

## REGIONAL TECHNICAL SUPPORT PROJECT

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**Development Alternatives, Inc.**

Bangkok Thai Tower  
8th Floor, Suite 803  
108 Rangnam Road  
Khwang Thanon Phayathai  
Khet Ratchathewe  
Bangkok 10400, THAILAND

CAMBODIA FAMILY HEALTH AND  
BIRTH SPACING PROJECT  
(442-0112)

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**U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT**

**CAMBODIA FAMILY HEALTH AND  
BIRTH SPACING PROJECT  
(442-0112)**

**LOP FUNDING: \$20,000,000  
AUTHORIZATION DATE: JULY , 1994**

**UNCLASSIFIED**

# CAMBODIA



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1994

## 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)
less than 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)
900-1,200	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 Annex I for additional demographic data, health sector statistics and social indicators taken from the 1993 World Bank Social Indicators of Development.

## PROJECT BACKGROUND AND DETAILED DESCRIPTION

### BACKGROUND

Cambodia is one of the poorest countries in the world, with an estimated per capita gross domestic product of about \$220. But even this low figure conceals wide variations. Rice yields and average farm size suggest that per capita income in rural areas is much lower than that -- and more than 80 percent of the population lives in rural areas. The numbers and proportion of the population living at or below the absolute poverty line have not yet been determined, but it is expected to be very high.

The health status of the population is both a cause and effect of this severe poverty. The impact of debilitating illness on family productivity is well known. Medical expenses for treating such illnesses can be devastating, and stories of selling the family buffalo to pay for treatment are widespread. As medical bills mount, family productivity (and income) collapses.

The unusually high ratio of females to males in Cambodia, the result of generations of men fighting interminable wars, adds another dimension to the importance of health services -- this in spite of the fact that Cambodia probably has the highest maternal mortality rate in the world, estimated at 1 percent of live births. Induced abortions by village midwives and even less-trained traditional birth attendants are a leading cause of maternal death.

Impeding the flow of health services is the debilitated state of the government's financial system. Resources for the public health system have steadily declined, reducing an already inadequate system to virtual non-performance. Total health spending by the public sector was less than \$1 per capita in 1993.

Donors have provided assistance to the health sector, but often this assistance supports non-government organizations (NGOs) operating at the local level. This assistance largely by-passes the central government, resulting in a patchwork of fragmented assistance heavily dependent on expatriate management that cannot and will not be sustained.

The qualifications of practicing health professionals has deteriorated almost beyond belief. Recently the World Health Organization (WHO) gave a simple test to 60 practicing physicians who had applied for up-graded skills-training abroad. The test consisted of diagnosing an illness based on (AIDS) symptoms, diagnosing an eclampsia pregnancy problem, asking what not to do if a pregnant woman was bleeding from the uterus, and asking them to name all four of the major ingredients in oral rehydration salts (ORS). Three quarters of them could not answer the first

three questions and none of them could name the four ingredients.

The physical infrastructure of the public health system has suffered from years of war and neglect. Given the financial constraints mentioned above, the Ministry of Health must rely on international donors to rehabilitate hospitals and clinics (and those hospitals and clinics that don't get donor support just do what they can to provide basic services). This is a country where an informed person just would not want to get sick -- but also a country where many men, women, and children do.

The health picture is not entirely bleak, however. The **World Health Organization (WHO)** has a large program in Cambodia, including long term advisors to strengthen health services provided by the Ministry of Health (MOH) and for faculty and curriculum development at the Phnom Penh Mixed Faculty of Medicine and Pharmacy. The **United Nations International Children's Fund (UNICEF)** provides all the vaccines needed to implement a national expanded program of immunizations (EPI), and provides long term advisors to strengthen maternal and child health (MCH) programs.

In addition, many American PVOs have active health projects in Cambodia. The **American Red Cross** has a health and disability rehabilitation project in the Kompong Speu provincial hospital. The **American Refugee Committee** has health and water/sanitation projects in Pursat and Banteay Meanchey provinces. **CARE** has an integrated health project in Pursat province, and a drinking water project in Kratie province. The **International Rescue Committee** has a MCH project in Kompong Chhnang province and a water/sanitation project in Battambang province. **Private Agencies Collaborating Together (PACT)**, in partnership with **John Snow, Inc.** and local NGOs, has health programs in Takeo and Svay Rieng provinces. **World Concern** has a MCH project in Prey Veng province, and **World Vision** assists the National Pediatric Hospital in Phnom Penh.

Population growth is high with estimates varying between 2.7 and 3.2 percent annually. The population pyramid shows a disproportionate number of young children. The average woman will bear 6-7 children over her lifetime. All reports indicate there is a large unmet demand for contraception, but there is no organized birth spacing system to deliver services and information. A few NGOs have initiated small birth spacing activities in some districts and communes, but there is no comprehensive birth spacing program today in Cambodia. There is little reliable information about fertility and birth spacing behavior; there are a few studies undertaken by NGOs. One such study indicates that among the 91 percent of women in the southeastern province of Svay Rieng who wanted birth spacing in 1993, abortion was the only method known to 60 percent of them.

A limited range of contraceptives is available in some pharmacies, mainly in the larger cities. The NGOs that have initiated birth spacing activities have supplied contraceptives for their projects, but some of these NGOs are now completing their activities and no provision has been made for continuing contraceptive supplies to the acceptors in these programs. As a result of limited information about birth spacing and limited access to contraceptives, contraceptive prevalence is extremely low, less than five percent of eligible women according to the few studies to date. Without information or access to contraceptives, many women are unable to avoid unwanted pregnancies and frequently resort to abortion. Complications related to these unsafe abortions crowd limited hospital services and frequently lead to death.

Although a surprisingly large number of health workers are employed by the MOH, this cadre of workers is poorly trained and service delivery is well below internationally acceptable standards. Few health personnel are trained in modern contraceptive technology and counseling. Focus is on curative care, with little emphasis on women's health or birth spacing. Training programs for these health workers is an essential, immediate need.

Salaries for health workers are only \$10 - \$20 per month. Although basic health and medical services are supposed to be provided free to poor patients at government outlets, most Cambodians pay for services. It is widely believed that without these payments the delivery of medical services would cease altogether, as the practitioners just cannot feed their families on their salaries.

Although government policy favors population growth to help the country recover from the heavy loss of lives over the past two decades of war and atrocities, the MOH has approved a birth spacing policy to promote better maternal and child health. The ministry plan calls for providing birth spacing services to 30 percent of eligible couples by 1997. As a first step it plans to implement birth spacing programs in provincial and district hospitals. Nevertheless, to achieve the 30 percent target implies almost two million couple years of contraceptive protection delivered in a two year period -- which is unattainable given the level of skills currently available.

Given the clearly expressed demand for birth spacing services and the shortcomings of current donor inputs, USAID/Phnom Penh has determined that a birth spacing intervention is the most appropriate venue for its first bi-lateral project in Cambodia. In discussions with NGOs operating health programs, the Ministry of Health, other government organizations and other donors, it has been determined that there is wide-spread unmet demand for birth spacing from women of child-bearing age, and that spacing

births will contribute significantly to decreasing mortality and morbidity in those women and their children.

The proposed USAID project should be viewed in the context of a multi-donor and NGO effort to improve maternal and child health while strengthening the institutional capabilities of the Ministry of Health to implement such programs. USAID's efforts will focus on birth spacing because changing fertility behavior is so important for Cambodia's longer-term economic development and because other donors have elected to focus on the other important elements of maternal and child health. Several other donors and NGOs will be supporting birth spacing activities and the USAID project will complement, not compete with, these activities. Brief descriptions of the activities of the major donors are provided later in this paper.

This project will improve family health by improving and expanding modern medical birth spacing services and the supply of contraceptives. Initial focus will be on urban population centers (especially Phnom Penh) and the most densely populated provinces (Kompong Cham, Kandal, Prey Veng, Takeo, Kompong Speu, Kompot, Svey Rieng, Banteay Meanchey, Kompong Som, and Kompong Chhnang). Other provinces will be included during later phases, as experience is gained and lessons are learned during project implementation.

#### DETAILED DESCRIPTION

The goal of this project is to improve family health. It is currently estimated that fewer than 5 percent of women of child-bearing age are informed about and have access to modern birth spacing techniques. The Cambodian government, through the Ministry of Health, wants to increase that number to 30 percent by 1997. After careful review, it seems that target is just too optimistic. It does seem possible, however, to reach that target by the year 2000. Thus one of the objectively verifiable indicators for goal achievement is a 30 percent contraceptive prevalence rate by the year 2000.

The purpose of the project is increased access to and use of voluntary birth spacing services. By the end of this project, it is planned that there will be increased access to contraceptives through both public and private outlets, increased access to sound medical services, again through both public and private outlets, and increased knowledge and practice of modern birth spacing techniques among all Cambodian women of child bearing age.

The Ministry of Health (MOH) does have a maternal and child health (MCH) system in place. A National MCH Center is responsible for setting policies, priorities, and protocols, for training and supervision, for developing IEC materials, and for

management information required for program implementation. In Cambodia's 21 provinces, provincial MCH committees (which follow the policies and programs set by the Center) support MCH programs in the 176 districts of Cambodia (including more than 1500 communes). The MOH has personnel in place at all levels, from the national level right down to and including the communes.

Since 1992, birth spacing services have been authorized as part of MCH services through public channels such as national hospitals, provincial hospitals, district hospitals, and even commune clinics, and through private channels such as private clinics and pharmacies. The MOH has the capability to distribute contraceptives through its Central Medical Stores (CMS) and has a pilot birth spacing program in operation at its MCH Center. There are private medical clinics and offices throughout the land, and some contraceptives are available from pharmacies in provincial towns.

In practice, however, the system does not work well. The health workers operating in public hospitals often do not have sufficient training to understand and implement a birth spacing program based on modern medical techniques. The same is true of private outlets. Consequently there is much misinformation and misuse of contraceptives, resulting in unwelcome side effects and unwanted pregnancies. In addition, contraceptive supplies sometimes dry up leaving women without the protection they were counting on. No one can blame them if they become skeptical and critical and drop out.

Widespread demand for effective birth spacing is unfilled, in spite of MOH good intentions and published targets to do more. The National MCH Center recognizes that its management capability is currently inadequate for the task of implementing a national birth spacing program, and seeks to take advantage of the considerable strengths of non-governmental organizations in initiating program activities.

This project is the beginning of a phased approach which will strengthen the health system and improve birth spacing practice. Education will be one of the cornerstones of the project. Technical expertise obtained through buy-ins to Global Bureau Cooperating Agencies (CAs) will review and improve the entire structure of medical training as it applies to birth spacing.

Experts from AID Cooperating Agencies will review all procedures and practices, and make recommendations for improvements. They will develop improved curricula for the medical faculty and nurse/midwife training centers, and recommend improved standard procedures regarding admittance, competency based training, and certification. They will review and make recommendations to improve CMS procurement and logistics systems and MCH Center systems for management of in-service training and supervision.

They will design and manage an information, education, and communications (IEC) program.

Medically sound birth spacing information and education will be incorporated into the National MCH Center in-service training programs for all health workers, including those in the private sector. For the first time in Cambodia women practicing voluntary birth spacing will be able to make informed decisions based on modern contraceptive methods, and will know when to use them and how to use them -- and will know what to do when something is wrong.

The CAs will also strengthen the MOH's ability to supervise a national birth spacing program by demonstrating how operations research, surveys, and studies can reveal program weaknesses and opportunities. The results of these studies will be presented to management for their consideration and will be used to improve management information systems developed to monitor the implementation of the project. Such feedback will also be used to adjust the nature of project implementation over time, strengthening the things that work and correcting the things that don't.

Contraceptives will be a major contribution of this project. At the current time supplies of contraceptives are irregular and inadequate, and often are not available through public hospitals. The Central Medical Stores (CMS) has the capability of importing and distributing contraceptives, but the government has no resources to purchase them and no major donor has indicated a willingness to supply them in the quantities needed.

Accordingly, this project will supply the bulk of the contraceptives, using CMS facilities and distribution systems, needed to meet the contraceptive prevalence targets established for this project.

The focal point for delivery of birth spacing services and contraceptives will be at the grass roots level, where the women in greatest need live. Non-governmental organizations (NGOs) will play the primary role here. At the current time, there are more than twenty AID-registered PVOs operating in Cambodia, and many of them (including CARE, PACT, American Red Cross, American Refugee Committee, International Rescue Committee, World Concern, World Vision, et al.) have experience in health projects, some including birth spacing. (Please see Annex J). Their experience will be invaluable in implementing this project.

The NGOs will support provincial, district, and commune level service and contraceptive delivery programs. They will work closely with public and private outlets, and will provide management systems, training, equipment, and supplies as needed to make those outlets capable of carrying out a modern medical

birth spacing program. If necessary, they will also arrange for the repair or rehabilitation of local health facilities to provide adequate settings for the program. The NGOs will demonstrate and reinforce at the local level the improvements designed and institutionalized by the CAs at the national level, encouraging and leading the public and private delivery systems to respond and improve.

Management of these project inputs would put too heavy a strain on current USAID staff. For this reason, dedicated management capability will be built into the project. A project officer (either a USDH, population fellow, or a PSC) will be recruited for this project and will have his office at USAID. This officer will have responsibility for overall planning, management, and coordination of this project, and thus must have a great deal of experience with AID population projects. A scope of work for this position has been developed and is included in Annex O of this document.

The project officer will be supported by a management team obtained through a cooperative agreement with an organization experienced in implementing population projects in least developed countries (a draft request for applications for this "super grant" is included as Annex N). This team will be charged with a wide range of project implementation functions, including:

- strategic planning and monitoring of activities for the phased approach to implementation of the project;
- counterpart technical assistance support to Cambodian government officials at the national level, e.g., at the National MCH Center (supplementing advisors in place from other donors and NGOs);
- coordination with other donors which are planning or implementing MCH or birth spacing projects;
- coordination of buy-ins to, and monitoring the performance of, the various CAs;
- incorporation of CA-generated improvements into the training provided by the National MCH Center for health workers nationwide and subsequent support for those training programs;
- administration of sub-grants to NGOs operating in target provinces;
- coordination of contraceptive ordering and distribution; and

- coordination of participant training.

With the project management structure in place, the technical expertise of the CAs and NGOs can be focused and reinforced, resulting in synergism that may be lost if the CAs and NGOs were to provide their services in isolation from one another.

Project outputs include effective public and private sector birth spacing service delivery outlets; a substantial increase in the number of trained birth spacing service providers; improved contraceptive logistics system(s) serving the public and private sectors; improved planning, management, and training capability at the MOH National MCH Center; and an IEC program developed and implemented. With these outputs in place, the project purpose of increased access can be achieved and make a real contribution to the goal of improved family health.

Project inputs will consist of the project officer and management team, buy-ins to Global Bureau Cooperating Agencies, grants to NGOs, contraceptives, and audit and evaluation services. Commodities, training, and local cost support will all be provided through those input mechanisms.

#### OTHER DONORS

All donors involved in the economic and social development of Cambodia are faced with the same environment as USAID -- a country that is barely at peace with itself, governed by a coalition of former adversaries who are without financial or managerial resources to undertake national social infrastructure programs. The donors are now wrapping up their rehabilitation programs and are beginning to reconstruct the under-pinnings of this nation. Thus all start at ground zero, and are just beginning to get economic development programs in place. At the current time, there is no major donor implementing a birth spacing program or importing significant supplies of contraceptives.

The UNITED NATIONS FUND FOR POPULATION ACTIVITIES (UNFPA) is planning an "institutional strengthening and family health improvement through birth spacing" project to be implemented over a three year period at a cost of \$1.45 million. The project will operate in twenty-five districts (not yet determined) of five provinces. Unfortunately, at the time of writing this PP, the two technical people to be brought in to implement the project are months away from arriving. Nevertheless the UNFPA project is seen as an important counterpart to this project, as it will operate with a minimum of imported technical assistance and is to be implemented with heavy dependance on Cambodian government systems.

The design for this AID project is significantly different from

the proposed UNFPA project (mainly because of reluctance of AID to depend on current Cambodian government systems), and thus comparison of the two projects over time is seen as an excellent opportunity to compare approaches. Lessons learned from the UNFPA project will of course be incorporated into this project.

The **ASIAN DEVELOPMENT BANK (ADB)** is considering funding a project to be implemented by the **WORLD HEALTH ORGANIZATION (WHO)** to establish a continuing education program for all levels of health workers in Cambodia. A certification system would be included as would development of health worker associations. The project would last two to five years and cost more than \$8 million. The ADB/WHO project fits very well with this proposed AID project because it establishes a system for continuing education into which the training protocols and curriculum development funded under this project could feed.

There is no redundancy between the projects, and in fact the WHO project officer (an M.D. with a Ph.D. in public health from Johns Hopkins University) is enthusiastic about the prospects of collaboration with JHPIEGO under the USAID bilateral project. The training plan for this project provides funds for in-country health worker training because the schedule for the ADB/WHO project is uncertain and the extent to which the ADB/WHO program will adequately cover birth spacing disciplines is not yet known. However, this project will defer to the ADB/WHO project for in-country training if an overlap seems likely.

**JAPAN** is reportedly planning to build a new maternal/child health teaching hospital in Phnom Penh (as of this writing, confirmation is not possible). Timing has not been established yet, but the 150-bed facility will also provide a new home for the National MCH Center - a distinct plus for this project. The current site, which is prone to flooding during the rainy season, has deteriorated to the point that rehabilitation is not economically feasible. With a new home from the Japanese and new technical expertise from this project, the effectiveness of the National MCH Center should increase substantially.

The **WORLD BANK** is currently planning a social fund which will be used for local infrastructure projects. This fund is not operational yet, but it is likely that these funds will be used in part for hospital rehabilitation projects which would in turn facilitate the establishment of more effective clinical outlets for birth spacing services. Also, the **UNITED NATIONS DEVELOPMENT PROGRAM (UNDP)** currently employs local labor to rehabilitate roads and other infrastructure throughout the country, including some hospitals and clinics.

The project management team will need to coordinate closely with these and other donors through the donor coordinating committee (COCOM) to make effective use of hospitals that might be

rehabilitated under these programs.

Other organizations with related programs include the **UNITED NATIONS CHILDREN'S FUND (UNICEF)**, which supports most MOH/MCH activities, including the provision of all vaccines through the nation-wide expanded program for immunizations (EPI). UNICEF has developed the Central Medical Stores (CMS) of the MOH 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, and the contraceptives imported under this project will be imported and distributed through CMS.

The **WORLD HEALTH ORGANIZATION (WHO)** provides assistance to strengthen health systems in the MOH; 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.

No other bi-lateral or international donors currently planning projects or programs that might impact on this project are known.

#### PROCUREMENT PLAN

The entire amount obligated with this project will be used to procure technical assistance (including TA to provide and strengthen management, improve training systems, improve logistical systems, improve IEC systems, and to conduct research, evaluations and audits), commodities, and participant training. Because of limited capacity within the government of Cambodia, it will play no role in this procurement. Therefore all procurement will be under AID procurement regulations. Nevertheless, all procurement will be discussed and cleared with the Cambodian government, and coordinated with other donors. The following paragraphs discuss the procurement planned and the proposed methods of procurement.

##### Project Officer

The most immediate procurement need will be for a project officer, to be obtained as a U.S. direct hire health/population officer, a population fellow or an American under a personal services contract (PSC). As soon as this project is authorized, recruitment for such a person should begin. Responsibilities will include overall project planning and implementation

monitoring, coordination and consultation with the government, other donor liaison, and general responsibility for smooth and timely implementation of the project (a scope of work for this person is attached as Annex O to this project paper).

The best person to fill this position is an AID population officer or a person who has great familiarity with AID population projects. The person will have to be completely familiar with AID procedures and regulations, and will occupy office space in the office of the USAID.

Assuming that this project is authorized by July, 1994, and that recruitment for the position occurs immediately after, and that funds for the project are obligated in FY1994, this person should be on board by January 1995. Depending on the nature of this procurement (USDH, PSC or population fellow) various officers of USAID, RSM/Bangkok, and AID/Washington will be involved.

The estimated cost of the project officer is \$750,000.

#### Cooperating Agencies

The top priority for the project officer will be to prepare all necessary documents for USAID to undertake initial buy-ins for the technical assistance services offered by Global Bureau Cooperating Agencies (CAs). The CAs will be responsible for the design or revision of IEC programs, logistical systems, commodity and contraceptive procurement, operations research, surveys and studies, training in reproductive health and birth spacing, and such other tasks the project officer and project management team may find necessary. The CAs will work closely with NGOs (see the following section) in developing the required programs and systems to assure applicability and acceptability in Cambodia.

The actual services and the source of those services will depend on the needs as defined at the time and the buy-ins available then, but the probable sources, the tasks they are to perform, and the estimated costs are:

Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), for training programs in the schools of medicine, nursing, and midwifery (including one long term resident advisor for the first year or two of project implementation), at an estimated cost to \$1,000,000;

Family Planning Logistics Management (FPLM), for contraceptive supply systems, clinical patient flow analysis, epidemiological training, and contraceptive prevalence analyses, or perhaps for support of similar activities initiated by UNICEF at CMS, at an estimated cost of \$200,000;

Training of Paramedical, Auxiliary, and Community Personnel (PAC), to design and evaluate the National MCH Center and NGO training activities at an estimated cost of \$200,000;

Demographic and Health Surveys (DHS), for knowledge, attitude, and practice (KAP) studies and contraceptive prevalence surveys at an estimated cost of \$200,000;

Population Communication Services (PCS), for the design and implementation of information, education, and communications (IEC) programs at an estimated cost of \$400,000;

Operations Research (OR), for studies and research to improve service delivery at an estimated cost of \$200,000; and

Population Technical Assistance Project (POPTECH), to evaluate the project (as detailed in the evaluation plan), at an estimated cost of \$150,000, and to provide short term technical assistance to the project as may be required, at an estimated cost of \$50,000.

The total cost for all CAs is thus \$2,400,000. The CAs that should be on the ground first are those addressing training and logistics (the first three listed above), and so buy-ins should be undertaken as soon as possible so that early project implementation is based on the excellence and experience of these CAs.

#### Project Management Team

The second priority in procurement should be the project management team. Responsibilities of this team will include day to day project management, development of an overall implementation strategy (including annual work plans if the project officer finds that necessary or desirable), and recommendations for and coordination of all project inputs. They will develop a close working relationship with the Ministry of Health (MOH), the National Maternal and Child Health (MCH) Center, Central Medical Stores (CMS), and other government offices and other donor organizations who potentially play roles in the implementation of this project. They will draft project implementation documents, scopes of work or other required documentation for non-governmental organizations (NGOs), and arrange training programs.

The probable source of the project management team is an established organization having extensive experience in management of population projects in least developed countries (a draft request for applications for this cooperative agreement is attached as Annex N to this project paper). A cooperative agreement is thought to be the best instrument to obtain these

services, since USAID will want substantial involvement in deciding on the nature of the flexibility to be exercised during phased project implementation.

Since it is desirable that this project management team be in place as soon as project implementation begins, advertisement for this team should also take place as soon as the project is authorized. Once again assuming that funds for the project are obligated in FY1994, a PIO/T should be prepared by USAID as soon as possible thereafter and forwarded to RSM/Regional Contract Officer for action. Proposals should be received by November or December 1994, and a cooperating agreement should be signed by RSM/RCO no later than March 1995. This team should be in place by May 1995.

The estimated cost of this management team is \$3,662,000. Details supporting this figure are found at the end of this section.

#### Non-Governmental Organizations

The first priority of the project management team will be to identify and make grants to NGOs that are willing and able to assist in the implementation of this project at the grass roots level ("grass roots level" will be defined by mutual agreement between the project officer, project management team, and NGO, and may be at the provincial, district, or commune level).

As this project paper is written, many American PVOs have active health projects in Cambodia. All totalled there are more than twenty AID-registered American PVOs operating in Cambodia, and many have indicated an interest in participating in birth spacing activities. Procurement should be limited to those AID-registered PVOs already operating in Cambodia, since the experience they have gained and the working relationships they have developed will be invaluable to smooth implementation of this project.

The selected NGOs will be responsible for supporting the planning and delivery of birth spacing services and commodities at the grass roots level. Delivery will be through both public and private outlets, and will include IEC and other outreach efforts. The NGOs will provide necessary management, equipment, and supplies (and training if necessary) to assure the informed and medically safe practice of birth spacing by women in their areas.

Once the project officer (and project management team) have chosen the nature and source of CA inputs to this project, it should be a relatively simple task for the project management team to develop a request for applications from the NGOs, negotiate sub-grants to them, and have them on board no later than January 1996.

The amount set aside for grants to NGOs is \$5,236,000. This amount will be included in the management team cooperative agreement, for the team to sub-grant to NGOs.

### Training

Training is one of the main components of the project, essential to strengthen the technical capability of Cambodian health workers to implement and continuously refine a national birth spacing program. The training component of the project will be implemented by the management team.

The Ministry of Health, through the Maternal and Child Health Center, has developed a fledgling program to train workers in child spacing methodologies (please see pp. 17 of Annex D, Technical Analysis, for a summary of MCH training to date). That program will be strengthened and standardized by technical experts brought in from Global Bureau Cooperating Agencies under this project. This project will then fund, through the management team or NGO grants, the cost of travel and per diem for health workers to train (or re-train) in that program.

The project plans on sending two long term participants for degree training (master of public health) in the United States, provided that suitable candidates can be identified. This project also includes travel abroad for senior officials to attend international conferences; three week study tours to Thailand, Malaysia, or Indonesia for senior officials (including provincial governors) and managers; and short term (up to 3 month) training for doctors (or highly qualified nurses or midwives) in specialized topics related to birth spacing technologies being practiced in neighboring countries (Thailand, Bangladesh, Indonesia, India, Philippines, etc.).

Total training costs for the project are planned at:

Birth Spacing	\$ 900,000
Degree Training	120,000
Training Abroad	282,000
TOTAL	\$1,302,000

Details supporting this figure are provided in the training plan. Training funds are to be included in the management team grant.

### Contraceptives

In order to meet the 30 percent prevalence rate by the year 2000, an annually increasing supply of contraceptives (a total of approximately 2 million couple years of protection) must be provided over the five year life of project. Based on the

experience of NGOs with birth spacing programs, it is assumed that approximately 60 percent of acceptors will use depo-provera, 20 percent will use pills, 10 percent will use IUDs, 7 percent will use Norplant, and 3 percent will use condoms. Applying a cost of \$1.00 for depo-provera, \$0.20 for pills, \$1.10 for IUDs, \$25.00 for Norplant, and \$0.05 for condoms, the total cost for contraceptives is \$7,175,610. The cost of shipping these contraceptives is generally budgeted at 10 percent of commodity cost, or \$717,561, so that total cost of contraceptives including shipping and handling is \$7,893,171 (details supporting this figure are provided in the technical analysis, Annex D).

This project has budgeted for approximately 80 percent of the contraceptives required; thus \$6,300,000 is identified for contraceptives. Procurement will be handled by an OYB transfer initiated by USAID and implemented by AID/W.

#### Other Procurement

A non-Federal audit of the Central Medical Stores (CMS) logistical system may be required if it is to import and distribute AID-funded contraceptives. If that is determined to be the case, \$50,000 is set aside for that purpose.

No other procurement is contemplated at this time. It is planned that all technical assistance, commodities, and training be accomplished through mechanisms described above. It is possible, however, that during project implementation the project officer will decide that other mechanisms are necessary. Such flexibility may be required to successfully implement the project, and must be retained throughout the life of the project.

FAMILY HEALTH & BIRTH SPACING PROJECT

MANAGEMENT TEAM

Position	Person Years	Rate (\$000)	Total (\$000)
Team Leader/Manager	4.0	140	560
Dep Leader/Mgt Systems	4.0	120	480
Khmer Support Staff (6)	24.0	30	720
Short Term Experts*	1.2		200
Office Rent (\$2000/month)			96
Start Up Costs **			150
Vehicles ***			50
Vehicle Operation #			40
Int'l Travel ##			32
Moving & Storage ###			50
Subtotal			2,378
Contingency (10%)			238
Subtotal			2,616
Overhead (40%)			1,046
<b>TOTAL</b>			<b>3,662</b>

Note: The rate used in the above calculations is based on current experience of USAID/Phnom Penh officials who estimate that it takes \$50,000 per year to provide housing and utilities to an expatriate. Adding that figure to the likely salary levels leads to the figure used.

The following footnotes refer to other cost calculations shown above:

\* Assumption: 7 trips, 2 months each trip for a start-up expert, a PVO grants officer, a training expert, or other required consultants.

Salary @ \$300/day, 280 days	\$84,000
Per Diem @ \$200/day, 420 days	84,000
7 Int Trips @ \$4000	28,000
Misc Costs	4,000
TOTAL	200,000

\*\* Assumption: \$50,000 each for one office & two houses in Phnom Penh. This amount "westernizes" the facility, provides a generator, furnishings, etc.

\*\*\* Assumption: two FWD vehicles at \$25,000 each.

# Assumption: \$5000 per vehicle per year for 4.0 years.

## Assumption: 2 two-person families, two round trips (assignment and home leave) at \$4000 per trip.

### Assumption: 2 families, \$25,000 per family.

PROCUREMENT PLAN					
ACTION	MODE OF IMPLEMENTATION	COMPETITIVE OR SOLE SOURCE	METHOD OF FINANCING	ESTIMATED COST	NOTES
PROJECT OFFICER	US PERSONAL SERVICES CONTRACTOR	COMPETITIVE	COST REIMBURSEMENT	\$750,000	REQUIRES USAID/W APPROVAL
MANAGEMENT TEAM	COOPERATIVE AGREEMENT	COMPETITIVE	FEDERAL RESERVE LETTER OF CREDIT	TA \$3,662,000 NGO'S \$5,239,000 TRAINING \$1,302,000	DRAFT RFA ATTACHED AS ANNEX N
COOPERATING AGENCIES (G/POP)	BUY-INS	NON-COMPETITIVE	FEDERAL RESERVE LETTER OF CREDIT	\$2,400,000	PIO/TS FOR BUY-INS WILL BE DEVELOPED OVER THE LIFE-OF-PROJECT BY MANAGEMENT TEAM
AUDITS AND EVALUATIONS	PURCHASE ORDER	COMPETITIVE (AS APPROPRIATE)	COST REIMBURSEMENT	\$50,000 NOTE: \$150,000 FOR EVALUATIONS IS INCLUDED IN THE \$2,400,000 FOR BUY-INS.	RSM CONTROLLER WILL SELECT
CONTRACEPTIVES	CPTs AND CONTRACEPTIVE ORDER CABLE TO G/POP	NON-COMPETITIVE	OYB TRANSFER	\$6,300,000	DONE THROUGH G/POP
TOTAL COSTS				\$20,000,000	

## IMPLEMENTATION PLAN

A co-signed Project Implementation Letter No. 1 will authorize USAID/Phnom Penh to implement this project on behalf of the Government of Cambodia. Actual implementation will be conducted by management experts brought in specifically under this project. Those experts will, at all times when it is possible and practical, consult and coordinate with the Government of Cambodia, as represented by the Ministry of Health and its subdivisions. Other donors will also be closely consulted and coordinated with during project implementation.

Implementation will begin with the bringing on board of a project officer. It has not been determined, at this stage, if that project officer will be a U.S. direct hire, a population fellow, or a U.S. personal services contractor (PSC). This project design has made provision for a PSC should that be the decision. The office of the USAID will pursue this question and make a decision during the process of approving the project paper and authorizing the project.

A draft scope of work for the project officer has been prepared (see Annex O), and recruitment should begin as soon as the project is authorized. Depending on the nature of this recruitment - USDH, population fellow, or PSC - action may be required from USAID, RSM/Bangkok, and AID/Washington. For smooth implementation of the project, the project officer should be on board by January 1995.

Concurrently with bringing on board a project officer, an effort will be undertaken to sign a cooperative agreement with a reliable and experienced organization to provide a management team for the project. This team will be responsible for strategic planning and monitoring of project implementation, counterpart technical assistance to the National MCH Center and other MOH entities, coordination and management of buy-ins to Global Bureau population cooperating agencies, administration of sub-grants, coordination of participant training, planning of contraceptive logistics and assistance to the USAID mission on the preparation of OYB transfer documentation to fund contraceptives. Responsible for day-to-day management of project implementation, the team will develop a management information system capable of monitoring and verifying performance of all inputs to the project. A member of the team will attend all health-related donor coordinating committee (COCOM) meetings and all NGO health coordination (MEDICAM) meetings.

A draft request for applications for the project management team has been prepared (see Annex N), and should be issued by the Regional Support Mission/Regional Contract Officer as soon as possible after the project is authorized. Assuming that funds are obligated for this project in FY1994, proposals should be

received in November or December of 1994 and a cooperative agreement should be negotiated and signed by March 1995. For smooth implementation of the project, the project management team should be in place by May 1995.

With the project officer in place, finalization of interventions from Global Bureau Cooperating Agency (CA) agreements can be firmed up and buy-ins prepared, initially for those CAs involved in training, contraceptive logistics and IE&C programs. The project officer will prepare required documents related to such buy-ins, and USAID will issue them and forward them to RSM/Bangkok or AID/Washington for appropriate action. Since the CA buy-in process is standardized, time consumed in this process should be minimal.

The CA organizations will design and institutionalize: training in reproductive health and birth spacing; information, education, and communication (IEC) programs; commodity procurement and logistical systems; operations research; surveys and studies; and project evaluation. This represents the technical core of the project, which combined with the management core (discussed above) and the grass roots action core (discussed below) comprise all essential elements of the project.

Implementing the project at the grass roots level will be non-governmental organizations (NGOs). Many AID-registered PVOs already have extensive experience in Cambodia (please see the Procurement Plan and Annex J for more details), and their knowledge of how things work in Cambodia will be invaluable for project implementation. The NGOs will be responsible for supporting birth spacing service and contraceptive delivery systems through both public and private outlets at the grass roots level. They will provide management, equipment, and supplies (and training if required) to support a national birth spacing program at the local level, including IEC and outreach mechanisms.

The NGOs will provide feedback to the CAs on their experiences, and the implementation approaches developed by the CAs will in fact reflect the hands-on experience of the NGOs. Accordingly, the NGOs should come on board at about the same time as the CAs. It is most desirable that sub-grants to the NGOs be made by the project management organization to ensure coordination of effort. To accomplish this, however, the cooperating agreement will have to be written so that "double" overhead (one to the management organization and one to the NGO) is not paid.

This project will provide the basis for a national birth spacing program based primarily in the public sector facilities of the MOH. Development of a fully staffed and capable management and training function at the MOH's National Maternal and Child Health (MCH) Center is clearly desired under this project, as is a

competent and accountable logistics system (for contraceptive distribution) based in the Central Medical Stores (CMS). It will be incumbent on the project officer and the project management team to develop close, professional working relationships with these organizations and transfer to them the skills they need to develop and institutionalize these capabilities.

There is one implementation issue which may require further study, namely, the need for repair or rehabilitation of public health facilities from which services and contraceptives can be dispensed or in which training can be conducted. To the extent that such repair or rehabilitation of a facility is required, funds to accomplish that should be limited and should be included in NGO grants. If, however, needs are more substantial than that, it is recommended that a health facilities expert be brought out by the management team (under a Global project if necessary) to review existing facilities and make recommendations on repairs and rehabilitation before committing project (contingency) funds. Prior to actually doing any construction or reconstruction, the need for an environmental assessment should be considered.

On the following pages the implementation plan is presented as a table with three components: (1) AID Project Development; (2) Project Management; and (3) Implementation Activities for Year One:

PROJECT DEVELOPMENT		
ACTION	DATE	NOTE
PROJECT PAPER AUTHORIZED	8/94	AUTHORIZATION VENUE: FIELD
PROJECT GRANT AGREEMENT NEGOTIATED AND SIGNED	9/94	USAID/W GC WILL DRAFT PROAG IN JULY
PIL #1 ISSUED TO AND CO-SIGNED BY GOVERNMENT	9/94	REQUIRES RSM CLEARANCES FROM RLA, RP AND FIN
PERIODIC CONSULTATIONS WITH USAID/GOC/IMPLEMENTING COOPERATOR	MONTHLY BEGINNING 9/94	USAID DETERMINES VENUE AND AGENDA

PROJECT MANAGEMENT		
ACTION	TARGET	NOTES
<i>PROJECT MANAGER POSITION</i>		
REVIEW AND INTERVIEW CANDIDATES	9/94	USAID & G BUREAU
SELECT FELLOW	11/94	USAID
PREPARE HOUSING, ETC	11/94	USAID
FELLOW ARRIVES	1/95	
<i>COOPERATIVE AGREEMENT</i>		
ISSUE REQUEST FOR APPLICATIONS	8/94	DRAFT RFA INCLUDED IN PP; MUST BE INCLUDED IN USAID/CAMBODIA FY95 PROCUREMENT PLAN
REVIEW PROPOSALS	11/94	USAID COMMITTEE WITH RSM PROCUREMENT OFFICE
INTERVIEWS	12/94	
BEST AND FINAL	12/94	OPTIONAL
NEGOTIATE & SIGN COOPERATIVE AGREEMENT	1/95	RSM/EA
ESTABLISH OFFICE AND BEGIN PROGRAM IMPLEMENTATION	3/95	MAY BE EARLIER IF RECIPIENT IS ALREADY IN CAMBODIA
PROCURE AND INSTALL OFFICE EQUIPMENT	3/95	WILL HIRE LOCAL STAFF AS NECESSARY
BEGIN PROGRAM COORDINATION WITH GOVERNMENT, NGOS AND OTHER DONORS	5/95	

**PROJECT IMPLEMENTATION  
ASSUMES 4/95 START-UP DATE**

ACTION	TARGET	NOTES
<i>BUY-INS TO G/R&amp;D/HEALTH COOPERATING AGENCIES</i>		
SUBMIT PIO/T FOR JHPIEGO TRAINING PROGRAM	2/95	WILL BE PREPARED IN ADVANCE BUT IMPLEMENTATION AWAITS ARRIVAL OF PROJECT MANAGER
SIGN BUY-IN	3/95	MUST BE INCLUDED IN USAID/CAMBODIA PROCUREMENT PLAN FOR 95
JHPIEGO ARRIVES	4/95	
JHPIEGO BUY-IN ACTIVITIES BEGIN	5/95	
SUBMIT PIO/T FOR FAMILY PLANNING LOGISTICS MANAGEMENT WITH FPLM CA	2/95	SOW AND TIMING WILL DEPEND ON JSI ACTIVITIES WITH WORLD BANK IN 8/94
SIGN BUY-IN	3/95	MUST BE INCLUDED IN USAID/CAMBODIA PROCUREMENT PLAN FOR FY95
FPLM ACTIVITIES BEGIN	4/95	
OYB TRANSFER FOR FIRST CONTRACEPTIVE ORDER	5/95	
CONTRACEPTIVES ARRIVE	8/95	
SUBMIT PIO/T FOR DEMOGRAPHIC HEALTH SERVICES (DHS) CA	2/95	
SIGN BUY-IN	3/95	
DHS ACTIVITIES BEGIN	4/95	
SUBMIT PIO/T FOR POPULATION COMMUNICATIONS SERVICES FOR IEC ACTIVITIES	2/95	
SIGN BUY-IN	3/95	MUST BE INCLUDED IN FY95 PROCUREMENT PLAN
IEC ACTIVITIES BEGIN	4/95	
<i>SUB-GRANT COMPONENT</i>		
REQUEST PROPOSALS FROM ELIGIBLE NGOS OPERATING IN TARGET PROVINCES	6/95	AS SOON AFTER MANAGEMENT TEAM ARRIVES AS POSSIBLE
REVIEW PROPOSALS WITH USAID AND GOC REPRESENTATIVES	8/95	

**PROJECT IMPLEMENTATION  
ASSUMES 4/95 START-UP DATE**

ACTION	TARGET	NOTES
AWARD SUB-GRANTS FOR STRENGTHENING RURAL DELIVERY SYSTEMS	9/95	
MONITORING SUB-GRANTS	PERIODIC	MANAGEMENT TEAM RESPONSIBILITY
<i>LONG-TERM TRAINING COMPONENT</i>		
SELECT LONG-TERM CANDIDATES	9/95	SELECTION DONE AFTER JPHIEGO ACTIVITIES BEGIN
ENGLISH LANGUAGE TRAINING	10/95	ASSUMES ALL POTENTIAL CANDIDATES WILL REQUIRE ELT
PROCESS AND ENROLL LONG-TERM CANDIDATES	1/96	
LONG-TERM CANDIDATES LEAVE FOR US	6/96	
LONG-TERM PARTICIPANTS RETURN	6/98	



## TRAINING PLAN

Training in reproductive health and birth spacing will be one of the main components of the project. The objective will be to strengthen the technical capability of Cambodian health workers to implement and refine a national birth spacing program.

The Ministry of Health, through the Maternal and Child Health Center, has developed a fledgling program to train these workers in child spacing techniques (see below). That program will be strengthened and standardized by technical experts brought in from Global Bureau Cooperating Agencies under this project. The focus will be on pre-service training at the level of the Faculty of Medicine and Pharmacy and the national and regional schools of nursing and midwifery, as well on in-service training for the large number of existing health workers.

Cambodia faces an acute shortage of medical and paramedical personnel qualified to perform at the levels their titles suggest. The Khmer holocaust of 1975-1979 mercilessly targeted people with any education, particularly those with higher education. Of the more than 500 Cambodian doctors practicing in 1975, only 43 could be found in 1979 (UNFPA, 1993). In one province, Prey Veng, fewer than five trained midwives survived the Pol Pot era (World Concern, 1993).

To redress this shortage, a crash program to create a cadre of health workers was undertaken by the State of Cambodia installed following the Vietnamese defeat of the Khmer Rouge in 1979. The lack of rigor in training programs has resulted in a large number of individuals with titles of health professionals - over 22,000 at present - but with minimal skills.

According to Ministry of Health statistics as of May 31, 1993, the health work force in Cambodia included the following numbers of workers in each profession from which the trainees under this project will be selected:

Doctors	986	
Medical Assistants	1,810	
Pharmacists	280	
Pharmacist Asst	126	
Secondary Nurses	2,622	(3 years of training)
Primary Nurses	6,920	(1 year of training)
Graduating Nurses	240	(from border camps)
Secondary Midwives	1,120	(3 years of training)
Primary Midwives	1,844	(1 year of training)
Traditional Birth Attendants	224	
General Health Workers	3,312	
TOTAL	19,484	

Medical education at the pre-service level is essentially didactic, with little opportunity for practical experience. MD's still graduate without instruction in basic reproductive health or contraception, and midwives commonly graduate without having assisted at a single delivery. Training in birth spacing skills under this project will thus have to be tailored to the unusual characteristics of the Cambodian health community.

One of the principal challenges confronting the cooperating agency (CA) charged with strengthening training will be to establish a comprehensive program of competency based medical education in reproductive health and birth spacing at the schools of medicine and nursing. Both pre-service and in-service training will have to be supported. Curricula will have to be developed. Teaching aids will have to be provided. Safe birthing kits will have to be provided to midwifery graduates to empower them to practice the skills acquired.

To a great extent, basic medical competency will have to be upgraded in addition to specialized training in birth spacing and reproductive health.

The USAID MCH/birth spacing project will benefit from the considerable efforts of the Royal Cambodian Government and other donors in raising medical competency. (Please see Annex D - Technical Analysis, section F.3 for more information on health and birth spacing training activities.

Persons to be trained under the USAID project will be screened and recommended by the cooperating agencies and relevant NGOs, working in cooperation with officials of the Ministry of Health and other donors involved in health programs). Assuming that about **half** of the health workers currently on MOH roles receive such training under the five year life of the project, the cost of training these health workers is \$900,000.

The tables below illustrate the approximate levels of per diem which would need to be provided under the project to support in-service training.

		\$ 000
Doctors and Medical Assistants		
Per Diem	1400 persons X 10 days X \$15	210
Travel	1400 persons X \$15	21
Pharmacists & Pharmacist Assistants		
Per Diem	200 persons X 2 days X \$15	6
Travel	200 persons X \$15	3

Secondary and Primary Nurses		
Per Diem	4900 persons X 6 days X \$12	353
Travel	4900 persons X \$15	74
Secondary and Primary Midwives		
Per Diem	1500 persons X 6 days X \$10	90
Travel	1500 persons X \$15	23
TBAs & General Health Workers		
Per Diem	1800 persons X 5 days X \$10	90
Travel	1800 persons X \$15	27

### Degree Training

The project plans on sending two long term participants for degree training (masters of public health) in the United States, provided that suitable candidates can be identified. Assuming that these candidates will require two years to receive their degree, and that training costs average \$30,000 per candidate per year, the cost of this degree training is \$120,000.

### Training Abroad

This project includes travel abroad for senior officials to attend international conferences; three week study tours to Thailand, Malaysia, or Indonesia for senior officials (including provincial governors) and managers; and short term (up to 3 month) training for doctors (or qualified nurses or midwives) in specialized topics related to birth spacing technologies practiced in neighboring countries (e.g., Thailand, Bangladesh, Indonesia, India, Philippines). The budgets are as follows (including an allowance for training fees that may be charged by hosting institutions):

#### International Conferences (annually for 4 years):

Travel (\$2,000 x 2 persons)	\$ 4,000
Per Diem (\$150 x 2 persons x 10 days)	3,000
Fees (\$500 x 2 persons)	1,000
Sub-total	8,000
Total for 4 years	\$32,000

#### Study Tours

Travel (\$1,000 x 30 persons)	\$30,000
Per Diem (\$121 x 30 persons x 22 days)	80,000
Fees (\$500 x 30 persons)	15,000
Total for 4 years	\$125,000

## Short Term Training

Travel (\$1,500 x 10 persons)	\$15,000
Per Diem (\$100 x 10 persons x 90 days)	90,000
Fees (\$2,000 x 10 persons)	20,000
Total for 4 years	\$125,000

Thus the total cost for international conferences, study tours, and short term training abroad is \$282,000.

Total training costs for these three categories are estimated at:

Birth Spacing	\$ 900,000
Degree Training	120,000
Training Abroad	282,000
TOTAL	\$1,302,000

Additional costs of the training component of this project are included in the buy-ins to cooperating agencies for medical and paramedical training.

## EVALUATION PLAN

Three evaluations are planned for this project. The first evaluation will be conducted in the third quarter of FY1996, to examine the interventions that have been put into place under the project and to determine if they are efficient and effective. Management information systems, training programs, IEC programs, contraceptive logistics, commodity procurement, demographic surveys and operations research will all be evaluated. These interventions will have been in operation for about one year by then, with several years left in the project to make modification or correction if required.

The second evaluation will be conducted in third quarter of FY1997, and will measure progress in meeting the targets established under the project. The evaluation will determine the rate at which effective public and private outlets for birth spacing services are being established, whether the capacity of the National MCH Center for planning, managing, and training is being improved, how IEC is being implemented, and whether the logistics system(s) for delivery of contraceptives has been improved. This is essentially an implementation evaluation at the mid-point of the life of project, and will indicate if the project is on track or not and will make specific recommendations for change.

The third and final evaluation will be an impact evaluation.

This evaluation will determine the extent to which increased access to and use of contraceptives has been attained and the extent to which institutional development has taken place. This evaluation will form the basis for recommendations for design and implementation of future projects.

All of these evaluations can be carried out by buy-ins to the Population Technical Assistance (POPTECH) Cooperating Agency agreement. The project management team will prepare scopes of work for the evaluations, and the project officer will review them and complete the necessary documentation to undertake the buy-ins. A total of \$150,000 is budgeted for these evaluations.

CONDITIONS AND COVENANTS - RESERVED

ANNEX A

NPD APPROVAL CABLE

ANNEX B

GRANTEE REQUEST FOR ASSISTANCE

ANNEX C  
LOGICAL FRAMEWORK

**Cambodia Family Health  
and Child Spacing Project**

LOP Funding: \$20 million  
PACD: 9/30/99

Narrative	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
<p><b>Goal:</b> To improve family health</p>	<ol style="list-style-type: none"> <li>1. Increase contraceptive prevalence to 30% of eligible women by the year 2000;</li> <li>2. Decrease infant/maternal mortality</li> </ol>	<ol style="list-style-type: none"> <li>1. Contraceptive prevalence surveys</li> <li>2. Demographic and Health Surveys;</li> </ol>	<ol style="list-style-type: none"> <li>1. Political stability;</li> <li>2. International support for Cambodia;</li> <li>3. Progress in economic development;</li> <li>4. US/Cambodia relationship continues</li> </ol>
<p><b>Purpose:</b> To increase access to and use of voluntary child spacing services</p>	<p>End-of-Project Status (EOPS):</p> <ol style="list-style-type: none"> <li>1. Increased access to modern contraceptives;</li> <li>2. Increased availability of contraceptive services through private and public delivery systems;</li> <li>3. Increased awareness of contraceptive methods.</li> </ol>	<ol style="list-style-type: none"> <li>1. Field surveys;</li> <li>2. Contraceptive Prevalence Surveys;</li> <li>3. Project Evaluation</li> </ol>	<ol style="list-style-type: none"> <li>1. Cambodian government support for birth spacing policy;</li> <li>2. Strong demand by Cambodian women for birth spacing</li> <li>3. Other donor collaboration and cooperation;</li> <li>4. Provincial peace and order prevails;</li> </ol>
<p><b>Outputs:</b></p> <ol style="list-style-type: none"> <li>1. Improved system for logistics and supply of contraceptives through public and private sectors (CMS, MOH Hospitals, clinics &amp; pharmacies);</li> <li>2. Improved training capacity at MCH Center</li> <li>3. Development and implementation of IEC Strategy;</li> <li>4. Increased effectiveness of service delivery and a substantial increase in the number of qualified service providers.</li> </ol>	<p>Magnitude of Outputs:</p> <ol style="list-style-type: none"> <li>1. Temporary contraceptive methods introduced in targeted hospitals as well as pharmacies and other private outlets;</li> <li>2. 9,800 service providers trained in-country;</li> <li>3. 42 professional staff receive short-term, third country training;</li> <li>4. 2 professionals receive US long-term degree training;</li> <li>5. Variety of IEC programs designed and implemented through PCS buy-in (e.g. radio, print, music, etc.)</li> <li>6. CMS and private sector contraceptive distribution systems through FPLM Buy-in;</li> </ol>	<ol style="list-style-type: none"> <li>1. Evaluation of methods and strategies employed by implementing organizations;</li> <li>2. Periodic project evaluations;</li> <li>3. Management team progress reports;</li> <li>4. Media coverage of programs</li> </ol>	<ol style="list-style-type: none"> <li>1. Cambodian government permits NGOs to implement birth spacing programs</li> <li>2. Continued NGO interest in working in Cambodia;</li> <li>3. Body of knowledge of birth spacing techniques can be successfully applied to Cambodia;</li> <li>4. Ministry service providers are available, able and willing to learn and deliver improved services;</li> <li>5. Qualified candidates for training available;</li> </ol>

ANNEX D  
TECHNICAL ANALYSIS

## TECHNICAL ANALYSIS

## 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. Please refer to Annex J for details of on-going NGO birth spacing 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.

## 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. Summaries of their experiences are presented in Annex J.

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

The population of Cambodia is currently estimated to be 9,100,000 persons. 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 percent of the women of child bearing age, or 600,000 women, practicing modern contraception by the end of the year 1999. The following calculations assume a 30 percent annual discontinuation rate. The result of the calculations is that the national birth spacing program will need to 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.

NEW AND CONTINUING BIRTH SPACING CLIENTS  
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
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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.

#### 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.

#### 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.

#### 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.

#### PHNOM PENH MIXED FACULTY OF MEDICINE, DENTISTRY AND PHARMACY (also known as Faculte Mixte (FM))

The Faculty of Medicine 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.

#### 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).

#### 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.

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 <sup>th</sup>	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.

#### 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.

#### 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 blood 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 should 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.

#### 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.

A more detailed analysis of NGO activities and experiences in health and birth spacing is found in Annex J.

#### 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 the proposed 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 through Central Medical Stores (CMS) 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 an \$8 million program of in-service training for the two year period 1995-1996. 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.

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. (Please see Annex J - NGO Analysis).

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. A brief description of NGO findings is located in Annex J. 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 GOC institutions;
- c. recommend the client and program information required for program management and evaluation; and
- d. develop an action plan for USAID to discuss with the MOH and other donors regarding collection and analysis of data essential for program management and evaluation.
- e. develop a scope of work for a possible USAID buy-in the DHS project for longer-term technical assistance.

ANNEX E  
ECONOMIC ANALYSIS

## 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 the USAID/Indonesia private sector family planning project would easily save the Government of Indonesia in educational and health expenditures alone, over 6.3 times the planned \$28 million invested in the project by USAID and the Indonesian Government. 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.

ANNEX F  
SOCIAL SOUNDNESS ANALYSIS

## 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 FPPIA, 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.

ANNEX G  
FINANCIAL ANALYSIS

ANNEX H

ADMINISTRATIVE ANALYSIS

## ADMINISTRATIVE AND INSTITUTIONAL ANALYSIS

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 Boun 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, and
- 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	Pharm- acist	Asst. MD	Den- tist	3-yr nurse	3-yr mid- wife	Lab tech.	1-yr nurse	mid- wife	misc staff	TOTAL	of which 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
PED. OPD	4		3		2	1		9	4	2	25	7
X-RAY			1		3					2	6	2
Laboratory		2			1		6	3		1	13	3
Dentistry				1				1		1	3	
O.R.	5		7		11	1		1	1	4	30	9
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 page.

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.

## The Salary Problem

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. Because A.I.D. is precluded from supplementing civil service salaries, the task of developing a dedicated cadre of national program managers represents a special challenge to the project management team which will help administer the bilateral program.

The National MCH Center is housed on the premises of the 7 January Hospital, also known 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 had 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=R2400) 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.

Central Medical Stores and UNICEF: Administrative and Institutional analysts

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 a potential 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</u>	
1994	1995	(000)	
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 during December 1993 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.

ANNEX I  
STATISTICS ON CAMBODIA

Table 1.1: Population Estimates

Year	Total (millions)	Growth Rate (%)
1981	6.68	--
1988	8.11	--
1989	8.33	2.7
1990	8.57	2.9
1991	8.81	2.8
1992 a/	9.26	5.1
1993 a/	9.65	4.1

a/ Includes repatriated population of about 375,000.  
Therefore, the figures for 1992 and 1993 do not match  
the figures in Tables 1.2 and 1.3 which exclude the  
repatriated population.

Source: Department of Statistics, Ministry of Planning.

Table 1.2: Population by Age Group and by Sex, 1990

Age Group	Total	Percent of Total Population	Percent Female in Total Pop.
All Ages	8,567,582	100.0	53.7
Over 15	4,547,673	53.1	57.3
6 to 15	2,600,130	30.3	49.7
1 to 5	1,062,559	12.4	49.6
Under 1	357,220	4.2	49.8

141-2

Source: Data from Directorate of Statistics of the Ministry of Planning; Jacqueline Desbarats.

**Table 1.3: Estimated and Projected Population  
by Province, 1981, 1986, and 1993**

Province or City	1981	1986	1993
(in thousands of persons)			
Phnom Penh	329	561	691
Kandal	720	762	893
Kompong Cham	1,066	1,205	1,417
Svay Rieng	292	329	442
Prey Veng	672	758	900
Takeo	531	598	675
Kompong Thom	379	427	498
Siem Reap	477	538	589
Banteay Meanchey	--	--	414
Battambang	718	810	574
Pursat	175	197	270
Kompong Chhnang	221	249	323
Sihanoukville	53	59	114
Kampot	354	399	482
Koh Kong	26	29	74
Kompong Speu	340	383	494
Preah Vihear	69	78	92
Ratanakiri	45	51	71
Strung Treng	39	44	67
Mondulkiri	16	18	23
Kratie	157	177	204
	6,682	7,672	9,308

11-3

Note: Figures may not sum to national total because of rounding.

Source: Department of Statistics, Ministry of Planning.

Table 1.4: Health Sector Statistics, 1993

Category	Total	Phnom Penh	% Share of Total	Provinces	% Share of Total
Doctors	986	626	63	360	37
Population/Doctor	9,440	1,104		23,935	
Medical Assistants	1,810	697	39	1,113	61
Primary Nurses	6,920	1,329	19	5,591	81
Primary Nurses/Doctor	7	2		16	
Secondary Nurses	2,622	931	36	1,691	64
Primary Midwives	1,844	84	5	1,760	95
Primary Midwives/Doctor	2	0.1		5	
Secondary Midwives	1,120	307	27	813	73

141-4

Sources: UNICEF and Ministry of Health.

Table 1.5: Social Indicators

	25-30 Years Ago	15-20 Years Ago	1990 (unless noted otherwise)
Life Expectancy at Birth	44.6	34.9	49
Crude Birth Rate	44 (1965)		38
Crude Death Rate	20 (1965)		15
Adult Literacy	36.1	-	35
Infant Mortality Rate per 1,000 live births	134	230.2	117
Infant Mortality Under 5 per 1,000 live births	-	-	200 (1989)
Education			
Enrollment Ratio:			
Primary			
- Total	77	42	53
- Female	56	35	43
Secondary			
- Total	4	6	-
- Female	4	6	-
Access to Safe Water (% of population)	-	-	12 (1982, rural)

sal-5

Sources: World Bank, Social Indicators of Development, 1993; World Development Report, 1993;  
and Social Dimensions of Reconstruction in Cambodia, 1992.

TABLE 1.6:

## POPULATION BY PROVINCES AND DISTRICTS IN CAMBODIA, 1991 AND 1992

Provinces and districts are listed in alphabetical order with Phnom Penh and the chief city of each province at the head of the list. The three figures in parentheses following the name of each province represent the number of districts, quarters and communes in the province. The penciled-in numbers at the right represent the estimated number of women of child-bearing age in the province. The 1991 figures are from the Ministry of Health Planning Unit. The 1992 figures are from the UNTAC census taken in preparation for the 1993 democratic elections.

Provinces	#:1991	#:1992	CHILD BEARING WOMEN
<u>PHNOM PENH (13) (4) 4 Khan (17)</u>			<u>136,000</u>
Dang Kor	67.065	52.815	
Khan Chamkar Mon	110.229	113.829	
Khan Daun Penh	105.153	110.130	
Khan 7 Makra	90.630	89.444	
Khan Tuol Kork	92.369	90.930	
Meanchey	82.583	80.013	
Muk Kampul	7.634	?	
Rusey Kao	74.920	77.313	
<u>BANTEAY MEANCHEY (1) (1) (54)</u>			<u>77,000</u>
* Banteay Meanchey **		56.155	
Bantay Ampil	12.357	12.857	
Mongkol Borei	102.566	102.566	
Phnom Srok	-	33.352	
Pranet Preah	52.550	52.550	
Serei Sophon *		35.420	
* Sisophon		-	
* Suay Chen		-	
* Thmar Puok		55.292	
<u>BATTAMBANG (10) (12) (56)</u>			<u>102,000</u>
* Battambang **	101.273	101.273	
Banan	43.824	43.824	
Battambang	83.014	83.530	
Boeal	53.880	53.060	
Ek Phnom	52.290	52.624	
Maung Russai	77.092	71.208	
Rattanak Mondul	10.644	4.654	
Sangka	72.830	72.099	
<u>KAMPONG CHAM (4) (15) (169)</u>			<u>282,000</u>
* Kampong Cham *			
Ba Theay	63.200	63.552	
Chceung Pray	61.900	62.938	
Chemcar Loeu	73.900	77.982	
Dombay	63.300	35.864	
Kampong Cham		30.878	
Kampong Siem	91.400	83.075	
Kang Meas	73.900	77.323	
Koh Sutin	67.000	69.962	
Krouch Chmar	71.300	77.187	
Memut	55.100	74.742	
Oraing Ov	63.200	72.801	

136,000

282,000

Ponnea Creek	79.900	88.422
Prey Chhor	82.300	105.885
Srey Santhor	90.400	92.607
Stung Trong	74.500	75.939
Tboung Khmum	144.600	184.036

KAMPONG CHHNANG ( 4 ) ( 6 ) [ 55 ]      CCC: 295.991    \*\* : 275.303

61,000

Kampong Chhnang	24.232	25.077
Beri Ber	31.237	30.186
Chhul Kiri	17.025	16.413
Kompeng Leang	25.230	25.704
Kompeng Trolaik	54.078	51.754
Roliepea	53.645	57.514
Samaki Meanchey	43.032	41.763
Tuk Phos	28.959	27.418

KAMPONG SOM ( 7 ) ( 1 ) 2 Khan [ 14 ]      CCC: 77.937    \*\* : 81.143

18,000

Khan Stung Hae	11.147	-
Khan Mitta Pheap	45.277	-
Prey Nup	43.942	-

KAMPONG SPEU ( 5 ) ( 7 ) [ 83 ]      CCC: 459.299    \*\* : 427.314

74,000

Kompeng Speu	25.747	30.482
Bo Set	87.388	85.471
Kong Pisay	78.183	73.834
Cral	7.363	6.847
Cudong	83.733	77.154
Phnom Sruocn	41.455	37.300
Semraong Teng	82.938	85.154
Th'Kong	31.206	31.092

KAMPONG THOM ( 9 ) ( 7 ) [ 69 ]      CCC: 489.503    \*\* : -

108,000

Kompeng Thom	52.342	-
Baray	134.039	-
Kompeng Svay	53.222	-
Prasat Balang	31.243	-
Prasat Semo	33.418	-
Sondan	31.459	-
Sontuk	42.871	-
Stong	83.247	-

KAMPOT ( 5 ) ( 7 ) [ 50 ]      CCC: 477.535    \*\* : 446.836

92,000

Kampot	21.294	21.824
Angkor Chey	62.822	65.533
Bantay Meas	72.835	75.829
Chhoeck	57.391	58.023
Chum Kiri	25.544	30.815
Dong Tum	39.735	39.725
Kampot	70.304	71.102
Kompeng Traik	84.398	83.808

KANDAL ( 1 ) ( 10 ) [ 140 ]      CCC: 852.850    \*\* : 780.564

172,000

Takhmau		31.439
Kandal Stung	57.793	55.340
Kien Svay	101.507	99.474
Koh Thom	119.990	112.138
Kaach Kandal	91.046	88.491
Loeuk Dek	35.032	32.355

Lovea Em	49.609	46.840
Muk Kompoul	56.461	61.585
Phnom Penh	65.083	63.649
Punya Leu	63.027	61.131
Saang	141.652	131.074

KCH KONG ( 3 ) ( 6 ) [ 27 ]      pop: 50.672 \*\* : 52.079      11,500

Koh Kong		3.012
Botum Sakor		7.208
Kiri Sakor		1.869
Koh Kong (?)		8.781
Mondul Saymar		3.550
Sray Ombul		25.577
Thmor + Bang		2.104
Bang		

KRATIE ( - ) ( 5 ) [ 45 ]      pop: 203.811 \*\* : 201.189      45,000

Kratie **	4.093	4.095
Chhloung	42.147	42.096
Preak Brosop	47.390	47.325
Sambour	31.444	31.397
Snuol	19.390	19.358

MONDUL KIRI ( 4 ) ( 4 ) [ 17 ]      pop: 21.163 \*\* : -      4,700

Sen Monorom	-	-
Keo Seima	-	-
Koh Nhek	-	-
Orsang	-	-
Pich Chenda	-	-

FREAH VTHEAP ( 1 ) ( 6 ) [ 43 ]      pop: 81.670 \*\* : -      18,000

Tbeng Meanchey	-	-
Chey Sain	-	-
Chhep	-	-
Chuum K'lan	-	-
Kou Lan	-	-
Rovieng	-	-
Sangkum Thmey	-	-

PREY VENG ( 3 ) ( 11 ) [ 108 ]      pop: 908.606 \*\* : 822.688      18,000

Pray Veng		39.532
Ba Phnom	69.335	68.357
Kan Chriek	43.700	43.757
Komchay Mia	63.622	60.188
Kompong Trabek	93.890	97.619
Mesang	90.420	83.912
Pia Rains	105.443	104.239
Piem Chor ?	443.086	41.199
Piem Ro	51.333	38.819
Preh Sdach	100.580	97.257
Preh Veng	52.079	81.701
Sithor Kandal	59.741	59.760

PURSAT ( 7 ) ( 4 ) [ 37 ]      pop: 243.386 \*\* : 236.263      52,000

Pursat	39.502	38.821
Bakan	85.000	79.862
Kan Dieng	41.509	40.078

Kro Kor 54.049 43.000  
Phnom Kravanh 36.432 31.999

RATTANAKIRI ( 31 (8) [46]		000:	65.222 ** : 61.103
Ratatrak Kiri **		9.923	
Banlung *	9.500	7.768	
Bern Sai	6.800	7.816	
Bokao	7.500	8.303	
Kon Mem	5.000	5.107	
Lumphat	6.400	6.722	
Ondong Mias	3.700	4.825	
Taveang	3.000	3.158	
Ya Dao	7.700	7.480	

14,000

SIEM REAP (10) (13) [99]		000:	535.173 ** : 537.668
Siem Reap **	69.034	69.034	
Angkor Chum	40.187	37.745	
Angkor Thom	8.048	15.020	
Bonty Srey	18.328	18.328	
Chi Kraeng	88.685	89.487	
Chong Cal	9.728	9.188	
Krolaing	45.371	45.371	
Puok	79.853	79.458	
Siem Reap	43.009	43.009	
Somraong	11.371	12.407	
Sot Nikum	75.999	75.999	
Srey Snom	20.563	20.563	
Svay Loeu	8.620	8.619	
Varin	13.460	13.460	

119,000

STUNG TRENG ( 4) (4) [30]		000:	54.193 ** : -
Stung Treng	-	-	
Se Sann	-	-	
Siemcang	-	-	
Thala Borivat	-	-	

12,000

SVAY RIENG ( 4) (6) [76]		000:	409.998 ** : 388.704
Svay Rieng	13.241		
Chanthrea (10)	29.000		
Kompong Re (12)	43.676		
Romdoul (10)	39.248		
Romlas Haek (14)	65.897		
Svay Rieng (17)	115.208		
Svay Tiep (11)	43.066		

87,000

TAKEO ( 3) (9) [95]		000:	533.432 ** : 602.068
Takeo	24.175	23.155	
Angkor Borey	30.799	29.797	
Bati	89.950	86.866	
Borey Chulasan	16.642	17.716	
Kiri Yeng	67.493	67.609	
Koh Ondaot	38.449	35.703	
Prey Kabah	70.714	69.555	
Som Rong	82.750	82.068	
Traing	81.314	73.597	
Tram Kek	131.165	116.011	

133,000

TOTAL CAMBODGE: 8.923.000 9.173.000

1,832,000

ANNEX J

NON-GOVERNMENTAL ORGANIZATIONS

## NGO EXPERIENCE IN MCH/BIRTH SPACING

There are many international non-governmental organizations (NGOs) and U.S. registered private voluntary organizations (PVOs) now operating maternal and child health programs in Cambodia.

Some of these organizations have conducted birth spacing surveys and have initiated birth spacing activities; many others have indicated an interest and willingness to begin work in birth spacing if funds became available.

Below is a brief summary of relevant experience of organizations engaged in MCH or birth spacing activities in Cambodia.

**1. Action Nord Sud - Battambang province, Maung Russei district hospital**

Action Nord Sud is a French voluntary agency which has supported the Maung Russei district hospital since July 1992. ANS has built new maternity, pharmacy and consultation buildings and has renovated other sections of the hospital. ANS has also built commune dispensaries in Battambang and Maung Russei district.

Beginning in July 1993, ANS launched a birth spacing program as part of the MCH outpatient program at the district hospital - the first BS project in Battambang Province.

Two primary midwives (one year of training) are the principal service providers at the MCH/BS clinic, open 8-11 Monday to Friday. A secondary midwife (three years of training) supervises, and a medical assistant in charge of MCH and maternity is on call for IUD insertions and medical consultations. Treatment, counseling and follow-up procedures follow the protocols established by MSF/HB.

Seventy five percent of the clients were between the ages of 26 and 40 with twenty five percent in each of the three age cohorts 26-30, 31-35 and 36-40. Twenty six percent of the women reported eight or more children; seventy-four percent of the women had four or more children.

*N.B.: These service statistics describe a population of women long denied opportunities for voluntary birth spacing.*

By the end of January 1994, after six months of operation, the clinic had registered 241 new and 151 continuing contraceptive clients, 26% coming from a distance of 5-10 km and 12% from more than 10 km. Clients were charged R1000 (\$.40) for a health record card at the first visit. Depo Provera was the most popular method, as shown in the data below.

<u>Method</u>	<u>New Clients</u>	<u>Continuing Clients</u>
Depo Provera	163	89
Oral Pills	52	56
Condoms	24	5
IUD's	2	1

At the end of the six month reporting period, 17% of clients were a month or more behind schedule for revisits and were presumed to have dropped out. An additional 9% were up to a month late for a scheduled follow-up visit. A survey of clients who dropped out was begun to ascertain reasons for discontinuing.

ANS believes that delivery of BS services should now be expanded from the district level to the commune and village level.

## **2. American Red Cross - Kampong Speu provincial hospital**

ARC support to the Kampong Speu provincial hospital dates from December 1991. ARC assistance has focused on renovation of facilities, training of resident MOH health workers and the development of curricula and supervision materials. A resident advisor, under recruitment, will conduct a baseline survey on BS practices and begin to strengthen training and service delivery in BS at the provincial hospital.

## **3. American Refugee Committee**

- Pursat Province, Kan Dieng district hospital
- Banteay Meanchey Province, Center for Continuing Health Education

ARC has been active since 1991 in Pursat and Banteay Meanchey provinces. ARC plans to initiate birth spacing delivery services in mid-1994 at Kan Dieng district of Pursat province. Support at the Banteay Meanchey provincial center for continuing health education includes instruction in BS.

## **4. CARE - Bakan District of Pursat Province**

CARE supports integrated MCH/BS training and service delivery programs in one district hospital (Bakan) and three commune clinics. CARE is supported in this effort with a \$2 million grant from USAID/Cambodia.

After two years of CARE participation, MCH/BS services have become available five days a week at the district hospital and one day a week at three commune clinics. Each commune (Khum) clinic is staffed by a primary midwife and a secondary nurse.

Nurses and midwives have been trained in MCH/BS skills, and 130 traditional birth attendants have been trained in safe delivery.

services. In the course of this training, CARE has field tested and modified the contraceptive counseling and service protocols developed by MSF/HB. CARE has also sponsored the establishment of a provincial coordinating committee, PROCOCOM, in support of MOH policy to replicate the national COCOM at the provincial level.

CARE, along with IFRC, is one of the few NGO's which has focused on the commune (Khum) level of service delivery. CARE has brought together for joint five-day training sessions two mutually suspicious groups - MOH midwives and traditional village birth attendants - and has created a cadre of master trainers drawn from both disciplines. CARE has also conducted six-day training courses in the villages - on the temple grounds - for traditional birth attendants, rather than asking them to come in for training at the district hospital. CARE has found that this approach of taking the training to the trainees has increased participation and skills transfer.

According to CARE, the results of the training of both MOH midwives and TBAs has been a stunning increase in quality of care, self-confidence on the part of the midwives, and increased appreciation by the community.

#### 5. Christian Outreach - Prey Veng Province and Kampot Province

Christian Outreach initiated a primary health care project in Kampot in October 1990, and a similar project in Prey Veng in 1991. Support has consisted primarily of training, technical assistance and facility renovation at the district hospital level.

##### - Pre Cla commune of Prey Veng Province

Informal surveys conducted in 1992 and 1993 indicated a high preference for small families and a high demand for birth spacing among 90 of 100 women interviewed. Other findings were:

- almost all women in each of six villages had heard of orals, depo-provera and IUD's; most information came by word of mouth from users or friends;
- the average of marriage is 19 years; 70% of women marry by that age;
- there are widespread misunderstandings regarding the side effects, real and imagined, of depo provera;
- both the pill and depo provera are believed to cause weight loss;
- women are prepared to pay R1000-1200 per month for services;

- preferences for contraceptive methods are as follows:

Depo-provera	90%
Oral pill	7%
IUD	3%

#### 6. Health Net - Svay Rieng Province

Upon the completion of support to Svay Rieng from MSF/HB at the end of 1993, Health Net assumed responsibility for all aspects of health care administration, including MCH/BS, in the three districts of Svay Rieng, Svay Teap and Romeas Hek, as well as at the provincial hospital in Svay Rieng.

The overall Health Net budget requirement is estimated at \$1.3 million for a three year period. USAID funds remaining unspent in World Concern's subgrant to MSF/HB (\$22,800) were transferred to Health Net for the period Jan-June 1994. A further proposal is under development for an additional \$30-35,000 for Health Net from World Concern's AID-funded Mother and Child Health Recovery Project. World Concern views these inputs as seed money; Health Net is supposed to secure the bulk of its funding from other sources.

The departure of MSF/HB from Svay Rieng left approximately 4,000 women who had begun using depo-provera for birth spacing without an assured source of resupply. By April 1994, the National MCH Center in Phnom Penh was able to secure supplies from former FUNCINPEC field hospitals - 10,000 doses of depo-provera and 7000 cycles of oral pills - to resupply the BS clients in Svay Rieng.

#### 7. International Medical Corps - Svay Teap District, Svay Rieng Province

IMC has been active since October 1992 in developing a village health training project. IMC is the recipient of a \$500,000 USAID grant to develop community outreach workers, focusing on the promotion of maternal and child health.

IMC training programs are designed for village community health workers, commune health clinic staff and local administrators. Current activities are concentrated on the development and dissemination of training curricula, and on the development of mechanisms to sustain the program beyond IMC's involvement.

#### 8. FPJA - Phnom Penh

With private funding from Planned Parenthood Association of America, FPJA established a pilot birth spacing program at the National MCH Center in May 1992. Support to the Center has been continued under a grant from USAID/Cambodia. This second project

was formally approved by the Cambodian government and launched in May 1994. By the end of 1993, the pilot project had recruited approximately 1,300 BS clients through one outpatient clinic at the 7 January Hospital.

Under the new grant, FPIA plans to support the establishment of a private birth spacing NGO which may eventually become a national planned parenthood association. IPPF/London has expressed interest in collaborating on this venture.

**- Svay Rieng Province:**

Svay Rieng is one of three provinces targeted by FPIA under its NGO grant from USAID/Cambodia. (The other two are Takeo and Kampong Speu). FPIA is exploring which of the remaining four districts in the province not supported by Health Net would be appropriate for support.

**- Kampong Speu Province:**

Sites for project activities are under discussion.

**- Takeo Province:**

Sites for project activities are under discussion.

**- Phnom Penh municipality:**

FPIA plans to establish a model clinic for BS as well as STD diagnostics, counseling and treatment. The site has been chosen for the clinic. FPIA also plans to expand an existing urban community based distribution (CBD) program from two to four districts in Phnom Penh

**9. International Federation of Red Cross and Red Crescent Societies (IFRC) - Kampong Chhnang, Battambang, Pursat, Kampong Thom and Takeo Provinces**

With a staff of 18 expatriates and 81 Cambodians, IFRC possesses strong assets to support MCH/BS programs. IFRC's health development program, which focuses on MCH, is active in eight districts of the five provinces listed above.

By June 1994, IFRC expects to have completed in-service training in MCH for the following numbers of personnel:

Primary midwives	199
Primary nurses	195
Supervisors (secondary nurses and midwives)	127
Traditional midwives	1066
Red Cross volunteers	2359

Primary nurses and midwives, and Red Cross volunteers, provide BS information only. Actual BS service delivery is limited to secondary nurses and midwives, who function as supervisors and on-the-job trainers.

In the experience of IFRC, primary midwives and nurses serve as de facto volunteers, because of the wholly inadequate wages they receive. The key advantage they bring to the program is local acceptance by the women in their villages, given that the primary midwives and nurses tend to return to their home towns following their nine months of course work in Phnom Penh or at a regional training school. Secondary midwives and nurses tend to be from outside the community.

In an effort to upgrade the service skills of nurses, IFRC reports that secondary nurses were successfully trained in IUD insertion during late 1993, despite the fact that such services are technically limited to physicians.

The experience of IFRC in focusing on improving the BS skills of paramedical personnel - nurses and midwives - offers useful precedents for replication in other provinces.

#### 10. International Rescue Committee - Kampong Chhnang Province

IRC is the recipient of a \$2 million USAID/Cambodia grant for development activities in Kampong Chhnang including hygiene, sanitation, and the provision of basic health services.

IRC supports the rehabilitation and construction of district and commune health centers, as well as in-service training for midwives and traditional birth attendants. With this history of participation in the development of health services, IRC represents a potential collaborator in a national birth spacing program.

#### 11. Medecins Sans Frontieres/Holland Belgium (MSF/HB)

With a staff of 49 expatriate professionals plus an additional 110 full-time Cambodian staff persons, MSF/HB is one of the strongest NGO's working in MCH in the country. MSF/HB has taken the lead in developing birth spacing protocols in the Khmer language and in training service providers at provincial and district levels. MSF/HB has received USAID funding through World Concern, a U.S.-registered PVO.

MSF/HB's main objective is to upgrade provincial and district hospital services in collaboration with Ministry of Health staff. MSF/HB is currently active in the following locations:

Siem Reap Province

Provincial Hospital  
 Kroliang District Hospital  
 Puok District Hospital  
 Sot Nikum District Hospital  
 Chi Kraeng District Hospital  
 Somraong District Hospital  
 Sassar Sadam Health Center

Kampot Province

Chhuk District Hospital  
 Tuk Meas District Hospital  
 Dang Tung O.P.D.  
 Chum Kiri O.P.D.

Pursat Province

Provincial Hospital  
 Phnom Kravanh District Hospital  
 Bakan District Hospital  
 Trapeang Chorn health center

Banteay Meanchey Province

Provincial Hospital "B" at Sisophon  
 Phnom Srok District Hospital  
 Pranet Preah District Hospital  
 Thmar Puok District Hospital  
 Svay Chak Health Center  
 Banteay Chhmar Health Center  
 Phkoan Health Center  
 Boeung Trakoun Health Center

MSH/HB is also active in a Bilharzia project in Kratie Province and, in collaboration with UNICEF, in the national essential drug distribution program nationwide.

MSF/HB has been a pioneer in the development of birth spacing training and service delivery at the provincial and district level, and is particularly well qualified to collaborate with AID-registered PVO's in BS program implementation.

MSF/HB has launched birth spacing programs at the following locations:

Banteay Meanchey (Sisophon)prov. hosp.	- Jan 1994
Pursat provincial hospital	- Mar 1993
Kravanh district hospital	- Jun 1993
Kampot provincial hospital	- Dec 1992
Tuk Meas district hospital	- Sep 1992
Chhuk district hospital	- Jan 1993
Dang Tung district hospital	- Oct 1993
Puok district hospital	- Oct 1993
Svay Rieng provincial hospital	- Dec 1992*

Svay Rieng district hospital	- Dec 1992*
Svay Teap district hospital	- Dec 1992*
Romeas Heck district hospital	- Dec 1992*

\*Program support responsibilities for these four locations were transferred to Health Net at the end of 1993.

Surveys conducted by MSF/HB in the Svay Rieng area in late 1991 indicated that widespread ignorance of BS methods persisted; e.g., among the 91% of women in Svay Rieng who wanted birthspacing services, abortion was the only method known to 60% of them. Induced abortions by village midwives were found to be a leading cause of maternal death.

MSF/HB began to offer BS services in January 1992 as part of an MCH program at the provincial hospital, at three district hospitals (Svay Rieng, Svay Teap and Romeas Heck) and in the commune of Chantrey in Romeas Heck district. The results after a year were as follows:

- by the end of 1992, 3100 women had enrolled in the program, of whom 2813 (91%) chose Depo Provera, 235 (7.5%) the pill, 43 (1%) the IUD, and 9 women chose the condom;
- 60% of the women were over 30 years of age;
- 60% reported more than four pregnancies;
- during the second half of the year, the percentage of clients coming from more than 10 km away doubled as news of the service spread;
- defaulters, defined as clients more than two months late for a follow-up appointment, totaled 17% by the end of the year; disaggregated by method of contraception, 25% of pill clients defaulted, 15% of depo provera clients dropped out, and 2 out of 43 IUD clients asked for removal without changing to another method of birth spacing.
- By mid 1993, the number of MCH patients seen each month at the provincial hospital had doubled. By August 1993, 65% of clients attending the Svay Rieng district hospital MCH clinic had come to request birth spacing services. Similarly, the district hospitals at Svay Teap and Romeas Heck reported that almost half of the MCH consultations were for birth spacing.
- By the end of 1993, depo-provera clients had risen to over 4000.

- Kampot Province: discontinuation study

MSF/HB initiated a birth spacing program in August 1992 in Tuk Meas, the capital of Bantey Meas district in Kampot. By early 1994, MSF/HB became aware of a high rate of defaulters, particularly among depo-provera clients.

Of 416 depo-provera clients enrolled between August 1992 through December 1993, 30% (N=131) were more than two months late for a follow-up appointment and were presumed to have dropped out. (During the same period, only one of 28 IUD clients discontinued, and five of seven pill clients discontinued).

Forty five clients who had defaulted were located for follow up interviews. Twenty percent of those interviewed wanted to be pregnant again, and eighteen percent were indeed pregnant.

Seventy two percent of the defaulters did so after their first visit to the BS clinic. Forty percent of those interviewed could remember no information on side effects. Thus the first visit seemed to be particularly important in terms of the need to insure understanding of contraceptive methods and the need to provide accurate counseling on side effects.

Other reasons given for discontinuation included weightloss, irregular bleeding, fatigue and loss of appetite. Considerable misinformation on alleged harmful side effects of contraceptives also emerged during the interviews, reinforcing the need to improve counseling and knowledge transfer.

#### - Banteay Meanchey Province

Dr. Kanika Shaw, MSF\HB physician at Sisophon provincial hospital, reported in May 1994 that there were approximately 70 visits per month for BS services at the hospital OPD, open 5 days per week. Roughly two thirds of the clients chose Depo Provera<sup>R</sup> and one third chose oral pills and IUD's. STD rates were high.

#### 12. Private Agencies Collaborating Together (PACT)

PACT is the recipient of a \$15 million USAID grant to continue managing a portfolio sub-grants to PVO's and NGO's for community based development programs, including maternal and child health programs. In this role, PACT serves both as mentor and manager of NGO sub-grant activities, as well as a support structure to foster the development of stronger local NGO's.

PACT provides small (under \$25,000) strategic assistance grants to local organizations in need of interim assistance. For example, as of this writing, PACT is considering a small grant to promote the development of a private professional association of Cambodian midwives.

PACT also manages a million dollar grant to the Cambodian-American National Development Organization (CANDO), which brings skilled Cambodian-Americans back for volunteer work in development programs.

In collaboration with John Snow, Inc., PACT also manages the compilation of information relevant to PVO's on MCH, birth spacing and sexually transmitted diseases, as well as the provision of professional advisory services to MOH policy makers in the national birth spacing program.

By virtue of its strong organizational and management capabilities, PACT serves as the de facto lead U.S. PVO/NGO agency, with potential to expand its participation in MCH and birth spacing programs.

#### 13. Servants to Asia's Urban Poor - Mean Chey District, Phnom Penh

Servants supports maternal and child health programs in three facilities in this district on the southern edge of Phnom Penh City - Chbar Ampoeu Hospital, Chak Angre dispensary and Prek Pra dispensary. The program has been active since April 1993.

#### 14. World Concern - Prey Veng and Svay Rieng provinces

With AID financial support through a PVO grant, World Concern has provided technical and material support to training and service delivery programs in MCH/BS since September 1992. Master trainers have been trained to teach nurses, midwives and traditional midwives at district and commune levels. Renovation and equipping of provincial MCH facilities has created suitable environments for training and service delivery. Many of World Concern's programmatic objectives in Prey Veng and Svay Rieng have been aided through collaboration with Medecins Sans Frontieres/HB.

#### 15. World Education - Prey Veng Province

The recipient of a \$2.3 million USAID grant, World Education is engaged in non-formal education for maternal and child health at the community level. World Education supports curriculum development, training of master trainers, dissemination of training materials and collaboration with MOH health officials at provincial and district levels in non-formal education.

In the process of involving villagers in the development of appropriate messages and materials, World Education has acquired valuable understanding of rural Cambodian attitudes and perceptions of maternal/child care and birth spacing. The

experience of World Education may be particularly useful in designing I.E.C. programs for birth spacing.

#### 16. World Vision International

World Vision is active in a number of health projects in Cambodia, including a \$2.3 million USAID project to strengthen the National Pediatric Hospital in Phnom Penh as a national training center.

World Vision's goals in this effort focus on curriculum development and training to improve prevention and treatment of childhood acute respiratory infections and diarrheal diseases. This program, combined with World Vision's on-going development experience in several provinces described below, suggests a strong capability for expanded participation in birth spacing activities.

##### - Kandal Stung District, Kandal Province

World Vision reported in September 1992 on a baseline survey among 278 mothers of Kandal Stung District, close to Phnom Penh. Seventy nine percent of the mothers stated that they did not want another child during the next two years. A year later, in 1993, a follow-up survey found that the percentage of women wanting no additional children had risen to 85%.

During 1993 World Vision collaborated with the district hospital in an expansion of birth spacing services as part of the MCH program.

In addition to support for outpatient services at the district hospital, World Vision organized a mobile team (a 3-year midwife and an assistant MD) to visit 19 commune clinics once or twice a week. Each commune clinic was typically staffed by a one-year nurse and a one-year midwife. Each commune health center maintained a registry of depo-provera users to allow for prompt follow up of missed appointments.

Village volunteers functioned as sources of information and counseling on contraceptive methods.

By the end of 1993, the percentage of mothers using contraception - mostly depo-provera - had risen to 6.9%. Based on this greater than anticipated achievement, The district health officers set a target of 15% of eligible women using a modern contraceptive method by the end of 1994.

As of late March 1994, approximately 2600 women were contracepting, mostly with Depo Provera.

##### - Preah Sre Commune, Oudong District, Kampong Speu Province

During November 1992, World Vision conducted a survey among a randomly selected sample of 98 mothers aged 40 years or less in this rural commune about 45 km from Phnom Penh.

Eighteen percent of the women were currently pregnant. Sixty two percent had received no antenatal care during their last pregnancy.

Seventy one of the women wanted no more children during the next two years, but only three of the women were contracepting, two with modern methods. Only 19% of the women were able to give a medically correct reason to the question "how are babies made."

The survey disclosed pervasive ignorance and misconceptions regarding contraceptive methods, demonstrating a need for accurate information and education on birth spacing options and side effects.

World Vision reported that birth spacing activities had been under way for six months as of March 1994; service statistics were not yet available.

- **Kampong Trolaik District, Kampong Chhnang Province**

Birth spacing services began in this district in early 1994. Service statistics were not yet available.

World Vision is also active in other health programs in Battambang, Kampot and Prey Veng provinces.

**ANNEX K**  
**COOPERATING AGENCIES**

Training in Reproductive Health II and III

Cooperating Agency JHPIEGO

Duration May 1987 - Sept 1994

Project Number 936-3045, 936-3069

Aug 1993 - Sept 1998

Agreement Number CCP-3069-A-00-3020-00

Agreement Level \$272,000,000

Geographic Scope Worldwide

**Purpose:**

To develop host country training capacity and to train selected health providers in modern reproductive health knowledge and skills, emphasizing voluntary sterilization, IUDs, injectables and implants.

**Description:**

The Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) works to: (1) establish the capacity of countries to train their own health care personnel to deliver quality FP services, emphasizing long term methods, through the development of national training systems; (2) meet the short-term national family planning needs, especially in long-term methods, through the training of service providers; (3) eliminate medical barriers and training policies which limit access to family planning services; (4) improve effectiveness and efficiency of reproductive health training materials; and (5) expand international reproductive health training resources and systems.

**Project Director**

AID/W

Noel McIntosh  
JHPIEGO  
Brown's Wharf  
1615 Thames Street, Suite 200  
Baltimore, MD 21231

Allen Brimmer  
G/R&D/POP/CMT, Room 806, SA-18  
Agency for International Development  
Washington, DC 20523-1819

Telephone: (410) 955-8558  
Fax: (410) 955-6199  
Telex: 6849019 or 6849118

Telephone: (703) 875-4565  
Fax: (703) 875-4413

### Family Planning Logistics Management

Cooperating Agency John Snow, Inc.

Project Number 936-3038

Agreement Number DPE-3038-C-00-0046-00

DPE-3038-Q-00-0047-00

Duration Sept 1990 - Sept 1995

Contract Level \$20,008,754

Geographic Scope Worldwide

#### Purpose:

To improve the capability of developing country public and private sector organizations to administer more effective and efficient contraceptive logistics systems; and to provide support to G/R&D/POP in managing the Office's Population Projects Database (PPD) and the management system for tracking contraceptive orders, shipments and financial accounts.

#### Description:

JSI collaborates with CDC and assists G/R&D/POP, USAID missions, and developing country family planning organizations to implement the following activities: 1) strengthen the ability of family planning programs to manage and implement efficient logistics systems; 2) institutionalize the capacity of family planning programs to forecast their contraceptive requirements; 3) develop the capacity of family planning programs to implement sound quality assurance programs; 4) implement and maintain G/R&D/POP's commodities MIS (NEWVERN) which tracks the procuring, shipping, storing, and financing of USAID supplied contraceptives; and 5) undertake special analyses on cross-cutting issues related to contraceptive logistics and USAID population programs. The logistics assistance activities are managed out of the Washington office and from regional offices in Latin America, and East and West Africa.

#### Project Director

Richard Owens  
John Snow, Inc.  
1616 North Fort Myer Drive, 11th Floor  
Arlington, VA 22209

Telephone: (703) 528-7474  
Fax: (703) 528-7480  
Telex: 272896 JSIW UR

#### AID/W

John Crowley  
G/R&D/POP/CPSD, Room 803, SA-18  
Agency for International Development  
Washington, DC 20523-1819

Telephone: (703) 875-4650  
Fax: (703) 875-4413

Family Planning Logistics Management

Cooperating Agency Centers for Disease  
Control

Project Number 936-3038

Agreement Number DPE-3038-X-HC-1015-00

Duration April 1991 - August  
1996

Contract Level \$13,771,326

Geographic Scope Worldwide

**Purpose:**

To improve the management and operation of FP programs in developing countries through the use of more effective logistics systems, the collection and analysis of demographic data, and the use of targeted epidemiological activities.

**Description:**

The five-year P.A.S.A. with the Division of Reproductive Health at the Centers for Disease Control (DRH/CDC) provides technical assistance to developing country family planning organizations in four areas: 1) logistics management - to improve the ability of local FP organizations to more effectively and efficiently manage their contraceptive supplies; 2) contraceptive prevalence surveys - to assist FP organizations in determining the patterns of contraceptive knowledge and use; 3) clinic management - to provide developing country family planning programs with the capability to use Patient Flow Analysis (PFA) to enhance the efficiency of clinic operations; and 4) epidemiological training and research - to conduct workshops and applied research on epidemiological issues related to contraceptive safety and reproductive health. In general, the local (in-country) costs of these activities are borne by the host organization.

**Project Director**

Tim Johnson  
Division of Reproductive Health  
MS K-22  
Centers for Disease Control  
Atlanta, GA 30333

Telephone: (404) 488-5612  
Fax: (404) 488-5967  
Telex: 549571 CDC ATL

**AID/W**

John Crowley  
G/R&D/POP/CPSD, Room 803, SA-18  
Agency for International Development  
Washington, DC 20523-1819

Telephone: (703) 875-4650  
Fax: (703) 875-4413

# CPSD

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## Contraceptive Procurement

### Contraceptive Procurement

Cooperating Agency N/A  
Project Number 936-3018  
Agreement Number N/A

Duration 1981 - Ongoing  
Contract Level N/A  
Geographic Scope Worldwide

#### Purpose:

To provide a consolidated G/R&D/POP budget for centrally funded contraceptives that are provided to centrally supported subprojects of Cooperating Agencies and to selected governmental programs in developing countries.

#### Description:

G/R&D/POP aggregates the contraceptive needs of family planning subprojects supported under various centrally funded Cooperating Agency grants. During FY 94, G/R&D/POP is funding the contraceptive needs of governmental programs in countries funded by USAID's Development Assistance account. G/R&D/POP, as the manager of contraceptive supply for worldwide USAID programs, also budgets funds for the maintenance of warehouse stocks to meet unplanned program needs of all programs. The funds budgeted in 936-3018 are transferred each fiscal year to the Central Contraceptive Procurement project (936-3057) which pools all USAID funds - central, Mission, regional - designated for contraceptive procurement and serves as the common fund for all contraceptive procurement contracts.

Project Director

AID/W

Contractors are designated under central project 936-3057.

Doris Anderson  
G/R&D/POP/CPSD, Room 803, SA-18  
Agency for International Development  
Washington, DC 20523-1819  
Telephone: (703) 875-4572  
Fax: (703) 875-4413

## Central Contraceptive Procurement

### Central Contraceptive Procurement

Cooperating Agency Various  
Project Number 936-3057  
Agreement Number Various

Duration 1990 - ongoing  
Contract Level Various  
Geographic Scope Worldwide

#### Purpose:

To provide an efficient mechanism for consolidated USAID purchases of contraceptives based on the transfer of all funds from all USAID accounts that support contraceptive procurement to a single central procurement account at the beginning of each operational year for implementation of the procurement process.

#### Description:

This project was established in FY 90 to provide an efficient central contraceptive procurement mechanism for all USAID offices whose programs require contraceptive supplies. Funds are transferred annually to this project through OYB transfers from each of the USAID accounts that support contraceptive procurement (e.g. DA, DFA, AIDS, ESF), and G/R&D/POP directs the use of these funds through a series of procurement contracts to provide the contraceptive supplies required by USAID programs worldwide. This project consolidates the procurement actions but leaves responsibility for the estimation of contraceptive needs in the USAID offices that support family planning delivery systems.

The central procurement system undertakes the purchase of several differently-packaged condoms: oral contraceptives; vaginal foaming tablets; NORPLANT®; the Copper T-380-IUD; and Depo-provera. For details on formulation, brands, prices, contract terms, and ordering procedures, please refer to the guidance issued by G/R&D/POP as part of its guidance for estimating contraceptive procurement needs. All shipping and warehousing of USAID-supplied contraceptives is provided by Panalpina, Inc.

#### Project Director

AID/W

Contractors may change annually because of competitive contract procedures. FY 94 contractors include:

Aladan Inc.; Finishing Enterprises Inc.; Leiras  
Pharmaceutical, Ortho Pharmaceutical Corp;  
Syntex Laboratories, Inc.; Wyeth-Ayerst  
International Ltd.; Upjohn Worldwide  
(prospective); Panalpina Inc.

Doris Anderson  
G/R&D/POP/CPSD, Room 803, SA-18  
Agency for International Development  
Washington, DC 20523-1819  
Telephone: (703) 875-4572  
Fax: (703) 875-4413

**FP Training for Paramedical, Auxiliary and Community Personnel**

Cooperating Agency Development Associates  
INTRAH, University of  
North Carolina

Duration Sept 1989 - Sept 1994  
Contract Level \$22,934,626 (DA)  
\$22,967,544 (INTRAH)

Project Number 936-3031

Geographic Scope Worldwide

Agreement Number DPE-3031-Z-00-9023-00  
DPE-3031-Z-00-9024-00

**Purpose:**

To strengthen and develop the capacity and capability of developing country institutions and agencies to design, implement, and evaluate training activities.

**Description:**

PAC IIb provides assistance in FP training to a variety of FP providers including nurses, midwives, auxiliary and community workers, and traditional practitioners. The project emphasizes building the capability of developing country institutions to carry on effective, self-sustaining FP training programs for PAC workers. Assistance includes technical and other support to develop and strengthen FP training institutions and programs; short-term technical assistance to supply specific technical training to on-going programs; and assistance in conducting training programs, assessing training results, and incorporating the findings into subsequent courses. Project efforts concentrate on strengthening the skills of personnel who train, manage, or supervise other PAC workers. The project emphasizes training in mid-level management/supervision, training of trainers, service delivery skills and pre-service education. Types and levels of assistance vary to meet needs specific to geographic regions and individual countries.

**Project Directors**

Edward Dennison (LAC)  
Joe Deering (ANE)  
Development Associates, Inc.  
1730 N. Lynn Street  
Arlington, VA 22209-2023  
Telephone: (703) 276-0677  
Fax: (703) 276-0432

**AID/W**

Estelle Quain  
G/R&D/POP/CMT, Room 306, SA-13  
Agency for International Development  
Washington, DC 20523-1819

Telephone: (703) 875-4655

Fax: (703) 875-4423

James Lea, INTRAH  
University of North Carolina  
208 North Columbia Street  
Chapel Hill, NC 27514  
Telephone: (919) 966-5636  
Fax: (919) 966-6816  
Telex: 3772242

### Demographic and Health Surveys III

Cooperating Agency Macro International, Inc.                      Duration Sept 1992 - Sept 1997  
Project Number 936-3023    Contract Level \$45,964,568  
Agreement Number CCP-3023-C-00-2012-00                      Geographic Scope Worldwide  
CCP-3023-Q-00-2013-00

**Purpose:**

To improve the information base for family planning and health program management through sample surveys.

**Description:**

DHS III continues successful elements utilized in DHS II, while giving increased emphasis to data dissemination, further analysis and utilization, and strengthening host-country capabilities. DHS III will conduct approximately 30 standard DHS surveys and five experimental surveys, and provide limited technical assistance in up to five countries. As in DHS II, DHS III activities include preparation and dissemination of country reports, in-country seminars, further analysis and data processing workshops at the country and regional level, and a series of comparative studies. New features of DHS III include special trend reports for countries where two or more surveys have been conducted, collaborative studies with developing country researchers, and long-term advisors to promote the use of DHS data in-country.

**Project Director**

Martin Vaessen  
Macro International, Inc.  
11785 Beltsville Drive  
Suite 300  
Calverton, MD 20705-3119

Telephone: (301) 572-0200  
Fax: (301) 572-0999  
Telex: 198116

**AID/W**

Rodney Knight/Amanda Glassman  
G/R&D/POP/P&E, Room 711, SA-18  
Agency for International Development  
Washington, DC 20523-1819

Telephone: (703) 841-7790 (Knight)  
(703) 875-4585 (Glassman)  
Fax: (703) 875-4693

# CMT

## PCS/PIP

### Population Communications Services/Population Information Program

Cooperating Agency Center for Communication Programs, The Johns Hopkins University  
Duration July 1990 - July 1995  
Contract Level \$60,000,000  
Geographic Scope Worldwide  
Project Number 936-3052  
Agreement Number DPE-3052-A-00-0014-00

#### Purpose:

To support the effective delivery of appropriate information, education and communication on family planning to selected audiences in developing countries. To develop in-country capacity to initiate, implement, and sustain effective communication programs for population and FP service delivery. Also, to inform population/FP professionals and policy-makers in developing countries of new developments in population, FP, and related health issues.

#### Description:

Population Communication Services (PCS) provides technical and financial support for communications projects in developing countries in all stages of communication program design and implementation, including audience identification, message design, media mix, production of materials, interpersonal communication, and evaluation. The project emphasizes the use of both public and private sector organizations engaged in FP communication and the development of communication planning and implementation capability in developing country institutions. Specific forms of assistance include: (1) assessing communication needs of family planning programs using qualitative and quantitative research; (2) planning and designing communication strategies; (3) development, pre-testing, and revision of communications materials and methods; (4) evaluation; (5) IEC training and curriculum development; (6) providing translations and copies of previously successful communications materials to population programs; and (7) marketing of services.

The Population Information Program (PIP) supplies information to the developing world through the authoritative review Population Reports, an international journal which covers important issues in population, FP, and related health literature. The online bibliographic database, POPLINE, is the world's largest database on population, FP, and related health literature. POPLINE searches can be obtained on line through the National Library of Medicine's MEDLARS system, by writing PCS/PIP, and on POPLINE CD-ROM. PCS and PIP were merged in December 1992.

#### Project Director

Jose G. Rimón II  
PCS/PIP  
Center for Communication Programs  
111 Market Street, Suite 310  
Baltimore, MD 21202-4024

Telephone: (410) 659-6300  
Fax: (410) 659-6266  
7 241431 JFH/PCS LR

#### AID/W

Deirdre LaPin  
G/R&D/POP/CMT, Room 806, SA-18  
Washington, DC 20523-1819

Telephone: (703) 875-4487  
Fax: (703) 875-4413

Strategies for Improving Service Delivery: Operations Research Technical Assistance (ORTA)

Cooperating Agency	The Population Council	Duration	Oct 1993 - Sept 1998 (AFR)
Project Number	936-3030		July 1990 - July 1995 (ANE)
Agreement Number	CCP-3030-C-00-3008-00 (AFR)		Sept 1989 - Sept 1994 (LAC)
	CCP-3030-Q-00-3009-00 (AFR)	Contract Level	\$17,918,445 (AFR)
	DPE-3030-C-00-0022-00 (ANE)		\$12,590,724 (ANE)
	DPE-3030-Q-00-0023-00 (ANE)		\$15,213,393 (LAC)
	DPE-3030-Z-00-9019-00 (LAC)	Geographic Scope	AFR, ANE, LAC

Purpose:

To improve the quality, accessibility, and cost-effectiveness of FP, reproductive health, and MCH delivery systems through operations research (OR) and technical assistance (TA); and to strengthen developing country institutional capabilities to use OR as a management tool to diagnose and solve service delivery problems.

Description:

The project provides technical assistance (TA) and funding for OR to both public and private sector service providers. Priorities for the project include using OR and TA to: (1) increase access to FP and other reproductive health services; (2) increase the availability and use of under-utilized contraceptive methods; (3) improve the efficiency and sustainability of programs; (4) improve the quality of existing services; (5) provide more acceptable services to special populations, including adolescents, post-abortion women, indigenous groups, men, and post-partum women; and (6) test the integration of other reproductive health services into family planning programs. To date, more than 300 subprojects have been completed, and 100 are ongoing in more than 55 countries in Asia and the Near East (ANE), Latin America and the Caribbean (LAC), and Africa (AFR).

Project Director

Andrew Fisher (AFR)  
 John Townsend (ANE)  
 James Foreit (LAC)  
 The Population Council  
 One Dag Hammarskjold Plaza  
 New York, NY 10017

Telephone: (212) 339-0500  
 Fax: (212) 755-6052  
 Telex: 9102900660 POPCO

AID/W

Patricia Coffey (AFR)/Barbara Feringa (LAC)/  
 Karin Ringheim (ANE)/Jeffrey Spieler  
 G/R&D/POP/R, Room 320, SA-13  
 Agency for International Development  
 Washington, DC 20523-1819

Telephone: (703) 841-7790, ext. 109 (Coffey)  
 (703) 875-4676 (Feringa)  
 (703) 841-7790, ext. 110 (Ringheim)  
 (703) 875-4591 (Spieler)  
 Fax: (703) 875-4413

Population Technical Assistance

Cooperating Agency	Basic Health Management, Inc.	Duration	Dec 1993 - Dec 1998
Project Number	936-3024	Contract Level	\$8,356,788
Agreement Number	CCP-3024-00-C-00-3011-00 CCP-3024-00-Q-00-3012-00	Geographic Scope	Worldwide

**Purpose:**

To improve the effectiveness of the design, implementation, management and evaluation of USAID-funded family planning and population programs worldwide by providing technical assistance.

**Description:**

The project provides professional short-term consultants in response to specific requests for technical assistance from missions and USAID/W in a broad spectrum of disciplines including demography, population policy, maternal and child health care, IE&C, fiscal management, medical science, training, administration, evaluation, logistics and other areas of family planning services delivery.

**Project Director**

Hussein Bulhan  
Basic Health Management, Inc. (BHM)  
1611 North Kent Street, Suite 508  
Arlington, VA 22209

Telephone: (703) 247-8630  
Fax: (703) 247-8640

**AID/W**

James Cummiskey  
G/R&D/POP/RCD, Room 713, SA-18  
Agency for International Development  
Washington, DC 20523-1819

Telephone: (703) 875-4573  
Fax: (703) 875-4413

ANNEX L

INITIAL ENVIRONMENTAL EXAMINATION

INITIAL ENVIRONMENTAL EXAMINATION

Project Name: Cambodia Family Health and Birth Spacing Project  
Project Number:  
LOP Funding: \$20,000,000  
PACD: 9/30/99

INITIAL RECOMMENDATION: Approval of a categorical exclusion as the initial environmental finding for this project.

BACKGROUND: AID environmental regulations allow a categorical exclusion if the following conditions are met:

Paragraph 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 purpose of the project is to provide birth spacing services to the women of Cambodia. Some repair and rehabilitation of facilities may be required (painting, repairing or replacing doors and windows, tiling for cleanliness, etc.). Since the structures are already existing, such minor repair will not have an additional effect on the natural or physical environment.

The goal of the project is to improve family health through birth spacing. AID does not have knowledge of nor control over how healthier families may one day effect the natural or physical environment.

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

\_\_\_\_\_  
Lee Twentyman,  
AID Representative  
USAID/Cambodia

Date: \_\_\_\_\_

Concur: \_\_\_\_\_  
Molly Kux, ANE/ASIA/TR

ANNEX M

STATUTORY CHECKLIST

ANNEX N

DRAFT REQUEST FOR APPLICATIONS

**FAMILY HEALTH AND BIRTH SPACING PROJECT**  
**Request for Applications (RFA)**

**I. SUMMARY**

The Regional Contracting Officer, USAID Regional Support Mission, Bangkok, Thailand, is soliciting applications for a grant to be provided under the Cambodian Family Health and Birth Spacing Project (AID Project Number 442-0112), said grant to finance a cooperative agreement with a non-profit organization to provide management support to the said project.

Application must be made on U.S. Government standard form ?????. Organizational capability statements, resumes, references, and other required information must accompany the application. Applicants should send their applications to Mr. Thomas Stephens, Regional Contracting Officer, Regional Support Mission/Bangkok, at the following international mailing address: U.S. Agency for International Development, 37 Petchburi Soi 15, Petchburi Road, Bangkok 10400, Thailand or from the U.S.A. to USAID/Bangkok, Box 47, APO AP 96546-7200. All applications must be received in Bangkok by \_\_\_\_\_, 1994. Late applications will not be reviewed and considered by the selection panel. Selection will be made by a selection panel based on information provided in the application and supporting documentation plus any follow-up inquiries the panel deems necessary or appropriate. No telephone requests will be honored.

**II. BACKGROUND**

Cambodia is one of the poorest countries in the world, with an estimated per capita gross domestic product of about \$220. But even this low figure conceals wide variations. Rice yields and average farm size suggest that per capita income in rural areas is much lower than that -- and more than 80 percent of the population lives in rural areas. The numbers and proportion of the population living at or below the absolute poverty line have not yet been determined, but it is expected to be very high.

The health status of the population is both a cause and effect of this severe poverty. The impact of debilitating illness on family productivity is well known. Medical expenses for treating such illnesses can be devastating, and stories of selling the family buffalo to pay for treatment are widespread. As medical bills mount, family productivity (and income) collapses.

The unusually high ratio of females to males in Cambodia, the result of generations of men fighting interminable wars, adds another dimension to the importance of health services -- this in spite of the fact that Cambodia probably has the highest maternal mortality rate in the world, estimated at 1 percent of live

births. Induced abortions by village midwives and even less-trained traditional birth attendants are a leading cause of maternal death.

Impeding the flow of health services is the debilitated state of the government's financial system. Resources for the public health system have steadily declined, reducing an already inadequate system to virtual non-performance. Total health spending by the public sector was less than \$1 per capita in 1993.

The qualifications of practicing health professionals has deteriorated almost beyond belief. Recently the World Health Organization (WHO) gave a simple test to 60 practicing physicians who had applied for up-graded skills-training abroad. The test consisted of diagnosing an illness based on (AIDS) symptoms, diagnosing an eclampsia pregnancy problem, asking what not to do if a pregnant woman was bleeding from the uterus, and asking them to name all four of the major ingredients in oral rehydration salts (ORS). Three quarters of them could not answer the first three questions and none of them could name the four ingredients.

Population growth is high with estimates varying between 2.7 and 3.2 percent annually. The population pyramid shows a disproportionate number of young children. The average woman will bear 6-7 children over her lifetime. All reports indicate there is a large unmet demand for contraception, but there is no organized birth spacing system to deliver services and information. A few private voluntary organizations (PVOs) have initiated small birth spacing activities in some districts and communes, but there is no comprehensive birth spacing program today in Cambodia. There is little reliable information about fertility and birth spacing behavior; there are a few studies undertaken by PVOs. One such study indicates that among the 91 percent of women in the southeastern province of Svay Rieng who wanted birth spacing in 1993, abortion was the only method known to 60 percent of them.

A limited range of contraceptives is available in some pharmacies, mainly in the larger cities. The PVOs that have initiated birth spacing activities have supplied contraceptives for their projects, but some of these PVOs are now completing their activities and no provision has been made for continuing contraceptive supplies to the acceptors in these programs. As a result of limited information about birth spacing and limited access to contraceptives, contraceptive prevalence is extremely low, less than five percent of eligible women according to the few studies to date. Without information or access to contraceptives, many women are unable to avoid unwanted pregnancies and frequently resort to abortion. Complications related to these unsafe abortions crowd limited hospital services and frequently lead to death.

Although a surprisingly large number of health workers are employed by the Ministry of Health (MOH), this cadre of workers is poorly trained and service delivery is well below internationally acceptable standards. Few health personnel are trained in modern contraceptive technology and counseling. Focus is on curative care, with little emphasis on women's health or birth spacing. Training programs for these health workers is an essential, immediate need.

Salaries for health workers are only \$10 - \$20 per month. Although basic health and medical services are supposed to be provided free to poor patients at government outlets, almost all Cambodians pay for services. It is widely believed that without these payments the delivery of medical services would cease altogether, as the practitioners just cannot feed their families on their salaries.

Although government policy favors population growth to help the country recover from the heavy loss of lives over the past two decades of war and atrocities, the MOH has approved a birth spacing policy to promote better maternal and child health. The ministry plan calls for providing birth spacing services to 30 percent of eligible couples by 1997. As a first step it plans to implement birth spacing programs in provincial and district hospitals. Nevertheless, to achieve the 30 percent target implies almost two million couple years of contraceptive protection delivered in a two year period -- which is unattainable given the level of skills currently available.

The MOH does have a maternal and child health (MCH) system in place. A national MCH Center is responsible for setting policies, priorities, and protocols, for training and supervision, for developing information, education, and communication (IEC) materials, and for management information required for program implementation. In Cambodia's 21 provinces, provincial MCH committees (which follow the policies and programs set by the Center) support MCH programs in the 176 districts of Cambodia (including more than 1500 communes). The MOH has personnel in place at all levels, from the national level right down to and including the communes.

Since 1992, birth spacing services have been authorized as part of MCH services through public channels such as national hospitals, provincial hospitals, district hospitals, and even commune clinics, and through private channels such as private clinics and pharmacies. The MOH has the capability to distribute contraceptives through its Central Medical Stores (CMS) and has a pilot birth spacing program in operation at its MCH Center. There are private medical clinics and offices throughout the land, and some contraceptives are available from pharmacies in provincial towns.

In practice, however, the system does not work well. The health workers operating in public hospitals often do not have sufficient training to understand and implement a birth spacing program based on modern medical techniques. The same is true of the private outlets. Consequently there is much misinformation and misuse, resulting in women having side effects they don't understand and pregnancies they don't want. In addition, supplies of contraceptives sometimes dry up leaving women without the protection they were counting on. No one can blame them if they become skeptical and critical, and drop out. Thus widespread demand for effective birth spacing is unfilled, in spite of MOH good intentions and published targets to do more. The MCH Center admits that its management ability is limited, and that it would very much like to implement a national birth spacing program based on modern medical techniques, but it just can't right now.

After considering all the above, USAID/Phnom Penh has determined that a birth spacing intervention is the most appropriate venue for its first bi-lateral project in Cambodia. In discussions with PVOs operating health programs, the Ministry of Health, other government organizations and other donors, it has been determined that there is wide-spread unmet demand for birth spacing from women of child-bearing age, and that spacing births will contribute significantly to decreasing mortality and morbidity in those women and their children.

The USAID project should be viewed in the context of a multi-donor and PVO effort to improve maternal and child health while strengthening the institutional capabilities of the Ministry of Health to implement such programs. USAID's efforts will focus on birth spacing because changing fertility behavior is so important for Cambodia's longer-term economic development and because other donors have elected to focus on the other important elements of maternal and child health. Several other donors and PVOs will be supporting birth spacing activities and the USAID project will complement, not compete with, these activities. Brief descriptions of the activities of the major donors are provided later in this RFA.

This project will improve family health by improving and expanding modern medical birth spacing services and the supply of contraceptives. Initial focus will be on urban population centers (especially Phnom Penh) and the most densely populated provinces (Kompong Cham, Kandal, Prey Veng, Takeo, Kompong Speu, Kampot, Svey Rieng, Banteay Meanchey, Kompong Som, and Kompong Chhnang). Other provinces will be included during later phases, as experience is gained and lessons are learned during project implementation.

This project is the beginning of a phased approach which will strengthen the health system and improve birth spacing practice.

Education will be one of the cornerstones of the project. Technical expertise obtained through buy-ins to Global Bureau Cooperating Agencies (CAs) will review and improve the entire structure of medical training as it applies to birth spacing. They will review all procedures and practices, and make recommendations designed to improve them all. They will develop improved curricula for the medical faculty and nurse/midwife training centers, and recommend improved standard procedures regarding admittance, passing, and certification. They will review and make recommendations to improve CMS procurement and logistics systems and MCH Center management and training systems. They will design and promote an IEC program.

This modern medically sound birth spacing information and education will be incorporated into MCH Center training programs for all health workers, including those in the private sector. For the first time in Cambodia women practicing voluntary birth spacing will be able to make informed decisions based on modern techniques, and will know when to use them and how to use them -- and will know what to do when something is wrong.

The CAs will also strengthen the MOH's ability to supervise a national birth spacing program by demonstrating what operations research, surveys, and studies can do to reveal program weaknesses and missed opportunities. The results of these studies will be presented to management for their consideration and will be used to improve management information systems developed to monitor the implementation of the project. Such feedback will also be used to adjust the nature of project implementation over time, strengthening the things that work and correcting the things that don't.

Contraceptives will be another important contribution of this project. At the current time supplies of contraceptives are irregular and inadequate, and often are not available through public outlets like the MOH hospitals. The CMS has the capability of importing and distributing contraceptives, but the government has no resources to purchase them and no major donor has indicated a willingness to supply them in the quantities needed. Accordingly, this project will supply 80 percent of the contraceptives, using CMS facilities and distribution systems, needed to meet the contraceptive prevalence targets established for this project.

The focal point for delivery of birth spacing services and contraceptives will be at the grass roots level, where the women users are. PVOs will play the primary role here. At the current time, there are more than twenty AID-registered PVOs operating in Cambodia, and many of them (including CARE, PACT, American Red Cross, American Refugee Committee, International Rescue Committee, World Concern, World Vision, et al.) have experience in health projects, some including birth spacing. Their

experience will be invaluable in implementing this project.

The PVOs will support provincial, district, and commune level service and contraceptive delivery programs. They will work closely with public and private outlets, and provide management systems, training, equipment, and supplies as needed to get those outlets capable of carrying on a modern medical birth spacing program. If necessary, they will also arrange for the repair or rehabilitation of local health facilities to provide an adequate home for the program. The PVOs will demonstrate and reinforce at the local level the improvements designed and institutionalized by the CAs at the national level, encouraging and indeed forcing the public and private delivery systems to respond and improve.

### III. STATEMENT OF WORK

The management team obtained through cooperative agreement will be responsible for day-to-day management of project activities. Accordingly, AID seeks an organization experienced in implementing population projects in least developed countries. The organization will field a full time management team which, working under the guidance of a USAID/Phnom Penh project officer, will be responsible for a wide range of project implementation functions, including:

- strategic planning and monitoring of activities for the phased approach to implementation of the project;
- counterpart technical assistance support to Cambodian government officials at the national level, for example at the MCH Center (supplementing advisors already in place from other donors and PVOs);
- coordination with other donors planning or implementing MCH or birth spacing projects
- coordination of buy-ins to and monitoring the performance of the various CAs;
- incorporation of CA improvements into the training provided by the MCH Center for health workers nationwide and subsequent support for those training programs;
- administration of sub-grants to PVOs operating in target provinces;
- coordinating contraceptive ordering and distribution through CMS;
- coordinating participant training; and

- development of a management information system and a progress reporting system that will regularly provide full and accurate information to USAID/Phnom Penh on the activities of the management team and all other inputs the team manages.

Among the specific inputs the management team will manage are:

#### Cooperating Agencies

AID/Washington Global Bureau Cooperating Agencies (CAs) will be responsible for the design or revision of IEC programs, logistical systems, commodity and contraceptive procurement, operations research, surveys and studies, training in reproductive health and birth spacing, and such other tasks the project officer and project management team may find necessary. The CAs will work closely with PVOs (see the following section) in developing the required programs and systems to assure applicability and acceptability in Cambodia.

The actual services and the source of those services will depend on the needs as defined at the time and the buy-ins available then, but the probable sources, the tasks they are to perform, are:

Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO), for training programs in the schools of medicine, nursing, and midwifery (including one long term advisor for the first year or two of project implementation);

Family Planning Logistics Management (FPLM), for contraceptive supply systems, clinical patient flow analysis, epidemiological training, and contraceptive prevalence analyses, or perhaps for support of similar activities initiated by UNICEF at CMS;

Training of Paramedical, Auxiliary, and Community Personnel (PAC), to design and evaluate the MCH Center and PVO training activities;

Demographic and Health Surveys (DHS), for knowledge, attitude, and practice (KAP) studies and contraceptive prevalence surveys;

Population Communication Services (PCS), for information, education, and communications (IEC) programs;

Operations Research (OR), for studies and research to improve service delivery; and

Population Technical Assistance Project (POPTECH), to

evaluate the project (as detailed in the evaluation plan), and to provide short term technical assistance to the project as may be required.

Please note that funds for these organizations are **not** included in the grant to the organization fielding the management team. However, the management team is expected to be familiar with the organizations and to be able to make judgements on when, where, and how this technical expertise can best be used during project implementation, and to prepare any required scopes of work or other documentation needed by the project officer to obtain their services.

#### Non-Governmental Organizations

All totalled there are more than twenty AID-registered American Private Voluntary Organizations (PVOs) operating in Cambodia, and many have indicated an interest in participating in this birth spacing project. Sub-grants should be limited to those AID-registered PVOs already operating in Cambodia, since the experience they have gained and the working relationships they have developed will be invaluable to smooth implementation of this project.

The selected PVOs will be responsible for supporting birth spacing planning and delivery systems (for both birth spacing services and commodities) at the grass roots level. Delivery will be through both public and private outlets, and will include IEC and other outreach efforts. The PVOs will provide necessary management, equipment, and supplies (and training if necessary) to assure the informed and medically safe practice of birth spacing by women in their areas.

The amount set aside for grants to PVOs is approximately five million dollars. This amount will be included in the management team cooperative agreement, for the team to sub-grant to PVOs, but **cannot be subject to overhead under that agreement.**

#### Training

Training is one of the main components of the project, done to strengthen the technical capability of Cambodian health workers to implement and continuously refine and improve a national birth spacing program. The training component of the project will be implemented by the management team.

The Ministry of Health, through the Maternal and Child Health Center, has developed a fledgling program to train these workers in child spacing technology. That program will be strengthened and standardized by technical experts brought in from Global Bureau Cooperating Agencies under this project. This project will then fund, through the management team or PVO grants, the

cost of travel and per diem for more than 9,000 health workers to train (or re-train) in that program.

The project plans on sending 2 long term participants for degree training (a master of public health) in the United States, provided that suitable candidates can be identified. This project also includes travel abroad for 8 senior officials to attend international conferences; three week study tours to Thailand, Malaysia, or Indonesia for 30 senior officials (including provincial governors) and managers; and short term (3 month) training for 10 doctors (or highly qualified nurses or midwives) in specialized topics related to birth spacing technologies being practiced in neighboring countries (Thailand, Bangladesh, Indonesia, India, Philippines, etc.).

Training funds totalling about \$1.3 million are to be included in the management team grant, but **only degree training and training abroad (less than \$400,000) can be subject to overhead under that agreement.**

#### Contraceptives

In order to meet a 30 percent contraceptive prevalence rate by the year 2000, an annually increasing supply of contraceptives (a total of approximately 2 million couple years of protection) must be provided over the five year life of project. This project will provide 80 percent of the contraceptives required. Procurement will be handled by an OYB transfer initiated by the FPLM CA in cooperation with USAID, but the management team will be responsible (in cooperation with the FPLM CA) for monitoring the performance of the CMS.

#### Counterparts

This project will provide the basis for a national birth spacing program based primarily in the MOH. Development of a fully staffed and capable management and training function at the MOH's MCH Center is clearly desired under this project, as is a competent and accountable logistics system (for contraceptive distribution) based in the CMS. It will be incumbent on the project management team to develop close, professional working relationships with these organizations and transfer to them the skills they need to develop and institutionalize these capabilities.

#### Other Responsibilities

There is one implementation issue that should be mentioned here -  
 - the need for repair or rehabilitation of public health facilities from which services and contraceptives can be dispensed or in which training can be provided. To the extent that **minor** repair or rehabilitation of a facility is required,

funds to accomplish that should be limited and should be included in PVO grants. If needs are substantial, however, it is recommended that a health facilities expert be brought out by the management team (under a CA if necessary) to review and make recommendations on such repairs and rehabilitation before such are authorized by USAID. Prior to actually doing any construction or reconstruction, the need for an environmental assessment should be documented.

#### IV. STAFFING

It is the responsibility of the applying organization to identify cost effective staff needs to efficiently and professionally carry out the responsibilities outlined above. Nevertheless, the following estimates are provided for your information:

##### Long-term Staff

One manager, professionally qualified in birth spacing programs in least developed countries, with extensive supervisory experience, as team leader.

One management systems expert, with extensive experience in information systems and data processing, as deputy team leader.

Two or three Khmer-speaking professional staff.

Three or four Khmer support staff.

##### Short-term Staff

Expertise in sub-grants, training, financial systems, administration, and other areas may occasionally be helpful.

#### V. COMMODITIES

The applying organization will be responsible for all commodity procurement that is required to successfully carry out this scope of work that is **not** undertaken by a CA or an PVO. It is the responsibility of the applying organization to determine what those commodity needs are, but the following examples are provided for your information:

Office Space and Equipment It is expected that the applying organization will be able to establish an **independent** office (although it may be co-located with other operations of the organization or other organizations) in Phnom Penh as a base of operations. This office will have to be equipped with telephone, facsimile, copy machine, personal computer, and other required equipment and furniture to as to be able to successfully carry out the responsibilities included in the

scope of work.

Vehicles It is expected that the applying organization will supply the transportation required (estimated at two FWD vehicles) to attend meetings, monitor project activities, and otherwise carry out the responsibilities included in this scope of work.

Housing To the extent that expatriate personnel are included in the application, it is expected that housing and furniture will be provided for them.

Medical Equipment It may be necessary to provide limited quantities of medical equipment to some hospitals in order to enable them to provide medically sound birth spacing services. It is expected that the management team will work with the PVO to identify such needs and arrange for such procurement.

Contraceptives It is anticipated that the quantities of contraceptives required will be estimated by the FPLM CA and will be ordered by USAID utilizing an OYB transfer in AID/Washington. Nevertheless the management team must be familiar with estimating contraceptive requirements and be able to order such contraceptives should the need arise.

## VI. INVOLVEMENT OF USAID

A cooperative agreement is being used to obtain the services of the management team because USAID wishes to have substantial involvement in project implementation. Such involvement will include, but not necessarily be limited to, approval of all expatriate staff, approval of all long term staff, approval of all CA and PVO inputs, approval of annual work plans, regular consultations on project implementation, special consultations on implementation problems, and such other involvement as USAID may subsequently identify in writing.

## VII. OTHER INFORMATION

Attached to this request for applications, for the information of the applying organization, are documents describing the administrative structure of the MOH, a description of selected on-going PVO programs in Cambodia, a description of major other donor programs, information on potential CAs, and a technical analysis of the project.

## IX. EVALUATION CRITERIA

Technical Capability Long term technical staff must be recognized experts in their fields. Bio-data must reflect a minimum of ten years experience in international programs in

developing countries. Knowledge of and experience with A.I.D. programs and procedures is preferred. Team leader and deputy team leader should be self-starters with solid judgement based on relevant background and experience, and possess strong interpersonal and cross-cultural skills, good political acumen and a demonstrated ability to work under difficult, unpredictable and frequently changing circumstances. Strong computer skills, especially word processing, spreadsheets, data bases and graphics, are also desirable. It is preferred that the team leader be a medical doctor, but a master's degree in population studies or public health is also acceptable. 35%

Organizational Capability The successful applicant will have a long and established history of implementing grant programs, and special consideration will be given to those who have implemented maternal - child health or birth spacing programs in least developed countries. Prior experience with AID and the implementation of AID programs will be a distinct plus. Demonstrated ability to organize and orchestrate a variety of inputs and successfully achieve project targets is desired, as is a demonstrated ability to make and supervise sub-grants. 35%

In-kind Contribution The USAID project is designed to provide expertise, training, and commodities to assist in attaining a target of 30 percent of eligible women practicing birth spacing by the year 2000. This project cannot provide for all requirements to meet that goal. The capability to the applicant to provide expertise, training, or commodities or other inputs **not funded by the project or other donors currently operating in Cambodia** is highly desired. 20%

Regional Experience Recent experience in Cambodia is highly desired. Experience in implementing projects in a Southeast Asian setting is required. Team members must be fluent in speaking and writing English. Ability of the team leader and deputy team leader to speak the Cambodian language (Khmer) is desirable but not required. Ability to speak French is considered an advantage. 10%

**ATTACHMENTS**

OTHER DONORS

All donors involved in the economic and social development of Cambodia are faced with the same environment as USAID -- a country that is barely at peace with itself, governed by a coalition of former adversaries who are without financial or managerial resources to undertake national social infrastructure programs. The donors are now wrapping up their rehabilitation programs and are beginning to reconstruct the under-pinnings of this nation. Thus all start at ground zero, and are just beginning to get economic development programs in place. At the current time, there is no major donor implementing a birth spacing program or importing significant supplies of contraceptives.

The UNITED NATIONS FUND FOR POPULATION ACTIVITIES (UNFPA) is planning an "institutional strengthening and family health improvement through birth spacing" project to be implemented over a three year period at a cost of \$1.45 million. The project will operate in twenty-five districts (not yet determined) of five provinces. Unfortunately, at the time of writing this PP, there is no UNFPA representative in country and the two technical people to be brought in to implement the project are months away from arriving. Nevertheless the UNFPA project is seen as an important counterpart to this project, as it will operate with a minimum of imported technical assistance and is to be implemented with heavy dependance on Cambodian government systems. The project design for this AID project is significantly different from the proposed UNFPA project (mainly because of great reluctance of AID to depend on current Cambodian government systems), and thus coordination and comparison of the two projects over time is seen as an excellent opportunity to compare the two approaches. Lessons learned from the UNFPA project will of course be incorporated into this project by project management.

The ASIAN DEVELOPMENT BANK (ADB) is considering funding a project to be implemented by the WORLD HEALTH ORGANIZATION (WHO) to establish a continuing education program for all levels of health workers in Cambodia. A certification system would be included as would development of health worker associations. The project would last two to five years and cost more than \$10 million. The ADB/WHO project fits very well with this proposed AID project because it establishes a system for continuing education into which the training protocols and curriculum development funded under this project could feed. There is no conflict between the projects, and in fact the WHO project officer (an M.D. with a Ph.D. in public health from Johns Hopkins University) is extremely excited about the prospects of collaboration with JHPIEGO. The training plan for this project provides funds for in-country health worker training because the schedule for the ADB/WHO project is uncertain. However, this project will clearly

defer to the ADB/WHO project for in-country training if an overlap seems likely.

**JAPAN** is reportedly planning on building a new maternal/child health hospital in Phnom Penh (as of this writing, confirmation is not possible). Timing has not been established yet, but the new facility will provide a new home for the MCH Center and that is seen as a distinct plus for this project. The MCH Center certainly needs a new home, since the current facility has deteriorated to the point that rehabilitation is not financially or economically feasible and the location is prone to flooding during the rainy season. With a new home (from the Japanese) and new technical expertise (from this project), morale at the MCH Center should increase dramatically and be reflected in new attitudes toward national health programs such as this one.

The **WORLD BANK** is currently planning a social fund which will be used for local infrastructure projects. This fund is not operational yet, but it is possible that these funds could be used for more major hospital rehabilitation projects than are contemplated under this project. Also, the **UNITED NATIONS DEVELOPMENT PROGRAM (UNDP)** is using local labor to rehabilitate roads and other infrastructure throughout the country, including some hospitals and clinics. The project management team will have to coordinate closely with these and other donors through the donor coordinating committee (COCOM) to make use of hospitals that might be rehabilitated under these programs.

Other organizations with related programs include the **UNITED NATIONS CHILDREN'S FUND (UNICEF)**, which supports most MOH/MCH activities, including providing all vaccines through the nationwide expanded program for immunizations (EPI). UNICEF has developed the Central Medical Stores (CMS) division of the MOH 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, and the contraceptives imported under this project will be imported and distributed through CMS.

The **WORLD HEALTH ORGANIZATION (WHO)** provides assistance to strengthen health systems in the MOH; assistance in the development of a National Maternal and Child Health Plan; assistance to limit increases in drug-resistance and further spread of malaria to the National Malaria Center and Control Program; 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 instrumental assistance in the formulation of a National AIDS Control Program.

No other bi-lateral or international donors currently planning projects or programs that might impact on this project are known.

Suggest that Annex D (Technical Analysis), Annex H (Administrative Analysis), Annex J (NGO Summary), and Annex K (Cooperating Agencies) be attached here.

ANNEX O

DRAFT PROJECT OFFICER SCOPE OF WORK

## PROJECT MANAGER SOW

SUBJECT: PSC POSITION IN USAID/CAMBODIA - PROJECT OFFICER FOR CAMBODIA FAMILY HEALTH AND BIRTH SPACING PROJECT

1. SUMMARY: USAID/Phnom Penh is seeking the long-term services of a project officer to provide oversight and monitoring for the \$20 million Family Health and Birth Spacing Project on behalf of USAID. The project officer will monitor the work of an institutional contractor who will be responsible for project implementation; schedule, prepare documentation and coordinate the work of buy-ins to G/POP cooperating agencies; review contractor activity and financial reports; and prepare required A.I.D. project documentation on behalf of USAID.
2. BACKGROUND: USAID is currently preparing the project paper for a family health and birth spacing program to provide information and birth spacing services working in collaboration with the government and a group of NGOs already involved in health programs in Cambodia. The government has recently shifted from a pro-natalist policy to one supporting birth spacing as a means of improving the health of women and children. Few birth spacing activities have been implemented in Cambodia to date, although USAID recently signed agreements with PSI for a social marketing program and FPIA to develop birth spacing programs in three provinces. UNFPA has recently signed an agreement to initiate birth spacing activities in five provinces, but implementation has not begun. Some NGOs have small birth spacing activities and early indications are that demand for services is high.
3. PRINCIPAL DUTIES: The project officer will be responsible for monitoring the activities of the institutional contractor and cooperating agencies whose services will be procured through buy-ins to G/POP agreements. The project officer will be responsible for all the duties of an A.I.D. health/population officer, including, but not limited to, close cooperation and coordination with all A.I.D. contractors, monitoring and keeping USAID informed of their performance, preparation of all A.I.D. and other documentation required for smooth implementation of or reporting on the project, coordination with the Regional Support Mission in Bangkok and with A.I.D. auditors, and other duties described in the attached scope of work. Field trips will be necessary and many may require overnight stays.

The project officer will report to \_\_\_\_\_.

4. REQUIRED QUALIFICATIONS:

A. NATIONALITY: This position is open to U.S. or Cambodian nationals.

B. WORK EXPERIENCE: Minimum of ten years experience in managing international population/birth spacing programs in developing countries. Knowledge of and experience with A.I.D. programs and procedures is preferred. Applicant should be able to work independently without need for daily supervision.

C. ACADEMIC TRAINING: Master's degree in population studies or public health is highly desired.

D. LANGUAGE CAPABILITY: Applicant must be fluent in speaking and writing English. Ability to speak the Cambodian language (Khmer) is desirable but not required. Ability to speak French is considered an advantage.

E. OTHER: The position requires a self-starter with solid judgement based on relevant background and experience. Applicant should possess strong interpersonal and cross-cultural skills, good political acumen and a demonstrated ability to work under difficult, unpredictable and frequently changing circumstances. Strong computer skills, especially word processing, spreadsheets, data bases and graphics, are also desirable.

5. BASIC INFORMATION: USAID/Cambodia's program has shifted over the past year from one of basically humanitarian assistance supporting the United Nation's effort to bring peace and hold elections to a more traditional bi-lateral program aimed at basic human needs. This "post-crisis transition" program may well be an instrumental factor in determining whether Cambodia continues on the path to democracy or falls back into a state of chaos. The program is being implemented under umbrella bilateral agreements with the newly established government which permit, in principle, more unusual approaches to implementation. Annual program levels are expected to remain at the \$35 million level.

The office of the A.I.D. representative is a small, but dedicated, group consisting of four USDH employees and a small but growing staff of PSCs occupying a building in the U.S. Embassy compound. It is a young and dynamic group with ample opportunities for innovation, problem solving, and independent action.

Cambodia has been the nation most devastated by the Indo-China conflicts of the past 25 years. Cambodia, with an estimated population of 9 million persons, has suffered from protracted periods of fighting, economic disruption, genocide, and massive displacement of the population. There are areas of the country that are still contested and large areas of the country are dangerous because of the immense number of explosive land mines. Travel to these areas is officially discouraged. Nevertheless, the people are friendly and it is possible to travel to the

temple complex at Angkor Wat - possibly the most inspiring archaeological site one can visit anywhere. This is a nation determined to put its difficult past behind it and is trying hard to get on with life. If there is a nation where the effects of development show immediately and where there is immediate satisfaction with a job well done, this is it.

Phnom Penh is an attractive, somewhat dilapidated, city of about one million inhabitants. It has broad, flowering tree lined avenues and a mix of French colonial and Asian architecture. Traffic jams are virtually unknown here, although the number of vehicles on the streets is increasing. Most people get around on bicycles, motorbikes, or three wheeled passenger carrying "cyclos". The congestion and large, dense populations of many Asian capital cities are blessedly missing here. Amenities are few, but the food is good and there are quite a few international restaurants (French, Italian, Western/American, Thai, Chinese, Indian and others). The people are friendly. While there are occasional robberies on the street, the target is seldom a foreigner. The pace of life is relaxed. There are beautiful beaches within a few hours drive. There are palaces, museums, and temples to visit and beautiful sunset cruises on the Mekong River, and a wonderful culture to learn about. Singapore, Kuala Lumpur, Bangkok, Vientiane, Hanoi and Ho Chi Minh City are only short flights away via direct airline connections; direct connections to Hong Kong and Manila may soon be available.

Nevertheless, this is a hardship post with a 25 percent differential and one rest and recuperation (R&R) per two year tour. Public health facilities are rudimentary and many tropical diseases are endemic. Water and sanitation are serious problems, even in Phnom Penh. Communication with the rest of the world is often problematic and always expensive. Virtually everyone depends on a generator for electricity since electric power here is even more unreliable than Manila (famed for its frequent "brown-outs"). The local currency, the riel, has been stable for the past months after a period of intense inflation. The U.S. dollar is generally accepted everywhere and seems to be the main means of exchange. Unemployment is a major problem, resulting in migration toward the cities, especially Phnom Penh. Household help is available, but training is often required and communication can be a problem with out knowledge of Cambodian. Destitute mothers and children often beg on the streets and this is a growing phenomenon. The international school conducts classes through grade eight, does the best it can, but most parents find it adequate only through grade six. If you cannot get along without the amenities of a city like Washington, D.C., Phnom Penh is probably not the place for you. But if you thrive on a challenge, believe in development, and think you personally can make a difference, then please apply.

6. APPLICATION/SELECTION PROCEDURES: Application must be made

on U.S. Government standard form 171 (SF-171). A resume, references, and other information may accompany the application if the applicant so desires. By cover letter the applicant must confirm availability to assume these duties by January 1995, or fully justify a later starting date. Applicants should send or FAX their applications to Thomas Stephens, regional contracting officer, Regional Support Mission/Bangkok, at the following international mailing address: U.S. Agency for International Development, 37 Petchburi Soi 15, Petchburi Road, Bangkok 10400, Thailand or from the U.S.A. to USAID/Bangkok, Box 47, APO AP 96546-7200; or to facsimile number 662-255-3730 in Bangkok. All applications must be received in Bangkok by \_\_\_\_\_, 1994. Late applications will not be reviewed and considered by the selection panel. Selection will be made by a selection panel based on information provided in the application and supporting documentation plus any follow-up inquiries the panel deems necessary or appropriate. No telephone requests will be honored.

7. CONTRACT: The contract will be an A.I.D. direct personal services contract for an initial period of two years, with the possibility of an extension for up to three more years. The contract will provide full USAID benefits and privileges in accordance with A.I.D. regulations. This may include, but is not necessarily limited to, salary, post differential, FICA, office space and furniture, and reimbursement for health and life insurance, medical evacuation coverage, shipping and storage of effects, housing and furniture, and international and local transportation. In addition, APO privileges, membership in the Bangkok commissary association and similar benefits will be requested from the U.S. Embassy/Bangkok. Salary will be based on qualification for the position, previous earning history, and A.I.D. regulations.

#### DRAFT SCOPE OF WORK - PROJECT OFFICER

Under the direction of \_\_\_\_\_, the project officer will be responsible for project planning, management and monitoring for USAID. This officer will be responsible for coordination and liaison with the GOC, other international donors and NGOs to assure that the Family Health and Child Spacing Project is well integrated with the efforts of other activities.

1. Coordinate with TA team, USAID offices, AID/W, MCH Center and other GOC institutions, UNFPA, UNICEF, WHO, UNDP, JICA, NGOs and centrally funded Cooperating Agencies.
2. Coordinate with the MCH Center and other GOC health-related institutions, such as Faculty of Medicine and Pharmacy, Schools of Nursing and Midwifery, Central Medical Stores, provincial and district health offices.

3. Coordinate with other relevant GOC ministries, such as rural development, women's affairs, education, agriculture, labor and industry, communications, and youth affairs.
  4. Coordinate with relevant Cambodian NGOs, including Cambodian Women's Association, Youth Association.
  5. Organize, prepare for and chair frequent meetings with project management TA team to review progress, identify problems hindering project performance, determine how to overcome problems and prepare memoranda to USAID summarizing meetings and issues to be resolved.
  6. Represent USAID on MOH/MCH Project Coordination Committee.
  7. Prepare reports and documents required by USAID for project management and implementation, including SOWs for cooperating agency buy-ins, PIOs, OYB transfers for central procurement of contraceptives, waivers, project agreements, contracts, periodic project activity reports, and responses to USAID or AID/W requests for information. Maintain project files for USAID.
  8. Make periodic visits to project sites to ascertain progress being made and to identify problems and issues needing resolution.
  9. Serve as main USAID contact for project management TA team.
  10. Review and approve on behalf of USAID all requests for short-term consultant travel by project management TA team, CAs and NGOs funded by project and coordinate such travel with relevant donors to maximize usefulness of each visit.
  11. Review and approve on behalf of USAID all requests for training.
  12. Participate in selection of project management TA team.
  13. Review and approve on behalf of USAID all sub-grants.
  14. Manage selected PVO grants.
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