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The International Development Association
Acting as Administrator of the Interim Trust Fund

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Report No. P-6913-KH

MEMORANDUM AND RECOMMENDATION

OF THE

MANAGING DIRECTOR

TO THE

PRESIDENT OF THE

INTERNATIONAL DEVELOPMENT ASSOCIATION

ON A

PROPOSED INTERIM FUND CREDIT

IN AN AMOUNT OF SDR 20.6 MILLION

TO

THE KINGDOM OF CAMBODIA

FOR A

DISEASE CONTROL AND HEALTH DEVELOPMENT PROJECT

NOVEMBER 15, 1996

Human Resources Operations Division
Country Department I
East Asia and Pacific Region

CURRENCY EQUIVALENTS

(as of October, 1996)

Currency Unit	=	Riel
US$1.00	=	2,600

WEIGHTS AND MEASURES

Metric System

ABBREVIATIONS AND ACRONYMS

AIDS	-	Acquired Immuno-deficiency Syndrome
DALY	-	Disability Adjusted Life Year
HIV	-	Human Immuno-deficiency Virus
MOH	-	Ministry of Health
NGO	-	Non-Governmental Organization
PCU	-	Project Coordination Unit
TB	-	Tuberculosis
UNICEF	-	United Nations Children Fund
WHO	-	World Health Organization

FISCAL YEAR

January 1- December 31

Vice President:	Nicholas Hope, Acting, EAP
Director:	Javad Khalilzadeh-Shirazi, EA1
Division Chief:	Sven Burmester, EA1HR
Task Manager:	Christopher Chamberlin, Sr. Economist

KINGDOM OF CAMBODIA

DISEASE CONTROL AND HEALTH DEVELOPMENT PROJECT

Credit and Project Summary

Borrower:	Kingdom of Cambodia
Implementing Agency:	Ministry of Health
Beneficiary:	Not applicable
Poverty:	Program of Targeted Interventions
Amount:	SDR 20.6 million (US$30.4 million equivalent)
Terms:	Standard IDA, with 40 years maturity and 10 years grace
Commitment Fee:	0.5% of undisbursed credit balances, beginning 60 days after signing, less any waiver
Onlending Terms:	Not applicable
Financing Plan:	See Schedule A
Net Present Value:	Not applicable
Staff Appraisal Report:	15596-KH
Map:	IBRD 27986
Project ID Number:	4034

MEMORANDUM AND RECOMMENDATION OF THE MANAGING DIRECTOR TO THE PRESIDENT OF THE INTERNATIONAL DEVELOPMENT ASSOCIATION (the Association Acting as Administrator of the Interim Trust Fund) ON A PROPOSED INTERIM FUND CREDIT TO THE KINGDOM OF CAMBODIA FOR A DISEASE CONTROL AND HEALTH DEVELOPMENT PROJECT

1. I submit for your approval the following Memorandum and Recommendation on a proposed development credit to the Kingdom of Cambodia for SDR 20.6 million (US$30.4 million equivalent) on standard IDA terms, with 40 years maturity and 10 years grace to help finance a Disease Control and Health Development Project (DCP).

2. **Country/Sector Background.** The development prospects of Cambodia are strongly shaped by three constraints: poorly developed official institutions and services as a result of 20 years of war and international isolation; a continuing rural insurgency that isolates certain areas of the country and distorts government expenditures; and a depleted human resource base due to the destructive policies of the Khmer Rouge Government in the 1970s. Those constraints are balanced by long term development potential based on valuable assets: abundant mineral and forest resources, compelling tourist attractions, extensive arable land, and trade and investment opportunities with the dynamic economies on its borders.

3. Health conditions in Cambodia have barely improved over the last twenty years, due to the virtual dismantling of the health system during the 1970s and overall lack of investment in the health system since then. Under-five mortality is estimated at 181 per thousand live births (of which the infant mortality rate is estimated at 115) with acute respiratory infections, diarrhea and malaria being the leading causes of childhood mortality. The maternal mortality ratio has been estimated as high as 900 per 100,000 births. Tuberculosis and malaria are widespread and are leading causes of death, and HIV/AIDS is rapidly reaching epidemic proportions.

4. Cambodia harbors some of the highest rates of TB in the world, with over half the population infected with the TB bacillus. From this pool of infection, about 35,000 active cases exist at any one time, making TB a leading killer of young adults and a significant threat to children. Malaria was the cause of 1,100 recorded deaths in 1994. The real figures may be up to five times higher. About 80 percent of the malaria infections are falciparum malaria, which has developed a high level of drug resistance, especially in the western provinces.

5. The human immuno-deficiency virus (HIV) was first detected in Cambodia in 1991, and since then the virus has spread relentlessly, and the country faces, potentially, the worst HIV epidemic in Asia. The rate of increase of HIV prevalence among blood donors is alarming, rising from 0.075 percent in 1991 to 8 percent in October 1995. HIV prevalence among high risk groups ranges up to 40 percent of commercial sex workers. Especially disturbing is the number of pregnant women found HIV-positive, over 4 percent in two cities.

6. The Ministry of Health (MOH) and its provincial service delivery staff have begun the process of rehabilitating and reforming the long neglected public health system. Up until 1993, the health delivery system was highly decentralized to provincial authorities, and this resulted in large variations in terms of resource allocation and the quality of health care among the different provinces. Since 1993, the MOH, with the support of advisors from WHO and UNICEF, has prepared the National Health Development Plan 1994-1996 which redefines the institutional framework for the health system and the services offered at each level, in an aim to rationalize the use of resources; develop district-based health services; integrate disease control and basic services at the district level; and build up the capacities, both physical and human, to deliver essential health care at the community level. Health coverage plans are being negotiated at the provincial level, in consultation with local authorities and communities, to define clearly the location of referral hospitals and health centers, the services offered, and their catchment areas.

7. **Project Goals and Objectives.** The project aims to support the Government of Cambodia in pursuing two of its principal health sector objectives: (i) reduce death and sickness from preventable diseases, especially malaria, TB and HIV/AIDS; and (ii) rehabilitate the health system infrastructure so as to deliver basic health services and disease control programs more effectively down to the community level. The project will support construction and/or rehabilitation of referral hospitals and health centers in 10 project provinces. Medical equipment, essential drugs, some referral-level in-service training, and operational support will also be provided. These investments, in concert with a revitalized primary-level in-service training program supported by the Asian Development Bank, will strengthen the service delivery capacities of the provincial system, and provide a foundation for more effective disease control activities supported by the MOH's national disease control programs for TB, malaria and HIV/AIDS, all three of which will be partially financed under the project. The project will therefore monitor the achievement of quantitative targets in health strengthening inputs and outputs and disease control outcomes and impact. These key performance indicators reflect the objectives of the project, and include the number of TB cases cured, the malaria case fatality rate, the incidence of HIV seropositive blood donors, and utilization rates for upgraded facilities.

8. **Project Description.** To achieve its objectives the project would finance the following components: (a) National Programs (US$13.0 million or 42 percent of base cost) in the areas of: (i) TB control, (ii) Malaria control, and (iii) HIV/AIDS control; (b) Health Service Strengthening (US$18.1 million or 58 percent of base cost), including provision of: (i) facility upgrading, (ii) equipment and transportation, (iii) drugs, (iv) limited in-service training and (v) operational support.

9. **Project Cost and Financing.** Total project cost is estimated at US$35.6 million equivalent with a foreign exchange component of US$18.4 million (51 percent of project cost). The proposed credit of SDR 20.6 million (US$30.4 million equivalent) would finance about 85.5 percent of project costs. The remainder would be financed by the Government's contribution of US$5.2 million. A breakdown of project costs and the financing plan are shown in Schedule A. Amounts and methods of procurement and disbursement and the disbursement schedule are shown in Schedule B. A timetable of the project's key processing steps and the status of Bank Group operations in Cambodia are shown in Schedules C and D, respectively. The Staff

Appraisal Report (SAR No. 15596-KH), dated November 15, 1996 is being distributed separately.

10. **Project Implementation.** The project would be implemented over a five year period by the Ministry of Health and its provincial health authorities. Day-to-day project coordination and management would be the responsibility of a Project Coordination Unit (PCU) under a PCU Manager reporting to the Project Director and the Minister, and of small Provincial Project Units under a Provincial Project Director in each of the 10 project provinces. Implementation of the project activities would be carried out by the institutes and departments of the MOH itself and the provincial health directorates and their staff. Management of the project and attainment of its objectives will be strengthened through the negotiation, signing and monitoring of annual Health Management Agreements. The Health Management Agreements to be signed between the MOH, Provincial Health Directors and Provincial governors for each of the 10 project provinces would establish agreed annual inputs, outputs and outcomes from the respective parties to the Agreements in support of the project activities. A Steering Committee composed of the Minister of Health, Minister of Economy and Finance, Minister of Planning, the Chairman of the Cambodia Development Council, and the Project Director would provide overall policy guidance for the project.

11. **Project Sustainability and Economic Analysis.** The incremental annual recurrent costs of the project are minor. These include maintenance and repair costs for facilities, replacement of foreign financed inputs, such as medical equipment, bednets and to a much smaller extent drugs, 80 percent of which will be financed by the Government budget during the project. These incremental recurrent costs of US$2.6 million would consume 5.2 percent of the projected health budget in the year 2001. Although of limited fiscal impact, two cost recovery options were analyzed and incorporated in the project: modest out-patient fees for health centers; and social marketing of bednets provided under the project.

12. The choice among alternative interventions followed a four step process: first, the epidemiologic profile was assessed to determine leading causes of premature mortality; second, those leading causes with clear public health characteristics (communicable diseases that individuals would not adequately control using their private resources) were selected as meriting public financing and project support (heart disease and injuries were ranked much lower, for example); third, the availability of substantial donor support was estimated so as to exclude well funded interventions (family planning and immunizations, for example); and fourth, the cost-effectiveness ratios for the remaining interventions were obtained in the secondary literature. This process led to the choice of the three national disease control programs; they are cost-effective interventions, high priorities of the Government, and they are underfinanced.

13. In regard to cost effectiveness, the treatment of TB by means of chemotherapy and hospitalization is ranked high at US$3 per Disability Adjusted Life Year (DALY) saved. Treatment of malaria, another communicable threat to public health, is also justified on cost effectiveness and public health grounds, although at higher cost (US$200 per DALY in areas of high case fatality and endemicity, as is the case in Cambodia). HIV prevention activities have been accorded the highest public health priority, especially in the early phases of the epidemic, as

in Cambodia. Thus, interventions such as blood screening for HIV, STD treatment, public information campaigns with support from a sentinel surveillance system, risk group behavior modification, and condom distribution and marketing to risk groups are highly recommended on a cost-effectiveness basis. Treatment of HIV/AIDS on the other hand is not considered highly cost-effective, thus narrowing the intervention choices to preventive measures given current medical technologies.

14. The more difficult choice of alternatives concern "least cost" issues within the broad disease control strategies. For example, distribution of insecticide-treated bednets is considered a highly promising intervention to control the disease vector, and experiments and pilots in Cambodia have shown impressive results in reducing transmission of the disease, but the least cost method of distributing bednets is still at issue. To identify least cost approaches, two studies were undertaken: the first to identify the least cost alternatives for organizing bednet distribution through the public health system and the second to assess the feasibility of social marketing of bednets through the private sector. Similarly, for TB control (food supplementation), HIV/AIDS (control of needle sharing by drug abusers) and other components, specific analysis of least cost options have been undertaken and their results incorporated in the project design.

15. **Lessons from Previous IDA Experience.** IDA project implementation experience in Cambodia is at an early stage. However, the importance of technical assistance to complement MOH capacities has been demonstrated in earlier project work. Also demonstrated was the ability of MOH staff to absorb quickly new procedures and policies, especially in the context of long-term institutional support provided by other donors such as WHO, UNICEF and the NGO Medecins Sans Frontieres in areas such as essential drug procurement and logistics and district health service reform. Thus, the project has been structured to build around emerging centers of capacity in the MOH, and will finance technical assistance in the early years of the project to fill gaps not already addressed by other donor activities.

16. **Rationale for IDA Involvement.** The project is consistent with IDA's Country Assistance Strategy discussed by the Board on June 8, 1995, and with the Country Assistance Strategy now being processed for Board consideration in the near future. It is also in line with the Government's development objectives which focus on addressing urgent near term priorities for institutional development, infrastructure rehabilitation, and restoration of basic social and economic services. These near term interventions will re-establish the foundation for investments in longer term growth based on the productive sustainable use of the country's considerable assets and endowments. With the Association in its fourth year of lending to Cambodia, the project is designed as a *transition operation* which would address several near term priorities of reconstruction and rehabilitation, while building up program capacities to exert a longer term impact on three priority public health problems.

17. Past experience in the sector was gained through the implementation of the Health Component of the Emergency Rehabilitation Project, through which equipment and essential drugs were procured and technical assistance provided. Also of value was the preparation of the health sector chapters in the ICORC donor meeting reports. The Asian Development Bank is preparing in parallel a Basic Health Services Project to strengthen provincial services in five

major provinces not covered by the proposed project. Collaboration and sharing of study results has permitted a high degree of consistency between the projects in policy, management and procurement areas.

18. **Agreed Actions.** During negotiations, a number of agreements were reached with the Government regarding project implementation and the policy framework. The most important agreements include, inter alia : (a) the Government will establish the PCU and appoint its officers as a condition of Credit effectiveness; (b) Provincial Project Units and their Directors shall be appointed for the Phase I six project provinces as a condition of Credit effectiveness; (c) no expenditures by any province for civil works or medical equipment will be made unless the MOH and the province concerned shall have entered into their respective Health Management Agreement for the first year of the Project; (d) an administrative officer and a financial officer will be appointed to the National AIDS Office, and the National AIDS Office elevated to Department status within the MOH by September 30, 1997; (e) the Government will prepare a National In-Service Training Plan and Strategy incorporating the disease control program training supported under the project, acceptable to IDA, by March 31, 1997; (f) the Government shall select health centers and referral hospitals to be upgraded under the project in accordance with criteria acceptable to IDA; and (g) the Government will provide semi-annual progress reports, a mid term evaluation report, and a final evaluative survey report and final project report.

19. **Poverty Category.** The beneficiaries of the project are overwhelmingly the rural poor, who disproportionately fall victim to the diseases targeted by the project and have less access to health services and facilities, also addressed by the project. The project is therefore eligible for the "Program of Targeted Interventions".

20. **Environmental Aspects.** The project has been ranked "C" for environmental assessment purposes. Specific provision in the project have been included to provide for the disposal of medical waste, including used syringes.

21. **Program Objective Categories.** The project will benefit women and children (women in development) and is a poverty alleviation project.

22. **Participatory Approach.** The approach to participation had four dimensions: first, surveys of health utilization, coverage, and expenditure at the household level have been built into project preparation and implementation to provide nationally representative indicators of beneficiary health status and access; second, project preparation was carried out by component and sub-component working groups composed of MOH staff, locally based donor technical assistance, and NGO representatives; third, the MOH convened special groups (donors, NGOs, MOH staff, provincial staff) to consider policy or technical issues specific to the project (an August 1995 seminar on AIDS Organization and Management Issues, a September 1995 seminar on provincial health directorate organizational options, the November 1995 Roundtable of provincial authorities and the MOH to review the draft Health Management Agreement); and fourth, the preparation effort sponsored studies of beneficiary demand for certain services, such as social marketing of bednets and hospitalization for TB chemotherapy, using focus group and other participatory methods.

23. **Project Benefits.** The performance of the project will be measured in detail in the 10 provinces in which the project will combine its health strengthening investments, its managerial improvements, and its national disease control activities. In addition, the project will measure results of the three disease control programs on a national basis, to measure the impact of indivisible national program investments. The benefits of the project, therefore, correspond to measurable indicators of impact on the three targeted disease control programs and measures of improved access to and use of basic health services.

24. For TB, the total number of treated cases over the five year period is targeted at 106,000, based on the need to reach an annual treatment target of 24,000 in the final year of the project, at which point the annual prevalent pool of cases should have begun to decrease and the incidence of new cases decline. The fatality rate of active, untreated TB cases is not known for Cambodia with precision. However, practitioners regard it, with malaria, as one of the leading causes of fatality among children and young adults. Impact on HIV incidence is difficult to predict due to the early stage of the epidemic. It is certainly probable that at a minimum, the rate of increase of seropositive blood donations will decline from its current doubling every year to far lower rates of increase, and that the same will occur in the data on key risk groups (prostitutes and soldiers), as has been the case in Thailand.

25. For malaria control, the project will intervene to treat the disease through more effective case management and to prevent infection through bednet vector control. Thus, the overall impact measure will be the prevalence of malaria at a point in time determined by means of periodic surveys of blood slide positivity in the population. The management of serious cases of malaria in hospitals can be measured through the case fatality rate, which will be reduced to less than 2 percent during the course of the project. In addition, two million people in rural areas of the 10 project provinces will benefit from increased access to new health centers and functioning referral hospitals.

26. **Risks.** There are three main project risks. First, is that the management capacities of the MOH and its provincial counterparts may have been overestimated, such that implementation of the provincial Health Management Agreements is slower than planned. Second, there may be a shortage of adequately skilled health personnel to staff and run the upgraded referral level facilities. Third, the zone of insecurity (due to the continuing insurgency) may expand rather than contract, causing the project to restrict its investments to a smaller scale than envisioned.

27. Care has been taken to minimize these risks during project preparation. In terms of management capacity, both the scale and phasing of the project have been designed to reflect the management and implementation capabilities at the provincial levels. Management capacity, measured in part by the presence of a donor-funded health advisor at the provincial level, was a key criterion in determining which provinces the project would cover and how to phase project inputs. Management training will be provided under a special contract and through a parallel, WHO-executed project.

28. As for the potential lack of adequately skilled and trained staff, the in-service training needs of the provincial and district health authorities have been assessed and an initial estimate

made of the resources committed to these programs by other donors. Sufficient resources are available to cover in-service training requirements. The Government has agreed to prepare a National In-Service Training Plan to guide the allocation of government and donor resources. The PCU will coordinate closely with the donors and NGOs involved in training, to ensure that the training needs of the Bank-financed provinces will be met. To meet one specialized requirement, surgeons and anesthetists for surgical referral facilities will also be trained under the project.

29. The only risk that could not be reduced through project preparation efforts is insecurity, a factor affecting all development investments in Cambodia. For the past year, the zone of insecurity has contracted steadily, an encouraging but not yet definitive development in the Cambodian context. The project design has taken the current security situation into account by excluding or reducing project activities in provinces where the security situation remains unstable. In addition, the civil works and equipment components will proceed in two phases, affording additional flexibility.

30. **Recommendation.** I am satisfied that the proposed Interim Fund Credit would comply with Resolution No. 184, adopted by the Board of Governors on June 26, 1996, establishing the Interim Trust Fund, and I recommend that the President approve it.

Gautam S. Kaji
Managing Director

Washington, D.C.
November 15, 1996

Attachments

Schedule A

CAMBODIA

DISEASE CONTROL AND HEALTH DEVELOPMENT PROJECT

Estimated Costs and Financing Plan
(US$ million)

	Local	Foreign	Total
Estimated Costs:			
A. National Programs			
1. TB Control	1.3	1.7	3.0
2. Malaria Control	1.2	2.3	3.5
3. HIV/AIDS Control	3.3	3.2	6.5
Subtotal	5.8	7.2	13.0
B. Health Service Strengthening			
1. Facility Upgrading	7.2	3.0	10.2
2. Equipment & Transportation	0.2	2.7	2.9
3. Essential Drugs Supply	0.1	2.1	2.2
4. In-service Training	0.2	0.0	0.2
5. MOH Strengthening	1.1	1.5	2.6
Subtotal	8.8	9.3	18.1
Total Base Cost	14.6	16.5	31.1
Physical Contingency	0.6	0.8	1.4
Price Contingency	2.0	1.1	3.1
Total Project Cost	17.2	18.4	35.6
Financing Plan:			
IDA	12.0	18.4	30.4
Government	5.2	0.0	5.2
Total	17.2	18.4	35.6

CAMBODIA

DISEASE CONTROL AND HEALTH DEVELOPMENT PROJECT

Summary of Proposed Procurement Arrangement
(US$ million)

Procurement Elements	ICB	NCB	Other[1]	NA[2]	Total[3]
Civil Works		7.9	4.1	0.1	12.1
		(7.1)	(3.7)		(10.8)
Goods					
a. Equipment & Vehicles	5.3	1.6	0.2	0.5	7.6
	(5.3)	(1.6)	(0.2)		(7.1)
b. Drugs & Pharmaceuticals	2.7				2.7
	(2.7)				(2.7)
Training, Technical Assistance & Studies					
a. Training			2.8	0.2	3.0
			(2.7)		(2.7)
b. Technical Assistance			2.8		2.8
			(2.8)		(2.8)
c. Studies			2.5		2.5
			(2.5)		(2.5)
Grants			0.7		0.7
			(0.7)		(0.7)
Operating Cost & Supplies			1.1	1.1	2.2
			(1.0)		(1.0)
Provincial Supervision Cost			0.2		0.2
			(0.1)		(0.1)
Maintenance				1.3	1.3
Staff remuneration				0.5	0.5
TOTAL	7.9	9.4	14.4	3.8	35.6
	(7.9)	(8.7)	(13.8)	(0.0)	(30.4)

1 Includes shopping and consultancy services.

2 Not applicable as these amounts are not financed by IDA.

3 Figures in parentheses are the amounts financed by IDA, totals may not add up exactly due to rounding.

CAMBODIA

DISEASE CONTROL AND HEALTH DEVELOPMENT PROJECT

Disbursement Categories

	Disbursement Category	ITF Allocation (SDR)	% of Expenditure to be Financed by the Credit
(1)	Civil Works	6,854,000	90%
(2)	Goods (except medical equipment)	4,472,000	100% of foreign expenditures, 100% of local expenditures (ex-factory cost) and 85% of local expenditures for other items procured locally.
(3)	Medical equipment	1,697,000	100% of foreign expenditures, 100% of local expenditures (ex-factory cost) and 85% of local expenditures for other items procured locally.
(4)	Consultants' services, training and studies	4,948,000	100%
(5)	Operating costs	543,000	85%
(6)	Provincial supervision costs	68,000	85%
(7)	Grants	475,000	100% of Grant amount.
(8)	Refunding of the Project Preparation Advance	1,000,000	Amount due pursuant to Section 2.02 (c) of this Agreement
(9)	Unallocated	543,000	
	Total	**20,600,000**	

Estimated Disbursement Schedule
(in SDRs)

Bank Fiscal Year	1997	1998	1999	2000	2001	2002
Annual	1.22	3.32	4.13	4.13	4.9	2.9
Cumulative	1.22	4.54	8.67	12.80	17.7	20.6

Schedule C

CAMBODIA

DISEASE CONTROL AND HEALTH DEVELOPMENT PROJECT

Timetable of Key Project Processing Events

(a)	Time taken to prepare the project:	15 months (December 1994 - March 1996)
(b)	Prepared by:	Government with assistance from IDA and consultants financed by a project preparation grant from the Japan Policy and Human Resource Development Fund
(c)	First IDA mission:	December 1994 (Identification)
(d)	Appraisal mission departure:	February, 1996
(e)	Negotiations:	March, 1996
(f)	Planned date of effectiveness:	January, 1997
(g)	List of relevant PCRs and PPARs:	None

This report is based on findings of an appraisal mission that visited Cambodia in February-March 1996. The mission comprised Christopher Chamberlin (Task Manager), Stanley Scheyer (Sr. Public Health Specialist); Rama Lakshminarayanan (Health Specialist), Mostafa El-Erian (Legal), Ji An Zhou (Human Resources Specialist) and consultants Michael Porter (HIV/AIDS specialist), Jim Herm (Management Specialist) and Cyril Bowman (Architect). Sarah Foster and consultants Chris Braden, Clydette Powell, Jenny Hill and Michael Cheng contributed to the preparation of the project in earlier phases. Peer reviewers were Willy de Geyndt (ASTHR), Bernhard Liese (HSDDR) and Maureen Lewis (LA2HR). The report was cleared by Sven Burmester (Chief, EA1HR) and J. Khalilzadeh-Shirazi (Director, EA1).

Schedule D

STATUS OF BANK GROUP OPERATIONS IN CAMBODIA

A. STATEMENT OF BANK LOANS AND IDA CREDITS /a

(As of September, 30, 1996)

Loan or Credit Number	Fiscal Year	Borrower	Purpose	Amount (US$ million)/b (less cancellations) IDA	Undisbursed
2550	1994	Cambodia	Emergency Rehabilitation	62.70	0.91
2664	1995	Cambodia	Technical Assistance	17.00	13.01
2739	1995	Cambodia	Social Fund	20.00	16.80
2781	1996	Cambodia	Economic Rehabilitation Credit	40.00	2.74
2782	1996	Cambodia	Phnom Pehn Power Rehabilitation	40.00	35.71
	Total			179.70	69.17
	of which has been repaid			0.00	
	Total Now Held By Bank and IDA			179.70	
	Amount sold	0.00			
	of which repaid	0.00			
	Total Undisbursed			69.17	69.17

/a The status of the projects listed in Part A is described in a separate report on all IBRD/IDA-financed projects in execution, which is updated twice yearly and circulated to the Executive Directors on April 30 and October 31.

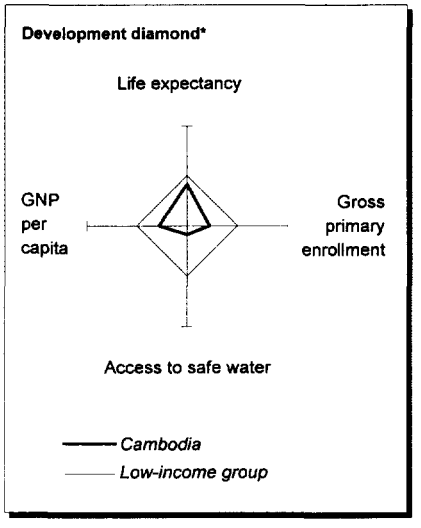
/b Principal amounts in US$ equivalent at date of negotiations, and undisbursed amounts in equivalent are valued at exchange rate applicable on the date of this statement.

B. STATEMENT OF IFC INVESTMENTS

None

Cambodia at a glance

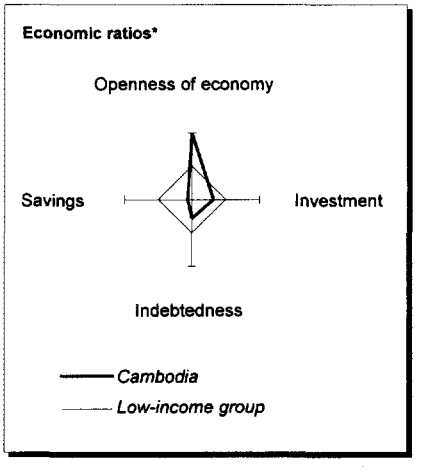
POVERTY and SOCIAL	Cambodia	East Asia	Low-income
Population mid-1995 *(millions)*	10.2	1,709	3,188
GNP per capita 1995 *(US$)*	260	830	460
GNP 1995 *(billions US$)*	2.7	1,418	1,466
Average annual growth, 1990-95			
Population *(%)*	2.9	1.3	1.8
Labor force *(%)*	2.6	1.4	1.9
Most recent estimate *(latest year available since 1989)*			
Poverty: headcount index *(% of population)*	..	..	..
Urban population *(% of total population)*	21	31	29
Life expectancy at birth *(years)*	53	68	63
Infant mortality *(per 1,000 live births)*	108	36	58
Child malnutrition *(% of children under 5)*	..	17	38
Access to safe water *(% of population)*	13	77	75
Illiteracy *(% of population age 15+)*	35	17	34
Gross primary enrollment *(% of school-age population)*	47	117	105
Male	48	120	112
Female	46	116	98



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

	1975	1985	1994	1995
GDP *(billions US$)*	..	..	2.4	2.7
Gross domestic investment/GDP	..	..	19.5	19.2
Exports of goods and non-factor services/GDP	..	..	21.5	32.5
Gross domestic savings/GDP	..	..	5.1	4.0
Gross national savings/GDP	..	..	5.8	4.4
Current account balance/GDP	..	..	-13.9	-16.2
Interest payments/GDP	..	..	0.0	0.0
Total debt/GDP	..	..	84.8	71.0
Total debt service/exports	..	..	0.4	3.1
Present value of debt/GDP	..	..	19.8	..
Present value of debt/exports	..	..	91.5	..

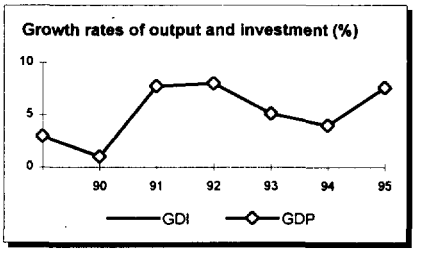
	1975-84	1985-95	1994	1995	1996-04
(average annual growth)					
GDP	..	..	4.0	7.6	6.9
GNP per capita	..	..	1.5	4.6	3.9
Exports of goods and nfs	..	..	..	..	..



STRUCTURE of the ECONOMY

	1975	1985	1994	1995
(% of GDP)				
Agriculture	..	..	45.2	44.6
Industry	..	..	18.3	18.7
Manufacturing	..	..	7.3	7.4
Services	..	..	36.5	36.7
Private consumption	..	..	83.7	86.3
General government consumption	..	..	11.1	9.7
Imports of goods and non-factor services	..	..	35.8	47.7

	1975-84	1985-95	1994	1995
(average annual growth)				
Agriculture	..	..	0.0	6.9
Industry	..	..	7.7	9.4
Manufacturing	..	..	7.8	9.0
Services	..	..	7.4	7.5
Private consumption	..	..	..	..
General government consumption	..	..	..	..
Gross domestic investment	..	..	..	..
Imports of goods and non-factor services	..	..	..	..
Gross national product	..	..	4.0	7.6

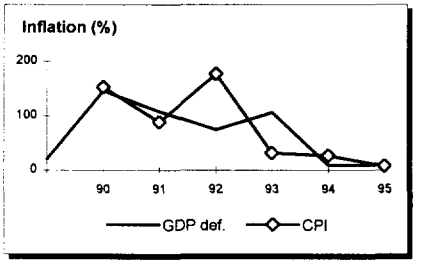


Note: 1995 data are preliminary estimates.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

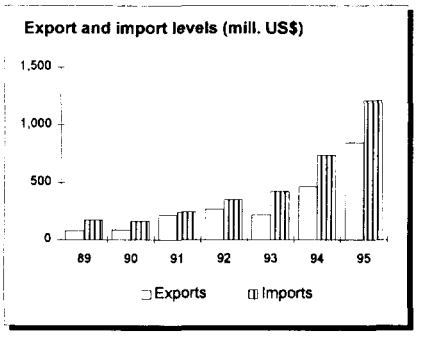
PRICES and GOVERNMENT FINANCE

	1975	1985	1994	1995
Domestic prices				
(% change)				
Consumer prices	..	..	26.1	7.8
Implicit GDP deflator	..	..	8.9	9.1
Government finance				
(% of GDP)				
Current revenue	..	..	9.6	8.9
Current budget balance	..	..	-1.5	-1.3
Overall surplus/deficit	..	..	-7.0	-8.0



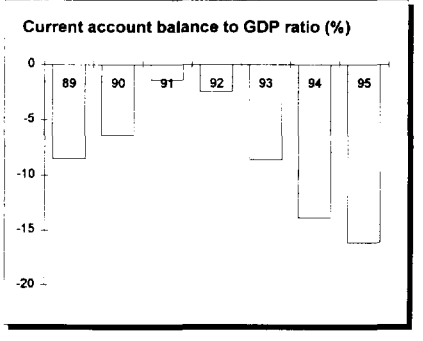
TRADE

	1975	1985	1994	1995
(millions US$)				
Total exports (fob) a/	..	..	463	847
Rubber	..	..	26	38
Logs and sawn timbers	..	..	198	184
Manufactures	..	..	11	41
Total imports (cif)	..	..	737	1,213
Food	..	..	..	..
Fuel and energy	..	..	..	..
Capital goods	..	..	..	..
Export price index *(1987=100)*	..	..	..	..
Import price index *(1987=100)*	..	..	..	..
Terms of trade *(1987=100)*	..	..	..	..



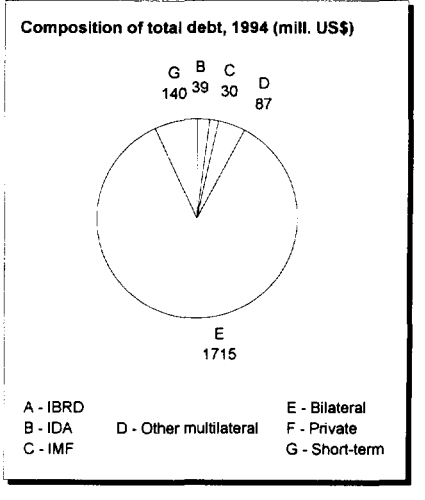
BALANCE of PAYMENTS

	1975	1985	1994	1995
(millions US$)				
Exports of goods and non-factor services	..	..	518	949
Imports of goods and non-factor services	..	..	864	1,394
Resource balance	..	..	-346	-445
Net factor income	..	..	1	-9
Net current transfers	..	..	15	20
Current account balance, before official transfers	..	..	-330	-434
Financing items (net)	..	..	300	348
Changes in net reserves	..	..	30	86
Memo:				
Reserves including gold *(mill. US$)*	..	..	100	186
Conversion rate *(local/US$)*	..	..	2,543.0	2,463.0



EXTERNAL DEBT and RESOURCE FLOWS

	1975	1985	1994	1995
(millions US$)				
Total debt outstanding and disbursed	1	7	2,011	1,900
IBRD	0	0	0	0
IDA	0	0	39	65
Total debt service	0	0	9	25
IBRD	0	0	0	0
IDA	0	0	0	0
Composition of net resource flows				
Official grants	44	6	235	270
Official creditors	0	0	54	82
Private creditors	0	0	0	0
Foreign direct investment	0	0	10	100
Portfolio equity	0	0	0	0
World Bank program				
Commitments	0	0	17	100
Disbursements	0	0	29	25
Principal repayments	0	0	0	0
Net flows	0	0	29	25
Interest payments	0	0	0	0
Net transfers	0	0	28	24



a. Total exports include re-exports.

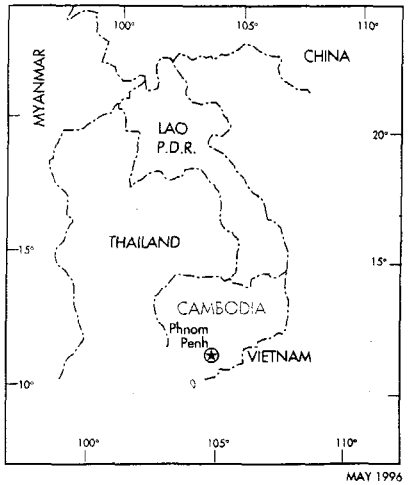
IBRD 27986

CAMBODIA

DISEASE CONTROL AND HEALTH DEVELOPMENT PROJECT

- HEALTH STRENGTHENING COMPONENT
- ADB ASSISTED PROVINCES UNDER THE BASIC HEALTH SERVICES PROJECT
- SELECTED CITIES
- PROVINCE CAPITALS
- NATIONAL CAPITAL
- RUINS
- ELEVATIONS >500 FEET
- MAIN ROADS
- RAILROADS
- RIVERS
- PROVINCE BOUNDARIES
- INTERNATIONAL BOUNDARIES

The boundaries, colors, denominations and any other information shown on this map do not imply, on the part of The World Bank Group, any judgment on the legal status of any territory, or any endorsement or acceptance of such boundaries.



MAY 1996

IMAGING

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