ACKNOWLEDGMENTS

The team gratefully acknowledges the invaluable contribution of the following persons: Dr. Joel Montague for his input and knowledge of the private sector in Cambodia; Dr. Sally Stansfield for her leadership and guidance; Dr. Hong Rathavuth for his time and input; Dr. Milton Amayun for his knowledge of the NGO sector and work on the inventory of NGO activities and coordinating committees; Mr. Borithy Lun for his historical perspective and invaluable assistance; Mr. Carl Hasselblad for help in arranging Kampot appointments; and last, but not least, Ms. Billie Slott for her patience and superb team “handling” abilities.
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EXECUTIVE SUMMARY

The Reproductive and Child Health Alliance (RACHA) was created at the behest of USAID by three Cooperating Agencies -- BASICS, SEATS and AVSC International -- to improve maternal and child health (MCH) in Cambodia over a five year period (1996 to 2000) in four focus provinces: Siem Reap, Kampot, Stung Treng and Pursat. Focusing on integrated reproductive health and child survival services in both the public and private sectors, RACHA’s ultimate goal (and USAID’s Results Package) is to increase contraceptive use and decrease infant and child mortality rates. An assessment of opportunities and constraints to expanding high quality MCH services in the private sector in the four focus provinces was commissioned by RACHA with USAID approval, and was carried out in April and May of 1998.

After having been decimated in the 1970s and 80s, the private health care sector in Cambodia has come roaring back. Private hospitals, clinics and drug stores open daily, and many (if not most) health care providers in the public sector have a private practice in operation during their off-duty hours. Pharmaceutical companies are developing their
distribution systems and sales outlets, and access to a large variety of over-the-counter and prescription drugs are widely available. The availability of health services in the private sector has remarkably improved, thus giving health care consumers more choice and relieving the public sector of the burden of being the sole provider of health care in the country. In addition, the quality of health care services provided by the private sector is typically better than those provided by the public, and the demand for services in the private sector is high. However, the cost of these services can be very high to many consumers; households spend an average of 21% of monthly income on health care and many go into debt to cover this cost. Moreover, the private health care sector has grown so fast that legal and regulatory systems -- laws as well as enforcement mechanisms -- needed to assure quality standards and protect the health care consumer have not kept pace. As a result, there are large variations in practice quality standards; the right kinds of services and treatment options are often not available (with a preference given to the more profitable curative rather than preventive services); medications are overprescribed and dispensed without medical supervision; and the smuggling of pharmaceutical products continues to be a problem.

In addition, Cambodia’s political situation has been, and continues to remain, uncertain. On the plus side, there is broad recognition within the Royal Cambodian Government of the significant contribution the private sector has made -- and will continue to make -- in the country’s development, and ubiquitous support for its continued growth. On the down side, the “July Events” of 1997 undermined the confidence of the local and international communities in the country’s prospects for democratic change. Opposition parties question the fairness of the upcoming elections (currently scheduled for July 1998) and -- although a diminished threat -- remaining Khmer Rouge insurgents have continued to distract the government and drain the country’s attention and resources. The outcome of the electoral process may also have an impact on USAID’s program in Cambodia which is currently confined to humanitarian assistance.

As a consequence of these uncertainties, the team concluded that any recommended program package for the private sector had to be opportunistic in nature. That is, RACHA had to be able to pick and choose between a number of suggested interventions, the selection of which would depend on the economic and political environment prevailing in the country, the absorptive capacity of the private sector, and the level of funding and manpower available for program implementation.

The team also chose to focus only on those service provider channels which would yield the most “bang-for-the-buck” in terms of increasing the availability of high quality reproductive health and MCH services in the private sector. This meant focusing on the most accessible and well organized service provider channels which had frequent contact with RACHA’s target population, lower income women and children. Thus, program opportunities (as well as constraints) with doctors in private practice (the most common private sector service provider in the focus provinces), midwives, pharmacies, drug stores and non-government organizations (NGOs) operating in the health sector were investigated. The status of the legal and regulatory framework which affects the operation of these service provider channels was also explored, as well as the capabilities of medical professional organizations. Since little in the way of large-scale, modern industry operated in RACHA’s four focus provinces, the potential for launching programs to provide reproductive health/MCH services at the worksite was not pursued. However, where there was a concentration of employers (such as in the hotel and tourist industry in Siem Reap), research was carried out on the possibility of linking this group to RACHA-sponsored service providers with some pre-payment or pre-arranged service fee mechanism put into place. Likewise, as the level of development of the health insurance industry in Cambodia was quite low and confined to expatriates and wealthy individuals living in Phnom Penh, the team chose not to invest time in exploring this avenue.

The team found some important limitations to working in the private sector in the four focus provinces; these would also be the case to a greater or lesser extent with the private sector operating anywhere in Cambodia outside of Phnom Penh. First, was the fact that the private sector in Cambodia was relatively new. Although the private sector was growing rapidly, it was disorganized and operating within a legal system that had not yet caught up with it. Second, in some focus areas – particularly Stung Treng Province as a whole and Pursat Province outside of Pursat Town -- population sizes and densities were probably too small to generate enough demand and purchasing power to stimulate and support a private health care sector of sufficient size to work with cost-effectively. Third, although the private sector in Cambodia was at a stage of development where small, demonstration-type interventions could be tested for impact and effectiveness, there was no institutional mechanism in place to "roll out" successful pilot interventions on a scale large enough to achieve national impact – with the one possible exception of the commercial pharmaceutical distribution system. Finally, the team found that accomplishing behavior change was a complex process requiring multiple channels of communication and influence interacting over long periods of time. Projects whose objectives concerned behavior change were likely to require, therefore, collaboration with multiple partners, considerable management and monitoring resources, and sufficient flexibility to respond to interim lessons learned.

In order to achieve RACHA’s and USAID’s Strategic Objective for Cambodia -- Improved Maternal Child Health -- the team recommended that RACHA pursue a three-pronged strategic approach to developing and supporting activities in the private sector. The first involved strengthening the policy and regulatory system to support high quality service provision in the private sector and its widest possible access. The second involved improving human resource
capacity and expanding the services of providers operating in the commercial health sector. And the third involved using social marketing to increase access to selected MCH, reproductive health and child survival products, and to increase access to related messages and information at the community and household levels through product sales.

Under each strategy, the team recommended a series of interventions which were flexible enough to be either stand-alone, demonstration-type activities or -- more optimally -- linked for greater synergy to yield more impact. Depending on the conditions prevailing in the country, successful interventions could then be scaled up (broadened or replicated elsewhere) or down (remain limited in scope or be phased out). Interventions recommended for RACHA by the team included:

- Providing technical assistance to the Ministry of Health to: (1) help develop relevant regulations, subdecrees, standards of practice, etc. governing private providers and the importation of pharmaceuticals and medical products; and, (2) study current enforcement mechanisms and make recommendations for improvements.
- Developing the institutional capacity in the private sector for disseminating and enforcing quality standards.
- Organizing consensus-building workshops for key government policy makers, change agents and service providers at the central and provincial levels where the role of, and benefits from, a thriving private sector can be discussed.
- Upgrading the skills and capacity of selected physicians, midwives and pharmacists/drug sellers to enable them to expand and improve the quality of reproductive health, safe motherhood and child survival services. As part of this, promote collaborative partnerships between physicians and midwives through the establishment of polyclinics.
- Providing consumer education to raise demand for and re-enforce high quality MCH, reproductive health and child survival services and practices in the private sector.
- Using social marketing, promote and expand the availability and use of safe birthing kits, iron tablets, IUDs and/or insecticide-impregnated hammock nets.
- Providing financial incentives created by sales of oral contraceptives, condoms and/or other selected products to increase the motivation of outreach workers to carry MCH, reproductive health and child survival messages to communities.

**BACKGROUND**

The Reproductive and Child Health Alliance (RACHA) was created at the behest of USAID by three Cooperating Agencies -- BASICS, SEATS and AVSC International -- to improve maternal and child health (MCH) in Cambodia over a five year period (1996 to 2000) in four provinces: Siem Reap, Kampot, Stung Treng and Pursat. Focusing on integrated reproductive health and child survival, RACHA’s ultimate goal (and USAID’s Results Package) is to increase contraceptive use and decrease infant and child mortality rates in the country. Currently, RACHA is engaged in activities at both the policy and service delivery levels in reproductive health (including birth spacing, STD prevention/treatment and HIV prevention), safe motherhood (including prenatal, intrapartum and postnatal care, emergency care and post-abortion care) and child survival (including controlling/managing acute respiratory infections, diarrheal diseases, and febrile illnesses) which support the widest possible access to MCH services. At the policy level, RACHA is working on policy formulation in specific technical areas; developing protocols, guidelines and curricula which reflect new national policy; strengthening the roles and relationships of the private and public sectors; and in the public sector, decentralizing services and expanding health care financing. At the service delivery level, RACHA is engaged in improving human resource capacity to expand and upgrade the quality of health services by providing technical assistance and training; strengthening provincial-level public sector institutions in planning, management and supervision; and improving MCH commodity accessibility and management. Improving the knowledge and quality of health services provided by private providers is also a major program component of improving human resource capacity.

Much work has progressed since RACHA’s inception to improve policies, protocols, guidelines, curricula, human resource capacity and MCH commodity accessibility and management in the public sector. Work to improve access, quality and human resource capacity to expand services in the private sector has yet to begin. Thus, an assessment of opportunities and constraints to expanding high quality MCH services in the private sector in the four focus provinces was commissioned by RACHA with USAID approval, and was carried out in April and May of 1998. The assessment focused on the formal private sector -- that is, for-profit institutions (including clinics, hospitals, private practices, pharmacies and drug stores) and non-profit, non-governmental organizations providing health care. Thus, the vast majority of health service providers in the country -- the so-called traditional, or informal private sector providers such as monks, bone setters, traditional healers and traditional birth attendants -- were not included.

In Cambodia, as in most other countries of the world, preventive health services are considered to be the prime responsibility of government, and the vast majority of preventive health services are provided by the public sector. However, the private sector is playing an increasingly important role in health service provision in the country. After having been decimated in the 1970s and 80s, the private health care sector in Cambodia is flourishing. Private hospitals, clinics and drug stores open daily, and many (if not most) health care providers in the public sector have a private
practice in operation during their off-duty hours. Pharmaceutical companies are developing their distribution systems and sales outlets, and access to a large variety of over-the-counter and prescription drugs are widely available. The availability of health services in the private sector has remarkably improved, thus giving health care consumers more choice and relieving the public sector of the burden of being the sole provider of health care in the country. In addition, the quality of health care services provided by the private sector is typically better than those provided by the public, although the cost of these services can be high to many consumers. Moreover, the private health care sector has grown so fast that legal and regulatory systems -- laws as well as enforcement mechanisms -- needed to assure quality standards and protect the health care consumer have not kept pace. As a result, there are large variations in practice quality standards; the right kinds of services and treatment options are not always available (with a preference given to the more profitable curative rather than preventive services); medications are overprescribed or dispensed without medical supervision; and the smuggling of pharmaceutical and other medical products continues to be a problem.

Affecting the future of the private sector -- and RACHA’s potential role -- is Cambodia’s political situation which has been, and continues to remain, uncertain. The “July Events” of 1997 undermined the confidence of the local and international communities in the country’s prospects for democratic change. Opposition parties question the fairness of the upcoming elections (currently scheduled for July 1998) and -- although a diminished threat -- remaining Khmer Rouge insurgents have continued to distract the government and drain the country’s attention and resources. On the plus side, however, is the fact that there is broad recognition within the Royal Cambodian Government of the significant contribution the private sector has made -- and will continue to make -- in the country’s development, and ubiquitous support for its continued growth.
FINDINGS

Demand For Health Services in the Private Sector

Focus group discussions held in Siem Reap and Kampot Provinces with mothers and grandmothers (also important caretakers of children, particularly orphans) combined with data obtained from two surveys (see, van de Put, “Empty Hospitals, Thriving Business”, an undated M.S.F. report; and, the National Public Health and Research Institute, “Results of Health Care Demand Survey and its Use for Health Policy Development and Implementation”, 1998) revealed the following:

• Demand for health services and the resulting burden on the household budget from paying for health care was very high, averaging almost 21% of monthly household income.

• When someone in the household was sick -- either an adult or child -- the most common response was to self-treat with medications or purchase medications for another family member from a private pharmacist or drug seller.

• For sick adults, the next most common response was to request a home visit from a private practitioner; seeking treatment at the office of a private practitioner was the next most common response followed by treatment from a public health facility.

• For sick children, the most common response was to take the child to a public health facility; almost as common was to seek treatment at the office of a private practitioner. Requesting a home visit by a private practitioner was the last and most expensive option used for a sick child, but still very frequently used.

• The very poorest Cambodians most often used public health facilities.

One will note the constant use of the word “treatment” above; the demand for preventive services -- including birth spacing -- is quite low. For example, only 7% of married women reported current use of a modern contraceptive method in 1995 (see, “KAP Survey on Fertility and Contraception in Cambodia”, National Maternal and Child Health Centre, 1995). Although the public health sector has made great strides to improve consumer knowledge of the importance of prevention (and, more preventive services are sought in the public sector than in the private), there is still much to be done in raising awareness through consumer health education programs.

Willem van de Put, in his anthropological study on health seeking behavior in Cambodia, states that Cambodians view modern health care as the act of receiving medications. This is consistent with the traditional view of curing (from traditional healers, natural remedies the supernatural, etc.) which always required some kind of “medicine”. For the average Cambodian, the quality of medical care is judged on how quickly they get well; that is, the perceived efficacy of the treatment (medicine) received. In addition, the low level of social integration in Cambodia is another important factor in health seeking behavior. The country is made up of families who are reluctant to leave the safety of their tight-knit communities and pay the cost of transport and time lost to seek medical care. As a result, says van de Put, the majority of curative health service “transactions” occur in the house of the patient.

These behaviors explain the impetus for not seeking treatment at all until the patient is very ill, for preferring self-treatment or home visits, or for seeking treatment from the nearest provider with the most efficacious/fastest working treatment options. This also explains why Cambodians most often seek treatment in the private sector, and why many are even willing to go into debt to pay the high cost of home visits. It is also easier to understand why the public health sector -- with its triage system requiring transport and long waiting times, its poorly equipped facilities, its lack of medications and inability to make home visits -- has such trouble competing with private providers.

Private Sector Service Provider Channels

The team did not attempt to duplicate Dr. Joel Montague’s ground breaking study of the commercial health sector in Cambodia (see, “Cambodia Commercial Health Sector Review”, Sections One and Two, WHO, 1997), where extensive survey work was carried out in private hospitals, clinics, maternitys, doctor’s offices, legal pharmacies and laboratories in the country’s two largest cities: Phnom Penh and Battambang. The Montague team also investigated prospects for employment-based programs and commercial health insurance schemes in Phnom Penh where the major industries are concentrated. Instead, the Private Sector Assessment Team focused on verifying the Montague study’s findings (as well as uncovering new data) in two of RACHA’s four focus provinces: Siem Reap and Kampot. These two provinces were chosen because of their higher population densities and their larger, and more active private sectors. Data on pharmacies/drug stores and the pharmaceutical distribution system were also gathered on the major highway linking Phnom Penh with another RACHA focus province, Pursat -- which is also the site of a pharmacist training program being implemented by CARE.

The team also chose to focus only on those service provider channels which would yield the most “bang-for-the-buck” in terms of increasing the availability of high quality reproductive health and MCH services in the private
sector. This meant focusing on the most accessible and well organized service provider channels which have frequent contact with RACHA’s target population, lower income women and children. Thus, doctors in private practice (the most common private sector service provider in the focus provinces), midwives, pharmacies, drug stores and non-government organizations (NGOs) operating in the health sector were investigated. (The service provider program matrices the team used to organize data collected are found in Appendix A.) The status of the legal and regulatory framework which affects the operation of these service provider channels was also explored, as well as the capabilities of medical professional organizations. Since little in the way of large-scale, modern industry operates in RACHA’s four focus provinces, the potential for launching programs to provide reproductive health/MCH services at the worksite was not pursued. However, where there was a concentration of employers (such as the hotel and tourist trade in Siem Reap), research was carried out on the possibility of linking this group to RACHA-sponsored service providers with some pre-payment or pre-arranged service fee mechanism in place. Likewise, as the level of development of the health insurance industry in Cambodia was quite low and confined to expatriates and wealthy individuals living in Phnom Penh, the team chose not to invest time in exploring this avenue.

Legal and Regulatory Systems in the Public and Private Sectors

Explosive growth in the private health care sector is not only attributable to newly found opportunities but to the fact that there has been a lack of policies, laws and regulations which could have restrained it. To fill this gap, the World Health Organization has played a leading role in Cambodia in health sector reform, working closely with the Ministry of Health to promote and pass health legislation, institute user fees and develop practice standards.

With regard to private practice, in 1991 the Royal Cambodian Government issued the first decree authorizing the establishment of private medical and dentistry offices, maternity homes and medical laboratories under certain conditions. Later that year, the Government followed up the decree by issuing circulars specifying the criteria and credentials of health care providers needed to open a practice. Under the decree, only physicians can open clinics and polyclinics. However, in reality, since there are no enforcement mechanisms in the public or private sectors to prevent one from opening a practice, others -- properly trained or not -- do, including midwives, nurses and medical assistants. According to the Montague study, the registration procedures in the provinces are even more lax than in Phnom Penh with provincial health officials largely unaware of the numbers and locations of facilities and individuals operating in the private sector. Moreover, systems for licensing and relicensing of medical personnel are weak, and practice standards -- if they exist -- are not enforced.

In the pharmaceutical sector, a new law on the management of pharmaceuticals was adopted by the National Assembly in 1996. This law governs issues related to products and their importation/exportation, advertising and the staffing and the operation of pharmacies. However, the law itself does not elaborate many of the issues which are to be governed under the law. Instead, sub-decrees and declarations (prakas) of the Ministry of Health (MOH) are cited as the regulatory instruments which will determine the law’s implementation. Most of these have yet to be produced: a sub-decree governing the importation and production of traditional medicines has been finalized, and two others concerning the classification, importation, exportation and production of poisons have been drafted. Others regarding good factory practices, the opening and closing of drug selling shops, the importation and distribution of drugs, drug registration and a narcotics manual are still being worked on. In any case, the number of government inspectors in charge of monitoring private pharmacies and drug stores is so small (only 20 according to a Unicef report) as to make real enforcement of regulations nearly impossible.

Regulatory and enforcement mechanisms in the private sector are in a similar state: the Cambodian Medical Association exists but is structurally weak and does not play an oversight role with regard to its membership. Only about 700 out of roughly 2,000 doctors practicing in the country belong. The organization is viewed as highly political with a constitution that has “turned off” many potential members. In addition, there are few services provided to members. Specialist “societes” also exist which address the professional development needs of a particular medical specialty area such as obstetrics and gynecology, and these may have more interaction with their members. Although a popular and very active group with dynamic leadership, the Cambodian Midwives Association also does not have the capability to “police” its members. Unlike the Medical Association, however, it does meet regularly, both in Phnom Penh and in the provinces, and provides services of value. For example, the Association (with RACHA support) is training trainers to upgrade the skills of its midwife members in three provinces. At present, however, Association leaders are volunteers and the organization is structurally thin, very much dependent on the leadership of its dynamic director. With 457 members, the Pharmacists Association of Cambodia is also quite active and is trying to enforce the laws and quality standards enacted by the Government. Most of its efforts have been spent in trying to close unlicensed and illegal drug sellers and depots -- a nearly impossible task under the current system.

Ironically, there may be another emerging area of concern in the legal and regulatory arena. At present, many public officials are suspicious of the private sector. Some even question why the private sector should provide health services at all, taking the traditional view that it is the government’s responsibility to provide these services and that the private sector is a competitor, not a partner in public health care provision. Thus, as laws and enforcement mechanisms
in the country are developed, there could well be an effort made to severely restrict the operations of the private sector; one example being a law which restricts the number of pharmacies that may be opened in a specific area (currently on the books). Thus, over regulation of the private sector also needs to be avoided so as not to stifle its development. In addition, more dialogue is needed between key public and private sector leaders -- particularly at the provincial level -- on their respective roles and responsibilities, and the value that both sectors have as providers of health care information, services and products to the Cambodian people.

For-Profit Private Providers

Physicians

In the focus provinces studied by the team (Siem Reap and Kampot), the majority of doctors who had a private practice were also employed by the public sector. These physicians would operate their private practices during the hours they were off-duty from the public sector. The physicians interviewed strongly supported this opportunity to supplement their very low public sector salaries (about $12.00 a month), and all felt they could provide better quality and more personalized services in their private practices. Most operated as a single practitioner but a few (those who were married to midwives) operated a small polyclinic. Most physicians added on one or two rooms to their homes to accommodate their private practice. If they could afford it (land is expensive), some built separate facilities -- either within their dwelling compounds or at another location. The cost of an add-on ranged from $2,000 in Kampot to $6,000 in Siem Reap. A separate facility could cost as much as $20,000 (land plus construction costs in Siem Reap).

Interestingly, all physicians interviewed did not want to work full-time in the private sector, unless they had a highly paid staff position in a private hospital. There were many reasons for this: first, was the perceived loss of credibility which leaving the public sector would bring. Since licensing and certification enforcement systems were absent, doctors who also worked in the public sector were considered de facto “certified” as legitimate professionals by their clientele. Second, doctors who worked full-time in the private sector were subject to taxes and other “levies” as well as some onerous business registration procedures. Third, physicians relied on their public sector work as a way to refer clients wanting longer consultation time and more personalized service to their private practice. In general, physicians found any other form of marketing -- other than word of mouth -- unprofessional. Fourth, physicians believed they saw more complex and, hence, interesting cases during their hours working in public hospitals. More routine cases tended to present themselves to their private practices. Finally, lacking options in the private sector, physicians depended on their public practices for personal and professional development opportunities, including access to medical/technology updates, seminars and overseas travel.

Consistent with the Montague study, physicians interviewed did not offer many integrated reproductive health and MCH services but tended to focus on curative care. Because these services were not profitable, patients wanting oral rehydration salts or preventive services such as well baby care, birth spacing (injectables, pills and condoms), antenatal visits, childhood immunizations and routine pelvic examinations were often encouraged to seek them at public facilities. Reinforcing this situation, of course, was the fact that the public lacked information on the importance of preventive, including birth spacing, services and tended not to seek these services anyway. Some MCH services -- because they were more profitable -- were offered such as treatment for acute respiratory infections (ARI), sexually transmitted disease (STD) diagnosis and treatment, malaria and TB treatment and prevention and IUD insertions. Treatment for diarrheal diseases could also be lucrative as long as antibiotics and antidiarrheal medications were prescribed. In general, IV-fluids and injections of any kind were very popular with patients. No thought was given by any physician interviewed to “bundling” lower and higher margin preventive and curative services together as a package (for example, STD treatment, ante- and postnatal visits with birth spacing) to attract more clients.

The problem with lack of interest in low-margin preventive services was exacerbated by the way physicians charged for services. To attract patients, doctors charged extremely low consultation fees, averaging $1.00 to $1.50 per visit. They made up for this by prescribing and dispensing as many medications as possible (consistent with the consumers’ need to feel they got their money’s worth) at inflated prices. Based on data obtained in Siem Reap from physician practices with average-to-high client loads, the team calculated that a physician could be making as much as about $170 per week, of which 45% was directly due to the sale of medications (see Appendix B, “Overview of the Private Pharmaceutical Sector in Cambodia” for data used in the calculation).

Consistent with the lack of system-wide practice standards and enforcement mechanisms was the wide variation in the quality of care provided by private practices, most readily apparent in the varied conditions of doctor-owned facilities. Most private practices and polyclinics visited by team members were clean and well equipped, but not
all were so. The Montague study cites the case of at least one private clinic where there was no running water. In addition to practice standards and protocols, doctors lacked quality assurance and clinic management skills. Although not observed by the team, the Montague study reported that patient record keeping systems in most practices were poor to non-existent.

The team also explored with the managers of some of the largest hotels in Siem Reap (where the tourist trade is quite active) their interest in using a network of RACHA-trained and certified physicians as “preferred providers” for their employees. Currently, hotels are using a few private physicians in this way -- some even come to the hotels to treat guests (employees go to the doctor’s office in transport provided by the hotel); doctors are used almost exclusively for curative care. In principle, most hotel managers interviewed were interested in pre-negotiating fees with RACHA-certified physicians, especially if it would lower current medical costs which they felt were quite high (doctors were aware that hotel owners were paying the bill for their employee-patients and they charged accordingly). Pre-arranged contracts with preferred providers for a preventive service such as birth spacing (about half of hotel staff were female) was also of interest.

**Midwives**

Historically, the midwife has played a central role in home-based deliveries, and births are steeped in tradition and ritual. Even today, traditional birth attendants (TBAs) do many home-based deliveries in rural areas, and work closely with the traditional healer who is involved both during the pregnancy and after delivery. Certified midwives now play an increasingly important role in urban and rural settings, but still face formidable competition from TBAs. Many certified midwives are young, have limited training and lack experience and credibility within the communities they serve. (They also do not receive training in the unharmful rituals and blessings that accompany traditional births; these are still highly desired among women and their families.) The most successful certified midwives have learned to collaborate with traditional healers and birth attendants and use them as a referral network for their services.

Ironically, although certified midwives are usually in the “front-lines” of both the public and private health care sectors, being widely accessible and living and working in the communities they serve, the skills of many are underutilized. They often suffer from low status and are given menial jobs to perform. For example, in a 1997 survey conducted by the Cambodian Midwives Association, only 17% of midwives in Siem Reap actually reported doing deliveries; only 3% provided birth spacing activities; only 9% provided antenatal care; only 3% provided postnatal care; and only 4% gave vaccinations. However, a whopping 56% reported doing “different (other) things” -- including menial tasks.

As with physicians, the majority of midwives interviewed in the focus provinces worked in the public sector but privately offered home-based delivery services when off-duty. (In Phnom Penh, some midwives work in private hospitals and large clinics.) At least two polyclinics were found -- one in Siem Reap and another in Kampot -- where a midwife jointly owned a practice with her physician husband, and deliveries seemed to be the major part of their polyclinic practices. Few midwives had the capital, income or entrepreneurial drive to open their own maternity facilities. Restrictive laws which prevented midwives from legally owning a single practice without the direct supervision of a doctor reinforced this (to get around this restriction midwives will also “rent” the name of a doctor -- an arrangement that many drug sellers have with certified pharmacists -- but most state they cannot afford the fee). Even more important, midwives lacked training in reproductive health and child survival which would allow them to offer a larger range of services.

The team did meet with three midwives in Siem Reap City who had a few (one to five) laying-in beds in their homes. These were not called clinics since none of the midwives partnered with a doctor, nor was there a sign on their house advertising the beds. All three did more home- than “clinic”-based deliveries (for example, one midwife reported doing five home-based deliveries but only two “clinic”-based deliveries that month). Only one out of the three had any reproductive health training; this one had also received training in IUD insertions in a private hospital and performed abortions (about 50 a month). None offered oral contraceptives or injectables.

Most midwives interviewed thought that having products to sell (such as oral contraceptives, condoms, baby kits, soap, iron tablets, etc.) would be a good motivator for doing community-based outreach activities. Some indicated that lack of transport -- especially in the rural areas -- could be a problem for conducting effective outreach. All were interested in training -- particularly in reproductive health -- to expand their skills and improve their knowledge and credibility. Other priorities mentioned included assistance in promoting collaborative partnerships with physicians; access to credit for equipment; and, marketing assistance.

**Commercial Pharmaceutical Sector**

A full overview of the commercial pharmaceutical sector in Cambodia is found in Appendix B.
Pharmacies and Pharmacists.

Pharmacy outlets, particularly larger or geographically well-placed outlets, serve not only end-users of drugs but also smaller drug outlets and some physicians as sources of pharmaceutical supply.

Licensed pharmacists play a negligible role in the sale of drugs and in the transfer of information to consumers in both legal and illegal pharmacy outlets in Cambodia. Drug sellers are often pharmacy owners -- individuals whose primary qualification has been access to the capital required to establish and stock a pharmaceutical outlet -- and their assistants -- family members, domestic helpers, or shop clerks. Few have received any technical training, and many base their recommendations and treatments on "trial and error" experience in the past.

Previous research supports current observations that drugs are overdispensed to Cambodian consumers. Both physicians and drug sellers commonly sell to each client more types of medicine than is needed for effective treatment of a given complaint. Drugs are also dispensed for conditions which do not require them. Treatment of diarrheal disease in children is a prime example. Antibiotics and anti-diarrheal drugs are regularly sold rather than the inexpensive packets of oral rehydration salts. Income generation is generally thought the primary motivating force for this phenomenon, but inadequate knowledge of proper treatment/risks of mistreatment is also widespread. Lack of consumer knowledge of correct treatment procedures and consumers' desires for a "quick cure" support continuing over/dis-pensing of drugs.

Overdispensing of drugs has contributed to the misuse of drugs, antibiotics in particular. Few consumers (or drug sellers) appear to understand the importance of a full-course of antibiotic consumption. A high prevalence of resistant bacterial strains has consequently developed in Cambodia.

Regulation of pharmacies and pharmacy practice is quite limited in Cambodia. Sub-decrees needed for implementation of the 1996 Law on the Management of Pharmaceuticals have not yet been drafted, and resources and mechanisms necessary for systematic enforcement do not exist. There are at least as many, some even say twice as many, illegal outlets for the sale of drugs in Cambodia as there are legal outlets. Some commercial pharmaceutical distribution executives estimate that as much as 15% of the total value of pharmaceuticals imported are smuggled into Cambodia.

Demand for a given product, demonstrated through both prescription-based consumption and direct purchases by consumers, appears to be the single most important factor in product availability in the retail marketplace. Products related to health behaviors which RACHA seeks to promote -- such as contraceptives, oral rehydration salts, iron tablets -- do not now enjoy significant levels of consumer demand. While these products are available within the Cambodian market, supplies may be shallow and inconsistently available.

The pharmaceutical market in Cambodia appears to be driven by fierce competition on the basis of price. Pharmacies work on remarkably small markups, often cited at as little as 10%. The desire for low cost drugs which are affordable to a majority of consumers has led to the widespread distribution of drugs manufactured in India, Vietnam, South Korea, and Thailand. The quality of some of these very low-priced drugs is questionable. Consumer confidence is said to be high in drugs manufactured in Europe and other Western countries, especially France; but their considerably higher prices limit their sale.

Pharmaceutical Importers and Distributors.

The total annual value of pharmaceuticals imported into Cambodia is estimated to be between US$40-50,000,000. The private sector share of the imported pharmaceutical market is estimated between US$15-25,000,000 annually. The annual value of locally produced pharmaceuticals (primarily antibiotics, fever relievers, and pain relievers) does not appear to be known. There are at least ten currently active, registered importers/distributors of pharmaceutical products in Cambodia.

A significant change has occurred in the Cambodian pharmaceutical market during the last year. In that time, several distribution companies have established branch offices in selected provincial capitals to facilitate speedier, more regular distribution of products to outlets; and most distribution companies have begun to operate regular (monthly and semi-monthly) sales and distribution routes to physician and pharmacy accounts in many provinces. Each sales team includes a van driver, a sales representative and a medical representative who provide information and promote products to physicians and larger pharmacies along the sales route. The distribution system no longer so completely relies on the travel of retailers from the countryside to wholesale market areas in Phnom Penh for the supply and re-supply of pharmaceutical products.

The transition of the Cambodian pharmaceutical market from a "pull" market into more of a "push" market is probably accelerated by the extremely competitive state of the pharmaceutical sector at this time.
The establishment of regular sales routes and the use of medical representatives and manufacturer-provided print materials to promote products has created a new channel through which current and correct information may reach pharmacists and physicians. Competition among distributors to gain and keep regular pharmacy and physician customers is also leading these companies to develop account record keeping systems (some even computerized) and to track sales. These databases may soon provide another, reliable source of information related to drug usage patterns and consumer/provider product preferences. Additionally, Population Services International (PSI), an international NGO, plans to initiate shortly what may be the first round of pharmaceutical retail audits in the country. The existence of such expertise in the marketplace creates the opportunity for tracking the consistent availability and stock turnover of many types of pharmaceutical products.

**Availability of Selected Pharmaceutical Products**

Pharmaceutical products of special interest to improved maternal and child health, child survival, and reproductive health in Cambodia include contraceptives, oral rehydration salts, iron tablets, improved drug technologies for treatment of malaria, and correct drug treatments for ARI. The drugs necessary for improved treatment of malaria and improved treatment of ARI are available in the marketplace. Enhanced availability and improved use of these products appear to be primarily a function of consumer and pharmacist/physician education and training.

There is limited current availability of oral rehydration salts (ORS) in the commercial market. Unicef, however, is developing a national campaign of mass media advertising and information, education and communication (IEC) for oral rehydration salts, and is working with an importer/distributor of pharmaceuticals to bring a commercially branded ORS product into the marketplace.

Iron tablets, which are particularly important in Cambodia for the health of nursing mothers, are not consistently available in outlets throughout the marketplace. While iron tablets are frequently categorized by retailers as another type of vitamin (and vitamins are widely sold in Cambodia), both retailers and distributors are aware of the widespread "availability" of free iron tablets (donated by Unicef) in the public sector and, consequently, do not attach much commercial significance to this product.

Some type of contraceptive product appears to be available in most drug outlets. In many smaller rural outlets the available contraceptive method is most likely to be the Chinese "once-a-month" pill and/or condoms. Several brands of low dose combined oral contraceptives can be found in larger or urban pharmacy outlets. PSI supports sales and widespread distribution of its own contraceptive brands (Number One condoms and OK oral contraceptives) with mass media advertising, promotional activities, medical representation, and pharmacist/provider training. There does not appear to be a low priced IUD available in the market at this time.

**Non-governmental Organizations (NGOs)**

**Overview**

Currently, about 130 local and 200 international NGOs operate in Cambodia. Figures from the Cooperation Committee for Cambodia (CCC) indicate that in 1994, NGO's disbursed $74 million in aid. Thus, they are an important player in Cambodia’s development and humanitarian aid arena.

In the health sector, at least two dozen NGOs operate programs; over half of these support maternal child health and birth spacing. Most of this support is provided directly to the public health sector, and address issues such as HIV/AIDS prevention, immunization, prevention of disease, reproductive health, safe motherhood, oral rehydration, etc. At least twenty NGOs offer contraceptive supplies, many of which are received through USAID or USAID-supported projects. Most NGO-sponsored birth spacing and child survival programs fall into three main categories:

- Direct assistance to Ministry of Health facilities to obtain equipment, supplies, training and contraceptives;
- Implementing programs within the public health structure with NGO staff operating both in facilities and in the community as outreach workers; and
- Stimulating the private sector through the establishment of NGO clinics, providing small grants to private practitioner associations or through social marketing programs.

Although numerous NGOs work in women’s reproductive health and safe motherhood, four of the most active include:

- The Reproductive Health Association of Cambodia (RHAC), a Khmer NGO affiliate of the International Planned Parenthood Federation which operates two urban-based clinics in Phnom Penh and Kompong Som and will soon open a third in Battambang;
• Population Services International (PSI), which, with USAID support, socially markets oral contraceptives and condoms to promote the correct and consistent use of modern birth spacing methods (country-wide);
• The Cambodian Women’s Development Association (CWDA), which implements a community-based distribution of contraceptives program, as well as referral and IEC activities in reproductive health and HIV/AIDS prevention; and
• RACHANA, which operates a highly successful birth spacing program in Kok Andeth District of Takeo Province where prevalence rates are reported to be 40%.

**International NGOs**

International NGOs (INGOs) have made a significant contribution to the rehabilitation and development of Cambodia. It seems likely that while the contribution of INGOs is now decreasing as a percentage of overall development aid as the larger bilateral and multilateral agencies have moved into Cambodia, many donors still rely on the INGOs – and to a lesser extent the local NGOs (LNGOs) – to implement programs on their behalf. As a result, NGOs have become contractors hired to implement specific programs initiated by donors. A list of donor and INGO supported programs that have -- or will have -- impact in the private health care sector is found in Appendix C.

Although most INGOs are engaged in high quality program work, some have been criticized for their lack of effective registration, monitoring and evaluation systems. Others operate without a formal agreement with the Cambodian government nor do they report in any formal way. Still others are engaged in religious proselytism, political or profit making activities which have little-to-no impact on the development of the country and the well-being of its people. Another problem is lack of NGO coordination which sometimes leads to duplicative efforts. For example in Siem Reap City, two private pediatric hospitals are planned to be built by the end of the year. One, a Swiss-backed NGO headed by Dr. Beat Richner, will construct a large, 180 bed facility, while the other, a Japanese NGO, Friends Without Borders, is planning a smaller 30 bed inpatient unit. The plan for two hospitals is controversial and lacks provincial-level government support. There is little need seen for two specialized facilities in one small area -- particularly when pediatric services are stretched very thinly in most other parts of the country.

**Local NGOs**

There are a several strong LNGOs with high quality health care programs operating in Cambodia; these include the Reproductive Health Association of Cambodia, the Cambodian Women’s Development Association, RACHANA and the Cambodian Health Committee. Most of the best either started out as international NGOs, received large doses of international assistance from intermediary agencies, and/or were run by Cambodians who were trained abroad. There are, however, a number of LNGOs currently running programs in Cambodia which suffer from a myriad of problems. These are largely related to the "newness" of their programs and their lack of experience as development institutions. Lack of institutional inexperience has been compounded by the fact that donors funding LNGO programs have frequently failed to provide training or other personnel support to develop the human resource capacity of these organizations. Frequently cited problems with LNGOs include:

- Weak project and organizational management skills;
- A lack of understanding of what constitutes quality programming and implementation;
- Little-to-no experience with monitoring and evaluation;
- A lack of a clear organizational mandate; and/or
- Little internal accountability.

Thus, to be effective, many LNGOs will require a great deal of organizational and human resource development and support, as well as more years of project implementation experience. Some of these LNGOs – particularly those which sprang into existence in response to the availability of funding rather than a real local need – will gradually fade away after failing to establish a credible track record.

**NGO Coordinating Committees**

Several NGO coordinating committees operate in Cambodia, the most important of which is the Cooperation Committee for Cambodia (CCC). This organization publishes the Directory of Cambodian NGOs, the Directory of International Humanitarian Assistance in Cambodia and the Guide to Provincial NGO Networks in Cambodia.
MEDICAM, the association of NGOs working in health in Cambodia includes both international and local NGOs and has growing influence. There are other NGO umbrella groups such as the NGO Forum, Federation of Ponleu Khmer, Star Kampuchea, etc. Some of these coalitions have received international NGO assistance and some have not, and a number of these groups are structurally weak. The main reason for this weakness is related to the profile of coalition members which can be broken down into two groups: those NGOs that have funding and are too busy implementing their own programs to be active in the coalition, and those that lack funding and are hoping to attract some by participating in coalition-sponsored activities. Donor funding for these coordinating committees may also compound problems as NGOs that lack funding struggle for control over coalition budgets.

Nonetheless, Cambodian coordinating committees serve a valuable function in that they are the main forum where NGOs and donors can come together to share program plans, opportunities and problems to avoid duplication of effort and wasting resources. Appendix D contains more detailed information on the role and function of the major coordinating committees in Cambodia.

**NGO Activities in RACHA’s Four Focus Provinces**

In RACHA’s four focus provinces -- Siem Reap, Kampot, Stung Treng and Pursat -- there are a number of international and local NGOs operating in the health sector with varying degrees of success. Appendix E contains an inventory of health sector NGOs operating in these four provinces. The team was unable to locate evaluation data which would document how well a particular NGO’s program was working and what impact the program was having on the surrounding population (the exceptions to this are CARE’s well documented pharmacist training program in Pursat, and the Cambodian Health Committee’s community development and TB program in Svay Rieng). In spite of this, these facts are known:

- The absorptive capacity of local NGOs is limited and assistance from a contractor such as RACHA must be accompanied by adequate organizational, program and financial management support;
- Limited conceptual capacity in most NGOs is overcome only with considerable hands on technical assistance;
- Language is a major barrier to the provision of technical assistance;
- Realistic time frames, objectives and indicators must be set for capacity building work with local NGOs;
- The sustainability of most NGO programs is a major issue as very few are sustainable without continued donor support.

In spite of these weaknesses and because they serve RACHA’s target populations and are located within target communities, NGOs are a valuable resource, particularly as vendors of specific services. Once RACHA defines its provincial-level program agenda (see Section III, Recommendations, for suggested strategies and interventions), NGOs with proven track records should be hired under contract as vendors to provide such services as training, outreach or product marketing and distribution. First, however, RACHA should spend time evaluating the organizational capacity and programs of potential NGO partners before investing in new NGO activities. Appendix F contains other guidelines that RACHA should consider when working with NGOs.
RECOMMENDATIONS

Important Concerns and Limitations

It is important that RACHA (and USAID) recognize that there are overriding concerns and limitations with working in the private sector in the four focus provinces; this would also be true to a greater or lesser extent with the private sector operating anywhere in Cambodia outside of Phnom Penh. First, is the fact that the private sector in Cambodia is relatively new. Although the private sector is growing rapidly, it is disorganized and is operating within a legal system that has not yet caught up with it. Second, in some focus areas – particularly Stung Treng Province as a whole and Pursat Province outside of Pursat Town -- population sizes and densities are probably too small to generate enough demand and purchasing power to stimulate and support a private health care sector of sufficient size to work with cost-effectively. Third, although the private sector in Cambodia is at a stage of development where small, demonstration-type interventions can be tested for impact and effectiveness, there is currently no institutional mechanism in place to "roll out" successful pilot interventions on a scale large enough to achieve national impact – with the one possible exception of the commercial pharmaceutical distribution system. Finally, accomplishing behavior change is a complex process that requires multiple channels of communication and influence interacting over long periods of time. Projects whose objectives are behavior change are likely to require, therefore, collaboration with multiple partners, considerable management and monitoring resources, and sufficient flexibility to respond to interim lessons learned. Impact evaluation is a critical component of this process to measure behavioral change and generate needed lessons. The team found very few instances where results of impact evaluation were available on projects being implemented in the private sector – both non- and for-profit.

Strategic Approach Used to Develop Private Sector Program Recommendations

In order to achieve RACHA’s and USAID's Strategic Objective for Cambodia -- Improved Maternal Child Health - the team recommends that RACHA pursue a three-pronged strategic approach to developing and supporting activities in the private sector: the first involves the policy and regulatory system; the second, health services; and the third, health-related products.


Rationale:

For the private sector to function effectively, a clear regulatory system needs to be put into place and enforced. Private (as well as public) practitioners need to be certified as competent in their professions and registered. Clear standards, guidelines and protocols must be enacted and enforced to ensure an unambiguous level of quality of care and that the health consumer's rights are protected. At the same time, these policies, regulations and guidelines cannot be so restrictive and costly as to stifle growth in the private sector and reduce its potential as an important provider of public health information, services and products. In addition, a consensus needs to be developed among policy makers and service providers on the issues and areas of service delivery which should be regulated by the public sector and those that should be left to market forces and private sector-based oversight institutions (such as professional associations) to control. This is the strategic element the leadership of the Ministry of Health is most interested in.

Recommended Actions:

- Coordinating/collaborating with WHO to avoid duplication, RACHA should give technical assistance to the Ministry of Health to help develop relevant sub-decrees and prakas, regulations, protocols, standards of practice and guidelines governing private practitioners, pharmacies and drug stores and the importation of medical equipment and pharmaceuticals, as well as mechanisms for their enforcement.

- RACHA should organize and sponsor information, motivation and consensus-building workshops for key government health sector policy makers, change agents and service providers beginning at the central and provincial levels where the role of and benefits from a thriving private health sector can be introduced and discussed. Topics could include: benefits accruing to the public health system from a dynamic private health sector; experiences and lessons learned from positive private-public sector partnerships in other countries; and, appropriate oversight and regulatory functions and roles for both public and private sector institutions, and how to put them into place.

2. Improve Human Resource Capacity and Expand Services of Providers Operating in the Commercial Health Sector.
Rationale:

Health practitioners operating in the commercial health sector – particularly physicians, pharmacists, drug sellers and midwives – are already important providers of health services and information. They are visible, accessible and have a great deal of influence over health status and behavior. As such, investments to build capacity, expand services and improve quality in this sector will have direct and positive impact on the three indicators of achievement: increased contraceptive prevalence; decreased infant mortality; and, decreased child mortality. At the same time that the supply of preventive and child survival services is being expanded in the private sector, however, consumer education and marketing is also required to raise consumer awareness of service quality issues and to create demand for high quality services. To effect real change, consumers need to know about (and practice) preventive health. But when they do get sick, consumers need to know when to seek treatment and what the most appropriate and efficacious treatment options are.

Recommended Actions:

• RACHA should encourage pre-service curriculum reform in medical and pharmaceutical education to strengthen medical ethics and targeted technical areas related to reproductive health and child survival.

• RACHA should design and support pilot projects with commercial health sector providers which test cost-effective ways to expand high quality preventive and child survival services and products. Before the start-up of some recommended activities, further research and fact-finding will be needed to validate assumptions and fine-tune project designs. RACHA should also use Operations Research (OR) as a monitoring and evaluation tool to measure impact and document which pilot approaches are most effective in achieving desired results.

• RACHA should give priority to pilot projects which establish collaborative institutional relationships with other for- and non-profit organizations already operating in the private sector, and build capacity. Linkages and overlap between different private provider and product channels should be fostered to build synergy and maximize impact – necessary for behavior change.

• RACHA should pick the "ripest plums". That is, given current manpower constraints, problems with absorptive capacity in the private (particularly non-profit) sector and wide variations in the size of target markets within the four focus provinces, RACHA should:

  • Target the most organized and accessible provider channels and those with the most contact with the target population – that is, physicians and midwives operating in the commercial sector rather than nurses and medical assistants. Physicians targeted for training should be those most potentially interested in adding preventive MCH and child survival services – younger, less experienced doctors struggling to establish their client base; and

  • Market higher margin preventive/child survival products – particularly when using physicians and retail drugstore outlets.

• RACHA should avoid general "NGO strengthening" projects. Instead, RACHA should contract with strong NGOs with proven track records and congruent interests as vendors for specific private sector support services (e.g., provider training, management/supervision, outreach capability, research, evaluation, and product packaging/distribution, etc.). In this way, RACHA will strengthen vendor NGOs by giving them hands-on experience, and (hopefully) also move them toward financial sustainability.

• As the private sector needs a critical mass of concentrated populations and potential customers who can afford to pay, RACHA should give priority to focus provinces where the private sector is the most developed and where the largest target markets live. Thus, Siem Reap and Kampot Provinces with larger provincial cities, larger population sizes (around 600,000 and 500,000 respectively) and higher population densities have more potential for success than Stung Treng Province where the potential market is quite small (total population size is less than 82,000) and widely scattered. Although the population of Pursat Province is only half that of Siem Reap's, there may be enough critical mass of suppliers and consumers in Pursat Town for cost-effective private sector program activities to take place there.

• Based on the outcome of tested approaches and how the political and economic environment of the country evolves, RACHA can "scale up" successful pilot projects -- either by deepening support to existing projects or broadening them through replication in other focus areas – and "scale down" less successful ones by either limiting further inputs or phasing them out altogether.
• RACHA must select priority public health messages, and target these for consumer education to raise demand for high quality preventive and child survival services. Without this, consumers will fail to understand the value of prevention, will not recognize good quality health services, and will continue to pursue unsafe health practices such as self-treatment and the over use of drugs. At the same time, multi-channeled continuous education for providers (practitioners, pharmacists and drug sellers) which reinforces these messages is also important: one-time provider training will not accomplish behavior change. Provider training coupled with consumer education and supported by community level acceptance of new ideas may lead to behavior change. Impact evaluation, to measure behavior change and to ascertain what is and is not working, is a critical element and must be built into planned consumer and provider education programs.

• RACHA should explore the value of developing the capacity of the professional medical association and/or an offshoot medical specialist group ("societe") as an oversight/peer review and professional development body for physicians. Priority should be given to targeting physicians who practice family medicine for quality standards enforcement and service provision to expand their knowledge and expertise. As a first step, the potential for developing this capacity should be explored with the Cambodian Medical Association (C.M.A.). However, given the current institutional weaknesses (and possible reluctance to entertain reforms) of the C.M.A., RACHA should also explore prospects for establishing a Societe for Family Health for family practice physicians. Corporate sponsorship by pharmaceutical companies now represented in Cambodia (as well as membership dues) could be sought for its long-term financial support.

3. Use Social Marketing to Increase Access to Selected MCH, Reproductive Health and Child Survival Products and Increase Access to Related Messages and Information at the Community and Household Level through Product Sales.

Rationale:

Social marketing has proven to be an effective, sustainable method of introducing and increasing the demand for and the use of reproductive and child health products. Condoms and oral contraceptives are already being successfully socially marketed in Cambodia by PSI. There is evidence that opportunities exist to introduce other important MCH products through social marketing, benefiting both the consumers who use them and the providers/retailers who sell them. The commercial distribution sector is now at a state of development where it is putting into place mechanisms for "pushing" out products nationally. Since this sector is very responsive to demand the importance of marketing and advertising to consumers cannot be underrated – if demand is present, the products will likely follow.

Recommended Actions:

• RACHA should explore distribution channels for both new and existing MCH products with market potential but of current limited availability. Products with the highest prospect of being sold on a sustainable basis should be given priority. Targeted advertising to raise consumer demand for the new products must also be done.

• As with expanding provider services, RACHA must target focus provinces for social marketing that have higher target population sizes and densities. A critical mass of potential demand is needed for sales and profit potential.

• RACHA should use product sales as a means of sustaining outreach message delivery. Outreach workers who reinforce health messages by offering needed products, and who are able to make a profit doing so, are most likely to carry on with their work.

Private Sector Program Recommendations

Many of the following recommended interventions are stand-alone activities, which can begin on a pilot basis. Some will require policy level activities and/or further research before start-up. Other recommended program interventions are linked – for example, the need for consumer education to accompany health provider skills upgrading and social marketing. Depending on the availability of manpower in RACHA, the absorptive capacity of the private sector and the level of resources available, successful interventions can be scaled up (broadened or replicated elsewhere) or down (remain limited in scope or be phased out).

1. Recommended interventions to strengthen the policy and regulatory system to support high quality service provision in the private sector, and its widest possible access.
**Intervention 1.** Provide technical assistance to the Ministry of Health in the development of necessary laws, sub-decrees, prakas, protocols, standards of practice, and guidelines governing the private practice of medicine, the importation of and trade in pharmaceuticals, and the registration and operation of pharmacies and other drug outlets. Coordination/collaboration with the WHO should be done to avoid duplication of effort. Current enforcement mechanisms should also be studied and recommendations for changes made.

Suggested tasks to be carried out under this intervention include:

- In collaboration with the relevant Departments in the Ministry of Health and with the Director General for Health, develop a prioritized list of areas for which such technical assistance is needed (e.g., pharmaceutical registration, certification of health care providers, standards of practice for selected areas of service delivery, licensing of pharmacies, enforcement mechanisms and the like).

- Develop an inventory of agencies/organizations/individuals who are potential providers of relevant technical assistance (such as the Centers for Disease Control, the AID-funded POLICY Project, World Bank, the new AID-funded Commercial Markets Project, the American Medical Association, WHO, the U.S. Public Health Service, AVSC, JHPIEGO, and the like). Ascertain their interest in/ability to provide needed technical assistance. Explore possibilities of joint or other funding for this technical assistance.

- Design and facilitate a forum for discussion of issues relevant to regulation for each of the priority areas selected. Ensure participation of a broad range of influential/participants (including the private/NGO and the private/commercial sectors where relevant) in these preliminary discussions. Elicit through each forum areas of particular concern and sensitivity, likely ramifications of potential regulation, and needs for regulation and guidance in the selected technical area. Explore possibilities for enforcement and/or implementation of regulations/protocols, which will be developed.

- Coordinate provision of technical assistance in the drafting of documents and the design of enforcement mechanisms.

- Develop a process for review of drafted laws, regulations, protocols, etc. Incorporate feedback into proposed drafts where appropriate.

- Provide assistance in the effective dissemination of newly developed laws, regulations, protocols, etc.

**Intervention 2.** Organize and sponsor informational and consensus-building workshops relevant to public/private partnerships and the role of the private sector in health care delivery for key central and provincial level government health sector policy makers and gate keepers. Provide opportunities for public sector gatekeepers to understand and appreciate the significant role which the private sector needs to play in health care service delivery, and to be less "allergic" to the motivating force of profit and how it operates.

Suggested tasks to be carried out under this intervention include:

- Identify an agency/organization (such as the AID-funded POLICY Project) which can provide technical assistance to RACHA staff in the development and implementation of these workshops.

- In collaboration with the Director General for Health, develop a broad agenda of public/private sector issues which should be brought forward for discussion and consideration in the Cambodian health care context.

- Develop a specific agenda for Round-One workshop. This agenda should include presentations on other country experiences, lessons learned, and definition of the private sector's potential role and should elicit areas of concern related to private sector participation. Workshop activities should lead toward development of province specific opportunities for public/private collaboration.

- Implement Round-One workshop for selected central level gatekeepers and provincial directors of health. Assess whether or not there is need for additional workshops or other discussion settings for these influential in order to facilitate public/private partnerships and private sector service delivery opportunities.

- If necessary, implement Round-Two workshops.

- Assess need for/benefit of providing technical assistance at the provincial level for development of "partnership plans" or provincial strategy for segmentation of health care service delivery "market".
• Provide this follow-up technical assistance at the provincial level, if deemed feasible.

2. **Recommended interventions to improve human resource capacity and expand services of providers operating in the commercial health sector.**

**Intervention 1.** Provide clinical, counseling and management training and basic equipment to competent -- but younger and less experienced doctors with smaller client loads -- in order to enable them to expand and improve the quality of their preventive and child survival services.

Suggested tasks to be carried out under this intervention include:

• Conduct a survey with targeted physicians regarding their interest in expanding preventive and child survival services and products. Which preventive and child survival services and products are they most interested in? What kinds of basic equipment and supplies are needed to carry out such services? Would they be interested in partnering with a midwife to expand services? What marketing strategies are most interesting and acceptable (for example, development of a family medicine network and logo with advertising? Preferred provider-type contract relationships with employers?) What business/practice management skills need upgrading? Would they be interested in joining a Societe for Family Medicine if it provided valued services? Which membership services would be most valued? What would be an acceptable membership fee?

• Collect baseline data on number and type of MCH/reproductive health/child survival services currently being provided by the target group.

• Identify training venues for physicians and investigate cost per physician trained. In addition to technical training, doctors will need training in consumer education, counseling and appropriate health messages. RACHA could seek assistance from the Program for Appropriate Technology in Health (PATH), based in Bangkok, which has experience providing consumer education/counseling training to pharmacists in Cambodia as well as Thailand. Possible institutions for technical and business management training which RACHA should explore include: the National Centre for Maternal and Child Health for training in reproductive health and child survival; the National Pediatric Hospital (for ARI, control of diarrheal disease (CDD), Dengue, and HIV/AIDS care for children); the National Public Health Research Institute (TB, general epidemiology); RHAC (reproductive health including clinical methods and clinical management training); and, possibly, the MOD group (management training). RACHA should focus on the more profitable services that appeal most to doctors such as ARI treatment and case management; proper CDD treatment; sexually transmitted disease diagnosis and treatment; dengue, malaria and TB treatment and prevention, and IUD insertions (particularly with female doctors). Until national guidelines for voluntary surgical contraception (VSC) provision are in place, the team does not recommend pursuing training for private practices in this area.

• If appropriate (that is, if desired by doctors), help physicians plan marketing strategies to promote their family health practices. This could include the development and advertising of a family health logo in the community; partnering with or employing midwives as community based health educators to raise demand for services (see below); and/or developing and promoting discounts for integrated service packages. Another option worth exploring is establishing a preferred provider network with employers for health services for their workers. The hotel industry in Siem Reap could be a good starting point.

• Supply trained physicians with a basic package of equipment and supplies needed to provide reproductive health, child survival and other preventive services. In exchange for free equipment and supplies, RACHA should get agreement from participating physicians that they will repay in kind by allowing monitoring activities, providing reports on services provided, and -- if appropriate -- offering certain services at a reduced price.

• Provide training in quality of care/quality assurance. Explore prospects for establishing a mentoring program where senior physicians trained in quality assurance provide technical assistance to target doctor group.

• Link the upgrading of family health practices to consumer health education in the same communities (see Intervention 5. below).

• Evaluate impact. Measure the effect of the intervention on: the number and type of MCH/reproductive health/child survival services being provided by target group; quality of care; cost of services.
**Intervention 2.** Upgrade and expand the skills of midwives to provide a wider range of reproductive health services in their private practices, and enhance their role in the provision of services to children under five.

Suggested tasks to be carried out under this intervention include:

- Clarify with the MOH which reproductive health, safe motherhood and child health services a midwife can perform in the private sector without the supervision of a physician.
  - Hold informational seminars and conduct surveys among members of the Cambodian Midwives Association in the focus provinces to ascertain level of interest in receiving training/refreshers to upgrade skills, and the current constraints midwives face in expanding service delivery. Survey questions might include: What kinds of training does the midwife need to upgrade technical and management skills?; What are her priority equipment/supply needs?; and, Is transport a problem and how far must she travel to reach her clients? Since many midwives may not readily see the benefits of expanding reproductive and child health services, a seminar to introduce and explain the concept may be in order. One strategy might be to explain that since mothers and babies "go together", they should be "treated together". Reproductive health/well baby/child health services which can be done in the mother's home (such as birth spacing, breast feeding, growth monitoring, first aid, etc.) should be emphasized since most midwives do not operate clinics. For increased synergy, RACHA should target the same province(s) where family practice physicians are most likely to be trained.
  - Arrange technical training for midwives by contracting with RHAC, the National Centre for MCH and/or the National Pediatric Hospital. Another option may be to retrain midwife trainers being sponsored by the Cambodian Midwives Association in child health and other services, and contract with them to provide training to targeted members in the focus provinces. If money and other business/practice management training is needed, RACHA could contact RHAC and/or the MOD group as possible suppliers of these services.
  - Upgrade the midwife's consumer education/marketing skills to develop her capacity to become an effective outreach worker – including collaborating closely with the respected traditional healers and birth attendants (the kru) in the community. Select priority messages for communication and develop supporting print materials. RACHA should explore with PSI its interest in assisting in this area. Consider developing a simple drug counseling handbook to raise the credibility and effectiveness of midwives. With regard to actual training, there are two ways to go about this: RACHA could develop its own marketing/communications skills training program, and identify entrepreneurial midwives with strong communications skills to use as mentors and/or on-site trainers. Or, RACHA could contract with carefully selected NGOs with previous community-based education experience such as the Cambodian Health Committee which operates in Svay Rieng and (soon) Kampot Provinces, or CARE in Pursat. CARITAS in Siem Reap may also be interested in training midwives and contracting with them to do outreach work and raise demand for public health center services, allowing them to sell products to earn income. Other potential NGO partners with midwives include UCC and MEMISA in Kampot.

- Identify valued products which midwives can sell to earn income and negotiate with commercial distribution companies and/or PSI (for oral contraceptives and condoms) for supplies (also see, Section C.3. Social Marketing, Intervention 5. below). Products could include oral contraceptives, injectables, ORS, birth kits, impregnated mosquito nets, after-birth baby kits (blanket, soap, pillow, etc.), body soap, laundry soap, iron tablets, etc.

- Evaluate impact. Measure the effect of the intervention on: the number and type of MCH/reproductive health/child survival services being provided by target group; quality of care; cost of services.

**Intervention 3.** Promote collaborative partnerships between RACHA-sponsored family health doctors and midwives to create "one-stop-shopping" practices – or polyclinics -- for the mutual benefit of both.

Suggested tasks to be carried out under this intervention include:

- Survey demand/interest for this kind of collaboration among doctors and midwives already participating under Interventions 1. and 2. Although there is already documented interest in partnering among midwives, RACHA may have to hold an informational workshop to convince doctors of the possible benefits accruing from this partnership.
• If sufficient demand exists, hold a workshop for interested midwives and doctors to discuss how the partnership could work. For example, doctors could focus on the more clinical and curative reproductive health and child survival treatment interventions while midwives could focus on community-based health education/outreach/demand creation, and the well-baby, maternity and non-clinical reproductive health needs of clients. The workshop will also have to explain the tax implications of operating a polyclinic – something RACHA will need to explore in advance -- and any legalities needed to formalize the partnership and protect both parties. Assistance will also probably be required in helping partners work out payment schedules and a division of fees that are equitable for both parties.

• Since the operation of a polyclinic will require a higher level of business management skill, assess provider capabilities in such areas as: patient record keeping systems; contraceptive/drug inventory control; accounting; and, pricing of services. If found lacking, provide or arrange for training.

  • Evaluate impact. Measure the effect of the intervention on: the number and type of MCH/reproductive health/child survival services being provided by target group; quality of care; cost of services

**Intervention 4.** Improve skills, knowledge, and performance of commercial pharmacists and drug sellers in dispensing appropriate drugs and correct information related to MCH, reproductive health and child survival to consumers.

Suggested tasks to be carried out under this intervention include:

• Assess the interest of new country personnel at CARE in collaborating with RACHA in Pursat Province in the development and implementation of a renewed training effort aimed at pharmacists and drug sellers.

• Review and/or assess the impact of previous pharmacist training by CARE in Pursat. Develop lessons learned.

• In collaboration with CARE staff, develop a health topic agenda for pharmacist training in Pursat.

• Inventory all re-enforcing communications channels (such as commercial distribution activities, private physician prescribing patterns, local radio, etc.) for pharmacist training currently available in Pursat. Identify the potential for new effective re-enforcing channels (other NGO collaborative activities and the like) for pharmacist training.

• Assess pharmacist/drug seller interest in proposed training topics. Assess current practice and level of knowledge to form baseline measurement.

• Assess willingness/interest of commercial pharmaceutical distribution companies to support proposed training through supplementary activities of their medical representatives and their own promotional materials.

• Assess current practices of neighboring physicians. Are they supportive/not supportive of desired behavior change in pharmacists?

• Assess current practices and level of knowledge of neighboring health center workers. Are they supportive/not supportive of desired behavior change in pharmacists?

• Develop a training plan which includes multiple channels for re-enforcing messages and schedule of continuous loop contacts with pharmacists for each communications channel. Possible TA/collaboration with PATH/Thailand should be sought.

• Develop a plan for consumer education which creates consumer demand for services/products supporting or enforcing pharmacist training. Use channels of influence such as community health centers, outreach workers, promotional/entertainment events, village leaders, etc.

• Implement activities which stimulate consumer support/demand for training-inspired behavior change among pharmacists.

• Initiate implementation of multi-faceted training plan.

• Monitor impact of activities through use of pharmacy mystery shoppers and other types of operations research. Revise schedule of contacts and types of channels used to communicate and re-enforce training according to operations research results.

**Intervention 5.** Consumer education to raise demand for and re-enforce high quality MCH, reproductive health and child survival services and practices in the private sector.
Suggested tasks to be carried out under this intervention include:

- Seek/contract for assistance with PSI and/or PATH/Thailand as they have in-country expertise in this area.
- Select priority MCH/reproductive health/child survival communications points.
- Organize focus groups with target clients for message development.
- Pre-test messages for appropriateness and comprehensibility.
- Inventory local/provincial mass media channels.
- Identify available, effective channels for face-to-face supportive communications.
- Train face-to-face communications agents (such as midwives, drug sellers, TBAs, etc.).
- Develop supporting print materials for use and distribution and distribution by change agents to points-of-service/sales and consumer homes.
- Liaise with commercial distribution companies for distribution of supporting materials to pharmacists and physicians in targeted areas.
- Negotiate with commercial distribution companies for educational support from medical representatives in targeted areas.
- Evaluate/conduct research on the impact and effectiveness of different communications strategies and messages.

**Intervention 6.** Develop institutional capacity in the private sector for disseminating and enforcing quality standards and peer review.

Suggested tasks to be carried out under this intervention include:

- Explore the value (in terms of cost, interest and level of effort) of a reformed/reconstituted Cambodian Medical Association (C.M.A.), or a to-be-created Societe for Family Medicine, with key MOH policy makers at the central and provincial levels, with C.M.A. officials and with influential family practice practitioners operating in focus provinces where RACHA-sponsored private sector activities are being implemented. Make go/no go decision.

- If go, with technical assistance from the American Medical Association (or similar group) organize a forum where standards of practice and other protocols developed as part of policy activities (see Section C.1., Policy, Intervention 1.) can be discussed and formally adopted. Help develop peer review and recertification processes and mentoring programs for family practice doctors to improve quality of care.

- Explore the feasibility of organizing corporate sponsors for selected professional development activities (such as conferences, workshops, research, etc.) to expand knowledge of, and support for, high quality preventive and child survival services and technologies.

3. **Recommended interventions to increase access to selected MCH/Reproductive Health/Child Survival products through social marketing and to increase sustainable access to related messages and information at the community and household level through product sales.**

**Intervention 1.** Promote the availability and use of a safe birthing kit.

Suggested tasks to be carried out under this intervention include:

- Implement focus groups with midwives, traditional birth attendants, and mothers/grandmothers to learn perceived need for such a product and what it should include (both for safe delivery and for desired, safe ritual practices) as well as perceived value and price willing to pay.

- Develop list of proposed kit contents and project-proposed retail price.
• Discuss market feasibility (availability of contents and price) of birth kit with selected distribution companies (such as Pritsons, etc.) Ascertain availability of suitable packaging in-country and packaging costs.

• Develop list of potential sub-distributors (e.g., NGOs working in selected areas, provincial offices of the Midwives Association, etc.) needed to reach targeted market.

• Assess with possible NGO partners the feasibility of a community level educational campaign (targeted to families and to midwives/birth attendants) which supports the benefits of and promotes the use of the safe birth kit.

• Develop a business plan including sales projections and revenue projections. Include estimation of wholesaler and retailer margins, which will be possible with proposed retail price.

• Assess overall feasibility of proceeding with product development and sales on the basis of a review of the business plan with potential commercial sector partners. Go/no go decision.

- If go decision, develop marketing plan.
- Ascertain availability of funds for implementing marketing plan.
- Negotiate contract/memorandum of understanding with selected distributor(s).
- Ensure availability of packaged product.
- Launch community level education campaign.
- Launch sales, promotion, and consumer advertising.
- Monitor sales and measure impact.

**Intervention 2.** Promote increased availability/accessibility of iron tablets, particularly for nursing mothers.

Suggested tasks to be carried out under this intervention include:

• Investigate current supplies and future plans for supplies of iron tablets from MOH and INGO/donor sources.

• Project need, if any, for additional supplies of iron tablets. If need identified, proceed.

• Consult with knowledgeable health care providers as to the iron tablet formulation most desirable from the point of view of health benefits and user satisfaction.

• Conduct focus group research among potential users to learn what, if any, is their previous experience with iron tablets, satisfactions/dissatisfactions, sources of supply, prices paid, most desirable potential outlets, and the like.

• Inventory commercial importers/distributors to ascertain which if any might be interested in new or expanded distribution of iron tablets. Inventory which distributors have good access to consumers’ most preferred outlets for iron tablets. Inventory which distributors have access to project’s most desired iron tablet formulation.

• Develop list of potential sub-distributors (e.g., NGOs working in selected areas, provincial offices of the Midwives Association, etc.) needed to reach targeted market.

• Assess with possible NGO partners the feasibility of a community level educational campaign (targeted to families and to midwives/birth attendants) which supports the benefits of and promotes the use of iron tablets.

• Develop business plan including sales projections and revenue projections. Include estimation of wholesaler and retailer margins which will be possible with proposed retail price.

• Assess overall feasibility of proceeding with product development and sales on the basis of a review of the business plan with potential commercial sector partners. Go/no go decision.

- If go decision, develop marketing plan.
- Ascertain availability of funds for implementing marketing plan.
- Negotiate contract/memorandum of understanding with selected distributor(s).
- Ensure availability of packaged product.
- Launch community level education campaign.
- Launch sales, promotion, and consumer advertising.
- Monitor sales and measure impact.

**Intervention 3.** Promote the availability and provision of a lower-priced IUD by selected health care providers to eligible users.

Suggested tasks to be carried out under this intervention include:

- Discuss with PSI management what its plans are, if any, with regard to procurement and distribution of a lower-priced CuT IUD.
- If possibilities exist for effective collaboration with PSI in the procurement, promotion and sales of IUDs, proceed in planning product introduction with PSI.
- Alternatively, inventory interest among commercial sector importers in importing, promoting, and distributing a lower-priced IUD to selected health care providers.
- Explore with Famy Care (a qualified Indian manufacturer of a CuT380a IUD) the lowest possible prices available for sale of its product to a Cambodian importer/distributor. (The AID-funded SOMARC project could provide assistance to RACHA in this undertaking.)
- Inventory need for training of providers in IUD insertion techniques.
- In collaboration with the MOH, explore possibilities for public sector training of selected providers in IUD insertion techniques.
- In collaboration with selected INGOs (such as RHAC) or other organizations (such as AVSC), explore possibilities for training of selected providers in IUD insertion techniques.
- Assess availability of NGOs who could provide community level education and support (among health workers as well as potential users) for expanded IUD use.
- Assess need for STD training and treatment which might accompany expanded IUD use.
- Assess the benefits and feasibility of linking product sales to a project-developed physician/midwife network in selected geographic areas.
- Develop business plan including sales projections and revenue projections. Include estimation of wholesaler and retailer margins which will be possible with proposed retail price.
- Assess overall feasibility of proceeding with product development and sales on the basis of a review of the business plan with potential commercial sector partners. Go/no go decision.
- If go decision, develop marketing plan.
- Ascertain availability of funds for implementing marketing plan.
- Negotiate contract/memorandum of understanding with selected distributor(s).
- Ensure availability of packaged product.
- Launch provider training in insertion techniques.
- Launch community level education campaign.
- Launch sales, promotion, and consumer advertising.
- Monitor sales and measure impact.

**Intervention 4.** Expand the availability and promote the use of insecticide-impregnated hammock nets by occasional workers in targeted geographic areas.

Suggested tasks to be carried out under this intervention include:

- Pursue discussions with WHO anti-malaria staff to learn more specifically the plans for product distribution, need for other donor financial and technical assistance support in development of promotional and advertising materials, and geographic areas "available" for RACHA collaboration in WHO test market plans.

- Assess whether or not geographic areas available for RACHA participation represent commercially feasible sites. Assess cost-effectiveness/impact of possible RACHA collaboration in other technical areas of this WHO project. Explore with the NGO, Partners for Development -- which is planning to market hammock nets in Kratie Province -- their interest in collaborating with RACHA in product launch and sales in another province. Go/no go decision.

**Intervention 5.** Increase motivation for outreach workers to carry MCH/Reproductive Health/Child Survival messages (and therefore sustainability of grass roots level communications activities) through financial incentives created by sales of condoms, oral contraceptives, and/or other selected products.

Suggested tasks to be carried out under this intervention include:

- Identify strong potential NGO collaborators who are working in geographic areas of RACHA focus.

- Identify health/behavior change messages which RACHA wishes to have communicated.

- Assess with potential NGO collaborators the possibility of developing a community/household level communications campaign which includes RACHA's desired messages.

- Inventory other possible supporting/re-enforcing communications channels in the selected geographic areas (such as public health centers, sales/promotional activities of commercial distribution companies, provider networks, etc.).

- Assess "community market" for health-related products most likely to sell well when offered by outreach workers at the household level.

- Ascertain feasibility of source/affordability of selected products (such as PSI for contraceptive products) for outreach workers and their potential customers.

- Develop with potential source(s) of product supply a plan for distribution and sale to outreach workers.

- Project possible sales and revenue to outreach workers.

- Assess potential feasibility/impact of overall project with NGO and commercial sector partners. Go/no go decision.

- Develop communications plan which includes all available channels for re-enforcing messages related to the desired behavior change.

- Develop and implement communications, sales, and money management training, as needed, for outreach workers.

- Ensure availability of initial product supplies and promotional and other support materials.

- Coordinate launch of communications activities among all participating channels.

- Launch product sales.

- Monitor sales, impact of sales on outreach workers, and impact of communications/education activities on consumers.
D. Suggested Timeline (first program year)

Please see the following page.
## Appendix A

### Service Provider Program Matrices

<table>
<thead>
<tr>
<th>SERVICE PROVIDER PROGRAM MATRICES</th>
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<tbody>
<tr>
<td>Physicians</td>
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<p>| | | | |
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<table>
<thead>
<tr>
<th>A. The majority of doctors operating in public sector facilities also operate a private practice when they are off duty. In the provinces, most operate as a single practitioner - usually in a one or two room clinic facility which has been added on to their own homes. Unclear where the capital to build/add on facility comes from - but doctors are able to make the investment. Cost ranges from $6,000 (add-on to an existing dwelling) to $20,000 (land plus construction of separate facility).</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. 1. Doctors understand and appreciate the opportunity to earn extra income from operating their own private clinics. Many feel they can provide better quality, more personalize services to clients from their own practices.</td>
</tr>
<tr>
<td>B. Doctors we held in high public esteem and we usually the providers of choice among clients who can afford to pay for services.</td>
</tr>
<tr>
<td>B. 1. High demand for services, particularly among doctors with established reputations and those who specialize. Clients are willing to go into debt to obtain services.</td>
</tr>
<tr>
<td>B. I. As the private sector market evolves and more physicians open private practices, clients will benefit from more choice and more competitive service-treatment fees.</td>
</tr>
<tr>
<td>C. There is a distribution of doctors in the pubic and private sectors. Large oversupply in Phnom Penh, particularly in the public sector.</td>
</tr>
<tr>
<td>C. 1. Physicians believe best place to earn income is in capital city where more - and better off - clients live. Among established doctors there is little incentive to move to provinces unless it is to a high paying job in an NGO hospital.</td>
</tr>
<tr>
<td>C. I. Younger, less experienced doctors struggling to establish a client base may be more willing to move to, or stay in, provinces if they see financial opportunities. As the economy improves, this may happen naturally, but some other incentives (easier access to credit, additional training, free equipment, materials, etc.) may also be necessary.</td>
</tr>
<tr>
<td>D. Doctors choose not to work full-time in the private sector.</td>
</tr>
<tr>
<td>D. 1. Perceived loss of credibility and prestige.</td>
</tr>
<tr>
<td>D. I. Establish certification process so that competence of doctor is known and guaranteed, whether in public or private sector. Explore the value of establishing private sector forums (such as a Societe for Family Health) where doctors can network and share expertise and research in MCH/RH</td>
</tr>
<tr>
<td>D.2. Loss of revenue from taxes and other &quot;levies&quot; from which pan-time public practitioners are exempt. Other onerous business</td>
</tr>
</tbody>
</table>
| D.2. Rough income calculations based on figures gathered can well established, average to above average client load
<table>
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<tr>
<th></th>
<th>Registration procedures and administrative duties may also be imposed if full-time. Anecdotal information that security of government pension for doctor (and family? may be important.</th>
<th>Practices in Siem Reap indicate that doctors earning relatively high pre-tax incomes from their private practices, so protection from onerous taxes and other levies is important. The government has expressed interest in creating a more business-friendly climate by reducing taxes and administrative burden on businesses (Cambodian DaitN, 30/04/98) Actual government actions flowing from this unclear situation is in flux. Need for the security of a government pension on will diminish over time as the doctor's ability to earn an income protected from onerous levies grows, and s/he is able to save.</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.3.</td>
<td>Loss of access to interesting/complex patient cases. Particularly important to highly experienced doctors who specialize.</td>
<td>D.3. Doctors will need to maintain staff privileges with Provincial Hospitals, but – over time – may be able to shift to private hospitals as they were opened.</td>
</tr>
<tr>
<td>DA.</td>
<td>Loss of access to personal and professional development opportunities such as technology updates, seminars, overseas travel.</td>
<td>DA. There is no immediate solution to this. Ideally, the Cambodian Medical Association should be the private sector-based venue providing these services to members. Currently, the organization is underfunded, highly political and has a mandate/constitution that does not attract many potential members. Only 760 out of 2000 doctors have joined.</td>
</tr>
<tr>
<td>D.5.</td>
<td>Loss of access to new clients for private sector practice. This is of particular concern to new, less experienced doctors with small client loads (the &quot;hungry&quot; doctor).</td>
<td>D.5. Focusing on the hungry doctor, need to provide new opportunities to generate new clients in the private sector with clinical skills training/updating to expand services/increase quality and marketing assistance.</td>
</tr>
<tr>
<td>E.</td>
<td>Doctors are not interested in providing a wide range of preventive services.</td>
<td>E. I. The provision of preventive services is not lucrative. This is exacerbated in countries like Cambodia where doctor consultation fees we very low and revenue is generated by prescribing/dispensing drugs, E. I.a. Only the &quot;hungry&quot; doctors may be interested in adding/promoting preventive and child survival services to attract new clients Preventive/child survival services that doctors may be interested in include higher margin produces and services such as ARI treatment, STD diagnosis and treatment, malaria</td>
</tr>
</tbody>
</table>
and TB treatment and prevention. IUD insertions. and selective service "packages" such as combining ante-
and postnatal services with birth spacing As a first step, research must be conducted among this target group of
physicians in one or more focus provinces to ascertain level of interest,
the relative competence and quality of the provider, and the kinds of
preventive/child survival services they would be interested in offering

<table>
<thead>
<tr>
<th>F. Doctors lack strong skills in the area of preventive medicine and child survival.</th>
<th>F. I. See section D. -little financial incentive to promote prevention. Also, some doctors prefer to work only with adults.</th>
</tr>
</thead>
<tbody>
<tr>
<td>G. Public lacks information on the importance of preventive/child survival services, and does not seek/demand these services from doctors, reinforcing observations D. and F. Results high reliance on abortion; high incidence of maternal and child deaths from too many pregnancies add preventable illnesses; a preference for drugs to treat equate quality service provision - diarrhea rather than DRS. Public also lacks information on what to expect/demand from doctors regarding service and treatment options and quality; how to recognize illness; and when to seek treatment.</td>
<td></td>
</tr>
<tr>
<td>G. I. Lack of public health education in schools, mass media, and in the public and private health sector to educate consumer in the importance of prevention ad contraceptive option for birth spacing. There is a traditional of self-medication and and under regulated pharmaceutical industry which makes this easy. Consumers also equate quality service provision as getting their money's worth if the doctor provides injection/medication with treatment-whether they are appropriate or not.</td>
<td></td>
</tr>
<tr>
<td>G. 1. Develop public health education campaigns which target products and services being expanded/strengthened in the target private sector focus province(s) to increase demand for these services. Publicize consumer rights and quality standards so that clients know what to expect (see section H.). Develop and advertise a logo that tells the consumer which doctor has been trained to provide high quality preventive/child survival services.</td>
<td></td>
</tr>
<tr>
<td>H. Doctors are driven by consumer demand in that they recognize the need to build trust confidence and client loyalty. That trust is easily eroded if the doctor cannot readily diagnose and treat the illness- The consumer sees a referral to a specialist or the provincial hospital for a complicated case as a sign of the doctor's incompetence.</td>
<td></td>
</tr>
<tr>
<td>H. 1. The basis of this perception is unclear. Available research (see van de Put/MSF study) and anecdotal evidence indicates that it probably related to the consumer's need for a quick recovery at the lowest possible cost. Costs of transport are high and even a trip to the public provincial hospital will involve considerable out of pocket expenses to &quot;top-off&quot; a doctor's fee to insure good service.</td>
<td></td>
</tr>
<tr>
<td>H.I. Indicates possible market for joint practices or doctor/midwife polyclinics.</td>
<td></td>
</tr>
</tbody>
</table>

E. I.b. Promote collaborative partnerships between midwives and the target doctors to create "one stop shopping" practices polyclinics -- for the mutual benefit of both providers. Doctors can focus on the more clinical and curative treatment interventions while midwives can focus on community-based health education/demand creation and the well baby and maternity needs of clients.
<table>
<thead>
<tr>
<th>1. There is a large variation in service quality between private practices.</th>
<th>1. 1. Quality standards and protocols have not been developed for the private sector.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Provide technical assistance to the MOH to develop practice standards and protocols. Involve key non-Ministry participants from private/commercial sector and NGO community in the process. Begin the development of channels to disseminate standards and protocols in the private sector. Organize consensus-building workshops relevant public-private partnerships.</td>
<td>1.2. Even if there were such quality standards, there is no enforcement mechanisms in place.</td>
</tr>
<tr>
<td>1.2. Provide T.A. to MOH to develop oversight capability in the public sector through licensing/relicensing and other procedures. Explore the development of channels to disseminate standards and protocols and peer review in the private sector (e.g., through a reformed/reconstituted C.M.A. or other institution such as a Societe for Family Medicine).</td>
<td>1.3. Doctors lack quality assurance skills.</td>
</tr>
<tr>
<td>1.3.a. Provide QA/QC training to target provider group.</td>
<td>1.3.b. Establish mentoring program between senior physicians trained in quality improvements and assurance and target doctors. Pay them to provide oversight and supervision for the target group.</td>
</tr>
<tr>
<td>1.3.c. Publicize quality standards so that consumers know what to expect from their provider.</td>
<td>J. Business and marketing skills</td>
</tr>
</tbody>
</table>
are week. according to what they think the market will bear, not on the actual costs of service provision. Will overcharge some clients undercharge others. Will subsidize low consultation fees by over prescribing ad overcharging on drugs. Anecdotal information that patient record keeping system are weak.

ensure that practices are organized effectively to cut unnecessary costs, ad fee are set according to the cost of doing business. Consumers education also need to ensure quality service delivery.

<table>
<thead>
<tr>
<th>OBSERVATIONS</th>
<th>SYMPTOMS/CAUSES</th>
<th>RESPONSE/OPPORTUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A. Midwives have a narrow view of what kinds of services they should be providing
   A.1. Lack of awareness and education on the importance of providing a range of integrated services.
   A.1. Hold workshops to introduce/inform midwives about opportunities from integrated service provision. Survey to ascertain level of interest.
   A.2. Lack of understanding of how providing a range of integrated services can expand client base.
   A.2. Ditto

B. Low demand for named midwifery services, particularly outside Phnom Penh and the main provincial cities.
   B.1. Midwives lack credibility in the community. Often young and inexperienced with limited skills. Ingrained tradition of using TBAs. The "ritual" involved with giving birth is important to clients.
   B.1. Need for refresher training to upgrade and expand skills (consider adding "ritual" to curriculum). Enhance role of midwives in child survival. Give basic obstetric/child survival equipment. including a scale for weighing mothers and children. Develop simple drug counseling manual for midwife use to enhance skills and credibility with clients. Consider providing transport so that the midwife is more accessible to clients. Add products for sale such as new baby kits, birthing kits, OCs, cheaper IUDs, ORS.
   B.2. Midwifery practices are "invisible"; cannot ban - sign in front of practice. Little proactive effort to build client base; midwife relies on word-of-mouth referrals.
   B.2. Need to build credibility in the community by providing good quality services people value. Build client base with proactive interaction with potential clients through house-to-house visits, other marketing strategies.

C. Quality of service varies between midwives.
   C.1. Practice standards and protocols have not been developed. No public sector oversight capability.
   C.1. TA to MOH to develop standards and protocols.
   C.2. Although Midwives Association is active and committed, NGO is not organized to enforce standards/police members
   C.2. Develop capacity of Midwives Association as oversight body. Encourage mentoring as a teaching tool.

D. Midwives have low status in health sector system. Restrictive laws reinforce this.
   D.1. Midwives cannot operate private clinic without a doc as a partner. Midwives must pay does to use their name but most cannot afford this. Will refer complicated owes to these docs or public sector.
   D.1. Organize consensus-building workshops between public health policy makers and midwives on their status and potential role. Promote collaboration/referral network with docs. Sensitize docs on role/importance of midwives.

E. Business and management skills low.
   E.1. Passive; not entrepreneurial. Ad hoc pricing based on what they think, market can bear.
   E.1. Provide business management and marketing training. Particularly for midwives who will operate as outreach workers and sell products.
<table>
<thead>
<tr>
<th>A. Maldistribution (or undersupply) of trained/licensed</th>
<th>Demand for easy access to drug suppliers (due recasts to impaired access to other health care Providers)</th>
<th>Improved access to affordable other care such as odw4ves with treatment handbook etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of regulations and/or capabilities</td>
<td>Technical assistance development of rational regulatory systems and laws</td>
</tr>
<tr>
<td></td>
<td>Cost of establishing a Cost of outlet I</td>
<td>Policy workshops to, influential cod other regulators</td>
</tr>
<tr>
<td>B. Over/mal prescription of drugs</td>
<td>Lack of knowledge inadequate training in identified MCH/RH treatments/interventions</td>
<td>Improved pharmacy school curricula including professional ethics</td>
</tr>
<tr>
<td></td>
<td>Desire to increase sales and profitability</td>
<td>Opportunistic multi-channel 'in-service' training, product education</td>
</tr>
<tr>
<td></td>
<td>Uneducated consumers</td>
<td>Consumer education: consumer rights, &quot;are you being ripped off?&quot;</td>
</tr>
<tr>
<td>C. inconsistent availability and/or shallow stock of targeted products in marketplace</td>
<td>Limited consumer demand for acceptance</td>
<td>Product advertising to consumers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IEC to consumers on appropriate treatments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alternative outlets (door to door and/or non-medical sources)</td>
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<td>D). Pharmacies are sources of product for some drug sellers, MDs, TEAS, midwives</td>
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<td></td>
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<td>Formal distribution stops at level of larger pharmacies on national roads</td>
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<td></td>
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<td>Test motivations which 411 encourage pharmacists to act as extension, of medical representatives in transmitting product IEC to lower level retailers</td>
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<tr>
<td></td>
<td></td>
<td>Purchasing decisions based largely on price</td>
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<tr>
<td>D). Pharmacies are sources of product for some drug sellers, MDs, TEAS, midwives</td>
<td></td>
<td>Support development and implementation of I quality standards and testing of imported and locally produced drug</td>
</tr>
<tr>
<td>E. Possibly lower quality products enjoy &quot;wide&quot; distribution</td>
<td></td>
<td>Consumer education</td>
</tr>
</tbody>
</table>
### 2. Manufacturers and Distributors

<table>
<thead>
<tr>
<th>A. Measurable increases in market penetration: branch offices, regular routes into provinces</th>
<th>developing competition seen in distribution promotional/sales &quot;push&quot; efforts</th>
<th>Availability potential collaborative channel's for regular distribution to sub-distributors such as provincial and district level NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Provision a-product information and materials to providers and pharmacies</td>
<td>Increasing competition for market share and market position</td>
<td>Availability of toted I collaborative channels for IEC and training of providers and pharmacy workers</td>
</tr>
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<td></td>
<td></td>
<td>Potential for manufacturer-sponsored health care seminars</td>
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<td></td>
<td></td>
<td>Potential for corporate sponsorships our selected professional societies like a Societe for Family Medicine</td>
</tr>
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<td>Potential for interest in new product introductions such as Indian-made CuT380a IUD</td>
</tr>
<tr>
<td>C. Development of MIS in commercial sector</td>
<td>Increasing competition to serve accounts effectively</td>
<td>Availability of more sources of data for monitoring and research</td>
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<td></td>
<td></td>
<td>Potential for contracting with PSI to use its retail audits to track other products presence in the marketplace</td>
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### NGOs

<table>
<thead>
<tr>
<th>OBSERVATIONS</th>
<th>SYMPTOMS/CAUSES</th>
<th>RESPONSE/SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGOs have weak infrastructure</td>
<td>NGOs have not been in existence more than 3 years- early stage of skill development</td>
<td>Strengthen systems as part of partnership/ support</td>
</tr>
<tr>
<td>Lack of cooperation and/or collaboration in NGO community or with government</td>
<td>Lack of regulation or coordination body in NGO or public sector</td>
<td>Support development of coordination body; Support government regulation of health care provision; Facilitate NGO responsiveness to government initiatives; Facilitate inter-NGO collaboration and/or public-private partnerships.</td>
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<tr>
<td>NGOs growing rapidly</td>
<td>High demand from donors and INGOs for NGO partners</td>
<td>Build on existing NGO programs; Integrate infrastructure support with program implementation plans; Phase in programs at a pace that is appropriate to the capacity of NGOs; Support evaluation of existing NGO programs—know what they do well before starting something new.</td>
</tr>
<tr>
<td>No national NGOs</td>
<td>Young organizations; Staff hired locally and require significant training; Phnom Penh staff hesitant to travel or work in remoter areas; Funded activities more often 'project-based' rather than focussed on building core competency in NGO.</td>
<td>Identify NGOs interested in working in other provinces or districts rather and replicate programs; Explore possibility of large NGOs playing intermediary role with grass roots organizations,</td>
</tr>
<tr>
<td>NGOs缺乏理解 between NGOs and donor community documented (PACT/JSI)</td>
<td>Only recent exposure to donor community; Multiple agencies with diverse proposal and institutional requirements;</td>
<td>Present clear guidelines to accounting practises, proposal needs, etc., Work collaboratively with NGOs other expatriate partners,</td>
</tr>
</tbody>
</table>
APPENDIX B

Overview of the Private Pharmaceutical Sector
OVERVIEW OF THE PRIVATE PHARMACEUTICAL SECTOR IN CAMBODIA

Retail Outlets. There are many retail outlets in which drugs are sold in Cambodia. Some are classified as legal pharmacies (because the license of the required type health care provider is posted in the store); others are classified as illegal pharmacies (because there is no posted license). Legal pharmacies are themselves divided into three groups: pharmacies, sub-pharmacies A, and sub-pharmacies B. Sub-pharmacies are differentiated from pharmacies according to the class of health care provider who operates the drug store. A licensed pharmacist is supposed to operate a pharmacy. Sub-pharmacies A must be operated by a medic/medical assistant and sub-pharmacies B by a nurse or midwife. Sub-pharmacies A and B can be operated in locations where the number of licensed pharmacies and sub-pharmacies does not meet the desired ratio of outlets to population set by the Ministry of Health.

To obtain a license, a pharmacist must have completed a three-year course in a recognized school of pharmacy (There is one such school currently in Cambodia: the University's Mixed Faculty of Medicine and Pharmacy.) and have registered him/herself with the appropriate bureau in the Ministry of Health, Department of Drugs and Food. Reportedly, no licensing fee is charged.

While the regulatory process for acquiring a pharmacist's license seems neither unduly difficult nor expensive, the investment required (cost of building space and initial stock of drugs) to open a pharmacy is beyond the reach of many licensed pharmacists. Where the pharmacy owner leases or purchases land in a provincial or national capital, builds his/her own pharmacy, equips the store, and stocks it with product, the cost may be as high as US$ 50,000, according to one source. One informant estimated that a relatively large pharmacy, well located in an urban area, might generate turnover of US$ 10,000/month with net profit of US$ 2-3,000/month. The owner of a small pharmacy shop near a hospital in a provincial capital estimated the value of her current stock at approximately US$ 7,000.

This information is somewhat at variance with the report of a 1997 WHO-funded survey of the commercial health sector in which 830 of a total of twelve legal pharmacies surveyed in Battambang and Phnom Penh reported daily sales of less than $100. One pharmacy surveyed estimated daily sales of $200-400, and another estimated daily sales at over $400. Of the twelve pharmacies surveyed, one estimated the value of current stock at less than $1000, five at $1000-2000, three at $2000-4000, and three at $5000-10000.

To realize some financial return on the investment of an education in pharmacy, some licensed pharmacists unable to afford the costs of opening a pharmacy are reported to, "sell" or "lease" their licenses to non-pharmacists. These untrained but financially more advantaged individuals are then able to open a "legal" pharmacy for business. Monthly payments to the pharmacist whose license is used may range from $100 in the provinces to $200 in Phnom Penh, according to some informants. The 1997 WHO-funded survey cited above also reports that of the twelve legal pharmacies surveyed in Phnom Penh and
Battambang, eleven had a qualified pharmacist. Eight of these pharmacists claimed to visit their pharmacy more than five times a month, while three visited five or fewer times per month. The RACHA private sector team, however, did not encounter a licensed pharmacist on duty at any of the pharmacies or drug shops which it visited.

Especially in urban areas where some regulatory monitoring occurs, business licenses are also displayed in pharmacies. These business licenses (or patents) are issued by the provincial (or capital city) tax department and cost approximately US$ 100-200/year in Phnom Penh and US$ 50100/year in the provinces. The amount charged for renewal of a business license can change from year to year and depends on the sales generated by the business and the tax revenue needs of the national budget.

The team also visited pharmacies which were operated under the license of a physician and a registered nurse. The certified nurse was being paid $50/month for the use of his license to operate the pharmacy in a provincial capital. In several cases, individuals operating pharmacies visited were themselves a midwife, a medical assistant, or a physician.

Less "conscientious" or in many cases smaller, more rural untrained/unlicensed drug sellers make no pretence of displaying a pharmacy license but simply open a shop and stock it to the extent financially feasible with pharmaceutical products. Small, rural drug sellers often combine sales of other types of consumer goods -- such as soft drinks, rubber sandals, plastic housewares, and the like -- with their sales of pharmaceutical products.

The Ministry of Health has made efforts during the past year to close illegal pharmacies in some areas. Licensed pharmacists and the Pharmacists Association have lobbied for the Ministry to increase its enforcement efforts in this regard. (Both ethical and financial concerns motivate licensed pharmacists to seek government action.) In reality, however, when police have moved into market areas and closed down pharmacy shops which displayed no license, shop owners have simply reopened for business within a few days in another nearby location.

In addition to pharmacies/drug shops, there are many individuals who act as retail outlets of pharmaceuticals. These drug traders may operate as "suitcase importers" of products from Thailand, for example; may purchase products from importers or smugglers of pharmaceutical goods; or may buy drugs from other retail outlets. These individuals are often found in market areas throughout the country and can be seen selling their stocks from bags. Some travel on bicycles or in cars, and a few appear to have sales areas or routes on which they call at certain intervals.

Since physicians in Cambodia frequently dispense medicines directly to their clients as part of their consultation/treatment practice, physicians must also be considered retail outlets for pharmaceutical products.

Availability of and Access to Pharmaceutical Outlets. Distribution of licensed pharmacies and sub-pharmacies throughout the country is shown in the following table:
The overwhelming number of pharmacies in Phnom Penh compared to the number in the rest of the country is born out by distributors’ estimates of the geographic distribution of their dollar sales. One national distributor estimated that sales in Phnom Penh represent at least half of his total business.

The existence of many more pharmaceutical outlets than those included in the list of licensed outlets above is demonstrated by the number of regular accounts currently serviced by a variety of pharmaceutical distributors and sub-distributors. For example, one national distribution company based in Phnom Penh estimates that it services 800 to 900 pharmacy accounts regularly; another estimates its regular pharmacy accounts at 800 to 1000. A provincial distributor in Siem Reap province estimates he serves approximately 85 accounts in the province, and another estimates a total of 100 core and casual customers. The medical representative of one national distribution company reported that

<table>
<thead>
<tr>
<th>Province</th>
<th>Pharmacies</th>
<th>Subpharmacy A</th>
<th>Subpharmacy B</th>
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<tbody>
<tr>
<td>Phnom Penh</td>
<td>163</td>
<td>61</td>
<td>70</td>
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<tr>
<td>Kandal</td>
<td>8</td>
<td>10</td>
<td>26</td>
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<tr>
<td>Pursat</td>
<td>3</td>
<td>1</td>
<td>16</td>
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<tr>
<td>Battambang</td>
<td>11</td>
<td>7</td>
<td>23</td>
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<tr>
<td>Koh Kong</td>
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<td>5</td>
<td>3</td>
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<tr>
<td>Kompong</td>
<td>6</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Mondul Kiri</td>
<td>0</td>
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<td>1</td>
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<tr>
<td>Kompong Thom</td>
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<td>TOTAL</td>
<td>261</td>
<td>145</td>
<td>323</td>
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<td>Takeo</td>
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<td>5</td>
<td>36</td>
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<tr>
<td>Kompong Cham</td>
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<td>36</td>
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<tr>
<td>Banteay Meanchev l</td>
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<td>23</td>
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<tr>
<td>Kra Tie</td>
<td>3</td>
<td>4</td>
<td>12</td>
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<tr>
<td>Preah Vihear.</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Prey Veng</td>
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<td>4</td>
<td>8</td>
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<tr>
<td>Svay Reang</td>
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<td>Steung Treng</td>
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<tr>
<td>Kompong Speu</td>
<td>4</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Preah Sihanouk</td>
<td>9</td>
<td>9</td>
<td>10</td>
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he regularly calls on 15 to 16 pharmacies in Kompot and that these are "only the larger ones."

Officers of the Pharmacy Association estimated for the team that in Phnom Penh there are 200 legal and 500 illegal pharmacies and that there are approximately 1000 illegal pharmacies nationwide.

The assessment team did not find any village it visited in four provinces (Siem Reap, Kompot, Kompong Chnang, Pursat) without at least one seller of drugs. At the small village level, the drug sellers were unlicensed and without training. These village stalls often offer for sale other, unrelated consumer goods such as rubber sandals and soft drinks as well as drugs.

Village drug sellers have a limited stock of pharmaceutical products on hand due to 1) their limited financial ability to buy a broader stock of goods and 2) the limited size and access to cash of their village market. Demand for a type of product, that is, relative volume of sales, appears to determine the products stocked. Goods stocked at the village level are those most likely to be requested such as antibiotics, pain and fever relievers, vitamins, and cough/cold preparations. Primary "competition" for these village drug sellers appears to be traditional medicines/ healers and the local health center where drugs for first-tier treatment of a limited number of illnesses are available with the payment of a 500-riel consultation fee.

Access to broader stocks of pharmaceutical products and to drug sellers with possible access to any product information which comes from formal pharmaceutical distributors appears to begin at the srok level (larger than a village, smaller than a commune) especially where the srok-level drug seller is located on a national road. Some of the larger drug sellers in these market areas function as the sources of supply for village drug sellers' stocks.

Availability and Pricing of Pharmaceutical Products in the Commercial Sector. From a casual review of pharmacy stocks and distributor price/order lists, it is hard to imagine that many types of drugs are not available in some form from some source in Cambodia. Consistency of a selected product's availability in a given location and/or depth of stock at a given outlet can, however, vary greatly.

Consumer demand for a product, i.e. expected turnover, is a primary consideration in the purchasing and stocking habits of pharmaceutical retailers and is therefore a primary operating factor in product availability at the retail level. Income and/or cash flow is sufficiently important to the trade that retailers do not wish to tie up capital for long periods of time in products which do not sell regularly. Products related to the preventive health behaviors supported by RACHA -- such as contraceptives, oral rehydration salts, iron tablets, and the like -- do not currently enjoy great consumer demand and are, therefore, less likely to be regularly or commonly stocked throughout the retail pharmacy system than more popular curative medicines such as antibiotics.

A variety of sources, including distributors and pharmacy operators themselves, reported to the team that many pharmacy owners do not purchase drugs that are new to the pharmacy operator to "prescribe" them to their customers. Pharmacists often rely on older drugs whose effects and indications for use they have had experience with over the years. Similarly, pharmacy owners reportedly do not purchase new or higher priced drugs for their stocks until they see evidence of physician prescriptions -- and therefore consumer demand -- for the product. Pharmacy owners are more likely, distributors say, to try a new lower-priced drug on "speculation" because the financial risk of stocking a lower-priced product for which consumer demand is not yet demonstrated is lower.

The continuing place of informally (unregistered or illegal) imported pharmaceutical products in the supply/distribution system in Cambodia additionally contributes to the
inconsistent availability of some brands/products in the market. Also, while formal (or registered) importers of pharmaceuticals are now increasingly likely to use branch offices in the provinces and/or traveling vans to facilitate regular delivery and sales of products outside Phnom Penh, some retailers continue to wait until they visit Phnom Penh themselves or "until the truck comes" (rather than calling in an order for interim delivery) to restock supplies. Such retailer practices can also lead to stock outages.

The team did not find in its limited number of site visits a pharmacy/drug seller without any type of contraceptive product except for one or two of the village level drug sellers. Especially in the case of the rural village drug sellers, however, the contraceptive almost always available was the "Chinese once-a-month pill." Village drug sellers reported that the Chinese pill is "very popular." The "Thai pill" (apparently a 28-day combined dose oral contraceptive), Regevidon (a low-dose, combined oral contraceptive) manufactured by Gedeon Richter, and Blue Lady Microgynon by Schering AG (apparently from public sector or other donated stocks) were seen in some of the pharmacy shops above the village level. The OK brand oral contraceptive marketed by PSI was seen in all the pharmacies visited in Kompong Chnang Town and in many of the pharmacies visited in Siem Reap Town.

DepoProvera was seen in one large pharmacy in Kampot. Even in pharmacies in Siem Reap province which did not carry DepoProvera, pharmacy operators sometimes reported that oral contraceptives do not sell strongly because women "prefer the injection."

Condoms seem to be widely available throughout all types of drug stores. PSI's Number One brand condom was the brand most frequently seen by team members.

Pharmacy operators who had heard of oral rehydration therapy had most often heard of Oralite, and a number of drug sellers reported having sold it in the past or currently stocking it. Oralite is originally available in Cambodia through donations to the public sector. Retail supplies of Oralite, therefore, appear to represent "leakage" from public sector supplies. One pharmacy owner remarked that he had been taught about oral rehydration therapy and that he knew that ORS products like Oralite are effective and "work." But, he said, "the people do not believe in it, so I don't sell it." Drug sellers and physicians interviewed in Kompot mentioned that ORS does not sell well because children do not like the taste and refuse to drink it. At least one pharmacy in Kompot carries Pharolit, an orange flavored ORS brand manufactured in Indonesia and priced at 200r/package. This product was also found by the team in Phnom Penh pharmacies. It is distributed by Khunaco. Virtually all drug sellers stocked antibiotics and/or Imodium-type products for treatment of diarrheal disease.

Pharmacy operators/drug sellers who had heard of or who, stocked iron tablets seemed most often to lump this product together with vitamins in general in their discussions with the team. Vitamins appear to be very popular among Cambodian consumers -- especially among "people who come from the farms," according to several retailers. Strong consumer demand for vitamins is also seen in urban areas, however. For several pharmacy operators visited, vitamins represent as large a share of sales as antibiotics.

Interestingly, one national pharmaceutical importer/ distributor indicated that his company's lack of interest in importing and distributing iron tablets was due to UNICEF's donation of free product into the country. He believes that the widespread availability of free iron tablets has eliminated the possibility of a profitable commercial market for this product. He does, however, import plastic ampules of a "drinkable" iron supplement; but this product is more expensive and not a significant seller.
The prices of all types of drugs at the retail pharmacy level appear to be governed primarily by the wholesale prices. Margins enjoyed by pharmacy owners are remarkably small – often reported, at least in Siem Reap who also acts as a provincial distributor to other retail outlets reports that he is operating with gross margins of only 5% out of which he must pay transportation costs (about 2%) to his provincial location for product which he purchases from importers in Phnom Penh. Some retailers, however, are said to inflate their margins/profitability by substituting "cheap" drugs from Thailand and Vietnam for French drugs and selling them at French drug prices.

A major pharmaceutical distributor located in Phnom Penh reported that competition. In the Cambodian pharmaceutical market is `Fierce" and that he sometimes has had to sell products at a loss just to be able to recover a part of his investment. This distributor believes that due to intense price competition 10% is the maximum mark-up any importer is able to place on products sold to wholesalers. He further stated that retailers set their prices to the consumer based on the competitive positioning of other retailers around them.

Distributors and wholesalers report that they give discounts only on the basis of volume purchased. No free goods, bonus products, or other such promotional techniques are used by distributors to encourage sales. (Product samples for physicians, however, are considered quite important by some distributors in generating prescriptions of new products.)

Pharmacy owners who report that they sometimes go into Phnom Penh to buy products for re-sale say that they do not obtain a lower price for the same product/brand from the wholesaler or distributor in Phnom Penh than they do from the distribution company vans which travel regular sales routes to their area. In fact, prices of products direct from the importer/distributor are customarily lower than the prices of the same products purchased from wholesalers. Similarly, the greater the number of rungs in the distribution chain through which a product has traveled before reaching the end-user, the higher its retail price is likely to be. For example, one tablet of the Chinese once-a-month pill costs 500r in the stall of a small village drug seller. The same product sells for 300r at a pharmacy shop about 7 km away on a national road.

Some variation in price which is seen: from outlet to outlet for the same brand of product is attributed to product distribution companies' exquisite sensitivity to changes in the value of the riel. Local prices are reportedly changed as soon as there is any increase in the rate of exchange with the dollar. Product already on retail shelves may, therefore, have a somewhat different (lower) price from the same brand sold to retailers only a week later.

At virtually all levels of the pharmaceutical distribution chain, buying decision appears to be based primarily on price. European, especially French, and other developed country drugs are often regarded as superior in quality to other available products; but higher prices limit their purchase. Competition among retail outlets, among wholesaler, and among importers/distributors for market share in a setting where price is the deciding factor keeps many prices as low as import prices allow. Sales of drugs by physicians to their clients appear to be an exception to this general rule, however, and are further discussed below.

Lower-priced drugs in the Cambodian market seem to come primarily from such countries as Thailand, South Korea, Vietnam, and India. There is considerable concern among public health regulatory agencies that the lower priced drugs coming into the market are also of lower or unreliable quality. There does not now appear to exist a regulatory mechanism for regular quality testing of imported pharmaceutical products.
Indian manufacturers are so competitive with each other on the basis of price that at least one major importer/distributor has ceased purchase of Indian products. The local manager for this company explained that in the eyes of his customers, "An Indian amoxycillin is an Indian amoxycillin: " in regardless of the reputation or quality of the manufacturer. Consequently, when an Indian manufacturer offers a distributor one price for such a product one week and a second Indian manufacturer seeking to undercut the first manufacturer's Cambodian business offers a lower price to another distributor the following week, a great deal of dissatisfaction with the first distributor (whose price was higher) develops among his Cambodian customers. The distributor has been unable, in other words, to establish a competitive position with his customers because of the relative instability of Indian product prices.

Many Cambodian physicians dispense pharmaceuticals to their clients as a part of their treatment practice. Physicians may also be considered, therefore, retail pharmaceutical outlets. Distribution companies give discounts on their prices only on the basis of volume purchased. Physicians do not sell products in the same volume as pharmacy operators, so physicians do not receive as great a discount on product prices from distributors as do pharmacy owners. Distribution companies estimated their direct sales to physicians and private clinics variously from as little as 3% of total sales to as much as 30%.

When the physicians buy drugs from pharmacy operators (retail) rather than from distributors (wholesale), pharmacy owners may give them a small discount (perhaps 3-5% on the retail price).

Physicians frequently resell drug to their clients as part of a flat fee for "consultation with medicine." Since the flat fee does not vary, the more cheaply the physician can obtain the drugs which she/he will dispense under this fee, the greater his/her profit from dispensing will be. Some pharmacy owners and distribution agents report that physicians "prefer" Indian drugs, which are often the cheapest brands of a given pharmaceutical formulation available in the marketplace. The team has estimated that at least in some physician practices the dispensing/sale of drugs may account for as much as 45% of the physician. Provider's net income. (See Table) The use of the flat fee for a consultation with medicines dispensed by the practitioner serves greatly to inflate the cost of medicines for the end-user.

Retail prices of selected pharmaceutical products seen by the team during its pharmacy/drug shop visits are listed below:

- Amoxycillin (French)/10 tabs
  - 3000r
- Amoxycillin (Indian)/10 tabs
  - 1000r
- Ampycillin/tab
  - 120r
  - 200r
  - 250r
  - 320r
- Antibiotic(bactrim, comoxa, ercefuryl)/tab
  - 300r(Thai)-1100r(French)
- Augmente (French)/12 tabs
  - $9.00
  - $8.50
- Number One condom/pkg of 4
  - 500r
- Chinese once-a-month contraceptive pill/tablet
  - 300r
  - 500r
Technical Competence of Pharmacists. The team's experience that Pharmacists are not often available in drug selling outlets is supported by many informants and previous reports. A 1997 UNICEF-funded baseline assessment of pharmacy practices related to treatment of diarrheal disease and acute respiratory infection concluded that pharmacists are not actively involved in drugstores. The majority of pharmacies included in the UNICEF survey were family enterprises where owners were the primary drug sellers; and shop clerks, domestic help, or other family members were secondary sellers. In an undated report "Pharmaceutical Distribution Assessment," shared with the team by UNICEF personnel, however, it is reported that of 25 pharmacies surveyed in Phnom Penh, eleven had a pharmacist present in the pharmacy at the time of that survey.

While pharmacy personnel in the UNICEF-funded baseline survey demonstrate to the researchers "adequate" knowledge of causes and risks of diarrheal disease and ARI, their knowledge of proper treatments and the risk of improper drug treatment was "inadequate." The undated report "Pharmaceutical Distribution Assessment," cited above, states that of 14 non pharmacists in charge of a pharmacy during that survey only one had received any training. "The most common source of knowledge/experience," the report continues, "was learning on the job and matching prescriptions with labels on bottle." This report finding is supported by the team's interview with a village drug seller who explained that it was her experience as a drug seller – that is, her customers' satisfaction with the efficacy of the drug/treatments she had "prescribed" – over the past several years which had taught her what drugs or prescriptions to recommend for various symptoms.

Pharmaceutical distribution company managers stated in several interviews with team members that pharmacists and pharmacy operators in Cambodia are not well informed about newer drug technologies and correct or current treatment practices. These companies are beginning to try to
educate pharmacy operators as well as physicians in improved treatment protocols, in improved
diagnosis of certain diseases/syndromes, and in current product/drug information. This education
is provided through the efforts of distribution company medical representatives who call on
pharmacies and physicians with the primary purpose of promoting sales/prescriptions of the
company's products. Instructive as well as promotional wall charts, leaflets, and the like are being
provided by international manufacturers to their Cambodian distribution agents who in turn place
these materials with pharmacy operators and physicians. Several suppliers are translating these
materials into Khmer before providing them to their customers.

Recognizing the general lack of training and technical competence of many operators of
pharmacies and other drug outlets, several INGOs and at least one LNGO have initiated training
interventions targeted to this group. CARE has sponsored training of drug sellers in Pursat
province where it has a continuing organizational presence. Contraceptive technology, client
counseling for birth spacing, and proper drug storage were the main topics covered. In general, the
drug sellers seemed eager to receive training. They received no payment for attending the training
course, and attendance was almost 100%. It was found, however, that the drug sellers use their
training selectively; they appear not to turn away customers on the basis of a contra-indication or
possible side effect even after training.

UNICEF and PATH are completing a two-year pilot project in the slum areas of Phnom Penh in
which among other activities 340 legal drug sellers have received training in appropriate
treatments for diarrheal disease and acute respiratory infections. Two drug sellers (usually the
owner to gain his acceptance of the training and one counter worker to reach the person with client
interaction) from each selected outlet were trained. Training for each group of pharmacy worker
was implemented over 2 ½-day period and covered three topics: technical and syndromic
information, communication skills, and attitude. This training is supported by community outreach
among mothers and an upcoming mass media public education campaign. Three follow-up surveys
to track the continuing availability of trained personnel in the targeted outlets have been planned.

PSI, as part of its contraceptive social marketing project, provides two-day training sessions for
drug sellers in contraceptive technologies. Special attention is being given to ensuring that drug
sellers who will have access to the OK brand oral contraceptive learn correct use and side effect
information. Retailers' transfer of this information to customers is not yet measured.

The Cambodian Health Committee is working in Svay Rieng province in HIV/AIDS/STD
prevention activities. Included in their development of community education and support for
HIV/AIDS/STD prevention has been a series of one-day training workshops for various
community leaders and influencers. One of these training workshops in 1997 was conducted
specifically for private pharmacists from the town and three districts. Thirty-four pharmacists
attended the workshop. Impact of the training on pharmacist knowledge/interaction with clients
has not been measured.

Client Characteristics. It is reported by some that as many as 80% of Cambodians first "self-treat"
when ill. Self-treatment appears to consist largely of going to a pharmacy or drug seller to
purchase a drug(s). Only when the pharmacist's or drug seller's "treatment" is not effective do
clients then go to a physician, clinic, or hospital. If this report is correct, then most Cambodians
would likely be customers i.e. the commercial pharmaceutical sector at some time or another each
year. The 1997 UNICEF-funded baseline assessment cited above indicated that only one-third of
pharmacy clientele present physician prescriptions for drug purchases. In supporting focus group
research, the majority of mothers in the groups stated their reliance on the recommendations of the
drug sellers.

The reason most often given by informants for consumers' choice of the pharmacist/drug seller as
the first line of treatment is the absence of the consultation fee which would otherwise have to be
paid to a physician. It may also be that the Cambodian's often stated desire for a "quick cure" leads him her to seek drug treatments straightaway. Further, the 1997 UNICEF-Funded baseline reported that there is a general level of satisfaction among clients with the attitudes of pharmacy workers toward them.

In the 1997 WHO-funded survey of the commercial health sector, operators of twelve legal pharmacies in Battambang and Phnom Penh variously reported that low income families represented from non to "almost all" of their clients. On Average, gender of clients of these twelve outlets was divided nearly equally between men and women, but the response range from pharmacy to pharmacy showed considerable variation.

**Pharmaceutical Manufacturers.** There are several firms in Cambodia which manufacture pharmaceutical products. These companies may include at least the following:

- Phnom Penh Medicine Manufacturers
- Ashford Laboratories
- Pharma Product Manufacturers

According to a 1996 report of the Cambodian Investment Board, Ashford Laboratories is wholly owned by a UK investor and gas annual sales turnover of approximately US$1.6 million, and Pharma Product Manufacturers is a joint venture between French (41%) and Cambodian (51%) investors. (Pharma Product Manufacturers is reportedly the re-incarnation of the old Ministry of Health parastatal drug manufacturing firm.)

At least one current importer/distributor of pharmaceutical product is building a pharmaceutical plant and plans to have it operational within about a year. This company is exploring the possibilities for licensed local manufacture of selected French product which it now imports.

Product and price lists given to pharmacies by these companies seem to indicate that antibiotic preparation and fever and pain relievers are among their primary products. Product/formulations appear to be selected for local production on the basis of their existing market popularity.

Companies which manufacture a line of pharmaceutical products in Cambodia distribute and promote their own products. Consequently, companies listed as manufacturers can also be identified as pharmaceutical distributors although they do not seem to distribute any products other than those which they make.

**Pharmaceutical Importers and Distributors.** All companies which import pharmaceutical products into Cambodia are, according to law, supposed to register themselves with the Ministry of Health. According to Dr. Chroeng Sokhan, Clinical Pharmacist, Ministry of Health/Department of Drugs and cod, there are now approximately sixty-five pharmaceutical companies registered to import pharmaceuticals in Cambodia. (See Appendix – for a list of the nearly fifty pharmaceutical distribution companies registered with the MOH by 1996; of this number, Dr. Chroeng estimates that ten of the sixty-five registered companies are functional at this time. The companies which import pharmaceutical products into Cambodia are also the companies which then distribute these products throughout the country.

International pharmaceutical distribution companies are allowed to operate in Cambodia but only through partnership with a local entity. The foreign company can, by law, own no more than a 41% percent share of the joint company.

Pharmaceutical companies now actively operating in Cambodia include at least the following companies whose trucks were observed by the team during its site visits, whose
managers were interviewed, or whose distribution activities were cited by physicians or pharmacy operators visited:

- Medical Supply Company,
- Medico,
- Zenaust,
- Pritsons,
- Khunaco,
- LYKA Labs/Hiepseng,
- Cyspharma,
- Taing Ly Sena Pharm, and
- DepoPharm Lab.

Pharmaceutical products are imported both formally and informally into Cambodia. Formal importation is accomplished through contracts for purchase of products between the Cambodian importer and international manufacturer. In instances where the Cambodian importer/distributor participates in a joint venture with an international pharmaceutical distribution company, the products of the companies which are represented by the international partner are imported for distribution in Cambodia. Pharmaceutical products are currently imported from a number of countries which include India, South Korea, Thailand, Vietnam, Australia, French, and other European countries, Hong Kong, and Japan. Very few products manufactured in United States appear to be imported here.

One Cambodian distribution company manager estimated for the team that the value of all pharmaceuticals imported (including INGO and public sector importation) is currently about US$ 40,000,000 annually. Approximately US$ 25,000,000 of this amount or 63% of the annual value of imports, he believes, is represented by French pharmaceutical products. (Because of their higher unit cost, French products represent a much smaller percentage of the total quantity of pharmaceuticals imported per year.) The same distributor estimates that the value of the private sector portion of these pharmaceutical imports is about US$ 15,000,000 annually. He further believes that with "education and improvements in promotion and distribution" the value of total pharmaceutical imports could easily be expanded to US$ 100,000,000 per year.

A second national importer/distributor of pharmaceuticals cited a recent "private survey" which shows total pharmaceutical imports into Cambodia of about $50,000,000/year. Of this total, legal private sector imports, according to the survey, represent $26,000,000/year; illegal imports about $7,000,000; MOH/national budget imports about $6-7,000,000/year; and INGO/donor imports about $10,000,000. Interestingly, of the $10,000,000 of pharmaceutical products imported by INGOS and international donors per year, approximately $6,000,000/year is imported, according to the survey cited, for the Kantha Bopha Children's Hospital (Numbers 1 and 2) alone.

(The undated report "pharmaceutical Distribution Assessment," shared with the team by UNICEF staff, provides a considerably different picture. This report states that in 1993 total private pharmaceutical sales in Cambodia were estimated at US$ 40,000,000 – an expenditure of approximately US$ 4/capita in the private sector for pharmaceutical products. The source of this estimation is not stated in the report. It is not clear to the team whether local production of pharmaceuticals could account for the difference between the current distributors' estimation of a US$ 15-25,000,000 private sector market for imported pharmaceuticals and the "Pharmaceutical Distribution Assessment" earlier estimation of US$ 40,000,000 sales in the total private sector pharmaceuticals market.)

An imported pharmaceutical private sector market of US$ 15,000,000-25,000,000/year and a population of about 10 million people appear to mean that about US$ 1.50-2.50/capita is the annual expenditure for imported pharmaceuticals in the Cambodian private sector. It is estimated in the WHO-sponsored 1997 report on the commercial
health sector in Cambodia that annual per capita expenditure for private sector health care
Cambodia is US$ 16. (The MoH planning and statistics unit's 1994 national health
statistics report is cited as the of this figure.) This seems to imply that either a fairly great
deal of money is spent on locally produced, smuggled, and traditional medicines or that a
large percentage of total private health care expenditures that perhaps expected goes to
services providers.

A January 1998 report from the National Public Health and Research Institute on the
results of a health care demand survey states that total monthly expenditure per household
for public and private sector health care is, on average, US$ 22.40. If each household
contain an average of six individuals, then annual per capita expenditure for both public
and private sector health care is approximately US$ 45 (US$22.40 divided by 6 individuals
time 12 months/year). The percentage of this annual per capita amount for health care
which might be attributed to private sector sales of pharmaceuticals is not given.

Informal importation of pharmaceuticals products is accomplish either through organized
smuggling or through more casual "suitcase importation" of product by individuals.
Thailand is often cited by drug sellers as well as by pharmaceutical distributors as a
primary source of informally imported products. The present of Thai products, informally
imported, appeared especially strong in drug outlets visited by the Team in Siem Reap
province. The geographic proximity of Siem Reap to the Thai border explains this
phenomenon.

The distribution chain for pharmaceuticals in Cambodia is quite complex largely due to the
multiplicity of sources available to each lower rung the chain and the current level of
disorganization in much of the sector. Pharmaceutical products "originate" in the country
through at least four mechanisms: 1) registered importers/distributors, 2) "organized"
smugglers, 3) "casual" smugglers, and 4) local manufacturers. Each of these sources of
product serve as distribution outlets directly to lower rungs in the distribution chain as
follow:

**Registered Importers/Distributors:**
Wholesalers in Phnom Penh
Provincial sub-distributors
Larger pharmacies
Provincial branch offices of the importer/distributor
Physicians

"Organized" Smugglers:
Wholesalers in Phnom Penh
Provincial sub-distributors
Individual salesmen

"Casual" Smugglers:
Individual salesmen
End-users

**Local Manufacturers:**
Wholesalers in Phnom Penh
Physicians
Provincial sub-distributors
Larger pharmacies
Second rung outlets in the distribution chain which are swerved directly by "orginators" of pharmaceutical products in the country in turn serve the following third rung outlets:

**Wholesalers in Phnom Penh:**
- Provincial sub-distributors
- Physicians
- Larger pharmacies
- Smaller pharmacies

**Provincial Branch Offices of the Importer/Distributor:**
- Physicians
- Larger pharmacies
- Smaller pharmacies

**Provincial Sub-Distributors:**
- Physicians
- Larger pharmacies
- Smaller pharmacies

**Individual Salesmen:**
- Physicians
- Smaller pharmacies
- End-users

**Larger Pharmacies:**
- Physicians
- Smaller pharmacies
- Village drug sellers
- End-users

**Physicians:**
- End-users

The final rung in the distribution of pharmaceutical products to end-users appears as follows:

**Smaller Pharmacies:**
- Village drug sellers
- End-users

**Village Drug Sellers:**
- End-users

Within the last year, a significant change has occurred in the way in which drugs are distributed in Cambodia. Previously, the pharmaceutical distribution system was predominantly a "pull" system. That is, importers/distributors brought product into the market, announced its availability, and waited for customers to pull the product out into the marketplace. Sales of product to wholesalers located in Phnom Penh (primarily in the Olympic Market area) who in turn sold to provincial retailers and sub-distributors who came into the capital to buy supplies was reportedly the extent of much of the organized distribution system's outreach into the market.
Retailers report that there has been a significant change in this system particularly within the last six months. In that time, a number of pharmaceutical distribution companies have begun to establish provincial branch offices from which products are distributed as well as to implement regular sales delivery routes into provincial areas where the companies have no branch offices. Sales teams composed of a van driver, a sales representative, and a medical representative make once to twice monthly calls on established pharmacy and physician accounts. Interim criers for product can be placed by the drug retailer by phone, radio, or messenger and can be filled within a day in Phnom Penh and as soon as a taxi, motorcycle messenger, arranged traveler can reach a provincial area.

Companies now also give additional "push" to their distribution efforts through product promotion. Medical representatives (usually a trained physician, medical assistant, or pharmacist) hired by distribution companies make regular calls on groups of physicians within provincial and other hospitals, on individual physicians in their private practices, and on larger pharmacies. The purpose of these visits by medical representatives is to educate potential customers to the medical indications for and benefits of the company's particular products. Print materials such as brochures, leaflets, and booklets are used by the medical reps in their presentations and are frequently left with the physicians and pharmacists to keep the product information fresh in their minds. Point of purchase materials (primarily wall charts and posters) promoting certain brands of products can now be seen in many retail pharmaceutical outlets. These IEC/promotional materials are provided free to the distributors by the international manufacturers of the products they distribute. At least two distributors are using their own scanners to put the print materials provided into computer files which allow them to substitute the English or French text in the original for Khmer.

At least one distribution company provides "compliments," such as pens and markers branded with its company and/or product names, to physicians and large pharmacy owners. This distributor plans soon to test the popularity of more scientifically oriented compliments, such as treatment and diagnostic charts, among its physician customers. Another very active distribution company appears to have given to the provincial hospital in Siem Reap a decorative, gated entrance to the facility. Plaques of a noticeable size which bear the company's name is embedded in each of the hospital gate's brick pillars.

Promotional activities adopted by local distribution companies do not so far include the provision of bonus goods or special price offers to the trade. Discounts are given only on the basis of volume purchased. Product sample for physicians, however, are considered quite important by some distributors in generating prescriptions of new products.

Credit terms are just beginning to be used as a sales promotional tool. All sales used to be for cash at the time of delivery of goods. Now provincial branch offices of a few distributors sell to their established accounts on a two-week consignment basis. Most sales, however, continue to be for cash.

**Distribution of Pharmaceuticals through Social Marketing Programs.** PSI operates the largest social marketing project in Cambodia. It markets condoms donated by the British government under the brand name Number One and oral contraceptives donated by the German pharmaceutical manufacturer Schering AG under the brand name OK. Currently, 850,000-1,000,000 condoms are sold per month and approximately 12,000-15,000 OOC cycles of oral contraceptives.

The project sells its condom products primarily to the network of wholesalers located in the Olympic Market area in Phnom Penh. These wholesalers in turn sell the condoms to the provincial subdistributors, and to the pharmacy and other outlet owners who regularly purchase stocks from...
them. To supplement the distribution efforts of the wholesaler distribution system, PSI has established its own sales force. This proprietary sales force concentrates on reaching outlets such as night clubs, brothels, and bars which are important to the **HIV/AIDS/STD** prevention objectives of the project but not to the usual consumer product distribution system. To reach remote and rural areas where the commercial distribution system is least likely to be effective, PSI sells its condoms to selected NGOs working in those regions. These NGOs in turn serve as sub-distributors to retail outlets in their areas of operation and also, in some cases, sell the condoms themselves through the efforts of their outreach workers.

Distribution of the OK brand oral contraceptive is considerably more limited for the following two reasons: 1) PSI is concerned to ensure that its oral contraceptive brand is not sold in areas where providers and pharmacy operators have not received training in contraceptive technologies, correct use of OCs, and side effect/contra-indications.

2) An increased rate of sales will exhaust available supplies of donated product before more products may be donated.

PSI's own sales force handles all distribution of OK oral contraceptives. Sales are targeted to NGOs and to private and NGO clinics.

The retail price of Number One condoms is 500r/package of four condoms and of OK oral contraceptives is $1/package of three cycles.

To support sales, PSI provides its wholesalers with promotional items (such as caps, T-shirts, matches, and kleenex boxes) to be given to the trade and occasionally with free product to be used as bonus goods for the trade. Television advertising for Number One condoms is aired every two to three months. A television ad for OK oral contraceptives has been developed and produced but may not be aired until additional product supplies are available.

Evenings of entertainment "sponsored" by project products are held from time to time in provincial capitals and have proved very popular. The most recent event which included performances by a puppet troupe, comedians, and other performers was attended by 5,000-6,000 people. A radio soap opera sponsored by project products is also broadcast. Project management believes that these types of promotions increase brand recognition and draw attention to birth spacing and HIV/AIDS/STD topics. Future consumer IEC focused on birth spacing and oral contraceptives is planned through outreach to places where women are likely to gather or work such as beauty salons and garment factories. Project managers believe that word-of-mouth plays an especially important role in promotion of birth spacing and use of oral contraceptives.

In addition to PSI, several other INGOs are initiating social marketing programs although on a much smaller scale. GTZ is planning a community based distribution system in two provinces where the sales agents for oral contraceptives and condoms will likely be village women or traditional birth attendants. Implementation plans for this project are not yet fully developed. An outreach program of the Ministry of Women's Affairs which uses volunteers to reach mothers with family health messages is beginning a pilot project in two provinces where 40 volunteers will be allowed to sell oral contraceptives and condoms as an incentive to continue their household calls. The source of the products which will be sold and the prices to be charged was not learned by the team.

The World Health Organization is well into development of a project to market insecticide-impregnated hammock nets through fifty selected distribution agents throughout the country. The target market for these nets are those people who go for
occasional work into the forested and mountainous areas where risk of malaria is greatest. The nets will initially be sold to the distributors at their cost of procurement (US$2.50 each) to test the commercial feasibility and sustainability of product sales. Initial promotion and advertising to support product sales will be provided by donors.

**Regulations and Policies Affecting Pharmaceutical Sector**. The Law on the Management of Pharmaceuticals was adopted by the National Assembly on 9 May 1996. This law governs all issues related to pharmaceuticals including the following:

- definition of a pharmaceutical product;
- qualifications necessary to engage in the production, import, export, and trade of pharmaceuticals and traditional medicines;
- definition of poisonous substances;
- conditions for the production, import, export, and trade of poisonous substances;
- technical procedures and conditions for the production of pharmaceutical products and the operation of pharmaceutical manufacturers;
- conditions for authorization to open, close, and/or change location of pharmacies, pharmaceutical manufacturing establishments, and/or companies involved in importing and exporting pharmaceuticals;
- conditions for application for a visa on the pharmaceutical logbook;
- technical conditions for the management and preservation of pharmaceuticals;
- conditions for advertising pharmaceuticals;
- procedures for production, import, export, and trade of pharmaceuticals;
- determination of the number of pharmacies for each commune or sangkat;
- conditions for the importation, exportation, and storage of pharmaceuticals and raw materials for the production of pharmaceuticals;
- requirements for staffing of pharmacies;
- veterinary medicines; and
- fines and penalties.

The law, itself, does not elaborate many of the topics which it indicates will be governed under the law. Sub-decrees and declarations (prakas) of the Ministry of Health are cited in the law as the regulatory instruments which will determine its implementation. The following items are, however, specifically stated in the law:

- Serum and vaccines, blood or blood products, traditional medicines, and products composed of poisonous substances are considered pharmaceuticals as well as the many kinds of substances which are primarily made from chemicals, bio-products, microbes, and plants to use in the prevention or treatment of human or animal diseases.
- Pharmacists who have the right to engage in the production, import, export, and trade of pharmaceuticals must have Khmer nationality, have a pharmaceutical diploma recognized by the MOH, have never been found guilty of a criminal offense, and have sufficiently good health to accomplish the job.
- The number of pharmacies for each commune/sangkat shall be determined by the MOH on the basis of the number of citizens in each commune/sangkat.
- MOH authorization is required for opening, closing, or changing of location of pharmacies, companies involved in importing and exporting pharmaceuticals, and pharmaceutical manufacturing establishments.
- MOH authorization is required for businesses involved in importing and exporting pharmaceuticals.
- MOH authorization is required for importation, exportation, and storage of pharmaceuticals and raw materials for the production of pharmaceuticals.
- MOH authorization is required for advertisement of pharmaceuticals.
A pharmacist must be present in each pharmacy. In the event of the absence of a pharmacist, there must be a replacement who possesses appropriate qualifications as determined by the MOH.

- Oversight and control of pharmaceutical activities shall be the competence of the MOH.

Dr. Chou Yin Sim, Director, Department of Drugs and Food, Ministry of Health, told the team that at the end of 1997 one sub-decree supporting the Law on the Management of Pharmaceuticals had been finalized. This sub-decree governs the importation and production of traditional medicines. Two additional sub-decrees have been drafted but not finalized: the sub-decree regulating the classification of poisons and the sub-decree regulating the import, export, and production of poisons. Currently, MOH staff are preparing drafts of the sub-decree regarding good factory practices (based on ASEAN standards) and the declarations (prakas) regarding opening and closing of drug selling shops, importation and distribution of drugs, drug registration, and a narcotics manual.

Enforcement of currently existing regulations regarding pharmacy operations and pharmaceutical products is widely believed to be minimal. According to the undated report "Pharmaceutical Distribution Assessment," shared with the team by UNICEF, there were at the time of that report only twenty government inspectors in charge of monitoring private pharmacies. Of the 25 pharmacies included in the report's survey, eight claimed never to have been inspected by the MOH, and the remaining seventeen claimed to have been inspected only once in the previous year. The present existence of a large number of illegal/unlicensed drug outlets throughout the country confirms the weakness of existing enforcement mechanisms.

According to staff in the Ministry of Health, Department of Drugs and Food, there is no import duty levied by the government on any drugs. There are, however, two taxes which are paid by the importer/distributor: 1) a 40 consumption tax on drugs and 2) a 5% turnover tax.

Under the investment law, there is some relief from "taxes on profits" given to foreign investors during their first five years of business operation in Cambodia. This tax relief is applicable to foreign investors in pharmaceutical manufacturer just as it is to foreign investors in any other sector.

**RETAIL PRICES OF SELECTED MEDICINES IN SIEM REAP CITY**

**Acute Respiratory infection**

Ampicillin
- 120r/tab
- 200r/tab
- 250r/tab
- 320r/tab

Paracetamol
- 100r/tab

Decongestant (chlorpromazine, promaxine, promedazine)
- 100r/tab

Vitamin C
- 50-100r/tab

**Diarrheal Disease**

Anti-biotic
- (bactrim, comoxa, erscefuryl)
ESTIMATION OF WEEKLY INCOME OF SELECTED PHYSICIANS IN SIEM REAP CITY

Average number of clients seen per week - 70
Consultation fee - 5000-7000 r
Fee including necessary medicines - 17000-23000r

Assumptions for calculation:
Half of clients (35) pay only consultation fee
Half of clients (35) pay fee which includes medicines
Consultation fee is 5000r
Fee including medicines is 19000r

Possible treatment (medicine) plans:

Acute Respiratory Infection

- Ampicillin or other antibiotic 3000r
  (200r X 15 tabs)
- Paracetamol 1500r
  (100r X 15 tabs)
- Decongestant 1000r
  (100r X 10 tabs)
- Vitamin C 500r
  (50r X 10 tabs)

Retail total 6000r
Less 3% discount to MD from pharmacist -180r
TOTAL COST OF DRUGS TO MD 5820r

Diarrheal Disease

- Antibiotic 3250r
  (650r X 5 tabs)
- Imodium 900r
  (450r X 2 tabs)
- Oralite 1000r
  (200r X 5 pkgs)
- Vitamins 875r
  (175r X 5 tabs)

Retail total 6025r
Less 3% discount to MD from pharmacist -181r
TOTAL COST OF MEDICINES TO MD 5844r

1. Suggested by Dr. Hong Rathavuth as likely practice by many MDs.
Client consultation fees  
\[(35 \times 5000)\]  
175000r

Client fees with medicines  
\[(35 \times 19000)\]  
665000r

Average cost of medicines to MD  
\[(35 \times 5832)\]  
-204120r

Net income from fees with medicines*  
460880r

WEEKLY "NET" INCOME:  
635880r

WEEKLY INCOME FROM ALL CLIENT FEES LESS COST OF MEDICINES  
(client consultation fees plus net income from fees with medicines)  
\[@ 3600r = \text{US}\$1\]  
US$177

* Net income from fees with medicines  
460880r

Less income attributable to consultation services included  
\[(35 \times 5000r)\]  
-175000r

Weekly profit from sales of medicines  
285880r

% contribution of profit from sales of medicines to weekly net income  
45%

(weekly profit from sales of medicines/weekly net income)-
<table>
<thead>
<tr>
<th>No.</th>
<th>Compagnie</th>
<th>Date d’ouverture</th>
<th>Pharmacien Responsable</th>
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<td>Médico Trading</td>
<td>1990</td>
<td>Dam Savanny</td>
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<td>Kuoch Huor</td>
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<td>Kampharimex</td>
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<td>Peou Puth Siha</td>
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<td>Médical Supply</td>
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<td>Delmex</td>
<td>1993</td>
<td>Luy Chhoeun</td>
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<td>CK Chan Kit</td>
<td>1993</td>
<td>Khy Keomony</td>
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<td>New World Medecin Trading</td>
<td>1993</td>
<td>Pen Bun Piv</td>
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<td>Roussel Cambodge</td>
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<td>Thai Med</td>
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<td>Central Pharma</td>
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<td>Pha Nguo Pharma</td>
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<td>Chea Thai Kham Sin</td>
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<td>Voeung Yim Heang</td>
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<td>Vêng Hour</td>
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<td>Thouk Rémy</td>
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<td>Kampuchea Thai Lay</td>
<td>1994</td>
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<td>Van Hor</td>
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<td>Keth Vanseth</td>
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<td>Sinh Lien</td>
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<td>21</td>
<td>Chea Cham Nan Pharmaceutical</td>
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<td>Arun Suorsdey</td>
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<td>Phnom Penh International Pharmaceutical</td>
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<td>Popy Intertrade</td>
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<td>Ankor Medical</td>
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<td>Asie Pharma</td>
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<td>Zenaust</td>
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<td>Cambodian Food and Pharmaceutical</td>
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<td>Khmer Agencie</td>
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<td>Oum Vireak</td>
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<td>Mutual Harvest</td>
<td>1995</td>
<td>Nea Kim Thorn</td>
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<td>Héng Lim Poly Pharma</td>
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<td>Phnom Penh International Pharmaceutical</td>
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<td>Asie Pharma</td>
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<td>Tong Ly Pharma</td>
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<td>Héng Lim Poly Pharma</td>
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<td>Dieltthem Pharma Trading</td>
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No. Compagnie Date d’ouverture Pharmacien Responsable
CHAPTER 1: GENERAL PROVISIONS:

ARTICLE 1:
The objective of this law is to govern all pharmaceuticals in the Kingdom of Cambodia.

ARTICLE 2:
A pharmaceutical is one or many kinds of substances which are primarily made from chemicals, bio-products, microbes, plants combined in order to:
- use in the prevention or treatment of human or animal diseases,
- use in the medical or pharmaceutical research or diagnosis,
- change or support the functioning of the organs.

ARTICLE 3:
Shall be also considered as pharmaceuticals:
1. scum and vaccines,
2. blood or blood products;
3. traditional medicines,
4. products which are composed of poisonous substances which are included in a list to be determined by Sub-Decree.

ARTICLE 4:
Pharmacists who may have the right to engage in the production, import, export and trade of pharmaceuticals are those who have fulfilled the following qualifications:
- have Khmer nationality,
- have a Pharmaceutical Diploma recognized by the Ministry of Health,
- have never been found guilty for any criminal offence,
- have sufficiently good health to accomplish the job.

Production, import, export and trading of the traditional medicines shall be determined by Sub-Decree.
CHAPTER II: MANAGEMENT OF POISONOUS SUBSTANCES FOR HEALTH

ARTICLE 5:
Poisonous substances refer to those pharmaceutical or substances or compounds of substances or plants that may cause danger to health or lead to the addiction of humans or animals.

These poisonous substances shall be determined by Sub-Decree.

ARTICLE 6:
The formalities and conditions for the production, import, export and trade of poisonous substances shall be determined by Sub-decree.

CHAPTER III: PRODUCTION, TRADE, IMPORT AND EXPORT OF PHARMACEUTICALS

ARTICLE 7:
Technical procedures and conditions for the production and the functioning of the pharmaceutical manufacturing establishments shall be determined by Sub-Decree.

A Prakas (Declaration) of the Ministry of Health shall determine:
• the formalities and conditions to apply for authorization to open, close or change of location of pharmacies, pharmaceutical manufacturing establishments, or companies involved in importing and exporting pharmaceuticals,
• the formalities and conditions for application for a visa on the pharmaceutical logbook,
• the formalities and technical conditions for the management and preservation of pharmaceuticals,
• the formalities and conditions for advertising of pharmaceuticals, and
• procedures for the production, import, export and trade of pharmaceuticals.

The determination of the number of pharmacies for each commune/sangkat shall be determined by the Ministry of Health based on the number of citizens in each respective commune or sangkat.

ARTICLE 8:
1. Authorization from the Ministry of Health shall be required for:
• the opening, closing or changing of location of pharmacies, companies involved in importing and exporting pharmaceuticals or pharmaceutical manufacturing establishments.
• businesses involved in importing and exporting pharmaceuticals,
• importation, exportation and storage of pharmaceuticals and raw materials for the production of pharmaceuticals;
• advertisement of pharmaceuticals.

1. The production, import, export and trade of pharmaceuticals for veterinarians shall be determined by a joint Prakas (joint Declaration) of the Ministry of Health and the Ministry of Agriculture, Fishery and Forestry.

2. In each pharmacy, there must be the presence of a pharmacist. In the event of an absence of the pharmacist, there must be a replacement who shall possess appropriate qualifications as determined by the Ministry of Health.

CHAPTER IV: AUTHORITY TO SUPERVISE

ARTICLE 9:
Oversight and control of pharmaceutical activities shall be the competence of the Ministry of Health.

Oversight and control of pharmaceutical for veterinarians shall be the competence of the Ministry of Agriculture, Fishery and Forestry.

CHAPTER V: PENALTIES

ARTICLE 10:
Shall be penalized to a fine from 1,000,000 (one million) to 10,000,000 (ten million) riels and to a suspension of (activity) production or import, export or trade of pharmaceuticals for a period from one (1) month to three (3) months, or to either one of the above two punishment terms, exclusive of punishment for other offenses, for any person who:
1- advertised pharmaceuticals without authorization from the Ministry of Health.
2- who violated procedures and conditions for the production, import, export and trade of pharmaceuticals.
3- opened or changed locations of pharmacies, conducted businesses involved in importing and exporting pharmaceuticals or manufactured pharmaceuticals without proper authorization from the Ministry of Health.
4- produced, imported, exported or stored pharmaceuticals or pharmaceutical raw materials without proper authorization from the Ministry of Health.
5- sold pharmaceuticals without approval or keeping a log-book or sold those pharmaceuticals which are prohibited by the Ministry of Health.
6- For repeated offenses, the offender shall be penalized twice the fine and be suspended from activities of production, import, export or may be subjected to either one of the two punishments.
Pharmaceuticals, raw materials, equipment and other materials which are connected to the offenses as stated in the sub-para. (4) and (5) shall be confiscated as State's property or be destroyed.

The Ministry of Health shall have the rights to immediately suspend temporarily the offending advertisement of pharmaceuticals, production, import-export and business of pharmaceuticals and shall prepare a judicial case to be forwarded to the court.

ARTICLE 11:
Shall be subjected to a fine of from 1,000,000 (One Million) to 5,000,000 (Five Million) riels or to punishment to imprisonment from six (6) days to one (1) month-or, to both of these two punishments, for any person who obstructed the competent agents as stated in article 9 above, to prevent them from accomplishing their inspection duties.

ARTICLE 12:
Shall be subjected to a fine from 20,000,000 (twenty million) to 50,000,000 (fifty million) riels or to punishment to imprisonment from (5) years to ten (10) years or, to both of the punishments, for any person who deliberately engaged in producing, importing, exporting or trading of pharmaceutical containing addictive substances without authorization, counterfeit pharmaceuticals, pharmaceuticals of damaged quality or expired pharmaceuticals which affected the health or lives of consumers.

ARTICLE 13:
Shall also be punished with the same terms as set forth in articles 10, 11 and 12, for any civil servant who acts as accomplice or who commits an abuse of his/her own duties during the implementation of articles 10, 11 and 12.

CHAPTER VI: TRANSACTIONAL PROVISION

ARTICLE 14:
From the date this law enters into effect until the year 2005, the Ministry of Health shall have the right to issue Prakas (Declarations) authorizing those retired health officials who have capacity to open pharmacies in the khums (communes) or sangkats (districts) which do not yet have proper pharmacies as specified in articles 4 and 7 of this law.

CHAPTER-VII: FINAL PROVISIONS

ARTICLE 15:
All provisions contrary to this law shall be hereby repeated.

The Acting President of the National Assembly
LOY SIM CHHEANG
UNICEF
Supports a program which trains pharmacists in the urban and peri-urban areas of Phnom Penh in proper counseling and treatment for acute respiratory infection (ARI) and the control of diarrheal disease (CDD). Public health education is an integral part of the program. Technical assistance is provided by PATH/Thailand.

WHO
WHO is embarking on a new program to socially market insecticide-impregnated hammock nets in high risk malarial areas.

Department of Investment and Foreign Development (formerly, ODA) -- DIFD
As part of DIFD’s new urban health project, the MOH will test different contracting schemes in squatter areas of Phnom Penh: one involves contracting with a physician or NGO to run an existing MOH facility; another is to contract with the clinic of a private physician or NGO who will provide services as an “approved” MOH provider. As part of this, the MOH will subsidize services provided and pay a per head fee. The third scheme to be tested involves spinning off an existing district level hospital as an autonomous unit -- still part of the public sector -- but independently managed with an autonomous budget. This project is still in the planning stages as there are a number of issues to consider such as the low business/financial management capability of district hospital staff and the criteria for selecting health facilities and private providers.

Population Services International (PSI)
With funding from USAID, PSI socially markets oral contraceptive and condoms nation-wide and provides consumer education in HIV/AIDS and STD awareness.

Marie Stopes International (MSI)
Just starting up is MSI’s Private Sector Initiatives Project which will be based mostly in and around Phnom Penh. MSI is looking for ideas and is eager to collaborate with RACHA.

International Planned Parenthood Foundation (IPPF)
With USAID support, IPPF established a local affiliate, the Reproductive Health Association of Cambodia (RHAC) which is now registered as a Cambodian NGO. RHAC operates two high quality reproductive health clinics and outreach programs in Phnom Penh and Kompong Som; another will open in Battambang this year. RHAC also offers reproductive health training services.

Australian Aid Agency (AusAID)
AusAID provides support to a number of NGO projects in HIV/AIDS, including a three year program with the International Red Cross.

Medecins San Frontieres, Holland/Belgium/Switzerland (MSF)
MSF has opened up an experimental private clinic in Russey Keo, Phnom Penh with mixed success. The organization does excellent work in the public sector in many parts of Cambodia.

Action Internationale Contre la Faim (AICF)
AICF’s program has included sales of condoms (provided by PACT) to brothels.

CARE International
CARE runs a model pharmacist training program in Pursat Town.

Christian Children’s Fund
This organization has an innovative payment plan for contraceptives as part of its program.

World Relief
Combining microcredit and health education, this group targets poor urban and rural women.

Partners for Development
In Kratie Province, Partners will socially market insecticide-impregnated bed and hammock nets.
### MAJOR NGO COORDINATING BODIES IN CAMBODIA

Compiled by Milton B. Amayun, MD, MPH

Presented below are the major coordinating bodies that are of interest to RACHA. Information on the following coordinating bodies in Cambodia was obtained in May 1998. Regular updates will be necessary due to the very dynamic character of the NGO community and the frequent changes of personnel among member organizations.

<table>
<thead>
<tr>
<th>Name, Address, Contacts</th>
<th>General Description</th>
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<tr>
<td><strong>1. Cooperation Committee for Cambodia (CCC)</strong>&lt;br&gt;35, St. 178, Psar Thmey II&lt;br&gt;Daun Penh, Phnom Penh&lt;br&gt;Tel/Fax: (855)-23-426-009;&lt;br&gt;426-907&lt;br&gt;E-mail: <a href="mailto:ccc@forum.org.kh">ccc@forum.org.kh</a>&lt;br&gt;Carole Strickler, Executive Director</td>
<td>The CCC was formed in 1990 by NGOs wanting to work in a spirit of cooperation and with full respect for the Cambodian people. Its charter has these objectives:&lt;br&gt;-facilitate information exchange&lt;br&gt;-provide forum for coordination.&lt;br&gt; The CCC represents NGOs to the Cambodian government, at regional and global development fora and official functions, strengthens the capacity of local NGOs, and facilitates sectoral working groups.&lt;br&gt;The CCC maintains a library and resource center, meeting rooms for lease, and an e-mail network. The CCC E-mail Network has more than 60 members and is a convenient method of reaching a wide cross-section of NGOs easily and cheaply.&lt;br&gt;The CCC supports 39 permanent working groups which meet regularly. It also acts as a clearinghouse among NGOs and between NGOs, embassies and international organizations.</td>
<td>The CCC has sectoral and ad hoc working groups for <em>community development</em>, <em>credit, health</em> (Medicam), <em>midwives</em> and <em>Women in Development</em>. The CCC has member NGOs with active involvement in these five working groups which could become suitable partners for sharing information and/or actual implementing partners for RACHA on private sector initiatives.&lt;br&gt;The CCC itself is not a suitable implementing partner for RACHA activities.</td>
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<td><strong>2. Medicam</strong>&lt;br&gt;12, St. 306, Phnom Penh&lt;br&gt;Tel: (855)-23-363-067&lt;br&gt;Fax: (855)-23-721-461&lt;br&gt;E-mail: <a href="mailto:medicam@forum.org.kh">medicam@forum.org.kh</a></td>
<td>Medicam is the membership organization for NGOs active in Cambodia’s health sector. It has 82 paid NGO members and 13 accredited sub-Cocoms or working groups which act as advisory bodies to the Ministry of Health on specific technical areas. Medicam also acts as the</td>
<td>Medicam is an association of NGOs and as such is not an operational body. However, it has members that have the potential of working with RACHA in different locations. Medicam is well-run, very active and has the added</td>
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| **Stéphane Pierre Rousseau, Executive Director** | CCC’s health sector working group, although Medicam preceded the CCC’s existence, and has a broader membership. Medicam serves its members through:  
- information-sharing  
- supporting/training local NGOs  
- representation of health NGOs  
- cooperation with other agencies  
Medicam has monthly meetings, an annual General Assembly, a newsletter and an e-mail network. | advantage of focusing on a priority sector receiving major donor attention. |
| **3. The NGO Forum on Cambodia**  
2nd Flr., CCC Building, 35, St. 178, Psar Thmey II, Phnom Penh 3  
Tel/Fax: (855)-23-723-242 360-119  
E-mail: ngoforum@forum.org.kh  
**Russell Peterson, Executive Director** | The NGO Forum brings NGOs together in working groups to initiate advocacy strategies on critical issues facing Cambodians. These working groups comprise both local and international NGOs working in partnership to implement these strategies.  
The NGO Forum works very closely with the CCC and with other NGO fora on Laos and Cambodia in the organization of overseas seminars. | The NGO Forum is not an operational body. Its primary role is advocacy. |
| **4. Federation of Ponleu Khmer (PK)**  
6, Watt Sampeou Meas, St. 214 Phnom Penh  
Tel/Fax: (855)-23-364-370  
E-mail: ponleukhmer@forum.org.kh  
**Kong Nary, Executive Director** | PK is a federation of Cambodian associations and NGOs working together to reconstruct and develop Cambodia. It developed out of the Walk for Peace and Reconciliation that was held just prior to the 1993 elections. The participants in the Walk agreed to create a coalition, which then grew into a federation which subsequently became registered.  
The most important focus of PK is human rights and government transparency in public service. | Until recently, PK was the largest and most influential grouping of Cambodian NGOs. However, it has been substantially weakened organizationally due to internal conflicts, staff resignations and departure of some member organizations. |
| **5. Star Kampuchea (SK)**  
245, Rd. 51, Cham Car Mon Khan Daun Penh, Phnom Penh  
Tel: (855)-23-721020; 012-802-460 | SK is a network of cooperating agencies committed to strengthen civil society in Cambodia. While it is also a registered NGO, Star carries out its work in close cooperation with and/or on behalf of other | SK is aggressively trying to establish itself as a mature force in the development sector of Cambodia. The staff are committed to transparency, political neutrality and |
Name, Address, Contacts | General Description | Remarks  
---|---|---  
Fax: (855)-23-360345  
E-mail: star@forum.org.kh | Cambodian NGOs. Its main activities are advocacy and information-sharing, capacity-building of local NGOs on issues of advocacy, civil society and ethics.  
Many of the member NGOs and staff of SK have their roots in Ponleu Khmer. | grassroots volunteerism.  
Nhek Sarin,  
Executive Director |  

**Appendix E**  
*Inventory of Health NGOs in RACHA focus Provinces*
Inventory of Health NGOs in RACHA Project Areas
KAMPOT Province

I. Health NGOs with Strong Potential for RACHA Collaboration

1. **Australian People for Health, Education, and Development Abroad (APHEDA)**
   - Phnom Penh Contact: Barbara Fitzgerald, Coordinator
   - Address: IOE, St. 302, Boeung Keng Kang, Cham Car Mon, Phnom Penh
   - Tel/Fax: (855)-23-216-034
   - E-mail: APHEDA.PP@bigpond-com.kh

   APHEDA is the overseas aid agency of the Australian Council of Trade Unions. It has three major projects in Kampot with the following partners:

   Department of Agriculture, Forestry and Fishery - technical and group extension training for staff of the department and local farmers in aquaculture, reforestation/tree planting and coastal resources protection.

   Department of Industry, Mines and Energy - courses in metal trades, TV/radio/cassette-player repairs, motorbike repair, electrical repair, English, trainers' training.

   Women in Development Center - women's skills training courses in textiles and design, literacy, typing (Khmer and English), hairdressing, trainers' training, HIV/AIDS prevention.

2. **Australian Red Cross (AustRC)**
   - Contacts: Michael Peyra, Helen Potts
   - Phnom Penh Address: 25A, St. 302, Charn Car Mon, Phnom Penh
   - Tel/Fax: (855)-23-362-885

   AustRC is the Australian branch of the International Red Cross, which supplies staff and volunteers. The approval of a follow-on phase with AusAID funding is anticipated.

3. **Memisa Medicus Mundi (Memisa)**
   - Phnom Penh Contact: Catherine Gourry
   - Pursat Contacts: Lex Miederna, Imelda Hutton (rural sociologist), Dr. Adrie Voorhoeve
   - Phnom Penh Address: 2, St. 408, Tuol Thom Pong, Phnom Penh
   - Tel: (855)-23-364-583
   - Kampil: 033-937-839

   Memisa was invited to take over Médecins sans Frontières' program in Kampot when the latter ended its activities in 1992. Memisa is a Dutch NGO involved in developing the capacity and infrastructure of the provincial health care system in Kampot. It supported the construction of the new district hospital and the renovation of some health centers.

   Memisa is also involved in community-based health programs, such as child survival and birth spacing. Under the leadership of an expatriate sociologist, aggressive grassroots social mobilization strategies are pursued to establish "essential village-based programs" which respond
to felt needs expressed by the community and validated by surveys. The involvement of the whole community is encouraged: all households are registered and have cards, representatives were chosen from and by villagers. Communities are involved in running the health center.

Memisa's village-based health program includes child survival interventions such as EPI, nutrition and growth monitoring, ARI case management, HIV/AIDS prevention, birth spacing, school health and treatment of minor illnesses. Memisa's funding is from the EU and private donors in Holland.

4. United Cambodian Community (UCC Development Foundation)
   Address: Kampot Town
   Contact: Linda McHinney, Country Director
   Tel: 015-330-126

UCC Development Foundation started out as an international development agency focused on improving economic security in rural areas through small businesses, but eventually took on an integrated approach to development. After six years of work in Kampot, it now has a multifaceted program targeting children, widows, amputees and permanently disabled, women and young girls. Its interventions include health, non-formal education, agricultural outreach, female literacy, vocational skills training, early childhood development, social support and civil society in addition to its original small business mandate. Initially hesitating to pursue health activities, it now has embraced health as part of its comprehensive and integrated approach to needs. Activities pursued by health staff include child health, HIV/AIDS awareness and prevention, health education, and treatment of simple illnesses.

UCC Development Foundation is not a formally registered PVO/NGO, but is a tax-exempt organization in the US. It is planning to study its current structure through a technical assistance grant. The current executive director is an expatriate who will soon be leaving. The deputy is a Khmer-American who also has the same vision to make UCC a totally local NGO. All the other 37 paid staff are from Kampot.

II. Other International NGOs

1. Handicap International (HI)
   Kampot Contact: Tep Chanda
   Phnom Penh Contact: Marc Bonnet,
   Tel. (855)-23-426-270
   Phnom Penh Address: 53, Blvd. Sothewos, Phnom Penh
   E-mail: hianscambodge@bigpond.com.kh

HI works with the Ministries of Social Affairs, Labor and Veterans Affairs in eight provinces of the country, including Kampot. It is focused on providing preventive and curative care in favor of disabled people.
2. Food for the Hungry (FHI)
Phnom Penh Contact: Mark Wilson
Phnom Penh Address: 259, St.51, Boeng Keng Kang I,
Phnom Penh Tel. (855)-23-362-145
E-mail: fhicam@bigpond.com.kh
FHI works with the Department of Hydrology in the provision of potable water to communities through the development of community-owned wells and the creation of "well enterprises."

3. Cooperation Internationale pour le Developpement et Is Solidarite (CIDSE)
Phnom Penh Contact: Brim Heidel
Tel: (855)-23-216-369 Fax: 018810761
Phnom Penh Address: 23. St. 294/57, Sangkat Boeung Keng Kang I, Phnom Penh
E-mail: CIDSECAM@bigpond.com.kh
CIDSE is a consortium of European Catholic organizations that began working in Cambodia since 1979 through an emergency food program. CIDSE works in solidarity with the Cambodian people in the implementation of integrated community development programs in several provinces. In Kampot, it collaborates with various provincial departments. It supports similar programs in Kandal, Svay Rieng and Rattanakiri. It also assists a network of local NGOs in their development as local organizations.

III. Cambodian NGOs

1. Association of Cambodian Local Economic Agencies (ACLEDA)
Phnom Penh Contact: Prak Sokal
Adresse: 132, St. 163, Tool Tom Pong 1, Phnom Penh
Tel/Fax: (855)-23-364-619
ACLEDA was established in 1993 with technical assistance and funding from UNDP/ILO. Its objective is to support small women's enterprises with business training, access to credit and ongoing technical assistance. It began expansion to Kampot in 1994. It currently has a nationwide credit portfolio of more than $1,000,000.

2. Cambodian Association for Repatriation to Development (CARDS)
Kampot Contact: Sar Sambath
Adresse: Chhuk District, Kampot Province
CARDS has completed the following projects since 1995: forest-clearing, food-for-work, vegetable growing and road digging.

3. Cambodian Human Rights Association (ADHOC)
Kampot Contact: Sim Sophea
Adresse: 1, St. 158, Sangkat Beomg Rang, Khan Dam Penh, Phnom Penh
Tel.: (855)-23-428-653
Fax: (855)-23-427-229
ADHOC's principal objective is to achieve respect for human rights through intensive information, education, and training programs on the monitoring, reporting and documentation of human rights violations. A micro-credit program and a publication were added in 1993-94.
4. Cambodian League for Promotion and Defense of Human Rights (LICADHO)
   Address: 103, St. 97, Phnom Penh
   Tel: 015-915-653
   Fax: (855)-23-427-626
LICADHO opened its first office in 1992, and has since become a nationwide organization with offices in Phnom Penh and 12 provinces, including Kampot. Its objective is to promote human rights and democracy, training the public, monks, police, women, children, prisoners, guards and civil servants on the identification of human rights violations.

5. Cambodian Disabled People's Organization (CDPO)
   Kampot Contact: Pon Samouth
   Phnom Penh Address: 25, St. 322, Boeung Keng Kang I, Chain Car Mon, Phnom Penh
   Tel: (855)-23-362-232
CDPO is a nationwide self-help and self-improvement organization benefitting disabled people. Its primary objective is to enable them to fully participate in society.

6. Cambodia Health Committee (CHC)
   Phnom Penh Contact: Sok Thim
   Phnom Penh Address: 18, St. 604, Boeung Kok 2, Tool Kork, Phnom Penh
   Tel/Fax: (855)-23-426-115
CHC was founded to respond to the enormous problem of tuberculosis. It has health cue and HIV/AIDS education, community outreach and credit activities. It is currently focused on Svay Rieng and is planning expansion to Kampot.

These other PVOs were mentioned in at least one of the databases for Kampot:
   Human Rights Vigilance (Vigilance)
   Buddhist Association for Relief of the Poor
   Socio-Economic Development Organization of Cambodia
I. Health NGOs with Strong Potential for RACHA Collaboration

1. Cambodia-Canada Development Program
   Phnom Penh Contact: Agnes Vant Bosch
   Phnom Penh Address: 198, St. 370, Phnom Penh
   Tel/Fax: (855)-23-217-338; 015-915-541
   E-mail:
   CCDP is a coalition of 21 Canadian NGOs working together with Cambodian partners to design and implement long-term development projects in Cambodia and to raise public awareness about Cambodia in Canada. CCDP's strategy focuses on strengthening the capacities of communities and institutions in Cambodia, especially in the province of Pursat, to promote development in the key sectors of health, agriculture and human resources development. The integrated community development program has been operational since 1993 and is now in its second phase. A full 65% of funding (CDN$5 million) from the Canadian International Development Agency for Cambodia will be spent in Pursat province. Five member agencies and their local counterparts will be responsible for program implementation.

2. CARE International in Cambodia
   Phnom Penh Contact: Graham Miller
   Address: 18A, St. 370, Boeung Keng Kang I Cham Car Mon, Phnom Penh
   Tel: (855)-23-362-984/721115.
   Fax: (855)-23-426-233
   E-mail: care.cam@bigpond.com.kh
   CARE Australia is the lead member of the federation of CARE offices worldwide. CARE International is involved in relief, rehabilitation and development activities with the goal of laying the groundwork for Cambodia's long-term development. CARE's institutional goal is to work with disadvantaged communities as they develop self-reliance and sustainable improvements in their livelihood and environment. In providing assistance to returnees, rural and urban based projects aim to improve health, literacy and household income. Village-based credit mechanisms, water and sanitation activities and the rehabilitation of roads are supported with resources and information/training.

   CARE is currently implementing the following projects in Pursat: Adult Literacy and Vocational Education, Birth Spacing IEC, and Jivit Thmey (New Life). All three projects receive funding from CARE USA and UISAID.

II. Other International NGOs

1. Concern Worldwide (CONCERN)
   Phnom Penh Contact: Rob Williams
   Phnom Penh Address: 36, Street 388, Tuol Svay Prey 1, Cham Car Mon, Phnom Penh
   Tel: (855)-23-365095; 362-636
Since 1990, CONCERN has been involved in providing emergency assistance to the internally displaced and
development activities in five provinces in the following areas: health, education, literacy, water resource
development, forestry, agriculture, and economic development. In Pursat, it is supporting the following
activities and has these partners:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Partner/Ministry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agricultural extension and credit</td>
<td>Ministries of Agriculture and Rural Development</td>
</tr>
<tr>
<td>School construction</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>Nursery establishment/Forestry</td>
<td>Department of Forestry</td>
</tr>
<tr>
<td>Women's literacy</td>
<td>Secretariat for Women's Affairs, Ministry of Education</td>
</tr>
<tr>
<td>Road and bridge construction</td>
<td>Department of Roads and Bridges</td>
</tr>
<tr>
<td>Well construction</td>
<td>Department of Hydrology</td>
</tr>
</tbody>
</table>

2. **Handicap International (HI)**

   Phnom Penh Contact: Mac Bonnet, tel. (855)-23-426-270
   Phnom Penh Address: 53, Blvd. Sothearos, Phnom Penh
   E-mail: hiansscambodge@bigpond.com.kh

HI works with the Ministries of Social Affairs, Labor and Veterans Affairs in eight provinces of the country,
including Pursat. It is focused on providing preventive and curative care in favor of disabled people.

3. **Oxfam Quebec (OCSD)**

   Pursat Contact: Jean Thiboutot
   Phnom Penh Address: 198, St. 370, Boeung Keng Kang, Phnom Penh
   Tel: (855)-23-720-929; 01-583-5376
   Fax: (855)-23-729-928
   E-mail: OXCAM@bigpond.com.kh

Oxfam Quebec is one of the implementing partners of the Cambodia-Canada Development Program. Oxfam
Quebec works directly with local grassroots groups, including women, farmers' associations and government
institutions to support sustainable development. It focuses on agriculture, small business development,
institutional strengthening and women in development.

4. **Quaker Service Australia (QSA)**

   Phnom Penh Contact: Audrey Cornish
   Phnom Penh Address: 13EI, St. 302, Boeung Keng Kang I Cham Car Mon, Phnom Penh
   Tel/Fax: (855)-23-362-732
   E-mail: qsa@bigpond.com.kh

QSA is an independent Australian aid agency that is supporting health education, agriculture, water
distribution and a sawmill in Pursat. The sawmill processed wood for school buildings and desks for several
years. QSA collaborates with the Department of Women's Affairs in supporting women at the Prek Leap
Agricultural College.
III. Cambodian NGOs

1. Cambodian League for the Promotion and Defense of Human Rights (LICADHO)
   Phnom Penh Contact: Dr. Kek Galabru
   Address: 103, St. 97, Phnom Penh
   Tel: 015-915-653
   Fax:(855)-23- 427-626

LICADHO opened its first office in 1992, and has since become a nationwide organization with offices in Phnom Penh and 12 provinces, including Pursat. Its objective is to promote human rights and democracy, training the public, monks, police, women, children, prisoners, guards and civil servants on the identification of human rights violations.

3. Buddhism Development and Supporting Environment (BDASE)
   Pursat Contact: Chan Sath
   Pursat Address: Peal Nhek Pagoda, Sangkat Phtah Prey, Pursat
   Tel/Fax: 56461-56463

BDASR promotes Buddhism as the basis of community development. It has completed projects to rebuild schools, produce brick tiles, and raise fish.

Other international and Cambodian NGOs mentioned in at least one database for Pursat:
- American Friends Service Committee
- Cham Khmer Islam Minority
- Human Rights and Development
- Human Rights and Community Outreach Projec
- Partage avec les Enfants do Monde
- Veterinaires Saus Frontieres
- World Vision International
- ZOA Refugee Care
Inventory of Health NGOs in RACHA Project Areas  
SIEM REAP Province

I. Health NGOs with Strong Potential for RACHA Collaboration

1. Caritas Cambodia (CARITAS)
   Phnom Penh Contact: Frederic Henriot
   Phnom Penh Address: 47, St.198, Sangkat Beng Pralith, Phnom Penh
   Tel/Fax: (855)-23-364-188/216-258
   E-mail: caritas@bigpond.com.kh
   Caritas Cambodia is the main social action arm of the Catholic community in Cambodia. It aims to be a partner of the poor to help them help themselves by mobilizing them and their ideas and by letting them live and develop their own projects and activities for the good of the community. Caritas obtains its funding from different congregations and governments.

   In Siem Reap, Caritas supports a primary health care (PHC) project benefitting the floating village population of the Tonle Sap.

2. Médecins sans Frontières (MSF)
   Phnom Penh Contact: Dr. Yves Coyette and Dr. Dominique Lapier
   Phnom Penh Address: 8, St. 211 and 5, St. 156, Khan 7 Makara, Phnom Penh
   Tel: (855)-23-428-308
   Fax: (855)-23-362-289
   E-mail: msfcam@bigpond.com.kh
   MSF is an independent, international, private humanitarian organization of volunteers that provides medical assistance to populations in danger. Staff for MSF's operations in Cambodia come from Belgium, France, Holland and Switzerland. In Cambodia, MSF has chosen to strengthen public health services at the periphery, focusing on provincial hospitals in Siem Reap and several other provinces. Assistance is provided in the form of personnel, technical assistance, essential drugs, renovation of buildings and medical equipment.

   MSF also supports health programs that have a nationwide scope, such as training in laboratory technology, anesthesiology, HIV/AIDS/STD prevention (with PSI's collaboration), and the National Essential Drugs Program.

   In January 1995, MSF supported a private, nonprofit clinic run by a local association, the Cambodian Urban Health Care Association (CUHCA). This clinic was an experiment to provide first line health care for vulnerable urban groups. The program was substantially changed and scaled back after a few months of operation. With MSF's support, CUHCA continues to provide services in Roussey Keo and Svay Pak, two suburban districts of Phnom Penh.

   MSF is the largest health-focused international NGO in Cambodia today. In 1997, it spent more than US$5 million in Cambodia. Its budget comes from governments (60%) and private fundraising from the public in different countries (40%).
3. Partnership for Development in Kampuchea (PADM)
   Phnom Penh Contact: Chanthou Boua
   Phnom Penh Address: 38, St. 57, Phnom Penh
   Tel/Fax: (855)-23426-224
   E-mail: padek@forum.com.kh
   Siem Reap Contact: Kho Chandara,
   Tel. 063-380-142

PADEK is a consortium of international donors that is in the process of transforming itself into a local NGO. Its goal is to empower disadvantaged people to improve their quality of life in a sustainable way. It is committed to encourage the formation of appropriate people's organizations, and support people to:

- access and manage resources to meet basic needs in a sustainable way
- sustain local initiatives
- network with government, other NGOs, and people to promote sustainable development
- promote gender equity
- capacity-building and social justice.

PADEK is working in 75 villages in Siem Reap and three other provinces and Phnom Penh. Health is one of eight development objectives, the others being organization-building, income generation, food security, environment, education and culture, staff development and social action.

II. Other International NGOs

1. Concern Worldwide (CONCERN)
   Phnom Penh Contact: Rob Williams
   Address: 36, Street 388 (193), Tool Svay Prey I, Charn Car Mon, Phnom Penh
   Tel: (855)-23-365095; 362-636; 012-888-897
   Fax: (855)-23-362-636
   E-mail: concerncam@bigpond.com.kh

Since 1990, CONCERN has been involved in providing emergency assistance to the internally displaced and to development activities in five provinces in the following areas: health, education, literacy, water resource development, forestry, agriculture, and economic development. In Siem Reap, it is supporting the following activities and has these partners:

- Agricultural extension and credit
- School construction
- Well construction

- Ministries of Agriculture and Rural Development
- Ministry of Education
- Department of Hydrology

2. Handicap International (HI)
   Phnom Penh Contact: Marc Bonnet
   Tel. (855)-23-217-300; 217-298; 982-811
   Fax.: 216-270
   Phnom Penh Address: 53, Blvd. Sothearos, Phnom Penh
   E-mail: hianscambodge@bigpond.com.kh

HI works with the Ministries of Social Affairs, Labor and Veterans Affairs in eight provinces of the country, including Siem Reap. It focuses on providing preventive and curative care in favor of disabled people.
3. Redd Barna Cambodia
   Phnom Penh Contact: Gunnar Andersen
   Phnom Penh Address: 9, St. 322, Boeung Keng Kang, Phnom Penh
   Tel: (855)-23-362-135; 362-143; 216-232
   Fax: (855)-23-362-523
   Siem Reap Contact: Khiev Sakhet,
   Tel. 063-380-067
   E-mail: ReddBarna.Cam@UNI.FI
Redd Bama is the Norwegian Save the Children office. It is committed to the improvement of the well-being of children and to ensure their rights to survival, development, protection and participation. It focuses on child-centered community development, school construction and improvement of primary education in Siem Reap Province.

III. Cambodian NGOs

1. Association of Cambodian Local Economic Agencies (ACLEDA)
   Phnom Penh Contact: Prak Sokal
   Address: 132, St. 163, Tool Tom Pong 1, Phnom Penh
   Tel/Fax: (855)-23-364-619
ACLEDA was established in 1993 with technical assistance and funding from UNDP/ILO. Its objective is to support small women's enterprises with business training, access to credit and ongoing technical assistance. It currently has a nationwide credit portfolio of more than $1,000,000.

2. Cambodian League for the Promotion and Defense of Human Rights (LICADHO)
   Phnom Penh Contact: Dr. Kek Galabru
   Address: 103, St. 97, Phnom Penh
   Tel: 0 15-915-653 Fax: 427-626
LICADHO opened its first office in 1992, and has since become a nationwide organization with offices in Phnom Penh and 12 provinces, including Siem Reap. Its objective is to promote human rights and democracy, training the public, monks, police, women, children, prisoners, guards and civil servants on the identification of human rights violations.

2. Cambodian Human Rights Association (ADHOC)
   Karnpot Contact: Sim Sophea
   Address: 1, St. 158, Sangkat Beoung Rang, Khan Dann Penh, Phnom Penh
   Tel.: (855)-23-428-653
   Fax: (855)-23-427-229
ADHOC's principal objective is to achieve respect for human rights through intensive information, education, and training programs on the monitoring, reporting and documentation of human rights violations. A micro-credit program and a publication were added in 1993-94.

These other NGOs were mentioned in one of the databases to have operations in Siem Reap:
Action Contre la Faim (ACF)
Actio Nord-Sud (ANS)
Adventist Development and Relief Agency (ADRA)
Cambodia Family Development Services (CFDS)

Catholic Office for Emergency Relief and Rehabilitation (COERR)
Halo Trust (HT)
Harvard Training Program in Cambodia (HTPC)
International women's Development Agency (IWDA)
Krousar Thmey (KT)
Mine Advisory Group (MAG)
Order of Malta (MHD)
Overseas Service Bureau (OSB-Australia)
Volunteer Services Overseas (VSO)
World Vision International Mine Awareness Team (WVI-MAT)
Inventory of Health NGOs in RACHA Project Areas
STUNG TRENG Province

I. Health NGOs with Strong Potential for RACHA Collaboration

1. Partners for Development (PFD)
Phnom Penh Contact: Louis O'Brien
Address: 35, St. 294, Phnom Penh
Tel/Fax: (855)-23-362-779; 426-224
E-mail: pfd.cambodia@bigpond.com.kh

Formerly AICF/USA- PFD currently implements the Northeast Cambodia Community Development Project (-NCCDP), an area development project that assists the underserved provinces of Kratie, Stung Treng, Mondulkiri and Rattanakiri. PFD/NCCDP promote an arewide, integrated community development approach through a combination of well-targeted initiatives. These include community organization and development, rural water supply, environmental sanitation, health education, and economic development. Project approaches include decentralization of service delivery, human resource development, private sector development, monitoring and evaluation.

PFD has recently received a grant from USAID's Child Survival Program to initiate a mother and child health program for Kratie, with the intent of expanding to Stung Treng. Several private sector initiatives have been initiated, including providing support to local retailers of key commodities and spare parts and assisting other agencies in the establishment of key health commodities.

2. Medecins sans Frontieres (MSF)
Phnom Penh Contact: Dr. Yves Coyette and Dr. Dominique Lapiere
Phnom Penh Address: 8, St. 211 and 5, St. 156, Khan 7 Makara, Phnom Penh
Tel: (855)-23-428-308
Fax: (855)-23-362-289
E-mail: msfcam@bigpond.com.kh

MSF is an independent, international, private humanitarian organization of volunteers that provides medical assistance to populations in danger. Staff for MSF's operations in Stung Treng come from Switzerland. As in other parts of Cambodia, MSF is currently assisting the provincial health system of Stung Treng by providing human resources, technical assistance, essential drugs, medical equipment and the renovation of buildings.

3. Youth with a Mission (YWAM)
Phnom Penh Contact: Pierre Tami Stung Treng
Contacts: Philip and Wendy Scott
Phnom Penh Address: 96, St. 118, Tuol Kork, Phnom Penh
Tel/Fax:(855)-23-368-083
E-mail: hagar@camnet.com.kh

YWAM is an international Christian humanitarian agency that seeks to meet human needs while affirming the dignity, value and self-worth of those being served. Each of the projects it supports aims to partner with the poor and assist them towards self-sufficiency.

Since 1992, YWAM has had a team of eight persons based in Stung Treng. An integrated area development program is currently implemented in all districts of the province, with education/training, health, water and sanitation, and social work as the major components.
Health interventions include midwife and TBA training, district health infrastructure development, malaria control, health education and prison assistance. All activities are pursued in close collaboration with the Ministry of Health and other local and international NGOs currently working in Stung Treng.

II. Other International NGOs

1. Cambodia Assistance to Primary Education (CAPE)
   Phnom Penh Contact: Edward Baxter
   Address: 2D, Street 302, Boeung Keng Kang I, Phnom Penh
   Tel: (855)-23-721-046; 017-816-923; 017-817028
   Fax: (855)-23-721-060 E-mail: cape@bigpond.com.kh

CAPE is a consortium consisting of World Learning, World Education, Save the Children USA, Save the Children Australia and the International Rescue Committee. It seeks to work within the existing education and community structures, in cooperation with the Ministry of Education, Youth and Sports, donors and other NGOs to build and strengthen these structures and to transfer skills to counterparts. It has a branch office in Stung Treng through which teacher training workshops, cluster school and community development activities are facilitated. CAPE has temporarily suspended its operations in the aftermath of the July 1997 events in Cambodia.

III. Cambodian NGOs

There are no Cambodian NGOs based in Stung Treng.
Appendix F
Suggested NGO Guidelines
SUGGESTED GUIDELINES FOR RACHA TO USE WHEN WORKING WITH NGOS

Overview

The contemporary literature on the role of NGOs in developing countries reveals that, where there has not been a history of indigenous NGOs, these new NGOs develop more along the lines of for-profit small businesses competing for a share of the market. The market is access to donor funds.

International agencies or donors often work on the assumption of a shared set of values and principles when working with local NGOs and this can lead to serious problems in programming and services. The assumption that NGOs are first and foremost created to be responsive, flexible and accountable to a client group is not necessarily the case. The reality is that these NGOs often have no relationship with the client group; they are often very political; and, in some cases, we closely tied to the government through such mechanisms as board membership or payment of 'consultancy lines' to government staff.

An agency assumption that NGOs have a mission to serve their client group and that they develop proposals in order to obtain funds to meet that goal does not always match the reality. This is the case where the NGO has a mission to attract funds and to gain a larger share of that market and therefore, develops proposals or identifies potential clients as a mechanism to reach that funding goal.

These observations do not necessarily mean that agencies cannot or should not work with local NGOs. What it does mean is that the agency will need to educate itself to the reality of NGO programs in the country and to be fully aware of the human and financial resources required in order to strengthen local NGOs and to develop partnerships with them.

Some Implications of New NGO Sectors

(For the purpose of these guidelines, "new" NGO means young and generically new to the culture. A "young" NGO, on the other hand, emerges in an established NGO culture, and would not necessarily face the same constraints or operate on the same assumptions.)

New NGOs may represent an individual or family financial interests as manifested in only family members or close friends being hired or put on the Board of Directors. Some NGOs operate with a 'public' board and a 'shadow' board which has the authority and influence to make policy and to direct programming decisions.
Financial management systems are often not transparent and me not equipped to handle the complexity of multiple donors and/or projects.

There may have been little or no program impact assessment or evaluation. Claims of success may only be expressed in numbers and, therefore, do not reflect client satisfaction or increased quality of services, for example.

New NGOs are often highly centralized, with most staff based in the headquarters and the budgets for administrative staff and functions representing a large proportion of the overall budget.

New NGOs rarely demonstrate accountability, to target clients. They have not established a mechanism for clients to give feedback on services, to be involved in program design and implementation, or to be represented on the Board. On the other hand, if they are entirely donor driven, these NGOs have reason to be confused at times over who their client is. Unless they have established services or programs based on client needs prior to approaching the donor, it is unlikely that they will be able to do that independently once they receive funds.

**Programming Options**

RACHA can choose to work only with existing, established NGOs and simply purchase their services and/or products. For example, training and curricula we available from the Reproductive Health Association of Cambodia (RHAC) without my other investment on the part of RACHA.

Another option is to work to develop local NGO partners with a long-term view to establishing sustainable programs for future support from other donors - or to move towards financial sustainability. This will require a long-term commitment of funds and staff on the part of RACHA. If this option is chosen, some next steps should be considered.

First, RACHA needs to establish a criteria for NGO selection: For example NGOs currently working in the four focus provinces that have the potential to expand their programming base in support of RACHA objectives; or NGOs currently working in the areas supported by RACHA who we willing and/or able to move into one or more of the four focus provinces.

Second, when working with NGOs, some initial steps need to be taken either during the assessment and selection phase or immediately upon contracting them. These include:

- A program Audit (impact evaluation);
- By conducting a program audit, RACHA will be able to establish a baseline of NGO activities against which future growth can be measured. It also enables the NGO to document actual impact and to identify weak areas. Successes can be used
for marketing and planning. Furthermore, it establishes the importance of evaluation as an integral part of all program steps - and the need for it to be in place at the beginning of all planning.

- **A Finance and Administration Audit:** During the financial audit, PACHA will need to establish transparency in all financial systems that are attached to PACHA funded programs. The audit provides an excellent opportunity to learn about mechanisms of control and decision-making within the NGO and to assist the NGO to identify weaknesses and training needs. If the NGO is going to be working with multiple donors, it is to RACHA’s benefit to assist the NGO with setting up systems to handle the multiple reporting needs. The Administrative audit looks at such personnel issues such as who does what, the skills and abilities of various staff, efficient use of human resources, existence of policies and procedures and identification of training needs.

- **During both of these audits, RACHA should focus on larger issues such as supervision and MIS (management information systems).** Supervision is an essential part of accomplishing both the technical strengthening activities of this stage and the later program objectives. Supervisors should be closely involved in all aspects of assessing and responding to personnel and organizational needs. Their role is crucial to the success of subsequent interventions.

- **MIS in this case refers to the larger scope of communications, information collection and daily practises that inform the NGO of what is happening within its organization as well as within the larger community.** When conducting financial audits, advisors should continually ask ‘who needs this information, when and for what purpose?’ so that MIS needs are met. In dealing with personnel issues, the same questions are asked as well as, ‘what information do you need in order to do this, when and in what format?’ This analysis, if built into the technical assistance, will work to create awareness of the importance of ongoing and effective communication as well as assist the advisor to identify interruptions or constraints to information flows.

Third. RACHA and partner NGOs will need to work towards a common understanding of the objectives, values and mission of the partnership. RACHA will need to approach this with sensitivity towards the local cultural norms and a recognition that local partners will quickly develop the appropriate vocabulary when working with donors. However, if there is a commitment to a more in-depth sharing of objectives over the long term, the work towards understanding each other and to clarifying both the potential and the limits to the partnership needs to remain an ongoing core activity.

Lastly, at the beginning of new contracts, it is helpful for systems to be highly structured and, in particular, for reporting and monitoring to be highly participatory and in person. There is often a tendency for reporting to become a ‘checklist’ of observed accomplishments and these checklists can take on a life of their own. Therefore, by encouraging managers and technical staff to report in person on activities, results, accomplishments and constraints (for example) strengthens their
ability to put the pieces together and to make Program decisions based on experience. At the same time, valuable rapport can be established through ongoing discussions about 'shared' responsibilities for program success.

One model of this could be informal monthly meetings with key program staff and more formal quarterly reports with all relevant staff involved. If higher level staff impede efforts to have program staff report, RACHA can build this in as a 'training' function for the lower staff to build their skills. Directors are sometimes willing for this to take place if they are told that having articulate program staff who can make good presentations will make their NGO more competitive and attractive to other donors.

With all reporting activities, RACHA will need to work to avoid having these activities become the outcome of projects. A completed report, a checklist or a presentation often begins to take precedence over actual services or programs for the clients. Therefore, it is also essential that client feedback systems be put in place right at the beginning or as soon as possible. As mentioned earlier NGOs are often unfamiliar with their actual or potential client groups and it is rarely the case that clients were involved in designing or evaluating programs. One exception to this is the program of the NGO UCC (in Kampot Province) for annual postgraduate follow-up. This involves sending staff out into the country to interview graduates and to see if their lives have improved. At that time, they ask if there are things that the course could have provided and didn't. This information is collated and used to revise curricula.

LIST OF PERSONS CONTACTED

U.S. Agency for International Development
Ms. Lois Bradshaw, Chief, Office of Health and Humanitarian Assistance
Dr. Jeffrey Ashley, Health and Population Officer
Dr. Chantha Chak, Project Management Specialist
Ms. Erica Aquino, Grants Manager

Ministry of Health
Dr. Eng Huot, Director General for Health
Dr. Hong Rathavuth, Director of Hospital Services
Dr. Chou Yin Sim, Director, Department of Drugs and Food
Dr. Chroeng Sokhan, Clinical Pharmacist
Dr. Dy Bun Chhem, Director of Provincial Health Department, Siem Reap
Dr. Lim Kaing Eang, Director of Provincial Health Department, Kampot
Dr. Toch Sokha, Director, Provincial Hospital, Kampot
Dr. So Savath, Provincial MCH Director, Kampot
Mr. Sun Po, Provincial MCH Vice Director, Kampot

Ministry of Tourism
Mr. Sam Promonea, Under Secretary of State

RACHA
Dr. Sally Stansfield, Child Survival Advisor
Ms. Judy Carlson, Reproductive Health Advisor
Mr. Carl Hasselblad, Planning/Management Advisor
Mr. Jim Eberle, Logistics Advisor
Mr. Borithy Lun, Private Sector Coordinator
Dr. Chim Sopharo, Siem Reap Provincial Coordinator
Dr. Phalkun, RACHA, Kampot Province
Dr. Jean Ahlborg, AVSC International Regional Reproductive Health Advisor
Ms. Billie Slott, Consultant

International Donors and Non-governmental Organizations
Dr. George Petersen, Representative, WHO
Dr. Stefan Hoyer, Medical Officer for Malaria Control, WHO
Mr. Graham Miller, Country Director, CARE
Mr. Rand Robinson, CARE
Dr. Gertrud Schmidt-Ehry, Senior Advisor, GTZ
Mr. John M. Deidrick, Director, PSI
Ms. Cynde Robinson, Vice Director, PSI
Ms. Ines Metcalfe, Resident Advisor to the Ministry of Women’s Affairs, UNFPA
Mr. Brian M. McLaughlin, Regional Representative, PATH/Thailand
Ms. Hara Srimuangboon, Community Health Educationist, PATH/Thailand

Mr. Andrew Morris, Country Advisor, UNICEF
Ms. Louise Bury, Private Sector Initiatives Project, Marie Stopes International
Ms. Jill Sherman, IEC & Marketing Advisor, Marie Stopes International
Ms. Satomi Naito, Registered Midwifery Nurse, MCH Project, JICA
Ms. Kay Suzuki, Project Coordinator, MCH Project, JICA
Dr. Anrie Voorhove, Medical Coordinator, Mimesa Medicus Mundi (Kampot)
Ms. Linda McInney, Country Director, UCC Development Foundation (Kampot)
Ms. Bernadette Glisse, Project Manager, Floating Health Center Siem Reap, CARITAS Cambodia

Cambodian NGOs
Dr. Sôh Thim, Executive Director, Cambodian Health Committee
Dr. Vong Vathiny, Executive Director, Reproductive and Health Association of Cambodia
Ms. Maggie Huff, Reproductive and Health Association of Cambodia

Professional Associations
Dr. Sau Sokkhonn, President, Cambodian Medical Association
Ms. Neang Ren, President, Cambodian Midwives Association
Mr. Sroy Sriev, President, Pharmacist Association of Cambodia
Mr. Yim Yann, General Secretary, Pharmacist Association of Cambodia

Physicians in Private Practice
Dr. Uy-Borany, Siem Reap
Dr. Neou Leakhena, Siem Reap
Dr. Chan Narinette, Siem Reap
Dr. Kong Rithy, Siem Reap
Dr. Keang Soktry (wife interviewed at private clinic), Siem Reap
Dr. Eth Saravaon, polyclinic owner (mother, a registered nurse, was interviewed), Siem Reap
Dr. Lao Vanna, Kampot
Dr. Ho Eang, Kampot
Dr. Neak Long, Kampot
Physician (name not recorded), polyclinic owner, Kampot

Midwives
Mrs. Keo Sovanna (Cambodia Midwives Association Branch Leader), Siem Reap
Mrs. Tra Tim, Siem Reap
Mrs. Phat Chamroeun, Siem Reap
Mrs. Teung Marady, Siem Reap
Mrs. Iy Sokoan, Siem Reap
Mrs. Nop Sothy, Siem Reap
Mrs. Kao Vanny, Siem Reap

Pharmacists and Drug Sellers
Drug seller, Samrong Village, Siem Reap Province
Drug seller, Samrong Village, Siem Reap Province
Pharmacy operator, Damdek, Siem Reap Province
Pharmacy owner, Damdek, Siem Reap Province
Pharmacy owner, market area, Siem Reap Town
Pharmacy owner, market area, Siem Reap Town
Pharmacy operator, provincial hospital area, Siem Reap Town
Drug seller, Ponley Village, Pursat or Kampong Chhnang Province
Drug seller, Pasar Village, Pursat or Kampong Chhnang Province
Pharmacy owner, Kampong Chhnang Town
Pharmacy owner, market area, Kampong Chhnang Town
Pharmacy owner, market area, Kampong Chhnang Town
Pharmaceutical Distributors
Mr. S.P. Venugopal, Manager Zenaust Pharma (Cambodia) Ltd.
Medical Representative, Zenaust Pharma (Cambodia) Ltd.
Mr. Anurag Mehrotra, Marketing Manager, Pritsons (Cambodia) Ltd.
Mr. Inder Mohan Singh, Commercial Manager, Pritsons (Cambodia) Ltd.
Mr. Dara Khim, Assistant Marketing Manager, Pritsons (Cambodia) Ltd.
Mr. Laing Ly, Director, Medical Supply Company, Phnom Penh
Local owner/partner, Medical Supply Company, Siem Reap
Angkor Pharmacy owner/distribution agent for Hiepseng/Lyka, Siem Reap

Insurance Industry
Mr. Long Phalita, Branch Manager, Indochine Insurance (Siem Reap)

Hotel Industry (Siem Reap)
Mr. Gilbert Madhavan, Hotel Manager, Grand Hotel d’Angkor
Mr. J. Vira (Noi), General Manager, Hotel Nokor Kok Thlok
Mr. Olivier Piot, Manager, Angkor Village Hotel

Other Resources
Dr. Joel Montague, Consultant
Dr. Milton Amayun, Team Leader, Asia, Middle East, Eastern Europe, World Vision Relief & Development Inc.

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