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Ministry of Health

OVERVIEW OF CAMBODIA'S INVESTMENT CASE FOR RMNCAH-N

In Support of the Global Financing Facility for Every Woman, Every Child (GFF)

December, 2018

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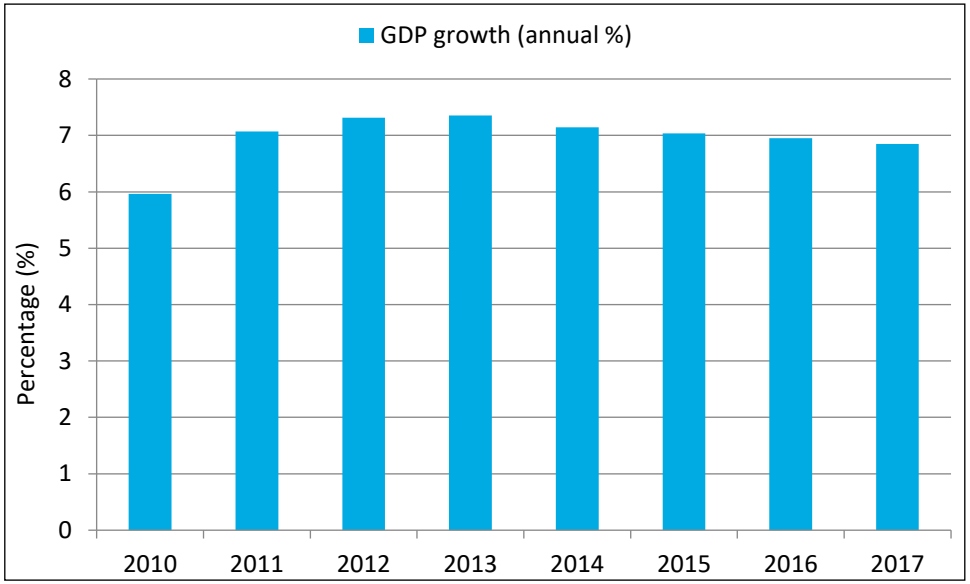
AGENDA

1. Background
2. Health Outcomes & the RMNCAH-N Burden
3. RMNCAH-N in the Cambodian Health System
4. Investment Priorities
5. Monitoring & Evaluation
6. Conclusions & Next Steps
7. Annexes

CAMBODIA'S HEALTH OUTCOMES AND THE RMNCAH-N BURDEN

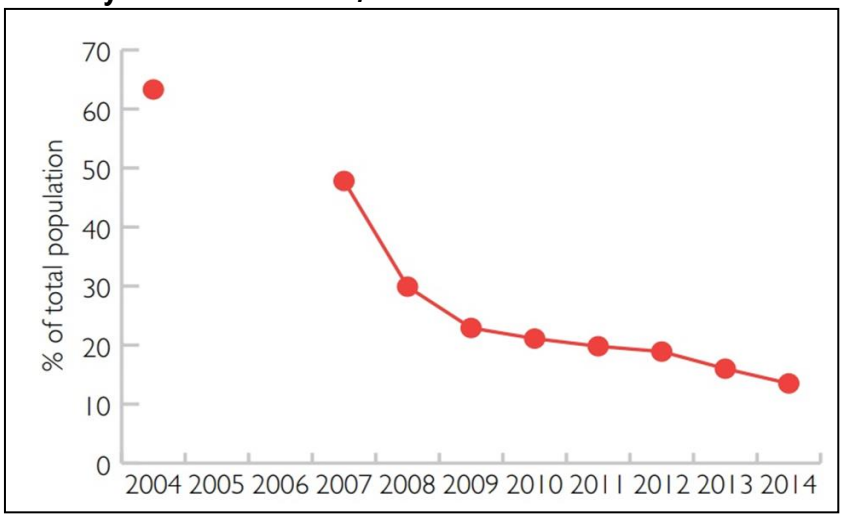
Over the past two decades, Cambodia has experienced robust economic growth and poverty reduction.

Economic growth in Cambodia, 2010-2017



Source: IMF World Economic Outlook, October 2018 ed.

Poverty trends in Cambodia, 2004-2014



Source: World Bank, 2017a.

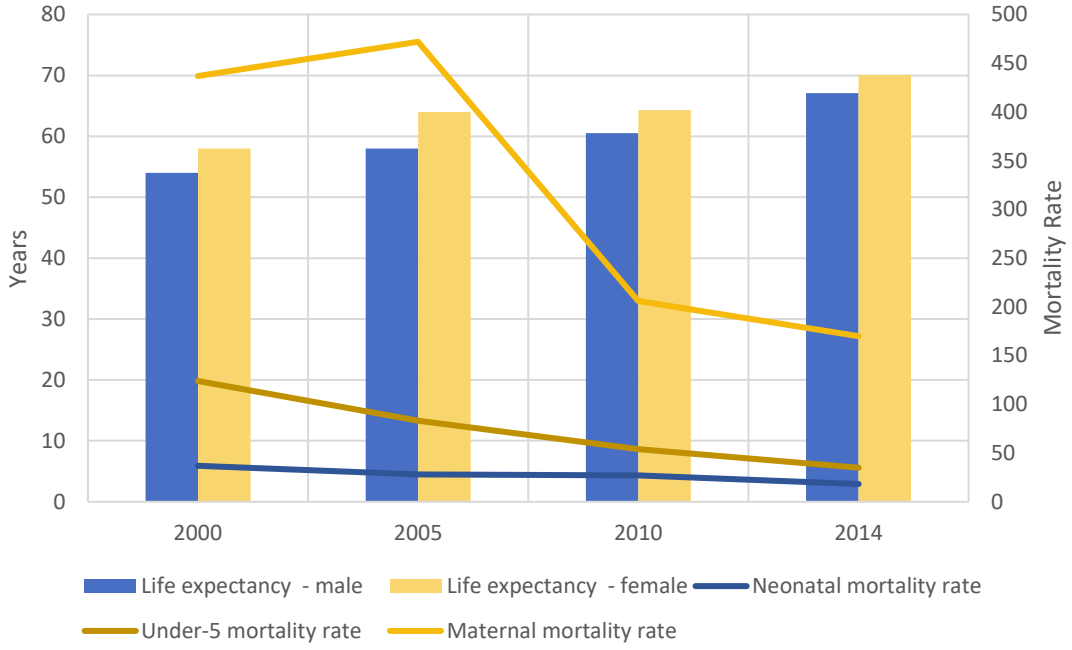
At 7.1% annual GDP growth, Cambodia is one of the fastest growing economies in the region.

Cambodia must redouble efforts to sustain RMNCAH-N progress, achieve the Sustainable Development Goal of 'leaving no one behind'

Under the Fourth Rectangular Strategy for Growth, Employment, Equity and Efficiency, RGC has committed to translating peace and prosperity into enhancing the human capital through investments in the Cambodian people.

EXEMPLARY AMONG LICs FOR ACHIEVING HEALTH GOALS

Increased life expectancy was driven by improvements in the social determinants of health and substantial progress in child (MDG4) and maternal (MDG5) health.

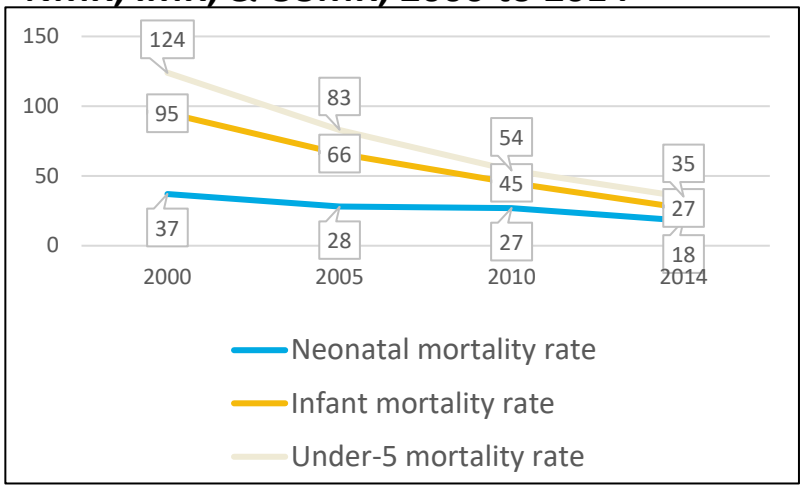


- **Cambodia is one of the very few countries globally to achieve both MDG4 and MDG5.**
- **Life expectancy for men & women** increased from 54 to 67, and from 58 to 70, respectively.
- **Maternal mortality rate** decreased from 437 to 170 deaths per 100,000 live births.
- **Under-5 mortality rate** decreased from 124 to 35 deaths per 1,000 live births.
- **Neonatal mortality rate** decreased from 37 to 18 deaths per 1,000 live births.

Source: CDHS 2000, 2005, 2010, and 2014.

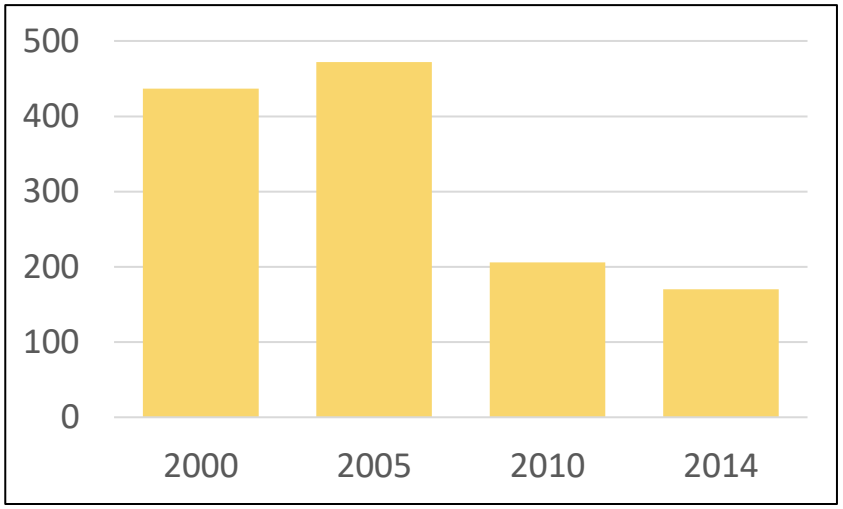
STEADY & SIGNIFICANT PROGRESS ON KEY HEALTH OUTCOMES

NMR, IMR, & U5MR, 2000 to 2014



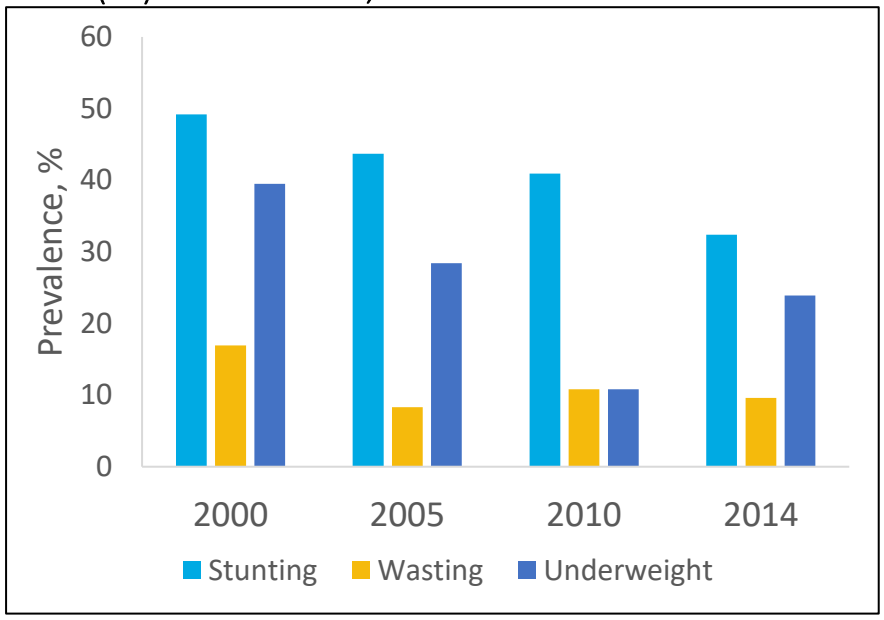
U5MR **decreased** (124 to 35 per 1,000 live births)
IMR **decreased** (95 to 27 per 1,000 live births)
NMR **decreased** (37 to 18 per 1,000 live births)

MMR, 2000 to 2014



MMR **decreased** (437 to 170 deaths per 100,000 live births)

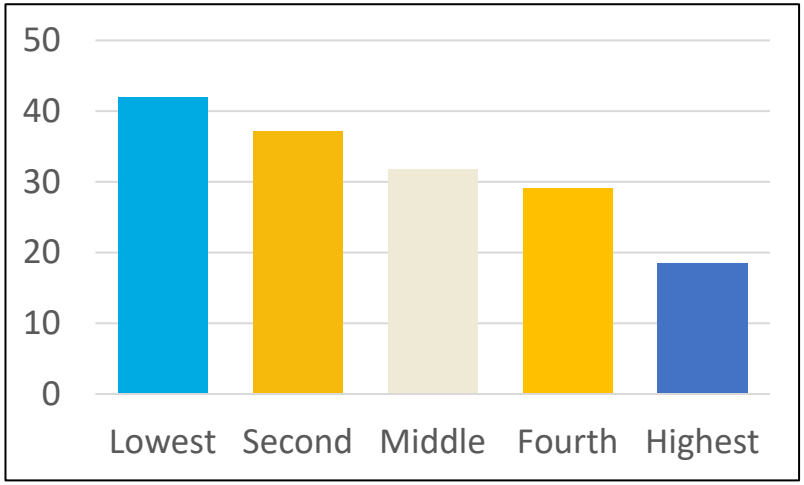
Child (<5) undernutrition, 2000 to 2014



U5 stunting **decreased** (50% to 32%)
U5 wasting **decreased** (17% to 10%)
U5 underweight **decreased** (39% to 24%)

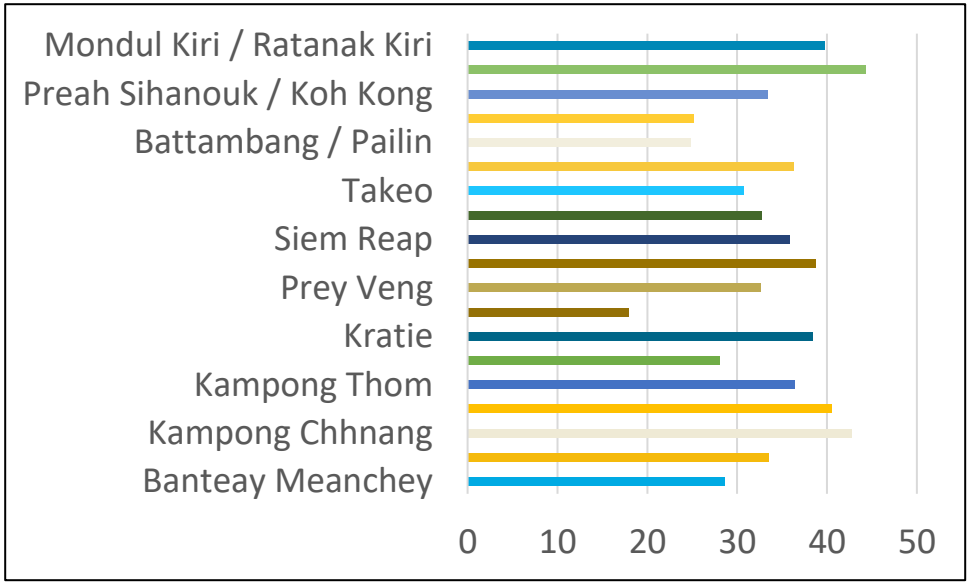
Inequities across income levels and geography is high, and increasing.

Stunting by income quintile



- 2 times higher among poorest than wealthiest
- Decreased 44% for the wealthy but only 29% for the poor*

Stunting by province



- 30% higher among rural than urban
- Decreased 44% in urban areas but only 34% in rural areas*

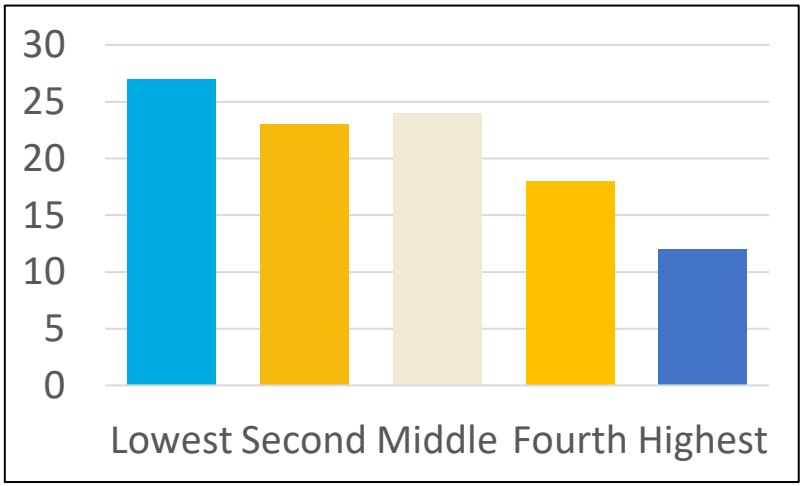
* Data 2000-2014

Source: CDHS 2014.

REMAINING CHALLENGES & UNEVEN PROGRESS: NMR

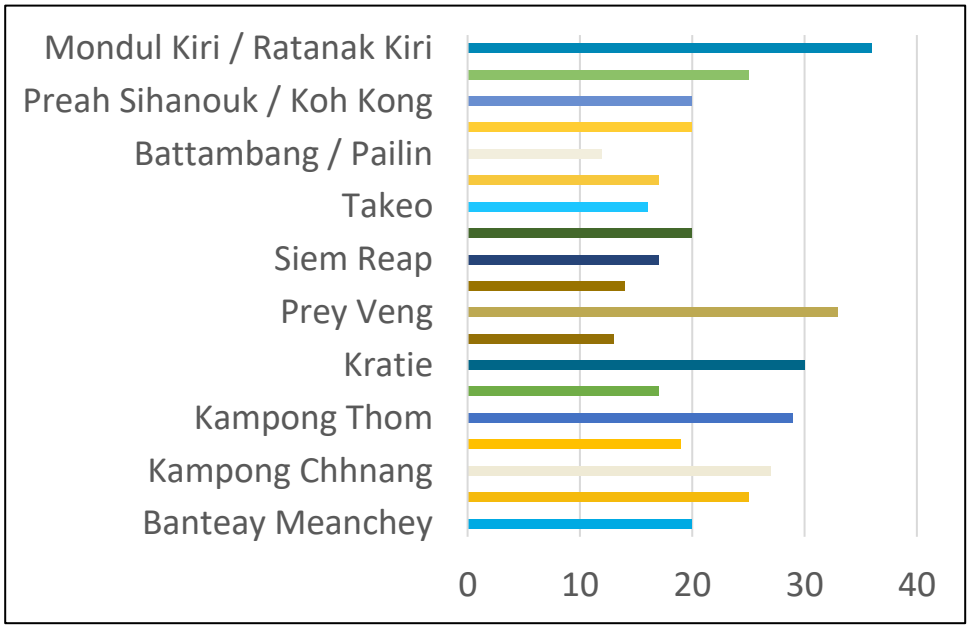
Inequities across income levels and geography is high, and increasing.

NMR by income quintile



- 4 times higher among poorest than wealthiest
- Decreased 60% for the wealthy but only 35% for the poor*

NMR by province



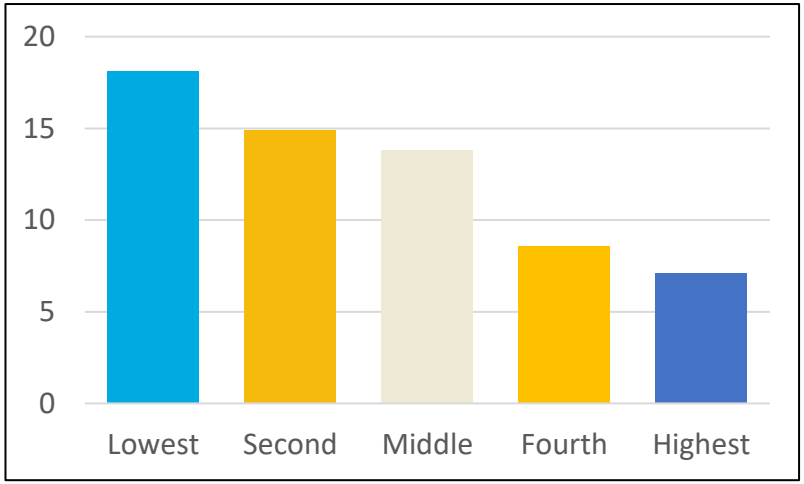
- 4 times higher among rural than urban
- Decreased 84% in urban areas but only 47% in rural areas*

* Data 2000-2014

Source: CDHS 2014.

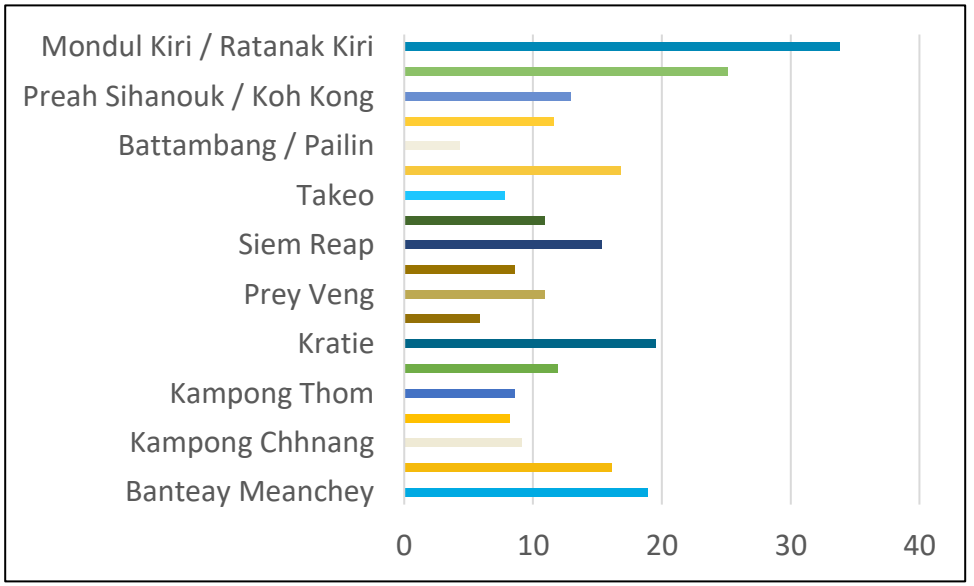
Inequities across income levels and geography is high, and increasing.

Teen pregnancy by income quintile



- More than 2.5 times higher among poorest than wealthiest
- Increased 110% among the poor and 25% among the wealthy*

Teen pregnancy by province



- More than 2 times higher among rural than urban
- Decreased 14% among urban but increased 56% among rural*

* Data 2000-2014

Source: CDHS 2014.

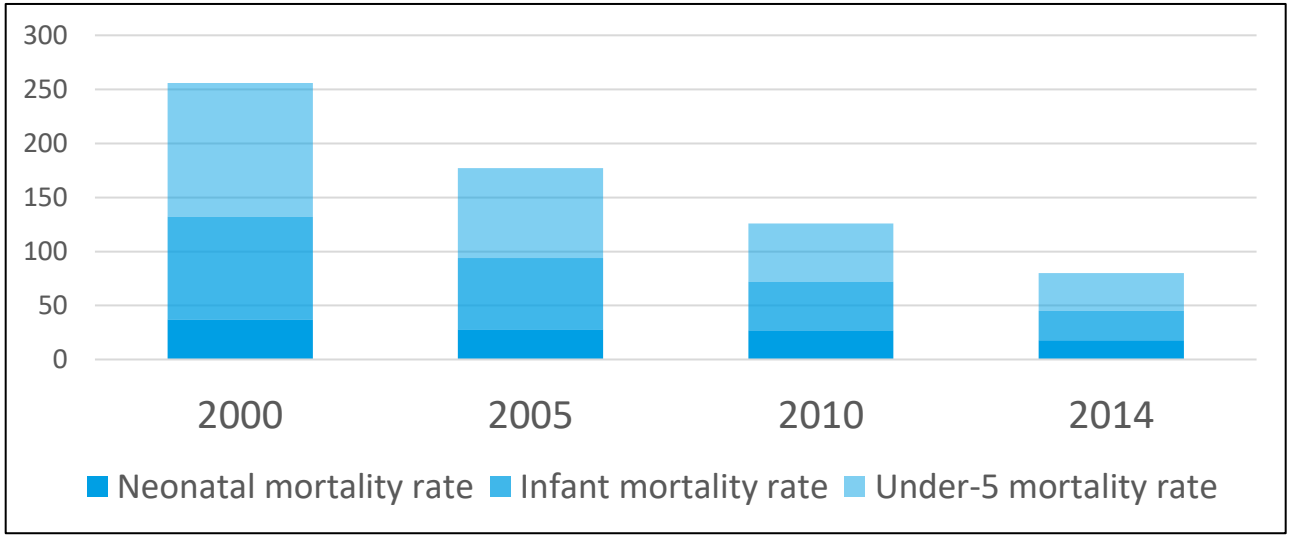
RMNCAH-N REMAINING CHALLENGES

Undernutrition

- Child stunting (32%) and wasting (10%) remain high, according to the WHO public health severity threshold.

Neonatal Mortality

- NMR (18 per 1,000 live births) remains high.
- NMR now constitutes a greater share (50%) of U5MR, and is the leading cause of death for children under-five.

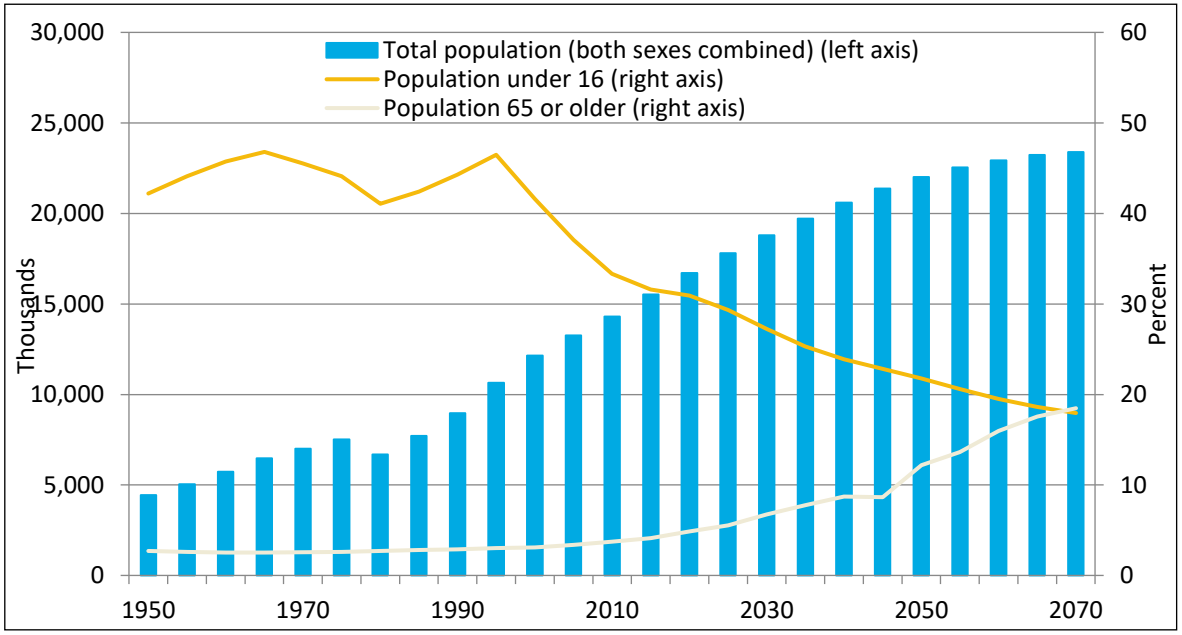


Teenage Pregnancy

- Teen fertility rate increased (44 to 57 per 1,000 women)
- % of teens who have begun childbearing increased 46% (8% to 12%)

With declining total fertility rate, the share of the population that is aged 65+ is increasing.

Population change over time.



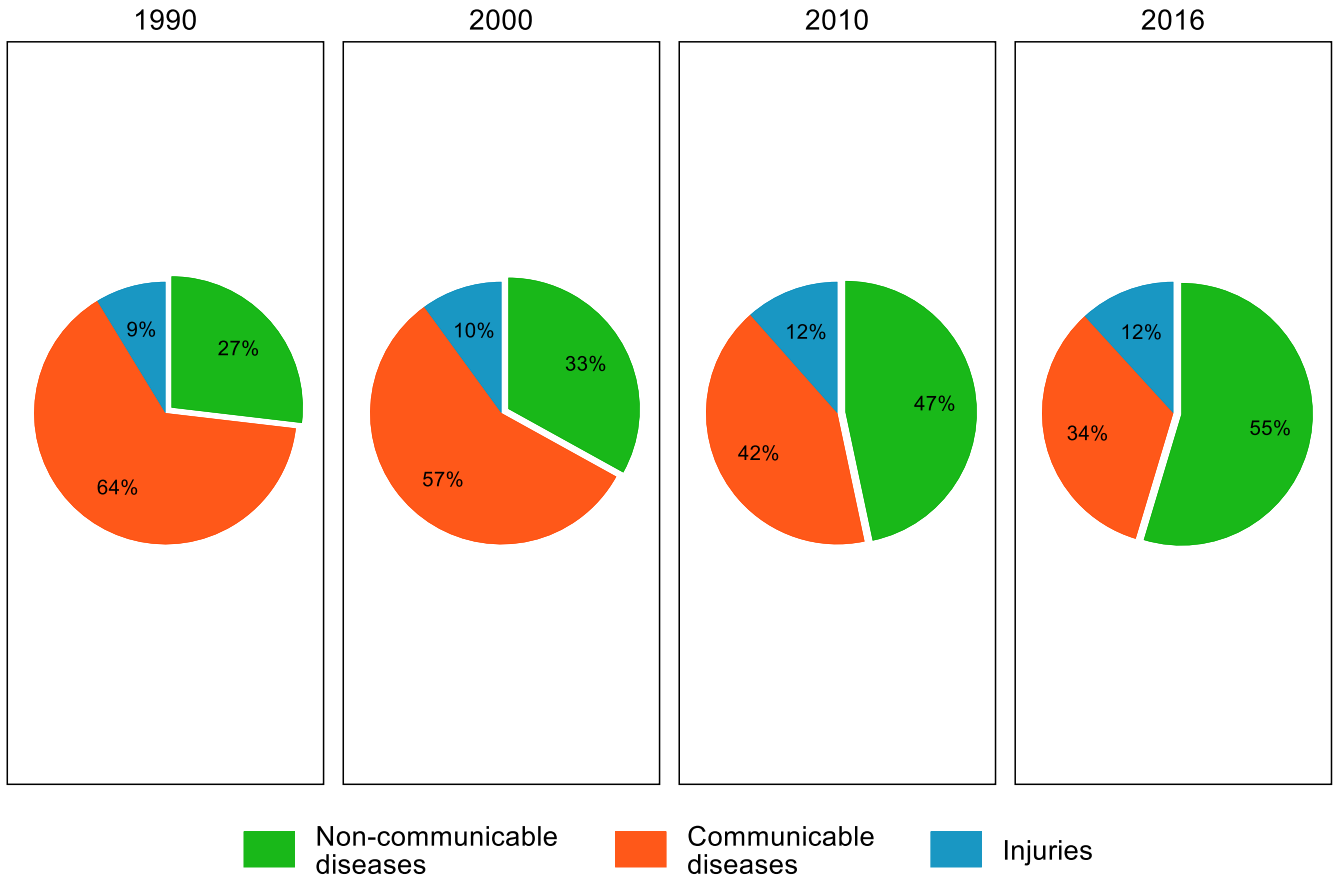
- From 2000 to 2014, total fertility rate declined from 4.0 to 2.7.
- By 2020, the total population of Cambodia will be 16.5 million, of which a third (27%) will be women of reproductive age.

Source: United Nations Population Division (2017).

Demand for adolescent and youth reproductive health services is expected to increase.

DUAL BURDEN OF DISEASE

An unfinished agenda related to communicable, maternal, neonatal, and nutritional diseases alongside a growing burden (over 50%) of non-communicable diseases.

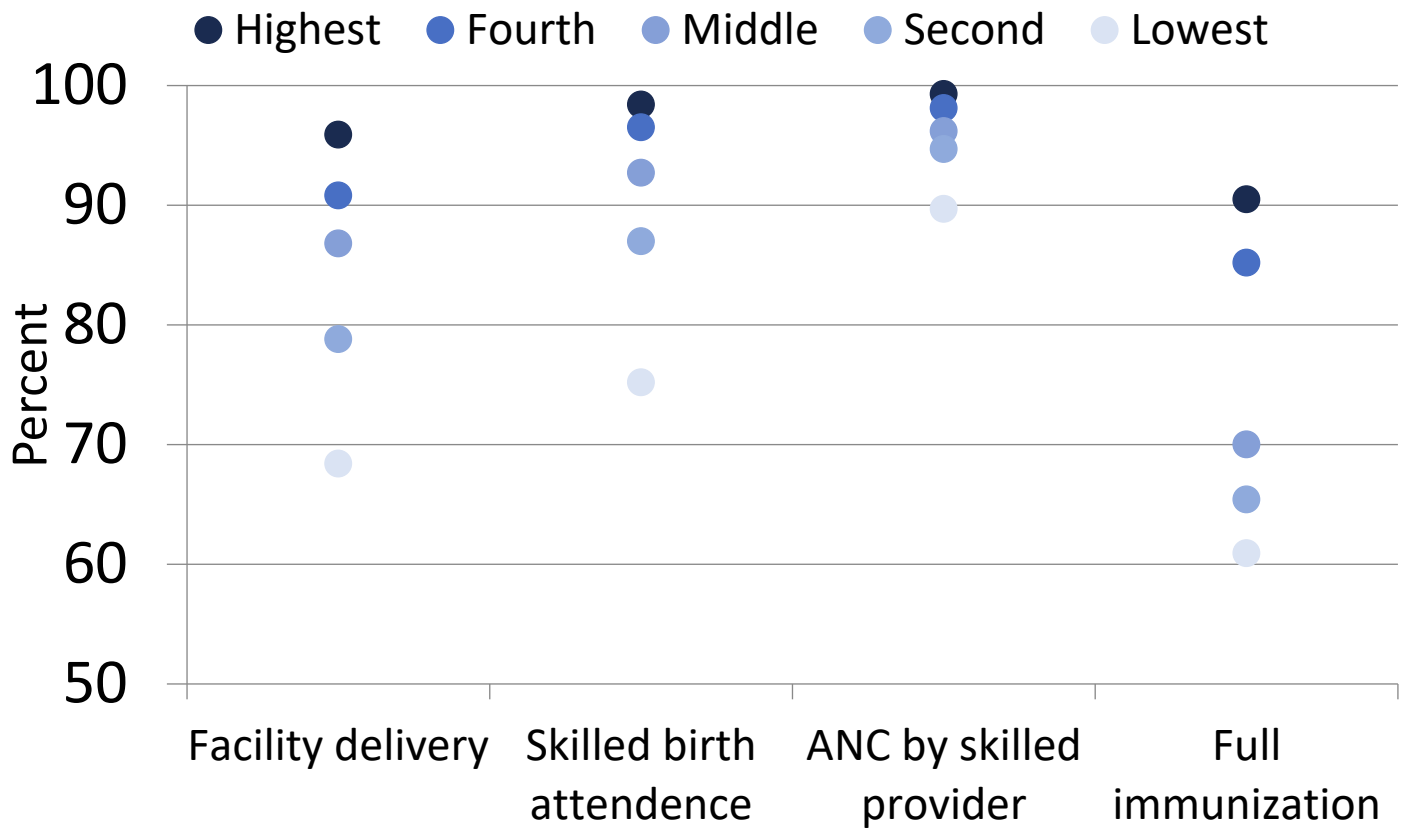


Source:Institute of Health Metrics and Evaluation

Note: "Communicable diseases" (Group I) include communicable, maternal, neonatal, and nutritional diseases.

RMNCAH-N IN THE CAMBODIAN HEALTH SYSTEM

Large income disparities for RMNCAH-N service coverage.

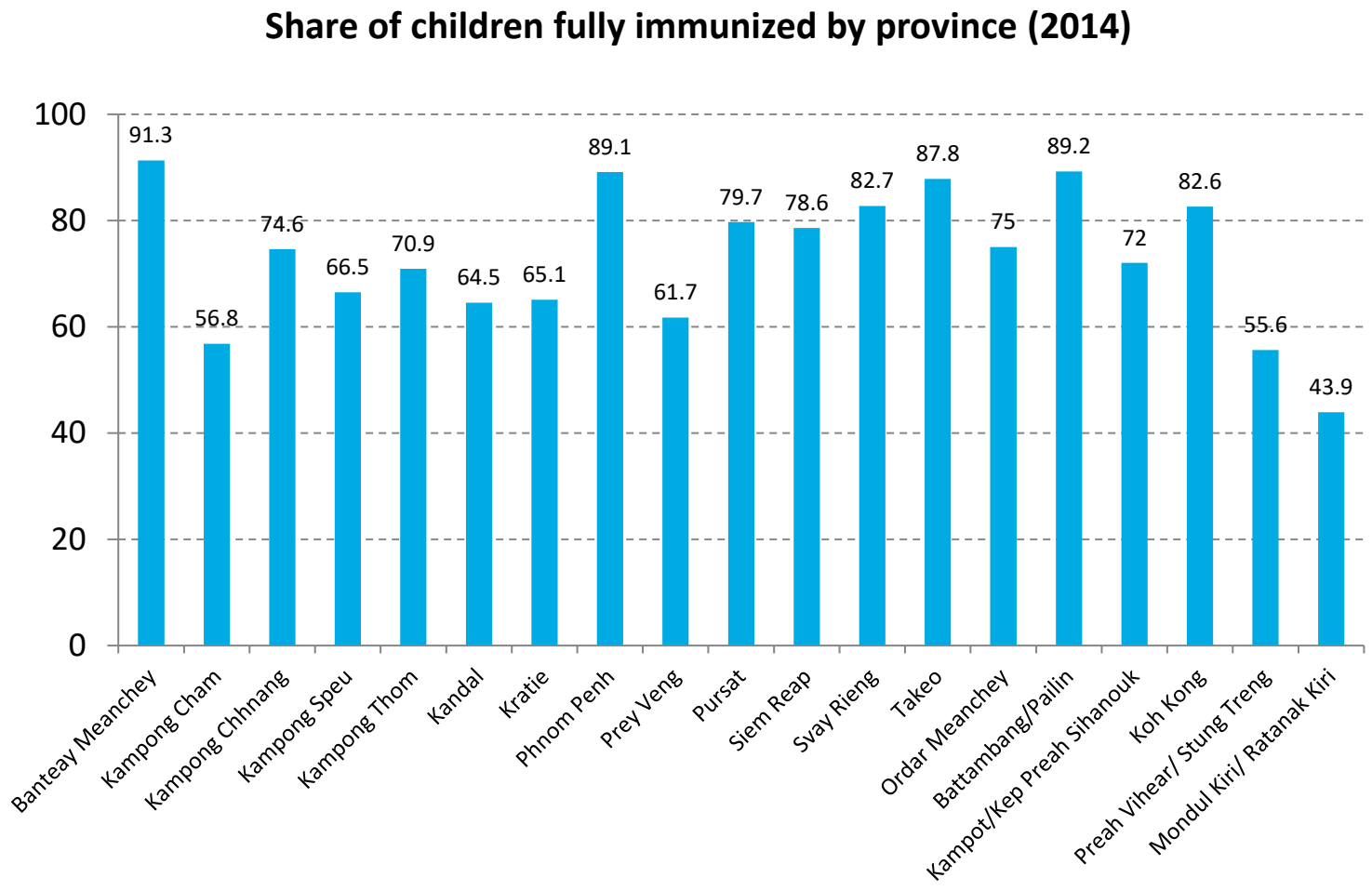


*For more info, see **ANNEX 3. SERVICE DELIVERY CHALLENGES & INEQUITIES***

Source: CDHS 2014.

SERVICE DELIVERY CHALLENGES & INEQUITIES (cont'd)

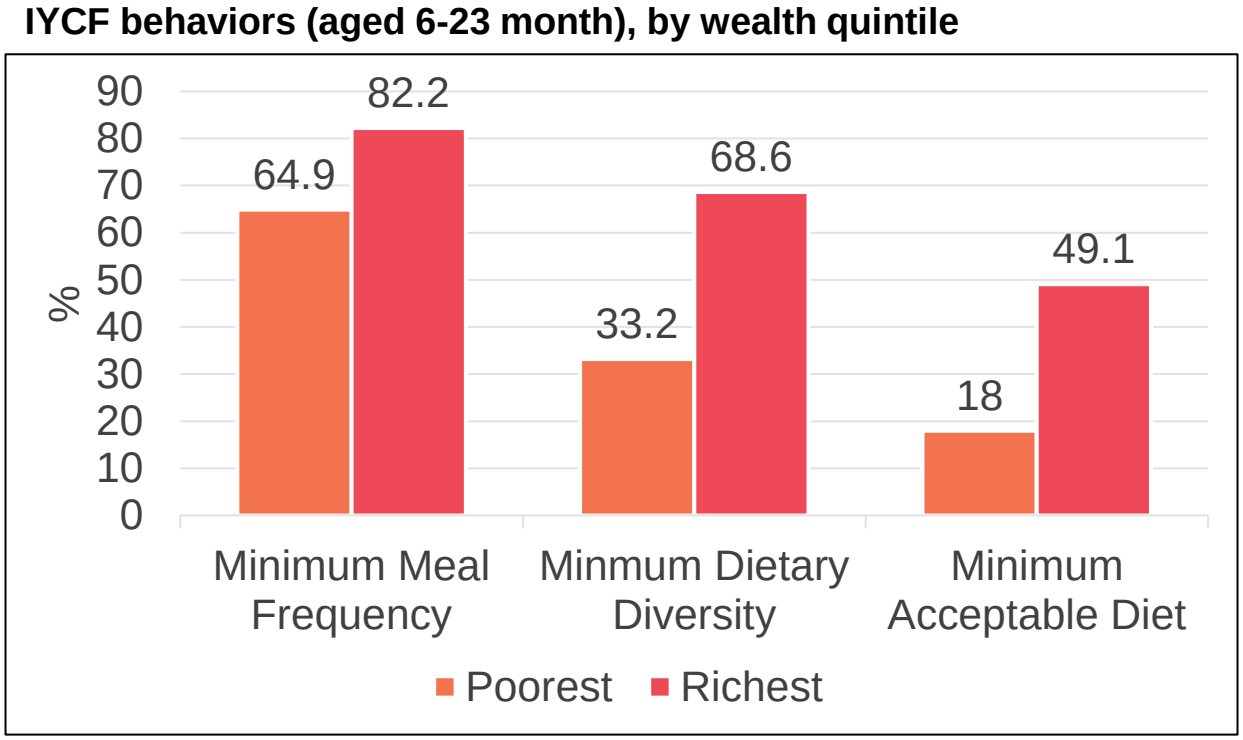
Large geographic disparities for RMNCAH-N service coverage.



*For more info, see **ANNEX 3. SERVICE DELIVERY CHALLENGES & INEQUITIES***

Source: CDHS 2014.

Challenges related to **access** to and **quality** of RMNCAH-N services constrain progress towards improved outcomes.



Ongoing MOH efforts to improve service delivery provide entry points for sharpening focus on IC priorities.

*For more info, see **ANNEX 3. SERVICE DELIVERY CHALLENGES & INEQUITIES***

Source: CDHS 2014.

SERVICE DELIVERY CHALLENGES & OPPORTUNITIES: ACCESS

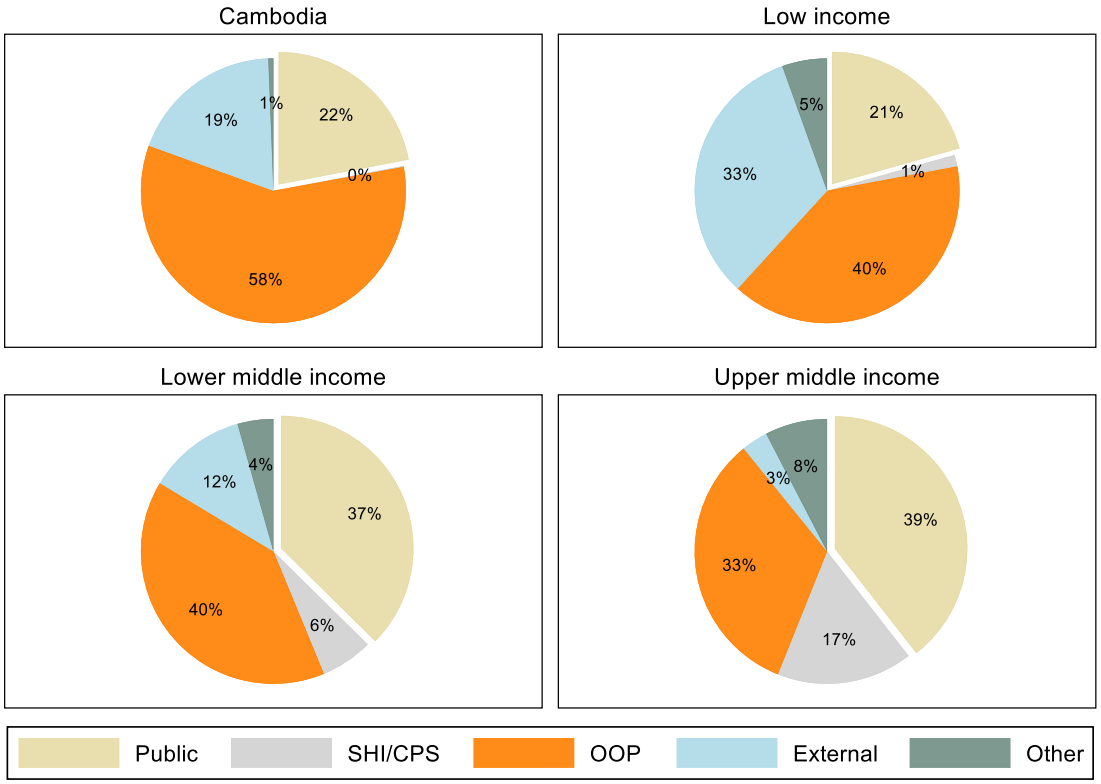
CHALLENGES	OPPORTUNITIES
Gaps in infrastructure	• Increasing availability and access to RMNCAH-N services through construction of new maternity wards and health centers, especially in remote areas. • Empowering HCs to invest in service readiness and fill gaps in functional infrastructure by increasing availability of resources at the frontlines.
• Insufficient health centers and health posts. • Inadequately-equipped emergency obstetric and newborn care facilities.	
Economic, geographic, and behaviral barriers	
• Potential economic barriers to access care increase for the poorer and more dispersed from HCs • Need to optimize mix and adequate financing of outreach services [against fixed site] to reach remote and hard-to-reach populations, limiting their access to essential RMNCAH-N services. • Low demand/awareness for essential RMNCAH-N services	
Distribution of skilled human resources	
• Between 2010 and 2016, Cambodia increased the number of health centers with two midwives but fell short of the 2016 target of 85% of health centers. • Low availability of health center staff has been cited as a barrier for conducting integrated outreach	

SERVICE DELIVERY CHALLENGES & OPPORTUNITIES: QUALITY

CHALLENGES	OPPORTUNITIES
Delivering RMNCAH-N services that meet the expectations of the population	• Institutionalized routine quality assessment of the MPA / CPA provided in public facilities via NQEMP • Improved pre-service and in-service training of health professionals. • Improving provider knowledge and skills using SDG-linked coaching. • Rewarding delivery of technically sound quality health services at all levels via performance-based financing using quarterly quality scorecards and SDGs. • Strengthening regulation of health professions to ensure quality of care and enforce compliance with national standards and practices.
• Real and/or perceived low quality in public sector service delivery drives high consumption of private services and OOP expenditure	
Inconsistencies and variable adherence to guidelines	
• Low provider knowledge/skills. • GMP is inconsistent: fixed site contacts with infants are primarily for immunization and sick children • Outreach focuses on immunization, with little attention to nutrition • Insufficient staff to undertake mandate • Low provision of maternal nutrition interventions during ANC	
Insufficient support and supervision	
• Limited frequency and quality of field supervision • Challenges in data collection, quality, and use for decision-making	

FINANCING CHALLENGES & OPPORTUNITIES

Dependence on OOP and external financing for priority RMNCAH-N interventions poses a challenge to **equity** and **sustainability**.



Ongoing health financing reforms aim to improve performance and efficiency of public health expenditures.

FINANCING CHALLENGES & OPPORTUNITIES

CHALLENGES	OPPORTUNITIES
Equity • Total health expenditure in Cambodia is on par with regional peers, yet is an outlier in that this expenditure is largely driven by out of pocket (OOP) expenditures. OOP expenditures, at an estimated 62-74%, are nearly double the average for low- and middle-income countries (39.4%). **Sustainability** • RMNCAH-N programs and services are heavily dependent on external financing and OOP expenditures. The NMCHC sub-programs in immunization, reproductive health, and nutrition remain largely donor dependent.	• Progress towards UHC outlined by the NSPPF 2016–2025, via expansion of HEF to non-poor informal workers and other groups; NSSF and other pre-paid insurance schemes, and social assistance initiatives targeting pregnant women and young children. • Increased financing and financial autonomy for peripheral health facilities using both fixed and performance-based grants (linked to the NQEMP) • Implementation of a Financial Management Information System • Implementation of program-based budgeting in the health sector

CAMBODIA'S RMNCAH-N INVESTMENT PRIORITIES

Due to limited domestic resources for RMNCAH-N with declining external financing, Cambodia must focus on smart, scaled, and sustainable financing of a subset of 'priorities of priorities', by:

1. Reducing the reliance on vertical financing and implementation of RMNCAH-N programs;
2. Leveraging sector-wide reforms and investments in public service delivery quality and health financing to achieve RMNCAH-N; and
3. Expanding public service availability and accessibility and engagement with the private sector.

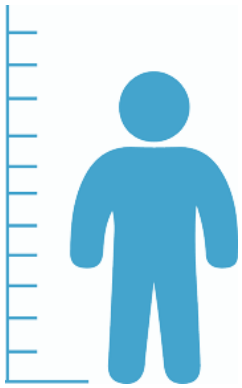
*For more information, see **ANNEX 4. PROCESS OF PRIORITIZATION***

GETTING TO THE PRIORITIES OF PRIORITIES

Representatives from RGC, UN agencies, donor partners, and civil society participated in a multi-phase consultative process to generate a short list of RMNCAH-N 'priorities of priorities' from Cambodia's key strategy documents.

WHY: Outcomes	Where is RMNCAH-N progress lagging? Where is there a need to accelerate results? What are key priorities in Cambodia across the GFF value proposition?
WHAT: Interventions	Which interventions can accelerate progress on the priority outcomes? Which interventions have highest equity, population health impact, supply side capacity, political feasibility, and strengthen financial protection?
WHERE: Geography	What is the prevalence of poor RMNCAH-N outcomes in the province? What is the absolute burden of poor RMNCAH-N outcomes? How does the province perform in relative terms on coverage of priority interventions? Does the province have a high share of disadvantaged population? (MPI) How prepared is the supply-side to deliver the interventions?
HOW: Modalities	How will Cambodia achieve transformational impact? How can we mobilize domestic resources? Engage with the community and create demand? Improve quality?

RMNCAH-N INVESTMENT CASE GOAL

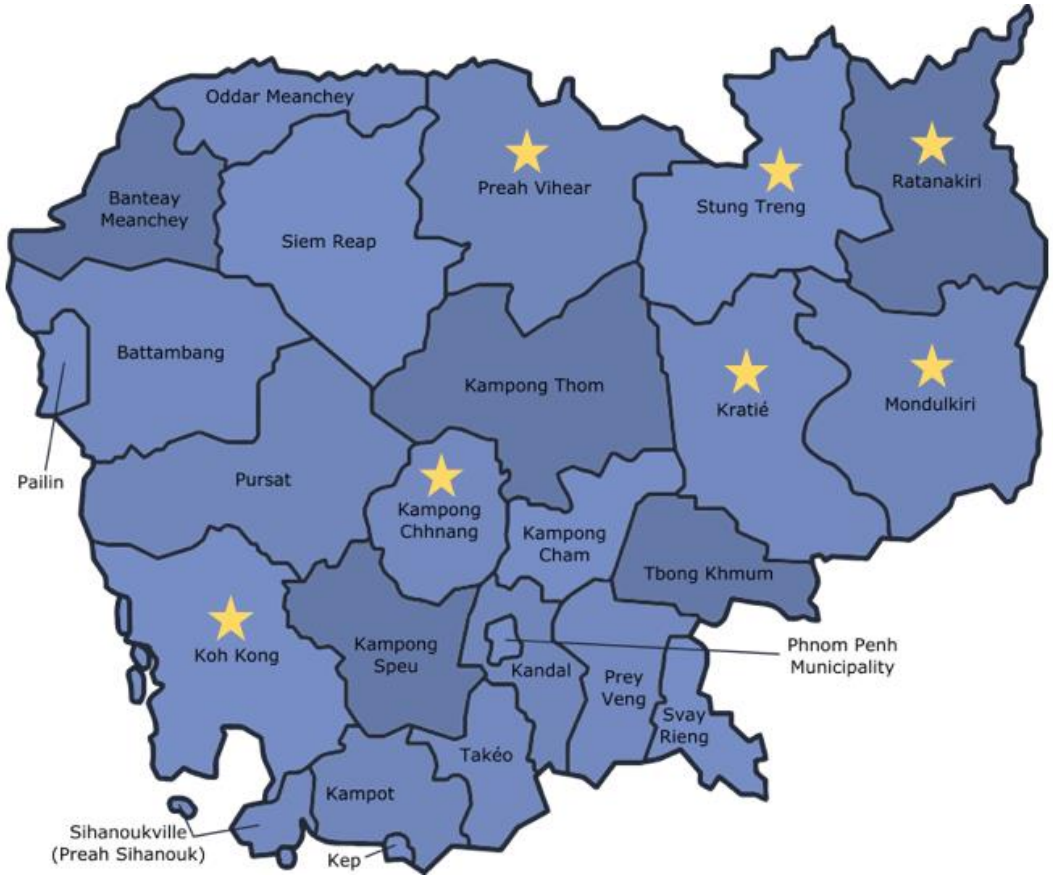


"To reduce inequities in *neonatal mortality, maternal and child undernutrition & teenage pregnancy"*

RMNCAH-N PRIORITIES OF PRIORITIES: GEOGRAPHY

Geographic prioritization to identify a subset of beneficiaries to be targeted with additional resources for scaling up the package

1. Ratanakiri
2. Mondulkiri
3. Preah Vihear
4. Kratie
5. Stung Treng
6. Kampong Chhnang
7. Koh Kong



REVISED SHORT-LIST OF PRIORITY INTERVENTIONS

ORIGINAL		REVISED	
1	Improve appropriate newborn care practices	3	Improve early and essential newborn care practices
2	Increase coverage, access to, quality, and quantity of ANC, particularly for rural and urban poor communities	1	Increase coverage, access to, quality, and quantity of ANC (including nutrition counselling) particularly for rural and urban poor communities
3	Improve nutrition counselling during ANC and follow-up		[ADDRESSED IN 1]
4	Increase coverage and access to quality delivery care	2	Increase coverage and access to quality delivery care
5	Improve quality and quantity of PNC	4	Improve quality and quantity of PNC
6	Improve quality of the management of sick newborn	5	Improve quality of the management of sick newborn
7	Improve the prevention and management of low birth weight	6	Improve the management of low birth weight births
8	Improve the quality and geographic coverage of EmONC	7	Improve the quality and geographic coverage of EmONC
9	Reduce gaps in basic infrastructure, drugs and equipment in EmONC facilities	8	Reduce gaps in basic infrastructure, drugs and equipment in EmONC facilities
10	Provide SRH education and parental education to adolescents	9	Provide SRH education and parental education to adolescents
11	Promote accessible and adolescent friendly services	10	Promote accessible and adolescent friendly sexual and reproductive health services
12	Provide adequate weekly IFA to adolescent girls		[DROPPED-Not applicable to etiology of anemia and no platform]
13	Improve access to UHC for pregnant women		[DROPPED, encompassed in maternal interventions]
14	Increase the coverage of community-based SAM screening		[ADDRESSED IN 11]
15	Expand the management and treatment of severe acute malnutrition (SAM) nationwide, including systematic follow-up visits of children under treatment to ensure provision of adequate care at community level, detect medical issues and prevent defaulting	11	Expand the screening, management and treatment of severe acute malnutrition (SAM) nationwide, including community-based screening, systematic follow-up visits of children under treatment to ensure provision of adequate care at community level, detect medical issues and prevent defaulting
16	Increase number of facilities offering and improve quality of GMP	12	Increase the availability of quality growth monitoring and promotion in health facilities and communities [BRINGS IN THE BFCI]
17	Promote integrated outreach services	14	Increase delivery of integrated outreach services
18	Improve management of pre-service training		[MOVED TO THE 'HOW' SECTION]
19	Build capacity of health care providers		[MOVED TO THE 'HOW' SECTION]
20	Increase social accountability to improve services provided in both public and private		[MOVED TO THE 'HOW' SECTION]
21	Increase quality, availability, and utilization of family planning services, especially long-term/permanent family planning methods & reduce traditional family planning	15	Increase quality, availability, and utilization of family planning services, especially long-term/permanent family planning methods & reduce traditional family planning
22	Reduce the number of high risk immunization communities for immunization from 1,832 to 1,080 by the end of 2020	16	Improve immunization coverage in high risk communities
23	Promotion of early initiation and exclusive breastfeeding and complementary feeding	13	Increase the availability and quality of maternal, infant, and young child nutrition promotion (including early initiation and exclusive breastfeeding and complementary feeding) in health facilities and communities. [BRINGS IN THE BFH]
24	Scaling up BFHI (build network between BFHI and BFCI)		[ADDRESSED IN 12 & 13, integrated in "HOW"]
25	Scaling up BFCI		[ADDRESSED IN 12 & 13; integrated in "HOW"]

16 high-impact interventions were prioritized for scale-up, drawing upon Cambodia's RMNCAH-N strategies.

1. Increase coverage, access to, quality, and quantity of **ANC**, particularly for rural and urban poor communities.
2. Increase coverage and access to **quality delivery care**.
3. Improve **early and essential newborn care** practices.
4. Improve quality and quantity of **PNC**.
5. Improve quality of the management of **sick newborn**.
6. Improve the management of **low birth weight births**.
7. Improve the quality and geographic **coverage** of EmONC.
8. Reduce gaps in **basic infrastructure, drugs and equipment** in EmONC facilities.
9. Provide **SRH education and parental education** to adolescents.
10. Promote accessible and adolescent-friendly **sexual and reproductive health services**.
11. Expand the screening, management and treatment of **severe acute malnutrition (SAM)** nationwide, including community-based screening, systematic follow-up visits of children under treatment to ensure provision of adequate care at community level, detect medical issues and prevent defaulting.
12. Increase the availability of quality **growth monitoring and promotion** in health facilities and communities.
13. Increase the availability and quality of **maternal, infant, and young child nutrition promotion** (including early initiation and exclusive breastfeeding and complementary feeding) in health facilities and communities.
14. Increase delivery of **integrated outreach services**.
15. Increase quality, availability, and utilization of **family planning services**, especially long-term/permanent family planning methods & reduce traditional family planning.
16. Improve **immunization coverage** in high risk communities.

*Consolidated from 25 shortlisted priorities. For more info, see **ANNEX 5. RMNCAH-N PRIORITIES OF PRIORITIES***

RMNCAH-N PRIORITIES OF PRIORITIES: OPERATIONAL SHIFTS

Key operational approaches to address the next generation challenges in RMNCAH-N….

1. Enhance quality of care across in the RMNCAH-N continuum
2. Leverage demand-side financing to increase utilization of priority services
3. Deploy community-based approaches to improve utilization and social accountability
4. Strengthen health worker skills and competencies to deliver the priority interventions

…. Leveraging existing platforms and investments, while switching focus to results

1. Service Delivery Grants
2. Health Equity Funds
3. Commune Platforms, including Committee for Women and Children

1. ENHANCE QUALITY OF CARE FOR RMNCAH-N

The performance-based SDG system provides an institutional MOH platform to strengthen RMNCAH-N service quality, and can further leverage existing investments being made in the institutions responsible to monitor and incentivize quality improvements.

Deepen the focus of the performance-based service delivery grant system on priority IC interventions

- Provide additional **performance-based financing** to health facilities to incentivize improvements in quantity and quality of priority IC interventions
- Revise existing vignettes and add new, as necessary, to enhance skills and competencies for priority IC interventions

Adopt management approaches that strengthen quality

- Performance assessment combined with **coaching** through the SDG system
- Finance and scale up quality improvement initiatives such as the Pediatric Care Alliance Team (**PCAT**)
- Promote the use of tools such as NQEMT for the **private sector**, potentially as part of accreditation processes.

2. DEMAND-SIDE FINANCING OF PRIORITY INTERVENTIONS

The Health Equity Fund system is the backbone of Cambodia's financial protection in health. Leveraging the HEF system, and promoting its greater utilization, can stimulate increased utilization of lagging priority services.

Promote and leverage Health Equity Fund system for priority IC interventions

- Expand **HEF coverage** for more **children (beyond IDpoor)** under age 2 to receive post-natal and well-child visits
- Reduce access barriers for the poorest families through **transportation allowances** for ANC and for children under 2 years.
- Expand HEF coverage for all children with **SAM** to receive treatment and transportation support
- Undertake HEF promotion systematically, acknowledging that the predominant beneficiaries of HEF are women and children

3. COMMUNITY-BASED APPROACHES TO IMPROVE UTILIZATION/SOCIAL ACCOUNTABILITY

One important missing link in frontline service delivery in Cambodia has been the absence of a formal community-level health platform that could effectively and sustainably deliver preventive and promotive interventions. This, combined with strategically delivered outreach services, holds the potential to stimulate demand and effectively connect communities to the wider health system.

Formalize community-based service delivery

- Revitalize and operationalize community participation policy in health
- Deliver a package of priority interventions, education, and community mobilization at village level
- Introduce performance-linked payments for community workers and formal linkage with commune and district authorities
- Strengthen linkage with the health system using HCMC meetings and I-SAF processes

Strengthen outreach to improve access and fill gaps in utilization of priority services

- **Intensify outreach** for hard-to-reach areas in order to make priority services more accessible
- Ensure delivery of **integrated outreach** including but not limited to immunization, for efficiency and sustainability of services to remote populations

4. HEALTH WORKER SKILLS AND COMPETENCIES TO DELIVER THE PRIORITY INTERVENTIONS

Though progress has been made in improving the number and skills of frontline health staff, continued investments in training and capacity building of the public health service is necessary to

Leverage the SDG platform to promote improvements in health provider performance

- Strengthen the involvement of NMCHC programs in performance management, defining coaching packages, and supporting OD coaches

Support and expand competency-based pre-service and in-service training

- Review **pre-service training curricula** and ensure coherence with best practice and explore opportunities to update
- Expand use of contextually proven innovation (e.g. **skill labs** and **MCAT**) to improve on-the-job performance

MONITORING & EVALUATION

M&E FRAMEWORK: INPUTS

Strategic areas (health system, capacity resourcing)

INDICATOR	SOURCE	TRACKED
SUSTAINABILITY		
Total net ODA to health sector (grant only)	HMIS	CAHI
Government health expenditure as % of total government expenditure	HMIS	CAHI
Total health expenditure on RAMNCHN (and as a % of total health expenditure)		NSRSH
Government health expenditure on RAMNCHN (and as a % of govt. health expenditure)		NSRSH
% population covered by social health protection systems	HMIS	CAHI
OOP health expenditure as % of total health expenditure	HMIS	CAHI
% of health facilities covered by formal payment systems whose benefit package includes the full RAMNCHN service package		NSRSH
% households with catastrophic expenditure % households impoverished after health payment	HMIS	CAHI
EQUITY		
% of the poor covered by HEFs	AHFR	FTRM-MNM
Ratio of physician per 1,000 population	HMIS	CAHI
Ratio of nurse per 1,000 population	HMIS	CAHI
Ratio of midwife per 1,000 population	HMIS	CAHI
Number and percentage of HC and RH submitted complete (100%) HC1 and HO2 report forms on time (by 16 January of a reporting year)	HMIS	CAHI
Number and % of licensed private providers / facilities registered in HMIS has reported	HMIS	CAHI
Number and % of HCs with functioning Health Center Management Committee	HMIS	CAHI
Number and % of HCs with staff in place as per MPA staffing norm	HMIS	CAHI
Number and % of HCs with staff in place as per CPA staffing norm	HMIS	CAHI
Number and % of Health workers registered and licensed by health professional councils	HMIS	CAHI
National Referral Lab, National Hospital and CPA3 Hospitals at provincial level	HMIS	CAHI
CAP2 RHs at provincial and district level (total number 35 lab,)	HMIS	CAHI

M&E FRAMEWORK: OUTPUTS

Health service delivery

INDICATOR	SOURCE	TRACKED
ACCESS		
% of health centers with at least 2 secondary midwives		NSRSH
% of RHs covered for obstetric care by HEFs	HFR	FTRM-MNM
Number of CEmONC facilities		FTRM-MNM
Number of BEMONC facilities		FTRM-MNM
Number of health center catchment areas implementing community care for mothers and newborns		FTRM-MNM
Number of health center catchment areas implementing community based distribution of contraceptives		FTRM-MNM
Number of health facilities offering comprehensive safe abortion and/or post abortion services		FTRM-MNM
# and % of public and NGO/Private health facilities providing safe abortion services		NSRSH
Number of hospitals providing SAM treatment	NNP	FTRM-N
Percentage of HC with stock-out of predetermined 15 items in the national Essential Drug List (%)	HMIS	CAHI
Percentage of new cases of IHR notifiable diseases (IHR) and other notifiable diseases have been notified	HMIS	CAHI
Outpatient consultations (new cases only) per person per year	HMIS	CAHI
Bed occupancy rate (%)	HMIS	CAHI
Ratio of hospital bed to 1,000 population	HMIS	CAHI
Number and percentage of all types of licensed private providers / facilities	HMIS	CAHI
Number and % of good practice pharmacies (GPP)	HMIS	CAHI

*Indicators disaggregated by IC province, SES, location (urban / rural), and age group (adolescent), where applicable. See **ANNEX 6. M&E BY PRIORITY INTERVENTION***

M&E FRAMEWORK: OUTPUTS (cont'd)

Health service delivery

INDICATOR	SOURCE	TRACKED
QUALITY		
SCORE ON ANC VIGNETTES		
% of pregnant women who had a blood sample taken during ANC		NSRSH
% ANC clients tested for HIV and received their results		NSRSH
% HIV+ pregnant women who receive ART during pregnancy		NSRSH
% of deliveries by Caesarean Section	CDHS	FTRM-MNM
SCORE ON PNC VIGNETTES		
SCORE ON WELL CHILD VISIT VIGNETTES		
SCORE ON FAMILY PLANNING VIGNETTE		
SCORE ON OPD PEDIATRIC VIGNETTE		
Data Quality Index (%)	HMIS	CAHI
% of new cases of IHR notifiable diseases (IHR) and other notifiable diseases have been notified	HMIS	CAHI
Hospital mortality rate (%)	HMIS	CAHI
Average length of stay (no of days)	HMIS	CAHI
Number and % of health facilities that increased quality score by 20% from the previous year	HMIS	CAHI
Number and % of referral hospitals that increased quality score by 20% from the previous year	HMIS	CAHI
Number and % of health center that increased quality score by 20% from the previous year	HMIS	CAHI
Number and % of medical laboratories at national and provincial level performed quality assurance and quality control (QA / QC) according to SOP	HMIS	CAHI
Number and % of public health care facilities with basic water supply	HMIS	CAHI
Number and % of public health care facilities (out-patient department only) with basic sanitation	HMIS	CAHI

*Indicators disaggregated by IC province, SES, location (urban / rural), and age group (adolescent), where applicable. See **ANNEX 6. M&E BY PRIORITY INTERVENTION***

M&E FRAMEWORK: OUTCOMES

Health service coverage

INDICATOR	SOURCE	TRACKED
PREGNANCY		
% of pregnant women received folic acid 90 tablets	HMIS	CAHI
% of post-partum women received folic acid 42 tablets	HMIS	CAHI
% of women attending 2 or more ANC sessions	CDHS	FTRM-MNM
% of pregnant women who received ANC4 consultation by health personnel	HMIS	CAHI
DELIVERY		
% of births delivery at health facilities	HMIS	CAHI
% of births delivery by skilled health personnel	HMIS	CAHI
% of deliveries by trained health personnel		NSRSH
% of women delivering with a skilled birth attendant	CDHS	FTRM-MNM
% of women delivering in a health facility with a skilled birth attendant	CDHS	FTRM-MNM
% of deliveries by caesarian section		NSRSH
NEWBORN		
% of infants who were breastfed within 1 hour after birth	HMIS	CAHI, NSRSH
% of newborns who have postnatal contact with a health provider within 2 days of delivery		NSRSH
POST-PARTUM		
% of post-partum women who received PNC consultation by health personnel	HMIS	CAHI
% of pregnant women receiving daily tablets of iron/ folate during pregnancy and for 3 months postpartum	HMIS	FTRM-N
% of women who have postpartum contact with a health provider within 2 days of delivery		NSRSH
% of women who receive at least 2 PNC checks		NSRSH

Indicators disaggregated by IC province, SES, location (urban / rural), and age group (adolescent), where applicable. See ***ANNEX 6. M&E BY PRIORITY INTERVENTION***

M&E FRAMEWORK: OUTCOMES (cont'd)

Health service coverage

INDICATOR	SOURCE	TRACKED
INFANT & YOUNG CHILD		
% of infants age 0-6 months exclusively breastfed		FTRM-N
% of children 6-23 months breastfed who meet minimum IYCF standards		FTRM-N
% of children 6-23 months non-breastfed who meet minimum IYCF standards		FTRM-N
% of children aged 6-59 months receiving Vitamin A capsules		FTRM-N, CAHI
% of children 12-59 months receiving mebendazole every 6 months		FTRM-N, CAHI
% of children with diarrhoea having received ORS + zinc		FTRM-N
% of children age 6-23 months receiving multiple micronutrient powder in the last month		FTRM-N
DPT-HepB-Hib 3 coverage rate (%)		
FAMILY PLANNING		
% of women using modern contraception		FTRM-N
Unmet need for family planning		NSRSH
Unmet need for birth spacing		NSRSH
Unmet need for birth limiting		NSRSH
% of women of reproductive age (15-49) whose need for family planning is satisfied (with a modern contraceptive method)		NSRSH
% of currently married women using LAPM (sterilization, implants, IUDs)		NSRSH
Abortion Rate (last 5 yrs.)		
% of women reporting multiple abortions		
% of women reporting an abortion who did not have help from a health professional at the time of the last abortion		

Indicators disaggregated by IC province, SES, location (urban / rural), and age group (adolescent), where applicable. See ***ANNEX 6. M&E BY PRIORITY INTERVENTION***

M&E FRAMEWORK: IMPACTS

Population health

INDICATOR	SOURCE	TRACKED
NEONATAL MORTALITY		
Neonatal mortality rate per 1,000 live births	HMIS	CAHI, NSRSH
UNDERNUTRITION - WOMEN		
Anemia prevalence in women of reproductive age	HMIS	CAHI
% of women aged 15-49 years with anaemia	CDHS	FTRM-N
% of pregnant women age with anaemia	CDHS	FTRM-N
UNDERNUTRITION - CHILD		
Proportion of children with low birth weight (<2,500g at birth)	CDHS	FTRM-N
% of children aged 0 – 59 months who are moderately or severely stunted (height-for-age less than 2 standard deviations below normal)	HMIS, CDHS	FTRM-N, CAHI
% of children aged 0 – 59 months who are moderately or severely wasted (weight-for-height less than 2 standard deviations below normal)	CDHS	FTRM-N
% of children aged 0 – 59 months who are moderately or severely underweight (weight-for-age less than 2 standard deviations below normal)	CDHS	FTRM-N
% of children aged 6-59 months with anaemia	CDHS	FTRM-N
TEEN PREGNANCY		
Adolescent birth rate aged 15-19 years	HMIS, CDHS	CAHI, NSRSH
Teenage pregnancy rate 15-19 years	HMIS, CDHS	CAHI, NSRSH

Indicators disaggregated disaggregated by IC province, SES, location (urban / rural), and age group (adolescent), where applicable.

CONCLUSIONS & NEXT STEPS

CONCLUSIONS

Harmonized, prioritized investments in improving child nutrition, reducing neonatal mortality, and reducing teenage pregnancy can help to accelerate progress for Cambodia's women and children and drive longer-term sustainable changes in the Cambodian health system.

- Investments in human capital will not only improve the health and wellbeing of these vulnerable groups, but strengthen the foundations of Cambodian society as it looks to transition to a middle income country by 2030.

NEXT STEPS

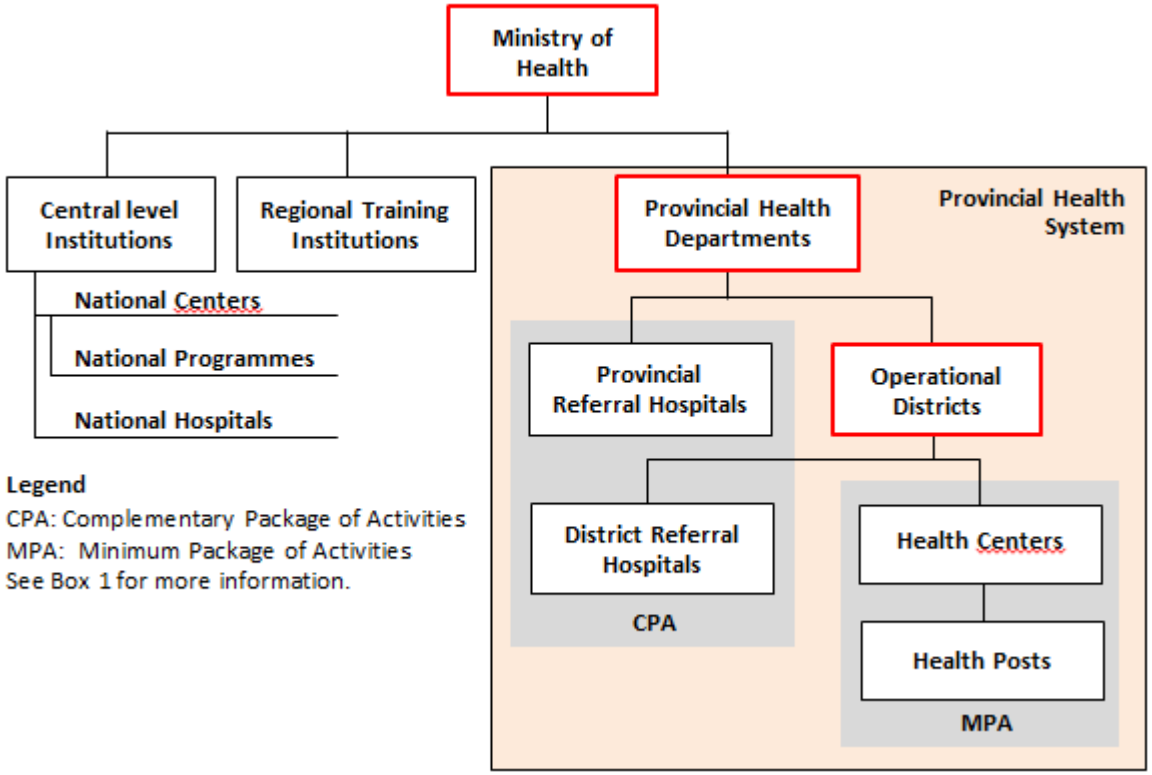
PREPARATION PHASE	• Final revisions to the IC (including Results Framework, baselines/targets) from workshop (as needed) • Share the IC and Results Framework with GFF Secretariat, and incorporate feedback (as needed) • MOH Approval and Finalization
IMPLEMENTATION PHASE	• TWG-Health continues to serve as GFF Multi-stakeholder coordination platform • Shared advocacy and commitment from partners leverage IC priorities to design future projects/ investments to move the needle on RMNCAH-N outcomes in Cambodia • Monitor the IC Results Framework, identify issues, mid-course correct, as needed

Next Session

1. Discuss costs and benefits of IC Priorities
2. Discuss current and forthcoming investments (including GFF Trust Fund) and alignment with IC Priorities

ANNEX 1. GOVERNANCE

The Third Health Strategic Plan (HSP3) 2016–2020 provides the strategic framework for Ministry of Health (MOH) engagement on RMNCAH-N.



Organizational setup of public health institutions

Source: World Health Organization (2017).

- HSP-3 aims to "effectively manage and lead the entire health sector to ensure that quality health services are geographically and financially accessible and socio-culturally acceptable to all people in Cambodia" through both public and private services.
- MOH is mandated to lead and manage the health sector, including public services and the private sector.
- RMNCAH-N activities are structured in three tiers: the **national level**, **provincial level** (health departments and provincial referral hospitals, and **operational district** (offices, referral hospitals, health centers and health posts).

GOVERNANCE (CONT'D)

The National Maternal and Child Health Center (NMCHC) governs the areas of nutrition, reproductive health, maternal and infant health, and child health and immunization and ensures strategic alignment with national priorities:

- Coordination, training, and supervision for lower levels on RMNCAH-N activities
- Programs with clearly outlined priority actions and objectives in sub-sector strategies such as: the National Strategy for Reproductive and Sexual Health in Cambodia 2017-2020 (NSRSH); Fast Track Roadmap for Improving Nutrition, 2014-2020 (FTRM-N); Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality, 2016-2020 (FTIRM); and National Immunization Program Strategic Plan 2016-202 (NIP-SP).

Implementation of nutrition interventions is the responsibility of line ministries and sub-national administration:

- MOH is responsible for nutrition-specific and health-sector nutrition-sensitive implementation.
- The Council of Agricultural and Rural Development (CARD), chaired by a Deputy Prime Minister, mandated to monitor, report, and coordinate multisectoral nutrition actions through the TWG-SP&FSN.

GOVERNANCE (CONT'D)

Actors at the community level are not covered under MOH administration

- MOH acknowledges the critical importance of community participation in health for accelerating health outcomes and improving health sector performance and accountability.

Private facilities are increasingly important for the provision of outpatient ambulatory services, including RMNCAH-N.

ANNEX 2. MOH POLICIES

POLICIES

MOH has developed and adopted several policies and guidelines addressing undernutrition and micronutrient deficiencies and related activities.

Policy	Year
Infant and Young Child Feeding Policy (MOH)	2002
Sub-decree on Management of Iodized Salt Exploitation	2004
Sub-decree on Marketing of Products for Infant and Young Child Feeding	2004
National Vitamin A Policy Guidelines - revision (MOH)	2007
National Guidelines for the Use of Iron/Folate Supplementation To Prevent and Treat Anaemia in Pregnant and Postpartum Women – revision (MOH)	2007
Community Participation Policy for Health (MOH)	2008
National Nutrition Strategy 2009-15 (MOH/NNP)	2009
School Health Policy (MOEYS)	2009
Fast Track Initiative – Road Map for Reducing MNR 2010-15 (MOH)	2010
Poverty in Cambodia – A New Approach (MOP)	2013
National Strategic Development Plan 2014-18 (RGC)	2014
Fast Track Road Map for Improving Nutrition 2014-2020 (MOH/NNP)	2014
National Strategy for Food Security & Nutrition 2014-18 (CARD)	2014
Estimating Health Expenditure in Cambodia: National Health Accounts Report (2012 Data) (MOH/WHO/CHAI)	2014
Neary Rattanak IV: Five Year Strategic Plan for Gender Equality & Women's Empowerment 2014-2018 (MWA)	2014
Success Factors for Women's and Children's Health: Cambodia (MOH/WHO)	2015
A Conceptual Budget for Cambodia's Fast Track Road Map for Improving Nutrition (CARD)	2015
Review of the Cambodian Emergency Obstetric & Newborn Care Improvement Plan 2010-15 (MOH)	2015
Annual Health Financing Report 2015 (MOH)	2015
Urban & Rural Disparities in Reproductive and Maternal Health, 2000-14 (MOP/MOH)	2015
National Action Plan for the Zero Hunger Challenge in Cambodia (2016-2025) (CARD)	2016
Estimating Health Expenditure in Cambodia: National Health Accounts Report (2012-2014 Data) (MOH)	2016
Health Strategic Plan 2016-2020 (MOH)	2016
Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality 2016-2020 (MOH)	2016
Emergency Obstetric & Newborn Care (EmONC) Improvement Plan 2016-2020 (MOH)	2016
Sexual and Reproductive Health of Adolescents and Youth in Cambodia: Analysis of 2000 - 2014 Cambodia Demographic and Health Survey Data (MOP/MOH)	2016
Roadmap on Integration of Health Volunteers for HCMC (MOH)	2017
National Family Planning Commodity Security 2017-20 (MOH)	2017
National Strategy for Reproductive and Sexual Health in Cambodia 2017-2020 (MOH)	2017
Guidelines for the Establishment of Enterprise Infirmaries (MOLVT)	2017

ANNEX 3. SERVICE DELIVERY CHALLENGES & INEQUITIES

SERVICE DELIVERY CHALLENGES & INEQUITIES

Coverage of high impact, evidence-based RMNCAH-N interventions remains low/variable

	National	Rural	Urban	Lowest Wealth Quintile	Highest Wealth Quintile
Child Health					
Treatment of diarrhea with ORS, % children	35	36	30	40	27
Treatment of diarrhea with zinc	5	10	5	5	5
Reproductive and Maternal Health					
Unmet need for family planning, % women age 15-49	12	13	11	17	10
Any ANC from a skilled provider*	95	95	99	90	99
At least 4 ANC*	76	85	74	--	--
Institutional delivery*	83	81	96	68	96
Skilled birth attendance*	89	88	98	75	98
Postnatal check-up within two days of birth*	90	89	98	84	96
Maternal and Child Nutrition					
Vitamin A supplementation in previous 6 months (% children 6-59 months)	70	71	64	69	68
Iron supplementation in previous 7 days (% children 6-59 months)	6	7	4	4	6
Deworming in previous 6 months (% children 6-59 months)	59	60	50	58	54
Households with iodized salt+	69	67	82	59	82
Consumption of 90+ iron tablets during pregnancy*	76	75	78	65	82
Deworming during pregnancy*	72	74	62	70	69

ANNEX 4. PROCESS OF PRIORITIZATION

Cambodia's GFF Consultation Process:
1. New Country Workshop in Ghana, February 2018

3 Main Questions

1. What are (initial) ideas on **key priorities** across the GFF value proposition? How will **your country achieve transformational impact?**

2. What are key next steps?

3. How can your country best **make use of the opportunity that the GFF provides** and **what support** may be needed?

Cambodia's GFF Consultation Process: *2. Orientation Mission, March, 2018*

Sensitization to the GFF engagement:

- Among government and partners working to address reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N)

Financing arrangement for GFF Trust Fund resources

- GFF Trust Fund grant of US$10 million will be linked to the upcoming IDA-supported Cambodia Nutrition Project with select IC priorities incorporated into the project design

Update of the GFF Roadmap for Cambodia

Cambodia's GFF Consultation Process: 3. *Investment Case Initiation Meeting, March 2018*

Meeting objectives were:

- To develop a roadmap for the preparation of the RMNCAH-N Investment Case (including timing, sequencing, roles, responsibilities)
- To engage multiple stakeholders in consultation on the long list of RGC RMNCAH-N priorities
- To discuss principles and criteria for prioritization to generate short list of priorities from long list

Key Meeting Outcomes:

- Use the HSP-3, Fast Track Road Maps for Nutrition/Maternal and Newborn Mortality as the basis for 'long list priorities' with more to be added in following weeks
- Focus investment case on MOH activities with links as needed to other sectors
- Conduct a smaller, multi-stakeholder consultation in Kep to begin prioritization from long list to short list

Cambodia's GFF Consultation Process:
4. Short Listing Workshop for RMNCAH-N Investment Case, Kep, May 2018

Objectives:

- *Reach consensus on* ***Priority RMNCAH-N Outcomes to be considered for inclusion in the Investment Case (IC);***
- ***Engage multiple stakeholders in the application of prioritization criteria*** *to the long-list of investment case priorities; and*
- ***Generate short list of priorities of priorities*** to be considered ***for inclusion in the IC***

Cambodia's GFF Consultation Process: Short Listing Workshop for RMNCAH-N Investment Case, Kep, May 2018

Kep Outcomes Pillar 1: 'The WHY'

Objective:

- *Highlight the main successes and remaining challenges in improving RMNCAH-N outcomes in Cambodia*
- *Review trends RMNCAH-N outcomes over time and across population groups in order to highlight key results in need of attention and additional resources*

The selected outcomes are:

- ***Reducing neonatal mortality***
- ***Reducing teenage pregnancy***
- ***Improving nutrition***

Kep Outcomes Pillar 2: "The WHAT"

Objective: *to select a short-list package of interventions for inclusion in the IC that are high impact, evidence- based, and feasible.*

Beginning with HSP-3, FTRM-Nutrition, FTRIM, and NIP SP, the long list of RMNCAH-N activities was narrowed down to 25 **activities*** aligned to reducing neonatal mortality, reducing undernutrition, and reducing teenage pregnancy including:

- Improving ANC and PNC quality and quantity
- Improving newborn care practices and EmONC
- Providing SRH education and parental education to adolescents
- Scaling up BFCI and BFHI
- Increasing SAM screening and treatment
- Promoting integrated outreach services
- Building capacity of health care providers, etc.

Cambodia's GFF Consultation Process: Short Listing Workshop for RMNCAH-N Investment Case, Kep, May 2018

Objective: To identify the target area and population

- Prioritization based on the following domains domains: equity, population health impact, and supply side capacity
- Selected provinces

Province	Number of Groups Selecting
Ratanak Kiri	4
Mondul Kiri	3
Preah Vihear	3
Kratie	2
Stung Treng	2
Kampong Chhnang	1
Koh Kong	1

Kep Outcomes Pillar 4: "The HOW"

Objective: *to find out solutions and leverage Cambodia's health financing and service delivery platforms to achieve better outcomes for women and children*

Suggested modalities for implementing RMNCAH-N activities:

- Common suggestions: HEF and SDG
- Other possibilities:

  Commune Investment Plan, VHSG

  Implementation of Social Accountability Framework (ISAF) and

  Community outreach

Resource Mapping (as of May 30th)

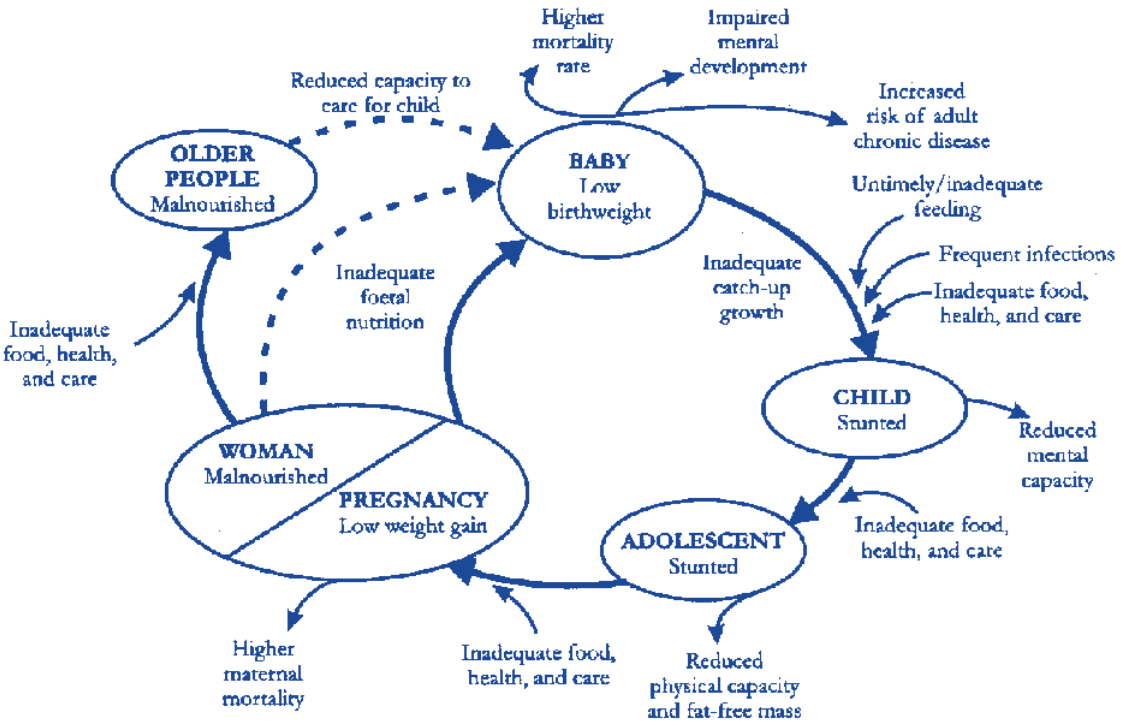
- To identify the RMNCAH-N activities and gaps in order to provide more inputs in developing the Cambodia's Investment case on RMNCAH-N
- Early finding related to under-prioritized activities:

Intervention Area	Activity	Number of Projects
Pregnancy, childbirth and postnatal care	Extra care for small and sick babies	2
Child health and development	Responsive caregiving and stimulation	2
Adolescent health and development	Supportive parenting	1
Adolescent health and development	Nutrition	2
Adolescent health and development	Psychosocial support	0

ANNEX 5. RMNCAH-N PRIORITIES OF PRIORITIES

RATIONALE FOR SELECTION

The RMNCAH-N life stages are pregnancy, childbirth and postnatal care, child health and development, and adolescent health and development.

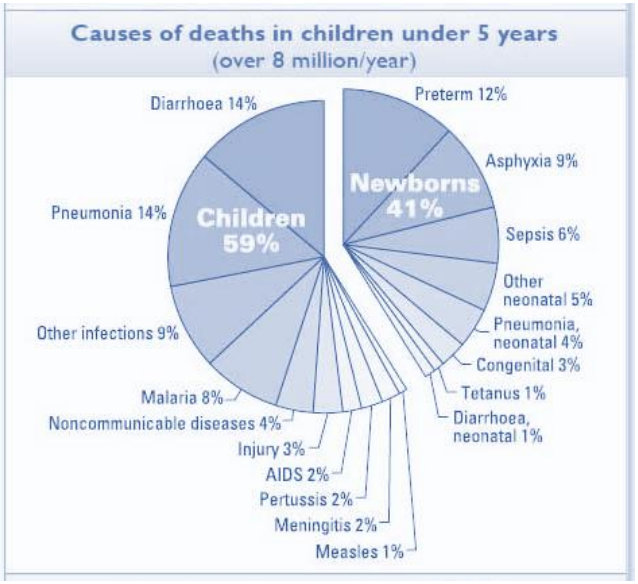


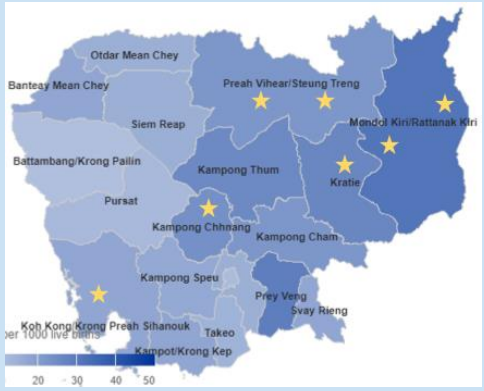
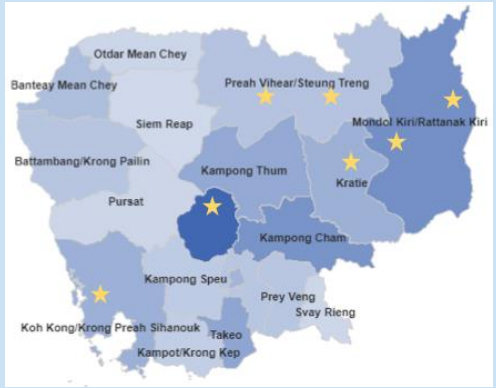
While services are delivered across the lifecycle, **extra focus is needed on (i) care for small and sick babies; (ii) post-natal care; (iii) responsive caregiving and stimulation; (iv) well-child visits; and (v) adolescent sexual and reproductive health, and psychosocial support**

RATIONALE FOR SELECTION: NEONATAL MORTALITY

The three major causes of neonatal deaths worldwide are **infections** (36%, which includes sepsis / pneumonia, tetanus and diarrhoea), **pre-term** (28%), and **birth asphyxia** (23%). There is some variation between countries.

Epidemiology of neonatal mortality in Cambodia: North-eastern Cambodia has among the highest prevalence–and also the highest absolute numbers– for neonatal mortality.

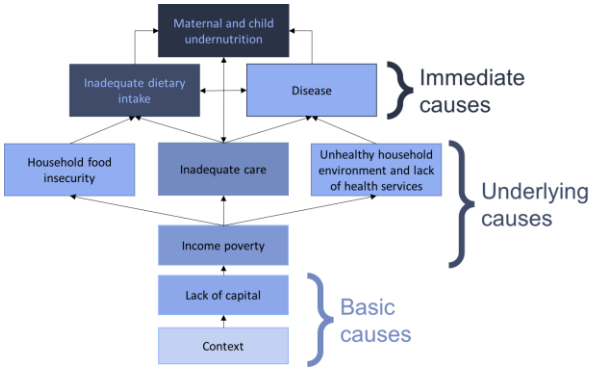


NMR	NM (absolute)
	

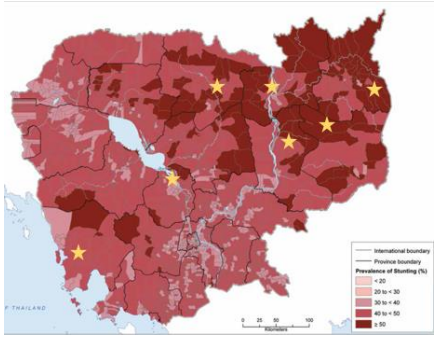
NMR for mothers who do not receive any ANC is 6 times higher than for those who receive ANC4+.

RATIONALE FOR SELECTION: UNDERNUTRITION

The causes and consequences of undernutrition. The determinants of undernutrition are multifaceted and interacting. At the immediate level, nutritional status is determined by the availability of nutrients to meet physiological needs (dietary intake) and the ability to absorb and store them (disease). The underlying determinants are household food security, maternal and infant care practices, and access to a healthy environment and health services.



Epidemiology of undernutrition in Cambodia: North-eastern Cambodia has among the highest rates of child stunting



Poor nutrition causes serious and costly health problems, from impaired cognitive and physical development to illness, disease and death; nearly one-half of all infant deaths are attributable to undernutrition. Child stunting affects educational attainment, workforce capacity and productivity, and adult wages.

RATIONALE FOR SELECTION: TEENAGE PREGNANCY

The causes and consequences of teenage pregnancy. The high incidence of teenage pregnancies is believed to be related, in part, to local traditional expectations of early marriage, but more research is needed. Teenage pregnancy increases the risk of adverse birth outcomes.

Epidemiology of teenage pregnancy in Cambodia: Adolescent fertility increased in the last five years, with majority of early childbearing taking place in rural, poor and least educated groups.

Selecting Domains for Prioritizing Interventions

1. **Impact on population health.** What is the magnitude of impact on population health? How many women, children, and adolescents benefit from the intervention, and to what extent?
2. **Equity.** How well does this address health disparities and the needs of the disadvantaged?
3. **Cost-effectiveness.** How cost-effective is the intervention? How much value does it bring for the cost?; and
4. **Supply-side capacity.** How prepared is the health system / supply-side to deliver on the intervention?

LONG-LIST OF DOMAINS
(HSP-3, WHO HSS, KRUBINER)

- Affordability
- Efficiency
- Equity
- Financial protection
- Impact
- Individual wellbeing
- Political feasibility
- Quality
- Resilience
- Respecting patients / preserving dignity
- Responsiveness
- Social value
- Supply-side capacity
- Sustainability