Kingdom of Cambodia
NATION - RELIGION - KING

National Strategy for Reproductive and Sexual Health in Cambodia

2006-2010

National Reproductive Health Programme

MINISTRY OF HEALTH
Royal Government of Cambodia

Phnom Penh
February 2006

CONTENTS

TABLES

BOXES

FOREWORD

The Ministry of Health developed the national strategy for reproductive and sexual health in Cambodia (2006-2010) to ensure an effective and coordinated response to reproductive and sexual health needs in the country. This strategy and upcoming operational plans provide the framework from which to advocate reproductive and sexual health priorities, engage in annual planning, and mobilise the resources necessary for effective action. The National Reproductive Health Programme initiated development based on four guiding principles: (a) human rights and empowerment, (b) gender equity, (c) multisectoral partnerships, linkages, and community involvement, and (d) evidence based programming.

Reproductive healthcare, particularly provision of effective services for maternal and newborn health and HIV/AIDS, is a significant challenge in Cambodia. Resources are limited and needs are great. This first strategy for reproductive and sexual health in Cambodia builds upon existing policies and strategies to address these needs in a more comprehensive and integrated way.

The goal is to attain a better quality of life for all Cambodians by improving the reproductive and sexual health status of women, men, and adolescents through effective and appropriate health programmes. The four strategic objectives are to:

(1) improve the policy and resource environment for reproductive and sexual health priorities in Cambodia[1];
(2) increase availability and strengthen delivery of quality reproductive and sexual health services;
(3) strengthen community understanding of reproductive and sexual health needs and rights and increase demand for services;
(4) expand the evidence base to inform policy and strategy development.

Phnom Penh, February 2006

His Excellency Professor Eng Huot
Secretary of State
Ministry of Health
Royal Kingdom of Cambodia

[1] Priorities include maternal and newborn health, STIs including HIV/AIDS, family planning, and equity (e.g. ARSH, gender-based violence, and male involvement)

ACKNOWLEDGEMENTS

This national strategy for reproductive and sexual health in Cambodia (2006-2010) is the result of a consultative development process undertaken by the National Reproductive Health Programme (NRHP), under the auspices of the Ministry of Health, Royal Government of Cambodia. This consultative process strengthened existing partnerships and linkages, drew attention to the need for additional linkages, ensured a broad ongoing debate, and contributed to a more coherent and representative national strategy.

The NRHP developed a first draft through a consultative process of meetings, interviews, field visits, and review of relevant literature [1-25]. The strategy development team made initial revisions based on feedback from key partners. The NRHP and partners then strengthened and finalised the strategy through a series of three national consultation workshops and meetings with key governmental and non-governmental partners.

Throughout the developmental process, key staff from governmental, non-governmental, bilateral, university, and UN organisations provided insight and feedback on critical components of the strategy, making the process truly participatory. We wish to thank the Ministry of Planning, the Ministry of Women's Affairs, and the Ministry of Education, Youth and Sport. Particular thanks go to the United Nations Population Fund in Cambodia (UNFPA) and Voluntary Service Overseas (VSO) for providing financial and technical support for the development and finalisation of this document.

ACRONYMS AND ABBREVIATIONS

AFRSH	Adolescent-friendly reproductive and sexual health
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
AOP	Annual Operational Plan
ASEAN	Association of Southeast Asian Nations
ARSH	Adolescent reproductive and sexual health
ART	Antiretroviral therapy
BS	Birth spacing
CAC	Comprehensive abortion care
CARE	CARE International in Cambodia
CBD	Community-based distribution
CDHS	Cambodian Demographic and Health Survey
CEDAW	Convention to Eliminate Discrimination Against Women
CIPS	Cambodia Intercensal Population Survey
CMA	Cambodian Medical Association
CMDG	Cambodia Millennium Development Goals
CPA	Complementary Package of Activities
CPR	Contraceptive prevalence rate
CS	Child Survival
CSWG	Contraceptive Security Working Group
DfID	Department for International Development-UK
EC	Emergency Contraception
EmOC	Emergency Obstetric Care
E-IUD	Emergency Intrauterine Device
EU	European Union
FP	Family Planning
GBV	Gender-based violence
GPCC	General Population Census of Cambodia
GTZ	Deutsche Gesellschaft für Techinsche Zusammenarbeit (German Technical Cooperation)
HC	Health Centre
HIS	Health Information System
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
INGO	International non-governmental organisation
ITN	Insecticide treated net
IUD	Intrauterine device
JICA	Japanese International Cooperation Agency
KfW	KfW Entwicklungsbank (German Development Bank)
LMIS	Logistic Management Information System
LNGO	Local non-governmental organisation
MCH	Maternal and child health
MCHC	Maternal and child health clinic
MDG	Millennium Development Goal
MEDiCAM	Membership organization for NGOs active in Cambodia's health sector
MMR	Maternal Mortality Ratio
MoEYS	Ministry of Education, Youth & Sport
MOH	Ministry of Health
MoP	Ministry of Planning
MoRD	Ministry of Rural Development
MoWA	Ministry of Women's Affairs
MPA	Minimum Package of Activities
MTEF	Midterm Expenditure Framework
NAA	National AIDS Authority
NCHADS	National Centre for HIV/AIDS, Dermatology, and STD
NCHP	National Centre for Health Promotion
NGO	Non-governmental organization
NHS	National Health Survey
NIPH	National Institute of Public Health
NIS	National Institute of Statistics
NMCHC	National Maternal and Child Health Centre
NNP	National Nutrition Programme
NRHP	National Reproductive Health Programme
OD	Operational District
PAC	Post Abortion Care
PADV	Project Against Domestic Violence
PCR	Polymerase Chain Reaction
PHD	Provincial Health Department
PMTCT	Prevention of mother-to-child transmission
PPH	Postpartum Haemorrhage
PSI	Population Services International
PSO	Population Services Organization, Holland
RACHA	Reproductive and Child Health Alliance
RH	Reproductive health
RHCS	Reproductive health commodity security
RHIYA	Reproductive Health Initiative for Youth in Asia
RPR	Rapid Plasma Reagin
RSH	Reproductive and sexual health
RTI	Reproductive tract infection
SBA	Skilled Birth Attendant
SES	Socio-economic status
SM	Safe Motherhood
STI	Sexually transmitted infection
TBA	Traditional Birth Attendant
TFR	Total fertility rate
ToT	Training of trainers
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCCT	Voluntary and Confidential Counselling and Testing
VHSG	Voluntary health support group
VSC	Voluntary surgical contraception
VSO	Voluntary Services Overseas
WHO	World Health Organization

1 INTRODUCTION AND CONTEXT

1.1 Purpose

The Ministry of Health (MOH) developed the national strategy for reproductive and sexual health in Cambodia (2006-2010) to ensure an effective and coordinated response to reproductive health needs in the country. This strategy builds on the national safe motherhood action plan (2001-2005), birth spacing policy (1995), and abortion law (1997) [26-28]. It draws from the national policy on infant and young child feeding practices (2002) and the health sector strategic plan (2003-2007) with its minimum and complementary packages of services [6, 29]. It is linked closely with the draft national strategic plan for a comprehensive and multisectoral response to HIV/AIDS (2006-2010), strategic plan for HIV/AIDS and STI prevention and care (2001-2005), draft national strategic plan for child survival (2006-2010), draft national standard guidelines for adolescent-friendly reproductive and sexual health services (2005), and nutrition investment plan (2003-2007) [8, 29-32].

This collaborative strategy is part of the government's initiative to build a comprehensive response to the health needs of Cambodian people. This strategy and upcoming operational plans provide the framework from which to advocate reproductive and sexual health priorities, engage in annual planning, and mobilise the resources necessary for effective action. Additional detail on relevant policies and strategies is available in Annex I.

1.2 Guiding principles

1.2.1 Human rights and empowerment

Respect for individual and collective rights underpin any effective and inclusive strategy. The International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing 1995) affirmed the human rights of women in reproductive and sexual health. In Cambodia, the National Population Policy (2003) further affirmed these rights [33].

A crucial principle of this strategy is personal empowerment within a culturally sensitive intervention framework, enabling people to make free and informed decisions about their reproductive lives. Many people have little control over reproductive or sexual health-related choices. The MOH supports explicit client and provider rights, and is developing and piloting a rights package.

1.2.2 Gender equity

This strategy recognises that mainstreaming gender is essential for effective development and implementation of programmes and services. This means deliberately giving visibility and support to gender-specific issues rather than assuming everyone will benefit equally from gender-neutral interventions.

Gender is inseparable from reproductive and sexual health. Women and girls are often more vulnerable in Cambodia, due to lower status within the family and community and biological differences (e.g. gender-based violence, pregnancy/childbirth, HIV risk). Research shows economic justification for investing in gender equity and safe motherhood. Avoiding maternal death has significant benefits on household income, the quality of household expenditures, the chance of survival of young children, and their future educational achievements. Empirical evidence shows the benefits of girl's education on family health outcomes, social stability, environment, and economic growth [34, 35].

In Cambodia, small children, elderly parents, and extended family are dependent on the economic, productive, and nurturing inputs of reproductive-age women. Women and girls generally work harder, are more likely to invest earnings in their children, are major producers as well as consumers, and shoulder critical, life-sustaining responsibilities without which other members of society could not survive much less sustain high levels of productivity. Women's empowerment is particularly important in influencing demographic trends. [35-37]

Efforts are being made to address a number of gender inequities in Cambodia [16, 38]. Gender-based violence (GBV) is both a moral and a development issue, and the government has made major progress through recent passage of the Domestic Violence Law (2005). Male involvement, seen by some as an important means of increasing gender equity, remains largely unrecognised globally. However, advocates in Cambodia have made great strides in bringing male involvement towards the forefront of the reproductive and sexual health agenda. A recent concept note on male involvement in reproductive health provides ideas for addressing gender inequities [16]. Though increasing male involvement is only one of many issues that affect successful implementation, research has shown that involving men improves male health-seeking behaviour, helping both men and their families.

1.2.3 Multisectoral partnerships, linkages, and community involvement

Reproductive and sexual health is a holistic issue and affects everyone. An effective strategy involves a wide range of sectors and disciplines. While the main institutional focus for reproductive and sexual health is the NRHP, several entities are responsible for planning and implementing aspects of programming. The NRHP will seek ways to develop or strengthen linkages and partnerships with key ministries, departments, programmes, and sectors.

Key ministries include the Ministry of Social Affairs (MoSA), Ministry of Women's Affairs (MoWA), Ministry of Education, Youth and Sport (MoEYS), Ministry of Information, Ministry of Interior, and Ministry of Rural Development (MoRD). Key MOH departments include Personnel (PD), Human Resource Development (HRD), Planning and Health Information (DPHI), Human Resources Development (HRD), Drugs, Food & Cosmetics (DDF), and Central Medical Stores (CMS). Key programmes and disciplines include the National Centre for Health Promotion (NCHP), National Maternal and Child Health Centre (NMCHC), Child Survival Partnership (CSP), National Nutrition Programme (NPP), National Aids Authority (NAA) and National Centre for HIV/AIDS, Dermatology, and STIs (NCHADS).

Clarification of roles, responsibilities, and relationships within the MOH and between centre, provincial health departments (PHDs), operational districts (ODs), referral hospitals, health centres, NGOs, and private sector entities is essential for effective strategy implementation. Community perspectives and experiences must inform both strategy and implementation, in order to promote effective initiatives and community ownership.

1.2.4 Evidence base

Priorities and approaches included in this strategy developed from the existing evidence base of international guidelines and best practices, staff and programme experiences, lessons learned, and national and community-level research. Research results, along with programme monitoring and evaluation, will continue to guide prioritisation and implementation.

1.3 Socio-demographic context

Cambodia covers 181,035 square kilometres and shares borders with Thailand, Vietnam, and Laos. The Mekong River and Tonle Sap Lake topographically dominate the country, which is divided administratively into 24 provinces. Total population is estimated at 13.1 million, with approximately 80% in rural areas. Average household size (at 5.1) has decreased slightly in both rural and urban areas since 1998. Women head a high proportion (29%) of households. Though woman-headed households are not statistically poorer, they are often more vulnerable (e.g. less land, more reliant on high-risk coping strategies). The economically active population increased to 66% in 2004, corresponding with a 2% increase in unemployment. School enrolment and literacy remain low despite improvements.

The population growth rate, at 1.8%, is second only to that of Laos among ASEAN nations. Over 38% of the population is under 15 years of age. However, the growth rate has decreased dramatically from 2.4 in 1998. Ethnically, approximately 90% of the population is Khmer, while 10% is minority groups such as Cham, ethnic Chinese, and Vietnamese. Approximately 95% speak Khmer. Least densely populated areas are the north and northeast.[12, 39]

Box 1. Map of Cambodia

Cambodia is one of the poorest countries in Southeast Asia. The periods of war and internal conflict (1970-1993) severely destabilised health infrastructure and services. Recovery was set further back in the 1990s by political upheaval and regional recession. The Paris Peace Agreements of October 1991 enabled peace and stability to be progressively re-established, allowing focus on longer-term development. Despite significant progress, major disparities continue between urban and rural living standards (e.g. 56% of urban versus 11% of rural households use electricity as their main source of light). Poverty remains high, with more than 35% below the poverty line and 15% in extreme poverty. This phenomenon is largely rural, with over 90% of the poorest living in rural areas. Limited linkages to the domestic economy, limited access to basic services, landlessness, environmental degradation, and little or no education exacerbate poverty.[6, 40]

Gross domestic product (GDP) is approximately US$300 per capita. From 1999 to 2002, GDP grew an average of 6.8%. Growth remains narrowly based and inequalities are increasing. Official development assistance remains high at around US$39 per capita. Bilateral and multilateral organizations, UN agencies, NGOs, and private sector organisations support development initiatives throughout the country.[40, 41]

Table 1. Selected indicators in Cambodia

Socio-Economic Indicators	Amount	Source
Gross domestic product (per capita)	USD 300	ADB 2004
Health expenditure (% of GDP)	total 12 / public 2.1	MOH 2002
Households with electricity as main source of light (%)	urban 56 / rural 11	CIPS 2004
Adult literacy rate (%)	female 64 / male 85	CIPS 2004
School enrolment (%)	female 55 / male 63	CIPS 2004
Completed primary school (%)	female 19.5 / male 27.3	CIPS 2004
Migration level (%)	rural-rural 69 / rural-urban 14	CIPS 2004
Demographic Indicators	**Amount**	**Source**
Average annual population growth rate (%)	1.8	CIPS 2004
Total fertility rate (births per woman)	3.3	CIPS 2004
Contraceptive prevalence rate[2] (%)	23.8	CDHS 2000
Health Indicators	**Amount**	**Source**
Average life expectancy at birth	female 63.4 / male 57.1	CIPS 2004
Infant mortality rate (IMR)	97 / 1,000	CDHS 2000
Under-five mortality rate (U5MR)	140 / 1,000	CDHS 2000
Maternal mortality ratio (MMR)	437 / 100,000	CDHS 2000
Under-five malnutrition/underweight (%)	45	CDHS 2000
Anaemia among women of reproductive age (%)	57.8	CDHS 2000

1.4 Health system

The mission of the MOH is to ensure sector-wide, equitable, and quality healthcare for all people of Cambodia through targeting resources, especially to the poor and to areas of greatest need. Health policy asserts that all people in Cambodia, regardless of gender, age, residency, or financial ability, should have access to good healthcare and information. The MOH administers health services through 24 Provincial Health Departments (PHD), 76 Operational Districts (OD), 69 referral hospitals, and 966 health centres (HC). NGO and private practitioners also provide health services.

The violent civil war decimated health infrastructure, personnel, and services. In 1991, Cambodia began rebuilding its political, social, and economic structures. However, the public health system is struggling to meet the needs of its population. Many revert to unregulated and often costly private healthcare providers. Cambodia's high fertility, morbidity, and mortality rates compromise government efforts to achieve a just and peaceful society, and raise the living standard of Cambodians. Further reductions in mortality, especially among low-income mothers and children, are fundamental to socio-economic development and poverty reduction in Cambodia.

Providing universal access to health services requires a viable and effective health workforce. However, as demand has increased and new delivery methods become available, insufficient recruitment and training, deterioration of existing skills, difficulties attracting and retaining staff (especially in remote areas), and loss of

[2] CPR refers to use of any modern or traditional contraceptive method among women age 15-49

trained staff to the private sector have become major challenges. Most visible are shortages and mal-distribution of health workers, particularly midwives.

Public sector salaries are insufficient for daily living expenses, and would need to be multiplied eight to ten times to make up for the cost of living [42]. Many health workers maintain both public and private practices to survive, but are motivated to remain in public service due to professional identity, training opportunities, and career progression. A recent study to quantify components of health practitioners' income and motivations found that salaries and allowances from public service represent a small portion of total remuneration. Most (80%) have at least one source of additional income, but the majority (94%) claim they want to remain in public service. Thus, undertaking dual public-private work ensures that public workers can combine the benefits of government service with incomes similar to those in the private sector. [40] This helps retain personnel in the public sector, but increases conflicts of interest, leading to distortions in health staff behaviour, productivity, and performance.

Another barrier is that fewer Cambodian women want to become midwives. The MOH estimates the need for trained midwives over the next five years at 4,050 (public and private sector), leaving an estimated gap of 1,500 midwives. A recent NRHP study found the main obstacles perceived were: (1) having to spend too many years studying, often away from home, (2) being posted to remote rural areas when qualified, (3) risk of contact with contaminated blood, and (4) insufficient salaries. If government offered incentives (e.g. financial, training) for postings in remote areas, young women would be more likely to choose midwifery careers.

1.5 National Reproductive Health Programme

Cambodia has made considerable progress over the last decade, but continuing challenges include high maternal, neonatal, infant, and under-five mortality rates, low rates of delivery by skilled personnel, high unmet need for contraceptive services, high levels of anaemia in women of reproductive age, and high STI and HIV transmission. Reproductive and sexual health is fundamental to individuals, couples, families, and the socio-economic development of the country.

Thus in 1994, the government created the National Reproductive Health Programme (NRHP) to meet Cambodia's reproductive health needs. The NRHP implements the reproductive health policies and strategies of the Kingdom of Cambodia, contributing toward achieving the Health Sector Strategic Plan, the National Strategic Development Plan, The ICPD Programme of Action, and the United Nations Millennium Development Goals (MDGs).

The NRHP mission is to contribute to the improved wellbeing of the Cambodian people through (i) better reproductive health nationwide, (ii) increased gender equity, and (iii) a more sustainable balance between population, resources, and socio-economic development.

2 REPRODUCTIVE HEALTH SITUATION

The ICPD Programme of Action defines reproductive health as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions'. Over fifty ministerial, departmental, and organisational stakeholders have direct involvement in aspects of reproductive health in Cambodia (see Annex III).

This section provides an overview of the current situation in relation to a range of reproductive health components. These are maternal and newborn care; adolescent reproductive and sexual health (ARSH); contraception and family planning; reproductive tract infections (RTIs), including sexually transmitted infections (STIs) and HIV/AIDS; gender equity (abortion, gender-based violence, and male involvement); and gynaecological cancers, subfertility, and peri/postmenopausal reproductive health. Each component includes a brief summary of status, opportunities, and constraints identified by stakeholders.

2.1 Maternal and newborn[3] care

Status

Cambodia has among the highest maternal and child mortality rates in the region. The maternal mortality ratio (MMR) in Cambodia is 437/100,000 live births, while the infant mortality rate is 95/1,000 live births.[4] A sisterhood estimate in 1996 gave a 1 in 47 lifetime risk of dying from maternal complications in Cambodia [43]. The main causes of maternal mortality in Cambodia, as elsewhere in the region, are abortion-related complications, haemorrhage, obstructed labour, sepsis, and hypertensive disorders.[11]

Each year, 46,000 infants die in Cambodia. Neonatal mortality (first 28 days) comprises approximately 30% of under-five mortality in Cambodia, while post-neonatal infant mortality (1-12 months) comprises 46%. Newborn deaths are due to neonatal sepsis, tetanus, and congenital syphilis (33%); birth asphyxia and injuries (28%); prematurity (24%); and congenital anomalies (10%). [11, 44]

Table 2. Selected maternal and newborn care indicators in Cambodia

Indicator	Value	Source
Maternal Mortality Ratio	437/100,000	CDHS 2000
Abortion Mortality Rate	130/100,000	WHO 2002
At least two ANC visits (ANC2) with trained staff (public-sector %)	47	MOH 2004
Pregnant women receiving at least two tetanus toxoid (TT2+) vaccinations (%)	51	MOH 2004
Vitamin A coverage for postpartum women (%)	21	MOH 2004
Deliveries attended by trained staff (%)	32	CDHS 2000
• Midwife	28	
• Nurse	1.6	
• Doctor	2.2	

The public sector provides most maternal and newborn care (virtually all antenatal care, many deliveries, and most treatment of obstetric and abortion-related complications). Approximately 47% of women attend public-sector antenatal care (ANC) at least twice during pregnancy, but only 9% attend four or more times [11]. The content of ANC care does not match the WHO 'four-visit' model, and it is necessary to increase coverage of

[3] Newborn care (for the first 28 days) is included in this strategy because maternal health is integral to newborn health and to strengthen the government's commitment to improving neonatal outcomes in Cambodia

[4] CDHS 2000. CDHS 2005 updates are expected in early 2006

vital services, such as tetanus toxoid immunization, iron/folate supplementation, and skilled birth attendance [22, 45].

Skilled birth attendance[5] is crucial to reducing maternal and neonatal morbidity and mortality [46, 47]. A recent NRHP study indicates that while demand for skilled delivery is high, access is constrained by costs and distance [18]. Young Cambodian women with higher incomes are increasingly utilising trained providers, while older and lower-income women often use TBAs. However, these women indicated they would also prefer a skilled provider, if one were more affordable and closer to home.

Birth preparedness increases the likelihood of skilled attendance by identifying the provider, emergency referral facility, and means of transport. The *Midwife-TBA alliance* is an initiative to increase skilled birth attendance and referral through collaboration between midwives and TBAs. It includes training selected midwives in life-saving skills and breastfeeding counselling, building maternity houses in remote locations, and encouraging TBAs to refer pregnant women to health centres, assist midwives with deliveries, and educate women in the community. Initial evaluation indicates that TBAs refer more complications and more women deliver in health centres through this initiative.

In Cambodia, 89% of women deliver at home and untrained providers attend two-thirds of births [11]. Though in larger urban areas, private maternity homes are increasingly available. 'Home birth kits' (e.g. single-use razorblade, soap, cord ties, and plastic sheet) are available in some locations to encourage clean deliveries. However, this does not address underlying issues and research indicates kits do not provide significant reductions in maternal mortality. Even if untrained providers recognise a complication, transport to health centres remains a serious problem.

Many women who develop complications have no access to immediate emergency care, and the MOH is strengthening emergency obstetric care (EmOC) services. The EmOC package includes basic essential obstetric care,[6] surgical obstetrics (e.g. caesarean section, laparotomy for ectopic/extrauterine pregnancy or ruptured uterus, repair of vaginal and cervical tears, evacuation of retained products of incomplete abortion, amniotomy); anaesthesia and blood replacement; and medical treatment of sepsis, shock, hypertensive disorders, and severe anaemia.

Postpartum care is not routine, despite national guidelines, and 46% of women receive no postnatal care. Of those that do, 85% receive care from untrained providers [11]. More than half of maternal deaths and one-third of child deaths occur within the first month after delivery, and WHO recommends four specific postnatal care visits for mother and infant at 6 hours, 6 days, 6 weeks and 6 months [48]. Breastfeeding practices remain poor and experts agree that insufficient breastfeeding and inadequate complementary feeding are the main causes of malnutrition in the first year of life. While 96% of Cambodian mothers breastfeed, only 11% initiate breastfeeding within the first hour of birth, and only 2% breastfeed exclusively for the first six months [44].

Unsafe abortion

The Abortion Law of Cambodia (November 1997) is one of the most liberal in Asia. However, a 2002 study found a significant need for safe abortion services and that unsafe abortion remains one of the most common causes of maternal death (20-29%). Up to 50% of clients in a Phnom Penh health facility were admitted for

[5] WHO defines a 'skilled attendant' as an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns. (Endorsed by WHO, ICM, FIGO, UNFPA, and the World Bank)

[6] Basic Essential Obstetric Care (bEOC) in Cambodia includes prevention and control of haemorrhage, active management of third stage of labour, removal of placenta and retained products, repair of perineal lacerations, control of convulsions with parental medication, treatment of sepsis with antibiotics, MVA for incomplete abortions, essential newborn care, non-surgical contraception, and referral to EmOC or CAC facilities. Comprehensive Essential Obstetric Care (cEOC) includes bEOC, surgical obstetrics (e.g. c-section, surgical contraception), anaesthesia, blood replacement, and newborn care.

abortion complications [49]. WHO estimates the abortion mortality rate in Cambodia as 130/100,000 [50]. A number of studies describe traditional methods of unsafe abortion (e.g. abdominal massage, oral herbal medication, insertion of plant stems into the vagina and cervix) used by TBAs and traditional healers known as *'Kru Khmer.*'

Comprehensive Abortion Care (CAC) includes pre-abortion counselling, abortion procedures, post-abortion counselling, and family planning. This approach takes into account factors influencing a woman's individual health needs, personal circumstances, and ability to access services. Unsafe abortion is a significant contributing factor to maternal mortality in Cambodia, yet a gap remains in supporting development and implementation of CAC services. Donor support is somewhat constrained due to political sensitivities. However, DfID plans to expand CAC support through the Safe Motherhood component of its support to the Health Sector Support Programme (HSSP).

As part of the process of reducing unsafe abortion in Cambodia, post-abortion care (PAC) has been included in this strategy, and a multisectoral technical working group will develop standards and guidelines. PAC focuses on reducing maternal mortality and morbidity from abortion complications and remains less sensitive than CAC.

Opportunities and constraints

Partners can build on existing political commitment and growing community awareness regarding maternal and newborn health issues to strengthen programmes and initiatives. Most women attend public sector services one or more times during pregnancy, providing an opportunity for advice and essential maternal services. The NMCHC is conducting maternal and perinatal death audits (currently 44 maternal death audits in 17 provinces, where staff have been trained). Though these are useful, funding is not available for expansion. Staff are revising inservice midwifery training and translating global guidelines for essential practice [45, 51]. The role of the private sector is expanding, as those who can afford it often prefer private providers. Drug supply has improved significantly, with no gaps reported in the past two years.

Implementation is constrained by a number of factors. Scarcity of trained staff, poor motivation, and inadequate access to operating funds are the most urgent. Costs and frequent referral delays challenge delivery of EmOC services. Inconsistencies in routine data collection, turnover of basic health staff, turnover and quality of voluntary health workers, and lack of service integration challenge the provision of consistent quality services. While the public sector has made some progress towards safe abortion services (e.g. draft protocol, model abortion clinics), a major constraint to full implementation of CAC is financial (e.g. training, equipment, and drug costs).

2.2 Adolescent reproductive and sexual health

Status

Society must assure adolescents of physical health, mental and emotional wellbeing, freedom from exploitation and abuse, and skills and opportunities for sustainable livelihoods. Adolescents have the right to participate in decisions and actions that affect their lives, and in being involved, to develop roles and attitudes compatible with responsible citizenship [20]. ARSH is relatively new in Cambodia, focusing on young people aged 10 to 24 years old[7] (i.e. approximately 36.5% of current population and projected to increase over the next fifteen years).

[7] WHO defines Adolescence as ages 10-19, Youth as ages 20-24, and Young People as covering both groups (i.e. ages 10-24). As the term 'adolescent reproductive health' is already familiar, NRHP has chosen to retain this terminology while recognising that services must include young people.

There are strong cultural norms against premarital sex in Cambodia. However, these norms are changing. In a recent survey 2% of young people, age 11-18, reported having sex [52]. Most sexually active young people were out of school youth, and only a third of those who were sexually active reported always using condoms.

While the mean age at marriage is 22.5 for females and 24.2 for males [39], many women marry young [11] and studies show that 6% of all births in Cambodia are to women less than 20 years old. An infant born to a teenage mother is more likely to be born prematurely and with low birth weight, and is 24% more likely to die in the first month of life than is an infant born to a mother aged 25-34 years.

Several ministries are considering development of a comprehensive youth policy, while an increasing number of public and NGO facilities offer youth-friendly reproductive health services. NGOs have been working for the reproductive and sexual health needs of youth in Cambodia since 1998, while government health centres began piloting youth-friendly reproductive health services in 2004.

Opportunities and constraints

Growing interest from policy makers, donors, and technical personnel provides a good environment for promoting ARSH and youth-friendly services. The MOH has acknowledged the importance of providing services for adolescents and NRHP has developed national guidelines for adolescent friendly reproductive and sexual health (AFRSH) services. The public sector could benefit from the lessons learned by civil organisations that have been 'filling the gap' with intervention programmes in this area

Effective ARSH initiatives are constrained by difficulties in reaching out-of-school and working youth, privacy issues, cultural norms against discussing sexual issues, and existing perceptions among providers and adolescents. Additionally, limited infrastructure, specialised training needs, and limited resources constrain programming.

2.3 Family planning

Status

Knowledge of at least one method of contraception is high in Cambodia, but access remains an issue. Fertility has declined (the average number of children per mother decreased from 6 to 3.3 between 1980 and 2004 [12]). NGOs, social marketing initiatives, and the private sector are important sources of contraception. Many methods are readily available in pharmacies, markets, and private clinics but access remains constrained in rural and remote areas.

Since 1995, family planning services have been available through the public sector. These include oral and injectable contraceptives, condoms, and counselling on appropriate temporary and permanent methods. In 1999, NRHP initiated the Community Based Distribution of Contraceptives (CBD) programme with UNFPA support. CBD complements existing NGO initiatives and now covers 10 provinces, 12 ODs, and additional NGO locations.

The MOH is expanding both existing services and the available method mix. IUD services are now available in 245 health centres, and within five years the NRHP plans to introduce Norplant 1-rod, the female condom, and emergency contraception (EC). However, only trained and registered providers (who can also give pre/post counselling on choice of ongoing contraception) will be able to provide EC.

Table 3. Cambodia contraceptive prevalence and method mix

Method	(%) CDHS 2000	(Public Sector %) HIS 2004
Three-month Injectables	7.4	9.2
Daily Pills	4.5	10.9
Monthly Pills[8]	2.7	-
IUD	1.3	0.5
Sterilization	1.5	0.1
Condoms	0.9	0.8
Other	0.2	-

Source: CDHS 2000

A considerable unmet need still exists for contraceptive services, with 33% of married women reporting that they do not have sufficient contraceptives. Method switching, pausing and discontinuation of contraception are common, primarily due to costs and fears of side effects. The greatest reported obstacle to use is side effects. Women did not report awareness, geographical access, or costs of injections, pills, or condoms as barriers. However, cost is still a barrier for more permanent methods, such as IUD and sterilization [53]. An IUD can cost US$5, while voluntary surgical contraception (VSC) sometimes exceeds US$20 [49].

Table 4. Unmet need for birth spacing among married women

Current need or usage reported	Percentage
Do not need	43
Unmet need	33
Modern contraceptive method users	19
Traditional contraceptive method users	5

Source: CDHS 2000

Opportunities and constraints

NRHP family planning activities can build on the relatively high levels of community knowledge about contraception and the importance of family planning. The wide availability of contraceptives in the open market also supports expansion of programme activities. Support for introduction of the female condom within the general population provides an opportunity to increase protective choices in the context of high husband to wife HIV transmission.

Constraints include low attendance and limited hours at public facilities, high dropout rates and fear of side effects, weak referral, and financial limitations and negative community perceptions of IUDs and sterilization.

2.4 RTIs (particularly STIs and HIV/AIDS)

Status

A 2001 NCHADS survey showed 6.1% of 451 women attending public sector reproductive health clinics were positive for STIs, mostly chlamydia (2.8%) and trichomonas (2.7%). Over half reported RTI symptoms, predominantly vaginal discharge (53%) and itching (36%), and 39% were positive for candidiasis [54].

[8] The monthly (Chinese) pill is not an approved method of contraception

Table 5. Prevalence of RTIs among women attending RH clinics in Cambodia (n 451)

Problem	Prevalence (%)	95%CI
Gonorrhoea (PCR)	0.0	(0.0-0.8)
Chancroid (mPCR positive ulcer)	0.4	(0.2-1.0)
Herpes (HSV-2)	0.4	(0.2-1.0)
Syphilis (RPR seropositivity)	1.3	(0.0-2.6)
Trichomonas (in-pouch)	2.7	(1.2-4.2)
Chlamydia (PCR)	2.8	(0.7-4.7)
Bacterial vaginosis (score)	11.6	(6.6-16.6)
Vaginal candidiasis (gram stain)	38.9	(30.1-47.5)
Lower abdominal pain (reported)	13.6	--
Dysuria (reported)	19.3	--
Vaginal Itching (reported)	35.7	--
Vaginal discharge (reported)	52.8	--

Source: STI Survey 2001

In 1997, NCHADS and partners (including WHO, France Cooperation, UNAIDS, UNFPA, Unicef) implemented a project focused on strengthening STI prevention and management. The MOH established STI clinics in Sihanoukville and Phnom Penh, and thirty clinics now exist. Additionally, several INGOs provide STI treatment. The NRHP and NCHADS are considering ways to provide access to comprehensive reproductive health and STI care for clients in the context of reproductive and sexual rights. However, many seek STI treatment from the private sector and self-treatment is common.

HIV has become a key reproductive health issue. The overwhelming majority of HIV infections are sexually transmitted, or associated with pregnancy, childbirth, and breastfeeding. In 2002, HIV prevalence at ANC clinics was 2.7%, the highest in the region, and an estimated two-fifths of new infections are due to husband-wife transmission [2]. Thus, the HIV/AIDS epidemic is becoming more generalised and family planning, safe motherhood, and primary HIV prevention services in health centres are more critical for a comprehensive response.

The Kingdom of Cambodia is making serious efforts to confront the HIV epidemic in the country. Surveys have documented high levels of commercial sex activity and high HIV prevalence among sex workers and male occupational groups reporting frequent commercial contact. Behavioural studies show a positive change in relevant indicators due to the 100% condom use programme and reduced rates of partner change [54]. However, sex workers are acting as an important bridge between high transmission networks and the general population. A 2003 study showed primary and secondary means of HIV transmission as being from husband to wife and mother to child respectively [55]. Both RSH and HIV/AIDS initiatives must be mutually reinforcing as the same root causes drive them (e.g. gender inequality, poverty, social marginalisation). Stronger programme linkages will result in more relevant and cost-effective programmes with greater impact. [56]

The MOH regards VCCT as an important intervention to reduce HIV risk behaviour, an integral component of the developing continuum of HIV care and treatment, and an entry point to other services, such as PMTCT. In 2002, the MOH released an updated VCCT strategic document in which it plans to strengthen and expand VCCT services [57]. Cambodia's PMTCT programme currently works through 28 centres, which will increase to 36 ODs by 2007.

Opportunities and constraints

One opportunity for increasing provision of RTI services is the regular contact many women have with other reproductive health services (e.g. ANC, BS). There is considerable political and donor commitment for reducing

HIV prevalence. Male involvement activities could help address issues such as HIV transmission between couples (e.g. promotion of dual protection), transmission education, and services for high-risk couples [16].

There are a number of constraints to RTI service provision. Currently, geographic coverage of public sector STI clinics and diagnostic resources are limited. Men are often reluctant to come to the public sector for these services, due to embarrassment or stigma and perceptions that public services are mainly for women and children. The result is that many go to the unregulated private sector or self-medicate with inappropriate treatments. Difficulties in partner tracing and follow-up also constrain quality service delivery.

2.5 Gender

Status

Enabling reproductive health services to be gender sensitive and uphold rights is a global priority. Gender-based violence is common in Cambodia. While causes are multiple and complex, the physical and emotional consequences for women and children range from loss of confidence to death. Gender-based violence carries reproductive health risks such as gynaecological problems, STIs/HIV/AIDS, unwanted pregnancies, miscarriages, and low birth-weight babies.

Some gender issues perpetuate women's poor health in Cambodia. Women have limited access to resources within their communities, particularly land and education. Women often feel disempowered by cultural attitudes to the care of mothers and children and most report having problems in accessing health care [11]. Anecdotal evidence suggests men see the health centre as a place for women and children that cannot meet their own needs.

Countries in the Western Pacific region report 16%-50% prevalence of partner abuse, which is likely to be an underestimation [58]. The new WHO 10-country study of gender-based violence documents the widespread prevalence of domestic violence and its negative affects on women's physical, mental, sexual, and reproductive health [59]. In Cambodia, 23% of ever-married women report experiencing violence at some point since age fifteen [11]. A 1996 domestic violence study found that 16% of women were physically abused by a spouse, 8% reported injuries, and 73% know at least one family in which there was wife abuse [15]. More than 10% of Cambodian men reported that they physically abuse their wives. A recent qualitative study of sweetheart relationships in Cambodia found that sexual coercion, threats, and violence against young women by young men is common [60].

In 2005, the National Assembly approved a law on domestic violence in Cambodia [38]. The government has taken an important step towards addressing gender-based violence in Cambodian society. However, ongoing effort is necessary to reduce violence levels.

Opportunities and constraints

Considerable awareness exists of the need to address gender issues and male involvement in reproductive health. The MOH is increasingly concerned with gender issues, and intends that the updated health sector strategic plan (2007-10) will be gender responsive. The new domestic violence law (2005) provides opportunities to raise awareness of gender-based violence issues, including the social, economic, and health costs of intimate violence. Additional opportunities exist to train health professionals in identification, treatment, and referral of GBV survivors. Encouraging men to use, or support their partners to use, appropriate

reproductive health services including contraception and safe motherhood services, could be important for increasing utilisation.

Limited information constrains programme development, and social service resources for survivors and perpetrators of gender-based violence are minimal. Given the current context of HIV/AIDS, the lack of a national policy on post-exposure prophylaxis (PEP) for rape victims is also an increasingly important equity issue.

2.6 Commodity security

Status

In 2001, the MOH created the Contraceptive Security Working Group (CSWG), with the support and involvement of public and private sector stakeholders, to oversee reproductive health commodity security (RHCS) for Cambodia. The CSWG continues to function satisfactorily, with full member participation and regular meetings. However, the group has not always communicated recommendations and conclusions clearly to other stakeholders. Formally reorganising the group with revised terms of reference, to help ensure that the MOH and key stakeholders receive updates regularly and can take timely action on commodity issues, will be an important step towards improving commodity security.

It is widely recognized that complete and comprehensive forecasting is necessary for all reproductive health related commodities. MOH anticipates working with the CSWG and key stakeholders to develop a longterm RHCS strategy. This will be based on a comprehensive forecasting exercise to be held in 2006, once CDHS 2005 data becomes available.

A logistic management information system (LMIS) has been organised to collect information down to district levels. While one system is functioning at the district and provincial levels, there are still two systems operating at the national level (i.e. Central Medical Stores and Department of Drugs and Food). These departments are now in the process of agreeing and developing one consolidated LMIS.

Opportunities and constraints

Opportunities include the existence of the well-functioning CSWG, which has been effective in addressing many contraceptive security needs. This group can restructure as a reproductive health commodities security Sub-Technical Working Group (TWG) Health, with expanded terms of reference.

Constraints include supplies forecasting and management, unregulated private sector quality, longterm financing, and the limited reliability of the current LMIS system. Currently, donors supply all commodities except public sector condoms, and a longterm strategy on sustainable RHCS must be developed to ensure sustainability.

2.7 Emerging issues and initiatives

NRHP planners anticipate that several reproductive health issues will become more important in Cambodia in the next five to ten years. Therefore, they are included for consideration and early attention during 2006-2010.

2.7.1 Cancers

Globally, breast cancer is the most common cancer to affect women, with a 1:11 lifetime risk. Cervical cancer is the second most common cancer among women. Screening through routine papanicolaou (pap) smears is the most cost-effective means of detecting cervical abnormalities in developing countries. Population-based screening programmes, even when imperfect, have significantly decreased cervical cancer incidence, though success is dependant on good attendance rates by women at high risk.[61]. In Cambodia, breast and cervical cancer screening is not commonly available. Clinics offering these services are usually in urban areas and larger provinces. Prostate and testicular cancer services are similarly lacking.

There is increasing political and donor interest in cost-effective methods of cervical cancer screening. Opportunities exist to link screening and treatment of gynaecological cancers with antenatal and postnatal services. However, limited community knowledge, services, information, data, and resources challenge service development and programming.

2.7.2 Subfertility

Experts do not know the prevalence of subfertility in Cambodia, though globally 8-12% of couples have difficulty conceiving a child. The most common indications for women are disorders of ovulation, tubal disease, and abnormal post-coital results, while those for men are abnormal semen or hormonal results, and abnormal testicular volume. Only one Phnom Penh hospital has facilities for diagnosis and treatment of subfertile women. Assessment of semen and hormone levels is available in a few Phnom Penh laboratories.

In Cambodia, as in most developing countries, subfertility is not a major public health concern but remains an important rights and equity issue. Childlessness often results in perceived role failure and social stigmatisation, particularly for women. Though a WHO study found that men were either the sole cause or a contributing factor to infertility in more than half of couples, women bear the greatest burden [62]. Perceived infertility places women at risk of social and familial displacement, or physical and psychological abuse.

Ongoing STI services could link with provision of subfertility services. However, limited availability of services, associated time and costs, and low community awareness make access difficult.

2.7.3 Peri/Postmenopausal reproductive health

Data is not available on the mean age at menopause, or prevalence of genitourinary symptoms or postmenopausal bone fractures in Cambodia. Few services exist for diagnosis and treatment of menopausal issues.

The NRHP is committed to developing guidelines and materials on peri/postmenopausal issues for distribution in health facilities. As the population ages, more women will experience symptoms, potentially increasing demand for appropriate services. Low levels of community knowledge and acceptance of menopausal symptoms, limited inservice training, and limited service coverage are constraints to improving services for menopausal women.

3 SCOPE AND IMPLEMENTATION

This strategy will guide the development, implementation, and use of resources to achieve agreed goal, outcome, and priority objectives for reproductive and sexual health in Cambodia [63-65]. Detailed activities and relevant indicators are found in Section 3.9.

3.1 Goal

To attain a better quality of life for all Cambodians by improving the reproductive and sexual health status of women, men, and adolescents through effective and appropriate health programmes.

3.2 Outcome

To have increased, by the end of 2010, access to quality reproductive and sexual health services for women, men, and adolescents, as progress towards the longterm outcome of universal access to quality services for all Cambodians.

3.3 Strategic Objectives

Stakeholders agreed on four objectives:

- Improve the policy and resource environment for reproductive and sexual health priorities in Cambodia;[9]
- Increase availability and strengthen delivery of quality reproductive and sexual health services;
- Strengthen community understanding of reproductive and sexual health needs and rights and increase demand for services;
- Expand the evidence base to inform policy and strategy development.

3.4 Improve the policy and resource environment for RSH priorities

Priorities agreed by stakeholders under the first strategic objective are (1) policy development and advocacy, (2) coordination, and (3) resource mobilisation. Key linkages with child survival and nutrition strategies include skilled birth attendance, newborn care, breastfeeding practices, and maternal nutrition. Linkages with the HIV strategy include delivery of primary prevention, STI prevention and treatment, VCCT, and PMTCT services.

3.4.1 Policy development and advocacy

Development efforts will focus on prioritising reproductive and sexual health issues in key policy documents. This includes prioritising RSH issues in the midterm review of the health sector strategic plan (2003-07), in the development of the health sector plan (2007-10), and in the upcoming youth policy (i.e. prioritising ARSH). The

[9] Priorities include maternal and newborn health, STIs / HIV/AIDS, family planning, and gender equity

MOH will work with relevant stakeholders to update MPA and CPA services, delivery mechanisms, training packages, and protocols in accordance with this strategy.

Increased availability of trained midwives is a priority of the health sector strategic plan (2003-07) and a joint monitoring indicator within the consultative group process. The MOH will work with other ministries and the Secretariat of Public Function to improve workforce status and conditions (e.g. civil service grade, overtime and rural service allowances) for key reproductive health providers. An annual midwifery forum is part of this process. See more on the planned midwifery review in Section 3.5.1.

The NRHP and others will undertake advocacy at all levels of the health and political system to increase support for reproductive health priorities and emerging issues. This includes advocacy with government, professional associations, and private sector alliances regarding the promotion of safe reproductive health practices and the prohibition of ineffective or unsafe practices and commodities (e.g. 'Chinese' monthly pill).

3.4.2 Coordination

The MCH Sub-Coordinating Committee will restructure as a sub-TWG-Health. This will strengthen advocacy, improve information sharing, and help reduce coverage gaps and parallelism. Restructuring and strengthening the existing group has the advantage of working within established structures. It is also timely as the MOH reviews and reorganises sub-sectoral groups.

This strategy will be operationalised within the existing MoH operational planning process. The strategy and relevant planning documents will inform development of the NRHP's Annual Operational Plans (AOP).

3.4.3 Resource mobilisation

A strategy priority is generating sufficient funds to support key reproductive and sexual health initiatives. A first step will be costing the strategy and priority outcomes and services. Government and other stakeholders will use this costing information to seek additional reproductive health funding from both national and international sources. By 2010, the MOH intends to increase total and per capita reproductive health expenditure by 25%, beginning with a minimum of a 10% increase in 2006.

3.5 Increase availability and strengthen delivery of quality RSH services

Priorities agreed by stakeholders under the second strategic objective are (1) increasing availability of trained staff, (2) ensuring availability of quality reproductive health commodities, (3) introducing or expanding key services (e.g. maternal and newborn care, birth spacing, abortion, AFRSH, gender-based violence), and (4) establishing and strengthening partnerships and linkages.

3.5.1 Increasing availability of trained RSH staff

The Royal Government of Cambodia has committed to increasing grade and benefits for key reproductive health providers. Implementing these changes will improve recruitment and retention of qualified staff, particularly midwives, and deployment in underserved rural areas. Within five years, 60% of current health centres should have at least two trained midwives, with at least one a secondary midwife.

The upcoming Health Sector Midterm Review in 2006 will provide a forum for addressing RSH human resource issues. As part of the midterm review, the MOH will undertake an in-depth Midwifery Review to address specific

issues in more detail. These include current coverage and capacity of midwives; preservice and inservice training; and recruitment, deployment and retention issues. NRHP and key stakeholders will revise specified materials, and conduct necessary training and follow up, based on outcomes of the review.

3.5.2 Ensuring availability of quality RSH commodities

The RHCS Working Group (expected to become the RHC Sub-TWG-Health) will continue to ensure the adequate supply, re-supply, forecasting, and management of reproductive health commodities in the country. This includes reducing unmet need for existing contraception and introducing new public-sector products to the method mix (e.g. female condom, 1-rod implant, emergency contraception). The group will aid development of health centre-level protocols on quality assurance for relevant drugs and supplies.

Within the next five years, the MOH and key stakeholders will support updated forecasting based on CDHS 2005 data. A longterm strategy for reproductive health commodity security will then be developed. Additionally, government and partners will work to improve the logistic management information system (LMIS) and build the capacity of the Forecasting Unit of the Department of Drugs, Food & Cosmetics.

3.5.3 Introducing or expanding key RSH services

The strategy development team initiated a process of identification and prioritisation of essential public reproductive health services to be introduced or scaled up over the next five years. The six prioritisation criteria were: (1) mortality reduction, (2) morbidity reduction, (3) cost-effectiveness, (4) sustainability, (5) feasibility, and (6) speed of impact. Services to be expanded or introduced include:

- MPA and CPA packages
- contraceptive CBD (including IUD, implant, and female condom)
- essential and comprehensive neonatal/postnatal care
- linked RH and HIV services
- adolescent reproductive and sexual health services
- gender-based violence identification and referral services
- abortion services (i.e. CAC and PAC)
- health centre quality-improvement tools and technical updates.

The essential service package for reproductive health is the basic set of reproductive and sexual health services for provision by midwives, health centres, and hospitals through minimum and complementary packages of activities. Box 2 provides a comprehensive list of current and proposed services. Detail on specific services provided by MPA and CPA is available in other documents and has not been included here.

Box 2. Proposed contents of the essential service package for RSH

ARSH Services
- Availability of AFRSH essential service package [8]

Family Planning Services
- Counselling on methods
- Availability of oral contraceptives
- Availability of three-monthly injectables
- Availability of implant (1 rod) services
- Availability of emergency contraception
- Availability of IUD services
- Availability of condoms for dual protection
- Availability of voluntary surgical contraception (male and female)

RTI Care
- Condoms
- Diagnosis and treatment of RTIs (including STIs)
- Primary prevention for HIV
- Availability of VCCT for HIV

Antenatal Care
- Scheduling four focused visits (12, 24, 36, 39 wks) [45]
- Birth preparedness (birth/emergency plan in Mother's Health Record)
- Availability of Midwife-TBA alliance
- Tetanus immunisation
- Provision of iron/folate
- Provision of mebendazole
- Detection and treatment of anaemia
- Detection and treatment of hypertensive disorders
- Detection and treatment of malaria
- Detection and treatment of tuberculosis
- Screening and treatment of syphilis
- VCCT for HIV
- Availability of PMTCT
- Mother class/Counselling (e.g. nutrition, recognition of complications/danger signs)
- Availability of EmOC (e.g. referral system, surgery)
- Availability of cEOC

Delivery Care
- Universal precautions (access to clean delivery)
- Availability of Midwife-TBA alliance
- Use of skilled birth attendant at delivery
- Availability of PMTCT
- Use of partograph
- Active management of third stage of labour
- Routine placenta examination
- Availability of parenteral anticonvulsants for pre-eclampsia/eclampsia
- Availability of oral and parenteral antibiotics
- Availability of EmOC (e.g. referral system, surgery)

Neonatal Care
- Thermal management
- Availability of neonatal resuscitation
- 'Kangaroo Mother Care' for high-risk neonates
- Promotion of immediate exclusive breastfeeding
- Care of the umbilical cord
- Early detection and management of infections and jaundice
- Availability of PMTCT
- Counselling (e.g. nutrition, exclusive breastfeeding, recognition of danger signs, early child development)

Postnatal Care
- Provision of four targeted visits (6hrs, 6 days, 6 wks, 6 mo) for every postpartum woman and her baby [48]
- Early detection and management of puerperal complications (e.g. bleeding, involuted uterus)
- Birth spacing plan and service provision
- Iron/folate supplementation
- Vitamin A supplementation
- Detection and treatment of anaemia
- Detection and treatment of malaria
- Tetanus immunisation (if not done at ANC)
- Screening for syphilis (if not done at ANC)
- Provision of mebendazole (if due)
- VCCT for HIV (if not done at ANC)
- Availability of Midwife-TBA alliance
- Counselling (e.g. nutrition, birth spacing, recognition of danger signs)
- Availability of EmOC (e.g. referral system, surgery)

Reducing Unsafe Abortion (CAC and PAC)
- Medical abortion at appropriate levels
- Manual vacuum aspiration at appropriate HC level
- Prevention and management of complications (e.g. injury, infection, shock, haemorrhage)
- Birth spacing plan and service provision
- Counselling (e.g. pre-abortion, family planning, self-care, recognition of danger signs)
- EmOC (e.g. referral system, surgery)

Cancers, Subfertility, Peri/Postmenopausal Services
- Counselling (e.g. breast self exams, lifestyle, nutrition, IEC packet) and referral

Gender Equity
- Identification, treatment, and referral for GBV survivors
- Access to post-exposure prophylaxis for rape survivors
- Counselling (e.g. gender equity, GBV, male involvement)
- Advocacy (e.g. gender equity, GBV, male involvement, partnership, cooperation, and responsibilities in RSH)

3.5.4 Establishing and strengthening partnerships and linkages

Public-private partnerships for service delivery

Many people seek treatment from the private sector, which is largely unregulated and often of poor quality. Two types of private providers, either fulltime or out-of-hours government staff, work in Cambodia. Current government initiatives indirectly strengthen the capacity of the second type. However, it remains important to work with both types to upgrade key technical and referral skills and strengthen knowledge of relevant policies, guidelines, and legislation.

The MOH will disseminate information on updated guidelines and legislation to private providers through relevant networks and associations (e.g. Cambodian Medical Council, Cambodian Medical Association, Cambodian Midwives Association) and explore training and collaboration opportunities with selected private sector representatives and partners under the auspices of a public-private partnership for reproductive health in Cambodia. The NRHP plans to develop public-private partnerships to train and monitor key first-line providers (e.g. drug sellers and private general practitioners) in quality reproductive health service provision.

In collaboration with relevant programmes, NGOs and associations, the NRHP will work to improve the quality of reproductive healthcare provision in the private sector. A key to this process is the strategic analysis of areas in which the private sector could add particular value in achieving MoH goals (e.g. potential capacity to provide rural communities with reproductive health services). The NRHP will work with private-sector actors, such as the Reproductive Health Association of Cambodia (RHAC), Population Services International (PSI), Cambodian Medical Association (CMA), Cambodian Midwives Association, and Cambodian Society of Obstetrics and Gynaecology. Key priorities include birth spacing, ARSH, gender based violence, antenatal care, and postnatal care, for which private-sector initiatives already exist.

Linkages and partnerships with key programmes (HIV, Nutrition, Child Survival)

Within the framework of a RH-HIV joint policy statement, the NRHP and NCHADS will explicitly articulate the links between RH and HIV services. NRHP will work with NAA and NCHADS to improve relevant programme linkages (e.g. primary HIV prevention, STI treatment, and PMTCT), particularly at health centre level.

The NRHP will work with the National Nutrition Programme (NNP) and relevant partners to support provision of iron/folate to all pregnant and postpartum women, provision of vitamin A (i.e. one 200,000 IU capsule within eight weeks after delivery) to all postpartum women, and immediate exclusive breastfeeding (i.e. from first hour to six months of age). The NRHP will seek technical input from the NNP on contents of nutrition counselling during antenatal and postnatal care.

The NRHP will work with the Child Survival Partnership (CSP) and other child health partners to strengthen newborn care provision. Specific areas include increasing provision of tetanus toxoid, skilled attendance at delivery, essential and special care for newborns (i.e. first month), and immediate exclusive breastfeeding.

Linkages with communities

Improving services at the community level requires assessing and strengthening existing mechanisms (e.g. feedback mechanisms such as Voluntary Health Support Groups) and referral linkages with current community providers (e.g. drug sellers, community leaders, traditional healers and birth attendants). Referral systems at all health centres will be established or strengthened. Additionally, the NRHP will encourage health centre staff to conduct regular outreach visits and meetings with community representatives. These will provide relevant

insight into ways community partners and stakeholders can expand community-based distribution, develop appropriate BCC (e.g. recognition of danger signs, nutrition, importance of skilled birth attendance), and select possible incentives for ANC and skilled birth attendance (e.g. iron/folate tablets).

3.6 Strengthen community understanding and increase demand for services

Priorities agreed by stakeholders under the third strategic objective are (1) development of a focused behaviour-change communications strategy, (2) dissemination of appropriate information by providers, and (3) community access to reproductive health services.

3.6.1 Behaviour change communications

To increase access and demand for available services, the NRHP will work with the NCHP and partners to develop reproductive and sexual health communications within the framework of the health sector behaviour-change communications (BCC) strategy. The NRHP, NCHP, and key stakeholders will then develop reproductive health communications initiatives and materials (e.g. mass media, posters, interpersonal communications). Specific materials will be developed on priority and emerging issues, such as delivery by trained providers, safe abortion, reproductive rights, gender-based violence, ARSH, new contraceptive methods, and condoms as dual protection.

3.6.2 Dissemination of appropriate information by providers

The NRHP will strengthen health communications skills among providers through implementation of MPA module 7, and disseminate tools and materials developed within the health sector BCC strategy framework. Health centre staff will be responsible for providing accurate information, training, and follow-up of community providers and informal health networks. To support health centre staff, NRHP will develop mechanisms to ensure they receive regular technical updates on relevant reproductive and sexual health issues.

3.6.3 Community access and barriers to reproductive health services

Lack of money is a significant barrier to services. The government has developed the National Strategic Framework for Equity Funds and National Equity Fund Implementation & Monitoring Framework (May 2005) to reduce the impact of significant unexpected health costs on the poor. Funds can help reduce financial barriers for poor families accessing services, thus expanding access to essential maternal and newborn services in referral hospitals, health centres, and communities. Equity funding will support pre-identification of women at risk, delivery of safe motherhood services (at home or facility), treatment fees, and transport and food costs for referral hospital level.

Service availability is another barrier. The NRHP will work with partners to expand existing community health mechanisms and strengthen referral to formal services. Programmatic experience in Cambodia indicates that CBD mechanisms are more sustainable and effective than volunteer systems. CBD mechanisms for contraceptives could provide additional services (e.g. iron/folate or insecticide treated nets) and are being evaluated. Midwives already attend domiciliary births, and this can be formalised and regulated. Health volunteers, supported and supervised by midwives, could bring specific maternal and newborn care services closer to families. For example, appropriately trained TBAs can identify and refer pregnant women for midwifery care, counsel families about danger signs, and provide domiciliary support (e.g. cleaning, childcare) for newly delivered women. Village Health Volunteers (VHV), under the guidance of the health centre or commune

council, can be trained in postnatal support (e.g. nutrition, hygiene, immunisations, breastfeeding, early child development, and homecare for sick children) [66].

Cultural and gender norms sometimes become barriers. However, many basic interventions (e.g. birth planning, sleeping under ITN, antenatal and postnatal care attendance, clean and safe delivery, immediate and exclusive breastfeeding, hygiene and cord care, drying and wrapping newborns) can be adopted in virtually every household, and can be encouraged using behaviour change strategies [67]. NRHP will work to involve men and sensitise commune councils in support of reproductive health issues and services for the family and community.

3.7 Expand the evidence base to inform policy and strategy development

Priorities agreed by stakeholders under the fourth strategic objective are (1) programmatic evaluation, (2) maternal and neonatal mortality and morbidity, and (3) gender equity.

3.7.1 Programmatic evaluation

The NRHP will conduct or commission evaluations and research to improve access and quality of reproductive and sexual health services, and inform future planning and implementation. Planned evaluations include community-based contraceptive distribution, effectiveness of public-private partnership initiatives, and provision of key services among trained providers (e.g. PAC, AFRSH).

3.7.2 Maternal and neonatal morbidity and mortality

Priority research for maternal and newborn care includes evaluation and expansion of maternal and perinatal death audits; neonatal resuscitation practices; and prevention and treatment of haemorrhage, sepsis, and eclampsia. Other possible research (i.e. according to interest and funding) includes:

- feasibility of using trained healthcare providers to conduct case management of newborn sepsis in the community and through peripheral services
- prevalence, types and causes of birth defects and injuries in Cambodia
- prevalence of malaria in pregnancy
- prevalence and impact of maternal mental health disorders (e.g. depression, post-traumatic stress disorder) on maternal and neonatal outcomes

3.7.3 Gender equity

Priority gender-mainstreaming research includes assessing the effect of male involvement on reproductive health seeking behaviours, and the impact of domestic violence on maternal and newborn health outcomes. Additional suggested research includes:

- qualitative research on gender based violence
- action research on male reproductive health seeking behaviour
- prevalence and perspectives of infertility in Cambodia

3.8 Monitoring and evaluation

This will be conducted as part of national monitoring and evaluation within the Joint Annual Performance Review framework. Main indicators have been selected to conform to HSP and CMDG monitoring frameworks to minimise data collection burden. CDHS 2005 data will provide an updated baseline in 2006. The NRHP may

also conduct a focused Midterm Review in 2008, depending on perceived need. Data for lower level indicators will come from routine data collection, while the CDHS 2010 results will be used to measure final impact in 2010-2011.

3.9 Results matrix

Hierarchy of Aims	Objectively Verifiable Indicators, Baselines & Targets	Means of Verification	Risks and Assumptions
Goal: To attain a better quality of life for all Cambodians by improving the RSH status of women, men, and adolescents through effective and appropriate health programmes	By the end of 2010, • MMR reduced from 437 to less than 243/100,000 (CMDG, NSDP) • IMR reduced from 95 to less than 60/1,000 (CMDG, NSDP) • HIV prevalence among adults 15-49 will not have increased above 1.9% (CMDG, NSDP) • HIV prevalence among pregnant women 15-24 visiting ANC reduced to 2.0% (CMDG) • TFR reduced from 3.3 to 3.0 (CMDG)	• CDHS 2010	• Supportive socio-political environment • Macroeconomic development and availability of funds • Stakeholder commitment
Purpose/Outcome: To have increased, by the end of 2010, access to quality RSH services for women, men, and adolescents, as progress towards the longterm outcome of universal access to quality services for all Cambodians	By the end of 2010, • % of deliveries by skilled health personnel increased from 32% to 70% (CMDG, NSDP) • % of women using modern birth spacing methods increased from 20% to 44% (CMDG, NSDP) with proportional increase in longterm methods • % of abortion-related complications reduced by 30% from 2006 baseline • % of health facilities providing priority RH services increased by 15% from 2006 baseline • % of public and private facilities offering AFRSH essential service package increased from 0% to 10%	• JAHPR • HIS • HIV Sero-Surveillance • Census 2008	
Outputs/Strategic Objectives: 1 Improved policy and resource environment for RSH priorities in Cambodia	By the end of 2010, • MPA/CPA services updated from only BS, SM to include all strategy elements • HSP 2003-07 extended to 2010 with all key RSH strategy elements prioritised • conditions and status of key RH providers will have improved[10] • MCH SubCoCom and CSWG restructured as Sub-TWG-Health and functioning according to appropriate new TORs • total and per capita RH expenditures will have increased by 25%	• MPA/CPA • HSP 2007-10 • Personnel Dept reports • MTEF	• Stakeholder commitment • Sufficient funding
2 Increased availability and strengthened delivery of quality RSH services	By the end of 2010, • % of health centres (HC) with at least 2 trained midwives (1 as secondary midwife) will have increased from 20% to 60% • longterm RHCS strategy will have been developed, implemented, and monitored • % unmet need for contraception among married women will have reduced from 33% to 20% • % of WRA (15-49) with iron deficiency anaemia (IDA) will have reduced from 58% to 32% (CMDG)	• CDHS • RHCS strategy forecasting • Surveillance reports	

[10] in terms of civil service grade and allowances: PMW from D.2.14 to C, SMW from C.3.14 to B.1.6, Doctor from A.3.13 to A.1, and Rural and Overtime Allowances in place.

	• % of pregnant women with IDA will have reduced from 66% to 39% (CMDG) • % of HIV-infected pregnant women attending ANC receiving a complete course of antiretroviral prophylaxis to reduce MTCT, will have increased from 2.7% to 35% (CMDG) • % of health centres offering GBV interventions will have increased from 0% to 20% • % of pregnant women who delivered by caesarean section increased from 0.8% to 3% (CMDG)	• Survey results • HRD reports • STI reports
3 Strengthened community understanding of RSH needs and rights and increased demand for services	By the end of 2010, • % of pregnant women who attend at least 2 ANC consultations will have increased from 47% to 75% (CMDG) • % of infants exclusively breastfed up to 6 months of age will have increased from 11% to 34% (CMDG) • % of youth aged 15-24 reporting use of a condom during intercourse with a non-regular sexual partner will have increased from 82% to 90% (CMDG) • % of health facilities with a functioning referral system will have increased from 0% to 30% • number of health facilities with functioning health equity fund will have increased from 16 referral hospitals to 30 referral hospitals and 20% of HC in at least 10 provinces	• CDHS
4 Expanded evidence base to inform policy and strategy development	By the end of 2010, • evaluation of existing maternal death audits and initiation of nationwide maternal and neonatal death audits will have been completed • comprehensive assessment of CBD programme will have been completed	• Research reports • Policy documents

Activities

1 *Improved policy and resource environment for RSH priorities in Cambodia*	
	Primary Responsibility
Policy development and advocacy	
1.1 Provide advocacy and technical inputs for RH elements of HS strategic plan midterm review	NRHP/MoH
1.2 Provide advocacy and technical inputs for RH elements of extension of HS strategic plan (2008-10) and new HS plan (2011-15)	NRHP/MoH
1.3 Provide advocacy and technical inputs for RH elements of the national youth policy	NRHP/MoEYS
1.4 Revise MPA service package	NRHP/MoH
1.5 Revise CPA service package	NRHP/MoH
1.6 Develop RH-HIV Joint Policy Statement	NRHP/NAA/NCHADS
1.7 Develop/Revise RH service protocols	NRHP/MoH
1.8 Hold annual midwifery forum	NRHP/MoH
1.9 Provide advocacy and technical inputs for RH elements of workforce planning, implementation, recruitment, deployment and motivation	NRHP/MoH
1.10 Develop the next national RH strategy (2011-15)	NRHP/MoH

Coordination	
1.11 Restructure/Strengthen MCH SubCoCom as MCH Sub-TWG-H with key functions (to share information; review progress, support, gaps; consult on relevant policies, technical issues; advocacy)	MoH
1.12 Restructure/Strengthen Contraceptive Security Working Group as RH Commodity Security Sub-TWG-H	MoH/NRHP
1.13 Engage actively with MoH coordination groups and departments (e.g. NCHADS for PMTCT and STIs; Midwifery training/workforce; Child Survival; Quality Improvement Working Group; Gender)	NRHP
1.14 Engage actively with multisectoral coordination groups and other government institutions (e.g. Youth, Gender, Cambodian National Council for Children, Cambodian National Council for Women, NAA, Professional Association and Council)	NRHP
Resource mobilisation	
1.15 Conduct costing of strategy, priority outcomes, and service packages	NRHP
1.16 Set annual human and financial resource targets based on costing (e.g. government, donor)	NRHP
1.17 Advocate/Mobilise increased govt and donor resources for RH activities	NRHP/MoH
2 Increased availability and strengthened delivery of quality RSH services	
Increasing availability of trained staff	
2.1 Support/Develop mechanisms for increased staff recruitment, deployment, and retention (e.g. MoH HR policy)	NRHP/MoH
2.2 Revise/Combine existing preservice and inservice training curricula and materials (e.g. those of JICA, RACHA, USAID)	NRHP/MoH
2.3 Revise RH component of preservice and inservice training courses for government health staff	NRHP
2.4 Conduct ToT for key trainings in 24 provinces	NRHP
2.5 Train key providers on updated SM, BS, PAC, CAC, and AFRSH service provision	NRHP
2.6 Conduct supportive/follow-up supervision of trainees within 3 months of training	NRHP
2.7 Allocate key staff to HCs (especially midwives) and referral hospitals	MoH/NRHP
Ensuring availability of quality RH commodities	
2.8 Conduct RHC forecasting based on CDHS 2005 data	RHCS Sub TWGH
2.9 Develop five-year RHCS strategy	RHCS Sub TWGH
2.10 Introduce new contraceptive methods (e.g. Implant 1-rod, female condom, EC)	NRHP
2.11 Develop HC-level protocols through RHC Sub-TWG-H on quality assurance for RH drugs	MoH/NRHP
2.12 Conduct routine quarterly supervisory visits (with CMS if feasible) to PHD, OD, RH, and HC	MoH/NRHP
2.13 Build capacity in RHC forecasting within the DDF Forecasting Unit	RHCS Sub TWGH/DDF
2.14 Develop/Improve the LMIS	DDF/CMS/NRHP
Introducing or expanding key services	
2.15 Strengthen/Expand MPA in all health facilities and provide all drugs/supplies in HCs and RHs	MoH/NRHP
2.16 Strengthen/Expand complete CPA coverage in all ODs	NRHP/MoH
2.17 Strengthen/Expand RH essential service package in selected health facilities	NRHP/MoH
2.18 Strengthen/Expand CBD of contraceptives (including introduction of 1-rod, EC, and female condom)	NRHP/MoH
2.19 Strengthen/Expand CAC and PAC services	NRHP/MoH

2.20 Strengthen/Expand ASRH and GBV services	NRHP/MoH
2.21 Train providers to recognise and appropriately refer victims of domestic violence	MoH/MoWA
2.22 Develop/Finalise national protocols for essential and emergency newborn care and essential postnatal care	NRHP/MoH
2.23 Introduce 'National standards for quality accreditation' or similar quality improvement tool at health facilities and train staff in its use	MoH
2.24 Conduct regular technical supervision and updates on 'state of the art' and int'l best practices for RH interventions	MoH/NRHP
Establishing and strengthening key partnerships and linkages	
2.25 Establish/Strengthen linkages with selected private sector and social marketing entities	NRHP
2.26 Develop and conduct training on quality RH service provision for private providers	NRHP
2.27 Establish/Strengthen partnership with NAA and NCHADS to improve RH-HIV programme linkages and expand primary prevention activities at HC level	NRHP/NAA/NCHADS
2.28 Establish/Strengthen partnership with NNP for promotion of exclusive breastfeeding and provision of iron/folate and vitamin A	NRHP/NNP
2.29 Establish/Strengthen linkages with Child Survival Partnership to improve TT provision, skilled attendance at delivery, and newborn care	
2.30 Establish/Strengthen referral system at all health facilities and conduct regular outreach visits from HC to villages	MoH/NRHP
2.31 Strengthen/Increase feedback mechanisms and meetings with community representatives	MoH/NRHP
3 Strengthened community understanding of RSH needs and rights and increased demand for services	
Development of a focused RH BCC strategy	
3.1 Review BCC strategies from country and region	NRHP/NCHP
3.2 Work with NCHP and partners to develop RH BCC component within the framework of the overall health sector BCC strategy	NRHP/NCHP
3.3 Disseminate and implement	NRHP/NCHP/MOH
Dissemination of appropriate information by providers	
3.4 Complete rollout of MPA module 7 to strengthen communication skills of RH providers	NRHP/MoH
3.5 Develop tools to support providers with RH BCC activities in communities	NRHP/MoH
3.6 Expand responsibilities of HC staff to include RH BCC training of informal community health providers	MoH/NRHP
3.7 Conduct follow-up supervision/evaluation of providers trained in RH BCC	NRHP/MoH
3.8 Develop mechanisms to ensure HC staff receive regular technical updates on RH issues	NRHP/MoH
Community access to reproductive health services	
3.9 Initiate/Strengthen referral mechanisms from communities to formal RH services	NRHP/MoH
3.10 Strengthen/Expand equity funds in selected health facilities	MoH
3.11 Expand/Strengthen community health networks to deliver correct RH information and specific services (e.g. CBD, IEC distribution, referral)	NRHP/NCHP/MOH
3.12 Sensitise/Involve commune councils to address community barriers	NRHP

3.13 Sensitise/Involve men in RH issues and services to encourage their support in improving RH status within the family	NRHP
4 Expanded evidence base to inform policy and strategy development	
Programme related evaluations	
4.1 Evaluate SM, BS, PAC, CAC, and AFRSH service provision among trained providers	NRHP
4.2 Conduct a comprehensive assessment of CBD programme	MoH/NRHP
4.3 Evaluate public-private partnership initiatives for RH	NRHP
Maternal and neonatal morbidity and mortality	
4.4 Evaluate existing maternal and perinatal death audits and initiate nationwide implementation	NRHP/MoH
4.5 Evaluate and improve neonatal resuscitation practices	NRHP
4.6 Assess the most effective means of active management of third-stage labour in communities (e.g. pilot use of misoprostol)	NRHP
4.7 Assess the need and feasibility of mental health screening at ANC	TPO/VSO/NRHP
Gender	
4.8 Estimate the impact of GBV, including domestic violence on maternal and newborn morbidity and mortality	MoWA/NRHP
4.9 Assess the impact of male involvement on family RSH care seeking behaviour	NRHP

4 REFERENCES

1. Asian Development Bank, et al., *A Fair Share for Women: Cambodia Gender Assessment*. 2004: Phnom Penh.
2. Ek, V. *Gender and HIV/AIDS Policy in Cambodia*. in *International AIDS Conference*. 2004. Bangkok.
3. Fordham, G., *Adolescent Reproductive Health in Cambodia: Status of Policies, Programs, and Issues*. 2003, POLICY Project,: Phnom Penh.
4. Helen Keller Int'l-Cambodia, *An Overview of Nutrition Sector Activities in Cambodia*. 2002, Helen Keller Worldwide: Phnom Penh.
5. Ministry of Health, *National Vitamin A Policy Guidelines*. 2000, NMCHC: Phnom Penh.
6. Ministry of Health, *Health Sector Strategic Plan (2003-2007)*. 2003: Phnom Penh.
7. Ministry of Health, *Guidelines for the Prevention of Mother-to-Child Transmission of HIV (draft)*. 2005: Phnom Penh.
8. Ministry of Health, *National Standard Guidelines for Adolescent-Friendly Reproductive and Sexual Health (AFRSH) Services*. 2005, NRHP: Phnom Penh.
9. Ministry of Health, *Post-Enumeration Survey 2003: Baseline Values, and Monitoring indicator development*. 2005, Health Sector Support Project: Phnom Penh.
10. Ministry of Health and NMCHC, *Revision of Log Frame and Baseline Indicators for the UNFPA Reproductive Health Sub Program*. 2005, Dept of Planning and Health Information: Phnom Penh.
11. Ministry of Planning, *Cambodian Demographic and Health Survey*. 2000, MOH: Phnom Penh.
12. Ministry of Planning, *Cambodia Intercensal Population Survey*. 2004, National Institute of Statistics: Phnom Penh.
13. Ministry of Woman's Affairs, et al., *Gender-Responsive Implementation of the Cambodian MDGs*. 2004: Phnom Penh.
14. NCHADS, *A guide for Implementation of Voluntary Confidential Counseling and testing for HIV (VCCT)*. 2004, MOH: Phnom Penh.
15. Nelson, E. and C. Zimmerman, *Household Survey on Domestic Violence in Cambodia*. 1996, Ministry of Women's Affairs-Project Against Domestic Violence,: Phnom Penh.
16. RH Promotion Working Group. *Draft guidelines on Male Involvement in Reproductive Health in Cambodia*. in *Workshop to Draft Male Involvement Guidelines*. 2005. Phnom Penh.
17. Tarr Chou Meng and Aggleton, *Young People and HIV in Cambodia - Meanings, Contexts, and Sexual Cultures.* AIDS Care, 1999. 11(3): p. 375-384.
18. UNFPA, *Obstacles to deliveries by trained health providers to Cambodian rural women*. 2005, Indochina Research Ltd: Phnom Penh.
19. WHO, *Transforming Health Systems: Gender and Rights in Reproductive Health*. 2001: Geneva.
20. WHO, *Adolescent Friendly Health Services - An Agenda for Change*. 2003, Department of Child and Adolescent Health Development: Geneva.
21. WHO, *Aging and Health: A Health Promotion Approach for Developing Countries*. 2003, Manila: WHO Regional Office for the Western Pacific. 71 pages.
22. WHO and UNICEF, *Antenatal Care in Developing Countries: An analysis of trends, levels, and differentials, 1990-2001*. 2003, Geneva.
23. WHO, UNICEF, and UNFPA, *Maternal Mortality in 2000: Estimates developed by WHO, UNICEF, and UNFPA*. 2004, Geneva: WHO Dept of Reproductive Health and Research.
24. Wilkinson, D., *A Model for Adolescent-Friendly Reproductive Health Services in Cambodia*. 2003, MOH/WHO: Phnom Penh.
25. World Food Programme, *Maternal and Child Health Follow-Up Survey 2004*. 2004: Phnom Penh.
26. Ministry of Health, *National Safe Motherhood 5 Year Action Plan (2001-2005)*. 2001: Phnom Penh.
27. Ministry of Health, *Birth Spacing Policy for Cambodia*. 1995: Phnom Penh.
28. National Assembly, *Abortion Law*. 1997: Phnom Penh.
29. Ministry of Health, *National Policy on Infant and Young Child Feeding Practices*. 2002, National Nutrition Programme,: Phnom Penh.
30. Ministry of Health, *Strategic Plan for HIV/AIDS and STI Prevention and Care in Cambodia (2001-2005)*. 2001, NCHADS: Phnom Penh.
31. Ministry of Planning, *Cambodia Nutrition Investment Plan (2003-2007)*. 2002, National Council for Nutrition,: Phnom Penh.
32. Royal Govt of Cambodia, *National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS (2006-2010) - draft*. 2005, National AIDS Authority: Phnom Penh.
33. Ministry of Planning, *National Population Policy*. 2003: Phnom Penh.
34. World Bank, *Summary gender profile for Cambodia*. 2005, http://genderstats.worldbank.org.

35. World Bank, *Gender and Development*. 2005, http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTGENDER/0,,menuPK:336874~pagePK:149018~piPK:149093~theSitePK:336868,00.html.
36. UNDP, *Mainstreaming gender into poverty reduction policies and interventions*. 2005, http://www.undp.org/poverty/gender.htm.
37. Jowett, M. and T. Ensor, *Safe Motherhood interventions in low-income countries: an economic justification and evidence of cost effectiveness.* Health Policy, 2000. 53(3): p. 201-28.
38. *Law on the Prevention of Domestic Violence and Protection of Victims*. 2005. p. 10.
39. Ministry of Planning, *National Population Census of Cambodia 1998. Women in Cambodia*. 1998, National Institute of Statistics: Phnom Penh.
40. Ministry of Health, *Institutional development and incentives for better healthcare: Cambodia Health Workers Incentive Survey*. 2004, Oxford Policy Management Fund, DfID: Phnom Penh.
41. UNFPA, *Population, Gender, and Reproductive Health: Cambodia at a Glance*. 2005: Phnom Penh.
42. Hardeman, W., et al., *Access to health care for all. User fees plus a health equity fund in Sotnikum, Cambodia.* Health Policy and Planning, 2004. 19: p. 22-32.
43. Sprechmann, S., et al., *Estimating the Magnitude of Maternal Mortality in Cambodia. An Application of the Sisterhood Method*. 1996, National Maternal and Child Health Centre: Phnom Penh.
44. Kum Kanal, *Child Health Status in Cambodia.* Health Messenger, 2004(20).
45. WHO, et al., *Pregnancy, Childbirth, Postpartum, and Newborn Care: a guide for essential practice*. IMPAC. 2004.
46. WHO, ICM, and FIGO, *Making pregnancy safer: the critical role of the skilled attendant. A joint statement by WHO, ICM and FIGO*. 2004, Geneva: Dept of Reproductive Health and Research.
47. WHO, *World Health Report: Make every mother and child count*. 2005: Geneva.
48. WHO, *Postpartum care of the mother and newborn: a practical guide*. 2005, Dept of Reproductive Health Research: Geneva.
49. van Lerberghe, W., *Safer motherhood in Cambodia. Health sector support programme*. 2001, DfID Resource Centre for Sexual and Reproductive Health: Lon.
50. WHO, *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000*. Fourth edition ed. 2004, Geneva.
51. WHO, et al., *Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors*. IMPAC. 2003.
52. Ministry of Education, Y.S., *National Survey on Youth Risk Behaviour (Age 11-18)*. 2004, Unicef, UNESCO: Phnom Penh.
53. Ramage, I. and G. Pictet, *Family Planning Survey: Contraception among married women of reproductive age in Cambodia (draft)*. 2005, Domrai Research and Consulting, KfW, MoH: Phnom Penh.
54. Ministry of Health, *Cambodia STI Prevalence Survey*. 2001: Phnom Penh.
55. Ministry of Health, *HIV Sero-Surveillance Study*. 2003: Phnom Penh.
56. *The New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health*. 2004. New York.
57. Ministry of Health, *Policy, Strategy and Guideline for HIV Counseling and Testing*. 2002: Phnom Penh.
58. WHO, *Domestic Violence: A priority public health issue in the Western Pacific region*. 1998, WHO Regional Office for the Western Pacific: Manila.
59. WHO, *WHO Multi-country Study on Women's Health and Domestic Violence against Women: Summary Report of initial results on prevalence, health outcomes and women's responses*. 2005: Geneva.
60. Wilkinson, D. and G. Fletcher, *Sweetheart Relationships in Phnom Penh*. 2002, Population Services International: Phnom Penh.
61. WHO, *Cervical cancer screening in developing countries: report of a WHO consultation*. 2002, Geneva: WHO.
62. WHO, *Infertility: A Tabulation of Available Data on Prevalence of Prevalence of Primary and Secondary Infertility*. 1991, Programme on Maternal and Child Health and Family Planning: Geneva.
63. Thompson Jr, A. and A. Strickland III, *Strategic management concepts and cases*. 1999, Boston: Irwin McGraw-Hill.
64. Mintzberg, H., *Crafting Strategy.* Harvard Business Review, 1987. 65(July-August): p. 66-75.
65. Bloisi, W., C. Cook, and P. Hunsaker, *Management and Organisational Behaviour*. 2003, Berkshire: McGraw-Hill Education.
66. Ministry of Health, *Draft National Standard Guideline on Postnatal Care of Women and their Babies*. 2005, NRHP: Phnom Penh.
67. Kak, L., et al., *Recommendations for Accelerating Maternal and Newborn Health Services in Cambodia*. 2005, USAID, ACCESS, BASICS: Phnom Penh.
68. Dept of Planning and Health Information, *Joint Annual Performance Review*. 2005, MOH: Phnom Penh.
69. WHO, *Millennium Development Declaration Goals.* 2003.

5 ANNEXES

ANNEX I. Health Policy Environment

This annex provides an overview of government policy as it relates to reproductive health.

National Policy on Birth Spacing, 1995

The MOH developed the birth spacing policy for Cambodia, following a high-level conference on 24-26 January 1995 and drawing on ICPD (1994) recommendations. Eighteen policy statements detail that birth spacing promotes maternal and child health and should be readily accessible and safe. The general principles state:

> *Everyone has a right to the enjoyment of the highest attainable standard of physical and mental health. Cambodia will take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes birth spacing and sexual health. Reproductive health care programmes should provide the widest range of services without any form of coercion. Couples and individuals have the right to decide freely and responsibly on the number and spacing of their children and to have the education and means to do so.*

National Policy and Strategies on Safe Motherhood, 1997

The MOH developed this policy and strategy document from a national workshop held in June 1997 and drew on Safe Motherhood Conference (Nairobi 1987) recommendations and ICPD (Cairo 1994) action plan. The 'four pillars' of Safe Motherhood (family planning, antenatal care, clean labour and delivery, and essential obstetric care) are integrated into the Cambodian health system on a foundation of increasing equity for women. The national Safe Motherhood policy focuses on improving:

- maternity care services, including child spacing and nutrition, at all levels of the healthcare delivery system starting from family and community (thus improving the quality of life of Cambodian women and children by improving pregnancy outcomes and reducing maternal and infant morbidity and mortality)
- community participation through behavioural and societal changes at community and service delivery levels

To avoid a vertical programme, the MOH has integrated Safe Motherhood strategies into existing MCH, BS, EPI, and Nutrition programmes. The MOH developed the draft Safe Motherhood five-year plan (1997-2001) and National Safe Motherhood Five-Year Action Plan (2001-2005) based on this document and in collaboration with partners.

Law and Prakas on Abortion, 1997 and 2001

The Abortion Law of 12 November 1997 legalised abortion in Cambodia. It has 5 chapters and 16 articles. The Prakas for Implementation (3 sections and 10 Praka) were signed in August 2002. The Abortion Law is one of the most liberal in Asia. General provisions (chapters 1 and 4) include:

Article 5: *Only medical doctors, medical assistants, or secondary midwives who have been authorized by MOH can perform abortions.*

Article 6: *Abortions can only be performed in hospitals, health centres, clinics, or public and private maternity units that have been authorized by MOH. All facilities thus authorised must have:*
- *technical capacity for rapid management of complications due to abortion*
- *means for referral to a higher level of care when necessary*

Article 8: *Abortion can be performed only at less than twelve weeks pregnancy. For pregnancies of more than twelve weeks, abortions may be allowed in certain cases (e.g. abnormal pregnancy or rape).*

Articles 12-15: *(Chapter 4) detail sanctions*

The MOH based the National Comprehensive Abortion Care Clinical Protocol of 2001 on this law.

National policy for the prevention of mother-to-child transmission of HIV, 2001

The Royal Government of Cambodia considers prevention of mother-to-child transmission (PMTCT) of HIV a high priority. The policy's main objectives are to:

> *"prevent women, their partners, and newborns from HIV infection; prevent stigma and discrimination; provide and improve access to care and support services; and to contribute to the improvement of the acceptability, accessibility, and quality of health services and information on reproductive health and HIV/AIDS/STIs. PMTCT is a critical element in the overall HIV prevention and control strategy, focused primarily within the reproductive health sector of healthcare services."*

To ensure synergism, coordination, and partnerships, PMTCT implementation is through existing health and social services. Both public and private sectors, with MOH authority, can use this policy to develop effective strategies for targeting young women to avoid HIV infection, prevent pregnancies for those infected, develop targeted prophylactic interventions in the peripartum, and promote community support.

Policy on voluntary and confidential counselling and testing for HIV, 2002

This policy states that all women and men, irrespective of HIV status, have the right to determine the course of their reproductive lives and health, and to access information and services that allow them to protect their own and their family's health. The government will promote family counselling, integrate it into RH and STI services, and implement a longterm VCCT strategy to protect HIV-infected women from stigmatisation and discrimination.

National Population Policy, 2003

Based on the ICPD Programme of Action and subsequent revisions, this policy recognizes the central role of reproductive health services, empowerment of women through equal access to education and public office, and the link between poverty and rapid population growth. Among its policy measures, this policy clearly aims "to support couples and individuals to decide freely and responsibly on the number and spacing of their children, and to have access to the information, education, services and means to do so."

Strategic Plan for Health Sector Development, 2003-2007

The Health Sector Strategic Plan (HSP) states that all people in Cambodia, irrespective of gender, age, residence, or ability to pay, should have equal access to good quality basic and essential health services, staffed by competent health professionals, at a cost they can afford. They should have information that empowers them to make informed choices about matters affecting their health and wellbeing and that of their families. Key sectoral priorities include: (1) increased accessibility to quality health services, based on (2) the Minimum Package of Activities (MPA) at health centre level, and (3) Complementary Package of Activities (CPA) at first referral level; (4) provider behaviour change to respond to clients' needs, (5) quality improvement; (6) human resource development; (7) health financing; and (8) institutional development.

Improved reproductive health is a clear priority. One of eight core strategies is to increase the number of midwives, through basic training, and strengthen the capacity and skills of existing midwives through continuing education. Service delivery strategy (c) is to strengthen the delivery of quality care, especially obstetric and paediatric, in all hospitals through measures such as the CPA.

Table 6. Relevant indicators from the health sector plan (2003-2007)

Outcomes
• reducing IMR to 84/1000
• reducing MMR to 305/100,000
• reducing TFR to 3.5
• reducing HIV/AIDS sero-prevalence among adults 15-49 to 12.1%
• improved nutritional status among children and women to 31%
Health service delivery (c)
• increased hospitalisation rate for deliveries
• increase in % deliveries by trained personnel
• increased rate of justified caesarean sections
• increase in antenatal care consultations by trained staff
• increase in % women 15-49 protected against tetanus during pregnancy
• increase in CPR
Human resource development (k)
• better essential obstetric care

Sectoral priorities for 2005-2006 from the recent Joint Annual Performance review are: (1) EmOC, (2) skilled delivery attendance, (3) integrated management of childhood illness, (4) full MPA status at health centres, and (5) birth spacing services [68].

Millennium Development Goals, 2000-2015

At the Millennium Development Summit in 2000, members from 189 countries, including Cambodia, committed toward a world in which sustained development and eliminating poverty would have highest priority [69]. The Millennium Development Goals (MDGs), targets, and indicators are an accepted framework for measuring progress. Of the nine health-related targets, three relate to reproductive health and NRHP's mandate in Cambodia. Delegates at the Millennium Development Review in 2005 confirmed universal access to reproductive health services as an indicator under Goal 5.

Table 7. MDGs and global targets

MDG	Target
4. Reduce child mortality	*5. Reduce by two-thirds, between 1990-2015 the under-five mortality rate*
5. Improve maternal health	*6. Reduce by three-quarters, between 1990-2015, the maternal mortality ratio*
6. Combat HIV/AIDS, malaria and other diseases	*7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS*

Implementation of the national strategy for reproductive and sexual health in Cambodia (2006-2010) will contribute towards achievement of these three reproductive health-related MDGs in Cambodia.

Table 8. CMDG indicators and targets of the MOH-NRHP in Cambodia

Indicators	Baseline 2000	Targets 2005	2010	2015
(5.1) Maternal Mortality Ratio (MMR)	437	343	243	140
(5.2) Total Fertility Rate (TFR)	4	3.8	3.4	3
(5.4) % of married women using modern birth spacing methods	20	30	44	60
(5.7) % of women aged 15-49 with BMI<18.5 kg/m^2 (BMI)	21	17	12	8
(5.8) % of women aged 15-49 with IDA	58	45	32	19
(5.5) % of pregnant women with 2+ ANC consultations with skilled health personnel (ANC2)	30.5	60	75	90
(6.2) % HIV among pregnant women aged 15-49 visiting ANC	2.5	2.4	2.0	1.5

(6.6) % HIV infected pregnant women attending ANC receiving a complete course of ARV prophylaxis to reduce the risk of HIV transmission	2.7	10	35	50
(5.6) % of pregnant women with iron deficiency anaemia (IDA)	66	50	39	33
(5.3) % of births attended by skilled health personnel (SBA)	32	60	70	80
(5.9) % of pregnant women delivered by justified caesarean section	0.8	2	3	4
(4.1) Infant Mortality Rate (IMR)	95	75	60	50
(4.7) % of mothers who start breastfeeding within 1 hour of birth	11	28	45	62
(4.6) % of infants exclusively breastfed up to six months of age	11.4	20	34	49
(6.1) % HIV among adults 15-49	3.0	2.3	2.0	1.8
(6.4) % of young people, aged 15-24 reporting use of a condom during sexual intercourse with a non-regular sexual partner	82	85	90	95

Draft National Strategic Plan for HIV/AIDS, 2006-2010

Seven broad strategies are designed to accomplish three overall goals, which are:
1. to reduce new infections of HIV
2. to provide care and support to people living with and affected by HIV/AIDS
3. to alleviate the socio-economic and human impact of AIDS on the individual, family, community, and society

Main linkages with the reproductive and sexual health strategy are primary prevention, PMTCT, VCCT, and STI prevention and control.

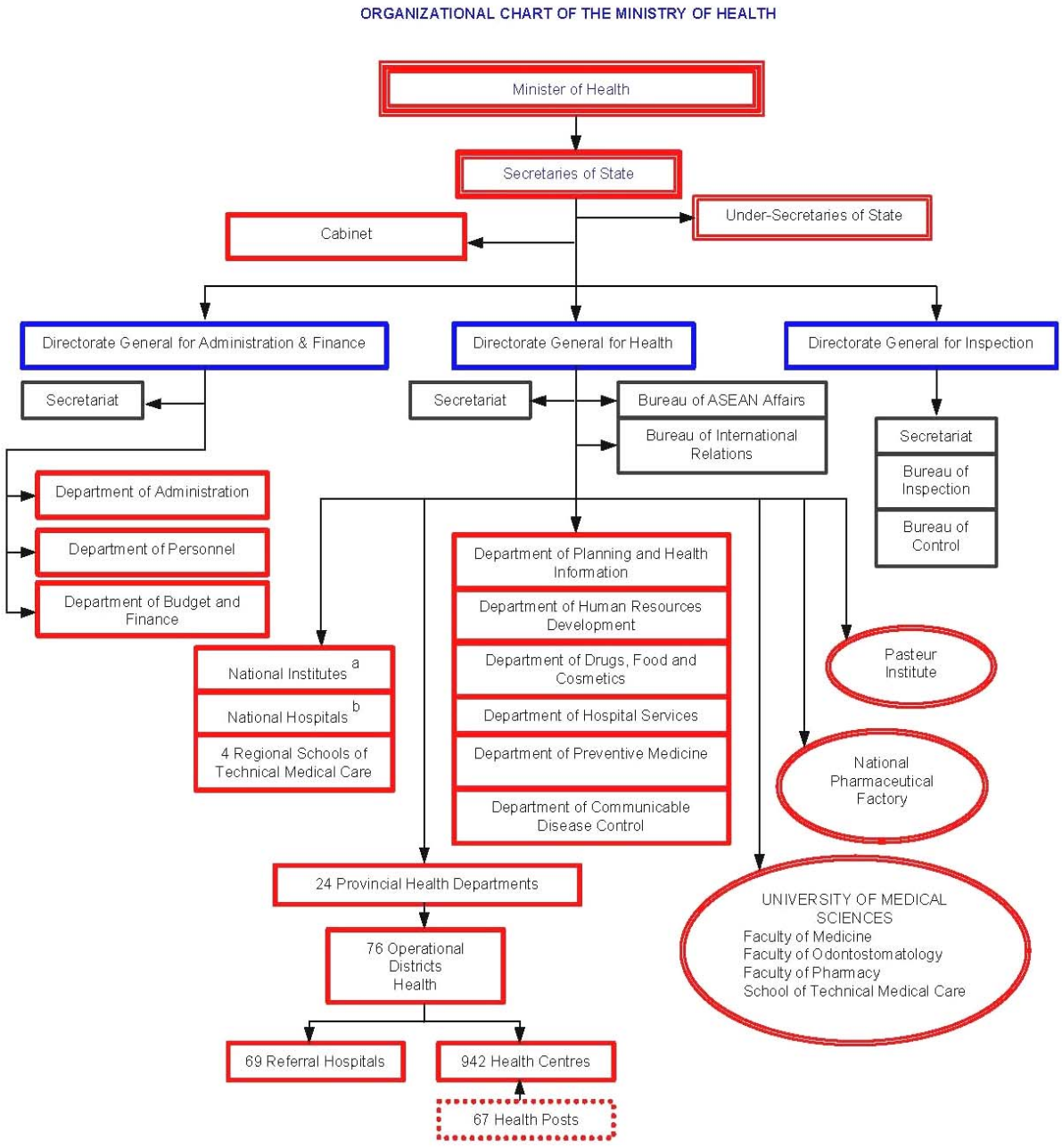
Draft National Strategic Plan for Child Survival, 2006-2010

The goal and purpose of the draft strategy are:

> "to reduce by 2015, under-five and infant mortality rates from 124 and 95 in 2000 to 65 and 50 deaths per 1,000 live births respectively," and "to guide stakeholders in designing, implementing, and evaluating programmes and projects aiming at improved child survival, health, and nutrition"

Its six components include policy setting and coordination, community action for child survival, health service delivery, human resources and capacity building, financing, monitoring and evaluation. Key linkages with the reproductive health strategy include skilled attendance at delivery, newborn care, and specific interventions (e.g. tetanus toxoid provision, vitamin A supplementation, immediate exclusive breastfeeding)

ANNEX II. Organisation of the public healthcare delivery system



NB:

[a] NCHADS, NCTB/Lepr, NCMalaria, NCMCH, NIPH, NCTraMed, NCDrugQuaCon, NCBloodTran

[b] Excluding Hopitals in NCMCH and NCTB/Lepr

[c] Battambang, Kampot, Kg. Cham and Stung Treng

Source: MOH/WHO

ANNEX III. List of reproductive health stakeholders

Ministries	Associations/Councils	Multilateral Organisations
Education, Youth & Sport Information Interior Planning Rural Development Social Affairs Women's Affairs National Programmes MCHC NAA NCHADS NRHP RTC MOH Departments Central Medical Stores Essential Drugs Human Resource Development Personnel Planning & Health Information Hospital Services Preventive Medicine	Cambodian Medical Association Cambodian Medical Council Cambodian Midwives Association LNGOs Cambodian HIV/AIDS Education and Care (CHEC) Cambodia Health Education Media Service (CHEMS) Indradevi association (IDA) Khmer HIV/AIDS NGO Alliance (KHANA) MARIE STOPES Cambodia (MSC) Mith Samlanh (Friends) Operation Enfants de Battambang (OEB) Reproductive and Child Health Alliance (RACHA) Reproductive Health Association of Cambodia (RHAC) Women's Development Association (WDA) Women's Media Centre of Cambodia (WMC) Bilateral Agencies Dept for International Development (DfID) European Union (EU) 'German Cooperation' (KfW / GTZ) Japanese International Cooperation Agency (JICA) United States Agency for International Development (USAID) Canadian International Development Agency (CIDA) Agence France Development (AFD)	United Nations Population Fund (UNFPA) United Nations Children's Fund (UNICEF) World Health Organisation (WHO) INGOs Adventist Development and Relief Agency (ADRA) CARE International in Cambodia (CARE) Family Health International/Impact (FHI/IMPACT) HealthNet International (HNI) Health Unlimited (HU) Medecins Sans Frontieres-Belgium (MSF-B) Partners for Development (PFD) Pharmaciens Sans Frontieres (PSF) POLICY Project Population Services International (PSI) Program for Appropriate Technology in Health (PATH) Save the Children-Australia (SCA) Services for Health in Asia and African Regions (SHARE) University Research Cooperation (URC) Voluntary Services Overseas (VSO) World Relief Cambodia (WRC) World Vision Cambodia (WVC)