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**PHNOM PENH**

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## FOREWORD

The publication of this report is part of the response of the Royal Government of Cambodia (RGC) to the request of the United Nations system requested by 65/234 — Follow-up to the International Conference on Population and Development beyond 2014 - to member states to undertake the International Conference on Population and Development (ICPD) Review to assess implementation of the Program of Action (POA) at country, regional and global levels.


The objective of this report is mainly to identify progress and achievements towards the goals set out in the landmark ICPD, as well as the constraints faced therein in the implementation of the Programme of Action at national and sub-national levels. Since the adoption of the Programme of Action (PoA) of the ICPD in 1994, the RGC is deeply committed to achieving inclusive economic growth, fully integrating the country into the ASEAN, graduating the country from Least Developed Countries (LDCs) Status, and also achieving social development targets, including the Cambodia Millennium Development Goals (CMDGs). The achievements included a great deal on many prioritized areas aspects: Public Health including Reproductive Health and Family Planning, Sanitation, HIV and AIDS, Youth Development, Agriculture and Food Security, Irrigation and Water Development, Education, Science and Technology, Transport Infrastructure, Climate Change, Natural Resources and Environmental Management, Rural Development, Energy, Mining and Industrial Development.

As to the ICPD review in 2013, the Government demonstrated that Cambodia had made significant progress in adopting and implementing national development policies and key sectoral strategies to achieve better development results, focusing on the realization of human rights, being guided by human rights standards and principles; strengthening efforts to improve gender equality, equity and women's empowerment; addressing adolescent reproductive health; forging new partnerships with civil society and the private sector and promoting integration of population dynamics and trends into development planning and policymaking.

Due to the fact that the fertility and mortality levels have come down substantially, the country at present is going through a phase of rapid demographic transition and this has opened up the demographic window of opportunity wherein a large number of youth are of the working ages and getting ready to enter the labour market to lead further economic development. As a result, income inequality is reducing, people are earning more and living better compared to what they did a few years back.

Taking cognizance of the impacts of population dynamics, reproductive health and gender on poverty, the RGC will seek to further strive to improve the quality of people's standard of living in the country through the next National Strategic

Development Plan 2014-2018, and as part of an effort to strive for full implementation of ICPD beyond 2014.

The Government believes that the successful implementation of the key priority areas will have positive implications on the achievement of the ICPD PoA and other pertinent development indicators. Stakeholders engaged in development activities in various sectors of the economy will be pleased to see the impacts of their efforts through this report. 



**Chhay Than**  
Senior Minister,  
Minister of Planning  
Phnom Penh, August 2013

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## LIST OF ACRONYMS

ADB	: Asian Development Bank
AIDS	: Acquired Immune Deficiency Syndrome
CARD	: Council for Agriculture and Rural Development
CDHS	: Cambodia Demographic Health Survey
CDRI	: Cambodia Development Resource Institute
CEDAW	: Convention on the Elimination of All Forms of Discrimination Against Women
CMDGs	: Cambodia Millennium Development Goals
CPR	: Contraceptive Prevalence Rate
CSES	: Cambodia Socio-Economic Survey
DP	: Development Partners
EmONC	: Emergency Obstetric and Newborn Care
FTI	: Fast Track Road Map for Reducing Maternal and Newborn Mortality
GDCC	: Government-Donor Coordination Committee
GDP	: Gross Domestic Products
GMAG	: Gender Mainstreaming Action Groups
GMAP	: Gender Mainstreaming Action Plan
ICPD	: International Conference on Population and Development
IUD	: Intra Uterine Device
KAP	: Knowledge, Attitude, and Practice
MDGs	: Millennium Development Goals
MMR	: Maternal Mortality Rate
MoH	: Ministry of Health
MoLVT	: Ministry of Labour and Vocational Training
MoP	: Ministry of Planning
MoSAVY	: Ministry of Social Affairs, Veterans, and Youth Rehabilitation
MoWA	: Ministry of Women's Affairs
NAPVAW	: National Action Plan to Prevent Violence against Women
NCHADS	: National Centre for HIV/AIDS Dermatology and STDs
NCPD	: National Committee for Population and Development
NPRS	: National Poverty Reduction Strategy
NMCHC	: National Maternal and Child Health Center
NPP	: National Population Policy
NRHP	: National Reproductive Health Programme

NSDP	: National Strategic Development Plan
PRK	: People's Republic of Kampuchea
PoA	: Programme of Action
RGC	: Royal Government of Cambodia
RMCH	: Reproductive, Maternal and Child Health
STI	: Sexually Transmitted Infection
TFR	: Total Fertility Rate
UFNSK	: United Front for National Salvation of Kampuchea
UNAIDS	: United Nations Programme on HIV and AIDS
UNAMIC	: United Nations Advance Mission In Cambodia
UNDP	: United Nations Development Programme UNFPA Population Fund
UNTAC	: United Nations Transitional Authority in Cambodia



## EXECUTIVE SUMMARY

Since the adoption of the Programme of Action (PoA) of the ICPD in 1994, the Royal Government of Cambodia (RGC) has put tireless efforts in tackling the population, reproductive health, and gender issues through implementation of its national policies, plans, and programmes, with special emphasis on abiding with a rights-based approach that promotes choice and access to social services including institutional health deliveries.

Cambodia has experienced rapid economic growth since the 2000s leading the country's poverty rate reduced from 47.8 per cent in 2007 to 22.9 in 2009, 21.1 per cent in 2010 and 19.8 per cent in 2011. Therefore, the country is well on the way to reaching the MDG goal by 2015. This growth is obviously in large part influenced by the shifts in the country's major population dynamics—low fertility and mortality, change of age structure, migration and urbanization, not to mention the improved social infrastructure, political stability and other major enabling factors which contributes to increased foreign direct investments, in particular in the industrial and service sectors. Another contributing factor in achieving poverty reduction have also been made possible thanks to the Government's effort in establishing and implementing national social protection strategy for the poor and vulnerable through the Programme on Identification of Poor Households, which has helped the Government to target programmes to reach the most vulnerable. Among these other services was the establishment of a national Health Equity Fund in 2009, which has the aim at providing free health services to the poor and is already having an impact on access to health care interventions.

Given that 58.7 per cent of the total population is in the productive age, Cambodia has already started to reap the benefits of the “demographic bonus” some time before the 2008 census and the duration of which is expected to last until about 2038. In order to realize these benefits, Cambodia will have to make a special effort provide educating and skill training its population to levels commensurate with that of most of its neighbors.

The literacy rate of among the population 7 years and above has increased. The net enrolment rate for girls in primary school has reached 96 per cent, while the dropout rate for girls in primary school has declined to 8.7 per cent. The level of completion of secondary school is low throughout Cambodian society, but there is a significant discrepancy between men (7.4 per cent) and women (3.6 per cent). Gender parity has been reached in primary education while the ratio is 100:90 in secondary education and 100:50 in tertiary education. Therefore, Cambodia's greatest development challenge remains the need to develop its human capacity including minimizing the gender parity especially at the tertiary education level.

The urban population in Cambodia has been increasing steadily since 1990 increasing from 12.6 per cent of the total in 1990 to 16.9 per cent in 2000 and 20.1 per cent in 2010. In addition, the growth is expected to increase more rapidly in the future. A recent national survey on internal migration and urbanization found that the

capital city of Phnom Penh is more than double in the ten years (1998 and 2008), growing from 570,000 residents to 1,240,000, an extraordinarily high rate of growth of 8 per cent a year, and 80 per cent of this growth was fuelled by migration.

The total fertility rate had declined from 3.4 births per woman in 2005 to 3.0 births per woman in 2010 throughout the country at all levels of education and regardless of household income in both rural and urban areas.

In Cambodia, the index of ageing increased slowly between 1998 and 2008, but is expected to increase more rapidly in the following 22 years. The old age dependency ratio shows an increasing trend and is expected to increase from 10.6 per cent in 2008 to 17.2 in 2030. Since Cambodia's elderly population is only now beginning to grow at a more rapid rate, the Government has time to begin to address these issues comprehensively, but it needs to start planning now.

In international rankings of gender equality, Cambodia's Gender Inequality Index value is 0.473, putting it at number 96 in a ranking of 147 countries. The proportion of women elected to the National Assembly increased from 5.8 per cent in 1993; 12.3 per cent in 1998; 19.5 per cent in 2003; and 21.1 per cent in 2008. The proportion of women elected to commune councils increased from 8 per cent in 2002 to 14.6 per cent in the 2007 elections and increased again to 17.9 per cent in 2012. In 2009, women comprised 10.1 per cent of provincial council members and 12.7 per cent of capital city council members. The proportion of seats held by women in the Senate is 14.8 per cent. Women were appointed as Deputy Governors in 24 capital city/provinces in 2008 and in all 187 towns/districts/khans in 2009.

One of the empowering agents for women is economic autonomy, and there is a significant number of Cambodian women who are engaged in wage employment reaching 45.8 per cent of all wage employees in 2011. Women are the vast majority of wage workers in industry, because of the importance of the garment industry in Cambodia—70.8 per cent of total industrial wage earners were women in 2011. The percentages were about equal in the agricultural sector (53.8 per cent women) while women were unequally represented in the service sector (28.8 per cent).

The main barriers to ending violence against women are: lack of public awareness concerning gender-based violence; acceptance of violence as a response to “wrong behavior” by women, men and local authorities; limited protection and counseling services available from professional service providers for victims of rape; limited access to services for victims of all forms of gender-based violence; reluctance of some victims to seek support from NGOs that work in the area of violence against women; lack of qualified staff at MoWA sufficient to respond to needs in the area of gender-based violence; and limited dissemination and understanding of relevant laws.

Despite the Royal Government of Cambodia's effort to reduce gender disparities, women's position, whether in education, technical skills or public life, is yet weaker compared to that of men in Cambodia. This requires the country to intensify its efforts in reducing gender inequality and inequity.

In terms of achieving the CMDG targets for reproductive health, Cambodia was on track for maternal mortality, while improvement needs to be made for both skilled birth attendance and antenatal care (one visit). The use of family planning methods in Cambodia is spreading, and this is certainly one of the major reasons for the fertility decline. Practically, all Cambodian women are familiar with at least some methods of contraception. The daily contraceptive pill, the male condom, the IUD, and injectables are known to more than 95 per cent of married women. Seventy-five per cent of women knew at least one traditional method of family planning.

The adolescent birth rate was 90 in 1993, 51 in 1998, and 52.3 in 2003, and the rate further declined to 41.8 in 2010. The unmet need for contraception has declined from 25 per cent in 2005 to 17 per cent in 2010, with a goal of reaching 10 per cent by 2016. Despite having no legal age restrictions on access to reproductive health services, including for contraceptives and access to abortion, there is a lack of understanding on just how easily young people are able to make use of such services. The big need is to ensure the continued supply of contraceptive commodities. Up to now, the commodities that were supplied through the public health system had all been financed by Development Partners (DP). In overall, among the reproductive health indicators, the rate for family planning, though shows encouraging sign, is lagging in that the CPR for modern methods was 35 per cent in 2010 while the CMDG goal is 60 per cent.

HIV prevalence in Cambodia peaked at 1.7 per cent in the years 1998-1999, declined to 1.2 per cent in 2004, and then declined significantly to reach a projected 0.7 per cent in 2012 and the CMDG goal has been met. One of the reasons that Cambodia has made strides in reducing its HIV prevalence rate is because of its success in linking the reproductive health programme with HIV/AIDS prevention and services.

The public health system has made great strides in ensuring that every health facility in the country has at least one secondary midwife whereas the goal is to have at least two secondary midwives per health facility. The number of both primary and secondary midwives is increasing rapidly—secondary midwives from 1,994 in 2011 to 2,432 in 2012 and primary midwives from 1,997 to 2,164. There also needs to be an effective referral system for more serious issues: emergency obstetric care for complications, antibiotics for premature rupture of membranes, neonatal resuscitation, and management of newborns with complications. In spite of the rapid growth in health personnel, Cambodia continues to have a lower number of specialized medical staff, including doctors, medical assistants, and nurses and midwives per capita than neighboring countries: in Cambodia there is one per every 1,000 people.

Infant mortality decreased from 95 in 2000 and continued to decline to 45 per 1,000 in 2010 while the under-five mortality decreased from 124 to 54 per 1,000 within the same period. This decline is attributable to the national immunization programme, promotion of exclusive breastfeeding, improved access to basic health services, and an overall reduction in poverty levels and greater access to education and health care, partially because of an expanded and improved road system. With regard to the

MMR, the country has already met the CMDG target of 250 in 2015. In 2010, the MMR was at 206/100,000 live births decreasing from 437 in 2000 to 472 in 2005.

Although there was a notable decrease of the MMR and the increase in percentage of deliveries at health facilities from 35 per cent in 2008 to 66 per cent in 2012, the quality of ante-natal care services needs continuing attention. One of the major effects of the increased number of ante-natal visits has been to inform women of the benefits of institutional delivery and to encourage them to go to a health facility when it is time to give birth. As a result, there been a dramatic rise in the percentage of institutional deliveries.

One of the major causes for maternal and neonatal death was related to the emergency obstetric and neo-natal care (EmONC) services. EmONC is integral to the Government's intensive strategic intervention in saving life of women in Cambodia, namely, the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality. Therefore an assessment was conducted and found that the country was lacking both basic and comprehensive EmONC facilities, with 1.6 basic facilities for 500,000 populations versus a recommended level of 5. EmONC Improvement Plan 2010-2015 was introduced with a number of health facilities upgraded to be able to respond to the complications of deliveries. For the delivery of the EmONC, skilled birth attendance, safe abortion and family planning services, the National Reproductive Health Programme (NRHP) ensures that there is proper technical support, well- equipped facilities, sufficient material, equipment and commodities, and relevant policies and guidelines in place at all levels of public facilities.

Overall, in view of the unique social and political conditions that the country has had, Cambodia has indeed made great strides in reducing poverty through implementing its National Strategic Development Plans, focusing on investments in population programmes in particular on reproductive, maternal and child health including family planning adhering on reproductive rights that promotes choice. The results to date provide greater confidence that the country is well on its way towards achieving its goals of further reducing poverty and promoting equality. Looking forward, the Government feels imperative that the Cambodia continues to be committed to further implementing national development agenda and priorities to move forward the core principles of ICPD and MDG beyond 2015.

## I. BACKGROUND

The latter part of the 20<sup>th</sup> century was a period of strife, turmoil and displacement for Cambodia so that at the time of the International Conference on Population and Development (ICPD), which took place in Cairo, Egypt, in September 1994, the country was in a transitional, post-conflict situation. In the almost twenty years since the Cairo Conference, however, the political, economic, and social situation of the country has been much more stable, even though there have been periods of difficulty and typical post-conflict situation. Because of this relative stability, the country has been able to make remarkable strides in implementing the ICPD Programme of Action, which will be documented in this report. In spite of this progress, the country still remains relatively less developed in its social and economic indicators in relation to its neighbors in Southeast Asia. This report will look at the areas in which Cambodia still falls short and what might be needed to make even greater improvements in the next five, ten, fifteen and twenty years.

Cambodia was led to independence from France by Prince Norodom Sihanouk in 1953. Beginning with the overthrow of the late King Father Sihanouk by General Lon Nol on 18 March 1970, Cambodia entered a period of internal civil strife and civil war that culminated when the communist Khmer Rouge captured Phnom Penh and declared the establishment of Democratic Kampuchea on 17 April 1975. The Khmer Rouge regime is remembered primarily for the harsh enforcement of its unique ideology, which resulted in mass genocide in the whole country. The Khmer Rouge regime broke off relations with the Socialist Republic of Viet Nam on 31 December 1977. The United Front for National Salvation of Kampuchea Salvation (UFNSK) with the help of Vietnamese troops captured Phnom Penh in January 1979 and established the People's Republic of Kampuchea (PRK). The PRK and the Khmer Rouge began an armed struggle that displaced an estimated 600,000 Cambodians to refugee camps along the border with Thailand.

The last Vietnamese troops withdrew from Cambodia on 26 September 1989, and peace efforts began in Paris in 1989, culminating two years later in a comprehensive peace settlement, signed on 23 October 1991. Under the terms of the agreement, the United Nations was given authority to supervise a cease-fire, repatriate displaced Cambodians along the border with Thailand, disarm and integrate the factional armies into a national force, and prepares the country for free and fair elections. The initial United Nations mission, the UN Advance Mission In Cambodia (UNAMIC) arrived in November 1991. The United Nations Transitional Authority in Cambodia (UNTAC) took over from UNAMIC in March 1992 and began full-scale repatriation of refugees. Prince Norodom Sihanouk was restored as king in 1993. Elections for a constituent assembly took place in May 1993, and a coalition government followed under a new constitution.

Thus, at the time of the ICPD in 1994, Cambodia was just at the cusp of a new era of independence and transition to democracy. In 1997, a special tribunal for prosecuting the crimes of the Khmer Rouge regime was established. Fresh elections were held in 1998, and a new coalition government took over. In 2003, new elections resulted in

the victory of one of the parties of the coalition, the Cambodian People's Party, and its majority in the National Assembly was increased in 2008. New elections are expected in 2013. In October 2004, King Norodom Sihanouk abdicated in favour of his son Norodom Sihamoni; the former king died in October 2012.

Cambodia remains a low-income country. According to the Ministry of Planning, per capita gross domestic product (GDP) was \$931 in 2011, (*Progress Report, p. 3*). The Royal Government of Cambodia, with a large amount of assistance from international development partners, spent most of the 1990s trying to rebuild the devastated country. Since the beginning of the century, it has been possible to take up more substantive development work, and this is reflected in the ICPD indicators that are highlighted below.

Partly because of the low base, Cambodia has experienced rapid economic growth—averaging 6.3 per cent a year during the period 1990-2010, according to the World Bank, with gains in the areas of garment manufacturing, construction, agriculture, and tourism, (*World Bank Development Indicators Online, 2012*). This was especially true for the period 2004-2007 when GDP grew by more than 10 per cent a year, but the country was affected by the global downturn that started in 2008, with growth in the Cambodian economy dropping to near zero in 2009, (*NSDP 2012 Annual Progress Report, p. 3*). The economic gains may well be fragile because of the concentration of economic activity in just a few sectors. For example, the 5 per cent of the workforce in the garment industry supply 70 per cent of the country's exports. This could change with the discovery of mineral resources, a growing market for raw rubber, efforts to increase agricultural exports such as rice, and the expansion of tourism.

The Cambodia Development Resource Institute (CDRI) estimates that Cambodia could reach lower level of middle income status by around 2016 if the economy were to grow at a high rate of 9 per cent a year (more than at present), by 2018 under the medium growth scenario of 7 per cent a year (more in line with current trends) but not until 2024 under a low-growth scenario of 5 per cent a year, all other things being equal, (*Annual Development Review 2011-2012, CDRI, p.4*).

Cambodia's economic development is predicated on encouraging capitalism through a market economy. However, the Government's development policy framework, the "Rectangular Strategy" is also designed to spread the benefits of economic growth and to support the least advantaged members of national society. The Rectangular Strategy aims to: (a) achieve rapid growth in the economy; (b) alleviate poverty and achieve the goals for social development laid down in the Cambodia Millennium Development Goals (CMDGs); and (c) create and sustain institutions of good governance.

## II. POPULATION AND DEVELOPMENT

According to the UNFPA Cambodia country office, “The country is at the beginning of entering the demographic window of opportunity which opened in 2011. Over the next 40 years there will be a low dependency ratio which will remain favorable until 2055. At that time there will be 24 million people in Cambodia of which 10 per cent are age 65 and over. With this demographic change and the economic development focused on Phnom Penh, the urbanization will reach 40 per cent. Rural subsistence farming will gradually be taken over by large scale farming for food exports”, (*UNFPA situation analysis, August 2012*). The population dynamics informing this analysis are the focus of the country’s planning and development efforts in the coming years.

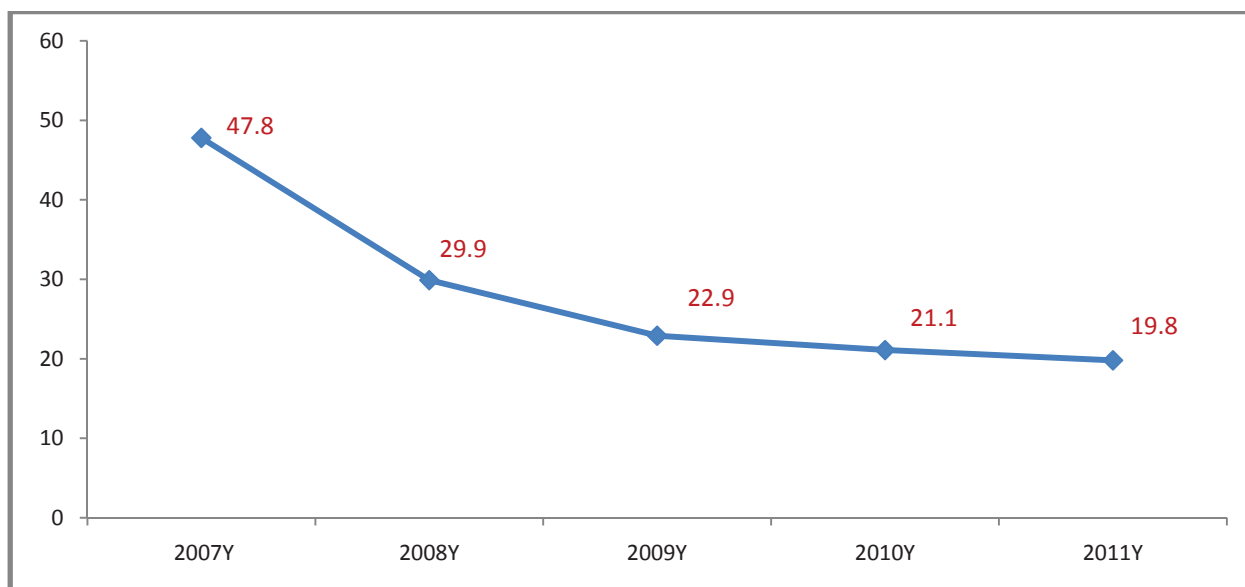
In terms of population dynamics, the major issues, which will be looked at in this report, are the large youth population, gender imbalances in certain age groups resulting from recent history, and migration (both internal and international). An issue that does not currently have the same urgency as in some neighboring countries, such as Thailand and Viet Nam, is ageing, but this will become more pressing as the population growth rate slows and life spans increase.

In terms of integrating population issues into development strategies, Cambodia has a National Population Policy (NPP) dating in 2003; National Poverty Reduction Strategy (NPRS) that was put in place for the years 2003-2005. Those two document was later incorporated into the National Strategic Development Plan 2006-2010 and its update (2009-2013). The country established a National Committee for Population and Development in 2001.

### 2.1. Population, Sustained Economic Growth and Sustainable Development

The ICPD endorsed the view that persistent widespread poverty and social and gender inequities are influenced by demographic factors such as population growth, structure and distribution. The Programme of Action sought to integrate population concerns fully into development strategies and into all aspects of development planning with the aim of fostering sustained economic growth, promoting social justice and helping to eradicate poverty.

The rapid economic growth that Cambodia has experienced since the 2000s and the Government’s economic policies have had a measurable impact on poverty in Cambodia. The country’s poverty rate has been reduced from 47.8 per cent in 2007 to 22.9 in 2009, 21.1 per cent in 2010 and 19.8 per cent in 2011, (*Poverty in Cambodia: A New Approach, p. 4*). Therefore the country is well on the way to reaching the CMDG goal of halving the proportion of people living under poverty line to 19.5 per cent by 2015.

**Figure 1: Poverty rate for different year, using the new poverty line of 2009**

Source: *Poverty in Cambodia: A New Approach, Redefining the poverty line, MoP April 2013*

One contributory factor in achieving the results in poverty reduction have come about through the Programme on Identification of Poor Households, which has helped the Government to target programmes to reach the most vulnerable. Among these other services was the establishment of a national Health Equity Fund in 2009, which has the aim of providing free health services to the poor.

In contributing to reach the Millennium Development Goal of reducing by half the proportion of people suffering from hunger, the Council for Agriculture and Rural Development (CARD) has set up a system that assembles, manages, analyzes and disseminates information about people who are food insecure and/or malnourished, or are at risk. It helps identify, locate and estimate the number of the food insecure and vulnerable in order to understand the causes of food insecurity and vulnerability and to find solutions.

One of the measurable results of improved economic conditions, reduction of poverty and greater access to health services since 1993 is that, according to the United Nations Population Division (UNPD), life expectancy at birth of Cambodian population has risen from 55.8 years in 1995 to 61.5 in 2010; the increase was from 54 years to 60 for men and from 57 to 63 for women, (*World Population Prospects, 2010*). This percentage increase of over 10 per cent in 15 years is higher than regional countries.

## 2.2. Population Distribution, Urbanization and Internal Migration

The ICPD Programme of Action says that the process of urbanization is intrinsic to economic and social development, but it calls for a more balanced distribution of population by promoting sustainable development in both major sending and receiving areas. Such development should be ecologically sound and promote economic, social and gender equity. One aim should be to reduce the various factors that push people to migrate.



The urban population in Cambodia has been increasing steadily since 1990. According to the United Nations Population Division, it has gone up from 12.6 per cent of the total in 1990 to 16.9 per cent in 2000 and 20.1 per cent in 2010. However, the rate of growth is expected to increase more rapidly in the future, reaching 23.8 per cent of the total in 2025 and 37.6 per cent in 2050, (*World Population Prospects, 2010*).

The growth of the urban population has not been matched by an improvement in the urban environment. It is estimated by UN Habitat that 79 per cent of all urban dwellers were living in slums in 2005, (*UN Habitat, Global Urban Observatory, 2009*). The Government has established the Partnership for Urban Poverty Reduction, in cooperation with UN Habitat, to work to reduce poverty, vulnerability and social exclusion through directly empowering slum communities in Phnom Penh to improve their access to affordable basic services and better living environments with the goal of achieving the target of “improving 100 slum-squatter settlements per annum.”

An important survey on internal migration in Cambodia was undertaken during 2011 by the Ministry of Planning with the support of UNFPA. It was published in August 2012 as Migration in Cambodia: Report of the Cambodian Rural Urban Migration Project (CRUMP). Among its major findings was that the city of Phnom Penh more than doubled in the ten years between 1998 and 2008, growing from 570,000 residents to 1,240,000, an extraordinarily high rate of growth of 8 per cent a year, and 80 per cent of this growth was fuelled by migration, (*2012 CRUMP Report, p. 18*).

The findings of the rural-urban migration project indicate the challenges faced by Cambodia and its Government in dealing with large-scale migration to cities, particularly to Phnom Penh, and the converse problem of coping with rural depopulation that leaves villages with a skewed population of very young and very old people. As indicated above in the statistic concerning urban slums, the study shows that “careful urban planning is needed to avoid haphazard urbanization”, (*2012 CRUMP Report, p. 94*). Likewise, the issue of rural outmigration has meant that 90 per cent of villages in Cambodia have seen a decrease in population in the last decade, with implications for support services for elderly populations left behind, (*2012 CRUMP Report, pp. 94-94*).

The Government is attempting to address the challenges posed by rapid urbanization. Through the Reclassification of Urban Areas in Cambodia, 2011, and the National Policy on Spatial Planning of the Kingdom of Cambodia, 2011, the Government has designated urban areas in which those districts of the country that meet certain criteria are subject to urban planning policies and regulations. Spatial plans have been developed for Battambang and Siem Reap cities and for the country’s coastal areas, based on the National Strategic Plan for Integration of Coastal Areas, with support from the Japanese Government. This now needs to be expanded to all cities in the country.

### 2.3. International Migration

The ICPD Programme of Action says that orderly international migration can have positive effects on both communities of origin and those of destination. It does, however, call on governments to make remaining in one's own country a viable option for all people. Cambodia has a net international migration rate (per 1,000 population) of -3.7 and workers' remittances account for 2.8 per cent of GDP in 2011, (*World Population Prospects, 2010, and Asian Development Bank, (Key Indicators for Asia and the Pacific, 2012)*).

In 2010, the Ministry of Labour and Vocational Training (MoLVT) adopted the Policy on Labour Migration for Cambodia. In 2011, the Ministry issued Sub-decree No. 190 on Sending Cambodian Workers to Work Abroad, which protects the interests of Cambodian workers abroad and gives authority to Ambassadors of the Royal Government of Cambodia to represent the interests of Cambodian workers in receiving countries and to facilitate assistance to workers in need. However, the Ministry of Labour and Vocational Training reports that it does not have the resources to make all Cambodian workers outside of the country aware of their rights and to publicize means of recourse against abuses. This is particularly an area of concern with women who migrate for work, who are at particular risk for abuse.

### 2.4. Population, Development and Education

In recent years, as has been demonstrated in the section above on fertility, Cambodia's total fertility has declined rapidly. Given the earlier, higher mortality levels, that means that the proportion of elderly (60+) is a slight increase 6.34% in 2008, but this proportion is likely to reach 11.01% in 2030 because of the life expectancy of the population has started increasing. The largest part of the population is in the most productive age group (15-59 years) increased from 51.93% in 1998 to 59.85% in 2008, and this trend is likely to reach to 63.92% in 2030. That means that Cambodia has already started to reap the benefits of the "demographic bonus", when declining fertility means that a large part of the population is in its peak years of productivity. However, the population momentum of previous years means that the population below age 15 is still quite large—31.9 per cent in 2010. It is this generation that will give Cambodia its best opportunity of taking advantage of the demographic window of opportunity, which started some time before the 2008 census and is estimated to last until about 2038 (*Integration of Demographic Perspectives in Development, Cambodia, MoP 2013, p. 10*).

However, this era of opportunity is predicated upon having a highly productive population in terms of health and education. In order to realize these benefits, current educational statistics indicate that Cambodia will have to make a special effort to educate its population to levels commensurate with that of most of its neighbors. Education is the key to gains from the demographic dividend, and currently Cambodia is lagging.

The ICPD Programme of Action states that education is a key factor in sustainable development. It is a component of well-being and a means to enable the individual to gain access to knowledge. It also helps to reduce fertility, morbidity and mortality

rates; empower women; improve the quality of the working population; and promote genuine democracy. It further states that the increase in the education of women and girls contributes to women's empowerment, to postponement of marriage and to reductions in family size. When mothers are better educated, their children's survival rate tends to increase.

The UNFPA Cambodia country office has reported that "the lack of national capacity, which is a legacy of years of civil strife, is of an immediate concern. The poor quality of training, the absence of higher education perspectives, with an overall lack of skilled workforce places the country at a human capital deficit. However, the demographic changes with a younger population, which is less traumatized, better informed, having different expectations may form an important counterweight to broaden that democratic platform", (UNFPA situation analysis, August 2012).

The literacy rate among the population 7 years old and above has increased from 67.4 per cent in 2004 to 72.7 per cent in 2009. The net enrolment rate for girls in primary school has reached 96 per cent, while the dropout rate for girls in primary school has declined to 8.7 per cent.

These figures reflect recent gains in the education system. However, Cambodia is still burdened with legacy of an educational deficit during the last quarter of the twentieth century. In 2007, for example, 53 per cent of men and 76 per cent of women aged 25+ had had no schooling or an incomplete primary education, while only 3 per cent of men and 1 per cent of women had post-secondary or tertiary education. However, the situation is changing rapidly—the completion rate at primary school went up from 46 per cent for males and 35 per cent for females in 1999 to 87 per cent for both sexes in 2010. In the case of completion rate at primary school, the CMDG is targeted to reach 100 per cent by 2015, which may not be attainable. The problems in achieving 100 per cent completion have strong regional dimensions. In order to achieve results in post-primary education, it will require a "quantum shift", (*2011 CMDG progress report, p. 14*).

Achieving the MDG target of parity among males and females at upper secondary level is not likely to be achieved even though there have been some advances; in 2004, it stood at 80.3 and reached 83.3 in 2009 (attending school). The picture at tertiary level is better; it was 86.7 per cent in 2009 and is likely to reach 100 per cent by 2015. However, only 3-4 per cent of persons aged 15-24 are in post-secondary institutions.

The public expenditure on education as a percentage of GDP more than doubled between 1999 and 2010, from 1.0 per cent to 2.6 per cent, but it is still low. Gender parity has been reached in primary education while the ratio is 100:90 in secondary education and 100:50 in tertiary education.

The Ministry of Women's Affairs reports that the obstacles to guaranteeing education for girls still include such factors as the lack of value that parents place on the education of girls, the lack of female role models in the community to encourage girls to continue their education. Problems faced by the girl child in terms of access to health

care, a safe environment, education and future opportunities are not seen by community and local authorities as being priorities because the challenges are “viewed as the normal state of affairs”, (*MoWA responses to ICPD Global Survey, p. 102*).

These issues concern particularly girls in the education system but many apply to boys as well. Cambodia’s greatest development challenge remains the need to develop its human capacity. Fortunately, the Government has recognized this need and has placed capacity development at the center of its National Strategic Development Plan, which is being developed for the years 2014-2018, which will position the country in addressing the post-2015 development agenda.

## 2.5. Protection of the Vulnerable

The ICPD Programme of Action states that policies and laws should ensure that all social and development policies provide support and protection for families, especially the most vulnerable, such as single-parent families. In recent years, the Royal Government of Cambodia (RGC) has begun the design and implementation of programmes to meet this commitment. The chief policy document is the Social Protection Strategy for the Poor and Vulnerable (2011-2015). However, the Government does not have adequate financial resources to provide extensive social support networks. The main financial support programme is the Emergency Relief Programme, which is a collaborative effort between the central government and local communities to supply emergency assistance, both monetary and in kind, to destitute families and individuals in need, including for female-headed households.

In terms of addressing inequities in access to health by poor families, the Government has adopted several schemes including user fee exemptions, government-subsidized payments, the Health Equity Fund, the voucher scheme for reproductive health, and community based health insurance. All of these have grown. In 2008, 44 referral hospitals participated in the health equity fund while 64 did so in 2012, while the number of participating health centers had increased almost four fold from 101 to 370. In 2012, of 79 health “operational districts”, 64 had the Health Equity Fund. The reproductive health voucher scheme is much smaller with only nine operational districts taking part in both 2011 and 2012, when the scheme was operational, (*MMR, p. 18*). It is important to note that the Health Equity Fund is not a national insurance scheme, which does not yet exist, but a pro-poor policy, which leaves out the “near poor”.

## 2.6. Fertility, Mortality and Population Growth Rates

The ICPD Programme of Action set as a global objective the facilitation of the “demographic transition” as soon as possible in countries where there is an imbalance between demographic rates and social, economic and environmental goals. The population growth rate in Cambodia was severely skewed during the period of the Khmer Rouge due to excess mortality and reduced fertility. Following the end of that regime, the total fertility rate shot up quickly and threatened the development gains that were being sought. The 1998 census, for example, estimated that the total fertility rate (TFR) 1986 was very high at 6.0, (*Census, p.4*). Fortunately,

the RGC was persuaded that even though the country had just gone through a period of increased mortality it would not benefit from a rapidly growing population and instituted a national family planning policy, (*Prof. Eng Huot, personal communication, 3 May 2013*).

Since then, Cambodia has made remarkable progress in the 20 years since the ICPD. In terms of fertility, according to the United Nations Population Division the TFR has declined from 5.7 in 1990 to 2.6 in 2010, (*World Population Prospects, 2010*). The MDG target for TFR for 2015 is 3.0, so Cambodia has already achieved and surpassed the target.

The lower fertility rate has meant that annual population growth has declined from an average of 3.2 per cent a year in the five years 1990-1995 to 1.1 per cent from 2005-2010, (*World Population Prospects, 2010*). United Nations population projections forecast that the total population of the country will peak at around 19-20 million at mid-century and could then start to decline. This would, however, be an increase of 6 million Cambodians in the next forty years, over the present population of 14.1 million, and most of the increase will take place in the ten years, with a projected population of 17.4 million in 2020.

The CDHS 2010 showed slightly different results. It reported that the total fertility rate had declined from 3.4 live births per woman in 2005 to 3.0 live births per woman in 2010, (*CDHS 2010, p. xix*). Its analysis showed that the average Cambodian woman would give birth to 1.1 children by the age of 25 and 1.9 children by age 30. There was a marked discrepancy in rates in urban areas (2.2 births per woman) compared to those in rural areas (3.3 births per woman). The survey found that fertility was lowest in Phnom Penh (2.0 births per woman) and highest in the rural northeastern provinces of Mondulkiri and Ratanakiri, reaching 4.5 children per woman, (*CDHS 2010, p. 58,59*).

In spite of these discrepancies, the CDHS found that fertility has been declining throughout the country, in both rural and urban areas, in all provinces, at all levels of education and regardless of household income. The survey found that a comparison of the mean number of children ever born to women age 40-49 (4.2) with the TFR (3.0) would indicate an average decline in fertility of 1.2 children per woman in Cambodia over the past few decades. The differences between the level of completed and current fertility are of similar magnitude in both urban (0.9) and rural (1.1) areas and fertility declines were recorded in all provinces. The largest differences in completed versus current fertility were found in the two provinces of Kampong Thom and Kampong Speu (1.6 and 1.5 children, respectively), while the smallest decline was found in Prey Veng province – a decrease of 0.3 children per woman, (*CDHS 2010, p.59*).

The CDHS looked at the level of fertility declines among different age groups in Cambodia and found that Age-specific fertility rates calculated over time from the CDHS 2010 provide further evidence of a substantial decline in fertility at all ages. In the 5-9 years preceding the survey, however, fertility declines were proportionately greater for women age 30 and older than for women in the prime childbearing ages of

20-29 years. Women age 30 and above experienced at least a 22 per cent decline in fertility. In the five years preceding the survey, the decline in fertility (23 per cent) was greater for women age 35 and older. This pattern is common in populations experiencing a fertility decline. It occurs during a fertility transition when older women, who may be more likely to have reached their desired family size, make a greater effort to limit their births than do younger women, who are likely to have not yet reached their desired family size", (CDHS 2010, p. 60).

The CDHS also found that declines in fertility are slowing down. The biggest drop was recorded between 2000 and 2005 when TFR decreased by 0.6 children per woman while the decline was 0.4 children per woman between 2005 and 2010. These fertility declines were also greater in urban areas, 0.6 children per woman in cities as opposed to 0.2 children per woman in rural areas, (CDHS 2010, p. 60-61).

The determinants of fertility -- level of education and household income levels -- found in other parts of the world also hold true in Cambodia. In Cambodia, a woman with no education had a TFR of 3.7, which was 0.3 more children than a woman with a primary school education (TFR of 3.4), who has one child more than a woman with a secondary or higher education, a TFR of 2.4. Likewise, there are great discrepancies according to income, the poorest Cambodian women had the most children (4.5) while those in the upper fifth of income had 2.4 fewer children -- averaging 2.1 per woman, (CDHS 2010, p.59).

Another of the determinants of fertility is age of first sexual contact and age of marriage. Therefore, the CDHS examined several aspects of sexual initiation as a way of understanding the dynamics behind Cambodia's fertility patterns. The survey found that 62 per cent of the women interviewed were either married or were living with a male partner. The survey found that the median age of marriage for women was 20.3 years, which had remained stable over the preceding 20 years. Also of interest, the median age of sexual initiation for women was approximately the same (20.8 years) over the same time span. In the case of men, the median age of marriage was 22.6 and the initiation of sexual relations was 22.1. The age of sexual initiation for both women and men is relatively late and could be one of the explanations for the decline in fertility. There were distinct patterns in age of marriage and sexual initiation, which mirror those in fertility rates. That is, women who lived in urban areas and women with higher levels of education had their sexual initiation and married later than corresponding women in rural areas and lower levels of education, (CDHS 2010, p.xix).

Early onset of childbearing is also an important determinant of fertility in that women who have their first child at an early age frequently have a longer reproductive span and a higher level of fertility. In Cambodia, the median age for first birth is 22.3 for all women age 25-49, with rural women starting about two years sooner than urban women. At 24.8, Phnom Penh has highest median age at first birth while the two northeastern provinces of Monduliri and Ratanakiri have the lowest -- 21.0. The CDHS did find that there was a correlation between level of education and age at first birth, but the difference only manifested itself with women who had a secondary or

higher education, with no difference being shown between women with no schooling and those that had just a primary education. Also, the survey found no differences at age of first birth between women of different income levels, (CDHS 2010, p.65).

## 2.7. Population Ageing

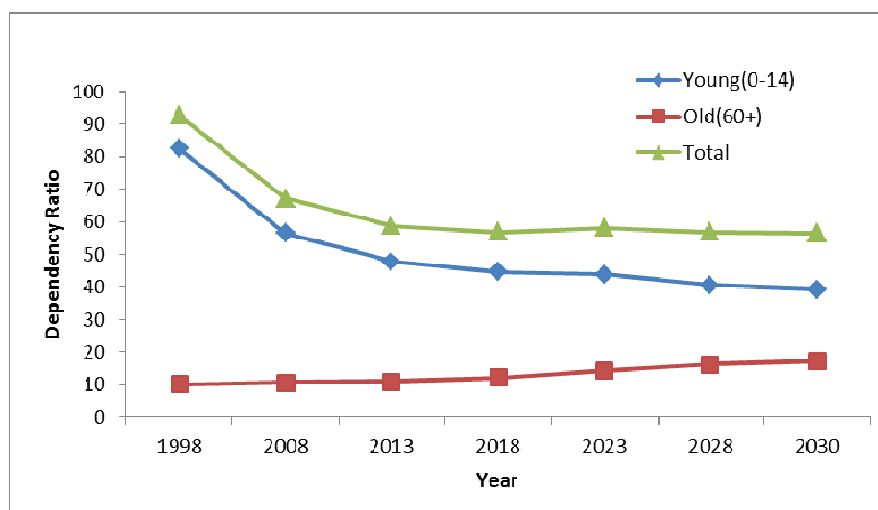
Like almost all countries in Asia, Cambodia's elderly population will increase rapidly as life expectancies rise, and fertility and mortality rates fall. According to a joint report by UNFPA and the international NGO Help Age International, the proportion of the population aged 60+ in Cambodia will grow from 6.6 per cent in 2012 to 19.0 per cent in 2050, (*Ageing in the twenty-first century: A Celebration and Challenge*, UNFPA, p. 170).

“Until recently, Cambodia like other developing countries in ASEAN countries, had a young age structure with the median age remaining at about 18.1 to 21.9 years from 1998 to 2008, and increasing marginally to 22.3 years in 2009. However, the projections suggest that the country is gradually but surely transitioning away from a young age structure with a steady increase in the median age to 28.3 years by 2030, (*Demographics of Population Ageing in Cambodia 2012*, MoP/NIS, p. 9).

“The index of ageing is the shift in the balance between the child and older populations and is expressed as the number of persons above 60 years for every 100 children below the age of 15 years. In Cambodia, the index of ageing increased slowly between 1998 and 2008, but is expected to increase more rapidly in the following 22 years. In 2008, the index of ageing was 18.7 elderly persons for every 100 children but this number is projected to increase rapidly to 43.9 elderly persons for every 100 children by 2030, (*Demographics of Population Ageing in Cambodia 2012*, MoP/NIS, p.9-10).

“While the young age (below 15) dependency ratio is expected to decrease from 56.5 per cent in 2008 to 39.2 per cent by 2030, the old age dependency ratio shows an increasing trend and is expected to increase from 10.6 per cent in 2008 to 17.2 in 2030”, (*Demographics of Population Ageing in Cambodia 2012*, MoP/NIS, p.12).

**Figure 2: Dependency Ratios, Cambodia, 1998-2030**



*Source: NIS, Demographics of Population Ageing in Cambodia, 2012*

The ICPD Programme of Action called upon governments to develop social security systems that ensure greater equity and solidarity between and within generations and that provide support to elderly people through encouragement of multigenerational families. Governments should also seek to enhance the self-reliance of elderly people so that they can lead healthy and productive lives and can benefit society by making full use of the skills and abilities they have acquired in their lives. Governments were called upon to strengthen formal and informal support systems and safety nets for elderly people and eliminate all forms of violence and discrimination against them.

The RGC is just beginning to tackle these issues. The Government set out a Policy for the Elderly in 2003, and the Department of Elder Welfare was established in 2011 under the Ministry of Social Affairs, Veterans and Youth Rehabilitation. Under its auspices, several policies have been developed, e.g., “Guidelines on Establishment and Management of Older People’s Associations” and the “Guideline on Home Care of Elderly People. In order to involve the elderly in the decisions that affect their lives, the Government has established the National Committee for Elderly People to provide input and advice on government policies impacting on the elderly.

The issues related to the elderly are integrated in the National Social Protection Strategy for the Poor and Vulnerable (2011-2015). The Government has begun to set up some social schemes to protect the elderly, especially for those who cannot depend on their families. For example, the national pension scheme provides for an annual pension of 20 per cent of base salary, and the Ministry of Health’s Health Equity Fund provides for the provision of health services to the indigent elderly. However, all of this is relatively new and there is a lack of research on what effects these programmes have had and what the gaps needed to be addressed. Since Cambodia’s elderly population is only now beginning to grow at a more rapid rate, the Government has time to begin to address these issues comprehensively, but it needs to start planning from now.



### III. GENDER EQUITY, EQUALITY AND EMPOWERMENT

#### 3.1. Empowerment and Status of Women

The ICPD Programme of Action says that the empowerment of women and improvement of their status are important ends in themselves and are essential for the achievement of sustainable development. The objectives that it cited were to achieve equality and equity between men and women and enable women to realize their full potential; to involve women fully in policy and decision-making processes and in all aspects of economic, political and cultural life as active decision-makers, participants and beneficiaries; and to ensure that all women, as well as men, receive the education required to meet their basic human needs to exercise their human rights.

In international rankings of gender equality, Cambodia's Gender Inequality Index value is 0.473, putting it at number 96 in a ranking of 147 countries (*Human Development Report 2013, p. 156*). This requires the country to intensify its efforts in reducing gender inequality.

The RGC is well aware of the challenges faced by the country in this area and has established several institutional mechanisms for promoting gender equality and the empowerment of women: the Ministry of Women's Affairs (1993) with provincial Departments and district offices of Women's Affairs; the Cambodia National Council for Women (2001), the Technical Working Group on Women (2004), the Gender Mainstreaming Action Groups in each of the line ministries (2005), Commune Committees for Women and Children (2005), and Women and Children Consultative Committees at provincial and district levels (2010).

A notable achievement of the RGC in terms of promoting the goals of the ICPD Programme of Action to foster gender equity and equality and to empower women has been the adoption of three successive five-year strategic plans for "Gender Equality and the Empowerment of Women in Cambodia"—Neary Rattanak I, II, and III (1999-2003, 2004-2008, and 2009-2013, respectively). The advantage of the three strategic plans was to combine the social, economic and legal goals for the empowerment of women into one comprehensive and holistic programme.

In terms of political participation, the proportion of women elected to the National Assembly increased from 5.8 per cent in 1993; 12.3 per cent in 1998; 19.5 per cent in 2003; and 21.1 per cent in 2008. The proportion of women elected to commune councils increased from 8 per cent in 2002 to 14.6 per cent in the 2007 elections and increased again to 17.9 per cent in 2012. In 2009, women comprised 10.1 per cent of provincial council members and 12.7 per cent of municipal council members, (*MoWA responses to ICPD Global Survey, p. 99*).

The proportion of seats held by women in the Senate is 14.8 per cent. Women were appointed as Deputy Governors in 24 municipalities/provinces in 2008 and in all 187 towns/districts/khans in 2009. The proportion of women members Provincial Board of

Governors is 10 per cent while the proportion of women on Provincial Boards of Governors is 28 per cent, (*MoWA responses to ICPD Global Survey, p. 99*).

However, the MoWA reports, “The main barriers in increasing participation in political bodies and the civil service have been the continuing lack of confidence in the abilities of women and the attitudes of mid-level managers. Women’s household burden often hinders them from taking a more active role. Attendance at the Royal School of Administration is often difficult because of distance and the fact that the program requires one year’s absence from home”, (*MoWA responses to ICPD Global Survey, p. 99*)

In the country’s MDG report for 2011, the advances that have been made were highlighted. However, the report questioned to what extent women exercised real power both in public administration and in governmental decision-making bodies. “Despite the Royal Government of Cambodia’s effort to reduce gender disparities... women’s position, whether in education, technical skills or public life, is yet weaker compared to that of men in Cambodia, (*MDG, p. 18*).

According to Neary Rattanak III: “Notable progress has also been achieved in strengthening the institutional mechanisms to support gender mainstreaming including the establishment of the Technical Working Group on Gender (TWG-G) as part of the Government-Donor Coordination Committee (GDCC); and formation of Gender Mainstreaming Action Groups (GMAGs) in nearly all line ministries. Gender Mainstreaming Action Plans (GMAPs) have been or are being prepared by many line ministries. Ten ministries have received national budget or donor support to implement [gender mainstreaming] activities in their plans.”

The key areas that were identified for improvement in Neary Rattanak III were women’s economic empowerment, gender and education, gender and health, violence against women, women in public decision-making and politics, and gender mainstreaming. Neary Rattanak III sets concrete targets in all of these areas for the year 2015. These include establishing parity in primary and secondary education between boys and girls, and 100:85 in tertiary education; establishing universal awareness that violence against women is wrongful behavior and a crime; increasing the proportion of women in the National Assembly to 30 per cent and the proportion of civil servants to 38 per cent. The action plan also aims to continue its work in mainstreaming gender into the action plans of all ministries, (*Neary Rattanak III, p. 8-11*).

According to the CDHS 2010, 27.1 per cent of Cambodian households were headed by women, (*CDHS 2010, p.11*). This large percentage highlights the economic vulnerability of women competing in an unfriendly labor environment whether they are sole sources of livelihood in a household or not. The Ministry of Women’s Affairs sees the need to empower women economically as one of its greatest responsibilities and challenges, realizing that many of the other goals of promoting gender equity and equality will be much easier to achieve if women have greater economic power.

These insights are applicable to the domestic area of Cambodian life as well. The 2010 Cambodian Demographic and Health Survey asked questions specifically designed to test the level of autonomous decision-making that women had in areas directly affecting their lives. It found that Cambodian women were usually involved in the three specific household decisions included in the survey, although the manner of how the decisions were made varied. About 45 per cent of women said they were empowered to make decisions concerning their own health care (which meant that more than half were not). Decisions about major household purchases and visits to the wife's family or relatives were usually made jointly by the husband and wife, the latter indicating that women did not have complete autonomy even in such a personal decision, (*CDHS 2010, p. 204*).

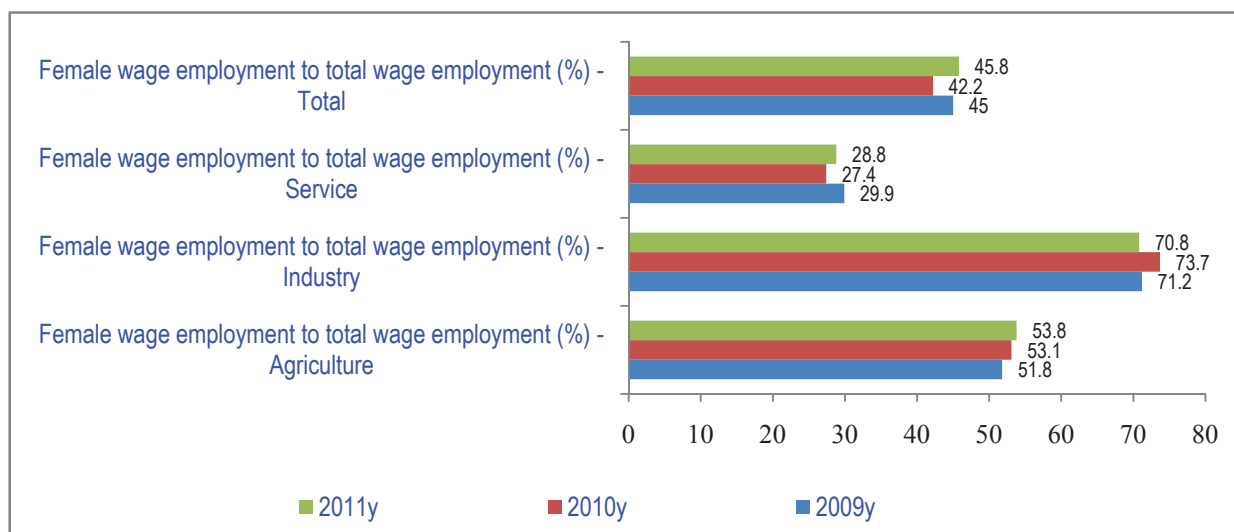
In order to improve the economic situation of rural women (and thereby tangentially increasing their decision-making powers), the Ministry of Women's Affairs has instituted an income-generation programme for rural women and economic livelihood improvement programme in the northeastern part of the country, which is the poorest region. National mechanisms have been established to promote economic empowerment of women including the National Committee on Technical Vocational Training, the National Employment Agency, Provincial Training Centers, Job Centers, and regional training centers established by different line ministries. The Ministry has established 13 Women's Development Centers and the Cambodia Women's Entrepreneurship Association. Through such programmes, women receive skills training and business support services in terms of increasing productivity, improving access to markets, and other management skills. The main barriers for women's economic empowerment have been the prevalence of low literacy rates of women, especially in rural areas, and the continuing lack of equal status for women in Cambodian society, (*MoWA responses to ICPD Global Survey, p. 98*).

A major impediment to gender equity and equality in Cambodia is differing education levels among women and men. There was only 73.6 per cent of Cambodian women were literate, an increase of 5 per cent from the 2005 findings, (*CDHS 2010, p. 43*). The level of completion of secondary school is low throughout Cambodian society, but there is a significant discrepancy between men (7.4 per cent) and women (3.6 per cent), (*CDHS 2010, pp. 12, 13*). In terms of current enrolment rate, the Cambodia Socio-Economic Survey has found that the ratio of females to males in the age group 11-17 attending school is slightly above 90 per cent (91.5 per cent in 2009, 95.8 per cent in 2010 and dropping to 92.7 per cent in 2011, (*NSDP 2012 Annual Progress Report, p. 20*).

One of the empowering agents for women is economic autonomy, and there is a significant number of Cambodian women who are engaged in wage employment, as defined by the Cambodia Socio-Economic Survey (CSES) 2010, reaching 45.8 per cent of all wage employees in 2011. Women are the vast majority of wage workers in industry, because of the importance of the garment industry in Cambodia –70.8 per cent of total industrial wage earners were women in 2011, according to the CSES. The percentages were about equal in the agricultural sector (53.8 per cent women)

while women were unequally represented in the service sector (28.8 per cent), (NSDP 2012 Annual Progress Report, p. 21).

**Figure 3: % of Female Wage Employment, by Usual Status, Sectors, and Years**



Source: NSDP 2012 Annual Progress Report, p. 21

### 3.2. Gender-based Violence

Another major area of concern for the Ministry of Women's Affairs and the Government as a whole are the worrying statistics on domestic violence and gender-based violence overall. A survey conducted by the Ministry of Women's Affairs in 2005 found that 64 per cent of the sample knew of a husband who had acted violently against his wife and 22.5 per cent of the female respondents had suffered violence from their husbands. This does not show any significant change from surveys in 1996 and 2000, (*NAPVAW*, p. 4). According to one study by Partners for Prevention, 36 per cent of men who had ever been in a relationship with a woman reported having carried out at least one act of physical or sexual violence against a partner, (*Men, Gender and Violence Against Women in Cambodia, Fulu*, p.5). The same study found high levels of sexual violence: 8 per cent of men reported raping a woman who was not a partner, and 21 per cent reported rape of an intimate partner, (*Men, Gender and Violence Against Women in Cambodia, Fulu*, p. 5).

The CDHS 2010 gathered information on women's and men's attitudes toward wife beating, which was seen as a proxy for women's status. According to the report, "respondents were asked whether a husband is justified in beating his wife if she burns the food, argues with him, goes out without telling him, neglects the children, refuses to have sex with him, and asks him to use a condom. Nearly half of women (46 per cent) but only 22 per cent of men believe that a husband is justified in beating his wife for at least one of the six specified reasons. Only 8 per cent of women and 3 per cent of men believe that wife beating is justified if a woman asks for her husband to use a condom", (*CDHS 2010*, p. xxii).

The legal framework in Cambodia for eliminating violence against women includes such instruments as the ratification of the Convention on the Elimination of All Forms

of Discrimination Against Women (CEDAW) in 1992, the adoption of a Law on Prevention of Domestic Violence and Protection of the Victims in 2005 and the Law on Suppression of Human Trafficking and Sexual Exploitation in 2008.

In order to supplement the legal framework to combat what is seen as widespread domestic and other gender-based violence, the Ministry of Women's Affairs adopted a National Action Plan to Prevent Violence on Women, approved by the full Council of Ministers, in February 2009 for the period 2009-2012. By 2012, the National Action Plan intended to create a society free from violence, to promote gender equity and equality, to assist victims, to punish perpetrators spread the message throughout society that violence against women and in the family is not acceptable, to make law enforcers aware of laws and procedures, and set minimum standards for the provision of social services. The plan has been implemented by raising public awareness, improving services, improving policies and laws and by building the capacity of implementers.

The NAPVAW also works to establish Policy and Related Mechanisms to increase access to the courts and strengthen the criminal justice and educational policy for prevention of violence in school and community, (*NAPVAW, MoWA, p. 9*). This involves encouraging punishment for perpetrators of violence and protecting its victims, setting up violence prevention mechanisms in schools, promoting non-violent parenting skills, incorporating sex education into curricula, preventing sexual harassment in the workplace, training the police on the domestic violence and anti-trafficking laws, and improving information systems about violations.

One of the major concerns of the Ministry of Women Affairs (MoWA) is to see that the Government's legal, judicial and administrative framework actively promotes a violence-free society. This has entailed amending laws and related regulations so that there is an interlocking protection and prosecutorial framework that ensures women their physical and emotional well-being and to mainstream those gender concerns into all the national mechanisms of government institutions and civil society. This also means that programmes need to be put in place to strengthen the capacity of officials dealing with gender-based violence as well as civil society organizations that work to protect women.

In order to implement the legal framework, the National Action Plan on Violence against Women makes clear that "local authorities need clear instructions for intervention and protection at commune and village levels. Judges and court clerks need procedures and forms to issue protection orders. Police need clear guidelines for the prevention of violence especially for intervention in civil cases. Local authorities need to recognize that domestic violence is not acceptable and to recognize their roles and responsibilities in protecting victim", (*NAPVAW, MoWA, p. 5*). The laws are meaningless unless they are enforced.

The goals established for the first National Action Plan to Prevent Violence on Women proved to be over-ambitious and the framework to support it inadequate. For example, in spite of the best efforts of the MoWA and its governmental and civil society partners, the targets set out in the National Action Plan to Prevent Violence

on Women for institutional recourse to domestic violence abuses are not being met. In 2011 only 7 protection orders were issued by courts as opposed to a 2013 target of 120 and 185 victims received counseling in 2011, while the 2015 target is 2,000.

The MoWA reports that the main barriers to ending violence against women are: lack of public awareness concerning gender-based violence; acceptance of violence as a response to “wrong behavior” by women, men and local authorities; limited protection and counseling services available from professional service providers for victims of rape; limited access to services for victims of all forms of gender-based violence; reluctance of some victims to seek support from Non Government Organisations (NGOs) that work in the area of violence against women; lack of qualified staff at MoWA sufficient to respond to needs in the area of gender-based violence; and limited dissemination and understanding of relevant laws, (*MoWA response to ICPD Global Survey, p. 100*).

Taking into account the need to strengthen the national framework for combating violence against women, the MoWA is currently finalizing the process for developing a second National Action Plan to Prevent Violence against Women for the period 2013 to 2017. The new plan, still in draft, takes into account some of the shortcomings of the first plan by stressing the need for adequate budget allocations, a clear definition of roles by different branches of the government, better coordination and cooperation among partners, coordination at the sub-national level, and capacity development.

One of the main innovations of the draft second national plan is to increase the provision of services to survivors of violence against women through the concept of a “one stop service center” that combines police, health, legal aid, counseling and other social services. If such a service center is endorsed when the draft action plan is presented to the Government for ratification, along with the other recommendations in the new plan, and if resources are set aside for the operation of such service centers, this should go a long ways towards improving the national response towards violence against women and towards meeting the goals of the second national action plan by 2017.

## IV. REPRODUCTIVE AND SEXUAL HEALTH

In terms of achieving the MDG targets for reproductive health, Cambodia was estimated by the Asian Development Bank (ADB) to be on track for maternal mortality, and slow for both skilled birth attendance and antenatal care (one visit), (*ADB, Key Indicators*). Among the reproductive health indicators, the rate for family planning is lagging in that the Contraceptive Prevalence Rate (CPR) for modern methods was 35 per cent in 2010 while the CMDG goal is 60 per cent, (*CMDG 2011, p. 22*). The Government continues to update and implement its National Strategy for Reproductive and Sexual Health in Cambodia—the previous strategy extended from 2006 to 2012 and the current strategy will extend to 2016.

### 4.1. Family Planning

The ICPD Programme of Action called for actions to help couples and individuals meet their reproductive goals; to prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality; to make quality services affordable, acceptable and accessible to all who need and want them; to improve the quality of advice, information, education, communication, counseling and services; and to increase the participation and sharing of responsibility of men in the actual practice of family planning.

The CDHS 2010 revealed some very important information that shows that the use of family planning methods in Cambodia is spreading, and this is certainly one of the major reasons for the fertility decline discussed above. The CDHS found that “More than half (56 per cent) of currently married Cambodian women say they do not want any more children or they say they are sterilized. Another 25 per cent would like to wait at least two years before having their next child. On average, Cambodian women would like to have 3.1 children. Practically all Cambodian women are familiar with at least some methods of contraception. The daily contraceptive pill, the male condom, the IUD, and injectables are known to more than 95 per cent of married women. Seventy-five per cent of women knew at least one traditional method of family planning”, (*CDHS 2010, p. xix*).

The CPR for modern methods has increased from 27 per cent in 2005 to 35 per cent in 2010, but is still far from the MDG target of 60 per cent. According to the CDHS, 50.5 per cent of married women were currently using a contraceptive method in 2010: 34.9 per cent of who were using a modern method while 15.7 per cent were using a traditional method, (*CDHS 2010, p. 75*). Interestingly, the CDHS 2010 found that use of modern methods of contraception was more common in rural areas than in urban areas (36 per cent compared with 31 per cent), (*CDHS 2010, p. 77*). Also unexpectedly, use of modern methods did not vary much by level of education. Use of modern methods was highest in the province of Oudormeanchey on the border with Thailand (44 per cent) and lowest in Kratie in the east (24 per cent), (*CDHS 2010, p.77*).

The Ministry of Health's health management information system showed that of 581,901 women who obtained contraceptive from the public health system 51 per cent chose pills, 36 per cent used injections, 4 per cent used condoms (indicating that the concept of "double protection" is not being applied), 8 per cent used IUDs, 1 per cent chose Norplant implant, and only 0.12 per cent opted for tubal ligation, (*MoH, Quarterly Bulletin, May 2012*). As one indicator of the spread of family planning services, the number of health centers offering IUD service increased from a mere 133 in 2000 to 907 in 2012 while no health centers offered implant services as late as 2009 whereas 288 did so three years later, (*MMR, p. 14*).

The CDHS looked at the means by which users obtained their contraceptive supplies. For example, the majority of users of female sterilization, injectables, IUDs, and implants obtain their method from the public sector. On the other hand, of those who use contraceptive pills, a significant proportion, 31 per cent, obtain them from the private sector, mostly from pharmacies, while 43 per cent rely on the public sector, mostly health centers. In the case of male condoms the majority (53 per cent) are obtained from the private sector while 47 per cent are procured through the public sector, (*CDHS 2010, p. 81*). These research findings have important implications as the Government looks at ways of expanding the use of modern contraception.

The unmet need for contraception has declined from 25 per cent in 2005 to 17 per cent in 2010, with a goal of reaching 10 per cent by 2016. According to the CDHS, "Just over half (53 per cent) of currently married women who are using a contraceptive method say that they intend to use a method in the future. Seventeen per cent of currently married women have an unmet need for family planning. That is, they do not want any more children or they want to wait at least two years before their next birth, but they are not currently using a method of contraception. The unmet need for limiting births (11 per cent) is higher than the unmet need for spacing births (6 per cent). Unmet need is especially high among women in the lowest wealth quintile and among women with a primary education or no schooling. Currently, 76 per cent of the total need for family planning is being met" (*CDHS 2010*). The CDHS reported that there were missed opportunities for increasing the use of family planning in that the number of visits by family health field workers had not increased between 2005 and 2010, (*CDHS 2010, p.85*).

The big need is to ensure the continued supply of contraceptive commodities. Up to now, the commodities that were supplied through the public health system had all been financed by donors, particularly the German Government through its development agency. This funding stream ended in 2012 and was taken up by UNFPA using funds made available by AusAID, but this funding will end in 2015. To date, the Government has not decided to allocate resources for contraceptives or even to set up a separate budget line within the Ministry of Health budget. If funding does not become available to ensure contraceptive supplies, the impressive gains in family planning will almost certainly be lost, and the MDG goal of a modern contraceptive prevalence rate of 60 per cent will remain elusive.



## 4.2. HIV/AIDS

HIV prevalence in Cambodia peaked at 1.7 per cent in the years 1998-1999, declined to 1.2 per cent in 2004, and then declined significantly to reach a projected 0.7 per cent in 2012, (*Estimation of the HIV Prevalence among General Population in Cambodia, NCHADS, p. 31*). In terms of the MDG of halting the spread of HIV and reversing its incidence, the goal has been met. In terms of reaching the Cambodia-specific target of reducing the adult prevalence of HIV to 0.4 per cent, which is not likely by 2015, (*CMDG, p. 24*). Also, in terms of therapy, the goal to increase the percentage of people with advanced HIV infection receiving antiretroviral combination therapy from 3 per cent in 2002 to 75 per cent in 2015 has been surpassed, with 97 per cent of eligible persons receiving treatment at the end of 2010, (*Annual Report 2010, NCHADS*).

The current Strategic Plan for HIV/AIDS and STI Prevention and Care is for the period 2011-2015. It is being implemented, among others, by the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) of the Ministry of Health and the National AIDS Authority. The strategic plan provides voluntary confidential counseling and testing for HIV within family planning services, behavior change communication on HIV along with sexual and reproductive health services, prevention of mother-to-child transmission of HIV within maternal health services, anti-retroviral treatment for persons infected with HIV, and for STI and HIV prevention programmes, especially for most-at-risk populations and young people.

One of the reasons that Cambodia has made strides in reducing its HIV prevalence rate is because of its success in linking the reproductive health programme with HIV/AIDS prevention and services. A pilot project for linking reproductive health, HIV and STD services was undertaken in 2001, was adopted in 2005, and was expanded nationally in 2009 based on cooperation between the National Maternal and Child Health Center (NMCHC) and NCHADS. The Ministry of Health issued “Standard Operating Procedures to Initiate a Linked Response for Prevention, Care, and Treatment of HIV/AIDS and Sexual and Reproductive Health Issues”. With the assistance of the Global Fund for HIV/AIDS, Tuberculosis and Malaria, a community health education and outreach programme has been put in place linking reproductive health, HIV and STDs. As part of the linked response between the National Maternal and Child Health Center and NCHADS, all pregnant women receive free HIV counseling and testing, using an opt-out approach. Along with other prevention programmes, this has resulted in notable advances in reducing HIV prevalence among pregnant women attending ante-natal care clinics: from 1.8 per cent in 1996 to a high of 2.9 per cent in 1999, falling to 0.9 per cent in 2006 and 0.46 per cent in 2010, (*Estimation of the HIV Prevalence among General Population in Cambodia, NCHADS, p. 12*). Given the cost of the screening programme and the current low rate of infections, the Ministry of Health is exploring the option of changing the policy that calls for all pregnant women to be tested for HIV during the first antenatal care visit and at the time of delivery. If adopted, a new policy would only test women in areas with high levels of infection.

One of the areas where the linkages between HIV/AIDS and reproductive health were examined was in a 2009 Ministry of Women's Affairs report on "Violence Against Women". One of the more disturbing findings of the survey was that the fact that the husband had an STD was seen as a justifiable reason for a woman to refuse to have sex with her husband by only 35 per cent of female respondents (41 per cent of males) while HIV/AIDS as a cause for refusal was even lower—35 per cent of men and 32 per cent of women, (*Report on VAW 2009, MoWA, p. 61*).

The CDHS 2010 looked at the prevalence of sexual practices that contribute to the spread of HIV. It found that almost no women and less than 2 per cent of men reported having had two or more sexual partners during the preceding 12 months. Disturbingly, however, of the men who had had multiple partners only 40 per cent reported wearing a condom at last sexual intercourse. In terms of commercial sex, 11 per cent of men reported ever paying for sex, and 4 per cent reported paying for sex in the 12 months preceding the survey. Of those men who did report having paid for sex in the preceding year, only 82 per cent of them reported using a condom during the last such encounter, (*CDHS 2010, p.xxii*).

The CDHS found that Cambodians were well informed about HIV and AIDS. In the sample they surveyed, 75 per cent of the women and 80 per cent of the men (aged 15-49) were able to tell the interviewer of the two major deterrents to sexual infection: using condoms and limiting sexual intercourse to one uninfected partner. However, the survey also found that there were many misconceptions that were still prevalent. "Only 63 per cent of women and 61 per cent of men know that a healthy-looking person can have the AIDS virus, and only 71 per cent of women and 75 per cent of men know that AIDS cannot be transmitted by mosquito bites," (*CDHS 2010, p. xxii*). The linking of reproductive health and HIV programmes seems to have had a pay-off in that almost 90 per cent of women were aware that HIV could be transmitted through breastfeeding, (*CDHS, p. xxii*). However, only 58 per cent knew about the ability of anti-retroviral drugs to reduce this transmission risk so there is much awareness-raising yet to be done.

HIV testing is relatively low in Cambodia. In the interviews conducted by CDHS in 2010, about 7 of 10 men and women know where to get an HIV test, but only 23 per cent of women and 24 per cent of men had actually had an HIV test and had learned the results, (*CDHS 2010, p. xxii*). However, as a result of the linking of reproductive health services with HIV prevention, a much higher percentage of pregnant women were aware of their HIV status - 57 per cent in 2010 compared to only 5 per cent in 2005, (*The Situation and Response Analysis on HIV/AIDS Epidemic in Cambodia 2008-2010, NAA*). Of HIV-positive pregnant women, in 2010 49 per cent received anti-retroviral drugs to reduce the risk of mother-to-child transmission, compared to only 4 per cent in 2005, (*UNAIDS, Glance, p. 2*).

Among these favorable trends in terms of HIV infection among the general population in Cambodia, HIV prevalence among high risk groups remains, of course, much higher. According to NCHADS, among female entertainment workers with more than seven sexual clients per week, the prevalence rate was 14.0 per cent in 2010,

(*Estimation of the HIV Prevalence among General Population in Cambodia, NCHADS, p. 11*). Among men who had sex exclusively with men the prevalence rate was 2.1 per cent and among men who had sex with men and women, it was 2.2 per cent, (*Estimation of the HIV Prevalence among General Population in Cambodia, NCHADS, p.13*). The most recent data for injecting drug users is not as recent, dating to 2007, but at that time the study showed a prevalence of 24.4 per cent, (*Estimation of the HIV Prevalence among General Population in Cambodia, NCHADS, 2010*).

Complicating the issue of preventing HIV among sex workers was the adoption by the Government of the Law on Suppression of Human Trafficking and Sexual Exploitation in 2008. Article 24 of that law punishes those who “willfully solicit another in public for the purpose of prostituting himself or herself”. The result of the enactment of the law was to close down brothels, which had previously been the target of a successful “100 per cent condom use” programme, with consistent condom use reaching 96 per cent in 2004 among direct sex workers, (*Estimation of the HIV Prevalence among General Population in Cambodia, NCHADS, p.15*). Following 2008, sex workers moved to more informal venues, such as karaoke bars and beer gardens. Therefore, the programmes aimed at and collecting data on direct sex workers were no longer possible, and the terminology shifted to “entertainment workers”. Because the police have had difficulty in interpreting the new law, women who were found to carry condoms have been subject to arrest, which at least one study has found has resulted in lower condom use in transactional sex, (*Annual Progress Report 2010, PSI*).

Likewise, a “Community Safety Policy” has targeted drug users, which has made it more difficult for drug users to access services. The latest data on drug use is now dated, going back to 2007, but it shows that reported sharing of needles at last injection reached 35 per cent, (*NCHADS, Drug User Survey*). More recent estimations by NCHADS would indicate that about 11 per cent of new infections in 2012 would come from that form of transmission, (*Estimation of the HIV Prevalence among General Population in Cambodia, NCHADS, p. 41*). The relatively low percentage is probably a reflection of the low level of injecting drug use in Cambodia. However, the use of methamphetamines is much higher, and a new sentinel surveillance report, not yet released, is reported to show that HIV prevalence among such users, while not a direct route of transmission, is escalating rapidly.

Interestingly, the rate of new transmissions among men who have sex with men is quite low, accounting for only about 1 per cent of estimated new HIV cases in 2012, (*Estimation of the HIV Prevalence among General Population in Cambodia, NCHADS, p. 41*). This would strongly indicate that condom promotion campaigns among these men have been successful. This is also shown by data that give the prevalence rate among men who have sex with both men and women to be 14.3 per cent among men 35 and older while it is only 3.5 per cent for men 25-34 years of age and 0.8 per cent for men younger than 25, (*Estimation of the HIV Prevalence among General Population in Cambodia, NCHADS, p. 14*).

As part of the “Three Zeros” strategy to combat HIV (no new infections, no deaths, and no lack of drugs), NCHADS has actively promoted the use of anti-retroviral treatment for HIV-positive persons meeting certain medical criteria. For those persons already infected, it has adopted a continuum of care approach, which includes home-based care teams and community-based self-help groups. Testifying to the positive results of this strategy, there has been a steady increase in the percentage of eligible persons currently receiving anti-retroviral treatment, rising from 12 per cent in 2003 to 38 per cent in 2005 and to 96.7 per cent at the end of 2010, (*Annual Report 2010, NCHADS*).

However, a potential threat to the high coverage rate for anti-retroviral treatment is the fact that the entire programme is funded by grants from the Global Fund for AIDS, Tuberculosis and Malaria, from which Cambodia has secured grants totaling \$289 million in seven out of nine funding rounds. If that funding stream were to end or be reduced, the country’s entire treatment programme for HIV-positive persons would be jeopardized.

### 4.3. Adolescent Reproductive Health

At the ICPD in Cairo in 1994, a major focus was on the population dimensions of children and youth, which at the time was increasing rapidly as a proportion of the population. Although globally the increase is slowing down, the past demographic push means that many countries including Cambodia will be faced with the largest cohorts of young people in the next few years. In the case of Cambodia that means that in 2010 31.8 per cent of the population was aged 0-14 and 12.2 per cent was aged 15-19, (*World Population Prospects, 2010*).

The goals of the ICPD Programme of Action were to promote the health, well-being and potential of all adolescents and youth; to meet their special needs, including social, family and community support as well as to access education, employment, health, counseling and high-quality reproductive health services and to encourage them to continue their education. The Programme of Action urged countries to give high priority to the protection, survival and development of children and youth and to make every effort to eliminate the adverse effects of poverty on children and youth.

As part of this effort to improve the circumstances of young people, the ICPD Programme of Action called for a substantial reduction in adolescent pregnancies. In Cambodia the adolescent birth rate (number of births per 1,000 women 15-19 years old) was 90 in 1993, 51 in 1998, and 52.3 in 2003, and the United Nations Population Division reports that that rate further declined to 41.8 in 2010, (*World Population Prospects, 2010*)

The 2010 Demographic and Health Survey presented a good summary of the situation of adolescent pregnancies in Cambodia. “Teenage fertility is a major health concern because teenage mothers and their children are at high risk of illness and death. Childbearing during the teenage years can have dire social consequences as well, curtailing the educational and employment opportunities of women. Early

initiation into childbearing is also often associated with higher lifetime levels of fertility, (CDHS 2010, p.65).

“[In Cambodia], the percentage of women who have begun childbearing increases with age, from almost none among women age 15 to 26 per cent among women age 19. Five per cent of urban women begin childbearing in their teens, as do 9 per cent of rural women. The level of teenage fertility is strongly associated with education. One in six teenagers who have never been to school has begun child-bearing, as compared with one in eight teenagers who have a primary school education and one in 20 teenagers with a secondary or higher education. The level of teenage fertility is also strongly associated with wealth: 13 per cent of the poorest teenagers have begun childbearing, as compared with only 4 per cent of the richest. The percentage of teenagers who have begun childbearing varies greatly among provinces, with the lowest in Phnom Penh (3 per cent) and the highest in Monduliri, Ratanakiri (17 per cent)”, (CDHS 2010, p. 66).

There are no legal age restrictions on access to reproductive health services in Cambodia, including for contraceptives and access to abortion. However, there is a lack of understanding on just how easily young people are able to make use of such services. The Ministry of Health is aware that in order to encourage use of services, they have to be made “adolescent-friendly”. A goal would be to have separate buildings within health facility compounds that would be devoted to provision of services to young people. However, that has proven to be too costly, and a new model that is being developed is to renovate a room or a corner of a room and set up a library with special service hours.

The National Maternal and Child Health Center has provided training to health-care staff nationwide on provision of adolescent reproductive health services, with the aim of seeing that an additional 20 per cent of health centers have staff able to provide private and comprehensive services each year. According to the Ministry of Health 91 health centers offered such adolescent-friendly services in 2009 and this number expanded quickly to reach 438 in 2012, (MMR, p. 140).

#### **4.4. Primary Health Care and the Health-Care Sector**

The ICPD Programme of Action stresses that all countries should make access to basic health care and health promotion the central strategies for reducing mortality and morbidity. Sufficient resources should be provided so that primary health services cover the entire population.

Cambodia’s health system still suffers from under-financing in spite of the great strides that have been made since 1993. In 2009, according to official statistics, the country spent 1.11 per cent of GDP for health, with the public health system spending reaching \$9.36 per capita and out-of-pocket expenditures amounting to \$25 per capita while external assistance provided \$9.15 per head, (*Health Sector Development*, p. 6). However, the expenditures for the public health system have continued to increase over the years, averaging over 20 per cent annually since 2007, (*Health Sector Progress*, p. 4). According to published budget figures, the 2011

health budget stood at 694 billion riel or approximately \$174 million, (*Health Sector Progress, p.4*). Along with improvements in the public health system, the Government has enhanced its ability to regulate the private sector, with only 7 per cent of private clinic facilities remaining unlicensed in 2010 compared to 59 per cent in 2008, (*Health Sector Progress, p. 6*).

Six national hospitals, 53 referral hospitals, and 141 health centers in the country provide support for poor patients through Health Equity Funds and subsidy schemes. However, this compares with a total of 8 national hospitals, 82 referral hospitals and 1,024 health centers in the country, so there are still gaps in the schemes to provide subsidized health services to the poor, (*34th National Health Congress, 2013*).

As of December 2012, there were 19,721 health workers in the public health sector, including 2,178 medical doctors (of whom 58 were specialists), 1,018 medical assistants, and 8,998 primary and secondary nurses. Delivery of reproductive and maternal health services were provided by 2,433 secondary midwives and 2,164 primary midwives. Secondary midwives have completed secondary school and three years of midwifery training and have greater responsibilities than primary midwives, who have only one year of training. The number of both is increasing rapidly – secondary midwives increased from 1,994 in 2011 to 2,432 in 2012 and primary midwives increased from 1,997 to 2,164 (*23rd National Health Congress Report, 2013*).

In spite of the rapid growth in health personnel, Cambodia continues to have a lower number of specialized medical staff, including doctors, medical assistants, and nurses and midwives per capita than neighboring countries: in Cambodia there is one per every 1,000 people, (*CDRI, p. 91*). The CDRI notes that “Cambodia’s health workforce is characterized by low density of clinical staff ... and an inequitable distribution between rural and urban areas”, (*CDRI, p. 91*). CDRI does note that, the second National Health Strategic Plan (2008-2015) is undertaking several strategies to increase the total number of trained staff, to improve their quality and to encourage more of them to work in rural areas, including through incentive schemes.

In highlighting some of the achievements that Cambodia has made in realizing the health goals of the MDGs, the Ministry of Planning’s publication “Achieving Cambodia’s Millennium Development Goals” stated, “perhaps the performance of the health sector requires detailed documentation, so that other countries at similar levels of development, which are still grappling with some of these targets, can draw some lessons from Cambodia. Also, there is scope to revise some of the targets”, (*CMDG, p. 23*). Such a goal revision needs to be part of Cambodia’s ICPD beyond 2014 planning and its post-2015 development agenda.

#### **4.5. Child Survival and Health**

The ICPD Programme of Action set specific targets for reducing infant and child mortality: reduce under-five mortality by one third by 2000, and by 2015 all countries should have infant mortality rates below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000 live births. The key indicator is that although child

mortality rates declined in line with MDG goals, neonatal mortality did not, and this worrying stagnation is discussed below in more detail.

According to the CDHS, infant mortality decreased from 95 to 66 deaths per 1,000 live births from 2000 to 2005 and then continued to decline further to 45 per 1,000 live births in 2010. Under-five mortality decreased from 124 to 83 deaths per 1,000 live births from 2000 to 2005 and then to 54 per 1,000 live births in 2010, (*CDHS, p. 115*). Another set of estimates produced by the Inter-Agency Group on Mortality Estimation gives the infant mortality rate per 1,000 live births at 87 in 1990, declining to 77 in 2000, and 43 in 2010. The same statistics show the under-five mortality rate (deaths/1,000 live births) to be 121 in 1990, 103 in 2000, 73 in 2005 and 51 in 2010. These figures give estimates for the early post-ICPD period before the first Cambodia Demographic and Health Survey took place in 2000, illustrating the high rates in the 1990s and the subsequent steep decline, (*The figures for 2005 and 2010 are close to those of CDHS and tend to validate the findings.*)

The Ministry of Health's publication "Health Sector Development, 2010" attributes the success in reducing the infant mortality rate to the national immunization programme, promotion of exclusive breastfeeding, improved access to basic health services, and an overall reduction in poverty levels and greater access to education and health care, partially because of an expanded and improved road system.

However, as noted, neonatal mortality rates have not experienced the same declines. The CDHS found that neonatal deaths per 1,000 live births were 37 in 2000, declining to 28 per 1,000 in 2005 and then stagnating at 27 per 1,000 in 2010. The health system sees this as a major deficiency and a priority for urgent action, (*Prof. Eng Huot, Secretary of State, MoH, and Prof. Tung Rathavy, National Maternal and Child Health Center, personal communications, May 2013*). The Ministry of Health officials said that some of the possible issues were that training for midwives is designed "only to take care of the mother" and that usually there is only midwife in a delivery room, who concentrates on the mother if there are complications. The public health system has made great strides in ensuring that every health facility in the country has at least one secondary midwife. But that is not adequate: the goal is to have at least two secondary midwives per health facility.

Midwives need to be better trained on the basic management of immediate newborns including clean and safe delivery, prevention of hypothermia (immediate drying, warm environment, skin-to-skin contact), immediate and exclusive breastfeeding, cord and eye care, rather than turning the babies over immediately to the care of families, which is often the current practice. There also needs to be an effective referral system for more serious issues: emergency obstetric care for complications, antibiotics for premature rupture of membranes, neonatal resuscitation, and management of newborns with complications.

The Cambodia Emergency Obstetric and Neonatal Care Improvement Plan 2010 - 2015 also looked at neonatal care and said "some newborn health interventions are easier to implement than others. Drying and wrapping the neonates can be implemented more readily than resuscitation, kangaroo mother care is more

achievable than incubator-based care, oral antibiotic treatment is easier than treating infants with gentamicin injections. It is more important to promote clean delivery kits and exclusive breastfeeding than build newborn care units in resource-constrained circumstances. If a health system cannot achieve sufficiently high levels of maternal tetanus toxoid coverage and reduce neonatal tetanus drastically, it is unlikely that it can effectively provide care for sick neonates at the health centre level,” (*Cambodia EmONC Improvement Plan 2010-2015, MoH, pp. 70-71*).

“To ensure that the life-threatening conditions are managed quickly and effectively, it is of fundamental importance that the providers closest to the communities have the necessary skills and the mandate to manage emergencies. ... At present, midwives and nurses and other staff in health centres cannot manage newborn babies with sepsis because they are not permitted to administer gentamicin injection.” (*Cambodia EmONC Improvement Plan 2010-2015, MoH, p.71*)

A UNICEF study has concluded that, in line with other forms of mortality, infant mortality is strongly associated with the place of residence of mothers and their household incomes. “Large gaps remain in how different demographic and socioeconomic groups experience childhood death. The largest predictor of neonatal mortality in 2010 was residence, such that 1 in 29 children born to mothers living in rural areas did not survive the first month of life, compared to just 1 in 91 children born to mothers living in urban areas. The largest absolute rate gap observed for under-five mortality was household wealth: in 2010, 1 in 33 children born into the richest households did not survive to their fifth birthday, compared to just 1 in 11 children born into the poorest households. Interesting patterns were also observed in how the gains in childhood mortality were distributed. For example, while the overall trend for neonatal mortality was positive, the likelihood of a child born to a mother living in the poorest households dying during the first seven days actually increased between 2005 and 2010, from 34/1,000 to 39/1,000 live births.” (UNICEF Equity, p. vii).

#### **4.6. Women’s Health and Safe Motherhood**

The ICPD set as global objectives the promotion of women’s health and safe motherhood, the achievement of a rapid and substantial reduction in maternal morbidity and mortality, and a significant reduction in the number of deaths and morbidity from unsafe abortion.

In 1995, a survey on knowledge, attitudes, and practices (KAP) sponsored by UNFPA that found that clandestine abortions were a major cause of maternal deaths. As a result, in 1996-1997 a new abortion law was prepared and adopted and a national “birth spacing” programme was launched. Such initiatives had some immediate results as reflected in the maternal mortality ratios for that and subsequent periods.

Calculating Maternal Mortality Rates (MMR) (the number of maternal deaths per 100,000 live births) is notoriously difficult, and it is not uncommon to have differing figures. This is also true for Cambodia. According to the United Nations Statistics Division, the maternal mortality rate was 250 in 2010. This figure is based on the work



of the Maternal Mortality Estimation Inter-Agency Group, which shows that the maternal mortality ratio has shown a steady decline going from 830 per 100,000 live births in 1990 to 750 in 1995, 510 in 2000, 340 in 2005, and 250 in 2010.

The 2010 Demographic and Health Survey came up with slightly different (lower) figures and justifies its numbers by saying “since 2000, a CDHS is conducted every five years, and being a survey dedicated to demographic/health issues it is considered more reliable for calculating MMR, IMR and such indicators”. Drawing from the CDHS reports for 2000, 2005 and 2010, the MMR was 437 in 2000, rising to 472 in 2005. It was this 472/100,000 live births figure that shocked the Ministry of Health and led to some immediate measures to improve maternal health care, including by recruiting and training more midwives. The measures paid off in that the MMR fell sharply to 206 per 100,000 live births in 2010, (*CHDS, pp. 111-112*). Since the base year for the MMR in terms of reaching the MDG goals was 1998 and the target set for 2015 was 250 per 100,000 live births, then the CDHS figures would indicate that the target has already been surpassed, (*CMDG 2011, p. 22*).

The main strategic formulation for the reduction of maternal mortality is the Ministry of Health’s “Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality 2010-2015”, which lays out a strategy based on four core components: emergency obstetric and newborn care (EmONC), skilled birth attendance, family planning, and safe abortion. It also includes three components conducive to an enabling environment: behavior change communication, removing financial barriers, and maternal death surveillance and response.

As exemplified by the sharp turnaround in maternal death figures, the strategy contained in the “Fast Track Initiative Roadmap” is working. The Ministry of Health sees that there have been positive developments in terms of significant increases in the proportion of deliveries assisted by skilled birth attendants, increasing ante-natal care coverage, growth in the number of deliveries in health facilities, and a better referral system for obstetric emergencies. In addition, there are other less direct factors that have had contributed to reducing maternal death (including the increase in contraceptive prevalence use, highlighted above under family planning). Each of these factors will be examined in turn.

#### **4.6.1. Trained assistance at birth**

In December 2005, the Ministry of Health sponsored a High-Level Midwifery Forum, which was informed by an assessment of the country’s midwifery needs, (*A final report of which was issued in September 2006.*). The assessment found that only 51 per cent of health centers had secondary midwives and that the total number of midwives working in the country (2,626 primary and secondary midwives) was inadequate to meet the demand, (*Report of the Comprehensive Midwifery Review 2006, MoH, pp. 6 & 21*). The Forum found that young women did not want to become midwives because in order to become a secondary midwife they had to earn the equivalent of a bachelor’s degree while salaries were not commensurate with the level of education. In addition, there were issues related to having to serve in areas far from home, lack of transportation, and poor living conditions.

One of the immediate results of the forum was the implementation of a pay-band increase for all midwives, (*Midwifery Review*, p. 6). As a result of the review and forum, the Ministry of Health increased recruitment and training of midwives and an incentive scheme was established (currently \$10 for every safe delivery in Phnom Penh, and \$15 elsewhere in the country). The results were shown in the increasing number of practicing midwives every year and the rise in trained assistance at birth.

The number of births attended by a trained health professional (i.e., doctor, nurse or midwife), which is seen as being critical in reducing maternal and neonatal mortality, has risen sharply in the last decade, from 34 per cent in 1998 to 44 per cent in 2005, reaching 71 per cent in 2010. The 70 per cent figure means that the health system will have exceeded its targeted goal of 70 per cent of trained attendance by 2015. First births were more likely to have trained assistance (80 per cent) than were the following births, (*CDHS*, p.127, 128). Since the CDHS 2010, the number of births attended by trained professionals has continued to increase, reaching 74 per cent of births in 2012, (*MMR*, p.12)

The CDHS reported: “Urban women are more likely (95 per cent) to receive assistance from a trained health professional during childbirth than rural women (67 per cent). Conversely, rural women are more likely (33 per cent) than urban women (5 per cent) to receive assistance during birth from a traditional birth attendant. Virtually all births (99 per cent) in Phnom Penh are assisted by a trained health professional. By contrast, in many provinces, the proportion of births assisted by a trained health professional is low. For example, 28 per cent of births in Preah Vihear/Steung Treng and 38 per cent of births in Mondulakiri/Ratanakiri are assisted by a trained health professional. As expected, women’s education has an impact on delivery care. Women with a primary school education (70 per cent) and women with a secondary education or higher (91 per cent) are more likely than women with no education (47 per cent) to receive assistance from a health professional during childbirth.” (CDHS 2010, p. 128)

A major factor in this increase in trained assistance at birth was the rapid growth in the number of midwives. In 2005, there were 1,941 primary midwives and 1,086 secondary midwives; by 2012 these numbers had increased to 2,431 and 2,178, respectively, (*MMR*, p.10). The implications for this were critical: in 2005, 292 out of a total of 832 health centers did not have a midwife; by 2009, all of the 984 health centers were staffed by at least one midwife. Since then, the number of health centers has continued to grow, reaching 1,024, and all of them have at least one midwife, (*MMR*, p. 11). However, one of the remaining issues is that many of the health centers have in fact only one midwife, and this puts a constraint in terms of how much service she can provide in a 24-hour day with possibilities of multiple births and the need to provide neo-natal as well as maternal care simultaneously.

#### **4.6.2. Antenatal care visits**

In 1998, only 34 per cent of pregnant Cambodian women had at least one ante-natal visit, but this went up to 89.7 per cent in 2010, while those with at least four visits increased from 9 per cent in 2000 to 59.4 per cent in 2010 (the same proportion of

women started antenatal care during the first three months of their pregnancy), (CDHS 2010, p. 123). Much of this increase came in the five years from 2005 to 2010—according to the 2005 CDHS the figure for at least four visits was only 27 per cent in 2005 while that for one visit was 69 per cent. In another way of looking at this encouraging trend, only 10 per cent of Cambodian women who had had pregnancies in the first decade of the 21st century had received no antenatal care at all.

In terms of the antenatal care that they received, 79 per cent of women were attended by midwives, while 9 per cent received care from a doctor, and 1 per cent visited a nurse professional. The usual determinants of access to health care are at work in terms of use of antenatal care services. The rural-urban divide exists, with 97 per cent of urban women accessing antenatal services with a health professional while only 88 per cent of women in rural areas did so. This is also reflected in a strong provincial differentiation. In the urbanized area of Phnom Penh virtually all (99 per cent) of women received ante-natal services while in the remote and rural provinces of Mondulakiri and Ratanakiri, this figure only reached 62 per cent, (CDHS 2010, p.121).

As in other areas, the use of antenatal care services was strongly linked with level of education. Women who had completed a secondary education or beyond were more likely to receive antenatal care from a trained professional (98 per cent) than women with only a primary education (89 per cent), and the rate was still lower for women with no education (77 per cent). In other words, almost one quarter of uneducated women received no antenatal care at all while this was true of only 2 per cent of women with a secondary education or higher, (CDHS 2010, p.121).

In 2008, the Centre for Health Promotion and the Provincial Health Promotion Units undertook a branded, targeted campaign to promote ante-natal care in seven provinces (Kampong Speu, Prey Veang, Svay Rieng, Kampong Thom, Otdormeancheay, Steung Treng and Mondulakiri) with mass media events (television, radio and print media) that took place nationwide. It included loudspeaker campaigns, banners and posters, television spots and a karaoke song, and point-of-service promotions. In addition, thousands of Village Health Support Group volunteers went door to door to promote the importance of ante-natal care through inter-personal communication. The results were striking: the percentage of ante-natal care visits in the seven targeted provinces went from 5 per cent to 35 per cent, (Ahmedzai, PowerPoint Presentation). This is an excellent demonstration that community-based promotion campaigns can work very well.

There are continuing questions about the quality of antenatal care services that women receive. According to the responses in a survey question of the CDHS 2010, only 80 per cent of those who received antenatal care reported that they were informed of the signs of pregnancy complications and approximately 10 per cent did not have their blood pressure measured while 10 per cent were not weighed. A total of 36 per cent had a urine sample taken and 44.5 per cent had blood drawn, (CDHS 2010, p. 124).

In order to protect against neonatal tetanus, it is necessary for pregnant women to receive tetanus toxoid injections. In an indication of the increasing effectiveness of ante-natal services, the CDHS 2010 found that 86 per cent of last-born children during the preceding five years were deemed fully protected against tetanus, which was a steep increase from the figure in the 2005 CDHS—69 per cent, (*CDHS 2010, p.125*).

Although the quality of ante-natal care services needs continuing attention, one of the major effects of the increased number of ante-natal visits has been to inform women of the benefits of institutional delivery and to encourage them to go to a health facility when it is time to give birth. As a result, there has been a dramatic rise in the percentage of institutional deliveries.

#### **4.6.3. Institutional deliveries**

The trend in favor of deliveries in health facilities is gaining speed. There has been a generalized decline in home deliveries (from 89 per cent in 2000 to 78 per cent in 2005 to 45 per cent in 2010) in favor of institutional deliveries, both in public and private facilities. The 2010 Demographic and Health Survey found that 66 per cent of first births took place in a health facility, more than the percentage for subsequent births, (*CDHS 2010, p.126*). The overall percentage of deliveries at health facilities has risen very quickly: from 35 per cent in 2008 to 66 per cent in 2012, (*MMR, p.12*).

Again, there is an urban/rural divide with 86 per cent of deliveries in urban areas taking place in a health facility while the comparable percentage for rural areas is only 48 per cent. The percentage of deliveries taking place in a health facility varies greatly by province, accounting for 93 per cent in Phnom Penh but only 21 per cent to 72 per cent in other provinces. As would be expected, there is a strong association between educational level and institutional deliveries. Women with a secondary education or higher had 75 per cent of their deliveries outside the home while only 34 per cent of women with no education did so, (*CDHS 2010, pp.126-127*).

It is important to understand the determinants impeding access to health care before, during and after childbirth in order to continue to expand the use of health facilities for maternal services. According to the CDHS the chief impediment was lack of money for treatment. This was cited by 65 per cent of the respondents. Education and income are mutually reinforcing: women with no education and in the lowest wealth quintile overwhelmingly listed lack of money as the main reason they did not access health services. The other main obstacles were unwillingness to go to a health facility alone (40 per cent) and inability to get permission to go to a health facility (33 per cent). Both of these are indicative of continuing issues concerning women's empowerment. In terms of access, 36 per cent indicated that distance to a health center was a deterrent; this was, as expected, a particular obstacle for rural women, (*CDHS, p.132*).

However, acknowledging these impediments and addressing them through such positive programmes as the Health Equity Fund and the establishment of maternity

waiting homes as a way of reducing economic and distance barriers, are something that the Government will focus on as ways forward.

#### 4.6.4. Emergency obstetric and neo-natal care (EmONC)

As stated above, in 2005 maternal mortality was found to be “stuck” at 472 per 100,000 live births and neonatal mortality at 28 per 1,000. To look at the causes for this, AusAID and UNFPA supported an EmONC assessment, which took place between September 2008 and May 2009. This resulted in an EmONC (2010-2015) improvement plan for the years 2010-2015, which was issued in December 2009.

The needs assessment found that the country was lacking both basic and comprehensive EmONC facilities, with 1.6 basic facilities for 500,000 population versus a recommended level of 5. The existent facilities were poorly distributed, with five provinces having no facilities and an additional eight lacking any basic facilities (in these cases, the only facility was a comprehensive facility in the provincial capital, emphasizing the lack of availability in rural areas). The recommended level of use of such facilities was 15 per cent of all births, while in Cambodia they only reached 11.4 per cent. Most significantly, only 12.7 per cent of the 15 per cent of women who developed complications used EmONC facilities: it should be 100 per cent. In all facilities, 1.3 per cent of births were via caesarean section, well below the recommended level of 5-15 per cent, (*National EmONC Assessment in Cambodia 2009, MoH, p.7*).

In order to improve this situation, the assessment concluded that standards and guidelines for EmONC needed to be established, policy issues relating to availability of certain drugs needed to be addressed, physical facilities would need to be upgraded (but no new construction was required), facilities needed to be equipped with certain critical supplies and equipment, more anesthetists, obstetricians and midwives were required, skills needed to be upgraded, safe blood supplies needed to be assured, facilities needed to be able to work 24/7, referral statistics needed to be regularized, transport needed to be available, deterrence of user fees needed to be examined and magnesium sulphate needed to be available at all times in all facilities, (*National EmONC Assessment in Cambodia 2009, MoH, pp. 9-11*).

The EmONC plan called for increasing the availability, utilization and quality of EmONC services by making skilled obstetric care available at all stages of pregnancy, childbirth and postnatal period and at all levels of the health system, ensuring the availability of a functioning referral system, developing the capacity of the health system to plan, manage and supervise EmONC and strengthening the utilization of those services. To achieve this by 2015, it will be necessary to set and enforce standards, improve utilization and access of services, upgrade the skills of service providers, and reinforce the referral system works, (*Cambodia EmONC Improvement Plan 2010-2015, MoH, pp. 8-9*).

The implementation of the strategy in terms of coverage is impressive: the number of health facilities offering basic EmONC increased from 19 in 2009 to 67 in 2012 while comprehensive EmONC went up from 25 to 34 health facilities, (*MMR, p. 13*). The

greater availability of referral services is also shown by the rising percentage of deliveries by C-section, from 1.5 per cent in 2008 to 2.8 per cent in 2012, although this percentage remains low, (*MMR, p.12*). The Cambodian Millennium Development Goal for C-sections is 4 per cent, (*CMDG, pp. 22-23*).

Another longer-term plan is to equip and staff all hospitals so that they can perform C-sections. In other words, upgrading what are now level “1” hospitals to level “2”. The total package of improved EmONC services is now being implemented and, as indicated, the available data show that results are already being seen. However, the total required budget to implement the plan is \$19 million over 5 years, and this funding has to be assured if the plan is to be realized.

#### 4.6.5. Other factors

There are also other external factors that have improved access and increase utilization of health facilities: more and better roads and bridges, de-mining, economic growth, and the spread of mobile phones throughout the country. In addition, the Ministry of Health has invested in the provision of ambulances, some of which were supplied by developed partners like UNFPA.

Along with the factors cited above, longer birth intervals have contributed to improved health status of both mother and child. Infants born within two years of the birth of a previous child experience a higher risk of health problems. In Cambodia, the interval between births is relatively long. The median number of months since the preceding birth is 40.0. However, in 2010, 16 per cent of non-first births in Cambodia occurred within 24 months of the previous birth, 26 per cent occurred from 24 to 35 months after the previous birth and 32 per cent occurred 36 to 59 months after a previous birth, and 25 per cent occur 60 months or more after the preceding delivery, (*CDHS 2010, p. 63, 64*).

The percentage of short-interval births (less than two years) is declining: it was 18 per cent in 2005 and 21 per cent in 2000, (In 2010, 6 per cent of births occurred less than 18 months after the preceding birth.). In 2010, 58 per cent of women gave birth to the succeeding child at least 36 months later, increasing from 52 per cent in 2005. Mothers with more education have longer birth intervals: the median birth interval for those with no education was 37.0 months, while those mothers who had had a secondary or higher education had a median birth interval of 41.7 months, (*CDHS, p.63,64*).

Abortion has been legal in Cambodia since 1997 and has been available on request since 2009, and both surgical and medical abortions are available. Trainings on comprehensive abortion care are provided to eligible medical staff according to the Abortion Law. According to the CDHS 2010, about 5 per cent of women aged 15 to 49 had had an abortion in the preceding five years, (*CDHS, p. 67*). Among those who had had an induced abortion, 26 per cent had had more than one, (*CDHS, p. 69*). Abortions most frequently took place in a private health facility or someone’s home while only 14 per cent took place in a public health facility, which is a significant finding since theoretically an abortion is available to any woman who requests it from

a public health facility, (CDHS, p.70). It was significant that in only 67 per cent of cases was the abortion performed by a doctor, nurse, midwife, or other health worker, (CDHS, p. 71). From the 2010 CDHS data, it goes without saying that there is still some way to go to ensure safe abortion to the women of Cambodia as provided in the Abortion Law. Having all abortions (another two thirds of the cases) performed by trained and qualified health professionals would certainly help save more women lives. More investments are needed to allow for full implementation of the Law to ensure Sexual Reproductive Health and Rights, in particular, legal right to safe abortion fully observed, thereby contributing to further reduction of maternal mortality in line with the Government's Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality.

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## Ministry of Planning

Nº. 386, Preah Monivong, Phnom Penh

Tel: 023 720 901

Fax: 023 210 944

023 210 698

Website: [www.mop.gov.kh](http://www.mop.gov.kh)

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