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UNCLASSIFIED

UNITED STATES AGENCY
FOR
INTERNATIONAL DEVELOPMENT
(USAID)

CAMBODIA FAMILY HEALTH AND
BIRTH SPACING PROJECT
(442-0115)

AUTHORIZED: MARCH 21, 1995
LOP FUNDING: \$20,000,000

ACTION MEMORANDUM FOR THE ACTING USAID REPRESENTATIVE TO CAMBODIA

Date : March 21, 1995

From : Ned Greeley, Director
Projects Office



Subject: Cambodia Family Health and Birth Spacing Project (442-0115); Project Authorization

I. Problem: Your signature is required to authorize the Cambodia Family Health and Birth Spacing Project (442-0115) and approve the Project Paper.

II. Authority: Pursuant to USAID Interim Redelelegation of Authority dated November 9, 1994, you have been granted authority to authorize the subject Project.

III. Background: The Cambodia Family Health and Birth Spacing (FHABS) Project is a five-year, \$20 million investment in reproductive and children's health which capitalizes on earlier investments made in this sector through the PVO Co-financing Project (442-0112). The purpose of FHABS is to increase access to and use of quality reproductive and children's health services, particularly birth spacing.

The Project is consistent with the recently-approved Cambodia Country Strategy and supports the Strategic Objective of improving family health as an integral component of meeting basic human needs.

IV. Discussion: Consistent with USAID's Mission Order on Project Authorization, the Project Paper has been reviewed by the Regional Legal Advisor (Manila), Regional Controller (Bangkok) and Regional Contracts Officer (Bangkok), in addition to appropriate Mission staff. The Project is recommended for immediate authorization.

V. Issues: USAID/W comments on the New Activity Description (NAD) have been addressed as follows:

A. *Simplicity and Flexibility* - Simplicity in the FHABS design is evidenced in: (1) the combination of the training organization with the subgrant program, reducing the number of direct procurement actions and minimizing USAID's direct management burden; (2) relying on already successful NGO programs country wide; (3) phasing the approach through the umbrella organization. Although FHABS does not preclude additional activities, they must conform to the simplified structure of the Project.

Flexibility to respond to changing conditions is incorporated as follows: (1) relying on grants rather than contracts, in recognition of the high motivation of grantees to implement such programs; (2) utilization of a network of NGOs in strengthening MOH staff capacity at the local levels through joint participation in training and service delivery activities; and (3) retaining direct USAID control over contraceptives in order to assess a variety of distribution channels, e.g. through the Umbrella Organization, CMS, private sector, etc.

B. *The Design Process* - This Project Paper was prepared under the interim design guidance. The Project design incorporated technical expertise from the Regional Technical Support Project (Development Alternatives, Inc.), the Global Bureau Office of Population, the Regional Support Mission (PDO services), as well as independent consultants (social soundness analysis). Annexes were prepared as analyses in preparation for the Project and do not necessarily reflect the exact PP targets.

C. *Regional Asian Support* - The NAD recommended Cambodia take advantage of regional experience, particularly for training. Participant training is not included in the Project due to the need for simplicity. This activity may be reconsidered at a later date.

D. *Placement of a FP Advisor in the MOH* - The NAD recommended USAID explore the placement of a Family Planning Advisor in the MOH as an interim strategy. Through an existing grant agreement with PACT/JSI under the PVO Co-fi, USAID has funded such an advisor.

VI. Project Management - The designated Project Officer for FHABS is Ned Greeley, Director of the Projects Office.

VII. Congressional Notification - Funds may not be obligated until the Congressional Notification clears.

VIII. Initial Environmental Examination (IEE) - The IEE for the Project was granted a categorical exclusion and is attached as Annex D.

IX. Host Country Contribution - Section 110(a) of the Foreign Assistance Act describes the 25% host country contribution required to approve projects. A waiver of Section 110(a) for this Project is being prepared for approval by the AA/ANE. Cambodia is a Relatively Least Developed Country (RLDC) and is eligible for a waiver. The RCG cannot contribute the required 25% as the health sector is seriously under-resourced. The RCG has tremendous, competing demands for its modest budget. Thus, it is recommended that the 25% contribution be waived. As this waiver authority may not be redelegated to the field, funds may not be obligated until the waiver has been signed.

X. Waivers: As FHABS represents a phased approach to implementation, no waivers are foreseen at this time.

XI. Recommendation: That you sign the attached PP facesheet and Project Authorization.

Draft: DRobertson, RSM/EA
Clear: DD'Antonio, PROG (subs)
MHenning, PD (subs)
JStanford, RSM/EA (draft)
MWard, OLA/Manila (draft)

AHuvos, PVO
J. ...mono, PVO (subs)
T...ephens, RSM/EA (draft)

APPENDIX 3A, Attachment 1
Chapter 3, Handbook 3 (TM 3:43)

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE: **A** (A = Add, C = Change, D = Delete) Amendment Number: _____ DOCUMENT CODE: **3**

COUNTRY/ENTITY: **CAMBODIA** 3. PROJECT NUMBER: **442-0115**

4. BUREAU/OFFICE: **ANE** 5. PROJECT TITLE (maximum 40 characters): **Family Health and Birth Spacing**

6. PROJECT ASSISTANCE COMPLETION DATE (FACD): MM DD YY **01 09 00** 7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4):
A. Initial FY: **95** B. Quarter: **3** C. Final FY: **98**

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FISCAL FY 95			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	7,500		7,500	7,500		7,500
(Grant)	(7,500)	()	(7,500)	(20,000)	()	(20,000)
(Loan)	()	()	()	()	()	()
Other L						
U.S. 2						
Host Country						
Other Donor(s)						
TOTALS	7,500		7,500	20,000		20,000

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) POP						5,000		10,000	
(2) ESE						2,500		5,000	
(3) DA								5,000	
(4)									
TOTALS				0		7,500		20,000	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): _____ 11. SECONDARY PURPOSE CODE: _____

12. SPECIAL CONCERNS CODES (maximum 7 codes of 6 positions each):
A. Code: _____ B. Amount: _____

13. PROJECT PURPOSE (maximum 480 characters):
to increase access to and use of quality reproductive and children's health services

14. SCHEDULED EVALUATIONS: Interim MM YY: **XX 98** Final MM YY: **01 00**

15. SOURCE/ORIGIN OF GOODS AND SERVICES: 000 941 Local Other (Specify) _____

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of _____ page PP Amendment.)

17. APPROVED BY: **George Laudato**, Acting AID Representative, OAR/Cambodia. Date Signed: **03 21 95**

18. DATE DOCUMENT RECEIVED IN AID/W. OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY: _____

PROJECT AUTHORIZATION

Country: Cambodia
Project: Family Health and Birth Spacing
Project Number: 442-0115

1. Pursuant to the Foreign Assistance Act of 1961, as amended, and to the Interim Redlegation of Project Authorization Authority dated November 9, 1994, I hereby authorize the Family Health and Birth Spacing Project (the "Project") involving planned Life-of-Project obligations of not to exceed \$20,000,000 (Twenty Million United States Dollars) over a five-year period from the date of initial obligation of funds, subject to the availability of funds in accordance with the U.S.A.I.D. OYB/allotment process.

2. The Project will increase access to and use of quality reproductive and children's health services, in particular birth spacing.

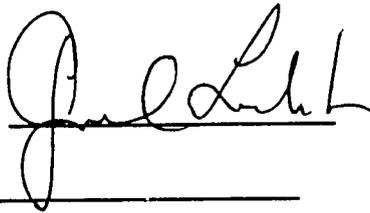
3. The assistance agreements necessary to implement the Project shall be subject to the terms and conditions stated herein and such other terms and conditions that U.S.A.I.D. may deem appropriate.

4. Source and Origin of Commodities; Nationality of Services. Except as U.S.A.I.D. may otherwise agree in writing, commodities and services financed by U.S.A.I.D. under the Project shall have their source and origin in the United States, and ocean shipping financed by U.S.A.I.D. under the Project shall only be on flag vessels of the United States.

Procurement in Cambodia which meets the criteria in U.S.A.I.D. Handbook 1, Supplement B, Chapter 18, Section 18A.1.c. is authorized. All other local procurement must be covered by a source, origin and/or nationality waiver in accordance with Handbook 1, Supplement B, Chapter 5.

5. Host Country Contribution. No funds will be obligated for this Project until U.S.A.I.D. in Washington has either approved a waiver of FAA Section 110 pursuant to U.S.A.I.D. Handbook 3, or approved the use of the notwithstanding authority in Section 547 of the FY 1995 Appropriations Act to obligate funds notwithstanding the requirements of FAA Section 110.

6. No assistance for Khmer Rouge. No funds made available for this Project may be available, directly or indirectly, for the Khmer Rouge.

Approved: 

Disapproved: _____

Date: 3-21-95

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ACRONYMS

ADB	ASIAN DEVELOPMENT BANK
AIDS	ACQUIRED IMMUNODEFICIENCY SYNDROME
CMS	CENTRAL MEDICAL STORES
CPP	CAMBODIAN PEOPLES PARTY
CYP	COUPLE YEARS OF PROTECTION
DA	DEVELOPMENT ASSISTANCE
FHABS	FAMILY HEALTH AND BIRTH SPACING
FPIA	FAMILY PLANNING INTERNATIONAL ASSISTANCE
FUNCINPEC	UNITED FRONT FOR AN INDEPENDENT COOPERATIVE AND PEACEFUL CAMBODIA
G/R&D/POP	G L O B A L B U R E A U / R E S E A R C H A N D DEVELOPMENT/OFFICE OF POPULATION
HPN	HEALTH, POPULATION & NUTRITION
IDI	INTERNATIONAL DEVELOPMENT INTERN
IEC	INFORMATION, EDUCATION AND COMMUNICATION
IUD	INTRA-UTERINE DEVICE
JICA	JAPANESE INTERNATIONAL COOPERATION AGENCY
KAP	KNOWLEDGE-ATTITUDE-PRACTICE
MCH	MATERNAL AND CHILD HEALTH
MoEYS	MINISTRY OF EDUCATION, YOUTH AND SPORTS
MOH	MINISTRY OF HEALTH
MSF	MEDECINS SANS FRONTIERES
NGO	NON-GOVERNMENTAL ORGANIZATION
O/KA	OFFICE OF KHMER AFFAIRS
O/RP	OFFICE OF REGIONAL PROCUREMENT
OYB	OBLIGATING YEAR BUDGET
PMI	MATERNAL CHILD HEALTH INSTITUTE
PMT	PROJECT MANAGEMENT TEAM
POP	POPULATION
PSI	POPULATION SERVICES INTERNATIONAL
PVO	PRIVATE AND VOLUNTARY ORGANIZATION
RCG	ROYAL CAMBODIAN GOVERNMENT
RLA	REGIONAL LEGAL ADVISOR
RSM/EA	REGIONAL SUPPORT MISSION FOR EAST ASIA
SDP	SERVICE DELIVERY POINT
STD	SEXUALLY TRANSMITTED DISEASE
TBA	TRADITIONAL BIRTH ATTENDANT
UNFPA	UNITED NATIONS FUND FOR POPULATION ACTIVITIES
UNICEF	UNITED NATIONS INTERNATIONAL CHILDREN'S EDUCATION FUND
UNTAC	UNITED NATIONS TRANSITIONAL AUTHORITY FOR CAMBODIA
USAID	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

EXECUTIVE SUMMARY

As Cambodia continues its steady progress toward reconstruction of the economy after two decades of civil war, there is a heightened sense of urgency to accelerate the process of rural development in order to improve the political, economic and social well-being of Cambodians throughout the country. This is particularly crucial to help bring an end to the brutal influence of the Khmer Rouge in the countryside. Toward this end, donors have stepped up their assistance programs to more directly support the Government and target vulnerable populations, such as women and children. By any measure, e.g. health, education, economics, these are truly the most disadvantaged Cambodians.

Improving overall family health as an integral component of meeting basic human needs is one of three strategic objectives for USAID in Cambodia. USAID supports the Royal Cambodian Government's (RCG) objectives to decrease child mortality and maternal mortality by 20% within five years and increase contraceptive prevalence from 5% to 30%. All donors are making important contributions in the health sector, especially training of health care workers.

Toward this end, USAID/Cambodia has already made significant contributions in restoring health care on a clinic-by-clinic basis providing desperately-needed services and increasing the capacity of health care givers utilizing a broad-based NGO approach. Over \$10 million has been committed throughout the country for NGO programs strengthening the District and Khum (village) health care structure, emphasizing reproductive and children's health care. Among the lessons learned resulting from these programs is a need for: immediate strengthening of the skills of health care practitioners at the district and khum level; greater attention to all aspects of birth spacing; substantial increase in the supply of contraceptives; and improved contraceptive method mix.

The Cambodia Family Health and Birth Spacing Project (442-0115) is a first step toward providing increased coordination and leadership of USAID activities in the health sector and capitalizes on the experiences of NGOs already receiving USAID assistance for their reproductive and children's health programs. *FHABS increases access to and use of quality reproductive and children's health service, in particularly, modern birth spacing practices.* The Project (FHABS) targets resources directly for relevant in-service training for both government and private sector health care givers, and expands NGO assistance directly to Service Delivery Points (SDPs) at the district and khum level. Finally, the Project provides for a substantial supply of contraceptives to meet the widely-acknowledge unmet demand with a range of modern methods.

FHABS will increase the choice of contraceptive methods available at all Project-assisted SDPs and ensure that there are at least forty trained and equipped SDPs offering quality reproductive and children's health services at the district and/or village levels. Finally, FHABS will directly supply the contraceptive needs of at least 150,000 acceptors and help to ensure a continuing

supply beyond the Project's completion date.

The Project will be implemented through a single competitively-awarded cooperative agreement to a US organization which: (1) provides reproductive and children's health in-service training to NGO and government health care givers; and (2) administers and monitors a substantial subgrant program to support NGO reproductive and children's health programs throughout the country at the district and village level. USAID strengthens the role of the Ministry of Health (MOH) in project implementation by providing opportunities to participate in selection of the US organizations receiving USAID assistance and in reviewing work plans and progress reports as a team. Total funding authorized under FHABS is \$20 million over a life-of-project (LOP) period of five years.

Prepared under USAID's Interim Design Guidance, the PP document focuses on the *Results Expected* over the life of FHABS and the tools required to monitor progress towards achieving those results. Results are presented as percentage changes from baseline, due to the paucity of reliable demographic and health data in reproductive health. FHABS provides funds for a full Demographic Health Survey (DHS) in year four of the Project -- this follows a baseline study being prepared presently with assistance from another lead donor. In addition, FHABS provides for CMS monitoring of contraceptive distribution and technical evaluation of health care training. In the beginning of Year five a structured evaluation/redesign exercise will take place. FHABS is an initial step, within an Agency undergoing structural re-engineering, toward a government-to-government partnership that provides broad health care on a sustainable basis.

FHABS is designed for simplicity in implementation as management resources are limited. The Project elects to begin selected interventions in training and contraceptive supply, where needs and probable impact are greatest. Moreover, due to the uncertainty of conditions in Cambodia and the need for USAID to be able to be responsive as new opportunities arise, project implementation emphasizes flexibility.

I. STATEMENT OF THE PROBLEM

A. Problem/Opportunity

1. Background

Cambodia is among the poorest nations in the world, measured by any standard¹. While all of the countries of Southeast Asia have seen improvements in social welfare over the last three decades, Cambodia has not. Per capita income, at \$180 per year, places Cambodia among the very poorest in the world. Literacy rates are estimated at less than 50% for adult males and less than 25% for adult females. Fertility rates at 4.5 are among the highest in the world. Cambodia stands at 136 out of 160 on the 1992 UNDP Human Development Index.

Health statistics in Cambodia are among the worst in the world. Life expectancy is less than 50 years. The infant mortality rate is 117 per thousand births and the child mortality rate at 185. Leading causes of mortality and morbidity in Cambodia are malaria, TB, diarrheal disease, childbirth, side effects of abortions, accidents, dengue hemorrhagic fever, measles, tetanus, polio, acute respiratory infections and malnutrition. Only 12 percent of the rural population has access to safe water. Half of the population does not have access to basic health care and three quarters of age one infants are not immunized. There are nearly 12,800 people per physician nationwide, and nearly 25,000 people per physician in the provinces.

Access to adequate health care is low, although Cambodians travel great distances and pay high prices in the private sector for what services they do get. The primary health care system is non-functional or in disarray in many provinces. While donor activities through NGOs have filled a critical service delivery gap, the abundance of individual programs has resulted in an uncoordinated patchwork of health activities. There is a need for the RCG to establish a coordinating function over these activities so that they address national priorities and meet minimum standards.

Although the recent flow of donor assistance in the health sector has achieved significant progress in the last two years, there remain daunting long-term problems in the sector. Public health services remain unavailable or ineffective in much of the country. Resources for public health have declined steadily since the beginning of the decade, maintaining an already inadequate system at an extremely low degree of quality and service effectiveness. Whereas public health experts estimate the cost of delivering a package of basic health services at \$12 per person, public sector health expenditures amounted to less than US \$1 per capita in 1993. Low salaries, coupled with systematic elimination of health professionals during the Khmer Rouge period has resulted in extremely low skills and motivation of health care providers. Consequently, training programs for health workers, at all levels in the health care system, is

¹ Measurement in the Cambodian context is not in any way precise. As described later in Section V, all estimates of parameters are at best "guesstimates" and do not reflect scientifically-derived sampling and estimation procedures. The estimation errors of these parameters are large and cannot be bounded by usual statistical principles.

one of the Ministry's highest priorities.

The size of Cambodia's vulnerable population has increased and its access to development opportunities has diminished through the civil strife of the last 30 years. Traditional family support networks have been decimated by years of war and social engineering. UNICEF estimates that 60 percent of Cambodia's farming households are headed by single women and UNFPA has estimated that one third of all households are headed by women whose spouses were lost to war, famine and disease. The population pyramid shows a disproportionate number of young children.

All reports indicate there is a large unmet demand for contraception. Maternal death rates are among the highest in the world, estimated at between 1 and 2 percent of deliveries, with induced abortions by village midwives being a leading cause of maternal death. Among the 91% of women in the southeastern province of Svay Rieng who wanted birth spacing in 1993, abortion was the only method known to 60% of them. Over 85% of women in Kandal Stung district interviewed by World Vision in 1993 wanted no more children during the next two years. Although the RCG has stated its support for making modern contraception universally available, it urgently needs assistance in implementing a viable program which will provide national coverage and make efficient use of RCG, donor and community resources.

2. USAID/Cambodia Country Development Strategy

As Cambodia has developed its national structure, USAID/Cambodia's program has evolved from a rapid response program, addressing relief and rehabilitation and supporting the peace process, toward a more traditional bilateral program addressing rehabilitation and growth. USAID reflects this transition in its recently-approved Country Strategy and its choice of new projects.

The goal of the overall USAID program is *to support the nation building effort which is being undertaken by the Cambodian people*. The current strategy covers the next three years recognizing that significant shifts in the country context may require shifts in program priorities.

USAID/Cambodia's strategy is built on three objectives:

- * strengthening pluralism and governance
- * supporting broad-based economic growth
- * meeting basic human needs

The strategy takes into account USAID/Cambodia's assessment of Cambodian needs and constraints, the RCG's recently formulated program to rehabilitate and develop Cambodia, other donor assessments and intentions, lessons learned from neighboring countries which have realized significant growth with equity, and USAID's comparative advantage for delivering programs.

Three tangible outcomes are expected by the end of the strategy period in the health sector: key providers of social services (civil servants) will receive basic training to improve skills and knowledge; contraceptive prevalence and health status will improve significantly; and basic health services, such as birth spacing, health education, prosthetics and care for displaced children and orphans will be delivered more effectively.

3. Role of MCH in USAID/Cambodia Program

Beginning in 1991, USAID/Cambodia began providing support for relief and rehabilitation work implemented by PVCs, recently incorporated in the Cambodia PVO Co-financing Project (442-0112). This project funds grants for activities aimed at achieving visible, high direct impact on beneficiaries primarily living in rural areas. USAID/Cambodia's intent is to promote sustainable approaches to service delivery consistent with USAID/Cambodia's strategic directions and to promote participation of groups and individuals throughout Cambodia. Most of the NGO programs have as one of a set of objectives improving the health and welfare of the populations they serve. Typically these are accomplished through a set of mutually reinforcing community-based activities.

NGOs have been encouraged to lend support to the emerging national social service delivery system, taking into account geographic, sectoral and gender aspects of coverage. NGOs not only provide effective services in a single target area, but are also encouraged to initiate training programs and identify technologies which can be replicated through NGOs, government, and private sector channels. Much of the training builds local capacity in sectors served by the NGO community and promotes expansion of successful activities beyond the realm of specific NGOs. High priority is given to addressing cost-recovery and sustainability issues so that NGO-administered activities will continue after USAID/Cambodia funding is no longer available and/or is shifted to other priorities over time.

A description of the activities of USAID-assisted NGOs can be found in USAID's "Briefing Book and Program Description." USAID supports MCH training and service delivery programs, such as EPI and Dengue Fever programs (with UN organizations) and a variety of small-scale, pilot MCH and reproductive health programs throughout Cambodia. The following comprise the original NGOs receiving USAID funding for programs that include reproductive and children's health activities:

- American Red Cross
- American Refugee Committee
- CARE
- PACT
- (subgrant: Helen Keller International)
- (subgrant: Healthnet)
- International Rescue Commission
- Medecins Sans Frontieres
- World Concern

World Education
World Relief
World Vision

Through several years of NGO program implementation, USAID has determined this approach to be an effective way of addressing family health issues. The Mission has learned from its successes and used feedback from NGOs in designing this Project.

In 1993, USAID further strengthened its support for birth spacing by signing grant agreements with the Family Planning International of America (FPIA) and Population Services International (PSI) to begin specific birth spacing programs in the public and private sector. In addition, USAID also agreed to support a full-time advisor through PACT/JSI whose responsibilities include coordination of information relevant to USAID-funded birth spacing programs among other donors and Ministry of Health (MOH) counterparts. The acceptance and enthusiasm for these early programs led to the development of the FHABS Project.

The FHABS Project incorporates the experience of these organizations, provides a mechanism for USAID to coordinate more closely with the Ministry, brings additional technical expertise to bear in the area of reproductive and children's health training, and provides greater leadership in the sector.

4. Royal Cambodian Government Development Objectives

The RCG places a high priority on providing adequate health care to Cambodian citizens, and has solicited broad-based donor support to meet the overwhelming needs. Following two decades of civil war and genocide, public statements of the government contain a pro-natalist policy intended to rebuild Cambodia's decimated population. However, although the government favors a growing population, it recognizes that the unusually high rates of maternal and infant mortality are exacerbated by uncontrolled fertility and the widespread practice of abortions. As a result, the government has shifted its policy to support birth spacing to improve the health of mothers and children. The government does not yet support a policy of birth spacing for demographic reasons.

The MOH, through the National Maternal and Child Health Center (PMI), issued its National Health Plan in 1994. According to the Plan, the Ministry's "Vision" is:

to improve the health of all mothers, children (to 15 years) and future mothers, by enhancing health promotion; by prevention and treatment of maternal, reproductive and childhood diseases in coordination with other sectors of the government and health services; and especially by educating the people in healthy lifestyles.

The primary objectives of the Plan are:

1. to reduce the mortality rates for children under 5 years in all provinces by 20% by

the end of 1996.

2. to increase the average length of time between birth and conception to at least 2 years for 30% of childbearing women by the end of 1996.

3. to reduce the maternal mortality rate by 20% across the country by the end of 1996.

4. to promote mothers' awareness of healthy lifestyle and the importance of disease prevention; and to develop their capacity to recognize and act on the signs of dangerous and priority diseases.

Provision of services through the national health system will focus initial attention at the district level and below. The District is a well-defined geographical and administrative area with a District headquarters office, usually in the principal town. District population varies widely from 3,000 to 150,000 people. For health management purposes, the MOH has divided the districts into categories based on population density and distance to public health care facilities, taking into consideration special circumstances such as geographic isolation. Below the district is the "khum," or subdistrict, and above it is the province.

The Ministry advocates vertical programs, integrated into a single service at Service Delivery Points (SDPs). The MOH has a clear mandate to promote, implement and support primary health care in the village as a District-based operation. Primary health care services are provided at SDPs at the district and khum level. The MOH, in cooperation with other donors, is in the process of developing, testing and standardizing training curricula for each level of health care worker.

The MOH strategy is to provide services from the periphery to the center, emphasizing that services are people-centered rather than health service-centered. In order to accomplish this, the organization of the district health service is being restructured to support primary health care in the villages, emphasizing flexibility and adaptability to local conditions. Alternative methods for financing district health services will be considered and tried out in full consultation with local communities and health staff. Examples might include user fees for services, community funding for drugs and supplies, and insurance schemes.

As described in the Technical Analysis, private health services are available in district towns and large commune centers. Almost all health personnel engage in private practice, which includes home visits and midwifery services. The MOH encourages a choice between private and public health services, but cautions that one must not be provided at the expense of the other, and quality must be maintained.

B. Project Goal and Purpose

1. Goal/Strategic Objective

The goal (or Strategic Objective) addressed by FHABS, as stated in the Country Strategy is *to improve family health as an integral component of meeting basic human needs*. FHABS' contribution to this SO is to assist in decreasing infant and maternal mortality as well as increasing contraceptive prevalence in Cambodia by the year 2000. Given the paucity of reliable data, FHABS indicators will be described in terms of percentage change from baseline to be refined as improved baseline information becomes available.

By the year 2000, then, it is expected that there will be a:

- * *15% decrease in the child mortality rate (under 5 years) from 185 to 158 per 1,000 births;*
- * *15% decrease in the maternal mortality rate from 500 to 425 per 100,000 live births;*
- * *25% increase in contraceptive prevalence from 5 - 30%.*

Measurement of these targets will be done through KAP and DHS Surveys. NGO experience gained through small-scale surveys suggests that contraceptive prevalence is somewhere between 3-5%. A KAP (Knowledge-Attitudes-Practices) Survey of 6,000 households was recently commissioned by UNFPA to establish credible baseline for birth spacing practices. This survey is nearly complete and results will be published in mid-1995. FHABS targets will be adjusted as necessary based upon this information. Changes from baseline will be based on a follow-up DHS to be conducted in year four of the Project.

2. Project Purpose/Program Outcome

FHABS is designed to support the RCG's objectives for healthier mothers and children. Consistent with USAID/Cambodia's Program Outcomes and RCG policy, the Project focuses on improvements in family health in general (rather than, for example, increases in family planning), and the increased use of modern contraceptive methods, including condoms.

The purpose of the Project, or Program Outcome to which FHABS contributes, is *to increase access to and use of quality reproductive and children's health services, particularly birth spacing*.

As discussed in analyses, bountiful evidence exists which suggests strong demand by Cambodian women for reproductive and children's health services. For example, the MSF/Holland MCH program in Svey Rieng Province reports that birth spacing services draws women on foot distances exceeding 10 km. MSF further validates the demand for birth spacing as an attraction for other reproductive health services, such as ante-natal care and immunizations that women would not ordinarily seek.

Consequently, by the end of the Project, it is expected that there will be:

- * *at least 3 modern contraceptive methods available at project delivery sites;*
- * *at least 50% of women receiving at least 1 pre-natal visit at project delivery sites;*
- * *at least one SDP offering quality reproductive and children's health care services in 40 out of a total of 140 Districts; and²*
- * *at least 150,000 birth spacing clients receiving quality reproductive health care at Project-assisted SDPs;*

C. Assistance Interventions

Using SDPs as the focal point, FHABS proposes three assistance interventions necessary to achieve its PO of increased access to quality care; targeted training, continued NGO support, and reliable contraceptive supplies. Each is described below:

1. **Reproductive and Children's Health Training**

Key to the FHABS training intervention are **standardization and quality**. The Project acknowledges that several organizations, mostly NGOs, are currently conducting reproductive and children's health training at all levels in the system. However, quality training must be based on national standards of practice or protocols which lay out basic principles associated with the subject matter. The foundation for quality reproductive health training are the ongoing FPIA and UNFPA programs in which standardized curricula are being developed based upon the experience of various NGO programs, e.g. CARE, MSF.

FHABS will support a US training organization which specializes in reproductive and children's health training with experience in a variety of developing countries. Currently, the range of organizations supported by USAID has emphasized NGO assistance for rehabilitation and general development. FHABS will likely include assistance from more technically-based organizations and universities. These additional resources will help focus on increasing the quality and standardization of training, and expanding the availability of services at SDPs currently supported by NGOs.

² - Based upon the projected 30% prevalence by the EOPS, the Project will strengthen NGO-supported programs providing services directly to at least 150,000 of the anticipated 483,200 continuous users of Project-provided contraceptives. This represents continuous users receiving improved quality reproductive health care, including birth spacing services at Project-supported SDPs. The balance of users will be receiving services from the at-large sources of health services.

The training organization's activities will contribute toward *expanded, integrated quality reproductive health services* and *improved capacity for training* throughout the health care delivery system. The training organization will bear in mind the following priorities of the RCG:

- * Continuing Education - In order to have the greatest impact, training will concentrate on those care givers already in the health care system rather than pre-service training, e.g. universities. Due to over-staffing within the RCG cadre of government workers, the RCG is limiting new entry classes in all professional schools. This policy places greater importance on interventions in continuing education. Government recognition and certification of FHABS training is essential for motivating health care givers. Government facilities for continuing education already exist, although they are in need of external support. Regional Training Centers are located in Stung Treng, Kampot, Battambang and Kampong Cham. Provincial Training Schools are located in Kampong Chhnang, Banteay Meanchey and Rattanakiri. Many NGOs also provide in-service training on a localized basis.
- * Bottom-up Approach - Reproductive and Children's health care services are most often the domain of the lower level care givers rather than doctors and doctor's assistants. For this reason, FHABS will emphasize a woman-to-woman approach (due to cultural sensitivities associated with discussing birth spacing) and direct training programs at the care givers closest to the clients, e.g. nurse midwives, nurses, traditional birth attendants and kru khmer (traditional healers). This approach also incorporates more women as beneficiaries, since there are few Cambodian females in the upper echelons of the medical community.
- * District-based Health Care - The Ministry's strategy places high priority on District-based health care to meet the critical health care needs of people living in the remote districts and villages of Cambodia, previously without access to any health services. Consequently, the training organization will seek institutional linkages and relationships which further this strategy.
- * Integrated Health Care - The Ministry wishes to work toward a more integrated health delivery system justified on technical as well as cost arguments. Consequently, training will broadly include reproductive and children's health services, including birth spacing, ante- and post-natal care, STD diagnosis and treatment, ARI and diarrheal disease, nutrition (including Vitamin A), general health promotion, and HIV/AIDS awareness and prevention.
- * Standardization - Training impact can be increased by further standardization of training materials and support. The training organization will help FHABS-supported NGOs, where appropriate, in improving materials and equipment for reproductive and children's health training.

FHABS will support the MOH in the development, testing and standardization of training in the classroom, the community, and health facilities for all levels of health care providers, with heavy emphasis on primary and secondary nurses and midwives. Once trained, these service personnel will provide a range of services depending on their level of training and government policy. In the reproductive health areas, trained midwives would provide pre-natal care including Tetanus Toxoid injections, birth spacing advice, septic deliveries and post partum services. They will work with village officials to provide health and birth spacing information on topics such as HIV/AIDS prevention; the economic benefits to the family and health benefits for mother and child derived from birth spacing practices; and other public health topics as directed by the MOH (EPI, personal hygiene, etc.).

FHABS will conduct at least 200 courses for health care service delivery workers over five years. This target is based on the Training Organization conducting approximately 10 in-service training courses per quarter with an average of 25 participants per course over the life-of-project. The number of courses will not be fixed, though, and will gradually increase over time. The accomplishments will be measured by progress reports submitted by implementing organizations. The quality of the instruction will be monitored during two scheduled evaluations of curricula, skills, and application at the clinic level.

2. Expanded NGO Support

The primary engine responsible for achieving FHABS targets is continued and expanded support for family health activities of NGOs. As described earlier, through the PVO Co-financing Project, a number of NGOs have already established a presence at selected provincial and district levels working with MOH officials and health care givers in the public and private sectors. FHABS will capitalize on the network of reproductive and children's health activities already taking place and provide additional resources throughout the 5-year Project to *expand and integrate quality reproductive and children's health services*. The Ministry acknowledges that without NGO support, it will be unable to achieve its objectives in providing services. Moreover, the relationship between the Ministry and NGOs permits unusual opportunities for innovation and experimentation in delivering low-cost, effective health care.

Whereas USAID's PVO Co-fi programs permitted program support for a variety of sectors, e.g. water/sanitation, literacy and birth spacing, NGO support under FHABS will be targeted. FHABS will concentrate resources on improving reproductive and children's health care service delivery at the district level in cooperation with the MOH. The Project includes funding for approximately 9-12 individual grants to NGOs for approximately 24 month programs. The result sought is equipped and trained project-assisted SDPs providing quality reproductive and children's health care in at least 40 districts by the end of the Project.

Improved coordination with the Ministry is an important objective of the Project, although it is recognized that differing local conditions require flexibility. Nonetheless, FHABS-supported NGO programs will include some or all of the following features:

- * Established relationship of NGO with local MOH authorities;
- * Broad-based assistance in reproductive and children's health care
- * Strategies for cost-recovery and fee-for-services;
- * Training in management (accounting, administration, inventory) as well as service delivery at the clinic level;
- * Private sector health care delivery mechanisms, e.g. kru khmer, traditional birth attendants (TBAs), pharmacists, etc.
- * MOH established protocols and standards of practice where necessary;
- * Sustainability Plans
- * Results monitoring

3. Contraceptives

The availability of a reliable, affordable supply of contraceptives has been identified by NGOs as one of the principal obstacles to improving reproductive health. Consequently, in addition to increasing access to reproductive health care services, FHABS will *ensure provision of an affordable, reliable supply of modern contraceptive methods* for both private and public delivery systems.

Estimated contraceptive procurement requirements are provided in the Financial Plan. FHABS top priority is to ensure that USAID-supported NGO programs will have adequate supplies of modern contraceptives. This is followed by the intent to provide sufficient resources to supply other reproductive health programs nationwide. The estimate is based upon USAID supplying 80% of contraceptives needed to reach 30% prevalence of modern methods by the end of 1999. Maintaining contraceptive supplies beyond the PACD will be a continuing issue for MOH and donor cooperation. Effective donor coordination in this area will be critical to sustain expected contraceptive prevalence gains.

The illustrative mix of contraceptive methods is based upon consultations with other donors and NGO reports of Cambodians' preferences. See the Social Soundness Analysis for more discussion of method mix. The mix in contraceptive methods is estimated to be:

- injectables (50%)
- orals (20%)
- IUDs (20%)
- condoms (10%)

Adjustments to the mix will be made as demand and distribution experience dictate. USAID will procure the contraceptive directly through the Global Bureau central procurement mechanism to take advantage of bulk purchase prices. Several shipments are envisioned, as demand and distribution dictate. With regard to condoms, there have been problems in the past with supply of the preferred 49mm size (USAID is standardizing on 52mm). Supplies are only guaranteed through the end of 1996.

Current practice is that all MOH pharmaceuticals, including contraceptives, are distributed nationwide through the Ministry's Central Medical Stores (CMS). CMS, as described in the annexed analyses, is considered to be an acceptable mechanism for distribution, but may require further support in logistics management. Under FHABS, contraceptives will initially be consigned to the training organization. The training organization must have the flexibility to assess distribution approaches at the time of delivery. Use of the CMS to distribute contraceptives will be based on the experience of other donors, especially UNFPA. Direct distribution by the Umbrella Training Organization to FHABS-supported NGOs is an alternative for the early stages of the Project. Finally, the training organization may experiment with private sector distribution approaches, as appropriate.

Contraceptives under FHABS are provided to NGOs and clinics free-of-charge. However, SDP may charge a modest amount to increase the incentives to health care workers and to attribute value to contraceptives. NGOs may also use contraceptives in cost recovery experiments.

FHABS will place high priority on ensuring there is an ongoing supply of contraceptives. As the MOH is in the early stages of launching a family health program, a number of other donors have not finalized plans. A sustainable source of contraceptives has not yet been secured. It is expected that as the number of trained caregivers and acceptors increases, in addition to improved economic conditions generally, the MOH and other donors will be able to identify fund sources for continued supply.

D. Coordination

USAID is a full member of the Ministry's Coordinating Committee for Health (COCOM). This is the official MOH structure for coordination of PVO/NGO activities in the health sector, and is chaired by the Under Secretary of State for Health. COCOM members include multi-lateral donors (WHO, UNICEF, UNDP/CARERE and IFRC), bilateral donors (France, Japan and USAID), as well as representatives of the NGO community. USAID has presented the FHABS Project to the COCOM for discussion.

Under the COCOM are subcommittees on sub-sector issues, including maternal and child health. The MCH sub-committee is chaired by the Director of the PMI. USAID participates in MCH sub-committee meetings regularly and has discussed FHABS on a number of occasions especially with relevant NGO organizations, e.g. FPIA, JSI and PSI. To avoid possibilities of a conflict of interest regarding the grant competition process, specific details of the Project have not been

shared with NGOs. They are, nevertheless, aware and strongly supportive of the project's objectives.

II. PLAN OF ACTION

In response to the guidance received from USAID/W, FHABS implementation is packaged to minimize the management burden on the Mission and permit flexibility to respond to changing conditions in Cambodia. This guidance requires accepting new ways of implementing projects, acceptance of less specificity at the outset and less control during implementation. The proposed implementation approach acknowledges both the small USAID staff and desirability of continuing NGO grant activities. FHABS consists, then, of only two implementation mechanisms, as outlined below:

A. The Umbrella Organization

FHABS, therefore, combines support for the training organization with the NGO grants into a *competitively-awarded, four-year cooperative agreement*. This umbrella training organization must have, in addition to the technical capacity outlined earlier, a demonstrated ability to administer and monitor subgrants.

Upon authorization of the Project, a Request for Applications (RFA) will be issued soliciting proposals to carry out the program described in this document. The Umbrella Organization will carry out all components of the Project with the exception of contraceptive procurement and results monitoring.

The Umbrella Organization will begin the training program by establishing a strong relationship with appropriate MOH-supported training organizations. Counterpart organizations will be determined in discussions with USAID, the Umbrella Organization and the Ministry, and may include one or more of the a regional or provincial-level center(s) in close proximity to USAID-funded NGOs.

Simultaneously, the Umbrella Organization will request proposals for subgrants. It will be clear in the Cooperative Agreement that USAID has prior approval authority of the solicitation request. Approximately 12 subgrants will be awarded for approximately 18-24 months periods.

B. Contraceptive Procurement

Contraceptive Procurement will be done directly by the USAID Project Manager in at least two installments. Consistent with past practice, the Project Manager will prepare a PIO/C based upon the projected demand for contraceptives determined in cooperation with USAID-assisted NGOs and other donors, proposed distribution channel, either the CMS or other approach. Contraceptives storage and distribution channels will be determined jointly between USAID and the Umbrella Organization at the time of each order. The first order will be consigned to the Umbrella Organization and at least a portion of the contraceptives will be stored and distributed

through private sector channels. To minimize risk of inventory shrinkage until such time that USAID is satisfied the CMS systems are sound, USAID will always maintain approval authority for contraceptive distribution channels.

Following the first installment, USAID will work with UNFPA and UNICEF to ensure contraceptives logistics and monitoring assistance is available to build CMS local capacity for contraceptive ordering and management. Based upon the findings of an assessment, recommendations will be developed for further support to the CMS.

The second, or subsequent installment(s) will take place later in the second year of the Project, subject to conditions at that time.

C. Stakeholders

FHABS stakeholders (defined as those who have a role to play or whose actions can affect the Project's success) include beneficiary organizations (direct and indirect recipients) as well as coordinating organizations. NGOs are the primary mode of implementation. Thus, they are among the most important stakeholders. They are both beneficiaries and implementing organizations.

FHABS will seek to increase the role of the MOH in coordination of USAID-supported NGO activities and improve the coordination among NGOs. Several key stakeholders are within the MOH, including the Maternal and Child Health Institute, the Central Medical Stores, and Human Resource Department. Their participation in implementation is described below.

Finally, coordination with other donors is essential. Hence, a review of the major donor activities in health is included.

1. **Royal Cambodian Government**

The Ministry of Health plays the lead RCG role in implementation of FHABS, although its role will be an evolving one. To date, the Ministry's closest interaction with USAID assistance in reproductive health has been through USAID-funded NGOs, e.g. FPIA, PSI, etc. USAID participates in COCOM meetings, MCH subcommittee meetings, etc. but has not negotiated agreements, funding levels, etc. with the Ministry. Whereas other donors have concentrated on placing technical advisors in the central Ministry, USAID will direct resources to the lower levels of the health system -- to the district level where primary health care services are being delivered.

Nonetheless, there is an increasingly important role for the Ministry to play in implementation of FHABS, summarized, *illustratively*, as follows:

- (a) Designating a Ministry Counterpart - The MOH will be requested to designate an official counterpart for the FHABS Project.

(b) Duty-free Entry of Project Contraceptives - Initially, the MOH will simply assist in the clearance of contraceptives through customs, rather than as consignee. However, as conditions warrant, it is expected that contraceptives will be consigned directly to the CMS for distribution. However, this decision will be made only after other donors have experienced success with the system, and USAID has approved monitoring and accounting systems.

(c) Participation in the Selection of the Umbrella Organization - The Ministry has never participated in the selection of AID grant recipients, although it has a role in approving NGO programs through the COCOM. In order to gain experience and provide MOH input, it is suggested that the Ministry designate a representative to sit on the selection committee, assuming language competency, as a non-voting member.

(d) Input into Award of Subgrants - At the discretion of the Umbrella Organization, the Ministry may be asked to participate in subgrant selection, or otherwise provide input into the subgrant process. The MOH will not, under any circumstances, have veto authority.

(e) Reviewing Implementation Progress - USAID and the MOH will meet with the Ministry counterparts annually to review FHABS progress with the Umbrella organization and subgrantee representatives.

FHABS will likely involve other RCG entities during implementation, usually in coordination with the Umbrella Training Organization or NGO subgrants. These include: (1) the Women's Affairs Secretariat which has demonstrated outreach capabilities to community groups for reproductive health information campaigns; (2) the Midwives Association which was recently established, and; (3) the Ministry of Education, Youth and Sports (MoEYS) can be tapped to access young adults, particularly for HIV/AIDS prevention activities.

2. PVO/NGOs

The greater community of PVO/NGOs in Cambodia is also a stakeholder in FHABS. Their principal role is that of implementation organizations as subgrantees. As current recipients under the PVO Co-financing Project, NGOs have contributed to the design of FHABS by reporting their findings, views and recommendations regarding reproductive and children's health issues. NGO experiences are well-represented in several local publications, including the November 1994 UNFPA-sponsored report entitled "A Report on NGOs Birth-spacing Activities in Cambodia: A Qualitative Analysis" and IMIC's February 1995 report, entitled "Contraceptive Obtention and Usage in Phnom Penh."

NGOs are the backbone of FHABS and they represent perhaps the most important stakeholders in the success of the Project. USAID has established close relationships with a wide range of NGOs whose continued participation is essential. They will continue to be members of the national team implementing reproductive and children's health programs

throughout the country.

In addition, NGOs are represented on the COCOM and MCH Subcommittee with the Ministry. NGO representatives are selected by the membership of MEDICAM, an NGO organization active in the health sector.

3. Other Donors

All major donors involved in the economic and social development of Cambodia face the same difficult development environment as USAID -- a country barely at peace with itself, governed by a coalition of former adversaries with limited financial and managerial resources to undertake national social infrastructure programs. Donors are actively seeking ways to provide more direct support to the RCG as strategies evolve from rehabilitation to reconstruction, but options are limited.

As the health sector is seriously under-resourced, many donors are involved to some extent. WHO and UNICEF are the most important agencies working at strengthening the overall health care system, and each has placed advisors in sections of the Ministry. The World Bank is still in the development stage of its health sector support assistance, but has explicitly excluded birth spacing. Nonetheless, the needs and opportunities in this sector are immense and all donors are encouraged to expand their assistance. The most significant need, though, is to coordinate assistance more closely with the MOH.

Donors involved in reproductive health and children's health comprise a smaller group. Considering the grant assistance provided to FPIA, PSI, and JSI, in addition to numerous US NGO programs funded under the PVO Co-financing Project, USAID is the largest funding source for reproductive health activities. However, UNFPA (described below) is considered the lead agency in this subsector, despite limited funds. As shown below, most donors have either chosen to target assistance more broadly in the health sector or have yet to finalize project assistance.

(a) United Nations Fund for Population Activities (UNFPA)

UNFPA has recently begun an "Institutional Strengthening and Family Health Improvement Through Birth Spacing" Project to be implemented over a three-year period at a cost of approximately \$1.45 million. The Project includes advisory services (long and short-term consultants) to the PMI and five provincial hospitals, support for a KAP survey, training in twenty-five districts of five provinces, a modest amount of contraceptives and pharmaceuticals. The UNFPA's assistance is concentrating on the PMI initially, and moving to the provincial level. Training mechanisms at the service delivery level are similar, involving NGOs. FHABS hopes to take advantage of UNFPA's early experience working with MOH institutions, particularly the CMS.

UNFPA has worked particularly closely with USAID on development of this Project.

(b) Japanese Government (JICA)

JICA has committed to building a \$15 million replacement National MCH Center (PMI) and maternal and child health teaching hospital in Phnom Penh to be completed by 1997. The current site, which is prone to flooding during the rainy season, has deteriorated to the point that rehabilitation is not economically feasible. JICA's assistance includes a single MCH Advisor to the PMI, short-term advisory services and training at the hospital. Construction of the new hospital has not yet begun. FHABS complements the JICA assistance by concentrating training at the District level whereas JICA's support is largely limited to central institutions.

(c) Asian Development Bank (ADB)

The ADB is proposing an estimated \$5 million, 5-year project to be implemented by the World Health Organization (WHO) to improve health worker training. The project will build overall capacity of the MOH, improve the training capability and provide in-service training of health workers. The design does not specifically address reproductive health but rather integrating services within the Ministry. However, progress is lagging and no official date for approval is available. Based upon its current design, the ADB/WHO project fits very well with FHABS because it will provide longer-term support to the MOH for continuing education. The training protocols and curriculum development funded under FHABS will be incorporated into the larger system of MOH continuing education.

(d) World Bank

The World Bank Health Sector Project (estimated \$40 million soft loan) is still in the appraisal process. The Project focuses on tuberculosis, malaria, general strengthening of the District Health Services, and HIV/AIDS. The Bank has explicitly excluded birth spacing from its project as it considers the sector adequately supported (including FHABS). Bank support will begin no *earlier* than early 1997.

(e) United Nations Children's Fund (UNICEF)

UNICEF provides considerable support for MCH activities, including the provision of vaccines through the nation-wide expanded program for immunizations (EPI). UNICEF has developed the CMS to the point where it now imports and distributes all pharmaceuticals used in the national health program. Other donors are encouraged to use the CMS facilities for the importation of medical supplies. UNICEF also supports an advisor to the PMI.

(f) World Health Organization (WHO)

WHO provides overall leadership to the MOH and acts as a coordinator of donor support in the sector. Through its Strengthening Health Systems Project, WHO provides several long-term advisors to the MOH. These include assistance in the development of a National Maternal

and Child Health Plan; assistance to the National Malaria Center and Control Program to limit increases in drug-resistance and further spread of malaria; a tuberculosis advisor to the National Anti-Tuberculosis Center; assistance to limit typhoid and cholera through the Diarrhoeal Disease Control Program; assistance for the Dengue Hemorrhagic Fever Control Program; and assistance in the formulation of a National AIDS Control Program. USAID has worked closely with WHO in designing this Project. WHO strongly supports the Project.

(g) Other Donors

Other donor assistance (Europeans and Australia) in the health sector generally supportive of the MOH stated priorities in the Health Sector Plan for 1994-96. Assistance comprises: (1) technical advisors at the national level in selected health institutes, including universities (Belgium, France); (2) NGO support from all sources, including Medecins Sans Frontieres, Enfance Espoir, Action Nord Sud, Save the Children/UK, Save the Children/Holland Belgium, CARE/UK; (3) long-term academic training opportunities (France and AIDAB); (4) limited pharmaceutical and contraceptive support (Germany and the UK); and (5) advisory assistance to the PMI (AIDAB). What is important to note is that assistance in the Health Sector is increasingly coordinated through the COCOM. All donors who are actively involved in reproductive health participate on the COCOM.

III. DEFINITION OF SUCCESS

A. Intended Results

At the end of the Project, the expected results will be:

1. Increased choice of contraceptive methods available at Project-assistance Service Delivery Points (SDPs);
2. At least one SDP offering modern contraceptive methods in 40 districts;³
3. 150,000 birth spacing clients receiving services from FHABS-assistance SDPs.

B. Indicators for Monitoring Project Level Progress

The following indicators will be used to measure progress toward the intended results:

1. Standardized curricula developed appropriate for the needs of the trainees;
2. An estimated 200 training courses for health care service delivery workers training in birth spacing, STD/HIV prevention, pregnancy care and child survival;

³ - At least 40 FHABS-supported districts will offer a selection of modern contraceptives as part of an organized birth spacing program as well as reproductive and child health services resulting from training received through the project.

3. % of clients counseled on STD/HIV/AIDS prevention;
4. Vaccination coverage rates in project delivery sites;
5. Establishment of a minimum of 20 new SDPs through NGOs.

C. Results Monitoring Plan

The Results Monitoring Plan for FHABS utilizes the tools described below.

1. **Demographic Health Survey** - FHABS baseline data and initial indicators will be sourced from the KAP Survey being undertaken by Save the Children/Holland and CARE/UK. This survey will be followed up almost immediately by a full Demographic Health Survey (DHS) funded by the UNFPA. This data will be used to cross-check FHABS indicators. In year four, FHABS will fund a follow-up DHS to measure results and project progress toward indicators. This DHS will also be used as an opportunity to improve the capability of the MOH by incorporating Ministry research staff, as appropriate. The results of the DHS will be shared widely with other donors. Funds for the DHS are provided in the Results Monitoring line item of the overall financial plan. These services may be obtained centrally through the Global Bureau or directly.

2. **Contraceptive Supply Logistics and Monitoring** - During Year two of the Project, USAID will engage the services of a firm to assess the logistics management capacity of the CMS for possible utilization by FHABS as a distribution channel for contraceptives. The objectives for contraceptive management assistance are generally to: (a) strengthen the ability of the CMS to manage and implement their logistics systems for contraceptives; (b) institutionalize a capacity for forecasting contraceptive requirements; (c) strengthen quality assurance programs; and (d) evaluate systems for storing and distribution. Funds for the contraceptive logistics and monitoring assistance are provided in the Results Monitoring line item of the financial plan. These services may be obtained centrally through the Global Bureau as buy-ins or directly through IQC services.

3. **Health Training Evaluation** - During years two and four of the Project, technical evaluation of health training activities, both of the training organization and NGO subgrants, will be carried out. The objectives of the evaluation will be to measure progress in strengthening the skill base of health care practitioners as well as the quality of the health care provided at FHABS-assisted SDPs. The early evaluation will be more formative, and be used as a basis for development of the Umbrella Organization's third annual work plan. Funds for the health training evaluation services are provided in the Results Monitoring line item of the financial plan. Services may be accessed through the Global Bureau as field support or directly through other mechanisms.

D. Timeframe - The implementation plan, below, presents a chronology of Project activities by quarter.

FHABS Implementation Plan Beginning with Initial Obligation																				
	Year One				Year Two				Year Three				Year Four				Year Five			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Umbrella Training Organization																				
*Issue Request for Applications	XX																			
*Review Proposals	XX																			
*Award CA	XX																			
*Mobilization	XX																			
*In-service Training Program Begins					XXXXXXXXXXXXX				XXXXXXXXXXXXX				XXXXXXXXXXXXX				XXXXXXXXXXXXX			
*Issue Request for subgrant proposals	XX																			
*Review subgrant proposals		XX																		
*Award subgrants		XX																		
*Monitoring subgrants					XXXXXXXXXXXXX				XXXXXXXXXXXXX				XXXXXXXXXXXXX				XXXXXXXXXX			
Contraceptive Procurement																				
*Order #1 installment	XX																			
*Order arrives					XXX															
*Distribution					XXXXXX															
*Order #2 installment													XX							
*Order arrives													XX							

FHABS Implementation Plan Beginning with Initial Obligation					
	Year One	Year Two	Year Three	Year Four	Year Five
*Distribution				XX	XXXX
Results Monitoring					
*Contraceptive Logistics Assessment		XXXXX			
*DHS				XXXXXXXXXXXXX	
*Formative health training evaluation			XX		
*Evaluation/Follow-on Redesign					XX

IV. ANALYSIS OF FEASIBILITY, KEY ASSUMPTIONS AND RELATED RISKS

A. Technical Analysis - The technical analysis describes the RCG policy toward birth spacing and maternal child health, contraceptive availability and preferences, training capacity of various private and public sector health care delivery systems, state of information regarding birth spacing, and current demographic data. The analysis strongly supports the initiation of a broad-based project in family health and birth spacing.

Although the RCG promotes a pro-natalist policy, countering the two decades of civil strife, there is a clear recognition that improved maternal and child health is a priority for the Government. Support for improved access to reproductive health services is seen by the Government as an important step toward improving general health, but not for demographic reasons. Indeed, the PMI targets increasing contraceptive prevalence from the current estimated 3-5% to 30% by the year 1997. This is probably an unattainable goal, but suggests a supportive policy environment for further investment in reproductive health.

Contraceptive availability in Cambodia is very spotty, and largely restricted to urban areas. The single most important barrier to increasing access to birth spacing services is the availability of contraceptives. Cambodian women have a decided preference for injectables, probably due to the convenience and confidentiality of the method. Other methods could become more acceptable with improved information and training of health care workers. Contraceptive distribution is done by the CMS, an RCG organization within the MOH, and supported by UNICEF.

Of perhaps equal importance to contraceptive availability is the general lack of training in birth spacing methodologies by health care workers at all levels in Cambodia. From the Faculty of Medicine in Phnom Penh down to Traditional Birth Attendants (TBAs), there is a critical need for training. In particular, there is a requirement for development of a birth spacing training curriculum and training materials, training a cadre of master trainers and implementing training courses for hospital staff at provincial and district hospitals. The PMI is the MOH-designated unit for development and implementation of the birth spacing program for Cambodia, although its role is evolving toward one more concerned with MCH policy.

Training materials and general information on birth spacing are limited and out of date. There has been no systematic KAP (Knowledge, Attitudes and Practices) Survey beyond anecdotal surveys conducted by NGOs. Radio appears to be the most comprehensive source of information (television is still limited although growing quickly as a communications medium). Newspapers and magazines are relatively effective given the modest literacy levels in Cambodia, and should be further exploited.

General demographic data is nonexistent for the purposes of the Project. A census was last conducted in 1962 (UNTAC conducted a special census in 1992 for the election, but did not examine indicators useful for birth spacing programs). It is necessary to, early on, assess the

data availability, identify with RCG and other donors, data requirements, and use the Project as a possible source of support (technical assistance and training) in collection of new data.

A wide variety of NGOs already operate in Cambodia, many in the area of maternal and child health. Based on the findings of two reports published in November 1994⁴, a number of these projects already have birth spacing components as a result of the strong interest expressed by women. Of particular note is the fact that the availability of birth spacing services attracts women into the system for other services, e.g. EPI, ante-natal care, etc. Some of these on-going programs -- and SDPs -- could be the bases for FHABS subgrants.

The diversity of service delivery models adopted -- such as clinic-based birth spacing services, community-based health promotion with a birthspacing component, social marketing of contraceptives, and workplace health promotion and distribution of contraceptives -- and their respective results, also lend support to the geographical distribution objective of FHABS. Indeed, based on the findings in Harmer's report, approximately 44 districts already have some form of birth spacing activity.

FHABS will use this information and data contained in these reports to ensure, capitalize and sustain work already being done in the birth spacing and child and maternal health sectors.

Most other donors are providing general health sector assistance to the RCG. Assistance is chiefly provision of advisors, health training at all levels (mostly in-country), and supply of pharmaceuticals (not contraceptives). The United Nations Fund for Population Activities (UNFPA) is the only other donor with a birth spacing project underway; it is small (\$1.45 million) and limited to provision of an advisor to the PMI, training and contraceptives. The Japanese Government's contribution to MCH includes an advisor to the PMI and the planned construction of a new hospital, including the PMI. MOH has a series of committees to monitor the various programs (pharmaceuticals, blood supply, human resources, etc.) and holds regular donor coordination meetings.

B. Economic Analysis - The lack of reliable data and the evolving environment in which this project is being planned and will be implemented precludes any standard benefit-cost analysis. However, from studies undertaken in many other developing countries, it is clear that birth spacing programs provide a high benefit to cost ratio. There is every reason to assume that the same high benefit to cost ratio will apply to the proposed project.

Decreased births and increased birth intervals lead to improved child and maternal health and survival. With increased contraceptive prevalence, more fertility decisions will be the result of deliberate informed choice. These choices are influenced by the health, economic and social

⁴Harmer, Anne: "A Report on NGO Birth Spacing Activities in Cambodia: A Qualitative Analysis," Cambodian Ministry, National MCH Center publication, November 1994 and "Survey of International NGO Birth Spacing Activity in Cambodia", Cambodian Ministry of Health, National, National Center for Maternal and Child Health, November 1994.

welfare of the family, better child survival, and better opportunities for future productive employment. It is assumed that investments in birth spacing have a real impact on reducing subsequent government expenditures over the long-term.

In Cambodia, the birth rate is estimated at 45 per 1,000 population; one of the highest rates of any country in the world. Maternal mortality is astronomical at 800 to 1,000 deaths per 100,000 live births; probably the highest rate of any country in the world. A leading cause of serious injury to women or maternal death is induced abortions by village midwives. The average Cambodian woman will have 6-7 children during her lifetime, creating a significant health hazard by itself. Infant and child mortality rates are also among the world's highest. The proposed project objectives offer an opportunity to significantly reduce maternal and infant mortality by increasing the spacing of pregnancies. It is not possible to estimate these benefits in dollar numbers, but the examples from other countries should make clear the high benefit to cost ratio one should anticipate from the proposed project interventions.

C. Social Soundness Analysis - The socio-cultural feasibility and appropriateness of the Project is confirmed by the analysis contained in the Social Soundness Analysis (Annex F). The central assumptions of the project -- that there is a high demand for birth spacing information and technologies is clearly articulated by potential beneficiaries and participants. The challenge of the Project is to improve service delivery, training and information at the level of the SDP in a way which incorporates gender concerns. In Cambodia, discussions of sexuality across sex lines is culturally inappropriate. The Project must tailor activities to the maximum extent possible to engage women at every level of implementation emphasizing "woman-to-woman" contact at the local level. This relates to the choice of NGOs as subgrantees, the choice of technical skills (midwives rather than physicians), training topics, locations and staff, and development of materials.

The primary beneficiaries are women of childbearing age who will have fewer children thereby improving their own health and the health of the reduced number of offspring. Benefits accrue to the entire family as limited land resources will need to support fewer people, and the family can afford better educational opportunities and medical care for their children. Men are direct beneficiaries of HIV/AIDS awareness and prevention activities.

The possible rapid spread of HIV/AIDS in Cambodia makes it imperative to proceed with information campaigns even where they might offend sensibilities. There is substantial evidence from neighboring Thailand that, through such a campaign, it is possible to change people's attitudes over time. Fortunately, PSI is already embarking on just such a campaign.

There are four possible sources of objections to the Project, from a social soundness perspective. The first would come from the pro-natalist voices within the government who are concerned to repopulate the country after decades of war. This issue is adequately addressed by focusing on the primary objectives of reducing maternal and infant mortality rates. Secondly, there could be some objections from religious organizations. Although Buddhism is not opposed to family planning, there is clear opposition to abortion. The program will emphasize that the availability

of birth control technologies provided within an integrated package of reproductive health measures helps to reduce the number of unwanted pregnancies and therefore, the number of abortions. Thirdly, there will likely be some resistance due to lack of knowledge regarding practice. This has to do with the level of inaccurate information which is circulating among Khmer concerning the side effects of certain birth control methods already in (improper) use. Finally, if there is a shift from central level control of birth spacing methods away from the male-dominated Ministry toward a more female-centered local level midwife and traditional birth attendant focussed system, there will likely be a negative reaction from the medical establishment.

D. Administrative and Institutional Analysis - The Administrative Analysis describes the organizational structure of various parts of the MOH, including the HRD Division, the PMI, and the CMS. There is no need for a broader RCG analysis at this time since it is accepted that the government will not be required to serve as a direct partner on day-to-day matters of what is essentially an NGO grant-funded program. The MOH's participation will be limited to policy oversight of the Project.

The PMI is the organization within the Ministry charged with strategic planning and implementation of birth spacing programs. The Director of the Center reports to the Director of Women's and Children's Services, which is under the direction of the Director General for Health Services. The Director General reports directly to the Minister.

The PMI takes primary responsibility for child health, including nutrition; maternal health, including safe pregnancy; birth spacing; control of diarrheal diseases; control of acute respiratory infection; MCH training and supervision; and information and management systems.

The PMI Center staff are also responsible for the 7 January Maternal and Pediatric Hospital in Phnom Penh. Approximate staff under the direction of the Center (including physicians, medical assistants, nurses, midwives, etc.) are as follows:

7 January Hospital	:	447 staff
Kantha Bopha	:	125
MCH Services	:	26

There are provincial MCH committees in a number of Cambodia's 21 provinces, which are theoretically charged with reporting MCH activities in the 176 districts. These committees do not function except in rare circumstances due to the overall institutional weakness of the Ministry's structure.

Although it has been acknowledged that all staff are seriously in need of skills training, the most important constraint facing the PMI (as well as all RCG employees) is the "salary problem." Government salaries average \$10-20/month resulting in low motivation, corruption, poor performance, etc. Some donors, e.g. the Swiss at Kantha Bopha Children's Hospital, pay salary supplements (up to nine times base salary). However, USAID regulations do not permit such

supplements. Consequently, the Project will use training as an incentive which, at its most fundamental level, makes health care professionals better able to market their services privately as is customary in Cambodia. The "salary problem" will persist in Cambodia as its economy develops. Indeed, it is a key assumption of the project that Cambodia's economy will continue to develop and benefit from increased trade and investment, and that those benefits will gradually be passed along to government workers in terms of better wages.

The CMS, described in the Technical Analysis, is a critical link in the administrative structure of the Project. It fulfills the role of nationwide distributor for pharmaceuticals under the general direction of UNICEF, and in this role, performs satisfactorily according to all reports. Nonetheless, USAID may provide additional technical assistance to the CMS in logistics management. Due to the relatively large amounts of contraceptives to be procured, additional strengthening of the CMS' capacity is desirable.

1. With the possible, but unpredictable exception of unrest caused by the Khmer Rouge, FHABS is a low-risk Project. Target provinces are those not expected to be affected by security problems.

2. The Project approach is based on a modified approach of the current PVO Co-financing Project. The approach is one which has already proved to work effectively in Cambodia.

3. Risks associated with contraceptive distribution are addressed by retaining USAID control. As opportunities present themselves to devolve more control to Ministry, it will occur gradually without affecting the success of the Project. Internal vulnerabilities are controlled.

E. Environmental

A categorical exclusion has been granted for the Project.

F. Issues and Conclusions

Based upon the NAD Review (Annex A) and subsequent analysis, FHABS has examined the following issues related to the successful implementation of the Project:

1. **Role of the Government** - Historically, USAID's focus on humanitarian assistance has involved the RCG only peripherally. USAID's current approach is evolving towards one which is more directly supportive of the RCG. FHABS accomplishes this in several ways, including closer participation by MOH officials in selection and monitoring of NGOs, a possible direct role in the distribution of contraceptive supplies, and a closer technical relationship between USAID, the Ministry and key agencies such as UNFPA and WHO. This relationship will continue to evolve throughout implementation, although direct implementation responsibilities for the Ministry appear premature.

2. **Paucity of Data** - There is general agreement that statistics on women and children's health are unreliable, where they exist. Sound project planning and implementation requires reliable baseline data from which to measure progress; these are not yet available. FHABS addresses this issue in two ways: (a) targets and indicators are typically expressed in terms of percentage increase and decrease from baseline, based upon technical assessments of what is achievable over five years (a short time in terms of changing behavior); and (b) incorporates specific tools for results monitoring that improve the overall level of quality of data available. A system of minimal data collection and analysis will be used to refine indicators during implementation and contribute to future project activities.

3. **Simplicity of Design** - Due to the limited USAID staff, and the admitted limited absorptive capacity of the Government, simplicity of design is a critical factor all USAID/Cambodia Projects. Simplicity in the FHABS design is evidenced in: (a) the combination of the training organization with the subgrant program, reducing the number of direct procurement actions and minimizing USAID's direct management burden; (b) relying on already successful NGO programs country wide; (c) phasing the approach through the umbrella organization.

Part of the price of simplicity is limiting the interventions to those areas where the greatest impact will be felt first. Consequently, there are a number of topics traditionally found in family planning projects which are not treated in the Project at this time, including IE&C and operations research. It has also been pointed out that no special consideration to specific concerns, such as young adults, post-abortion care, etc. Although FHABS does not preclude additional activities, they must conform to the simplified structure of the Project, as subgrant activities through the Umbrella Organization.

4. **Need for Flexibility** - Donors realize that Cambodia's struggling economy and peace are fragile and in need of substantial resources. Moreover, inputs to the health care system are unstable, e.g. a poorly-trained, poorly-remunerated staff, poorly equipped clinics, etc. Therefore, implementation mechanisms must retain flexibility to apply resources where they are most effective at improving access and improving quality of reproductive health care. FHABS does this by: (a) relying on grants rather than contracts, in recognition of the high motivation of grantees to implement such programs; (b) utilizing a network of NGOs in strengthening MOH staff capacity at the local levels through joint participation in training and service delivery activities; and (c) retaining direct USAID control over contraceptives in order to assess a variety of distribution channels, e.g. through the Umbrella Organization, CMS, private sector, etc.

5. **Waivers** - Section 110(a) of the FAA requires a 25% host country contribution for project assistance. This contribution may be waived, on a case-by-case basis, for Relatively Least Developed Countries (RLDCs) when the initiation and execution of an otherwise desirable project is handicapped primarily by the 25% percent contribution. The RCG is not able to make such a contribution due to serious financial constraints, particularly in the seriously under-resourced health sector.

A waiver of the 25% contribution signed by the AA/ANE is in process. Funds may not be obligated until the waiver is signed.

G. Principal Assumptions and Risks to Successful Implementation

1. **Demand** - A key assumption is the high, unmet demand for reproductive and children's health services. Given the lack of national data concerning the practice of birth spacing, FHABS builds on the experiences of individual NGOs which are implementing MCH programs now. All NGOs report tremendous demand, from Phnom Penh down to the commune clinic.

2. **RCG Support** - In order to be successful, FHABS does require continued RCG support. The Ministry must: (a) support the efforts of NGOs; (b) release MOH staff for in-service training; and (c) pay salaries for MOH staff. The RCG has demonstrated this support already through its strong commitment to NGOs as an integral part of the health care system. There is little risk to successful implementation.

Assurance of RGC support is further assured since the Government acknowledges that accelerating rural development and increasing the quality of life of Cambodians is the only solution to eliminating the influence of the Khmer Rouge. This Project is consistent with the Government's strategy to improve quality of life, particularly for women and children.

3. **Sustained Support** - It is widely acknowledged that the incentive structure for government workers does not support sustained delivery of government services. This is especially true in the current health system, where untrained practitioners do not have minimum facilities or equipment to deliver even basic health care services. Wages are below poverty level and working conditions are not conducive to provide adequate health care services. There is, however, a significant private sector network from which most Cambodians obtain their health care services. FHABS hopes to improve the mix of public, for profit and non-profit provision of services to include an expanded role for the public sector by proper training and equipping of district and khum level SDPs, and experimenting with cost recovery strategies that help to sustain the SDPs. This is an important part of improving access to health services, especially to those Cambodians who have had little or no access to health services in the past. FHABS is a first step towards addressing the problem of sustainability, and the principal contribution will be information to apply toward a longer-term solution.

H. Risk Monitoring and Management

Risk monitoring and management of FHABS is the responsibility of the Project Manager and management team(s). Within USAID, the Project Manager consults regularly with appropriate contract, financial and legal support offices, and participates in regular project review with Mission management. Project Implementation Reporting will be prepared congruent with USAID/Cambodia's re-engineered systems.

With other FHABS stakeholders, the Project Manager organizes an annual Project review. This is attended by MOH counterparts, the Umbrella Training Organization and subgrantees, as appropriate. The focus of these meetings is the review of annual work plans and progress reports, as well as special topics of interest, e.g. DHS and contraceptive logistics management.

I. Project Implementation "Thresholds"

Five years is a relatively short time period for realizing significant impact from major interventions in the health sector. Consequently, the objectives of the Project focus on improving the capacity and number of USAID-assisted SDPs and staff. The issue of "thresholds" at the training and NGO support is addressed through the annual work plan reviews between the Mission and the Umbrella Organization. For contraceptives, effectiveness is addressed at the time of distribution of each order. USAID will work with MOH and other donors to monitor effectiveness and efficiency of contraceptive delivery. Following major procurements, USAID will assess the distribution channels and make adjustments.

V. FINANCIAL PLAN

A. Resource Requirements

The following table presents the major project elements and their estimated costs over the five-year LOP. These are illustrative and subject to change as conditions and circumstances warrant.

Illustrative Financial Plan (by Project Element)		
Project Element	Estimated Total Cost	Notes
1. Training	\$4,000,000	Detailed Estimate Below
2. NGO Subgrants	\$11,000,000	Approximately 10 NGO subgrants at \$1,000,000 each
3. Contraceptives	\$ 3,800,000	Detailed Estimate Below
4. Results Monitoring	\$ 1,200,000	
GRAND TOTAL	\$20,000,000	

ILLUSTRATIVE BUDGET FOR THE PROCUREMENT OF CONTRACEPTIVES						
	1995	1996	1997	1998	1999	TOTALS
DEPO-PROVERA (\$0.96/VIAL)	\$ 92,160	216,960	382,464	613,755	928,512	\$ 2,233,851
ORALS (LO-FEMENAL) (\$0.1874/CYCLE)	23,388	40,658	97,058	155,754	235,629	552,487
IUDS (CT-380A) (\$1.10/UNIT)	10,560	17,600	26,400	39,600	57,200	151,360
CONDOMS (\$0.0475/UNIT)	22,800	53,675	94,620	151,838	230,993	553,926
SUBTOTALS:	\$ 148,908	328,893	600,542	960,947	1,452,334	\$ 3,491,624
OCEAN FREIGHT (7% OF COST)	10,424	23,023	42,038	67,267	101,664	244,416
GRAND TOTALS:	159,332	351,916	642,580	1,028,214	1,553,998	\$ 3,736,040

NOTES TO THE CONTRACEPTIVE PROCUREMENT TABLE

1. Prices used are as of March 1995. They have not been adjusted for inflation.
2. Client estimates have not been adjusted for increases in the number of women entering the reproductive age group, 15-49 years, over the life of the project.
3. Freight costs may be higher than the average used for all contraceptive estimates, 7%, because of the distance. There is about \$64,000 more in the budget than is calculated above for contraceptive procurement. Those funds can be used for freight costs.
4. No allowance was included for inventory loss.

ILLUSTRATIVE BUDGET FOR TRAINING ORGANIZATION			
Line Item	Description	Total Amount	Notes
Expatriate Staff	3 full time professionals @ \$150,000/year for four years	1,800,000	
Local Staff	5 full time local staff @ 5,000/year for four years	100,000	
Office Expenses	\$60,000/year for four years	240,000	
Vehicles and Operations	\$15,000/year for four years x 2 vehicles	120,000	
Local Travel	\$10,000/year x 4 years	40,000	
International Travel	\$50,000/year x 4 years	200,000	
Local Training Costs	\$100/participants x 25 x 200 participants	500,000	
Overhead	Approximately 30% of subtotal	1,000,000	
Total Training Organization		4,000,000	
Subgrants	estimate 10 grants @ \$1,000,000/each	10,500,000	
Passthrough fee	Est 2-3%	500,000	
GRAND TOTAL		15,000,000	

B. Expected Obligation Actions

The following table is the planned schedule of obligations. FHABS funds will be obligated through a Limited Scope Grant Agreement (LSGA). Fund sources are unknown beyond

FY95.

OBLIGATION SCHEDULE (\$000)			
FISCAL YEAR	INCREMENTAL OBLIGATION	CUMULATIVE OBLIGATIONS	NOTES
FY95	5,000 (POP) 2,500 (ESF)	7,500	
FY96	6,000	13,500	
FY97	4,000	17,500	
FY98	2,500	20,000	
TOTAL	20,000	20,000	

C. Expenditures by Project Element by Fiscal Year

The following demonstrates the rate of expenditure by project element. The accepted limit for pipeline age is 18 months. Due to the use of grant agreements and federal reserve letters of credit as the method of financing for the PMT, the rate of expenditure will most likely be reported more slowly than actual expenditures occur.

EXPENDITURES BY PROJECT ELEMENT (\$000)							
PROJECT ELEMENT	FY95	FY96	FY97	FY98	FY99	FY00	TOTAL
UMBRELLA TRAIN ORGANIZATION	500	6,000	4,000	2,500	1,500	500	15,000
CONTRACEPTIVES	-0-	500	695	1,050	855	700	3,800
RESULTS MONITORING	-0-	-0-	500	400	200	100	1,200
TOTAL	500	6,500	5,195	3,950	2,555	1,300	20,000
CUMULATIVE	500	7,000	12,195	16,145	18,700	20,000	20,000

C. Recurrent Costs

The issue of recurrent costs is not addressed directly in FHABS as the Cambodian economy is in the reconstruction phase. The aim of the Project is to begin what is a lengthy process of strengthening institutions and people. Serious attention to recurrent costs presumes the RCG economy has reached a point where there is capacity. Without donor support for the next several years, it is agreed that the government would cease to operate.

D. Management Costs

1. **Program Costs** - In addition to the \$20 million made available directly for this Project, there are three other likely sources for assistance. These resources are not required to obtain the anticipated results, but enhance the flexibility of FHABS to respond to changing conditions:

(a) **Cambodia Technical Support Project** - The Cambodia Technical Support Project (442-0111) provides short- and long-term technical assistance services in support of USAID/Cambodia's overall development assistance program. This Project may be utilized for evaluation, project management, and audit services.

(b) **Global Bureau Resources** - The Global Bureau has a range of technical support contracts available in the family planning/population area. It is up to the discretion of the Mission, but cost sharing is possible for certain services, e.g. DHS and contraceptive logistics management. Mission requirements must be submitted early to capture full benefits of these projects.

(c) **RSM/EA Regional Projects** - Contracts awarded under the East Asia Regional Training (410-0004) and Regional Technical Support (410-0005) Projects provide the full range of short- and long-term training services as well as short- and long-term technical assistance. The services of these contracts are available to the Mission at no cost upon consultation with the RSM/EA.

2. **Operating Costs** - Implementation of FHABS is accompanied by the recruitment of a an HPN Officer as an IDI. OE burden includes all support costs for the position. This is estimated at \$163,000 the first year and \$155,000 for each year thereafter.⁵

VI. MANAGEMENT PROCEDURES

A. Systems for Tracking Resources and Results

Results Monitoring is a continuous and ongoing part of implementation of FHABS and the responsibility of the Project Manager, the Director of the Projects Office. In addition, there is an IDI specializing in Health and Population who will assist. However, at this time, the Mission does not have USDH Position available subsequent to the completion of her IDI program. The Director of the Projects Office reports directly to the USAID Representative.

Project Manager implementation monitoring responsibilities include work plan review and approval, site visits, stakeholder team meetings, etc.

B. Reporting, Evaluation, and Audits

1. Umbrella Organization provides quarterly progress reports.
2. Subgrants share reports with USAID through umbrella organization.
3. Funds are available for Agency audits, should that be determined to be necessary.
4. Results monitoring reports are de-facto evaluations of project progress. In addition, there will be a final evaluation/redesign exercise in Year five.
5. The implementor under the Umbrella Training Cooperative Agreement will be subject to audit under provisions of OMB Circular A-133. As a result, the costs of audit are included in the agreement. Funding in the amount of \$150,000 is included in the line item for Results Monitoring for Agency contracted audits or financial assessments, as appropriate.

C. Procurement Plan

The full amount obligated through FHABS will be used for AID Direct procurements, e.g.

⁵ - OE cost estimated based on following:

Salary + Post Dif	\$75,000
Housing	25,000
Renovation (Yr 1)	8,000
Residential Lease	5,000
In-country Travel	1,500
Intl Travel	13,500
Shipment/Storage	35,000

grants, contracts, etc. Because of limited capacity within the RCG, all procurement responsibility for FHABS resources will rest within USAID. Nevertheless, as a general rule, procurement matters will be discussed with the FHABS counterparts at the Ministry, and coordinated among other donors. The table below presents FHABS Procurement.

1. Umbrella Training Organization - FHABS recommends the use of a assistance (grants and cooperative agreements) rather than acquisition instrument (contract) to support continued NGO reproductive and children's health programs as well as related in-service training for MOH staff. The rationale is that this program is principally a transfer of funds to support a public purpose; that being to improve access to quality reproductive and children's health services. However, USAID wishes to have "substantial involvement" in the program, characteristic of cooperative agreements rather than grants. Although this will be described in more detail in subsequent procurement documentation, USAID's substantial involvement will include:

- a. Review and approval of annual work plans by the recipient;
- b. Approval authority for expatriate professionals employed by the recipient; and
- c. Concurrence authority on subgrant recipients.

2. Contraceptives - Contraceptives are procured directly through USAID/W to take advantage of bulk prices. This is consistent with standard Agency practices.

3. Results Monitoring - The Mission will select from a range of options for results monitoring. Approximately \$150,000 is reserved for possible Agency audits and financial assessments which could be contracted through IQC mechanisms. Other aspects of Results Monitoring, e.g. DHS, will be contracted directly or through Global Bureau buy-ins. In any case, all will be directly procured through the RSM's Office of Regional Procurement.

4. Support for 8(a) Businesses - Direct contracting under FHABS is limited to the Results Monitoring Line Item. The Mission will make every effort to include 8(a) firms in carrying out those activities, e.g. Agency audits, evaluations, etc. through IQCs, Global Bureau CAs and other qualified firms.

TABLE 1 - FHABS PROCUREMENT PLAN				
ACTION	IMPLEMENTATION MODE	FINANCING METHOD	ESTIMATED COST	NOTES
Umbrella Cooperative Agreement	AID Direct Competitive RFA	FRLC	\$15,000,000	Contains estimated \$11,000,000 subgrant component
Contraceptives	Central Procurement through Global Bureau	Cost-Reimbursement	\$ 3,800,000	Ordered in annual installments over LOP; consigned to either umbrella organization, RCG or private organization, as appropriate
Results Monitoring Tools (including audits)	IQCS, Buy-ins, as appropriate	Cost-reimbursement	\$ 1,200,000	
Total			\$20,000,000	

D. Assessment of Counterpart Agency Internal Controls/Procurement Procedures

1. Funds in FHABS are administered directly by US NGOs rather than RCG institutions. As described above, USAID will award a single cooperative agreement to a US entity.

2. USAID will experiment with contraceptive distribution through a variety of channels, including through the CMS. The vulnerabilities of the CMS were recently assessed by a World Bank team contracted to Management Sciences for Health and judged to be acceptable, relying on ongoing management assistance from UNICEF. To the extent that FHABS relies on utilization of the CMS, however, it will be performance-based, taking into consideration service delivery effectiveness, as acknowledged by FHABS-assisted NGOs.

Modified Project Logical Framework
Cambodia Family Health and Birth Spacing Project (442-0115)
 LOP Funding: \$20 Million PACD: 9/30/00

Project Narrative	Objectively Verifiable Indicators	Results Monitoring Tools	Feasibility and Risks/Important Assumptions
<p>Strategic Objective/Goal:</p> <p>To improve family health as an integral component of meeting basic human needs</p>	<p>BY THE YEAR 2000:</p> <ol style="list-style-type: none"> 1. Decrease child mortality rate 20% (from est. 185 to 158). 2. Decrease maternal mortality rate 20% (from est. 500 to 400 per 100,000 births). 3. Increase contraceptive prevalence by 25% (from est. 5% - 30%) 	<ol style="list-style-type: none"> 1. Demographic & Health Surveys (DHS); 2. Contraceptive prevalence surveys; 	<ol style="list-style-type: none"> 1. Political stability; 2. Continued international support for Cambodia; 3. Continued progress in economic development; 4. Continued multilateral & bilateral donor cooperation & coordination.
<p>Program Objective/Purpose:</p> <p>To increase access to and use of quality reproductive and children's health services, particularly birth spacing</p>	<p>Results Desired/End-of-Project Status (EOPS):</p> <ol style="list-style-type: none"> 1. 50% of women receiving at least 1 pre-natal visit at project delivery sites; 2. At least one SDP offering modern contraceptive methods located in 40 districts; 3. 150,000 birth spacing clients receive services from a project delivery sites 	<ol style="list-style-type: none"> 1. Field surveys; 2. KAP Survey; 3. Training Evaluation 4. Service Statistics 5. MOH & PVO/NGO reports 	<ol style="list-style-type: none"> 1. Cambodian government policy support for reproductive health and birth spacing; 2. Strong demand by Cambodian women for birth spacing services;
<p>Interventions/Outputs:</p> <ol style="list-style-type: none"> 1. Expanded, integrated quality reproductive health services; 2. Improved capacity for training; 3. Trained cadre of health workers providing standardized, quality reproductive health services; 4. Reliable supply of modern contraceptive methods; 	<p>Indicators of Success/Magnitude of Outputs:</p> <ol style="list-style-type: none"> 1. Standardized curricula developed and utilized nationally; 2. Est. 200 courses for health care service delivery workers, including FP, STD/HIV Prevention, Pregnancy Care, Child Survival; 3. 3 modern methods of contraceptives consistently available at project delivery sites; 4. Increased number of new reproductive health care delivery points with recently trained staff & standardized and approved services. 	<ol style="list-style-type: none"> 1. PVO/NGO progress reports; 2. Logistical system monitoring reports; 3. MOH Coordination Committee meetings; 4. NGO/PVO Coordination meetings 	<ol style="list-style-type: none"> 1. Cambodian government supports PVO/NGO-based approach to implement reproductive health programs; 2. Effective contraceptive distributions can be utilized; 3. Effective reproductive health training strategies can be successfully applied to Cambodia; 4. Appropriate incentives exist among MOH service providers to learn and deliver improved services.
<p>Resource Requirements/Inputs:</p> <ol style="list-style-type: none"> 1. Reproductive Health Training; 2. Subgrants to PVO/NGOs; 3. Contraceptives; 4. Results Monitoring 	<p>Magnitude of Inputs (Program Only):</p> <ol style="list-style-type: none"> 1. Cooperative Agreement comprising: <ul style="list-style-type: none"> * Reproductive Health Training: \$ 4.0 million * PVO/NGO Sub-grants/contracts: \$11.0 million 2. Contraceptive supplies: \$ 3.8 million 3. Results Monitoring services: \$ 1.2 million 	<ol style="list-style-type: none"> 1. Signed umbrella cooperative agreement; 2. Results Package Team Meetings 3. USAID/W and RSM technical support 	<ol style="list-style-type: none"> 1. RCG approval and support (e.g. visas, work permits, duty free clearances, etc.) for commodities and PVO/NGOs; 2. Appropriate procurement and finance support from RSM/EA and USAID/W (ANE & G/PNH)

PD-ABL021

CAMBODIA FAMILY HEALTH AND
BIRTH SPACING PROJECT
(442-0115)

VOLUME II
ANNEXES

ACTION: AID INFO: COM DCM POL RF

ANNEX B

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F RUEHC #9243/21 2851039
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O RUEFPF/AMEMBASSY PHNOM PENE 7900
NFC RUEHBK/AMEMBASSY BANGKOK 9572

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442-0115 / 16 C.

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AGS:

SUBJECT: CAMBODIA FAMILY HEALTH AND CHILD SPACING (FHCS) PROJECT (442-0115) - APPROVAL OF NAD

REFERENCE: PENOM PENE 00248 JANUARY 27, 1994

AA/ANE APPROVES THE NEW ACTIVITY DOCUMENT (NAD) FOR THE CAMBODIA FAMILY HEALTH AND CHILD SPACING PROJECT AND WILL APPROVE FIELD AUTHORIZATION OF THE FIVE YEAR PROJECT OR UP TO 20 MILLION DOLLARS. AUTHORITY WILL BE DELEGATED UPON COMPLETION AND AID/W APPROVAL OF OAR AND RSM MISSION UNDER ON PROJECT DESIGN, AUTHORIZATION, AND OBLIGATION RESPONSIBILITIES. THE OAR/CAMBODIA WILL THEN RECEIVE A STANDING DELEGATION OF AUTHORITY FOR PROJECT AUTHORIZATION AND THE APPROVAL TO USE THE DELEGATION FOR THE FHCS PROJECT.

THE ANE BUREAU REVIEW OF THE NAD WAS CONDUCTED ON MARCH 2, 1994, CHAIRED BY ANE/ASIA/PD AND INCLUDED PARTICIPATION BY THE FIELD DESK OFFICER, THE HEALTH AND POPULATION OFFICERS FROM THE TECHNICAL RESOURCES DIVISION, AND REPRESENTATIVES FROM THE GLOBAL BUREAU, CENTER FOR EXCELLENCE IN HEALTH AND POPULATION, THE WID OFFICE, AND THE MANAGEMENT BUREAU.

THE OVERVIEW AND INSIGHTS PROVIDED BY AIDREP LEE TWENTYMAN WERE KEY TO THE REVIEW.

IN CAMBODIA WHERE OVER 20 PERCENT OF THE POPULATION UNDER THE AGE OF FIVE THE CHALLENGES OF FAMILY PLANNING ARE ENORMOUS, THE MOST IMPORTANT OF WHICH IS THE POTENTIAL RISK OF PRO-NATALIST CONCERNS WHICH MIGHT SLOW DOWN AN EMERGING NATIONAL CONSENSUS. IT IS CRITICAL FOR FAMILY PLANNING EFFORTS TO BEGIN SOON TO AVOID THE NEGATIVE SOCIAL AND ECONOMIC RAMIFICATIONS OF A POPULATION EXPLOSION IN 10-15 YEARS. KEY DESIGN AND POLICY ISSUES ARE DISCUSSED BELOW.

PROJECT FOCUS AND RANGE OF ACTIVITIES

THE EXTENT TO WHICH THE GOVERNMENT OF CAMBODIA WANTS TO MOVE FORWARD WITH REPRODUCTIVE HEALTH AND BIRTH SPACING ACTIVITIES WILL BE A MAJOR DETERMINANT OF THE PROJECT FOCUS AND RANGE OF ACTIVITY. LIMITED ACCEPTANCE OF FAMILY PLANNING/BIRTH SPACING MIGHT RESULT IN AN ACTIVITY OR

ALL PROJECT THAT WOULD BE SIMPLY A BIRTH SPACING
EDUCATION PROGRAM FOR CAMBODIA LEADERSHIP COUPLED WITH
EXTENSIVE SUPPORT. WE UNDERSTAND
THE ASSISTANCE PLAN IN THE NAD REFLECTS THE OAR'S BEST
ESTIMATE OF WHAT CAN BE DONE, ESPECIALLY GIVEN RCG'S
LIMITED ABSORPTIVE CAPACITY IN THIS AREA. IN DELEGATING
THE AUTHORITY TO OAR/ CAMBODIA, WE RECOGNIZE THE WIDE
RANGE OF POSSIBLE FINAL DESIGNS FOR THE PROJECT. TO DEAL
WITH THE DESIGN, TWO FACTORS ARE IMPORTANT:

(1) SIMPLICITY AND FLEXIBILITY

GIVEN THE EVOLVING POLICY AND LIMITED ABSORPTIVE CAPACITY
AND INSTITUTIONAL BASE, THE PROJECT DESIGN PROCESS WILL BE
COMPLEX BUT WE SUPPORT THE OAR PLANS FOR KEEPING THE
PROJECT SIMPLE AND FLEXIBLE TO BUILD ON OPPORTUNITIES AS
THE SITUATION CHANGES. THAT THE OAR IS ALREADY WORKING
WITH THE GOVERNMENT AND SUPPORTING NGOS IN THE
IMPLEMENTATION OF MATERNAL AND CHILD HEALTH ACTIVITIES IS
A POSITIVE EARLY STEP. WE ALSO SEE TECHNICAL WORK BY
HEALTH AND FAMILY PLANNING CONSULTANTS AS WELL AS SOCIAL
SCIENTISTS (INCLUDING GENDER ISSUE REVIEW) PRECEDING THE
DESIGN PROCESS AS MAKING GOOD SENSE. THEIR ASSESSMENTS
AND ASSISTANCE WOULD ESTABLISH PLANS FOR MOH DEVELOPMENT
AND APPRAISE WHAT NGOS AND OTHER DONORS ARE DOING IN
FAMILY HEALTH AND BIRTH SPACING.

Simple
flexible

(2) THE DESIGN PROCESS

THE DESIGN TEAM IS KEY TO THE DEVELOPMENT OF AN
APPROPRIATE INTERVENTION IN CAMBODIA. STRONG AND WELL
BALANCED TECHNICAL CAPABILITIES IN FP, MCH, AND THE SOCIAL
SCIENCES WILL BE REQUIRED. WE ARE NOT SETTING OUT THE
DESIGN SCOPE AND SCHEDULE AT THIS TIME, BUT WILL RELY
THE OAR TO COLLABORATE CLOSELY WITH RSM, THE ANE BUREAU,
AND GLOBAL BUREAU HEALTH AND POPULATION DIVISIONS TO DRAW
TOGETHER THE NEEDED EXPERTISE.

IN ORDER TO KEEP THE PROJECT SIMPLE AND YET FLEXIBLE, A
PHASED PROJECT MIGHT BE PRACTICAL AND SHOULD BE
CONSIDERED, WITH THE SECOND PHASE TO BE DEVELOPED BASED ON
AN OAR ASSESSMENT OF THE INITIAL ACTIVITIES.

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P. RURAL EXTENSION OF SERVICES

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SPECIALY, THE MISSION WILL CONCENTRATE ITS EFFORTS ON ACCESSIBLE AREAS THAT ARE POLITICALLY SECURE. IN ITS PROJECT DESIGN, THE MISSION MAY WANT TO ADDRESS AN OUTREACH COMPONENT FOR THE EVENTUAL EXPANSION OF SERVICES. IN THE LONG TERM, A SUCCESSFUL FAMILY HEALTH PROGRAM IN CAMBODIA WILL BE DEPENDENT ON THE DEVELOPMENT OF A SUFFICIENT RURAL INFRASTRUCTURE FOR EASY ACCESS TO SERVICES.

C. REGIONAL ASIAN SUPPORT

THE MISSION SHOULD ENCOURAGE CAMBODIANS TO TAKE ADVANTAGE OF REGIONAL EXPERIENCE. INDONESIA HAS OFFERED USE OF THEIR FACILITIES FOR CAMBODIANS TO INCREASE THEIR TECHNICAL KNOWLEDGE OF FAMILY HEALTH ISSUES. OTHER ASIAN COUNTRIES, FOR EXAMPLE PHILIPPINES, MIGHT BE CONSIDERED. FROM THE PERSPECTIVE OF USAID REGIONAL SUPPORT, WE SUGGEST THAT YOU CONSIDER JUMP-STARTING THE TRAINING PROCESS BY USING THE EAST ASIA REGIONAL TRAINING PROJECT.

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L. HOUSEHOLD AND GENDER-LED PROGRAMMING

THE REVIEW COMMITTEE DISCUSSED THE IDEA OF "GENDER-LED PROGRAMMING" OR A HOUSEHOLD APPROACH TO CAMBODIA'S FAMILY HEALTH AND CHILD SPACING NEEDS. ANE/ASIA/TR WILL BE PROVIDING ADDITIONAL INFORMATION ON THESE APPROACHES. BECAUSE THE INSTITUTIONAL AND SERVICE DELIVERY BASE FOR ALL FAMILY HEALTH SERVICES IS SO LOW, CAMBODIA HAS A SPECIAL OPPORTUNITY AND A CHALLENGE TO MOVE QUICKLY TO ADDRESS FAMILY HEALTH NEEDS. USAID CAN HELP ESTABLISH INNOVATIVE APPROACHES THAT ARE PARTICIPATORY, CUSTOMER DRIVEN AND FOCUSED ON THOSE MOST IN NEED. A HOUSEHOLD OR GENDER-LED PROGRAMMING CAN BE SUCH AN APPROACH. AS DISCUSSED WITH THE OAR, THE SOCIAL SOUNDNESS ANALYSIS IS THE RIGHT VEHICLE TO IDENTIFY AN APPROPRIATE APPROACH TO

FAMILY HEALTH AND BIRTH SPACING. ANE/ASIA/TR CAN PROVIDE CAPOL RICE, TECHNICAL ADVISOR FOR AIDS AND CHILD SURVIVAL TO HELP IN THE DESIGN INCLUDING THE SSA.

N. PLANNING FOR SHORT TERM MOE ADVISORY ASSISTANCE

GIVEN THE NEED TO DEVELOP POLICY REGARDING FAMILY AND REPRODUCTIVE HEALTH INTERVENTIONS, AND TO DEVELOP AND STRENGTHEN THE HEALTH INFRASTRUCTURE WITHIN THE RCG, PLACING A STAFF MEMBER IN THE MOE EVEN BEFORE THE PROJECT DESIGN STAGE, AS RECOMMENDED BY THE OAR, IS CONSIDERED DESIRABLE. MECHANISMS AVAILABLE THROUGH THE RSM TECHNICAL SUPPORT PROJECT OR THE GLOBAL BUREAU, CENTER FOR EXCELLENCE IN HEALTH AND POPULATION SHOULD BE EXPLORED TO SECURE THE PLACEMENT OF SUCH AN ADVISOR IN THE MOE.

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ព្រះ រាជានាម ចក្រកម្ពុជា
ជាតិ - សាសនា - ព្រះមហាក្សត្រ
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លេខ : ១៤៩៧ ស.កទក

ភ្នំពេញ, ថ្ងៃទី ១២ ខែ មិថុនា ១៩៩៤

រដ្ឋមន្ត្រី សុខាភិបាល
គោរពជូន

ឯកឧត្តម អោត ឃាត់ ទេសរដ្ឋមន្ត្រី
និងជាអនុប្រធានក្រុមប្រឹក្សាភិបាលក្រុមប្រឹក្សា

ក ម ខ ត ៖ សំណើដើម្បីធ្វើអន្តរាគមន៍ទៅ អង្គការ USAID អោយជួយវិស័យសុខាភិបាល ។

លេចក្តីដំបូងនៅក្នុងកម្មវត្ថុខាងលើ ខ្ញុំសូមជម្រាបឯកឧត្តមថា កាលពី ថ្ងៃទី ១៣ ខែ មិថុនា ១៩៩៤ លោក Ned Greeley នាយកអំឡុងទំនាក់ទំនងអង្គការ USAID បានជួបពិភាក្សាជាមួយតំណាងក្រសួងសុខាភិបាល ហើយបានសន្យាថា នឹង ពិនិត្យ លទ្ធភាពជួយដល់ក្រសួងសុខាភិបាល លើវិស័យសុខភាពគ្រួសារ និង គំរោងពន្យារកំណើតលើក កំណែសុខភាពគ្រួសារ និង ផលិតភាពផលមានគំរោងសមាសភាពលំដាប់ ដ៏ដ្ឋានដ៏ល្អសំខាន់ៗ មិនអោយមានកូន ការចេះចង្ការ ការផ្សព្វផ្សាយ និង ផ្គត់ផ្គង់កម្មវិធី គំរោងមាតា និង ទារកចង្កើនផលមានគំរោងសង្ខេបរបស់ USAID ផ្តល់ភ្ជាប់មកជាមួយនេះ ។

អាស្រ័យពេតដូចបានជម្រាបជូនខាងលើ សូមឯកឧត្តមមេត្តាពិនិត្យ និង ជួយ ធ្វើអន្តរាគមន៍ដល់អង្គការខាងលើ តាមសំណើដោយអនុគ្រោះ ។

សូមឯកឧត្តមមេត្តាទទួលខ្ញុំ លេចក្តីគោរពដ៏ខ្ពង់ខ្ពស់អំពីខ្ញុំ ។ *(Signature)*


ស្រី.នា. ថាខ

Modified Project Logical Framework
Cambodia Family Health and Birth Spacing Project (442-0115)
 LOP Funding: \$20 Million PACD: 9/30/00

Project Narrative	Objectively Verifiable Indicators	Results Monitoring Tools	Feasibility and Risks/Important Assumptions
<p>Strategic Objective/Goal:</p> <p>To improve family health as an integral component of meeting basic human needs</p>	<p>BY THE YEAR 2000:</p> <ol style="list-style-type: none"> 1. Decrease child mortality rate 20% (from est. 185 to 158). 2. Decrease maternal mortality rate 20% (from est. 500 to 400 per 100,000 births). 3. Increase contraceptive prevalence by 25% (from est. 5% - 30%) 	<ol style="list-style-type: none"> 1. Demographic & Health Surveys (DHS); 2. Contraceptive prevalence surveys; 	<ol style="list-style-type: none"> 1. Political stability; 2. Continued international support for Cambodia; 3. Continued progress in economic development; 4. Continued multilateral & bilateral donor cooperation & coordination.
<p>Program Objective/Purpose:</p> <p>To increase access to and use of quality reproductive and children's health services, particularly birth spacing</p>	<p>Results Desired/End-of-Project Status (EOPS):</p> <ol style="list-style-type: none"> 1. 50% of women receiving at least 1 pre-natal visit at project delivery sites; 2. At least one SDP offering modern contraceptive methods located in 40 districts; 3. 150,000 birth spacing clients receive services from a project delivery sites 	<ol style="list-style-type: none"> 1. Field surveys; 2. KAP Survey; 3. Training Evaluation 4. Service Statistics 5. MOH & PVO/NGO reports 	<ol style="list-style-type: none"> 1. Cambodian government policy support for reproductive health and birth spacing; 2. Strong demand by Cambodian women for birth spacing services;
<p>Interventions/Outputs:</p> <ol style="list-style-type: none"> 1. Expanded, integrated quality reproductive health services; 2. Improved capacity for training; 3. Trained cadre of health workers providing standardized, quality reproductive health services; 4. Reliable supply of modern contraceptive methods; 	<p>Indicators of Success/Magnitude of Outputs:</p> <ol style="list-style-type: none"> 1. Standardized curricula developed and utilized nationally; 2. Est. 200 courses for health care service delivery workers, including FP, STD/HIV Prevention, Pregnancy Care, Child Survival; 3. 3 modern methods of contraceptives consistently available at project delivery sites; 4. Increased number of new reproductive health care delivery points with recently trained staff & standardized and approved services. 	<p>1. PVO/NGO progress reports;</p> <ol style="list-style-type: none"> 2. Logistical system monitoring reports; 3. MOH Coordination Committee meetings; 4. NGO/PVO Coordination meetings 	<ol style="list-style-type: none"> 1. Cambodian government supports PVO/NGO-based approach to implement reproductive health programs; 2. Effective contraceptive distributions can be utilized; 3. Effective reproductive health training strategies can be successfully applied to Cambodia; 4. Appropriate incentives exist among MOH service providers to learn and deliver improved services.
<p>Resource Requirements/Inputs:</p> <ol style="list-style-type: none"> 1. Reproductive Health Training; 2. Subgrants to PVO/NGOs; 3. Contraceptives; 4. Results Monitoring 	<p>Magnitude of Inputs (Program Only):</p> <ol style="list-style-type: none"> 1. Cooperative Agreement comprising: <ul style="list-style-type: none"> * Reproductive Health Training: \$ 4.0 million * PVO/NGO Sub-grants/contracts: \$11.0 million 2. Contraceptive supplies: \$ 3.8 million 3. Results Monitoring services: \$ 1.2 million 	<ol style="list-style-type: none"> 1. Signed umbrella cooperative agreement; 2. Results Package Team Meetings 3. USAID/W and RSM technical support 	<ol style="list-style-type: none"> 1. RCG approval and support (e.g. visas, work permits, duty free clearances, etc.) for commodities and PVO/NGOs; 2. Appropriate procurement and finance support from RSM/EA and USAID/W (ANE & G/PNH)

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Translation

Annex C

Ministry of Health
No.465

Kingdom of Cambodia
National Religion King

Phnom Penh, 17 August 1994

Minister of Health

In respect to

H.E. Kiet Chhon, Minister of State and Vice Chairman of
Cambodian Development Council

Subject: Request for USAID's involvement in health sector

Reference to above subject, I would like to inform Your Excellency that on June 13, 1994 Mr. Ned Greeley, Director of USAID projects, had a meeting with the Representative of Health Ministry, in this meeting he promised to look for a possibility in helping Ministry of Health on Family Health and Birth Spacing in order to improve family health and productivity by providing important materials such as contraceptives, training, and supporting mother and child care program (see attached USAID's summary outline).

As request, please Your Excellency kindly facilitate the above organization.

Please accept my highest consideration.

Minister of Health

Dr. Chea Thang

ANNEX D

INITIAL ENVIRONMENTAL EXAMINATION

Project Name: Cambodia Family Health and Birth Spacing Project
Project Number: 442-0115
LOP Funding: \$20,000,000
PACD: 9/30/00
Prepared By: Denny Robertson, USAID/RSM/EA

INITIAL RECOMMENDATION: Approval of a categorical exclusion from further consideration under the AID environmental procedures as the initial environmental finding for this project.

BACKGROUND: AID environmental regulations allow a categorical exclusion if the following conditions are met (Section 216.2, Categorical Exclusion):

(i) The project does not have an effect on the natural or physical environment, and

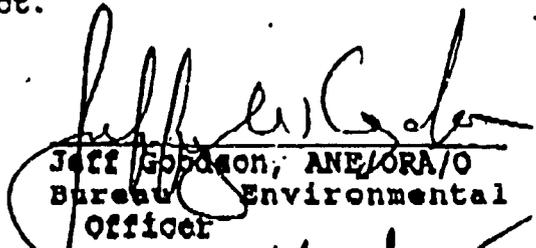
(ii) AID does not have knowledge of or control over, and the objective of AID in furnishing assistance does not require, either prior to approval of financing or prior to implementation of specific activities, knowledge of or control over the details of the specific activities that may have an effect on the physical and natural environment for which financing is provided by AID.

DISCUSSION: The goal of the project is to improve family health, cited as one of the major obstacles to further economic development in Cambodia. The purpose of the project is to increase access to birth spacing services principally through increased availability of contraceptives and improved training capacity by health workers in the public and private sectors. The project does not include any construction activities. Because the project will be limited to providing education, training and technical assistance, it is categorically excluded pursuant to 22 CFR 216.2(c)(2)(1).

RECOMMENDATION: That you approve a categorical exclusion for the Family Health and Birth Spacing project.


 George Sposito
 Acting AIE Representative
 USAID/Cambodia

Date: March 16 1995


 Jeff Godson, ANE/ORA/O
 Bureau Environmental
 Officer

Date: 21 March 95

CAMBODIA

DEMOGRAPHIC AND ECONOMIC HIGHLIGHTS

9.1 million	Total population
\$220	Annual per capita income (US\$ equivalent)
2.7%	Annual population growth rate
45-48	Birth rate (births per 1,000 population)
20	Death rate (deaths per 1,000 population)
7	Total fertility rate (births per woman)
3-5%	Contraceptive prevalence rate (percent of women of reproductive age using some form of contraception)
115-135	Infant mortality rate (annual deaths among children less than 1 year old per 1,000 live births)
185	Child mortality rate (under 5)
500-1,200	Maternal mortality rate (deaths among women related to childbearing per 100,000 deliveries)
51	Life expectancy at birth (years)
65%	Illiteracy rate (percent of population over age 15 unable to read or write a short, simple statement about everyday life)
37%	Female labor force (percent of total labor force)

The above figures are derived from several sources, including USAID, World Bank and WHO. Please note: all figures are estimates and should be treated as such.

See additional demographic data, health sector statistics and social indicators taken from the 1993 World Bank Social Indicators of Development.

A. Background

Organized birth spacing programs are almost unknown in Cambodia. Contraceptive prevalence is informally estimated to be three to five percent of women of reproductive age. Contraceptives are not available in most public health facilities, but are available in some pharmacies and through some private physicians.

Within the past year, several NGOs have initiated small birth spacing activities in a limited number of sites, generally in conjunction with the MCH component of their health programs. Demand for birth spacing services appears to be high based on the results of these projects. The UNFPA has authorized a birth spacing project, but the detailed planning for and implementation of any activities will be delayed until the June 1994 arrival of the UNFPA advisors.

USAID awarded grants to two U.S. PVOs in late 1993. FPIA received a grant of \$5 million to develop birth spacing projects at one hospital in Phnom Penh and three provincial hospitals; the FPIA long-term advisors arrived in early 1994 and activities are still in the planning stage.

Similarly, PSI received a \$2.5 million grant to develop a contraceptive social marketing program; the PSI long-term advisors arrived in early 1994 and an implementation plan is now being developed. If PSI is able to adhere to its planned schedule, it will initiate a condom sales program in September 1994.

Both the FPIA program and the PSI program include HIV prevention components. PSI's private sector activities will market condoms not only for birth spacing purposes, but also as STD and HIV preventive measures. PSI has also indicated the possibility of marketing KY jelly in the future as a means of increasing condom acceptance and compliance. FPIA plans to establish a model service delivery clinic for both birthspacing and STD diagnosis and treatment. HIV counseling will be provided at this clinic.

Analyses of development programs in Cambodia, particularly health programs, highlight certain persistent problems. There are few technically trained Cambodians in government service and not many more in the private sector. As described in other sections, the administrative structure of government entities is only beginning to take shape, staff are poorly trained and poorly paid. The physical infrastructure of hospitals and clinics at most levels is in poor condition. Equipment, drugs and other supplies are in short supply. The government's budget is limited in all sectors and most ministries must rely heavily on donor support for any service activities.

The international NGO community is well represented in Cambodia by about 125 organizations. About 60 of these NGOs have on-going health programs and most of them have expressed an interest in initiating birth spacing programs as well.

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B. Policy Environment

Following two decades of civil war and genocide, public statements of the government have supported a pro-natalist policy intended to build up the decimated population of Cambodia. Many couples do not agree with the pro-natalist policy; after long periods of severe deprivation, they wanted to space their children and limit family size.

Although the government still favors a growing population, it has recently recognized that the unusually high rates of maternal and infant mortality are exacerbated by frequent pregnancies, uncontrolled fertility and the widespread practice of abortions - many septic. As a result, the government has shifted its policy to support birth spacing to improve the health of mothers and children. The government does not support a policy of birth spacing for demographic reasons.

There does not appear to be any significant opposition to the new birth spacing policy. On the contrary, the prompt provision of birth spacing services is viewed as a tangible expression of the government's responsiveness to expressed needs of the people. One of the main objectives of the MOH is to make modern contraceptives available at provincial and district hospitals. Although a detailed national plan to extend birth spacing services has not been developed, the government has encouraged NGOs to initiate birth spacing activities to meet the clear and substantial demand.

The MOH, through the National MCH Center, issued its policy and program goals in a published report on November 18, 1993. The major goal related to family health and birth spacing is to reduce the maternal mortality rate by 20% across the country during the 18 months to the end of 1996. To reach this goal, the MOH has established 11 sub-goals, as follows:

1. Increase the average length of **time between birth and conception** to at least 2 years for 30% of childbearing women by the end of 1996.
2. For the number of women attending **routine antenatal care** at least twice during pregnancy to be increased to 50% of all pregnant women in urban areas and rural areas by the end of 1996.
3. To ensure that, by the end of 1996, all women giving birth at hospital, and 50% of women giving birth at home, are attended by a TBA or midwife who has received recent approved training in **safe delivery techniques**.
4. By November 1994, to estimate the current **maternal mortality rate** throughout Cambodia, and to reduce the rate in hospital facilities by 20% by the end of 1996.

5. To improve analysis of maternal mortality by extending the **confidential survey** on maternal mortality to one additional provincial hospital each year.
6. To formulate and implement by July 1994 a policy and **system for referring** at risk women and children between different levels of MCH services, ensuring adequate communication and feedback between referring parties.
7. To ensure that by the end of 1996, district, provincial and national MCH **referral centers are appropriately equipped and staffed** to recognize, accept and treat referred cases.
8. To improve the case **management** of women at risk of complications of pregnancy and birth.
9. To work with the Ministry of Health Technical Section to improve the extent and speed of **supply of blood** to hospitals, especially in emergency situations.
10. To work towards regulation and monitoring the **private health services** to improve the quality of private maternity services.
11. To work with the Ministry of Health to develop policies and regulations concerning reduction in the number of **unwanted pregnancies**.

C. Birth Spacing Knowledge, Attitudes and Practices - Surveys and Experience to Date

Clear evidence of the great unmet demand for birth spacing services has emerged from small surveys and from pilot service delivery programs. A number of NGOs have collaborated with MOH hospitals in these path finding efforts.

In addition to the work of the NGOs, a recently published master's thesis provides an interesting study of reproductive health and behavior of a sample of women in Phnom Penh. This thesis by Tsuyoshi Enomoto is entitled "Factors affecting the pregnancy interval among the mothers in reproductive age: a study in Phnom Penh, Cambodia, Mahidol University, 1994".

This MPH thesis was based on interviews of 350 mothers who attended ante-natal clinics during February 1994 at two public maternity hospitals in Phnom Penh, the 7 January hospital and the Phnom Penh municipal hospital.

The mean pregnancy interval among the women interviewed was 27 months. In 57% of the mothers, however, the interval was less than two years. Mean age was 28. This group of urban mothers had fewer than two living children on average.

Nearly 40% of the mothers had experienced one or more interrupted pregnancy. One-fourth of the mothers had ended the previous pregnancy in stillbirth or abortion - 4 stillbirths, 41 spontaneous and 38 induced abortions.

Seventeen percent of the women had been using contraceptives an average of 14 months; over 80% of those using contraceptives had received birth spacing services from a private clinic or pharmacy.

Questions on knowledge of contraceptive methods indicated persistent misunderstandings, e.g., 50% believed that an IUD would cause massive bleeding, and 45% believed that pregnancy intervals in excess of two years would result in a mother's physical weakness.

D. Estimated Contraceptives Requirements and Suggested Method Mix

To raise contraceptive prevalence from the currently estimated 3-5 percent of women of child-bearing age to 30 percent by the year 1999 will be a major undertaking. It will require substantial amounts of contraceptives to meet the current unmet demand as well as the increased demand anticipated to develop through the training and IEC components of the project. In addition, demand will be stimulated by the activities of the FPIA, PSI and UNFPA projects. While each of those projects will provide some contraceptives, it is clear that USAID will be the major supplier of contraceptives, funded from this project. Although the estimates provided below are for the total amount of contraceptives required to meet the target, USAID anticipates providing 80 percent, with other donors providing the remaining 20 percent.

At this early stage of the birth spacing program in Cambodia, it is difficult to forecast the demand for contraceptives over the next five years or to forecast the likely contraceptive method mix over the same period. However, in order to develop budget estimates for the project paper, the design team has made some forecasts. The team assumes that USAID will supply most of the contraceptives needed for the program and has based its estimates on the following five-year projection of increasing numbers of new acceptors and continuing users. The method mix upon which the contraceptives is based is as follows:

- 60% - injectable contraceptives
- 20% - oral contraceptives
- 10% - IUDs
- 7% - contraceptive implants
- 3% - condoms

Cambodian women of child bearing age are approximately 22 percent of the population, or 2.0 million women. The birth spacing goal is to have 30 % of the women of child bearing age, or 600,000 women, practicing modern contraception within five years. Calculations assume a 30% annual discontinuation rate. The result is that the national birth spacing program will need to

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attract 860,000 new clients between 1995 and 1999, of whom 604,500 are expected to be continuing users by the end of the project. If these targets are achieved, the national birth spacing program will have provided about 2,000,000 couple years of contraceptive protection.

<u>NEW AND CONTINUING BIRTH SPACING CLIENTS</u> 1995-1999				
1995	1996	1997	1998	1999
<u>60,000</u>	42,000	29,400	20,580	14,406
	<u>100,000</u>	70,000	49,000	34,300
		<u>150,000</u>	105,000	73,500
			<u>225,000</u>	157,500
				<u>325,000</u>
60,000	142,000	249,400	399,580	604,500

Total continuing clients = 604,500

Total new clients = 860,000

The cost of the contraceptives required to meet this projected demand is \$7.9 million (including shipping and handling costs), as follows:

<u>Contraceptive</u>	<u>Clients</u>	<u>Quantity</u>	<u>Cost</u>	<u>Est. CYP</u>
Depo-provera	873,300	3,493,200	\$3,493,200	873,300
Pills	291,100	3,784,300	756,860	291,100
IUDs	145,500	145,500	160,050	436,500
Norplant	101,880	101,880	2,547,000	407,520
Condoms	43,700	4,370,000	218,500	43,700

One couple year of protection (CYP) is based on the following calculations:

Depo-provera	4 doses = 1 CYP
Pills	13 cycles = 1 CYP
IUDs	1 IUD = 3 CYP
Norplant	1 implant = 4 CYP
Condoms	100 condoms = 1 CYP

There will be some losses due to shipping, breakage, losses and unused contraceptives, so the above CYP estimates are somewhat on the high side.

E. Technical and Managerial Capability

1. Key Elements of the MOH

All government institutions, including the Ministry of Health, possess limited technical and managerial capability. They are short of trained staff, personnel changes are frequent, and frequent leadership shifts make it difficult to assure continued policy and program support for any particular project.

a. National Maternal and Child Health Center (MCH)

The Maternal and Child Health Center is responsible for developing and monitoring birth spacing programs for the government. It has a total staff of 26 persons. Dr. Koum Kanal, deputy director of the Center, will be the main project liaison person. He is responsible for the birth spacing programs of the government, developing birth spacing policy, reviewing and managing the government's approval process for all donor assistance proposals, chairing periodic donor coordination meetings, preparing in Khmer appropriate medical and technical protocols for use of each contraceptive method and other service delivery related procedures. The MCH has gained experience over the past few years in dealing with donor organizations for planning and monitoring health programs and, to a limited extent, birth spacing activities of several donor agencies.

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b. Central Medical Stores (CMS)

The CMS is responsible for importing and distributing all medical supplies, including pharmaceuticals, to all government hospitals (national, provincial and district) and to about 75% of commune clinics. CMS handles all medical supplies procured through UNICEF, the World Bank and other donors. According to the UNICEF advisor at CMS, the distribution system is entirely government; all drugs are provided free; record keeping is good; appropriate medical supplies, including pharmaceuticals, are adequately supplied and delivered on scheduled basis by CMS trucks; and overall, the system works well. Unofficially, almost no pharmaceuticals are provided free to patients. Nearly all patients make unofficial payments for medical services and pharmaceuticals, but these payments are not reported. It is this system of unofficial payments that keeps the system in operation and helps provide adequate compensation to health workers by supplementing salaries which are too low to sustain a family.

The CMS employs 17 persons at its central facility in Phnom Penh, including both professional and support staff. The UNICEF advisor is expected to remain for several more years.

c. National Center for Hygiene and Epidemiology (CNHE)

The CNHE was created to be the MOH's center of expertise in communicable disease surveillance and control. However, because of limited funding, CHNE's role has been reduced to management of the national expanded program of immunizations (EPI) and a rural water and sanitation program, both funded by UNICEF. The MOH's 1994-1995 health policy and strategic guidelines paper proposes staff training to help CHNE develop a research and training capacity. CHNE has recently taken on responsibility for undergraduate public health training at the faculty of medicine. Thirty trainers have begun training with WHO technical assistance. The MOH anticipates that CHNE will take the lead role in developing public health continuing education for health workers. At present, some CHNE staff members are conducting surveys and investigations and improving their skills in epidemiologic surveillance.

CNHE employs 174 persons, including 16 physicians, 12 medical assistants and 29 nurses. The center has limited staff capability to undertake additional research tasks. Some of the professional staff members are now abroad for graduate studies; others will be leaving in the fall of 1994. Before initiating any research with the center, one would need to identify a particular researcher at the institute and determine qualifications and availability during the period of research. Over the long-run, donor assistance is needed to strengthen the research capability of the CNHE staff.

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d. Phnom Penh Mixed Faculty of Medicine, Dentistry and Pharmacy

The Faculty of Medicine (Faculte Mixte) is the only institution in Cambodia which trains medical, dental and pharmacy personnel. Among its total staff of 84 persons are 26 physicians, 12 medical assistants, 11 pharmacists 13 nurses and 9 laboratory technicians.

In the "Health Policy and Strategy Guidelines for 1994-1995", prepared by the MOH with WHO technical assistance, future plans call for medical training to become competency based and community oriented. All health professionals serving in a training capacity are to be trained in modern teaching and educational methodology and evaluation. All curricula will be reviewed based on MOH job descriptions and revised to a primary health care (PHC) approach augmented by skills required for referral. Emphasis will be on improving the quality of both theoretical and practical teaching, with special emphasis on improving the relevance and quality of basic science teaching and expansion of public health. Links will be strengthened with primary health care (PHC) projects, the national hospitals and institutes to provide adequate practical application and experience. The MOH will seek to identify resources to upgrade the infrastructure and provide improved teaching and learning facilities.

e. Schools of Nursing

At present there are schools of nursing in Phnom Penh, Kompot, Kompong Cham, Battambang and Stung Treng. The nursing schools are responsible for training both nurses and midwives in either one year or three year courses.

The national school of nursing and midwifery is known as the Ecole des Cadres Sanitaires (ECCS). Located in Phnom Penh, it trains nurses, midwives, post-basic anesthetic nurses, laboratory technicians and physio-therapists. This institution, along with the faculty of medicine, will be key foci for cooperating agency training inputs.

(Please see section F.3 below for more information on training at these two schools).

f. Phnom Penh Hospitals

Existing public hospitals in Phnom Penh - particularly those providing MCH care - represent potential outlets for birth spacing services. These facilities may be appropriate sites for the introduction of high quality counseling and contraceptive provision at an early stage of program implementation.

As an illustration of potential hospital-based outlets for birth spacing services, the table on the next page shows 1992 data on inpatient and outpatient visits for maternal and pediatric care at the main hospitals in Phnom Penh.

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HOSPITAL	Maternity in-patient bed days	Pediatric in-patient bed days	Maternity out-patients	Pediatric out-patients
Calmette	8,960		3,968	
Kantha-Bopha		38,880		67,787
National Pediatric		63,718		156,514
Sihanouk	8,945	5,987	2,157	6,079
January 7 th	total 64,622 and	maternal pediatric	13,686	23,281
Municipal	14,561	5,310	12,300	7,254
Worker's	4,359		984	3,120
Mean Chey	2,352	800	5,067	6,417
Russey Keo	960	1,440	2,895	11,772
Chamkar Mon Dispensary			19,105	8,892

There are also a number of private maternity and pediatric clinics operating in the environs of Phnom Penh. Along with the public facilities, they represent potential service outlets for the urban population.

During the course of program implementation, the project management team will need to assess the possibilities of NGO support in introducing birth spacing services at several of these locations.

g. Provincial and District Hospitals

The MOH operates hospitals in 21 provinces (two provinces have two hospitals each) and in most of the 176 districts. The hospitals vary widely in their current state of repair. The 1994-95 development plan prepared by the MOH with WHO technical assistance includes a plan for construction of eight provincial and 19 district hospitals and the renovation of 9 provincial and 49 district hospitals. No funding sources have been identified for this ambitious infrastructure improvement plan.

Once the project is approved, it is essential that the MOH identify the specific provinces and districts to which the project resources will be channeled. The MOH, together with the provincial and districts hospitals, will need to identify the specific venues where birth spacing program will function and any remodeling or renovations required.

h. Coordinating Committee of the Ministry of Health (COCOM)

This coordinating committee was established in 1989 to serve two major advisory functions for the MOH:

the rehabilitation of Cambodia's health services; policy development and health planning, including determining health sector needs for financial and human resources, and

the coordination of current and future activities of all international and non-governmental organizations working in the health sector.

COCOM is chaired by the vice-minister of health and includes all senior health department heads, representatives from WHO, UNICEF, International Committee of the Red Cross (ICRC) and International Federation of Red Cross and Red Crescent Societies (IFRC). Three elected NGO representatives are elected by MEDICAM (the NGO health coordination body, see below) and are members of COCOM. Currently the NGO representatives are Medecins Sans Frontieres H/B, save the Children Fund UK, and International Rescue Committee. Meetings are held monthly and minutes of each meeting are prepared and available to interested parties.

COCOM has established technical sub-committees to address specific issues or undertake reviews or special tasks. Specialists from donor organizations serve on these sub-committees which are now addressing the following problems:

Pharmacy Sub-committee - Develop an essential drugs and equipment list for the country;

Blood Safety Sub-committee - Review existing blood banks and advise on establishment of a national transfusion system;

Human Resources Sub-committee - Review the status of human resources in the health field and provide COCOM with policy and strategy options for continuous development of these resources; and

Health Information Systems Sub-committee - Review existing health information and advise on development of a new national standardized system.

COCOM has recommended to provincial health directors that they establish provincial health coordinating committees (PROCOCOM) and six provinces have already established working groups to plan and coordinate health activities. COCOM provides a useful forum for government, donor agencies and NGOs working in health to meet regularly to discuss issues and seek expert advice.

i. International Non-governmental Organizations (NGOs)

At present there are at least 125 international NGOs actively involved in health programs in Cambodia, including at least 20 that are PVOs registered with A.I.D. Several have initiated small birth spacing programs, generally in conjunction with their on-going maternal and child health activities. From discussions with representatives of the health NGOs/PVOs, many are interested and anxious to add a birth spacing component. Many NGO representatives indicate that a large percentage of women attending their MCH or other health activities are anxious to practice birth spacing.

The single biggest barrier at present limiting NGOs from initiating birth spacing activities is the lack of contraceptives. Also needed are training materials, training for their own staffs, IEC materials, and assistance in setting up simple registries to monitor clients and programs. Most of the NGOs have developed mechanisms for distributing medicines and other supplies from Phnom Penh to the district health facilities where they are working.

MEDICAM is a health sector forum for non-governmental organizations working in Cambodia. It was organized in 1989 to facilitate exchange of information between all agencies working in health. Beginning in 1990, MEDICAM became the health sector gathering for the Cooperation Committee for Cambodia, an umbrella organization providing information on the programs of all the NGOs working in Cambodia.

F. Project Specific Considerations

1. Contraceptive Technology and Distribution Mechanisms

Most modern temporary contraceptive methods are available in Cambodia, but in limited supply and at limited outlets. These include condoms, oral contraceptives and injectables. Injectables appear to be in highest demand. This may be because of the method's simplicity and infrequency of application, the ease of hiding the fact of use from a disinterested or opposed spouse or other family members, and a preference for an injection over daily pill taking. There has been little promotion of the condom, which is perceived as an accessory for sex outside of marriage. The MOH physicians prefer to recommend the IUD which has a higher couple years of protection advantage, but may have increased risk for STD and other vaginal infections. Almost no implants have been used in Cambodia to date so their acceptance is not known, although the senior staff at the MCH Center view it as an acceptable method. The MOH does not allow voluntary sterilization as part of its birth spacing program.

The distribution channels for contraceptives will be expanding rapidly during the remainder of 1994 as the FPIA, PSI and UNFPA projects move into the implementation stage. The UNFPA will utilize the Central Medical Stores mechanism for distribution of contraceptives to the 25 districts in which it will develop birth spacing programs. FPIA is authorized to procure contraceptives through the A.I.D. Office of Population's central procurement system. The exact mechanism FPIA will use for storage and delivery of contraceptives and other commodities from arrival in Phnom Penh to field distribution is still in the planning stage. PSI will be developing its own system for supplying its social marketing outlets, probably by utilizing an established local distributor.

2. Project Management

Management resources will be provided at two levels: first, to assure that USAID possesses the capacity to manage the bilateral project and to and provide adequate oversight for any major new undertaking; and second, to assure that the project activities are carefully planned, funded, implemented, monitored and evaluated.

To deal with the first requirement, USAID proposes to add to the staff a highly trained and experienced population and health officer, either a U.S. direct hire employee, a population fellow or a long-term personal services contractor. To deal with the second requirement, USAID proposes to solicit and select a competent and technically qualified organization under a cooperative agreement to assume overall project management responsibilities.

USAID has a small authorized USDH staff of four persons which will be increased to five later in 1994. While an additional USDH ceiling to add a qualified health/population officer to the staff would be preferable, it seem highly unlikely at this time. Therefore, USAID is making

alternate arrangements to secure the services of a population fellow or a long-term PSC project manager. USAID has already prepared the scope of work and is ready to circulate it to AID/W, all USAIDs, other donor agencies and the population and health cooperating agencies community. The SOW calls for a population specialist with experience managing population projects in developing countries who would serve as the USAID project manager. USAID plans to delegate all but a few essential managerial, procurement and oversight responsibilities for the project to this person. USAID anticipates that it might have the project manager selected and on board some months before arrival of the contractor's project management team.

USAID has developed a scope of work for a project management team and plans to utilize a cooperative agreement as the contracting mode. The project management team would be charged with a wide range of project implementation functions:

- a. Strategic planning and monitoring of activities for the phased approach to implementation of the project;
- b. Counterpart technical assistance support to Cambodian government officials at the national level, for example at the National MCH Center;
- c. Coordination and monitoring of buy-ins to selected centrally-funded population cooperating agencies;
- d. Administration of sub-grant program to NGOs operating in ten target provinces; and
- e. Estimating, ordering and distributing contraceptives to NGOs.

USAID involvement in the project would be limited to the following:

- review and approval of annual work plans;
- participation in the sub-grant selection process;
- approval of long-term expatriate staff; and
- formal processing of buy-ins for CAs.

3. Training

As a result of the all the civil strife over the past two decades, all MOH staff is poorly trained at all levels. There has been almost no training in birth spacing at any level of health worker so there is an immediate need for development of a birth spacing training curriculum and training materials, training a cadre of master trainers and implementing training courses for hospital staff at provincial and district hospitals. Development of a birth spacing curriculum and training materials for the medical school, nursing schools and midwifery training schools is another priority.

The best information on the status of health personnel comes from a draft report prepared in December 1993 by the MOH's Human Resources Department.

There are two grades of medical personnel, doctors and medical assistants, all of whom are trained at the only medical school in Cambodia, the Phnom Penh Mixed Faculty of Medicine, Dentistry and Pharmacy. At the time of the report, there were 1,731 students enrolled in the seven year doctor's program and 1,338 enrolled in the five year medical assistants program. The faculty has not admitted any new medical assistant students since 1991. Few doctors have any specialty training and only three doctors have obtained MPH degrees (from Australia and Thailand). Although many doctors are assigned to positions requiring management and training skills, they have had no training in these areas. Training for both doctors and medical assistants is curative focused. In some isolated provincial hospitals and at district hospitals, medical assistants often serve as doctors. About 64 percent of trained doctors practice in Phnom Penh as do about 38 percent of medical assistants.

Pharmacists receive five years of training at Phnom Penh Mixed Faculty of Medicine, Dentistry and Pharmacy and were expected to work mainly at the central and provincial levels. Pharmacy assistants receive four years of training, also at Phnom Penh Mixed Faculty of Medicine, Dentistry and Pharmacy; they were expected to work primarily at the district hospitals. However, at present more pharmacists than pharmacy assistants work at the district level. The school has not admitted new pharmacy assistant students since 1991.

At present there are few trained nursing and midwifery educators in Cambodia, apart from an occasional foreign specialist working with a donor or NGO. There is no career structure within the nursing profession; as a result the better qualified and motivated nurses seek training in other fields in order to advance their careers. Development of a cadre of well-trained nurse and midwife educators is essential for future training of nurses and midwives in Cambodia. There are nursing schools in Phnom Penh, Kompot, Kompong Cham, Battambang and Stung Treng which train both primary and secondary nurses. Secondary nurses receive three years of largely curative care training; any preventive health care is done on as in-service training after graduation. Primary nurses receive one year of training, mainly curative. Primary nurses work mainly at the district hospital or commune level, but recruitment is difficult given the isolation and lack of basic facilities at many posts.

The schools of nursing listed above also train primary and secondary midwives. Secondary midwives receive three years of training and work in hospitals at all levels. Their work is generally limited to midwifery and most have private practices (deliveries at the home of the mother). At the district and commune level, about half of all deliveries are done at home with the assistance of a Traditional Birth Attendant (TBA), rather than a midwife. As a result many of the secondary midwives are under-utilized at the hospital. Primary midwives receive one year of training and work mainly at the district and commune level. Similar to the primary nurse, these midwives play a limited role in the health system. A third category of nurses, graduated

nurse, received two years of training in border refugee camps. MOH statistics list 240 of them, but their location and current employment status is unknown.

Traditional birth attendants are in all communes and deliver about 50 percent of babies at that level. None are employed by the government. Their basic training is not formalized, there is no registration or certification and their role in the health system needs to be determined.

All of the above categories of health workers could play a role in a national birth spacing effort, but will require training to play an effective role.

Donor organizations have already contributed or have plans to assist the government to expand training programs in health and birth spacing. A brief description of these programs and planned programs follows.

The Asian Development Bank is considering a \$5 million program of in-service training. The aim will be to establish a training structure to upgrade essentially all medical workers to acceptable professional standards and to reorganize pre-service medical education.

WHO has budgeted \$700,000 for 1994 and \$1.5 million for 1995 for technical assistance to support this effort and to help the Ministry of Health plan and manage a program of continuing medical education for a more carefully rationalized national health staff. The ADB/WHO plan calls for the development of a core cadre of 30 health professionals to undergo a six month program on competency based training as preparation for leadership roles at regional and provincial levels.

NGO health educators who already function at provincial and district levels will be invited to participate in the next stage of the program, the development of a cadre of 400 trainers to extend competency based training at the district, commune and community levels of the health system.

The program will establish a central unit for continuing health education in Phnom Penh, and will utilize four existing regional schools of nursing as centers for continuing education, and will use 17 provincial facilities for continuing education at the province level.

This combined ADB/WHO program, collaborating with NGO's and existing MOH facilities, will also begin to address the needs of pre-service training through support to the central and regional schools of medicine and nursing. WHO has laid an important foundation for this effort by having reached consensus with the MOH to collapse 59 existing types of health diplomas into 23 categories, with the proviso that all professionals will need re-certification following complementary in-service training.

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Other donors have also begun to support the infrastructure needed for effective training.

At the **Battambang** provincial Center of Continuing Health Education and Regional Nurse Training School, UNDP/CARERE has proposed a \$250,000 project (phase II) for renovation, equipment/furniture and technical assistance for calendar 1994. This project will support continuing medical education for 1000 health staff persons and 816 student nurses.

At the **Banteay Meanchey** provincial Center for Continuing Health Education, UNDP/CARERE has proposed for 1994 a \$100,000 project of continued in-service training for the 650 staff members of the provincial health service.

At **Pursat**, UNDP/CARERE has proposed to support in-service training for 450 health staff persons at the provincial Center for Continuing Health Education.

In addition, several NGO's have funded the renovation of training centers and health facilities which serve as training venues.

Training supported under the USAID MCH/BS project will provide the specialized skills in reproductive health and birth spacing that is frequently overlooked in generalized training programs. Such specialized training has been undertaken in a few pilot courses in Cambodia. This experience will be useful in designing the detailed training strategy to be determined by the project management team and the specialized cooperating agency brought in to focus on this area.

The section below describes recent efforts which the Ministry of Health has made in birth spacing training.

The **National MCH Center** currently conducts courses lasting four to six weeks to train approximately five master trainers from each province; the master trainers - typically MD's, assistant MD's, 3-year nurses and 3-yr midwives - are then responsible for managing the training of district and commune practitioners.

As of March 1994, the heads of MCH services from 13 provinces had completed T.O.T. training, with an additional 5 in progress.

At the province level, trainers from the districts undergo a two week course to prepare them to train other district and commune staff. At the commune level, midwives typically receive 4 1/2 weeks of training, nurses 2 1/2 weeks and TBA's six days.

The **National MCH Center** believes that adequate training in birth spacing would require about 10 days for district level staff, and about three days for commune level staff, with the bulk of

the time spent on counseling strategies and contraceptive methodologies. The MCH center also stresses the need to train traditional midwives in safe delivery protocols because of the greater confidence that village women have in TBA's as compared to the 1-year and 3-year midwives employed by the MOH, who tend to be younger and less experienced, and who tend to be from outside the district.

The MCH Center encourages NGO's to collaborate at the provincial and district level to strengthen the training given by provincial staff. Much of this in-service training focuses on basic skills which for various reasons have never been mastered. For example, an American nurse-midwife with World Concern reported in November 1993 that only about one third of nurses and midwives in her classes were able to pass word problem literacy tests involving common drug names used in the clinics.

Other NGO's have reported that the initial training activities must be designed to bring nurses and midwives up to the minimal performance levels expected of the professions.

The MCH Center also manages supervision visits to provincial level MCH programs as a means of conducting in-service training and continuing professional education on site.

During 1992, the MCH Center managed a number of training courses as follows:

- four key staff members to Thailand for an IUD study tour
- 13 MD's and medical assistants trained in IUD insertion (10-day courses)
- 26 medical staff trained in birth spacing methodologies (5-day courses)
- trained 57 members of the Cambodian Women's Association in birth spacing (3-day courses)
- in addition, the MCH Center developed curricula and service protocols for IUD's, condoms and oral contraceptives

During 1993, the MCH Center managed a number of training activities as follows:

- clinical management of delivery procedures, pediatric care and sexually transmitted diseases for 200 health workers from twenty provinces;
- birth spacing methodologies for 48 members of the Phnom Penh Women's Association,
- birth spacing training for 37 physicians, medical assistants and auxiliary health workers in Kandal province, and various staff members of health centers in Phnom Penh; as part

of these courses, the MCH Center also developed training curricula in birth spacing techniques and practices;

- pediatric nursing care, 6 sessions in the provinces of Kompong Speu, Takeo and Phnom Penh for 68 health workers;
- national vitamin A workshop

During 1993, key members of the national MCH committee also participated in training programs in Indonesia and Thailand, with emphasis on I.E.C. program development and advanced clinical management of BS clients.

The USAID project will build on this experience through the infusion of technical assistance and financial support, principally through one or more specialized cooperating agency and the NGOs.

4. Information, Education and Communications (IEC)

This is an area largely uncovered by existing donor and NGO programs. Some training materials have been developed and prepared in the Khmer language. There has been no systematic attempt to identify contraceptive knowledge, attitudes and practice (KAP) other than in some district and commune level surveys by various donor organizations. In general, the current situation could be described as one where there is a lack of accurate information combined with much misinformation. At the same time, there is clear evidence that women respond positively when accurate information and contraceptive services are made available.

Radio appears to be the main source information in Cambodia, since television has limited coverage and literacy is low. There is limited circulation of newspapers and magazines.

With many NGOs now interested in birth spacing activities, development of a national IEC strategy with common themes and materials would be highly cost effective for all donors. USAID could initiate the process for developing an IEC strategy by requesting an initial visit by experts from the Population Communication Services (PCS) project at Johns Hopkins University. It is likely that such a visit by 1-2 experts could be financed under the PCS agreement from the AID/W Office of Population. The visit could lead to development of an action plan which could be funded by a USAID buy-in to the PCS project.

5. Data Gathering and Analysis for Management and Evaluation

Demographic data is scarce, consisting of the 1962 census and the 1992 census conducted by UNTAC in preparation for democratic elections. There is little of the data one would find in a demographic and health survey which could provide the MOH, donors and NGOs with baseline information for program design and evaluation. With more birth spacing activities now

at the implementation stage, and more in the planning stage, it is essential to develop standard data collection instruments and to conduct a standardized sample survey to establish baseline data against which to measure progress.

As an initial and immediate step, USAID could request a specialist from the Demographic and Health Surveys project to visit Cambodia to:

- a. assess available data;
 - b. assess the data collection and analysis capabilities of
 - c. recommend the client and program information required
 - d. develop an action plan for USAID to discuss with the
 - e. develop a scope of work for a possible USAID buy-in the
- GOC institutions;
for program
management and
evaluation; and
MOH and other
donors regarding
collection and analysis
of data essential for
program management
and evaluation.
DHS project for
longer-term technical
assistance.

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ECONOMIC ANALYSIS

The lack of reliable data and the evolving environment in which this project is being planned and will be implemented precludes any standard benefit-cost analysis. However, from studies undertaken in many other developing countries, it is clear that birth spacing programs provide a high benefit to cost ratio. There is every reason to assume that the same high benefit to cost ratio will apply to the proposed project. Examples from two countries illustrate this point.

In Indonesia, a break-even analysis using extremely conservative assumptions demonstrated that USAID/Indonesia's private sector family planning project would easily save the Government in educational and health expenditures alone, over 6.3 times the planned \$28 million invested in the project. In addition, an analysis of the benefit streams in education yielded an internal rate of return of 54% annually.

In Morocco, the cumulative benefits, net of costs, over a 20 year period corresponded to an internal rate of return of 175% annually. For the shorter term, the study concluded that the benefit-cost ratio is greater than one after only two years. Even a doubling of the estimated family planning costs per user does not significantly alter the qualitative conclusions reached by the analysis (the benefit-cost ratio would still be above one after two years). These figures were obtained even though the estimate of benefits did not include savings from not having to treat as many women with health problems related to childbearing, whether such acute treatment occurred in the ambulatory or hospital system; nor did it include child-related savings to the government beyond the ambulatory health system (e.g., hospital costs, primary and secondary education). The analysis concluded that family planning is a very attractive investment for the government.

Decreased births and increased birth intervals lead to improved child and maternal health and survival. With increased contraceptive prevalence, more fertility decisions will be the result of deliberate informed choice. These choices are influenced by the health, economic and social welfare of the family, better child survival, and better opportunities for future productive employment. It is assumed that investments in birth spacing have a real impact on reducing subsequent government expenditures over the long-term.

In Cambodia, the birth rate is estimated at 45 per 1,000 population; one of the highest rates of any country in the world. Maternal mortality is astronomical at 800 to 1,000 deaths per 100,000 live births; probably the highest rate of any country in the world. A leading cause of serious injury to women or maternal death is induced abortions by village midwives. The average Cambodian woman will have 6-7 children during her lifetime, creating a significant health hazard by itself. Infant and child mortality rates are also among the world's highest.

The proposed project objectives offer an opportunity to significantly reduce maternal and infant mortality by increasing the spacing of pregnancies. It is not possible to estimate these benefits in dollar numbers, but the examples from other countries should make clear the high benefit to cost ratio one should anticipate from the proposed project interventions.

SOCIAL SOUNDNESS ANALYSIS

Socio-cultural context There was a census in Cambodia in 1962. The next census was conducted by UNTAC in 1992 in preparation for democratic elections. There is no good national system for collecting data, much less analyzing it. Many international NGOs have been working in Cambodia for some years. From information gleaned from NGO reports, as well as information and insights gained from discussions with staff of NGOs, donor agencies and government officials, we have attempted to prepare an overview of the socio-cultural context within which the proposed project must operate. Much of the information is anecdotal; little would be classed as scientific research, but it is all there is available to work with in Cambodia. Some of the information is conflicting.

Cambodia ranks as one of the poorest countries in the world with an annual per capita income equivalent to US \$220. Devastated by the Khmer Rouge holocaust which claimed over a million victims in a country of only 8 million persons at that time, destroyed family structure, social cultural institutions and most government and private institutions, and subjected to continual warfare for two decades, the people and government of Cambodia are only beginning to recover and develop a new nation and reform family and social institutions.

The health of women and children was especially affected by the civil wars and disasters of the past two decades, with widespread starvation, extreme malnutrition and a near total lack of health services. During the wars, many men were killed or maimed in battle or by the hundreds of thousands to millions of land mines planted indiscriminately throughout the country. As a result, by the early 1980's, women represented 64 percent of the population; currently, women represent 57 percent of the population. About 35 percent of families are headed by a woman. Many other families have disabled husbands with limited earning power, putting the breadwinning responsibility on the woman.

Maternal mortality is shockingly high, with estimates of 800-1,000 deaths per 100,000 live births. The UNFPA reports that complications from induced abortions are the leading cause of maternal mortality.

Infant and child mortality rates are similarly high with an IMR estimated at 125-135 per 1,000 live births. About 20-25 percent of children die before reaching age five. Premature delivery and delivery complications cause about two thirds of infant mortality. Waterborne diseases are a leading cause of infant and child morbidity and mortality.

The fertility rate is among the highest in the world, with estimates of 40-60 live births annually per 1,000 population. Birth spacing services are seldom available; only three

percent of couples are estimated to be using contraceptives. From the limited studies undertaken in refugee camps and a few local areas, the demand for birth spacing services appears to be high. Over half of women interviewed do have some knowledge of at least one contraceptive method. Knowledge of the reproductive system is limited. Demand for injectable contraception is particularly high. This may be because of the ease of use; convenient and infrequent need to visit a center for service; ease of hiding one's contraceptive use if the husband is opposed; and the frequently perceived benefits of getting a "shot" of medicine.

HIV/AIDS rates are increasing dramatically. One limited 1992 survey of prostitutes showed 9.2 percent were infected with HIV. Condom use is low; prostitution appears to be increasing; and many misconceptions about HIV/AIDS and its transmission persist.

Birth spacing information and services appear to be of great interest to women. In the limited areas where services have actually been offered, demand has been high. This is perhaps the best available indicator birth spacing is acceptable and wanted by women (and couples).

The government has moved from a pro-natalist policy to one encouraging birth spacing within the context of improving the health of mothers and children. There does not appear to be any strong religious opposition to birth spacing.

Beneficiaries The major beneficiaries of the proposed project will be the Cambodian women of reproductive age. By adopting birth spacing, they should have fewer, healthier babies with a greater chance to grow to adulthood. The mothers will avoid much of the danger to their own health and lives by a reduction in the high maternal mortality rate due to decreased demand for induced abortion. Children will also be beneficiaries of the proposed project because of the potential for improvements in their health and life expectancy due to better spacing of pregnancies and lower numbers of children born to each mother.

Participation Women will also become major active participants in the birth spacing program. Primarily women will be trained to serve as birth spacing providers of information and services. As the program expands, new job opportunities will be created for women as service providers, especially at the district and village levels. A national association of midwives is in the early planning stages and might include provincial associations at a later date. This would be an important step in securing greater recognition for midwives.

Socio-cultural Feasibility Pilot projects have been initiated by NGOs in selected districts and refugee camps. Demand for birth spacing services has been much higher than anticipated with little opposition from men, families, religious or political leaders. There is every evidence, based on the limited birth spacing projects now being implemented, that a

significant proportion of women will take advantage of birth spacing services once the services are available at convenient times and places.

Impact Only a few limited scope birth spacing activities have actually begun implementation. During the next few months there will be a significant expansion of birth spacing programs, as already authorized projects of FPIA, PSI and UNFPA get underway. Each of these projects, as well as the smaller activities undertaken by NGOs, will satisfy a portion of existing demand for birth spacing. Along with the proposed activities under this project, each project will provide valuable information to guide all donor organizations, NGOs and the government in refining their programs, permitting greater replication in additional districts and improving the quality of programs in existing districts.

Issues Once the project is approved and detailed project implementation plans are developed in coordination with the MOH, NGOs and district health officials, there may be a need for more detailed socio-cultural studies to guide the development of birth spacing IEC programs, counseling programs, service delivery mechanisms, and to measure the impact of the program, especially the impact on the health and welfare of women and children.

Health Service Delivery at the Commune and Village Level and the Role and Status of Women

A detailed situational analysis of health service delivery at the commune and village level in Oudong District of Kompong Speu Province was undertaken by staff of the Australian Red Cross and the Oudong District Health Center Planning Team from July to December 1993 and a report was issued in March 1994. Although covering only one district, the analysis presents an excellent picture of health services at the local level, villager and local health worker views of health services and health providers, and some insights into the status and concerns of village women about health care. The survey included two inventories of commune health centers, focus group discussions with health workers and village women, and some individual in-depth interviews with widows, female returnees and women with small children.

Women want better health care for themselves and their families, especially their children. Traditional birth attendants and traditional healers (kru khmer) are trusted far more for health services and information than are commune health workers. Women were particularly concerned about health care during delivery and in the immediate post-partum period. They recognize that this is a period of high risk for them and their children because of their own poor health, unsafe delivery procedures by TBAs, and their vulnerability to supernatural and spiritual forces. The most common reported causes of maternal death are retained placental tissue and post-partum hemorrhage. Women continue to follow traditional socio-cultural practices and ceremonies following delivery to protect the mother and baby from witches and ghosts and strengthen the mother's health.

Many families cannot take advantage of district and provincial-level health services because of the financial costs. To utilize these services often means selling off some family assets, such as a cow, which compromises future family earning capacity, or going into debt. Although the villagers recognize that government health services may provide superior health care, they put their money and trust in the hands of less professional private practitioners (TBAs and kru khmer), possibly because these village neighbors will accept payment plans or in-kind contributions to make the health care affordable.

Less than one-third of all TBAs and drug sellers and less than two-thirds of private practitioners had received at least some modern training in health care. Commune health workers reported feeling a lack of support from district, commune and village officials and this limited support has declined substantially since May 1993. Only one-third of commune health workers received a government salary which also adds to their low morale. The number of active village health volunteers has also decreased sharply in the past year. Commune and village level health services suffer a serious "image" problem stemming from low motivation, limited visibility of the workers (exacerbated by little or no salary and few resources). Women in the community held the commune health workers in low esteem because of actual or imagined favoritism in delivery of services and medicines, limited knowledge of health and inexperience.

TBAs, on the other hand, are in greater demand and play a more important role (physically and culturally) in providing maternal health services. About half of the TBAs are consulted by women during their pregnancies. This indicates the need for TBA training in providing proper antenatal advice, recognizing high-risk pregnancies and the need for referral of such cases. The kru khmer are consulted frequently by women for advice on beliefs in the supernatural and spiritual.

Apart from health concerns related to pregnancy and delivery, women also were concerned with folk illnesses, vaginal discharge, uterine infections and menstrual problems. There appears to be a large unmet demand for information about sexuality, fertility and birth spacing. Injectable contraceptives were most in demand with oral contraceptives a close second. From discussions with village women, if modern birth spacing information and contraceptives are not readily available at the village level, they will seek services from uninformed private drug sellers or rely on abortion to terminate unwanted pregnancies. Women wanted health education, especially women's health and preventive health practices, training for TBAs and commune health workers, and fairer allocation of available health resources.

Widows and female returnees identified general social issues as more important to them than health issues. At present they get little recognition or support from government officers at any level and find it especially difficult to improve their lives or those of their children.

ADMINISTRATIVE AND INSTITUTIONAL ANALYSIS

MCH Center Organizational Structure

At the national level, the Cambodian Ministry of Health has assigned overall responsibility for birth spacing programs to the National Maternal Child Health Center, also known as the PMI (Protection Maternelle et Infantile) Center. As of this writing (May 1994) the official organization chart of the Ministry of Health has yet to be issued, but in practice the chain of responsibility is as follows:

The National MCH Center is one of several organizations reporting to the Director of Women's and Children's Services. The next higher level of supervision is the Director General of Health Services who reports to the Minister of Health through one of three under-secretaries of state for health. As of this writing, the under-secretary of state to whom the MCH Center reports is Dr. Mam Bun Heng. Currently, Dr. Hun Chhun Ly is the Director General of Health.

At the level of Cambodia's 21 provinces, the MCH committees of provincial health departments are responsible for the provincial MCH program, which reflects the priorities of the national center, e.g., maternal health, acute respiratory infection control, birth spacing, nutrition and control of diarrheal disease. The provincial MCH committees are responsible for supporting MCH programs in the 176 districts, which in turn support MCH activities in approximately 1500 communes and 11,300 villages.

Reorganization under the New Government of Cambodia

Beginning in 1994, a major structural change took place in the health services, (as well as in most other national services). Provincial (and district) health departments are no longer dependent on budgetary support and administrative direction from provincial governments. Rather, budgets and line authority are channelled directly from the Ministry of Health in Phnom Penh.

Vertical structure replaced horizontal structure. Equally important, a national budget was established for the first time to support provincial health departments which until then had to depend on allocations from provincial governments.

This fundamental administrative reorganization - to establish vertical authority and national budgets - made much more feasible the development of a national program based on consistent norms and administrative procedures. Because of this reorganization, the potential to organize a national birth spacing program became much greater in 1994 than it had been in 1993. At the top of this new structure stands the organization responsible for technical

and administrative management of the MCH program, the National MCH Center.

The MCH Center is directed by an executive committee of six physicians:

Dr. Eng Huot, Director
Dr. Koum Kanal, Deputy Director and Chief of Birth Spacing
Dr. Seang Tharit, Chief of OB/GYN
Dr. Tann Vouch Chheng, Chief of OPD
Dr. Sann Chansoeun, Chief of maternity and tech. bureau
Dr. Or Sivarin, Chief of curriculum development

This same team also constitutes the national birth spacing committee.

As the chief technical office in charge of the MCH program, the National MCH Center is responsible for setting policies and protocols, for training and supervision, for developing IEC materials, and for managing data required for program implementation. The key programmatic elements falling under the direction of the Center are:

Child health (including nutrition)
Maternal health (including safe pregnancy)
Birth spacing
Control of diarrheal diseases
Control of acute respiratory infection
MCH training and supervision
Information and management systems

The MCH Center has also begun to develop national norms and protocols for contraceptive methods and for service delivery. The Center has held policy and planning workshops with key professional staff from the provinces beginning to implement birth spacing activities and has developed and administered training programs for provincial master trainers.

The Center has prepared important service guidelines by adapting and translating into Khmer the following technical documents:

- contraceptive pill protocol from WHO
- condom protocol from FPIA
- lippes loop IUD protocol from WHO
- copper T IUD protocol from FPIA
- contraceptive counseling protocol from Population Reports
- pill and injectable protocol from FPIA
- service reporting forms from FPIA
- contraceptive methods wall chart from Population Crisis Committee

Staffing Pattern of the National MCH Center, 7 January Hospital and Kantha Bopha Hospital

Section	MD	Pharma cist	Asst MD	Den- tist	3-yr nurse	3-yr m.w.	Lab tech	1-yr nurse	1-yr m.w.	misc staff	TOTAL	No. in CME*
Direction	6										6	
Personnel			2			1		1		11	15	7
Pharmacy		7			1			5		12	25	10
Technical Bureau	5		3		3					1	12	1
Maternity	24		12			101		4		21	162	15
Pediatrics	11		8		8			3		6	36	8
Nursery			3					3		10	16	12
Mat. OPD	9		16			19		1	4	6	55	10

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Annex H - Administrative Analysis
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Section	MD	Pharma cist	Asst MD	Den- tist	3-yr nurse	3-yr m.w.	Lab tech	1-yr nurse	1-yr m.w.	misc staff	TOTAL	No. in CME*
Ped. OPD	4		3		2	1		9	4	2	25	7
X-ray			1		3					2	6	2
Laborator		2			1		6	3		1	13	3
Dentistry				1				1		1	3	
O.R.	5		7		11	1		1	1	4	30	
Administr.			1		1			10		22	34	2
Kantha-bopha H.	18	3	10		78	5	7	21		9	151	16
TOTAL	82	12	66	1	108	128	13	63	9	108	590	102

*continuing medical education

Staffing

The staffing pattern of the MCH Center as of March 1994 is present in the chart on the preceding pages.

The staff of the National MCH Center also has formal responsibility for the administration of the 7 January Maternal and Pediatric Hospital, and for the administration of the Kantha Bopha Children's hospital. In practice, the staffing situation is fluid, particularly in the case of the overlapping responsibilities which the key MCH staff have for managing both the MCH Center and the 7 January hospital.

The 1994 national budget for the Ministry of Health shows the approximate number of staff under the direction of the MCH Center as follows:

7 January hospital	447
Kantha Bopha hosp.	125
MCH Services	26

These staffing patterns show the preponderance of staff assigned to clinical facilities and the relatively small number of core staff presently available to manage a national MCH birth spacing program. Thus one of the principal developmental objectives of a national program will be to strengthen the professional staff capability to plan and manage an ever-expanding service delivery network. Although the Kantha Bopha Children's Hospital is under the nominal direction of the MCH center, it operates semi-autonomously with substantial financial and technical support from a Swiss NGO.

Government Salary Scales

As an example of one of the fundamental administrative difficulties facing not only the MCH Center but also the Ministry of Health as a whole, the staff of the Kantha Bopha Children's Hospital receive salary supplements from the Swiss NGO of up to nine times their government salary of \$10-20 per month. The staff at the MCH Center, on the other hand, must depend on outside income, generally from private clinics, to support their families.

To address the salary problem, external donors currently provide salary supplements to key staff persons at the MCH Center to enable them to devote a greater proportion of the workday to public programs. A.I.D. is precluded by law and logic from supplementing salaries. Thus, the task of developing a dedicated cadre of national program managers represents a special challenge to the project management team.

The National MCH Center is housed on the premises of the 7 January Hospital, also known

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as the Chinese Hospital, which serves as one of the principal public maternity and pediatric hospitals in Phnom Penh. The building is in poor repair and has been judged unsuitable for renovation. The ground floor is several feet below street level and subject to flooding. Electrical and plumbing utilities are inadequate.

The Japanese Government has indicated a willingness to build, equip and provide technical assistance to a new 150-bed MCH teaching hospital on the grounds of the old Pha Nga Ngam Hospital at a cost of \$10-\$15 million. This fully equipped facility, designed to manage approximately 500 trainees per year, would also include 12 classrooms, curriculum materials production facilities and dormitories for out-of-town trainees. Teams to prepare detailed designs of the physical facilities and the technical assistance package are due in Phnom Penh in the summer of 1994. If work proceeds according to schedule, the new facility may open in mid-1996.

Financial administration

As noted above, 1994 is the first year in the post Vietnam war era in which the MOH has had a meaningful budget, roughly \$24 million, six times the 1993 budget. Approximately half the budget is for Phnom Penh and half is for the health system in the provinces and districts.

For 1994, the MCH Center is budgeted at 69,189,482 Riels (approximately \$29,000 @ \$1=₭2400) and the 7 January Hospital at 1,348,340,041 Riels (approximately \$560,000). During the first quarter of 1994, administrative procedures had yet to be worked out between the Ministry of Finance and the line ministries for smooth allocations of funds under the new budget system, and not surprisingly, disbursements ran behind schedule.

Nevertheless, under the new vertical organization and with the new national budget system in place for the Ministry of Health, the MCH Center is better positioned to take the first steps toward planning for a comprehensive national program.

The MCH Center has gained useful administrative experience in managing donor assisted projects. UNICEF, for example, reports satisfaction with the procedures which the Center has established for budgeting and accounting for UNICEF funds provided in support of training and information programs in various MCH disciplines. FPIA similarly reports satisfaction with the way in which the center has managed both its programmatic reporting and its financial reporting during the two year period of its privately-funded pilot project (May 1992 - May 1994).

As the Center gains greater administrative experience with the new national budget system, as well as with donor-supported programs, e.g., FPIA, UNFPA, it should become increasingly well-qualified to manage larger programs.

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Central Medical Stores and UNICEF: Administrative and institutional analysis

The Central Medical Stores, a unit of the Ministry of Health, serves as the Cambodian Government's central facility for the logistical management of medical and pharmaceutical supplies. CMS arranges for customs clearance of medical commodities funded from the government budget, as well as commodities financed by international organizations, e.g., UNICEF, ODA, World Bank, the German Government, etc.

UNICEF provides full time technical assistance to Central Medical Stores and relies on CMS for the distribution of UNICEF essential drug kits to district hospitals and to commune dispensaries. UNICEF also relies on CMS for the distribution of vaccines used in the Expanded Program of Immunization (EPI), as well as pharmaceuticals used in specialized vertical programs, malaria, T.B. and leprosy.

CMS appears to be an appropriate mechanism for contraceptive logistical support under this proposed USAID bilateral birth spacing project. UNICEF has given assurances during project design discussions that they would welcome the addition of AID-funded contraceptives to the CMS supply network. They also indicated a willingness to pay port storage charges for any AID-funded contraceptives which arrive prior to the availability of bilateral funds to cover such charges.

UNICEF's interest in collaborating on contraceptive logistics reflects their own professional judgement of the importance of increasing contraceptive availability as part of a comprehensive primary health care program, as well as their preference to avoid creating a separate parallel distribution network.

AID's interests would probably best be served in this matter by having the AID cooperating agencies which manage the Family Planning Logistics Management Project (John Snow and CDC/Atlanta) conduct an assessment of the capabilities and effectiveness of Central Medical Stores as a contraceptive logistics system. Recommendations for further technical assistance to strengthen the institutional capabilities of CMS could then be available to the bilateral project managers.

UNICEF Provincial Advisors

A further asset which UNICEF is prepared to bring to bear on the contraceptive distribution system is the team of five long term advisors assigned to provincial health offices.

Each resident advisor is an MD/MPH. Each is assigned to focus on the first province listed below during 1994, and then to extend his or her advisory services to include the adjacent province during 1995.

<u>Provinces</u>	<u>Population (000)</u>	
	1994	1995
Battambang Pursat	615	265
Siem Reap Banteay Meanchey	580	450
Svay Rieng Prey Veng	425	805
Kandal Takeo	825	630
Kampong Cham		1,320

Discussions with these UNICEF provincial advisors confirmed their strong belief in the importance of making contraceptives available as part of the integrated health programs they oversee, as well as their willingness to monitor the distribution of contraceptive supplies provided by AID.

Non-Governmental Organizations

Please see summary analyses of the institutional capabilities of NGOs in MCH and birthspacing programs.

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable to the eligibility of countries to receive the following categories of assistance: (A) both Development Assistance and Economic Support Funds; (B) Development Assistance funds only; or (C) Economic Support Funds only.

A. COUNTRY ELIGIBILITY CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUND ASSISTANCE

1. Narcotics Certification

(FAA Sec. 490): (This provision applies to assistance provided by grant, sale, loan, lease, credit, guaranty, or insurance, except assistance relating to international narcotics control, disaster and refugee relief assistance, narcotics related assistance, or the provision of food (including the monetization of food) or medicine, and the provision of nonagricultural commodities under P.L. 480. This provision also does not apply to assistance for child survival and AIDS programs which can, under section 522 of the FY 1995 Appropriations Act, be made available notwithstanding any provision of law that restricts assistance to foreign countries, and programs identified in section 547 of that Act and other provisions of law that have similar notwithstanding authority.) If the recipient is a "major illicit drug producing country" (defined as a country in which during a year at least 1,000 hectares of illicit opium poppy is cultivated or harvested, or at least 1,000 hectares of illicit coca is cultivated or harvested, or at least 5,000 hectares of illicit cannabis is cultivated or harvested) or a "major drug-transit country" (defined as a country that is a significant direct source of illicit drugs significantly affecting the United States, through which such drugs are transported, or through which significant sums of drug-related profits are laundered with the knowledge or complicity of the government):

(1) has the President in the March 1 International Narcotics Control Strategy Report (INCSR) determined and certified to the Congress (without Congressional enactment, within 30 calendar days, of a resolution disapproving such a certification), that (a) during the previous year the country has cooperated fully with the United States or taken adequate steps on its own to satisfy the goals and objectives established by the U.N. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, or that (b) the vital national interests of the United States require the provision of such assistance?

(1) N/A

(2) with regard to a major illicit drug producing or drug-transit country for which the President has not certified on March 1, has the President determined and certified to Congress on any other date (with enactment by Congress of a resolution approving such certification) that the vital national interests of the United States require the provision of assistance, and has also certified that (a) the country has undergone a fundamental change in government, or (b) there has been a fundamental change in the conditions that were the reason why the President had not made a "fully cooperating" certification.

(2) N/A

2. Indebtedness to U.S. citizens (FAA Sec. 620(c): If assistance is to a government, is the government indebted to any U.S. citizen for goods or services furnished or ordered where: (a) such citizen has exhausted available legal remedies, (b) the debt is not denied or contested by such government, or (c) the indebtedness arises under an unconditional guaranty of payment given by such government or controlled entity?

No

3. Seizure of U.S. Property (Foreign Relations Authorization Act, Fiscal Years 1994 and 1995, Sec. 527): If assistance is to a government, has it (including any government agencies or instrumentalities) taken any action on or after January 1, 1956 which has the effect of

No

nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without (during the period specified in subsection (c) of this section) either returning the property, providing adequate and effective compensation for the property, offering a domestic procedure providing prompt, adequate, and effective compensation for the property, or submitting the dispute to international arbitration? If the actions of the government would otherwise prohibit assistance, has the President waived this prohibition and so notified Congress that it was in the national interest to do so?

4. **Communist and other countries** (FAA Secs. 620(a), 620(f), 620D; FY 1995 Appropriations Act Secs. 507, 523): Is recipient country a Communist country? If so, has the President: (a) determined that assistance to the country is vital to the security of the United States, that the recipient country is not controlled by the international Communist conspiracy, and that such assistance will further promote the independence of the recipient country from international communism, or (b) removed a country from applicable restrictions on assistance to communist countries upon a determination and report to Congress that such action is important to the national interest of the United States? Will assistance be provided directly to Cuba, Iraq, Libya, North Korea, Iran, Serbia, Sudan or Syria? Will assistance be provided indirectly to Cuba, Iraq, Libya, Iran, Syria, North Korea, or the People's Republic of China? Will assistance be provided to Afghanistan without a certification, or will assistance be provided inside Afghanistan through the Soviet-controlled government of Afghanistan?

No. Cambodia is no longer considered to be a Communist country by the USG.

5. **Mob Action** (FAA Sec. 620(j)): Has the country permitted, or failed to take adequate measures to prevent, damage or destruction by mob action of U.S. property?

No

6. **OPIC Investment Guaranty** (FAA Sec. 620(l)): Has the country failed to

No

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enter into an investment guaranty agreement with OPIC?

7. **Seizure of U.S. Fishing Vessels** (FAA Sec. 620(o); Fishermen's Protective Act of 1967 (as amended) Sec. 5): (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing vessel because of fishing activities in international waters? (b) If so, has any deduction required by the Fishermen's Protective Act been made?

(a) No
(b) N/A

8. **Loan Default** (FAA Sec. 620(q); FY 1995 Appropriations Act Sec. 512 (Brooke Amendment)): (a) Has the government of the recipient country been in default for more than six months on interest or principal of any loan to the country under the FAA? (b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the FY 1995 Appropriations Act appropriates funds?

(a) No
(b) No

9. **Military Equipment** (FAA Sec. 620(s)): If contemplated assistance is development loan or to come from Economic Support Fund has the Administrator taken into account the percentage of the country's budget and amount of the country's foreign exchange or other resources spent on military equipment? (Reference may be made to the annual "Taking Into Consideration" memo: "Yes, taken into account by the Administrator at time of approval of Agency OYB." This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)

Yes, taken into account by the Administrator when approving the OYB

10. **Diplomatic Relations with U.S.** (FAA Sec. 620(t)): Has the country severed diplomatic relations with the United States? If so, have relations been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?

Yes. Diplomatic relations were restored in September, 1993. There is a new Bilateral Agreement.

11. **U.N. Obligations** (FAA Sec. 620(u)): What is the payment status of the country's U.N. obligations? If the

No arrears with UN

country is in arrears, were such arrearages taken into account by the A.I.D. Administrator in determining the current A.I.D. Operational Year Budget? (Reference may be made to the "Taking into Consideration" memo.)

12. International Terrorism

a. **Sanctuary and support** (FY 1995 Appropriations Act Sec. 529; FAA Sec. 620A): Has the country been determined by the President to: (a) grant sanctuary from prosecution to any individual or group which has committed an act of international terrorism, or (b) otherwise support international terrorism, unless the President has waived this restriction on grounds of national security or for humanitarian reasons? (a) No
(b) No

b. **Airport Security** (ISDCA of 1985 Sec. 552(b)): Has the Secretary of State determined that the country is a high terrorist threat country after the Secretary of Transportation has determined, pursuant to section 1115(e)(2) of the Federal Aviation Act of 1958, that an airport in the country does not maintain and administer effective security measures? No

c. **Compliance with UN Sanctions** (FY 1995 Appropriations Act Sec. 538): Is assistance being provided to a country not in compliance with UN sanctions against Iraq, Serbia, or Montenegro and, if so, has the President made the necessary determinations to allow assistance to be provided? No

13. Countries that Export Lethal Military Equipment (FY 1995 Appropriations Act Sec. 563): Is assistance being made available to a government which provides lethal military equipment to a country the government of which the Secretary of State has determined is a terrorist government for purposes of section 40(d) of the Arms Export Control Act? No

14. Discrimination (FAA Sec. 666(b)): Does the country object, on the basis of race, religion, national origin No

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or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?

15. **Nuclear Technology** (Arms Export Control Act Secs. 101, 102): Has the country, after August 3, 1977, delivered to any other country or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards, and without special certification by the President? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device? If the country is a non-nuclear weapon state, has it, on or after August 8, 1985, exported (or attempted to export) illegally from the United States any material, equipment, or technology which would contribute significantly to the ability of a country to manufacture a nuclear explosive device? (FAA Sec. 620E(d) permits a special waiver of Sec. 101 for Pakistan.) **No**

16. **Algiers Meeting** (ISDCA of 1981, Sec. 720): Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Assembly of the U.N. on Sept. 25 and 28, 1981, and did it fail to disassociate itself from the communique issued? If so, has the President taken it into account? (Reference may be made to the "Taking into Consideration" memo.) **N/A**

17. **Military Coup** (FY 1995 Appropriations Act Sec. 508): Has the duly elected Head of Government of the country been deposed by military coup or decree? If assistance has been terminated, has the President notified Congress that a democratically elected government has taken office prior to the resumption of assistance? **No**

18. **Exploitation of Children** (FAA Sec. 116(b)): Does the recipient government fail to take appropriate and adequate measures, within its means, to **No**

protect children from exploitation, abuse or forced conscription into military or paramilitary services?

19. **Parking Fines** (FY 1995 Appropriations Act Sec. 564): Has the overall assistance allocation of funds for a country taken into account the requirements of this section to reduce assistance by 110 percent of the amount of unpaid parking fines owed to the District of Columbia as of August 23, 1994?

Yes

B. **COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO DEVELOPMENT ASSISTANCE ("DA")**

Human Rights Violations (FAA Sec. 116): Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?

No

C. **COUNTRY ELIGIBILITY CRITERIA APPLICABLE ONLY TO ECONOMIC SUPPORT FUNDS ("ESF")**

Human Rights Violations (FAA Sec. 502B): Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the President found that the country made such significant improvement in its human rights record that furnishing such assistance is in the U.S. national interest?

No

5C(2) - ASSISTANCE CHECKLIST

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

YES

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. **Host Country Development Efforts** (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

Project indirectly contributes to the economic development of Cambodia through improving health and productivity of families, in particular, women and children.

2. **U.S. Private Trade and Investment** (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

The Cambodian economy is very fragile after two decades of civil war. Most donors are involved in reconstruction of the economy to permit increase trade and investment in the medium-term.

3. **Congressional Notification**

a. **General requirement** (FY 1995 Appropriations Act Sec. 515; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the Appropriations Act notification requirement has been waived because of substantial risk to human health or welfare)?

Yes

b. **Special notification requirement** (FY 1995 Appropriations Act Sec. 520): Are all activities proposed for obligation subject to prior congressional notification?

Yes

c. **Notice of account transfer** (FY 1995 Appropriations Act Sec. 509): If funds are being obligated under an

N/A

appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

c. Cash transfers and nonproject sector assistance (FY 1995 Appropriations Act Sec. 536(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. Engineering and Financial Plans (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

N/A

5. Legislative Action (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

N/A

6. Water Resources (FAA Sec. 611(b)): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)?

N/A

7. Cash Transfer/Nonproject Sector Assistance Requirements (FY 1995 Appropriations Act Sec. 536). If assistance is in the form of a cash transfer or nonproject sector assistance:

N/A

a. **Separate account:** Are all such cash payments to be maintained by the country in a separate account and not commingled with any other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)?

b. **Local currencies:** If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

N/A

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S.

N/A

assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively?

9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

Project indirectly contributes to the economic development of Cambodia through improving health and productivity of families, in particular, women and children.

10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

The Cambodian economy is very fragile after two decades of civil war. Most donors are involved in reconstruction of the economy to permit eventual increases in trade and investment.

11. **Local Currencies**

a. **Recipient Contributions** (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

Cambodia is an RLDC and the U.S. owns no Cambodian currency.

b. **U.S.-Owned Currency** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No

12. **Trade Restrictions**

a. **Surplus Commodities** (FY 1995 Appropriations Act Sec. 513(a)): If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets

N/A

at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

No

b. Textiles (Lautenberg Amendment) (FY 1995 Appropriations Act Sec. 513(c)): Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3) (as referenced in section 532(d) of the FY 1993 Appropriations Act): Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

No

14. PVO Assistance

a. Auditing and registration (FY 1995 Appropriations Act Sec. 560): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.?

Yes All assistance to PVOs complies with USAID registration requirements.

b. Funding sources (FY 1995 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization),

Yes; All assistance to PVOs complies with USAID registration requirements.

does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government?

15. Project Agreement Documentation (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision).

Yes

16. Metric System (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

- (1) Yes
- (2) Yes
- (3) As appropriate

17. Abortions (FAA Sec. 104(f); FY 1995 Appropriations Act, Title II, under heading "Population, DA," and Sec. 518):

a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? (Note that the term "motivate"

No

does not include the provision, consistent with local law, of information or counseling about all pregnancy options including abortion.)

b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? **No**

c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? **No**

d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? (As a legal matter, DA only.) **Yes**

e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? (As a legal matter, DA only.) **No**

f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? **No**

g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? **No**

18. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life? **N/A**

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19. U.S.-Owned Foreign Currencies

a. **Use of currencies** (FAA Secs. 612(b), 636(h); FY 1995 Appropriations Act Secs. 503, 505): Are steps being taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.

The U.S. does not own any Cambodian currency.

b. **Release of currencies** (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No

20. Procurement

a. **Small business** (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?

Yes

b. **U.S. procurement** (FAA Sec. 604(a)): Will all procurement be from the U.S., the recipient country, or developing countries except as otherwise determined in accordance with the criteria of this section?

Yes

c. **Marine insurance** (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

Yes

d. **Insurance** (FY 1995 Appropriations Act Sec. 531): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. insurance companies have a fair opportunity to bid for insurance when such insurance is necessary or appropriate?

Yes

e. **Non-U.S. agricultural procurement** (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such

N/A

procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

f. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) **N/A**

g. Cargo preference shipping (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? **No**

h. Technical assistance (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? **Yes**

i. U.S. air carriers (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? **Yes**

j. Consulting services
(FY 1995 Appropriations Act Sec. 559): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?

Yes

k. Metric conversion
(Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes

Yes

As appropriate

l. Competitive Selection Procedures (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes

m. Notice Requirement (FY 1995 Appropriations Act Sec. 568): Will project agreements or contracts contain notice consistent with FAA section 604(a) and with the sense of Congress that to the greatest extent practicable equipment and products purchased with appropriated funds should be American-made?

Yes

21. Construction

a. Capital project (FAA Sec.

601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A

b. **Construction contract** (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A

c. **Large projects, Congressional approval** (FAA Sec. 620(k)): If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress? N/A

22. **U.S. Audit Rights** (FAA Sec. 301(d)): If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights? N/A

23. **Communist Assistance** (FAA Sec. 620(h)). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries? Yes

24. **Narcotics**

a. **Cash reimbursements** (FAA Sec. 483): Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated? Yes

b. **Assistance to narcotics traffickers** (FAA Sec. 487): Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been Yes

an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?

25. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? **Yes**

26. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? **Yes**

27. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? **Yes**

28. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? **Yes**

29. **Export of Nuclear Resources** (FY 1995 Appropriations Act Sec. 506): Will assistance preclude use of financing to finance--except for purposes of nuclear safety--the export of nuclear equipment, fuel, or technology? **Yes**

30. **Publicity or Propaganda** (FY 1995 Appropriations Act Sec. 554): Will assistance be used for publicity or propaganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propaganda purposes not authorized by Congress? **No**

31. **Exchange for Prohibited Act** (FY 1995 Appropriations Act Sec. 533): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that **No**

foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

32. **Commitment of Funds** (FAA Sec. 635(h)): Does a contract or agreement entail a commitment for the expenditure of funds during a period in excess of 5 years from the date of the contract or agreement? No

33. **Impact on U.S. Jobs** (FY 1995 Appropriations Act, Sec. 545):

a. Will any financial incentive be provided to a business located in the U.S. for the purpose of inducing that business to relocate outside the U.S. in a manner that would likely reduce the number of U.S. employees of that business? No

b. Will assistance be provided for the purpose of establishing or developing an export processing zone or designated area in which the country's tax, tariff, labor, environment, and safety laws do not apply? If so, has the President determined and certified that such assistance is not likely to cause a loss of jobs within the U.S.? No

c. Will assistance be provided for a project or activity that contributes to the violation of internationally recognized workers rights, as defined in section 502(a)(4) of the Trade Act of 1974, of workers in the recipient country, or will assistance be for the informal sector, micro or small-scale enterprise, or smallholder agriculture? No

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1995 Appropriations Act Sec. 513(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety N/A

improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

2. **Tied Aid Credits** (FY 1995 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

No

3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N/A

4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

The Project meets the expressed desires of Cambodian women to limit the size of their families and to provide for improved health care for their children, the most basic of needs.

5. **Economic Development** (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

The Project contributes toward increased health of Cambodian families, indirectly an input toward improved economic performance.

6. **Special Development Emphases** (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in

development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

7. Recipient Country Contribution (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

8. Benefit to Poor Majority (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

9. Contract Awards (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

10. Disadvantaged Enterprises (FY 1995 Appropriations Act Sec. 555): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic

- (a) the Project improves access to health care for women and children
- (b) N/A
- (c) The Ministry of Health list improved health care as one of its top priorities
- (d) The Project targets the health of women in particular.
- (e) N/A

Cambodia is an RLDC.

Yes

Yes

Where competitive contracting is involved, 10% of awards will be recommended for disadvantaged enterprises.

Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

11. **Biological Diversity** (FAA Sec. 119(g): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas? (Note new special authority for biodiversity activities contained in section 547(b) of the FY 1995 Appropriations Act.)

N/A

12. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act):

N/A

a. **A.I.D. Regulation 16:** Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

Yes

b. **Conservation:** Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end

N/A

destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

c. **Forest degradation:** Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas;

No

(3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

d. **Sustainable forestry:** If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

e. **Environmental impact statements:** Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

No

13. **Energy** (FY 1991 Appropriations Act Sec. 533(c) as referenced in section 532(d) of the FY 1993 Appropriations Act): If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

N/A

14. **Debt-for-Nature Exchange** (FAA Sec. 463): If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks

N/A

and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

15. Deobligation/Reobligation
(FY 1995 Appropriations Act Sec. 510): If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

N/A

16. Loans

a. Repayment capacity (FAA Sec. 122(b)): Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

N/A

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

N/A

c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

N/A

d. Exports to United States
(FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

N/A

17. **Development Objectives** (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

The Project directly supports the Royal Cambodian Government Ministry of Health to strength the delivery of basic health services at the District and sub-district level, including the training of MOH staff (particularly women).

18. **Agriculture, Rural Development and Nutrition, and Agricultural Research** (FAA Secs. 103 and 103A):

N/A

a. **Rural poor and small farmers:** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

b. **Nutrition:** Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement

and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

c. Food security: Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

19. Population and Health (FAA Secs. 104(b) and (c)): If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

The Project is provincial, district and sub-district base to focus on the poorest members of society. Project adopts the RCG strategy of employing development as a means to overcome the influence of the Khmer Rouge. Training will target lowest level MOH staff, including traditional birth attendants, nurse midwives, and nurses. Community based approaches will be employed where possible.

20. Education and Human Resources Development (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

N/A

21. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy,

private voluntary organizations, and selected development problems, describe extent to which activity is:

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

N/A

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

N/A

c. research into, and evaluation of, economic development processes and techniques;

N/A

d. reconstruction after natural or manmade disaster and programs of disaster preparedness;

N/A

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance;

N/A

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development.

N/A

22. **Capital Projects** (Jobs Through Export Act of 1992, Secs. 303 and 306(d)): If assistance is being provided for a capital project, is the project developmentally sound and will the project measurably alleviate the worst manifestations of poverty or directly promote environmental safety and sustainability at the community level?

N/A

C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

1. **Economic and Political Stability** (FAA Sec. 531(a)): Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? Yes

2. **Military Purposes** (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes? No

3. **Commodity Grants/Separate Accounts** (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? (For FY 1995, this provision is superseded by the separate account requirements of FY 1995 Appropriations Act Sec. 536(a), see Sec. 536(a)(5).) N/A

4. **Generation and Use of Local Currencies** (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? (For FY 1995, this provision is superseded by the separate account requirements of FY 1995 Appropriations Act Sec. 536(a), see Sec. 536(a)(5).) N/A

5. **Capital Projects** (Jobs Through Exports Act of 1992, Sec. 306): If assistance is being provided for a capital project, will the project be developmentally-sound and sustainable, i.e., one that is (a) environmentally sustainable, (b) within the financial capacity of the government or recipient to maintain from its own resources, and (c) responsive to a significant development priority initiated by the country to which assistance is being provided. (Please note the definition of "capital project" contained in section 595 of the FY 1993 N/A

Appropriations Act. Note, as well, that although a comparable provision does not appear in the FY 94 Appropriations Act, the FY 93 provision applies to, among other things, 2-year ESF funds which could be obligated in FY 94.)

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**UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
ACTIVITY DATA SHEET**

PROGRAM: CAMBODIA

CP 81-05 (4-85)

TITLE Family Health and Birth Spacing Project (FHABS)		FUNDING SOURCE ESF, POP, DA	PROPOSED OBLIGATION (In thousands of dollars)		
			FY 12,000	LIFE OF PROJECT (Auth.) 20,000	
NUMBER GRANT <input checked="" type="checkbox"/> LOAN <input type="checkbox"/>	NEW <input checked="" type="checkbox"/> CONTINUING <input type="checkbox"/>	PRIOR REFERENCE None	INITIAL OBLIGATION FY 95	ESTIMATED FINAL OBLIGATION FY 98	ESTIMATED COMPLETION DATE OF PROJECT FY 00

Purpose: to increase access to and use of quality reproductive and children's health services, particularly birth spacing and HIV/AIDS prevention.

Background: Cambodia is one of the world's poorest nations with social and economic indicators below most African countries owing to two decades of civil war. The country exhibits one of the highest maternal mortality rates (900/100,000 births), an infant mortality rate of 115 per 1,000 live births and has a population growth rate of 2.7%. There is also strong evidence suggesting the AIDS pandemic has reached Cambodia threatening the country's much hoped for economic recovery. Rapid improvement in the health of Cambodian families, particularly women and children, is one of the Government's highest priorities.

Project Description: FHABS is a five-year, \$20 million Project which strengthens the delivery of basic health services to women and children through support for continuing education of health care workers. FHABS will focus on strengthening reproductive and children's health care quality at service delivery points through training health care workers. The Project will increase the quantity of service delivery at the local level by continuing and expanding grant support to US NGO reproductive and children's health programs. The Project also supplies contraceptives required to sustain current programs while exploring alternatives for future requirements.

By the end of the Project, FHABS will significantly increase acceptors to modern contraceptive methods, increase the range of contraceptive methods available at service delivery points and increase the number of service delivery points offering quality reproductive and children's health care. Baseline data is being collected by other donors to fix appropriate results targets.

FHABS is characterized by simplicity of design and flexibility to respond to changing conditions. The principal implementation instrument will be a single competitively-awarded cooperative agreement with one or a group of US NGOs specializing in reproductive health training. This organization will also be responsible for administration and monitoring of a substantial subgrant program to US NGOs.

Relationship of Project to Country Strategy: FHABS is fully consistent with the Mission's approved Country Strategy – enhancing access to basic services and humanitarian assistance – and proposed Program Outcomes – improving family health programs on a national scale, leading to improved health of women and children and increased access to safe and reliable modern methods of contraception.

Host Country and Other Donors: The Royal Cambodian Government's Ministry of Health has targeted improved health service delivery at district level as its priority in the ICORC Paris 1995 meetings and has solicited substantial donor support to meet the huge needs. The MOH acknowledges the importance of and supports birth spacing as an essential component to improve maternal and child health. The MOH strategy is to strengthen basic preventative and curative health services at the district and subdistrict-level to make them more accessible, or better quality and better reflect the needs of the community that they serve. Numerous donors are involved in basic maternal and child health, including the UNFPA, WHO, UNICEF as well as other bilateral donors, e.g. ODA, AIDAB. The FHABS design complements activities of other donors working in the sector.

Beneficiaries: Direct beneficiaries of the Project are Cambodian women and children, among the most vulnerable populations in the country. Cambodian men are also direct beneficiaries although, to-date, men have not actively sought reproductive health services. This Project incorporates STD treatment and encourages condom use for protection against HIV/AIDS infection.

<u>A.I.D.-Financed Inputs (\$000)</u>	<u>Life-of-Project</u>
Training	\$ 4,000,000
NGO Subgrants	\$11,000,000
Contraceptives	\$ 3,800,000
Results Monitoring	\$ 1,200,000
Total	\$20,000,000

U.S. FINANCING (In thousands of dollars)				PRINCIPAL CONTRACTORS OR AGENCIES
	Obligations	Expenditures	Unliquidated	
Through September 30, 1993	0	0	0	UN PVO/NGOs
Estimated Fiscal Year 1994	0	0	0	
Estimated Through September 30, 1995	12,000	500	0	
		Future Year Obligations	Estimated Total Cost	
	12,000	8,000	20,000	

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