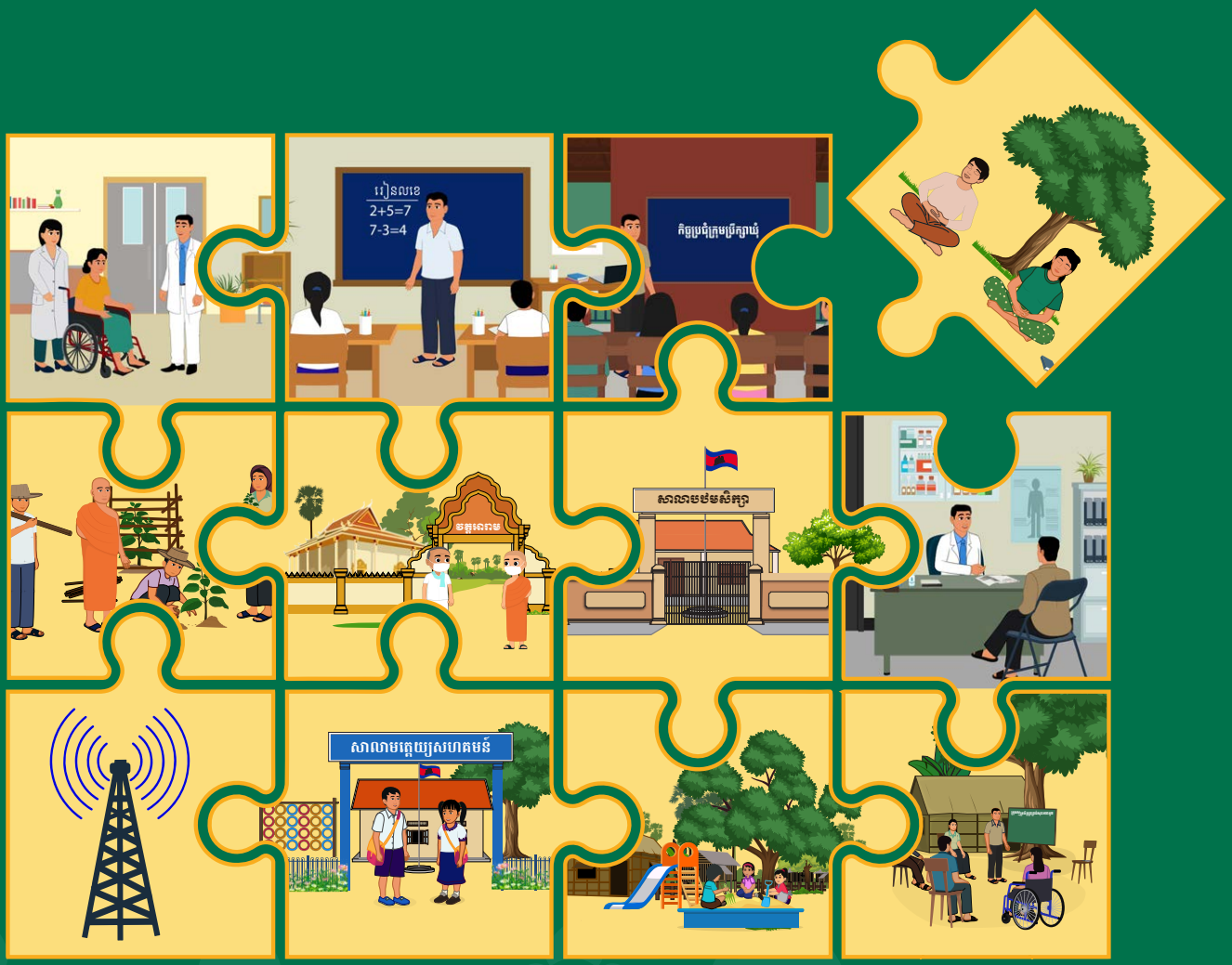
KINGDOM OF CAMBODIA

NATION RELIGION KING

Primary Health Care Booster Implementation Framework (PHC-BIF)



June 2023

FOREWORD

Primary health care is whole society approach for health to ensure better health and wellbeing by focusing on population's needs and timely response to those needs including provision of services from prevention, protection up to treatment and palliative care and focuses on the well-being of people. Primary health care has been the central ethos of health system reform in Cambodia since 1995. The current district health system which comprised of health centre and referral hospital, provides a geographical focus and population base for strengthening the health infrastructure, provision of comprehensive, cost effective, equity and allow closely monitor health activities for better response to its population needs toward achieving universal health coverage (UHC) and sustainable development goals (SDGs).

Under the proactive leadership with long term vision and wise decisions of **Samdech Akka Moha Sena Padei Techo HUN SEN**, Prime Minister of the Kingdom of Cambodia, health sector has made remarkable progress, in which primary health care has been improved and had contributed to significant health outcomes in Cambodia including dramatic reductions in new-born, children under five and maternal mortality; communicable diseases such as HIV & AIDS, malaria, and tuberculosis (TB). Moving forward, like other countries in the region, economic growth and the changes of demographics lead to progressives increase in expectations of the population on quality of services. This was all amidst growing burdens of Non-Communicable Diseases (NCDs), mental health challenges and needs brought about by a future ageing population.

The health sector needs to be ahead of the curve and embrace opportunities such as those presented by the decentralization and de-concentration process, greater innovation and technological advancement, digital penetration in the country, – connectivity – both nationally and globally to further primary health care as a quality and trusted first point of contact in an advancing health system in Cambodia. The Health Strategic Plan 2023-2033 (HSP) highlights a further focus on PHC as the foundation for the health system and progress toward UHC. There is, therefore, a need to further boost PHC by optimizing the roles of local authorities, stakeholders, and communities around health to tackle social determinant of health, promote health, prevent diseases, improve quality of care and facilitate timely utilization of services.

The primary health care booster implementation framework (PHC-BIF) determines core actions to be implemented by national, sub national and local authorities and communities to improve integrated people-centred primary health care in ways relevant and impactful to their context and health needs. Our deep appreciation devoted to the dedicated task force to develop and to manage PHC-BIF chaired by H.E. Dr. Or Vandine, Secretary of State for Health that progressed well for the successful developed this important PHC-BIF with its effort to widely consult with related government ministries/ institutions, sub-national authorities and health partners including technical and financial support by the World Health Organization in this work.

On behalf of the Ministry of Health, I call for close collaboration and support from relevant Ministries, national and sub-national level especially local authority, development partners, civil societies, private sector, individuals, families and community for the success of its implementation which eventually aspires to make Cambodian people be healthier, happier and have longer life.

Phnom Penh, 02 June 2023

Minister of Health

Prof. MAM BUNHENG

ACKNOWLEDGMENTS

On behalf of the Taskforce to develop and manage Primary Health Care Booster Implementation Framework (T.P.H.C Booster), I highly appreciate the senior management officers and relevant institutions for their important contribution from the start of the development process until the drafting of the PHC Booster Implementation Framework was completed.

Our gratitude to **H.E. Prof. MAM Bunheng**, Minister of Health, who has always supported and worked to enhance primary health care for better health and well-being of Cambodian people and for his guidance and vision during the development of the PHC Booster Implementation Framework.

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Thanks to the MOH's management group and the T.P.H.C taskforce's members including relevant MOH's Departments and National Centers and twenty-five Administrative Governors and Provincial Health Departments, Cambodian Red Cross, Committee for Sub-national Democratic Development (NCDD) and relevant Ministries for the shared vision, constructive comments, experiences and inputs during the development process of the framework.

Our acknowledgment to Dr Li Ailan, WHO Representative to Cambodia for her strong dedication and support to Ministry of Health in particularly for strengthening primary health care in Cambodia.

This achievement is realized with the strong technical and financial support from WHO Cambodia country and regional office. Thanks to WHO, UNICEF and other health partners including NGOs such as UNFPA, USAID, CHAI, RACHA, FHI360, GIZ, World Bank and KOFIH for their support to this framework.

Thanks to T.P.H.C Booster's Secretariat team led by National Center for Health Promotion for their dedication and hard work in coordination, facilitation and organization of consultation workshops, core group, individual meetings, field data collection as well as undertaking the writing of the framework.

Lastly, I would also like to extent my sincere thanks to His Excellencies, Lok Chumteav, representative from relevant Ministries, sub-national officers and community workers who have contributed their inputs during the consultation workshops and during field consultation and data collection.

Phnom Penh, 02 June 2023

Secretary of State and Chair of T.P.H.C Booster

Dr. Or Vandine

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LIST OF ABBREVIATION

CCWC	Commune Committee for Women and Children
CDHS	Cambodia Demographic and Health Survey
C-DOTS Watcher	Community Direct Observed Treatments for Short course
CPA	Complementary Package of Activities
CSDGs	Cambodia Sustainable Development Goals
CSES	Cambodia Socio-Economic Survey
D&D	Decentralization and De-concentration
DHS	Demographic and Health Survey
GDP	Gross Domestic Product
HC	Health Center
HCMC	Health Center Management Committee
HEF	Health Equity Fund
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HPG	Health Partner Group
HPV	Human Papilloma Virus
HSP	Health Strategic Plan
IHME	Institute for Health Metrics and Evaluation
IMC-PHC	Inter-Ministerial Committee for Primary Health Care

ITU	International Telecommunication Union
LGBTQIA	lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual
MoH	Ministry of Health
MoI	Ministry of Interior
MPA	Minimum Package of Activities
NCD	Non-Communicable Diseases
NHA	National Health Account
NSSF-C	National Social Security Fund – Civil Servants
OD	Operational District
OOP	Out-Of-Pocket
OPD	Out-Patient Department
PHC	Primary Health Care
PHC-BIF	Primary Health Care Booster Implementation Framework
PHDs	Provincial Health Department
SDGs	Sustainable Development Goals
T.P.H.C booster	Taskforce to develop and manage Primary Health Care Booster Implementation Framework.
TRC	Telecommunication Regulator of Cambodia
UHC	Universal Health Coverage
VHSGs	Village Health Support Groups
VMWs	Village Malaria Workers
WHO	World Health Organization

GLOSSARY

EMPANELMENT

Empanelment entails the assignment of individual patients or populations to individual primary care providers, teams or facilities, which encourages providers and teams to take responsibility for a holistic approach to the health of the people under their care.

MULTIDISCIPLINARY PHC WORKFORCE

A multidisciplinary PHC workforce might include general practitioners, nurses and nurse practitioners, community health workers, counsellors, mental health specialists, physiotherapists, podiatrists, health promoters, and those with expertise in engaging people and communities, such as community development specialists or anthropologists. They may work together as part of the same health facility or come together from multiple facility.

PHC network: Including the linkages amongst Village Health Support Group (VHSG), Health Center, Health Center Management Committee (HCMC), Commune Committee for Women and Children (CCWC) referral hospital (CPA1, CPA2 and CPA3) and Operational District.

PHC workforce: Health care professionals and community workers who delivered PHC services at all levels to community.

NON-MEDICAL SKILL

Non-medical skill refers to soft skills that support health care workers to perform their jobs effectively. Those include communication skill, teamwork, emotional, cultural sensitivity, planning, monitoring, supervision and evaluation,

Whole of Government (WoG) approach: - an approach in which public service agencies work across portfolio boundaries' to develop integrated policies and programs towards the achievement of shared or complementary, interdependent goals[1].

Whole of Society (WoS) approach: - moving beyond public authorities and engaging all relevant stakeholders, including individuals, families and communities, intergovernmental organizations, religious institutions, civil society, academia, media, and the private sector and industry.[1]

INTRODUCTION

Ensuring full peace, political stability, social security and public order through the Win-Win Policy of **Samdach Akka Moha Sena Padei Techo HUN SEN,** Prime Minister of the Kingdom of Cambodia is the foundation of Cambodia's development within the last three decades.

The government has set four strategic goals in the fourth phase of Rectangular Strategy to continue Promoting Cambodia's sustainable development towards the following vision: Cambodia is an upper middle-income status country in 2030 and high-income country in 2050. Cambodia has attained huge achievements in economic, social, and health development in the last decades. Macroeconomic stability and active fiscal management have mainly acted in maintaining economic growth and consistence with the fast reduction of poverty, strong health system, expansion of social protection system and improvements of social determinants which affect health outcome etc. All this progress has driven the improved survival of children and the enabled elderly living longer, reflecting improvement of quality of life and the better health status of the Cambodian people.

Shifts in disease burden in Cambodia to ever rising non-communicable diseases can mean longer term multimorbidity leading to higher treatment costs to the health system and patients impacting productivity and overall economic growth.

A shift in organizing health services and how they are delivered is needed to prioritize prevention and promotion, engaging individuals, families and communities as well as taking multisectoral action to address determinants of and maintain health to control escalating costs resulting from particularly growing non-communicable diseases.

Primary Health Care (PHC) is a whole-of-society approach to health that aims to ensure health and well-being by focusing on people's needs and timely response to those needs including provision of services from health promotion and disease prevention to treatment, rehabilitation and palliative care.

PHC focuses on the comprehensive and interrelated aspects of physical, mental, and social health and wellbeing for health needs throughout the life-course. It is widely accepted that a PHC based health system is therefore the most cost effective, equitable and sustainable pathway to reaching Universal Health Coverage (UHC) and the health-related Sustainable Development Goals (CSDGs).

Cambodia has had a high priority on PHC for decades. The National Policy on Primary Health Care (2000) defines PHC as "essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford. Primary health care embedded in the health system of the country with main function which need to be paid attention. On the other hand, it is a complete part of the social and economic development of the community."

The policy goes on to emphasize that PHC forms a central part of the country's health system contributing to the overall social and economic development of the community.

The policy was accompanied by a set of implementation guidelines on PHC (2002) and community participation policy (2003) and the definition of a Minimum Package of Activities (MPA) for health centers that is periodically reviewed and updated, the latest revision being in 2018.

PHC has contributed to significant health gains in Cambodia including dramatic reductions in maternal newborn and under five mortality and communicable diseases such as HIV & AIDS, malaria, and tuberculosis (TB). Future challenges such as growing burdens including of Non-Communicable Diseases (NCDs) and mental health challenges and needs brought about by a future ageing population, are most effectively reduced and addressed through a PHC based approach, this includes preventing, or at least detecting and managing early health burdens associated with these so that people can live happier and healthier lives and costs to the health system, households and society more broadly are minimized.

The COVID-19 pandemic showed us that PHC based approach is essential to health systems prepared for and resilient to public health threats. Local authority – health center and community collaboration central to information sharing, community mobilization, surveillance, detection and response.

The Health Strategic Plan 2023-2033 (HSP) highlights a further focus on PHC as the foundation for the health system and progress toward UHC as the first of five strategic shifts over the next decade to address the health needs for Cambodia's future. There is therefore a need to further boost PHC by optimizing the roles of local authorities, stakeholders, and communities for better health.

PHC needs to be re-oriented from treating illness to maintaining and improving health and well-being through a comprehensive approach that engages individuals, families and communities in their own health, addresses broader determinants of health and provides integrated people centered care covering promotive, preventive, protective, curative, rehabilitative and palliative services across the life course.

Moving forward, the health sector needs to be ahead of the curve and embrace opportunities such as those presented by the decentralization and de-concentration process, greater innovation and technological advancement and digital penetration in the country, connectivity nationally and globally to further primary health care as a quality and trusted first point of contact in an advancing health system in Cambodia.

PURPOSE OF DOCUMENT

This primary health care booster **implementation framework** (PHC-BIF) aims to **enable action** by national, sub national and local authorities and communities to improve integrated people-centered primary health care in ways relevant and impactful to their context and health needs.

It provides particularly sub national authorities with a set of priority actions organized under six CORE ACTION AREAS that could be taken to boost and strengthen primary health care in their provinces, districts, communes, villages and to support communities' active participation in their own health and health services.

It outlines national level policy and process actions that may best enable boosting of PHC at subnational levels.

The key consideration to carry out PHC-BIF proposed PHC maturity matrix that can guide what types of actions under each CORE ACTION AREAS might be more appropriate given the relevant context of PHC in that community district or province as an example. Further details on the potential

practical design and implementation of key actions and principles for deciding what might be most relevant and impact in what context and situations will be provided in the subsequent PHC Booster implementation guideline and M&E framework.

PROCESS FOR DEVELOPING THE PHC BOOSTER IMPLEMENTATION FRAMEWORK

Ministry of Health (MoH) established "Task Force to develop and coordinate Primary Health Care Booster Implementation Framework (T.P.H.C booster)" through nomination letter No. 083 អប់ស. ស្រ័បអ, dated March 4, 2022. The secretariat of this taskforce was coordinated by the National Centre for Health Promotion (NCHP).

The development of the PHC-BIF-which was intensive, employed collective thinking and branstorming:

- **a review and lesson learning process -** including key document review of global regional and national PHC policies, strategies and guidelines as well as academic and broader literature, including discussion of lessons from the COVID-19 pandemic and implementation of the PHC policy to date.
- **a grounds-up, broad and structured consultation process –** listening and gathering insights and directions from including in a number of provinces communities, health centre staff, and village leadership and commune, district and provincial administrations, leaders as well as national stakeholders including from Ministry of Health, other Ministries and development partners.

CONTEXT FOR THE DEVELOPMENT OF PHC-BIF

BACKGROUND OF PHC IN CAMBODIA

The Alma-Ata Declaration 1978 and the Declaration of Astana in 2018 outlined the importance of a PHC led approach for health system development and population health and well-being. Member States, including Cambodia, reaffirmed their commitment to strengthening PHC towards the achievement of health for all without distinction of any kind, reaffirmed this in the 2019 Political Declaration of the High-level Meeting on Universal Health Coverage and adopted resolution WHA72.2 on primary health care at the World Health Assembly (WHA) of 2021as well.

In the 1980s, Cambodia rebuilt its health system by implementing some of the aspects of primary health care approach, building health facilities close to communities, and prioritising prevention and care for mothers and children. Primary health care has been central to health system reform since 1995. The success of implementation of PHC approach is to address illness in a holistic way. This requires the health workers to see the social and economic causes of illness, as well as view themselves as working within the district health system. The district health system provides a geographical focus and population base for strengthening the health infrastructure which allows district health managers to organize, plan, and monitor comprehensive health activities and makes it possible to achieve much more than individual disease control and promotion program efforts. The development of health service is based on the National Health Development Plan and the National Health Coverage Plan established in 1996 which include the development of system of health centres and referral hospitals which respond to the basic health needs of the population.

The National Policy on PHC 2000 has been developed by IMC-PHC following a clear need to provide focus and coordinate the efforts of relevant stakeholders. The document highlighted six principles: 1- Universal access and coverage, 2- Community participation in health and development, 3-Intersectoral in health, 4- Appropriate technology and cost effectiveness, 5- Sustainability and 6- Monitoring and Evaluation. Following this issuance of policy, the PHC Implementation Guideline which was published in 2002 to provide guidance for policy implementation, explain mechanism of multi-sector collaboration, community participation and M&E, explain and clarify role and responsibility of line ministries, support agencies, private sector and communities; identify mechanisms to build up capacity of PHD personnel at all levels.

Recognizing community participation as one of leading factors to increase functioning of health centres, MOH developed a Policy on Community Participation in the development of HC in 2003.

ACHIEVEMENTS TO DATE

PHC has been implemented in Cambodia since decades and there are great progress by Ministry of Health in strengthening its health systems including investing in primary health care by building a network of health centres with connected to other level of care such as referral hospital to provide comprehensive services for maternal and child health, including immunization, resulting in laudable reductions in maternal, new born and child mortality as well as increased HIV/AIDS treatment and

prevention, malaria prevention, and improving its path toward UHC. Life expectancy has increased from 62.3 in 2008 to 75.5 in 2019 based on national census estimations.

MATERNAL, NEWBORN AND CHILD HEALTH

Significant improvements have been achieved in maternal neonatal and child mortality over the past two decades. Cambodia has already achieved the SDGs on under five and neonatal mortality with under five mortalities falling to 16 and neonatal mortality to 8 per 1000 live births in 2021-22 (ref CDHS 2021-22). The SDG on skilled birth attendance with a target of 95% coverage was also reached with 99% of women giving birth with a skilled provider in 2021-22.

The maternal mortality ratio fell from 437 per 100,000 live births in 2000 to 154 in CDHS 2021-22[1], though this remains higher than the 2020 CSDG target of 141 towards a goal of 70[2] by 2030.

Over the period, National Immunization Program (NIP) has made significant impact on vaccine preventable diseases thus contributed to important health gains for women and children. Cambodia was certified as Polio-free in 2000 and since then maintaining this status and it achieved maternal and neonatal tetanus elimination status in June 2015. Cambodia also achieved hepatitis B control goal (Reducing Hepatitis B prevalence to less than <1%) in May 2018. The percentage of fully vaccinated children aged 12-23 months has increased from 73% in 2014 to 76 % in 2021 and MR1 coverage from 79% in 2014 to 83% (CDHS 2014 & 2021-22). To reduce the burden of diseases, the NIP also introduced new vaccines into the routine immunization program between 2000 and 2015 including HIB, Rubeola, Measle, IPV (Inactivated Polio Vaccine) Polio in the type of injection, Japanese Encephalitis, Meningococcal meningitis vaccines, PPV (Pneumococcal Polysaccharide Vaccine.

NON-COMMUNICABLE DISEASES & MENTAL HEALTH AND SUBSTANCE ABUSE

Cambodia adopted the WHO Package of Essential NCD Interventions for Primary Health Care (WHO PEN) in 2013. Since then, NCD services have been established in 162 Health Centres (13% of the total) and 51 Referral Hospitals. Peer education networks have been piloted in 22 ODs and 28 provincial and district hospitals, which have NCD clinics for the management of complicated NCD cases. The PEN (Package of Essential Non-communicable diseases) approach focus on education and counselling, and to the integrated management of hypertension and diabetes.

In addition, prevention and screening for cervical cancer is one among priorities. The Royal Government developed strategy for vaccination of cervical cancer for girl and strengthen cervical screening among women. As result, fourteen percent of target women have been screened for cervical cancer at least once[3].

The provision of mental health and substance abuse services is aligned with the WHO-mhGAP intervention guide- 2016 (3) which integrated into MPA and CPA services. Up to 2021, the service has been expanded to total 454 health facilities (2 national hospitals, 25 provincial hospital, 72 district referral hospitals and 355 health centres).

1 Cambodia Demographic and Health Survey 2021-2022
2 CSDG revised targets and indicators list MoP Sept 2022
3 MoH 2022. National Strategic Plan for the Prevention and Control of Noncommunicable Diseases 2022-2030

COMMUNICABLE DISEASES

The country has made impressive progress in the reduction of the main communicable diseases. Malaria cases reduced by more than 95% in the past decade and there have not been any malaria deaths since 2018. The incidence of Tuberculosis has reduced 53% between 2000 and 2020[4], while HIV incidence dropped 46% in the last decade[5]. Trachoma and filariasis have been eliminated and schistosomiasis stopped being a public health problem in 2016.

PROGRESS TOWARDS UHC

The Minimum Package of Activities (MPA) outlines services that should be provided at primary care level and hospitals provide a Complementary Package of Activities (CPA) at a CPA1, 2 or 3 level over which services are more comprehensive and specialized (particularly surgery).

Cambodia's UHC service coverage index reached "high coverage" in 2019 at 61 -higher than average for lower middle-income countries (average 58). Around 3.2 outpatient visits per person were made in Cambodia in 2019 with around 75% of these being in private sector.

PHC SITUATION IN CAMBODIA

SERVICE DELIVERY CAPACITY

There are 1,288 public sector health centers in Cambodia[6], or approximately 1 health center for every 13,000 people. Most health centers have services provided by nurses and midwives, with an average of 8 staff per health center. Few health centers have medical doctors. In the public sector there are also 125 health posts, and 132 hospitals.

In the private sector there are about 13,700 private health care facilities, 96% of which are small individual cabinets. The smaller health facilities include more than 5,000 nursing posts, 4,000 medical cabinets, 1,500 ante-natal care rooms and 1,000 dental cabinets. However, there are fewer than 500 large private health facilities.

According to Cambodia Socio-Economic Survey 2019/20, the first provider sought among the household members who needed care for illness, injury or other health problem in the last 30 days was highest for private health care provider, which constituted about 69 percent, and followed by public health care provider, with about 23 percent.

HEALTH WORKFORCE

Cambodia has set a standardized staffing norm by health facilities based on MPA and CPA guidelines (MPA for health center, and CPA for different levels of hospitals). Staff per health center ranges from 8 to 11, majority of whom are nurses and midwives while CPA staffing requirements vary according to its levels. In 2021, however 60% of total health centers across the country did not meet this MPA staffing norms.

4 CENAT 2021. National Strategic Plan to End Tuberculosis in Cambodia 2021- 2030

5 National AIDS Authority 2019. The Fifth National Strategic Plan for a Comprehensive, Multi-Sectoral Response to HIV/AIDS (2019-2023)

6 National Health Congress Report 2023

Doctor, nurse, and midwife ratio was 13.6 (public sector) and 27.5 (both public and private sectors) per 10,000 population in 2021 which is still relatively low comparing to other countries across the region. Health workforce requirement for achieving UHC and SDGs defined by WHO, known as the SDG index threshold, is 44.5 skilled health workers (doctors, nurses, and midwives) per 10,000 population. It considers some of the increased need for health workers due to global ageing, noncommunicable diseases rising, ongoing public health emergencies including disease pandemics and economic growth. Hence, Cambodia will need total 80,664 doctors, nurses, and midwives by 2030 which is a shortfall of 36,681 in absolute numbers.

FINANCING PRIMARY HEALTH CARE

Government investment in health rose substantially during the COVID-19 pandemic with government health budgets approximately 80% higher than pre-pandemic levels. This is important given the relationship between the proportion of total health expenditure supported by domestic government financing and performance of the health system including progress toward UHC. Cash incentives to both public health care providers and pregnant women initiated in 2018 have substantially increased use of maternal and child health services particularly antenatal care, deliveries in health facilities and post-natal care.

Around 40% of the population have social health protection coverage, and this is set to increase, with plans for extension of population coverage over the next few years. Currently just over 3 million people through the Health Equity Fund (HEF) and another just over 2 million people through the National Social Security Fund schemes for formal workers and civil servants (NSSF-F and NSSF-C)[7]. Despite increased population coverage of these schemes, persisting high out of pocket costs (64% of total health expenditure in 2019)

COMMUNITY AND LOCAL ADMINISTRATIVE ENGAGEMENT FOR HEALTH

Ministry of Health is implementing Sub-decree 193 អនក្រ. បក issued on 04 December 2019 which is around the Functional Assignments of management and Health Service Delivery to the municipal / provincial Administrations in close collaboration with the Ministry of Interior and Ministry of Economic and Finance. As of 2021, the Ministry of Health has transferred the function to municipal and provincial administrative function. These comprise of 25 provinces, 103 operational districts, 25 municipal and provincial hospitals, 94 referral hospitals, 1,250 health centers and 129 health posts.

Health center management committee is functioning as mechanism to foster utilization of health services and development of health center. According to the health congress report in 2022, nationwide, 87.8% HCMC are functioning, more than 75% members participate in the meeting and available meeting agenda and report.

Other mechanisms exist, such as the Commune Committee for Women and Children (Ministry of Interior) at commune level, composition mostly institutional (commune and village chiefs, police, school, HC).

The two Village Health Support Group (VHSG) workers per village are the main providers of community health activities in Cambodia often also taking other rolls such as community TB directly observed treatment monitors (C-DOTS Watcher), Village Malaria Workers (VMWs), Red Cross Volunteers.

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PHC FOR THE FUTURE NEEDS IN CAMBODIA

ECONOMIC DEVELOPMENT

Cambodia is set to become an upper-middle income country by 2030 and a high-income country by 2050. After a long period of sustained economic growth, Cambodia suffered the economic impact of COVID-19. GDP fell by 3% in 2020 and is expected to recover in the subsequent years, though macro fiscal challenges remain. Following a few years of unstable growth, real GDP increase is projected at 6.5% per annum at least until 2030[8]. A large part of this growth will come from technological sectors, and it is expected that by 2050, GDP growth will be around 7%, poverty would be reduced to 10% and more quality jobs will be created[9].

FUTURE HEALTH NEEDS AND CHALLENGES

Cambodia is undergoing a demographic transition and based on current projections, 13% of population will be above 60 years by 2030 and 19% by 2050 (UN Pop Div estimate), or 2.3 and 3.8 million people, respectively. The increase of senior population will result in increased health needs especially for chronic condition, NCDs, Mental Health, and care for the elderly.

Sixty four percent (64%) of deaths in Cambodia are attributable to non-communicable diseases and WHO atlas 2017 revealed that Suicide mortality rate in Cambodia is 5.3 per 100,000 population[10], which are often preventable and many times avoidable, reflecting changes needed in lifestyle. Main challenges for future health needs and PHC include:

- Increased NCDs, mental problems and ageing conditions causes demand in health service needs, prevention and continuum of care, as well as the participation of individuals, families and communities in the decisions about their health.
- HC have not yet become the first point of contact for wider population. In addition, MPA has not yet fully implemented due to shortage as well as limited capacity of HC staff and supplies. HCs provide more priority to treating episodic illnesses or health conditions rather than prevention, health promotion, counseling services, and patients support.
- Financial limit for PHC services that translates in the lack of essential public health functions and hinders the crucial increase in service coverage such as effective referral system, screening services, comprehensive integrated and continued treatment, and care.
- Insufficient attention is given to the determinants of health and their influence on health risks. And lack of ownership and leadership from the other non-health sectors, especially the roles of local authorities in promoting and maintaining community health have not yet strengthened.

8 International Monetary Fund 2021. Cambodia Article IV 2021 Consultation. IMF Country Report 21/260

9 Royal Government of Cambodia 2018. Rectangular Strategy for Growth, Employment, Equity and Efficiency: Building the Foundation towards realizing the Cambodia Vision 2050. Phase IV

10 https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2017-country-profiles/khm.pdf?sfvrsn=c5bb150c_1&download=true

- Culture of innovation insufficiently ingrained in the health system.,
- Community engagement system, VHSG and HCMC has not yet fully meet the needs of the health needs of the population due to lack of motivation, support, and capacity building mechanism to support the functioning of Village Health Support Groups (VHSG). In addition, HCMC has not yet played the important role in managing VHSG, linking health services to local authorities and community. Individual, families, and community lack of health information leading them to inappropriate health seeking behavior and delay access to adequate health services.

OPPORTUNITIES

Despite challenges, there are opportunities that Cambodia should embrace to enable the implementation of PHC-BIF as following:

- **Decentralization and De-concentration:** The sub-decree on The Functional Assignments of Management and Health Service Delivery to the Capital / Provincial Administrations (2019) aims to improve the health service delivery.
- **Digitalization:** Increases in technological innovation and access to digital technology across a wide range of domains have enabled significant advancements in the provision of health care, resulting in greater numbers of people having access to services and data that might previously have been out of reach or unaffordable.

  The Royal government has launched CAMBODIA DIGITAL GOVERNMENT POLICY 2022-2035 to drive digital adoption across all sectors and followed by the first-ever digital health strategy with clear roadmap for the next decade, the **Cambodia Digital Health Strategy 2021-2030** *"the Strategy 2030"* aims to provide a strong digital foundation for the health system Cambodians need and deserve.

GOALS OF THE PHC-BIF

GOAL

Cambodian people Healthier, Happier and Longer life.

OBJECTIVES

Individual and family received people-centred health services that are integrated (prevention, promotion, palliative care) quality, innovative, equitable and accessible without financial barriers.

PHC is not a separate program, and it is a part of Cambodia health system; and successful PHC implementation required local administrative engagement and intersectoral collaboration to address social health determinants and action for health.

CHARACTERIZING PHC IN 2030

People-centred and enabling individuals and communities making their own health decisions: services tailored to people's needs, using evidence from social and behavioural sciences providing the information necessary for people to make their own decisions, favouring lifestyle changes, and discussing courses of action and prognostics with their PHC providers. Accountability is enhanced by users registering with specific health providers, which defines the population served by individual PHC workforces.

Equitable and Gender sensitive: everybody has access to the services they need. Previously unreached are reached through a more comprehensive package of services, reduction of financial barriers and by using all possible platforms to make services more accessible.

Comprehensive: the package of services provided includes promotion, prevention, protection, management, rehabilitation, and palliative care, provided along the life course, and thus encompassing reproductive, maternal, newborn, child and adolescent services, common communicable diseases, selected NCDs, ageing and mental health through a variety of platforms including the health facilities, non-health institutions, outreach, and the patients' homes.

Providing continuity: moving from episodic contacts generated by a health complaint to a regular, lifelong interaction between providers and users where personalized health plans are tailored to the patients' needs, including changes in health behaviour, screening for the most likely conditions for sex and age, management of diseases and their complications, and providing support and comfort in the final stages of life.

Coordinated and integrated: in addition to providing the services contained in the package for the level, the PHC workforce also connects users to other providers, such as hospital services, diagnostics, or pharmacy outlets, which may include accredited private providers of various types, or non-health providers, such as social services. PHC services are part of functional service delivery networks –the district health system—with which they share protocols and guidelines, information systems, and management procedures.

Quality: infrastructure and equipment are adequate for the services to provide, offering sufficient privacy and appropriate technology. Staff are sufficient and well qualified; their combined skills enable them delivering the whole package. Medicines are appropriate to cover complete courses of treatment and of acceptable quality.

Innovative: all opportunities provided by digital technologies are used to improve communication and education of individuals and communities, increase interaction between providers and users and providers of different levels, manage service organization and delivery, and manage data essential for patient and service management.

CORE ACTION AREAS OF PHC BOOSTER IMPLEMENTATION FRAMEWORK

TWO COMPLEMENTARY APPROACHES

The PHC Booster results from the interaction between community and health services. A trust relationship between individuals, families and communities and the health providers will be re-built and reinforced.

COMMUNITY APPROACH

Better informed and engaged individuals and families will modify their health behaviour, reducing risks associated with lifestyle. Under community leadership and in collaboration with sectors beyond health, the health determinants will be influenced, and public health risks reduced. Growing health awareness will result on increased demand for quality health services tailored to the needs of the population, where they participate in the planning, decision making and operations of the interventions. Community approach encompasses multisectoral action to address social determinants of and maintain health.

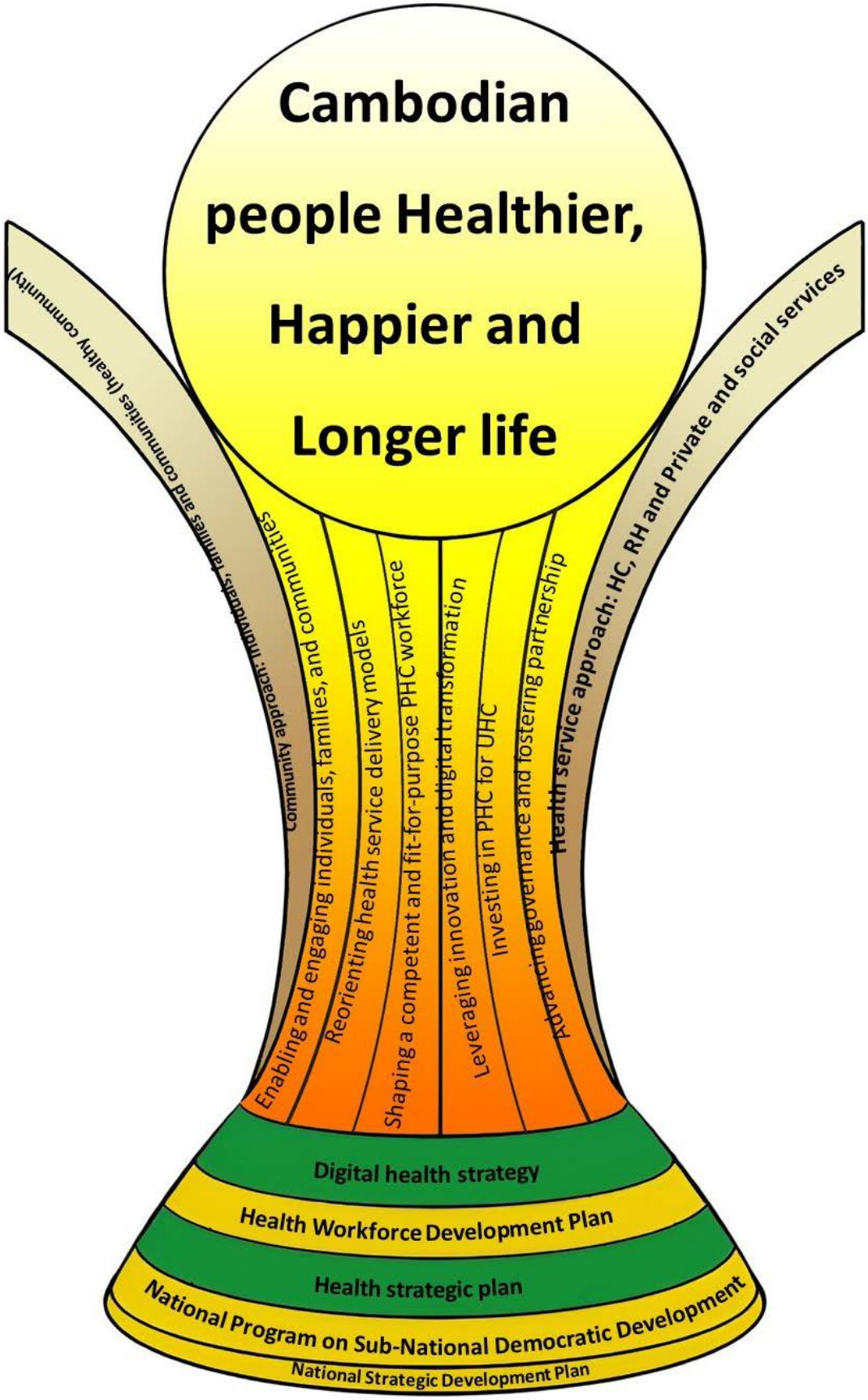
HEALTH SERVICE APPROACH

On the other side, health services will respond to expressed needs and expectations through the delivery of an expanded package of services of sufficient quality including information and counselling that focus on prevention and early diagnosis and addressing health issues such as NCD pandemic, mental health, ageing conditions, adolescent youth friendly health service and so on.

Providers and users will engage through modalities of empanelment (MPA service), in a lifelong relationship enabling the creation of individual health plans. All possible platforms will be used to deliver this package to those previously unreached.

The booster is structured in the six key interaction core action areas as described below. For example, adopting a different service delivery model may also fall under innovation, and an expanded role for VHSG volunteers is also part of building a fit-for-purpose workforce.

FIGURE 1. THE CAMBODIA PRIMARY HEALTH CARE BOOSTER IMPLEMENTATION FRAMEWORK



The diagram illustrates that the National, Provincial, District and Commune levels with all the relevant stakeholders will work together with the communities to implement the National Strategic Development Plan and the Health Strategic Plan 2023-2033 and to operationalize the six CORE ACTION AREAS which include,

1. Enabling and engaging individuals, families and communities
2. Reorienting health service delivery models
3. Sharping a competent and fit for purpose PHC workforce
4. Leveraging innovation and digital transformation
5. Investing in PHC for UHC
6. Advancing governance and fostering partnerships

By working together, within their Primary Health Care Booster Implementation Framework, there is an intention for the country to have empowered populations receiving the highest quality of life through a primary health care system which delivers high quality comprehensive services across the life course, which are equitably distributed and responsive to people and their communities.

CORE ACTION AREA 1: ENABLING AND ENGAGING INDIVIDUALS, FAMILIES, AND COMMUNITIES

Individuals, families and communities are active participants in their own health and health services

The Declaration of Astana on primary health care envisioned *"Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being"*.[1]

Individuals, families, and communities should be engaged as 1) advocates for their needs that promote and protect health and well-being, 2) as co-designers of health and social services and holding them to account, and 3) as self-careers and caregivers.

Engaging and enabling individuals, families and communities supports a focus on keeping people healthy not just treating diseases and helps ensure that improvements in health services are understood, influenced, and valued by people, and hence are increasingly in line with future needs and expectations of Cambodian citizens, supporting well-being peace and security.

The involvement of empowered people and communities as co-developers of services improves cultural sensitivity, acceptability and buy in increasing use and improving health outcomes. Supporting their advocacy can improve access to health services as well as of health determining infrastructure at community level beyond the health sector such as water and sanitation, waste disposal and facilities for physical exercise. Determinants of health can be influenced positively when the linkages between the community and health services are strengthened, along with improved collaboration between health and other sectors.

Engaging individuals, families and communities as self-careers and caregivers includes improving health literacy, supporting access to valid and accurate information and improving people's ability to identify and ignore misinformation. Realizing what the risks are and the measures that exist to prevent or identify them at an early stage may stimulate the health seeking, seeking information, use of preventive services and screening and early detection of common NCDs and other health issues.

CORE ACTION AREA 1: Enabling and engaging individuals, families, and communities			
Main Activities	**Priority actions**	**Nat**	**Sub-Nat**
Build health literacy & skills of individuals, families and communities to support their own health and the health of those they care for	Developing appropriate health related messages specific to need and audience including use of appropriate and influential peer groups and social networks	✓	✓
	Formation of national media campaigns for behavior change and improve health literacy	✓	
	Establish and implement platforms that community can clearly identify as credible health information including understanding social networks and influential sources of information	✓	✓
	Develop mechanisms for all individual to engaging & give easy to understand information to support management of own health	✓	✓
	Equip VHSGs with health literacy to impart practical skills for individuals and families for both self-care and care giving, including chronic diseases and rehabilitation ensuring availability of necessary materials as relevant.		✓
	Stimulate participation with involvement of vulnerable group (e.g., people living with HIV, disabilities, adolescent and youth, survivors of violence, indigenous people, LGBTQI+, poor families etc.)		
	Develop and update practical and engaging guidelines for priority in home self-care	✓	
Support participatory co-design processes for new health interventions and services across the PHC network	Build skills in co-design processes at sub national administrations and health authorities Include key principles and approaches to community codesign.		✓
	Ensure participation of vulnerable groups in co-design processes (planning and budgeting) including ethnic minorities, people with disabilities.	✓	✓

CORE ACTION AREA 1: Enabling and engaging individuals, families, and communities			
Enhance structures and processes for health service engagement with and accountability to communities	Strengthen functioning HCMC	✓	✓
	Update community participation policy and accompanying guidelines, outlining clear roles and responsibilities of commune councils and health centers.	✓	
	Build advocacy skills of and involve key representatives of different groups (older persons associations, women's groups, pagoda committees) especially vulnerable group in different health groups at sub national level.		✓
	Strengthen community feedback as part of quality enhancement management tools for health centers, including ongoing learning and improvement on what works in this area, ensuring voices of vulnerable often excluded groups are particularly supported.	✓	✓
	Scale up and continuously improve community accountability of and engagement with health services.		✓
Strengthen local leadership for health including multi-sectoral action	Strengthen existing multi-sector forums highlighting relevant priority topics for health improvement – WASH, spaces for physical activity, fuel in the home (to reduce in house pollution health risk)	✓	✓

CORE ACTION AREA 2: REORIENTING HEALTH SERVICE DELIVERY MODELS

A PHC network with the health center at its core provides quality continuous and integrated people-centered primary health care services across the life course coordinating care across providers from community to hospitals and back.

PHC sservice covers the full continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care and should be responsive to individual community and population needs according to local context.

Reorienting health service delivery includes defining and strengthening both the services and the health service architecture (platforms and pathways) through which they are delivered. This includes the management, organization, and processes of PHC provision so that people can appropriately receive the services as Government has committed to deliver to the citizens of the country.

REDEFINE AND STRENGTHEN THE PHC NETWORK AND SERVICES IN CAMBODIA

Health services should be provided at all levels, through many platforms, not limited to the health facilities. Some interventions such as those addressing social determinants of health across sectors and delivering promotion and prevention are most appropriately delivered at community level, others requiring sub-specialty care need to be delivered at hospitals. Platforms such as outreach services should be better optimized in reaching vulnerable populations at risk of being left behind (such as those in remote areas, single female households or and / or older people as example).

The operational health district forms a good basis for an integrated service delivery network. The health center is at the core of the Cambodian PHC network and coordinate of health care across other levels of the health system. Referral hospitals reorienting patients to primary care for follow-up or to avoid unnecessary admissions (service that provided at health center), and by collaborating with primary health care workforce to develop their capacity and reduce referrals, by scheduling referral hospital staffs come to provide service at health center).[1]

An individual or community should be able to receive a range of services in a single contact with health facilities. For example, for an older person visiting a health center for a headache include vision, hearing and mobility screening, blood pressure and supportive discuss on nutrition along with treatment for the headache. It may also mean the delivery of integrated outreach, particularly for remote and vulnerable populations providing a range of screenings (eye, blood pressure, blood glucose etc.) in one outreach visit to a community along with health promotion messaging. This requires a restructuring of minimum package of activities to support integrated care provision across the life course, as well as appropriate financing arrangement.

The relationship between providers and users should not be limited to the episodes of disease but aiming at an understanding of need and continuity of care that is needed to maintain good health. Regular check-ups, for example, require the mutual knowledge between the served population and the providers. Identifying a population linked to PHC network and understanding their health needs is a first step. Digital technology allows assigning users a Unique Patient Identification Number (UPIN) which could also support linkages with PHC network and providers within it.

STREGNTHENING PHC AS FIRST CONTACT WITH THE HEALTH SYSTEM

Primary care should be the first contact for most diseases both prevention and treatment. Given that treatment for the same uncomplicated condition can be provided at the primary health care level at lower cost to patient and the health system. Provision of effective PHC as first contact and coordinator of care is associated with improved coverage, health outcomes and financial protection, furthering UHC.

To strengthen PHC as first contact and coordinator of services in the health system requires both growing trust in PHC so that people are willing to attend services as well as having supply side structures that incentivize and promote PHC as the entry point to the health system. Quality of care is essential for improving performance, maintaining trust, ensuring the sustainability of the health system, and guaranteeing that all efforts and resources invested in facilitating access to and delivering care.

PRIORITIZING PREVENTION, PROMOTION AND PREPAREDNESS

Curative services are often prioritized over promotive and preventive services given their immediacy and often due to financing and other structures and incentives. A greater focus on promotion and prevention is necessary to meet future health needs, particularly the growing burden of NCDs and reduce the need for later higher treatment costs.

Improving health outcomes and health equity requires a renewed focus on tackling the social and economic determinants of health and consideration of health in all policies. Different sectors need to be coordinated to address the social determinants of health.

A focus on strengthening the essential public health functions also promotes resilience by ensuring preparedness to all form of public health threat including through surveillance, responding to outbreaks, and counselling on and offering preventive measures.

CORE ACTION AREA 2: REORIENTING HEALTH SERVICE DELIVERY			
Main Activities	**Priority actions**	**Nat**	**Sub-Nat**
Redefine and strengthen the PHC network in Cambodia	Enumerate population health status and needs of village and communes considering appropriate linkages to a PHC network.		✓
	Strengthen supportive policies and guidelines for a PHC network architecture in Cambodia, including review of roles and functions considering local contexts (remoteness, etc) in consultation with Public Health Facilities and administrations.		✓
	Operational district together with district administrations identify and make plans to address any key bottlenecks, challenges or gaps in functioning of PHC networks.		✓
Strengthen PHC as first contact care – improve availability, readiness and quality of services	Local authorities work with communities and health centers to consolidate data and information on ongoing service readiness to deliver priority MPA services including staff, equipment and essential medicines and medical supplies needs		✓
	Strengthen and expand outreach services to include preventive care, screening, and management of chronic conditions through multi-platform	✓	✓
	Review the Minimum Package of Activities to support integrated care across the life-course including specific guidelines and packages for outreach services to reach vulnerable populations	✓	
	Implement MPA guidelines with quality of the provided services by conducting periodic assessment.		✓
	Update essential medicines and supplies list in line with revised MPA and using information from assessment on service readiness and key gaps.	✓	
	Strengthen periodic monitoring and reporting of stock outs of essential medicines and medical supplies identified in the review above.		✓

CORE ACTION AREA 2: REORIENTING HEALTH SERVICE DELIVERY			
	Co-design with communities for feedback to obtain community perceived quality and availability of services and strengthen the use of this information in improving the quality of the health services.	✓	✓
	Build roles and skills of HCMC in use of data and evidence to plan and monitor performance of Health Centers.		✓
	Strengthen essential public health functions in PHC with capacity for local preparedness and response. This should build on the work of the local preparedness teams during the pandemic response.		✓
Strengthen PHC as first contact care – through supportive referral structures	Identify and strengthen referral systems using national guidance but adapting to local context and need	✓	✓
	Provide training and support to health centers on referral mechanisms and requirements including referral and feedback back to health centres from hospital level care	✓	✓
Strengthen promotion and prevention to maintain health and address broader determinants for health	Enhance integrated packages for health promotion, prevention and early detection according to local context and health needs including co-design with communities, other sectors and health centers	✓	✓
	Enhance functioning of cross sectors for health at village and commune level to address broader determinants of health		✓
	Enhance forums, highlighting, sharing, and rewarding sub national good practices in addressing social determinants of health across sectors and investments in prevention and promotion	✓	

CORE ACTION AREA 3: SHAPING A COMPETENT AND FIT-FOR-PURPOSE PHC WORKFORCE

Well-trained and motivated health workers are an essential ingredient of a successful health system that supports promotion, prevention and ensure the sustainability and effectiveness of PHC responses into the future to contribute to people well-being.

More health workers are needed to ensure capacity for the growing population health needs. Expanding workforce for PHC takes time and resources, so a focus on maximizing the utilization, productivity and performance of the existing workforce is critical. This can be done through optimizing the skill mix of health professionals through sharing and expanding role of specific workforce cadres.

In addition, doctors, midwives, and nurses alone cannot meet all their patients' primary care needs; thus, a wider and more diverse range of team members are needed to support the management of health conditions, strengthen efforts prevent ill health, promote well-being and address workforce shortages. There are also several health-related volunteers at the community level, the most numerous being the VHSG and VMW which could be utilized in the health activities like implementing educational activities, and community health surveillance, essential public health functions and provision of home-based care for vulnerable populations. Health workforce should learn new skills and adapt to the changed needs including non-medical skill such as communications, teamwork and emotional.

Deployment of the workforce should follow facility standards according to served population figures.

CORE ACTION AREA 3: SHAPING A COMPETENT AND FIT-FOR-PURPOSE PHC WORKFORCE			
Main Activities	**Priority actions**		
Strengthen the policy environment for attracting and retaining PHC workforce	Identify main drivers of workforce shortages for PHC especially in rural remote areas	Nat	Sub-Nat
	Reviews health workforce policy using PHC information from assessment of drivers (above) including potential for rural pipeline pathways for the attraction of students from underserved areas into health professional training to ensure distribution and retention of workforce in rural and remote area.	✓	✓
	Refine and implement community participation policy in order to ensure retention and performance of the HCMC and VHSGs.	✓	

CORE ACTION AREA 3: SHAPING A COMPETENT AND FIT-FOR-PURPOSE PHC WORKFORCE			
Develop multidisciplinary workforce based as well as individual primary health care skills & competencies through pre-service training and in-service professional development	Ensure personal and population PHC services and needs, including particularly core public health functions, are highlighted, and appropriately included in competency-based education frameworks and curricula for all health professionals.	✓	
	Regularly assess multidisciplinary workforce competencies and use this evidence for further workforce development	✓	✓
	Fill identified gaps in workforce competencies through planning of in-service training and appropriate task shifting and sharing, documenting workloads and outcomes	✓	✓
	Build capacity of PHC workforce on the use of digital device and/or service-delivery platforms before roll out and ensure easy availability of refresher training in connection with updates to the software or devices.	✓	✓
Secure advanced leadership and management in primary health care	Develop leadership and management skill through PHC pathway development.	✓	
	Identify and select a cohort of primary health care leaders (at sub national administration, health department, district hospital, health centre and community level) each year through competition for leadership and management development (training, coaching, in place exercises etc.)	✓	✓
	Update the role of a unified community structure like the VHSG, define their workload, potential tasks and dedication, and training needs following the community participation policy.	✓	
	Build and utilize networks of alumni from primary health care leadership and management courses.	✓	

CORE ACTION AREA 4: LEVERAGING INNOVATION AND DIGITAL TRANSFORMATION

Innovation means "a new or improved solution with the transformative ability to accelerate positive health impact". This is not limited to digital health but new things and ways of doing things broadly, including emphasizing "grounds up" approach using input from users and beneficiaries of the innovation

Innovation requires a supportive environment – leadership and governance, policy settings that allow change – as well as health providers that are open to new and different ways of working.

INSTITUTE A CULTURE OF INNOVATION ACROSS INSTITUTIONS AND HEALTH SERVICES

The adoption of a culture of innovation should be encouraged at workplace and community by institutionalizing the exchange of views among the workforce and community leaders whenever a problem –health or health service related—is identified.

PROMOTE USE OF DIGITAL HEALTH TECHNOLOGY FOR PATIENT ACCESS AND SERVICE ORGANIZATION

Harnessing existing information technology infrastructure to support PHC and the health system in general will require significant investment by government. To ensure effective use of existing and new digital platforms, government must address the required infrastructure, legal frameworks, and regulatory capacities to advance digital technology for health, while mitigating the risks including that of inequity.

The Ministry of Health has finalized a draft digital health strategy which presents a comprehensive roadmap for the creation of a fully specified digital health system.

ADOPT TECHNOLOGY FOR BEHAVIOUR CHANGE AND SELF-CARE

Digital technology and the utilization of behavioural insight, media habit analysis, social networks or specific applications may improve the dissemination of health information and educational materials, for example on behaviour change and its effects on NCD risks. Dedicated applications may facilitate communication between users and providers, or help expressing the patients' satisfaction with the health services. These applications can also be used to improve service delivery.

IMPROVE DATA PROCESSING, INFORMATION SHARING AND EVIDENCE-BASED DECISION-MAKING

The digital health strategy advocates for each individual to have a single unique patient identifier number (UPIN), and a single electronic medical record (EMR). It also provides for the integration of the main databases of the health sector in a common platform, Databases to integrate would include the existing HMIS, programme-specific datasets (e.g., malaria), as well as those containing data on human resources, logistics and others. This integration would improve access to relevant data to health workers, managers, and researchers, and facilitate periodic analysis and utilization of data for decision making.

CORE ACTION AREA 4: LEVERAGING INNOVATION AND DIGITAL TRANSFORMATION			
Main Activities	**Priority actions**	**Nat-**	**SubNat**
Institute a culture of innovation across institutions and health services	Promote opportunities to identify and learn from new solutions from the ground, including experiences from other sectors and from the community (grounds-up building of solutions).	✅	✅
	Encourage the adoption of a culture of innovation in workplace and community by institutionalizing the exchange of views among the workforce and community leaders.	✅	✅
	Adopt and adapt processes that bring advantages over the existing ones, either in clinical, managerial or communication areas.	✅	✅
	Use all opportunities provided by the monitoring and evaluation processes to understand the root causes of the events identified and apply that learning to the next round of planning.	✅	✅
	Invest into research and development for the expended use of digital innovations.	✅	✅

CORE ACTION AREA 4: LEVERAGING INNOVATION AND DIGITAL TRANSFORMATION			
Promote use of digital health technology for patient access and service organization	Promote implementation of the Digital Health Strategy, including the development, launching, and use of unique patient identification and single electronic medical records. The assignment of a UPIN facilitates coordination of referred patients as well as enables communication between primary care multi-disciplinary team members.	✓	✓
	Adopt digital platforms for service delivery (such as telemedicine, remote health monitoring tools) especially for hard-to-reach population. Test and scale up platforms developed during the pandemic response to augment the range of service provision digital health ecosystem.	✓	✓
	Develop guidelines and train health workers in the utilization of adopted digital tools.	✓	
	Strengthen supporting digital infrastructure of existing health facilities, including electricity, phone lines and internet connectivity.	✓	✓
Adopt technology for behaviour change and self-care	Use digital technology to improve health education and communication, interaction with service providers.	✓	✓
	Capacity building for community networks on digital tools and establish digital platform for information sharing, communication and promote wider adoption.	✓	✓
Improve data processing, information sharing and evidence-based decision-making	Link and ensure interoperability of existing and new data systems. This includes linking patient level health records (with the unique patient ID) to the HMIS to facilitate data integration.	✓	✓
	Ensure appropriate technical capacity for electronic data management, analysis and use, including cross-analysis of multi-sectoral data.	✓	✓
	Develop standards for data governance to ensure appropriate confidentiality and privacy.	✓	

CORE ACTION AREA 5: INVESTING IN PHC FOR UHC

Effective financing for PHC is an investment as it is the most cost-effective way to improve health and reach UHC and the health sustainable development goals. The proportion of domestic government investment in health and how much of this is allocated to primary health care is associated with progress toward UHC.

FINANCING PHC INCLUDES CONSIDERATIONS OF

- How much funding goes to PHC and where this comes from (central government, social health protection schemes or out of pocket costs for example).
- how it is distributed to primary health care facilities and how it can be used

  how primary health care providers are paid for services delivered. Each of these influences what services are provided, the affordability of services and therefore access, equity in who receives them, whether services are integrated and people-centered and the quality-of-service delivery.

EFFECTIVE INVESTMENT FOR PHC SHOULD THEREFORE ASSIST BOTH PATIENTS AND THE HEALTH SYSTEM BY:

1. Minimizing cost to the health system by incentivizing people to attend PHC services for PHC conditions at health center rather than accessing care from hospitals.
2. Appropriately investing in promotion, prevention and early detection activities so that higher costs associated with later treatment can be avoided wherever possible.
3. Promote integrated people-centered care – where multiple services that people need are provided when and where they need them.
4. Motivate quality and equity, not placing a barrier to use these necessary close to community health services.

ACTION AREA 5. INVESTING IN PHC FOR UHC			
Main Activities	**Priority actions**	**Nat**	**SubNat**
Increased level and flexibility of financing for PHC	Establish targets benchmarks for proportion of financing for primary health care and monitor progress such as for proportion of health in commune investment plans and health center and public health spending as a proportion of total health spending at province level	✓	✓
	Advocate to utilize costing of revised MPA to calculate per capita base and target rates of financing for primary health care, adjusting for drivers of cost of delivering care (such as remoteness, age profile of population served etc.)	✓	
	Increase flexibility in funding for drugs and medical supplies	✓	✓
	Implement a PHC infrastructure quality improvement plan including a focus on key IPC needs such as WASH and waste management	✓	✓
Ensure financing models that equalize incentives between prevention and promotion and individual acute care and support integrated people centered care	Establishing benchmarks for increased investment in prevention and promotion activities	✓	✓
	Increasing develop ring fenced budget at sub national level for integrated event-based (fever, respiratory symptoms etc) surveillance with community engagement		✓
	Create financial / non-financial reward scheme for health centres & communes that reach defined targets for prevention and promotion activities such as communities reached with priority messages, innovative activities award supporting health promotion prevention		✓

ACTION AREA 5. INVESTING IN PHC FOR UHC			
Implement financing approaches supportive of financial protection and PHC as first contact with the health system ("gate-keeping")	Periodically explore reasons for bypassing or use of private providers particularly for those covered for care only in public sector and use results to guide PHC financing strengthening efforts	✓	✓
	Monitor key indicators of PHC quality and availability alongside utilization rates to evaluate impacts of increased investment in PHC		✓
	Reduce the gap between hospital and health center level reimbursements for primary care conditions under social health protection schemes.	✓	✓
	Strengthen regulation and monitoring of private practice at PHC level (cabinets etc) using licensing and accreditation and reporting requirements		✓

CORE ACTION AREA 6: ADVANCING GOVERNANCE AND FOSTERING PARTNERSHIP

The health sector alone, even in close collaboration with community structures, cannot implement the PHC BIF to its full potential. Modifying the determinants of health and social wellbeing require collaboration with many government sectors and partners beyond the health sector. The decentralization process attributes additional resources and responsibilities to sub-national government bodies which may result in funding opportunities for PHC. Partnerships with other stakeholders, within and outside the sector may ensure that health services are delivered where they are most effective, including non-health facility venues. The private sector, where most PHC services are provided, should be properly regulated, and monitored.

SUPPORT COMMUNITY INITIATIVE

The inception of the community initiative offers enhanced opportunities to engage government and non-government stakeholders in the development, funding, implementation, and monitoring of the community initiative plans. Several government departments are active at commune and community levels, working on topics that have synergies with the health sector.

A map of potential areas of collaboration and competition should be drawn for each sub-national administrative unit, to enhance areas of synergy and increase the efficiency of the resources available.

BUILD LEADERSHIP FOR PHC

PHC policies and leaderships are closely intertwined. Leaders, champions are needed at all levels to promote and establish the policies and goals of the health system. Health authorities at the sub-national levels have a responsibility to capacitate actors within and outside institutions to improve effective stewardship and accountability.

PARTNERING WITH THE PRIVATE SECTOR

Private health providers contribute to better access health services by population. But the range and quality of services they provide is all but unknown. So, there is need to consider what services and how services are provided and how to improve quality under a regulatory ambit where it can be integrated within the national health information system.

CORE ACTION AREA 6: ADVANCING GOVERNANCE AND FOSTERING PARTNERSHIP			
Main Activities	**Priority actions**	**Nat**	**Sub-Nat**
Ensure implementation space for the new community initiative	Mapping stakeholders at national and sub-national level for potential areas of synergies and competition. This includes expanding synergies to private sector to include both health and non-health private providers, including Civil Society Organizations.	✓	✓
	Involve commune, district, and provincial authorities in supporting actively the implementation of community initiative plans. Involve representatives from other sectors (education, women's affairs, social service, rural development, agriculture, etc.) to participate in health-related meetings, provision of services and activities		✓
	Reinforce coordination across different levels of the system in support of PHC by establish learning and accountability mechanisms for monitoring, evaluation and translating evidence to adapt and improve implementation	✓	✓
Build leadership for PHC	Enable a network of leadership for PHC and public health by identifying and supporting political champions for PHC	✓	✓
	Strengthen local government leadership for health at all levels (village, commune, district, province) to make decision and learn from the ground		✓
	Build capacity of local authorities and community leaders in planning and budgeting for PHC		✓
Partnering with the private sector	Promote the integration of accredited private providers in service delivery networks through regulatory reforms	✓	✓
	Expand coverage of health financing scheme to cover accredited private providers	✓	✓
	Integrate relevant data of private sector on service provision to the health information system, and promote their use of nationally adopted unique patient identification and/ or electronic health records	✓	✓

KEY CONSIDERATION TO CARRY OUT PHC-BIF: DO ADAPT AND ACHIEVE

PHC is a core component of the strategic shift of the Health Strategic Plan 2023-2033 (HSP). PHC-BIF needs to alignment with HSP, and with other important strategies for the next decade for the Health Workforce and Health Financing, among others. All these should be living documents, continuously adapting their implementation to the needs of population and health system.

The PHC-BIF will be launched with the overarching approach of Do, Adapt and Achieve (DAA). This implies continuously driving implementation and making required changes based on the lessons learned to strengthen PHC system at all levels, and to share best practices of PHC nationally and internationally.

Further guidelines for the implementation of PHC-BIF will be subsequently developed to outline in-depth of option activities and process. PHC-BIF drives PHC transformation to meet the health need in the future; the process can be incremental or through large-scale implementation and requiring bold action from policy makers to address changes in national health system. To embark the PHC shift agenda stakeholder can consider the points below to help guide decision-making along the journey to the future of PHC.

IDENTIFY ENTRY POINT TO EMBARK PHC OF THE FUTURE

Identifying adequate entry points for the transformations proposed is essential for implementation success. Those entry points may coincide with the biggest challenge or with an easy, success-granted activity. PHC-BIF proposed PHC maturity matrix to guide leadership of all stakeholders engaged in PHC at all levels including community, health centre, operational health districts and administrative districts to understand their current status of PHC, to identify direction of PHC system, and pathway of PHC and steps they want to take as well as plan for resources skills and time needed. (Annex1)

In addition, at the community side, implementation should begin by assuring the leadership of the community engagement using exiting mechanism and make model of inter-sector collaboration to address priority health problem identified by the community. A community health initiative addresses community health needs through building local leadership and preparedness, and multi sectoral approach (Annex2), it also requires the empowerment of communities to participate in planning and decision-making, as well as collaboration with community groups and leaders.

ENGAGE, CONSULT, AND BUILD CONSENSUS

Success implementation of PHC-BIF requires engagement, consultation and build consensus among all stakeholders:

- MoH has important role in bringing all stakeholders together around common objectives of PHC BIF and leveraging support for implementation of the framework.
- Build further and sustain the ongoing consultative process with communities. Acceptance of the new community engagement approach by those same communities is a pre-requisite for its implementation.
- Leverage on the strengths of stakeholders in addressing concerns for building mutual trust so that there is commitment across political, administrative and community levels to support implementation of the framework.

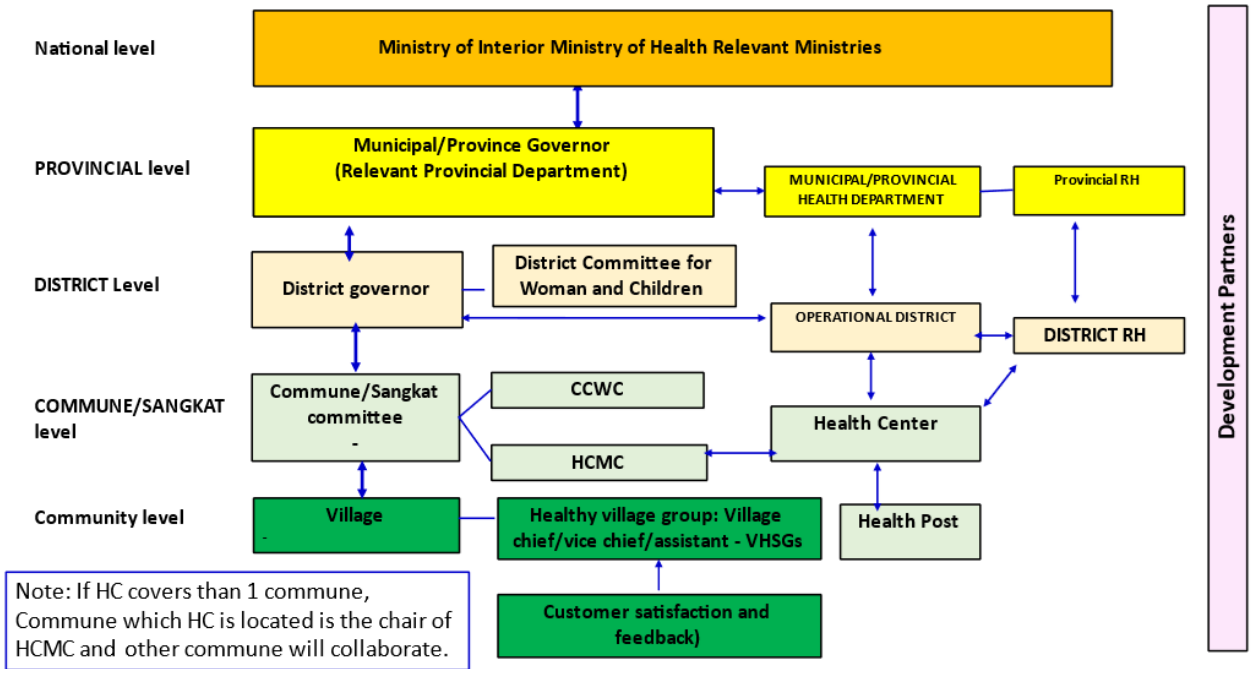
IMPLEMENTATION ARRANGEMENTS

Appropriate structures are needed to support the implementation of the PHC Booster, at different levels of the system and the government (Fig 2).

- National level – The PHC-TF has been established to provide overall oversight of the framework development and implementation. A health beyond the health sector approach should be taken to collaborate with other sectors in creating an enabling environment for the implementation of the Booster. This collaboration should be replicated in all the levels of implementation.
- Provincial level – provincial administrative and PHDs play a critical role in the PHC Booster and should jointly be the governing mechanism at subnational level to overseeing of implementation of PHC-BIF in the province.
- District level – District administrative has a role to strengthen collaboration with other sectors and mobilize resource to support implementation of the PHC-BIF while OD play a vital role in the structuring of PHC services, by providing the necessary technical and managerial support to frontline facilities.
- Commune level – there are Health Centre and health centre management committee. The support of the Commune/Sangkat administration is crucial for the success of the BIF community component.
- Community/village level –village group lead the implementation of healthy village activities at the ground level, through existing mechanisms.

For each level, the roles and responsibilities for all stakeholders should be clarified, and the coordination processes for the structures at different levels should also be defined. With different implementing structures at various levels of the system, it is critical to ensure continued alignment of purpose and coordination across all the levels.

Figure 2: Sub-national PHC BIF Institutional Framework.



MONITORING AND EVALUATION

Implementation of PHC-BIF will be regularly monitored to measure ongoing performance, generate evidence and to adjust planning "do, adapt and achieve". A set of clear indicators (outcome, output, and process) will be developed/selected in alignment with health strategic plan 2023-2033 (HSP). Most data use for PHC-BIF monitoring will be extracted from existing M&E framework of HSP, Health Management and Information System, routine data collection and reviews process therefore do not require additional resources. National, sub-national level, and local authorities should:

- Select clear indices for measuring ongoing performance and establish an M&E framework, which can be embedded in the HSP M&E framework. Ensure that the metrics can capture different aspects of system performance as well as the contribution of the community. This M&E framework should also reflect milestones at national, sub-national and community levels.
- Document and learn from implementation, generating evidence to adjust health system planning and service delivery including through research, quantitative and qualitative analysis. This will require some investment into implementation research, to dig deeper into the factors or enablers for good or poor performance.
- Regularly review progress for plans and implementation plans, with systematic mechanisms to respond to lack of progress, and for holding relevant teams to account for timely completions and deliverables. This could be through routine annual review processes, that can be conducted at subnational level or at national level by incorporating the voices and feedback from the communities.

Various sets of indicators are recommended and shown in Annex 3. Most will be extracted from the National Monitoring Framework of the HSP and focus on health system performance and the assessment of NCD and risk factors prevalence and impact, as well as health system response. National Monitoring Framework indicators are calculated as a routine, and therefore do not require additional resources.

Ministry of Health will work with sub-national levels and relevant institutions in setting up or strengthening monitoring of PHC performance in alignment with this PHC-BIF and their related priority metrics. PHC-BIF M&E frameworks will be integrated in the implementation guidelines of PHC-BIF.

ANNEXES

ANNEX 1- PRIMARY HEALTH CARE IMPLEMENTATION MATURITY MATRIX

This matrix is set out in a series of tables of progression to guide community, health center, district hospital and health department and district administration leadership in selecting activities that will strengthen primary health care according to their current situation of PHC and their local health needs and priorities.

This recognizes that PHC is built on a lot of existing structure and mechanism that can simply be strengthened to support PHC but that these are likely to have been developed in different ways and at different paces according to local needs, priorities and resource and other constraints.

The use of the mature matrix in PHC boosting is intended to be a participatory process, different stakeholders should be brought around the table to use the mature matrix in developing PHC booster plans including representatives from communities, local leaderships, CSOs, health centres, district hospital, health department and administrations among others (including potentially social services, private sectors etc.).

There is no uniform way that is best to hold these discussions and health leadership in districts together with health centres and commune leadership should come together to decide an approach appropriate to their local context.

Initial discussion using the mature matrix may focus on questions such as:

1. Where do we want our PHC system to be in 3 years' time (looking at mid or mature columns)
2. Do we have strategic action s to get there (foundation and mid stages)
3. What are the first steps we want to take-what needs to be prioritized and why?
4. Do we have what we need (skills, resources, time) to be able to take these first steps and if not, how will we get them.

Further guidance will be provided in detailed PHC-BIF guidelines which will also detail the option activities in more depth.

CORE ACTION AREA 1: Enabling and engaging individuals, families, and communities

Main Activities	Foundation	Mid	Mature
Build health literacy & skills of individuals, families, and communities to support their own health and the health of those they care for **Support participatory co-design processes for new health interventions and services across the PHC network** **Enhance structures and processes for health service engagement with and accountability to communities** **Strengthen local leadership for health including multi-sectoral action**	Create and strengthen education network such as telegram group, peers, community meeting place Strengthen capacity and motivate health educators including VHSG, HCMC, community health workers, influential villagers and elderly villagers. Ensure HCMC functions in managing health disseminating and solving community problem.	Ensure community (including vulnerable group) participates in identified health problems; solving health problems, Social Health Determinant such as food hygiene, health, clean water, measures to prevent non-communicable diseases Develop and integrate health activities plan into commune investment plan. Create mechanism for monitoring performance and motivation VHSG and other community networks on community health activities.	Advocacy and enable involvement of key representatives of different groups (older persons associations, women's groups, pagoda committees) especially vulnerable group in different health groups at sub national level Strengthen community feedback as part of quality enhancement management tools for health centers, including ongoing learning and improvement on what works in this area, ensuring voices of vulnerable often excluded groups are particularly supported. Scale up and continuously improve community accountability of and engagement with health services. Strengthen existing multi-sector forums highlighting relevant priority topics for health improvement – WASH, spaces for physical activity, fuel in the home (to reduce in house pollution health risk)

CORE ACTION AREA 2: REORIENTING HEALTH SERVICE DELIVERY

Main Actions	Foundation	Mid	Mature
Redefine and strengthen the PHC network in Cambodia **Strengthen PHC as first contact care – improve availability, readiness and quality of services** **Strengthen PHC as first contact care – through supportive referral structures** **Strengthen promotion and prevention to maintain health and address broader determinants for health**	Include community needs as priority into health center activities plan Map health and social service providers for both public and private sectors at commune and district level for further strengthen public health services Ensure health facilities has adequate essential drugs and supplies. Implement MPA guideline by prioritize activities for prevention and health promotion	Prioritize prevention activities, screening and PHC services based on health needs. (Screening Create communication system and regular feedback between providers acting in PHC network (including social service) including clients lost to follow up Used integrated approach to deliver service based on life course stage and community health needs.	Integrated multidisciplinary PHC team (beyond health, include social support services) which support by interoperable information system People use health center as first point of contact and eventually has increased utilization rate of HC. Provide and regularly evaluate integrated services which bases on priority health needs and life course stages of each individual. Implement integrated outreach services include CD and NCD to old population and vulnerable group. Full function of integrated event-based surveillance systems to detect and report of acute outbreaks and ongoing cases of illness. Identify priorities and analysis of key public health function

CORE ACTION AREA 3: SHAPING A COMPETENT AND FIT-FOR-PURPOSE PHC WORKFORCE

Main Activities	Foundation	Mid	Mature
Strengthen the policy environment for attracting and retaining PHC workforce **Develop multidisciplinary workforce based as well as individual primary health care skills & competencies through pre-service training and in-service professional development** **Secure advanced leadership and management in primary health care**	Identify main drivers of workforce shortages for PHC especially in rural remote areas Prioritizing recruitment of the applications who are from and distribute to underserved areas, rural and remote health facilities. Regularly assess multidisciplinary workforce competencies and use this evidence for further workforce development Strengthen the functions of VHSG, CCWC, and HCMC to implement health-delivery activities at the community level, such as outreach or campaign events to hard-to-reach population.	Implement community participation policy in order to ensure retention and performance of the VHSGs. Expand and diversify PHC workforce, VHSG, VMW, CCWC, and HCMC should be better utilized to support for some health activities in each health center's catchment areas. Build technical capacity of PHC workforce including non-medical skills[11], the use of digital device and/ or service-delivery platforms.	Improve capacity of health managers in health workforce development, planning, and implementation to ensure that recruitment and distribution of health workforce is based on gaps and the needs to delivery PHC services. Deploy multi-disciplinary PHC workforces to include new roles such as: coordinator, case managers and other specialties including general practitioners, nurse practitioners, counsellor, mental health specialist, …

11 For example: Communication skills, team works and emotional, cultural sensitivities, planning, monitoring, supportive supervision, and evaluation

CORE ACTION AREA 4: Leveraging innovation and DIGITALTRANSFORMATION

Main Actions	Foundation	Mid	Mature
Institute a culture of innovation across institution and health services **Promote use of digital health technology for patient access and service organization** **Adopt technology for behavior change and selfcare.** **Improve data procession, information sharing and evidence-based decision-making.**	Assess/explore the possibility to develop and use new innovation and technology at the ground to improve health. Ensure digital infrastructure: electricity, phone lines and internet connection. Develop apps for health education and interaction with service providers.	Develop and use new innovation and technology at the ground to improve health. Develop guidelines on the use of digital tool for clinical and managerial including UPIN, telemedicine, remote health monitoring tools. Build capacity of health workers on the use of digital tool for clinical and data management. Inform and/or orient community on how to use the Apps for health education and communication.	Implement digital platforms for service delivery to reach hard-to-reach population. Implement UPIN to facilitate coordination as well as enables communication between primary care multi-disciplinary team members to refer patients to needed services. Interoperate data systems, Ex: Linking HMIS data for use by all levels Use apps for health education and communication by community.

CORE ACTION AREA 5: INVESTING IN PHC FOR UHC

Main Actions	Foundation	Mid	Mature
Increased level and flexibility of financing for PHC **Ensure financing models that equalize incentives between prevention and promotion and individual acute care and support integrated people centered care** **Implement financing approaches supportive of financial protection and PHC as first contact with the health system ("gate-keeping")**	Create financial / non-financial reward scheme for health centres & communes that reach defined targets for prevention and promotion activities such as communities reached with priority messages, innovative activities award supporting health promotion prevention Periodically explore reasons for bypassing or use of private providers particularly for those covered for care only in public sector and use results to guide PHC strengthening efforts	Monitor key indicators of PHC quality and availability alongside utilization rates to evaluate impacts of increased investment in PHC Consider to establish targets benchmarks for proportion of financing for primary health care and monitor progress such as for proportion of health in commune investment plans and health center and public health spending as a proportion of total health spending at province level Reduce the gap between hospital and health center level reimbursements for primary care conditions under social health protection schemes	Set up target for more investment on the prevention and promotion activities Increase ring fenced budget at sub national level for integrated event-based (fever, respiratory symptoms etc) surveillance with community engagement

CORE ACTION AREA 6: ADVANCING GOVERNANCE AND FOSTERING PARTNERSHIP

Main Activities	Foundation	Mid	Mature
Ensure implementation space for the new community initiative **Build leadership for PHC** **Partnering with the private sector**	Mapping potential stakeholders/ institution at national and sub-national level to including public and private health providers, and other non-health stakeholders, civil society organizations to identify synergies efforts and competition. Involve local authorities in actively support implementation of community initiative and engage other sectors such as education, women affairs, agriculture, rural development… to participate in meeting, service provision and other activities related to health. Identify champions to promote political leadership and network to leverage PHC agenda in their communities.	Strengthen coordination at different level in supporting PHC through creating mechanism for learning and accountable for monitoring, evaluation and use of evidence to improve planning and implementation. Build leadership of local administrative at all level (village, commune, district and province) on health, in decision making and learn from the ground.	Establish strong linkages with non-health sectors such as social services, child support services, disability, and rehabilitation, where people can access all services under one roof by sectors that co-develop health. To leverage on multisectoral collaboration to take onboard development partners and donor agencies, having consensus on existing and developing national priorities and actions. Local authorities encourage community engagement in local health decision making, carry out community-level health promotion and health improvement initiatives, and engage in citizen-led feedback and accountability processes for PHC services. Integrate accredited private providers into formal service delivery networks that covered by formal financial schemes. Leverage integrated of accredited private providers in health service network through revision on regulation. Integrated data from private service in the HMIS and leverage utilization of single unique patient identifier number (UPIN), and a single electronic medical record (EMR)

ANNEX 2. THE HEALTHY COMMUNITY INITIATIVE

THE HEALTHY COMMUNITY INITIATIVE

The aim of the Healthy Community initiative is that individuals, families and communities take responsibility for their own health. The expected outcomes are adopting behaviour changes –following healthier lifestyles and habits, contributing to reduce public health risks and increasing the demand for health services, particularly in prevention and screening.

The Healthy Community initiative should build on the experience gained with the existing mechanisms of community participation in health (HCMC, VHSG), and will utilize existing structure at sub national level especially at Commune/Sangkat level to strengthening collaboration with other sectors, obtaining resources to facilitate community engagement, and organizing activities that may increase access to health information.

The Healthy Community initiative strengthens local leadership. The HCMC should play a role to support commune council on Healthy Community initiative and link health center and commune council (for both commune with and without health center located. The HCMC coordinate planning for healthy community initiative it should include an assessment of the situation, proposal of activities to perform, estimation of resources necessary and monitoring plan –including budget execution and accounting mechanisms—, which should be integrated in the Commune Investment Plan (CIP).

The activities included in the Healthy Community initiative may fall in three main categories:

- Facilitate information sharing and participation of individuals and families in lifestyle changing activities. The expected outcome is the adoption of healthier lifestyles, resulting in reduced prevalence of risky behaviours such as creating Healthy Friendly Clubs, public parks and areas for physical activities and make available correct and unbiased information on healthy behaviour to population.
- Influence health determinants at the local level thorough inter-sector collaboration. The expected outcome is the reduction of public health risks through the improvement of access to water and sanitation, removal of vector breeding sites, etc.
- Strengthen involvement of individuals and families in improving quality of health services and social services with aims to strengthen and expansion of promotive and preventive health services which resulting in better coverage of reproductive, mother-and-child services, adolescent and youth, NCD and cancer screening, health sector response to VAW/GBV and others.

THE ROLE OF THE HEALTH SERVICES

The Healthy Community initiative is not just a community participation in health initiative. Some of its expected outcomes include increased demand and better utilization of health services, which implies that these health services should be ready to absorb this demand and provide the right combination of quality health services accessible and affordable to all.

MONITORING AND EVALUATION

Provincial, district and commune authorities will monitor plan implementation of Healthy Community initiative. Levels of accomplishment will be defined, and rewards given to achieving communities. Measuring outcomes in terms of behaviour change is notoriously difficult.

Further guidance on Healthy Community initiative will be provided in detailed in PHC-BIF Implementation guidelines.

ANNEX 3: RECOMMENDED INDICATORS FOR PHC-BIF

These indicators are extracted from M&E framework of HSP. They measure progress of 1) Improved community engagement to accountable in their own health, build trust and use a PHC network, 2) resilient health system, 3) Strengthened financial protection, 4) Ensured value-based care to achieve highest health gains from our investment, and 5) People centered care meeting health needs of the person in convenience and coordinated ways that are reflected in the six-core area of actions of PHC-BIF.

No	Indicators	Level
1	OPD consultations (new cases only) per person per year	Outcome
2	Percentage of pregnant women who received ANC4 consultation by health personnel	Outcome
3	Percentage of post-partum women who received PNC consultation by health personnel	Outcome
4	OPD consultation (new cases) per children under 5 per year	Outcome
5	Percentage of viral suppression among people on antiretroviral therapy (adult and children)	Outcome
6	TB case detected	Outcome
7	Malaria Incidence per 1,000 population	Outcome
8	Percentage of people aged 25-65 years with high blood pressure received treatment (new cases)	Outcome
9	Percentage of adults aged over 25with diabetes type II received treatment (new cases)	Outcome
10	Percentage of women aged 30-49 years screened for cervical cancer at least once	Outcome
11	Percentage of adult population with depression received treatment	Output/ outcome
12	Percentage of people with drug used received treatment	Output/ outcome
13	Percentage of the population covered by social health protection systems i.e., Health Equity Funds and Social Health Insurance schemes.	Outcome
14	Out-of-pocket health expenditure as percentage of the total health expenditure (%)	Outcome
15	Ratio of physician/nurse/midwife per 1,000 population	Outcome

No	Indicators	Level
16	Number and percentage of HCs with staff in place as per (MPA) staffing norm	Output/ outcome
17	Number and percentage of public health care facilities with basic water supply	Output/ outcome
18	Percentage of HCs with functioning Health Center Management Committee	Output/ outcome
19	Percentage of client satisfaction with health facility	outcome
20	Health literacy rate of Village Health Support Groups	outcome
21	Health literacy rate of people aged from 15 years.	outcome
22	Core capacities for IHR implementation- Index score (and sub-components)	outcome

ANNEX 4: NOMINATION LETTERS

ព្រះរាជាណាចក្រកម្ពុជា

ជាតិ សាសនា ព្រះមហាក្សត្រ

ក្រសួងសុខាតិបាល

លេខ...០៥៣...អប្រស.សប្រអ

ថ្ងៃសុក្រ ៤កើត ខែ.ផល្គុន..ឆ្នាំឆ្លូវ ត្រីស័ក ព.ស ២៥៦៥

រាជធានីភ្នំពេញ, ថ្ងៃទី ៤ ខែ មីនា ឆ្នាំ២០២២

លិខិតបង្គាប់ការ

- តាមការចាំបាច់របស់ ក្រសួងសុខាតិបាល ក្នុងការឆ្ពោះទៅពង្រឹងការថែទាំសុខភាពបឋមដើម្បីឆ្លើយតបនឹងតម្រូវការ ធ្វើឱ្យប្រសើឡើងនូវសុខភាពរបស់ប្រជាជននាពេលបច្ចុប្បន្ន និងពេលអនាគតដោយផ្តោតលើការផ្តល់សេវាតាមបែប អភិក្រមប្រជាជនជាមជ្ឈមណ្ឌលកណ្តាល (people center approach)។

បានបង្កើតក្រុមការងារអភិវឌ្ឍ និងគ្រប់គ្រងក្របខ័ណ្ឌអនុវត្តការជំរុញបង្កើនការងារថែទាំសុខភាពបឋម ហៅកាត់ថា "**ក.ជ.ថ.ស.ប**" ជាភាសាអង់គ្លេស (Taskforce to develop and manage Primary Health Care Booster Implementation Framework "T.P.H.C booster") និងក្រុមលេខាធិការដ្ឋាននៃក្រុមការងារអភិវឌ្ឍ និងគ្រប់គ្រងក្របខ័ណ្ឌ អនុវត្តការជំរុញបង្កើនការងារថែទាំសុខភាពបឋម ដូចមានរាយនាមដូចខាងក្រោម៖

១	លោកជំទាវវេជ្ជបណ្ឌិត ឱ វណ្ណឌីន	រដ្ឋលេខាធិការក្រសួងសុខាតិបាល	ប្រធាន
២	ឯកឧត្តមវេជ្ជបណ្ឌិត ម៉ឹង វណ្ណារុំ	អនុរដ្ឋលេខាធិការក្រសួងសុខាតិបាល	អនុប្រធាន
៣	ឯកឧត្តមវេជ្ជបណ្ឌិត ហុក គឹមចេង	អគ្គនាយកបច្ចេកទេសសុខាតិបាល	អនុប្រធាន អចិន្ត្រៃយ៍
៤	លោកស្រីបណ្ឌិត ឈា ឆដាកា	ប្រធានមជ្ឈមណ្ឌលជាតិលើកកំពស់សុខភាព	អនុប្រធាន
៥	លោកវេជ្ជបណ្ឌិត លី វិជ្ជាវ៉ាវុធ	ប្រធាននាយកដ្ឋានផែនការ និងព័ត៌មានសុខាតិបាល	សមាជិក
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៧	លោកវេជ្ជបណ្ឌិត ឈិត សុផល	ប្រធាននាយកដ្ឋានសុខភាពផ្លូវចិត្ត និងការបំពានគ្រឿងញៀន	សមាជិក
៨	លោកវេជ្ជបណ្ឌិត សុខ ស្រ៊ុន	ប្រធាននាយកដ្ឋានមន្ទីរពេទ្យ	សមាជិក
៩	លោកឱសថបណ្ឌិត ហេង ប៊ុនគៀត	ប្រធាននាយកដ្ឋានឱសថ ចំណីអាហារ បរិក្ខារពេទ្យ និងគ្រឿងសំអាង	សមាជិក
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១១	លោកវេជ្ជបណ្ឌិត អ៊ុក វិជ្ជា	ប្រធានមជ្ឈមណ្ឌលជាតិប្រយុទ្ធនឹងជំងឺអេដស៍សើស្បែក និងកាមរោគ	សមាជិក

ទីស្តីការក្រសួងសុខាតិបាល ជីឡូតិ៍លេខ ៨០ វិថីសម្តេច ប៉ែន នុត (២៨៩) ភ្នំពេញ ទូរស័ព្ទ-ទូរសារ: (៨៥៥-២៣)៨៨៥ ៩៧០/៨៨៤ ៩០៩

១២	លោកស្រីវេជ្ជបណ្ឌិត គឹម រ័ត្ននា	ប្រធានមជ្ឈមណ្ឌលជាតិគាំពារមាតា និងទារក	សមាជិក
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១៤	លោកវេជ្ជបណ្ឌិត ហួត ចាន់យុដា	ប្រធានមជ្ឈមណ្ឌលជាតិកំចាត់ជំងឺរបេង និងហង់សិន	សមាជិក
១៥	លោកស្រីវេជ្ជបណ្ឌិត តេង ស្រី	អនុប្រធាននាយកដ្ឋានប្រយុទ្ធនឹងជំងឺឆ្លង	សមាជិក
១៦	លោកវេជ្ជបណ្ឌិត លឹម ពេជ្រ	អនុប្រធានមជ្ឈមណ្ឌលជាតិលើកកំពស់សុខភាព	សមាជិក
១៧	លោកស្រីវេជ្ជបណ្ឌិត ថែម រ៉ាវណ្ណ	អនុប្រធាននាយកដ្ឋានសហប្រតិបត្តិការអន្តរជាតិ	សមាជិក
១៨	កញ្ញាឱសថការី ជូ ផល្លីកា	អនុប្រធាននាយកដ្ឋានសុខភាពផ្លូវចិត្ត និងការបំពានគ្រឿងញៀន	សមាជិក
១៩	លោកស្រីវេជ្ជបណ្ឌិត លុន មណ្ឌល	អនុប្រធាននាយកដ្ឋានផែនការ និងព័ត៌មានសុខាភិបាល	សមាជិក
២០	លោកឱសថការី សៀ ថុល	អនុប្រធាននាយកដ្ឋានឱសថ ចំណីអាហារ និងគ្រឿងសំអាង	សមាជិក
២១	លោកស្រីវេជ្ជបណ្ឌិត អ៊ុក សុគន្ធ	ប្រធានការិយាល័យបច្ចេកទេសនៃមជ្ឈមណ្ឌលជាតិលើកកំពស់សុខភាព	សមាជិក
២២	លោកវេជ្ជបណ្ឌិត លុន ហានវុឌ្ឍ	អនុប្រធានការិយាល័យបច្ចេកទេសនៃមជ្ឈមណ្ឌលជាតិលើកកំពស់សុខភាព	សមាជិក
២៣	ឯកឧត្តម-លោកជំទាវ អភិបាលរង នៃគណអភិបាល រាជធានី-ខេត្តទាំង២៥ (ទទួលបន្ទុកផ្នែកសុខាភិបាល)		សមាជិក
២៤	ឯកឧត្តម-លោកជំទាវប្រធានមន្ទីរសុខាភិបាលរាជធានី-ខេត្តទាំង២៥		សមាជិក
២៥	តំណាងមកពីកាកបាទក្រហមកម្ពុជា		សមាជិក
២៦	តំណាងមកពីអង្គការសុខភាពពិភពលោក (WHO)		សមាជិក
២៧	តំណាងមកពីអង្គការយូនីសេហ្វ (UNICEF)		សមាជិក
២៨	តំណាងអង្គការដៃគូពាក់ព័ន្ធផ្សេងៗ (តាមតម្រូវការចំបាច់ និងតាមការសម្រេចរបស់ប្រធានក្រុមការងារ)		សមាជិក
២៩	លោកវេជ្ជបណ្ឌិត សាន់ បូណ៌មី	ប្រធានផ្នែកថែទាំសុខភាពបឋមនៃមជ្ឈមណ្ឌលជាតិលើកកំពស់សុខភាព	លេខាធិការ
៣០	លោកវេជ្ជបណ្ឌិត ឈឺន វិសាលបញ្ញា	មន្ត្រីការិយាល័យធានាគុណភាពសុខាភិបាល	លេខាធិការ
៣១	លោកវេជ្ជបណ្ឌិត កី ម៉ាលី	មន្ត្រីនាយកដ្ឋានការពារសុខភាព	លេខាធិការ

ក្រុមការងារ "**អ.ជ.ថ.ស.ប**" មានការកិច្ចដូច ខាងក្រោមនេះ៖

- ស្រាវជ្រាវ ពិគ្រោះយោបល់ជាមួយភាគីពាក់ព័ន្ធ និងវិភាគស្ថានភាពបច្ចុប្បន្ន ទិសដៅ ការរំពឹងទុក ការការពារសុខភាព ទាក់ទងនឹងការថែទាំសុខភាពបឋម។
- អភិវឌ្ឍក្របខណ្ឌអនុវត្ត និងទស្សនៈ សម្រាប់ជំរុញបង្កើនការលើកកម្ពស់ការថែទាំសុខភាពបឋម។

- អនុវត្តសាកល្បង (demonstration sites) អនុលោមតាមយុទ្ធសាស្ត្រ គោលនយោបាយសុខាភិបាល និង ក្របខណ្ឌអនុវត្ត និងទស្សនៈជំរុញបង្កើនការលើកកម្ពស់ការថែទាំសុខភាពបឋមជាក់ស្តែង នៅតាមសហគមន៍នៃបណ្តារាជធានី-ខេត្តដែលបានជ្រើសរើស ដើម្បីសិក្សាអំពីលទ្ធភាពក្នុងការអនុវត្តន៍នៅទូទាំងប្រទេស។
- គៀងគរការគាំទ្របច្ចេកទេស ធនធាន និងថវិកាពីដៃគូនានាសម្រាប់គាំទ្រការអនុវត្តន៍សាកល្បងនូវក្របខណ្ឌអនុវត្ត និង ទស្សនៈជំរុញបង្កើនការលើកកម្ពស់ការថែទាំសុខភាពបឋមនៅទីតាំងសហគមន៍ដែលជ្រើសរើស។
- ពិភាក្សានូវតម្រូវការចូលរួមពីភាគីដៃគូពាក់ព័ន្ធលើការងារអភិវឌ្ឍ និងគ្រប់គ្រងជំរុញបង្កើនការថែទាំសុខភាពបឋម ហើយប្រធានក្រុមការងារនេះមានសិទ្ធិសម្រេចក្នុងការអញ្ជើញ និងដាក់បញ្ចូលដៃគូសហការនោះក្នុងក្រុមការងារខាងលើតាមតម្រូវការចំបាច់។
- កិច្ចការពាក់ព័ន្ធទៅនឹងការសម្របសម្រួលសម្រាប់ការអភិវឌ្ឍ និងគ្រប់គ្រងក្របខណ្ឌអនុវត្តការជំរុញបង្កើនការងារថែទាំសុខភាពបឋម។
- រៀបចំកិច្ចប្រជុំ ពិគ្រោះយោបល់ និងកិច្ចប្រជុំនានាសម្រាប់ក្រុមការងារ។
- រៀបចំផែនការសកម្មភាពការងារសម្រាប់ក្រុមការងារអភិវឌ្ឍ និងគ្រប់គ្រងក្របខណ្ឌអនុវត្តការជំរុញបង្កើនការងារថែទាំសុខភាពបឋម។
- ចាត់ចែងការអនុវត្តន៍សាកល្បងយុទ្ធសាស្ត្រ គោលនយោបាយ ឬក្របខណ្ឌទស្សនៈដើម្បីកែប្រែការថែទាំសុខភាពបឋមសម្រាប់អនាគត។
- រៀបចំរបាយការណ៍ប្រជុំរបស់ក្រុមការងារនិងរបាយការណ៍ពាក់ព័ន្ធទៅនឹងការងារអភិវឌ្ឍ និងគ្រប់គ្រងក្របខណ្ឌអនុវត្តការជំរុញបង្កើនការថែទាំសុខភាពបឋម។
- អនុវត្តភារកិច្ចផ្សេងៗទៀតតាមការណែនាំរបស់ប្រធានក្រុមការងារ។
- តាមដាន និងវាយតម្លៃការអនុវត្តក្របខណ្ឌអនុវត្តនិងទស្សនៈជំរុញបង្កើនការថែទាំសុខភាពបឋមនៅតាមសហគមន៍ ព្រមទាំងលើកជាអនុសាសន៍សម្រាប់កែតម្រូវ និងពង្រឹងជំរុញការអនុវត្តន៍ការងារថែទាំសុខភាពបឋមស្របតាមគោលនយោបាយយុទ្ធសាស្ត្រសុខាភិបាល។

លិខិតបង្គាប់ការនេះមានប្រសិទ្ធភាពចាប់ពីថ្ងៃចុះហត្ថលេខាតទៅ។

រដ្ឋមន្ត្រីក្រសួងសុខាភិបាល

ម៉ម ប៊ុនហេង

កន្លែងទទួល៖
-នាយកដ្ឋាន និងផ្នែកពាក់ព័ន្ធ(ជ្រាបជាព័ត៌មាន)
-សាមីខ្លួន
-ឯកសារ កាលប្បវត្តិ

ព្រះរាជាណាចក្រកម្ពុជា

ជាតិ សាសនា ព្រះមហាក្សត្រ

ក្រសួងសុខាតិបាល

លេខ:២០៤.ស.ស.ប្រអ

ថ្ងៃចន្ទ ៧ កើត ខែរោងឆស័ក ឆ្នាំខាល ចត្វាស័ក ព.ស.២៥៦៦

រាជធានីភ្នំពេញ, ថ្ងៃទី ០៣ ខែ តុលា ឆ្នាំ២០២២

លិខិតបង្គាប់ការ

- យោងលិខិតបង្គាប់ការលេខ ០៨៣ អបស.សប្រអ ចុះ ថ្ងៃទី ០៤ ខែ មីនា ឆ្នាំ២០២២
- យោងតាមការចាំបាច់របស់ក្រសួងសុខាតិបាល។

ត្រូវបានបន្ថែម **ឯកឧត្តមវេជ្ជបណ្ឌិត ឃួ ខាសនាគីរី** ផ្នែលេខាធិការក្រសួងសុខាតិបាល ជាអនុប្រធានក្រុមការងារអភិវឌ្ឍ និងគ្រប់គ្រងក្របខ័ណ្ឌអនុវត្តការជំរុញបង្កើនការងារថែទាំសុខភាពបឋម «**ក.ជ.ថ.ស.ប**» (Taskforce to develop and manage Primary Health Care Booster Implementation Framework "T.P.H.C booster") ។

លិខិតបង្គាប់ការនេះ មានប្រសិទ្ធភាពចាប់ពីថ្ងៃចុះហត្ថលេខាតទៅ។

រដ្ឋមន្ត្រីក្រសួងសុខាតិបាល

ម៉ម ប៊ុនហោ

កន្លែងទទួលៈ
- នាយកដ្ឋាន និងផ្នែកពាក់ព័ន្ធ (ជ្រាបជាព័ត៌មាន)
- សាមីខ្លួន
- ឯកសារ កាលប្បវត្តិ

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