (access), and health facilities. The following M&E activities were implemented within the target districts and provided budget lines to which to conduct M&E activities. The findings of the M&E for the earmarked PBG needs be considered when formulating the national budget to support country wide function, transfer of primary health care responsibilities.

Bakan	Kandeang	Rokha Kiri	Koh Krolor	Mong Russey
OD & DA sent representatives to participate at monthly HC meeting	OD and DA carried out inspections in all HCs	OD & DA able to advice and monitor HC & its HCMC	DA conducted HC service delivery monitoring, participated at HCMC meeting to compare progress against monthly work plan	OD provided technical back-stopping to all 9 health centers on regular and request basis
OD & DA representatives interviewed citizens at HCs and community to examine service delivery and citizen perceptions	27 governance inspection trips to monitor PBG implementation, provide technical advice to improve planning and budget performance Regular HC facility construction and maintenance inspections	HC prioritization and its screening PBG utilization Technical matters ie vaccination, drug quality inspection Collection of people's views on HC service delivery performance & improvement LDDHS & HC service delivery improvement reported and discussed at monthly district's council meeting	OD meeting conducted monthly governance inspection, reviewed HC's monthly reports and participated at local health public forums	OD & DA conducted regular monitoring on PBG implementation at HCs, especially during the constructions, repairs and connections of electricity for all 9 HCs

Koh Krolor - Battambang Province

"LDDHS is the first primary health sector project that involves district councils. We've gained new knowledge and capacity related to local service delivery planning, budgeting and monitoring".

"The M&E component was useful as we regularly visited our HCs to inspect HC's facility's constructions or maintenance repairs, enquired about health service provision from citizens ask patients. This allowed us to report to our council at our monthly meeting. On project expenses, we could ask our district finance and administration personnel and follow-up progresses.

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Voat Po Health center

Photograph Copyright @ UNCDF

LDDHS Sucessfully Coordinating National and Local Actors

A Joined Up Approach

The core aim of the LDDHS project was to demonstrate through testing the feasibility and an innovative budget practice to support the transfer of permissive primary heath functions from the MoH to district administrations.

The project facilitated the formation of an inter-ministry joint technical working group (JTWG). The proactive JTWG that included representatives from the MoH, MoEF, and NCDD worked with the sub national actors to sucefsuly transfer heath care functions.

6 Project Management Arrangements

LDDHS supported the demonstration of decentralised primary health care function transfers in five district administrations located within two adjacent Provinces. The pilot project and innovative fiscal transfer mechanisms were developed to allow the RGC gain experiences and develop evidence informed policy leading to national implementation (roll out) of the transfer of primary health care functions and allocation of associated budgets to the district authorities.

The implementation of the LDDHS project was conducted in two phases. Phase I from January to April 2014 focusing on preparatory tasks. Phase 2 was completed between June 2014 and December 2015 to test and demonstrate function transfers and introducing an innovative earmarked PBG to finance function transfers and impact monitoring.

LDDHS is the first intervention that has pioneered the testing of functon transfers from national to sub national government institutions in Cambodia

A standard UNDP National Implemntation Modality (NIM) project organization was established during Phase I to provide for overall coordination and oversight functions reporting to a project board. The LDDHS board was composed of high-level officials of NCDDS, MOH, MEF and UNCDF Bangkok Regional Office. Direct implementation and management of project was carried by the Executive Vice Chair of NCDD-S and Under Secretary of State of Ministry of Interior, and the associated JTWG.

The organization of the first LDDHS Project Board Meeting in October 2014 included a total of 51 participants from government officials and Development Partners (DPs). The meeting was organized under the presence of LDDHS Board Chair, and Secretary of State of Ministry of Interior and Chairperson of NCDD-S.

LDDHS Project Board Meeting

LDDHS Board Meeting approved and signed:	* *LDDHS 2015 work plan and budget;* * *NCDD-S-MoH-District kick-off PBG to be implemented in all 5-target districts;* * *Distributions of LDDHS motorbikes and computer sets to all five particpating districts.*

The project board on behalf of H.E. Te Kuyseang, Secretary of State and chairperson of D&D working group from the Ministry of Health, led the joint technical working group (JTWG) to conduct an oversight mission of the implementation of the LDDHS project in all five-target districts in Pursat and Battambong between 25-26 May 2015.

The high-level mission reviewed all LDDHS district level activities, discussed implementation challenges and identified "*quick win*" outputs with all stakeholders, providing recommendations and solutions to mitigate encountered bottlenecks.

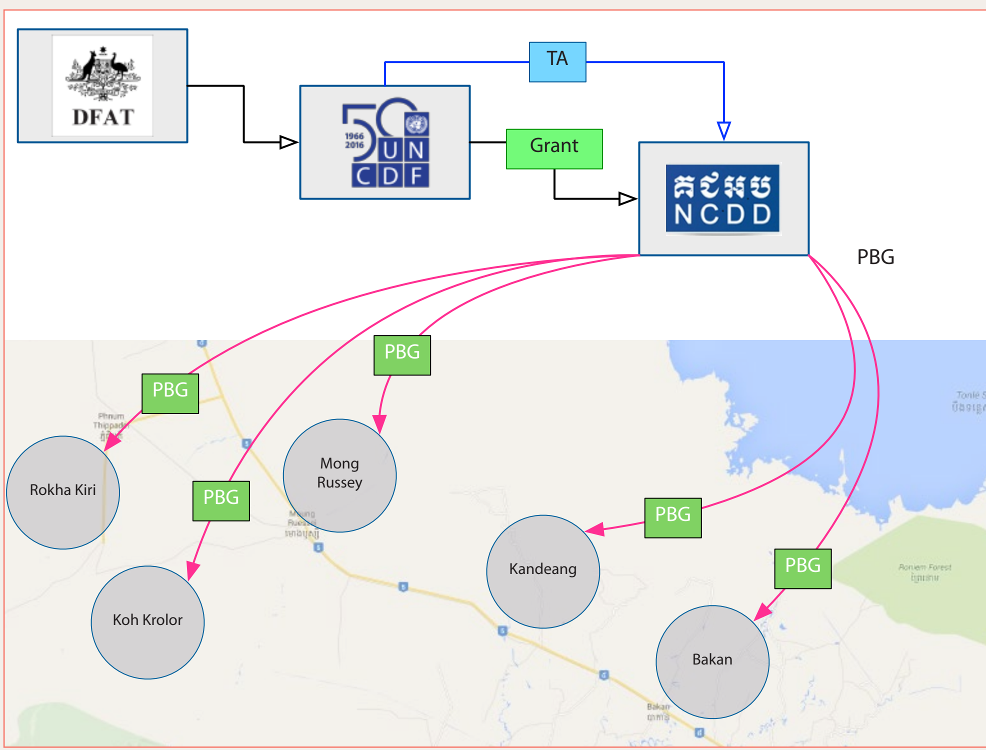
At the implementation level the JTWG guided the district administrations to facilitate and conduct M&E activities to gather lessons & experiences from this pilot for further national policy decision-making. Under the direction of the Executive vice Chair of NCDD-S and Undersecretary of State of Ministry of Interior the JTWG proved to be a responsive implementation advisory body for the LDDHS project at national and sub national levels. The JTWG provided various types of support and backstopping, and conducted regular field monitoring activities throughout LDDHS project cycle.

A full-time project advisor, a finance assistant, and a national planning specialist technically supported the JTWG. These inputs were complimented with short-term support of two international consultants missions. The international consultants were involved at the start of LDDHS implementation to prepare LDDHS Phase II Action Plan and to design the PBG in the context of financial flows and procedures.

LDDHS Project Board Field Visit

LDDHS Project Board Field Trip	* *High-level mission's photo with Battambang and Prey Tralach Health Staff at Prey Tralach Health Center, Rokha Kiri District - 26 May 2015.*

7 Summary of Expenditures



Financially, LDDHS operated with three different layers of financial transfers as illustrated above.

Explanatory Notes:

* *DFAT transferred LDDHS fund to UNCDF;*
* *UNCDF directly disbursed and responsible for TA component, and transferred other operation budget and PBG amounts to NCDD-S;*
* *NCDD-S had two bank accounts: (1) direct disbursement for operations of LDDHS and (2) for District PBG;*
* *Five Districts managed its PBG via ACLEDA Bank.*

NCDD-S expenditure portion under direct disbursements for three outputs:

* Output 1: *A detailed action plan composed of five district sub-plans, for testing transfer of an initial set of public health functions - agreed between NCDDS and MoH;*
* Output 2: *Capacity for Public Health Administration Developed in 5 Districts;*
* Output 3: *Policy and plan for roll-out of transfer of primary health functions US$ 158,736. Under PBG financial transfer system (i.e. NCDD-S separated bank account to District Administration Operational Accounts).*

7.1 Project Expenditure

The following expenditure has been recorded by the LDDHS project. All transfers were made as performance based grants being managed and implimented outside of the national treasury system. The recipient district authorities established commercial bank accounts to receive the PBG and financially accounted for its use complying to NCDD-S district fund guidelines. The second tranche disbursement was based on the districts adequately complying to the performance criteria set by UNCDF. In all cases the district authorities attained performance compliance during the project cycle.

The LDDHS PBG's upgraded the performance of the district administrations introducing performance criteria, measures and procedures to make the use of public budgets mor transparent.

The use of non-treasury systems ensured that the PBG's were expedited in a timely manner, limiting treasury system bottlenecks associated with vertical transfers that are commonly found in the country.

The PBG system allowed for the subsequent testing of an innovative sub national performance based grants mechanism to finance function transfers from a line ministry to sub national district authorities. With the PBG being outside of the normal treasury transfers clear results and observations could be formulated to inform subsequent policy reforms. It is anticipated that the PBG mechanism will be embedded into the treasury system to scale up the transfer process associated with primary health care services being provided by local government.

Year	Received (US$)	Expenses (US$)	Balance (US$)	Remarks
For outputs 1 to 3				
2014	50,615	47,070	3,545	*NIM financial reports are submitted to UNCDF separately*
2015	112,833	111,666	1,167	
Total	163,448	158,736	4,712	
Under PBG Financial System - to achieve Output 4: Implementation of initial sets of delegated health functions by district administrations (30 Health Centers)				
2014 PBG	50,000	50,000	0	*Transferred to five target Districts & under direct District management*
2015 PBG	100,000	100,000	0	
Total PBG	150,000	150,000	0	

8 Lessons Learned & Outstanding Challenges

In conclusion, the LDDHS pilot has produced many positive results, especially in the context of demonstrating innovative systems and verifying sub-national capacities to support function transfer. The early results of project suggest that when effective and realistic budgets are applied to support function transfers improved service delivery is witnessed. It is essential to acknowledge that service delivery provision at sub national level in Cambodia will be, going forward, highly dependent upon budget transfers. For this reason, capacity development and / or systems process enhancements will not necessarily translate into improved public service delivery unless finance is attached. The successful implementation of the LDDHS earmarked PBGs clearly illustrated this issue. The project has proven that earmarked performance-based grants translate into effective and efficient local service delivery, this being subsequently verified through local health care statistics. Further, it may be propositioned that through the 24/7 availability of services availability efficiency gains in public service delivery has been attained with public assets being utilized 24 hours / day.

Statistics illustrate and validate the viability of function transfer of primary health care service delivery from national to sub-national entities.

In terms of improved local health service delivery, statistics recorded at all 30 health centers show impressive results in terms of improved access and outreach. In all districts higher levels of attendance at the HCs were recorded. This has enhanced the number of maternity checks and vaccinations taking place. This achievement suggests that through the injection of adequate public financial resources to local government public services delivery improved public services provision can be realized.

The LDDHS project and its demonstrations carried multiple objectives. In addition to examining the ability of local administrations to manage primary health care the process also "*tested*" the feasibility and necessary requirement new financial flows to implement function transfers and to examine the suitability of an earmarked PBG as a direct funding mechanism. Through the application of the PBG mechanism LDDHS has assisted NCDD to determine the level of additional budget required per HC to effectively enable the function transfer of primary health care services nationally. As an added value output the financial transfers additionally introduced the concepts of "asset maintenance budgeting" at district level.

The application of the PBG provides evidence to policy makers related to the fiscal sub national budget requirements to transfer primary health care functions to local government.

The LDDHS demonstration provides valuable data and an evidence base to support the RGC undertake "*obligatory*" functional assignment policy development related to sub national budget transfers. In this context, LDDHS has assisted to respond to some long-term reservations held within government related to functional re-assignment and competency needs at both, national and sub-national levels. LDDHS provided the following lessons and experiences:

8.1 Capacity and ownership at community level

According to MoH policy on health sector reform (1997), commune councils have always played a formal role in improving HC's performance. However , and in practice, commune chiefs nor the CCWC chair nominated to lead HCMC have taken up pro-active roles. This is partly because of knowledge gaps and assumptions that health physicians are technically more knowledgeable than councilors.

At the same time the VHSGs have been established to act as "*the messenger*" for villagers and as an agent for the HCs supporting outpatients and community outreach programs. These volunteer groups are, in the main, supported by NGOs who themselves are heavily dependent on external donations. Using the LDDHS PBGs the district administrations have reactivated these grass roots community health groups, as one VHSG member explained:

> *"... our VHSGs in Kandeang District have 230 members of whom 183 are women, and been operational since 1999 under both technical and financial support of RACHA NGO. Since September 2013, RACHA has pulled out from the District. Without external support, most of our VHSG's members stopped coming to HCMC meeting, disseminating relevant information to out-patients and providing grassroots support to respective HCs. This situation is now resolved under LDDHS support".*

In terms of inclusiveness and local government capacity commune planning, financial and administrative systems have been in place since 2002. Within the framework of the project the communes were involved in primary health care planning and budgeting in addition to their regular commune planning. They also actively participated at HCMC's bimonthly meetings where they have now receive support from their district to discuss health service delivery issues.

8.2 Capacity and ownership at district level

The LDDHS demonstration has supported NCDD to develop new capacities and staff competencies within the district administrations to enable local management and delivery of primary health care functions. These new capabilities that have been transferred to the district administrations include more effective planning that factors in maintenance, financial capacity to ensure compliance to transparently manage earmarked PBGs, service provision monitoring, inter-agency cooperation, and closer working partnerships with their constituents.

The success of the LDDHS intervention that has tested the transfer of primary health care functions to district authorities illustrate that local government is ready to take a more responsible role in local public service delivery.

The successful pilot transfers of primary health care functions suggest that sub national district administrations are ready to take up a more accountable role in local public service delivery. Within this context the district administrations have been able to adequately plan, prepare budget and implement district-wide local health service delivery strategies. This outcome provides a key success factor for the promotion of function transfers that mandate local service delivery and implement the governments D&D reform policy.

Rural health service delivery in the past had been limited mainly due to the lack of budget resources and coordination amongst national and local actors. The LDDHS PBG, provided the tools to enable district and commune administrations strategically plan and invest public finance to improve primary health care delivery within their jurisdiction. As one district administrator put it;

> *"…this project has not only provided us opportunity to learn about financing, project bidding and activity progress reporting, but more importantly allowed us to have HC's performance under control. This includes the possibility for our on-site/HC monitoring, coordinating their 24-hour shifts, HC's community outreach activity work planning, consulting with HC's personnel on their concerns & needs, and collecting people's feedback during our visits to community and organising public forums".*

8.3 Capacity and attitude of HC and OD staffs

Citizens as well as commune and district administrations have always respected the HC and OD staffs. These staffs (HC and OD) are involved in preparing annual work plans and budgets (in the form of annual operation plan – commonly called AOP). The OD managers (medical doctors) are able to professionally articulate an approach to primary health care being experts within their professional field and budget operations.

In the absence of public finances the heads of the HC's were found to commonly dedicated more efforts towards service fee collection as to addressing the most pressing local health priorities. This characteristic resulted in the initial negative attitude displayed by these senior staff towards the concepts of function transfer of primary health care to district administrations (barriers to change). As one senior staff member commented during the kick-off of LDDHS in March 2014

"...decentralized health service delivery under district administration should better wait until we have some number of retired medical doctors in the council".

Post LDDHS a new view of the effective management of primary health care services by the district administrations has emerged within this group. The three ODs having a health sector mandate in LDDHS target areas have actively participated in all discussions and now regard district administrations as their direct partners. They have increasingly communicated with their respective district administrations on HC's issues and community health improvement's matters.

A significant "*attitude shift*" of the staff of the HCs that have participated within the LDDHS pilot and who have managed the PBGs has been realized. As Koh Krolor Health Center's Chief suggested:

> *"…through this pilot project, we are now able to handle critical financial matters. Our staff has a more positive attitude towards patients, respect for working hours and collaborate with our district administration. Our ambulance driver is now motivated and performed much better. Our HC is now operating with a clean and hygienic toilet, delivery room, kitchen that provides a good working environment. New electrical connections have helped us in many ways, especially to enable the night shift. Furthermore and through organized district public forums on health service delivery we now obtain and understand people's health concerns, needs, and priorities. Citizens and communities have also changed their practices and now increasingly utilize our services and actively participated with our activities".*

8.4 Improved Horizontal Integration

The LDDHS project provided an opportunity for all stakeholder ministries coordinating through the JTWG to gain experiences and knowledge for preparing the framework and mechanisms for function re-assignment and developing new vertical fiscal flows for the transfer of mandatory functions. However, gaining trust and mutual understanding from relevant institutions, especially MoH and MEF for country-wide functional and earmarked transfers within a limited project life cycle has proved to be and continues to remain a significant challenge.

The LDDHS project developed JTWG has assited in enhancing horizontal policy integration at national level in context of function transfers within the heath sector. This activity has aditionally tested a suitable mechanism and has established a national process to support function transfers in other sectors. The evidence generated from the M&E component and analysied by the JTWG was used to foster the acceleration of decision-making related to primary health service delivery functional re-assignments and accompanied budget transfer.

Although the members of the JTWG participated at LDDHS organized events they refrained from taking the lead for the function transfer demonstration of primary health care services. The MoH was more confident with the technical aspects of local health service delivery carried out by HC and OD (i.e. the minimum package of activities – MPA), rather than pursuing the functional assignment agenda.

The LDDHS pilot testing of function re-assignments using the PBG will be pursued in four new districts in Kampong Speu, Kandal, and the capital by NCDD within the framework of IP3-2

Despite the above the MoH has, within the framework of LDDHS, reconfirmed its commitment to expand the transfer of primary health care functions. Based upon the evidence generated by the project the ministry is now proposing to NCDD for full-re-assignment of this set of sub-functions and delegation of similar sub-functions to four more districts in Kampong Speu, Kandal Provinces, and Daungkor Khan in Phnom Penh Capital.

The treasury voiced some reservation of the applied LDDHS financial mechanisms due to the utilization of private/commercial bank accounts to enable the implementation of the LDDHS PBG. It is to be noted that injecting fund (in this case, PBG) into district administration accounts held at commercial banks actually expedited the implementation of the PBG. However, given internal audit procedures the national treasury have suggested that the national and provincial treasuries are utilized for any future scale-up of the function transfer process highlighted within the NCDD IP3-2 work plan. This situation presents a new opportunity to support the enhanced integration of future earmarked PBGs or conditional grants for function reassignment provided by external sources within the treasury system. It is noted that the new health sector project H-EQIP will also use commerical bank accounts to provide dircet grants to the sub national health service providers (HCs) suggesting a scale up of LDDHS in the context of grant mechanisms.

8.5 Central ministry's ownership over functional assignment

A key feature of the LDDHS pilot has been to support NCDD stimulate and promote a wider ownership within government related to the D&D reform process through the testing the implementation of functional re-assignments. Within this context the LDDHS JTWG, through was able to hold to account line ministries and agencies to implement fundamental decentralization strategies as follows: -

Ministry of Health

* *To undertake the leading role in developing policy and strategy instruments for function reassignments of primary health care functions to district administrations aligning to the D&D policy and the NP-SNDD. This includes the development of sub-decree on country-wide transfer via assignment or delegation of primary health service delivery (administrative) management function to SNAs;*
* *To develop guidelines and tools for HC and HP as well as district administrations, and build capacity for HC, HP personnel and VHSG on technical aspects and HCMC and district administrations on primary health care service delivery;*
* *To coordinate, mobilize and allocate new earmarked transfers to support the function re-assignment;*
* *To monitor and evaluate progress of the LDDHS demonstration.*

National Committee for Sub-National Democratic Development

* *To support commune and district administrations in adopting new capacities in relation to primary health care service delivery;*
* *To collaborate with MoH in monitoring the performance of the LDDHS demonstration and the improvement of capacity held by the SNAs, capturing the development of the internal technical and financial capacity of district and commune administration to delivery primary health care services;*
* *To lead and facilitate development of regulatory documents necessary for the country wide scale up or primary health care function re-assignment to SNAs.*

Ministry of Economy and Finance

- *To capture lessons learnt and experiences from LDDHS and its PBG implementation, especially related to the financial capacity of district and commune administrations;*
- *To utilize inputs from these lessons and experiences of LDDHS and its PBG implementation for relevant policy formulation to support function transfer through effective and adequate fiscal transfer.*

8.6 Identified challenges emerging from the LDDHS pilot

The process of function transfers is fraught with challenges revolving around issues that are internal to the process but also relate to external environmental factors that impact upon the speed and depth of transferring functions. In the latter context political capital, global economic impacts and macro-economic components continually reshape the "*decentralization ecosystem and process*" as strains on public sector budgets or politically motivated policy constraints come in to play.

During the implementation of the LDDHS pilot project such factors have influenced the speed and depth of the demonstration process revealing new strategic gaps and issues that need to be addressed. As a value added output of the LDDHS project, this information will assist NCDD to develop newly informed evidence based policy to roll out the initial transfer of functions as identified within the IP3-2 work plan. The following issues are provided as knowledge outputs of the LDDHS pilot.

10.6.1 LDDHS short project cycle

LDDHS was the first ODA project to test the functional transfer process based upon previous function reassignment studies completed by line ministries under the auspices of IP3-1. Prior to the project a lengthy and costly process for identifying the components of function transfers to implement the RGCs D&D reform using a total government approach was completed during IP3-1 (2011-2013). The process involved a dedicated partnership between NCDD, the RGC and the DPs to design and implement; (1) an analytical stage (functional mapping) and (2) a decision making stage (functional review).

LDDHS was the first project to test out and demonstrate the feasibility and budget requirements to transfer service delivery functions to district authorities.

Six line ministries were involved in the functional transfer identification process: (i) the Ministry of Education, Youth and Sports (MOEYS); (ii) the MpH; (iii) Ministry of Agriculture, Forestry and Fisheries (MAFF), (iv) Ministry of Rural Development (MRD), (v) Ministry of Social Affairs (MSA) and (vi) Ministry of Environment (MoEnv).

Therefore, successes and lessons learned from the implementation of LDDHS pilot and its PBG in the five target districts are crucial for the formulation new policies that are relevant to the implementation of country-wide function reassignment grant program in the next 3-5 years. In this regard the two year LDDHS Project life (2014-2015) and one year LDDHS PBG implementation (2015) are considered too short for informing the NCDD and RGC of the above mentioned function reassignment strategies and associated budget allocation process.

This is especially the case since the results of LDDHS activities have highlighted various bottlenecks that hold the potential to impede the speed and depth of function transfers. These bottlenecks concern of public finance management, inter-ministry cooperation, joined up national planning and sub national institutional capacity. The latter issue of institutional capacity is considered to related to political capital, policy capacity, financial management, and planning for local public service provision (including public assets maintenance).

8.6.2 Different health administrative coverage

The population-based primary health coverage policy is delivered through 80 operational districts (ODs) and over 1,000 health centers and health posts. The administrative territorial arrangements consists of 120 districts and 600 communes which are covered by the 80 OD's creating an "*administrative mismatch*" across the local government and health sectors. This administrative mismatch results in district administrators sharing the institutions associated with primary health care delivery. Some ODs capture populations from two or more district administrative territories. Likewise some administrations are depending upon service delivery from neighboring district located ODs for local health services.

LDDHS highlighted the need for the government to address the issue of aligning the health operational districts to administrative territories

The LDDHS project considered this inhomogeneity of the OD and HC geographical boundaries providing one criteria for the selection of target districts. Specifically, Rokha Kiri, Mong Russey, and Koh Krolor districts are located within one health operation district. Bakan district has its own complete health operation district. Kandeang district is an administrative district sharing health delivery services with four other districts from the perspective of the OD configuration.

Through implementation and results analysis LDDHS has revealed the necessity to conduct a comprehensive assessment on DA-OD and OD-HCMC-HC geographical arrangement and working relations in the context of local service provision and the functional role of the district administrations The limited activity of LDDHS within this area has resulted in the development of what can be considered as being only superficial evidenced based policy inputs. Further analysis work needs to be undertaken and adequate resources attached. The successes and challenges resulting from OD coordination in distant locations (such as Mong Russay OD covering Rokha Kiri, Mong Russey, and Koh Krolor administration districts) could not be verified as evidence based inputs to function transfer and fiscal transfer policy recommendation.

8.6.3 Under-resource primary health care services

Large portions of incurred primary health expenditures continue to come from out-of-pocket/private households sources. In some situations families are being placed in economic risk as basic primary health services (maternal checks) are not fully funded through by the public sector budget. To mitigate service gaps related to access and availability the DPs, religious groups and civil society contribute considerable levels of finance to public health service activities at sub national level.

The RGC has annually increased its health budget and already introduced a "*bottom-up*" planning and budget process taken place in the form of 3-year Rolling Plan (3YRP) and Annual Operational Plan (AOP) at HC and OD levels. Nonetheless, resource allocations to HCs are reportedly small compared to overall national budget.

Given public finance constraints and pressures there remains a reluctance from the MoH to transfer finances from their national health budget to sub national district administrations to fund the transfer of identified primary health care functions. The LDDHS has provided evidence and an accountable transfer mechanisms system to validate sub national capacity and competency to deliver primary health care services.

Internal barriers to change within the line ministries still require to be addressed to expedite function transfers and increased fiscal transfers to local governments.

The developed evidence from the LDDHS project that illustrates an improved level of service delivery provides enough information to enable the MoH to support a transfer budget and re-assign primary health care functions (access and provision of) from the national to sub national level whilst maintaining function control over service scope, quality, and medical staff.

The current reluctance of MoH to fully implement the function transfer for primary health care illustrates current issues related to political capital and inter-ministry coopertaion (joined up policy solutions) that remain to be addressed. These issues are commonly positioned outside the control of external actors and external projects and remain an internal issue that requires to be resolved by the RGC. However, given the relative limited scope and capacity of LDDHS, it would be prudent for DFAT to consider a follow on and upscale of LDDHS so as to provide the necessary broad evidence base for function transfers that can be main-streamed into national policy making and implementation.

9 Conclusions and Recommendations

9.1 Key Lessons Learnt

LDDHS has demonstrated the feasibility of function transfers as a tool to implement the RGC's D&D reform policy.

The LDDHS pilot has clearly demonstrated the feasibility of function transfer from line ministries to district administrations for selected and limited service delivery sub-functions. It has also innovated vertical transfer mechanisms introducing PBG's that are earmarked for function reassignment ensuring local government financing of public service provision and asset maintenance, the later being crucial to provide and maintain citizens inclusive access to local public services.

The utilization of a commercial bank to support funds transfer has also illustrated the efficiency gains that can be attained within the treasury system through dedicated PPPs or service outsourcing (similar to the current civil service payroll system). The use of the commercial bank promoted higher levels of transparency and accountability and expedited funds transfer from national to sub national entities reducing the normalized delays associated with treasury transfers that use the central bank mechanisms.

In the context of institutional strengthening, improvements have been realized as the LDDHS project facilitated the five district administrations to improve service delivery planning, financing, and monitoring budget expenditure. A key consideration has been to introduce "*asset maintenance*" as a new budget line within district level public service delivery related expenditures.

The project has also promoted a shift in the "*mind sets*" of OD staff in relation to transfer of primary health care service delivery mandates to district administrations. However structural issues relating to the geographical mismatch of ODs and district administrative territories needs to be addressed. LDDHS has, through its intervention, revealed bottlenecks to service delivery due to such mismatch.

9.2 Recommendations

Based upon the data and evidence generated through the implementation of the LDDHS pilot project to demonstrate the feasibility and viability of function transfer from national to sub national district authorities the following recommendations are provided. Although the LDDHS specially studied a single case i.e. local primary heath care service delivery, the following recommendations may be applicable to other function reassignments identified by the RGC and more importantly the requirements for adequate increases in vertical fiscal transfers to match the envisaged service delivery mandates of sub national entities: -

* *It is of the utmost importance that NCDD-S forms a permanent working group with MoH to gather and institutionalize collective voice for primary health care functional reassignment on a nationwide scale;*

* *Primary heath care functions are considered "obligatory" in the sense that once they are transferred, accompanying resources in the form of a conditional earmarked grant must be provided. Since relevant policy and implementation guidelines on earmarked conditional grants have not been formulated, similar demonstrations to further test the initial results delivered by LDDHS should be implemented (scale up);*

* *The LDDHS JTWG should further be motivated to continue their lessons learned gathering and provide relevant inputs into NCDD-S policy formulation process, in particular, the conditional grant regulations;*

* *For LDDHS lessons learned and experiences to become valuable inputs into relevant policy formulation NCDD Sub-Committee on Functions and Resources should be re-activated to review those lessons and experiences, and eventually set future relevant policy direction with clear targets. LDDHS JTWG should transform into a secretariat for NCDD Sub-Committee on Functions and Resources;*

* *MoH D&D working group should convince its own ministry to institutionalize their roles with accompanying resources for policy formulation and consolidation of field experiences related to decentralization. Today a policy gap is witnessed whereby the national decentralization policy is not fully embedded within the sector policy nor sector planning in terms of function and associated resource (human and financial) transfers;*

* *The results and findings generated through the LDDHS demonstration verified a requirement for the continuation of external ministry assistance delivered by NCDD to MoH in terms of TA related to this specific functional transfer process and relevant policy development. Specific DP's should factor in this finding to enable to facilitate and support this process and to capitalize upon the function reassignment exercises completed through DP funds. It is essential that all partners acknowledge that the success of the D&D strategy hinges upon the transfer of functions and improved and adequate volumes of financial flows to support such transfers (i.e. complimentary increases to sub national transfers to cover recurrent costs and capital investments);*

* *MEF should utilize inputs from LDDHS lessons and experiences and its PBG implementation for formulation of policy and regulations on earmarked conditional grant transfer to accommodate function transfer processes.*

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LDDHS
Log Frame Analysis

To fully support a transparent and responsive approach to project management LDDHS was designed and implemented using a dedicated log frame. Flexibility within the project was ensured through the continual update of the log frame as emerging policy and operational issues were encountered.

The logical approach to the function transfer process has allowed the LDDHS project to sucesfully demonstrate the viability of transfering functions to SNAs . In additon the LDDHS project developed an innovative performance -based financing grant instrument (PBG) to identify the level of new financing requored to enable district administrations take up their mandate to delivery primary health care services.

Review of LDDHS Log Frame Performance

The LDDHS project log frame was incorporated in the project document signed by all parties. In this section of the report the performance of the project against the targets set in the log frame are discussed.

Effectiveness of the new mechanisms demonstrated through improved efficiency of budget execution and measurable improvement in service delivery

Although some delays were experienced that are indicative of the heavily bureaucratized systems in place, expenditures at the end of the project cycle were in alignment to the work plan.

Improved performance and satisfaction of health centre staff were recorded during field visits, However, no base line or post project survey was conducted.

Improved statistics that include vaccinations, out patent visits, accompanied births and the health centres were recorded and detailed. The transfer of service provision to local government that has ensured 24/7 coverage and improved access as resulted in improved delivery levels.

A detailed action plan with five sub-plans for testing of an initial set of public health functions is agreed between MoH and NCDDs

Two provinces and five target districts were identified through a transparent selection system by NCDD-S and MoH.

District administration developed plans for transfer of primary health care delivery were developed and approved by MoH and NCDD. These documents were developed in Khmer and provided a basis for the PBG transfers.

An international consultant mission commissioned by UNCDF allowed NCDD to develop a specific vertical transfer mechanism utilizing performance based grants to support fund transfers and flows. In addition individual district accounts were established with ALCEDA bank for the purpose of the testing the LDDHS PBG mechanisms.

A capacity development plan for district administrations was developed and approved, providing a basis for training and workshops.

Baseline performance assessment completed during the project cycle but was delayed due to procurement issues. The baseline was used to verify and approve the transfers of the second tranche.

Transfer of initial set of public health functions tested in five districts

Actions plans provided funding architecture for the use of the PBG. The total PBG funds transfer equated to US$ 150,000 at the end of the project cycle. In year 1 33% of this total was dispersed and PBGs implemented in all districts.

Capacity for public health administration developed in five districts

Training for district level administrations in health service management (public service delivery). The imparted training was limited to ensuring access to HCs and provision of access to primary health care services was extended to the staffs of the OD and HCs themselves. A total in excess of 200 persons received training in this area. The training did not provide any focus on quality of public health services, ie capacity of medical staff.

Financial training for primary health care service provision and the use of the PBG mechanisms was delivered to in excess of 60 persons that included staff of the health centres and the ODs.

The LDDHS project invested heavily into reenergizing the village level primary health care groups. Through the provision of funding through the PBG mechanisms district administration were able to finance incentive payments, workshops and public forums that reestablished the VHSG and HCMCs.

Policy and plan for the roll-out of the transfer of primary public health services to district authorities

Performance in this area has been weak as a clear strategy for the roll-out of the function transfers has not been agreed by the MoH and NCDD-S. The LDDHS project did demonstrate the feasibility of the transfer of primary heath care functions from a line ministry to district administrations.

However issues related to the reorganization of the ODs to align to administrative boundaries, budget transfer to sub national administrations due to limited public finance envelope and the reluctance of line ministries to "*loose*" budget have impacted upon the roll out.

Although LDDHS has provided some valuable lessons, government officials especially from the MoH are voicing their concerns that LDDHS has a limited scope and more testing is required.

Promoting Local Development through Decentralized Public Health Services (			
Outcome / Output	Indicator (project derived)	Baseline	Target
The effectiveness of new mechanisms demonstrated through improved efficiency of budget execution and a measurable improvement in the delivery of selected services.	Timeliness of disbursement of approved expenditures	From Situation Analysis (District)	All expenditures compl within 1 month
	Satisfaction of HC staff with new budget arrangements for expenditures	From Situation Analysis (District)	HC staff have a positive assessment of new arra
	Measured improvement of at least 1 service in each district (defined in AP)	From Situation Analysis (District)	Detailed district action for primary health care
Output 1 A detailed action plan with five district sub plans for the testing of selected function transfer of an initial set of public health functions is agreed between NCDD-S and MoH	NCDD-S and MoH jointly approve the selection of target districts	Project Document	by December 2013
	NCDD-S and MoH jointly approve district action plans for primary health care	Project Document	by February 2014
	Fund flows and financial management arrangements designed and approved	IC Mission Report	by February 2014
	Capacity development plan prepared	Project Document	by February 2014
	Baseline performance assessment completed	IC Mission Report	by February 2014
Output 2 Transfer of an initial set of public health functions tested in 5 selected districts	Action plans funded by PBG are integrated with District budgets	0	by March 2014
	100% dispersion of PBG by end of the fiscal year	0	Minimum of 90% targe
Output 3 Transfer of an initial set of public health functions tested in 5 selected districts	Number of District staffs trained in public health care administration	0	200
	Number of District staffs trained in public health care financing	0	60
	Number of citizens re-trained in community health structures	0	1600
Output 4 Policy and plan for the roll-out of the transfer of public health functions country-wide	NCCD-S and MoH jointly agree the sub functions to be transferred	none	by August 2014
	NCDD-S and MoH agreed a work plan for the transfer of public health functions	none	by September 2014
	Program developed to roll-out transfer of functions country wide	none	by October 2014

(LDDHS) - Annotated Project Logframe

	Actual(s)	Means of Verification		Comments / Notes
eted	All PBG expenditures delivered in one month for all districts	*Performance Assessment*	✓	Delays encountered
ngements	All HC staffs attended 4 project capacity development events	*Performance Assessment*	✓	
plans services	Improved rates of attended births recored in all discricts	*Performance Assessment*	✓	
	Completed February 2014	*Project report Phase I*	✓	Delays encountered due to the internal bureaucratic procedures of the government in addition to horizontal constraints at institutional level. The formation of the inter-ministry Joint Technical Work Group (JTWG) mitigated the initial issues in relation to inter ministry cooperation to enable fully funded function transfer of primary health care services to sub national administrations. The internal barriers to function transfers and requirements for budget changes delayed the actual delivery of these actions.
	Completed May 2014	*Project report Phase I*	✓	
	Completed and approved by MoEF October 2014	*Project report Phase I*	✓	
	Compleated by February 2014 Training started April 2014	*Project report Phase I*	✓	
	Completed October 2014 Procurement Delay (NCDD)	*Project report Phase I*	✓	
	July 2015	*Project Report*	✓	Innovative Performance Based Grant designed to facilitate function transfers to district administrations. Initial set of grants implemented with a slight delay due in the main to bureaucratic procedures of the government.
t	Final Tranch July 2015 100% delivery	*District Accounts*	✓	
	220 Training Delivered: April 14	*Project Reporting*	✓	The project delivered a substantial amount of training for the district administrations in public health care and public health financing. The results of the training can be readily assessed as the innovated Performance Based Grants have been implemented in each district with the nominated US$ 150,000 being fully utilized within the project cycle. It can be assumed that new competencies have been introduced by the LDDHS project.
	60 Training Delivered: Oct & Dec 14	*Project Reporting*	✓	
	1600 - Training events in all districts Delivere: April 15	*Project Reporting*	✓	
	Prakas issued 10 October 2014 by MoH and MoI	*Project Reporting*	✗	Although the LDDHS intervention has proved the viability of the function transfer process barriers to the roll-out nation wide are delaying this process. The LDDHS project clearly illustrates the capability of the district administrations to take up this role. However, the associated line ministry still requires to address the issue of territorial alignment of the ODs to further propagate the transfer of functions
	Completed October2014	*Project Reporting*	✓	
	IP3 - 2 Issued December 2014	*RGC Decree*	✗	

Updated based upon end of project report (NCDD-S)

UNCDF Statement of Account
LDDHS Project

Project Number 0008667

Start: 2014
End: 2016

UN Capital Development Fund

Interim Statements of Accounts

Consolidated from 1st January 2014 ended 31st January 2016

Project Title: Local Development Decentralize
Project No. : 00088667
Donor: Australian AG Int'l. Development

	2014	2015	2016	Grand Total
INCOME				
Contributions	428,734	-	-	**428,734**
EXPENDITURE				
Programme Expenditures	162,761	187,422	74,669	**424,853**
FUND BALANCES				
Fund balance 1 January		265,972	78,550	
Fund balance 31 January 2016	265,972	78,550	3,881	**3,881**

We hereby confirm that the above amounts have been paid for the proper execution of the Programme in accordance with the terms and conditions of the Grant Agreement in respect of the Programme in reference and with the principle of sound financial management. All documentation authenticating these expenditures will be maintained by UNCDF in accordance with its document retention policy and not less than five years after the Grant.

Endorsed by :
Eric Dietz
Programme Finance Specialist

Approved by :
Fasil Dessie
Finance Specialist

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