WORLD BANK: SUPPORT TO CASH TRANSFER PILOT AND THE NATIONAL SOCIAL PROTECTION STRATEGY IN CAMBODIA

Mid-Term Review (September 9-18, 2015)

AIDE MEMOIRE

I. INTRODUCTION

1. A World Bank (WB) mission team comprising Claudia Zambra Taibo (Operations Officer), Munichan Kung (Rural Development Officer), Mariana Infante Villarroel (Consultant), Sreng Sok (Procurement Specialist), Sophear Khiev (Financial Management Analyst), and Virak Chan (Water and Sanitation Specialist), conducted the Mid-Term Review for the Cash Transfer (CT) Pilot Program Focused on Maternal and Child Health and Nutrition from September 9-18th, 2015. The mission team received support from Da Lin (Program Assistant) throughout the mission. Pablo Acosta (Senior Economist and Task Team Leader), Alassane Sow (Country Manager for Cambodia) and Jehan Arulpragasam (Practice Manager for EAP Social Protection Unit) provided overall guidance to the mission.

2. The mission objective was to conduct a Mid-Term Review of the project in collaboration with the two implementing agencies, NCDD-S and CARD, consisting of a joint assessment of the project's design, implementation and performance to date, and the extent to which project objectives are being fulfilled. The team conducted a full review of the project cycle, the project Operations Manual, progress to date on key project indicators, project budget, financial management and procurement, and provided technical assistance to the implementing agencies to develop a set of concrete actions to ensure that project activities are completed and project development objectives are met by the Project's closing date. This includes recommendations related to ongoing issues with beneficiary registration, grievance redress mechanisms, communications, and monitoring and evaluation of program co-responsibilities. The team also reviewed activities under Component 1, Support to the National Social Protection Strategy.

3. The mission included a field visit to both districts of the pilot (SreySnam, in Siem Reap province; and Phnom Srok, in BanteayMeanchey province) to observe the third cycle of cash transfer payments; to meet with commune focal persons and district focal persons and advisers in both districts, as well as health center staff; to observe educational workshops; and to meet with CT pilot beneficiaries. The team joined a meeting of the Social Protection Coordination Group (SPCG) to discuss the GoC's new policy direction on social security; updates on key developments from the National Social Security Working Group (NSSWG), led by MEF, which is the lead agency for the new policy framework; and potential coordination of the new NSPS (still under preparation) with the new social security strategy, and potential technical inputs from various donors to inform this ongoing discussion. The team also met with UNICEF and Save the Children to share progress on their respective cash transfer programs.

4. This memoire summarizes the mission's principal findings, recommendations and key agreements. The mission opening was chaired by H.E. Ngy Chanphal, Secretary of State of the Ministry of Interior (MOI) and Vice Chair of the Council for Agricultural and Rural Development (CARD) on September 10th, 2015, with participation of authorities from the National Committee for Sub National Democratic Development Secretariat (NCDD-S), and the Ministry of Economy and Finance (MEF).

II. SUMMARY OF RECOMMENDATIONS

5. The following is a summary of the recommendations of the Mid-Term review, along with agreed dates of implementation. The CT pilot recently entered its fourth cycle of cash transfers to beneficiaries (to occur in November 2015). To date, beneficiaries have received cash payments in a timely manner, and it is expected that this process will become more and more streamlined until the end of the pilot. As such, the processes and systems leading up to the successful disbursement of cash to beneficiaries are now in place, with improvements and refinements to be implemented as needed, and as explained in greater detail in Section IV. Of greater concern during this Mid-term Review is the general finding thatprogram objectives and co-responsibilities have not been well explained to beneficiaries nor understood by them—and the pilot is therefore unlikely to lead to behavior change that will improve maternal and child health and nutrition. Awareness and compliance with co-responsibilities appears very low as per MIS data. It is therefore essential to the pilot's success that the project now turn its attention to two fundamental and inextricable issues: 1) a need for improved and sustained communications with beneficiaries about the CT Pilot, its objectives, and the role of beneficiaries; and 2) a need to improve monitoring and verification of co-responsibilities, including clarity of roles and responsibilities at the district and commune levels.

6. **Improve communication of project objectives and co-responsibilities at all levels:**A systematic approach and strategy for informing beneficiaries about program objectives and co-responsibilities should be developed and implemented, emphasizing links between services and bonuses. Underscoring that, however, there is a need for better communication and clarity with project staff, particularly CFPs, about their roles and responsibilities. The communications strategy should include:
   - **District CT re-orientation events**: One in each district, to reinforce program objectives and co-responsibilities. Transportation for beneficiaries to the events should be factored into the event budget. (October 2015)
   - **Clearer communication roles**: One CFP should be responsible for communications: including communicating program objectives and co-responsibilities to beneficiaries at every event or contact, such as registration, cash-out sessions, and CBLS. The District adviser should support his/her role by for instance explaining to beneficiaries why they are being paid, when their next payment will be and the potential they have to increase their benefit by complying with applicable co-responsibilities while they cash out. Village chiefs can reinforce messages in a more personalized way as part of their regular information sharing functions. (October 2015)
   - **Reinforcing messages at CBLS**: RACHA facilitators should start each CBLS with a reminder of program objectives and co-responsibilities to reinforce messages. They should also have CT pilot materials (flyers) to distribute. (October 2015)
   - **Materials about the project should be made readily available:** Flyers should be disseminated at every event such as registration, cash-out sessions, and CBLS. Material should also be available at health centers and health center staff could help to inform

beneficiaries about the program (if they observe that they are IDPoor 1 and 2). The possibility of sending text messages to beneficiaries' phone numbers registered by AMK can be explored. Providing program T-shirts to those that comply with co-responsibilities can provide an additional-long lasting incentive that can spread the message in communities. At the commune level, NCDD-S should encourage the commune clerks (who issue birth certificates) to inform families about the program when they issue birth certificates for IDPoor 1 and 2 babies. (October 2015)

7. **Facilitate compliance with co-responsibilities and verification:**

   - **Improve growth monitoring** at health centers by encouraging staff to record it in log books, record it in yellow books, and creating awareness among parents about it at CBLS and through CFPs, as well as at the re-orientation events. (Ongoing)

   - **Ensure that services accessed outside the commune are verified** by recording them in yellow and/or pink books and making sure CFPs are aware of them. Beneficiaries should ensure that CFPs verify their pink/yellow books at CBLS, payment events and other points of contact. There should be one CFP in charge of verification of co-responsibilities at these events. Again, it is crucial that beneficiaries have an increased awareness of the health center's responsibilities.

   - **Increase the chances of bonus for CBLS** participation by adding additional CBLS sessions after March 2016 and making information on CBLS widely available to allow beneficiaries to attend sessions in other villages. (TBD)

   - **Cooperate with organizations providing complementary services:** For example, in SreySnam, reach out to Malteser International to explore the possibility of coordinating M&E of the growth monitoring co-responsibility with their growth monitoring program, which is already in place. Also explore the possibility of inviting them to the CT re-orientation event in the district. Improve cooperation with HCs in both districts. (October 2015)

8. **Improve payment processes:**

   - **Fixed payment schedule to facilitate operations in the field**. Currently, payment events are defined by NCDD-S a few days before they actually take place. There is no reason why these days cannot be set in advance for the duration of the pilot (e.g. every second week every two months). This can a) facilitate AMK's planning processes for payment events; b) facilitate the communications process as beneficiaries will know in advance when payment will happen and only reminders would need to be communicated at the local level. (October 2015)

   - **Reorganize AMK staff to focus on payments.** Currently four AMK staff are divided equally between payments and new account openings. However, the number of clients to be paid is much higher than those opening accounts, so three AMK staff should focus on payments and one can handle account openings to speed up payments. (November 2015 and ongoing)

- **Promote client-oriented service.** Two actions can greatly improve client satisfaction with the payment process: a) AMK can make payments on a first-come-first-serve basis instead of making beneficiaries wait to be called as per AMK's lists; b) AMK's policy for the CT pilot dictates that AMK field staff can issue new cards to beneficiaries that have lost theirs during payment events, but field staff seem unaware of this special provision; reminding field staff of this avoids making beneficiaries travel to AMK offices to get new cards. (November 2015 and ongoing)

9. **Community Based Learning Sessions:**

- **Promote more inclusive sessions by making them widely publicized in villages.** All villagers should be welcome to join them, though there should be clarity that only registered beneficiaries can expect to receive a bonus. Moreover, attendance of registered beneficiaries is required to obtain bonus payments—should representatives be sent to the sessions instead, these sessions will not count toward the bonus. (October 2015)
- **Encourage elderly beneficiaries to bring younger family members along.** This can help messages be better understood in households where elderly people are the main caregivers of program beneficiaries. (Ongoing)

10. **Update budget and Operations Manual:**

- Reallocation of expenses for the communications strategy outlined in point a) needs to be reflected in the budget; also for other expenses like travel, communications, etc, as agreed during the Mid-term Review. This includes the decision to apply NCDD-S Circular No. 37 for meetings and trainings. An updated budget should be submitted to the Bank for no-objection. (October 2015)
- The Operations Manual should be revised to reflect the actual and expected roles of all project stakeholders based on current knowledge and the findings of the Mid-term Review (District, Commune, Village chiefs, etc.), including roles associated to communications stated in point a); and better processes for verification of co-responsibilities (point b) as discussed during this mission need to be reflected in the Operations Manual. (October 2015)
- Chapters on CBLS and actual payment processes will be added to the Operations Manual. (October 2015)

III. IMPLEMENTATION UPDATESSINCE THE PREVIOUS MISSION

A. Cash transfer and bonuses (Component 2)

11. Activities under Component 2, and its underlying administrative and M&E procedures, have become more consistent and streamlined (the project cycle is reviewed in depth in Section IV). Cash transfers are in place since May 2015 and are being disbursed bi-monthly, the third round of cash payments having been delivered in September 2015. The MIS is fully operational, and beneficiary registration is ongoing at the commune level. There have also been three rounds of account opening for beneficiaries with AMK, the payment agent. NCDD-S has consistently

updated the MIS with new registrations—this is now taking place at the district level after NCDD-S provided MIS training to District Focal Persons and District Advisors in June 2015. The District Advisor position for Phnom Srok was re-advertised, and a consultant hired to fulfill this role. NCDD-S has also held three training rounds (including one during this mission) with project staff at the commune and district levels.

12. Since the previous mission, NCDD-S procured the services of RACHA, a local NGO, to conduct community based learning sessions in the pilot districts. RACHA is already providing lessons on water and sanitation, nutrition, and maternal and child health over nine different modules (one module per month). Learning sessions were launched in July 2015. Only two procurement packages are pending (for office furniture and a camera), and are currently underway. Of the list of pending activities outlined in the previous Aide Memoire, only two items have yet to be completed: a full update of the Operations Manual (NCDD-S has made a preliminary revision) and a full work plan and schedule of activities for the remainder of project implementation.

13. Through August 2015, the CT pilot included a total of 1,851 registered beneficiaries in the two districts, of which 215 were pregnant women and 1,636 were children aged 0-5—comprising 1,497 households. This is an increase from 1,576 beneficiaries in the first round of registration in February 2015, but remains significantly lower than the projected number of beneficiaries at appraisal (potential causes for this shortfall are discussed in detail in section VI). Of the registered households, 203 had yet to open accounts with AMK in August 2015 to receive cash transfers. Between March and August 2015, a total of $47,423 were distributed as cash transfers to registered beneficiaries – from this total, only $3,040 pertained to bonuses obtained for compliance with co-responsibilities or conditions of the CT pilot.

14. As such, it is evident that a system has been put in place that is effectively delivering cash to beneficiaries, who are receiving basic (or unconditional) transfers; on the other hand, there is limited compliance to date with program co-responsibilities, resulting in missed opportunities for beneficiaries. This underlies the need for a detailed and robust communications strategy by NCDD-S to beneficiaries (as well as other local stakeholders), clearer roles for project staff at the districts and communes, particularly regarding communications, but also for monitoring and verification of compliance with co-responsibilities.

B. Support to the National Social Protection Strategy (Component 1)

15. There was progress since the last mission on Component 1, as the two pending consultant contracts (for a Senior Consultant and a Data Manager)for CARD were finalized in August 2015. A Research Assistant was hired in June 2015.The Bank gave its no objection to CARD to revise its budget for Component 1 to include capacity development and training related to social protection, reallocating unused budget for consultant salaries (because of the procurement delays experienced in hiring consultants, some of the budget for consultants was unallocated). CARD has yet to submit to NCDD-S its revised budget with specific training activities included, for subsequent submission to the Bank for no-objection.

16. CARD was invited to join the NSWGG, led by MEF, to develop a new national social security policy and implementation framework. The policy framework will comprise a unified national social security scheme, including pensions, health insurance, unemployment and disability. The NSWGG has retained the services of Ernst & Young to assess financial and policy implications of the strategy. ILO is providing policy inputs in the area of pensions. There has been some discussion to date with MEF on the inclusion of social assistance as an integral component under the aegis of social protection, in addition to social security. This would include four components: maternal support, housing, child allowances, and support to the elderly. The new NSPS, which is the key output under Component 1, is to be closely aligned with the developing social security strategy, as well as the new Industrial Development Policy 2014-2024, defining clear links between social protection (and investments in social assistance) as a basis for human capital development and increased labor productivity. CARD is working to develop consensus within the NSWGG on an approach that links social security and social assistance. The first draft of the NSPS is expected in December 2015.

17. The Bank joined a meeting of the Social Protection Coordination Group (SPCG), led by UNICEF, which also included ILO and GIZ, to discuss the NSPS and its potential alignment with the ongoing MEF-led work on social security. In addition to providing continued support to the NSPS through Component 1, the Bank also agreed to cooperate with GIZ on a study of the IDPoor program, to be led by GIZ. The next round of IDPoor is currently underway, to be completed by 2016—where GIZ was currently a funder, it is now providing technical assistance to the Ministry of Planning. Given that the majority of social protection programs in Cambodia rely on IDPoor for targeting, and the experience of several programs that have used it, it was the agreement of the SPCG that the updated NSPS should address IDPoor implementation in dialogue with MoP. The Bank will provide GIZ with results obtained from the baseline survey of the CT Pilot impact evaluation, and will follow up on this activity regularly.

IV. PROJECT DEVELOPMENT OBJECTIVES AND RESULTS FRAMEWORK

18. The Project Development Objective (PDO) is to help increase the utilization of essential health services by pregnant women and children (0 to 5 years of age) in targeted districts and enhance the readiness of delivery mechanisms of the social protection system. The project's impact evaluation (data obtained from baseline and endline surveys) will provide the metrics to measure increased service utilization. Data analysis (mostly descriptive) from the baseline survey is underway, and has already provided baseline estimates for two out of four PDO indicators (Percent of female beneficiaries that delivered in a health facility and Percent of enrolled children receiving all six recommended vaccinations) (See Annex 2-Results Framework). Compliance with CT pilot co-responsibilities (increased compliance and therefore bonus payments over time) can also be used as a proxy for increased utilization of services; however, as co-responsibilities are time-bound, it is as of yet difficultto determine with certainty whether the project is on track to achieve the first part of the PDO. Low awareness by beneficiaries about program objectives and co-responsibilities may hint to potential risks to effective compliance and thus to increased utilization of essential health services. Therefore, implementation of a targeted

communications strategy is essential to achieving a positive impact on compliance with co-responsibilities related to health service utilization.

19. The second part of the PDO, related to delivery mechanisms of the social protection system, is on track. Registration of beneficiaries is ongoing, verification of co-responsibilities is taking place on a monthly basis, beneficiary information is being updated in the MIS on a monthly basis, and cash transfers have been made on time.

20. The following section will provide a detailed review of the project's implementation structure and processes, as well as recommendations for enhanced delivery to ensure that the project meets its objectives. The Operations Manual will be modified accordingly to reflect the agreements reached in this AM.

V. MID-TERM REVIEW: FINDINGS AND RECOMMENDATIONS

A. CT Pilot Implementation Structure

21. Identification of CT Pilot implementation structures and the roles (actual and potential) of different stakeholders are one of essential component of the Mid-term Review, to ensure that any gaps in the project cycle are addressed. With a few exceptions, the structure and staffing of the pilot at the national, district, and commune levels is in line with the original design of the pilot (as described in the Operations Manual), though, in a few cases, responsibilities have shifted to better accommodate project needs. In other cases, particularly at the commune level, there is still a need to further define roles and responsibilities to ensure more consistent participation and performance. This section provides a brief overview of the existing arrangements at all levels, and recommendations for how to make more efficient use of existing staffing arrangements at each level.

22. NCDD Secretariat: A Project Coordinator and a Project Director provide oversight for implementation, and four additional staff have been allocated to the project to assist with daily operations. These includea Project Manager, M&E Officer, Procurement Officer, and Finance Officer. Two other staff were also assigned as alternate officers to provide back up as needed. Three consultants were hired by the project to support the team: a Project Management Advisor, a Financial Management Officer, and an M&E Officer. An MIS consultant was also hired for a short period to design and set up the MIS system, which is now operational.

23. Districts and Communes:Two District Advisers, one per district, were hired as consultants to support District Focal Persons (DFPs, two in each district) and Commune Focal Persons (four per commune for a total of 48). All District and Commune Focal Persons (CFPs) were appointed to the project by the respective District Governor. CFPs are in charge of registration, communications, monitoring and verification of co-responsibilities, and coordination of payment events, community based learning sessions, and other activities at the commune level. District staff are in charge of coordinating CFPs, troubleshooting, collecting monitoring forms from the communes on a monthly basis, and updating the MIS with verified co-responsibilities. They are also in charge of coordinating events and meetings at the district level.

24. All CFPs in Phnom Srok district are either a Commune Chief, Deputy, or Councilor, with one of them as the head of the Commune Committee for Women and Children (CCWC). Differently, in SreySnam district, among 24 CFPs there are 7 from Commune Councils, 9 arevillage leaders, and 8 are ordinary villagers. Two of them belong toCCWCs in their communes. The varied composition of the CFPs reflects the field observation that not all of the CFPs work equally or at the same capacity. It has not been clarified whether or not any of the CFPs in either district belong to Village Health Support Groups (VHSGs), or whether these structures remain active; as such, the project management team has not leveraged these groups. (See Annex 3: Project Staff List).

25. Health Centers: There are 11 health centers (HC) in the 12 communes of the two target districts; in SreySnam there are two communes that share one health center. There are variations in the performance of and services offered by health centers in these two districts, possibly because they belong to different Health Operational Districts (ODs). The mission found that the health centers in SreySnamgenerally perform better than those in Phnom Srok, particularly on growth monitoring of children ages 1-5 and sharing records with CFPs. Health centers in Phnom Srok admitted that they gave less attention to growth monitoring and suggested that some budget support from the project to the health center would help to improve the compliance monitoring there. Health centers and CFPs consistently confirmed that HCs are not the only places wherelocal people access health services,as there are also the district referral hospitals and provincial hospitals, especially the KunthaBopha hospital in Siem Reap town. During the field visit,it became evident that not all HCs were aware of the cash transfer project from the beginning.

26. AMK: Following the contract agreement with NCDD-S, AMK, a microfinance institution, has been the cash payment agent for the project, including opening a main transit account for NCDD, opening accounts for CT Pilot beneficiaries, and conducting mobile cash withdrawal services for those recipients at the commune level (bi-monthly). AMK assigns two to four field staff during each cash transfer cycle to perform deliver cash in each district, usuallyat the speed of one commune per day concurrently in both districts.

27. NGO:RACHA, a national NGO, was hired by the project to provide community based learning sessions (CBLS) in the pilot districts. RACHA started to provide CBLS to target populations in July on Module 1 (prenatal care) concurrently with preparation of some further modules. RACHA has allocated two staff per district and they conduct CBLS at an average speed of 4 villages per day (each staff takes 1 village/day) and roughly complete one module in every single village in one month. By the time the mission took place, they completed two modules and were deliveringModule 3 (breast feeding and child nutrition). At the current rate, RACHA would be able to complete all nine modules byend-March2016. Some of the CFPs, who are inCCWCs, took part in the sessions as resource person for their commune. All trainers from RACHA confirmed that they went through a brief orientation on the CT Pilot before starting the CBLS and they proved to have a basic understanding of the project. Until now, however, their contribution to project communications, particularly for explaining the pilot to beneficiaries and encouraging them to comply with co-responsibilities, is limited.

28. Beneficiaries:It is the nature of cash transfer programs, particularly conditional cash transfers, that beneficiaries play an active role, since transfers are conditioned on particular behaviors. Thus far, beneficiaries are playing an active role in terms of attending registration and payment sessions, and also CBLS, but they are playing a less active role with respect to health seeking behavior.

Recommendations

29. A clearer distribution of roles and responsibilities for project staff, particularly CFPs in each commune, would render efficiency gains. The current division of labor tends to center around distribution of villages in the commune, which has beenimpractical for some and inefficient for most. Instead, a division of labor that is based on the distribution of tasks could be a more efficient and practical use of human resources (e.g.tasks such as new registrations, grievance redress management and communication;monitoring and verification of co-responsibility compliance; coordination ofCBLS with RACHA; and coordination of cash payment with AMK). The Operations Manual should be updated to reflect the evolving roles and responsibilities of all stakeholders.The roles and working procedures of AMK and RACHA should also be included in to the Operations Manual to provide more clarity and possibility for cross support between these agencies and CFPs/DFPs.

30. Given the central role of health centers to the program's success, improved communication with MOH at the national level, and OD and health center staff at the decentralized levels, is highly recommended. One potential action is to host a separate orientation event for health center staff, including staff at the operational district level, to explain the CT pilot to them and solicit their feedback and ideas for improving health seeking behavior as well as monitoring and verification of co-responsibilities by CFPs.

31. In light of the apparent information gap, CT pilot beneficiaries should receive a full re-orientation about the project and their co-responsibilities at every opportunity (all payment events, CBLS, etc). Sections C and D contain additional findings and recommendations relating to project communications to improve registration, co-responsibility compliance and verification.

B. Identification of beneficiaries

32. Identification of CT Pilot beneficiaries has been carried out as stated in the Operations Manual based on IDPoor 1 and 2and further categorical criteria: pregnant women and children ages 0-5. The pilot does not allow for post-identification of those who were excluded from the IDPoor list from 2012, but believe they are poor. Initial estimationsof nearly 2,800 beneficiaries (1,566 for Phnom Srok and 1,242 for SreySnam)[1], proved high compared to the actual number of beneficiaries thatsubsequently registered.Some potential factors that may have led to overestimation of beneficiaries include higher fertility rates during the design stage than those

[1]Estimations included IDpoor data and projections of pregnancies and changes in target beneficiaries. For instance fertility rates, of 113/1000 women of reproductive age based on CDHS 2010 data were used to calculate estimated number of pregnant women eligible for the program in both provinces.

actually observed[2]andhigh levels of labor migration to Thailand. This last factor will have important implications for project operations as will be described in subsequent sections.

33. In terms of the use of IDPoor as the targeting and eligibility mechanism, the criterion is well understood by communities and by project staff at the commune and district levels. Grievances related to IDPoor (loss of card, perceived poverty status, etc.) have been limited in number and have been dealt with accordingly (see section on Grievance redress mechanisms). The fact that the program is targeted to pregnant women and children 0-5 years of age, that is to say categorical criteria,is also well understood and no major grievances or misunderstandings have been found during enrollment.

C. Registration of beneficiaries

34. Registration of beneficiaries has been implemented in three different ways: one large registration event in February 2015 in all 12 communes; on-demand registration; and registration during cash transfer/payment days. To date, 1,851 beneficiaries have been registered, out of which 1,576 were registered in the registration event inFebruary 2015. Registration campaigns (for the large registration) were announced mainly through word of mouth spread by commune focal points and village chiefs.

35. Large registration processes varied in every commune. In some communes, CFPs briefed potential beneficiaries about the program outside of registration centers (beneficiaries gathered around a speaker who explained the project in detail to the crowd of people that was present—this activity was not repeated later in the day for those who might not have been present). In others, program information was provided inside the centers to a few beneficiaries at a time, after these were "vetted" and understood to be eligible for the program. However, for the most part, information was provided (in the form of a speech to a large audience of beneficiaries, with little interaction between the speaker and the audience) only once in each commune to the beneficiaries present at the time. This resulted in beneficiaries missing the program briefing if they came later or had already left by the time of the briefing.

36. Twenty-two grievances were received and recorded during the registration event, most of which were related to the lack of necessary documentation for registration (see section on Grievance/Redress).Because labor migration (much of it seasonal) is prevalent in both districts, actual household structure has been found to differ from household structure as defined by IDPoor—in other words, IDPoor parents often leave their children in the care of family or other members of the community while they are away in Thailand or elsewhere for work. Enrollment criteria were updated in the Operations Manual after the registration event to reflect these cases (e.g. children left behind with IDPoor households are eligible while those in non-IDPoor households are considered ineligible).

37. Registration on demand happens at payment events (every two months) or by approaching the commune at any time. Program objectives and co-responsibilities are however not well explained to beneficiaries, if at all, as observed during the MTR, leading to confusion

[2] CDHS data shows a consistent decline in fertility rates over time. CDHS 2010 data showed the average woman in Cambodia to bear 3.0 children on average, whereas CDHS 2014 data saw that number drop to 2.7 children.

among beneficiaries, or a complete lack of understanding about why they are part of the program (for instance the fact that there are conditional transfers to which they are entitled based on their behavior). CFPsare in charge ofexplaining the program to beneficiariesbut the practice is not consistent, and district advisers, who are there to supervise, are not focused on this either. Paperwork captures most people's attention during payment and registration events, with beneficiaries signing a memorandum of understanding for the project without being properly explained its content (for example, in one case the district officer had to be reminded to ask the beneficiary if she could read and when she said she could not, the commune chief explained the project to her). Visual aids, such as posters, which areavailable and visiblein all commune centers, are not being used for the purpose of explaining the program.

Recommendations

38. A systematic approach to informing beneficiaries about the program, as well as to informing beneficiaries about project objectives, co-responsibilities, and bonuses, needs to be taken at the commune level. At least one CFP needs to be assigned to and feel responsible for communicating program information to beneficiaries and needs to do so in a systematic way and at all CT Pilot events. Additional materials are needed for commune centers and health centers, such as posters, and flyers for beneficiaries to take home with them.

D. Co-responsibilities

1) Awareness/Compliance

39. Awareness and compliance with co-responsibilities appears very low as per MIS data. One possible reason is that many of the co-responsibilities need several months to reach full compliance and therefore it may still be early to judge the real rate of compliance based on current MIS data. For instance, health centers in both districts confirm increased use by pregnant women and children under 5 of health services in the last quarter, but this is not apparent from the MIS.However, field visits consistently reveal signs that the monitoring of co-responsibilities performed by the CFPs may fail to discover or track all health visits (for example, use of health services outside of health centers, unrecorded growth monitoring, etc.) and also that compliance may not be on track for some co-responsibilities, particularly growth monitoring.

40. The first obstacle to compliance is low awareness of key co-responsibilities (and of program objectives in general) among beneficiaries (at least those interviewed during field visits, and as stated by CFPs). Some were not aware of the additional cash bonuses they could receive by accessing services. The only exception seems to be community-based learning sessions, which beneficiaries associated with the program and with additional benefits (most likely because they occur on a monthly basis and entail a person-to-person interaction with the trainer, who explains that attendance of sessions leads to bonus payments). Low awareness can hamper overall compliance and translate into beneficiaries getting lower benefits that those they are eligible for, and hence the overall impact of the project can be lower than expected. The second obstacle that could potentially lead to low compliance is the difficulty of recording (e.g. growth monitoring) and monitoring information in health centers. This will be discussed at length in sections 2) and 3) below.

Recommendations

41. Communication and linkages between health services and program bonuses or co-responsibilities need to be strengthened (e.g. even if beneficiary pregnant women comply, they need to understand that they will receive money for that). CFPs and present at payment processes need to explain to beneficiaries why they are being paid and remind them that further compliance with co-responsibilities leads to further bonuses. It is important for new beneficiaries to clearly understand the program objectives and co-responsibilities when they sign up for the program, and this message needs to be consistently delivered throughout the length of the program.

42. Practical ways of improving communications include hanging up posters at health centers, communication of co-responsibilities at health centers (i.e. asking health center staff to refer IDPoor 1 and 2 patients to the program), providing flyers to all beneficiaries (to be distributed at CBLS and during payment sessions). The team has also recommended that NCDD-S host two re-orientationevents (one per district), inviting all relevant stakeholders, disseminating information (flyers) about the CT pilot, hosting informational booths on water and sanitation, nutrition, and maternal and child health (perhaps to be led by RACHA); having CFPs present to register new beneficiaries and to update monitoring sheets (asking beneficiaries to bring their pink and yellow cards to the event); and perhaps having a station for growth monitoring of children. Providing program T-shirts during the event, for example, to those who comply with co-responsibilities can provide an additional-long lasting incentive that can spread the message in communities.Sending text messages to beneficiaries' phone numbers registered by AMK could be explored to as a way to remind beneficiaries of co-responsibilities.

2) Supply side/ service provision

43. Prenatal care: HC staff interviewed in both pilot districts cited a perceived increase in antenatal care (ANC) visits (confirmed by 2014 CDHS data), and also probably as a result of the program. Interestingly, one health center staff in SreySnam pointed out that this increase in ANC access was mostly by women living in remote villages. They also cited a general awareness by the population about the importance of ANC. These two factors, high awareness and increased utilization, particularly by those living in remote areas, suggest the program adds value by providing an additional incentive to seek complete ANC packages, particularly for women who face additional constraints.

44. Institutional delivery and postnatal care:increased ANC visits lead to increased contact with health facilities and a tendency to increase institutional delivery and access immediate postnatal care, as confirmed by CDHS 2014 data. Analysis of MIS data at the end of the program is expected to confirm this tendency. To date, there are 40 cases of birth delivery at the health center by CT Pilot beneficiaries.

45. Immunization: Health center staff also suggest high awareness about immunization. Moreover, health center staff often perform "mobile" vaccinations outside of the health center as part of health outreach efforts.

46. Growth monitoring: There is very low awareness among beneficiaries (and also amongHC staff) about the importance of growth monitoring, both for the wellbeing of their

children and for the purpose of getting program bonuses. All beneficiaries interviewed suggest they take their older children (2-5 years) to the health center only if they are sick, and many think they do not need to bring their yellow books. Beneficiaries are also not aware of the growth monitoring section in the back of the child's yellow card (which allows for recording of weight and height until the age of 5) and have no recollection of particular advice given to them in case their child's growth has dropped to warning levels. Most HCs do not practice growth monitoring for children 2-5 years old unless it is specifically requested by the parent. As such, during the field trip it was observed that in most of the cases where growth monitoring had been practiced and recorded in the yellow book, children tended to drop to below average weight and height after their second year, thus highlighting the need to encourage this practice beyond two years of age and to provide advice or specific treatment if available.

47. Issues related to growth monitoring were confirmed by health center staff, and practices seem to differ between districts. In Phnom Srok there were very few yellow cards with recorded growth monitoring. In SreySnam,health center staff claimed they provide advice when growth drops and they even provide treatment (i.e. vitamin supplements and nutritional advice) for cases of acute malnutrition. SreySnam also appears to have a growth monitoring program sponsored by Malteser International, which could explain the greater awareness of the issue in this district. This suggests the potential to strengthen the link between the CT program co-responsibility on growth monitoring and services provided at the health center.

48. Record keeping at health centers varies and has been posing difficulties to commune focal points who verify co-responsibilities (see section below).There are several log books: a) Health Equity Fund (HEF) book where all IDpoor patients should appear; b) children 0-1 where immunization is recorded; c) children older than 1 and adults (general log book for sick patients); d) pregnant women; e) institutional deliveries; f) post-natal care.Health centers suggest double recording for IDPoor patients: in the HEF log book and in the other corresponding log book.

Recommendations:

49. One possibility is for health centers to record "growth monitoring" as such every time a child goes for growth monitoring and/or other reasons and growth is monitored. However, this would probably prove cumbersome to HC staff, and their compliance is not verifiable. Another more realistic option is to encourage HC staff to record growth monitoring in yellow books and reinforce messages at HCs and CBLS of the need to bring yellow books to thehealth center every time parents take their children there.HC staff understand the importance of recording growth monitoring and committed to doing so systematically in both districts (however, not all health centers were able to send a representative to the meetings conducted). Lastly, HCs should be encouraged to provide advice (and treatment if necessary and available) whenever a child's growth path drops to the warning/danger areas.

50. NCDD-S must continue to engage proactively with health care providers in pilot areas. NCDD-S can capitalize on the goodwill of health centers and include them in project information activities to the extent possible, and, if possible provide a separate training event for them to explain the CT pilot and explore realistic solutions to improve monitoring capabilities. In SreySnam, the project should attempt to meet with a representative from the Malteser

International program to explore the possibility of coordination on the growth monitoring co-responsibility.

3) *Community based learning sessions (CBLS)*

51. The third module of the community-based learning sessions was underway at the time of the Mid-Term Review. The CBLS module observed lasted for three hours, and comprised groups of between 8-15 attendants, all female (mothers and grandmothers). Materials and messages used by the partner NGO, RACHA, were consistent and complied with the standards expected for the session: recap of previous topics such as prenatal care, delivery, warning signs, breastfeeding, new born care and nutrition.The Bank's water and sanitation team collaborated with RACHA to assist in the design of materials for upcoming sessions focused on water, sanitation and hygiene.

52. Facilitators interviewed have been involved with the organization for about 1.5 to 2 years, came from nearby areas and seemed experienced in managing community discussions. One session displayed more interaction from beneficiaries and can be encouraged as best practice, since this generates more interest and helps review concepts and knowledge shared. Awareness of the program was found to be relatively high among facilitators though it is not common practice to reinforce program information to beneficiaries.

53. CFPs were not always present at the sessions. If they are not present, facilitators take attendance and give it to CFPs. In this way, co-responsibilities are verified. After this CBLS cycle is completed, compliance with CBLS attendance and eligibility for bonus will become apparent.

54. Sessions are planned to include about 10 participants, though facilitators only spend a day in each village, which means there are 2 sessions per village at most. Beneficiary households are invited by the village chiefs. This arrangement poses several issues from the perspective of attendance. First, beneficiaries only have one chance to attend the session and will miss it ifthey are busy that particular date and time. Second, only beneficiaries invited are in principle welcome to the session. Facilitators say that if other villagers attend the sessions they are welcome but, in reality, the message is that sessions are exclusive for beneficiaries (e.g. limited snacks are cited as a reason why not all villagers are welcome).Third, even beneficiary households from other villages may not be aware that a session is being carried out ina nearby village, missing an opportunity to attend a session and increase the chances of getting a bonus. Lastly, there are few instances where cash-out/registration sessions organized at the commune level clash with CBLS schedules. Beneficiaries are encouraged by CFPs to send a household "representative" to the CBLS while the main caregiver goes to cash out, which is not a practice encouraged by the program, as this renders them ineligible to receive the bonus and hampers effective dissemination of CBLS messages in the household.

Recommendations:

55. Community based learning sessions should be widely announced and non-beneficiary villagers should be welcome, too, though clearly advised that they are not eligible for bonuses under the program. Similarly, information about CBLS per commune (as in, the schedule for the entire commune, not just the village in question) should be widely available with plenty of

advanced notice to allow beneficiaries to attend sessions in other villages if needed. Sessions should be used as an opportunity to foster an environment of inclusion to the extent possible.

56. As part of its wider communications strategy, NCDD-S should leverage the connection between RACHA trainers and beneficiaries to disseminate program information. CBLS should be used as an opportunity to remind beneficiaries of program objectives and co-responsibilities and to provide them with flyers or answer questions. An explanation of the program, including all co-responsibilities, at the beginning of each session, should be a systematic practice. RACHA has confirmed its agreement to integrate this practice into their curriculum. NCDD-S should provide materials (posters and flyers) to RACHA for them to redistribute to beneficiaries.

57. CBLS can also be leveraged by CFPsas an opportunity to monitor co-responsibilities (rather than always travel to the HC, CFPs can monitor compliance in a space where several beneficiaries are gathered, leading to efficiency gains). Beneficiaries should be instructed to take their pink and/or yellow cards to these sessions (which take place once a month). If one CFP is assigned to this task, that person can use this venue to verify co-responsibility compliance by checking health cards, and also remind beneficiaries of program objectives and co-responsibilities.

58. Toward the end of the program, NCDD-S can assess the need for one additional CBLS cycle, teaching all nine modules in each district (perhaps teach sessions at the commune level, rather than the village level, giving an opportunity to beneficiaries to attend any sessions they may have missed).

59. Beneficiaries (i.e. account holders/primary caregivers of beneficiary children) and CFPs should be remindedthat only beneficiaries who personally attend the CBLS will obtain bonuses (in other words, sending a "representative" does not result in compliance). As the primary caregivers, they will benefit the most from the information provided and the co-responsibility on attendance cannot be fulfilled without their presence. If beneficiaries cannot attend the sessions, they should be able to access information about and attend sessions in nearby villages and/or inform CFPs about the need for additional sessions to cover up for the missing ones toward the end of the project.

E. Monitoring and Verification of Co-responsibilities

60. Effective monitoring and verification of co-responsibilities is the key to running and maintaining any successful conditional cash transfer program.As previously noted, for the CT pilot, health center records are essential for the verification of co-responsibilities, as are pink and yellow cards. Moreover, however, district and commune level staff (District Advisors, District Focal Persons and Commune Focal Persons) have to exercise ownership over the process—their role is not only to monitor compliance at the health centers and CBLS, but also to enforce it by providing information, guidance, and encouragement to beneficiaries to comply with co-responsibilities.

61. The main obstacle cited by CFPs during the mission was their ability to monitor and verify co-responsibilities. Commune focal points claim that the plethora of log books makes verification cumbersome, as they verify all log books in the health center (many of which keep

five or so logs for different groups). The HEF list would, in theory, be the most convenient place for CFPs to verify compliance of health-seeking behaviors,but the HEF list is usually submitted to ODs every 2 weeks, which renders the timing inconvenient (CFPs usually monitor compliance once per month). In addition, health centers have different practices for recording in the HEF list, and some HCs do not always keep an updated copy of it (for instance one HC staff admitted that he only brings the copy of HEF list to the OD at the end of the month, when he goes to collect the HEF reimbursement). So CFPs need to verify all general log books to find the actual information of CT pilot beneficiaries. In addition, CFPs also claim they need several trips a month to the HC to verify co-responsibilities since some log books (e.g. for immunization) are taken out of the HC during health outreach sessions. Overall, it appears that CFPs are placing limited or no reliance on pink and yellow cards to verify co-responsibilities.

62. There are particular difficulties associated with recording of growth monitoring at HC level for children 1-5. The first one is that parents usually only take their children to the HC when they are sick, so even if growth monitoring is performed, it is not recorded as such in the log book (only the diagnostic is recorded). As mentioned earlier, it is also not a systematic practice to record growth monitoring in the yellow book, or to monitor growth at all for children 2-5 years. The second issue relates to the lack of a particular log book for this age group resulting in CFPs having to go through the general population log book to try to find beneficiary children 1-5.

63. An additional issue, and one that was also brought up by CFPs, is that it is difficult to monitor compliance if beneficiaries access services in HCs or hospitals outside the commune. All these difficulties can become a serious issue for program beneficiaries, if they do indeed comply but the program fails to capture their compliance properly, potentially translating into increased grievances and lack of trust in the program.

Recommendations

64. Health center staff that attended meetings with the Bank team expressed willingness to collaborate more closely with the program in both districts, especially with regard to verification of co-responsibilities (and also in terms of referral of patients to the program). In Phnom Srok, HCs even mentioned the possibility of getting paid for taking the extra effort of filling the monitoring sheet (and CFPs were also willing to give their travel allowance to health center staff if they did so).A more systematic approach would be to include HCs in a formal verification role, but this mayrequire an agreement at central level with MoH.The viability of this option may fall beyond the scope of this pilot, but increased cooperation and communication between DFPs, CFPs, and health centers, is strongly encouraged.

65. In the meantime, CFPs should encourage beneficiaries to demand that HC staff record their visits in their pink and yellow cards (as HC are already responsible for this, but do not always comply), and request that HC staff fulfill their duties in this respect. If HCs record ANC visits, delivery and post-natal package (on pink cards), and vaccinations and growth monitoring in yellow cards, it would facilitate verification. Beneficiaries should be encouraged to bring theirpink and/or yellow cards to the CBLS, where CFPs can verify compliance (rather than

always relying on the HC—even if not everyone attends the CBLS, there would still be a significantly shorter list to verify at the HC).

66. In terms of usage of district or other health facilities, reliance on pink and yellow cards would also simplify verification. Beneficiaries that access services outside the commune HCs need to make sure services are registered in yellow and/or pink books for CFPs to verify at CBLS and/or at commune offices where beneficiaries can approach them to show the books.Overall, CFPs should be encouraged to check pink and yellow cards at group gatherings to facilitate their job, and not just go to HCs as the sole source for verification. On occasion, they should provide spot checks of health center lists to ensure that annotations on pink or yellow cards correspond with the information at the health center.

67. More informal solutions should also be explored directly between CFPs and health center staff: e.g. coming at less busy times for HC staff to help the CPF find CT pilot beneficiaries in log books, HC staff can try to keep HEF lists updated for CPFs to have easy access to IDPoor beneficiary information, etc. However these solutions are not systematic and their efficacy would need to be tested as a lessons-learned exercise.

F. Management Information System

68. The CT Pilot MIS has been fully operational since March 2015. NCDD-S has relied on the MIS to calculate the payroll for each bi-monthly payment to beneficiaries, based on monitoring data that is collected by CFPs at the commune level and compiled by DFPs. An MIS training was conducted for all district staff, and monitoring data is now being entered into the MIS at the district level, verified at the national level by NCDD-S. It is unclear whether complaints are being entered consistently into the MIS.

Recommendations

69. Due to the previously described difficulties in verifying co-responsibilities, district advisers noted that information submitted by CFPs is usually incomplete. Following the recommendations from previous sections, there is a need to strengthen capacity of CFPs and also to coordinate better with health centers to simplify verification. It was noted on several occasions that some CFPs are more adept at monitoring and verification than others; as such, this exclusive role should be assigned to those CFPs (one or two per commune at most), as data collection and entry are essential to the success of the pilot; other duties should be distributed among the remaining CFPs.

70. Testing of the MIS should be conducted every other month to ensure that data entered renders the correct calculations, particularly before the next cycle, since a new co-responsibility (attendance of three CBLS) will be triggered for the first time after Module 3, which is currently being delivered, is completed. All complaints filed should be entered consistently into the MIS and monitored by NCDD-S.

G. Grievance redress mechanism

71. NCDD-S has been collecting grievances since the time of the initial CT pilot registration event in February 2015. Based on the types of complaints received, "categories" of complaints

were updated in the MIS to assist with tracking them. It is unclear whether all claims filed at the time, and ever since, were entered into the MIS. Based on the observations of the mission in February 2015, claims were not systematically entered into the MIS (particularly those that were resolved—for example, most people who went to the event but were unable to register because they did not bring or did not have the proper documentation, were asked to file claims and return at a later time with their documents—these cases were not filed in the MIS, however). Most complaints are handled and resolved at the commune and district level.

72. Due to the limited number of claims (19) in the MIS, which is down from 22 that were recorded in March 2015, it is difficult to pinpoint the main sources of grievances. Of the 19 in the system, only four are related to IDPoor, namely people claiming that they are poor but were missed in the last IDPoor survey in 2012. The project has yet to establish links with the Ministry of Planning, which is in charge of IDPoor, to refer these cases directly to them, though it is the understanding of the team that MoP does not currently have mechanisms in place to resolve these types of complaints, nor to conduct post-identification. Nonetheless, these grievances should be collected by NCDD-S.

Recommendations:

73. Effective grievance redress mechanisms are a cornerstone to gaining the trust of the communities and beneficiaries in pilot districts. NCDD-S should monitor more closely how complaints are being collected, filed, and resolved, and how case management is being communicated to the claimants. Moreover, to ensure the integrity of the system, NCDD-S should closely monitor how this information is being entered into the MIS by the districts and ensure that it goes in the system, even if a claim is resolved.

H. Payments

74. The third payment cycle was observed during the Mid-term Review in both districts. Overall, payments are running smoothly and cash is reaching beneficiaries as intended. Most beneficiaries in the communes visited went to cash out their transfers during the cash out event, which indicates that a) benefit levels are a good incentive for people to go to communes bimonthly for this purpose, and b) there is good communication about cash-out days. Most beneficiaries brought their card and the few that lost it were advised to go to an AMK office to get a new one. During the event, AMK officers were also available to open accounts for newly registered beneficiaries, or other registered beneficiaries that had been unable to coincide with other account opening days.

75. Beneficiaries are not required to withdraw their transfers from their AMK accounts. It was observed, however, that a DFP or CFP in both districts wererecordingwho was cashing out, and how much. This is an unnecessary (and potentially conflictive) practice that is not specified in the Operations Manual, since account information is confidential; moreover, AMK is able to generate a digital and more reliable account of that information, should it be needed for any reason.

76. The speed of cash distribution on cash out days varied; overall, though, payments could be made in a way that is both more efficient, and also more client-centered. The team observed,

for example, that in SreySnam there were only two payment agents, whereas in Phnom Srok there were four agents. Payments were made much more slowly in SreySnam as a result of fewer AMK staff. Several stakeholders noted that inefficiencies in handing out cash had led in some cases to AMK wrapping up for the day with several beneficiaries still in line to be paid. These beneficiaries were referred to another payment point in the district the following day, or asked to go to an AMK office to withdraw their cash. In Phnom Srok, in spite of having four agents, only two were focused on cash distribution, while the other two were opening new accounts. Beneficiaries were being called to retrieve their cash not by order of arrival, but according to their order on the payroll list. As such, some beneficiaries were made to wait longer times than others even though they had arrived earlier. AMK noted that beneficiaries are usually called up by village, starting with the furthest village, and that looking up names on the list (if they honor order of arrival) was more time-consuming. Finally, the mission also observed that AMK only brings the exact amount of cash on the payroll to the cash out events. As a result, some beneficiaries were unable to withdraw the full cash amount that had accumulated in their accounts if they have missed previous cash out days for whatever reasons; most were only able to withdraw the payment corresponding to the current cycle.

77. Awareness of why beneficiaries are being paid and how they could get more benefits by complying with co-responsibilities is low. Cash-out events are not being used as an opportunity to reinforce these messages.The mission even observed a case of an elderly account holder who had no idea what the project was about (and thought the money was for her own medicines) but was allowed to be the account holder because her daughter had just given birth. This practice should not be encouraged, and is in fact counter to the conditions for registration (only if parents are abroad can there be another account holder). Account holders that still live in the area should be the mother or caregiver as per Operations Manual, to ensure the money is linked to the beneficiary and to co-responsibilities as per program objectives.

Recommendations:

78. Overall, the main recommendations in this section relate to making cash payments friendlier to beneficiaries, while remaining efficient. For example, AMK should allocate four staff per district to ensure that all beneficiaries are paid in their respective communes and do not need to travel beyond that. Second, NCDD-S could discuss with AMK the possibility of bringing more cash to the events in case some beneficiaries wish to cash out accumulated balanced in their accounts (based on their experience in previous cash-out days, AMK should have some notion of the ratio of payroll to disbursements and could base their calculation on this). NCDD-S could also discuss with AMK the possibility of serving beneficiaries on a first-come, first-served basis, by using alphabetized lists that can speed up the process. Finally, NCDD-S should remind AMK that they are under contractual obligation as per the terms of their contract with NCDD-S, to provide new bank account cards on the spot to beneficiaries that have lost theirs (rather than encourage them, as the mission observed, to go to an AMK office to obtain a new card).

79. Instead of DFPs or CFPs recordingthe amounts that beneficiaries are cashing out, they should instead be seated next to AMK officers and explain to each beneficiary why they are being paid (for example, basic transfer plus four ante-natal visits), when their next payment will

be, and the potential they have to increase their benefit by complying with applicable co-responsibilities. This would reinforce the communications strategy.

80. Finally, NCDD-S should prepare a payment schedule for the duration of the project, to be shared with AMK and also to be disseminated among beneficiaries. If payments are predictable (for example, the second week of every other month), it will allow AMK to better organize its own staff, and beneficiaries to be prepared and plan ahead. It will also save time for CFPs, who are currently in charge of alerting beneficiaries to payment dates, which are variable.

I. Procurement

81. The mission found that very significant procurement progress has been made from the previous mission. In accordance with the procurement tracking form submitted by NCDD-S, only two small packages of goods (two fixed cameras and office furniture) are in the procurement process being carried out by NCDD-S, while the external financial audit is included in the bundled audit, for which the audit firm will be engaged by MEF. The Bank will carry out the procurement post review during the next supporting mission.

J. Financial Management

1) Disbursements

82. Cumulative Disbursements: As of September 16, 2015, the cumulative disbursement of the Cash Transfer Pilot Project Focused on Maternal and Child Health and Nutrition Project was US$507,225, or about 60 percent of the total grant amount of US$850,000. This leaves an undisbursed balance of US$342,775. The project received US$107,225 from the World Bank fromJuly-September 2015, from 3 sets of withdrawal applications (WA), #02, #03 and #04, which were replenished by the Bank.Going forward, in order to more closely align disbursements with project expenditures, the Bank will not accept any further Withdrawal Applications until such time as the funds currently allocated in the Designated Account have been depleted.

2) Financial Management (FM)

83. The Financial Management Performance Rating of the Projectis *"Moderately Satisfactory"*. The project has established an adequate FM structure and staff to meet functional needs. The project district accounts have been opened at the nearest ACLEDA Bank branches, an initial advance of US$1,600 was received by each district of SreySnam and Phnom Srokin early August 2015. The District monthly Bank account reconciliation for August will be completed and submitted to NCDD-S for consolidation by the end of September 2015. The simplified financial management manual will be reviewed by NCDD-S to incorporate the use of funds at the commune and at the district, and especially local standard travel rate, DSA, international travel, vehicle rental, training, and purchase of operating cost and training related items. The revised budget plan for the remaining project period (from now until the closing date of the project) will be submitted for Bank's no objection by September 30, 2015. The interim unaudited financial report for the quarter ending June 30, 2015 was submitted to the Bank in a timely manner.

84. Component 1- Work Plan and Budget: There is a savings of US$17,140 from the Consultant's Services budget and CARD has requested to use it for overseas training of staff. The TTL has in principle agreed with the concept and requested CARD to submit the detailed activities and the estimated cost for overseas training. A formal request with the estimated budget and overseas training proposal should be submitted to the Bank by end of September 2015 for further consideration.

85. Conditional Cash Transfer and Bonus under Component 2:Two tranches were released in March and June 2015. The total expenditures reported by Component 2 were US$26,966 or 6 percentofthe Component 2 allocated budget of US$450,000. The Project and the Bank mission discussed the current spending rate under this Component. It was agreed that in order to accelerate the release of cash to the beneficiaries by AMK, NCDD-S will prepare a disbursement schedule of cash projections for the beneficiaries until the closing date of the project. This disbursement schedule of cash requirement will give NCDD-S an idea to effectively manage the funds under this component.

86. Annual Budget and Project Cash Flow:Overthe course of this Mid–term Review mission, the project and the Bank discussed the project's disbursement performance. The project's activities have started to scale up during the second quarter of 2015, and continue to rise to the level of activities as per the approved work plan and budget. Thus, the project will deliver major activities for health and nutrition education to target beneficiaries, releases of cash transfer and bonuses to the selected beneficiaries, to the new potential beneficiaries, and payments for procurement of goods, and consultant services. NCDD-S and the Bank mission team discussed how to maximize the utilization of project funds for the remaining period until the project closing date of April 30, 2016. It was agreed that the project will prepare monthly cash flow projections and an annual budget for the remaining period until the closing date of the project by incorporating the revised budget from Component 1 andrevisions for travel and communications-related expenses under Component 3 and submit for the Bank's no objection by September 30, 2015.

87. AMK (Financial Institution), a third Party Pay Agent for Component 2:The Project generated a pay list (or payroll), which is generated from the MIS every two months. The list of beneficiaries, after verification made by the NCDD-S project team, will continue to be sent to AMK every two months for payment to the beneficiaries. The total amount of the beneficiaries' portion plusAMK's service fees is transferred to AMK. When funds are transferred to AMK, it was agreed that the project will treat this as an advance until AMK submitsthe financial report confirming the funds were released to the beneficiaries and the beneficiaries actually received the cash. Thesefinancial reports will be submitted to NCDD-S within two working days after AMK releases cash to the beneficiaries.

88. Revision of Project Simplified Financial Management Manual: The current FM Manual will be updated by NCDD-S to be in line with some aspects related to the use of funds at the Commune and at the District. This manual will need to update specific aspects on cross-cutting issues faced by the project and agreed during this mid-term review mission. NCDD-S and the Bank agreed that this manual shall include local standard travel rates, DSA, international travel,

vehicle rental, training, and purchase of non-procurement items. In addition, the commune and the district focal pointswill have a clear job description, and a contract agreement with the project for the project to provide monthly travel lump sum and also some costs to cover administrative expenses in the merit of their working for the project at the commune and at the district, which was proposed by the project. The revision of the manual will be submitted for the Bank's no objection by mid-October 2015. Once the project receives the Bank's no objection, NCDD-S will organize training to commune and district focal pointson the use of funds at the Commune and at the District including roles and responsibilities.

89. Delay of Submission of District Monthly Account Reconciliation to NCDD-S:The two districts - SreySnam and Phnom Srok - have not yet submitted their monthly account reconciliation to NCDD-S for consolidation for the month of August 2015. The project mentioned that the District needs assistance since it was their first time to close the monthly account. It was agreed that NCDD-S' finance consultant will provide hands-on support to the district accountants to complete the reconciliation and to submit it to NCDD-S by end of September 2015.

90. Mobile phone expenses of $10 per individual mission members who traveled for work-related missions were charged by CARD to the project in every trip. In total, thesemobile phone expenses amounted to$400. Given thenature of the mission, these expenses were rendered ineligible. Therefore, as agreed with MEF, CARD shall promptly return $400 of cell card expenses to the project. MEF confirmed that the sub-decree 216 allows for reimbursement of food, pocket money and meal expenses, which comes up to $34 per day. Every mission team member received the $34.

91. Interim Unaudited Financial Report (IFR): TheIFR for the second quarter of 2015 was received by the Bank, and the next IFR for the third quarter of year 2015 is due on November 14, 2015.

92. External Audit for the Project:NCDD-S will formally send a letter to the Ministry of Economy and Finance (MEF) to appoint an external auditor for the project by end of September 2015.

Annex 1: Mission Schedule
Cambodia SP Cash Transfer Pilot Project (P132751) and Cambodia TA for SP Systems (P153091)
September 9-18, 2015
(Team: Claudia Zambra Taibo, Mariana Alba Infante, Munichan Kung, Sophear Khiev, Sreng Sok, Da Lin)

Date	Time	Person / Position / Agenda	Venue	Contact Persons	Mission Members	Status/ Notes
Sep 9	**10:00-11:00**	Meet with Karl Johan Remoy & Nicole, Indochina Research	MR4,WB		Claudia	***Confirmed***
	14:00-15:00	Meet with UNICEF, Maki Kato	UNICEF		Claudia, Munichan	***Confirmed***
	15:30-16:15	Meet with ILO, Ms. Ok Malika	ILO	Malika, 017 426 203	Claudia, Munichan	***Confirmed***
	16:30-17:30	Meet with Save Children, Inna Sacci and Phorn Yoeum	Save Children		Claudia, Munichan	***Confirmed***
Sep 10	**10:00-12:00**	Internal Team Meeting	MR4,WB		All team members	***Confirmed***
	14:30-17:00	Kick-off meeting (Chair by H.E. Ngy Chanphal): - Discuss the mission objectives - Review the progress - Mission schedule coordination	MOI	Chey Sambatphalla H/P: 011 903 007	All team	***Confirmed***
Sep 11	**9:00-12:00**	- Meet with NCDD-S FM team to review overall FM performance, issues, solution.	NCDD	Ms. Soth Chenglen H/P: 012 306 991	Sophear Khiev for FM. Sreng Sok for	***Confirmed***

Date	Time	Person / Position / Agenda	Venue	Contact Persons	Mission Members	Status/ Notes
					Procurement	
	10:30-12:00	Meet with CARD (H.E. Sann Vathana) - Progress and issue of Component 1 - SP coordination network	His office	Sann Vathana H/P: 012 950 410	Claudia, Munichan, Mariana, Vathana	***Confirmed***
	14:30 – 17:00	Meet with NCDD (Mr. Chey Sambathphalla and team) - POM update/amendment - MIS and Cash payment update	NCDD	Chey Sambatphalla H/P: 011 903 007	Claudia, Munichan, Mariana	***Confirmed***
	14:00-17:00	Review of accounting system, MFI fund release, project expenditures, record and file	NCDD	Ms. Soth Chenglen H/P: 012 306 991	Sophear Khiev &NCDD-S FM team	***Confirmed***
Sep13	**10:30 AM**	Travel to Siem Reap			Claudia, Munichan, Mariana	
Sep 14	**8:00-17:00**	In Phnom Srok District - Observe Health training and meet RACHA trainers - Observe Cash payment and meet AMK field staff. - Meet with: . District officers/focal		Chey Sambatphalla H/P: 011 903 007	Mission team	***Confirmed***

Date	Time	Person / Position / Agenda	Venue	Contact Persons	Mission Members	Status/ Notes
		persons . Commune focal persons . Health center staff . Project beneficiaries (group discussion)				
	9:00-12:00	Meet with CARD-FM team to review overall FM progress	CARD	Ms. Sreypov H/P: 078 791 471	Sophear Khiev &CARD FM team	***Confirmed***
	14:00-17:00	FM wrap- up meeting with participation of FM team from NCDD-S and CARD	NCDD		Sophear Khiev,NCDD-S, and CARD FM teams	***Confirmed***
Sep 15	**8:00-17:00**	In SreySnam District - Observe Health training and meet RACHA trainers - Observe Cash payment and meet AMK field staff. - Meet with: . District officers/focal persons		Chey Sambatphalla H/P: 011 903 007	Mission team	***Confirmed***

Date	Time	Person / Position / Agenda	Venue	Contact Persons	Mission Members	Status/ Notes
		. Commune focal persons . Health center staff . Project beneficiaries (group discussion)				
Sep 16	**8:00**	Travel back to Phnom Penh			Claudia, Munichan, Mariana	
Sep 17	**9:00-10:00**	Meet AMK, MrSathPhirath Feedback from the field on cash payment.	WB	Mr. SathPhirath, 066 777 456	Claudia, Mariana, Munichan	***Confirmed***
	10:30-12:00	Meeting RACHA: Feedback from the field on Health Education. - Progress and quality of the health education. - Preparation of the remaining modules?	RACHA	Ms. Chan Theary, 012 333 383	Claudia, Mariana, Munichan	***Confirmed***
	12:00-13:30	Meet with Brett Ballard, Consultant-UNICEF	Java Cafe	bmarcballard@gmail.com	Claudia, Mariana	***Confirmed***
	14:00-16:00	Social Protection Coordination Group Meeting	UNICEF		Claudia, Mariana, Munichan	
	16:30-17:30	Meeting with Alassane	His office		Claudia, Mariana,	***Confirmed***

Date	Time	Person / Position / Agenda	Venue	Contact Persons	Mission Members	Status/ Notes
					Munichan	
Sep 18	**Morning**	Meeting with NCDD, Mr. Phalla and team	NCDD	Chey Sambatphalla H/P: 011 903 007	Claudia, Mariana, Munichan	***Confirmed***
	14:30-16:30	Closing meeting (chaired by H.E. NganChamroeun)	NCDD	Chey Sambatphalla H/P: 011 903 007	All team	***Confirmed***

Annex 2: Results Framework

Cambodia: Cash Transfer Pilot for Maternal and Child Health and Nutrition

Indicator Name	Core	Unit of Measure	Baseline	Cumulative Values for each Year						Frequency	Data Source/ Methodology	Responsibility for Data collection
				2014 (Oct-Dec)		2015 (Jan-Dec)		2016 (Jan-Apr)- [Endline]				
				Target	Actual	Target	Actual	Target	Actual			
A.Project Development Objective Indicators												
A.1 Percent of female beneficiaries that delivered in a health facility		Number	94%	60%	0%	70%	13%			Annual	Baseline data and MIS	World Bank, NCDD-S and CARD
A.2 Percent of enrolled children receiving all six recommended vaccinations		Number	90%	60%	0%	70%	10%			Annual	Baseline data and MIS	World Bank, NCDD-S and CARD
A.3 Percent of female beneficiaries attending at least four nutrition/water and sanitation workshops		Number	0	45%	0%	70%	0%			Annual	Project MIS	NCDD-S

A.4 Percent of eligible beneficiaries with information updated in program MIS		Number	0	60%	0%	75%	15%			Annual	Project MIS	NCDD-S
B. Intermediate Result Indicators												
Component 1: Support to the National Social Protection Strategy												
B.1.1 NSPS update drafted		Text	None in existence	Nil	Nil	Draft completed with inputs from the project	Not yet started to update NSPS			One		NCDD-S and CARD
Component 2: Cash transfer and bonuses												
B.2.1 Percent of eligible beneficiaries receiving cash transfers		Number	0	45%	Nil	75%	83%			Annual	Project MIS and IDPoor data	NCDD-S
B.2.2 Percent of beneficiaries that comply with coresponsibilities related to ante-		Number	0	60%		80%	44%			Annual	Project MIS	NCDD-S and Health Center

natal visits												
B.2.3 Percent of beneficiaries that comply with coresponsibilities related to health center delivery and post-partum care package		Number	0	50%	Nil	75%	13%			Annual	Project MIS	NCDD-S and Health Center
B.2.4 Percent of beneficiaries that comply with co-responsibilities related to growth monitoring and vaccinations		Number	0	TBD	Nil	TBD	10%			Annual	Project MIS	NCDD-S and Health Center
B.2.5 Percent of beneficiaries that attend at least one nutrition/water and sanitation workshops		Number	0	75%	0%	85%	0%			Annual	Project MIS	NCDD-S and Local NGO
Component 3: Strengthening of cash transfer implementation systems												
B.3.1 Creation and updating of program MIS, linked to existing		Text	MIS in place at NCDD through the CDB.	Program MIS created	Not yet designed and	Program MIS created	CTMIS had been completed and well			Annual	Project MIS	NCDD-S

systems				and regularly updated	developed	and regularly updated, and linked to existing systems	functioned in data entry, monitoring, payroll and report					
B.3.2 Number of people at the district and commune levels trained to implement and monitor CT pilot		Number	None trained in CCT implementation. Some existing capacity for M&E	75	248	75	60			Annual	Project Management Unit	NCDD-S

Annex 3: Project Staff List

	Name	Sex	Position in Government	Position in Project	Remarks
	NCDDS				
1	H.E. Ngy Chan Phal	M	Secretary of State, MOI Deputy Chairman, CARD	Coordinator	
2	H.E. NganChamroeun	M	Under Secretary of State Deputy Chief, NCDDS	Director	
3	Chey Sambath Phalla	M	Deputy Chief, Policy Unit, NCDDS	Manager	
4	Eam Piseth	M	NA	Management Adviser	
5	Chum Chan Muny	F	FM Officer	FM	
6	Soat Cheng Len	F	NA	FM Adviser	
7	Poch Monika	F	Procurement Adviser	Procurement	
8	Uk Sotha	M	M&E Officer	M&E	
9	Ngoun Eng	M	NA	M&E Adviser	
10	ToatVannak	M	Policy Officer	Project Officer	
11	Sok Mary	F	FM Officer	FM Alternate	
	CARD				
1	H.E. San Vathana	M	Deputy Secretary, CARD	Head of Component 1	
2	Kong Chanthy	M	Sr. SP Officer	Project Officer	
3	KhimSreyPov	F	Officer	Focal Person	
4	Poch Vannak	M	NA	Specialist for SP Policy	
5	Meas Vanna	M	NA	Data Management TA	
6	HounDalin	F	NA	SP Research TA	
	SreySnom District				
1	Lot Nhean	M	Staff of Planning and Commune support office	DFP, SreySnom	
2	Van Savath	M	Staff of Planning and Commune support office	DFP, SreySnom	
3	SomSokha	M	NA	District Adviser	
4	UkSophany	F	Commune Councilor	CFP, ChroyNeang-ngoun	
5	Nin Ly	M	Villager, Chroy	CFP, ChroyNeang-ngoun	
6	Lay Eang	F	Villager, RusseiSanh	CFP, ChroyNeang-ngoun	
7	KhutVor	M	Villager, RusseiSanh	CFP, ChroyNeang-ngoun	
8	PrumSavda	F	Commune Councilor	CFP, Khlang Hay	
9	MormHy	F	Villager, L-boek	CFP, Khlang Hay	
10	PechSath	M	Village Chief, Sleng Kong	CFP, Khlang Hay	
11	ThourSavy	M	Village Chief, Samrong	CFP, Khlang Hay	
12	Part Chy	M	Village Chief, Pongro	CFP, Tram Sasor	
13	Son Sam	M	Village Chief, Thlok	CFP, Tram Sasor	
14	Nep Choung	M	Village Deputy, Prech	CFP, Tram Sasor	
15	KarnChoey	M	Village Chief, Romdeng	CFP, Tram Sasor	
16	Sor Seat	M	Villager, MongChoeng	CFP, Mong	
17	Lay Reaksmey	F	Villager, MongChoeng	CFP, Mong	
18	Seng Sokhom	F	Villager, MongThbong	CFP, Mong	
19	Chea Phalla	F	Villager, Kh-vek	CFP, Mong	

20	Sok Mang	M	Village Chief, Prey 1	CFP, Prey	
21	RoengSarun	M	Commune Deputy	CFP, Prey	
22	MakHak	M	Commune Councilor	CFP, Prey	
23	Doer Het	M	Village Deputy, Prey 1	CFP, Prey	
24	ChimChray	M	Commune Deputy	CFP, Sleng Spean	
25	Kung SKor	M	Villager, Chroneang	CFP, Sleng Spean	
26	Date Polo	M	Commune Councilor	CFP, Sleng Spean	
27	Kao Kong	M	Commune Councilor	CFP, Sleng Spean	
	Phnom Srok District				
1	Pull Sinath	F	District Officer	DFP, Phnom Srok	
2	PringSophat	M	District Officer	DFP, Phnom Srok	
3	Seng Chan Kan-nha	F	NA	District Adviser	
4	Peng Bunthatra	M	Commune Chief, Poy Char	CFP, Poy Char	
5	Sun Moen	M	Commune Deputy	CFP, Poy Char	
6	NakSaroeng	F	Commune Councilor	CFP, Poy Char	
7	Diep Pep	M	Commune Councilor	CFP, Poy Char	
8	Ly Meng	M	Commune Chief	CFP, SrasChik	
9	Lath Seng Chiat	M	Commune Deputy	CFP, SrasChik	
10	Keo Bunroeun	F	Commune Councilor	CFP, SrasChik	
11	ThokPik	M	Commune Councilor	CFP, SrasChik	
12	Kim Lang	F	Commune Deputy 1	CFP, Spean Sreng	
13	Pok Barn	M	Commune Deputy 2	CFP, Spean Sreng	
14	So Kong	M	Commune Councilor	CFP, Spean Sreng	
15	Don Cheng Lay	F	Commune Councilor	CFP, Spean Sreng	
16	SomThouk	M	Commune Chief	CFP, Phnom Dey	
17	Book Ley	M	Commune Councilor	CFP, Phnom Dey	
18	Hang Phoeun	F	Commune Councilor	CFP, Phnom Dey	
19	Phal Sokha	M	Commune Councilor	CFP, Phnom Dey	
20	Tuan Thol	M	Commune Chief	CFP, Nam Tao	
21	Chea Chart	M	Commune Councilor	CFP, Nam Tao	
22	Horm Sao Roe	F	Commune Councilor	CFP, Nam Tao	
23	SounSamnangPely	M	Commune Councilor	CFP, Nam Tao	
24	So Soal	M	Commune Councilor	CFP, Ponley	
25	Phlong Theary	F	Commune Councilor	CFP, Ponley	
26	Chim Ho	M	Commune Councilor	CFP, Ponley	
27	Duch Khan Nhoeng	F	Commune Admin staff	CFP, Ponley	