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ACKNOWLEDGEMENTS

The Ministry of Health acknowledges the contribution of the many people involved in the production of this document and its other three volumes. First and foremost, I express my deep appreciation to the Core Group led by Dr. Youk Sambath for having worked at a very intensive pace to produce the Health Sector Strategic Plan for 2003-2007, the first of its kind for the Ministry of Health in Cambodia. The Ministry is proud of the quality of the work of the Group, and its efforts in ensuring a participatory, consultative process to enable a variety of stakeholders to contribute in the development of all the volumes of the strategic plan. A big thank you to Dr. Penelope Key, Dr. Stephanie Simmonds, Dr. Aye Aye Thwin and Dr. Indermohan Narula the advisers to the Core Group for their valuable, strong and consistent support throughout the design and drafting process (also see the next page).

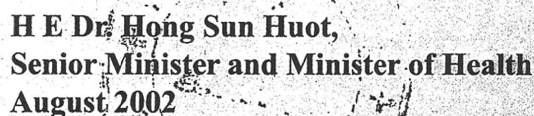
The Core Group worked very closely on the content of the strategic plan with 6 working groups. These were on health service delivery led by Dr. Mean Chhi Vun, behavioural change led by Dr. Lim Thai Pheang, quality improvement led by Prof. Koum Kanal, human resource development led by Mrs. Keat Phuong, health care financing led by Ms. Khout Thavary and institutional development led by Mr. Huy Seth. The Ministry is also grateful to the other senior professional staff members from both central and provincial levels who, in spite of their busy schedules and heavy workload, actively worked on developing the strategic plan. I also thank other members of the working groups from among our external partners who provided technical assistance and supported my staff in drafting strategies (see the next page).

I express my gratitude to our core partners for strategy development, WHO, DFID, UNICEF, GTZ, and JICWELS who were generous with their financial, technical and moral support throughout the process. I also acknowledge other partners such as CIDA, UNFPA and USAID who have assisted us in specific design activities.

The link with a key partner, the professional associations is crucial and I appreciate it. The associations represent a very important and valued stakeholder group and their collaboration takes us closer to achieving the desired outcomes in this strategic plan. We also continue to benefit from the contribution and support given by other Ministries and we pledge to work closer with them for mutual gains for the development of our country.

Last, but not the least, I thank my senior management team in the ministry, especially His Excellency Dr. Mam Bun Heng, His Excellency Dr. Ung Phyrun, His Excellency Prof. Eng Huot, His Excellency Dr. Te Kuy Seang and Dr. Char Meng Chuor for their able leadership, wisdom and guidance in all aspects of development of this strategic plan. Their constructive thoughts, ideas and bold sense of direction has inspired us all to take major strides in strengthening the sector to make a difference in the health status of Cambodians, especially among those who are poor and socially disadvantaged.

H E Dr. Hong Sun Huot,
Senior Minister and Minister of Health
August 2002



KINGDOM OF CAMBODIA
MINISTRY OF HEALTH
HEALTH SECTOR STRATEGIC PLAN 2003-2007

FOREWORD

I am very pleased to present this Strategic Plan for the further development of our country's health sector. Improving the health of the nation is at the heart of the policies of our Government. Although considerable progress has been made, as with the eradication of poliomyelitis, containment of HIV/AIDS and decrease in malaria, still too many women die in childbirth and our children go hungry and die from easily preventable diseases. Much more remains to be done in the years ahead.

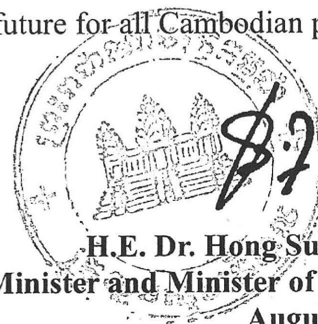
This document provides the framework that will guide our efforts throughout the next five years. It reflects the values behind all that we do. In particular, we are determined that services should be equally available to all people, without discrimination by gender, age, ability to pay or place of residence. They must also especially focus on the needs of mothers and children as well as those of poor people. For them all, ill health can be a personal tragedy apart from being an economic burden that reinforces their impoverished circumstances.

To meet these ideals this plan includes strategies that will strengthen health services and improve outcomes. As a priority, we will target infant and maternal mortality rates with an aim to achieve significant improvements. The needs of deprived people in rural areas will receive special attention. We encourage the involvement of local communities in health affairs and intend to empower all people to take decisions based on informed choices. These proposals, together with many others in the plan, are all designed to improve the health of Cambodians and fulfill the Government's commitment, in 2002, to the ASEAN Nations ambitious Declaration on Healthy Lifestyles.

To bring about all the enhancements in clinical care and public health services we must also change and develop our support services. New ways of working must be brought in and greater emphasis be given to quality in all that we do. More efficient practices will be essential and systems and procedures must be revised. Seeking constant improvement must become our normal way of working. For all this we depend on the continued dedication of all our staff.

To make our ambitions possible, it will be essential to secure realistic funding. We are fortunate that this plan will be underpinned by support from many international partners, who are all committed to the same goals and outcomes. This strategic plan is the first step in moving towards sector wide management that weaves together all our efforts to improve health. This assistance, linked to our own Government's funding commitment will bring fruit to this plan. To all our donor partners and other external agencies, we are extremely grateful.

This Strategic Plan embodies our ambitions for a better and healthier future for all Cambodian people. I commend it most strongly.



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EXECUTIVE SUMMARY

The Mission of the Ministry of Health, Royal Government of Cambodia is commitment to ensure sector wide equitable, quality health care for all the people of Cambodia through targeting resources, especially to the poor and to areas in greatest need.

To achieve this mission, the ministry has developed a policy statement outlining future directions for the next 5 years, which have guided this strategic plan development.

In summary, the policy asserts that all people in Cambodia, of whatever gender, age, place of residence or ability to pay, should have equal access to good-quality, basic and essential specialised health services, staffed by competent health professionals, and at a cost people can afford; that they should have information that empowers them to make informed choices about matters affecting the health and well-being of themselves and their families.

Infant and child mortality rates have actually risen over recent years and the maternal mortality ratio remains unacceptably high. Around half of all children are malnourished. The burden of communicable disease, especially malaria, tuberculosis and HIV is heavy. And, at the same time, chronic conditions related to non-communicable diseases, and to injuries, are emerging as major public health issues.

Critical success factors on which to better plan and build the future have been identified. They include strong political commitment, visible and effective leadership and stewardship, ownership, timely provision of adequate funds, good planning, management, monitoring and evaluation systems at all levels, availability of competent staff and useful medicines, community participation in health activities and forming technical and funding partnerships within government and local non-governmental stakeholders as well as with external agencies.

To make significant progress towards the achievement of its mission and policy, Ministry of Health has adopted 20 strategies, of which 8 form the essential core, in 6 priority areas of work. These strategies are intended to be the focus for action by the Ministry and all health sector partners over the next 5 years.

The core 8 strategies are:

Health service delivery

1. Further improve coverage and access to health services especially for the poor and other vulnerable groups through planning the location of health facilities.
2. Strengthen the delivery of quality basic health services through health centers based upon minimum package of activities.
3. Strengthen the delivery of quality care, especially for obstetric and paediatric care, in all hospitals through measures such as the complementary package of activities.

Behavioural change

4. Change for the better the attitudes of health providers sector wide to become more responsive to consumer needs especially of the poor through sensitisation and building interpersonal skills.

Quality improvement

5. Introduce and develop a culture of quality in public health, service delivery and their management through the use of Ministry of Health quality standards.

Human resource development

6. Increase the number of midwives through basic training and strengthen the capacity and skills of midwives already trained through continuing education.

Health financing

7. Ensure regular and adequate flow of funds to the health sector especially for service delivery through advocacy to increase resources and strengthening financial management.

Institutional development

8. Organizational and management reform of structures, systems and procedures in the Ministry of Health to respond effectively to change.

Overall outcomes to be achieved by 2007 include reduced infant mortality rate, child mortality rate, maternal mortality ratio, total fertility rate, and household health expenditure especially among the poor, and a more effective and efficient health system.

Implementing the strategic plan is recognised as a critical next step that will involve all stakeholders – the government, all levels of the Ministry of Health, all partners, consumers and even private sector providers. Sector wide management, an approach recently adopted by the ministry, will greatly facilitate effective and efficient implementation.

Responsibility for delivering the outcomes rests with the Ministry of Health and will call for strong human and financial resource planning and management, as well as thorough monitoring and evaluation to measure results. Tools have been developed to enable this process – a revised planning manual to facilitate better operational planning and budgeting, and three frameworks: for financial resourcing, for monitoring and evaluation, and for annual operational plans. Feedback mechanisms from consumers have been built in to ensure the pro-poor focus is realised.

Responsibility for the 6 areas of work has been assigned to lead departments and implementing units. Key to successful implementation are the critical success factors mentioned earlier and increased financial investment by the Royal Government of Cambodia and its partners.

Risks to successful implementation have been recognised. They include reduced government allocation to the health sector, reduced support from international partners, inadequate increases in professional staff salaries and health workforce resistance to management change.

This strategic plan is volume 1 of four volumes. Volume 2 is the medium term expenditure framework. Volume 3 is the sector monitoring and evaluation framework. Volume 4 contains the framework for annual operational plans to be developed by each budget management centre. There is also a short booklet that summarises the strategic plan. The booklet and all the volumes are available in both Khmer and English.

MISSION STATEMENT OF THE MINISTRY OF HEALTH, KINGDOM OF CAMBODIA

The Mission of the Ministry of Health, Royal Government of Cambodia is commitment to ensure sector wide equitable, quality health care for all the people of Cambodia through targeting resources, especially to the poor and to areas in greatest need.

VALUES OF THE MINISTRY OF HEALTH

- Right to health
- Equity
- Pro-poor

WORKING PRINCIPLES OF THE MINISTRY OF HEALTH

- Social protection for vulnerable groups
- Listening to what people want
- Affordability and sustainability
- Focus on rural areas and the poor
- Capacity building including human resource development
- Sector wide management
- High quality evidence based interventions
- Good governance and accountability

POLICY STATEMENT 2003 -2007

The policy statement of the Ministry of Health, Kingdom of Cambodia is based on the national health policy, which can be found in the booklet called 'Health Situation Analysis 1998 and Future Direction for Health Development 1999-2003'.

The following 13 elements that comprise the policy statement provide the basis for this strategic plan. The 20 strategies in the strategic plan flow from these elements.

Policy Statement

- Implement sector wide management through a common vision and effective partnerships among all stakeholders
- Provision of basic health services to the people of Cambodia with the full involvement of the community
- Provision of affordable, essential specialised hospital services
- Decentralization and de-concentration of financial, planning and administrative functions within the health sector
- Priority emphasis on prevention and control of communicable and selected chronic and non-communicable diseases, on injury, the elderly, adolescents and vulnerable groups such as the poor, and on managing public health crises
- Priority emphasis on provision of good quality care to mother and child especially essential obstetric and paediatric care
- Active promotion of healthy lifestyles and health-seeking behaviour among the population
- Emphasis on quality, effective and efficient provision of health services by all health providers
- Optimisation of human resources through appropriate planning, management including deployment and capacity development within the health system
- Increase promotion of effective public and private partnerships for effective and efficient basic and specialist care
- Effective use of the health information for evidence-based planning, implementation, monitoring and evaluation in the health sector
- Implement health financing systems to promote equitable access to priority services especially by the poor
- Further development of appropriate health legislation to protect the health of providers and consumers

CHAPTER 1: CONTEXT

Commitment to Global Goals and ASEAN Declaration

In box 1a are the relevant global 2001 millennium development goals for the health sector.

Box 1a. Global millennium development goals for achievement by 2015

- Halve, between 1990-2015, the proportion of people whose income is less than US$ 1 a day
- Reduce by two thirds between 1990 and 2015 the under-five mortality rate
- Reduce by three quarters between 1990-2015 the ratio of maternal mortality
- Attain universal access to safe reliable contraceptive methods by 2015
- Have halted by 2015, and begun to reverse, the spread of HIV/AIDS
- Have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases

The above goals are highly ambitious for Cambodia given our extremely high levels of mortality and morbidity and poor resource base. So, Cambodia has set the health targets in box 1b to be achieved by the end of 2007, in other words within the time frame of this strategic plan. Achievement of the targets will contribute to reducing extreme poverty.

Box 1b. Millennium related development targets for achievement by Cambodia by 2007

- Reduce the proportion of under-weight children aged less than 5 years from 45% to 31%
- Reduce infant mortality from 95 to 84 deaths per 1,000 live births, and for under-five mortality from 125 to 111 deaths per 1,000 live births
- Reduce the ratio of maternal mortality from 437 to 305 deaths per 100,000 live births
- Increase modern contraceptive prevalence rate from 19% to 35% among women aged 15-49 years
- Reduce HIV infection rate from 2.8% to 2.1% among those aged 15-49 years
- Reduce incidence of malaria from 11% to 8%, and mortality from 10% to 7%

In 2002, together with its neighbours in the region, Cambodia signed up to the Association of South-East Asian Nations' Declaration (ASEAN) on Healthy Lifestyles which includes the following: "We envision by 2020 that health shall be at the centre of development and ASEAN cooperation in health shall be strengthened to ensure that our peoples are healthy in mind and body and living in harmony in safe environments."

National Constitution

The National Constitution of the Royal Government of Cambodia highlights political commitment to the goals stated above.

Article 31 of the National Constitution of 1993, and as amended in 1999, clearly affirm the recognition and respect for human rights including the rights of women and children, as stipulated in the United Nations Charter, the Universal Declaration of Human Rights, the Covenants, the Child Rights Convention and in related Conventions. The constitution states that all Khmer citizens shall have rights to obtain social security and other social benefits as determined by law. Both Articles 46 and 73 in the Constitution express that women, in particular those in rural areas and have inadequate social support, shall be provided with opportunities to get medical care in health facilities such as infirmaries and maternities.

More importantly, Article 72 of the National Constitution expresses clearly the responsibility of the Ministry of Health. It reads: "The health of the people shall be guaranteed. The State shall give full consideration to disease prevention and medical treatment. Poor citizens shall receive free medical consultation in public hospitals, infirmaries and maternities. The State shall establish infirmaries and maternities in rural areas".

National policies and plans

Poverty alleviation is the main goal for the second cycle of the government's socio-economic development plan. The plan aims to achieve equitable growth distribution, promote the accessibility of the poor to basic social services including health, education, credit, market opportunities and information, and to improve management of natural resources emphasising sustainable development.

In its poverty reduction strategy the government has proposed a 'New Social Policy Agenda' for Cambodia. The government plans to reduce poverty through promoting growth by investing in human capital to increase people's capabilities and opportunities to contribute towards economic development. There is overall commitment towards improving access to health and education services especially for women and girls, and increasing participation and empowerment of the poor.

The public investment programme for 2001-2003 aims to ensure the success of both public health programs and the rehabilitation of basic health services. The areas of investment focus on strengthening health systems, priority health programs such as maternal and child health programmes, and the control of priority infectious diseases, strengthening hospitals and laboratories, and preparedness and response to emerging problems including the development of health education, primary health care and mental health. This health sector strategic plan provides the basis for the next cycle of the public investment programme.

Socio-economic environment

The long period of war and internal conflict, which started in 1970 and continued until 1993, severely de-stabilised Cambodian society, and created a deficit growth in the nation's economy. The country's economic recovery was further set back by domestic political upheaval in 1997 and the region's financial crisis. Over 80% of the nation's population resides in rural areas with poor access to basic services. More than 36% of Cambodians live below the poverty line and rural poverty accounts for almost 90% of total poverty.

Throughout the past 15 years, labour force participation of men and women has remained low reflecting the loss of human capital and skills as a result of the war. The majority of Cambodians have little or no education. Only 7% of men, and 4% of women have completed primary school, and at present, one in three women in Cambodia are illiterate.

There are major disparities in living standards between urban and rural areas. On average, only 17% of households in the country have electricity. The figure rises to 61% among urban households and drops to 9% in rural areas. During the dry season, almost 30% of the population gets their drinking water from open sources such as rivers, ponds or lakes and only one in five households has access to a latrine.

Box 2. Selected socio-economic indicators

Indicator	Value
• Total population (2001)	13.1 million
• Population projection (2011)	16.6 million
• Percentage of population in rural areas (1999)	80%
• Population below poverty line (1999)	36%
• Proportion of national poverty in rural areas (1999)	90%
• Gross domestic product per capita (2002)	US$ 360
• Annual per capita income (1999)	US$ 250
• Percentage of women who are illiterate*	32%
• Percentage of men completed primary school*	7%
• Percentage of women completed primary school*	4%
• Households in the country with access to electricity*	17%
• Percentage of households in rural areas with access to electricity*	9%
• Population who obtain drinking water from open sources during the dry season*	30%
• Households with latrines*	21%

*(2000)

The slow growth of the agro-based rural economy, the lack of improvement of farmers' incomes, and the more recent 'boom' of the textile industry have caused many young people to migrate to the capital city seeking employment as garment factory workers or in other manufacturing and service sectors. As a result, Phnom Penh has grown rapidly without corresponding development of its infrastructure. Around 25% of the city's population lives in slum areas without adequate water, sewerage or sanitation systems and has poor access to basic services. The population of Phnom Penh city is expected to double in 15 years signaling the need for some attention towards urban poverty and its health effects.

Urbanisation and the rapid change towards a free market economy have also resulted in changing lifestyles and risk factors among the middle and upper income brackets such as smoking, alcohol use, more sedentary work routines, less breast feeding due to aggressive marketing of breast milk substitutes, and possible changes in diet.

Post crisis (1979-onwards)

The civil war of the seventies and the ensuing political unrest during the past twenty years left Cambodia with a poor public sector infrastructure and services. The Khmer Rouge decimated the health system: of the 1,000 doctors trained prior to 1975, less than 50 survived the regime. In 1979, the restoration of a functioning health care system became one of the highest priorities of the new government of the People's Republic of Kampuchea.

The period 1980 to 1989 was one of reconstruction and rehabilitation, with many health workers being trained through accelerated training courses. The Faculty of Medicine, Dentistry and Pharmacy was one of the first educational training centres to be rebuilt by government and was opened early 1980.

The health service delivery system was set up as a socialist model and publicly financed, comprising Khum (commune) clinics, district hospitals, provincial and national hospitals based on administrative districts. All national programmes such as control of tuberculosis, malaria, dengue, diarrhoeal diseases and nutrition functioned vertically throughout the system.

Box 3. Post crisis related problems in the health sector

- Destruction of the physical infrastructure, and dismantling of professional and administrative cadres in the 70s
- Very high levels of mortality and morbidity
- Extremely high birth rate during the post-war period
- Distorted population pyramid, both in terms of sex and age
- Emotional, mental and physical trauma resulting from the war, including disabilities due to landmine accidents

The period 1989 to 1995 was a time of recovery with substantial government and donor investment. In 1993, the first Royal Government took office and authority and responsibility for programme development and budgetary control at local health units were transferred from local government to the Ministry of Health. Basic legislation on key organisations in the sector and regulations for the management of pharmaceuticals were prepared and laws passed between 1995 and 1998. In the 1990s, health staff started to augment their monthly government salaries of US$ 10-15 by working in the private medical sector.

During the 1980s only UNICEF and a few other international non-governmental organization (NGOs) were active in Cambodia. Other external partners gradually started programmes or projects in the 1990s. From 1991 onwards the Ministry of Health re-examined its strategies and policies to focus on improving accessibility to health services in the rural areas. With support from the World Health Organization, in 1996, the health coverage plan was set up to establish a network of health centres and referral hospitals based on 'operational districts', a new version of health service jurisdiction areas demarcated by population distribution. The new system moved away from the original set-up of Khum clinics and district hospitals based on administrative districts.

In the mid-90s, international finance institutions such as the World Bank and the Asian Development Bank began contributing investment funds to develop rural health infrastructure, especially for civil works and strengthening of basic skills. During the same period, these institutions and many other international donors also started financing recurrent costs of health service delivery, the latter mostly through NGO assisted projects. A health financing charter introduced financial reforms to enable provincial and district health managers to access public and private funds to build and regulate their health systems.

CHAPTER 2: WHERE ARE WE NOW ?

Current health and demographic indicators

Box 4. Selected health and demographic indicators

Indicator	Value
• Life expectancy at birth (1998)	58.3 (females) 54.5 (males)
• Total fertility rate*	4.0
• Maternal mortality ratio*	437 deaths per 100,000 live births
• Infant mortality rate*	95 deaths per 1,000 live births
• Under-five mortality rate*	125 deaths per 1,000 live births
• Percentage of children under five years with stunting*	45%
• Percentage of children who are underweight*	45%
• Tuberculosis incidence rate (2001)	540 per 100,000 population
• Malaria incidence rate (2001)	8 per 1000 population
• HIV seroprevalence rate among 15-49 years*	2.8%

*(2000)

The 2000 Cambodian demographic and health survey provides the most recent estimates of priority indicators. The population structure reflects the impact of the Khmer Rouge regime between 1975 and 1979 during which mortality levels were high, particularly for men, and fertility levels decreased. In post-conflict times, a baby boom occurred to create a large proportion of people aged 20 years or less. This age group now comprises 55% of the total population.

Cambodia has experienced a period of fertility decline from 5.4 to 4.0 children per woman aged 15-49 years in the last ten years. The largest decline is in the capital city, Phnom Penh. However, it is notable that the hilly remote provinces of Mondulkiri and Ratanakiri show an increase in fertility levels over the same period.

About one in five Cambodian women who died in the seven years prior to 2000 did so from pregnancy or pregnancy-related causes. The maternal mortality ratio for the period of 1994-2000 is estimated at 437 deaths per 100,000 live births-an alarming figure.

Infant and under-five mortality rates signal a disturbing picture of child health in Cambodia. Almost one in every ten babies does not survive to his or her first birthday (95 infant deaths per 1,000 live births). Under-five mortality is 125 per 1,000 live births. Diarrhoeal diseases, acute respiratory infections and vaccine-preventable diseases cause about half of the under-five deaths. Over the past ten years, both infant and child mortality have steadily increased. The causes of this phenomenon need to be analysed more carefully. Post-neonatal mortality - currently estimated at 58 per 1,000 live births - has increased, constitutes the bulk (61%) of infant mortality and is a critical priority to be addressed.

Chronic malnutrition among Cambodian children is high, with 45% moderately stunted and more than one in five children severely stunted. The level of stunting increases with age from 15% among children less than six months to about 45% among children aged 3 years or older. Among children and women there is a high prevalence of micronutrient deficiencies, especially iron, and vitamin A, and iodine. Only 12% of households use iodised salt.

The burden of infectious diseases is heavy. The incidence rate of all forms of tuberculosis (TB) is estimated at 540 per 100,000 population, with a case fatality rate of 90 per 100,000. The number of new TB cases seen at public health facilities has trebled over the last decade. In 2001, the incidence of clinical malaria cases reached 8 per 1000 persons, with a case fatality rate of 9% among the severely ill.

The HIV epidemic seems to have reached its peak, and since 1999, the percentage of adult Cambodians who are infected with HIV has decreased from 3.2% to 2.8%. However, sero-surveillance and behavioural survey reports indicate that there is no room for complacency. By the year 2000, 169,000 persons have been estimated as infected with the virus, over 17,000 young people have died already from HIV infection, and over 8,000 cases of AIDS have been reported. Statistical projections imply that 7,000 children under 10 years of age have been orphaned by the epidemic and this number will grow to 48,000 by 2003. It is estimated that 74,000 adults and 16,700 children will have died as a result of HIV infection. The effects on the elderly are also grim: having lost their life's savings in the care and treatment of their children afflicted with AIDS they are often destitute and abandoned, perhaps with the burden of looking after orphaned grandchildren.

As in many other countries, the population aged 65 years or more is expected to increase resulting in a host of emerging chronic diseases such as cardio-vascular and renal disorders, cancer, and diabetes. Also, as commercial and industrial sectors expand, the health sector will also see increasing numbers of work-related injuries and road traffic accidents unless more attention is given to prevention.

Box 5. Health and demographic priorities to be addressed in the next five years

- The rise in infant and child mortality including increasing post-neonatal mortality, mortality and morbidity from diarrhoeal diseases, acute respiratory infections, vaccine-preventable diseases, dengue and malaria
- The high rates of under-nutrition among women and malnutrition among children
- High maternal mortality ratio, and deaths from obstetric trauma and septic abortions
- High case fatality from infectious diseases particularly HIV/AIDS, TB, and malaria
- The high total fertility rate
- Population growth
- Harmful practices among consumers and providers including unhealthy lifestyles and widespread inappropriate health seeking behaviour

The role and structure of the Ministry of Health

The role of the ministry at all levels is to give overall policy direction, regulate and legislate the sector, and develop, manage and finance public sector health systems and services.

The current organisational structure of the ministry is shown in Annex A1. At Annex A2 is the provincial organisational chart. The ministry currently comprises three directorates at the central level: health services, finance and administration, and inspection with the Minister of Health as chief executive. The activities of national hospitals, national programmes and national institutes are supposed to be coordinated by different technical departments of the ministry. However, in reality, they all report directly to the Director General of Health.

The structure, roles and functions are being reviewed as part of institutional strengthening related to this strategic plan. This review will be completed in the first year of implementation and will then become an ongoing process until 2007.

More recently in 2000, a private sector participation task force with representation from several key departments was formed to further develop strategies to improve participation and regulation of commercial and non-profit health providers and organisations.

At operational district level, health services are delivered within a framework of a minimum package of activities through health centers and a complementary package of activities for district referral hospitals and provincial hospitals. The provincial health department under the ministry's direction implements health policy and strategies through annual plans. Another main role of this department is to monitor and supervise operational district teams to ensure service delivery and effective utilisation of resources.

Since the mid-nineties, the ministry has established several mechanisms to coordinate and discuss sector-level issues with its partners. The coordinating committee (CoCom) and provincial coordinating committee (ProCoCom) were set up to coordinate inputs from international organisations, NGOs and donors at national and provincial levels. The CoCom provides the forum to promote dialogue and clear understanding of Ministry of Health priorities and has been used for debate and consultation on policy and strategy development. The ProCoCom is for provincial health department to coordinate and plan its work among all government, NGOs and other partners in each province according to specific needs, problems and priorities.

What is working well?

Some of the initiatives started in the mid-90s are now having positive outcomes. In this section we look at critical success factors upon which to better plan and build the future.

As stated earlier, during the early 1990s, the ministry launched a health sector planning and reform programme to reorganise the public sector health system and relocate facilities in order to improve accessibility especially in the rural areas. The expansion of basic health services has continued, 81% of the planned 940 health centres have been reconstructed or newly built and are providing the minimum package of activities to some extent. One positive impact is that attendance rates have increased, especially with regards to curative care contacts as well as antenatal care and birth spacing. But, overall attendance rates are still too low. The critical success factors for increasing rates include the availability of competent staff and medicines, budget access for recurrent costs and extension of services through outreach activities.

In 2001, Cambodia was declared polio-free. The ministry has now initiated programmes for eliminating neonatal tetanus and controlling measles. The reasons for the success in eradicating polio relate to strong commitment, active political participation at the highest level, technical and financial support from all partners, effective mass media campaigns and community participation. Active surveillance, careful planning, supervision and monitoring systems with timely and adequate provision of funds, vaccines and commodities also contributed to this achievement.

The observed reduction in the prevalence rate of HIV/AIDS among the adult population during the last years is another encouraging indicator. Although the Ministry of Health recognizes that partly this reduction is due to the increased number of deaths, the epidemiological and behavioural sentinel surveillance shows a reduction in the number of new infections among high risk groups and an improvement in the rate of condom utilization during commercial sex. These encouraging results are directly linked with the implementation of successful preventive interventions such as the 100% condom use programme.

Likewise, other services such as the directly observed treatment short course for tuberculosis (TB DOTS) are now extended to many new health centres, and the cure rate is being maintained at 85%.

Mortality from malaria has decreased and outbreaks are managed effectively. The critical success factors common to these two diseases include political commitment, effective intervention strategies as well as good multi-sectoral collaboration involving civil society, communities and other ministries.

Along with organizational reform, financial reforms are also in place to ensure the effective use of funds allocated to health. The Ministry of Health made a bold move in 1996 to levy official charges for services in order to regulate under-the-table payments and reduce household expenditures. Since 1997, household health expenditures have reduced from US$ 29 to US$ 24. Indirectly, self-regulatory measures and performance based contract management within facility teams have been effective in controlling unofficial payments. In connection, community linkages through Health Centre Management Committees and Village Health Support Groups formerly called Feedback Committees, have also contributed to regulating prices and promoting public health facilities and services.

Budgetary reform programmes such as accelerated district development (ADD), and the priority action programme (PAP) were introduced to increase access to the national budget resources for health systems development at district and provincial levels. To date public expenditures in these pilot areas have increased annually as a result of more flexible financing arrangements as well as political commitment to ensure budget access.

The ministry is better able to manage pharmaceutical supply systems. Expenditures on essential drugs and medical supplies have increased by 50% during the last three years and logistic management systems have improved at all levels. The strengthened management has mainly resulted from relevant, practical capacity building.

An innovative strategy of contracting health services to NGOs in very poor districts has recently been piloted with significant success in achieving dramatic increases of health service coverage and reducing of out-of-pocket expenditures. The critical success factors include the increase in financial resources from external sources, the injection of external management culture through non-governmental non-profit organisations and giving more authority to district health managers.

The partnership between the Ministry of Health and NGOs is strong and continues to be nurtured from both sides. Likewise, the ministry has good relationships with most external and international partners. Success factors in these partnerships includes actions by the ministry to initiate structures and processes to improve collaboration and coordination, and relevant technical, management and financial support.

Box 6. Critical success factors in the health sector

- Strong political commitment and good planning, supervision and monitoring systems at all levels of the health system for very specific cost-effective public health interventions
- Timely and adequate provision of funds and commodities
- Availability of essential drug supplies
- Adequate income for staff
- Active human resource management
- Extending services through outreach activities
- Mass media campaigns
- Community participation in health activities
- Flexible financing arrangements
- Regulatory measures through performance based contracting
- Partnerships with NGOs
- Appropriate technical, management and financial support from all partners

What are the key challenges ?

Health and population issues

The high rates of infant and child mortality are linked to poor coverage of critical child health services especially immunisation and poor access to and utilisation of trained providers for treatment of childhood illnesses, particularly for acute respiratory infections. The use of oral rehydration solution for children under five years of age with diarrhoea is fairly low. Also, exclusive breastfeeding for babies below five months of age is rarely practiced and there are also inappropriate complementary feeding practices. There is a high prevalence of micronutrient deficiencies. These all contribute to limited growth and development and reduced resistance to infection.

The coverage of maternal health services still remains low, especially for essential obstetric care. There is high unmet need for birth spacing and many women do not have access to safe abortion. The use of midwives, and availability of emergency obstetric care all need to be improved especially in remote areas.

Earlier in this strategic plan it was mentioned that there is a large proportion of people aged 20 years or less. This means that adolescent health is an emerging public health challenge. Of particular concern are the poverty related high rates of child/adolescent labour and the trafficking of young people, mainly for the sex trade.

The country still has large geographical areas that do not have access to cost-effective interventions that limit the high burden of infectious diseases. Such interventions are particularly needed to prevent and provide appropriate care and treatment for HIV/AIDS, TB, malaria, and dengue. Further efforts are required to continue building a well-functioning health system and to develop hospitals that can provide services at standard quality for many serious emergency conditions. Likewise, alternative strategies for targeting and extending access for example, through outreach, should be implemented as a priority to address the needs of the poor and socially disadvantaged.

There has been some success in the past in controlling and/or eradicating certain diseases. However, the vertical approach of many disease control programmes has not spread benefits throughout the system. Focusing on a single health problem has resulted in missed opportunities to address others of similar nature within the same target group calling for an alternative, more cost-effective approach to sustain the delivery of basic services.

Consumers and providers

Much more attention to behavioural change is required to improve the household health practices of consumers and carers with regards to nutrition, the use of preventive measures and healthy lifestyles. More efforts are needed to promote important behaviours such as immunisation, contraceptive use, breast-feeding, oral rehydration therapy, the use of trained providers for delivery and for treatment of childhood infections, and the means of protection against major infectious diseases such as condom use and bednets for vector control. A summary of priority health service interventions can be seen in box 12.

At all service delivery levels, poor communication between providers and consumers is a major obstacle in promoting family health. Poor quality within the public sector – from both professional as well as consumer perspectives - has deterred effective utilisation of basic health services. Limited resources, poor dissemination of clinical standards and limitations in technical as well as counseling skills has affected client trust in providers. It is prime time to sensitise providers on professional ethics and build their skills in interpersonal communication and counseling in order to build trust and empower consumers to make appropriate choices in adopting healthier lifestyles and practices.

Costs and sector financing

The price of health care is a major barrier to health service use especially at referral hospitals. The demographic and health survey of 2000 revealed that:

- On average, households spend almost US$ 24 per capita on health services amounting to 9% of GDP;
- Among those who sought care, 80% had to use savings, or even borrow or sell assets to pay for health care costs.

Informal private sector providers such as drug sellers are the first source of care for the majority of consumers raising issues of poor quality and low effectiveness due to the lack of regulation. The ministry and its partners face challenges to limit the impoverishing effects of inappropriate health expenditures and enable equitable access to low-cost high impact services through targeting measures and innovative financing schemes.

The system suffers from limited staff availability and capacity especially in relation to midwives, nursing staff and others especially in peripheral areas. The difficulty in deploying and distributing adequate staff is partly due to recruitment procedures and the lack of identified posts and establishments needed for each health services resulting in mal-distribution of staff. Other issues related to staff distribution and motivation, particularly the lack of incentives or motivating factors especially for those who serve in remote areas. Training new staff and strengthening the skills of qualified people through continuing education is inadequate due to lack of trainers and financial resources.

The most critical factor that limits effective delivery of health services in the country is the low level of salaries for Ministry of Health staff which currently range between US$ 15-30 per month. This low salary forces qualified personnel to devote their energies to private practice in order to earn a living wage. A key challenge in the next five years is to develop interim strategies that improve the income of government health staff in order to have a functioning health system especially in poor and remote areas, while broader public administrative reforms are being established. There is also need to strengthen regulation of private practice, i.e. practitioners and facilities and services in order to ensure quality and reduce malpractice.

The health sector is seriously under-funded at less than 1% of the country's gross domestic product through public sources. The government has attempted to increase access to the national budget through various fiscal and financial reforms. A new challenge will be to ensure that funds are allocated equitably, used effectively and that there is value for money. The national health budget has increased from almost US$ 2 per capita in 1999 to US$ 3 per capita in 2001. However, expenditures remain low and different budgetary reforms to improve access to funds are being piloted. The ministry needs to strengthen budget implementation including proper use of monitoring and financial auditing procedures.

Box 8. Summary of key challenges in the health sector

- Low utilisation of cost-effective public health interventions
- Poor attitudes and practices among service providers in communicating with consumers
- Mal-distribution of health service providers, especially trained midwives
- Poor quality of care in both public and private sectors
- The emerging public health issue of adolescent health
- High demand for family planning/birth spacing advice and commodities
- Low salaries of health staff in the public sector and lack of incentives to work in remote areas
- High prices, limited access to essential services among the poor, especially to referral hospitals
- Irregular and inadequate flow of funds to service delivery
- Poor management and leadership capacity, especially in monitoring, evaluation, supervision and for evidence-based, delegated decision making
- Inadequate capacity in human resource development including training and personnel management
- Limited coordination on external financing in the sector
- Managing major public health crises

Institutional challenges

Organisationally, the ministry encounters a lack of clarity about roles and functions within its departments and institutions and limited leadership linked to inadequate management skills. Partnerships among institutions at the central level as well as with field level departments have been quite rare. The challenge is to build institutional linkages for managing, coordinating and monitoring the implementation process in order to facilitate central departments, programmes, institutions and field personnel to interact closely and work as teams to produce common outcomes.

There is unnecessary duplication of resources, especially in terms of personnel and finances, when planning, training and supervision for different programmes are conducted independently and separately leading to lack of clarity within line management. It is important to start integrating service delivery and management systems at district level and upwards.

The Ministry of Health is committed to building collaboration and coordination processes with private providers for effective delivery of health services. The potential of private sector, including both for-profit and not-for-profit providers, will be harnessed to complement the provision of publicly funded services. At present, the ministry faces low capacity and unclear mechanisms to effectively monitor and regulate private providers through legislation and registration mechanisms.

Effective coordination with external partners is a priority. The mechanisms for consultation, collaboration and coordination are established for strategic technical issues, but less so for financial resources. The opportunity for the ministry to take the lead in consistently analysing health priorities in the sector, and deciding on resource allocation is often secondary to strategies and plans initiated by external partners. The development of this sector strategic plan is the first step for the ministry to increase the ministry's leadership in sector-wide management. The strategic plan highlights the ministry's new partnership approach towards working with donors and lending agencies in developing policy and in planning and financing the health sector in the country.