DFID HEALTH RESOURCE CENTRE

Reproductive Health Commodity Security
Country case study: Cambodia

Commissioned jointly by
The Department for International Development and the Netherlands Ministry of Foreign Affairs

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February 2006

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ABBREVIATIONS AND ACRONYMS

BS	Birth spacing
CDHS	Cambodia Demographic and Health Survey
CMS	Central Medical Stores
COC	Combined oral contraceptive
CPA	Complementary Package of Activities
CPR	Contraceptive prevalence rate
CSWG	Contraceptive Security Working Group
DDF	Department of Drugs and Food
DFID	Department for International Development
DMPA	Depot medroxyprogesterone acetate
EDB	Essential Drug Bureau
EFs	Equity Funds
HSP	National Health Strategic Plan
HSSP	Health Sector Support Project
JAPR	Joint Annual Performance Review
JICA	Japan International Cooperation Agency
KfW	KfW Development Bank, Germany
MEF	Ministry of Economy and Finance
MoH	Ministry of Health
MPA	Minimum Package of Activities
NAA	National AIDS Authority
NCHADS	National Centre for HIV/AIDS, Dermatology and STD
NGO	Non-governmental organization
NLDQC	National Laboratory for Drug Quality Control
NMCHC	National Maternal and Child Health Centre
NRHP	National Reproductive Health Programme
OD	Operational District
ODDID	OD Drug Inventory Database
OI	Opportunistic Infections
POP	Progestogen only pill
PR	Principal Recipient, Global Fund, Ministry of Health
PSI	Population Services International
RACHA	Reproductive and Child Health Alliance
RGoC	Royal Government of Cambodia
RHAC	Reproductive Health Association of Cambodia
SM	Safe motherhood
SWiM	Sector wide Management
TFR	Total fertility rate
TWG-H	Technical Working Group on Health
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Cambodia has a population of around 13 million, some 40% being below 15 years of age. Eighty-four per cent of the population lives in rural areas and many are poor - in 2003, 36% of the total population was officially living below the poverty line, reaching as high as 80% in some rural areas. The total fertility rate (TFR) in 2004 was 3.3 and in 2000, the use of modern methods of contraception was 19% and the maternal mortality ratio, 437 per 100,000 live births.

Significant efforts have been made since 1993 to improve the health service delivery system in Cambodia. The Ministry of Health (MoH) introduced health system reforms to improve and extend primary health care through a district health system according to a national health plan and decentralization of financial resources. However, significant problems remain which undermine the effective provision of health packages and concomitant gains in health status. These include problems of financing; management; extremely poor staff salaries at all levels of the system; poor quality of care of services provided through the public sector; a rampant private informal sector; lack of transparency; and inefficient use of resources, resulting in the poor finding it difficult to access services, particularly in reproductive health.

The MoH adopted a sector wide management approach (SWiM), rather than a full SWAp, to implement a National Health Strategic Plan (HSP). In 2003, the Health Sector Support Project (HSSP) was set up to support the HSP; provide a coordinating mechanism between existing vertical health programmes; and assist in alignment of donor support. UNFPA joined the SWiM process to ensure that funding for safe motherhood and birth spacing was integrated into central level planning and included at the Provincial and Operational District (OD) levels. The first HSP, in 2002, established the strategic objectives for the MoH for 2003–2007 and indicators for each strategic area. A monitoring and evaluation process was established and annual targets are reviewed at a Joint Annual Performance Review (JAPR).

As part of efforts to build an accessible and equitable health system, international support has helped provide the base for the provision of reproductive health services, although much of this support has been towards contraception and HIV/AIDS. However, to achieve greater access for the poor and an improvement in reproductive health indicators, a stronger commitment is required from government. Moreover, poverty and gender issues coupled with a significant lack of information and knowledge at the community level, especially in rural areas, mean that a significant effort must be made, if there is to be impact on reproductive health and related MDGs.

The National Reproductive Health Programme (NRHP), which is finalizing a National Reproductive Health Strategy (NRHS), is recognized as a key health programme, major elements of reproductive health being given priority in the 2005 JAPR – yet it has limited visibility and capacity. It is a small unit with few staff based in the National Maternal and Child Health Centre, unlike the National HIV/AIDS Programme, which is a National Health Centre in its own right and has significant staffing and funding. Advocacy on reproductive health and the creation of political awareness with government, as well as with community leaders, is essential to ensure that reproductive health, as well as the role and status of NRHP to achieve it, is given the support it requires.

There is little information on the demand for and access to reproductive health services, other than for contraception. While there have been significant efforts to increase access to qualified midwives, little information is available on the provision,

quality and use of safe motherhood services, as such, an assessment of needs for safe motherhood should be undertaken. With regard to STIs, the National HIV/AIDS Programme has begun a programme to expanding diagnosis and treatment. Recent reports indicate that although oral and injectable contraceptives and condoms are generally accessible, absence of clear information and inadequate counselling have created misconceptions about contraceptive methods; fear of side-effects; and high discontinuation rates. An IEC campaign for both providers and users should be developed to address these issues. In addition, interventions to increase awareness of communities and empower women to understand their reproductive health needs and enable them to work with the health care system to address them are essential to stimulate knowledge around reproductive health and demand for basic services.

Reproductive health commodities are financed and procured through different mechanisms. All drugs for use for safe motherhood are financed and procured by the MoH, as are condoms for the public sector. Drugs for the treatment of sexually transmitted and opportunistic infections and anti-retrovirals are being made available through the public sector, financed and procured by the GFATM principal recipient, World Bank and to a lesser extent other donors including ADB and DFID. All other contraceptive supplies for the public and social marketing sectors have been funded by the donor community and procured externally. The principal donor, since 1993, has been KfW.

Although new standard procurement procedures were recently adopted by government, few people were aware of them. HSSP or its successor must ensure that the Procurement Unit is strengthened to take full responsibility for implementing the standard procurement procedures over the medium term. However, major problems in implementation remain and donors, particularly those supporting the HSSP, should work with the MoH to address them and negotiate with the Ministry of Economy and Finance to allow the selection of commodities from the tendering process to be based on quality specifications as well as price. Until this is done, donors or programmes with external sources of funding will continue to use different procurement procedures.

In part because of the fragmentation of financing and procurement, and in part because of differences in programme visibility and resources, there is no mechanism or body addressing and coordinating reproductive health commodity security needs. The work of the Contraceptive Security Working Group (CSWG) has been limited to contraception and the link between programmes using similar commodities (e.g. condoms for HIV and family planning) has been limited in terms of coordination and implementation. NCHADS and NRHP should look at how the two groups could be brought together. There appears to be no mechanism to address safe motherhood commodity needs. The proposal to change the CSWG to, or be incorporated into a sub-working group under the umbrella of the Technical Working Group for Health should be pursued to allow it to give more visibility to, and advocate for, reproductive health commodity security. Furthermore, a recent draft of the NRHS addressed RH commodity security implicitly rather than explicitly - something that must be given a high priority.

The CSWG will develop medium term projections of contraceptive requirements based on demographic data and trends, contraceptive behaviour and method choice from the 2005 DHS (due to report in 2006). A medium term strategy should also be developed whereby the Essential Drug Bureau (EDB) is strengthened so that a MoH department has the skills and is responsible for forecasting and projecting needs. There has been no quantification of overall reproductive health commodity requirements and it is proposed that the CSWG addresses this, as well as estimating

total funding requirements, funding gaps and potential sources of funding. However, should support to public sector contraceptive commodities be phased out by KfW in under three years time, it is unlikely that the MoH could obtain additional budget support for the $1 million/year needed. Hence, UNFPA and/or other donors will have to either increase funding and/or use funds more productively, for example, UNFPA has begun procuring generic products at better prices than from western manufacturers, such as those used by KfW. The use of cheaper generic contraceptives of proven quality, i.e., from companies prequalified by WHO, for both the public and social marketing sectors should be seriously considered. This would allow the country, or the donors, to either buy the forecasted quantities for a lower price or increased quantities for the same level of funding.

While there is a broad acceptance and knowledge of the public and social marketing sectors, at least in urban areas, visits to pharmacies showed that the purely commercial private sector plays an extremely limited role in the provision of contraceptives. Consideration was given to a total market approach (TMA), in which the potential of commercial manufacturers would be used to provide products to those who have the ability to pay, allowing the public and social marketing sectors to focus on poorer people. However, since most clients have a limited ability to pay; social marketing of products through pharmacies is proving successful; and a TMA would involve the sale of a more expensive product alongside the OK product in the same pharmacy outlets, a TMA is unlikely to be a viable option.

The public and social marketing sectors are likely to remain key in strategies to increase the use of modern contraceptive methods for birth spacing and limiting. Nevertheless, the CSWG should study the relative roles of the public sector and the social marketing sector, in terms of which clients they are, or could be, serving and developing linkages between the monitoring and forecasting activities of both sectors. Given the need for donor subsidy, the long term role of social marketing in commodity security and its relation to government plans must be addressed. It would also be appropriate to investigate the possible role of a community-based approach to social marketing, using community-based organizations. Whilst it was difficult to address the role of the different sectors for other reproductive health commodities, it is likely that the public sector will continue to be the principal provider.

The Central Medical Stores (CMS) is responsible for clearance, storage and delivery of all essential drugs and commodities in the public sector. However, decreasing salary support has lead to the loss of trained staff. It is considered critical that support is made available to motivate staff and increase their skills. RACHA, a NGO, has played a major role in establishing an OD Drug Inventory Database (ODDID) for inventory monitoring of contraceptives in OD pharmacies and the ordering of new stock from CMS. This has allowed the CSWG and the CMS to know the stock situation more precisely. However, maximum benefit would be achieved if the system included not only all reproductive health commodities but all essential drugs, as well as demand from all outlets and all sources of supply. It should be incorporated fully into the EDB and staff capacity be strengthened.

The NRHP is urged to consider using WHO's Strategic Approach to Improving Reproductive Health Policies and Programmes for both the introduction of new contraceptive technologies, as well as the introduction of MVA and medical abortion in the provision of comprehensive abortion care. In addition, since WHO has recommended that the widely available Chinese once-a-month pills should not be provided because of safety and efficacy concerns, the DDF should consider removing them from use in the private sector where they are widely available.

1 INTRODUCTION AND METHODOLOGY

DFID wishes to contribute towards an improved understanding of RH commodity security (RHCS) at country level within the wider policy environment and support for sexual and reproductive health and rights by:

- applying a 'drivers of change' lens to the agents, structures and institutions involved in selected countries and examining the impact of new aid mechanisms including PRBS and health SWAps on commodity security;
- undertaking detailed country studies that lead to specific proposals for action at country and/or international level; and
- providing evidence for consensus building with bilateral and multilateral donors towards effective resolution of RH commodity supply crises and strengthening dialogue within the Reproductive Health Supplies Coalition.

DFID is supporting country studies in Cambodia, Nigeria, Uganda and Zambia. With regard to the Cambodian case study, a team of two consultants, Peter Hall, Morges, Switzerland and Chan Chhuong, Phnom Penh, Cambodia spent 19-27 September in Phnom Penh, supported by DFID and in collaboration with the DFID and UNFPA offices in Phnom Penh. A list of people visited is attached as Annex 1 and documentation consulted as Annex 2.

Interview of key respondents and review of official and other documents and reports were the methodologies used in this study. In addition, visits were paid to pharmacies in the Phnom Penh area. The consultants used a series of questions developed by the DFID Health Resource Centre team and the consultants undertaking the four country studies, with input from DFiD and UNFPA country offices.

2 CONTEXT

Cambodia has a population of around 13 million, some 40%, 5.1 million, being below 15 years and the median age, just under 20 years. The total fertility rate (TFR) in 2004 was 3.3 and the annual population growth from 1998-2004 was 1.8%. Eighty-four per cent of the population lives in rural areas, but there is a significant migration to urban centres, especially among young people. The Constitution guarantees women and men the same legal rights and some 67% of women are literate, compared with 82% of men. Although maternal mortality declined during the 1990s, in 2000 the maternal mortality ratio remained high at 437 per 100,000 live births.

The Human Development Index in 1990 was 0.51, increasing to 0.57 in 2002, moving Cambodia from the low to the medium human development category. Nevertheless, Cambodia still has some of the worst human development indicators in South-East Asia. In 2003, the per capita gross domestic product was US$ 306, with 36% of the total population still living below the official rural and urban poverty lines of US$ 0.46 and US$ 0.63 (1999). In some rural areas the percentage of the population living below the poverty line is almost 80%.

2.1 National policy and strategy context and mechanisms

2.1.1 The health system

In the 1990s, RGoC introduced health sector reforms through a district health system and decentralization of financial resources to provinces. There are 76 operational

districts (ODs), each with 100,000 to 200,000 people, with access to 69 referral hospitals providing a 'complementary package of activities' (CPA) and 942 health centres delivering primary health care to a target population of 10,000 through a 'minimum package of activities' (MPA). Despite international donors supporting infrastructure and equipment in many ODs, significant problems remain, such as: extremely poor staff salaries at all levels of the system; poor quality of care of services provided through the public sector; a rampant private informal sector; lack of transparency; and inefficient use of resources (Soeters et al, 2003).

Conway (2000) concluded that "while there are gaps that need filling, policy in Cambodia is probably sufficiently well developed to not delay starting a SWAp and could indeed benefit from a more sectoral approach to development assistance." However, the MoH adopted a sector wide management approach (SWiM), rather than a full SWAp, to provide coordinated support for implementation of the National Health Strategic Plan (HSP). In 2003, the Health Sector Support Project (HSSP) was set up to support the HSP, co-funded by ADB, WB, DFID and later by UNFPA. HSSP provides funding and technical assistance, partly through pre identified activities, partly through funds allocated through the annual operational planning process. A mid-term review of the HSP and the HSSP is planned by government in 2006. It is understood that the World Bank, DFID and UNFPA will continue to support movement towards a SWAp for the next phase of their support to the sector

UNFPA joined the SWiM process in 2004 to ensure that funding for safe motherhood and birth spacing are integrated into central level workplan review and disbursal of funding occurs within the annual provincial health operational plan. It ensures that these components of reproductive health are included in the decentralization of management at the Provincial and OD levels. One national programme, NCHADS, is supported with flexible sub-sector finance by DFID.

The first HSP was developed in 2002, establishing the strategic objectives for the Ministry of Health for 2003–2007 and indicators for each strategic area. A monitoring and evaluation process has been established and annual targets are reviewed at a Joint Annual Performance Review (JAPR). Based on the JAPR, the National Health Congress issues directives for the next annual operational plan. The JAPR process is the one time a year that key stakeholders in health, central ministry, provincial and operational district staff, village health support groups, consumer and provider groups, national and international NGOs, and multi- and bilateral donors come together. Each programme component produces a full progress report and working groups are held on key areas of work.

2.1.2 Reproductive health and poverty reduction and approaches to improve equity

The Cambodian PRSP describes reforms in financial management, budgeting and procurement. The National Poverty Reduction Strategy 2003-2005 proposed a series of priority actions. While these documents do not directly explicitly link reproductive health and poverty reduction, RGoC is developing a new five year strategy and the draft National Strategic Development Plan (NSDP) Results Matrix, 2006-2010, currently being finalized does address reproductive health in health services, gender equity and a population policy (see Annex 3). The NSDP will be agreed by Government early in 2006 and funding sought. Presently, the World Bank is currently undertaking a poverty assessment based on data collected in 2004 (CSES) and complementary studies.

Equity Funds (EFs) have been developed in Cambodia, intended to compensate health care providers for services delivered to the poorest at hospital level. It is

intended to identify poor households eligible for assistance; and provide compensation necessary to help the poor access hospitals and to get hospitals to treat them. Through the payment of user fees, the objective is to remove barriers faced by the poor in accessing health care. The EFs are part of the National Poverty Reduction Strategy 2003-2005 and there are plans to expand EFs to 11 Operational Districts in 2005 under HSSP, in addition to the smaller scale EFs already around the country. EFs are also seen as a possible source of funding of the poorest households' premiums under a national social health insurance project. While EFs appear to have been responsible for an increase in access of the poorest to hospital services, objective data are not yet available (personal communication, 2005).

The Cambodia Millennium Development Goals Report gave national goals to be achieved by 2015 and which formed the basis for the National Strategic Development Plan, 2006-2010. Table 1 shows selected reproductive health targets and indicators. Other national MDGs to be achieved by 2015, include reducing under-five mortality to 65/1000 live births; infant mortality to 50/1,000 live births; and HIV prevalence to 1.8%.

Table 1. Cambodia Millennium Development Goals – selected reproductive health targets and indicators

Indicator	Base year	Targets		
	2000	2005	2010	2015
5.1 Maternal mortality ratio	437	343	243	140
5.2 Total fertility rate	4.0	3.8	3.4	3.0
5.3 Proportion of births attended by skilled health providers	32%	60%	70%	80%
5.4 Proportion of married women using modern birth spacing methods	20%	30%	44%	60%
5.5 Proportion of pregnant women with 2 or more ANC consultations from skilled health providers	30.5%	60%	75%	90%
5.6 Proportion of pregnant women with iron deficient anaemia	66%	50%	39%	33%

2.1.3 National drugs policy, legal and regulatory issues

The Department of Drugs and Food (DDF) is the national regulatory authority with responsibility for oversight and strengthening of public drug supply, regulation of the public and private pharmaceutical sectors, and ensuring public safety in therapeutic drug use. In the past year, the DDF has received World Bank funding through HSSP to assist in supervisory activities at Provincial Health Departments, ODs and health centres and strengthening regulatory and associated legal activities.

Cambodia has an approved national essential drug and commodity list, which delineates what commodities should be included in the CPA and MPA drug kits. An updated list will be available shortly. It includes the key reproductive health products for contraception, treatment of STIs and those required for ante-natal, delivery and post-partum use. MVA syringes are not on the 25 Jan 2002 list, but misoprostol is.

In 1995, the DDF, with the assistance of WHO, began the process of ensuring that all drugs available in Cambodia are registered. This is being applied equally to products being imported for both the public and private sectors. As such, there are no barriers to the registration of generic products, something that is important for contraceptive commodities in the future. Importation taxes are not levied on products

procured through donor funding, we did not ascertain how taxes and tariffs are applied to commodities imported for either the public or private sectors.

2.2 National Reproductive Health Programme and Strategy

The latest JAPR was held in March 2005 and the report stated that: "Reproductive health activities showed moderate improvements, continuing the trend from the year before. ANC2 coverage reached a coverage of 47% which was 7% above the 2004 target of 40%. Thirty three percent (33%) of deliveries were attended by trained health professionals in 2004, against a target of 35%. An eight province survey conducted by the National Reproductive Health Programme, in collaboration with UNFPA, revealed that more than 60% of women in the provinces preferred to be delivered by trained health professionals, whether at home or in health facilities. Use of modern contraceptive methods for birth spacing and limiting remained at 20%, below the target of 25%. This is despite a large unmet need for contraception (33%) as documented during the CDHS 2000." (Ministry of Health, 2005). (NB. The use of modern methods quoted in the report refers solely to public sector provision.)

With regard to targets for 2006, the report went on to say: "Although utilization and coverage of public health services, the pace of improvement remains slow. Strong commitment is needed to strengthen current and develop alternative health service delivery strategies that will expand health services to the poor and the vulnerable. Equity funds established to cover catastrophic medical care costs for the poor and the vulnerable will be significantly expanded across the country. Special attention will be given to deliver and strengthen a system for monitoring and improving the quality of MPA services. In particular, strategies need to be developed to increase coverage of and access to:

- reproductive health services, such as birth spacing, safe delivery, safe abortions, emergency obstetric care, iron supplementation and post-partum care; and
- child health services, especially in areas where coverage has remained insufficient."

The JAPR specifically identified the following five priorities for the MOH for 2005-2006, which were endorsed by the National Health Congress:

- emergency obstetric care;
- attendance at delivery by trained health providers;
- integrated management of childhood illnesses;
- full MPA status at health centres; and
- birth spacing services.

The National Reproductive Health Programme (NRHP) is responsible for implementation of reproductive health services and, as such, for three of these priorities. It falls under the National Centre for Maternal and Child Health, one of the eight National Institutes under the Ministry of Health. Training and supervisory activities have been undertaken mainly by staff at the central level but recently staff at Provincial and OD levels have been trained. UNFPA has provided direct support to the NRHP since 1994.

The NRHP is finalizing a National Reproductive Health Strategy (NRHS), with support from UNFPA. This is for the period 2006-2010, which overlaps with the remaining two years of the National Health Strategic Plan and will provide significant

inputs into the extension of the HSP to 2010. The draft strategy addresses the following four objectives:

1. To improve the policy and resource environment for RH priorities in Cambodia.
2. To improve delivery of quality targeted RH services in communities, Health centres and referral hospitals.
3. To improve community understanding of RH and demand for services.
4. To improve the evidence base by conducting operational research that will feed future policy and strategy development.

2.3 Reproductive health commodities

All necessary drugs for use for safe motherhood are on the national essential drug list and are supplied by the public sector, through Central Medical Stores (CMS).

Drugs for the treatment of STIs, opportunistic infections (OI) and ARVs are being made available through the public sector by the GFATM principal recipient, by the World Bank and to a lesser extent through other donors including DFID and ADB. In its operational plan for 2005, NCHADS intends to procure and supply (through the CMS) necessary drugs, consumables and laboratory reagents to 28 STD clinics throughout the country and to provide STD services at health centres; supply clinic and laboratory consumables and drugs for OIs to 20 operational district sites; and ARVs to 24 provinces. There is a rolling programme for expanding diagnosis and treatment for STDs, including HIV, and OIs throughout the country (NCHADS, 2004).

With regard to contraception, commodities are provided through the public, private and social marketing sectors. Annexes 5 and 6 provide estimates by PSI on the relative provision by the three sectors which are summarized in Table 2.

Table 2. Provision of contraceptive commodities by the public, social marketing and commercial private sectors

	Public sector	Social marketing	Commercial sector
Oral contraceptives	55%	35%	10%
DMPA	67%	9%	24%
Condoms	9%	88%	3%

The NRHP has a contraceptive security working group (CSWG), established in 2002 in response to a request from KfW. As such, its main role has been to support and monitor KfW's activities in the provision of contraceptives. The Group comprises representatives of the DDF/MoH, the National Reproductive Health Programme, and CMS; UNFPA; PSI; and the national NGOs, RACHA and RHAC. It is chaired by the Deputy Director, DDF. As well as monitoring contraceptive supply, the CSWG has been addressing contraceptive and condom forecasting, long-term security, research to support promotion campaigns and the development of training as part of an expanded IUD insertion programme. To date, the work of the CSWG has been limited to contraception rather than broader reproductive health supplies.

2.4 Financing, procurement and distribution arrangements

2.4.1 Financing

Overall, health sector financing absorbs approximately 10% of GDP, the highest percentage among developing countries in Asia. However, RGoC health expenditure

was US$3.30 per capita in 2003 and an estimated 70% of health sector financing is from 'out-of-pocket' payments, representing approximately US$24 per capita. The balance is funded by donors.

The MoH budget process is annual, the MoH requests budgets from the various components of the health system, compiles a total budget and forwards it to the Ministry of Economy and Finance (MEF). For commodities, the Essential Drug Bureau (EDB) of the DDF, collects requirements from operational districts, provincial health departments and national programmes and plans total commodity needs, which it submits to the MoH Department of Budget and Finance. By late September, the MEF provides an approved budget under various chapter headings, eg, chapter 10, salaries; chapter 11, running and infrastructure costs; chapter 13, priority action programmes; etc. All commodities are purchased out of the chapter 11 allocation, this includes all essential drugs procured by the MoH and distributed through the CMS. The overall public sector drug and consumables budget in 2005 amounted to R83 billion ($20.7 million), 35% of the total MoH budget and these are supplemented by donor and NGO budgets, which are not always fully quantified, as well as user fees.

Reproductive health commodities are financed by different funding mechanisms. Except for condoms provided through the public sector which are funded by RGoC, all contraceptive supplies have been funded by the donor community. In recent years, most public sector supplies have been funded by KfW. Commodities for safe motherhood are all purchased, along with other essential drugs, through the annual budget allocation from the MEF to the MoH. However, some funding for equipment and other supplies for safe motherhood has been provided by JICA. Commodities for STIs were initially funded through the annual budget, however since the creation of NCHADS and the availability of funding from the Global Fund for AIDS, TB and Malaria (GFATM), these are now being financed from GFATM funds.

2.4.2 Procurement, logistics and distribution

There is significant fragmentation of the procurement process for essential drugs, including reproductive health commodities:

- The bulk of contraceptive commodities are procured on behalf of RGoC through external consultants to KfW.
- Commodities for diagnosis and treatment of STIs are funded through the GFATM's Principal Recipient, based in a separate office in the MoH, with procurement being undertaken via UN procurement channels.
- The HSSP has its own procurement process, linked to the Procurement Unit (PU) in the DDF.
- The majority of the remaining reproductive health commodities, principally those required for safe motherhood, are procured by the PU. The majority of drugs acquired through the national budget are procured via this channel.
- National hospitals also procure through the PU using their national budget allocation and directly using internally generated user fees, although it was understood that Provinces and Operating Districts can procure directly, according to a specified competitive tender procedure, using funds from the national budget as well as internally generated user fees. It was not clear how this latter procurement procedure operates.

Tendering by the PU is done with the support and direction of the Pre-Qualification, Evaluation and Award Committee. On completion of the tender process, a preferred supplier is selected and is submitted together with information on the other tender

bids to the MEF. While the Procurement Unit selects a supplier on various criteria, including quality, the MEF only looks at price. Hence, sometimes the MEF may not approve the selected supplier. If the MoH wishes to contest the MEF's choice this can take several months and may or may not be approved. Many suppliers may be excluded from tendering or disinterested in bidding due to the fact that the MoH makes payments normally only in local currency, sometimes takes up to a year before paying invoices and is not allowed to raise Letters of Credit (LC).

Within DDF, the Essential Drug Bureau is responsible for oversight, forecasting and, in conjunction with Central Medical Stores (CMS), coordination of MoH funded public drug supply. EDB includes sections responsible for supply, training and supervision and rational drug use. Distribution of all essential drugs and commodities in the public sector, whether government or donor funded is undertaken by the CMS. It responds to the needs of the 76 Operational Districts on a request or "pull" system. While procurement by the national hospitals, provinces and ODs is small, it is not known what the impact of will be on forecasting at the central level.

To facilitate the inventory monitoring of contraceptives in OD pharmacies and the ordering of new stock from CMS, an OD Drug Inventory Database (ODDID) was established. The ODDID was developed by the NGO, RACHA, with funding from USAID. RACHA established a logistics management information system (LMIS) for the EDB. Training courses have been held for OD pharmacy staff and KfW has supported the provision of computers to additional Operational Districts. The ODDID is now operational in 61 of the 76 ODs. Table 3 shows information from RACHA on the quantities of contraceptives distributed in recent years.

Table 3. The amounts of contraceptive distributed (in thousands of units)

Thousands	2001	2002	2003	2004	2005 - stock received to 31Aug
COCs	1,610	2,002	2,679	2,768	(3,552)
POPs	62	52	38	39	0
DMPA	712	657	687	752	0
IUDs	9.0	9.0	7.6	5.4	32.5
Condoms	4,289	2,860	2,124	1,542 +1,492	4,000

The storage and delivery of all essential drugs is undertaken by the CMS. It has two storage facilities, one in central Phnom Penh and a new facility by the airport. It works closely with EDB, RACHA and the ODs and senior staff consider that, as a consequence of implementation of the ODDID, there is now far better stock control at all levels of the system.

CMS prepares all importation and clearance documents for shipments arriving in the country, which are then cleared through customs by private clearance agents. There are no importation taxes on donor funded supplies, although CMS has to make an application for tax exemption. CMS is responsible for transport to the central stores, storage and delivery to the ODs. Whilst the CMS is responsible for distribution to the ODs, it only provides transport to the provincial capitals where CMS vehicles are met by OD vehicles and supplies are transferred.

3 FINDINGS AND KEY ISSUES

3.1 Demand for and the need to strengthen reproductive health services

There is little information on the demand for overall reproductive health services. While there have been significant efforts to increase access to qualified midwives, little information was available on demand for, and the quality of, safe motherhood services. The last DHS showed a contraceptive prevalence rate of 19% for modern methods and 24% for all methods and that 32.6% of women wanted to limit or space their children (DHS, 2000). Data collection was underway for new DHS and results will be available in early 2006. There is consensus that CPR has increased; this view is reinforced by the rapid decline in TFR from 4.0 in 1998 to 3.3 in 2004 (Cambodian Inter-censal Population Survey, 2004).

A contraceptive survey of married women in Phnom Penh and three rural provinces was recently undertaken (Domrei Research and Consulting, 2005). The principal findings are summarized in Annex 4. Use is low despite women saying that COCs, injectables and condoms are both accessible and affordable. It is probable that women are poorly counselled about side effects and that there are espoused myths and misconceptions about side effects at the community level. In addition, it is reported that people in the lowest economic quintile often purchase commodities from the private sector because they do not access public health facilities.

Although, the JAPR report and other documents recommend that reproductive health be given an extremely high priority by the MoH, it is not obvious how this is being addressed. For example, a recent KfW report, identified major problems which must be addressed if birth spacing is to be strengthened. These included, among others, a high unmet demand for contraception, particularly in rural areas; a significant fear of side effects by many women; high discontinuation rates by contraceptive users; a low acceptance of long-term methods such as IUDs; poor interpersonal communication and counselling skills among providers; poor capacity for projecting long-term commodity needs; and uncertain commodity security (Lehmann et al, 2005).

Most respondents considered that there are few political barriers to the implementation of national policy and the NRHS at the community level. The barriers that do exist in Cambodia relate to resources, both human and financial as well as barriers created through lack of communication and coordination; and to political sensitivities over wider population policy issues; family planning (named 'birth spacing', to avoid the use of FP) and sterilization; as well as potential and actual conflicts of interest regarding public sector development among high ranking policy makers.

Moreover, the NRHP has limited visibility and reproductive health does not appear to have the political support required to implement the NRHS, compared to, say HIV/AIDS. Without this, and the commitment to adequate funding, it is impossible to see how reproductive health services can be strengthened at the OD level. This is reflected in the NRHP being a small unit with few staff within the National Maternal and Child Health Centre, whereas the National HIV/AIDS Programme has a National Health Centre (NCHADS) in its own right with significant staffing. The HIV/AIDS programme has significant visibility through two bodies, the NAA (for overall co-ordination) and NCHADS (for the health sector response), and significant funding, viz, the $35 million over two years just approved by the GFATM.

The HIV/AIDS focus and funding has been due to strong political commitment. Within the HIV sector, the NAA coordinates the intersection of HIV/AIDS and SRH, however, the role of SRH in the prevention of HIV infection does not appear to be acknowledged and the interaction with NRHP appears to be limited, other than the development and implementation of a PMTCT programme between NMCHC / NRHP

and NCHADS. This is reflected by the NAA considering supporting the launch of a new condom. Since, the HIV epidemic in Cambodia is now shifting to women and the newborn, the NAA wishes to increase condom use in families with the introduction of a new condom branded for the prevention of HIV. Rather than introducing a "HIV/STI prevention" condom for the same target group as the OK condom, there should be a major information campaign developed in collaboration with NRHP. Closer collaboration between NRHP and the HIV/AIDS programme is essential.

3.2 Efforts to strengthen financing, forecasting, procurement and supply

3.2.1 Financing

It is difficult to estimate the overall budget for reproductive health commodities, especially that required for safe motherhood. However, Table 4 shows external funding for contraceptives, which includes all commodities for the public sector other than condoms purchased by the MoH. By 2008, KfW will have supported the public sector for 15 years and considers that the RGoC should budget for public sector contraceptives from 2009. KfW is likely to continue funding commodities for social marketing beyond 2009. While no funds are currently allocated for the provision of injectable contraceptives for social marketing from 2007, it is hoped that this can be covered by UNFPA trust funds. However, the public sector is likely to face significant financing problems for commodities from 2009 onwards. The CSWG needs to begin to address both these issues in the very near future.

Table 4. Allocations for contraceptive commodity supplies by donors, 2003-2011

		2003-2005	2006-2008	2009-2011
		(million euros)	(million euros)	(million euros)
KfW				
Public sector	COCs	1.810	1.400	0?
	POPs	0.040	0.040	0?
	DMPA	1.766	1.270	0?
	IUDs	0.024	0.020	0?
	Condoms	0	0	0
Social marketing	COCs	0.400	1.700	tbd
	DMPA	0	0	?
	Condoms	0	0	0
Total (euros)		4.04	4.43	
		(million $)	(million $)	(million $)
USAID				
Social marketing	COCs	0	tbd*	tbd*
	DMPA	0.3	tbd*	tbd*
	Condoms	0	0	
DFID				
Social marketing*	Condoms	1.21	0.8 + tbd*	tbd*
UNFPA				
Public sector	COCs	0	tbd	tbd
Social Marketing	COCs	0.42	tbd	tbd
	DMPA	0.12	tbd	tbd
Government				
Public sector	Condoms	?	?	?
Social Marketing	IUDs	**	0	0
	POPs	**	0	0
Total (US$)		2.05	tbd	tbd
Grand total (US$)		6.94	tbd	tbd

* to be determined by a joint DFID-USAID review of the PSI programme.
** MoH provided 1,620 IUDs and 20,000 POPs to PSI for social marketing through Sun Quality Health network in 2005.

Since DFID's current programme of support to PSI is due to end in May 2006, (USAID's ended in September 2005) the two agencies commissioned consultants "To design the scope and scale of a new five-year programme for the social marketing of quality health commodities ……taking account of the wider context for health and the security of funding for contraceptives (including condoms) and other reproductive and child health commodities." (DFID, 2005a). This review was undertaken in November 2005.

While social marketing plays a significant role in the provision of contraceptive commodities, and particularly for condoms, from the statements above it is likely to receive the funding it requires over the medium term. However, what is its long term role in terms of sustainability?

And what about the public sector, which is, and will remain, the principal provider of contraceptives other than condoms? HSSP commissioned a study on drug financing for the public sector (Eurohealth, 2005). The consultant explored the need to ensure adequate financing of essential drugs and, while acknowledging that "the drug budget execution process is poorly coordinated in part because no one player has all information for the overview", considered that "In the near term drug financing appears to be adequate, and this is borne out both by the costing and review of financing carried out, and by reports of adequate supply from ODs and health centres. However, this assessment of the adequacy of drug finance is against a very low level of articulated demand…." He continued by saying "While drug budgets are adequate for the products that are currently being purchased, there are major problems with drug budget execution in Cambodia, particularly arising from poor liquidity and time-consuming procedures."

Box 1 Visits to pharmacies

Visits were paid to 26 pharmacies in central Phnom Penh, Olympic market and Chbar Ampov. The products found are summarized in Annex 6.

- All sold OK pills and condoms from PSI, usually around the PSI social marketing price, around 25%, also sold the OK injectable
- Some 20% sold Diamond Lady pills from the public sector (sold to them by "people from the provinces"). Three also had 100 vial boxes of DMPA (Contracep) from the public sector.
- Very few contraceptive products are imported by the private sector A negligible number of pharmacies stock "western" manufactured products.
- The generic contraceptives found were the COC, Preme in one pharmacy and generic DMPA injectable, Depo-M, in six - both are from Thailand.
- The emergency contraceptive, Postinor, was available in a couple of pharmacies and the identical generic product, Norlevo from France, in one pharmacy.
- A Chinese once-a-month pill was widely available and because of its low price for one month coverage, is used by many poorer women.
- Mifepristone is sometimes available from China, as is misoprostol, found in a couple of pharmacies.

Given the already significant public sector expenditure on drug and consumables, an increase in the MoH budget of $1 million/year needed to cover existing donor funding of contraception to the public sector is just not feasible. Therefore, should support to public sector contraceptive commodities be phased out by KfW, UNFPA or other donors will have to fill this gap. It is hard to see alternative funding sources.

Could the private sector play a greater role in the provision of RH commodities, particularly, contraceptives? Findings of visits paid to a randomly selected group of pharmacies to ascertain what was being provided by the "commercial" private sector, as opposed to the private sector channel for social marketing are shown in Box 1 above. It was clear from these visits that the purely "commercial" private sector plays an extremely limited role in the provision of contraceptives, even in urban centres such as Phnom Penh. However, there is a broad acceptance and knowledge that pharmacies are principal outlets for socially marketed products.

3.2.2 Forecasting

As with funding, the forecasting of reproductive health commodities for the public sector is also undertaken separately, depending on the funding mechanisms.

- For products for safe motherhood, this is undertaken by CMS, based on requests from the ODs and previous year requirements.
- Forecasting drugs for the treatment of STIs, opportunistic infections (OI) and ARVs is being undertaken by the GFATM principal recipient and NCHADS.
- For contraceptive commodities this is undertaken by the CSWG, on behalf of the EDB/DDF.

It has been recognised that forecasting and determining longer term projections are major capacity building issues for the CSWG. UNFPA undertook population-based

projections in 2001 and, more recently, KfW did utilization based projections and forecasting work for the purposes of finalizing their funding support for 2006-2008. However, the CSWG does not consider that consultants recruited to date have facilitated its capacity for making longer-term projections, which requires a more detailed consideration of, for example, the effect of method mix and health systems on uptake levels. This is being addressed by UNFPA.

Annex 7 shows the forecast for 2006, which was based on historical use and the delivery of contraceptives to the ODs by the CMS; the projections for 2007 and 2008 which were based on the 2006 forecast with an increment to allow for population growth. With regard to longer term projections, UNFPA has committed to provide technical and financial support for DDF/EDB and the CSWG from 2006 to undertake population based projections using the new CDHS data and to build capacity for implementing long-term RH commodity security.

3.2.3 Procurement

The MoH procurement system has lead to both stock-outs of critical commodities, as well as, limitations in choice of suppliers, particularly in products from abroad or in selecting products with adequate standards of quality. Hence, where commodities have been funded by donors, procurement procedures have been used that bypass the MoH procurement system. Recently, new Standard Operating Procedures (SOP), developed by government with the World Bank and the Asian Development Bank, were adopted by RGoC, however, few respondents were aware of them.

Funding of contraceptive supplies is provided under German Financial Cooperation (FC) through KfW to RGoC. RGoC, as the contracting body, is responsible for all aspects of the procurement process, such as, preparation of the bidding documents, evaluation of the bids, award of contracts, etc. However, RGoC uses independent consultants, based in Germany, to undertake these activities and contracts their services with FC-funds. To date, COCs have been purchased from either Schering or Wyeth in Germany and DMPA from a Thai generic manufacturer, TNP. Delays in finalizing the 2003-5 Sector Related Program, Health and Family Planning, resulted in UNFPA, with funding from the Dutch, having to respond with an emergency shipment of COCs.

3.2.4 Supply system

On our visit, CMS appeared to have adequate stocks of ferrous sulphate, folic acid, oxytocin, magnesium sulphate and lidocaine. However, there has not been a review of the availability of drugs and other commodities required for safe motherhood at the provincial and OD level. Although it is on the essential drug list, misoprostol was not available at CMS, due in part to a lack of experience in using it for induction of labour and treatment of post-partum hemorrhage (WHO, 2005).

There have been significant efforts made to improve the short term security of contraceptive supply and the avoidance of stock-outs at district level. These have been made through supervision and monitoring by DDF and the implementation of the ODDID system by RACHA. Currently, EDB enters reports from ODs into central reporting files and databases manually. Efforts are being made to provide the information directly to the EDB from the ODs by email. RACHA has also developed a National Drug Inventory Database (NATDID) which will eventually allow data to be imported from the ODDID to be used by EDB and CMS.

A recent report by consultants from KfW stated that "After eight years of cooperation between EDB and RACHA, efficient logistics management for operational districts (ODDID) and at national level (NATDID) has almost reached maturity and the system is internationally recognized. ODDID has surely contributed to the stability of contraceptive supply in Operational Districts (OD). However, there are ODs in which the LMIS is not functional now, because trained personnel have left or there are hardware or software problems. It takes substantial effort in support to maintain the LMIS functioning in so many peripheral units. This will become even more relevant if the transmission of data from ODDID to EDB is conducted electronically by GSM modems. This technology is more susceptible to failures in installation or configuration. The need for support and perhaps even more training at local level will surely increase."

We did not go into how this system could be expanded to cover all commodities in the public sector and how it would handle the various procurement mechanisms described previously. However, CMS is suffering from decreasing salary support which is creating a strain on the system through the loss of trained staff. This could have a significant impact on the logistics management and delivery of all essential drugs and commodities, not only reproductive health supplies.

The Eurohealth report also considered that "in the medium term, an institutional change such as the establishment of an Autonomous Medical Store may well provide the best solution to difficulties with financing and procurement." (Eurohealth, 2005). This could be the base for bringing together forecasting, procurement, logistics management, storage and delivery of all essential drugs and commodities. It could be supervised and monitored by the MoH's EDB. It would require an initial fund to be established which could then be replenished by the MoH's annual budget. Whilst this would make it easier for donors to support local procurement, including GFATM, KfW and other donors, it is likely to take a considerable act of persuasion because of the existing responsibilities and vested interests in the current system. It will be of great interest to see whether MoH is willing to take this proposal further and try to generate the necessary political support since it has the potential of streamlining and improving the whole essential drug programme.

3.3 Increasing and rationalizing choices in reproductive health

In order to expand contraceptive choice, the NRHP plans to introduce emergency contraception, the single rod implant, Implanon and the female condom into the public sector programme with UNFPA support. The social marketing of the female condom has been piloted and future steps are to be decided by the MoH and its partners. In meetings with UNFPA and the NRHP, I pointed out that WHO's Strategic Approach to Improving Reproductive Health Policies and Programmes was originally developed to address the introduction of contraceptives into country programmes and that it would be important to contact WHO concerning technical assistance for the optimal introduction of new methods (see http://www.who.int/reproductive-health/strategic_approach).

Visits to pharmacies showed that there is substantial use of a Chinese once-a-month pill. Because of its low cost (often as little as $0.10), staff in several pharmacies said that it is often purchased by poorer women. Recently, a systematic review on safety and efficacy data and concern regarding risk associated with prolonged exposure to high doses of estrogens, resulted in the Chinese National Family Planning Programme in China withdrawing once-a-month pills (SIPPR & WHO, 2004). DDF must consider removing it from use in Cambodia.

As part of its support within the HSSP, DFID has issued a notice for expressions of interest for a new project which to support the development and quality improvement of comprehensive abortion care (CAC) services and permanent and longer lasting family planning methods in line with the National Reproductive Health Strategy. The project will include the planning, procurement and distribution of commodities for manual vacuum aspiration (MVA), voluntary surgical contraception (VSC) and IUD insertion. There is a wide range of syringes commercially available for MVA, ranging from single valve syringes manufactured in Viet Nam and which are currently available in Cambodia for $1, through to the new double valve syringes from Ipas which have been purchased in Cambodia for $42. Hence, it will be necessary to assess quality versus cost within the project. One issue that is not addressed in the project document is medical abortion. This method, like MVA, is one of the preferred methods for early abortion described by WHO (WHO, 2003) and which may also have a role in CAC in Cambodia, particularly since there shortly will be a combined mifepristone-misoprostol product available at a preferential public sector price. The project should consider the use of medical abortion under its operations research component.

4. CONCLUSIONS AND *RECOMMENDATIONS*

4.1 Opportunities for improving reproductive health and commodity security

4.1.1 Strengthening the National Reproductive Health Programme through advocacy and political commitment

Beyond efforts to build an accessible and equitable health system, international support has also helped provide the base for provision of reproductive health services, although much of this support had been towards contraception. Major problems of financing, management, poor quality of care and service delivery capability remain, with the poor finding it difficult to access services, particularly in reproductive health. Poverty and gender issues coupled with a significant lack of information and knowledge at the community level, especially in rural areas, mean that a significant effort must be made, with even more support from the international community if there is to be impact on the MDGs and reproductive health.
To achieve greater service access for the poor and an improvement in reproductive health indicators, a stronger commitment is required from government as well as continuing donor support. Support to staff salaries at all levels of the system, whether through the current user fee system or any other mechanism, is key to improvements in the system but the question remains whether equity in health can be achieved by the rural poor.

NRHP is recognized as one of the key health programmes and major elements of reproductive health were given priority in the 2005 JAPR – yet it has limited visibility and capacity. This is, in part, because it is a small unit with a miniscule staff within the National Maternal and Child Health Centre, unlike the National HIV/AIDS Programme, which is a National Health Centre (NCHADS) in its own right and has significant staffing and funding

Advocacy on reproductive health is required at both the political and community levels. Creating political awareness in both the CPP and FUNCINPEC, as well as with community leaders would provide new opportunities to ensure that reproductive health is given the support it requires. This political awareness must also include the role and status of NRHP.

Recommendation:
a) Advocacy is undertaken by both multilateral and bilateral donors to strengthen reproductive health and the role of NRHP at the political and community levels.

4.1.2 Addressing reproductive health needs

There is little information on the demand for and access to reproductive health services, other than for contraception. While there have been significant efforts to increase access to qualified midwives, little information is available on the provision, quality and use of safe motherhood services. NCHADS is at an early stage in the expansion of diagnosis and treatment of STDs, including HIV.

Many people feel that the ongoing DHS will reveal a far high CPR than the 19% for modern methods reported in 2000 and that part of the high unmet need will have been addressed. However, recent reports (Domrei Research and Consulting, 2005, Lehmann et al, 2005) indicate that although COCs, injectables and condoms are generally accessible, absence of clear information and inadequate counselling have created misconceptions about contraceptive methods; fear of side-effects; and high discontinuation rates. This could be addressed by the development of a well-crafted IEC campaign for both providers and users, based on WHO's "Selected Practice Recommendations for Contraceptive Use" (WHO, 2004). Also, arguably more importantly, it would to look at interventions, such as "Stepping Stones" that would increase awareness of communities and empower women to understand their reproductive health needs and enable them to work with the health care system to address them (www.actionaid.org.uk/1201/stepping_stones.html). Such initiatives in Cambodia would stimulate knowledge around reproductive health and demand for basic services.

Recommendations:
a) An assessment of needs for safe motherhood is undertaken in the coming year.
b) An information campaign is developed for providers and users on all aspects of contraceptive use, including the benefits and drawbacks of contraceptive methods and their expected side effects.
c) A study is funded to identify where poorer people access reproductive health services and commodities and why.
d) Consideration should be given to interventions that would increase awareness of communities and, in particular, empower women to understand and address their reproductive health needs.

4.1.3 Broadening the role of the CSWG

In part because of the fragmentation of financing and procurement, and in part because of differences in programme visibility and resources, there is no mechanism or body addressing and coordinating reproductive health commodity security needs. The work of the NRHP's CSWG has been limited to contraception rather than the broader issue of reproductive health supplies. It has addressed contraceptive commodity needs between government and donors, however, the link between programmes using similar commodities (e.g. condoms for HIV and family planning) has been limited in terms of coordination and implementation. NCHADS and NRHP should look at how the two groups could be brought together. There appears to be no mechanism to address safe motherhood commodity needs.

A recent draft of the National Reproductive Health Strategy addressed RH commodity security, however, it did so implicitly rather than explicitly. It is critical that

this is given a higher priority and that the CSWG is given the task of developing activities, targets and indicators, as well as identification of funding sources.

Recently, an UNFPA consultant recommended expansion of the scope of the CSWG to reproductive health commodities and proposed that it should include representation from the major public, private and NGO partners that have an interest in all aspects of reproductive health commodities (Friel, 2005). Certainly, its brief should be expanded to include responsibility for all aspects of reproductive health commodity security. This should include quantifying the overall funding for reproductive health commodities currently allocated by government and donors; determine projected needs and overall funding requirements of the public sector for 2006-10; identify funding gaps; and begin to address long-term sustainability.

Several sub-groups have been established to oversee and coordinate the implementation of the HSP and report to the Technical Working Group for Health (TWG-H). In order to support expansion of the brief of the CSWG as well as giving more visibility to, and a forum to advocate for, reproductive health, the proposal to change it to a sub-working group under the umbrella of the TWG-H should be actively pursued. The TWG-H is currently reviewing its sub-groups and would need to consider whether the CSWG should become separate sub-group or linked with existing sub-groups for drugs and MCH.

Recommendations:
a) The feasibility of combining NCHADS's condom group with the CSWG should be explored.
b) An information campaign should be undertaken to explain that condoms prevent both pregnancy and HIV/STIs, instead of trying to sell two identical products to the same target group.
c) A study should be undertaken by the CSWG to quantify the overall funding for reproductive health commodities currently allocated by government and donors; determine projected needs and overall funding requirements of the public sector for 2006-10; identify funding gaps; and begin to address long-term sustainability.
d) Commodity security is given a higher priority in the National Reproductive Health Strategy with activities, targets and indicators, as well as identification of funding sources.
e) Political support be sought to broaden the scope of the CSWG to become a sub-working group of the Technical Working Group for Health.

4.1.4 The potential role of the public, private and social marketing sectors in ensuring reproductive health commodity security

With regard to contraceptives, there is a broad acceptance and knowledge of the public and social marketing sectors and the findings from the pharmacy visits showed that the "commercial" private sector plays an extremely limited role in the provision of contraceptives. The idea of developing a total market approach (TMA) was considered, in which the potential of the private sector, in particular commercial manufacturers, would be harnessed to take over a greater market share of those with ability to pay, allowing the public and social marketing sectors to focus on the poorer segments. However, it is unlikely that a TMA would be appropriate at this time for contraceptives in Cambodia. This is because most clients have a limited ability to pay but also because social marketing of products through pharmacies is proving successful and a TMA would involve the sale of a more expensive product alongside the OK product in the same pharmacy outlets.

The public and social marketing sectors are likely to remain the key components in strategies to increase the use of modern contraceptive methods for birth spacing and limiting. However, as the CSWG undertakes a long-term RH commodity supply study, it should also look into the relative roles of the public sector and the social marketing sector, in terms of which clients they are, or could be, serving and develops linkages between the monitoring and forecasting activities of both sectors. Given the need for donor subsidy, the long term role of social marketing in commodity security and its relation to government plans must be addressed. Moreover, it would be appropriate to investigate the possible role of a community-based approach to social marketing, using community-based organizations

Whilst it was difficult to address the role of the different sectors for other reproductive health commodities, however, it is likely that the public sector is the principal provider. While it may be worth evaluating the role of the private sector in provision of commodities for safe motherhood, it is unlikely that it will be significant outside the major urban centres.

Recommendation:
a) CSWG should look into the relative roles of the public sector and the social marketing sector, in terms of which clients they are, or could be, serving and develops linkages between the monitoring and forecasting activities of both sectors; and the long term role of social marketing in commodity security.
b) A community-based approach to social marketing, using community-based organizations should be investigated.

4.1.5 Ensuring choice of appropriate technologies

The NRHP is urged to consider utilization of WHO's Strategic Approach to Improving Reproductive Health Policies and Programmes for both the introduction of new contraceptive technologies, as well as the introduction of MVA and medical abortion, in the provision of comprehensive abortion care. In addition, since WHO has recommended that the widely available Chinese once-a-month pills should not be provided because of safety and efficacy concerns, the DDF should consider removing them from use through the private sector.

Recommendations
a) WHO's Strategic Approach to Improving Reproductive Health Policies and Programmes is used for the introduction of new technologies.
b) The DDF should consider removing the Chinese once-a-month pill from pharmacies because of safety and efficacy concerns.

4.2 Opportunities for improving financing, forecasting and procurement

Significant fragmentation remains around both financing and procuring reproductive health commodities. Despite the efforts of the HSSP to strengthen procurement systems, financing, and supply systems through the MoH, there remain different channels for different commodities. Many senior officials understand and support the need for harmonization of processes in government but true change will be difficult until there is real political commitment to this.

Cambodia is likely to depend on donor financing for contraceptive commodities for many years to come, for example, it is unlikely to be feasible for the MoH to obtain additional budget support for the $1 million/year needed to cover existing donor funding of contraception to the public sector. Should support to public sector contraceptive commodities be phased out by KfW, UNFPA and/or other donors will

have to fill this gap. Although it has been proposed that the CSWG looks at long-term funding and sustainability, it is difficult to propose other possible scenarios, particularly since the bilateral donors appear to be focussing on subsidies to social marketing products.

UNFPA will provide technical and financial support for EDB and the CSWG from 2006 to build capacity to implement long-term RH commodity security. Despite the key role ascribed to the CSWG, it is important that, in the medium term, the EDB is strengthened so that eventually a MoH department, rather than a Working Group, has the skills and can be responsible for forecasting needs.

Few people in the MoH were aware of newly adopted Standard Procurement procedures. However, major problems in tendering and procurement exist and donors, particularly those supporting the HSSP, should work with the MoH to address them and negotiate with the MEF to allow the selection of commodities from the tendering process, that are based on clear specifications which include demonstrable quality of product, not only price. Meantime, funders of commodities will need to continue separate procurement procedures. HSSP or its successor must ensure that the Procurement Unit is strengthened to take full responsibility for implementing the standard procurement procedures over the medium term.

Even when standard procurement procedures are implemented, there is still likely to be a need for, or at least advice on, international procurement. A small number of generic manufacturers can provide cheaper contraceptives (and other pharmaceuticals) of good quality available for both the public and social marketing sectors. Whether purchased through government or donor funding, the country could obtain forecasted quantities of commodities for a lower price or increased quantities for the same level of funding, enabling existing financing to go further. The COC being purchased through KfW funding from Wyeth/Schering appears to cost about $0.19/pack, in line with what UNFPA purchases this product from these manufacturers. However, UNFPA has recently been able to obtain the same product, with proven quality, at a significantly lower price from a generic manufacturer. As UNFPA begins to use more qualified generic drug manufacturers, prequalified by WHO, it is likely to be the most cost-efficient route for procuring contraceptives in the medium term.

The CMS undertakes clearance, storage and delivery of all essential drugs for the public sector. However, it is suffering from decreasing salary support which is creating a strain on the system through the loss of trained staff. It is critical that support is made available to motivate staff and increase their skills. RACHA, a NGO, has played a major role in establishing an OD Drug Inventory Database (ODDID) for inventory monitoring of contraceptives in OD pharmacies and the ordering of new stock from CMS. This has allowed the CSWG and the CMS to know the stock situation more precisely. However, maximum benefit would be achieved if the logistics management information system included a) all essential drugs; b) demand from all outlets; and c) all sources of supply. Also building on the LMIS, together with closer involvement of the ODs, the CSWG, together with the EDB, should establish procedures for monitoring reproductive health commodity security at the district level

Recommendations

a) A medium term strategy should be developed, in collaboration with the CSWG, to build the forecasting ability of the EDB.

b) The Procurement Unit should be strengthened to implement the new standard procurement procedures.

c) Donors should negotiate with the MEF to improve tendering procedures, so that the MoH can a) purchase commodities based on quality and not just price; and b) facilitate international purchases.
d) The logistics management information system (LMIS) should be extended to include a) all essential drugs; b) demand from all outlets; and c) all sources of supply. It should be incorporated fully into the EDB and staff capacity strengthened.
e) Once WHO has prequalified generic hormonal contraceptive manufacturers, they should be used to supply both the public and social marketing sectors. Until this list of approved companies is available, UNFPA's Procurement Services can make recommendations on which generic manufacturers could be used now.
f) CSWG, together with the EDB, should establish procedures for monitoring reproductive health commodity security at the district level.

ANNEX 1

List of people met

Ministry of Health

HE Dr Mam Bun Heng	Secretary of State for Health
HE Dr Te Kuy Seang	Director General of Administration and Finance
HE Dr Tia Phalla	Secretary General, National AIDS Authority
Dr Mean Chhi Vun	Director, National Centre for HIV/AIDS, Dermatology and STD
Mr Chea Kim Long	Director, Department of Budget and Finance
Dr Chroeng Sokhan	Deputy Director, Department of Drugs and Food
Prof Dr Koum Kanal	Director, National Maternal and Child Health Centre
Dr Tung Rathavy	Manager, National Reproductive Health Programme
Mr Chea Chhiv Srong	Director, Central Medical Stores
Dr Sok Srun	Deputy Director, Department of Hospital Services
Dr Nam Nivanna	Director, National Laboratory for Drug Quality Control
Dr Or Oudam Rath	Chief, Essential Drug Bureau, DDF
Prof Dr Sim Bun Sakun	Vice Chief, Registration Bureau, DDF
Prof Dr Veng Thai	Director, Phnom Penh Municipal Health Department
Mr Yim Yann	President, Pharmacists' Association of Cambodia
Mr Gunatilake Kodituwakku	Procurement Advisor, Global Fund Principal Recipient
Dr Vijay Rao	M&E Advisor, Health Sector Support Project

Development Partners/NGOs

Ms Lizzie Smith	Health Advisor, DFID
Ms Joanna Nicholls	Health Associate/Professional Officer, DFID
Ms Bettina Maas	UNFPA Representative
Ms Alice Levisay	Deputy Representative, UNFPA
Dr Sok Sokun	Reproductive Health Manager, UNFPA
Mr Andrew Boner	Country Director, PSI
Dr Chantha Chak	Family Health Team Leader, Office of Public Health, USAID
Dr Hen Sokun Charya	Development Assistance Specialist for MCH/RH, Office of Public Health, USAID
Ms Pamela Messervy	Technical Officer, WHO
Mr Philip Passmore	Consultant, WHO
Mr Tim Conway	Poverty Specialist, World Bank Country Office
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ANNEX 2

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ANNEX 3

Extract from Draft National Strategic Development Plan Results Matrix, 2006-2010

The current draft includes the following relevant "Rectangular strategies" and goals:

Rectangular Strategy 4b: Improving health services

- Goal 1: Reduce infant and child mortality
- Goal 2: Reduce maternal mortality
- Goal 3: Reduce prevalence and fatality case of infectious diseases including HIV/AIDS, Malaria, and Tuberculosis
- Goal 4: Reduce fatality case due to infectious diseases
- Goal 5: Reduce household health expenditure, especially for the poor women
- Goal 6: Promote health seeking behaviour and consumer-provider rights.
- Goal 7: Address major public health concerns including non-communicable and chronic diseases, road accidents, occupational injuries and disasters
- Goal 8: Improve efficiency and accountability of public health system performance
- Goal 9: Promote gender equality in health sector
- Goal 10: Increase proportion of cases of domestic violence counselled by qualified staff to 50% in 2010

Rectangular Strategy 4c: Fostering gender equity

- Goal 1: Ensure all government policies and programs mainstream gender and promote more women into decision-making positions
- Goal 2: Promote economic empowerment of women
- Goal 3: Strengthen legal protection of women and girls
- Goal 4: Promote better health of women, youth and children
- Goal 5: Promote participation of girls and women in education

Rectangular Strategy 4d: Implementing population policy

- Goal 1: Ensure a socially cohesive Cambodia without poverty
- Goal 2: Support free and responsive decisions on number and spacing of children and provide access to information, education, services and means to do so
- Goal 3: Promote a small family norm
- Goal 4: Reduce potential negative impact of rural-urban migration
- Goal 4: Promote gender equality and equity and enhance human resource development
- Goal 5: Alleviate impact of population pressure on the environment and natural resources

ANNEX 4

Summary of findings from "Family planning survey: Contraception among married women of reproductive age in Cambodia"
Domrei Research and Consulting (2005)

Contraceptive preference

- Rural women prefer COCs and injectable contraceptives, the latter being more popular with women of higher parity. In Phnom Penh, the IUD is used more by wealthy, educated women, whilst the monthly pill is preferred by poorer women.
- The women least likely to use any modern method are the rural poor.
- Overall, modern contraceptive prevalence is as high in the three rural provinces as in Phnom Penh.

Obstacles to the use of modern contraceptives

- Awareness and geographical access are not an obstacle to contraception, nor is the cost of injectables, COCs and condoms. The IUD and female sterilization are the only two methods for which cost is an obstacle.
- The most important obstacle to contraceptive use is perceived or real side effects. This is the first reason given for not trying a method or for discontinuing a method. Perceptions of the various methods, and in particular on side effects are the same in the provinces and in Phnom Penh.

Method discontinuation

- Whilst the average duration of use of the IUD is three to four years, a substantial proportion of users drop-out before their third month of use. In rural areas, more than 50% of COC users drop out after three months or less and a quarter of discontinuers drop out having completed only one cycle.

Product perception

- Female sterilization was ranked as the least accessible but most effective method, whilst COCs were ranked as the most accessible but least effective.
- COCs were ranked as the easiest method to use and the IUD as the hardest.
- The condom was considered to be the method with the least impact on health and the IUD, the most.
- Injectables and the IUD were ranked as the methods with the greatest long term impact on fertility and COCs, the least.

Brand awareness and perception

- COCs: 84% of women knew the social marketing brand, "OK", while only 6% in Phnom Penh and 19% in the provinces named the public sector brand "Diamond Lady". Despite being less known, the Diamond Lady brand ranked higher than the competition in terms of price and side-effects and in the rural areas, equalled OK in terms of accessibility and effectiveness.
- Condoms: There are two social marketing brands, "Number One" and "OK", the public sector brand is "Protector". Number One was the most well known brand, 63% of women in Phnom Penh and 56% in the provinces gave its name. OK condom was second (27% and 10% respectively) and Protector third at 5%. Number One Condom was ranked as the cheapest, most effective, most accessible condom. It also was ranked as having the most side effects.

ANNEX 5

Contraceptive market share (from PSI Cambodia)

Market share has been estimated using results from the PSI Distribution Survey (DS) conducted in 2002. As no other data is available, PSI used the DS 2002 estimates for the commercial sector market share in 2003 and 2004.
Estimates by units (condoms – piece; OCPs – monthly pack; DMPA – vial)

Condoms	**2002**	**2003**	**2004**
PSI Sales	19,099,100	20,044,300	21,542,289
MOH Consumption (OD to HC)	2,342,214	2,216,565	2,128,649
Commercial	663,133	688,480	732,091
Est TOTAL MARKET	**22,104,447**	**22,949,345**	**24,403,029**
% of Market Share (MOH Consumption)			
PSI	86%	87%	88%
MOH Consumption	11%	10%	9%
Commercial	**3%***	3%	3%

OCPs	**2002**	**2003**	**2004**
PSI Sales	1,501,368	1,273,000	1,717,296
MOH Consumption (OD to HC)	1,808,894	2,450,347	2,372,940
Commercial	367,807	413,705	454,471
Est TOTAL MARKET	**3,678,069**	**4,137,052**	**4,544,707**
% of Market Share (MOH Consumption)			
PSI	41%	31%	38%
MOH Consumption	49%	59%	52%
Commercial	10%*	10%	10%

DMPA	**2002**	**2003**	**2004**
PSI Sales	23,839	63,694	109,763
MOH Consumption (OD to HC)	675,011	654,210	665,377
Commercial	220,689	226,707	244,781
Est TOTAL MARKET	919,539	944,611	1,019,921
% of Market Share (MOH Consumption)			
PSI	3%	7%	11%
MOH Consumption	73%	69%	65%
Commercial	**24%***	24%	24%

Trends of markets from 2002-2004:

- growth of total market: COCs, 24 %; injectables, 11 %; condoms, 10 %.
- Increase in number of condom brands
- COC and 3-month injection brands have remained the same
- lines between private and public sectors are not so clear: public sector brands are sold in the private sector (Diamond Lady COCs); PSI condom brand can be found in the public sector (Number One condoms)
- social marketing may be beneficial in the sense that it “crowds out” non-registered brands with questionable quality and high prices.

ANNEX 6

Hormonal contraceptives found in pharmacies in Phnom Penh

COCs

Sector/product	Manufacturer	Price per cycle + (outliers)	Estimated market share
Public:			55%
Diamond Lady	Wyeth/Schering, DE	$0.12- $0.20	
Private:			10%
Diamond Lady (from public sector)	Schering, DE	$0.20-$0.70	
Chinese Pill	Beijing Chan FiKan	($0.05) $0.10-0.50	
Diane	Schering, Thailand	$3.30-4.00	
	Schering, DE	$7.00	
Adepal	Wyeth, France	$2.00-2.40	
Minidril	Wyeth, France	$3.50	
Preme	TNP, Thailand	$2.40	
The following brands have been reported by PSI and are available by ordering through specific pharmacies			
Trinordiol	Wyeth, Fr	$4	
Marvelon	Organon, NL	$5	
Stediril	Wyeth, Fr	$3	
Minulet	Wyeth, Fr	$6.60	
Triquilar ED	Schering, DE	$3	
Meliane	Schering, Fr	$6.40	
Jasmine	Schering, Fr	$6.40	
Pheava	Schering, Fr	$10	
Cilest	Codepharma, Fr	$11	
Cerazette	Organon, Fr	$7	
Social marketing:			35%
OK Pill, PSI	Wyeth/Schering	$0.19-0.25 ($2.00) PSI: $0.175	

Injectable contraceptives (DMPA)

Sector/product	Manufacturer	Price per vial	Estimated market share
Public:			67%
Contracep	TNP, Thailand	$0.35	
Private:			24%
Depo-M	Vesco, Thailand	$0.30-0.50 ($1.00)	
Depo-provera	Pfizer, Belgium	$0.75	
Contracep (from public sector)	TNP, Thailand	$0.30-0.40	
Social marketing:			9%
OK Injection, PSI	Pfizer, USA	$0.25-0.50 PSI: $0.25	

EC (dedicated product)

Sector/product	Manufacturer	Price per 2 tabs
Private:		
Postinor	Gedeon-Richter, Hungary	$0.50-1.00
Norlevo	HRA Pharma, France	$7

ANNEX 7

Forecast need for contraceptive commodities for 2006; projections for 2007 and 2008; funding gaps; and donors

	2006			2007			2008			2009		
	need ('000s)	gap	donor	need ('000s)	gap	donor	need ('000s)	gap	donor	need ('000s)	gap	donor
Public sector												
COCs	2,823	0	KfW	2,926	0	KfW	3,100	0	KfW	?3,100	?3,100	?
POPs	48	0	KfW	53	0	KfW	60	0	KfW	?60	?60	?
DMPA	928	0	KfW	1,002	0	KfW	1,065	0	KfW	?1,065	?1,065	?
IUDs	6.7	0	KfW	7.4	0	KfW	8.3	0	KfW	?8.3	?8.3	?
M condom	tbc	tbc	Gov	tbc	tbc	Gov	tbc	tbc	Gov	tbc	tbc	Gov
F condom	tbc	tbc	UNFPA	tbc	tbc	UNFPA	tbc	tbc	UNFPA	tbc	tbc	UNFPA
Social marketing												
COCs	1,834	0	KfW	2,157	0	KfW	2,585	0	KfW	?2,585	0	KfW
IUDs	tbc	tbc	KfW	1.9	0	KfW	2,7	0	KfW	?2,7	0	KfW
DMPA	207	0	USAID, PSI	276	276	? UNFPA	355	355	? UNFPA	?355	355	? UNFPA
M condom	25,200	0	DFID	26,500	0	DFID	27,800	0	DFID	?27,800	0	DFID

tbc: to be calculated