KINGDOM OF CAMBODIA

NATION – RELIGION – KING

MINISTRY OF HEALTH

National Maternal and Child Health Centre

National Reproductive Health Programme

National Strategy for Reproductive and Sexual Health in Cambodia

2017-2020

Phnom Penh

May 2017

Forward

Over the last four years, the Cambodian Ministry of Health made very good progress improving the reproductive health and rights of women, men and young people. The National Reproductive Health Programme (NRHP) of the National Maternal and Child Health Centre (NMCHC) achieved four out of five of its goal level targets and nearly half of its outcome and objective level targets for 2013 to 2016.

While good progress was made, more work remains to be done if we are to achieve the Sustainable Development Goals by 2030. In order to achieve these goals, the NRHP/NMCHC will need to build on what has worked, address outstanding issues and equity gaps, and improve the quality and accessibility of reproductive and sexual health (RSH) services in both the public and the private sector. The third National Strategy for Reproductive Health 2017-2020 will guide this work, and will ensure that all people in Cambodia benefit from improved RSH status and rights.

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Prof. ENG HUOT
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Acronyms and Abbreviations

AFRSH	Adolescent Friendly Reproductive and Sexual Health
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
CAC	Comprehensive Abortion Care
CBD	Community Based Distributor
CCMN	Community Care for Mothers and Newborns
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHW	Community Health Worker
CIP	Commune Investment Plan
CPR	Contraceptive Prevalence Rate
CDHS	Cambodian Demographic and Health Survey
EmONC	Emergency Obstetric and Newborn Care
EPOS	EPOS Health Management
FP	Family Planning
FTIRM	Fast Track Initiative Roadmap
GBV	Gender Based Violence
HC	Health Center
HCMC	Health Center Management Committee
HIV	Human Immunodeficiency Virus
HKI	Hellen Keller International
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HRD	Human Resources Department
LAPM	Long Acting or Permanent Method
LMIS	Logistics Management Information System
MCAT	Midwifery Coordination and Alliance Team
MDSR	Maternal Death Surveillance and Response
MgSO4	Magnesium Sulfate
MMR	Maternal Mortality Rate
MoH	Ministry of Health
NE	Northeast
NGO	Non-governmental organization
NIP	National Immunization Programme
NRHP	National Reproductive Health Programme
NMCHC	National Maternal and Child Health Centre
NSDP	National Socio-Economic Development Plan
NSSF	National Social Security Fund
OD	Operational District
PLW	Pregnant and Lactating Women
PMTCT	Prevention of Mother to Child Transmission
RGC	Royal Government of Cambodia
RSH	Reproductive and Sexual Health
RMNH	Reproductive Maternal Newborn Health
PNC	Postnatal Care
PPH	Post-Partum Hemorrhage
SBA	Skilled Birth Attendance

SCA	Save the Children Australia
SE	South East
SPF	Sugar Palm Foundation
UBC	University of British Columbia
UHS	University of Health Sciences
UN	United Nations
UNFPA	United Nation's Fund for Population Activities
URC	University Research Corporation
USAID	United States Agency for International Development
VAW	Violence Against Women
VHSG	Village Health Support Group
VIA	Visual Inspection by Acid Acetic
WHO	World Health Organization

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Context

The National Strategy for Reproductive and Sexual Health (RSH) 2017-2020 outlines the RSH priorities to be addressed between 2017 and 2020. It defines key intervention areas and lays out relevant indicators and targets for monitoring progress over time, and will be used to inform annual planning and budget allocations.

As a sub-sectoral strategy specifically focusing on reproductive and sexual health, the National Strategy for RSH2017-2020 contributes to the achievement of the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality 2016-2020, the Health Strategic Plan 2016-2020,the National Strategic Development Plan 2014-2018 and the Sustainable Development Goals.

Global norms and standards

Reproductive health was first defined at the 1994 International Conference on Population and Development (ICPD) in Cairo, and later by WHO and others, as *"a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters related to the reproductive system and to its functions and processes*". Reproductive rights, also initially clarified at ICPD, recognize the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and means to do so, and to attain the highest standard of sexual and reproductive health. It includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed inhuman rights documents. The ICPD Programme of Action (ICPD-PoA)[1]includes a call for all states to:

- ensure that comprehensive and factual information and a full range of reproductive healthcare services, including family planning, are accessible, affordable, acceptable and convenient to all users;
- enable and support responsible voluntary decisions about child-bearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so; and
- meet changing reproductive health needs over the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities.

Methodology

The National Strategy for RSH 2017-2020 was developed through a consultative process and was informed by a thorough review of the previous RSH strategy 2013-2016. A consultative workshop was held on 17 and 18 November 2016 in Phnom Penh, Cambodia, and during this workshop participants reviewed progress to date, and provided inputs on key intervention areas, indicators and targets. Workshop participants included government health staff from provincial and national level, and development partner staff working in RSH.

Progress to date

Cambodia made very good progress toward achieving the goal of its 2013-2016 National Strategy for RSH in Cambodia - attaining a better quality of life for all Cambodians by improving the RSH status and rights of women, men and young people. It achieved or exceeded four out five of its goal level targets, and nearly half of its outcome and objective level targets. Cambodia should be commended for these results.

The goal level results are shown below and more detailed information can be found in the objective sections of this document and in the separate review report titled: Review of the National Strategy for Reproductive and Sexual Health in Cambodia 2013-2016.

Indicators	Baseline 2010	Target 2016	Verification	Achieved 2016	Comments	Status
• Maternal Mortality Ratio	206	140	CDHS	170 (2014)	Cambodia made good progress and achieved 2015 MDG target, but did not achieve 2016 National Strategy for RSH target of 140.	
• Neonatal Mortality Rate	27	20	CDHS	18 (2014)		
• Infant Mortality Rate	45	35	CDHS	28 (2014)		
• HIV Prevalence among adults 15-49 yrs.	0.9%	0.6%	Cambodia Aids Epidemic Modeling (AEM) 2014	0.6% (2016)	Estimation from Cambodia's 2014 Aids Epidemic Modeling. Found in the in the Cambodia Country Progress Report – NAA.	
• Total Fertility Rate	3.0	2.7	CDHS	2.7 (2014)		

Strategy

The third National Strategy for Reproductive and Sexual Health 2017-2020 will guide work in RSH between 2017 and 2020, and will ensure that all people in Cambodia benefit from improved RSH status and rights. The new strategy will build on what has worked and will focus on increasing coverage, quality and utilization of interventions proven to improve reproductive and sexual health and rights, and to reduce maternal mortality. This strategy aims to contribute to achieving the unfinished agenda of the MDGs and gears toward achieving HSP3 and the SDGs.

As Cambodia is now close to achieving near universal coverage amongst the wealthier and better educated groups for a number of key RSH interventions, particular attention will be given to improving access and utilization in poor performing locations, such as the north and north-east of the country, and amongst vulnerable groups such as adolescents, minorities, migrant workers (including garment factory, construction, entertainment and farm workers,) and persons with disabilities.

The goal and objectives of the strategy are articulated below, and each objective is divided into key priority areas.

Goal

The goal of the new National Strategy for Reproductive and Sexual Health in Cambodia is to contribute to the better health and well-being of all people in Cambodia by improving the RSH status and rights of women, men and young people.

Objective One

Increase equitable access and quality of RSH services through strengthened governance and service delivery.

Strengthen Family Planning Information and Services

Rationale

Family Planning is critical for improving RSH and rights. It provides individuals and couples with the means to decide if and when they want to have children and increasing the modern contraceptive prevalence rate and reducing the unmet need for family planning reduces maternal and newborn mortality, morbidity and malnutrition. Fewer unwanted pregnancies also lead to higher educational attainment and improved opportunities for women, economic gains for households and communities, and reduced pollution and use of natural resources.[1]

Between 2010and 2014 Cambodia increased its contraceptive prevalence rate (CPR) and utilization of long-acting and permanent contraceptive methods (LAPM), but fell short of reaching its 2016 RSH targets for these two indicators. Surprisingly, usage of modern contraceptives was highest in rural, poor and least educated groups, and the proportion of wealthy, urban women using traditional family planning methods, particularly withdrawal, increased between 2010 and 2014.[2,3] It is not entirely clear why this was the case, but it likely reflects fears of using hormone based contraceptives and undesirable side effects. It also likely reflects limited quality of services, weak counseling skills amongst some providers, and limited availability of family planning services at hospital level.

In going forward, Cambodia needs to increase the quality and utilization of family planning services for women, men and young people in both the public and private sector, and reduce traditional method usage. Particular attention needs to be given to increasing coverage and quality of services in poor performing locations (Kampong Cham, Kampong Chhnang, Kratie, Phnom Penh, Preah Vihear/Stung Treng,) and amongst highest need groups (15-24 year olds, 40-49 year olds, rural, poor and least educated groups); to increasing provider capacity for counseling; to increasing the availability of LAPM; to increasing the availability of FP services at hospital level, and to ensuring that the health equity fund payment scheme allows for reimbursement of immediate post-partum and post abortion family planning services.

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

1.1. Strengthen FP information and services

1.1.1. Increase quality and availability of FP services

1.1.1.1. Increase capacity of service providers for FP counseling and service provision through training, on-site coaching and supportive supervision

1.1.1.2. Develop and implement innovative strategies to improve awareness and utilization of FP services in poor performing locations and amongst highest need groups (e.g. 15-24 year olds, 40-49 year olds, unmarried, poorest, least educated) and vulnerable groups (including entertainment workers (EWs), garment factory workers, construction workers, farm workers, minorities and persons with disabilities)

- Offer FP services on weekends

[1] WHO, Identifying Actions for Scaling-Up Long-Acting Reversible Contraception in Cambodia, 2016.
[2] Mop, MoH, ORC Macro, Cambodia Demographic and Health Survey – 2000, 2001.
[3] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015.

1.1. Strengthen FP information and services

- Use CBD/mobile services for hard to reach population

1.1.1.3. Rationalize existing Community Based Distribution (CBD) coverage, and increase coverage in remote and hard to reach locations

1.1.2. Increase availability and utilization of long-term/permanent FP methods

1.1.2.1. All Referral Hospitals should be able to provide at least 3 long-term/permanent FP methods

- Create a separate section for FP at RH
- Increase capacity of RH staff to provide counseling and service provision for long-term methods through training, coaching and supportive supervision

1.1.2.2. All HCs should be able to provide at least 1 long-term FP method (IUD and/or implants)

- Increase capacity of HC staff to provide counseling and service provision for long-term methods through training, coaching and supportive supervision

1.1.2.3. Review comparative pricing of contraceptives (LAPM vs. short term methods) in public sector health facilities and revise if necessary

1.1.2.4. Produce and disseminate FP IEC materials

1.1.2.5. Increase male involvement in IEC and behavior change interventions

1.1.2.6. Consider expanding CBD activities to include promotion of LAPM and referral to appropriate health facilities.

1.1.3. Increase availability and utilization of post-partum FP services (interventions related to post abortion FP can be found in the safe abortion services section below)

1.1.3.1. Reinforce implementation of updated birth spacing guidelines which include immediate postpartum short and long term family planning

- Use Midwifery Coordination Alliance Team (MCAT) meetings to present/discuss quality birth spacing services, information and counseling

1.1.3.2. Ensure FP commodities available in maternity wards

1.1.3.3. Request that HEF allow payment for immediate post-partum FP as a separate service (also included in health financing interventions under objective two)

1.1.4. Ensure FP commodity security

1.1.4.1. Finalize and Disseminate 2016 RH commodity forecasting and costing report and ensure contraceptive supply to the public sector.

1.1.4.2. Use 2016 RH commodity forecasting and costing report to advocate for govt. financial commitments for RH commodities 2017-2020 and onward.

1.1.4.3. Strengthen function of commodity security working group.

1.1.4.4. Strengthen Logistics Management Information System (LMIS)

1.1.5. Strengthen public-private partnership to ensure quality FP service provision and timely and accurate reporting from the private sector

1.1.5.1. Strengthen partnerships with private sector providers through periodic meetings

1.1.1.2. Advocate that new law on regulation of health care facilities and services includes:

- Provision that all facilities/services must be in compliance with MoH policies, guidelines and protocols
- System for routine reporting and quality assurance of private health facilities

1.1. Strengthen FP information and services

1.1.6. Reduce Traditional Family Planning Usage

1.1.6.1. Increase knowledge that traditional FP methods(particularly withdrawal) are not effective or reliable, and reduce fears and mis-information about modern contraceptives

- Strengthen FP counseling skills of public and private sector providers through training, coaching and supportive supervision
- Awareness raising or campaign using mass media

Strengthen ANC Services

Rationale

Antenatal Care (ANC) is an essential intervention for improving maternal and newborn health, and for reducing maternal and newborn mortality. All women should receive multiple ANC checks during their pregnancy, starting immediately after their menstrual period has stopped. Cambodia is currently working to ensure that all women receive at least 4 ANC checks during their pregnancy, and, as of November 2016, WHO increased the recommended number of ANC visits per pregnancy to 8.

Between 2010 and 2014, good progress was made in increasing antenatal care (ANC) attendance and, as of 2014, 75.6% of pregnant women had received at least 4 ANC checks. This exceeded the 2016 RSH strategy target of 65%. However, the quality of ANC care continues to be a concern, and the 2014 Cambodian Demographic and Health Survey (CDHS) found that only 49% of pregnant women had a urine sample taken during ANC, and only 77% had a blood sample taken.[4]These concerns about the quality of ANC were further reinforced by the findings of the recent Level 2 facility assessments.[5]

While the CDHS 2014 found that 96% of women received iron supplementation during pregnancy, Cambodia continues to struggle with high levels of anemia amongst pregnant women (and amongst children under five and women of reproductive age.) Additional research was recently undertaken by the Royal Government of Cambodia, the Institute of Research for Development, UNICEF, ICF International and Copenhagen University to better understand this issue, and these research findings suggest that anemia in Cambodia is not due to iron deficiency. While the underlying causes of anemia in Cambodia are not yet entirely clear, this research suggests that Cambodia's high levels of anemia are at least partially due to hemoglobinopathies, hookworm infections, folic acid and other micronutrient deficiencies.

Between 2017 and 2020, it will be important that the quality of ANC is improved; that all women receive at least 4 ANC checks starting immediately after their menstrual period has stopped; that anemia and hookworm are effectively addressed, and that accessibility and utilization of services is increased in poor performing locations such as Kratie, Mondolkiri/Rattanakiri and Preah Vihear/Stung Treng, and amongst vulnerable groups.[6]

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

[4] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015.
[5] URC, Presentation – Results from Level 2 Assessment Process, 2015, slide 30.
[6] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015.

1.2. Strengthen ANC services
1.2.1. Increase coverage and quality of ANC 1.2.1.1. Reinforce FULL ANC service package (as outlined in the Safe Motherhood protocol for Health Centers) through training, on-site coaching and supportive supervision. (At least 4 ANC visits (ANC 4+) starting immediately after menstrual period has stopped; components include weight monitoring; checks for pre-eclampsia, anemia, syphilis, HIV; provision of preventive measures (including micronutrient supplementation and de-worming) and counseling on family planning, nutrition and self- care, etc.) 1.2.1.2. Strengthen outreach activities and develop and implement innovative strategies to increase awareness and utilization of ANC services especially in poor performing locations and amongst high-risk, hard-to-reach and vulnerable populations. 1.2.1.3. Consider adding ANC to hospital service package (CPA) and setting up ANC services in all provincial and district hospitals
1.2.2. Increase knowledge and demand for ANC4+ 1.2.2.1. Increase knowledge and practice of FULL ANC service package (starting immediately after menstrual periods stop) 1.2.2.2. Encourage Village Health Support Group (VHSG), Community Based Distributors (CBDs) and new social health protection promoters (former Health Equity Fund Promoters)to promote and support access to ANC services 1.2.2.3. Increase male involvement in IEC and behavior change interventions

Increase identification and treatment of HIV and Syphilis during pregnancy

Rationale

Identification and treatment of HIV and Syphilis during pregnancy are essential interventions for Preventing Mother to Child Transmission (PMTCT) of HIV and Syphilis. Between 2010 and 2014, good progress was made in increasing the proportion of HIV positive pregnant women receiving Anti-Retroviral Therapy (ART) for PMTCT. As of 2014, 76% of HIV positive pregnant women received ART for PMTCT and this exceeded the 2016 RSH strategy target of 75%.

In going forward, it will be important to increase the proportion of pregnant women receiving HIV/Syphilis counseling and testing during ANC, and the proportion of HIV positive pregnant women receiving ART. It will also be important to ensure good coordination between the responsible national programmes so that seamless care can be provided for mothers, partners and newborns.

Key Interventions

To address the above, the following interventions have been prioritized for 2017 to 2020. These interventions are described in further detail in the new National Strategic Plan for Prevention of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B.

1.3. Increase identification and treatment of HIV/Syphilis during pregnancy
1.3.1. Increase identification of HIV/syphilis during pregnancy 1.3.1.1. Ensure consistent availability of dual test kits at every public sector ANC service delivery

point through:

- Adequate procurement forecasting based on projected need, taking required buffer[7]and wastage allowance into consideration;
- Regular tracking and monitoring of stock availability at OD pharmacies and HC/RHs; and
- Close liaison with Central Medical Stores and placement of "exceptional requests" when necessary to avert/correct stock outs.

1.3.1.2. Revise the rules/procedures governing HC refrigerators to allow storage of heat-sensitive reagents/test kits as well as vaccines.

1.3.1.3. Coordinate with midwifery pre-service programs to integrate HIV/syphilis testing and counseling into pre-service curricula

1.3.2. Increase treatment of HIV/syphilis during pregnancy

1.3.2.1. Scale up boosted integrated active case management (B-IACM) through training of providers and OD/PHD managers, and supportive supervision; ensure tracking and follow-up of seropositive women and their infants.

1.3.2.2. Train/monitor HC midwives in implementation of new guidelines for rapid test during labor and delivery if the mother's HIV status is unknown and initiation of ART pending confirmatory test.

1.3.2.3. Ensure emergency supply of ART at RH maternity wards through collaboration with ART sites and monitoring of stock levels by OD/PHD managers.

1.3.2.4. Ensure availability and accessibility of syphilis treatment for pregnant women and newborns.

Strengthen intrapartum and delivery care

Rationale

Quality care during delivery is essential for improving maternal and newborn health and reducing maternal and newborn deaths. Between 2010 and 2014, very good progress was made in increasing the proportion of deliveries by trained health personnel and the proportion of deliveries in health facilities. By 2014, 89% of pregnant women were delivering with a trained health professional, and 83% were delivering in a health facility, and Cambodia exceeded its 2016 targets for both of these indicators.[8]

During this time period, Cambodia also managed to decrease disparities between geographic, income and educational groups, and between 2010 and 2014 the largest increases were seen in the rural, low income, and low education groups. This is likely to be due to a range of supply and demand side interventions that were implemented during this period including increasing availability and competency of midwives, particularly at health center (HC) level, providing incentives for midwives to perform deliveries in health facilities, increasing coverage of health financing schemes that increased access for the poor, and implementing behavior change interventions that increased awareness and demand at community level.

However, despite these advances, there continue to be concerns about the quality of intrapartum care and shortages of secondary midwives at the health center level. In going forward it will be important to focus on improving and better regulating the quality of intrapartum and delivery care in both the public and private sectors, getting two secondary midwives in all HCs, and increasing utilization in poor performing locations

[7] 6 month buffer at national level (CMS), 2 months at OD pharmacies and 1 month buffer at each health facility.
[8] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015.

such as Kratie, Preah Vihear/Stung Treng and Mondolkiri/Rattanakiri, and amongst the poorest, least educated and vulnerable groups.[9]

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

1.4. Strengthen intrapartum/delivery care

1.4.1. Reinforce implementation of safe motherhood protocol

1.4.1.1. Scale-up Midwifery Coordination Alliance Teams (MCATs) to cover all ODs, and use MCAT meetings to present/discuss safe motherhood protocol
1.4.1.2. Update pre-service training curriculum to be consistent with safe motherhood protocol
1.4.1.3. Strengthening capacity of Provincial and OD MCH staff to provide coaching
- Use maternal death/near-miss cases to develop coaching scenarios

1.4.2. Develop/implement innovative strategies to improve awareness and utilization of intrapartum/delivery care particularly in poor performing locations and amongst hard to reach and vulnerable groups (including entertainment workers (EWs), garment factory workers, construction workers, farm workers, minorities and persons with disabilities)

1.4.2.1. Strengthen linkages between health centers (HCs), commune councils, VHSGs, and TBAs in order to promote deliveries in health facilities, and to support referrals when necessary

1.4.3. Strengthen maternal and fetal monitoring during labor and recognition of danger signs and risk factors through use of the partograph

1.4.3.1. Strengthen capacity of hospital preceptors for coaching
1.4.3.2. Improve quality and consistency of partograph use through on-site coaching and supportive supervision.

1.4.4. Strengthen prevention, immediate treatment, stabilization and referral for post-partum hemorrhage

1.4.4.1. Improve the quality of implementation through on-site coaching and supportive supervision
- Use maternal death/near-miss cases to develop coaching scenarios

1.4.5. Strengthen diagnosis, immediate treatment and referral for pre-eclampsia/eclampsia including introducing the use of injectable MgSO4 as a loading dose prior to referral

1.4.5.1. Increase confidence/willingness of EmONC trained midwives to use MgSO4
1.4.5.2. Ensure consistent availability of MgSO4 in all EmONC facilities
1.4.5.3. Improve the quality of implementation through on-site coaching and supportive supervision
- Use maternal death/near-miss cases to develop coaching scenarios

1.4.6. Improve infection prevention and control

[9] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015.

1.4. Strengthen intrapartum/delivery care
1.4.6.1. Improve the quality of implementation through on-site coaching and supportive supervision 1.4.6.2. Ensure required water, sanitation, and waste facilities and disinfection equipment are in place and functional
1.4.7. Reinforce early initiation of exclusive breastfeeding and reduce prelacteal feeding 1.4.7.1. Strengthen support for breastfeeding, and counsel parents/families on appropriate options for working women and risks of breast milk substitutes. 1.4.7.2. Improve/strengthen implementation of Baby Friendly Hospital Initiative (BFHI) including enforcement of Sub-Decree 133 on Marketing of Products for Infants and Young Child Feeding 1.4.7.3. Increase community awareness of the importance of exclusive breastfeeding through commune committees for women and children (CCWC)
1.4.8. Increase regulation/oversight of private maternity clinics 1.4.8.1. Advocate that the new law on regulation of health care facilities and services includes: • Provision that all facilities/services must be in compliance with MoH policies, guidelines and protocols • System for routine reporting and quality assurance of private facilities 1.4.8.2. Reinforce committee under provincial administration to regulate private providers

Increase Coverage of EmONC

Rationale

Good quality Emergency Obstetric and Newborn Care (EmONC) is essential for reducing maternal and newborn morbidity and mortality. In recent years, mixed progress was seen in improving access to EmONC and cesarean sections. Between 2009 and 2015, the number of Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities increased from 25 to 43, the number of Basic Emergency Obstetric and Newborn Care (BEmONC) facilities increased from 19 to 120, and the proportion of deliveries by cesarean section increased from 3% in 2010 to 6.3% in 2014.[10,11,12,13]While Cambodia exceeded its target for C-sections, and nearly met its target for CEmONC facilities, it did not achieve its target for BEmONC facilities and access to EmONC remains largely at hospital level and in urban areas.

There are also new concerns regarding the rapid increase in deliveries by cesarean section (C-Section), particularly in Phnom Penh. The proportion of deliveries by cesarean section in Phnom Penh increased from 9.9% in 2010 to 14.4% in 2014.[14,15]This is not entirely surprising given the improvements in EmONC services in recent years, and that Phnom Penh is home to all of the country's tertiary care facilities. However, C-Section rates will need to be carefully monitored as WHO's 2015 Statement on Cesarean Sections confirms

[10] MoH, Cambodia EmONC Improvement Plan 2010-2015, 2009.
[11] NMCHC, Service Availability Report, 2016.
[12] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2010, 2011.
[13] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015.
[14] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2010, 2011.
[15] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015.

that C-Section rates higher than 10% are not associated with reductions in maternal and newborn mortality.[16]

Between 2017 and 2020, it will be important that priority is given to increasing the quality and availability of EmONC, particularly BEmONC, and fully implementing the new National EmONC improvement plan 2016-2020. Particular attention and support will need to be given to building the capacity of provinces/districts to develop, implement and monitor realistic, local EmONC action plans, and to reducing the number of non-medically indicated caesarean sections in both the public and private sector.

[16] WHO, Statement on Cesarean Section Rates, 2015.

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

1.5. Increase Coverage and Improve Quality of EmONC

1.5.1. Improve the quality and geographic coverage of EmONC

1.5.1.1. Prepare and implement provincial level action plans showing priority actions for each year (2017-2020).
- Priority should be given to increasing the # of functional BEmONC facilities and ensuring that every province has at least 1 functional CEmONC facility (except Kep)

1.5.1.2. Increase competency of staff in designated EmONC facilities to perform core signal functions
- For BEmONC staff, organize hands-on coaching at CEmONC facilities on shortfall signal functions

1.5.1.3. Increase # of designated CEmONC facilities with adequate surgeon (MD capable of C-section)and anesthetist/nurse anesthetist to provide 24/7 service, and the ability to perform blood transfusion (signal functions 8 and 9)

1.5.2. Reduce gaps in basic infrastructure, drugs and equipment in EmONC facilities

1.5.2.1. Upgrade infrastructure based on agreed provincial level action plans 2016-2020

1.5.2.2. Request/procure and install required medical equipment and supplies based on agreed provincial level action plans 2016-2020

1.5.2.3. Ensure regular supply of life-saving drugs for mothers and newborns

1.5.2.4. Develop/strengthen blood depot/blood banks
- Request/procure and install required equipment and material for establishment of blood depots and blood banks
- Establish special blood type donation groups (peers)

1.5.3. Reduce non-medically indicated C-section

1.5.3.1. Develop and disseminate Prakas or instruction on compliance with medical justification of C-section

1.5.3.2. Advocate that new law on regulation of health care facilities and services includes:
- Provision that all facilities/services must be in compliance with MoH policies, guidelines and protocols
- System for routine reporting and quality assurance of private facilities

1.5.3.3. Strengthen C-section counseling to ensure that C-sections are only performed when medically indicated.

1.5.4. Develop anesthesia pre-service training curriculum

1.5.4.1. Establish core team under the Human Resources Department (HRD) or the University of Health Sciences (UHS) to develop anesthesia training curriculum

1.5.4.2. Offer the anesthesia curriculum at recognized universities and/or regional training centers

1.5.5. Increase # of MDs trained as surgeons (capable of doing C-section)

1.5.5.1. Develop curriculum on basic surgery for medical doctors

1.5. Increase Coverage and Improve Quality of EmONC
1.5.5.2. Offer curriculum at selected universities 1.5.5.3. Require public sector MDs trained as surgeons to stay at least 5 years in assigned public sector facility
1.5.6. Improve recording and reporting of obstetric complications and newborn cases in all health facilities 1.5.6.1. Reinforce group coaching at health facilities • Use maternal death/near-miss cases to develop coaching scenarios

Strengthen PNC services

Rationale

Postnatal Care (PNC) is an essential intervention for improving maternal and newborn health, and for reducing maternal and newborn morbidity and mortality. However, like newborn care, it did not receive adequate global (or local) attention in the past, and coverage and quality of care remain limited.

Coverage of early PNC (within 24 hours of delivery) increased between 2010 and 2014, and the proportion of women receiving early PNC exceeded the RSH strategy target for 2016. However, more women received early PNC visits than newborns, early initiation of breastfeeding decreased from 65.8% in 2010 to 62.6% in 2014, and the proportion of women receiving at least 2 PNC visits decreased from 70% in 2010 to 52% in 2014.[17,18] This situation is likely to be due to the limited availability and support for midwives to do outreach for PNC, lack of community awareness of the importance of multiple PNC checks, issues with HEF reimbursement for pre-discharge PNC , and increases in prelacteal feeding particularly amongst urban and wealthy women.

In going forward, it will be important to address the above issues, improve the quality and utilization of PNC services, and increase community awareness of the importance of early and exclusive breastfeeding and 4 PNC checks for both mothers and newborns. As PNC did not received adequate attention in the past, priority will need to be given to increasing quality and utilization of PNC throughout the country, as well as in poor performing locations such as Mondolkiri/Rattanakiri, and amongst vulnerable groups.[19]

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

1.6. Strengthen PNC services
1.6.1. Increase coverage and quality of PNC 1.6.1.1. Strengthen implementation of FULL PNC package (4 visits starting with first PNC check pre-discharge for both mothers and newborns including post-partum micronutrient supplementation and deworming and physical screening of neonates for disabilities and/or birth defects)

[17] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2010, 2011.
[18] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015.
[19] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015.

1.6.1.2. Reinforce importance of 4 PNC checks for BOTH mothers and newborns
1.6.1.3. Undertake PNC home visits during outreach, and develop/implement innovative strategies to increase awareness, availability and utilization of PNC services, particularly in poor performing locations and amongst hard-to-reach and vulnerable populations.
1.6.1.4. Request that HEF allow payment for pre-discharge PNC as a separate service (also included in health financing interventions under objective two)
1.6.1.5. Improve identification and referral for danger signs of neonatal morbidity and mortality, and for birth defects

1.6.2. Increase knowledge and demand for PNC

1.6.2.1. Midwives (or other health care providers) to provide pre-discharge counseling for women, men and families on the importance of 4 PNC visits for both mothers and newborns
1.6.2.2. VHSG/CBD and new social health protection promoters to increase awareness of the importance of 4 PNC visits for both mothers and newborns, and support women/newborns to access PNC care

Strengthen Safe Abortion Services

Rationale

Unsafe abortion is a significant case of maternal morbidity and mortality, and increasing modern contraceptive prevalence and access to safe abortion services are key interventions for reducing unsafe abortion. Between 2010 and 2016, Cambodia made good progress in strengthening safe abortion services, and, as of 2016, 58% of health centers were able to provide safe abortion services.[20] This exceeded the RSH Strategy target of 30% by the end of 2016. However, no progress was made in decreasing the proportion of women seeking multiple abortions, or in the proportion of women reporting unsafe abortions, and only limited progress was made in expanding medical abortion services at health center level. There also continues to be confusion regarding reimbursement of safe abortion services by HEFs, and immediate post-abortion FP services are not currently reimbursable as a separate service.

As can be expected, differences in utilization of abortion services were seen between geographic and educational groups, and, as of 2014,slightly more urban and poorly educated women reported having abortions than their rural and educated counterparts. There were also differences between provinces, and abortions were reported to be highest in Phnom Penh and Banteay Meanchey, and lowest in the north-east provinces, Prey Veng and Kampong Thom. [21]

Between 2017 and 2020, the roll-out of safe abortion services must continue, but additional attention will need to be given to information and access issues, to expanding medical abortion services, and to ensuring that financial protection schemes/payment mechanisms (HEF and the health insurance scheme under the National Social Security Fund) cover both abortion and immediate post-abortion FP services.

[20] NRHP and NGO reports
[21] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015.

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

1.7. Strengthen Safe Abortion Services

1.7.1. Increase coverage and quality of safe abortion services

1.7.1.1. Assess and upgrade eligible facilities (including adequate materials and equipment) and train additional staff on comprehensive abortion care (CAC)

1.7.1.2. Undertake on-going quality assurance and coaching for all facilities performing CAC

- Expand and strengthen local quality assurance and coaching teams

1.7.1.3. Strengthen CAC data collection, recording and reporting systems, and use data for decision making

1.7.2. Increase availability, quality and monitoring of post abortion FP (linked to FP section above)

1.7.2.1. Increase counseling skills and capacity of CAC providers to provide post abortion FP

1.7.2.2. Ensure FP commodities are available in CAC rooms

1.7.2.3. Request that post-abortion FP is included in HIS and CDHS (also included in other section under objective three)

1.7.2.4. Request that HEFs allow payment for immediate post abortion FP as a separate service (also included in health financing interventions under objective two)

1.7.3. Increase availability of medical abortion at the HC level in a phased-in approach

1.7.3.1. Disseminate findings of pilot in selected provinces and agree next steps

1.7.3.2. Extend medical abortion service at HCs providing surgical abortion and provide refresher training/coaching, if necessary

1.7.4. Increase regulation/oversight of private provision of medical and surgical abortion

1.7.4.1. Advocate that the new law on regulation of health care facilities and services includes:

- Provision that all facilities/services must be in compliance with MoH policies, guidelines and protocols
- System for routine reporting and quality assurance of private health facilities

1.7.5. Reduce unsafe and repeat abortions

1.7.5.1. Increase knowledge that abortion is legal

1.7.5.2. Disseminate the abortion law

1.7.5.3. Increase knowledge and awareness of the dangers of unsafe and multiple abortions and where to go for safe abortion services

1.7.5.4. Actively promote post abortion FP

Strengthen Adolescent Friendly Reproductive and Sexual Health (AFRSH) information and services

Rationale

Cambodia is home to the largest youth population in all South East Asia, and increasing availability and access to AFRSH information and services will be essential for addressing the growing problem of teenage pregnancy. Between 2010 and 2016, Cambodia made good progress in increasing the coverage of Comprehensive Sexuality Education and the number of health centers trained to provide adolescent friendly reproductive and sexual health services (AFRSH). The proportion of health centers offering AFRSH services increased from 26% in 2010 to 65% in 2016, and this exceeded the RSH Strategy target of 50% by the end of 2016. However, utilization of these public sector AFRSH services is expected to be low, unmet need for family planning amongst 15-19 year olds is high, and teenage pregnancy is a growing concern, particularly in the northeast of the country and amongst the rural, poor and least educated groups.[22]

These recent increases in teenage pregnancy require further investigation and attention and highlight the need to prioritize the following between 2017 and 2020:

- Design innovative approaches and leverage public private partnerships to address AFRSH particularly in poor performing locations and to reach specific target groups (including entertainment workers (EWs), garment factory workers, construction workers, farm workers, minorities and persons with disabilities);
- Advocate that public and private health facilities with capacity to provide quality AFRSH information and services (e.g. Public Sector Health Facilities trained in AFRSH, RHAC, MSIC, Sun Quality Clinics) are included as contracted facilities under the new Social Protection Scheme;
- Develop youth focused interventions and BCC that promote the delay and spacing of births, particularly in the northeast of the country, and
- Do further research to understand the drivers behind teenage pregnancy and the bottlenecks that adolescents face to access RSH information and services.

Key Interventions

1.8. Strengthen AFRSH information and services
1.8.1. Increase coverage and quality of AFRSH services (public sector) 1.8.1.1. Disseminate new AFRSH service guidelines 1.8.1.2. Do TOT for national and provincial trainers on new AFRSH service guidelines 1.8.1.3. Provinces and ODs to roll-out training to facility level 1.8.1.4. Monitor training roll-out and implementation 1.8.1.5. Ensure on going-coaching and supportive supervision to ensure AFRSH services are provided in line with the national guidelines
1.8.2. Expand public private-partnerships and improve linkages and coordination with other sectors and local authorities 1.8.2.1. Establish the linkages between health facilities, schools and communities

[22] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015, pg. 71.

1.8. Strengthen AFRSH information and services

1.8.2.2. Advocate that public and private health facilities with capacity to provide quality AFRSH information and services (e.g. Government health facilities trained in AFRSH, RHAC, MSIC, Sun Quality Clinics) are included as contracted facilities under the new Health Insurance Scheme that is part of the National Social Security Fund (NSSF).

1.8.3. Design innovative approaches and leverage public private partnerships to address AFRSH particularly in poor performing locations and to reach specific target groups (including entertainment workers (EWs), garment factory workers, construction workers, farm workers, minorities and persons with disabilities);

1.8.3.1. *Entertainment workers:*

- Strengthen and extend RSH information and services to EWs
- Strengthen health education and referral to health services

1.8.3.2. *Garment factory workers/Construction Workers*:

- Finalize and support implementation of the workplace infirmary guidelines in collaboration with Ministry of Labor and Vocational Training (MoLVT)
- Strengthen services and capacity of staff at infirmaries, especially counseling skills and knowledge of referral facilities
- Develop linkages and referral system between workplace infirmaries and outside health facilities, including those contracted under the new health insurance scheme that is part of the NSSF

1.8.3.3. *Migrant farm workers:*

- Strengthen and extend RSH information and services to migrant farm workers
- Strengthen health education and referral to health services

1.8.3.4. *Ethnic Minorities:*

- Strengthen and extend RSH information and services to ethnic minorities
- Sensitize health providers so they can provide more acceptable services

1.8.3.5. Persons with disabilities

- Provide AFRSH information and services in settings accessible to persons with disabilities
- Develop linkages and communication between disabled people's organizations and AFRSH providers
- Strengthen AFRSH education for persons with disabilities through peer/role model approach. This will enable persons with disabilities to provide good examples among their peers and to challenge common misconceptions about the RSH needs and rights of persons with disabilities

1.8.4. Reduce Teenage Pregnancy:

1.8.4.1. Continue expansion of Comprehensive Sexuality Education through MoEYS.

1.8.4.2. Promote delay and spacing of childbearing (particularly in north and northeast of country)

1.8.4.3. Undertake additional research to better understand drivers behind teenage pregnancy and bottlenecks for adolescents to access RSH information and services. Use results to inform design of interventions and BCC. (also included in operational research section below)

Strengthen gynecological services

Rationale

Quality gynecological services are essential for improving the reproductive and sexual health of women, men and young people, and cervical cancer is an emerging concern in the country. Between 2010 and 2016, Cambodia made good progress in strengthening gynecological services and increased the proportion of health facilities (health centers, hospitals and NGO clinics) providing screening for cervical cancer from 0% to 13%, which exceeded the 10% target for the end of 2016. Work is also currently underway to introduce the Human Papilloma Virus (HPV) vaccine.

Cervical cancer is the leading cause of cancer amongst women in Cambodia, and the crude incidence rate is estimated to be higher than the average crude incidence rate for South-East Asia.[23] In 2013, URC, Marie Stopes, EPOS and the Ministry of Health's (MoH) Preventive Medicine Department, introduced a cervical cancer screening programme with HSSP II support, and the MoH subsequently adopted protocols following the latest WHO guidelines. WHO and UNFPA are now supporting the MoH to develop a National Action Plan for the Prevention and Treatment of Cervical Cancer and this is expected to be completed by mid-2017.

Between 2017 and 2020, attention will need to be given to finalizing, implementing and monitoring the national action plan for the prevention and control of cervical cancer, and to expanding screening and treatment services particularly at lower level health facilities. Attention will also need to be given to disseminating the new law on organ donation and transplantation, and the MoH prakas on surrogacy within the health sector.

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

1.9. Strengthen gynecological services
1.9.1. Increase coverage and quality of cervical cancer prevention, screening and treatment services 1.9.1.1. Introduce and roll-out HPV vaccination programme with support from GAVI 1.9.1.2. Finalize, disseminate and monitor implementation of the national action plan for the prevention and treatment of cervical cancer 1.9.1.3. Based on results of existing screening and treatment pilots, expand screening services at health centers and referral/provincial hospitals, and cryotherapy at referral/provincial hospitals 1.9.1.4. Improve infrastructure for cryotherapy 1.9.1.5. Include cervical cancer screening as part of gynecological exams and IUD insertion. 1.9.1.6. Increase awareness of the importance of cervical cancer screening through CBDs, VHSGs and social health protection promoters
1.9.2. Disseminate new law on organ donation and transplantation and MoH prakas on surrogacy

Strengthen GBV/VAW related health services

Rationale

Gender Based Violence (GBV) continues to be a serious issue in Cambodia. The 2015 National Survey on Women's Health and Life Experiences in Cambodia found that 21% of ever partnered women aged 15-64

[23] HPV Information Centre, Human Papillomavirus and Related Diseases Report, 2016.

reported physical and/or sexual abuse and 32% reported emotional violence by an intimate partner. Two thirds of these women reported adverse physical or mental health consequences as a result of this violence, but only half of them ever reported seeking health care for their injuries.[24]

The Ministry of Women's Affairs developed the 2nd National Action Plan to prevent violence against women (VAW) (2014-2018) to address these issues, and the MoH subsequently adopted national guidelines for the management of violence against women and children, and recently developed a clinical handbook, training plan and curriculum. As of 2016, 6% of health facilities (referral hospitals, health centers and NGO clinics) were providing a package of GBV related medical services and referral, but this fell short of the target of 10% by the end of 2016. However, this number is expected to increase rapidly as the new clinical handbook and training curriculum are rolled out in early 2017.

For 2017-2020, attention will need to be given to rolling out the new guidelines, training package and post-training follow-up, and disaggregating cases of violence against women from the overall injury category in the HIS.

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

1.10. Strengthen GBV/VAW related health services
1.10.1. Roll-out new guidelines, clinical handbook, training package and post training follow-up
1.10.2. Ensure privacy and confidentiality for VAW victims in health facilities
1.10.3. Strengthen multi-sectoral collaboration for VAW through national, provincial, district, and commune committees 1.10.3.1. Include GBV/VAW in Health Center Management committee (HCMC), referral hospital and OD meeting discussions 1.10.3.2. Put budget in Commune Investment Plan (CIP) for GBV/VAW service delivery and referral 1.10.3.3. Ensure rapid/timely diagnosis of cases of GBV/VAW 1.10.3.4. Strengthen multi-sectoral referral network/system at all levels
1.10.4. Improve record keeping for GBV/VAW 1.10.4.1. Request that cases of GBV/VAW are disaggregated from the overall injury category in the HIS, and also disaggregated by age, sex and disability, if possible (also included in other section under objective three)

Objective Two

Increase equitable access and quality of RSH services through increased financial and human resources.

[24] Ministry of Women's Affairs, National Survey on Women's Health and Life Experiences in Cambodia, 2015.

Scale up social health protection systems, including health equity funds, that cover the full RSH service package

Rationale

Reduced financial barriers are widely recognized as one of the key drivers behind the impressive increases in the proportion of deliveries by skilled birth attendants and deliveries in health facilities in recent years. Social Health Protection systems expanded between 2010 and 2016, and Health Equity Funds (HEFs) covered 88 or 100% of Operational Districts by the end of 2016. This exceeded the RSH Strategy target of 77 Operational Districts by the end of 2016.

While HEFs expanded in multiple dimensions during this time period, including increased geographic coverage and increased coverage of Sexual, Reproductive, Maternal and Newborn Health Services at both the health center and referral hospital level, there continue to be gaps in the HEF benefit package/reimbursement system. For example, abortion is not explicitly included or excluded in the benefit package, and this results in it is not being claimed or reimbursed. The same is true for cervical cancer, and reimbursement is not currently allowed for pre-discharge postnatal care (PNC), and immediate post-partum and post-abortion family planning services.

Reproductive Health (RH) vouchers also expanded between 2013 and 2016, and as of the end of 2016, the voucher scheme for reproductive health care and vulnerable groups covered six provinces and 21 Operational Districts (ODs). This scheme provides coverage for abortion, immediate post-abortion and post-partum family planning, cervical cancer and long-acting and permanent contraceptive methods in both the public and private sectors. However, this scheme will be integrated into HEF support starting in mid-2017, and there is a need to ensure that coverage for these services and related costs are not lost.

In going forward it will be important to rectify the above reimbursement issues, and to ensure that coverage for services and transport costs currently being paid for through the voucher scheme are not entirely lost. It will also be important to ensure that the new Health Insurance Scheme that is part of the National Social Security Fund (NSFF) covers the full RSH service package at all levels of care where services are provided.

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

2.1. Scale up social health protection systems, including health equity funds, that cover the full RSH service package
2.1.1. Advocate for 100% coverage of the poor with HEFs, and 100% coverage of formal sector workers/civil servants with the NSSF Health Insurance Scheme which have benefit packages/payment systems that cover the full RSH service package at all levels of care where services are provided (including pre-discharge PNC, immediate post-partum and post-abortion FP, comprehensive abortion care and cervical cancer.)
2.1.2. Advocate that public and private health facilities with capacity to provide quality AFRSH information and services (e.g. Government health facilities trained in AFRSH, RHAC, MSIC, Sun Quality Clinics) are included as contracted facilities under the new Health Insurance Scheme that is part of the National Social Security Fund (NSSF).
2.1.3. Advocate for role of new social health protection promoters (former health equity fund promoters) to include promoting awareness of social protection scheme benefits and access to quality RSH services in both public and private sector facilities • Particular attention being given to promoting awareness of benefits and access amongst

vulnerable groups (ethnic minorities, migrants, factory workers, people with disabilities, etc.)
2.1.4. Request that HEF reimbursement system allow the following: • Reimbursement of immediate postpartum family planning and post abortion family planning as separate services (reimbursement for delivery or abortion + reimbursement for immediate FP provision (example: IUD insertion)) • Reimbursement of pre-discharge PNC as a separate service (reimbursement for delivery + reimbursement for PNC); reimbursement for PNC should only be provided if the service is for BOTH mother and child. • Reimbursement of transport costs for poor patients (with poor ID) seeking RSH services at the HC (as well as at the referral hospital)
2.1.5. Request development and dissemination of prakas or instruction that clarifies that safe abortion services (CAC) (and cervical cancer screening and cryotherapy) are allowed to be claimed and reimbursed under the HEF scheme

Increase government financing for RSH services

Rationale

Government expenditure on health and contraceptive commodities increased in recent years and this is essential for long-term sustainability of service delivery and demand side financing initiatives. Between 2010 and 2014, the overall value of the health budget increased from 160 Million US Dollars (USD) to 241 Million USD, and from 6.5% to 7.6% of the overall government budget.[25] Government financing of contraceptive commodities also increased during this period and went from USD $100,000 in 2014 to USD $2.00 million in 2016. The increase in the government's financing of contraceptive commodities is a very positive step toward forward. It is essential for long-term commodity security, and it also has the double benefit of reducing health service costs associated with unwanted pregnancies, deliveries and abortions.

In going forward, it will be important to advocate for increased government expenditure on RSH, and to reinforce the importance of improving reproductive and sexual health as a means of achieving the goals set out in the Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality, the new Health Strategic Plan, the National Strategic Development Plan and the Sustainable Development Goals.

[25] MoH, Bureau of Health Economics and Financing, Department of Planning and Health Information, Annual Health Financing Report 2015, 2015.

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

2.2. **Increase government financing for RSH services**
2.2.1. Advocate for increased government health expenditure on RSH (including commodity procurement, routine govt. budget and service delivery grants) 2.2.1.1. Build capacity of health facility staff in financial management 2.2.1.2. Advocate for including the following in the Commune Investment Plan (CIP): • HCMC and VHSG activities (including outreach related to RSH, GBV/VAW, AFRSH, etc.) • AFRSH activities • GBV/VAW service delivery and referral 2.2.1.3. Maintain support for the Midwifery Incentive (incentive for midwives performing deliveries at health facilities) 2.2.1.4. Advocate for increased government budget for IEC materials/BCC activities for RSH, FP, GBV/VAW, AFRSH, nutrition, etc.

Improve the competence and availability of midwives

Rationale

In addition to reducing financial barriers to care, increasing the competence and availability of midwives, particularly at health center level, is seen as a key driver behind the impressive increases in the proportion of deliveries by skilled birth attendants and deliveries in health facilities in recent years. Between 2010 and 2016, Cambodia increased the number of health centers with 2 midwives from 77% to 81%, but the country fell short of reaching its target of 85% by the end of 2016.

In going forward, it will be important to address these outstanding coverage gaps, and to update and rationalize midwifery pre-service training. It will also be important to strengthen the technical and socio-cultural skills of existing midwives through competency-based training, supportive supervision and expanding opportunities for practice and on-site coaching.

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

2.3. **Improve the competence and availability of midwives**
2.3.1. Pre-Service: 2.3.1.1. Update the pre-service midwifery curriculum, strengthen practical training for midwifery students and expand the preceptor program • Ensure that all RSH services (including EmONC, AFRSH, GBV/VAW, cervical cancer, abortion, newborn screening of birth defects etc.) AND RSH rights and socio-cultural awareness (e.g. gender, disability, ethnicity and adolescence, etc.) are included in the pre-service curriculum • Prioritize enrollment of local students in pre-service training from locations where HCs don't yet have enough midwives 2.3.1.2. Rationalize existing midwifery pre-service training courses 2.3.1.3. Undertake review of Associate and Bachelor Degrees 2.3.1.4. Undertake Midwifery review

2.3.1.5. Develop Midwifery Education Pathways
2.3.1.6. Develop Midwifery Education Regulatory Framework

2.3.2. In-Service:

2.3.2.1. Strengthen midwifery technical skills and socio-cultural awareness through competency-based training, supportive supervision and through expanding opportunities for practice and on-site coaching
- Establish skill labs at CPA3 RHs
- Rotate care providers from low case facilities to high case facilities
- Increase capacity and professional development (CPD) opportunities for provincial trainers/supervisors and coaches

2.3.2.2. Reinforce quarterly midwifery coordination and alliance team (MCAT) meetings
- Use MCAT meetings to update midwives on new protocols, guidelines, prakas, socio-cultural awareness, etc.
- Involve MDs and midwives from RHs in MCAT sessions to clarify issues regarding complicated deliveries, and to provide feedback on referral cases.

2.3.3. Regulation and Licensing: Strengthen registration, licensing and relicensing systems

2.3.3.1. Finalize and implement new law on regulation of health practitioners

2.3.4. Availability: Increase the number of secondary midwives at HC level

2.3.4.1. Civil service recruitment of secondary midwives for HCs
2.3.4.2. Explore options of contracting secondary midwives at HC level and/or upgrading primary midwives to secondary midwives
2.3.4.3. Advocate for appropriate incentive for secondary midwives who work in remote areas

Objective Three

Increase equitable access and quality of RSH services through strengthened RSH information systems.

Strengthen Maternal Death Surveillance and Response (MDSR) system

Rational

A Maternal Death Surveillance and Response System is an important tool for reducing maternal mortality. It is a continuous action cycle consisting of four steps: 1) identify suspected maternal deaths; 2) confirm maternal deaths, and assess quality of care received and any non-medical factors contributing to the deaths; 3) analyze the avoidable factors and make immediate recommendation for corrective actions; and 4) implement recommendations and monitor responses. This type of system helps health professionals understand when, where and why mothers have died, and supports them to design appropriate actions to prevent similar maternal deaths in the future.

Between 2010 and 2016, Cambodia made very good progress in strengthening and expanding its maternal death surveillance and response system. The country audited 90% (90/100) of its reported maternal deaths in 2015, and exceeded its 2016 RSH Strategy target of 50%. In 2015 it also updated the membership and roles and responsibilities of the National Maternal Death Audit Committee, and the National Protocol for

Maternal Death Audit. While these changes have had positive impact, a recent study showed that capacity and financing for maternal death surveillance and response, particularly at the provincial and district level, remains weak, and there is a need to increase involvement of provincial technical experts and to increase capacity of provincial committee members to develop and implement actionable recommendations.

In going forward, it will be important that these issues are addressed, and that government budget is available to fund the MDSR system on an on-going basis.

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

3.1. Strengthen Maternal Death Surveillance and Response (MDSR) system
3.1.1. Strengthen capacity of the National Maternal Death Audit Committee to support Maternal Death Audits (MDA)in national hospitals and provinces 3.1.1.1. Organize quarterly national maternal audit committee meetings to review maternal death reports from provincial committees and national hospitals and to provide feedback. 3.1.1.2. Monitor and provide hands-on coaching to the provincial maternal death audit committees and national hospitals. • Use information from previous MDAs to develop case scenarios that can be used for on-site coaching 3.1.1.3. Develop and disseminate instructions/directives to public and private facilities on the requirements for maternal death audits and reports. 3.1.1.4. Provide guidance on the investigation of deaths across provinces and national hospitals 3.1.1.5. Monitor implementation of recommendations through provincial and national MDA committee meetings and annual meeting.
3.1.2. Increase capacity and financing for MDSR, particularly at the provincial and district level 3.1.2.1. Strengthen provincial/district capacity to develop and implement actionable recommendations 3.1.2.2. Increase involvement of provincial technical experts
3.1.3. Improve linkages to vital registration system 3.1.3.1. Improve linkages between the health center and the commune office where the health center is located
3.1.4. Consider introducing investigation of near misses 3.1.4.1. Apply MDA review format to near misses and use the result to provide feedback during MCAT meetings and to develop coaching scenarios.

Introduce Neonatal Death Review/Audit system

Rationale

Similar to Maternal Death Surveillance and Response, Neonatal Death Review also consists of a four step action cycle and helps health professionals understand when, where and why neonates have died, and supports them to design appropriate actions to prevent similar neonatal deaths in the future. While

Cambodia has been planning to introduce a neonatal death audit system for some time, the introduction of the system was postponed pending publication of the new WHO guide for audit and review of stillbirths and neonatal deaths.

As the new WHO guide was released in 2016, Cambodia can now move forward with development and introduction of the new neonatal death review/audit system, and it is expected that development of the new system will start in 2017.

Key Interventions

To address the above, the following interventions have been prioritized for 2017-2020.

3.2. Introduce Neonatal Death Review/Audit system
3.2.1. Develop Cambodian Neonatal Death Review/Audit system through adapting and contextualizing new WHO guidelines
3.2.2. Integrate/link perinatal death audit system with MDSR system

Conduct Operational Research and Other

Rationale

Operational Research is a tool for improving programming. Between 2010 and 2016, Cambodia undertook in-depth research on the causes of maternal anemia and on reproductive preferences in Cambodia, and the country has recently identified a number of priority research areas for 2017-2020. These research areas are based on the issues and priorities noted in the above sections and include teenage pregnancy, non-iron deficiency anemia and traditional family planning usage.

Cambodia has also identified a number of HIS related interventions for 2017-2020 and these are also noted below.

Key Interventions

The following interventions have been prioritized for 2017-2020.

3.3. **Conduct Operational Research**
3.3.1. Undertake pilot studies and/or commission research. Priority research topics include: • Teenage pregnancy – drivers of teenage pregnancy and bottlenecks to adolescents accessing RSH information and services • Traditional family planning methods- drivers and how to reduce
3.4. **Other**
3.4.1. Request that cases of GBV/VAW are disaggregated from the overall injury category in the HIS, and also disaggregated by age, sex and disability, if possible (also included in GBV/VAW section under objective one)
3.4.2. Request that post-abortion FP is included in HIS and CDHS (also included in post abortion FP section under objective one)
3.4.3. Request disaggregation of married and unmarried within 15-19 and 19-24 yr. age groups

Monitoring and Evaluation

The National Strategy for Reproductive and Sexual Health in Cambodia 2017-2020 will be monitored on an annual basis using the monitoring and evaluation framework included below. A more thorough review will be undertaken in 2020 when new CDHS data is available.

The monitoring and evaluation framework was developed through a participatory process and indicators and targets are aligned with the new Health Strategic Plan, the Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality, and the new National Strategic Plan for Prevention of Mother-to-Child Transmission of HIV, Syphilis and Hepatitis B. Where relevant indicators and targets were not already available, global indicators or CDHS indicators were used to ensure ease and consistency of reporting.

Annex 1: Monitoring Framework

	Indicator	2010	Baseline	Target 2020	Source
Goal					
To contribute to the better health and well-being of all people in Cambodia by improving the RSH status and rights of women, men and young people.	Maternal Mortality Ratio	206 per 100,000	170 (2014)	130	CDHS
	Neonatal Mortality Rate	27 per 1,000	18 (2014)	14	CDHS
	Total Fertility Rate	3.0	2.7 (2014)	2.5	CDHS
	Adolescent Birth rate (15-19)	46	57 (2014)	51	CDHS
	Teenage Pregnancy Rate (15-19 yrs.)	8.2%	12% (2014)	8%	CDHS
	Unmet need for Family Planning	16.6%	11.9% (2014)	8%	CDHS
	Unmet need for birth spacing	6%	5% (2014)	4%	CDHS
	Unmet need for birth limiting	10.6%	6.9% (2014)	4%	CDHS
	% of women of reproductive age (15-49) whose need for family planning is satisfied (with a modern contraceptive method)	50.5%	56.3% (married women) (2014)	62%	CDHS
Objectives					
1. Increase equitable access and quality of RSH services through strengthened governance and service delivery.	Modern Contraceptive Prevalence Rate (married women)	35%	39% (2014)	48%	CDHS, HIS
	% of currently married women using traditional FP methods	15.7%	17.5%	15%	CDHS
	% of currently married women using LAPM (sterilization, implants, IUDs)	6%	9.6% (2014)	14%	CDHS
	% of pregnant women receiving at least 4 ANC checks	59.4% (2010)	75.6% (2014)	90%	CDHS, HIS

	Indicator	2010	Baseline	Target 2020	Source
	% of pregnant women who had a blood sample taken during ANC	15.3% (2010)	77.1% (2014)	90%	CDHS
	% ANC clients tested for HIV and received their results	41.7% (CDHS 2010)	82.5% (2015) (PMTCT database) 70.3% (CDHS 2014)	> 95%	PMTCT database OR CDHS
	% HIV+ pregnant women who receive ART during pregnancy	45% (2010)	75.5% (2014)	90%	Cambodia Country Progress Report NAA OR PMTCT database
	% of deliveries by trained health personnel (overall and disaggregated by income quintile and educational group)	71% (2010) 47% (no education) 49% (lowest income)	89% (2014) 72% (no education) 75% (lowest income)	90% 80% (no education) 80% (lowest income)	CDHS, HIS
	% of deliveries in a health facility (overall and disaggregated by income quintile and educational group)	54% (overall) 34% (no education) 35% (lowest income)	83% (overall) 68% (no education) 68% (lowest income quintile)	90% (overall) 80% (no education) 80% (lowest income quintile)	CDHS, HIS
	% of deliveries by caesarian section (overall and subnational)[26]	Overall: 3% Kampong Speu:1.1% Pursat:2.1%	Overall: 6.3% Kampong Speu: 2.2% Pursat: 2.2%	Overall: 10% Subnational: No province below 3.5% and Phnom Penh not	CDHS, HIS

[26] Showing locations with lowest and highest C-section rates for 2010 and 2014 (CDHS)

	Indicator	2010	Baseline	Target 2020	Source
		Preah Vihear/Stung Treng: 0.9% Phnom Penh:9.9%	Preah Vihear/Stung Treng: 2.3% Phnom Penh: 14.4%	above 17%	
	# EmONC facilities per 500,000 population	1.64 (2009)	4.84 (2015)	≥5.0 (≥160 EmONC facilities)	EmONC assessment + NMCHC service delivery report
	% of women who have postpartum contact with a health provider within 2 days of delivery	70%	90% (2014)	95%	CDHS, HIS
	% of newborns who have postnatal contact with a health provider within 2 days of delivery	NA	76.5%	95%	CDHS, HIS
	% of women who receive at least 2 PNC checks	70%	52.26%	60%	HIS ,CDHS
	% of infants who were breastfed within 1 hr. of birth	66%	63%	75%	CDHS
	Abortion Rate (last 5 yrs.)	5%	6.9%	5%	CDHS
	# and % of public and NGO/Private health facilities [27] providing safe abortion services	Total: 175 (Health Sector Progress Report)	Public: 762/1248 (61%) NGO/ Private: 200/249 (80%) TOTAL: 962/ 1497 (64%) SPF: 88 RH+ 559 HC PSK: 179 sun quality clinic MSI:13 RH+ 102 HCs+	Public: 811/1248 (65%) NGO/ Private: 224/249 (90%) TOTAL: 1035/1497 (69%)	Health Sector Progress Report 2015 + NRHP and NGO reports

[27] # of Health Facilities = Nat. hospital + RH + HC + NGO clinic. As of 2015: # of h. facilities: all hospitals (8+99) + HC (1141) + NGO clinic (6 MSI; 15 RHAC; 179 /228 Sun Quality). Public = 107+1141= 1248; NGO = 200; Total: 1448

	Indicator	2010	Baseline	Target 2020	Source
			6 MSI clinics RHAC: 15 RHAC		
	% of women reporting multiple abortions	1.4%	3.6% (2014)	2.0%	CDHS
	% of women reporting an abortion who did not have help from a health professional at the time of the last abortion	40%	40% (2014)	30%	CDHS
	# and % of public and NGO/ Private health facilities[28] providing AFRSH services	Total: 26% (Health Sector Progress Report)	Public: 718/1240 (58%) (2014) NGO/ Private: 15/249= 6% (2015) TOTAL: 733/1489= 49% Public: 718 HCs and RHs MSI: 0 MSI clinics RHAC = 15 RHAC clinics PSK: 0 sun quality clinics	Public: 770/1240 (62%) NGO/ Private: 15/249 (6%) TOTAL: 785/1489 (53%)	NRHP and NGO/ Private reports and Health Sector Progress Report
	# and % of public and NGO/ Private health facilities[29] providing cervical cancer screening	Public: 0, 0% NGO/ Private: 0, 0%	Public: 161/1248 (13%) NGO/ Private: 31/249 (12%) TOTAL: 192/1497 (13%) EPOS: 118 HCs and 15 RHs =133 MSI: 1 public + 6	Public: 312/1248 (25%) NGO/ Private: 62/249 (25%) TOTAL: 374/1497 (25%)	Preventive Medicine and NGO/ Private reports

[28] # of Health Facilities = referral hospitals + health centers + NGO clinics. As of 2015: # of h. facilities: referral hospitals (99) + HC (1141) + NGO clinic (6 MSI; 15 RHAC; 228 Sun Quality). Public = 99+1141= 1240; NGO = 249; Total: 1489

[29] # of Health Facilities = National Hospitals + Referral Hospitals + Health Centers + NGO clinics. As of 2015: # of h. facilities: all hospitals (8+99) + HC (1141) + NGO clinic (6 MSI; 15 RHAC; 228 Sun Quality). Public = 107+1141= 1248; NGO = 249; Total: 1497

	Indicator	2010	Baseline	Target 2020	Source
			MSI= 7 RHAC = 15 RHAC PSK: 10 sun quality clinics Govt. Pilot: 4 NH, 1, RH + 15 HC (K. Cham)=20 WHO Pilot: 2 RH + 5 HC (Takeo + Siem Riep)= 7		
	# and % of public and NGO health facilities[30] providing GBV/VAW related medical services and referral	Public: 0, 0% NGO: 0, 0%	Public: 77/1240 (6%) NGO: 15/249 (6%) TOTAL: 92/1489 (6%) CARE: RH+HC= 21 RHAC: 15 RHAC GIZ: RH+HC= 18 CWPD: RH + HC = 38	Public: 186/1240 (15%) NGO: 15/249 (6%) TOTAL: 201/1489 (13%)	NRHP and NGO reports
2. Increase equitable access and quality of RSH services through increased financial and human resources.	% of health facilities[31] covered by formal payment systems whose benefit package includes the full RAMNCHN service package	23% of health facilities covered by HEF (282/1203) (benefit package/payment system partially covered full RAMNCHN service package)	89% of health facilities covered by HEF (1186/1329) (payment system covers full RMNH service package except immediate post-partum and post-abortion FP, pre-discharge PNC, cervical cancer and abortion) (2015)	100%	MoH reports
	Total health expenditure on RAMNCHN (and as a % of total health expenditure)	265.48M USD (25.7% of total health expenditure) (2012)	257.89M USD (24.4% of total health expenditure) (2014)	27%	NHA
	Government health		29.01M USD	25%[32]	NHA

[30] Health Facilities = Referral Hospital + Health Centers + NGO clinics. As of 2015: # of h. facilities: RH (99) + HC (1141) + NGO clinic (6 MSI; 15 RHAC; 228 Sun Quality). Public = 99+1141= 1240; NGO = 249; Total: 1489

[31] Health Facilities = National Hospitals + Referral Hospitals + Health Centers+ Health Posts (2010=1203; 2014=1317, 2015=1329)

[32] How to calculate: Based in NHA report. Nominator: RSMNCH budget (programme 1) + ¼ of HSS programme (programme 4). Denominator: Total annual health budget

	Indicator	2010	Baseline	Target 2020	Source
	expenditure on RAMNCHN (and as a % of govt. health expenditure)		(13.8% of government health expenditure) (2014)		
	% of health centers with at least 2 secondary midwives	Not available	41% (452/1105) (2015)	50%	MoH Staff reports
3. Increase equitable access and quality of RSH services through strengthened RSH information systems.	% of maternal deaths investigated through MDSR system	30%	90% (90/100) (2015)	95%	NMCHC Report
	Neonatal death audit system established and functional	No neonatal death audit system	No neonatal death audit system	Neonatal death audit system in place and functional	NMCHC Report

Annex 2: Key Intervention Framework

Key Intervention Areas
Objective 1: Increased equitable access and quality of RSH services through strengthened governance and service delivery
1.1. Strengthen FP information and services
1.1.1. Increase quality and availability of FP services 1.1.1.1. Increase capacity of service providers for FP counseling and service provision through training, on-site coaching and supportive supervision 1.1.1.2. Develop and implement innovative strategies to improve awareness and utilization of FP services in poor performing locations and amongst highest need groups (e.g. 15-24 year olds, 40-49 year olds, unmarried, poorest, least educated) and vulnerable groups (including entertainment workers (EWs), garment factory workers, construction workers, farm workers, minorities and persons with disabilities) • Offer FP services on weekends • Use Community Based Distribution (CBD)/mobile services for hard to reach populations 1.1.1.3. Rationalize existing CBD coverage, and increase coverage in remote and hard to reach locations
1.1.2. Increase availability and utilization of long-term/permanent FP methods 1.1.2.1. All Referral Hospitals should be able to provide at least 3 long-term/permanent FP methods • Create a separate section for FP at RH • Increase capacity of RH staff to provide counseling and service provision for long-term methods through training, coaching and supportive supervision 1.1.2.2. All HCs should be able to provide at least 1 long-term FP method (IUD and/or implants) • Increase capacity of HC staff to provide counseling and service provision for long-term methods through training, coaching and supportive supervision 1.1.2.3. Review comparative pricing of contraceptives (LAPM vs. short term methods) in public sector health facilities and revise if necessary 1.1.2.4. Produce and disseminate FP IEC materials 1.1.2.5. Increase male involvement in IEC and behavior change interventions 1.1.2.6. Consider expanding CBD activities to include promotion of LAPM and referral to appropriate health facilities.
1.1.3. Increase availability and utilization of post-partum FP services (interventions related to post abortion FP can be found in the safe abortion services section below) 1.1.3.1. Reinforce implementation of updated birth spacing guidelines which include immediate postpartum family planning. • Use Midwifery Coordination Alliance Team (MCAT) meetings to present/discuss new birth spacing guidelines

Key Intervention Areas
1.1.3.2. Ensure FP commodities available in maternity wards 1.1.3.3. Request that HEF allow payment for immediate post-partum FP as a separate service (also included in health financing interventions under objective two)
1.1.4. Ensure FP commodity security 1.1.4.1. Finalize and Disseminate 2016 RH commodity forecasting and costing report and ensure contraceptive supply to the public sector. 1.1.4.2. Use 2016 RH commodity forecasting and costing report to advocate for govt. financial commitments for RH commodities 2017-2020 and onward. 1.1.4.3. Strengthen function of commodity security working group. 1.1.4.4. Strengthen Logistics Management Information System (LMIS)
1.1.5. Strengthen public-private partnership to ensure quality FP service provision and timely and accurate reporting from the private sector 1.1.5.1. Strengthen partnerships with private sector providers through periodic meetings 1.1.5.2. Advocate that new law on regulation of health care facilities and services includes: • Provision that all facilities/services must be in compliance with MoH policies, guidelines and protocols • System for routine reporting and quality assurance of private health facilities
1.1.6. Reduce Traditional Family Planning Usage 1.1.6.1. Increase knowledge that traditional FP methods (particularly withdrawal) are not effective or reliable, and reduce fears and mis-information about modern contraceptives • Strengthen FP counseling skills of public and private sector providers through training, coaching and supportive supervision • Awareness raising or campaign using mass media
1.2. Strengthen ANC services
1.2.1. Increase coverage and quality of ANC 1.2.1.1. Reinforce FULL ANC service package (as outlined in the Safe Motherhood protocol for Health Centers) through training, on-site coaching and supportive supervision. (At least 4 ANC visits (ANC 4+) starting immediately after menstrual period has stopped; components include weight monitoring; checks for pre-eclampsia, anemia, syphilis, HIV; provision of preventive measures (including micronutrient supplementation and deworming) and counseling on family planning, nutrition and self- care, and breastfeeding etc.) 1.2.1.2. Strengthen outreach activities and develop and implement innovative strategies to increase awareness and utilization of ANC services especially in poor performing locations and amongst high-risk, hard-to-reach and vulnerable populations. 1.2.1.3. Integrate ANC service to hospital service package (CPA) and setting up ANC services in

Key Intervention Areas
all provincial and district hospitals
1.2.2. Increase knowledge and demand for ANC4+ 1.2.2.1. Increase knowledge and practice of FULL ANC service package (starting immediately after menstrual periods stop) 1.2.2.2. Encourage Village Health Support Group (VHSG), Community Based Distributors (CBDs) and other health promoters to support access to ANC services 1.2.2.3. Increase male involvement in IEC and behavior change interventions
1.3. Increase identification and treatment of HIV/Syphilis during pregnancy
1.3.1. Increase identification of HIV/syphilis during pregnancy 1.3.1.1. Ensure consistent availability of dual test kits at every public sector ANC service delivery point through: • Adequate procurement forecasting based on projected need, taking required buffer[33] and wastage allowance into consideration; • Regular tracking and monitoring of stock availability at OD pharmacies and HC/RHs; and • Close liaison with Central Medical Stores and placement of "exceptional requests" when necessary to avert/correct stock outs. 1.3.1.2. Revise the rules/procedures governing HC refrigerators to allow storage of heat-sensitive reagents/test kits as well as vaccines. 1.3.1.3. Coordinate with midwifery pre-service programs to integrate HIV/syphilis testing and counseling into pre-service curricula
1.3.2. Increase treatment of HIV/syphilis during pregnancy 1.3.2.1. Scale up boosted integrated active case management (B-IACM) through training of providers and OD/PHD managers, and supportive supervision; ensure tracking and follow-up of seropositive women and their infants. 1.3.2.2. Train/monitor HC midwives in implementation of new guidelines for rapid test during labor and delivery if the mother's HIV status is unknown and initiation of ART pending confirmatory test. 1.3.2.3. Ensure emergency supply of ART at RH maternity wards through collaboration with ART sites and monitoring of stock levels by OD/PHD managers. 1.3.2.4. Ensure availability and accessibility of syphilis treatment for pregnant women and newborns.
1.4. Strengthen intrapartum/delivery care
1.4.1. Reinforce implementation of safe motherhood protocol 1.4.1.1. Scale-up Midwifery Coordination Alliance Teams (MCATs) to cover all ODs, and use MCAT meetings to present/discuss safe motherhood protocol 1.4.1.2. Update pre-service training curriculum to be consistent with updated safe motherhood

[33] 6 month buffer at national level (CMS), 2 months at OD pharmacies and 1 month buffer at each health facility.

Key Intervention Areas
protocol 1.4.1.3. Strengthening capacity of Provincial and OD MCH staff to provide coaching to HCs and RHs 1.4.1.4. Use maternal death/near-miss cases to develop coaching scenarios
1.4.2. Develop/implement innovative strategies to improve awareness and utilization of intrapartum/delivery care particularly in poor performing locations and amongst hard to reach and vulnerable groups (including entertainment workers (EWs), garment factory workers, construction workers, farm workers, minorities and persons with disabilities) 1.4.2.1. Strengthen linkages between health centers (HCs), commune councils, VHSGs, and TBAs in order to promote deliveries in health facilities, and to support referrals when necessary
1.4.3. Strengthen maternal and fetal monitoring during labor and recognition of danger signs and risk factors through use of the partograph 1.4.3.1. Strengthen capacity of hospital preceptors for coaching 1.4.3.2. Improve quality and consistency of partograph use through on-site coaching and supportive supervision
1.4.4. Strengthen prevention, immediate treatment, stabilization and referral for post-partum hemorrhage 1.4.4.1. Improve the quality of implementation through on-site coaching and supportive supervision • Use maternal death/near-miss cases to develop coaching scenarios
1.4.5. Strengthen diagnosis, immediate treatment and referral for pre-eclampsia/eclampsia including introducing the use of injectable MgSO4 as a loading dose prior to referral 1.4.5.1. Increase confidence/willingness of EmONC trained midwives to use MgSO4 1.4.5.2. Ensure consistent availability of MgSO4 in all EmONC facilities 1.4.5.3. Improve the quality of implementation through on-site coaching and supportive supervision • Use maternal death/near-miss cases to develop coaching scenarios
1.4.6. Improve infection prevention and control 1.4.6.1. Improve the quality of implementation through on-site coaching and supportive supervision 1.4.6.2. Ensure required water, sanitation, and waste facilities and disinfection equipment are in place and functional
1.4.7. Reinforce early initiation of exclusive breastfeeding and reduce prelacteal feeding

Key Intervention Areas

1.4.7.1. Strengthen support for early and exclusively breastfeeding, and counsel parents/families risks of breast-milk substitutes and appropriate options for working women including breast-milk expression

1.4.7.2. Improve/strengthen implementation of Baby Friendly Hospital Initiative (BFHI) including enforcement of Sub-Decree 133

1.4.7.3. Increase community awareness of the importance of exclusive breastfeeding through commune committees for women and children (CCWC)

1.4.8. Increase regulation/oversight of private maternity clinics

1.4.8.1. Advocate that the new law on regulation of health care facilities and services includes:

- Provision that all facilities/services must be in compliance with MoH policies, guidelines and protocols
- System for routine reporting and quality assurance of private facilities

1.4.8.2. Reinforce committee under provincial administration to regulate private providers

1.5. Increase Coverage and Improve Quality of EmONC

1.5.1. Improve the quality and geographic coverage of EmONC

1.5.1.1. Prepare and implement provincial level action plans showing priority actions for each year (2017-2020).

1.5.1.2. Priority should be given to increasing the # of functional BEmONC facilities and ensuring that every province has at least 1 functional CEmONC facility (except Kep)

1.5.1.3. Increase competency of staff in designated EmONC facilities to perform core signal functions

1.5.1.4. For BEmONC staff, organize hands-on practical training with patients at CEmONC facilities on shortfall signal functions

1.5.1.5. Increase # of designated CEmONC facilities with adequate surgeon (MD capable of C-section)and anesthetist/nurse anesthetist to provide 24/7 service, and the ability to perform blood transfusion (signal functions 8 and 9)

1.5.2. Reduce gaps in basic infrastructure, drugs and equipment in EmONC facilities

1.5.2.1. Upgrade infrastructure based on agreed provincial level action plans 2016-2020

1.5.2.2. Request/procure and install required medical equipment and supplies based on agreed provincial level action plans 2016-2020

1.5.2.3. Ensure regular supply of life-saving drugs for mothers and newborns

1.5.2.4. Develop/strengthen blood depot/blood banks

- Request/procure and install required equipment and material for establishment of blood depots and blood banks
- Establish special blood type donation groups (peers)

1.5.3. Reduce non-medically indicated C-section

1.5.3.1. Develop and disseminate Prakas or instruction on compliance with medical justification of C-section

Key Intervention Areas
1.5.3.2. Advocate that new law on regulation of health care facilities and services includes: • Provision that all facilities/services must be in compliance with MoH policies, guidelines and protocols • System for routine reporting and quality assurance of private facilities 1.5.3.3. Strengthen C-section counseling to ensure that C-sections are only performed when medically indicated.
1.5.4. Develop anesthesia pre-service training curriculum 1.5.4.1. Establish core team under the Human Resources Department (HRD) or the University of Health Sciences (UHS) to develop anesthesia training curriculum 1.5.4.2. Offer the anesthesia curriculum at recognized universities and/or regional training centers
1.5.5. Increase # of MDs trained as surgeons (capable of doing C-section) 1.5.5.1. Develop curriculum on basic surgery for medical doctors 1.5.5.2. Offer curriculum at selected universities 1.5.5.3. Require public sector MDs trained as surgeons to stay at least 5 years in assigned public sector facility
1.5.6. Improve recording and reporting of obstetric complications and newborn cases in all health facilities 1.5.6.1. Use maternal death/near-miss and obstetric complicated cases for developing coaching scenarios to improve recording and reporting practices at health facilities
1.6. Strengthen PNC services
1.6.1. Increase coverage and quality of PNC 1.6.1.1. Strengthen implementation of FULL PNC package (4 visits starting with first PNC check pre-discharge for both mothers and newborns including post-partum micronutrient supplementation and deworming and physical screening of neonates for disabilities and/or birth defects) 1.6.1.2. Reinforce importance of 4 PNC checks for BOTH mothers and newborns 1.6.1.3. Undertake PNC home visits during outreach, and develop/implement innovative strategies to increase awareness, availability and utilization of PNC services, particularly in poor performing locations and amongst hard-to-reach and vulnerable populations 1.6.1.4. Improve identification and referral for danger signs of neonatal complications, and for birth defects.
1.6.2. Increase knowledge and demand for PNC 1.6.2.1. Midwives (or other health care providers) to provide pre-discharge counseling for women, men and families on the importance and appropriate timing of 4 PNC visits for both mothers and newborns

Key Intervention Areas

1.6.2.2. VHSG/CBD and other health promoters to increase awareness of the importance and appropriate timing of 4 PNC visits for both mothers and newborns, and support women/newborns to access PNC care

1.7. Strengthen Safe Abortion Services

1.7.1. Increase coverage and quality of safe abortion services

1.7.1.1. Assess and upgrade eligible facilities (including adequate materials and equipment) and train additional staff on comprehensive abortion care (CAC)
1.7.1.2. Undertake on-going quality assurance and coaching for all facilities performing CAC
1.7.1.3. Expand and strengthen local quality assurance and coaching teams
1.7.1.4. Strengthen CAC data collection, recording and reporting systems, and use data for decision making

1.7.2. Increase availability, quality and monitoring of post abortion FP (linked to FP section above)

1.7.2.1. Increase counseling skills and capacity of CAC providers to provide post abortion FP
1.7.2.2. Ensure FP commodities are available in CAC rooms
1.7.2.3. Request that post-abortion FP is included in HIS and CDHS (also included in other section under objective three)
1.7.2.4. Request that HEFs allow separate payment for immediate post abortion FP as a separate service from abortion or post abortion care (also included in health financing interventions under objective two)

1.7.3. Increase availability of medical abortion at the HC level in a phased-in approach

1.7.3.1. Disseminate findings of pilot in selected provinces and agree next steps
1.7.3.2. Extend medical abortion service at HCs providing surgical abortion and provide refresher training/coaching, if necessary

1.7.4. Increase regulation/oversight of private provision of medical and surgical abortion

1.7.4.1. Advocate that the new law on regulation of health care facilities and services includes:
- Provision that all facilities/services must be in compliance with MoH policies, guidelines and protocols
- System for routine reporting and quality assurance of private health facilities

1.7.5. Reduce unsafe and repeat abortions

1.7.5.1. Increase knowledge that abortion is legal
1.7.5.2. Disseminate the abortion law
1.7.5.3. Increase knowledge and awareness of the dangers of unsafe and multiple abortions and where to go for safe abortion services
1.7.5.4. Actively promote post abortion FP

1.8. Strengthen AFRSH information and services

Key Intervention Areas

1.8.1. Increase coverage and quality of AFRSH services (public sector)

1.8.1.1. Disseminate new AFRSH service guidelines
1.8.1.2. Do TOT for national and provincial trainers on new AFRSH service guidelines
1.8.1.3. Provinces and ODs to roll-out training to facility level
1.8.1.4. Monitor training roll-out and implementation
1.8.1.5. Ensure on-going coaching and supportive supervision to ensure AFRSH services are provided in line with the national guidelines

1.8.2. Expand public private-partnerships and improve linkages and coordination with other sectors and local authorities

1.8.2.1. Establish the linkages between health facilities, schools and communities
1.8.2.2. Advocate that public and private health facilities with capacity to provide quality AFRSH information and services (e.g. Government health facilities trained in AFRSH, RHAC, MSIC, Sun Quality Clinics) are included as contracted facilities under the new Health Insurance Scheme that is part of the National Social Security Fund (NSSF).

1.8.3. Design innovative approaches and leverage public private partnerships to address AFRSH particularly in poor performing locations and to reach specific target groups (including entertainment workers (EWs), garment factory workers, construction workers, farm workers, minorities and persons with disabilities)

1.8.3.1. Entertainment workers:
- Strengthen and extend RSH information and services to EWs
- Strengthen health education and referral to health services

1.8.3.2. *Garment factory workers/Construction Workers*:
- Finalize and support implementation of the workplace infirmary guidelines in collaboration with Ministry of Labor and Vocational Training (MoLVT)
- Strengthen services and capacity of staff at infirmaries, especially counseling skills and knowledge of referral facilities
- Develop linkages and referral system between workplace infirmaries and outside health facilities, including those contracted under the new health insurance scheme that is part of the NSSF

1.8.3.3. *Migrant farm workers*:
- Strengthen and extend RSH information and services to migrant farm workers
- Strengthen health education and referral to health services

1.8.3.4. *Ethnic Minorities*:
- Strengthen and extend RSH information and services to ethnic minorities
- Sensitize health providers so they can provide more acceptable services

1.8.3.5. Persons with disabilities
- Provide AFRSH information and services in settings accessible to persons with

Key Intervention Areas
disabilities • Develop linkages and communication between disabled people's organizations and AFRSH providers • Strengthen AFRSH education for persons with disabilities through peer/role model approach. This will enable persons with disabilities to provide good examples among their peers and to challenge common misconceptions about the RSH needs and rights of persons with disabilities
1.8.4. Reduce Teenage Pregnancy: 1.8.4.1. Continue expansion of Comprehensive Sexuality Education through MoEYS. 1.8.4.2. Promote delay and spacing of childbearing (particularly in north and northeast of country) 1.8.4.3. Undertake additional research to better understand drivers behind teenage pregnancy and bottlenecks for adolescents to access RSH information and services. Use results to inform design of interventions and BCC. (also included in operational research section below)
1.9. Strengthen gynecological services
1.9.1. Increase coverage and quality of cervical cancer prevention, screening and treatment services 1.9.1.1. Introduce and roll-out HPV vaccination programme with support from GAVI 1.9.1.2. Finalize, disseminate and monitor implementation of the national action plan for the prevention and treatment of cervical cancer 1.9.1.3. Based on results of existing screening and treatment pilots, expand screening services at health centers and referral/provincial hospitals, and cryotherapy at referral/provincial hospitals 1.9.1.4. Improve infrastructure for cryotherapy 1.9.1.5. Include cervical cancer screening as part of gynecological exams and IUD insertion. 1.9.1.6. Increase awareness of the importance of cervical cancer screening through CBDs, VHSGs and social health protection promoters
1.9.2. Disseminate new law on organ donation and transplantation and MoH prakas on surrogacy
1.10. Strengthen GBV/VAW related health services
1.10.1. Roll-out new guidelines, clinical handbook, training package and post training follow-up
1.10.2. Ensure privacy and confidentiality for VAW victims in health facilities
1.10.3. Strengthen multi-sectoral collaboration for VAW through national, provincial, district, and commune committees 1.10.3.1. Include GBV/VAW in Health Center Management committee (HCMC), referral hospital and OD meeting discussions 1.10.3.2. Put budget in Commune Investment Plan (CIP) for GBV/VAW service delivery and referral 1.10.3.3. Ensure rapid/timely diagnosis of cases of GBV/VAW

Key Intervention Areas
1.10.3.4. Strengthen multi-sectoral referral network/system at all levels
1.10.4. Improve record keeping for GBV/VAW 1.10.4.1. Request that cases of GBV/VAW are disaggregated from the overall injury category in the HIS, and also disaggregated by age, sex and disability, if possible (also included in other section under objective three)
Objective 2: Increased equitable access and quality of RSH services through increased financial and human resources.
2.1. Scale up social health protection systems, including health equity funds, that cover the full RSH service package
2.1.1. Advocate for 100% coverage of the poor with HEFs, and 100% coverage of formal sector workers/civil servants with the NSSF Health Insurance Scheme which have benefit packages/payment systems that cover the full RSH service package at all levels of care where services are provided (including pre-discharge PNC, immediate post-partum and post-abortion FP, comprehensive abortion care and cervical cancer.)
2.1.2. Advocate that public and private health facilities with capacity to provide quality AFRSH information and services (e.g. Government health facilities trained in AFRSH, RHAC, MSIC, Sun Quality Clinics) are included as contracted facilities under the new Health Insurance Scheme that is part of the National Social Security Fund (NSSF).
2.1.3. Advocate for role of new social health protection promoters (former health equity fund promoters) to include promoting awareness of social protection scheme benefits and access to quality RSH services in both public and private sector facilities 2.1.3.1. Particular attention being given to promoting awareness of benefits and access amongst vulnerable groups (ethnic minorities, migrants, factory workers, people with disabilities, etc.)
2.1.4. Request that HEF reimbursement system allow the following: 2.1.4.1. Reimbursement of immediate postpartum family planning and post abortion family planning as separate services (reimbursement for delivery or abortion + reimbursement for immediate FP provision) 2.1.4.2. Reimbursement of pre-discharge PNC as a separate service (reimbursement for delivery + reimbursement for PNC); reimbursement for PNC should only be provided if the service is for BOTH mother and child. 2.1.4.3. Separate payment of post-discharge PNC from the mother and newborn (payment for post-discharge PNC for mother + payment for post-discharge PNC for newborn; separate payment for post-discharge PNC should only be provided if the service was provided to BOTH mother and child. 2.1.4.4. Reimbursement of transport costs for poor patients (with poor ID) seeking RSH services at the HC (as well as at the referral hospital) for high-risk and hard to reach areas.
2.1.5. Request development and dissemination of prakas or instruction that clarifies that safe abortion services (CAC) (and cervical cancer screening and cryotherapy) are allowed to be

Key Intervention Areas

claimed and reimbursed under the HEF scheme

2.2. **Increase government financing for RSH services**

2.2.1. Advocate for increased government health expenditure on RSH (including commodity procurement, routine govt. budget and service delivery grants)

2.2.1.1. Build capacity of health facility staff in financial management

2.2.1.2. Advocate for including the following in the Commune Investment Plan (CIP):

- HCMC and VHSG activities (including outreach related to RSH, GBV/VAW, AFRSH, etc.)
- AFRSH activities
- GBV/VAW service delivery and referral

2.2.1.3. Maintain support for the Midwifery Incentive (incentive for midwives performing deliveries at health facilities)

2.2.1.4. Advocate for increased government budget for IEC materials/BCC activities for RSH, FP, GBV/VAW, AFRSH, nutrition, etc.

2.3. **Improve the competence and availability of midwives**

2.3.1. Pre-Service:

2.3.1.1. Update the pre-service midwifery curriculum, strengthen practical training for midwifery students and expand the preceptor program

- Ensure that all RSH services (including EmONC, AFRSH, GBV/VAW, cervical cancer, abortion, newborn screening of birth defects etc.) AND RSH rights and socio-cultural awareness (e.g. gender, disability, ethnicity and adolescence, etc.) are included in the pre-service curriculum

2.3.1.2. Prioritize enrollment of local students in pre-service training from locations where HCs don't yet have enough midwives

2.3.1.3. Rationalize existing midwifery pre-service training courses

2.3.1.4. Undertake review of Associate and Bachelor Degrees

2.3.1.5. Undertake Midwifery review

2.3.1.6. Develop Midwifery Education Pathways

2.3.1.7. Develop Midwifery Education Regulatory Framework

2.3.2. In-Service:

2.3.2.1. Strengthen midwifery technical skills and socio-cultural awareness through competency-based training, supportive supervision and through expanding opportunities for practice and on-site coaching

- Establish skill labs at CPA3 RHs
- Rotate care providers from low case facilities to high case facilities
- Increase capacity and professional development (CPD) opportunities for provincial trainers/supervisors and coaches

2.3.2.2. Reinforce quarterly midwifery coordination and alliance team (MCAT) meetings

- Use MCAT meetings to update midwives on new protocols, guidelines, prakas, socio-cultural awareness, etc.

Key Intervention Areas

- Involve MDs and midwives from RHs in MCAT sessions to clarify issues regarding complicated deliveries, and to provide feedback on referral cases.

2.3.3. Regulation and Licensing: Strengthen registration, licensing and relicensing systems

2.3.3.1. Finalize and implement new law on regulation of health practitioners

2.3.4. Availability: Increase the number of secondary midwives at HC level

2.3.4.1. Civil service recruitment of secondary midwives for HCs
2.3.4.2. Explore options of contracting secondary midwives at HC level and/or upgrading primary midwives to secondary midwives
2.3.4.3. Advocate for appropriate incentive for secondary midwives who work in remote areas

Objective 3: Increase equitable access and quality of RSH services through strengthened RSH information systems.

3.1. Strengthen Maternal Death Surveillance and Response (MDSR) system

3.1.1. Strengthen capacity of the National Maternal Death Audit Committee to support Maternal Death Audits (MDA) in national hospitals and provinces

3.1.1.1. Organize quarterly national maternal audit committee meetings to review maternal death reports from provincial committees and national hospitals and to provide feedback.
3.1.1.2. Monitor and provide hands-on coaching to the provincial maternal death audit committees and national hospitals.
- Use information from previous MDAs to develop case scenarios that can be used for on-site coaching

3.1.1.3. Develop and disseminate instructions/directives to public and private facilities on the requirements for maternal death audits and reports.
3.1.1.4. Provide guidance on the investigation of deaths across provinces and national hospitals
3.1.1.5. Monitor implementation of recommendations through provincial and national MDA committee meetings and annual meeting.

3.1.2. Increase capacity and financing for MDSR, particularly at the provincial and district level

3.1.2.1. Strengthen provincial/district capacity to develop and implement actionable recommendations
3.1.2.2. Increase involvement of provincial technical experts

3.1.3. Improve linkages to vital registration system

3.1.3.1. Improve linkages between the health center and the commune office where the health center is located

3.1.4. Consider introducing investigation of near misses

Key Intervention Areas
3.1.4.1. Apply MDA review format to near misses and use the result to provide feedback during MCAT meetings and to develop coaching scenarios.
3.2. Introduce Neonatal Death Review/Audit system
3.2.1. Develop Cambodian Neonatal Death Review/Audit system through adapting and contextualizing new WHO guidelines
3.2.2. Integrate/link perinatal death audit system with MDSR system
3.3. Conduct Operational Research
3.3.1. Undertake pilot studies and/or commission research. Priority research topics include: • Teenage pregnancy – drivers of teenage pregnancy and bottlenecks to adolescents accessing RSH information and services • Traditional family planning methods- drivers and how to reduce
3.4. Other
3.4.1. Request that cases of GBV/VAW are disaggregated from the overall injury category in the HIS, and also disaggregated by age, sex and disability, if possible (also included in GBV/VAW section under objective one)
3.4.2. Request that post-abortion FP is included in HIS and CDHS (also included in post abortion FP section under objective one)
3.3.2. Request disaggregation of married and unmarried within 15-19 and 19-24 yr. age groups

Annex 3: Essential RSH service package

ARSH Services

- Availability of AFRSH essential service package

Family Planning Services

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

RTI Care

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

Antenatal Care

- At least four visits
- Access pregnancy status (both mother and fetus)
  - Check for danger signs and management such as pre-term labour, anaemia, vaginal bleeding, fever, fetal movement, hypertensive disorders…
- Detection and treatment of malaria and tuberculosis
- Screening and treatment of syphilis
- VCCT for HIV
- Availability of PMTCT
- Tetanus immunization
- Provision of iron/folate and mebendazole
- Mother class/counseling (e.g. nutrition, recognition of complications/danger signs, family planning)
- Birth preparedness (birth/emergency plan in Mother's Health Record)
- Availability of EmONC (e.g. referral system, surgery)
- Availability of CEmONC

Delivery Care

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

Neonatal Care

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

Postnatal Care

- Assessment and care of the postpartum woman and her newborn up to 6 weeks (4 visits)
- Response to observed signs and volunteered problems
- Early detection and management of puerperal complications (e.g. bleeding, involuted uterus)
- Birth spacing plan and service provision
- Iron/folate supplementation
- Vitamin A supplementation
- Detection and treatment of anaemia
- Detection and treatment of malaria
- Tetanus immunization (if not done at ANC)
- Screening for syphilis (if not done at ANC)
- Provision of mebendazole
- VCCT for HIV (if not done at ANC)
- Counselling (e.g. hygiene, nutrition, birth spacing, recognition of danger signs, emergency preparation, and routine and follow – up visit)
- Availability of EmONC (e.g. referral system, surgery)
- Danger signs to the newborn prior to discharge
- Care of all newborn until discharge
- Identification of newborn problem needing special management

Reducing Unsafe Abortion (CAC and PAC)

- Medical abortion at appropriate levels
- Manual vacuum aspiration at appropriate HC level
- Prevention and management of complications (e.g. injury, infection, shock, haemorrhage)
- Birth spacing plan and service provision
- Counselling (e.g. pre-abortion, family planning, self-care, recognition of danger signs, prevention of STI/HIV transmission)
- EmONC (e.g. referral system, surgery)

Cancers, Subfertility, Peri/Postmenopausal Services

- Counselling and basic screening and treatment (e.g. breast self-exams, lifestyle, VIA, HPV vaccine, nutrition, BCC) and referral

Gender Equity

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

Annex 4: Costing the National Strategy for Reproductive and Sexual Health (NSRSH) in Cambodia 2017-2020

1. Background

This costing exercise is performed through literature review of existing costing tools and data available in the country, and then validated and adjusted to the components of the Strategy and timeframe. Two main steps were followed:

- **Step 1: Review the costing tools and data available**
  - Review the existing costing tools and data currently available [One Health tool costing, FP costing, Minimum Package of Activities (MPA) for Health Centre Costing, Complementary Package of Activities (CPA) for Referral Hospital Costing, EmONC Improvement Plan Costing, etc.]
  - Review the components of the NSRSH 2017 – 2020 and cross-check with the costing tools and data available

- **Step 2: Produce costing data for the NSRSH 2017 - 2020**
  - Prepare a draft estimate of the cost of implementing the NSRSH 2017 - 2020

2. Costing tools and data currently available

A number of current costing model estimates were reviewed and analyzed to provide the source data for the NSRSH 2017 – 2020 costing estimates. Most applications were based on the utilization in the Cambodian context of the One Health Tool (OHT). OHT is a comprehensive costing tool developed by the UN Interagency working group on costing (comprised of WHO, UNFPA, UNICEF, World Bank, UNAIDS and UNDP). The tool is relies on input-based costing and enables the estimation of a wide range of indicators to inform national planning processes, including the direct costs (by year, by programme, by inputs), the health systems investments requirements as well as the health impact (e.g. expected impact on maternal mortality), among others.

Most notably, the following recently completed analyses are used to provide inputs for the NSRSH 2017 – 2020 costing:

- **The Reproductive, Maternal, Neonatal and Child Health (RMNCH) costing**: this analysis used OHT to estimate the cost of implementing the recently developed Health Strategic Plan 3 (HSP3) 2016-2020. It included a range of health interventions and the following were included in the current analysis: family planning, antenatal care, HIV and syphilis

during pregnancy, intrapartum and delivery care, EmONC, postnatal care, safe abortion as well as limited information on programme costs for adolescent interventions. It also provided some of estimates for the health systems investment requirements.

- **The costing of Non-Communicable Diseases (NCDs) Program**: also used OHT to estimate the cost of programmes for cardiovascular disease, diabetes, and breast & cervical cancer. This source provided estimates for costs of breast and cervical cancer.
- **Reproductive Health Costing 2006-2015**: this source provided cost estimates up to 2015. While the scope didn't include all interventions in the NSRSH 2017 – 2020, the current analysis compared the major costs elements to identify any variations with respect to the previous RSH strategy.
- While these sources provided some of the information required for costing the NSRSH strategy, some interventions were not available from existing estimates. The current analysis used specific assumptions for a certain number of new interventions, namely for violence against women, cervical cancer and adolescent health. Despite our best efforts, some of the strategy elements have not been yet costed at the moment.

The costing information from the currently available sources was mapped out against the NSRSH activities at the intervention level to estimate the expected cost for each of these interventions. This information was then consolidated in order to generate cost estimates at the component- and objective-level for the NSRSH.

3. NSRSH 2017 – 2020 costing estimates

The NSRSH 2017 – 2020 has four main objectives which aim to increase equitable access and quality of RSH services through strengthened capacity in three key areas (namely, governance & service delivery, financial &human resources RSH information systems), plus monitoring & evaluation (M&E), through integrated supervision and cross-cutting activities.

As seen in Table 1, below **Objective 1** is expected to require most of the investment, starting around $31.2M in 2017 and increasing up to around $35M in 2020. As discussed further below, Objective 1 includes key service delivery activities, which contribute to making it the most costly overall. **Objective 4** shows up as the second mostly costly objective, primarily because it includes infrastructure and capital expenditures that require substantial investment. However, such investments have a cross-cutting nature and therefore cannot be allocated individually to specific NSRSH objectives. In addition, it should be noted that, while M&E activities can be costly, they can also offer good value-for-money and are important and very much needed to ensure the strategy's overall effectiveness and sustainability. Finally, **Objectives 2 and 3** are estimated as the least resource-intensive objectives in the strategy.

Table 1: NSRSH 2017 – 2020 annual costs, by main objectives

Objective	Year 2017	2018	2019	2020
1. Increased equitable access and quality of RSH services through strengthened governance and service delivery	$31.2M	$32.4M	$33.3M	$35.0M
2. Increase equitable access and quality of RSH services through increased financial and human resources	$2.6M	$2.6M	$2.6M	$2.6M
3. Increase equitable access and quality of RSH services through strengthened RSH information systems	$0.3M	$0.2M	$0.2M	$0.2M
4. Monitoring & evaluation, integrated supervision and cross-cutting activities	$7.4M	$5.4M	$7.4M	$5.4M

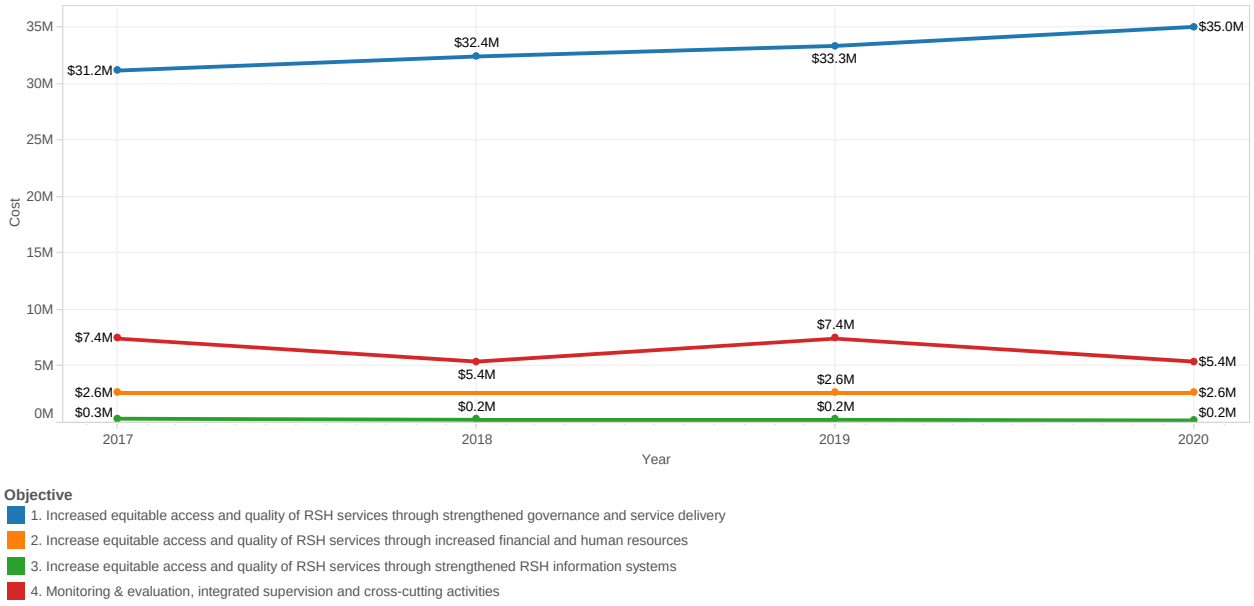
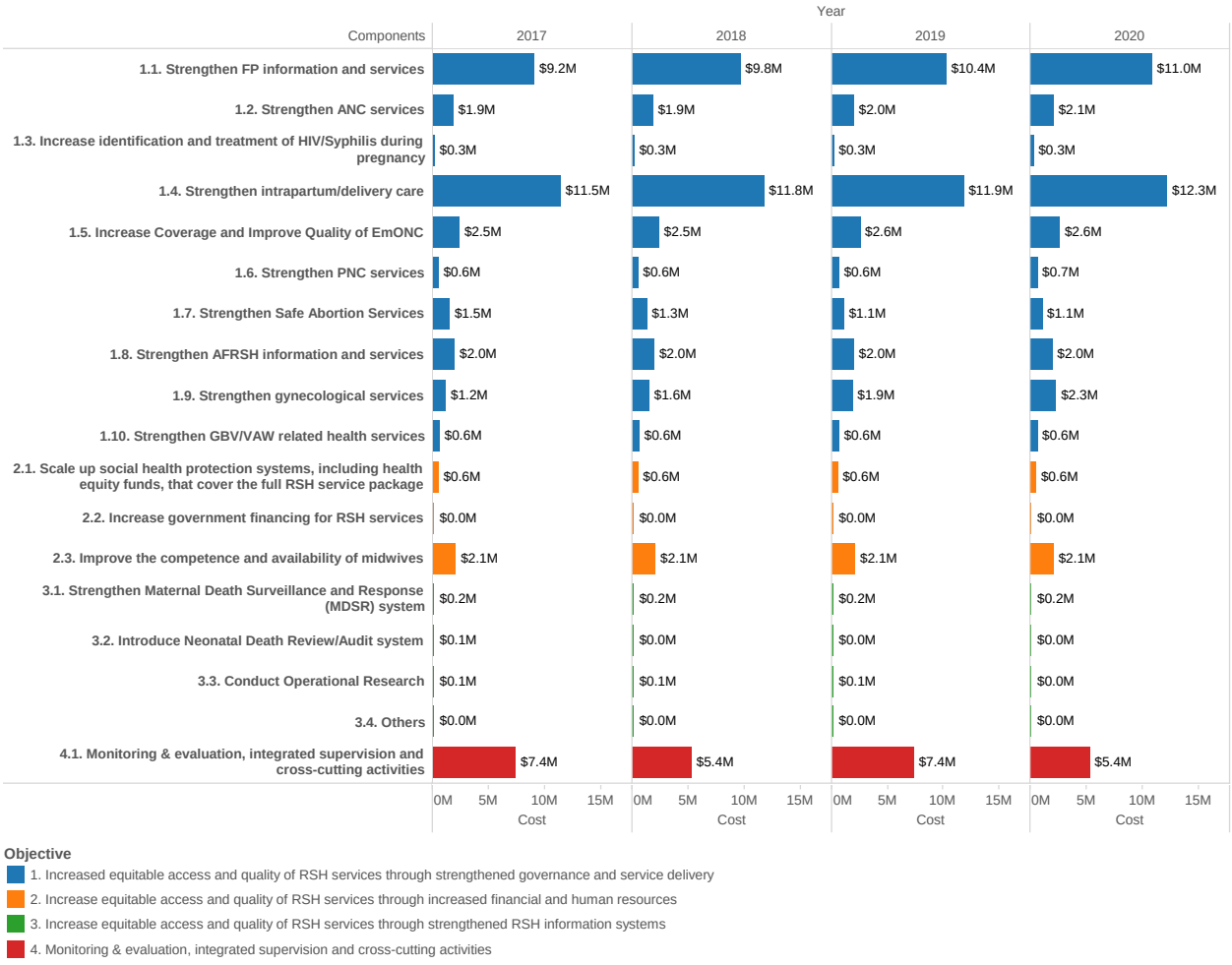


Figure 1provides a little bit more disaggregation by comparing the annual estimated cost at the component level for each of the four strategic objectives. It shows clearly that under Objective 1 there are two components that account for most of the total cost. As seen in Annex 1 (which disaggregates the information up to intervention level), the cost of **Component 1.4** comes from the implementation of new safe motherhood protocol (intervention 1.4.1) and, to a smaller extent, by intervention 1.4.2 which aims to improve awareness and utilization of intrapartum and delivery care, particularly amongst hard to reach and vulnerable groups. Similarly, the cost of **Component 1.1** is accounted for by the purchase of family planning commodities, services, delivery (but not including training to health care providers). Other components that contribute

a relatively large share of total cost include strengthening ANC services and the coverage and Quality of EmONC, as well as the cross-cutting activities discussed above.

Figure 1: NSRSH 2017 costs, by main components



4. Next steps

This analysis provides initial estimates for the expected cost of implementing the NSRSH in the period 2017-2020. The costing is essential to enable advocacy efforts to ensure that appropriate results are actually invested in the implementation of the strategy. Going forward, this analysis should be complemented by other types of information gathering and analysis that focus on other related issues, for instance, cost-efficiency (the need to ensure that inputs are purchased or contracted at the best unit price possible), efficiency in the generation of concrete

outputs and cost-effectiveness (how well and at what cost the inputs and outputs get translated into outcomes and ultimate impacts).

Estimated cost of NSRSH 2017-2020 interventions, by strategic objectives and components

Objective	Components	Interventions	2017	2018	2019	2020	Total
1. Increased equitable access and quality of RSH services through strengthened governance and service delivery	1.1. Strengthen FP information and services	1.1.1. Increase quality and availability of FP services	$347,300	$347,300	$347,300	$347,300	**$1,389,200**
		1.1.2. Increase availability and utilization of long-term/permanent FP methods	$347,300	$347,300	$347,300	$347,300	**$1,389,200**
		1.1.3. Increase availability and utilization of post-partum FP services (interventions related to post abortion FP can be found in the safe abortion services section below)	$347,300	$347,300	$347,300	$347,300	**$1,389,200**
		1.1.4. Ensure FP commodity security	$7,456,626	$8,026,794	$8,612,278	$9,213,767	**$33,309,465**
		1.1.5. Strengthen public-private partnership to ensure quality FP service provision and timely and accurate reporting from the private sector	$165,000	$181,500	$199,650	$219,615	**$765,765**
		1.1.6. Reduce Traditional Family Planning Usage	$500,000	$500,000	$500,000	$500,000	**$2,000,000**
	1.2. Strengthen ANC services	1.2.1. Increase coverage and quality of ANC	$1,619,197	$1,685,552	$1,750,994	$1,833,203	**$6,888,946**
		1.2.2. Increase knowledge and demand for ANC4+	$250,000	$250,000	$250,000	$250,000	**$1,000,000**
	1.3. Increase identification and treatment of HIV/Syphilis during pregnancy	1.3.1. Increase identification of HIV/syphilis during pregnancy	$129,907	$133,001	$136,155	$139,380	**$538,443**
		1.3.2. Increase treatment of HIV/syphilis during pregnancy	$129,907	$133,001	$136,155	$139,380	**$538,443**
	1.4. Strengthen intrapartum/delivery care	1.4.1. Reinforce implementation of new safe motherhood protocol	$7,984,402	$8,325,590	$8,660,743	$9,010,437	**$33,981,172**
		1.4.2. Develop/implement innovative strategies to improve awareness and utilization of intrapartum/delivery care particularly in poor performing locations and amongst hard to reach and vulnerable groups (including entertainment workers (EWs), garment factory workers, construction workers, farm workers, minorities and persons with disabilities)	$1,510,448	$1,510,448	$1,170,336	$1,170,336	**$5,361,568**

Objective	Components	Interventions	2017	2018	2019	2020	Total
		1.4.3. Strengthen maternal and fetal monitoring during labor and recognition of danger signs and risk factors through use of the partograph	$60,000	$60,000	$60,000	$60,000	**$240,000**
		1.4.4. Strengthen prevention, immediate treatment, stabilization and referral for post-partum hemorrhage	$752,517	$803,307	$857,365	$914,951	**$3,328,140**
		1.4.5. Strengthen diagnosis, immediate treatment and referral for pre-eclampsia/eclampsia including introducing the use of injectable MgSO4 as a loading dose prior to referral	$160,044	$171,750	$180,092	$186,771	**$698,657**
		1.4.6. Improve infection prevention and control	$225,000	$180,000	$180,000	$180,000	**$765,000**
		1.4.7. Reinforce early initiation of exclusive breastfeeding and reduce prelacteal feeding	$654,000	$654,000	$650,000	$650,000	**$2,608,000**
		1.4.8. Increase regulation/oversight of private maternity clinics	$110,000	$110,000	$110,000	$110,000	**$440,000**
	1.5. Increase Coverage and Improve Quality of EmONC	1.5.1. Improve the quality and geographic coverage of EmONC	$897,666	$897,666	$897,666	$897,666	**$3,590,664**
		1.5.2. Reduce gaps in basic infrastructure, drugs and equipment in EmONC facilities	$97,500	$62,500	$62,500	$97,500	**$320,000**
		1.5.3. Reduce non-medically indicated C-section	$1,253,122	$1,305,850	$1,360,542	$1,417,355	**$5,336,869**
		1.5.4. Develop anesthesia pre-service training curriculum	$80,000	$80,000	$80,000	$80,000	**$320,000**
		1.5.5. Increase # of MDs trained as surgeons (capable of doing C-section)	$157,046	$157,046	$157,046	$157,046	**$628,184**
		1.5.6. Improve recording and reporting of obstetric complications and newborn cases in all health facilities	0	0	0	0	**$0**
	1.6. Strengthen PNC services	1.6.1. Increase coverage and quality of PNC	$317,929	$347,266	$379,353	$414,755	**$1,459,303**
		1.6.2. Increase knowledge and demand for PNC	$250,000	$250,000	$250,000	$250,000	**$1,000,000**
	1.7. Strengthen Safe Abortion	1.7.1. Increase coverage and quality of safe abortion services	$497,120	$323,920	$150,720	$150,720	**$1,122,480**

Objective	Components	Interventions	2017	2018	2019	2020	Total
	Services	1.7.2. Increase availability, quality and monitoring of post abortion FP (linked to FP section above)	$200,000	$200,000	$200,000	$200,000	**$800,000**
		1.7.3. Increase availability of medical abortion at the HC level in a phased-in approach	$40,000	$10,000	$10,000	$10,000	**$70,000**
		1.7.4. Increase regulation/oversight of private provision of medical and surgical abortion	$320,000	$320,000	$320,000	$320,000	**$1,280,000**
		1.7.5. Reduce unsafe and repeat abortions	$450,000	$450,000	$450,000	$450,000	**$1,800,000**
	1.8. Strengthen AFRSH information and services	1.8.1. Increase coverage and quality of AFRSH services (public sector)	$206,250	$206,250	$206,250	$206,250	**$825,000**
		1.8.2. Expand public private-partnerships and improve linkages and coordination with other sectors and local authorities	$200,000	$200,000	$200,000	$200,000	**$800,000**
		1.8.3. Design innovative approaches and leverage public private partnerships to address AFRSH particularly in poor performing locations and to reach specific target groups (including entertainment workers (EWs), garment factory workers, construction workers, farm workers, minorities and persons with disabilities)	$1,097,500	$1,097,500	$1,097,500	$1,097,500	**$4,390,000**
		1.8.4. Reduce Teenage Pregnancy	$500,000	$500,000	$500,000	$500,000	**$2,000,000**
	1.9. Strengthen gynecological services	1.9.1. Increase coverage and quality of cervical cancer prevention, screening and treatment services	$1,222,462	$1,611,694	$1,905,487	$2,333,840	**$7,073,483**
		1.9.2. Disseminate new law on organ donation and transplantation and MoH prakas on surrogacy	0	0	0	0	**$0**
	1.10. Strengthen GBV/VAW related health services	1.10.1. Roll-out new guidelines, clinical handbook, training package and post training follow-up	$500,000	$500,000	$500,000	$500,000	**$2,000,000**
		1.10.2. Ensure privacy and confidentiality for VAW victims in health facilities	0	0	0	0	**$0**
		1.10.3. Strengthen multi-sectoral collaboration for VAW through national, provincial, district, and commune committees	$125,000	$125,000	$125,000	$125,000	**$500,000**

Objective	Components	Interventions	2017	2018	2019	2020	Total
		1.10.4. Improve record keeping for GBV/VAW	0	0	0	0	**$0**
		SUB-TOTAL OBJECTIVE 1	**$31,160,541**	**$32,411,534**	**$33,347,732**	**$35,027,374**	**$131,947,181**
2. Increase equitable access and quality of RSH services through increased financial and human resources	2.1. Scale up social health protection systems, including health equity funds, that cover the full RSH service package	2.1.1. Advocate for 100% coverage of the poor with HEFs, and 100% coverage of formal sector workers/civil servants with the NSSF Health Insurance Scheme which have benefit packages/payment systems that cover the full RSH service package at all levels of care where services are provided (including pre-discharge PNC, immediate post-partum and post-abortion FP, comprehensive abortion care and cervical cancer.)	$50,000	$50,000	$50,000	$50,000	**$200,000**
		2.1.2. Advocate that public and private health facilities with capacity to provide quality AFRSH information and services (e.g. Government health facilities trained in AFRSH, RHAC, MSIC, Sun Quality Clinics) are included as contracted facilities under the new Health Insurance Scheme that is part of the National Social Security Fund (NSSF).	$50,000	$50,000	$50,000	$50,000	**$200,000**
		2.1.3 Advocate for role of new social health protection promoters (former health equity fund promoters) to include promoting awareness of social protection scheme benefits and access to quality RSH services in both public and private sector facilities	$450,000	$450,000	$450,000	$450,000	**$1,800,000**
		2.1.4. Request that HEF reimbursement system allow the following:	0	0	0	0	**$0**
		2.1.5. Request development and dissemination of prakas or instruction that clarifies that safe abortion services (CAC) (and cervical cancer screening and cryotherapy) are allowed to be claimed and reimbursed under the HEF scheme	0	0	0	0	**$0**
	2.2. Increase government financing for RSH	2.2.1. Advocate for increased government health expenditure on RSH (including commodity procurement, routine	0	0	0	0	**$0**

Objective	Components	Interventions	2017	2018	2019	2020	Total
	services	govt. budget and service delivery grants)					
	2.3. Improve the competence and availability of midwives	2.3.1. Pre-Service:	$200,000	$200,000	$200,000	$200,000	**$800,000**
		2.3.2. In-Service:	$1,252,000	$1,252,000	$1,252,000	$1,252,000	**$5,008,000**
		2.3.3. Regulation and Licensing: Strengthen registration, licensing and relicensing systems	$30,000	$30,000	$30,000	$30,000	**$120,000**
		2.3.4. Availability: Increase the number of secondary midwives at HC level	$600,000	$600,000	$600,000	$600,000	**$2,400,000**
		SUB-TOTAL OBJECTIVE 2	**$2,632,000**	**$2,632,000**	**$2,632,000**	**$2,632,000**	**$10,528,000**
3. Increase equitable access and quality of RSH services through strengthened RSH information systems	3.1. Strengthen Maternal Death Surveillance and Response (MDSR) system	3.1.1. Strengthen capacity of the National Maternal Death Audit Committee to support Maternal Death Audits (MDA) in national hospitals and provinces	$75,000	$75,000	$75,000	$75,000	**$300,000**
		3.1.2. Increase capacity and financing for MDSR, particularly at the provincial and district level	$75,000	$75,000	$75,000	$75,000	**$300,000**
		3.1.3. Improve linkages to vital registration system	$-	$-	$-	$-	**$-**
		3.1.4. Consider introducing investigation of near misses	$-	$-	$-	$-	**$-**
	3.2. Introduce Neonatal Death Review/Audit system	3.2.1. Develop Cambodian Neonatal Death Review/Audit system through adapting and contextualizing new WHO guidelines	$50,000	$-	$-	$-	**$50,000**
		3.2.2. Integrate/link perinatal death audit system with MDSR system	$25,000	$25,000	$25,000	$25,000	**$100,000**
	3.3. Conduct Operational Research	3.3.1. Undertake pilot studies and/or commission research. Priority research topics include:	$100,000	$50,000	$50,000	$-	**$200,000**
	3.4. Others	3.4.1. Request that cases of GBV/VAW are disaggregated from the overall injury category in the HIS, and also disaggregated by age, sex and disability, if possible (also included in GBV/VAW section under objective one	$-	$-	$-	$-	**$-**
		3.4.2. Request that post-abortion FP is included in HIS and CDHS (also included in post abortion FP section under objective one)	$-	$-	$-	$-	**$-**

Objective	Components	Interventions	2017	2018	2019	2020	Total
		3.4.3. Request disaggregation of married and unmarried within 15-19 and 19-24 yr. age groups	$-	$-	$-	$-	**$-**
		SUB-TOTAL OBJECTIVE 3	**$325,000**	**$225,000**	**$225,000**	**$175,000**	**$950,000**
4. Monitoring & evaluation, integrated supervision and cross-cutting activities	4.1. Monitoring & evaluation, integrated supervision and cross-cutting activities	4.1.1. Integrated supervision for reproductive and sexual health	$775,920	$775,920	$775,920	$775,920	**$3,103,680**
		4.1.2. Medical equipment and materials	$2,331,550	$300,000	$2,331,550	$300,000	**$5,263,100**
		4.1.3. Meetings and workshops	$1,812,000	$1,812,000	$1,812,000	$1,812,000	**$7,248,000**
		4.1.4. Printing RMNCH record	$2,500,000	$2,500,000	$2,500,000	$2,500,000	**$10,000,000**
		SUB-TOTAL OBJECTIVE 4	**$7,419,470**	**$5,387,920**	**$7,419,470**	**$5,387,920**	**$25,614,780**
		TOTAL	**$41,537,012**	**$40,656,455**	**$43,624,203**	**$43,222,294**	**$169,039,965**