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MCH PROGRAM DESCRIPTION

Cambodia



Overall MCH and health sector situation

Many of Cambodia's key health indicators have improved as the country's economy has developed, although there are large disparities in coverage of maternal and child health services between urban and rural populations and wealth quintiles. Child mortality has declined dramatically since 2000: IMR decreased from 99 to 66/1,000 live births, and U5MR dropped from 124 to 83/1,000 live births. The leading causes of death for children under 5 are ARIs (mainly pneumonia), diarrheal diseases, and neonatal conditions, and, in some geographic areas, malaria and dengue fever are a considerable burden. Neonatal deaths are still the highest in Southeast Asia and remain a major contributor to childhood mortality, accounting for more than one-third of overall child deaths. Although antenatal care and assisted deliveries by trained attendants have increased, 78 percent of births still take place at home, with only 44 percent of all births attended by an SBA. Alarming, over the past 5 years, the MMR has stagnated at 472 per 100,000 live births. Hemorrhage during and after delivery is the main cause of maternal deaths.

Numerous government-wide reforms are under way in Cambodia against a background of rapid social and economic change (Cambodia has experienced double digit economic growth for the last 3 years). Health system developments have included a new Health Sector Strategic Plan (2008–2015) that places emphasis on reproductive and maternal and child health, design of “contracting” or performance-based models for health service provision, and piloting/expansion of health financing schemes. Despite these reforms, challenges to effective delivery of MCH services include numbers and distribution of human resources across Cambodia, with medical doctors and other trained professionals concentrated in the cities and towns, and ongoing concerns regarding the quality, distribution, and retention of staff remaining in rural areas; limited capacity for decentralized health planning and management (particularly in health centers and operational districts); inadequate financing (from other than out-of-pocket sources that comprise a large share of total health expenditures); rapid proliferation of a largely unregulated private sector; fragmented implementation of MCH programs; and inequitable demand and access to quality.

MCH interventions at the Mission level

Focus will be on the high-impact interventions to address the main causes of maternal and child mortality. Interventions may include, but are not limited to, AMSTL, misoprostol, treatment of postpartum hemorrhage and preeclampsia/eclampsia, essential newborn care, treatment of childhood illness including pneumonia and diarrhea, POU water disinfection, vitamin A, immunization, promotion of infant and young child nutrition including breastfeeding and complementary feeding, and birth spacing.

Delivery approaches and mechanisms supporting expanded coverage/use of interventions

USG supports this goal through new and ongoing activities that increase births attended by trained personnel; improves PMTCT through antenatal, delivery, and postpartum care; strengthens facility and community MCH services; increases access to and improvement of referral systems; develops management capacity at provincial and district

levels; supports the implementation of community-based health insurance and health equity funds; and promotes community involvement in quality improvement of public health services. New activities will include water, hygiene, and sanitation activities at household and health center levels. By 2009, 51,562 births will have been attended by skilled providers, 53,440 newborns will have received essential care, and 10,010 people will have been trained in maternal/newborn health.

Specific actions supported as part of the MCH approach

The USG depends on both public and private support for other goals including rapidly scaling up 12 key child survival interventions; harmonizing training curriculum; improving human resource deployment and supervision; and assuring coordination, planning, and monitoring at all levels of the health system.

The USAID program's geographic focus

Over the next 5 years, USAID will support activities in 12 of the 24 provinces. Based on the MOH's population estimates, USAID's target population in these provinces is approximately 3.4 million (children under 5 years of age and women of reproductive age), which is about 27 percent of the total population.

USAID and other development partners work collaboratively in support of the Royal Government of Cambodia's Health Strategic Plan 2008–2015. USAID implementing partners work to support all levels – national, provincial, district, and community – of the public health system and, whenever possible, in collaboration with other donor-funded programs.

The Mission program's relationship to the country's health sector and development plans and strategies

Under other ongoing projects, USAID supports activities for HIV and STI prevention in high-risk groups and people living with HIV/AIDS (PLWHA). The MCH program will complement these efforts by mainstreaming HIV prevention messages into mass media and community-based BCC and youth reproductive health services. In addition, PMTCT services will be expanded as an integrated part of MCH services.

Potential for linking Mission MCH resources with other health sector resources and initiatives

The MCH program was designed to provide support within the common framework of Cambodia's Health Sector Strategic Plan. In addition, a multi-donor, sector-wide approach program, the Health Sector Support Project 2 (HSSP2) is expected to commence in January 2009 with pooled financing from several donors at a level of over \$100 million for 5 years. The HSSP2 donor consortium and MOH hopes to leverage USAID non-pooled funds and technical experience in such areas as health equity funds, provincial/district monitoring, and community-level programming, among others.

Planned results for the Mission MCH investments over the next 5 years

USAID's maternal and child health programs in Cambodia are working to reduce maternal and under-5 morbidity/mortality by 25 percent by the end of 2013 through high-impact interventions, while building human capital, improving the provision of clinical services, reducing poverty, and strengthening society.

MCH COUNTRY SUMMARY: CAMBODIA	VALUE
MCH FY08 BUDGET	8,555,000 USD
Country Impact Measures	
Number of births annually*	340,000
Number of under-5 deaths annually	28,000
Neonatal mortality rate (per 1,000 live births)	28
Infant mortality rate (per 1,000 live births)	66
Under-5 mortality rate (per 1,000 live births)	83
Maternal mortality ratio (per 100,000 live births)	472
Percent of children underweight (moderate/severe)	33%
Birth Preparedness and Maternity Services	
Percent of women with at least one antenatal care (ANC) visit	73%
Percent of women with at least four antenatal care (ANC) visits	28%
Percent of women with a skilled attendant at birth	44%
Percent of women receiving postpartum visit within 3 days of birth	64%
Newborn Care and Treatment	
Percent of newborns whose mothers initiate immediate breastfeeding	35%
Immunization	
Percent of children fully immunized at 1 year of age	60%
Percent of DPT3 coverage	78%
Percent of measles coverage	77%
Maternal and Young Child Nutrition, Including Micronutrients	
Percent of mothers receiving iron-folate	58%
Percent of children receiving adequate age-appropriate feeding	82%
Percent of children under age 5 receiving vitamin A supplement in the past 6 months	35%
Percent of children under 6 months exclusively breastfed	60%
Treatment of Child Illness	
Percent of children with diarrhea treated with ORT	60%
Percent of children with diarrhea treated with zinc	N/A
Percent of children with pneumonia taken to appropriate care	48%
Water, Sanitation, and Hygiene	
Percent of population with access to improved water source**	65%
Percent of population with access to improved sanitation**	28%
<small>* Census International Database ** Joint Monitoring Programme for Water Supply and Sanitation 2008 Report (Unless otherwise noted, the data source is the 2005 Demographic and Health Survey.)</small>	