Cambodia Global Health Initiative Strategy

September 9, 2011

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Acronym List

ANC	Antenatal care
ART	Anti-retroviral treatment
CDHS	Cambodian Demographic Health Survey
CMWG	Civilian-Military working group
DOD	Department of Defense
EW	Entertainment workers
EmONC	Emergency obstetric and newborn care
FP	Family planning
FTI	The Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality (FTIRM, referred to as FTI)
GHI	Global Health Initiative
HCMC	Health center management committee
HEF	Health equity funds
HSP-2	Health Strategic Plan (Phase 2)
HSSP 2	Health Sector Support Program (Phase 2)
HMIS	Health management information system
LMI	Lower Mekong Initiative
MCH	Maternal child health
MDG	Millennium Development Goal
M&E	Monitoring and evaluation
MMR	Maternal Mortality Ratio
MNH	Maternal and newborn health
MOH	Ministry of Health
NCHADS	National Center for HIV/AIDS, Dermatology and STDs
NGOs	Non-governmental organizations
NIP	National Immunization Program
OI/ART	Opportunistic infection/anti-retroviral treatment
PCV	Peace Corps volunteers
PEPFAR	President's Emergency Plan for HIV/AIDS Relief
PLHIV	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
PPH	Post-partum hemorrhage
RACHA	Reproductive and Child Health Alliance of Cambodia
RHAC	Reproductive Health Association of Cambodia
RGC	Royal Government of Cambodia
RMNCH	Reproductive, maternal, newborn and child health
STI	Sexually-transmitted infection
TB	Tuberculosis
TWGH	Technical Working Group for Health
USG	United States Government
US-CDC	U.S. Centers for Disease Control and Prevention
USAID	United States Agency for International Development
VHSG	Village Health Support Group
WHO	World Health Organization
WGGE	Women and girls and gender equality

CAMBODIA's GHI STRATEGY

I. Global Health Initiative Vision

The vision of the Global Health Initiative (GHI) for Cambodia is healthier Cambodians with an emphasis on improving the health of mothers and newborns. Cambodia has made substantial progress on health in the last decade, and is expected to reach or exceed the Millennium Development Goals (MDG) for HIV/AIDS, Tuberculosis (TB), and Child Health. However, despite some improvement, Cambodia has among the highest levels of maternal mortality in the region, and neonatal mortality rates have remained stagnant over the last five years.

Under GHI, the U.S. Government (USG) will assist the Royal Government of Cambodia (RGC) to implement a multi-donor/partner effort to improve maternal and newborn health. In order to reduce maternal and neonatal mortality, the GHI strategy focuses on increasing access to services, improving quality health systems, and increasing demand for quality services. The strategy builds on successful interagency coordination efforts, and experience gained through The President's Emergency Plan for HIV/AIDS Relief (PEPFAR).

The U.S.-Centers for Disease Control and Prevention (US-CDC), USAID, the U.S. Department of Defense (DOD) and Peace Corps implement health activities in Cambodia. GHI will take advantage of common geographic focus areas and unique agency technical strengths to identify opportunities to accelerate gains in reducing maternal mortality, improving child health and nutrition, and reducing HIV and tuberculosis.

II. GHI Partner Country Priorities and Context

Health overview: Cambodia is one of Asia's poorest nations and the health of its population is among the worst in the region. In 2005, Cambodia's maternal mortality ratio (MMR) was 472/100,000. Modeling exercises predict that the 2010 MMR in Cambodia will be lower, but still not on target to meet the related MDG.[i] Only 35 percent of couples reported using contraceptives in 2010.[ii] Perhaps in response to the devastating population loss during the Khmer Rouge period, the government is resistant to long-term family planning (FP) methods. Up to one-third of entertainment workers (EW)[iii] report having had an abortion in the past 12 months.[iv]

Under-five mortality has decreased over the past ten years, but neonatal mortality[v] has plateaued. In the preliminary results of the 2010 Cambodia Demographic Health Survey (CDHS), neonatal mortality was 27/1,000 live births, compared to 28/1,000 live births in 2005. Malnutrition and stunting indicators for children have not changed and in some cases have worsened since 2005. Anemia rates in children and women are high. Breastfeeding rates have declined while bottle feeding has increased.

Cambodia is one of 22 high-burden countries for TB and has the highest estimated incidence of

TB in Asia (442/100,000). Nearly two thirds of Cambodians have active or latent TB.

Not all of the country's health indicators are lagging. Cambodia has been successful in its response to HIV/AIDS and received a MDG Award for its national leadership, commitment and progress towards achievement of Goal 6 - Combating HIV, malaria and other diseases. In the past decade, the USG provided almost 40 percent of the funding for the national response to HIV/AIDS and contributed to reducing adult HIV infection rates from 2.0 percent in 1998 to 0.78 percent in 2010.[vi] More than 94 percent of those in need are receiving antiretroviral treatment.

Major causes of maternal and neonatal mortality: The leading causes of maternal mortality in Cambodia are post-partum hemorrhage, eclampsia and unsafe abortion. Death results from complications during or shortly after delivery, or unsafe abortions. They are difficult to predict and require rapid and appropriate care to prevent death. While treatment strategies for the most common maternal health problems are well-known, correct and timely diagnosis and treatment in Cambodia remains a problem. Almost 50 percent of women still deliver in their homes. Women and newborns need the assistance of skilled health care providers at delivery, and those providers must be able to identify and respond quickly and effectively to complications. Trained providers require medicines, equipment and updated surgical facilities. There is evidence of progress, however. For example, the percentage of pregnant women who make at least one antenatal care (ANC) visit increased from 69 percent in 2005 to 89 percent in 2010. Births conducted by a skilled health care provider rose from 44 percent in 2005 to 71 percent in 2010.

The major causes of neonatal deaths in Cambodia are preterm birth, birth asphyxia, sepsis, and pneumonia, followed by congenital malformations and tetanus. As with maternal mortality, the majority of deaths occur around the time of birth and require prompt diagnosis and treatment. Therefore, achieving rapid decreases in maternal and neonatal deaths will require better access to and demand for high quality services throughout the country.

Royal Government of Cambodia (RGC) response: The RGC's Health Strategic Plan 2 for 2008-2015 (HSP-2) addresses communicable diseases, non-communicable diseases, and reproductive, maternal and child health. The strategy calls for a strong health management information system (HMIS), a competent workforce, a regular supply of commodities and equipment, and a well-financed health system that offers high quality services affordably.

In 2010 the Prime Minister of Cambodia announced that the highest health priority was to reduce maternal mortality. In response, with support from the USG and other technical partners, the Ministry of Health (MOH) developed the Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality Initiative (FTI), 2010-2015. The key interventions in the FTI are ensuring that women deliver in health facilities, have access to high quality emergency services and use FP. The USG only supports activities under the FTI that are consistent with U.S. laws and policies. The strategy also incorporates educating girls, removing financial barriers, and changing behavior so that women seek improved delivery care.

Donors agree on the importance of addressing maternal mortality and endorse the FTI priorities.

The USG is the largest single donor in maternal and neonatal health, spending approximately $14 million per year[vii] for district, provincial, and national-level programs in all priority areas of the FTI.[viii]

Alignment of GHI Principles and GHI opportunities in Cambodia: Achieving MDG 5 by 2015 is currently the highest health priority for the RGC.[ix] The First Lady of Cambodia was named the Champion for the UN Secretary-General's Action Plan for Women's and Children's Health and is an advocate for healthy motherhood in Cambodia. Many RGC policies, strategies and delivery systems incorporate the GHI principles, such as building and sustaining a strong health system. Three of the seven essential components of the FTI relate to health systems strengthening, including surveillance to identify the causes of maternal death, behavior change communication and improved financing.

The RGC has also endorsed a number of other strategies that are consistent with GHI principles, such as:

- improving women's health though strengthening girls' education and increasing gender equity;
- using data gathered through the nationwide web-based HMIS to make funding and programmatic decisions, and;
- integrating antenatal care (ANC) services with those that offer HIV testing through strong coordination between two government departments, the National Center for HIV/AIDS, Dermatology and STDs (NCHADS) and the Reproductive, Maternal, Newborn and Child Health (RMNCH) Department.

Under GHI, the USG will build on these and other opportunities to assist Cambodia to reach its goal of reducing maternal/neonatal mortality. Specifically, the USG will:

- *Align activities with the priorities of the RGC and other donors:* USG will continue to collaborate with donors and the RGC to achieve the goals of the national health strategy.
- *Use resources to monitor and improve existing programs and fund small, innovative activities:* If proven successful, USG will advocate that they be expanded through other resources, such as the Global Fund for HIV/AIDS, TB, and Malaria (the Global Fund)[x] or pooled government/donor funding for maternal and child health.
- *Participate in government technical and policy forums to accelerate progress towards reaching GHI targets:* USG technical experts and partners will continue to participate in the RMNCH Task Force, which measures progress and leads the implementation on FTI. The Task Force is a useful platform to gauge progress on the FTI.

Under GHI, the USG will build on successful PEPFAR approaches to improve maternal and neonatal health by:

- building on the Linked Response program for Prevention of Mother to Child Transmission (PMTCT) of HIV to increase the quality and coverage of ANC services and identify high risk

pregnancies;
- tracking program performance through better use of routine monitoring systems, and;
- integrating FP and HIV services in Family Health clinics for EWs and for women with HIV/AIDS at anti-retroviral treatment (ART) sites.

The U.S. Mission in Cambodia has three interagency working groups related to health - the Civilian-Military working group (CMWG), the Health/Lower Mekong Initiative (LMI) working group, and the PEPFAR working group. Under the leadership of the Ambassador, these working groups have provided opportunities for information exchange, program planning, and better coordination of USG-funded activities. Under GHI, the USG will continue to use these forums for program planning and monitoring.

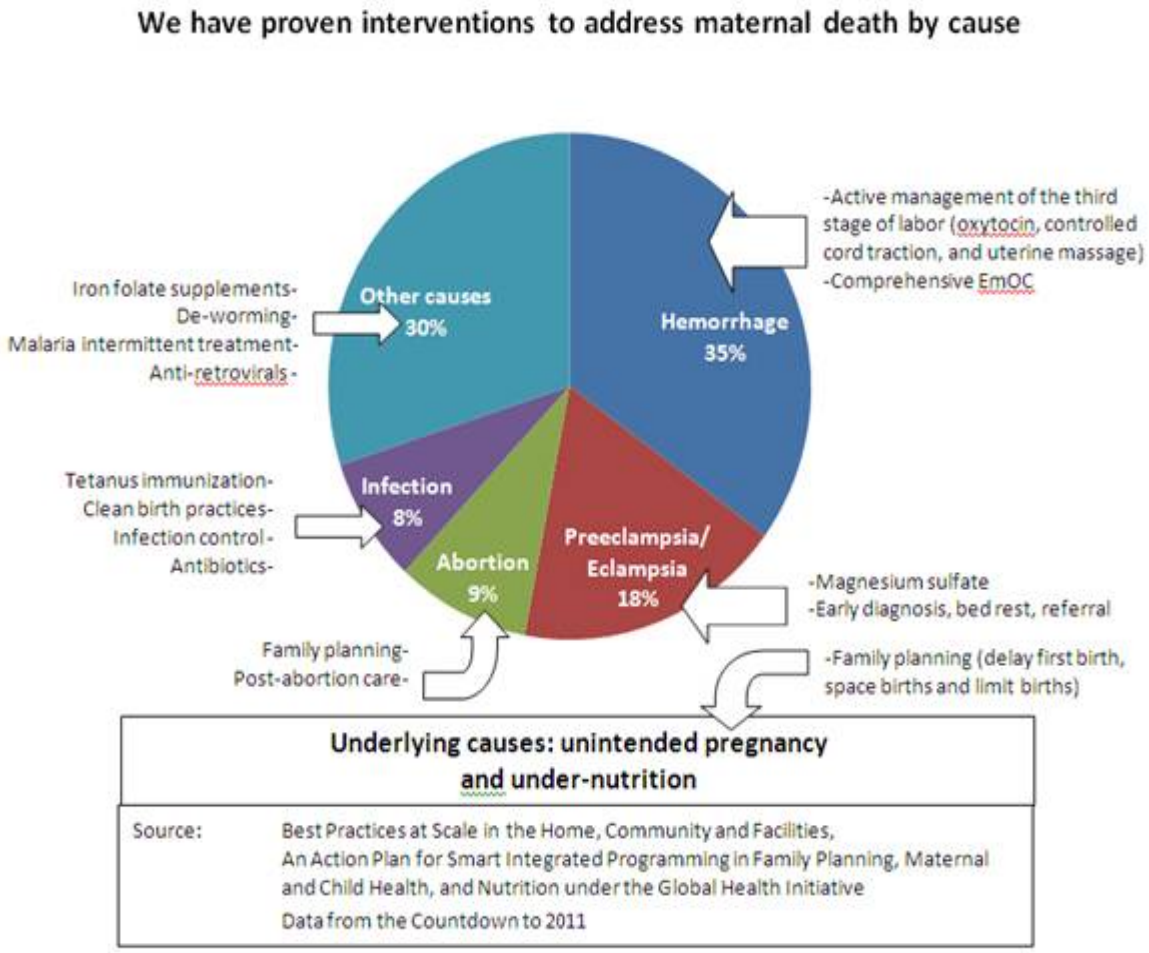
Building strong health care delivery systems that are not dependent on donor funding is a central priority of the USG. The USG and USG partner technical staff work directly with the government to foster technical, financial, and management expertise. To reach rural, marginalized and poor Cambodians and to strengthen community-level public sector health services, the USG directly funds three Cambodian non-governmental organizations (NGOs), along with four international organizations. They, in turn, fund more than forty local NGOs with services delivered throughout the country.

III. GHI Objectives, Program Structure, and Implementation

Addressing major causes of mortality of mothers and newborns: During the last five years, there have been health care advances in Cambodia. This has resulted in increased use of ANC, delivery conducted by a skilled provider, and deliveries conducted at a health facility. The proportion of women who use contraceptives[xi] also increased, although rates are still well below national targets.

Improvements in other sectors, such as education have also been achieved. For example, secondary education for women increased from 25 percent in 2005 to 35 percent in 2010. There are visible improvements in roads, transport and telecommunications throughout the country.

Additional improvements are needed, however, to reduce maternal and neonatal mortality to rates that are more on par with other countries in the region and those with similar levels of socio-economic development. Addressing maternal and newborn mortality will require further strengthening of the health care work force and infrastructure that were decimated during the Khmer Rouge era. Major causes of maternal mortality and interventions to address them are included in the table below.



Activities under GHI will build on existing programs and address specific barriers related to:

- Unmet Family Planning needs: Voluntary FP is one of the most cost effective approaches for reducing maternal mortality. The USG has been a leader in FP in Cambodia since 1996. USG partners train community volunteers to provide FP counseling and short-term methods and train doctors to provide long-term methods. As a result, women have greater access to a range of contraceptives. Although contraceptive use has increased, there is still unmet demand, particularly for long-term methods. This is critically needed for EWs who have a 30 percent per year abortion rate. The current government policy does not adequately promote long-term FP.
- Lack of integrated services: Service delivery is fragmented. A mother is not offered FP when she takes her child for a well-child check-up. Sexually-transmitted infection (STI) testing, HIV testing, and voluntary FP services for EWs are provided in three different sites. PEPFAR programs have started to integrate services to increase access for EWs and

people living with HIV/AIDS (PLHIV).

- Inadequate transport and referral: Women often delay going to a higher-level referral hospital because they do not have money to pay for emergency transport. This increases their risk when a normal delivery becomes an emergency.
- Out of pocket expenditure for health: Fifty-six percent of Cambodians live on less than $2/day[xii] yet Cambodians continue to pay for health care out of their household budgets.[xiii] USG experts contributed to the development of a government insurance scheme, the Health Equity Fund (HEF), which is being implemented in 44 out of 77 districts in the country. Women who do not have HEFs are often denied emergency obstetric and newborn care (EmONC) and FP services because of their inability to pay for services up front.
- Private practice: Many public sector doctors and midwives supplement their low government salary through income earned in private practice. As a result, health professionals are often available for only a limited time or not at all during normal health facility business hours.
- Policy and guidelines: Cambodia's Safe Motherhood Protocol for health centers outlines clinical guidelines for maternal and newborn health interventions delivered in a health center. The MOH recently authorized the administration of Magnesium Sulfate by midwives for pre/eclampsia. USG technical expertise was instrumental in developing these policies and other maternal newborn health clinical practice guidelines. What is missing, however, is a plan by the government for how these policies will be rolled-out. Safe Motherhood Guidelines for hospitals are needed urgently since many maternal and newborn emergencies take place in hospitals. The need for updated policies on child health and family planning, for example for growth monitoring in health centers or paying for long-term FP methods through the HEF, impedes the delivery of important services.
- Human resource shortage: Most public health facilities are under-staffed or do not have enough health providers with the right clinical skills. Cambodia has only 0.77 per 1,000 population, far short of the World Health Organization (WHO) recommendation of 2.5. Secondary midwives[xiv] are the main providers of 24 hour care and only 61 percent of hospitals and 7 percent of health centers have secondary midwives available around the clock.
- Human resource performance: Providers lack skill and confidence to perform essential maternal, newborn, and FP services. The caesarian-section rate in Cambodia is only 1.8 percent (2008) compared to a WHO-recommended minimum of 5 percent because there are too few trained obstetricians and operating rooms. The USG has begun training midwives so that they diagnose, treat and refer, correctly and quickly. In the institutions where these midwives work, there has been an increase in the correct application of techniques to reduce post-partum hemorrhage (PPH). Several models that link payment to performance are being tested by the USG. In one scheme, USG implementing partners release funds to community-based organizations based on high performance scores in health care delivery, consistent with USAID Forward goals.
- Commodities: Even if a provider has been trained and a woman reaches a hospital in time, live-saving drugs, such as oxytocin to treat PPH, may not be in stock.
- Inadequate infrastructure: There are not enough facilities equipped to provide EmONC services nor are they equitably distributed across the country. Women have to travel long

distances to reach even basic or EmONC services.[xv] Blood supply for treatment of PPH is only available in referral hospitals, and, in general, blood donors are inadequate nationwide. The USG is upgrading hospitals and strengthening EmONC services in accordance with the government's EmONC Improvement Plan (2010-2014), and working with the National Center for Blood Services to improve access to safe blood.

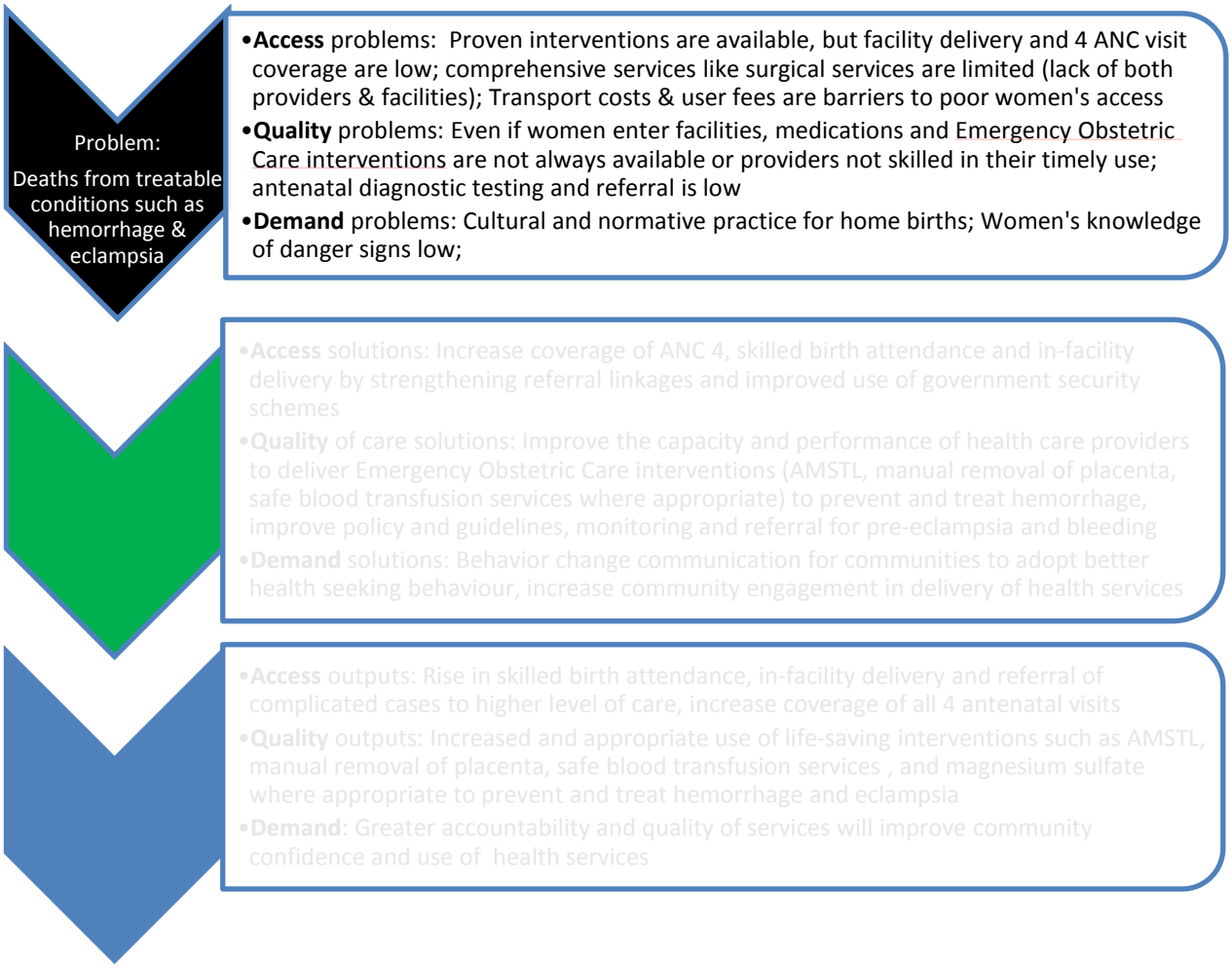
- Data on maternal deaths: Maternal deaths in the community and in private hospitals are under-reported and there is no effective system for capturing those deaths through vital statistics or the community. Only about 30 percent of the estimated maternal deaths are being reported through the HMIS; the rest are "invisible."
- Unregulated private medical sector: Forty-eight percent[xvi] of Cambodians use the private sector as their first source of medical care. Because the private medical sector is unregulated in Cambodia, doctors routinely prescribe unnecessary treatment or overcharge for services. The USG conducts continuing medical education courses for public and private providers on a range of medical topics and is incorporating private sector service delivery data into the HMIS. This effort brings the private sector into compliance with RGC standard operating procedures.

To assist the RGC in achieving the targets committed to in the FTI, the USG will invest its collective resources to improve maternal and neonatal health (MNH). Through GHI, the USG will focus on improving:

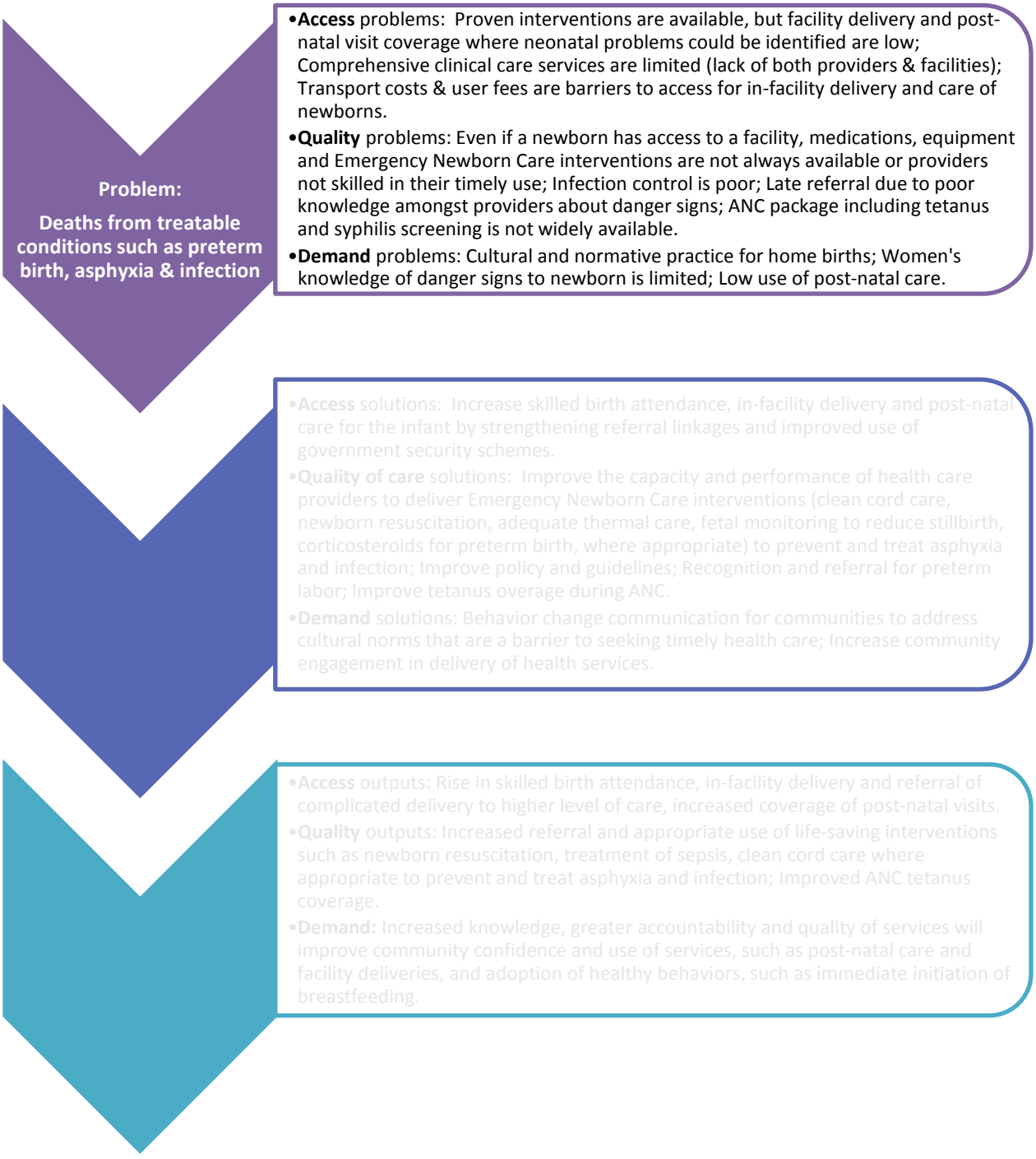
1. access to quality health care services;
2. health systems, and;
3. demand for quality health services.

These objectives reflect common priorities of the RGC, USG, and other donor partners as represented in the country's HSP-2 and FTI. GHI will measure success through achievement of standard MNH output and outcome indicators. (See GHI Results Framework in Annex 1)

Logic model for reducing Maternal Mortality due to hemorrhage and eclampsia, the two largest causes of maternal deaths in Cambodia



Logic model for reducing Neonatal Mortality due to preterm birth, asphyxia and infection, the three leading causes of neonatal deaths in Cambodia



Intermediate Result 1 (Focus Area 1): Improved access to quality health services

A woman's use of preventive and lifesaving health care is contingent on her being able to access services. Access is affected by high costs, the need to go to different sites for essential services, and a lack of skilled health care providers. The USG will focus on three broad areas under access:

1. *Increased availability of strategically integrated ANC and maternal, neonatal, and child health services, including nutrition and family planning:* USAID and US-CDC PEPFAR programs will continue to integrate FP/STI services with HIV prevention and treatment wherever feasible. The USG will work with the Ministry of Health to develop guidelines and protocols for the integration of services, support curriculum development and train HIV providers in FP to target EWs and PLHIVs.

The USG, through PEPFAR, will evaluate and adapt the Linked Response program which tests pregnant women for HIV under the national strategy to eliminate pediatric HIV. Using a "one stop shop" approach, women will receive a variety of health services during quality, comprehensive ANC. High-risk pregnancies will be identified. This builds on existing activities started through PEPFAR and takes advantage of Global Fund resources which fund PMTCT programs.

FP and maternal child health (MCH) services will be offered during immunization outreach sessions conducted by the US-CDC-funded National Immunizations Program (NIP). Peace Corps Volunteers (PCV) and USAID Village Health Support Group (VHSG) volunteers will mobilize community members to attend immunization services.

The USG is already building maternity waiting homes in 68 health centers so that women travel shorter distances in an emergency. This activity will be evaluated through GHI and expanded if successful.

Even if public sector services are accessible due to close geographic proximity, health providers are often not available because they practice in the private sector during normal health center delivery hours to supplement their salaries. The USG will examine newly-introduced performance-based incentive schemes that reimburse doctors based on whether quality services were delivered. Donor and government funds pay for the actual cost of services. The USG will also assist the MOH to monitor and strengthen implementation of the 60,000 riel policy, which pays health care providers for every child delivered in a health facility.

2. *Strengthened referral linkages:* A critical gap for women living in rural areas is the limited access to hospitals and emergency health care services. The USG will tap into local community organizations, such as VHSGs and health center management committees (HCMC), to establish an emergency transportation system that ensures pre-paid, pre-arranged transport. USAID PEPFAR partners already provide clients with transportation to HIV services. Through GHI, we will use the same system to assist pregnant women to reach facilities.

Prior to the GHI, US-CDC and the RGC developed an information system that tracks clients from their first appointment to ensure that they receive all the HIV services that they need. As a result, there are now fewer drop-outs and more women receive needed health services. A recent concept paper submitted for funding to the Office of the Global AIDS Coordinator would refine this information system by establishing a unique identifier code to help track whether a client has used relevant health services. Under GHI this system will be expanded to MCH. The USG will train providers to make timely referrals.

3. *Improved use of government social security schemes:* Thirty-five percent of Cambodians are registered as poor.[xvii] The cost of services and transport, particularly for critical, emergency care services, can be the one determining factor in whether a woman decides to seek more specialized services. The USG helped to spearhead the first HEF model that covers direct health care costs, medications for the poor, and reimbursement for transport. In the areas where HEF was implemented the number of women receiving ANC and childbirth services at hospitals and health centers increased substantially. The RGC recently announced that the insurance scheme will be offered in every health center and hospital in the country. The cost, estimated at approximately $8-9 million, will be borne by the government and other donors. The USG will help by monitoring the effectiveness of the model as it is expanded to all 77 districts.

The GHI principles – using information systems to provide comprehensive services, increasing access for women and girls, and building on multilateral and other bilateral programs – will expedite our ability to expand access to quality health care.

Intermediate Result 2 (Focus Area 2): Improved health systems

Improving maternal and neonatal health depends on a well-performing health care delivery system. In order to accelerate progress, the USG will prioritize activities in the following areas:

1. *Improved policies and guidelines:* Although Cambodia has endorsed a number of important MNH guidelines and policies, leaders have been slow to revise policies related to accessing services. For example, family planning is not provided at referral hospitals and Safe Motherhood Guidelines for hospitals that would define how services are delivered for women with PPH are still not finalized. Under GHI the USG will increase its advocacy efforts on FP to educate policy makers on the importance of FP in reducing maternal deaths.

In the next five years, policies and standard operating procedures will need to be updated as new technologies and medications are developed, and the capacity of the health system changes. The USG has had significant success in shaping current Government policies. Through GHI, USAID and US-CDC will work with the MOH to update policies and guidelines to improve MNH services.

2. Improved capacity and performance of health care providers to deliver quality services: The USG team will build on PEPFAR's experience in training and mentoring public health leaders and providers at hospitals, laboratories, and health centers. The USG will improve the supply and quality of midwives as well as train other cadres, such as medical assistants, that are essential for improving emergency maternal and neonatal services. For

example, the USG will work with the MOH to:

- improve pre-service and in-service education for midwives and physicians ensuring that the curriculum reflects the current guidelines of the MOH, new technology, and international best practices;
- conduct practical rotations during pre-service education in well-performing hospitals;
- strengthen provision of FP and improve counseling skills to dispel myths about long-term methods of family planning;
- strengthen supervision by referral hospital, operating district, and provincial health department officers to providers after training is completed to build confidence and ensure that providers are performing to expectations;
- develop and implement a health coverage plan that will help rationalize the placement of staff/services, and;
- develop quality control standards for private clinics, in partnership with the Cambodia Medical Association and MOH.

3. Improved quality of infrastructure and facilities: The RGC has developed a long term plan to renovate and equip health facilities to meet quality standards required to provide basic and EmONC services. The USG will channel DOD experience and resources to direct new construction projects in areas where other USG activities are implemented and where the RGC has identified infrastructure needs.

The US-CDC, DOD, and USAID, through PEPFAR, currently renovate laboratories and upgrade hospitals to organize out-patient, in-patient, and critical care services more efficiently. Under GHI, the renovations will be coordinated and planned jointly so that the entire hospital is upgraded, rather than just one component.

4. Improved collection and use of information for program planning and learning: Cambodia's GHI strategy will strengthen existing information systems to monitor the progress of FTI and to improve allocation of health sector resources. Under PEPFAR, the USG successfully used monitoring systems to quickly identify underachieving sites when new initiatives were being introduced and scaled-up. This same monitoring system will be used to track the effectiveness of new maternal and neonatal health interventions. The most extensive system for routinely-reported health service data in the public sector is the HMIS. Under GHI, the USG will:

- expand the HMIS system to monitor progress on reducing maternal and neonatal morbidity and mortality;
- integrate service delivery and health data contained in the HMIS, with commodities and human resources data to improve resource allocation based on patient load and services, and;
- start collecting delivery statistics in private sector hospitals through the HMIS.

Intermediate Result 3 (Focus Area 3): Increased demand for quality health services

Community and individual beliefs and behaviors can lead to poor health practices and discourage a woman from seeking critically-needed services. The USG will work with people who have the greatest influence on whether or not a woman adopts good health behaviors, such as peers, health care providers, VHSGs, and local/district government councils. Areas of engagement are described below.

1. Increasing knowledge and adoption of good health practices: Through GHI, the USG will place PCVs in areas where the USG has other activities to educate communities about positive health behaviors for themselves and their newborns. USAID and Peace Corps will train VHSG volunteers to provide accurate health information on pregnancy, delivery, post-natal care, and FP. Feed the Future programs will link agricultural extension workers with VHSG volunteers to promote breastfeeding, iron supplements for pregnant women and consumption of vitamin-rich foods. USAID will expand current programs which use private sector pharmacies and shops to provide FP information and products.

2. Increased community engagement in the delivery of health services: Community leaders, HCMCs, and commune councils (elected officials) are expected to take an active role in health care delivery in their communities. Through GHI, USAID partners and PCVs will work in the same communities engaging with commune councils and HCMCs. They will assist commune councils and local community bodies to take the lead in tracking pregnancies, live births and maternal and neonatal deaths. Community leaders will promote healthy behaviors through encouragement by USG partners and PCVs.

Improving the quality and use of health services will result in more women seeking health services and lead to faster impact on maternal and neonatal mortality.

IV. Approaches that Demonstrate GHI Principles

Through the GHI planning and strategy development process, the USG identified GHI principles already in use and those that it will incorporate going forward:

Strategic integration: US-CDC and USAID, through PEPFAR, fund HIV counseling and testing sites, STI clinics, and services for PLHIVs. A critical gap in FP services exists for EWs and PLHIVs, who encounter stigma in regular public sector services. GHI creates an opportunity to bring FP, HIV, and STI services together to address unmet FP needs among marginalized groups. Additionally, integrated services under one roof reduce the number of women who are "lost to follow-up" and never receive the services for which they were referred.

Referral and transport systems established through PEPFAR will be used for pregnant women who need emergency services. PCVs will provide ongoing mentorship to USAID-trained village health volunteers in locations where both are working.

Capitalizing on multilateral/bilateral and Health Sector Support Program (HSSP 2)[xviii] resources: The USG uses its technical expertise and flexibility in funding to develop and test activities and new approaches. This has been extremely useful in the PEPFAR program, given the relatively modest levels of USG funding compared to resources of the Global Fund, and the pooled

donors. The USG will advocate with other donors under GHI to expand HEFs and performance-based contracting.

Monitoring and evaluation to enhance data-driven decision making and accountability: The HMIS collects nationwide service delivery data and is envisioned to incorporate human resource, pharmaceutical, and private sector data. The USG will continue to work with the government to use information from the HMIS to monitor programs and make annual planning and budget decisions.

Country ownership: The GHI strategy is planned around the RGC FTI. Indicators and targets of the GHI strategy are consistent with those identified in the FTI.

V. Women and Girls and Gender Equality (WGGE) through GHI

A Gender Assessment conducted in 2010 pointed out a number of key barriers to women.[xix] There are still too few qualified women in all sectors and institutions, including among elected officials, in the justice system, in academia and as civil servants. Cambodian society remains patriarchal and hierarchical to a large extent with strong traditional norms that assign higher status to men and marginalize women who are not married. Traditional belief systems that suggest the "proper" roles for men and women have a strong influence on women in leadership roles in society and other dimensions of women's and men's daily lives and opportunities. More men than women work in the formal sector due to gender differences in educational attainment and beliefs concerning suitable employment for women and men. Women make up the majority of the agricultural workforce and own nearly two-thirds of micro/small/medium enterprises. Yet, women have less access to inputs including credit, technologies and market information. While there is near gender parity in primary school enrollment, girls are more likely than boys to drop out of school. Fifteen percent of women in a recent study on domestic violence said they missed work or lost income as a result of violence. Although fewer people find violence acceptable, more than half of the general population believes that violence is acceptable if a woman is disrespectful or argumentative.[xx]

USG programs address a number of the barriers highlighted in the gender assessment and identified as key elements in the WGGE guidance. Activities described below will be continued, and other activities modified to end barriers based on gender. Recommendations from the 2010 gender assessment, data from the 2010 CDHS, and sex-disaggregated data from the government HMIS will inform program changes. Analysis of barriers related to gender will be applied and incorporated into all new designs.

Empowering girls through social networks and educational opportunities: Cambodia is strengthening girls' education opportunities through two programs implemented by USAID's Improving Basic Education in Cambodia Project. The "Girls' Counselors and Peer Support Network" provides support to at-risk girls by linking school administrators with parents to convince them to keep their daughter enrolled in school. In the "Life Skills for Girls at Risk" project, schools organize special life skills classes that target girls with histories of dropout and poor attendance. Some topics, such as cooking and sewing, are deliberately geared to get the

attention of parents, while other topics incorporate budgeting, team work, and problem solving.

The Peace Corps, through the Girls Leading Our World Program, empowers adolescent girls by building self-esteem, self-confidence and awareness and eventually increases skills in career and life planning. GHI will build on these areas.

Ensuring equitable access to health services: The USG funds programs that make transportation available for women during delivery, either through HEFs or through Commune Investment Plans[xxi] operated by local elected leaders. HIV programs also ensure access to opportunistic infection/anti-retroviral treatment (OI/ART) and social services by covering transportation costs. These transportation schemes will be expanded and made available to pregnant women. To address stigma that PLHIVs or EWs experience when using mainstream public sector health services, the USG integrates voluntary FP services into STI and OI/ART sites.

Through PEPFAR, the USG implements Smart Girl clubs for women in the entertainment business. These clubs provide a support network to women and serve as a trusted source of advice, linking women to STI, FP, and other health services.

Engaging men and boys as role models: The USG is using an innovative televised entertainment-education program called "You're the Man" to engage men and boys as role models for gender equality. The program features challenges that reward individuals who make healthy choices pertaining to HIV/AIDS and other risks, and who model respect for the interests of women and girls. The USG-funded research demonstrated a positive correlation between supportive attitudes of men toward contraception and increased FP use. Media campaigns have been implemented that promote engagement of men in FP decision making. Through the DOD, the USG will explore possibilities for promotion of positive gender norms, using uniformed service personnel as models and teachers. Further, there may be opportunities to promote positive gender norms through current healthy workplace activities conducted in garment factories.

Community-level approaches: The USG is using different approaches at the community level to improve health for women and girls. The Reproductive Health Association of Cambodia (RHAC) operates 18 clinics and trains VHSG volunteers to convey health information and link women to services. The Reproductive and Child Health Alliance of Cambodia (RACHA) engages commune councils and HCMCs to allocate greater resources to health care delivery. They are also helping to establish micro-finance "savings" groups that set aside money for health care emergencies, such as delivery.

PCVs will work with VHSG volunteers, community elected leaders and HCMC's to respond to community problems, particularly those rooted in negative gender stereotypes.

VI. Monitoring, Evaluation and Learning

The monitoring and evaluation (M&E) framework for GHI will track progress on the three focus areas and GHI outcome indicators for maternal health, child health, FP, HIV, TB, and nutrition.

The GHI team will use headquarter-developed indicators, as well as country-level indicators included in the RGC's HSP-2 and FTI. Because most of the USG resources support public sector service delivery, USG PEPFAR and Investing in People indicators already match the indicators used by RGC MOH. GHI will be able to track the progress of indicators by gender and age, since the data are already disaggregated.

The HMIS collects monthly data from service delivery sites.[xxii] For community-level data, USG implementing partners will collect information through annual surveys. These surveys will be harmonized as much as possible with the CDHS, which is carried out every five years. The 2010 CDHS will serve as the primary baseline for GHI output, outcome, and impact indicators on maternal and newborn health. Success will be measured through improvements in skilled birth attendance, contraceptive prevalence rate, and ANC coverage. These indicators align with those included in HSP-2 and the FTI. The 2015 CDHS will be used to monitor the impact of GHI.

The USG will strengthen the MOH's capacity at the national and provincial level to collect and use data to make resource and programming decisions. The success of GHI will rely on continued RGC/MOH commitment and leadership to improve the quality of health services and maintenance of USG, Global Fund, and other donor resources at currently-projected levels.

VII. Cambodia's Learning Agenda

The GHI learning agenda will test and evaluate service delivery models to identify solutions that can reduce maternal and newborn death. This approach applies GHI principles of research and innovation and the USAID Forward priority of enhanced monitoring and evaluation. The USG will:

Identify the optimal package of FP services for Cambodia: FP is being provided through community-level workers in the private sector and in public sector clinics. There is duplication in some of the services provided. Under GHI, the USG will use partner reporting systems, the RGC MOH reporting systems, and special studies in five provinces to determine the optimal package of services for the best results.

Assess whether routine outreach activities for immunization can be used to provide additional services like nutrition support, ANC, post-natal care, and FP to communities that don't have easy access to health facilities: USAID/Cambodia funds partners that facilitate immunization outreach to remote communities. US-CDC works with the NIP to increase immunization coverage. USG will work with the NIP to expand the services offered at routine outreach immunization events. Data from annual community-based surveillance surveys carried out by USG partners and the routine government HMIS system will be used to monitor the activities.

Conduct a maternal mortality study to determine where and under what circumstances maternal deaths are occurring: Given the weakness in the existing RGC reporting systems, there is concern that a large number of maternal deaths are occurring "outside" the reach of both the health and RGC administrative systems. The government has noticed, for example, that

despite extremely high measles immunizations rates, outbreaks still occur. This indicates that government immunization programs are not reaching certain populations. Similarly, it is likely that maternal deaths happening outside the system are not reported. Another study of maternal mortality will be carried out targeting migrants and marginalized populations living in floating villages and emergent unregistered villages.

Assess different referral systems and their effectiveness in successfully linking women requiring emergency obstetric care to those services.

Determine the prevalence, severity, and causes of anemia in pregnant women through a combined medical record and extensive lab-based screening for known causes of anemia: The study, conducted with the National Maternal and Child Health Center will inform the extent, causes, and possible interventions for maternal anemia. The US-CDC and DOD will assist the MOH to update the National Blood Transfusion Strategy based on the results.

Where feasible, data will be triangulated using existing USG and RGC monitoring and evaluation and survey data. The USG will partner with RGC on all studies to increase learning and the likelihood that study results will be reflected in changed policies and practices.

The USG will consult with the RGC MOH and other donors to refine the focus, methodology, and implementation of the GHI Learning Agenda. Early engagement with all relevant participants will lead to greater acceptance of the study findings and allow for rapid expansion of the most promising interventions.

VIII. Communications and Management Plan

Existing USG forums such as the PEPFAR interagency team, the CMWG, and the Health/LMI Working Group will be used to improve coordination and enhance GHI implementation. These forums allow respective USG agencies to present concepts for activities to determine if they fit into USG objectives and RGC priorities. US-CDC and USAID are actively involved in each of these interagency groups and, in the case of PEPFAR and the Health/LMI group, function as chair. USAID/Health and the US-CDC were physically co-located in 2010 to improve coordination and integration on HIV/AIDS, MCH/FP, and TB.

GHI implementation will be carried out in close collaboration with the RGC and in consultation with other donors. The HSP-2 is coordinated by the Technical Working Group for Health (TWGH) and its Secretariat. The USG will continue to be integral in the TWGH which meets monthly and is chaired by the MOH and Co-Chaired by the Lead Donor Facilitator. There are also Health Partner meetings and numerous sub-technical working groups where the USG is an active member. The USG participates in the Joint Annual Appraisal Review where the RGC annually takes stock of the progress made in the health sector.

The USG will continue to engage with key partners, including civil society, professional associations, and the private sector. The USG works directly with three Cambodian NGOs and, through sub-agreements, with more than forty local civil society organizations. The USG collaborates with Microsoft on education and the local private sector through its health

programs. Progress made in executing GHI will be integrated into existing monthly meetings with USG implementing partners.

The USG also collaborates on health related activities with the Cambodian Ministry of National Defense, Ministry of Women's Affairs, Ministry of Interior, Ministry of Education, and the Ministry of Social Affairs, Veterans and Youth Rehabilitation.

IX. Linking High-level Goals to Programs

Management systems: The USG will use the work plan review process to focus implementing partner activities on the GHI Cambodia goals. Partners will describe GHI activities in their work plans and the expected achievements as a result of using GHI principles. Semi-annual reports will also describe how the GHI process helped to achieve results.

In the next six months, the USG will explore opportunities to work through USAID's education program to address gender barriers, specifically to:

- create opportunities amongst in- and out-of-school adolescent girls and boys to address negative gender norms;
- expand current community networks that assist adolescent girls to stay in school, and;
- combine expertise from USG education and health projects with PCVs to develop a curriculum that addresses health and gender issues.

The Health/LMI USG interagency working group will develop a schedule of future activities organized by agency, following the model developed by the CMWG. Agencies will plan their activities to take advantage of projects being implemented by other USG agencies.

For GHI implementation the USG will build on the existing PEPFAR working group, which includes representation from USAID, US-CDC, Peace Corps, DOD and State. The working group will meet on a regular basis to ensure transparency, good coordination, and better planning. When relevant, USG implementing partners will participate to enhance coordination. The working group will develop a GHI implementation plan that identifies short and longer term joint activities.

As new projects are designed or evaluated, particularly on maternal and neonatal health, USAID (the most likely agency to be leading a design) will engage US-CDC, and when relevant, DOD and Peace Corps. New projects developed by the implementing agencies will incorporate GHI principles. For example, USAID's upcoming HIV/AIDS project that is being developed will address women, girls and gender equity.

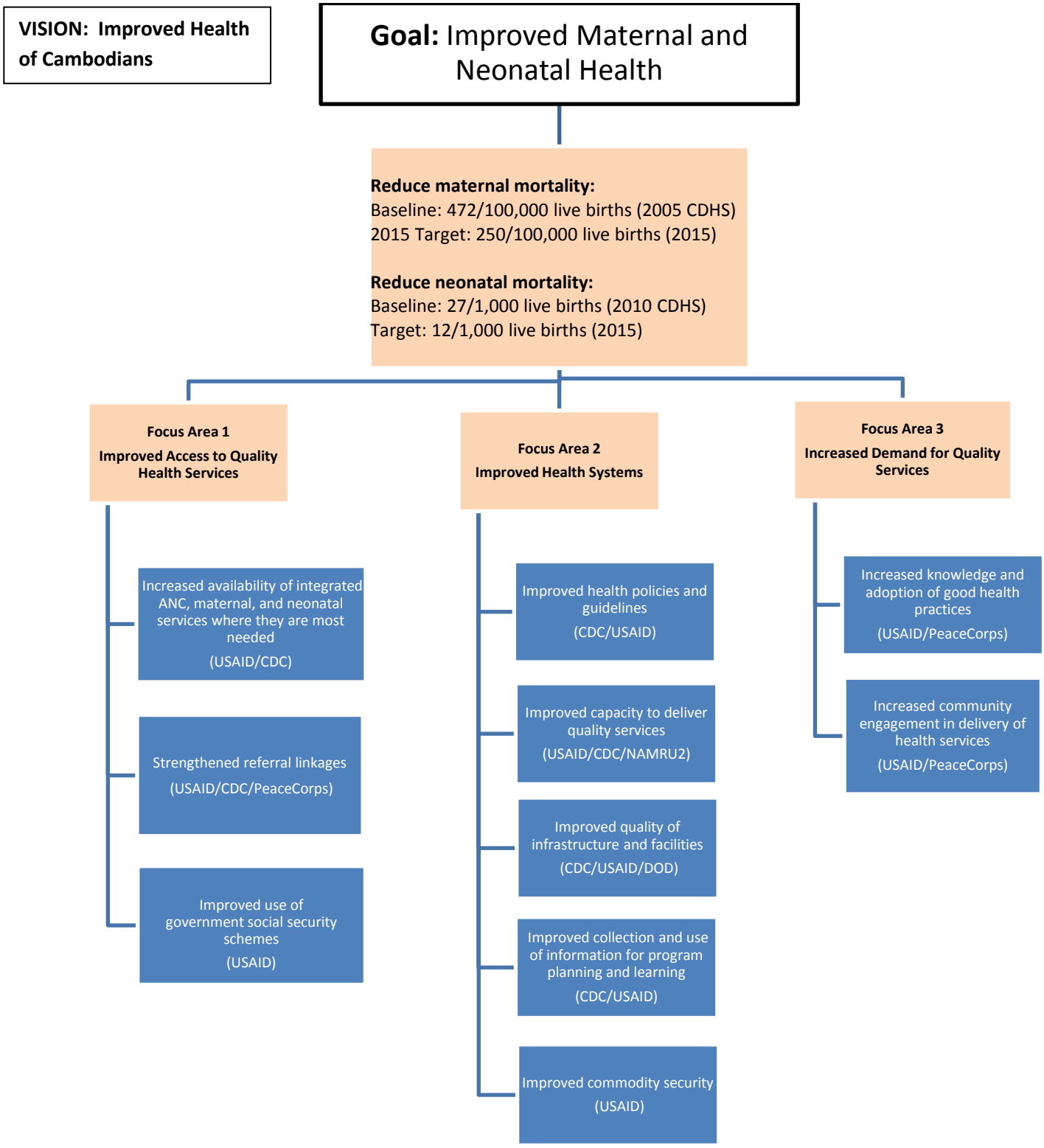
Strategic coordination: Over the next year, US-CDC and the RGC plan to conduct a study on anemia testing in hospital wards. Based on the results, USAID implementing partners will introduce the new anemia testing protocol in their program areas. USAID and US-CDC will use their respective channels to advocate for adoption of this and other new protocols and standard operating procedures.

The USG will organize technical meetings for partners to share their experiences and learn from one another. US-CDC and USAID will continue to collaborate on activities to improve the use of health information systems and surveillance data at the local and national levels.

GHI and external communication: The USG will advocate for a larger role amongst donor partners who have decision making authority over the use of HSSP- 2 funds. USG interventions that have proven to be successful could be expanded beyond where the USG is working through RGC and other donor funds.

The USG will develop GHI communication materials, including a one-page summary document of GHI/Cambodia and a PowerPoint presentation that can be used to brief high-level visitors and USG constituents on GHI in Cambodia.

Cambodia Global Health Initiative Strategic Framework



GHI Principles: Focus on woman, girls, and gender equality; Encourage country ownership and invest in country-led plans; Build sustainability through health systems strengthening; Strengthen and leverage key multilateral organizations, global health partnerships and private sector engagement; Increase impact through strategic coordination and integration; Improve metrics, monitoring and evaluation; Promote research and innovation

Cambodia Global Health Initiative (GHI) Strategy Matrix

GHI Goal: Maternal Health • Reduce maternal mortality by 30% across assisted countries		
Baseline Info/country specific-target (year, data source): **Maternal deaths per 100,000 live births:** Baseline: 472 (2005 Cambodia Demographic Health Survey [CDHS]) Target: 250 (2015, CDHS) **Proportion of women delivering with a skilled birth attendant:** Baseline: 58% (2008, Health Information System [HIS])) Target: 80% (2015, HIS) **Proportion of women attending two or more ANC consultations:** Baseline: 81% (2008, HIS) Target: 90% (2015, HIS)	**Key Priority Actions likely to have the largest impact:** **Increased Access** -Assist the Royal Government of Cambodia (RGC) to expand the government social security scheme that provides free Emergency Obstetric and Newborn Care (EmONC) and caesarian sections (C-sections). -Test different emergency referral and transport models. -Use the National Center for HIV, AIDS, Dermatology and STD (NCHADS) Linked Response platform to provide comprehensive, high quality antenatal care (ANC) to identify high-risk pregnancies. -Develop a health coverage plan with RGC to rationalize the placement of staff/services so that EmONC and C-sections are widely available. -Use electronic referral system to ensure continuity of care. **Improved Health Systems** -Test performance-based incentive schemes to	**Key GHI Principles:** **Women and Girls** -The GHI strategy targets women and reduces barriers that negatively affect women's health. **Strategic Integration** -Proactive coordination with USG partners to deliver maternal health services better. -US-CDC and USAID will test and advocate for new maternal health approaches. -With DOD funds, assist the RGC to equip and upgrade health clinics to provide basic EmONC services. **Country Ownership** -Alignment with RGC Fast Track Initiative Road Map (FTIRM, referred to as FTI) for Reducing Maternal and Newborn Mortality (2010-2015). -Reducing maternal mortality is a high priority of the RGC. **Health Systems Strengthening** -Train and mentor providers on key EmONC interventions. -Work with RGC to order and ensure supply of oxytocin and MgSulfate. -Test performance-based incentive schemes to link payment to quality service delivery. -Assist RGC to expand Health Equity Funds (HEF) to provide free emergency services (C-sections, EmONC) and referral transport. -Finalize Safe Motherhood Protocols for hospitals. -Assist commune councils and health center management

Cambodia Global Health Initiative (GHI) Strategy Matrix

Number of women receiving Active Management of Third Stage of Labor (AMSTL) through USG-supported programs: Baseline: 98,833 (2010, HIS) Target: 150,000 (2015, HIS) **Proportion of deliveries by C-section:** Baseline: 1.8% (2008, HIS) Target: 4% (2015, HIS)	link payment to quality service delivery. -Improve performance of public and private health care providers through pre- and in-service training, supervision and mentoring. -Upgrade hospitals and clinics to meet EmONC standards, using U.S. Department of Defense (DOD) humanitarian assistance funds with technical support from USAID and U.S. Centers for Disease Control and Prevention (US-CDC). -Finalize Safe Motherhood Protocols for hospitals. -Work with RGC to order and ensure supply of oxytocin and Magnesium Sulfate (MgSulfate). -Improve safe blood supply and access through US-CDC, RGC and DOD. -Strengthen maternal death surveillance system to understand factors leading to maternal death. **Increased Demand for Quality Services** -Train village health support group (VHSG) volunteers through Peace Corps Volunteers (PCV) and USAID partners to improve individual, family and community care practices before and during pregnancy, childbirth, and postpartum. -Engage community leaders in maternal death "audits" to understand causes of deaths. -Educate adolescent girls about reproductive health.	committees (HCMC) to ensure pre-paid, pre-arranged emergency transport. **Learning and Accountability through Monitoring and Evaluation** -GHI will use same indicators and targets as those in RGC country strategies to measure achievements. -Use data through health information management systems and maternal death "audits" to make resource and programmatic decisions. **Leverage other efforts** -Use RGC and donor funds through the Cambodia – Second Health Sector Support Project (HSSP 2) to expand insurance models that increase access to high-cost services.

Cambodia Global Health Initiative (GHI) Strategy Matrix

Key Partners: National Maternal, Neonatal and Child Health (NMNCH) Department, Ministry of Health (MOH); National Center for HIV/AIDS, MOH (NCHADS); Population Services International (PSI); The Reproductive and Child Health Association (RACHA); The Reproductive Health Association of Cambodia (RHAC); University Research Corporation (URC); Support for International Family Planning Organizations, Marie Stopes International (SIFPO-MSI); The United Nations Children's Fund (UNICEF); The United Nations Population Fund (UNFPA); Japan International Cooperation Agency (JICA); The Australian Agency for International Development (AusAID); The Second Health Sector Support Project (HSSP2).		
Relevant Key National Priorities/Initiatives: FTI: -Objective: To contribute to the achievement of Cambodia's MDG-5 target of less than 250 deaths per 100,000 live births by 2015. MOH's Health Strategic Plan, 2008-2015 (HSP-2): -Reduce maternal, newborn and child morbidity and mortality with increased reproductive health.		

Cambodia Global Health Initiative (GHI) Strategy Matrix

GHI Goal: Child Health • Reduce under-5 mortality by 35% across assisted countries		
Baseline Info/country specific-target (year, data source): **Number of deaths of neonates per 1,000 live births:** Baseline: 27 (2010, CDHS) Target: 22 (2015, CDHS) **Number of cases of child diarrhea treated in USAID-assisted programs:** Baseline: 624,745 (2010, HIS) Target: 1,000,000 (2015, HIS) **Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs:** Baseline: 157,494 (2010, HIS) Target: 300,000 (2015, HIS)	**Key Priority Actions likely to have the largest impact:** **Increased Access** -Test different emergency referral and transport models. -Assist the government to expand the government social security scheme to provide free neonatal care services and emergency transport. **Improved Health Systems** -Improve performance of public and private providers on newborn resuscitation and essential newborn care through pre- and in-service training, supervision and mentoring. -Assist the RGC to upgrade hospitals and strengthen EmONC services. -Upgrade hospitals and clinics to meet EmONC standards, using DOD humanitarian assistance funds with technical assistance from USAID and US-CDC. **Increased Demand for Quality Services** -Educate communities and women through PCVs and USAID partners about the importance of post-natal care visits, immunizations, and	**Key GHI Principles:** **Strategic Integration** -Through PCVs and USAID partners, educate communities and women about importance of post-natal care visits, immunizations, and exclusive breastfeeding. -With DOD funds, assist the RGC to equip and upgrade health clinics to provide emergency obstetric and newborn care services. **Country Ownership** -GHI interventions and goals align with FTI and HSP-2. **Health Systems Strengthening** -Improve performance of health care providers on newborn resuscitation and essential newborn care. -Assist RGC to expand health equity funds (HEFs) to provide neonatal care services and emergency transport free of charge. -Finalize Safe Motherhood Protocols for hospitals. -Assist commune councils and HCMCs to ensure pre-paid,

	breastfeeding.	pre-arranged emergency transport. -Assist the RGC to upgrade hospitals and strengthen EmONC services. **Learning and Accountability through Monitoring and Evaluation** -GHI will use the same indicators and targets as those in RGC country strategies to measure achievements.
Key Partners: NMNCH Department, MOH; National Immunizations Program (NIP); Global Alliance for Vaccines Initiative (GAVI); Global Alliance for Improved Nutrition (GAIN); RACHA; UR; World Health Organization (WHO); RHAC; UNICEF; Save the Children; HSSP 2.		
Relevant Key National Priorities/Initiatives: <u>From HSP-2:</u> -Integrated Management of Childhood Illnesses. -Essential pediatric care. -Adolescent / Youth health. -Key family practices. <u>From the Child Survival Strategy (CSS):</u> -Improving coordination, planning and policy formulation. -Strengthening human resources and capacity building. -Promoting community action for child survival. -Ensuring health care financing for child survival. -Improving efficiency and quality in service delivery. -Strengthening monitoring and evaluation.		

Cambodia Global Health Initiative (GHI) Strategy Matrix

GHI Goal: Family Planning and Reproductive Health

- Reaching a modern contraceptive prevalence rate of 35 percent across assisted countries.
- Reducing from 24 to 20 percent the proportion of women aged 18-24 who have their first birth before age 18.

Baseline Info/country specific- target (year, data source):	**Key Priority Actions likely to have the largest impact**	**Key GHI Principles:**
Total Fertility Rate: Baseline: 3.0 (2010, CDHS) Target: 2.8 (2015, CDHS) **Contraceptive prevalence rate (CPR):** Baseline: 35% (2010, CDHS) Target: 60% (2015, CDHS) **Unmet need for family planning:** Baseline: 25% (2005, CDHS) Target: 18% (2015, CDHS)	**Increased Access** -Integrate family planning (FP) and other maternal child health (MCH) services, namely post-natal care and immunizations. -Integrate FP counseling and service delivery into sexually transmitted infection (STI) clinics and opportunistic infection (OI)/anti-retroviral (ART) treatment clinics, targeting entertainment workers (EW) and people living with HIV/AIDS (PLHIV). -Advocate with RGC to cover the cost of FP services under the HEF. **Improved Health Systems** -Advocate with RGC to change the policy that referral hospitals cannot provide family planning. -Ensure supply of commodities, addressing funding, ordering and logistics issues.	**Women and Girls** -Address unmet need of EWs and female PLHIVs for FP. -Address unmet need for long-term FP methods. **Strategic Integration** -Train HIV service providers to counsel and refer clients for FP services. -Strategically integrate MCH/FP and HIV services for a "one-stop shop" approach. -Train VHSGs with USAID and PCVs to provide accurate health information on FP. **Country Ownership** -Advocate with national and provincial leaders to promote FP as a key intervention for reducing maternal mortality. -GHI interventions and goals align with FTI and HSP-2.

Cambodia Global Health Initiative (GHI) Strategy Matrix

	-Improve skill and performance of public and private sector providers to insert intra-uterine devices (IUD) and implants. -Improve infrastructure of facilities (e.g. privacy) to insert IUDs and implants. **Increased Demand for Quality Services** -Train community-based distributors (CBD) and health clinic providers to counsel women on FP, particularly to address myths. -Advocate for policy that pays some remuneration for CBDs as key providers of short-term FP methods. -Train PCVs to counsel and promote FP. -Advocate with Parliamentarians and high-level policy makers about the importance of FP to reducing maternal mortality.	**Health Systems Strengthening** -Assist RGC to forecast, order, and procure contraceptives. -Provide practical training for midwives and physicians to improve performance, particularly for IUDs and implants. -Strengthen FP counseling skills of community-based and clinic providers. -Develop a health coverage plan with RGC to rationalize the placement of staff/services so that FP services are widely available. -Fund small renovations or purchase needed supplies for health centers and hospitals where there are gaps in FP service delivery. -Advocate with RGC to change the policy that referral hospitals cannot provide family planning. **Learning and Accountability through Monitoring and Evaluation** -Collect FP data from PSI and private clinics funded by USG and incorporate into HMIS. -GHI progress and achievements will use same indicators and targets as those in RGC country strategies. **Leverage other efforts** -Work with other donors (AusAID and UNFPA) to ensure commodity supply and build government capacity to order, procure and distribute FP commodities.

Cambodia Global Health Initiative (GHI) Strategy Matrix

Key Partners: NMNCH Department, MOH; NCHADS, MOH; *Kreditanstalt für Wiederaufbau (*KfW); RHAC; RACHA; URC; SIFPO-MSI; PSI; Family Health International (FHI); Khmer HIV/AIDS NGO Alliance (KHANA); UK Department for International Development (DfID); UNFPA.		
Relevant Key National Priorities/Initiatives: <u>From the National Strategy for Reproductive and Sexual Health:</u> -To improve the policy and resource environment. -To increase availability and strengthen delivery of quality services. -To improve community understanding. -To increase demand for serves and expand the evidence base for policy and strategy development.		

Cambodia Global Health Initiative (GHI) Strategy Matrix

<table>
<tr><td colspan="3">GHI Goal: Nutrition

• Reduce child under nutrition by 30% across assisted food insecure countries, in conjunction with the President's Feed the Future Initiative (FTF).</td></tr>
<tr><td>Baseline Info/country specific-target (year, data source):

Proportion of children under 5 underweight:

Baseline: 28% (2010, CDHS)

Target: 20% (2015, CDHS)

Proportion of children under 5 with chronic malnutrition (stunting):

Baseline: 40% (2010, CDHS)

Target: 28% (2015, CDHS)

Proportion of children under 5 wasted:

Baseline: 11% (2010, CDHS)

Target: 8% (2015, CDHS)

Percentage of children under six-months of</td><td>Key Priority Actions likely to have the largest impact

Increased Access

-Introduce fortified foods for children (e.g., "Sprinkles").

-Mobilize community members to come for vitamin A distribution.

-Increase access to Aquatabs (water purification tablets) through the private sector.

Improved Health Systems

-Increase the number of nutritionists in Cambodia by creating a Master's Degree nutrition program.

-Advocate with RGC to introduce growth monitoring in communities and at health centers.

Increased Demand for Quality Services
-PCVs and USAID partners train community-level workers to counsel and provide information on correct nutrition behaviors, e.g. complementary feeding, exclusive breastfeeding, care of sick child,</td><td>Key GHI Principles:

Women and Girls

-Target women for nutrition education provided at the community level.

Strategic Integration

-Integrate health and education activities to increase awareness of good hygiene in schools.

-PCVs and USAID partners teach community members about good nutrition.

-Link with USG Feed the Future program to reduce malnutrition in children.

Country Ownership

-Advocate for incorporation of "Sprinkles" into national policy, based on USG-funded operations research.</td></tr>
</table>

age exclusively breastfed: Baseline: 74% (2010, CDHS) Target: 90% (2015, CDHS)	treatment of diarrhea/acute respiratory infection (ARI), hygiene and sanitation. -Promote hygiene and sanitation in schools and provide water filters and tanks to reduce diarrheal disease.	
Key Partners: National Nutrition Program, MOH; WHO; National Institute of Public Health (NIPH); UNICEF; RACHA; RHAC; URC; International Relief and Development (IRD); USG Feed the Future Initiative.		
Relevant Key National Priorities/Initiatives: <u>From HSP2 and the National Nutrition Strategy (2008-2015):</u> -To contribute to improved maternal and child survival, and better nutritional status of women and children.		

Cambodia Global Health Initiative (GHI) Strategy Matrix

GHI Goal: HIV

- Support the prevention of more than 12 million new infections.
- Provide direct support for more than 4 million people on treatment.
- Support care for more than 12 million people, including 5 million orphans and vulnerable children.

Baseline Info/country specific-target (year, data source):	**<u>Key Priority Actions likely to have the largest impact:</u>**	**Key GHI Principles:**
HIV prevalence: Baseline: .8 (2010) 2011 Estimation meeting, NCHADS) Target: <.6% (2015, HSS) **Number in care:** Baseline: 53,100 (adults 15+ in 2011, from the 2007 HIV consensus estimates) Target: 45,135 (2015, HIV consensus estimates) **Number in treatment:** Baseline (estimated): 46,500 (Quarter 2, 2010 -350 CD4 count) Target: 39,525 (2015, NCHADS program	**Increased Access** -Expand and strengthen the Continuum of Care (CoC) for adults and children living with HIV at operational district (OD) level. -Improve coverage of Continuum of Prevention to Care and Treatment (CoPCT) services for MARPs. -Address stigma amongst health care providers to reduce barriers to accessing services. -Refer MARPS from health to non-health services. -Establish MARPs-friendly services that ensure access to birth spacing, opportunistic infection/antiretroviral treatment clinics, and HIV and STI care sites for MARPs. -Integrate STI care and treatment services for the general population, MARPs and PLHIV at the referral hospital and STI care and treatment services at health centers. **Improved Health Systems**	**Women and Girls** -Interventions target women who are solicited for commercial and transactional sex. **Strategic Integration** -Integrate FP with HIV in STI clinics and in OI/ART services to meet needs of EWs and PLHIVs. **Health Systems Strengthening** -Strengthen the quality of services (CoC and CoPCT) provided through the government's service delivery system. **Learning and Accountability through Monitoring and Evaluation** -Use RGC surveillance systems to track HIV prevalence in

Cambodia Global Health Initiative (GHI) Strategy Matrix

data) **Number of the most-at-risk population (MARPS) group members provided with comprehensive package of prevention, care, and treatment services:** *Entertainment Workers (EW):* Baseline: 16,483 (GHI implementing partner program data) Target: 20,000 (2015, GHI implementing partner program data) *Injecting drug users (IDU):* Baseline: 1,113 (2010, GHI implementing partner program data) Target: 1,000 (2015, GHI implementing partner program data)	-Build the capacity of health staff in the CoC. -Establish and implement models for palliative care and nutrition support for PLHIV. -Ensure the use of strategic information for decision-making through HIV monitoring and evaluation, including impact. **Increased Demand for Quality Services** - Improve peer support activities for people living with HIV/AIDS (PLHIV).	the general population and amongst high risk groups. -Test a unique identifier system to track patients across different services to prevent drop outs and to ensure full access to care.
Key Partners: NCHADS, MOH; The Department of Planning and Health Information (DPHI), MOH; The National AIDS Authority (NAA); FHI; KHANA; PSI; RACHA; RHAC; URC; WHO; The Joint United Nations Programmed on HIV/AIDS (UNAIDS); The Global Fund for AIDS, Tuberculosis, and Malaria (GFATM).		
Relevant Key National Priorities/Initiatives: <u>From the NCHADS Strategic Plan III (draft):</u> -To reduce the HIV prevalence rate to between 0.6 and 0.9%.		

Cambodia Global Health Initiative (GHI) Strategy Matrix

-To increase survival of People Living with HIV/AIDS in Cambodia to more than 85%.

-To ensure that NCHADS and provincial programs, including OD activities, are cost-effectively managed.

From the NAA NSP3:

-To reduce the number of new HIV infections through scaled targeted prevention.

-To provide care and support to people living with and affected by HIV and AIDS.

-To alleviate the socioeconomic and human impact of AIDS on the individual, family, community and society.

-Increase coverage and quality of comprehensive and integrated treatment, care and support services addressing the needs of a concentrated epidemic.

Cambodia Global Health Initiative (GHI) Strategy Matrix

<table>
<tr><td colspan="3">GHI Goal: Tuberculosis (TB)

• Save approximately 1.3 million lives by treating a minimum of 2.6 million new TB cases and 57,200 MDR cases of TB, contributing to a 50 percent reduction in TB deaths and disease burden</td></tr>
<tr><td>Baseline Info/country specific-target (year, data source):

Estimated prevalence of TB per 100,000 population:

Baseline: 693 (2009. WHO Cambodia TB profile)

Target: 626 (2015. WHO Cambodia TB profile)

TB mortality rate per 100,000 population:

Baseline: 91 (2011. WHO Cambodia TB profile)

Target: 87 (2015. WHO Cambodia TB profile)

Percentage of health centers (HC) with community-based directly observed treatment, short course (CDOTS):

Baseline: 71% (2009, National Center for</td><td>Key Priority Actions likely to have the largest impact

Increased Access

-Expand CDOTS to improve the percentage of TB cases identified.

-Train private sector pharmacies and labs to refer suspect TB cases to the public sector.

-Increase identification of TB cases in high-risk populations, including children and prisons.

Improved Health Systems

-Expand new diagnostic tests to enable faster and more accurate TB and MDR-TB diagnosis.

-Improve performance of lab personnel to collect good sputum samples.

-Transition funding and management of TB programs to CENAT.

-Improve infection control in clinics and facilities.</td><td>Key GHI Principles:

Women and Girls

-Encourage the TB program to target vulnerable populations, including poor women.

Strategic Integration

-Ensure that the TB program coordinates with HIV programs to ensure that every TB patient is tested for HIV and every HIV patient is tested for TB.

-U.S.-CDC and USAID support evaluation of roll out of new TB diagnostics technology, e.g. Gene-Expert.

Health Systems Strengthening

-Transition management of TB programs to CENAT.</td></tr>
</table>

Tuberculosis and Leprosy Control [CENAT]) Target: >80% (2015, National TB program data) **Percentage of Operating Districts (OD) with TB/HIV services:** Baseline: 96% (2009, CENAT program data) Target: 100% (2015, CENAT data) **Number of TB cases (all forms) notified:** Baseline: 40,199 (2009, CENAT data) Target: 40,000 (2015, CENAT program data) **Notification rate, smear positive TB:** Baseline: 131 (2009, CENAT program data) Target: 112 (2015, CENAT program data) **Percentage of TB patients that have been tested for HIV among total number of**		

Cambodia Global Health Initiative (GHI) Strategy Matrix

registered TB patients: Baseline: 71% (2009, CENAT program data) Target: 80% (2015, CENAT program data) **Number of multi-drug-resistant (MDR) TB cases enrolled on second line treatment:** Baseline: 39 (2009, CENAT program data) Target: 110 (2015, CENAT program data) **Percentage of TB labs showing adequate performance on TB microscopy:** Baseline: 60% (2008, CENAT program data) Target: 85% (2015, CENAT program data)		
Key Partners: CENAT, MOH; NCHADS, MOH; TB Care; Cambodian Health Committee (CHC); RHAC; JICA; GFATM.		
Relevant Key National Priorities/Initiatives: <u>From the National Health Strategic Plan for Tuberculosis control in the Kingdom of Cambodia 2011-2015:</u> -Consolidate and maintain high quality TB services nationwide in order to achieve universal access to quality diagnosis and treatment. -To improve and ensure equitable access to TB services focusing on the poor and community participation (i.e. Community DOTS). -To respond to TB/HIV co-infection, drug-resistant TB, childhood TB and other high risk groups and challenges -To ensure adequate resources and strengthening coordination for TB control and contribute to health system strengthening. -To strengthen Monitoring and Evaluation System and to promote research activities for TB control.		

Cambodia Global Health Initiative (GHI) Strategy Matrix

[i] The official Maternal Mortality Ratio from the 2010 CDHS is expected to be available in November 2011.

[ii] Cambodia Demographic Health Survey, 2010.

[iii] Entertainment workers are women who work in entertainment establishments (beer gardens, karaoke bars, massage parlors, and restaurants).

[iv] National Behavioural Surveillance Survey (BSS), 2007, found that 0.6% of brothel-based sex workers, 17.2% of beer garden workers, 30.3% of beer promoters and 24.7% of karaoke workers reported having an abortion in the past 12 months.

[v] Neonatal mortality is defined as death of an infant < 28 days old per 1,000 live births.

[vi] 2011 Estimation Meeting, NCHADS.

[vii] Other donor's planned contribution in 2011 to the Health Sector Support Program is $38 million. HSSP 2 resources fund the broader health system, of which maternal child health programs are one component. In FY2010, the USG contributed $14.0 million in FY2010 funds to maternal child health programs and the RGC allocated approximately $6.7 million.

[viii] Component 4 of the FTI is Safe Abortion. USG programs fund post-abortion care, only, through midwife training and provision of post-abortion care services in Reproductive Health Association of Cambodia (RHAC) clinics. The USG does not support FTI activities prohibited by U.S. law, including laws prohibiting certain abortion-related activities.

[ix] RGC's MDG 5 goal is to reduce maternal mortality to 250/100,000 live births by 2015.

[x] The Global Fund is the largest donor in Cambodia, with a total of $331 million in approved GF grants to date. HIV grants alone total $176 million.

[xi] Contraceptive prevalence rate increased from 19 present in 2000 to 35 present in 2010.

[xii] World Bank, 2007, Poverty Headcount Ratio.

[xiii] Peter Leslie Annear, "Cambodia: Developing a Strategy of Social Health Protection."

[xiv] Secondary midwives receive 4 years of training (three years basic training plus one) and are the primary provider responsible for deliveries. They work in health clinics and hospitals and must be available on a 24 hour basis.

[xv] The average distance a woman travels to reach a health center is 5 km. The average distance travelled to reach a referral hospital is 10-15 km.

[xvi] Cambodia Demographic Health Survey, 2005.

[xvii] Ministry of Planning, 2005. This figure pertains to those eligible for Health Equity Funds.

[xviii] The HSSP 2, Health Sector Support Program 2, is an agreement between the RGC and specific donors who allocate their funds into a joint account with the government, often described as "basket funding." USG does not allocate funds directly into HSSP 2, but rather, provides technical assistance to implement HSSP 2 health care delivery models, e.g., Standard operating agents/service delivery grants, Annual Operating Plans, and Joint Appraisal Performance Review.

[xix] Gender Assessment, USAID/Cambodia, September 2010.

[xx] Ministry of Women's Affairs, 2009b, "Violence Against Women: Follow-up Survey," Final Study Report, GTZ Promoting Women's Rights Project.

[xx] HMIS indicators, which are compiled monthly from the health center and referral hospital, have been included as a resource document.