KINGDOM OF CAMBODIA

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Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality

2016-2020

May 2016

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PREFACE

Improving the health and well-being of women and newborns is transformative. Women and newborns are increasingly receiving the health services they need and to which they have a fundamental right, and fewer are now dying from preventable causes. Cambodia has become a healthier place for both women and newborns and we are proud of this achievement. We achieved our goal of reducing maternal mortality below 250 deaths per 100,000 live births by the end of 2015, and we also achieved our targets for Skilled Birth Attendance, Deliveries in Health Facilities, Antenatal Care, and for reducing financial barriers to obstetric care for the poor.

While much has been achieved, more work remains to be done if we are to achieve the Sustainable Development Goals to which the Royal Government recently committed itself. A key priority will be to address the un-finished agenda of the Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality 2010-2015. This will include increasing the quality and coverage of family planning, emergency obstetric and newborn care and safe abortion care, and improving individual, family and community care practices. It will also mean addressing emerging issues such as teenage pregnancy and newborn care.

This work will not be easy, but we can build on our successes and what has worked so far. The new Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality 2016-2020 will guide our way and ensure that we are able to achieve further rapid and lasting reductions in maternal and newborn mortality that will be of great benefit to our country.

Phnom Penh, 31 May 2016

MINISTER

Dr. MAM BUNHENG

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Special thanks is given to Ms. Alice Levisay, WHO's consultant, for her technical assistance in development this new road map through a cohesive and participatory process..

Finally, we wish to thank WHO for their support for the publication of the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality (2016-2020).

Acronyms and Abbreviations

ANC	Antenatal Care
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
CAC	Comprehensive Abortion Care
CBD	Community Based Distributor
CCMN	Community Care for Mothers and Newborns
CDHS	Cambodian Demographic and Health Survey
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
EmONC	Emergency Obstetric and Newborn Care
FP	Family Planning
FTIRM	Fast Track Initiative Roadmap for Reducing Maternal & Newborn Mortality
HC	Health Center
HMIS	Health Management Information System
INC	Immediate Newborn Care
LMIS	Logistics Management Information System
MDG	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response
MgSO4	Magnesium Sulfate
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
NE	Northeast
NGO	Non-governmental organization
NMR	Neonatal Mortality Rate
NSDP	National Socio-Economic Development Plan
OD	Operational District
PLW	Pregnant and Lactating Women
RGC	Royal Government of Cambodia
RH	Reproductive Health
RMNH	Reproductive Maternal Newborn Health
PNC	Postnatal Care
SBA	Skilled Birth Attendance
SE	South East
UN	United Nations
VHSG	Village Health Support Group

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Background

The Fast Track Initiative Roadmap (FTIRM) for Reducing Maternal and Newborn Mortality 2010-2015 was developed in 2009 as a means of accelerating reductions in maternal and newborn mortality and progress toward achieving Millennium Development Goal (MDG)4 and 5. The FTIRM 2016-2020 is an extension of the first FTIRM and outlines the priorities for reducing maternal and newborn mortality between 2016 and 2020 in line with the targets established for the Sustainable Development Goals (SDG).

Context

The FTIRM 2016-2020 is a high level document that is nested between and aligned with the Health Strategic Plan 2016-2020, and sub-sectoral strategies and plans such as the Sexual and Reproductive Health Strategy, the Emergency Obstetric and Newborn Care (EmONC) Improvement Plan and the Five-Year Action Plan for Newborn Care.

The FTIRM is a high level prioritization document, and its main purpose is to highlight priority interventions for rapidly reducing maternal and newborn mortality over the next five years. The FTIRM will be used to inform development of sub-sectoral strategies and annual plans, and to inform resource mobilization and budget allocations.

Methodology

The FTIRM 2016-2020 was developed through a consultative process and was informed by the review of the FTIRM 2010-2015 and new data from the Review of the Emergency Obstetric and Newborn Care Improvement Plan, the Five-Year Action Plan for Newborn Care and the Cambodia Demographic and Health Survey (CDHS) 2014.

Progress to date

Tremendous progress was seen in improving maternal and newborn health between 2010 and 2015, and, as of 2014, Cambodia's Maternal Mortality Ratio (MMR) was estimated at 170 deaths per 100,000 live births and its Neonatal Mortality Rate was estimated at 18 deaths per 1,000 live births.[1] These figures exceeded Cambodia's MDG targets for the end of 2015, and the country also exceeded its FTIRM and MDG targets for skilled birth attendance, deliveries in health facilities, Antenatal Care (ANC2+), deliveries by caesarian section, proportion of referral facilities covered by health equity funds (HEFs) and proportion of the poor covered by HEFs. The Royal Government of Cambodia and development partners should be commended for these impressive results.

A summary of the results from the FTIRM 2010-2015 can be found below, and more detailed information is available in the FTIRM 2010-2015 Review Report.

[1]MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015, pgs. 125 & 129.

Indicator	Baseline 2008	2010	2014/2015	Target 2015	Achieved (Green)/Partially Achieved (Yellow)/Limited Achievement (Red)
1. Number of CEmONC facilities	25		37(Service availability report 2015)	42	
2. Number of BEMONC facilities	19		110(Service availability report 2015	132	
3. Proportion of deliveries by Caesarean Section	1.8%	3% (CDHS-2010)	6.3% (CDHS-2014)	4%	
4. Proportion of women delivering in a health facility with a skilled birth attendant	39%	54% (CDHS-2010)	83% (CDHS-2014)	70%	
5. Proportion of women delivering with a skilled birth attendant	58%	71% (CDHS-2010)	89% (CDHS-2014)	80%	
6. Proportion of referral health facilities covered for obstetric care by HEFs	67% (original baseline) 56% (2014 Health Financing Report)** 44% (URC HEF Reports)†	54% (2014 Health Financing Report) ** 53% (URC HEF Reports)†	82% (URC HEF report Aug 2015) ◊	85%	
7. Proportion of the poor covered by HEFs	73% (11% according to the Annual Health Financing Report 2014)	35% (Annual Health Financing Report 2014)	90% (Annual Health Financing Report 2014)	95%	
8. Proportion of women using modern contraception	26%	35% (CDHS-2010)	39% (CDHS-2014)	60%	
9. Number of health facilities offering comprehensive safe abortion and/or post abortion services	25		604 (Data from MSIC & SPF)	933	
10. Proportion of women attending 2 or more ANC sessions	81%	85% (CDHS-2010)	92% (CDHS-2014)	90%	

Indicator	Baseline 2008	2010	2014/2015	Target 2015	Achieved (Green)/Partially Achieved (Yellow)/Limited Achievement (Red)
11. Number of health center catchment areas implementing community care for mothers and newborns	0	36% of the villages in 17 Operational Districts (UNICEF - Innovative Approaches to Maternal and Newborn Health (end 2011)	No information available	Not set	
12. Number of health center catchment areas implementing community based distribution of contraceptives	N/A	462 HC catchment areas implementing CBD (2013 – NRHP report) 62% of ODs had some HC catchment areas implementing CBD (2010 evaluation)	709 HC catchment areas implementing CBD (709/1105 HC = 64% of HCs have CBD) (Nov 2015 - NRHP reporting)	Not set	

Of course, challenges remain and the country has partially achieved its FTIRM objectives related to emergency obstetric and newborn care (EmONC), family planning, safe abortion care and improving individual, family and community care practices.

The new FTIRM 2016-2020 will build on the above results and will focus on addressing the unfinished agenda of the FTIRM 2010-2015 and will address emerging issues such as teenage pregnancy and newborn care.

Goal

The goal of the new FTIRM 2016-2020 is to reduce maternal mortality to 140 maternal deaths per 100,000 live births and to reduce Neonatal Mortality to 14 neonatal deaths per 1000 live births by 2020.

Core Components

The FTIRM 2016-2020 has five core objectives/components and two enabling components. All of the core components from the FTIRM 2010-2015 will continue and a new objective/component related to newborn care will be added. However, only two of the enabling components from the previous FTIRM will be

continued - Reducing Financial Barriers to access health service and Behavior Change Communication. Maternal Death Surveillance and Response will now be incorporated as a key intervention under Emergency Obstetric and Newborn Care.

Objective/Component One: Skilled Birth Attendance

To increase the quality and coverage of ANC, Skilled Birth Attendance and PNC (overall and particularly amongst the lowest income and educational groups)

Rationale

Cambodia made very good progress between 2010 and 2015 in increasing ANC coverage, skilled birth attendance and deliveries in health facilities, and exceeded its 2015 FTIRM targets for SBA, deliveries in facilities, ANC2 and its 2015 MDG target for SBA (87%).Differences can still be seen between different geographic, income and educational groups, but the situation is becoming more equitable over time and greater increases took place in the lower income, education and rural groups. However, challenges remain and there continue to be concerns with the quality of ANC, delivery and PNC care, and there are shortages of secondary midwives at HC level and stock-outs of life-saving drugs such as Magnesium Sulfate (MgSO4).

For the FTIRM 2016-2020 it will be important to build on what has worked and to increasingly focus on quality and outstanding coverage gaps as near universal coverage for skilled birth attendance is achieved for the richer and better educated groups. Improving the quality and timing of ANC and PNC and the quality of delivery care and immediate newborn care (INC) will be essential, as well as increasing the competence and availability of secondary midwives, particularly at health center level, improving and rationalizing midwifery training and resolving stock-out issues for life saving drugs.

Detailed information on how these issues will be addressed will be included in the new National Strategy for Sexual and Reproductive Health in Cambodia 2017-2021. However, a summary of key interventions for 2016 to 2020 can be found below.

Key Interventions

1.1. <u>Continue to improve the competence and availability of midwives</u>

1.1.1.<u>Pre-Service</u>:

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

1.1.1.2. Rationalize existing midwifery pre-service training courses

- Midwifery Curriculum Review
- Midwifery review (the Role and responsibility of Primary MW)
- Midwifery Education Pathways
- Develop Midwifery strategy
- Midwifery Education Regulatory Framework

1.1.2. In-Service: Strengthen midwifery skills through competency-based training and through expanding opportunities for practice and on-site coaching

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

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

1.1.4.1. Civil service recruitment of secondary midwives for HCs, particularly in remote areas

1.1.4.2. Explore options of contracting secondary midwives at HC level and/or upgrading primary midwives to secondary midwives

1.2. Improve quality and quantity of ANC

1.2.1. Reinforce FULL ANC service package (4+ visits starting in 1st trimester as soon as menstruation is missed; all components including 90 Iron/Folic Acid)

1.3. Improve quality of intrapartum/delivery care

1.3.1. Strengthen monitoring of maternal and fetal status during labor & delivery and improve recognition of danger signs and risk factors through correct use of the partograph

1.3.2. Strengthen prevention/immediate treatment/stabilization and referral for post-partum hemorrhage

1.3.3. Strengthen diagnosis/immediate treatment /referral for pre-eclampsia/eclampsia including introducing the use of injectable MgSO4 for loading dose prior to referral

1.3.4. Improve infection prevention and control

1.4. Improve quality and quantity of PNC

1.4.1. Strengthen implementation of the FULL PNC package (4 visits starting with first PNC check pre-discharge for both mothers and newborns)

1.4.2. Improve diagnosis and referral for congenital anomalies

Objective/Component Two: Emergency Obstetric and Newborn Care

To improve EmONC coverage so that there are least 5 EmONC (CEmONC+BEmONC) facilities per 500,000 population including at least 1 comprehensive (CEmONC) facility

Rationale

Cambodia made progress between 2009 and 2015 in terms of improving EmONC coverage and quality. The number of CEmONC facilities increased from 25 to 37 and the number of BEmONC facilities increased from 19 to 110.Progress was strongest in terms of expanding coverage of Comprehensive EmONC care (CEmONC), and by 2015, Cambodia had exceeded international standards for CEmONC coverage. Improvements were also made in expanding the number of functional Basic EmONC (BEmONC) facilities, but progress has been slower in this area. Only 28 of the 110upgraded BEmONC facilities were found to be fully functional

(performing all 7 BEmONC signal functions in the 3 months preceding the EmONC Review). Improvements were also found in the proportion of births taking place in functional EmONC facilities, reductions in financial barriers to EmONC care, reductions in the Direct Obstetric Case Fatality Rate, and performance of specific signal functions.

However, Cambodia still has fewer than half of the recommended number of EmONC facilities for the country, and EmONC facilities are still largely concentrated at the hospital level and in urban areas, with one province still lacking any EmONC facilities. The needs of newborns with complications are also being insufficiently met. In order to address these and other remaining challenges, a new EmONC Improvement Plan is proposed for the period 2016 - 2020.

Key Interventions

2.1. Improve the quality and geographic coverage of EmONC

2.1.1. At provincial level use EmONC maps to identify and select priority EmONC facilities for strengthening 2016-2020. Once priorities for 2016-2020 are agreed with the MoH, prepare/implement a provincial level action plan showing priority actions for each year. (Priority should be given to increasing the # of functional BEmONC facilities)

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

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

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

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

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

2.2.3. Provide and install appropriate medical equipment and supplies based on agreed provincial level action plans 2016-2020

2.3. Collaborate with DPHI to update national EmONC map using GIS based on the EmONC improvement plan 2016-2020

2.4. Improve recording and reporting of obstetric complications and newborn cases in all health facilities

2.5. Strengthen implementation of Maternal Death Surveillance and Response (MDSR) system and introduce Neonatal Death Review/Audit system (linked/integrated with MDSR)

2.5.1. Strengthen capacity of the National Maternal Death Audit committee to support MDA implementation at provincial level

2.5.2.Strengthen implementation of recommendations from maternal death audit meetings
2.5.3. Introduce neonatal death review

2.5.4.Improve linkages to vital registration system

2.5.5.Consider introducing investigation of near misses

Objective/Component Three: Newborn Care

To improve quality and coverage of newborn care

Rationale

Newborn care is an area that has recently received additional global and regional attention. The global Every Newborn Action Plan and the Action Plan for Healthy Newborns in the Western Pacific Region were both launched in 2014, and the Five Year Action Plan for Newborn Care in Cambodia 2016-2020 was endorsed by the Ministry of Health in December 2015. While neonatal mortality decreased from 27 per 1,000 live births in 2010 to 18 deaths per 1,000 live births in 2014, it is now responsible for over 60% of infant mortality and 50% of under-five mortality in the country. [23]

As can be seen from the recent 2014 EmONC assessment, there is an under diagnosis of newborn issues and significant gaps in newborn care practices. The CDHS 2014 also showed drops between 2010 and 2014 in immediate and exclusive breastfeeding with 66% of women initiating breastfeeding within one hour of birth in 2010,and 63% starting breastfeeding within one hour in 2014. [45] This decrease is a concern, especially given the impressive gains made in breastfeeding in recent years.

Detailed information on how these issues will be addressed is included in the Five-Year Action Plan for Newborn Care in Cambodia 2016-2020. However, a summary of key interventions for 2016 to 2020 is noted below.

Key Interventions

3.1. <u>Improve quality and availability of newborn care at EmONC and other health facilities through a phased in approach:</u>

3.1.1.Initiate and/or strengthen provision of the first embrace for all newborns (including C-section babies)

3.1.2.Initiate and/or strengthen diagnosis/case management for neonatal asphyxia

3.1.3.Initiate and/or strengthen diagnosis and provision of care for pre-term and low birth weight newborns including Kangaroo Mother Care (KMC), antibiotics for treatment of pre-term rupture of membranes and the use of antenatal steroids for pre-term births

[2]MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2010, 2011, pg. 114.
[3]MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015, pg. 129.
[4]MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2010, 2011, pgs. 134, 153.
[5]MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015, pg. 151, 178.

3.1.4. Initiate and/or strengthen diagnosis and provision of care for sick newborns including those with asphyxia, newborn sepsis, congenital anomalies and other newborn problems/infections

3.1.5. Initiate and/or strengthen diagnosis, referral and provision of care for the seriously sick or constricted newborn including the creation of Neonatal Care Units at CPA3 and CEmONC facilities

3.2. Reinforce early initiation of exclusive Breastfeeding

3.2.1. Strengthen support to breastfeeding and counseling on risk of breastmilk substitutes to parents/family.

3.3. Improve quality and quantity of PNC (linked to SBA section above)

3.3.1. Strengthen implementation of the FULL PNC package (4 visits starting with first PNC check pre-discharge for both mothers and newborns)

Objective/Component Four: Family Planning

To increase the use of modern contraception methods and increase the proportion of demand for family planning satisfied.

Rationale

Cambodia has experienced a slow but steady growth in modern contraceptive use since 2000 with usage increasing at an average rate of 1.5 percentage points per year. Usage is currently highest in the rural, poor and least educated groups. [6]While the modern contraceptive prevalence rate (CPR) increased and unmet need decreased between 2010 and 2015, Cambodia fell short of reaching its FTIRM and MDG contraceptive prevalence rate (CPR) target of 60% by the end of 2015. Traditional contraceptive usage also increased during this period, and is currently highest among urban, wealthy women.

Teenage pregnancy is an increasing concern, and adolescent fertility increased between 2010 and 2014.[7] The majority of early childbearing occurred amongst the rural, poor and least educated groups and was most common in the northeast of the country. While the unmet need for the 15-19 year old age group decreased between 2010 and 2014, it was highest among this group and the oldest, 45-49, year old age group.[8] As the majority of this early childbearing appears to be amongst 18-19 year olds it is not considered to be high risk, but the situation is still a clear concern and deserves further investigation and attention.

In going forward, Cambodia will need to increase the quality and utilization of family planning services, convert traditional method usage to modern method usage and continue to reduce unmet need and increase the proportion of demand satisfied. Particular attention will need to be given to increasing the

[6]MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015, pg. 89.
[7]MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015, pg. 71.
[8]MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015, pg. 116.

availability of permanent and long term methods and post-partum and post abortion family planning services, expanding youth friendly services, improving commodity security and further understanding and addressing the increasing usage of traditional family planning methods.

Key Interventions

4.1. Increase quality, availability and accessibility of FP services

4.1.1. Increase capacity/skill for counseling and service provision

4.1.2. Increase CBD coverage for remote and hard to reach locations

4.1.3. Improve access for remote and vulnerable groups such as garment factory workers, persons with disabilities, key populations and ethnic minorities through offering FP services on weekends and/or strengthening outreach

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

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

4.3. **Increase availability and utilization of post-partum and post abortion FP services** (specific details related to post-abortion FP included in the safe abortion section below)

4.3.1. Strengthen implementation of updated birth spacing guidelines which include immediate post-partum family planning.

4.3.2. Ensure FP commodities available in maternity ward

4.4. Expand youth friendly RH information and services

4.4.1. Arrange room with relevant and accessible IEC materials for youth friendly services

4.5. Ensure FP commodity security

4.5.1. Develop Contraceptive Forecasting and a Family Planning Action Plan for 2016 – 2020 which include a medium term sustainable financing plan that shows Development Partner and government contributions

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

Objective/Component Five: Safe Abortion

To increase the number of facilities offering safe abortion services and to reduce the proportion of women undertaking multiple abortions and unsafe abortions

Rationale

Significant progress was made in increasing the availability of safe abortion services between 2008 and 2015. However, Cambodia fell short of reaching its FTIRM target of 933 health facilities offering comprehensive safe abortion services by the end of 2015. While abortion was made legal in 1997, few services were available until technical guidelines were introduced and the national safe abortion training program was introduced in 2006. As of 2008, only 25 health facilities had received training in safe abortion and post abortion care, but this number had increased to 604 as of mid-2015 through strong collaboration between the MoH and NGOs. [9]

While it appears that the absolute number of women seeking abortions increased between 2005 and 2014, unsafe abortions appear to have decreased between 2005 and 2010 and then stagnated between 2010 and 2015. The percentage of women having multiple abortions followed the same trend and decreased from 2005 to 2010, and then stagnated between 2010 and2014.

While availability and access to safe abortion services has improved in recent years, the number of women reporting unsafe abortions (40%) remains unacceptably high.[10] Clearly the national roll-out of safe abortion services needs to continue, and information and access issues also need to be addressed to ensure a decrease in unsafe abortions.

Key Interventions

5.1. Increase coverage and quality of safe abortion services (All eligible HCs and RHs offer safe abortion services by 2020)

5.1.1. Assess and upgrade eligible facilities and train additional staff on comprehensive abortion care (CAC)

5.1.2. Undertake on-going quality assurance checks for all facilities performing CAC

5.1.3. Strengthen CAC data collection, recording and reporting systems

5.2. Increase availability and quality of post abortion and post-partum FP (specific details linked to post-partum FP included in FP section above)

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

5.2.2. Ensure FP commodities available in CAC room and maternity ward.

[9] Report from Marie Stopes International Cambodia, Oct 2015

[10] MoP, MoH, ICF Macro, Cambodia Demographic and Health Survey – 2014, 2015, pages. 82-83.

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

Enabling Components

Objective/Component Six: Removing Financial Barriers to Access Health Services

To ensure that all women in reproductive age have access to full package of key reproductive, maternal and newborn health services without financial hardship, when needed.

Rationale

Health Equity Funds (HEFs) are the Ministry of Health's main social health protection mechanism to reduce financial barriers to health services for the poor. HEFs expanded significantly between 2010 and 2015 and are expected to exceed the FTIRM 2010-2015 targets and cover over 85% of referral hospitals and 100% of the poor by the end of 2015. Expansion occurred in multiple dimensions including increased coverage of the poor, and increased coverage of RMNH services at health center and referral hospital level. The HEF benefit package was updated in 2014, and will be further revised in 2016, and currently includes the full package of Reproductive, Maternal and Newborn Health Services.

Reduced financial barriers is widely recognized as one of the key drivers behind the impressive increases seen in the proportion of deliveries by skilled birth attendants and deliveries in health facilities in recent years. However, some challenges and coverage gaps remain. A number of hospitals have applied for HEF but are still covered by the government subsidy package, and only one national hospital is currently covered by HEFs. There are also issues related to the reimbursement levels for key RMNH services such as PNC and post-partum and post-abortion family planning.

The Royal Government of Cambodia is committed to achieving Universal Health Coverage (UHC) for its population ensuring that all people obtain the health services they need without financial hardship when paying for them. The Government is currently developing a comprehensive national strategy for social protection system, which includes health insurance system for salaried workers/employees and civil servants, as well as Cambodian citizens in the informal sector, while the poor are covered by Health Equity Funds.

Key Interventions:

are to ensure that:

6.1 All women in reproductive age and newborns are enrolled under national health insurance.

6.2 The full package of reproductive, maternal and newborn health services are included in benefit packages of Health Equity Funds and national health insurance.

Objective/Component Seven: Behavior Change Communication

To improve individual, family and community care practices and care seeking for women and newborns.

Rationale

While knowledge and behavior related to key reproductive and maternal health practices have improved, and there is now nearly universal knowledge of modern family planning methods and high levels of deliveries in health facilities, there are outstanding areas where more work is required. This is particularly true for topics such as traditional family planning usage, ANC, PNC and abortion, and for emerging issues such as teenage pregnancy, newborn care and immediate and exclusive breastfeeding. Attention also needs to be given to poor performing locations and specific targets groups such as ethnic minorities in the North East of the country, and youth (including garment factory workers).

Key Interventions

7.1 **Increase utilization of ANC4 and PNC4**

- **7.1.1** Increase knowledge and practice of ANC4+ (starting in first trimester)and PNC4 for both mothers and newborns (starting prior to discharge)
- **7.1.2** Encourage VHSG/CBD to support women for ANC and PNC visits

7.2 **Increase immediate and exclusive breastfeeding**

- **7.2.1** Increase knowledge and practice of early breastfeeding and exclusive breastfeeding to 6 months

7.3 **Improve appropriate newborn care practices**

- **7.3.1** Increase knowledge and use of appropriate newborn care practices including the "First Embrace" for all newborns and Kangaroo Mother Care for low-birthweight and preterm babies

7.4 **Reduce Teenage Pregnancy**

- **7.4.1** Promote delay and spacing of childbearing
- **7.4.2** Undertake additional research to better understand this emerging issue and design BCC interventions based on findings

7.5 **Reduce Traditional Family Planning Usage**

- **7.5.1** Increase knowledge that traditional FP methods(particularly withdrawal) are not effective or reliable, and reduce fears and misinformation about modern contraceptives

7.6 Reduce unsafe and repeat abortions

7.6.1 Increase knowledge that abortion is legal

7.6.2 Disseminate the abortion law

7.6.3 Increase knowledge and awareness of the dangers of unsafe and multiple abortions and where to go for safe abortion care

Monitoring and Evaluation

The FTRIM 2016-2020 will be monitored on an annual basis using the monitoring and evaluation framework included below, and a more thorough review will be undertaken in 2020 when new CDHS and emergency obstetric and newborn care assessment data is available.

The monitoring and evaluation framework was developed through a participatory process and indicators and targets were taken from existing national, sectoral or sub-sectoral documents whenever possible. Where local indicators and targets were not available, regional and global indicators and targets were used to ensure ease and consistency of reporting.

Monitoring and Evaluation Framework

	Indicator	2010	Baseline 2014	Target 2020	Source
Goal					
To reduce maternal mortality to 130 maternal deaths per 100,000 live births and to reduce Neonatal Mortality to 14 neonatal deaths per 1,000 live births by 2020.	Maternal Mortality Ratio	206 per 100,000 live births	170	130	CDHS
	Neonatal Mortality Rate	27 per 1,000 live births	18	14	CDHS
Components/Objectives					
1. Skilled Birth Attendance: To increase the quality and	% of health center with at least 2 secondary midwives	Not available	41% (452/1105)	50%	MoH Staff reports

	Indicator	2010	Baseline 2014	Target 2020	Source
coverage of ANC, Skilled Birth Attendance and PNC (overall and particularly among the lowest income and educational groups.)	% of women receiving at least 4 ANC checks	59% (CDHS 2010)	76% (CDHS 2014)	90%	CDHS, HIS
	% of deliveries in a health facility (overall and disaggregated by income quintile and educational group)	54% (overall) (CDHS 2010) 34% (no education) 35% (lowest income quintile) (CDHS 2010)	83% (overall) (CDHS 2014) 68% (no education) 68% (lowest income quintile) (CDHS 2014)	90% (overall) 80% (no education) 80% (lowest income quintile)	CDHS, HIS
	% of women receiving early PNC (within 2 days of delivery)	70% (CDHS 2010)	90% (CDHS 2014)	95%	CDHS, HIS
2. <u>Emergency Obstetric and Newborn Care:</u> To improve EmONC coverage so that there are at least 5EmONC (CEmONC+BEmONC) facilities per 500,000 population including at least 1 comprehensive (CEmONC) facility	# EmONC facilities per 500,000 population	1.64 (2010)	4.84	At least 5 (≥160EmONC facilities)	EmONC assessment
	# BEmONC facilities per 500,000 population	0.71 (2010)	3.62	At least 4 (≥125BEmONC facilities)	EmONC assessment
	# CEmONC facilities per 500,000 population	0.93 (2010)	1.22	At least 1 (≥35CEmONC facilities)	EmONC assessment
	% of deliveries by caesarian section	Overall: 3% (CDHS 2010)	Overall: 6.3% (CDHS 2014)	Overall: 10%	CDHS, HIS

	Indicator	2010	Baseline 2014	Target 2020	Source
	(overall and subnational)[11]	Kampong Speu:1.1% Pursat:2.1% PreahVihear/Stung Treng: 0.9% Phnom Penh:9.9% (CDHS 2010)	Kampong Speu: 2.2% Pursat: 2.2% PreahVihear/ Stung Treng: 2.3% Phnom Penh: 14.4% (CDHS 2014)	Subnational: No province below 3.5% and Phnom Penh not above 17%	
3. <u>Newborn Care:</u> To improve quality and coverage of newborn care	% of skilled birth attendants trained in Early Essential Newborn Care/Immediate Newborn Care	NA	NA	80%	MoH reports
	% of targeted facilities implementing Expanded INC	NA	NA	90%[12]	Facility Survey
	% of newborns receiving early PNC (within 2 days of delivery)	NA	76.5% (CDHS 2014)	95%	CDHS, HIS
	% of infants who were breastfed within 1 hr. of birth	66% (CDHS 2010)	63% (CDHS 2014)	76%	CDHS

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

[12] Target Facilities for Expanded INC = All provincial hospitals(except Kep (CPA1)) PLUS Phnom Penh) Total=24

	Indicator	2010	Baseline 2014	Target 2020	Source
4. Family Planning: To increase the use of modern contraception methods and increase the proportion of demand for family planning satisfied	% of women whose demand for family planning is satisfied % of women whose demand for family planning is satisfied with modern contraceptive	75.6% (CDHS 2010) 52.2%	82.7% (CDHS 2014) 57.4%	85% 62%	CDHS CDHS
	Modern Contraceptive Prevalence rate	35% (CDHS 2010)	39% (CDHS 2014)	48%	CDHS, HIS
5. Safe Abortion Care: To increase the number of facilities offering safe abortion services and to reduce the proportion of women undertaking multiple and unsafe abortions.	# of health facilities offering safe abortion services	25	604	880	MoH/ NGO Reports
	% of women reporting multiple abortions	1.4% (CDHS 2010)	3.6% (CDHS 2014)	2.0%	CDHS
	% of women reporting an abortion who did not have help from a health professional at the time of the last abortion	40% (CDHS 2010)	40% (CDHS 2014)	30%	CDHS
6. Remove Financial Barriers to Access Health Services: To ensure that all women in reproductive age have access to full package of key reproductive, maternal and newborn health services without financial hardship	% of women in reproductive age covered by social health protection schemes (including HEF and national health insurance schemes and others)	-	TBD	TBD	MOH report

	Indicator	2010	Baseline 2014	Target 2020	Source
when needed					
7. <u>Behavior Change Communication:</u> To improve individual, family and community care practices and care seeking for women and newborns	Adolescent Birth rate (15-19)	46 per 1000 15-19 year old women (CDHS 2010)	57 (CDHS 2014)	51	CDHS
	% of currently married women using traditional FP methods	15.7% (CDHS 2010)	17.5% (CDHS 2014)	12%	CDHS
	% of women who know that abortion is legal	NA	12% (in 8 PSL supported provinces; PSL baseline 2014)	30%	survey

Annex

Key Intervention Framework: FTIRM 2016-2020

Objectives/Components	Key Intervention Areas
1. **Skilled Birth Attendance**: To increase the quality and coverage of ANC, Skilled Birth Attendance and PNC (particularly among the lowest income and educational groups.)	**1-1 Continue to improve the competence and availability of midwives** 1-1.1 Pre-Service: 1-1.1.1 Update the pre-service midwifery curricula, strengthen practical training for midwifery students and strengthen and expand the preceptor program 1-1.1.2 Rationalize existing midwifery pre-service training courses • Midwifery Curriculum Review • Midwifery review (the Role and responsibility of Primary MW) • Midwifery Education Pathways • Develop Midwifery strategy • Midwifery Education Regulatory Framework 1-1.2 In-Service: Strengthen midwifery skills through competency-based training and through expanding opportunities for practice and on-site coaching 1-1.3 Regulation and Licensing: Strengthen registration, licensing and relicensing systems 1-1.4 Availability: Increase the number of secondary midwives at HC level 1-1.4.1 Civil service recruitment of secondary midwives for HCs, particularly in remote areas 1-1.4.2 Explore options of contracting secondary midwives at HC level and/or upgrading primary midwives to secondary midwives **1-2 Improve quality and quantity of ANC** **1-2.1** Reinforce FULL ANC service package (4+ visits starting in 1st trimester as soon as menstruation is missed; all components including 90 Iron/Folic Acid) **1-3 Improve quality of intrapartum/delivery care** 1-3.1 Strengthen monitoring of maternal and fetal status during labor & delivery and improve recognition of danger signs and risk factors through correct use of the partograph 1-3.2 Strengthen prevention/immediate treatment/stabilization and referral for post-partum hemorrhage 1-3.3 Strengthen diagnosis/immediate treatment /referral for pre-eclampsia/eclampsia including introducing the use of injectable MgSO4 for loading dose prior to referral 1-3.4 Improve infection prevention and control **1-4 Improve quality and quantity of PNC** 1-4.1 Strengthen implementation of the FULL PNC package (4 visits starting with first PNC check pre-discharge for both mothers and newborns) 1-4.2 Improve diagnosis and referral for congenital anomalies

Objectives/Components	Key Intervention Areas
2. Emergency Obstetric and Newborn Care: To improve EmONC coverage so that there are least 5EmONC (CEmONC+BEmONC) facilities per 500,000 population including at least 1 comprehensive (CEmONC) facility	**2.1. Improve the quality and geographic coverage of EmONC** 2.1.1. At provincial level use EmONC maps to identify and select priority EmONC facilities for strengthening 2016-2020. Once priorities for 2016-2020 are agreed with the MoH, prepare/implement a provincial level action plan showing priority actions for each year. (Priority should be given to increasing the # of functional BEmONC facilities) 2.1.2. Increase competency of staff in designated EmONC facilities to perform core signal functions 2.1.3. Increase # of designated CEmONC facilities with adequate surgeon (MD capable of C-section) and anesthetist/nurse anesthetist to provide 24/7 service and the ability to perform blood transfusion (signal functions 8 and 9) **2.2. Reduce gaps in basic infrastructure, drugs and equipment in EmONC facilities** 2.2.1. Upgrade infrastructure based on agreed provincial level action plans 2016-2020 2.2.2. Ensure regular supply of life-saving drugs for mothers and newborns 2.2.3. Provide and install appropriate medical equipment and supplies based on agreed provincial level action plans 2016-2020 2.3. **Collaborate with DPHI to update national EmONC map using GIS based on EmONC improvement plan 2016-2020** **2.4. Improve recording and reporting of obstetric complications and newborn cases in all health facilities** **2.5. Strengthen implementation of Maternal Death Surveillance and Response (MDSR) system and introduce Neonatal Death Review/Audit system (linked/integrated with MDSR)** 2.5.1. Strengthen capacity of the National Maternal Death Audit committee to support MDA implementation at provincial level 2.5.2. Strengthen implementation of recommendations from maternal death audit meetings 2.5.3. Introduce neonatal death review 2.5.4. Improve linkages to vital registration system 2.5.5. Consider introducing investigation of near misses.

Objectives/Components	Key Intervention Areas
3. **Newborn Care**: To improve quality and coverage of newborn care	**3.1. Improve quality and availability of newborn care at EmONC and other health facilities through a phased in approach:** 3.1.1. Initiate and/or strengthen provision of the first embrace for all newborns (including C-section babies) 3.1.2. Initiate and/or strengthen diagnosis/case management for neonatal asphyxia 3.1.3. Initiate and/or strengthen diagnosis and provision of care for pre-term and low birth weight newborns including Kangaroo Mother Care (KMC), antibiotics for treatment of pre-term rupture of membranes and the use of antenatal steroids for pre-term births 3.1.4. Initiate and/or strengthen diagnosis and provision of care for sick newborns including those with asphyxia, newborn sepsis, congenital anomalies and other newborn problems/infections 3.1.5. Initiate and/or strengthen diagnosis, referral and provision of care for the seriously sick or constricted newborn including the creation of Neonatal Care Units at CPA3 and CEmONC facilities **3.2. Reinforce early initiation of exclusive Breastfeeding** 3.2.1. Strengthen support to breastfeeding and counseling on risk of breast milk substitutes to parents/family. **3.3. Improve quality and quantity of PNC (linked to SBA section above)** 3.3.1. Strengthen implementation of the FULL PNC package (4 visits starting with first PNC check pre-discharge for both mothers and newborns)
4. **Family Planning**: To increase the use of modern contraception methods and increase the proportion of demand for family planning satisfied	**4.1. Increase quality, availability and accessibility of FP services** 4.1.1. Increase capacity/skill for counseling and service provision 4.1.2. Increase CBD coverage for remote and hard to reach locations 4.1.3. Improve access for remote and vulnerable groups such as garment factory workers, persons with disabilities, key populations and ethnic minorities through offering FP services on weekends and/or strengthening outreach. **4.2. Increase availability and utilization of long-term/permanent FP methods** 4.2.1. All Referral Hospitals should be able to provide at least 3 long-term/permanent FP methods

Objectives/Components	Key Intervention Areas
	4.3. **Increase availability and utilization of post-partum and post abortion FP services** (specific details noted related to post-abortion FP included in safe abortion section below) 4.3.1. Strengthen implementation of updated birth spacing guidelines which include immediate post-partum family planning 4.3.2. Ensure FP commodities available in maternity ward **4.4. Expand youth friendly RH information and services** 4.4.1. Arrange room with relevant and accessible IEC materials for youth friendly services **4.5. Ensure FP commodity security** 4.5.1. Develop Contraceptive Forecasting and a Family Planning Action Plan 2016 - 2020 which include a medium term sustainable financing plan which shows Development Partner and government contributions **4.6. Strengthen public-private partnership to ensure quality FP service provision and timely and accurate reporting from NGOs and the private sector**
5. **Safe Abortion Care**: To increase the number of facilities offering safe abortion services and to reduce the proportion of women undertaking multiple abortions and unsafe abortions.	**5.1. Increase coverage and quality of safe abortion services (All eligible HCs and RHs offer safe abortion services by 2020)** 5.1.1. Assess and upgrade eligible facilities and train additional staff on comprehensive abortion care (CAC) 5.1.2. Undertake on-going quality assurance checks for all facilities performing CAC 5.1.3. Strengthen CAC data collection, recording and reporting systems **5.2. Increase availability and quality of post abortion and post-partum FP (specific details linked to post-partum FP included in FP section above)** 5.2.1. Increase counseling skills and capacity of CAC providers to provide post abortion FP 5.2.2. Ensure FP commodities available in CAC room. **5.3. Increase availability of medical abortion at the HC level in a phased-in approach**

Objectives/Components	Key Intervention Areas
6. Removing Financial Barriers to Access Health Services To ensure that all women in reproductive age have access to full package of key reproductive maternal and newborn health services without hardship when needed	6.1 All women at reproductive age and newborn are enrolled under national health insurance. 6.2 The full package of reproductive, maternal and newborn health services are included in benefit packages of Health Equity Funds and national health insurance.
7. **Behavior Change Communication**: To improve individual, family and community care practices and care seeking for women and newborns	**7.1. Increase utilization of ANC4 and PNC4**: 7.1.1. Increase knowledge and practice of ANC4+ (starting in first trimester)and PNC4 for both mothers and newborns (starting prior to discharge) 7.1.2. Encourage VHSG/CBD to support women for ANC and PNC visits **7.2. Increase immediate and exclusive breastfeeding** 7.2.1. Increase knowledge and practice of early breastfeeding and exclusive breastfeeding to 6 months **7.3. Improve appropriate newborn care practices** 7.3.1. Increase knowledge and use of appropriate newborn care practices including the " First Embrace" for all newborns and Kangaroo Mother Care for low-birthweight and preterm babies **7.4. Reduce Teenage Pregnancy**: 7.4.1. Promote delay and spacing of childbearing 7.4.2. Undertake additional research to better understand this emerging issue and design BCC interventions based on findings **7.5. Reduce Traditional Family Planning Usage**: 7.5.1. Increase knowledge that traditional FP methods(particularly withdrawal) are not effective or reliable, and reduce fears and misinformation about modern contraceptives **7.6. Reduce unsafe and repeat abortions**: 7.6.1. Increase knowledge that abortion is legal 7.6.2. Disseminate the abortion law 7.6.3. Increase knowledge and awareness of the dangers of unsafe and multiple abortions and where to go for safe abortion care

List of participants met during the development process of FTIRM

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