Kingdom of Cambodia

Nation – Religion – King

Ministry of Health

(Final Draft)

SPECIAL OPERATING AGENCY MANUAL

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MAIN TEXT

Department of Planning & Health Information

Preface

The public sector environment is increasingly complex and demanding of public administrations. Governments around the world have experimented with alternative designs to improve the delivery of public services because traditional bureaucratic models have often proven too rigid and unresponsive to people needs. Simplifying and streamlining bureaucracy and making it operate more business like through alternative service delivery models is an innovative response to today's environment of increasing demands and scarce resources.

The Royal Government approved the Policy on Public Services Delivery as a cornerstone to the National Program for Administrative Reform. The policy provides direction to ministries on how best to improve the quality and delivery of their services. It calls for enhanced performance and accountability in the provision of public services through the streamlining of delivery processes, their transparency and responsiveness to people's needs. In effect, it calls for a change of paradigm within the Civil Service from that of an administrator of rules to that of a provider of public services.

The policy draws attention to an array of mechanisms to improve the delivery of public services. Special Operating Agencies (SOAs) are one of these instruments to rapidly enhance the quality and delivery of public services. SOA type institutions have been used around the world. Both developed and developing countries have been using such a mechanism under various names. In every case, they are part of a movement that aims to restructure and transform the administrative machinery of government to improve operational efficiency, quality, access, and responsiveness in the provision of public services.

SOAs are being used, with success, as part of reforms programs that, much as the Royal Government's Governance Action Plan mainly aims to:

- improve the quality and delivery of public services;
- streamline central government ministries and bring government closer to people;
- strengthen personnel and financial management emphasizing performance;
- rationalize compensation and benefits regimes;
- develop human and institutional capacity; and,
- improve information management systems.

We are Cambodianizing the SOA concept to conform to Cambodian reality and the administration capacity to implement. SOAs are a very innovative mechanism much like Priority Mission Groups (PMGs) and Merit Based Performance Incentive (MBPI) that the government is deploying to enhance performance and accountability within the Administration.

His Majesty the King signed the Royal Decree on Principles for the Establishment and Implementation of Special Operating Agencies on March 28, 2008 to provide a legal framework for the deployment, management and monitoring of Special Operating Agencies. This guide was developed to assist ministries in the design, establishment and management of SOAs within their jurisdiction. The guide will be updated periodically to reflect the experience of ministries in implementing the scheme.

Sok An

Deputy Prime Minister,

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SPECIAL OPERATING AGENCY MANUAL

Acronyms and abbreviations

AOP	Annual Operational Plan
CAR	Council for Administrative Reform
CBHI	Community Based Health Insurance
CPA	Complementary Package of Activities
HC	Health Center
HEF	Health Equity Fund
HIS	Health Information System
HPs	Health Partners
HSP2	Second Health Strategic Plan (2008-15)
HSS	Health Systems Strengthening
HSSP1	First Health Sector Support Project
HSSP2	Second Health Sector Support Program
MBPI	Merit Based Performance Incentive
MEF	Ministry of Economics and Finance
MG	Monitoring Group
MOH	Ministry of Health
NCs	National Centers
NGOs	Non Governmental Agencies
OD	Operational District
ODO	Operational District Office
PHD	Provincial Health Department
PMAS	Performance Management and Accountability System
PMG	Priority Mission Group
PRH	Provincial Referral Hospital
RH	Referral Hospital
RTC	Regional Training Center
SDG	Service Delivery Grant
SOA	Special Operating Agency

SPECIAL OPERATING AGENCY MANUAL

I. GENERAL

a) Introduction

Special Operating Agencies (SOAs) are one of a set of new instruments being introduced by the Council for Administrative Reform (CAR) across the civil service. Their purpose is to improve the quality and delivery of public services, including health services.

Special Operating Agencies provide public service delivery organisations with a degree of autonomy in making the best use of their human and financial resources to deliver the highest possible quality of services in the most cost-effective way. They are grounded in the Royal Government's approved Policy on Public Services Delivery [as] a cornerstone of the National Program for Administrative Reform. The policy provides direction to ministries on how best to improve the quality and delivery of their services. It calls for enhanced performance and accountability in the provision of public services through the streamlining of delivery processes and making them more transparent and responsive to people's needs. In effect, it calls for a change of paradigm within the Civil Service from that of an administrator of rules to that of a provider of public services.

In the health sector, SOAs will deliver health care of a good quality to Cambodians especially to poor people. This manual sets out the way SOAs will be implemented and managed. It is informed by and follows the guidance of CAR as set out in "Special Operating Agencies: Implementation Guide, Performance and Accountability" (General Secretariat, Council for Administrative Reform June 2008). It aims to set practical standards for the organization of SOAs, their administration, management, financial and accounting processes, reporting, monitoring and evaluation.

This manual has three sections. Following this introduction, Section I defines The SOA's values, ethics and discipline, what they are and what are their characteristics.

Section II defines the setting up of SOAs and which types of organisations are eligible for conversion into SOAs provided they met eligibility criteria. Models of health sector SOAs are discussed and illustrated. The criteria against which organisations are assessed for readiness for SOA conversion is also included. It defines the potential sources of funds for different types of health sector SOA.

Section III defines the ways SOAs are to be managed, especially SOA finances as they are so important to a SOAs financial stability. It also describes the way SOA performance will be monitored and assessed.

b) Values, Ethics and Discipline

The Policy on Public Service Delivery calls for the transformation of public officials into public servants. This involves a change of attitude and behaviour from that of administrators to service providers. SOAs are at the forefront of the Royal Government's efforts to transform the Administration into an effective provider of public services and a trusted development partner.

SOA management and staff are expected to uphold the vision and values for the Administration outlined in the Policy on Public Service Delivery. They are expected to systematically seek to improve the quality and delivery of public services. They also are expected to promote team work and respect internal rules. SOAs should develop a Code of Ethics to guide the attitude and behaviour of SOA staff. This code would specify, for examples, that SOA staff could not seek or accept payments or gifts, that they shall avoid conflict of interest.

Staff performance will be managed by the Performance Management and Accountability System (Section III) and will include a system of rewards and sanctions. Managers and staff shall be routinely appraised against indicators of probity and service. The PMAS covers grievance and redress procedures and is anchored into the provisions of the Common Statutes, the Particular Statutes and system wide regulations.

SOA staff will be engaged by Personal Service Contracts (Annex 8) which specify the terms and conditions of employment with the SOA. These terms and conditions will be based on the SOA Code of Ethics.

SOAs shall be beacons of probity and services quality. Only then can they build trust and fulfil their mandate. Disclosure and transparency become essential components to managing SOAs. Ease of access to information about SOA services and operations is integral to an SOA Performance Management and Accountability System.

c) What are Special Operating Agencies in Health Sector?

Definition:

SOAs are new organisations in the health sector. They are part of the Ministry of Health but given operational autonomy, within an agreed mandate, to provide services under contract to the Ministry.

Objectives:

The objectives of SOAs in the health sector are to:

1. Improve the quality and delivery of government health services in response to health needs;

2. Change the behaviour of health sector staff gradually towards the principles of motivation, loyalty, service and professionalism;
3. Promote prudent, effective and transparent performance based management;
4. Develop sustainable service delivery capacity within the available resources.

d) Characteristics of SOAs in the health sector

The key characteristics for SOAs in the government health sector are as follows:

- Legal status: in the public sector, part of MoH
- Governed: by MoH
- Director: appointed by MoH
- Assets: owned by MoH
- Access to credit: not permitted to borrow from commercial sources
- Mandate: defined by terms of reference and management agreement
- Service provision: under a precisely defined contract with MoH or its representative agency (Provincial Health Department)
- Authority: operational autonomy defined and delegated by the Minister
- Management board: convened by SOA head and endorsed by MoH and Provincial Government to advise on strategy and operations with representation from senior SOA staff, Provincial Government, supporting Health Partners and community leaders
- Services: defined by a Service Delivery Management Contract with MoH or its representative Provincial Health Department within an approved operational plan and budget
- Staff:
    - legal status public servants but may be contract staff selected by SOA management
    - employed by MoH under performance management and accountability (PMAS) terms
    - Head of SOA has delegated authority to recruit contract staff after approval of post
- Financial management: delegated to SOA subject to internal and external audits

II. SETTING UP A SPECIAL OPERATING AGENCY

a) Organisations in the health sector eligible for conversion to SOAs

The CAR "Special Operating Agencies: Implementation Guide..." states that the best candidates for SOA status share the following characteristics:

1. Are primarily concerned with the delivery of public services that are priorities to government and the citizens;
2. Would operate under a stable policy framework with a clear, ongoing mandate;
3. Are able to be held accountable individually by the parent ministry or institution;
4. Could be subjected to clear practical performance targets in relation to results;
5. Represent a discrete unit of sufficient size to justify special consideration and the costs associated with setting up the agency;
6. Are staffed by managers and employees who are committed to performance management; and,
7. Require no significant ongoing involvement in operation by the parent ministry
8. But are not, nor intended to be, Public Establishments, such as National Hospitals.

Subject to achieving readiness criteria, candidates for conversion to SOA status in the health sector include:

1. Operational districts
2. Provincial hospitals (CPA 2 & 3)
3. Regional Training Centres
4. National Centres providing products and services directly (eg Blood Transfusion Centre and Central Medical Stores)

There are two main kinds of SOAs in the health sector:

1. Former Operational districts and eligible referral hospitals: termed here 'health service provider SOAs'
2. Regional Training Centres, termed here 'Regional Training Centre SOAs'; and some National Centres, termed here 'National Centre SOAs'

b) Contracting and commissioning arrangements

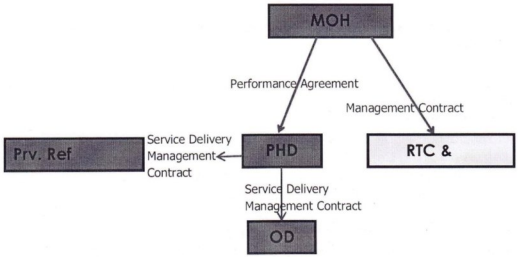
Services provided by SOAs are governed by Service Delivery Management Contracts (Annex 2) between service commissioners and the SOA providers based on their Annual Operational Plans. In the case of health service provider SOAs (typically former Operational Districts and Provincial Hospitals) the commissioners are the Provincial Health Department in that Province on behalf of the Ministry of Health.

The signatories of Management Contracts with health service SOAs are the appropriate PHD Director, endorsed by Minister of Health.

In the case of other SOAs (for example Regional Training and National Centres) the commissioner is the central Ministry of Health. The signatories of Management Contracts between MoH and central agency SOAs (RTCs, NCs) are the Minister of Health and SOA Heads. Service Delivery Management Contracts with central agency SOAs are managed by the MoH Monitoring Group.

The Ministry of Health establishes Performance Agreements (Annex 3) with each commissioning Provincial Health Department based on their Annual Operational Plans and Three Year Rolling Plans. They specify the priority services to be commissioned and the outputs expected. These specify the conditions under which services will be commissioned from SOAs by the Ministry's PHD representatives. The signatories of Performance Agreements with PHDs are the Minister of Health (or Representative) and PHD Directors. Performance Agreements with PHDs are managed by the MoH Monitoring Group.

The diagram below illustrates this commissioning-contracting structure.



c) Models of Special Operating Agencies in the Health Sector

This section describes how the SOA model will be applied in Operational Districts, Provincial Referral Hospitals, and Regional Training Centres and selected National Centres, together with roles and responsibilities at different levels.

1. Model of a Health Service Delivery SOA (Operational Districts and Provincial Hospitals)

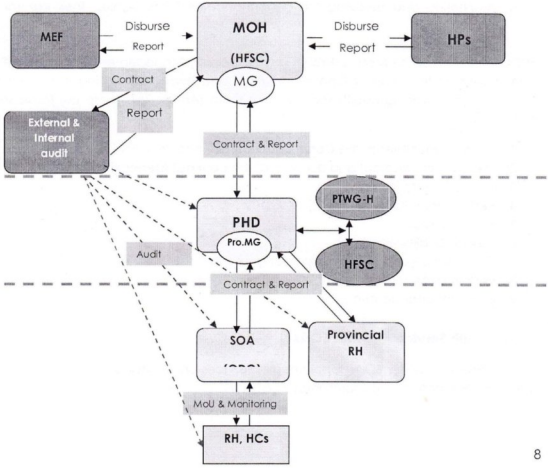
a. Central MoH level:

MoH establishes Performance Agreements with PHDs based on their Three Year Rolling Plans defining the conditions under which they can commission health services from SOAs. These Performance Agreements (Annex 3) set out:

1. the management standards expected of PHDs in order to manage contracts with health service providers;
2. the medium term objectives for improving health services in the Province in line with the Three Year Rolling Plan
3. the specific targets for the coming year based on the Annual Operational Plan.

The MoH Monitoring Group (MG) has overall responsibility for agreeing the terms of Performance Agreements and for managing them. Performance, including financial performance is audited by the Internal Audit Department and subject to external audit.

MEF & MoH will allocate funds to support the operations of SOAs although they are able to mobilise resources from other sources. MoH is responsible for ensuring that MEF and HP funds reach SOAs in accordance with agreements reached. MoH reports to MEF and to HPs on the use of funds.



b. Provincial level:

1) Provincial Health Department (PHD)

PHDs are commissioners of health services from Operational Districts which become Health Service Provider SOAs once they achieve readiness criteria. PHDs achieve readiness criteria to be health service commissioners based on MoH Assessment Tools (See SDG Manual).

The main roles of the commissioning PHD include:

1. negotiating contracts with Health Service Provider SOAs in the Province to supply health services of a stated quality and volume in line with MoH policies and strategies
2. providing support to SOAs to develop Three Year Rolling Plans and AOPs
3. offering technical support in improving service quality introducing new forms of health financing and developing support systems such as HIS and other national programmes
4. monitoring and assessing the performance of SOAs against their contract provisions.

PHDs, on behalf of the MoH, establish Service Delivery Management Contracts with SOAs based on their Annual Operational Plans and Three Year Rolling Plans as the basis for commissioning health services from them (Annex 2a). These contracts set out:

1. The responsibilities of the Commissioner (PHD) and Provider (SOA)
2. The commencement and duration of the contract (generally one year)
3. The services to be provided
4. Performance targets
5. Financial plan
6. Service quality standards
7. Governance and stewardship arrangements
8. Performance management
9. Payment arrangements

2) Health Service Provider SOAs

Health Service Provider SOAs supply health services under Management Contracts with their PHD, acting as a representative of MoH.

Each ODO applying to become an SOA prepares a Business Plan based on its Annual Operational Plan setting out its objectives, operational strategies and financial forecasts (Annex 5). These are assessed by the MoH Monitoring Group which makes recommendations to the Health Financing Steering Committee. A SOA's Business Plan forms the basis of its Terms of Reference and Management Contract which are sent to the Council for Administrative Reform for approval.

In order to become an SOA, ODs achieve readiness criteria based on MoH Assessment Tools. Once accredited, Health Service Provider SOAs also have access to Service Delivery Grants under HSSP II (see Service Delivery Grants Operational Manual).

3) Health Service providers (RHs, HCs)

Referral Hospitals and Health Clinics within an SOA are governed by the provisions of the SOA's Management Contract with its parent PHD. SOAs may establish sub-contracts with Health Centres and Referral Hospitals if appropriate.

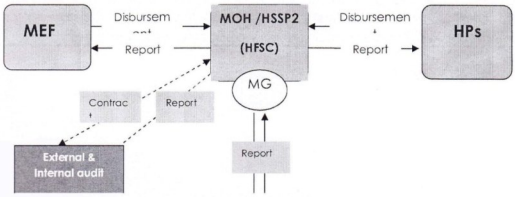
4) The special case of single Operational District Provinces

In the case where there is only one Operational District in a Province and one Referral Hospital, which may be small (CPA 2), both the Operational District and the Referral hospital are eligible to become an SOA. Normally, the Deputy PHD Director responsible for the former Operational District will become the head of the SOA supplying primary care services and the Deputy PHD Director responsible for the Referral Hospital will become the head of the hospital SOA.

2. Model of a Regional Training Centre / National Centre SOA:

a. Central MoH level:

Regional Training Centres (RTC) and some National Centres (NC) are SOAS and supply services under Management Contracts with MoH. MoH headquarters commissions services directly from Regional Training Centres and National Centres deemed to qualify for SOA status.



The MoH main commissioning roles include:

1. negotiating contracts with each SOA to supply services of a stated quality and volume in line with MoH policies and strategies
2. providing support to SOAs to develop Three Year Rolling Plans and AOPs
3. offering technical support in improving service quality and developing support systems such as HIS and other national programmes
4. monitoring and assessing the performance of the SOAs against their contract provisions.

The MoH establishes a Service Delivery Management Contract with each RTC or NC SOA (Annex 2b) setting out:

1. The responsibilities of the Commissioner (MOH) and manager RTC SOA
2. The commencement and duration of the contract (generally one year)
3. The services to be provided
4. Performance targets
5. Financial plan
6. Service quality standards
7. Governance and stewardship arrangements
8. Performance management
9. Payment arrangements

In the first year, these items will be part of the SOA's Management Contract with MoH. In subsequent years they will be prepared and negotiated on an annual basis. RTC and NC SOAs are not eligible for Service Delivery Grants. However, MoH assists them in preparing proposals to mobilise Health Partner financial and technical support. Once agreed, MEF & Health Partners (HPs) will allocate funds under HSSP II to support these developments. MoH reports the use of funds to MEF and to HPs.

The MoH Monitoring Group (MG) is responsible at the central level for the oversight of RTC and NC SOAs and monitors implementation.

b). Regional Training Centre (RTC) or National Centre (NC):

Each RTC or NC applying to become an SOA prepares a Business Plan based on its Annual Operational Plan and Three Year Rolling Plan setting out its objectives, operational strategies and financial forecasts (Annex 5). These are assessed by the MoH Monitoring Group which makes recommendations made to the Health Financing Steering Committee. A SOA's Business Plan forms the basis of its Terms of Reference and Management Contract which are sent to the Council for Administrative Reform for approval. In order to become an SOA, ODOs achieve readiness criteria (Annex 4) based on MoH Assessment Tools (see SDG Manual).

d) Assessing readiness for SOA status

Organisations applying for SOA status will be required to meet readiness criteria as assessed by MoH using assessment tools which were developed earlier and recently updated.

The skills of staff and organisational systems in the following domains will be assessed (Annex 4):

1. Provincial Health Departments and Operational Districts

- Planning
- Supervision
- Financial management
- Contract management
- Human resource management
- Supplies management

2. Provincial hospitals

- Planning
- Infrastructure management
- Financial management
- Contract management
- Human resource management
- Inpatient services
- Outpatient services
- Technical services
- Supplies management

3. RTCs and NCs

- Planning
- Financial management
- Contract management
- Human resource management
- Service management
- Supplies management

e) Funding for health sector SOAs

Funding for SOA services can come from three sources: from the government, from health partners, from other sources. Forecasts of income from each source form part of the financial tables of the SOA's Business Plan (Annex 5).

1. Government

The MoH allocates a budget to the SOA based on its Management Contract and on an approved Business Plan. The budget will be in kind and in cash for capital and recurrent spending. Budgeting and the budget request follow MoH/DBF budget procedures.

2. Health Partners

Health partners have agreed to allocate funds under HSSP II to finance service delivery grants (SDGs) for Health Service SOAs (formerly ODs and Provincial Hospitals) once they have achieved SDG readiness criteria, but not for other SOAs. The procedures for allocating and managing these funds are set out in the SDG Operational Manual.

Health Partners are also continuing to finance Health Equity Funds under HSP II on an expanded scale and these will be available to Health Service SOAs (formerly ODs and Provincial Hospitals). Allocation criteria and tariffs are set out in the Health Equity Fund Guidelines and Financial Manual.

Although RTC and NC SOAs are not eligible for Service Delivery Grants under HSSP II, they can apply for other HSSP II financial and technical support or may obtain it from other Health Partners.

3. Other revenue

A further source of revenue for health service provider SOAs is Community-Based Health Insurance Schemes (CBHI) where they exist.

Additional revenue can be generated from user fees.

f) Establishing an SOA

The following steps need to be followed in order to establish a Special Operating Agency.

1. The Business Plan

Organisations applying to become an SOA develop Business Plans based in their Annual Operational Plans and Three Year Rolling Plans covering the next three years and having the following sections:

- Executive summary
- Introduction
- Purpose & mission
- Markets (Clients & other suppliers)
- Special features (USPs)
- Key strategies
- Business model
- Development strategies
- Structure & management
- Workplans
- Key personnel
- Financial tables
  - Expenditure forecasts
  - Funding forecasts

Business Plans define and address local priority health needs. Business Plans not only say what is to be done but how it is to be done. A Business Plan template forms Annex 5.

Business Plans are assessed by the MoH Monitoring Group to ensure that they are in line with Annual Operational Plans and Three Year Rolling Plans as appropriate, that they address local health priorities in an effective and feasible way, that they allocate human and financial resources efficiently, that they represent value for money and that they are financially sound. Once agreed, Business Plans are used as the basis for constructing the SOA's Terms of Reference and Management Contract.

2. Decision to proceed and the Business Case

This first step leads to a decision in principle to proceed with the establishment of an SOA involving the parent ministry, the Office of the Council of Ministers and the Ministry of Economy and Finance. The decision is made on the basis of a business case submitted by the MoH that makes a compelling rationale for establishing the SOA in terms of expected costs-benefits and risks. The Business Case document constitutes the core of the Agency's eventual Terms of Reference and Management Contract.

The MoH submits Business Case documents as part of an 'application in principle' to CAR on behalf of groups of organisations applying to become SOAs. It is structured as follows:

a. Description of the current programme and services as baseline;
b. Definition of anticipated programme objectives/performance;
c. Evaluation of the range of alternative delivery structures against defined objectives;
d. Analysis of the selected/feasible options in terms of benefits, cost and risk;
e. Recommendations; and,
f. Outline of an Implementation plan.

3. Nomination of SOA Head

Once approval to proceed is obtained, the Head of each SOA is nominated by the MoH. SOA Heads combine the functions of chief executive officer and chief operating officer. The Head of the SOA and its senior management are recruited from the Ministry management. It is important that the SOA Head be selected shortly after the decision to proceed with the establishment of an SOA. The selected SOA Head is an integral part of the Ministry's team responsible for the establishment of the SOA. He/she should be involved in the development of the SOA Terms of Reference and the first Management Contract.

4. The Terms of Reference

This is the framework document, in essence the "Constitution" of the SOA. Terms of Reference (TORs) are promulgated by Sub-Decrees.

They set out:

- The mission and the services that will be provided;
- The accountability relationships;
- The Agency's authorities;
- The key indicators on which the Agency will be evaluated; and,

- The process to account for results, including monitoring, reporting and ensuring that transparent information is accessible to the public, particularly with regard to services and fees.

The TORs spell out how management will be held accountable for results as well as how often (and in what form) they will report to the MoH. The TOR is developed cooperatively with the prospective management of the agency and key stakeholders such as Health Partners and groupings of users of health services.

This framework document is an agreement to provide stability. It is a public document that will be accessible to the service users of the SOA. The TORs are reviewed periodically in light of results and evolving circumstances. Annex 6 contains a template for Terms of Reference (TORs).

5. The Service Delivery Management Contract

The Service Delivery Management Contract is the natural extension of the Terms of Reference. It is based in the SOA's Business Plan which, in turn, is based on its Annual Operational Plan (and Three Year Rolling Plan if appropriate). It provides a clear description of how the agency will fulfil its mission and mandate as set out in the Terms of Reference and its service delivery priorities for the year. As such, the Service Delivery Management Contract is essential to the approval process leading to the establishment of an SOA. In the case of health service provider SOAs, PHDs act as the Minster's representative. The Service Delivery Management Contract is between proposed SOAs and their parent PHD. For other SOAs the Service Delivery Management Contract is between MoH and the SOA.

In both cases, the Service Delivery Management Contract assures the Minister that the SOA management has a clear sense of direction, is dealing with the right issues and is managing its affairs accordingly. The contract also indicates clearly in business terms where the SOA is going over the next few years, how it intends to get there and how it will measure progress.

The first SOA Service Delivery Management Contract is submitted for approval at the same time as the draft Anukret and TORs that establish the Agency. Thereafter, Service Delivery Management Contracts are rolling contracts submitted annually as part of the MoH planning exercise. Typically, Service Delivery Management Contracts cover the objectives, strategy, operational priorities, expected results and indicators, resources requirements, monitoring and reporting obligations of an individual SOA. The document also includes a section on sanction mechanisms in the case of non compliance and a process for reinforcement.

Service Delivery Management Contracts are supported by Personal Service Contracts between the SOA head and his/her managers and between them and

individual staff. The managers and staff of commissioning PHDs will also have Personal Service Contracts (as will the managers and staff in MoH headquarters eligible for MBPIs).

Annex 2 provides template for Service Delivery Management Contracts between PHDs and Health Service Provider SOAs (Annex 2a) and between MoH and other SOAs (Annex 2b). Annex 7 provides a template for Personal Service Contracts.

6. Obtaining approval

The Director-General of Finance and Administration in MoH will prepare and submit to CAR Sub-Decrees for each SOA for approval. The Sub-Decrees will include the names of all SOA permanent staff and will be accompanied by draft Terms of Reference and a Draft Service Delivery Management Contract. The requests for approval will be submitted through the Office of the Council of Ministers and the Ministry of Economy and Finance.

7. Appointment of the SOA Head

The Sub-decree establishing the SOA provides the Minister with authority to appoint the SOA Head.

8. Structuring the SOA

Anticipating approval and as soon as possible, work should proceed in parallel to structure the agency: organizing work including position descriptions, preparing staffing plans, setting up management processes including the Performance Management and Accountability System (PMAS) and generally preparing for launch including an information/dissemination programme. CAR advises that MoH should initiate a project to develop the ministry's and agency's capacity to plan, implement and monitor operations and to establish and manage internal systems such as the PMAS.

9. Management Board

The Head of the SOA is supported by the appropriate management committee, where possible one that already exists: in the case of SOA hospitals by a hospital management committee; in the case of OD SOAs by the District Health Development Committee. It meets on a regular (possibly quarterly) basis. Its functions include, among other things:

1. to review progress against contracted service delivery targets
2. to propose efficiency, quality and equity improvements

3. to advise on emerging health priorities and developments that could become part of future AOPs.

The terms of reference of existing committees should be adjusted so that they fulfil these functions. The SOA Head proposes the composition of the Management Board for endorsement by MoH.

The main processes required to establish an SOA in the health sector are summarised in the form of a logframe on the next page.

Establishing a Health Sector SOA Log Frame

No.	Process	Action Taken By	Outputs	Decision Makers
1	Develop business plan	OD/RTC/NC (External support)	Business plan	MoH
2	Develop business case	Ministry focal point (External support)	Business case	MoH
3	Seek the approval in principle	Minister Designated senior officials	Approval in principle	CAR, MEF
4	Develop framework documents (TORs etc.)	MoH (External support)	Framework documents	MoH /CAR
5	Seek final approval	Minister Designated senior officials	Final approval	CAR, MEF
6	Issue Ministerial Prakas	Minister Designated senior officials	Ministerial Prakas circulated	Minister
7	Nominate SOA head	MoH	SOA head	MoH, CAR
8	Develop personal service contracts	SOA Head (External support)	Signed service contracts	Ministry, (HPs)

III. SPECIAL OPERATING AGENCY MANAGEMENT

a) Managing the SOA

1. Managing staff performance and accountability

The SOA instrument is about performance and accountability. An effective system to plan, implement and monitor operations and to account for results is essential to both. A Performance Management and Accountability System (PMAS) is an essential companion to performance and merit based human resource management, demand driven capacity development and effective financial management. PMAS are routinely deployed in the central MoH to support and strengthen improvement in implementation activity. They are to be introduced at all levels

PMAS templates are provided in the *MoH PMAS Operational Manual*.

2. Managing organisational performance

a. Key functions

SOAs should aspire to become increasingly effective and efficient over time. This will require the development of staff capabilities and the systems to support them. The key staff and systems required for effective SOA operation are the same as those set out in the 'SOA readiness criteria' (Annex 4). However, for applying the criteria, the MOH Assessment Tools will need to be revised for evaluation of all sets of criteria. SOAs will be assessed periodically to ensure that they continually improve their capabilities in these areas. ODs and other organisations will be assessed against the same criteria for 'readiness' to be converted to SOAs

b. Improvement plans

Business Plans and Service Delivery Management Contracts include provisions for organisational capability and system improvements. The SOA Head is responsible for defining the key improvements required, what can be achieved in the coming year and costing the support required. These improvements should be included as targets in the AOP and Business Plan for the coming year. MoH is responsible for coordinating the supply of agreed technical assistance to support the implementation of organisational improvement plans under HSSP II. MoH also coordinates agreed training, financed under HSSP II, for SOA managers and clinical staff.

b) Managing human resources

The SOA Head has delegated authority to deploy and assign staff to specific duties.

SOA Business Plans and Management Contracts include staffing plans. In general SOAs use existing staff in-as-much-as possible. However, provided the SOA has achieved readiness criteria for HR Management, the SOA head has the authority to recruit contract and temporary staff if suitably qualified government staff are not available.

1. Establishing SOA posts

Unless recruitment is foreseen into existing established posts, posts need to 'established' before recruitment. This involves the following steps:

1. Preparation of a brief justification for the post, referring to the Business Plan and Management Contract
2. Preparation of a post description outlining the responsibilities of the post (terms of reference) and qualifications required for the job
3. Submission to the Provincial Health Department for approval
4. Inclusion in the Annual Operational Plan.

SDG grants may contribute funding for such posts, provided recruitment is competitive and transparent without the necessity of applying international procurement procedures.

2. Recruiting staff

The SOA Head has delegated authority from the Ministry of Health to recruit staff into approved posts agreed in the Service Delivery Management Contract. The steps to be following in recruiting temporary and contract staff are set out in Annex 7.

3. Staff remuneration

Subject to Management Contract agreement, the SOA head has delegated authority to set SOA staff remuneration in line with retention and recruitment requirements. SOA heads may use MBPI and PMG rates as guides for staff remuneration but these will be financed from the SOAs own financial resources (such as SDG, HEF or user fee revenues).

SOA staff terms and conditions of employment are set out in Personal Service Contracts (see Annex 8). Staff will be subject to performance management under the PMAS system.

c) Asset management and procurement

Although SOA assets will be owned by the MOH, SOAs are responsible for managing them. All SOAs should keep an up-to-date asset register.

Procurement procedures are set out in the government procurement procedures and, for HSSP financed procurement in the HSSP 2 Operational Manual.

d) Managing financial resources

The financial management procedures to be followed by all SOAs are outlined in various manuals as summarized below.

1. MoH Budget

The allocation and disbursement of MoH resources will follow established existing procedures.

2. Service Delivery Grants

Service Delivery Grants are only available to Health Service Provider SOAs that have achieved readiness criteria. The allocation formula used for 2009 can be found in the SDG Operations Manual. An Excel model used for estimating allocations based on population and population distance from facilities is available on the CD accompanying the SDG Operations Manual.

The disbursement procedures and fund flows will be undertaken in accordance with the HSSP 2 Financial Policies and Procedures Manual and are set out in the SDG Operations Manual.

3. Health Equity Funds

The procedures for managing HEFs are set out in the Health Equity Fund Guidelines and Operations Manual.

4. GAVI funds and Global Funds

Financial management of GAVI and Global Funds in SOAs will be undertaken in accordance with the respective manual and forms developed for the GAVI Health Systems Strengthening (HSS) Project and Global Funds.

5. Fees

The management of fee revenue will follow existing MoH procedures.

6. Consolidation of financial information

The SOA should consolidate all financial information on a monthly basis and submit financial reports to MoH and the HSSP Secretariat for management and monitoring purpose. The format for such Global Information Reports is shown in the HSSP 2 Financial Policies and Procedures Manual.

7. Auditing

Auditing of the operation of SOAs will be part of the routine work programme of the MoH Internal Audit Department and will be the subject of a specific annual external audit commissioned jointly by the Ministry of Health on behalf of other central government Ministries and the pooling Health Partners, as well as continuing audit by the External Auditor.

In both respects this can form part of broader audit programmes but with specific reports and thus reduce the burden on field organisations of multiple audits.

e) Monitoring contract performance

A central feature of HSP II is the introduction of commissions and contracts as a way of managing health service delivery. Under HSP II PHDs will commission health services from health service provider SOAs; MOH will commission training services from Regional Training Centre SOAs and other services as appropriate from National Centres who qualify for SOA status.

The performance of these contracts is a central part of achieving the important objective of SOAs to improve accountability. The assessment of contract performance will be an integrated sub-set of the HSP 2 Monitoring and Evaluation System (see HSP 2 and the HSSP 2 Operational Manual)

The targets agreed in the Performance Agreements between MoH and PHDs and the Service Delivery Management Contracts between PHDs and health service provider SOAs and between MoH and other SOAs, are the same as those used to monitor contract performance (Annexes 2 and 3). The indicators to be measured are arranged as follows and can be seen in Annexes 2 and 3. However, the actual targets to be achieved are those specified in the Performance Agreements and Service Delivery Management Contracts. They depend on local health priorities and health improvement achievements to date.

Performance Agreements between MoH and PHDs will include indicators for tracking HSP2 Goals.

HSP 2 Goal 1: Reduce maternal, new-born and child morbidity and mortality with increased reproductive health
HSP 2 Goal 2: Reduce morbidity and mortality of HIV/AIDS, malaria, TB and other communicable diseases
HSP 2 Goal 3: Reduce the burden of non-communicable diseases and other health problems
HSP 2 Goal 4: Improved organisational capacity, systems and processes

Service Delivery Management Contracts between PHDs and health service providing SOAs

1. Service outputs and quality of health care delivery
2. Effective organisation
3. Financial management
4. Community participation and views

Management Contracts between MoH and other SOAs

To be developed on the basis of agreed service delivery targets on a case-by-case basis.

Monitoring contract performance will utilise the same instruments: quarterly performance reporting and the Health Information System, supported by data from national surveys, small sample surveys, client satisfaction surveys and community scorecards (See HSSP 2 Operations Manual).

PHDs will have front line responsibility for monitoring the performance of their SOAs. The MoH Monitoring Group will have front line responsibility for monitoring the performance of PHDs and other SOAs.

At the national level, MoH may hire/ contract with an external agency to monitor PHD and health service SOAs. The evaluation output and outcomes will be measured by using performance indicators.

annex 32

Subdecree Establishing the First SOAs in the Health Sector (2008)

THE ROYAL GOVERNMENT
OF CAMBODIA

Council For Administrative Reform
Secretariat

Annex 25
NS/RKT/0308/346

Royal Decree
On
The Common Principle of the Establishing
And
Functioning Special Operating Agency

3

We,

Preah Karona Preah Bath Samdech Boromneat Sihamoni Sakmanphoumcheatsasna Rakaktakateyear Khemrarathreas Puthentrea Thormrea Moha Ksat Khemreach Near Sakmohaopheas Kampuch Ekreach Rath Bornak Sante Sophakmungkolear Serey Vibolear Khemra Srey Pereas Preah Chau Krong Kampuchea Thipdey

- Whereas the Constitution of the Kingdom of Cambodia;
- Whereas the Kret NS/RKT/0704/124 dated July 15, 2004 on the appointment of the Royal Government of the Kingdom of Cambodia;
- Whereas Kram 02/NS/94 dated July 20, 1994 on the organization and functioning of the Council of Ministers;
- Whereas Kram 06/NS/94 dated October 26, 1994 on the Common Statute of Civil Servants of the Kingdom of Cambodia;
- Whereas the Kret NS/RKT/0904/284 dated September 27, 2004 on the Supreme Council for State Reform.
- Whereas the proposal of Samdach Akakmahasenabadey Decho HUN SEN, the Prime Minister of the Kingdom of Cambodia.

Hereby Decides

Chapter 1
GENERAL PROVISIONS

Article 1:

The objective of this Royal Decree is to define the common principles for establishing and operating Special Operating Agency (SOA) in order to increase the effectiveness of public service delivery.

Article 2:

SOA is a mechanism available to ministries or institutions to deliver public services, with numerous integrated functions which together provide the SOA with sufficient characteristics to be consistent and coherent with other service delivery mechanisms with the Royal Government.

Article 3:

The purpose of SOA is to:

- Improve the quality and the delivery of public services where and when needed.
- Change the attitude and behavior of civil servants towards characteristics of encouragement and strong motivation to work, loyalty, focus on service and professionalism within the Administration;
- Enhance management through result base performance in ways that are effective, transparent and prudent ; and,
- Develop capacity for service delivery.

Chapter 2
CHARACTERISTICS OF SOA

Article 4:

SOA is an agency of a ministry or institution which has a separate structure from that of the ministry or institution parent. SOA shall have the following main characteristics:

- Procedures and bureaucracy in service delivery processes to users shall be reduced;
- SOA head has the right to manage both finance and human resources;
- SOA head is responsible and accountable for the management and expected results to the parent ministry or institution; and
- Shall have Terms of Reference, Management Contract, and clear reports.

Article 5:

SOA shall have Terms of Reference that defined clearly the targets, purposes, roles, functions, expected results, type of services provided to users, monitoring and evaluation guidelines, responsibilities and accountabilities of the SOA Head including the duties and authorities given by the ministry or institution.

Article 6:

Under the Terms of Reference, SOA Head shall agree on annual Management Contract with the Minister of the parent Ministry. The Management Contract shall define measurable and evaluable results using indicators of performance. The Management Contract shall be signed by the SOA Head and the Minister or the representative of the parent ministry.

The Management Contract shall focus on:

- Targets, nature and quality standards of services that the SOA shall provide to users;
- Service fees and delivery time for users;
- Main activities that the SOA shall implement;
- The resources that the SOA needs;
- Indicators for expected results;
- Modalities and procedures for monitoring and evaluation;

- Internal rules;
- Reporting regime to the parent ministry or institution and other relevant ministries; and,
- Rewards and sanctions.

Article 7:

SOA shall produce an activity report, auditing report, regular monitoring and evaluation reports to the parent ministry or institution and other relevant ministries or institutions.

Chapter 3
MANAGEMENT OF WORK ACTIVITIES

Article 8:

SOA shall operate from suitable locations to facilitate access by users to the services being provided.

The agency shall have a front office that directly interacts with users and the agency may have a back office to support the front office with such functions as human resources management and development and financial management. This agency structure is to be flexible to meet operational needs.

Article 9:

The parent ministry or institution shall be responsible for the effective monitoring and control of the implementation of the SOA Management Contract.

All activities of an SOA shall focus on achieving results based on set expected results.

Article 10:

SOA shall establish a hierarchy of personal service contracts for individual staff with clear responsibilities and expected results.

SOA staff shall be regularly evaluated according to the activities planned in the personal service contract.

SOA shall report regularly as stipulated in the Terms of Reference and the Management Contract.

Chapter 4
PERSONNEL MANAGEMENT

Article 11:

SOA is led and managed by a Head and is staffed with civil servants or contracting staff of the parent ministry or institution. Personnel management shall focus on:

- Performance;
- Transparency and professionalism;
- Individual and group accountability; and,
- Enhancing the capacity for operations.

Article 12:
SOA has the authorities and obligations necessary to lead and manage personnel as stipulated in laws and regulations for the management of the Civil Service such as recruiting staff, rewards, the use of contracting staff, and other conditions as stipulated in the Management Contract.

Article 13:
The remuneration of civil servants working in SOA includes salary, other indemnities and rewards as specified in the Personnel Service Contract.

The remuneration for contracting staff will be determined in a separate official document.

Article 14:

All SOA staff will enter into a Personal Service Contract with the SOA Head which include the following:
- Respect for internal rules
- Fulfill the work of their assigned position with accountability and responsibility;
- A clear list of work activities;
- Expected results to report on; and,
- Rewards and sanctions.

Chapter 5
FINANCIAL MANAGEMENT

Article 15:
SOA must have:
- Predictable and stable operational budgets;
- Reliable financial management processes that conform with existing laws and regulations; and,
- Transparent management and regular reports.

Article 16:
The budget of a SOA is part of the annual budget of the parent ministry or institution.

The parent ministry or institution and other relevant ministry or institution shall define and ensure that the budget is provided on time. The SOA budget shall be based on planned operations.

Article 17:

SOA financial resources may come from:

- National budget;
- A portion of user fees;
- Financing from development partners; and,
- Other sources

Article 18:

SOA has the following main authorities and obligations:

- Prepare its annual expenditures plan
- May engage expenditures according to plans and defined principles; and,
- Expenditure shall follow due process.

Article 19:

User fees and the portion of user fees that may be retained by the SOA shall be determined in light of the location and circumstances of an individual SOA, the joint Prakas of the Minister in charge of the Office of the Council of Ministers and the Minister of Economy and Finance on the recommendation of the parent ministry or institution.

Article 20:

The management, control, inspection and auditing of all revenues and expenditures and of working processes shall be done according to rules and regulations in effect.

Chapter 6
USE OF INFORMATION TECHNOLOGY

Article 21:

Parent ministry or institution and other relevant ministry or institution shall encourage the use of ICT for communication in order to facilitate access to its services and to improve transparency and efficiency in their delivery to users.

Article 22:

The information technology shall also be used to strengthen SOA internal processes such as human resources management and financial management processes.

Chapter 7
ESTABLISHMENT AND OPERATIONS

Article 23:

Each parent ministries or institutions are encouraged to use special operating agencies in order to improve the delivery of public services according to the need of users.

Article 24:

The Office of the Council of Ministers is responsible for the facilitation, promotion and use of every special operating agency and for monitoring their implementation.

Article 25:

The establishment and operation of special operating agencies shall be made by Sub-Decree with the Term of Reference and Management Contract as annexes.

The assignment of SOA Head and the staff will be will be specified in the Sub-Decree establishing the SOA.

Chapter 8
FINAL PROVISIONS

Article 26:

Ongoing Public Establishments can not be transformed into Special Operating Agency.

Article 27:

Any provisions contrary to this Royal Decree shall be considered null and void.

Article 28:

SAMDECH AKKAK MOHA SENA PADEI DECHO HUN SEN, the Prime Minister of the Kingdom of Cambodia shall be responsible for the enforcement of this Royal Decree from the date of Royal signature.

Done at the Royal Palace, ...,

Kings Signature and stamps

Norodom Sihamoni

Submitted to His Majesty
the King for Royal Signature by:

Signature

Samdech Akka Moha Sena Padei Decho HUN SEN

annex 34

SOA Terms of Reference Template (2008)

KINGDOM OF CAMBODIA
Nation-Religion-King

MINISTRY OF HEALTH
Institutional development and incentives for better healthcare

[Template for SOA Terms of Reference]

Annex 34

Terms of Reference for _____SOA

Preamble

The Royal Government's vision for the Cambodian Public Administration is to **serve people better**. For this purpose, the Public Administration is to become **an effective provider of public services and a trusted development partner**. This document sets out the general Terms of Reference of the _____ Special Operating Agency (SOA). It comes into force from the date of the signing of the Anukret creating the SOA. The Terms of Reference are a standing agreement between the Ministry of Health and the _____ SOA. They may be amended from time to time by a Prakas of the Minister of Health following discussions between all parties concerned.

The Policy on Public Service Delivery (PPSD)

To realize the vision of serving people better, the Council for Administrative Reform articulated a program of reform along four strategic thrusts: improving service delivery, enhancing pay and employment, developing the capacity of people and institutions, and promoting the use of information and communications technologies. The Royal Government approved the first of these policies: the Policy on Public Service Delivery as the corner stone to the other policies. The **objective** of the policy is **to make public services of quality accessible where and when needed throughout the country**. To do so, it encourages ministries and civil servants to streamline service delivery, service by service, and to use an array of alternative instruments to make services more transparent, accessible, responsive and reliable.

In the words of the Prime Minister in the Preface to the policy: the Administration has to have four characteristics:

1. **Encouragement and strong motivation to work**: the Administration must be devoted to work and encourage civil servants to work;
2. **Loyalty**: the public administration that is the assistant of the Royal Government shall be loyal to the State and the people;
3. **Focus on service**: the Administration has to be transformed from "administrator" to respectful "service provider" and be fair in serving and responding to the real needs of the people; and,
4. **Professionalism**: the Administration has to perform its duties with transparency, capacity and effectiveness.

The Royal Decree on Special Operating Agencies

The service delivery policy identifies the use of alternative delivery processes such as 'special operating agencies' as part of a mix of alternative service delivery tools ranging from privatization and contracting-out to de-concentration and decentralization. SOA are being introduced for the first time in Cambodia. The Royal Decree on the Common Principles on the Establishment and Functioning of SOA was approved on March 28, 2008. It covers the following sections:

- Characteristics of SOAs
- Management of work activities
- Personnel management

- Financial management
- Use of information technology
- Establishment and operations

It encourages the operations and management of SOAs to be innovative, while ensuring responsibility and accountability. These Terms of Reference are based on the principles and directives in the Royal Decree.

The Importance of health services

Health services are important in Cambodia and throughout the world in extending human life and improving its quality. Better health, in turn, reduces poverty by increasing the ability of children to learn and enhancing productivity.

The Ministry of Health has crafted a set of policies and strategies under its Health Strategic Plan 2008-2015 (HSP II) to enhance the contributions health services make to the welfare of all Cambodian citizens. Its focuses the attention of health service managers and staff on five working principles:

1. Social health protection, especially for the poor and vulnerable groups;
2. A client focused approach to health service delivery;
3. An integrated approach to high quality health service delivery and public health interventions;
4. Human resource management as the cornerstone for the health system; and
5. Good governance and accountability.

The responsibility of the _____ Special Operating Agency is to apply these five working principles in the delivery of health services to the people of _____ Operational District.

[Template for SOA Terms of Reference]

1. Mission, Mandate and Objectives

The Mission of _____ SOA

[service delivery, geographic coverage... this should come from the AOP and Business Plan of the SOA: define health service facilities as appropriate]

The _____ Special Operating Agency comprises [name]_____ Referral Hospital, [number] _____health centres and _____ health posts in _____ Operational District. These facilities serve a population of [number]_____ people. Of these, [number]_____ live in urban areas and [number]_____in rural areas of which [number]_____ are considered to be poor/remote. [Other key geographical features: swampy, difficult access, highway, etc]. The people of _____ District face the following main hazards to health _____; _____.

[give key health indicators here such as IMR, CMR, MMR, malaria incidence, HIV-AIDS incidence, TB incidence, hazards from accidents and injuries and main NCDs.....]

The Objectives of _____ SOA

[targeted services, markets, indicators) – this should come from the AOP and Business Plan of the SOA]

The _____ Special Operating Agency's overall objectives are to reduce health risks and improve access to healthcare. Its Annual Operational Plan and Business Plan define the following main health improvement targets for the next three years:

1. _____
2. _____
3. _____

The Operating Principles of _____ SOA

(the key words of PPSD) - – this should come from the AOP and Business Plan of the SOA

1. **Encouragement and strong motivation to work**: The _____ SOA will promote this by ----------
2. **Loyalty**: The _____ SOA will promote loyalty by - ----------
3. **Focus on service**: The _____ SOA will provide better quality and more effective basic health services by ---------- ----------
4. **Professionalism**: The _____ SOA will demonstrate transparency, capacity and effectiveness in its work by ---------- ----------.

[Template for SOA Terms of Reference]

2. Accountability and Relationships

The Responsibilities of the Ministry of Health and _____ Provincial Health Department

The central Ministry of Health will provide through its Departments and National Centres guidance on health policy and national strategic goals and priorities in health for Cambodia. It will provide support for the _____ SOA according to the functions of its departments and agencies.

The _____ PHD will provide supervision of the activities of the _____ SOA according to the terms of the Management Contract agreed annually between the two parties. The Provincial Health Department will monitor the achievement of SOA targets against the agreed indicators, and will ensure that financial and human resource management practices and outcomes accord with the agreed policies of the Ministry of Health.

The Responsibilities of the _____ SOA

The _____ SOA will provide health services to the population within the _____ Operational District as summarised above, within the national strategic priorities of the Ministry of Health as determined by the Health Strategic Plan II and the Annual Review, and as described from year to year in the Annual Operational Plan of the _____ SOA and the _____ PHD. It will be guided by national health policies and priorities. These services comprising the Minimum Package of Activities defined by the MoH will be provided through Health Centres and Posts, and through its Referral Hospitals. In addition a Complementary Package of Activities will be provided through the [name(s)] _____District Hospital[s] in accordance with its CPA status.

The _____ SOA will also liaise with and respond to local communities within the District covered by the SOA and shall encourage the participation of local authorities and individuals in formal committees to be determined from time to time.

_____ SOA Management board

[if appropriate]

The SOA Head will be assisted and advised by a Management Board comprising the following members

[state representation, not names: eg Finance Director, District Council, Commune Representative etc.]

_____

_____

_____

Authorities delegated to _____ SOA head

The Minister of Health formally delegates the following Financial Authorities to the head of the _____ SOA:

[Template for SOA Terms of Reference]

1. To manage the _____ SOA's budget in ways that ensure maximum financial efficiencies.
2. To make expenditures agreed in the SOA's Management Contract budget with the _____ PHD, following government financial rules and procedures and those of Health Partners contributing funds to the SOA budget.

The Minister of Health formally delegates the following Personnel Authorities to the Head of the _____ SOA:

1. To recruit and assign staff in order to make the best use of the SOA's human resources and according to the requirements of SOAs service delivery objectives within a budget agreed in the SOA's Management Contract with the _____ PHD

The Minister of Health formally delegates the following other Authorities to the Head of the _____ SOA:

1.

3. Human Resources Principles

Performance and merit based HR practices

The staff of the _____ SOA will be recruited on the basis of merit as assessed by job-relevant experience; job-specific skills and knowledge; relevant professional, vocational and educational qualifications; and training related specifically to the position requirements.

They will be managed, work planned and their performance assessed and recorded using the MoH Perfomance Management and Accountability System (PMAS).

Organization of work in _____ SOA

Table of job descriptions and competency profiles (for key staff only, i.e. SOA Head, SOA Finance Manager, SOA Contracts Manager, Director of RH, Health Centre Chiefs)

Remuneration and benefits for staff in _____ SOA

The following principles will be adopted in setting the level of remuneration and benefits for the _____ SOA staff taking into account the requirements for retention and recruitment of the appropriate levels of skills required by the _____ SOA.

[Summarise here rates for key staff, i.e. SOA Head, SOA Finance Manager, SOA Contracts Manager, Director of RH, Health Centre Chiefs. If appropriate divide by government/floating/contract. Mention any special or hard to recruit skills here]

_____

_____

_____

_____

_____

_____

DSA: when working more than _____kms from the assigned post, the following Daily Subsistence Rates will apply.

_____

_____

[Template for SOA Terms of Reference]

[Outline of any bonus scheme if appropriate]

[Template for SOA Terms of Reference]

4. Financial Principles

Developing the Budget of the _____ SOA

Income *[take estimates for next three years from Business Plan]*

Expenditure *[take estimates for next three years from Business Plan]*

	2009	2010	2011
Income			
Expenditure			

Sources of revenue for _____ SOA

[tick as appropriate]

Government budget	
Income from user fees	
Income from HEF	
Income from CBHI	
Income from Service Delivery Grants (SDGs)	
Other Health Partner payments [state specific sources]:	
•	
•	
•	

Financial management

The management of the _____ SOA's financial resources will be the responsibility of [name] _____who is a properly qualified SOA Finance Director.

Planning and budgeting for all funding sources will be undertaken in accordance with the MOH Planning Manual 2003 and making use of the 2009 updated formats (and subsequent revisions).

[Template for SOA Terms of Reference]

Financial management in the _____ SOA will be undertaken in accordance with the manual and forms developed for the GAVI Health Systems Strengthening (HSS) Project, adapted to take account of SDG requirements.

Expenditure will be subject to the rules governing the use of funds from each source, in the case of SDGs, following the terms of the SDG Operational Manual.

The _____ SOA will prepare accounts on a monthly basis, with completion no later than 10 days following the end of each month. These will be audited on a continuing basis by the External Auditor and at least twice annually by the MoH Internal Audit Department.

Procurement and the management of assets

The procurement of supplies and equipment will follow the procedures set out in the MOH Procurement Manual and, where appropriate, Health Partner procurement procedures.

The _____ SOA will maintain an asset register and update it every three months.

[Template for SOA Terms of Reference]

5. Planning and Reporting

Performance Indicators and Annual Plan for 2009

The Management Agreement between the _____ PHD and the _____ SOA includes the following performance indicators, expected results, expenditure plans and resource moblisation targets for 2009.

Performance indicators and Expected results

[Same as indicators and targets included in the Service Delivery Management Contracts]

1. Service Outputs

Performance Indicator	Expected Result 2009

2. Quality of Health Care Delivery

Performance Indicator	Expected Result 2009

3. Effective Organization

Performance Indicator	Expected Result 2009

4. Community Participation and Views

Performance Indicator	Expected Result 2009

SOA expenditure plan

[proposed expenditure by level (Referral Hospital, Hospital, other programmes) proposed expenditure by economic classification (chapter headings)]

PROPOSED EXPENDITURE BY LEVEL	
	Proposed Expenditure 2009
Operational District Office	
Referral Hospital	
Health Centres	
Total Proposed Expenditure	

PROPOSED EXPENDITURE BY ECONOMIC CLASSIFICATION (CHAPTER HEADING)	
	Proposed Expenditure 2009
Chapter 60	
Chapter 61	
Chapter 62	
Chapter 63	
Chapter 64	
Chapter 65	
Total Proposed Expenditure	

[Template for SOA Terms of Reference]

Resources needed

[funding required by sources of funding
cash flow plan showing what funding is expected in each quarter].

	Total Resources Needed 2009	Resources Needed by Quarter			
		Quarter 1	Quarter 2	Quarter 3	Quarter 4
Government budget					
Income from user fees					
Income from HEF					
Income from CBHI					
Income from Service Delivery Grants (SDGs)					
Other Health Partner payments [state specific sources]:					
•					
•					
•					

Monitoring and Evaluation Plan

Monitoring and evaluation of _____ SOA performance

[Summarise monitoring and evaluation arrangements]

[Template for SOA Terms of Reference]

Annual Report Template

The format below will be the basis for Annual Reports by the _____ SOA to the _____ PHD, to the responsible officer in MoH and to the Council for Administrative Reforms.

Key achievements:

_____

_____

Expected results and actual results

1. Service Outputs

Performance Indicator	Expected Result 2009

2. Quality of Health Care Delivery

Performance Indicator	Expected Result 2009

3. Effective Organization

Performance Indicator	Expected Result 2009

[Template for SOA Terms of Reference]

4. Community Participation and Views

Performance Indicator	Expected Result 2009

Planned expenditure and actual expenditure

PROPOSED EXPENDITURE BY LEVEL		
	Planned Expenditure 2009	Actual Expenditure 2009
Operational District Office		
Referral Hospital		
Health Centres		
Total Proposed Expenditure		

PROPOSED EXPENDITURE BY ECONOMIC CLASSIFICATION (CHAPTER HEADING)		
	Planned Expenditure 2009	Actual Expenditure 2009
Chapter 60		
Chapter 61		
Chapter 62		
Chapter 63		
Chapter 64		
Chapter 65		
Total Proposed Expenditure		

Priorities for further improvements in [2010]

1. Service Outputs Improvements

_____

_____

2. Quality of Health Care Delivery Improvements

_____

_____

3. Effective Organization Improvements

_____

_____

4. Community Participation and Views Improvements

_____

_____

annex 35

Service Delivery Grants – Operational Manual (2008)

KINGDOM OF CAMBODIA
Nation-Religion-King

MINISTRY OF HEALTH
Institutional development and incentives for better healthcare

Annex 35
Kingdom of Cambodia
Nation – Religion – King

Ministry of Health

Service Delivery Grants – Operational Manual

November 2008

Department of Planning and Health Information

Abbreviations and Acronyms

ANC	Ante Natal Care
AOP	Annual Operating Plans
ART	Anti Retroviral Treatment
BTC	Belgian Technical Cooperation
CBHI	Community Based Health Insurance
CMS	Central Medical Stores
CPA	Complementary Package of Services (at Hospitals)
CPR	Contraceptive Prevelance Rate
CVD	Cardio Vascular Disease
DBF	Department of Budget and Finance
DPHI	Department of Planning and Health Information
EMOC	Emergency Maternal Obstetrical Care
GOC	Government of Cambodia
HC	Health Centre
HCMC	Health Center Management Committee
HEF	Health Equity Fund
HIS	Health Information System
HIV/AIDS	Human Intracellular Virus/Auto Immune Deficiency Syndrome
HPs	Health Partners
HSD	Health Service Delivery
HSP	Health Strategic Plan
HSSP	Health Sector Support Project
IAD	Internal Audit Department
IMR	Infant Mortality Rate
INGO	International Non Governmental Organization
MBPI	Merit Based Performance Incentive
MEF	Ministry of Economy and Finance
MOH	Ministry of Health
MMR	Maternal Mortality Rate
MOP	Ministry of Planning
MPA	Minimum Package of Services (at Health Centers)
MW	Midwife
NGO	Non Governmental Organization
OD	Operational District
PHD	Provincial Health Department
PLHA	People Living with HIV/ AIDS
PRH	Provincial Referral Hospital
PMGs	Priority Mission Groups
RHs	Referral Hospitals
SDGs	Service Delivery Grants
SOA	Special Operating Agency
TFR	Total Fertility Rate
TORs	Terms of Reference
VHSG	Village Health Support Group

Introduction

This document provides operational guidance on the implementation of "Service Delivery Grants" (SDGs). It consists of seven sections and 17 supporting annexes:

Section 1 – the context for Service Delivery Grants including roles and relationships; the uses and limitations on SDGs;

Section 2 – identifies the key processes and systems necessary for the effective implementation of SDGs.

Sections 3 to 7 – provide more detailed guidance on each of the processes and are supported by the relevant Annexes.

The manual provides guidance to Provincial Health Departments and Health Partners involved in the funding of Service Delivery Grants and support to associated organisational development and internal contracting.

The manual may be modified from time to time by the Ministry of Health following consultation with the health partners. The focal Ministry Department is the Department of Planning and Health Information and any queries on it should be addressed to that Department.

A number of Annexes form part of this manual. These are:

Annex 1:	Eligible Expenditures by Budget Chapters
Annex 2:	Performance Contracting and SDG Fund Flows
Annex 3:	Calculating Grant Size
Annex 4.	Planning Formats for 2009
Annex 5:	Financial Management Criteria for Provincial Health Departments
Annex 6:	Assessment Instrument for Provincial Health Departments
Annex 7:	MOH-PHD Performance Agreement
Annex 8:	Prakas on the awarding of the certificate of recognition for the contribution to the referral hospital and health center quality improvement
Annex 9:	OD Assessment Instrument
Annex 10:	Health Center Assessment Tool
Annex 11:	Referral Hospital Assessment Tool
Annex 12:	Service Delivery Management Contract
Annex 13:	Financial Reporting Formats
Annex 14:	HSSP2 Financial Manual
Annex 15:	Sample Audit Programme
Annex 16:	Functions of Internal Audit Department
Annex 17.	TORs External Monitor

Context

Service Delivery Grants (SDGs) will be made directly to ODS/PRHs to support the objectives of the 2nd Health Strategic Plan (HSP2) in increasing utilisation of quality health services by the whole population. This is in accordance with broader government policies to improve service delivery. SDGs will be allocated to Operating Districts (ODs) and Provincial Referral Hospitals (PRHs) in accordance with its Annual Operational Plan (AOP) and through the mechanism of Service Delivery Management Contracts (Annex 12)

Government has created new opportunities for the management of service delivery and motivating health care providers. A management contract is signed between the Director of the OD/PRH and the Minister or representative of the line Ministry or institution. This is in accord with the policy of the Ministry of Health (MOH) expressed through HSP 2 to use contracting mechanisms to assist in improving utilisation and quality of health services. Thus, PHDs will enter into management contracts with selected ODs and PRHs (this being described as "internal contracting" and replacing the existing contracting arrangements with NGOs from 2009).

PHDs, ODs, and PRHs will also have available to them GOC legal mechanisms for the improvement of staff incentives – specifically Priority Mission Groups (PMGs) and, in the case of PHDs, Merit Based Performance Incentives (MBPIs)- although ODS/PRHs will need to finance these from their own resources. Within the limitations and terms described in the management contract, ODS/PRHs will be able to establish employment contracts which can include additional performance related rewards ("bonuses").

The GOC and Development Partners (DPs) wish to move progressively to reliance on government systems for the management of all resources used in service delivery. Therefore, this Operational Manual for SDGs will not create a parallel system but indicate how SDGs can be managed through the use of approved government systems, and indicate any specific arrangements to meet the requirements of Health Partners.

1. Roles and Relationships

The MOH will develop the policies and strategies required to guide resource allocation and the mechanisms for resource distribution (including contracting mechanisms). The MOH will agree with the HPs the formula for allocation of SDGs, the criteria for eligibility to receive SDGs, and the mechanisms for monitoring and auditing the use of SDGs. The MOH will undertake the management of SDGs through the following functions and responsible Departments.

Table 1

Function	Responsible Department
Overall Management and Coordination	DPHI
Planning, Resource Allocation Formula, and Monitoring	DPHI
Financial Administration, including Budget Disbursement and Reporting	DFB
Performance monitoring (routine)	MOH/PHD
Performance Monitoring (verification of results and standards)	Independent Firm/Team (to be selected by MOH)
Auditing SDGs expenditures	IAD; External Audit

PHDs will establish Service Delivery Management Contracts with OD and PRH based on agreed service delivery targets and financed in part by SDGs.The role of the PHD will therefore include situation analysis, understanding the concerns of communities and citizens, assessing the capabilities of ODs and PRHs, monitoring performance, and managing contractual relationships.

Operating Districts and Referral Hospitals will be the immediate providers of services. They will provide services in accordance with the terms of the contract agreed with the PHD. The Service Delivery Management Contract will be established on the basis of all of the sources of funding of the OD / PRH (including SDG derived funds) and be cognizant of any specific limitations on the use of funds from different sources.

Eligible Expenditure

Service Delivery Grants (SDGs) are a means of supplementing government budgets for health care delivery. In this respect health care delivery also includes outreach services, and community participation aimed at improving the quality of services, as well as the direct costs of service delivery. Spending of SDGs will be in accordance with the overall budget agreed between the PHD and OD / PRH and the programmatic priorities and targets specified in the contract. SDGs are to be used to support the recurrent costs of service delivery consistent with the expenditure descriptions of Chapters 60, 61, 62, 64, and 65, and subject only to the limitations indicated in Annex 1. SDG payments may be allocated for staff remuneration and performance bonuses. However, total allocation to staff costs from Health Equity Funds, Community Based Health Insurance, User Fees, and SDGs will not exceed 80 per cent of the total revenue from all of these sources (SDG Allocation, Annex 3).

SDG payments are one component of the funding sources of an OD / PRH. In constructing the business plan for the OD / PRH and in the contract sum agreed between the PHD and OD / PRH, all sources of funds should be taken into account in meeting all of the costs.

It will be noted that SDG funds are not used for the following categories of expenditure:

- Capital Expenditure
- Routine Acquisition of pharmaceuticals
- Basic Salaries
- MBPI payments
- Training, except if provided by OD trainers

Procurement needs will be assessed to ensure consistency with the limited procurement allowed under SDGs. The MOH Procurement Manual will provide guidance on all SDG procurement.

In respect of capital expenditure it should be noted that at present there is no financial limit distinguishing recurrent items from capital items. Until this is clarified it should be assumed that items of a life of more than one year and costing in excess of Riel 5 Million should be classified as capital expenditure and not eligible for SDGs. However, such items may be included in annual investment programmes that may receive support under HSSP2 procurement arrangements.

Training expenses will be allowable under SDGs only if OD trainers are used. Other external training provided by PHD, MOH or from elsewhere will be included in the AOPs and will be funded separately

2. Key Processes and Systems

For the implementation of SDGs there are five main processes that are involved:

- Resource Allocation
- Planning and Budgeting
- Performance Management
- Financial Flows, Recording and Reporting
- Auditing

These are the same processes that apply to the use of the main budget government funds and with the same interests:

- Use of funds for purpose intended
- Use of funds for eligible expenditures in line with policies, priorities, strategies, and plans
- Positive impact on health outputs and outcomes

Therefore it is the intention to make use of government systems and strengthen and modify such systems where required and in the light of local experience.

Specific Requirements for Service Delivery Grants

In order to meet the **specific conditions** of HPs for the use of SDGs, the systems will be applied or modified as follows:

- To be eligible to manage the SDGs, among other things, each managing entity shall meet the minimum financial management criteria as set out in policies section of the Financial Management Manual.

- In 2009, the current Contractors will provide the 11 targeted ODs with technical assistance for further building capacity.

- Performance Agreements between the MOH and PHDs will include within a Standing Agreement a specific set of management criteria applied through an assessment instrument which will form the basis of the decision on "readiness to receive" SDGs

- Service delivery management contracts from PHDs to ODs and Provincial Referral Hospitals will include a set of management and service criteria, applied through assessment instruments, to be met as the basis for the addition of SDG derived supplements to budgets / contract sums.

- MOH will commission independent monitoring of activity information and conformance to standards

- The MOH and Partners will commission jointly an annual external financial and performance audit of the management and use of SDGs as well as a continuing audit of use of SDG funds.

- Review of use of SDGs to form part of Joint Annual Performance Review and will be monitored by the Joint Programme Management Group.

3. Resource Allocation

Calculation of Target Sums for Service Delivery Grants
The target allocation of SDGs will be based on a formula reflecting the relative needs of the eligible ODs. The allocation will be calculated based on the following:

1) A fixed per capita element– to reflect the size of the population in the OD and average distances to health centers and referral hospitals

2) Taking into account capacity to raise other revenues from user fees, Health Equity Funds, Community Based Health Insurance, and other relevant sources.

The target allocation will consider the total population of the participating ODs. Actual annual allocations will depend on whether the ODs / PRHs have fulfilled the readiness criteria for receiving SDGs.

The methodology for calculation of Service Delivery Grants is attached as Annex 3.

Resource Allocation Arrangement

In 2009 allocation of SDGs will be determined as follows:

(a) Under the guidance of the Health Sector Steering Committee, the Joint Programme Management Group will determine an overall ceiling for SDGs and indicative minimum allocations to individual ODs based on a formula which in total represents 80% of the available ceiling.

(b)The remaining 20% will be partly allocated as follows:

- 15% of SDGs will be held back as a provision for performance based allocations during the year.
- 5% of SDGs will be held back for special circumstances and will be allocated based on contract negotiations.

Joint MOH / PHD contracting teams will hold discussions with eligible ODs to determine the extent of SDG allocation above the indicative sum based upon "financing gaps" related to particular constraints on service delivery and specific activities to take forward the priorities of HSP 2 (e.g. in reducing maternal mortality), and absorptive capacity indicated by assessment scorings.

(c) Final decisions on 2009 allocations will be announced by the MOH.

(d) Additionally, the Ministry of Health and the Health Partners have agreed that SDGs will be reduced with 10% every year for reasons of sustainability and as an incentive to OD/PRH to increase revenue from other sources.

4. Planning and Budgeting

Planning and Budgeting for all resources including SDGs will be undertaken in accordance with the MOH Planning Manual 2003 and making use of the 2008 updated formats (and subsequent revisions).

The key planning tools for use of grants will be the 3 year Rolling Plans and Annual Operation Plans (AOP) of the Provinces.

A comprehensive AOP will be among the preconditions for the disbursement of grants included in the Standing Agreement section of the Performance Agreement. In order to do this the following minimum information will be required:

- Proposed expenditure by level (PHD, Provincial Referral Hospital, OD, Health Centers, other programmes)
- Proposed expenditure by HSP 2 Programme
- Proposed expenditure by economic classification (chapter headings) sources of funding
- SDG cash flow plan showing what funding is expected in each quarter.

From the AOP it should be possible to extract plans for spending by each source including schedule of spending of SDGs. The GOC expected allocations should match with the budget agreed for health by the Province with the Ministry Of Finance.

In promoting the goals of HSP2 the use of SDGs will focus on funding priority services. These are mostly delivered at the health centre level although some can only be provided at equipped hospitals (e.g. Emergency Obstetric Care) with some provided directly by the province. Grants will be expected to support spending on:

- PHC services provided at Health Centres that meet MPA standards
- Referral Hospital Services mainly for:
    - Emergency Obstetric Care at hospitals provided they are equipped to carry out caesarean sections (CPA 2/3)
    - Hospitalisation for sick children (under 5 years)
    - Other HSP2 priorities

In 2009 AOPs, SDGs will focus in supporting the MOH fast track initiative to reduce maternal mortality and support EMOC related activities

- Emergency transport for Emergency Obstetric Care
- Limited spending on public health activities of ODs not exceeding an agreed percentage of the total grant awarded

These priorities will be reflected in the spending plans in three year rolling plans, annual operational plans and business plans, and will then be expressed through contract agreements with ODs and PRHs.

5. Performance Management

5.1. Overall Arrangements

In accordance with the service delivery policies of the GOC, HSP2 emphasizes the importance of accountability for the achievement of results at the various levels of the health system. The basis of this accountability is the formulation and implementation of comprehensive AOPs and relevant Service Delivery Management Contracts.

5.2. Performance Agreements for SDG Funding

On an annual basis, and usually in November, a Performance Agreement will be made between the MOH and the PHDs. The Performance Agreement will consist of three main sections.

Section 1 or the "Standing Agreement" will describe the management standards that are expected to be fulfilled on a continuing basis so that the functions of the PHD can be adequately performed. Whilst the Standing Agreement may be modified over time to reflect changing roles and responsibilities it is unlikely to change substantially from year to year. The specific conditions for demonstration of effective financial

management are described in Annex 5. Adherence to the Standing Agreement will be tested initially by an MOH Assessment Team using the instrument attached as Annex 6 and an annual certificate of compliance will be issued as part of the subsequent jointly commissioned external performance monitoring.

Section 2 of the Performance Agreement will set-out the medium term objectives agreed between the Ministry and the Provincial Health Department in line with the content of the Three Year Rolling Plan.

Section 3 of the Performance Agreement will set out specific targets for the coming year and will be based upon the Annual Operational Plan. Most of these targets will be directly derived from the Indicators in HSP 2. There may also be some PHD specific targets (for example related to major physical developments, correction of previous failures, etc).

Adherence to the requirements of the Standing Agreement will be a precondition for receipt of SDGs.

Annex 7 *is a Model MOH-PHD Performance Agreement*

5.3. Service Delivery Management Contracts

The Royal Decree on Special Operating Agencies sets-out the main components of the management contract between the representative of the Minister and the Director of the OD/PRH. These are:

- ***targets, types of services and service quality standards which the Special Operation Agency guarantees to provide to the service users***
- ***service charges and time which are provided to the service users***
- ***important activities which are implemented by the Special Operation Agency***
- ***resources which are needed for the Special Operation Agency***
- ***indicators of the expected results***
- ***methods and procedures of monitoring and evaluation***
- ***internal rules***
- ***reporting schedules to the line ministry or institution and concerned ministries and institutions***
- ***incentives and punishment***

Service Delivery Management Contracts between PHDs and ODs / PRHs will be consistent with these elements and will encompass:

- Description of the main activities to be undertaken (consistent with MPA and CPA status)
- Conditions for entering into the contract (times of service availability; schedule of user fees; employment conditions for staff and internal rules; service delivery and quality standards to be achieved)
- Contract Management Arrangements (reporting arrangements; monitoring arrangements)
- Service Delivery Outputs and Performance Targets
- The Contract Sum and overall budget for service delivery

Eligibility for contract will depend on the achievement of satisfactory scores using the MOH assessment tools. The Prakas on "The Awarding of the Certificate of Recognition for the contribution of the Referral Hospital and Health Centre Quality Improvement through a Level 1, Step 1 of Quality Assessment Tools" (Annexes 10 & 11) provides the existing basis for these preconditions.

The tools referred to for assessment are included as Annex 9 (for ODs), Annex 10 (for Health Centres) and Annex 11 (for Referral Hospitals). The minimum requirement for inclusion of SDG funding in the contract sum will be:

For an OD:

- OD achieves the minimum required standards in OD assessment and adopts the action plan for achievement of higher standards
- 60% of Health Centres in the OD achieving the "Recommended" score of 65% in Year 1, and 75% Health Centres achieving a score of 75% in Year 2 and subsequently
- Referral Hospital scoring a minimum of 65% in Year 1, and 75% in Year 2 and subsequently

For a Provincial Referral Hospital:

- Scoring at least 65% in Year 1 and 75% in Year 2 and subsequently

The 11 currently contracted ODs and 5 provincial hospitals in Preah Vihear, Rattanakiri, Mondulkiri, Takeo, and Koh Kong will be pre-selected for receiving SDGs in 2009 regardless of the assessment scores attained. . In this case, the MOH will allow a provisional contract eligibility on the basis of an agreed improvement plan to be achieved by the end of 2009 and re-evaluated by existing assessment tools. Those currently pre-selected ODs' will lose eligibility if they do not achieve the required performance by the later assessment.

Adequate external support, adequate staff to manage contracts and comply with the financial management criteria, and adequate service delivery staff to guarantee the continuum of services will be a precondition for the SDGs becoming effective in these provinces and ODs not meeting the minimum required standards.

The SDG sum allocated in the contract will be based on the 80%, 15% and 5% allocation system described under resource allocation above.

Normally all Service Delivery Performance contracts between PHDs and ODs / PRHs will be agreed by November of the year.

***Annex 12** is a Service Delivery Management Contract.*

5.4. Contract Management and Monitoring

MOH-PHD Performance Agreements will be monitored quarterly by the MOH. Service Delivery Management Contracts will be managed and monitored by the PHD. A key aspect of the Standing Agreement between the MOH and PHD is the availability of a competent Contract Manager and that the processes and systems required for contracting are in place. It is recognised that these capabilities may not be in place at the commencement of HSP2. All Provinces will be the recipients of a package of capacity strengthening implemented in phases to ensure the development of the required capabilities (and separately funded).

Two types of monitoring will be done:

i) Internal (MOH/PHD) monitoring -quarterly and
ii) External independent monitoring- bi-annually *(TORs External Monitor, Annex 17).*

Each one will look into Management and Performance, with the emphasis on the achievement of performance targets on an annual basis within the context of the

three year rolling programme. Included is the arrangement for internal and external audit of finances and will include audit of activity and performance information. The MOH organisational assessment tool will provide the basis of the management monitoring arrangements

Both the External Monitor and the MOH will monitor compliance in terms of performance. This will be linked to the monitoring and evaluation arrangements established as part of the Performance Agreements between MOH and PHD and the Service Delivery Management Contracts between the PHD and the OD/PRH.

Monitoring and evaluation will be linked to the review of performance and will be drawn from a number of sources:

- The MOH Annual Performance Review Meeting
- A performance review meeting between MOH and each PHD to formalise the above
- Quarterly monitoring meetings
-

Annual Performance Review: A formally constituted performance review meeting will be conducted and informed by the report of the Annual MOH Assessments, the summary of performance against the contract monitoring indicators for the year, and the final accounts for the year. External evaluations may be undertaken by the MOH and PHD to test the validity of information.

Quarterly Review: A quarterly meeting informed by the PHD monthly, quarterly and annual data, including collated PHD data for HIS; other activity data; financial management information; summaries of PHD monitoring visits etc.
Quarterly Reviews will focus particularly on any exception and to address any emerging difficulties in relation to the contract. These meetings will include community representation.

Internal Review: This process will be supported by the internal processes of continuous quality improvement undertaken by the Provider, in particular the active supervision using the Integrated Supervisory Checklist.

Community Participation: The OD will actively involve communities in the governance of health facilities in accordance with the MOH "Community Participation Policy for Health". Quarterly monitoring meetings will include the opportunity for participation of representatives of VHSGs and HCMCs, NGOs, CBHI and HEF schemes. Health Centre Management Committees will sign quarterly performance scorecards (see Schedule E of this contract).

Semi annual external monitoring: A consultant firm will be hired by the MOH to provide independent validation of HIS and MOH Quarterly Reports. Reports of the External Monitor will be used for recommending improvement and decision making at different levels.

6. Performance Monitoring

6.1. Internal Performance monitoring
MOH will conduct quarterly performance monitoring, which will trigger the performance incentive and bonus payments.

6.2. External Performance Monitoring
The performance of both PHD and OD/PRH will be independently verified by the External Monitor in respect of selected performance indicators by a third party

contracted by the Ministry of Health. The External Monitor (firm) will conduct at least twice a year an independent performance based monitoring (ref to TORs, Annex 17). The operator has to be procured (and included in the 2009 procurement plan).

External monitoring, including unannounced spot checks, will be conducted bi-annually. This will include spot checks to validate service delivery output data. The Commissioner and the Provider will make available relevant records and will allow access to facilities as requested by the External Monitors.

7. Financial Flows, Management, and Reporting

7.1. Outline of Financial Flows

The Ministry of Health will establish a "Pooled Account" and selected discrete accounts with the National Bank of Cambodia or a commercial bank into which the Pooling and Discrete Partners will make payments in accordance with agreed respective sums and in line with the requirements established in the AOP. For the SDGs funded from the Pooled Account, as required within the Financial Management Manual, the Ministry of Health will establish a "Counterpart Fund Account" into which it will pay the corresponding share of the cost of the AOP. Payments made from these accounts will be consistent with the proportions agreed with partners in financing agreements. Annex 2 outlines Performance Contracting and SDG Fund and Reporting Flows.

Following the agreement of a Service Delivery Management Contract between the PHD and the OD / PRH, during November of each year, the responsible officer in the Ministry of Health will be provided with a copy of the contract which will include a statement of cash requirements by quarter and by source. The responsible officer will make direct payment to the commercial bank account of the OD/PRH a sum representing the requirements from SDG. Funds will be disbursed from the pooled fund and counterpart funds for the first two quarters of the year (in the first year of SDG receipt) and for the quarterly payment subsequently will be disbursed in a parallel manner.

The OD/ PRH will locally establish their own USD bank accounts for receipt of SDG funding. They will prepare accounts on a monthly basis, with completion no later than 10 days following the end of each month. These will be audited on a continuing basis by the External Auditor and at least twice annually by the Internal Audit Department.

30 days prior to the commencement of the second quarter the OD will make a request for its cash requirements for quarters 2 and 3. No later than 15 days following the end of the first quarter, the OD / PRH will provide to the PHD and responsible officer in the MOH a summary account for that quarter of receipts and expenditure from all sources and for all purposes in accordance with the economic and functional formats in Annex 13 and the contract monitoring information for the first quarter. Subject to resolution of any accounting / audit queries, and endorsement by the PHD of acceptable contract compliance, the responsible officer will make payment of the 3rd quarter requirement no later than 60 days prior to the commencement of the third quarter. The quarterly contract monitoring meeting will thus be held between the 15th and 30th days following the end of a quarter.

This process will be repeated quarter by quarter. No later than 30 days following the end of the financial year, the OD / PRH will prepare full annual accounts.

7.2. Financial Management System

Financial management in PHDs, ODs, and PRHs will be undertaken in accordance with the financial manual and forms, now adapted to take account of SDG requirements, included here as Annex 14.

SDGs are provided as a lump sum allocation to ODs / PRHs. Allocation will be made against OD reporting. Spending is to be reported in accordance with government chapters and codes, but the rules of disbursement for government budget funds do not apply to SDGs.

7.3 Auditing

7.3.1. Internal Audit

Auditing of the operation of SDGs will be part of the routine work programme of the Internal Audit Department and will be the subject of a specific annual external audit commissioned jointly by the Ministry of Health on behalf of other central government Ministries and the pooling and discrete Health Partners funding SDGs, as well as continuing audit by the External Auditor.

In both respects this can form part of broader audit programmes but with specific reports and thus reduce the burden on field organisations of multiple audits. The contents of the audit are described in Annex 15 and may be modified from time to time. It will be noted from the listing of functions in Annex 16 in accordance with Sub-Decree 40 of the GOC that the IAD has broad audit functions. As they develop competence in these functions so the intensity of the detailed content of the external audit may be reduced.

7.3.2 . External Audit

Ref. to external audit TORs (Financial Management Manual)

Annex 1

SDG Eligible Expenditure

The allocation per capita will give the OD/PRH freedom to manage at best inside their package the item allocations to reach their targets.

CH	Acc.	Sub Acc.	Description	Eligible	Govt. Condition	SDG specific Condition
60			**PURCHASES**			For a maximum ceiling of USD 5,000 for SDG life time
	601		**Supplies**			
		6011	Supplies – Cleaning / Sterilisation	Yes	R5M or below per single purchase	
		6012	Supplies – Building Maintenance	Yes	R5M or below per single purchase	
		6014	Supplies – Machine Maintenance	Yes	R5M or below per single purchase	
		6015	Fuel and Oil	Yes	R5M or below per single purchase	
	602		**Supplies for Administration**			
		6021	Office Supplies and Printing Stationary	Yes	R5M or below per single purchase	
		6022	Books and Documents	Yes	R5M or below per single purchase	
		6028	Others	Yes	R5M or below per single purchase	Related to service delivery
	604		**Clothes and Decorations**			
		6041	Clothes	Yes	R5M or below per single purchase	
		6042	Safety Clothes	Yes	R5M or below per single purchase	
		6043	Medals	No		
		6048	Others	No		

605		**Furniture and Equipment**			
	6051	Equipment	Yes	R5M or below per single purchase	Items over R5M and has more than one year useful life, is to be supported by capital programme; and is not eligible under SDG.
	6052	Furniture	Yes	R5M or below per single purchase	Items over R5M and has more than one year useful life, is to be supported by capital programme; and is not eligible under SDG
	6053	Supplies	Yes	R5M or below per single purchase	
	6058	Others	Yes	R5M or below per single purchase	
606		**Utilities**			Limited to maximum of 25% of SDG value of OD/PRH/Health facility per annum
	6061	Electricity	Yes		
	6062	Water	Yes		
	6068	Others	Yes		
607		**Medical Equipment and Supplies**	Yes	R5M or below per single purchase	Items over R5M and has more than one year useful life, is to be supported by capital programme; and is not eligible under SDG
608		**Other Supplies**	Yes	R5M or below per single purchase	
61		**OUTSIDE SERVICES**			
611		**Contract with enterprises**	Yes		Related to service delivery
612		**Vehicle Rental**	Yes		
613		**Fare and charges (non furniture)**	Yes		
614		**Training cost (contracting experts)**	Yes		For training in health care delivery skills

615		**Repair and Maintenance**		
	6152	Repair and Maintenance	Yes	
	6154	Other Maintenance	Yes	
	6156	Vehicle Repair and Maintenance	Yes	
	6157	Repair and Maintenance of office equipments	Yes	
	6158	Repair and maintenance of technical equipments	Yes	
616		**Insurance**	No	
617		**Research and experimentation**		
	6171	Research and experimentation	No	
618		**Transportation cost**		
	6181	Goods deliver	Yes	
62		**OTHER OUTSIDE SERVICES**		
621		**Outside Staff**		
	6211	Contracted national staff	Yes	
	6212	Contracted foreign staff	No	
	6213	Other public collective staff	No	
	6218	Other outside staff	No	
622		**Publicity**		
	6221	Reception for nationals	No	
	6222	Reception for foreigners	No	
	6223	Meetings – workshops and conferences	Yes	Related to service delivery; community participation
	6224	Festivals and Ceremonies	No	
	6225	Local and outside souvenirs	No	
	6226	Local and overseas exhibitions	No	
	6227	Publicity cost	Yes	Related to service delivery
623		**Newspapers and documents**	Yes	Related to service delivery, e.g. guidelines
624		**Domestic Mission Expenses**		
	6241	Cost of transport	Yes	Related to service delivery
	6242	Per diem	Yes	Related to service delivery

		6243	Accommodation	Yes	Related to service delivery
	625		**Overseas Mission Expenses**	No	
			Communication Cost		
	626	6261	Postage Fee	Yes	
		6262	Telecommunication Fee	Yes	
	627		**Banking Charge**	Yes	
	628		**Other charges**	No	
63			**Taxation**	No	
64			**Staff**		
	642		**Remuneration and Allowances for permanent staff**		
		6421	Basic salary	No	
		6422	Specific work allowances	No	
		6423	Overtime	No	
		6424	Allowances for pedagogy	No	
		6425	Supplement for special living	No	
		6426	Location allowances	No	
		6427	Supplement for responsibility	No	
		6428	Supplement for heavy or hazardous work	No	
	643		**Other Allowances**		
		6431	Priority Mission Group	Yes	Health Service Delivery staff performance incentives and bonus payments
		6432	Allowances for competition	No	
		6433	Rewards	Yes	As part of a bonus scheme approved in the Contract
		6434	Supplements for others ministerial staff	No	
		6435	Foods for government staff	No	
		6438	Others	No	
	644		**Remuneration and allowances for non government and temporary staff**		

		6441	Basic salary for non government staff	**Yes**[1]	
		6442	Remuneration for non government staff	Yes	
		6443	Basic salary for temporary staff	Yes	
		6444	Other remuneration for temporary staff	Yes	
	645		**Social Allowance**		
		6451	Family Allowance	No	
		6452	Grant for sick staff	No	
		6453	Death Compensation	No	
		6454	Retirement Grant	No	
		6455	Resignation Grant	No	
		6456	Accident Grant	No	
		6457	Grant for delivery of child	No	
		6458	Grant for orphans of health staff	No	
65			**Financial Support and Social Aids**		
	653		**Financial Support to Public Administrative Institutions**	No	
	656		**Contribution to international organisations**	No	
	657		**Donors and Allowances**		
	657	6571	Assistance to the poor patients	No	
		6572	Drugs	Yes	Limited to urgent supplies and maximum of $5,000 for 5 years
		6573	Food and supply (for every citizen)	No	
		6574	Assistance to victims of natural disasters	No	
		6575	Foods reservation of state	No	
		6576	Domestic university scholarships and researches	No	
		6577	Overseas university scholarships and researches	No	
		6578	Others	No	

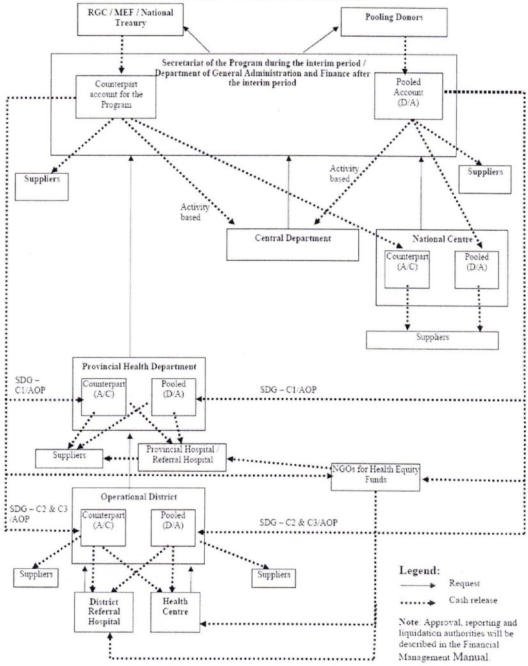
[1] See Annex 18: Contracted Staff Recruitment Procedures

658		**Financial support to social and cultural organisations**		
	6581	Community Support	Yes	If part of community participation in governance of health facilities
	6582	Support to Orphan Centres	No	
	6583	Support for relaxation and study	No	
	6584	Support to red cross	No	
	6585	Support to sport and cultural community	No	
	6586	Support on rehabilitation and training to handicap centres	No	
	6587	King's social affairs	No	

Annex 2. Peformance Contracting, SDG Fund Flows and Reporting Flows

The funding flow to from central Ministry to OD will be transferred directly from the central level account to the OD bank account.

FIGURE 1 – FUNDS FLOW DIAGRAM



N.B. The same fund flows will be used for discrete account SDG fund flows

Source: Project Appraisal Document. World Bank, May 27, 2008

Annex 3 Calculating Grant Size

The SDG allocation model

The allocation of SGDs is based on a model which is available in Excel and works as follows:

1. The average per SDG per capita per annum is set by the user.

2. The Ministry of Health and the Health Partners have agreed on an average per capita SDG of $1.50 in year 1 (2009).

3. The annual allocation of SDGs to each eligible OD/PRH is given by the average SDG per capita per annum multiplied by the population estimates of each OD provided by the 2008 Census.

4. An additional allocation is made to ODS/PRHs in Provinces where the average distance between villages and health facilities is greater than the average distance for the whole country. This additional SDG allocation is proportional to the difference between the average distance for the province and the average distance for the country as a whole multiplied by a weighting factor which is set by the user.

5. For 2009, this weighting has been set at 30% as this gives a result closest to the 2009 financial tables submitted by the ODs/PRH.

6. Average distances to health facilities has been selected as the modifying variable because
   a. provinces with sparse facilities are generally poorer and have lower health status, and
   b. the costs of delivering health services are higher.

7. The allocation of SDGs to each OD achieving SDG readiness criteria is based on the computed allocation to the Province where they are situated.

8. This means that all ODs in Provinces with a relatively dense network of health facilities get an equal SDG per capita, which is slightly less than the average allocation for all ODs. ODs in Provinces with sparse health facilities get a variable amount greater than the average allocation for all ODs.

9. For 2009 the `base allocation' has been set at 80% of the full allocation to allow for:

   a. the correction of anomalies and additional allocations for special circumstances (eg where the referral hospital is a Provincial Referral Hospital and therefore has a catchment area greater than that of the district where it is situated)
   b. a provision for an allocation which is performance-related.

As an example, the allocation of the formula to OD and PRH in 2009, results in the allocations shown in the table below

Operational District	SDG per Capita	Population	SDG Allocation (US$)	80% Base Allocation (US$)	15% Performance Based Allocation (US$)
Memot	1.24	134,133	166,325	133,060	24,949
Ponhea Krek	1.24	205,021	254,226	203,381	38,134
Smach Meanchey	3.28	62,231	204,118	163,294	30,618
Sre Ambel	3.28	77,462	254,075	203,260	38,111
San Monorom	4.64	60,811	282,163	225,730	42,324
Tbeng Meanchey	3.51	170,852	599,691	479,752	89,954
Pearaing	1.24	193,065	239,401	191,520	35,910
Preah Stiach	1.24	118,121	146,470	117,176	21,971
Ban Lung	3.52	149,997	527,989	422,392	79,198
Ang Roka	1.24	135,695	168,262	134,609	25,239
Kirivong	1.24	223,091	276,633	221,306	41,495
Total		**1,530,479**	**3,119,353**	**2,495,482**	**467,903**
5% of SDGs allocated based on contract negotiations					**155,968**

Additional points

- A maximum of 60% of income from user fees, health equity funds and community based health insurance can be used for payments to staff.
- SDGs can be used for staff remuneration, but not more than 80% of the total revenue from user fees, health equity funds, community based health insurance and SDG Base Allocations can be used for staff remuneration.
- The ODS/PRH head can decide on the level of remuneration for individual staff members.
- However, individual remuneration will not be lower than the PMG rates
- The OD/PRH Head can decide on how a performance bonus will be used.

Example:

SDG	125,000
SDGs (80% base allocation)	100,000
User Fees (UF)	30,000
Health Equity Fund (HEF)	20,000
Community Based Health Insurance (CBHI)	0
Total Revenue	**150,000**
Maximum available for staff remuneration (80% of total revenue)	120,000
Maximum from UF, HEF, CBHI available for staff remuneration (60% of 50,000)	30,000
SDG used for staff remuneration	**90,000**

In the case where there is a provincial referral hospital, the commissioning PHD will negotiate the division of the district allocation between the provincial referral hospital and the OD.

Commissioning PHDs may choose to negotiate SDG payments to provincial referral hospitals on the basis of fees for emergency services (trauma and obstetrics).

SDG allocations after 2009

It is expected that the same formula will be adopted with the following modifications:

1. Subject to contingencies, new ODs/PRHs entering the scheme will begin with the same allocations as for 2009. However, beginning in Year 2, SDG allocations will be reduced by 10 per cent per year. This will provide OD/PRH Heads with incentives to raise revenue from other sources, particularly from HEFs, User Fees and CBHI, and to take into account increasing government salaries.

2. The allocation formula will be reviewed frequently to assess its impact on the volume and quality of services.

Annex 4
Planning Formats

3 Year Rolling Plans

Table 1: 3 year-rolling plan

NAME OF INSTITUTION: YEAR: 2009 – 2011

PROGRAM	Sub-PROGRAM	Indicators	Baseli 2007	Target			Strategic Activity	Budget															
								2009					2010					2011					
								Goven't			User fee	Donor	Goven't			User fee	Donor	Goven't			User fee	Dono
				09	10	11		Op. Cost	Salary	Capi. Cost			Op. Cost	Salary	Capi. Cost			Op. Cost	Salary	Capi. Cost		
Program 1																							
	Sub-Program 1																						
							HSD																
							HCF																
							HRH																
							HIS																
							HSG																
Program 2																							
	Sub-Program 1																						
Non-Program																							

Annual Operating Plans

Table 1: Activity Pan

Institution name:

				TIMING					
	ACTIVITY		RESPONSIBLE UNITS	Q1	Q2	Q3	Q4	PROCESS INDICATOR / OUTPUT	TARGET
	Reduce maternal, new born and child morbidity and mortality with improved reproductive health.								
	To improve the nutritional status of women and children								
	• % of pregnant women receiving iron/folate supplementation								
	• % of postpartum women receiving iron/folate supplementation								
	• % of children 6-59 months receiving vitamin A 2 doses during the last 12 months								
HSD	HSD1								
		Supervision							
	HSD2								
	HSD3								
	HSD4								
	HSD5								
HCF	HCF1								
	HCF2								
	HCF3								
	HCF4								
	HCF5								

HRH	HRH1								
	HRH2								
	HRH3								
	HRH4								
HIS	HIS1								
	HIS2								
	HIS3								
	HIS4								
HSG	HSG1								
	HSG2								
	HSG3								
	HSG4								
	HSG5								
	HSG6								
Sub-program2	To improve access to quality reproductive health information and services								
	• 2 or more ANC health personnel consultation								
	• % of currently married women using modern contraceptive method								
	• % of HIV+ pregnant women receiving ART for PMTCT								
	• Proportion of pregnant women tested for HIV during ANC								
	ACTIVITY		RESPONSIBLE UNITS	TIMING				OUTPUT	
				Q1	Q2	Q3	Q4		
HSD	HSD1								
	HSD2								
	HSD3								
	HSD4								

	HSD5								
HCF	HCF1								
	HCF2								
	HCF3								
	HCF4								
HRH	HRH1								
	HRH2								
	HRH3								
	HRH4								
	HRH5								
	HRH6								
HIS	HIS1								
	HIS2								
	HIS3								
	HIS4								
HSG	HSG1								
	HSG2								
	HSG3								
	HSG4								
	HSG5								
	HSG6								
Sub-program3	To improve access to essential maternal and newborn health services and better family care practices								
	• Proportion of newborns protected against tetanus through the immunization of the mother								
	• % births delivery by trained health personnel								
	• % births delivery by trained health personnel at health facilities								

	• % of deliveries by C-section							
	ACTIVITY	RESPONSIBLE UNITS	TIMING				OUTPUT	
			Q1	Q2	Q3	Q4		
Sub-program4	To ensure universal access to essential child health services and better family care practices							
	• Consultations (new cases) per Children under 5 years							
	• % of child 6-59 months receiving mebendazole every 6 months							
	• % of expected ARI cases in children under 5 years treated in public health facilities							
	• % of expected diarrhoea cases in children under 5 years treated in public health facilities							
	• % of children under one year immunized against measles							
	• % of children under one year immunized with DPT3							
	• % of HCs implemented IMCI							
	ACTIVITY	RESPONSIBLE UNITS	TIMING				OUTPUT	
			Q1	Q2	Q3	Q4		
Program 2	**Reduce morbidity and mortality of HIV/AIDS, Malaria, TB, and other communicable diseases**							
Sub-program1	To reduce the HIV prevalence rate (< 1%)							
	• # of Voluntary Confidential Counselling and Testing sites operating in public and non-for profit sector							
	ACTIVITY	RESPONSIBLE UNITS	TIMING				OUTPUT	
			Q1	Q2	Q3	Q4		
Sub-program2	To increase survival rates of People Living with HIV/AIDS							
	• % PLHAs on ART alive after a 12-month treatment.							
	ACTIVITY	RESPONSIBLE UNITS	TIMING				OUTPUT	
			Q1	Q2	Q3	Q4		

Sub-program3	To achieve a high Case Detection Rate of over 70% and to maintain a high Cure Rate of more than 85% for pulmonary TB smear positive cases
	• Case detection rate of smear (+) pulmonary TB (%)
	• TB cure rate (%)

ACTIVITY	RESPONSIBLE UNITS	TIMING				OUTPUT
		Q1	Q2	Q3	Q4	

Sub-program4	To Reduce malaria related mortality by 50 % and morbidity rate by 30% among the general population
	• # of malaria cases treated at public health facilities per 1,000 pop
	• % of families living in high malaria endemic areas (< 1 km from forest) of 20 provinces have sufficient (1 net per 2 persons) trea

ACTIVITY	RESPONSIBLE UNITS	TIMING				OUTPUT
		Q1	Q2	Q3	Q4	

Sub-program5	To reduce burden of other communicable diseases
	• Incidence of diabetes reported from public health facili-ties
	• Incidence of cervical cancer
	• Percentage of population with head trauma due to road traffic accident received treatment
	• Incident of hypertension
	• % IDUs enrolled in Opioids substitution treatment

ACTIVITY	RESPONSIBLE UNITS	TIMING	OUTPUT

		Q1	Q2	Q3	Q4
Program 3	Reduce risk behaviors leading to non-communicable diseases (KAP): diabetes, cardiovascular diseases, cancer, mental health, su abuse, accidents and injuries, eye care, oral health , etc.				
Sub-program1	To improve access to treatment and rehabilitation for NCDs: diabetes, cardiovascular diseases, cancer, mental health, substance accidents and injuries, eye care, oral health, etc.				

	ACTIVITY	RESPONSIBLE UNITS	TIMING	OUTPUT
			Q1	Q2
Sub-program2	To ensure Essential Public Health Functions: environmental health, food safety, disaster management and preparedness			
	• Percentage of adult smoking			
	• % of blindness			
	• % Decayed missing filling teeth for children			
	• % of mental health cases receiving treatment			
	ACTIVITY	RESPONSIBLE UNITS	TIMING	OUTPUT
			Q1	Q2
Sub-program3	To reduce risk behaviors leading to non-communicable diseases (KAP): diabetes, cardiovascular diseases, cancer, mental health substance abuse, accidents and injuries, eye care, oral health, etc.			

	ACTIVITY	RESPONSIBLE UNITS	TIMING	OUTPUT
			Q1	Q2
Program 4: Health System Strengthening				
	• # of HCs and RHs built according to HCP			
	• % of HCs providing full MPA			
	• % of RH providing full CPA			
	• % of population with access to full MPA			
	• % of population with access to at least CPA2			
	• Bed Occupancy Rate			
	• Average Length of Stay			
	• % of Health Center that faced stock-outs of essential drugs ?			
	• # of health facilities applied Clinical Guidelines according to MPA and CPA			
	• % client satisfied with quality of public services			
	• Gov't health expenditure per capita			
	• Share of donor funding reported to MoH as % AOP			
	• Donor contribution to public health per capita			
	• % of total budget allocated to provinces			
	• Share of Gov't health funding reaching province, OD and facilities			
	• # of patient visits exempted at health facilities with user fees systems			
	• # of people covered by CBHI			
	• # of cases covered by HEF			
	• # of OD implementing contracting arrangement			
	• Ratio of MoH doctors (including MA) per population			

	• Ratio of MoH midwives per population				
	• Ratio of MoH nurses per population				
	• % of health institutions compliance with financial performance standard				
	• % of routine health unit performance data report submitted to MoH on time				
	• Number of staff covered by incentive schemes (MBPI, PMG, and contracting)				
	• % of RH, ODO, PHD offices with computerised HIS				
	• % HIS reports submitted on time				
	• % external funds for health included in 3YRP				
	• Compliance with International Health Regulation				
	• Number of private entities licensed: policlinics, consultation cabinets, pharmacies				
	• % of HC with functioning Health Center Management Committee				
	ACTIVITY		RESPONSIBLE UNITS	TIMING	OUTPUT
				Q1	Q2
HSD	HSD1				
	HSD2				
	HSD3				
	HSD4				
	HSD5				
HCF	HCF1				
	HCF2				
	HCF3				
	HCF4				
HRH	HRH1				
	HRH2				

	HRH3				
	HRH4				
	HRH5				
	HRH6				
HIS	HIS1				
	HIS2				
	HIS3				
	HIS4				
HSG	HSG1				
	HSG2				
	HSG3				
	HSG4				
	HSG5				
	HSG6				

PROGRAMS BUDGET:

- NATIONAL HOSPITALS
- TB HOSPITAL/TB CENTER
- MCH HOSPITAL/NMCHC
- PROVINCIAL HOSPITALS
- DISTRICT HOSPITALS
- HEALTH CENTERS

NON-PROGRAM BUDGET:

- CENTRAL LEVELDEPT, NATIONAL CENTERS, OTHER CENTRAL LEVEL INSTITUTIONS
- PROVINCIAL AND OD LEVEL: RTCs, PHDO, ODO

Annex 5

Financial Management Criteria for Provincial Health Departments and ODs/PRHs

1. Structure

- Adequate number of trained finance staff in post to carry out the duties as required in the job description.
- Income, assets, payments of expenditure, cash/bank, general ledger and reporting) in post demonstrating competence in basic accounting procedures (see Annex 1).
- All finance staff will have job descriptions.
- There is segregation of duties (i.e. separation of operational responsibility from record keeping and separation of authorisation of transactions from the custody of related assets).
- Operational manuals are available for all routine operations with clear responsibilities for preparation, checking, and authorisation of all forms of transactions.
- Hardware and accounting software available for data entry and reporting.
- Staff competencies are assessed and performance of staff is appraised regularly.
- Training is undertaken to ensure adequate competencies and update in new requirements.

2. Budget Planning

Preparing medium term strategic plan that fits with broader government health strategy.

The plan is cascaded down to OD and PRHs under the provincial department.

An annual budget is prepared that is linked clearly linked to the priorities in the Annual Operating Plan and includes income derived from all sources.

The total budget allocated to budget heads in the Provincial Health Department, the Referral Hospital, and the Operating Districts.

The budget is presented in terms of economic categories (Chapters 60 to 65) and functional classification (HSP2 Programmes)

3. Management of Income

Setup and maintain a proper internal control system to ensure compliance with the relevant requirements in the Financial Management Manual of the Program.

System in place for recording of income from all sources.

System in place for reporting of receipts from user fees at health centres and hospitals.

4. Management of Expenditure

Systems in place for recording and accounting of all expenditure in line with budget classifications and sources of funds.

Significant variances in expenditure are reported to the Provincial Health Director and plans for correction agreed.

5. Management of Cash

System in place for receipt, recording, safe-keeping, and timely banking intact of cash receipts.

Systems in place for cash advances, retirement of same and timely follow-up.

An imprest system should be in existence to manage payments by cash. The imprest is a level of cash float that should be maintained by the cashier. At each point in time the value of receipts for payments made and the cash in hand should total to the value of the imprest or float. Each request for reimbursement for cash expenditure should be accompanies by a reconciliation of the imprest.

Monthly bank reconciliations are undertaken and signed off by responsible senior official.

6. Management of Assets

An asset register is maintained and updated every three months.

Financial Procedures related to procurement, separation of the functions, raising of requisitions and purchase orders, as well as receipt of related goods.

7. Record Keeping

Password systems in place for all electronic records with appropriate hierarchy of access.

Electronic records are backed-up daily and stored securely.

Paper records are maintained in an orderly manner, are complete for each accounting period, stored securely, and retrieved with ease.

8. **Reporting and Requests**

ODs/PRHs will establish USD commercial bank accounts. Quarterly expenditure reports and monthly bank reconciliation statements and requests submitted complete and submitted on time.

Financial Reports are discussed with the Provincial Health Director and made available to the Internal Audit Department.

All donor reporting requirements are met in full and in accordance with timetables.

Reports from PRHs and ODs are collated and summarised.

9. Financial Supervision of Operating Districts and Referral Hospitals

Regular Reports on Income and Expenditure of budget received by ODs/PRHs.

Significant variances are made known to the Provincial Health Director for correction.

Spot checks are undertaken to check on accuracy of reports.

Physical inspections are made of arrangements for collection, recording, safe keeping, and banking of user fees.

10. Auditing

Documentation required for internal and external audits is made available on a full and timely basis.

Auditors are given full cooperation in their work including space and facilities and access to staff and patients.

Action plans based on audit reports are produced and regularly monitored.

Reasons for continuing non compliance are reported to the appropriate Ministry.

Basic Accounting Competencies

- Prepare and review transaction vouchers
- Prepare cheques
- Perform double entry book keeping
- Maintain cash books
- Record entries in the general ledger
- Complete a trial balance
- Undertake bank reconciliations
- Prepare advances
- Maintain a fixed assets register
- Prepare tables for monthly financial report
- Preparation of regular reports/returns to senior management

Annex 6: Provincial Capacity Development Assessment Tool

Name of PHD: ..... Assessor's name: .....Tel: ..... Date: .....
Interviewee: .....Responsibility: .....Tel: .....
Part I: Planning

1. AOP and 3 Year Rolling Plan Preparation

Questions	Verification and Scoring	Score	Note findings
1) Did provincial team conduct annual review and completely document it?	- No Annual Review done or no written record available = 0 If PHD manager claims that Annual Review was conducted, please check and score accordingly: - Attendance list available = 1 - Doc. of Analysis indicators available = 1 - Doc. of Situation analysis (weaknesses & strengths) = 2 - Annual review was conduct in January = 1 - **Total score**		
2) Was an Annual Review conducted with participation of all stakeholders?	*Please review: attendance list, list of invitees and date of event* - Attendance list not available = 0 If attendance list available, please calculate percentage of attendees divided by number of invited = ... Score as follows: - <50% = 1 - 50 %-74% = 3 - 75%-100 % = 5		
3) Was situation analysis done, including discussion of indicators that reached less than 80% of target?	*Please review: Doc. of Analysis indicators vs. Doc. of Situation analysis.* Then score as follow: - Both doc. are not available = 0 - ≤50% of indicators that reached <80% of target were analyzed = 3 - >50% of indicators that reached <80% of target were analyzed = 5		
4) Did the PHD team set priorities for their province?	*Please review: the latest AOP* - No document explains priorities for PHD = 0 If document available, please check and score: - PHD set priorities based on the situation analysis = 2 - PHD priorities correspond to MoH priorities (JAPR) = 2		

Questions	Verification and Scoring	Score	Note findings
	- **Total score:** ……..		
5) Does AOP of PHD follow MoH standard ? (For MoH standard, see Annex 8)	*Please compare PHD's AOP with each section in Annex 8:* - AOP was not available = 0 - ≥ 5 points were identified that did not follow annex 8 = 1 - 3-4 points were identified that did not follow annex 8 = 2 - 2 points were identified that did not follow annex 8 = 3 - 1 points were identified that did not follow annex 8 = 4 - All sections follow annex 8 = 5		
6) Does 3 year rolling plan of PHD follow MoH standard?	*Please review 3 years rolling (annex 2: Table 1) vs. Activities plan (annex 2: Table 2)* - No 3 Year Rolling plan available = 0 - 3 Year Rolling is not up to date (new format) = 1 - 3 Year Rolling is up to date but not completed/ incorrect = 3 - 3 Year Rolling is up to date, completed and correct = 5		
7) Does activities plan of AOP of PHD follow MoH format?	*Please review Activities plan of PHD then score as follow:* - Implemented institution = 1 - Time line = 1 - Expected output = 2 - Indicators = 1 - Means of verification = 1 - **Total score ……..**		
8) Does the Annual Operational Plan match Year 1 of the 3 Year Rolling plan?	*Please review Year 1 of the 3 Years Rolling plan Vs AOP* - Indicators consistent = 1 - Target consistent = 1 - Main activities consistent = 1 - Consistent budget and programs and sub-programs = 2 - **Total score**: ……..		
9) Is there consistency between Activities plan and Budget plan in terms of programs, sub-programs, indicators, main activities/ budget?	*Please review Activities plan and Budget plan* - No documents available to compare consistency = 0 - There is some consistency but not all = 3 - All points are consistent = 5		

2. AOP Appraisal & Feedback

Questions	Verification and Scoring	Score	Note finding
10) Did PHD team conduct AOP appraisal for OD and units below PHD?	*Please review appraisal form & feedback form* - No appraisal done or no reference document = 0 - <50% of total units under PHD were reviewed and given feedback = 1 - 50%-74% of total units under PHD were reviewed and given feedback = 3 - ≥ 75%of total units under PHD were reviewed and given feedback = 5		
11) Did PHD team provide feedback to OD team and units below PHD on AOP development?	*Please review appraisal form & feedback form* - No feedback or no reference document = 0 - Feedback done but it was not specific = 2 - Feedback done in meeting with specific points written down in minutes of meeting = 5		

3. AOP Implementation

Questions	Verification and Scoring	Score	Note finding
12) Was quarterly review of plan conducted?	- No Quarterly Review plan done or no written record available = 0 - If PHD manager claims that Quarterly Review plan was conducted, please check and score accordingly: - Attendance list available = 1 - Doc. of Analysis indicators available = 1 - Doc. of Situation analysis (weaknesses & strengths) = 1 - Quarterly plan available = 2 - Evidence of using information to monitor plan = 1 - **Total score** ……..		
13) Was the last quarterly review plan conducted with participation of all stakeholders?	*Please review: attendance list, list of invitation and date of event* - Attendance list not available = 0 If attendance list available please calculate percentage of attendees divided by number invited = ……. and score as follow: - <50% = 1; 50%-74% = 3; 75%-100 % = 5		
	Total score for Planning (maximum = 66) **Percentage for Planning (score/66)**		

AOP 2008 FORMAT REQUIREMENTS (USE AS REFERENCE DURING ASSESSMENT)

1. Progress and achievements in Year 2006
   (Summary in Tables 1 and 2 from planning manual)
2. Main Challenges faced in implementation of AOP 2006
   (Summary in Tables 1 and 2 planning manual)
3. JAPR Health sector 2008 priorities and provincial priorities
4. Main Activities planned for achieving Priorities
5. Expected Outcomes of AOP 2008
   (Provincial targets for sub- program performance indicators)
6. Budget Investment for 2008
   - Total Budget for Province
   - Budget for each Operational District
7. Summary of AOP 2008 preparation process including stakeholders participation.

8. Annexes
   a. 3 Year Rolling Plan
   b. Detailed Action Plan (Table 1)
   c. Budget Plan (Table 2)
   d. Costing table (Form A)
   e. Facilities Checklist

Provincial Capacity Development Assessment Tool

Name of PHD: ..... Assessor name: .....Tel: ..... Date: .....

Interviewee: .....Responsibility: .....Tel: .....

Part II: Supervision and Monitoring

A. Supervision

Questions	Verification and Scoring	Score	Note finding
1) Did PHD Supervisors develop a schedule for supervision of ODs and RHs?	*Review supervision schedule of PHD supervisors* - No up to date supervision schedule = 0 - Schedule available (supervision of ODs & RHs) = 5		
2) Did PHD Supervisors conduct regular supervision visits to ODs?	*Review ISC checklist for ODs (report of the last 6 months visits)* - No ISC ODs records available or supervision was not conducted in any OD = 0 - ≤50% of supervision schedule was conducted = 1 - > 50% but ≤ 75% of supervision schedule was conducted = 3 - > 75% of supervision schedule was conducted = 5		
3) Did PHD Supervisors conduct regular supervision visits to RHs?	*Review ISC checklist for RHs (report of the last 6 months visits)* - No ISC RHs records available or supervision was not conducted in any RH = 0 - ≤50% of supervision schedule conducted = 1 - > 50% but ≤ 75% of supervision schedule conducted = 3 - > 75% of supervision schedule conducted = 5		
4) Did PHD Supervisors complete the ISC checklist for ODs during their visit?	*Review ISC checklist for ODs (report of the last 6 months visits; randomly select 1 record per OD to review)* - ≤ 70 % of questionnaires were completed = 0 - > 70 % of questionnaires but not all were completed = 2 - All questionnaires were completed = 5		
4) Did PHD Supervisors complete the ISC checklist for RHs during their visit?	*Review ISC checklist for RHs (report of the last 6 months visits; randomly select 1 record per RH to review)* - ≤ 70 % of questionnaires were completed = 0 - > 70 % of questionnaires but not all were completed = 2 - All questionnaires were completed = 5		
6) OD. Did the last part of	*Review ISC checklist for ODs (report of the last 6 months visits and randomly*		

Questions	Verification and Scoring	Score	Note finding
supervision (section II, Discussion) list problems that match the problems identified identified in ISC checklist?	*select 1 record per OD to review)* - No section II on discussion (ISC OD) available = 0 - ≥ 3 problems identified in ISC OD were not brought up in discussion = 1 - 1-2 problems identified in ISC OD were not brought up in discussion = 3 - All problems identified in ISC OD were brought up in discussion = 5		
7) RH. Did the last part of supervision (section II, Discussion) list problems that match the problems identified in ISC checklist?	*Review ISC checklist for RHs (report of the last 6 months visits and randomly select 1 record per RH to review)* - No section II on discussion (ISC RH) available = 0 - ≥ 3 problems identified in ISC RH were not brought up in discussion = 1 - 1-2 problems identified in ISC RH were not brought up in discussion = 3 - All problems identified in ISC RH were brought up in discussion = 5		
8) Did the last section of supervision checklist for OD contain problems that match with causes and activities plan?	*Review ISC checklist for ODs (report of the last 6 months visits and randomly select 1 record per OD to review)* - No section II on discussion (ISC OD) available = 0 - ≥ 2 problems do not match with causes & activities plan = 1 - 1 problem does not match with causes & activities plan = 3 - All problems match with causes & activities plan = 5		
9) Did the last section of supervision checklist for RH contain problems that match with causes and activities plan?	*Review ISC checklist for RHs (report of the last 6 months visits and randomly select 1 record per RH to review)* - No section II on discussion (ISC RH) available = 0 - ≥ 2 problems do not match with causes & activities plan = 1 - 1 problem does not match with causes & activities plan = 3 - All problems match with causes & activities plan = 5		

Health Information System

Questions	Verification and Scoring	Score	Note finding
10) Did PHD managers send the Pro4 report on time?	*Review Pro4 reports of the last 12 months (review date of signature of PHD Director, usually by the 20th of the month)* - <50% submitted on time = 0 - 50%-90% submitted on time = 3 - 91% -100% submitted on time = 5		
11) Did PHD managers complete the Pro4 report correctly?	*Randomly select one Pro4 report and check completeness and correctness (verify some figures, all OD's data included?)* - Incomplete = 0 - Complete = 2 - Complete + accurate = 5 ** Complete = All health facilities included for all time periods ** Accuracy consistency, e.g. Male + Female = total		
12) Did PHD managers provide feedback to OD in terms of data sent re timeliness, accuracy, completeness ...etc?	*Ask PHD managers and check for reference documents that PHD team provides feedback to OD on HIS (reports, minutes of meeting, supervision reports)* - No evidence of feedback or no document available = 0 - There is some evidence of providing feedback but not regularly = 3 - Evidence of regular feedback = 5		
13) Did PHD managers analyze HIS data and compare results between ODs each quarter?	*Visible Graph, chart, sheet use during meeting, table* - No evidence PHD uses HIS data = 0 - HIS analysis done but does not compare OPD, RH BOR, EPI, ANC, delivery performance between ODs or over time = 3 - HIS done and trends analyzed across ODs to identify performance in each of the following areas relative to same time previous year: OPD, RH BOR, EPI, ANC, deliveries = 5		
	Supervision & Monitoring Maximum score (maximum = 65)		
	Percentage for Supervision & Monitoring (score/ 65)		

Provincial Capacity Development Assessment Tool

Name of PHD: ..... Assessor name: .....Tel: ..... Date: .....
Interviewee: .....Responsibility: .....Tel: .....

Part III: Human Resource Allocation

Questions	Verification and Scoring	Score	Note finding
1) Percent of staff currently absent PHDO? (leave without pay, long course training or absent without reason for more than 1 month)	*Review staff list and ask chief of admin.* - >10 % of total staff absent = 0 - 5-10 % of total staff absent = 1 - <5% of total staff absent = 3		
2) How many MOH technical staff are assigned to the PHD? (not counting cleaners, drivers)	*See Personnel Records, PHD Organogram, Payroll* **Normal province** - Staffing numbers cannot be determined – no records or records out of date = 0 - PHD has fewer than 35 or more than 70 staff = 1 - PHD has 61– 70 staff = 2 - PHD has between 36 - 60 staff =3 **Large province: Kg cham, Phnom Penh, Prey Veng, Kandal, Battambang, Siem Reap** - Staffing numbers cannot be determined – no records or records out of date = 0 - PHD has fewer than 65 or more than 100 staff = 1 - PHD has 91– 100 staff = 2 - PHD has between 66 - 90 staff =3		
3) How many MOH technical staff are assigned to the ODOs? (not counting cleaners, drivers)	*Review Personnel Records, Payroll* - Staffing numbers cannot be determined – no records or records out of date = 0 - One or more ODOs have fewer than 10 or more than 35 staff = 1 - All ODOs have 10 or more staff, but one or more has 21-35 staff = 2 - All ODOs have between 10 – 20 staff = 3		

Questions	Verification and Scoring	Score	Note finding
4) Does every ODO have at least 3 doctors/MAs?	*Review Personnel Records, Payroll* - No ODO has more than 1 doctor/MA = 0 - All ODOs have 1 or 2 doctor/MA, none have 3 = 1 - Some ODOs have 2 and some have 3 doctor/MAs = 2 - All ODOs have 3 doctor/MAs = 3		
5) Does every ODO Technical Bureau have a Secondary Midwife?	*Review Personnel Records, Payroll* - No ODO has a Secondary Midwife in its Technical Bureau = 0 - Some, but not all, ODOs have a secondary Midwife in the technical bureau = 1 - All ODOs have at least 1 secondary MW in the technical bureau and some have more = 2 - All ODOs have 2 or more Secondary MWs in the technical bureau = 3		
6) Does every ODO have at least one pharmacist or pharmacy assistant?	*Personnel Records, Payroll* - No ODO has a Pharmacist or pharmacy assistant = 0 - One but not all ODOs have a Pharmacist or pharmacy assistant = 1 - Two but not all ODOs have a Pharmacist or pharmacy assistant = 2 - All ODOs have a Pharmacist or pharmacy assistant = 3		
7) Does every ODO have at least one person with a training certificate in accounting or book-keeping?	*Personnel Records, Payroll* - No ODO has anyone trained = 0 - Some but not all ODOs have person trained =1 - All ODOs have person trained, but some are trained < 6 months s = 2 - All ODOs have person trained > 6 months = 3		
8) Does every HC have at least 1 Secondary midwife *or* female MA/MD? (MOH staff or floating)	*Personnel Records, Payroll* - No HC has a secondary midwife or all secondary midwives on leave = 0 - <70% of HCs have a secondary midwife who is not on leave =1 - More than 70%, but not all, HCs have a Secondary Midwife who is not on leave = 2 - All HCs have a secondary midwife who is not on leave = 3		
9) Does every HC have at least 2 midwives (primary or secondary; MOH or floating)?	*Personnel Records, Payroll* - No HC has 2 midwives that are not on leave = 0 - <70% of HCs have two MWs who are not on leave = 1		

Questions	Verification and Scoring	Score	Note finding
	- More than 70%, but not all, HCs have two MWs who are not on leave = 2 - All HCs have two MWs who are not on leave = 3		
10) Does every HC have at least 1 secondary or higher level person for consultation (MOH or floating)? (Secondary Nurse/MA/doctor)	*Personnel Records, Payroll* - No HC has a secondary or higher consultation staff or are on leave =0 - <70% of HCs have a secondary or higher consultation staff who is not on leave=1 - More than 70%, but not all, HCs have a secondary or higher consultation staff who is not on leave = 2 - All HCs have a secondary or higher consultation staff not on leave = 3		
11) Does every HC have at least 5 technical (primary or higher) staff (including floating staff)?	*Personnel Records, Payroll* - No HC has 5 or more trained staff that are not on leave = 0 - <70% of HCs have 5 or more trained staff who are not on leave=1 - More than 70%, but not all, HCs have 5 or more trained staff = 2 - All HCs have 5 or more trained staff who are not on leave = 3		
12) Does every RH have technical staff according to CPA guideline?	*Personnel Records, Payroll* *CPA1 = 36-48, CPA 2 = 50-71 and CPA3 = 132-181* - None of RH has number of staff according to CPA guideline = 0 - ≤50% of RHs have number of staff according to CPA guideline =1 - > 50% of RHs have number of staff according to CPA guideline =2 - 100% of RHs have number of staff according to CPA guideline =3		
13) Does every RH have doctors/MAs following CPA guideline? (including floating staff)?	*Personnel Records, RH Personnel, Payroll* *CPA1 = 4-6, CPA 2 = 10-12 and CPA3 = 20-32* - No RH has number of MD/MA according to CPA guideline = 0 - ≤50% of RHs have number of MD/MA according to CPA guideline =1 - > 50% of RHs have number of MD/MA according to CPA guideline =2 - 100% of RHs have number of MD/MA according to CPA guideline =3		
14) Does every CPA2/3 RH have at least 3 surgeons (doctor or MA)?	*Personnel Records, RH Personnel, Payroll* - No surgeons in any CPA 2/3 RH = 0 - At least 1 surgeon in every CPA 2/3 RH = 1 - Some but not all CPA 2/3 RHs have 3 surgeons = 2 - All CPA 2/3 RHs have 2 or more surgeons = 3		

Questions	Verification and Scoring	Score	Note finding
15) Does every CPA2/3 RH have at least 3 anesthetists?	*Personnel Records, RH Personnel, Payroll* - No anesthetist in any RH = 0 - At least 1 anesthetist in 1 RH = 1 - Some but not all CPA 2/3 RHs have 3 anesthetist = 2 - All CPA 2/3 RHs have 3 or more anesthetist = 3		
16) Are staff performance appraisal scores individualized? (for increasing salary)	*Staff appraisal forms* - No staff appraisals done = 0 - <50% of staff that needed performance evaluation were conducted=1 - ≥50% of staff that needed performance evaluation were conducted = 2 - 100% of staff that needed performance evaluation were conducted =3		
17) Are staff performance appraisal scores individualized? (for providing reward)	*Staff appraisal forms* *Note: 2% senior managers, 3 % of technical staff (MD, MA, Pharmacist), 5% of primary technical staff & secretary should be evaluated and receive reward such as a medal* - No staff appraisals done = 0 - <50% of staff that needed performance evaluation were conducted=1 - ≥50% of staff that needed performance evaluation were conducted = 2 - 100% of staff that needed performance evaluation were conducted =3		
18) Does PHD admin. develop report on personnel and submit to MoH regularly?	*Review last report* - Never develop any report on personnel = 0 - Report but not regularly = 1 - Report regularly but not correct = 2 - Report regularly and correct up to date = 3		
	Human Resource Allocation score (Maximum = 54)		
	Human Resources Allocation Percentage (score / 54)		

Provincial Capacity Development Assessment Tool

Name of PHD: ..... Assessor name: .....Tel: ..... Date: .....
Interviewee: .....Responsibility: .....Tel: .....

Part IV: Technical Support

Questions	Verification and Scoring	Score	Note finding
1) Are all HCs Secondary Midwives and primary midwife with delivery experience LSS Trained?	*Check CE records of PHD CE Unit, compare with total # of midwife HCs* - < 50% of midwives LSS trained = 0 - 50 – 75% midwives LSS trained = 1 - >75% but not all midwives LSS trained = 2 - All midwives LSS trained = 3		
2) Have all RH Secondary Midwives in maternity ward had CPA midwife refresher training?	*Check CE records of PHD CE Unit, compare with total # of midwife RHs* - < 50% of secondary midwives trained = 0 - 50 – 75% of secondary midwives trained = 1 - >75% of secondary midwives trained but not all = 2 - All secondary midwives trained = 3		
3) How many of the 13 MPA modules have been introduced in the province? (FHCT same as modules 1,2)	*Check CE records of PHD CE Unit,* - Less than 3 modules introduced or planned = 0 - 4-5 modules introduced or planned = 1 - 6-7 modules introduced or planned = 2 - 8 or more modules introduced or planned = 3		
4) Have at least 2 staff of all the HCs that are open received IMCI training?	*Check CE records of PHD CE Unit* - < 50% of HCs have 2 staff fully trained or in training = 0 - 50 – 75% of HCs have 2 staff fully trained or in training= 1 - >75% but not all HCs have 2 staff fully trained or in training = 2 - All HCs that are open have 2 staff fully trained or in training = 3		
5) After IMCI training, was follow-up IMCI supervision done at least 2 times in the 6 months after training?	*IMCI supervision report for HCs trained $\geq$ 6 months ago* - No IMCI training done yet or only 1 follow-up IMCI supervision = 0 - <50%of HCs trained in IMCI received 2 or more follow-up supervision = 1 - 50-75% but not all HCs trained in IMCI 2 or more received follow-up supervision = 2 - >75% but not all HCs trained in IMCI received 2 follow-up supervision = 3		

Questions	Verification and Scoring	Score	Note finding
	- All HCs trained in IMCI received 2 or more follow-up supervision = 4		
6) Have all current PHTAT had health service management training (NIPH course or equivalent)	*CE of PHD Unit record or interview PHD senior managers* - <25% of PHTAT members trained or in training now = 0 - 25% – 50% of PHTAT members or in training now = 1 - 51%– 75% of PHTAT members or in training now = 2 - >75% of PHTAT members are trained = 3		
7) Have all current PHD Directors/Vice Directors had health service management training (NIPH course or equivalent)	*CE of PHD Unit record or interview PHD senior managers* - <25% current PHD Directors/Vice Directors trained or in training = 0 - 25 – 50% current PHD Directors/Vice Directors trained or in training = 1 - > 50 % but not all current PHD Directors/Vice Directors trained = 2 - All of the current PHD Directors/Vice Directors are trained = 3		
8) Are the appropriate staff sent for training?	*Personnel records CE record, and interview 5 members of staff* - Out of the last 5 staff sent for training and returned, none currently do work that requires the skills taught = 0 - Out of the last 5 staff sent for training and returned, 1-3 currently do work that requires the skills taught = 1 - Out of the last 5 staff sent for training and returned, 4 currently does work that requires the skills taught = 2 - Out of the last 5 staff sent for training and returned, all currently do work that requires the skills taught = 3		
	Technical Support Sub-Total (maximum = 36)		
	Percentage Score for Technical Support (score/36)		

Provincial Capacity Development Assessment Tool

Name of PHD: ..... Assessor name: .....Tel: ..... Date: .....

Interviewee: .....Responsibility: .....Tel: .....

Part V: Essential Drug Management

Questions	Verification and Scoring	Score	Note finding
1) Did PHD pharmacist train on drug management and drug supply?	*Interview PHD senior management team* - Never received drug management and supply to ODs = 1 - Received drug management and supply to ODs = 2		
2) Did all OD pharmacists receive training in drug management and drug supply?	*Interview PHD senior management team and Pharmacist of PHD* *Total number of ODs in PHD = ...* - 0-30% of OD pharmacists trained = 1 - 31% -70% of OD pharmacists trained = 2 - 71% -100% of OD pharmacists trained = 3		
3) Did the PHD review, approve and submit last quarter's OD drug requests quickly?	*Review request doc. from ODs for last quarter with signature & stamp (verify the date of doc. into and out from the PHD)* - PHD pharmacist delayed request > 10 days (working days) = 0 - PHD pharmacist delayed request 7-10 days (working days) = 1 - PHD pharmacist delayed request 5-6 days (working days) = 2 - PHD pharmacist delayed request <5 days (working days) = 3		
4) Did ODs pharmacist request additional drugs following MoH guideline?	*Review request for additional drugs doc. submitted by OD pharmacist to PHD and compare with drug request for last quarter from same OD* - No OD submitted additional drug request to PHD= 0 - Some ODs submitted additional drug request to PHD but not all = 1 - All ODs submitted additional drug request to PHD = 2		
5) Did PHD pharmacist develop schedule for supervising drug management?	*Review supervision schedule and approval from PHD Director* - No supervision schedule available = 1 - Supervision schedule available but it was not approved = 2 - Supervision schedule available and approved = 3		
6) Did PHD pharmacist report on results with indicators after conducting supervision of drug management?	*Review report and indicators of supervision on drug management* - No report available = 0 - Report available but it has no indicators for monitoring drugs = 1 - Report available with indicators on monitoring drugs but it was not approved		

Questions	Verification and Scoring	Score	Note finding
	by PHD Director = 2 - Report available with indicators on monitoring drug and it was approved by PHD Director = 3		
7) Did PHD pharmacist developed AOP?	*Review AOP* - No AOP = 0 - AOP available but it lists supervision activities only = 1 - AOP available and it lists supervision activities plus other necessary activities = 2		
8) Did PHD provide support and technical assistance to develop budget request for monitoring and supervision of drug management?	*Review mission letter, report of supervision of drug management and interview senior PHD managers* - No supervision on drug management = 0 - Mission letters for conducting supervision are available but there is no report on results from conducting supervision = 1 - Mission letters for supervision are available with the report on results from conducting supervision, but it was not completed for all trips = 2 - Mission letters for conducting supervision are available with the report on results from conducting supervision and it was completed for all trips = 3		
9) Were all drug items on quarterly drug supply & consumption reports entered into Pro DID data base system?	*Look in Pro-DID System in computer and number of reports from OD* - No reports from ODs were not entered into Pro-DID system = 0 - <50% of all reports from ODs were entered into Pro-DID = 1 - 51% -100% of all report sfrom ODs were entered into Pro-DID = 2		
10) Did PHD submit report from drug system supervision to MoH, highlighting monitoring indicators on drug management?	*Report and indicators* - Report was not sent to MOH = 0 - PHD submitted report to MOH = 3		
	Essential Drug Management Subtotal (maximum = 26)		
	Percentage score for Essential Drug Management (score/26)		

Provincial Capacity Development Assessment Tool

Name of PHD: ..... Assessor name: .....Tel: ..... Date: .....

Interviewee: .....Responsibility: .....Tel: .....

Part VI: Financial Management

Questions	Verification and Scoring	Score	Note finding
1) Did PHD develop budget quarterly plan and submit on time?	*Review the last quarterly budget plan* - No quarterly budget plan or submitted late > 20 days = 0 - Quarterly budget plan was submitted late 11-20 = 1 - Quarterly budget plan was submitted late 1-10 = 2 - Quarterly budget plan was submitted on time = 3		
2) Were last quarter's expenditure reports completed correctly and on time? (10 days after the end of the quarter) (this is focus on government budget)	*Expenditure reports, MOH Guidelines* - No expenditure report done = 0 - Last report incomplete or incorrect = 1 - Reports are complete and in the correct format = 2 - Reports are complete and in the correct format and on time = 3		
3) Is the operating budget (Program budget and non-program budget) disbursed to the ODs quickly upon receipt in the PHD?	*PHD and OD finance records* - Some or all ODs received budget more than 7 working days after receipt at PHD= 0 - All ODs received budget within 7 working days of receipt at PHD= 1 - All ODs received budget within 5 working days of receipt at PHD = 2 - All ODs received budget within 3 working days of receipt at PHD = 3		
4) Was the last full calendar year's operating Program budget and non-program budget proportionately allocated in accordance with AOP?	*PHD Financial records AOP* - Percent of budget received allocated to PHD or some OD differs from plan by more than 20% = 0 - All ODs received operating budget proportional to AOP within +/- 20% = 1 - All ODs received operating budget proportional to AOP within +/- 15% = 2 - All ODs received operating budget proportional to AOP within +/- 10% = 3		
5) Did PHD develop detailed budget plan (expenditure item) for each institution below PHD based on adjusted annual budget plan of PHD?	*PHD Budget Plan* - Detailed budget plan is not available = 0 - Detailed budget plan is available = 3		

6) Is the Provincial Hospital budget spent according to the approved plan for the last full calendar year?	*PHD Financial records, RH Financial records (must visit RH)* - Percent of budget spent for item differed from budget by more than 30% = 0 - Percent of budget spent for any item differed from budget by +/-20 -29% = 1 - Percent of budget spent for a line items differed from budget by 15 - 19% = 2 - Percent of budget spent for all line items was within +/- 10% of budget = 3		
7) Does the PHD spot-check accuracy of expenditure reports from ODs and Provincial RH?	*PHD Financial records* - No spot check or no record for any OD or the Provincial RH in past year = 0 - PRH had spot check but no OD in past year = 1 - At least one OD and the PRH had spot-check in past year = 2 - Spot-check conducted for each OD and the PRH in past year = 3		
8) Are approved User Fee Systems in place in all HCs and RHs?	*MOH letter of approval for HC/RH user fee system, Financial Reports from ODs* - No MOH-approved user fee system in any HC/RH = 0 - Some but not all HCs/RHs have MOH-approved user fee system in place = 1 - All HCs and RHs have MOH approved user fee system in place but not all report the income to PHD = 2 - All HFs have MOH approved user fee system in place and report to PHD = 3		
9) Do PHD/ODs have systems to track, record, analyze, and summarize financial transactions on timely basis?	*Preparation and approval, Accounting and supporting documents* - No system = 0 - Systems exist but incomplete entry = 1 - Systems exist and complete entry = 2 - Systems exist and used for management monitoring = 3		
10) Are petty cash (national budget) and advance (external funding) procedures correctly followed at PHDO?	*Petty cash and advance registers* - No petty cash /advance register = 0 - Petty cash /advance register exists = 1 - Maintain petty cash/advance register to monitor timeliness of liquidation = 3		
11) Is there a system of safeguards to protect assets from fraud, waste and abuse functioning effectively?	*Inventory list Records* - No register records of fixed assets and stocks = 0 - Register records of fixed assets and stocks exist = 1 - Register records of fixed assets and stocks exist and updated = 3		
	Financial Management Sub-Total (maximum= 33)		
	Percent Score for Financial Management (score/33)		

Provincial Capacity Development Assessment Tool

Name of PHD: ..... Assessor name: .....Tel: ..... Date: .....

Interviewee: .....Responsibility: .....Tel: .....

Part VII: Coordination

Indicator	Verification and Scoring	Score	Note finding
1) Has the Pro TWG-H been officially formed?	*PHD Letter requesting nominees from NGOs and Provincial Governors Office and replies or PHD letter informing MOH of Pro TWG-H members* - PHD has not yet formed Pro TWG-H or is informal (official membership) = 0 - PHD has formed Pro TWG-H but membership does not include all of the following: PHTAT, OD Directors, NGOs active in health in the province, representative of Governor's office = 1 - PHD has officially formed Pro TWG-H and membership is complete (PHTAT, OD Directors, NGOs & Governor's office) = 2		
2) How many times in the past 3 months has the Pro TWG-H met?	*Minutes of meeting or attendance sheets* - Pro TWG-H not formed or not met yet = 0 - Pro TWG-H met once in past 3 months = 1 - Pro TWG-H met twice in past 3 months = 2 - Pro TWG-H met three or more times in past 3 months = 3		
3) Are quarterly reports on the Pro TWG-H proceedings sent to the MOH?	*Quarterly reports from Pro TWG-H Secretariat to MOH TWG-H Secretariat* - No quarterly reports submitted in last quarter or Pro TWG-H not formed =0 - A report submitted for last quarter = 1		
4) Do external partners (NGOs/donors) actively participate in the Pro TWG-H?	*Meeting attendance sheet PHD list of Pro TWG-H members* - Pro TWG-H not formed or has not met yet = 0 - Less than 50% of partner agencies attended the last meeting = 1 - 50 - 75% of partner agencies attended meeting = 2 - More than 75% of partner agencies attended the last meeting = 3		
	Coordination Sub-Total (maximum = 12)		
	Percent Score for Coordination (score/12)		

Province: _____ **Assessment Date:** _____

Section	Score: Current_____%	Previous _____%
I. Planning		
Strengths:		
Weaknesses:		
II. Monitoring and Supervision		
Strengths:		
Weaknesses:		
III. Human Resource Allocation and Management		
Strengths:		
Weaknesses:		
IV. Technical Support		
Strengths:		
Weaknesses:		
V. Essential Drug Management		
Strengths:		
Weaknesses:		
VI. Financial Management		
Strengths:		
Weaknesses:		

I. Assessment Findings:

II. Group Discussion and Plan to Strengthen Weak Areas

1.1 Problem Area	Cause(s)	Action Plan

Reviewed and Discussed By:

PHD Director: _____ Head of Assessment Team: _____

Date: _____ Date: _____