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**NEEDS ASSESSMENT AND PROPOSAL FOR  
FPMD TECHNICAL ASSISTANCE TO  
PROMOTE THE DEVELOPMENT OF AN  
INTEGRATED MATERNAL CHILD HEALTH  
AND CHILD SPACING SERVICES IN  
CAMBODIA**

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## **I. INTRODUCTION**

The Khmer Affairs office of USAID/Bangkok requested the Family Planning Management Development Project of Management Sciences for Health to assess the possibilities of providing technical assistance to NGOs and other institutions which are responsible for the development of the maternal child health programs to develop a range of activities which will reduce maternal mortality.

Ensuring access to appropriate care during pregnancy and birth to rural women by trained providers and the availability of child spacing services constitute the focus of USAID interventions. The goal of such technical assistance would be to ensure that integrated maternal health and child spacing services evolve within the framework of a national program, rather than as uncoordinated, ad hoc projects. USAID, which is currently providing support to health and development activities reaching these vulnerable and high risk groups through the US based NGOs, is committed to having these programs evolve in a coherent, integrated and coordinated manner.

FPMD visited Phnom Penh from 27 April to 7 May 1992 to assess possibilities and modalities of providing technical support to NGOs and their counterparts to achieve the aforementioned goal. FPMD met with a variety of officials from NGOs, international organizations, and the Ministry of Health (See Annex 1) and reviewed a variety of documents (See Annex 2). The results of the visit including an analysis of MCH and the child spacing situation in Cambodia and a proposal for technical assistance from MSH are presented below. Because child spacing services require special management support to ensure their coherent and coordinated development, this report places particular emphasis on this area.

## **II. BACKGROUND**

Cambodia is going through a critical period in achieving political stability. The arrival of United Nations Transition Authority for Cambodia, the proliferation of foreign investors, and the mushrooming of organizations providing technical assistance in many different sectors, have led to a combination of cautious optimism and concern about the future course of national development.

In this atmosphere, conditions in Cambodia appear to be evolving which are propitious for the introduction and development of a child spacing activities in the context of a MCH program which will meet the demand and needs of rural and urban families.

The NGOs which play an active role in rehabilitating the devastated health infrastructure and which are key to the development of preventive health services for vulnerable maternal and child populations of Cambodia, are likely to be the principal organizations through which integrated child spacing - maternal child health services can be implemented.

The high birth rate (40 per 1000), the high infant and child mortality, and the extremely high maternal mortality rate in Cambodia, estimated as high as 9 per 1000 live births, make integrated child spacing activities imperative in rehabilitating the health infrastructure. The introduction of MCH services figure in the work of the majority of NGOs involved in health related programs and are priorities for UNICEF and WHO as well.

Child spacing as a component of MCH services is in a very early stage of development. It is only recently that the government has adopted a supportive policy and that a few NGOs have begun to pilot these services. However, child spacing starts in a very propitious if not unique environment. Demand for child spacing appears to be strong. A Women's Association of Cambodia survey indicated that 80% of their sample of women desire some form of contraception. Additional anecdotal evidence from NGO personnel support this finding, though at present the demand seems to be voiced mostly among high parity women with 5 or more offspring.

The NGOs keenly support this program which they rightly see as basic to reducing the very high rates of maternal and infant mortality and morbidity. The Government, while not supportive of efforts to reduce population growth per se, does recognize the relationship between child spacing and maternal and child health and is thus very supportive.

Although the MCH/child spacing program is at an early stage of development, action needs to be taken now in order to ensure that quality, coverage and sustainability underlie all initiatives. This can only be achieved if activities are developed from the outset in the framework of a national program.

### **III. THE DEMOGRAPHIC SITUATION**

The demographic situation in Cambodia is such that serious efforts in providing maternal child health and child spacing services are necessary.

- The population is estimated at 8 million (the last national census was conducted in 1962) with a birth rate estimated between 40 and 60 per thousand, which would make it the highest in Asia.
- Owing to continual war, it is estimated that women comprise nearly 65% of the population. Children under 15 make up more than half of the population with children under four about a third of this population. Observers often note high parity women in their forties with three or four children under five.
- Mortality rates are equally discouraging. Infant mortality is high 120 per thousand.

- Of equal concern is the extremely elevated rates of maternal mortality, estimated as high as 9 per 1000 (some put it as high as 23/1000), which would be among the highest in the world, too. Although evidence is limited, observers suggest that much of the mortality is contributed by septic abortions. The Obgyn unit of the 7 Janvier Hospital in Phnom Penh counts 12 deaths monthly due to septic abortions.

#### **IV. STATUS OF MATERNAL AND CHILD HEALTH SERVICES**

##### **1. Organization of Maternal and Child Health Programs**

The concept and practice of Maternal and Child Health services (including antenatal and postnatal consultations, vaccinations, growth monitoring and nutrition) is a recent innovation in Cambodia. Health care during the colonial period was mainly curative and hospital based. Before 1975 only 29 health centers existed and these functioned as private clinics dispensing curative care. Under the Khmer Rouge health care providers were introduced into the subdistrict and villages, but for the most part their activities existed only on paper.

The recent emphasis on the provision of the package of services associated with services is a product of humanitarian relief and, most recently, development-oriented foreign assistance. Assistance for MCH is directed a variety of ways:

- Vertical programs such as EPI and Tetanus Toxoid vaccination
- The development of MCH services in provincial and district hospitals
- The development of primary health care, community based outreach activities through midwife and TBA training
- Health education components in women in development programs

##### **2. Technical Assistance in MCH**

In the absence of bilateral aid program, the main providers of technical assistance to MCH are the UN organizations and the NGOs.

- UNICEF is the largest supporter of MCH activities largely through its support of EPI and essential drugs programs. UNICEF will be working at the district levels to build up health services capacity and will coordinate with NGO activity at this level.
- WHO is focussing on developing planning and management capacity at the central level. It has been working with the MOH and PMI to formulate a national child spacing policy.

- UNFPA has indicated interest in initiating a program in Cambodia after a preliminary assessment and is planning a second more detailed program assessment.
- A recent survey of 71 NGOs providing relief and development assistance found 37 engaged in health related work, and of these 21 are implementing MCH related activities through hospital based programs, PHC, community health, health center development type of activities, training or curriculum development activities.
- By far the largest service NGO delivery program is that of Medicin Sans Frontiers Holland/Belgium. The Save the Children Funds of UK, Australia and Norway are actively supporting the development of midwifery and TBA training. The SCF/A is conducting a TBA training program in one of its provincial based activities.
- Of the 10 USAID funded NGOs, 2 are currently involved in MCH activities (World Vision, and the American Red Cross) and 4 are planning to implement a primary health care service delivery approach at the district and subdistrict level including TBA training (CARE, American Refugee Committee) or health education programs in WID programs (World Education, World Relief) which maternal and child risk groups will be targeted.

### **3. Cambodian leadership in MCH Service Development**

UN organizations and NGOs alike look to the Protection Maternelle et Infantile (PMI) program of the Ministry of Health in their efforts to develop a national MCH program.

- PMI has recently introduced the MCH TBA training program, which many NGOs are beginning to implement in their own training activities.
- Over the past year, the PMI has taken action to integrate EPI into its MCH services.
- PMI with WHO assistance recently surveyed the NGOs to map out their areas of activities. The PMI now chairs a coordination committee meeting of the various donor groups.
- NGOs also hope the PMI will establish a policy on child spacing which can serve as a framework for their activities.

In practice though, most of NGO health related activities including MCH operate in a highly decentralized environment because of the political situation. The NGOs tend to function

through a series of loose agreements with local authorities, most of whom are mainly interested in material inputs (pharmaceuticals and hospital construction and renovation) rather than preventive health care programs.

#### **4. Strategies for delivering MCH Services**

As NGOs shift to the provinces or away from direct relief to refugees to health development activities, the following approaches to developing MCH services have evolved.

- Development of an integrated MCH service in Obgyn departments and as outpatient services within provincial hospitals. The goal of this effort is to ensure appropriate referral capacity for high risk cases, when district and community outreach services are in place.
- Once provincial hospital MCH are established, development of similar services at the district level hospital. This often involves intensive training and retraining of midwives and nurses, and the development of supervisory "systems" from the provincial to the district level.
- Development of PHC or community outreach services at the subdistrict commune (khum) level. Here the focus is on training khum midwives, nurses and TBAs to promote preventive and community health activities.
- Integration of health education into WID and a variety of credit and other self-help economic schemes.

#### **5. Constraints to MCH Development**

The pace of development is universally acknowledged to be extremely slow and subject to a variety of political and social forces. These include:

- The lack of technically qualified leadership in health at the provincial and district level.
- Currently only a small percentage of the population seeks health services. (9 % in Svay Rieng where MSF/Holland-Belgium operates). A smaller percentage seek MCH services where these have been developed as part of the reconstruction of the services. A recent study of health seeking behavior by a MSF medical anthropologists suggests that Cambodian culture promotes self medication as the most preferred form of health care and that most midwives and nurses who work at the khum level function primarily as extensions of self medication.

- TBAs have very low status and limited tasks. Cambodians prefer the assistance of relatives in delivery (less than 25% deliveries were assisted by TBAs in one study) and resort to "kru khmers" (traditional healers) when problems arise. (One survey suggests that most deliveries are assisted by either midwives or TBAs.)
- EPI and Tetanus toxoid coverage varies. Some surveys conducted by NGOs have indicated results are extremely low and that the data available from the government are unreliable.

## **V. STATUS OF CHILD SPACING ACTIVITIES**

### **1. Demand for Child Spacing**

Under conditions of extreme rural and urban poverty (in a recent survey women indicated their most pressing need was for food), compounded by a recent history of high birthrates (compensate for the extremely low birth rates during the 1975-79 period), it is not surprising that women would seek some form of contraception. Indeed, evidence for a strong demand for child spacing is beginning to grow. Most of the evidence at present is anecdotal. NGOs involved in health and women in development work report high levels of demand by women (and some men) for contraception, higher than for other obgyn service. Data are gradually accumulating to verify the anecdotal attestations. Various community surveys include questions on child spacing. The results of several of these studies are presented below:

- A World Vision rural community assessment found almost 97% of women respondents would use contraception if available.
- A World Vision survey of district health workers indicated found 80% thought child spacing was a priority.
- MSF/HB initial pilot program in delivery child spacing program found women receptive to these services, growing to nearly 350 clients in 5 months. Women also have come relatively long distances to use the child spacing service set up at the provincial and district hospitals.
- A Women's Association of Cambodia survey found 80% of respondents in urban and rural areas interested in child spacing.

## **2. Extent of Contraceptive Practice**

At present no one knows the extent of contraceptive practice. It will be important to carry out KAP studies and to gather baseline data through a Demographic Health survey as soon as the national census is completed and population denominators have been established. The available anecdotal or small survey evidence on contraceptive practice is as follows:

- Although demand is high ignorance is also high both among clients and providers.
- Both private physicians and midwives provide contraceptive services. Private practices is unregulated and there are no data.
- Many NGOs indicate that women resort to abortions to terminate pregnancies. Data from the Obgyn Department of the 7 Janvier Hospital indicate about 12 cases per month of women presenting with abortions complications. There are also indications of high mortality due to abortion related complications.
- Oral contraceptives, condoms and IUDs are widely available in local pharmacies in urban areas. The contraceptives come from all over the world and expired OCs have been found on the market. At present injectables appear to be the most popular method in rural areas while pills appear to be the method of choice in urban settings.

## **3. Government Policy on Child Spacing**

Child spacing is slowly becoming officially acceptable.

- The Ministry of Health has adopted a policy to integrate child spacing in MCH services as a means of reducing maternal mortality. The policy was recommended by the National Health Congress and approved by the Council of Ministers.
- Several NGOs (World Vision and MSF/HB) have begun to pilot child spacing activities rural areas while other NGOs (CARE, ARC) are planning to introduce child spacing in their health and women's development programs.
- The MOH has negotiated a program with FPIA to set up a child spacing service in one of Phnom Penh's major referral hospitals.
- UNFPA has been studying the possibility establishing a program.

#### **4. Issues in Developing a Child Spacing Program**

Provider organizations have started to and will continue to confront several major issues, including:

- **Contraceptive methods.** Choices need to be made about an acceptable contraceptive method mix which are consistent with the ability of providers to ensure quality service and which are based on sound technical knowledge. Current experience indicates women prefer injectables. However, MOH personnel and the MOH seems to have a bias against injectables. Despite the apparent high incidence of Reproductive Tract Infections and Sexually Transmitted Diseases in urban and rural women, and the absence of infrastructure to treat infections, the MOH currently advocates IUDs for rural areas.
- **Contraceptive supply.** Programs will need a dependable logistics system to ensure quality contraceptives are always available. Presently, the NGOs providing child spacing services obtain small quantities of contraceptives from a variety of sources. These severe supply problems undermine efforts to offer clients a choice of methods.
- **Information.** Service organizations will need to monitor child spacing services using similar indicators in order to be able to compare program activity and progress. At present the NGOs are beginning to send reports to the MOH but there is no agreement on the information. In addition, the information will need to be compatible with the general health information system, the development of which is also in the early stages.
- **Supervisory protocols.** Currently, NGOs are using their own clinical supervisory systems. However, as the number of players increases, it will become very important for a suitable common set of protocols to be developed and adopted by all providers. There is both a risk that the NGOs might waste time recreating already tried and true protocols and a danger that quality of care might be compromised if the expected rapid increase in demand materializes before accepted standards are developed and implemented.

## **VI. TECHNICAL ASSISTANCE IN HEALTH AND THE ROLE OF NGOS IN CAMBODIA.**

### **1. International Technical Assistance**

Most development efforts are occurring under arduous conditions created by recent civil and political events. The MOH physical infrastructure, personnel, service, resource and managerial base is rudimentary. The UN has a major presence through UNTAC in Cambodia and many of its specialized agencies from UNDP, WHO and UNICEF are beginning to play major roles in national development especially in health and areas concerning women.

- WHO is emphasizing the development of planning and management capacity in the MOH.
- UNICEF is supporting a variety of public health activities but focussing at the development of provincial management capacity because of the currently highly decentralized nature of the governmental and ministerial infrastructure.

There are few official bilateral aid programs providing direct support to the Ministry of Health because of the political situation. Most international assistance is passed through international NGOs. As funds become increasingly available and the environment open to their involvement, the number and types of NGOs is expected to rise. They have already tripled since 1989. For the foreseeable future, they can be counted on to be in the forefront of international technical assistance to aid the goals of national reconstruction, since, unfortunately, there is only one indigenous NGO.

### **2. The NGO community: Strengths and limitations**

#### **a) Strengths:**

- NGOs are working in all areas of technical assistance. Many which have been highly involved in relief work with refugees in Thailand and during repatriation to Cambodia are shifting their role from relief to development.
- In general, most NGOs have flexibility to respond to needs as they arise and take advantage of opportunities as they emerge in the rural areas.
- The NGOs have small but highly dedicated and creative staff who are eager to meet the challenges posed by the current situation in Cambodia. Such characteristics overcome many limitations in size and variety of skills. In addition, there are a few with growing numbers of staff as programs expand.

- Although currently concentrated in Phnom Penh or one or two provinces, the NGOs are beginning to move out into the rural areas and into a variety of sites, thus ensuring more equitable coverage. With the mapping of NGO activity being carried out under the auspices of the PMI, the trend to balanced coverage will continue.
- The NGOs are relatively well organized and have developed institutional mechanisms for coordination among themselves and working with and through the government. There appears to be a genuine willingness to work within the guidelines of the PMI and to support the PMI in standardizing aspects of service delivery.
- Some NGOs have strong capabilities which can be put at the service of the larger program and which can be used as the basis for developing major systems, for example, CARE's predominant capability in procurement and distribution.

#### b) Limitations

- As all NGOs including those supported of USAID operate under limited budgets, most staffing increases will be directed to supporting service delivery such as nurses and midwives. The NGOs which are working at the national level in collaboration with the PMI are mainly in the training area for midwives and TBAs and in nursing curriculum. Such technical limitation among the NGOs will require supplementary assistance to ensure that their efforts fit into a coordinated national program.
- As the number of NGOs grows in the next few years, the majority will be new to Cambodia and will therefore have to spend most of their energies and resources in establishing themselves and their programs rather than on focussing on the national elements of programs.
- Few NGOs have the necessary personnel or experience in the development of management systems to support a national program, such as planning, supervision, information, finance, and logistics and to develop local institutional capability and the skills of managers. Yet these are the key systems required for sustained growth and quality of all programs.
- Few NGOs have experience in child spacing and the basic management systems upon which child spacing programs depend. Several are making important transitions from relief to development and face important adjustments and must undertake internal changes to deal with new circumstances and new programs such as MCH and child spacing.

- USAID sponsored NGOs will double. These will include Cambodian American organizations without long experience in providing technical assistance. If they are to play any role in MCH and child spacing, they will require support to prepare them for the technical assistance challenge in general and that of health and MCH in particular.

### **3. NGO relation's with the Ministry of Health**

Until now there has been a great deal of autonomy and laissez faire approach to NGO activity. Most NGOs have had very general agreements with the Ministry of Foreign Affairs and MOH and have often tended to take advantage of opportunities to establish programs. Recently with WHO assistance, the MOH has begun to inventory and map out the technical assistance its receives and has begun to require more defined agreements.

On the NGO side, several organizations established in the past few years facilitate and promote greater national level coordination both among the NGOs and between the NGOs and the Ministry of Health. These are as follows:

- **Intra-NGO Coordination:** The Coordination Committee of Cambodia and Medicam provide a mechanism for sharing general and program specific information
- **Inter NGO-MOH Coordination:** The Coordination Committee is comprised of the MOH, representatives from International Organizations, and NGOs and provides a forum for dialogue on program specific issues and transmitting program guidelines.
- **NGO Technical Assistance to the MOH:** NGOs are working closely with the PMI. An often cited exemplary model of such counterpart relations is the SCF/Australia and SFC/UK efforts to develop MCH curricula for training midwives and TBAs, and for integrating child health activities such as EPI into MCH interventions.

Most NGOs wish to develop their programs in the context of a national policy and program. They are predisposed to working with the PMI to develop technical guidelines and directives and to follow them in the implementation of their individual programs. Since child spacing is a new initiative and is regarded as a sensitive area, NGOs put special emphasis on ensuring that their individual activities are accepted by all relevant parties.

## **VII. STRATEGIES FOR DEVELOPING SUSTAINABLE AND QUALITY INTEGRATED MCH/CHILD SPACING SERVICES**

This section presents a framework for how MSH will assist the NGOs and their counterparts to develop a national integrated MCH/child spacing program.

### **1. Strategies for MCH Development**

In the foreseeable future, NGOs are likely to continue to be the principal source of support for the provision and extension of MCH services. NGOs are likely to expand their activities in the direction of service implementation at the district and subdistrict levels with emphasis on primary health care, community outreach, using a variety of strategies from training, development of supervisory capabilities, along with the supply of basic materials, equipment and drugs. However, delivery of services needs to occur in an environment of clearly articulated strategies to achieve the goals of ensuring quality, maximizing coverage, and strengthening sustainability.

In order to ensure that MCH services reach the vulnerable groups and that the rural populations avail themselves of existing services several, FPMD will collaborate with USAID supported NGOs, other NGOs and with Cambodian MCH leaders to develop strategic elements of an MCH program which will attain the aforementioned goals. The main strategic area for collaboration are the following:

- **Establishing Priorities.** Given the large number and heterogeneous NGO players, a coordinated coherent program will require common goals and strategies. Common priorities will promote this type of coordination. Reducing maternal mortality needs to be the highest priority given the extraordinarily high rates prevailing in Cambodia. FPMD will assist in promoting strategic planning type of initiatives to bring to NGOs and national MCH leaders a common vision with respect to the goals of MCH services.
- **Strengthening the PMI.** Strengthening and continuing support to the PMI will be key to the development and implementation of a coherent and coordinated program. In addition to standardizing training for midwives and TBAs, the PMI program will have to address over the next few years systems for setting service standards, supervision, program monitoring and evaluation, logistics, and finance. FPMD will identify strategies for strengthening both the technical and managerial capacity of the PMI and identify locally available and other resources to support these initiatives.

- **Developing local area based planning.** Given the urgent need for MCH services, all programs addressing women should incorporate a health education component aiming to improve health related behaviors and promote utilization of existing MCH services. FPMD will assist NGOs to conduct common area based planning so that all NGOs working in the same province or district develop mutually reinforcing programs, with common education activities.
- **Developing networks and partnerships among all service and information providers.** At the subdistrict and village levels, programs should involve a variety of personnel who are involved in providing health care, not only midwives or TBAs. Although these are important, other traditional healers such as the kru khmers play an important role in health related decision making. FPMD will work with NGOs and local leaders to create networks for bringing in different groups into the service delivery and informational components of MCH services.
- **Developing management systems.** Basic management systems need to be put into place to ensure sustainable MCH programs. Key systems include supervision, information and logistics. Many of the NGOs have predominant capabilities or experience in one or more of these management systems which can be used as the basis for national systems. FPMD will work with NGOs on systematizing predominant capabilities.

## **2. Strategies for Developing Child Spacing Services**

Child spacing has special requirements in regard to training, counselling, logistics, and information. Even when integrated into MCH programs, these requirements need to be explicitly discussed and addressed to ensure integration occurs smoothly and that contraceptive information and clinical services are delivered efficiently and effectively.

The next few years are critical ones for the development and expansion of an integrated MCH/child spacing services in Cambodia. Decisions made now will be felt for years to come. The following analysis is prepared with the objective of assisting Cambodia to benefit from the experiences of other countries, to avoid mistakes made elsewhere and, thus, to meet the MCH/child spacing needs of the population within a much shorter period of time.

The delivery of quality, widely accessible and sustainable MCH/child spacing services in Cambodia, as elsewhere, requires the integration of several levels of a client oriented delivery "system."

Figure I illustrates the child spacing system. At the center of the system is the individual client in need of services. This individual must become a satisfied client who will actively seek out MCH services and use safe, effective and appropriate methods of contraception until another child is desired. In order to achieve client satisfaction, four levels must be integrated.

- In order for this critical event to occur, there must be a provider who can offer information, counselling, and clinical services.
- In order to ensure the delivery of quality information, counselling and clinical services, the provider needs to function in an organization which makes resources available and offers supportive and effective supervision.
- Each organization, public, NGO, or commercial, must operate within a national program. It is the responsibility of the program to set standards, develop clear strategies, rationally allocate roles and responsibilities among the providers, and ensure that shared management systems (such as MIS and logistics) function effectively.
- The final level of the child spacing system is the environment. This level consists of the socio-economic and cultural realities of the country (factors not amenable to short term intervention) and of legal, policy, administrative barriers which may impede the provision of quality child spacing services. In particular child spacing service effectiveness will require the removal of environmental barriers.

Experience to date has shown that most support for child spacing programs occurs at the organization and provider levels. Far less support is directed to the program and environmental levels. Although considerable progress is made by working with organizations and providers, the lack of attention to program and environmental levels is one of the key reasons why there is still so much unmet need for family planning in so many countries around the world.

The FPMD approach will be to assist Cambodia from the outset to develop a child spacing program which addresses all levels.

We have prepared the analysis of the situation in Cambodia regarding child spacing using the client oriented system described above. The analysis is presented in the form of three linked matrixes to demonstrate the relationship between the integrated, coordinated client oriented system, the current Cambodian situation, immediate priorities to begin progress toward achieving integration and coordination, and the potential FPMD role in supporting these actions.

**Matrix 1: Client Oriented System goal vs Current Situation**

Level	Effective Program Characteristics	Current Situation in Cambodia
Provider	Quality information; technical services; supplies and equipment	<ul style="list-style-type: none"> <li>■ Heavy dependence on expatriots;</li> <li>■ Insufficient local managerial capacity;</li> <li>■ Few trained personnel with minimal capacity to train others;</li> <li>■ Provider bias (anti depo-provera-pro IUDs in rural areas oral contraceptives in urban);</li> <li>■ Insufficient attention to appropriate methods suitable to client conditions;</li> <li>■ Inadequate consideration of RTIs;</li> <li>■ Unreliable sources of contraceptive supply.</li> </ul>
Organization	Quality assurance; availability of resources	<ul style="list-style-type: none"> <li>■ Isolated pilot activities, ad hoc and fragmented:</li> <li>■ child spacing through MCH projects of MSF and World Vision;</li> <li>■ child spacing through comm.dev. projects of Care, ARC;</li> <li>■ FPIA to start program in national hospital in 5/92.</li> </ul>
Program	Technical standards; clear strategies; optimal allocation of roles and responsibilities; development of common systems	<ul style="list-style-type: none"> <li>■ Positive child spacing policy:</li> <li>■ NGO-MOH Coordinating Ctte addressing child spacing</li> <li>■ National MCH program established</li> </ul>

Level	Effective Program Characteristics	Current Situation in Cambodia
Environment	Removal of barriers impeding service delivery; initiating positive policies	<ul style="list-style-type: none"> <li>■ Devastated infrastructure leading to services barriers;</li> <li>■ No outreach due to underdeveloped district and provincial referral capabilities;</li> <li>■ No salaries for MOH personnel below nat. level;</li> <li>■ Insufficient number of trained and supported cadre;</li> <li>■ Completely unreliable supply system;</li> <li>■ Lack of most basic data.</li> </ul>

Matrix 2: Current situation vs immediate priorities for action

Level	Current Situation in Cambodia	Immediate Priorities for Cambodia
Provider	<ul style="list-style-type: none"> <li>■ Heavy dependence on expatriate organizations;</li> <li>■ Insufficient local managerial capacity; Few trained personnel and limited capacity to train others;</li> <li>■ Provider bias (anti depo provera-pro IUDs in rural areas oral contraceptives in urban);</li> <li>■ Insufficient attention to appropriate methods suitable to client conditions;</li> <li>■ Inadequate consideration of RTIs;</li> <li>■ Unreliable sources of contraceptive supply.</li> </ul>	<ul style="list-style-type: none"> <li>■ Train all providers in counselling and clinical methods</li> </ul>

Level	Current Situation in Cambodia	Immediate Priorities for Cambodia
Organization	<ul style="list-style-type: none"> <li>■ Isolated pilot activities, ad hoc and fragmented:</li> <li>■ child spacing through MCH projects of MSF and World Vision;</li> <li>■ child spacing through comm.dev. projects of Care, ARC;</li> <li>■ FPIA to start program in national hospital in 5/92.</li> </ul>	<ul style="list-style-type: none"> <li>■ Define appropriate method mix,</li> <li>■ Address provider biases through training and supervision,</li> <li>■ Set up basic systems to support expansion of services: supplies, supervision, clinical training.</li> </ul>
Program	<ul style="list-style-type: none"> <li>■ Positive child spacing policy:</li> <li>■ NGO-MOH Coordinating Ctte addressing child spacing</li> <li>■ National MCH program established</li> </ul>	<ul style="list-style-type: none"> <li>■ Identify locus of child spacing activities in government institutions</li> <li>■ Develop capacity to coordinate and lead NGO child spacing efforts.</li> </ul>
Environment	<ul style="list-style-type: none"> <li>■ Devastated infrastructure leading to de facto barriers;</li> <li>■ No outreach due to underdeveloped district and provincial referral capabilities;</li> <li>■ No salaries for MOH personnel below nat. level;</li> <li>■ Insufficient number of trained and supported cadre;</li> <li>■ Completely unreliable supply system;</li> <li>■ Lack of most basic data.</li> </ul>	<ul style="list-style-type: none"> <li>■ Promote integrated child spacing messages and services provided by traditional and non traditional channels;</li> <li>■ Apply innovative approaches to child spacing to overcome service barriers.</li> </ul>

Matrix 3: Immediate priorities for action and MSH role

Level	Immediate Priorities for Cambodia	FMPD Role in supporting child spacing program development
Provider	<ul style="list-style-type: none"> <li>■ Training in counselling and clinical methods</li> </ul>	<ul style="list-style-type: none"> <li>■ Assist NGOs to better understand provider needs through focus groups and other methods.</li> </ul>
Organization	<ul style="list-style-type: none"> <li>■ Define appropriate method mix,</li> <li>■ Address provider biases through training and supervision,</li> <li>■ Set up basic systems to support expansion of services: supplies, supervision, clinical training.</li> </ul>	<ul style="list-style-type: none"> <li>■ In collaboration with MOH/NGOs develop national guidelines for information, logi-stics, clinical training, counselling and IEC.</li> <li>■ Ensure that appropriate technical expertise is provided either through MSH or from other specialized sources.</li> </ul>
Program	<ul style="list-style-type: none"> <li>■ Identify locus of child spacing activities with in government institution</li> <li>■ Develop capacity to coordinate and lead NGO child spacing efforts.</li> </ul>	<p>Build consensus among NGOs concerning</p> <ul style="list-style-type: none"> <li>- child spacing goals and priorities</li> <li>- method mix</li> <li>- development and use of common support systems, particularly MIS, logistics and supervision.</li> </ul>
Environment	<ul style="list-style-type: none"> <li>■ Promote integrated child spacing messages and services through traditional and nontraditional channels;</li> <li>■ Apply innovative approaches to child spacing to overcome service barriers.</li> </ul>	<ul style="list-style-type: none"> <li>■ Assist Cambodia to draw upon the expertise and experience of countries in the region with more advanced child spacing programs.</li> </ul>

## **VIII. SCOPE OF WORK FOR FPMD TECHNICAL ASSISTANCE TO THE MCH/CHILD SPACING PROGRAM IN CAMBODIA.**

FPMD will provide assistance to the NGOs and their counterparts with the goal of helping Cambodia develop the foundation for a robust child spacing program which will lead to the expansion of quality and sustainable services. The objectives of the FPMD contribution to this effort and specific activities are outlined below:

### **1. Objectives**

- To assist NGOs involved in health programs and other development programs affecting the economic and social well-being of women to develop integrated MCH/child spacing activities within the framework of a national program.
- To support the development of technical and managerial guidelines for MCH/child spacing program based on quality, coverage and sustainability.
- To accelerate the transfer and application of relevant MCH/child spacing technology and experience from other countries to Cambodia in order to promote the development of the national program.

### **2. Specific Activities:**

- Document in a systematic way the experience of different NGOs in establishing and implementing MCH/child spacing services in order to provide guidance for continued NGO support to the development of a national program.
- Provide direct technical assistance to NGOs and counterpart organizations in management training, strategic planning, and systems development.
- Coordinate NGOs and counterparts in the development of technical and managerial support systems (e.g. information, logistics, supervision) common to all providers.
- Identify additional technical assistance needs and resources to support MCH/child spacing program development and bring these to the attention of USAID.
- Establish long-term collegial relationships between local MCH/child spacing program leaders and program counterparts in other countries with relevant experience.

### **3. Technical Assistance**

In order to achieve these objectives, FPMD will field one full-time Senior Technical Advisor (STA) for two years.

- The STA will lead strategic efforts to promote coordinated and fuccussed evolution of Cambodia's MCH/child spacing program.
- FPMD will provide specialized technical and training consultants to develop common management systems (e.g. MIS, supervision) and work through USAID to access other specialized services (e.g. contraceptive logistics and IEC).
- FPMD will coordinate closely with USAID sponsored NGOs. For example, FPMD's STA would work out of the PACT program office. PACT which will coordinate the funding of 10 additional NGOs has expressed a willingness to offer this service and FPMD efforts will certainly benefit from PACT's coordinating role of US NGO subgrantees.
- FPMD may also call upon the services of the major FPMD sub-contractor, CEDPA, (Center for Development of Population Activities) an organization with great experience in promoting NGO development, especially for women managed NGOs.

### **4. Senior Technical Advisor Job Description**

- Organize meetings and other colloquia in conjunction with existing coordinating committees to address basic issues in the development of national MCH/child spacing program.
- Make extensive field visits to identify critical components in MCH/child spacing programs which will affect quality of care, expansion of coverage and sustainability of services.
- Provide direct technical assistance to NGOs and their counterpart organizations to develop and implement strategic planning process as a means of guiding the evolution of a national MCH/child spacing program.

- Provide direct technical assistance to NGOs and their counterpart organizations to develop management capabilities for integrating child spacing services in MCH and other women's oriented development programs.
- Prepare an inventory of additional technical assistance needs and develop methods for NGOs and their counterpart organizations to access resources to provide such technical assistance.
- Provide frequent analyses to USAID, NGOs and their counterpart organizations, and other international organizations on the evolution of the MCH/child spacing activities and resource requirements to ensure quality, expansion and sustainability.

#### **5. FPMD Institutional support**

- FPMD will draw on Management Sciences for Health experience with providing technical expertise to MCH and child spacing programs and with furnishing a wide range of support to resident advisors throughout the developing world.
- MSH has technical programs in the areas of Population, MIS, Drug supply Management, Health Finance, Strengthening Health Services, and Management Training. Experts from these technical programs will be available to provide the specialized consultancies to the NGOs and their counterparts.
- The STA will be able to call upon these expert services, as needed. MSH will ensure that these specialized consultants will establish a relationship with the Cambodian program and as far as possible, the same individuals will return for all the technical assistance missions in their area.

## **6. FPMD Headquarter Management Support**

- Responsibility for Cambodia will rest with FPMD's Asia Near East Division. The FPMD project extensive collegial network with MCH child spacing programs throughout the developing world and strong working relationships with the CAs and the major donors. These contacts will be used to benefit Cambodia as its MCH/child spacing program evolves.
- A wide range of administrative and technical backstopping will be made available from the home office in Boston. One support person will be available on a half-time basis to help the STA with all logistical matters and to provide much needed services such as arranging for study tours, contacting and following up with organizations in the U.S. and elsewhere, and undertaking literature searches.
- A senior technical backstop from FPMD Asia Near East Division will be in frequent and regular contact (usually weekly) with the resident advisor to discuss the local situation and to offer guidance and support. This individual will visit the advisor on a regular basis, usually in conjunction with other travel to the region in order to reduce costs.

## **ANNEX I: PERSONS CONTACTED**

### **1. USAID**

**Sheryl Keller, Officer of Khmer Affairs, Bangkok**  
**Ron Briggs, Office of Khmer Affairs, Bangkok**

**US Mission, Phnom Penh**

### **2. Non-Governmental Organizations**

**AMERICAN REFUGEE COMMITTEE,**

**Patricia Seflow, Project Director**

**CAMBODIA DEVELOPMENT RESOURCE INSTITUTE,**

**Steve Thorne**

**CARE,**

**MJ Conway, Director**

**COOPERATION COMMITTEE FOR CAMBODIA**

**Deborah Brodie, Executive Secretary**

**CAMBODIAN NETWORK COUNCIL, Vannath Chea, Consultant**

**CONCERN (Ireland),**

**Vivien Lusted, Public Health Nurse**

**INTERNATIONAL MEDICAL CORPS,**

**Nancy A Aosse, President,**

**Matthew Frey (FHI), Laura Wedeen (IPPF), consultants**

**INTERNATIONAL WOMEN'S DEVELOPMENT AGENCY,**

**Margeret Bywater, Director**

**MEDICINS SANS FRONTIERES, HOLLAND-BELGIUM,**

**Maurits Van Pelt, General Coordinator**

**MENNONITE CENTRAL COMMITTEE,**

**Jonathan Clemens, Director**

**PACT,**

**Sarah Newhall, Director, Greg Black, Administrator**

**REDD BARNA (SCF Norway),**

**Wendy Hammond, So Myngh, Rural Project Director**

**SAVE THE CHILD FUND, AUSTRALIA,**

**Sandy Cross, Program Manager**

**WORLD EDUCATION,**

**Tomi Ito, Program Director**

**WORLD RELIEF,**

**Joel Copple, Director**

**WORLD VISION,**

**Nel den Boer, Rural Health Project Manager**

### **3. International Organizations**

#### **WHO**

**Jean Paul H. Menu, Representative**

**Penny Key, Consultant**

**Richard Renas, GPA consultant**

#### **UNICEF**

**Eric Mercier, Health Program Officer**

**Paulo Operti, PHC Advisor**

### **4. MINISTRY OF HEALTH**

**Dr. Mam Bun Heng, Director of Health**

**Dr. Eng Huot, Director, PMI**

**Dr. Keo Sinthay, Vice Technical Director, Curative and Preventive Medicine**

**Tea Kim Chhay, Pharmacist**

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