Kingdom of Cambodia

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Ministry of Health

Country Report on Caring and Promoting Health for Mother and Child toward Healthy Next Generation in Cambodia

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Forward

This Country Report is prepared to respond to the request from the organizer of The 6th ASEAN and Japan High Level Officials Meeting on caring Societies: Healthy Next generation – under the Tight Collaboration between Health and Social Welfare – to be presented in Tokyo, Japan to the Meeting from 8 to 11 September 2008. Representatives from the Ministry of Health of Cambodia participated in several meetings on similar concept but under different schemes to address common important issues, share knowledge and experiences among ASEAN countries and Japan. Responding to the invitation from the Organizer, the Ministry of Health of Cambodia nominated its tow senior officials to attend this important meeting:

1. **Prof. Dr. Sann Chan Soeung** (Mr.) Deputy-Director General for Health
2. **Dr. Or Vandine** (Mrs.) Director, International Cooperation Department

It is anticipated that this paper will provide a basis of understanding of how the issue of "Healthy Next Generation" is addressed by the Ministry of Health of Cambodia. It will serve as a tool for:

1. Information sharing and learning experiences for maternal and child health policy and services,
2. Facilitate mutual understanding of health sector in Cambodian context,
3. Explore possibility of future planning and resource allocation for future shaping the collaboration between ASEAN countries and Japan in general, between Cambodia and Japan in particular with promoting networking.

The Ministry of Health of Cambodia wishes to express its sincere thanks to the Organizer - Ministry of Health, Labour and Welfare (MHLW) of Japan and Japan International Corporation of Welfare Services (JICWELS) – for inviting and supporting its representatives to attend this important meeting with our trust that their participation will further enhance and strengthen collaboration between the two countries (Cambodia and Japan) and between ASEAN countries. We are more than happy to receive your comment on this document and on the next steps for future cooperation and collaboration.

Phnom Penh, 25 July 2008

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I.1. Introduction

Healthy children can have ability to learn better, grow better, and have better chance of succeeding in life. Healthy mother will help to reduce and even safe more expenditure on health care for family, thus impact on poverty alleviation. Routine childhood immunization will protect children from sickness due to preventable diseases. Thus, addressing the improvement of Maternal and Child Health services in Cambodia is vital, given the serious impact of infectious diseases such as HIV/AIDS among pregnant women, the risk of unsafe deliveries and/or abortions and the high rate of maternal and child mortalities. Reduction of Maternal and Infant mortality is a priority of the Ministry of Health (MoH) among other public health concerns and it constituted as one of a main focused area of the National Health Sector Plan. Protecting the health of mothers and children is very important for the "Healthy Next Generation". Increased investment in Maternal and Child Health (MCH) will contribute to wider development goals because it enables mother to become healthy and productive healthy child.

Reducing maternal and child mortalities in Cambodia is both a human rights and a socio-economic issue. Avoiding maternal and child death will have significant benefits on household income, the quality of household expenditures, the chance of survival of young children and their future educational achievements[1]. However, despite the prioritization of maternal health, the maternal mortality ratio (MMR) has changed little in the last 10 years, with the MMR estimated at 437 per 100,000 live births in the 2000 Cambodia Demographic and Health Survey (CDHS) and 472 per 100,000 live births in the 2005 CDHS. This corresponds to a life time risk of dying from a pregnancy related cause as 1 in 50. Maternal related deaths account for 17.1% of women ages between 15-49 years[2].

It is widely acknowledged that improvements in maternal and newborn health are reliant on women having access to a functioning health system during pregnancy, in the intra-partum and postnatal period. Women need access to a continuum of care including family planning; safe abortion services (where legal), focused antenatal care (ANC), delivery by a skilled attendant, referral to emergency obstetric care and postnatal care. Where HIV/AIDS rates are high, health care and intervention should be integrated to ensure access to Prevention of Mother to Child Transmission (PMTCT) and care and treatment programmes for the woman and family members. Therefore, maternal and child mortalities are an important proxy indicator of the overall effectiveness and efficiency of health system and a woman's ability to access services[2].

Due to variety of services to address the issue of MCH, this paper is intended to present a general observation and key informant on national policies and strategies to address the issue of MCH with some selected challenges and recommendations for the implementation of the national policies and strategies that can provide relevant information on how Ministry of Health of Cambodia pays attention to the topic of "Healthy Next Generation" with limited

[1] World Bank Summary gender profile for Cambodia 2005 http://genderstats.worldbank.org
[2] Report on Cambodia's Health Sector Review (2003-2007) by HLSP – August 2007

resources.

I.2. Current Situation of Maternal and Child Health in Cambodia

Cambodia has made considerable progress over the last decade, but continuing challenges with high maternal, infant and under-five mortality rates, low rates of delivery by skilled personnel, high unmet need for contraceptive services, high levels of anemia in women of reproductive age and high STI and HIV transmission[3]. The health situation for women and children is remarkably improved. Based on the CDHS 2005 conducted jointly between the Ministry of Health (MoH) and the Ministry of Planning shown that in the last five years, child mortality rate has declined about 30% (approximately 6% decrease per year) and among this figure it is noted that infant mortality rate decreased from 95 per 1000 live births in year 2000 to 66 per 1000 live births in year 2005 and under-five mortality rate has declined from 124 to 83 per 1000 live births in 2005. However, maternal mortality rate has not yet declined and remains high during the last five years with the rate of 472 per 100,000 live births[4]. The total fertility rate (TFR) decreased from 4 to 3.4 over the 5 years (2000 to 2005). Table 1 below shows comparison of selected health parameters values based on the data from CDHS in 2000 and 2005. Declined in child mortality rate reflected the effectiveness of the implementation of Integrated Management of Childhood Illness (IMCI) strategy that up to 2007, the MoH has trained its health professionals and implemented in 533 health centers (in 2003, only 95 HCs implemented IMCI)[5].

Immunization coverage for children under 1 year of age has increased especially for diphtheria, tetanus and pertusis from 73% in 2003 to 82% in 2007[6]. Measles are slightly less clear. Improvement comes late in the period of 2005 that confirm an upward trend (Table 2). Malnutrition for children less than 5 years old declined with the proportion of wasting from 15% in 2000 to 7% in 2005, of stunting from 45% in 2000 to 37% in 2005, and of under-weight from 45% to 36% (based on CDHS 2005).

For maternal services, delivery by trained health professionals increased about 2 times: 22.4% in 2003 to 46% in 2007. In late 2007, the Royal Government of Cambodia has issued a policy for supporting midwives for safe delivery at public health sector. With this mechanism, number of delivery is remarkably increased especially at HC level. Contraceptive prevalence rate (for any method) for birth spacing among women aged 15 to 49 years old has increased also during the last five years from 19% in 2000 to 27% in 2005 based on CDHS 2005. Total fertility rate is decreased from 4 births per woman in 2000 to 3.4 births per woman in 2005. Coverage for pre-natal consultation for second time augmented from 33% in 2003 to 68% in 2007. Breastfeeding and food supplementation for infant less than 6 months of age has introduced in three baby friendly hospitals in year 2003 and this policy is further expanded into seven hospitals in the countrywide. Infants exclusively breastfed up to 6 months of age is increased from 10% in 2003 to 60% in 2007 (CDHS 2005).

[3] National Strategy for Reproductive and Sexual Health in Cambodia (2006-2007) – February 2006.
[4] Report on Health Achievements 2003-2007 delivered by H.E. Prof. Eng Huot, Secretary of State for Health during the 29th National Health Congress and 6th Joint Annual Programme Review (JPRA) on Health Achievements from 2-4 April 2008 at Raffles Hotel Le Royal, Phnom Penh, Cambodia.

Table 1: Comparing Health Parameter Values in 2000 and 2005 CDHS.

		2000		2005
Mortality and fertility				
Age adjusted maternal mortality rates (per 1,000 women- year of exposure) for the period 0-6 years prior to the survey		0.55		0.50
Maternal mortality ratio (per 100,000 live births) for the period 0-6 years prior to the survey		437		472
Infant mortality rate (per 1,000 live birth)				
for the 0-4 year period prior to the survey		95		66
for the 5-9 year period prior to the survey		91		109
for the 10-14 year period prior to the survey		78.8		93
Under-five mortality (per 1,000 live birth)				
for the 0-4 year period prior to the survey		124.4		83
for the 5-9 year period prior to the survey		119.4		127
for the 10-14 year period prior to the survey		114.7		124
Total fertility rate		4.0		3.4
Women's health				
% BMI<18.5 kg/m^2 (total thin)		20.7		20.3
% height <145cm		5.5		7.7
% anemia (moderate and severe level)		14.0		11.2
% teenage (15-19) pregnancy		5.6		5.2
% with at least one abortion in the past 5 years		1.9		3.5
% experienced violence in the past 12 months		15.2		10.3
		2000		**2005**
Child health				
% children<5 with height-for-age <-3 S.D.		20.5		12.9
% children<5 with height-for-age <-2 S.D.		44.6		37.3
% children<5 with weight-for-height <-3 S.D.		3.9		0.8
% children<5 with weight-for-height <-2 S.D.		15.0		7.3
% children<5 with weight-for-age <-3 S.D.		12.6		6.9
% children<5 with weight-for-age <-2 S.D.		45.2		35.6
% 6-59 months have anemia		63.4		61.9
% children receiving all basic vaccine		39.9		66.6
Injury/accident				
% injured or killed in an accident in the past 12 months		0.9		1.9
% household population physically impaired		1.6		2.2
% involving road accident among those injured or killed in the past 12 months		33.2		45.9
% involving landmine/unexploded bomb among those injured or killed in the past 12 months		3.0		0.7
Health services utilization				
% women with live birth in the past 5 years who utilized antenatal services (doctor/nurse/midwife)		37.7		69.3
% women giving birth in the past 5 years preceding the survey with no postnatal checkup		45.9		30.1
% live births in the 5 years preceding the survey delivered by doctor/nurse/midwife		31.8		43.8
% household member ill/injured in last 30 days seeking treatment		88.6		91.5
% live births (in 5 years before survey) delivered in health facility		9.9		21.5

Note: This Table1 is extracted from "Report on Cambodia's Health Sector Review (2003-2007) by HLSP – August 2007.

Vitamin A supplementation for infant aged 6 to 58 months increased from 47% in 2003 to 86% in 2007 and women received vitamin A during 6 weeks after delivery also augmented from 21% in 2003 to 59% in 2007.

Table 2 below shows historic data for outpatient service utilization in Cambodia include three parameters[5] that cover the period from 1998 to 2005. Data on health service utilization in the public sector support the understanding of a positive development of service utilization that may be included maternal and child health services. Antenatal coverage also shows a clear improvement from 1998 to 2005. Based on national health statistic 2007 of the MoH, the total coverage for antenatal care for second time (ANC2) is about 68% for the whole country.

Table 2: Trends in Utilization of Outpatient Services

	1998	1999	2000	2001	2002	2003	2004	2005
Outpatient contacts/capita/year	0.31	0.29	0.31	0.37	0.36	0.39	0.40	0.50
Antenatal coverage	30.2	36.1	40.9	43.0	41.0	46.1	45.2	53.2
EPI coverage: measles (% of target group)		63	69	69	65	69	65	79

Note: This Table2 is extracted also from "Report on Cambodia's Health Sector Review (2003-2007) by HLSP – August 2007.

Other main health indicators are summarized as the following[6]:

1. Demographic Data

- Estimated population (millions) 14,364,519
  - i. Urban 15%
  - ii. Rural 85%
  - iii. Males 48.3%
  - iv. Females 51.7%
  - v. Distribution by age group
    - 0-4 years 11.1%
    - 0-14 years 38.69%
    - 5-14 years 27.5%
    - 15-49 years 26.0%
- Crude Birth Rate 2.56%
- Estimated population under 1 year 2.36%
- Annual Population Growth rate 1.81%
- Male life expectancy at birth 58
- Female life expectancy at birth 64
- Average household size 5.1

2. Education

- Total adult literacy (age 15 and over) 73.6%

[5] From National Health Statistics 2005

[6] From National Health Statistics 2007, Department of Planning and Health Information, Ministry of Health (Draft only, not official yet)

i. Male 84.7%
ii. Female 64.1%
iii. Urban (both sexes) 83.8%
iv. Rural (both sexes) 71.7%

3. Economic

- Government expenditures on health per capita per year (USD) 4.64

4. Delivery

- Expected Pregnancies 367,706
- Total deliveries 261,425
- Delivery by health professionals 168,188
- %of delivery by health professional 46%

5. EPI Coverage Rate

- BCG 90%
- OPV3 82%
- DPT3_HepB3 82%
- Measles 79%
- Full Immunization 72%
- TT2+ for pregnant women 50%

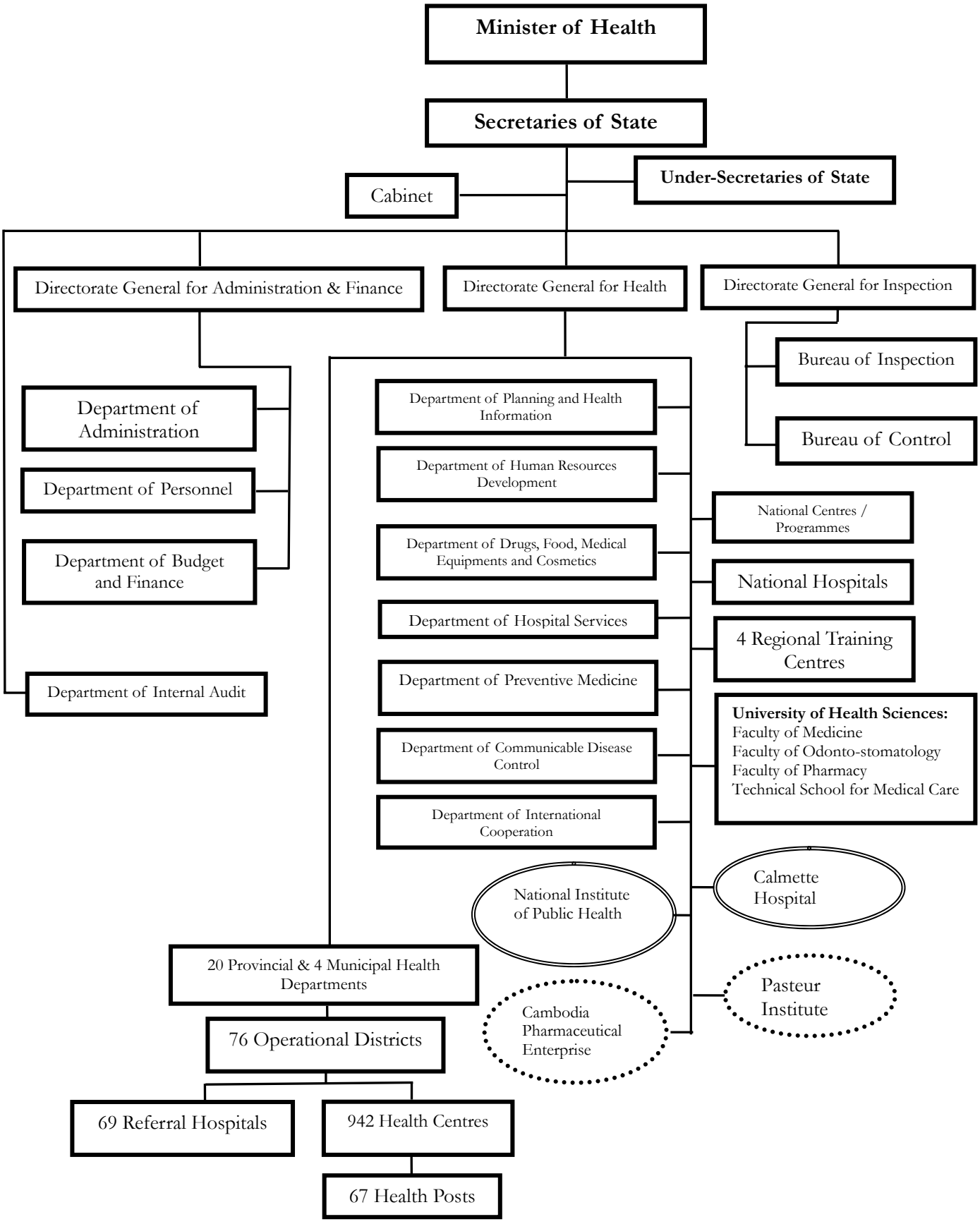
II. INSTITUTIONAL, POLICY AND STRATEGY FOR MATERNAL AND CHILD HEALTH IN CAMBODIA

II. 1. Management Structure of the Ministry of Health of Cambodia

The MoH is operated under the overall supervision and management of Minister of Health and Secretaries of State for Health who are members of the Royal Government of Cambodia. The MoH Cabinet is responsible for the smooth and effective functioning of the MoH management which composed of Minister of Health, Secretaries of State for Health and Under-Secretaries of State for Health. There are three general directorates: directorate general for inspection, directorate general for health and directorate general for administration and finance. Each directorate consisted of several departments and each department has several bureaus. Figure 1[7] below lays out clearly the organizational structure of the MoH. The National Centers and/or Programmes are under direct supervision of directorate general for health but technically link with respective department. Maternal and Child Health enter (NMCHC) is considered as one of the National Center/Programme with having its role and responsibility for maternal and child health in the whole country. Chart 2 shows management structure of the NMCHC approved by the MoH on 02 July 2007.

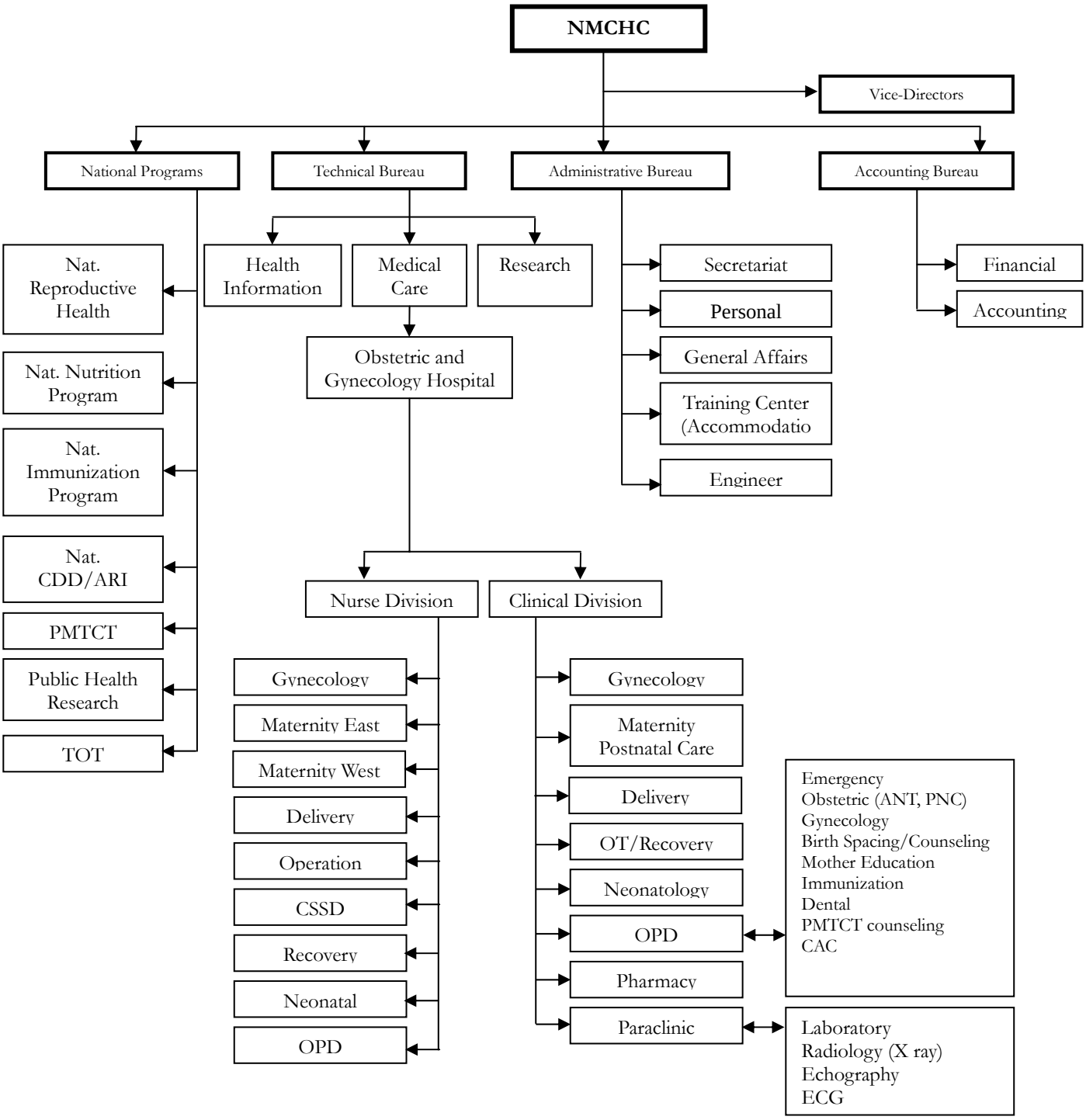
[7] http://www.moh.gov.kh

Chart 1: Organizational Chart of the Ministry of Health (MoH)



II. 2. National Maternal and Child Health Center

Chart 2: Organizational Chart of National Maternal and Child Health Centre (NMCHC)



II.3. National Policy and Strategy for Maternal and Child Health

In April 2008, Health Strategic Plan 2008-2015 (called HSP2) was officially lunched for its implementation by Deputy-Primer Minister during the closing session of the National Health Congress held at Raffles Hotel Le Royal, Phnom Penh, Cambodia. It indicated a step moving toward enhancement of health sector development and improvement of health and well-being of Cambodian people with particular attention to improving health of mothers and children that will contribute to healthy next generation, poverty alleviation and socio-economic development. Among other key elements of policy and strategic priorities of the Health Sector Strategic Plan of 2008-2015, the programme priority areas and essential services to be addressed under the Reproductive, Maternal, Newborn and Child Health are included in the following box:

Family planning and birth spacing; safe abortions; maternal and child nutrition; antenatal care; PMTCT; skilled birth attendance; emergency obstetric care; integrated postnatal care of mothers and newborns; immunization including measles and tetanus elimination, and introduction of new vaccines; IMCI; essential pediatric care; adolescent/youth health; key family practices[8]

Goals and outcomes[9] for above priority strategy for maternal and child health is included in the following box:

- *Reduced maternal mortality*
- *Reduced neonatal and infant mortality*
- *Reduced under five mortality*
- *Improved nutritional status among children and women*
- *Increased contraceptive prevalence*
- *Increased delivery assisted by skilled birth attendants*
- *Reduce morbidity and mortality of acute respiratory infection (ARI), diarrhea and vaccine-preventable diseases*
- *Increased expanded programme for immunization coverage*

In addition to the HSP2, other policies and strategies which influence strategic planning and implementation of sexual and reproductive health (SRH) services are as the following[9]:

- National Policies and Strategies on Same Motherhood 1997, including the four pillars of Safe Motherhood (family planning, ANC, clean labour and delivery and essential obstetric care), the draft Safe Motherhood 5 year plan 1997-2001 and the National Safe Motherhood 5 year action 2001-2005.
- National Strategy for Reproductive and Sexual Health in Cambodia 2006-2010 which provides a comprehensive framework from which to advocate SRH priorities, to

[8] Health Sector Strategic Plan 2008-2015, p 20
[9] Report of Health Sector Review 2003-2007 by HLSP, August 2007, p. 33

engage in annual planning and to mobilize the resources necessary for effective action.

- National Policy on Birth Spacing 1995 and the National Population Policy 2003 – based on the ICPD Programme of Action and subsequent revisions. These policies recognize the central role of reproductive health services empowerment of women and the link between poverty and rapid population growth.
- National Strategic Plan for Child Survival 2006-2010 - key linkages with SRH include skilled attendance at delivery, newborn care and specific interventions (Tetanus Toxiod provision, Vitamin A supplementation, immediate and exclusive breastfeeding)
- Law and Prakas on Abortion 1997, 2001. The abortion law is one of the most liberal in Asia. The MoH based the National Comprehensive Abortion Care Clinical Protocol of 2001 on this law.
- The Domestic Violence Law 2005 – which provides legal protection for women who are victims of gender based violence.

Related policies and linked to MCH issue:

- National Strategic Plan for HIV/AIDS 2006-2010 – the main linkages to SRH are primary prevention, PMTCT, VCCT and STI prevention and control.

Table 3: Toward Achieving Cambodia MDG 4 and 5 for MCH

Indicators	CMDG 2005 Target	CDHS 2005	CDMG 2010 Target	CDMG 2015 Target
CMDG 4				
Under-five Mortality Rate	105	83	85	65
Infant Mortality Rate	75	66	60	50
% of children fully immunized	80	77	85	90
% of infants exclusively breastfed up to 6 months	20	60	34	49
CMDG5				
Maternal Mortality Rate	343	472	243	140
Total Fertility Rate	3.8	3.4	3.4	3.0
CPR of modern contraception	30	27	44	60
% of birth attended by SBA	60	44	70	80
% of ANC from skilled health professionals	60	69	75	90

Note: This Table 3 is extracted from the presentation of "Strategy to Improve Maternal and Child Health as Cross-Sectoral Issues" to Technical Working Group for Health (TWGH) by Prof. Koum Kanal, Director of National Maternal and Child Health Center, Ministry of Health on 07 June 2007.

Table 3 above illustrates the achievement for the implementation of maternal and child health policies and strategies by comparison between the target for five years interval to improve maternal and child health in Cambodia Millennium Development Goals (CMDG) 4 and 5 and data from CDHS 2005. Based on this comparison, it shows that much more need to be done and the above policies and priority strategies in relation to maternal and child health will address this need given the fact that not only the MoH but Development Partners

(DPs) shall play much more important role and shall pay more attention in providing their assistance (both technical and financial) in supporting these priorities setting by the MoH in HSP2 in order to meet CMDG 4 and 5.

Integrated management of childhood illness strategy (IMCI) is one of the national strategies to strength capacity of health care workers, health care system including referral and community and family participation in the management of childhood illnesses.

Strategic objectives for National Reproductive and Sexual Health Strategy 2006-2010 are presented in this Chapter as the following:

Strategic Objective 1: *Improve the quality and resource environment for reproductive and sexual health priorities in Cambodia*

The activity for implementation includes policy development and advocacy, coordination with different levels and sectors, resource mobilization and linkages with child survival strategy, nutrition, STI and HIV strategies (prevention, treatment, VCCT and PMTCT)

Strategic Objective 2: *Increase availability and strengthen delivery of quality reproductive and sexual health services*
The main focus for implementation is as the following:

- Increasing availability of trained staff
- Ensuring availability of quality reproductive health commodities
- Introducing or expanding key services: contents of the essential service package for RSH
- Establishing and strengthening partnerships and linkages

Strategic Objective 3: *Strengthen community understanding of reproductive and sexual health needs and rights and increase demand for services*

Activities are focused on development of behavior change and communication strategy, dissemination of appropriate information by providers, and community access to reproductive health services.

Strategic Objective 4: *Expand the evidence base to inform policy and strategy development*

Implementation will be concentrated on programmatic evaluation, maternal and neonatal mortality and morbidity and gender equity toward RSH services. Monitoring and Evaluation is as part of national monitoring and evaluation within Joint Annual Performance Review (JAPR), HSP, CMDGs and data collected from routine Health Information System (HIS) and from CDHS 2010 for analysis and review.

Key elements for scaling up activities in MCH are identified to be:

- availability of comprehensive quality birth spacing services – which should also involve men in order to increase joint decision making between men and women

- improved abortion and post-abortion services – which needs to include and address the needs of adolescents
- widespread and accessible antenatal care – which is integrated with PMTCT services, and addresses the continuing needs for HIV treatment and care of the mother and baby in the post partum period
- increased access to skilled attendants for deliveries – with particular focus on rural areas
- Focus on the early initiation of and exclusive breastfeeding
- Developing and implementing approaches to working more extensively with volunteer health workers (e.g. provision of Vitamin A) and addressing the transition between use of the traditional birth attendant and skilled attendant
- Ensure the WHO recommendations for the minimum numbers of Comprehensive and basic Obstetric Facilities are applied
- Improve the referral between all levels of the system, including community
- Review and improve monitoring of maternal newborn and child deaths including maternal and newborn death audits, and the reporting from the private sector
- Increase the focus on immunization for pregnant women, babies and children
- Increase linkages with the malaria programmes to scale up prevention and treatment
- Focus on early detection and treatment of childhood ailments, e.g. pneumonia and diarrhea

Progress in this area will call for strengthened institutional arrangements, including the national reproductive and sexual health programme, and improved involvement and co-ordination of work of the donors. The above mentioned main elements to be scaled up are quoted from the Report of Health Sector Review 2003-2007.

III. SELECTED PLAN AND ACTIVITY TO ADDRESS PMTCT AS AN EXAMPLE FOR MCH INTERVENTION

From the time of lunching the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), NMCHC has prepared a proposal for 5 years to fill the funding gap for PMTC under HIV/AIDS component of GFATM Round 4. The 5-year proposal was approved by the GFATM and started to implement in September 2005 until August 2010.

III.1. Project Summary

Goal: to reduce the percentage of HIV infected infants born to HIV infected mother in Cambodia

Objectives of the project

To increase the percentage of HIV-infected pregnant women and their newborns who receive ARV prophylaxis to prevent mother-to-child transmission of HIV people with advanced HIV infection receiving ARV treatment

Main Activities

- Provide incentive to PMTCT staff
- Renovate/expansion new PMTCT sites (61 sites renovated/106 sites with completes package of PMTCT)
- Produce bill board/IEC materials of PMTCT to raise public awareness (60 ODs)
- PMTC: ANC, VCCT, ARV (816 HIV+ pregnant women referred to receive PMTCT in target areas)
- Provide training on PMTCT to health providers/counselors (1070 people)

Location : The project is implemented in 16 provinces as the following:
Kampong Cham, Rattanakiri, Mundolkiri, Udormeanchey, Takeo, Siem Reap, Battambang, Kandal, Kampong Speu, Kampong Chhang, Pailin, Preah Vihear, Kratie, Prey Veng, Sihanouk Ville, and Kampot provinces.

Total Budget Plan and Expenditures:

Total budget for 5 years:	USD 1,716,681.00
Total budget for Year 1 and Year 2:	USD 688,295.00
Total expenditure for Year 1 and Year 2:	USD 536,743.00
Total expenditures as of June 2008:	USD 746,029.00

III.2. Project Plan[10]

		Service to be delivered					
Description		Service includes primary prevention among women of reproductive age, family planning counseling and education among HIV- infection women, referral to VCCT for pregnant women, ARV prophylaxis for HIV- infected pregnant women and newborns, and counseling and education on optimal infant feeding practices					
Coverage indicator		***Baseline***	***Year 1 target***	***Year 2 target***	***Year 3 target***	***Year 4 target***	***Year 5 target***
1	# and % of provincial & OD that have at least 1 facility offering full package of PMTCT service	6 8.7% (2003)	22 30.1% (2005)	30 41.0% (2006)	36 49.3% (2007)	36 49.3% (2008)	36 49.3% (2009)
2	# of ANC clients in target health facilities who receive VCCT, including testing and pre and post test counseling	4,081 (2003)	12,165 (2005)	20,165 (2006)	99,140 (2007)	147,140 (2008)	195,140 (2009)
3	# of HIV-infected pregnant women who receive complete course of antiretroviral prophylaxis to reduce the risk of MTCT of HIV	109 (2003)	285	425	1,184	1,664	2,104
4	% of identified HIV-infection mothers in targeted ODs who use exclusive formula OR exclusive	< 4%	10%	20%	30%	40%	50%

[10] Cambodia Coordinated Proposal for Round 4 – HIV/AIDS Component - submitted by Country Coordinating Committee (CCC) in Cambodia to GFATM Geneva - 2004, p. 30-48.

	breastfeeding for first 6 month						
5	Number of service delivered points with sufficient ARV drugs and HIV test kits supply	6 (2003)	22	30	79	91	100
6	-# of m heath care worker, counselors and PLHA trained in PMCTC and able to demonstrate competency in their respective areas of delivering PMTCT services	66	24	184	786	886	986
7	% of HCs in targeted ODs providing information and referral to VCCT, STI, and PMCTC services.	This indicator from the coordinated proposal was dropped in June 2006 due to inappropriate reflection to the program and the new revised indicator in row below was done in June 2006 also to replace this indicator for inclusion in the Memorandum of Understanding (MoA) for Phase 2 dated December 18, 2007.					
	# of HIV infected pregnant women who are referred to receive PMTCT in the target health facilities	72 (2006)			664	904	1,144
8	# of OD with IEC/BCC activities related to PMTCT of HIV	6	22	30	50	55	57
9	# PMTCT sites renovated	8	16	30	60	80	100

5.1 Project Implementation/Achievement up to 2 years[11]

Indicators	IRQ8	ARQ8	% of achievement
1. # and % of provincial OD that have at least 1 facility offering full package of PMTCT service	35	40	114%
2. # of ANC clients in target health facilities who receive VCCT, including testing and pre and post test counseling	32,603	51,140	157%
3. # of HIV-infected pregnant women who receive complete course of antiretroviral prophylaxis to reduce the risk of MTCT of HIV	425	724	170%
4. % of follow-up HIV infected mothers in targeted OD reporting using exclusive breast feeding for the first 6 months	20%	Q6: 67% (18/27)	
5. # of service delivered points with sufficient ARV drugs and HIV test kits supply	60	66	110%
6. # of new trained health care workers, counselors and PLHA trained on PMTCT	510	686	135%
7. # of HIV- infected Pregnant women who are referred to receive PMTCT in the targeted health facilities	215	424	197%
8. # of OD with IEC/BCC activities related to PMTCT of HIV	35	40	114%
9. # PMTCT sites renovated	33	40	121%

[11] Annual Progress Report submitted by NMCHC to MoH as Principal Recipient for GFATM – letter No. 025/08 NMCHC dated 23 January 2008 and the revised targets done in June 2006 and included in the MoA for Phase 2 dated December 18, 2007.

By the end of year 2, NMCHC set up in 40 ODs at least one facility can offer full package of PMTCT services including IEC/BCC related activities. All 66 PMTCT sites under NMCHC's program have been supported additionally by National Center for HIV/AIDS, Dermatology and STDs (NCHADS) in terms of ARV drugs and HIV test kits. Forty out of all sites have been renovated by the end of Q8.

There were 51,140 ANC clients came to the VCCT including pre and post test counseling. Of 24,141 pregnant women who accepted the HIV test, 21,524 women returned for the test result. Of those who received the test, 221 and 5 pregnant women are HIV positive for the first test and second test respectively.

724 HIV positive women received the complete course ARV prophylaxis to reduce the risk of MTCT of HIV. Of 242 HIV+ mothers who delivered in the targeted PMTCT sites, 96 mothers received AZT during pregnancy, 39 mothers received only ARV prophylaxis during labor and delivery, 97 mothers received HARRT, and 10 mothers received no ARV drug due to arriving late in delivery services.

NMCHC mentioned that it was very difficult to measure the percentage of HIV infected mothers in targeted ODs where reported for exclusive breastfeeding for the first six months to their babies. This is because of the follow up system for HIV positive mother is not strong enough and most of the HIV positive mother tried to hide their HIV status.

By Q8, there were 424 HIV positive pregnant women referred to receive PMTCT in health facilities. Since the system change, there are two ways of refer for the HIV positive pregnant women: refer to and refer from. NMCHC reported that there were 179 HIV positive women referred from VCCT to PMTCT and 224 others identified at ANC/PMTCT referred to OI/ART services.

Overall Evaluation of Performance:

The PMTCT program has been implemented since 2001 under the privilege of the national maternal and Child health center, Ministry of Health. In 2003, the program started to scale up to many provinces with support from difference partners including UNICEF, US-CDC, FHI, RACHA, CARE, MARYKNOLL and JICA. However, expansion was slow because the program relied on the interest of funding agencies.

In September 2005, NMCHC received a GFATM grant to implement PMTCT activities. Since then, the program has scaled up PMTCT services more rapidly. As a result, PMTCT sites have increased from 24 sites in 2005 to 69 sites by the end of June 2007. Of 69 sites, there are 37 Referral Hospitals (RHs) and 32 Health Centers (HCs). In the same year (2005), the program changed the ARV regiment to prevent mother-to-child transmission of HI, from single dose of Nevirapine (NVP) to an ARV drug combination (AZT starting from 28 weeks of gestation with single dose of NVP during labor) and AZT+3TC to prevent resistance to NVP in the future. Health facilities provided ARV prophylaxis to HIV positive women are RHs and former District Hospitals (FDH) which have sufficient physicians to monitor pregnant women taking AZT. Amongst 69 health facilities with PMTCT services, 2 National Hospital, 35 Referral Hospital, 14 Former District Hospitals and 18 Health Center are outside the compound of RHs. During the period from January to June 2007, the

program has achieved many areas such as launching the 5 PMTCT sites to raise awareness of the targeted population about HIV/AIDS and PMTCT services in particular, linked with maternal and newborn child health and coaching activities - on-the-job trainings were also provided to the staff at new PMTCT sites. Six health facilities in 6 provinces were assessed for PMCTC services. Supervision and monitoring conducted in 25 sites. Training activities were conducted as planned with 100 % of the budget for training covered from GFATM - 69 participants from 8 provinces from target PMCTC sites attended counseling training, and 24 participants from NMCHC, Calmette hospital and 2 provinces attended TOT training. Two provinces supported by UNICEF and other 2 provinces supported by GFATM participated in 2 province supported by UNICEF and other 2 provinces supported by GFATM PMTCT Referral Training - Refresher training: 51 participants attended from 22 provinces - to meet the needs of new PMTCT sites as well as the existing ones due to the change of the National Guidelines in ARV drug regimen.

III.3. Success Stories and Other Programme Results

PMTCT Programme was established in 2000 with formulation of Technical Working Group to develop Policy and Guideline for PMTCT under the auspice of the MoH. It is one of the five main programmes working under umbrella of the NMCHC of the MoH. The PMTCT Programme is a programme that links HIV services and MCH services. Hence, in order to provide a comprehensive care to HIV pregnant women, their partners and their exposed babies, the two national programmes – NCHADS and NMCHC – have to work collaboratively.

As a component of the Continuum of care framework and a component of MCH care, a comprehensive PMTCT service has to link ANC services with laboratory service, maternity services, and OI/ART service. ANC service is an entry point for pregnant women and their partners to receive HIV counseling and testing. Laboratory is the place where drawn blood samples are sent for HIV testing. Identified HIV-infected pregnant women are referred to OI/ART service for ARV prophylaxis assessment and treatment. Maternity is the place where ARV prophylaxis can be provided to HIV-infected mothers during labor and to their HIV-exposed babies after deliver.

As of December 2007, the PMTCT services have increased steadily from 60 sites to 98 sites in 58 Operational Districts (ODs). Of 98 PMTCT sites, 95 Health centers (HCs) have ability to provide ANC services with HIV counseling and testing. Three of 49 Referral Hospitals (RHs) do not have HC within their compounds. Therefore, HIV testing and counseling have not seen yet provided to prefnant women at those RHs. The three hospitals that do not have ANC services are Battambang RH, Thmar Kol RH, and Rattanakiri RH. To achieve the targets, there were many activities to be involved such as conducting site assessments, training workshops, coaching, supervision, etc.

Under the grant of GFATM Round 4, the PMTCT Programme has an opportunity to quickly scale up the PMTCT services to all provinces in Cambodia. In contribution to the Programme, the GFATM grant have been used to complement activities supported by other partners such as UNICEF, FHI, CARE, WVC, RHAC, MARYKNOLL, MAGNA, US CDC and NGOs, through building up capacity of the staff at all PMTCT sites,

renovation/extension of the existing buildings for PMTCT counseling activities, provision of incentive to the local staff for motivation, of office equipments and furniture to support IEC activities to cover monitoring and supervision making the Programme run smoothly and effectively resulting in a fruitful outputs as described above.

IV. KEY CHALLENGES AND RECOMMENDATIONS IN IMPLEMENTING MOTHER AND CHILD HEALTH POLICIES AND STRATEGIES

Although effort has been made by the MoH to implement MCH policies and strategies, previous experiences shown number of challenges in different areas:

IV.1 Human Resource

- ***Challenges and issues:***
  - Lack of qualified midwives and skilled birth attendants (SBAs) in rural areas due to lack of graduated midwives and very competitive incentives for private sector.
  - Little attention and focus on other skilled attendants such as secondary nurses who can play a role as birth attendance also.
  - Lack of skill for private practitioners who practice at home delivery in remote areas particularly very limited skill and knowledge of traditional birth attendants (TBAs) such as lack of hygiene, lack of diagnostic, based on her own practice, no follow up or antenatal care, lack of safety and responsibility (still refer to hospital), etc.

- *Recommendations:*
  - Establish attractive incentives for midwives who work in remote areas
  - Increase in-service training and/or on-job training to build capacity of health professionals and midwives by giving priority to health staff working in rural area.
  - Develop policy and/or guidance for the transition from unskilled to skilled attendance especially to identify an approach to develop mechanism for integration TBAs into the health center as health volunteers – e.g. for referral pregnant woman to health facility when she contacted such TBA for delivery at home.
  - Each health center will have at least one midwife by 2011.

IV.2 Basic Health Services:

- ***Challenges and issues:***
  - Limited accessibility to basic health services for women and children due to financial barriers, poverty, lack of transportation for referral, low level of education, etc.

- Lack of good quality and adequately equipped health facilities to provide comprehensive package of health services.
- Increase demand for abortion (% of women having at least one abortion in the last 5 years: 1.9% in 2000 to 3.5% in 2005 based on CDHS 2005).
- Discontinuation of contraceptive method due to side effects of contraceptive usage and high cost for intra-uterine device (IDU) (Family Planning Survey 2005) that may influence in the quality of counseling and method available to women.
- Disproportion of ANC between urban and rural areas due to disparities between educational level and geographical areas. ANC coverage range from 30 to 90% (CDHS 2005) and concept of women do not feel sick during pregnancy so why attend ANC is still an issue.
- Limited effort to integrate maternal health, RH and HIV/AIDS especially continuum of care during pregnancy, child birth and postnatal period. Only prevention of mother to child transmission is focused in PMTCT Programme rather than introducing full PMTCT approach such as specific prevention approaches, family planning and RH/HIV/AIDS services for women during and following pregnancy. Level of funding from some DPs are also focused toward specific HIV/AIDS service provision alone neglected this linkage.

- ***Recommendations:***
  - Upgrade and expand health infrastructure with equipment and essential drugs for appropriate health service coverage.
  - Improve women's knowledge on health related issues by providing health education, developing IEC materials, using health volunteers for education at home, mother class at HC, etc.
  - Expand equity funds nationwide to help the poor in rural areas
  - Quality of services shall be increased to meet the need of demand for health facility usage such as family planning services to meet the need of demand for pill and IUD by informing women about the real side effects and disproving rumors, train health workers/volunteers for providing appropriate information and choice, availability and choice of contraceptive methods in HCs, demonstration for IUD usage, promote each method by informing about its benefit and explain its effect on health, etc.
  - Improve emergency obstetric care during delivery and within 24hours after delivery to address the cause of maternal death.
  - Improving quality, acceptability and accessibility of birth spacing services including post-abortion contraceptive services is essential factor to prevent women from seeking repeated abortion.
  - Increase quality of ANC to ensure women receive benefit from full range of ANC services and awareness-raising around benefit of ANC.
  - Identify and define clear policy on linkage between MCH and HIV/AIDS intervention to address full package of PMTCT.

IV.3 Community participation

- ***Challenges and issues:***
  - Role of communities in supporting the efforts to reduce maternal and child mortality and morbidity has been introduced in the integrated management of childhood strategy (IMCI) and other strategies but limited participation by family and community in implementing such strategies due to lack of training, limited resources to work with community level in a wider range, low level of understanding among families and communities particularly in the remote area – e.g. Families may not recognize the early signs of danger for mother and/or for child and bring them for seeking care on time, etc.

- ***Recommendations:***
  - Reinforcement of the policies and strategies and encouragement of community and family participation in utilization of health care services for MCH is needed. Community involvement can build local support for interventions and help programs more effectively address MCH needs.
  - Use of mass media (especially radio) is one of adolescents' preferred and most commonly used sources for sexual and reproductive health information. It could help to reach youth and mother and/or family members and/or community who have limited access to information and services.

IV.4 Resource Allocation

- ***Challenge and issue:*** Report on External Assistance to Health Sector 2007-2009 shown that around half of donors funding every year concentrated substantial part of their funds in preventing and combating communicable diseases and even attracted more funding on this area. But Mother and Child Health programs specifically receives little attention with only about 15% of donor funding forecasts[12] - Example of 2007: MoH's budget planned (both government and donor) for communicable diseases including HIV/AIDS was about 22% comparing to maternal and child health about 3.39% only[13].

- ***Recommendation:*** it is time for development partners to change their behavior to support the national priorities rather than following their own policies especially more attention shall be focused on maternal and child health in order to meet CMDGs.

[12] Report on External Assistance to Health Sector 2007-2009, March 2008, p. 23
[13] Slide presentation of Prof. Koum Kanal, Director of National Centre for Maternal and Child Health dated 07 June 2007 to TWGH.

V. SELECTED TOPIC FOR PRESENTATION TO THE MEETING

Due to variety of issues surrounding MCH, Child Survival Situation is selected as topic for the presentation to the meeting as the following slides:

Child Survival Situation in Cambodia

Prepared by Dr. Tung Rathavy, Deputy-Director of NMCHC who apologized for not being able to participate in the meeting

Presented by Dr. Or Vandine, Director of DIC, MoH

at the 6th ASEAN & Japan High Level Officials Meeting on Caring Societies: Healthy Next generation – under the Tight Collaboration between Health and Social Welfares

8-11 September 2008
Tokyo, JAPAN

Background

- After genocidal period (1975-1979) and two decades of civil war, mortality was very high in Cambodia:
  - Under-5 mortality rate estimated- 115/1000 lives births.
  - IMR- 180/ 1000 live births
  - MMR- 600/100 000 live births
- The major direct causes of deaths in children in Cambodia are acute respiratory infections (ARI, mainly pneumonia) and diarrhoeal diseases
- In certain geographic areas malaria and dengue fever are a considerable burden of morbidity and mortality

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National Efforts

- For monitoring progress, Cambodia localized the Global MDGs in 2003, and these called Cambodia Millennium Development Goals (CMDGs), which reflected Cambodian realities based on national consensus.
- CMDGs has 9 Goals and 25 overall targets covering: (1) Eradicate extreme poverty and hunger; (2) Achieve universal primary education; (3) Promote gender equality and women's empowerment; (4) Reduce child mortality; (5) Improve maternal health; (6) Combat HIV/AIDS, malaria and other diseases; (7) Ensure environmental sustainability; (8) Global partnership for development and (9) De-mining, UXO and victim assistance.

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Strategies and Regulation

- Maternal and Child health are the main priorities for RGoC, particularly MoH.
- Health Sector Strategic Plan 2003-2007 (HSP1) & 2008-2015 (HSP2).
- Sub-decree on the marketing of products for infants and young child feeding was approved in 2005.
- Child Survival Strategy
- National reproductive and sexual health strategy 2006-2010.
- IMCI Strategy

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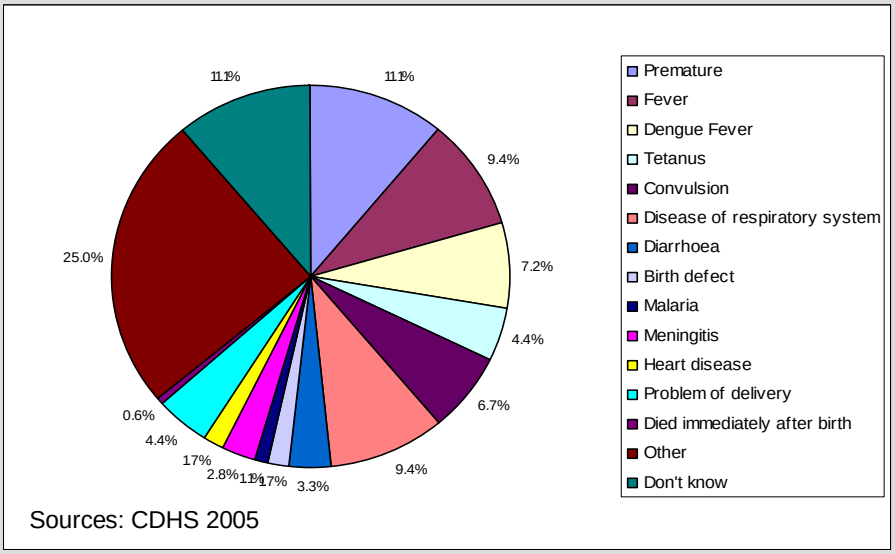
Causes of Deaths among Infants and Young Children



Sources: CDHS 2005

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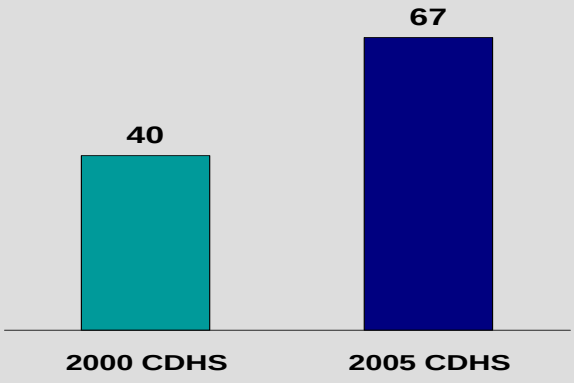
Vaccination Trends

Percent of children 12-23 months who are fully vaccinated



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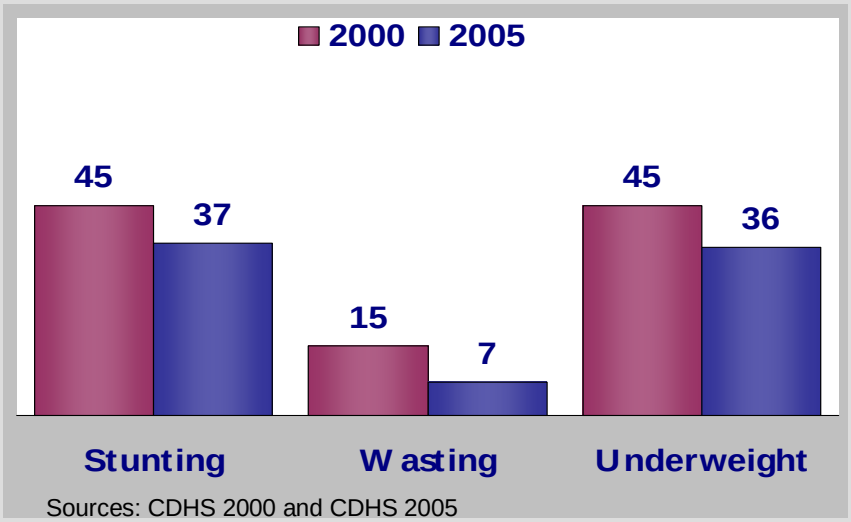
Trends in Children's Nutritional Status



Sources: CDHS 2000 and CDHS 2005

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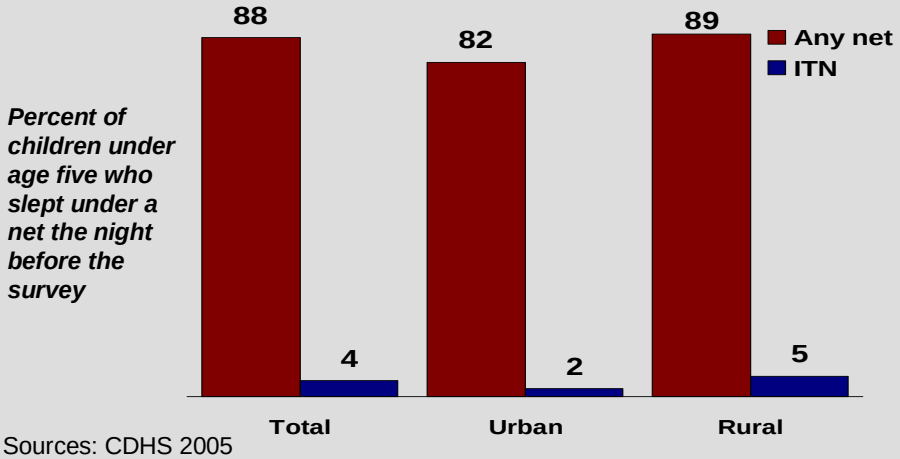
Children's Use of Bednets



Sources: CDHS 2005

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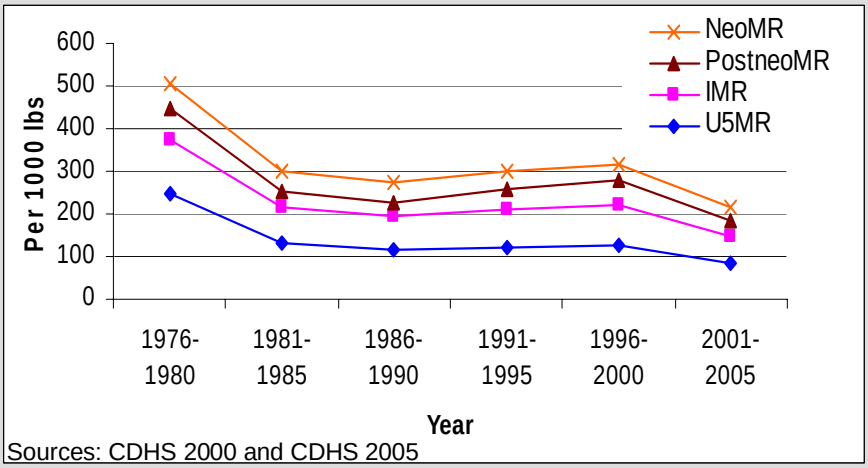
Trends in Childhood Mortality



Sources: CDHS 2000 and CDHS 2005

Child Survival Coordination Mechanism

- The high-level Child Survival Steering Committee (CSSC) was established in 2004.
- The Child Survival Management Committee (CSMC) was established in July 2005 and served as the main coordinating mechanism for the MoH to improve child survival throughout the country. It memberships includes representatives from MoH departments, national programs (NNP, NIP, NMCP, NDCP, IMCI, NADC, NRHP) related to CS; representatives of the three main CS donors (WHO, UNICEF, USAID) and representative from NGOs (MEDICAM).

Cambodia Child Survival Strategy

- Cambodia Child Survival Strategy (CCSS) was completed and officially endorsed in 2006.
- An important component of the CCSS was the development of the Cambodia Child Survival Scorecard, which identified 12 specific high impact child survival interventions that need to be scaled-up throughout Cambodia.

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Scorecard interventions with indicators and targets (1)

Intervention	Coverage		Target		
	CDHS 00	CDHS 05	2007	2010	Progress
Early initiative of BF	11%	35%	35%	60%	on track
Exclusive BF	11%	60%	65%	80%	on track
Complementary Feeding	76%	82%	85%	95%	action required
Vitamin A	31%	35%	80%	85%	action required
Measle vaccine	55%	77%	86%	92%	action required
Tetanus toxoid	30%	54%	75%	80%	action required

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Scorecard interventions with indicators and targets (2)

Intervention	Coverage		Target		
	CDHS 00	CDHS 05	2007	2010	Progress
Insecticide Treated Nets	9%	24%	80%	80%	action required
Dengue vector control	181%	-	80 sites	<10 sites	action required
ORT	74%	58%	70%	85%	high alert
Antibiotic for pneumonia	35%	48%	62%	75%	action required
Malaria treatment	2%	0.3-3.3%	85%	95%	action required
Skilled birth attendance	32%	44%	55%	70%	high alert

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Other activities

- IMCI health facility survey: 140 health facilities in 24 ODs which included case observation of 456 children, exit interviews with care taker, re-examination of the sick children and checking equipment and supplies.
- Updating IMCI guidelines in early 2007
- Finalizing Child Survival costing exercise
- Social marketing of diarrhoea treatment kit "Orasel" : 2 sachets of low osmolarity ORS and 10 dispersible Zinc 20mg tablets
- NGO-Child Survival working group

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Challenges

- Funding shortage - MoH and donor commitment
- Shortage of health staffs and staff motivation
- Quality of service delivery
- Referral system
- Community awareness and behavior change
- MMR is still high- 472/100 000 live births

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Thank you very much in continuing support our children for promoting their health toward "Healthy Next Generation"

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VI. REFERENCES

1. World Bank Summary gender profile for Cambodia 2005, http://genderstats.worldbank.org .
2. Report on Cambodia's Health Sector Review 2003-2007 by HLSP – August 2007, p. 2-41.
3. National Strategy for Reproductive and Sexual Health in Cambodia (2006-2007) – February 2006.
4. Report on Health Achievements 2003-2007 delivered by H.E. Prof. Eng Huot, Secretary of State for Health during the opening of the 26th National Health Congress and 6th Joint Annual Annual Performance Review (JPRA) on Health Achievements from 2-4 April 2008 at Raffles Hotel Le Royal, Phnom Penh, Cambodia.
5. National Health Statistics 2005
6. Draft National Health Statistics 2007, Department of Planning and Health Information, Ministry of Health – February 2008.
7. Http://www.moh.gov.kh/ - Organizational Chart of the Ministry of Health.
8. Health Sector Strategic Plan 2008-2015, p.20.
9. Report on Cambodia's Health Sector Review 2003-2007 by HLSP – August 2007, p. 33.
10. Cambodia Coordinated Proposal for Round 4 – HIV/AIDS Component: Continuum of Care – submitted by Country Coordinating Committee (CCC) to GFATM Geneva - 2004, p. 30-48.
11. Annual Progress Report submitted by NMCHC to MoH as Principal Recipient for GFATM – letter No. 025/08 NMCHC dated 23 January 2008.
12. Report on external Assistance to Health Sector 2007-2009 - March 2008, p.23.
13. Presentation on "Strategy to Improve Maternal and Child Health as Cross-Sectoral Issues" by Prof. Koum Kanal, Director of National Maternal and Child Health Center, Ministry of Health, on 07 June 2007 to Technical Working Group for Health (TWGH).
14. National Strategy for Reproductive and Sexual Health in Cambodia 2006-2010 - February 2006.
15. Cambodia Demographic and Health Survey 2005, December 2006 – National Institute of Public Health (Ministry of Health) and National Institute of Statistic (Ministry of Planning) and ORC Macro, Calverton, Maryland, USA.
16. Presentation on "The Development Study on Strengthening Maternal and Child Health service Performance in the Kingdom of Cambodia" by Prof. Koum Kanal, Director of National Maternal and Child Health Center, Ministry of Health, and JICA Study Team on 18 January 2007 to Technical Working Group for Health (TWGH).
17. Memorandum of Agreement between the MoH as Principal Recipient for GFATM and NMCHC – MoA Number: CAM-405-G05-H-NMCHC1 dated July 12, 2005 and CAM-405-G05-H-NMCHC1 dated December 18, 2007.