Making motherhood safer: A gender sensitive appraisal of the effectiveness of service delivery for maternal health care and budget allocations for reproductive health

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MINISTER’S PREFACE

The contributions provided by the authors in this publication are the personal opinions of the individuals concerned who are commenting.

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Mr. Horng Vuthy, an economist with the Cambodian Development Resource Institute provided a valuable contribution to the research by exploring the planning and budgeting processes in the Ministry of Health with respect to reproductive health, and assessing the possibilities of tracking expenditures in relation to benefits enjoyed by the users of the public health system.

We wish to thank the Ministry of Health for its encouragement and support for this research, in particular the members of the Gender Action Group led by H.E. Ouk Monna, Secretary of State, Dr. Tung Rathavy, Chief of Maternal and Child Health Institute in the Ministry of Health, and Ms. Hout Mann, Deputy Director of Administration, and member of the Gender Action Group. Mr. Chin Kim Long, Chief of the Finance Department, and Dr. Srey Vuth, MEF Financial Controller to MoH and chief advisor on the MTEF at the MoH provided the team with much cooperation and insight.

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The great and enthusiastic support, plus valuable discussions with Dr. Kate Frieson has certainly made this research come along way with an innovative approach in the reproductive health aspects. Finally the study team, without them the logistics of this research approach could not have been done.
EXECUTIVE SUMMARY

Maternal and child health are the serious public issues in Cambodia. Particularly, women living in rural areas have high mortality rate and low access to health care. This study proposed to explore the social realities of rural women and constraints they are facing in accessing health services and the extent to which the budget allocations may hamper the maternal and child health responses.

Documents review and qualitative design were used for this study including ethnographic fieldwork in Kampong Thom province and in-depth interview with health professionals, Gender Mainstreaming Action Group, and key financial representatives from Ministry of Health and Ministry of Economics and Finance.

The study found that even though the current planning and budgeting system was not competent to ensure that the funds were used in the way that would bring about the most positive changes in safe motherhood responses, Ministry of Health is currently making efforts in planning, strengthening accountability, improving performance, and increasing transparency in the public sector.

Various factors contributed to high maternal mortality rate in Cambodia. Women had difficulty in expressing their health concerns. Men played an important role in supporting their spouses in reproductive health matters. Though the skill of traditional birth attendance was limited, most rural women preferred them because of their similar socio-economic status, personal knowledge of local women, and affordability. Health center staff was the group that was most acceptable by women in the community, but referral hospital staff received most negative image. Misconceptions on nutrition during pregnancy and wrong belief and practices after delivery also contributed to high maternal and child mortality in Cambodia.

These findings suggested that the Ministry of Women Affairs should work with Ministry of Health to mobilize resources to work effectively in the area of maternal and child health. A comprehensive advocacy strategic plan for mobilizing resources should be developed and implemented. By enabling women in decision making for appropriate health seeking behavior and changing their belief and practices, as well as changing the attitude of the health providers would improve maternal and child health. Traditional birth attendances may play a crucial role in assisting rural women to complement the current system but their skills should be continuously enhanced and monitored.
Cambodia is one of the poorest countries in Southeast Asia. The periods of war and internal conflict (1970-1993) severely destabilized health infrastructure and services. Recovery was set further back in the 1990s by political upheaval and regional recession. The Paris peace agreement of October 1991 enabled peace and stability to be progressively re-established, allowing focus on longer-term development. Despite significant progress, major disparities continue between urban and rural living standards (e.g. 56% of urban vs 11% of rural households use electricity as their main source of light). Poverty remains high, with more than 35% below the poverty line and 15% in the extreme poverty. This phenomenon is largely rural, with over 90% of the poorest living in rural areas. Limited linkages to the domestic economy, limited access to basic services, landlessness, environmental degradation, and little or no education exacerbate poverty. (6,40)

Compared to other countries in the region, Cambodia has almost the highest maternal mortality rates and under-five infant mortality rate in the region except for its neighboring countries. The maternal mortality ratio (MMR) in Cambodia is 472/100,000 live births, while the infant mortality rate is 65/1000 live births and under-five mortality rate is 83/1000 live births (CDHS 2005). The main causes of maternal mortality in Cambodia, as elsewhere in the region, are abortion-related complications, haemorrhage, obstructed labour, sepsis, and hypertensive disorders. (11). Urban and rural differences are also clear among these health indicators. Women living in rural areas in general have higher mortality rates, lower access to health care during their pregnancy and delivery than those living in urban areas.

It is therefore important to better understand the social realities of rural women and the constraints they face in accessing rural health facilities by investigating the social and cultural context of childbirth, the attitudes and the responses of health care
providers to rural poor women’s understandings of the childbirth process, and the extent to which the budget allocations for reproductive health respond to obstacles faced by women in exercising their right to health care services.

The objectives of the study were as follows:

- To undertake an analysis of government budget planning and resource allocations related to reproductive health in relation to service delivery needs of women.
- To describe and analyze the Ministry of Health planning and budgeting approaches to maternal and reproductive health
- To identify factors and underlying causes for the continued high maternal mortality rates in Cambodia from a gender perspective.
- To explore women’s behaviours and practices towards child delivery
- To examine obstacles that poor women experience in seeking health care

II. BACKGROUND INFORMATION

1. Current women’s health indicators

In the five years preceding the 2005 CDHS survey, more than two in three (69 percent) women received ante-natal care from trained personnel (doctors, nurses, and midwives) at least once. Sixty-one percent of women received care during pregnancy from midwives, 6 percent received care from a doctor, and 2 percent from a nurse. More than one fourth (28 percent) of women received no antenatal care in the preceding five years. There are differences in the use of antenatal care services between urban and rural women. Health professionals provided antenatal care for 79 percent of mothers in urban areas and 67 percent of mothers in rural areas. Additionally, in rural areas, 30 percent of women received no antenatal care at all, compared with 19 percent in urban areas.

A large majority of births (78 percent) in the five years before the survey were delivered at home, with only 22 percent being delivered in a health facility. Children born in urban areas (50 percent) are three times more likely to be delivered in a health facility than children born in rural areas (17 percent). Forty-four percent of births are delivered with the assistance of a trained health professional, (i.e., a doctor, nurse, or midwife).

Urban women are much more likely (70 percent) to receive assistance from a trained health professional during childbirth than rural women (39 percent). Conversely, rural women are more likely to receive assistance during birth from a trained birth attendant (60 percent) than urban women (28 percent).
Thirty percent of women received no postnatal care. Sixty-four percent of mothers received postnatal care within the crucial first two days of delivery, with 32 percent receiving care within four hours of delivery. Urban women are more likely to receive postnatal care (74 percent) than rural women during the first two days after delivery (62 percent). Forty-one percent of women received postnatal care from a health professional (midwife, doctor, or nurse), and 29 percent of women received postnatal care from traditional birth attendants. Health professionals are twice as likely to provide postnatal care to mothers in urban rather than rural areas (66 percent versus 37 percent).

2. Santuk district, Kampong Thom province

In the two districts that were selected for this study, only the commune of Bong Lovea in the district of Santuk had a poverty rate close to the national average. Typical poverty rates were in excess of 50 percent as the following table reveals with the highest rate of poverty being 68 percent in the commune of Ti Pou also in the district of Santuk.

The Gini Index – that measures the extent of inequality – demonstrates that apart from Kompong Chen Tboung in Stoung, which has a Gini Index of 0.39, the other communes are in the range between 0.27 and 0.30. This is not surprising given the location of and nature of these communes, which have not experienced any significant level of rural modernization as against some truncated forms of rural development.

Table 1 – Incidence of Poverty in Study Communes

<table>
<thead>
<tr>
<th>Province</th>
<th>District</th>
<th>Commune</th>
<th>Poverty Incidence (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kampong Thom</td>
<td>Stoung</td>
<td>Kg Chen Cheung</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kg Chen Tboung</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trea</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Banteay Stoung</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rung Roeang</td>
<td>64</td>
</tr>
<tr>
<td>Santuk</td>
<td></td>
<td>Kraya</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Boeng Lovea</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ti Pou</td>
<td>68</td>
</tr>
</tbody>
</table>

Source: Poverty Data, MOP, 2004

However, the above data is derived from a statistical exercise undertaken more than 5 years ago does not disaggregate poverty at the village level. In 2004 the District Office of Social Welfare in Stoung together with GTZ undertook a poverty assessment of 18 villages in each of the five districts. This assessment identified the poorest households and these ranged from a high of 24 percent in Leap Tong Village
of Trea Commune to a low of 2 percent in a village of the same name in Kompong Chen Tboung Commune.

In Stoung settlement took place quite some time ago. During the early 1900s there were not only ethnic Khmer living in districts around Stoung but also ethnic Chinese although the latter were primarily located in the town of Stoung rather than the rural villages. However, there was considerable interaction between the two groups with the ethnic Chinese being the providers of credit in return for liens on what could be produced locally or more rarely services provided by village people. In Santuk there are fewer reports of such interactions because until very recently the district has been more-or-less a forested district on the road to Kompong Thom. During the Khmer Rouge period Stoung was “depopulated” although there were some work brigades in areas surrounding the villages. In Santuk there were villages where the Khmer Rouge attempted to construct a fairly large irrigation system (Stung Chinit) that involved both local villagers and people transported in from outside the area.

Agro-ecologically Santuk is more forested than Stoung. The latter district is blessed with more water that contains fish at least at the end of the dry season than Santuk but lacks the forest and vegetation cover of Santuk. Hence villagers in Stoung are better off in relation to water based natural resources than Santuk but Santuk is better off in relation to forest based natural resources.

II. RESEARCH METHODOLOGIES

Document reviews and qualitative study were employed to assess how well the planning and budgeting processes of the Ministry of Health was translated into providing the services required by women seeking public reproductive health services and to examine the cultural and social experiences of women in order to determine how well their needs were met by the services.

Qualitative study included ethnographic fieldwork in Kampong Thom and in-depth interview with health professionals, the Gender Action Group in the Ministry of Health and key financial representatives from Ministry of Health and Ministry of Economic and Finance. The ethnographic study in Kompong Thom province was to examine the cultural and social experiences of women in their reproductive years with a view to determining how well their needs were met by services.

The appreciative Inquiry Approach method was employed for the ethnographic research. This method is increasingly being used in a range of different contexts, including the corporate sector where it was developed, to look at strengths rather than weaknesses of people and organizations. It has been successfully applied in a range of different developmental contexts, including an understanding the strengths of existing healthcare delivery systems rather than just focusing on their weaknesses such as lack
of financing, personnel, equipment, training, and ability to reach out to local people especially poorer and vulnerable women.

This approach has four different building blocks to arrive at a better understanding of these strengths based on the active participation of both the research team and local participants in the focus group discussions (FGD). The researchers structured the interviews of the women to first look at the discoveries (the high points in their lives), then dreams (what they would like to see happen in their village), then designs (how they could realize their dreams), and finally deliveries (practical ways and means to implement their designs), and concluded with the proposed interventions.

Kompong Thom was chosen to carry out the field work because of its high level of poverty at the village level, and because a variety of healthcare programs that have been financed and implemented by a variety of organizations, including NGOs. It needs to be stated here that the study focused only on ethnic Khmer, there being small groups of ethnic Vietnamese living in villages of Stoung close to the Tonle Sap but in Santuk there are no other ethnic groups living in the rural villages of the districts. Hence the analysis in this study applies to ethnic Khmer in this area.

The qualitative study included 25 FGDs and in each FGD, there was a minimum of 10 participants and maximum of 15 participants. Participants are women of reproductive ages in the study villages, traditional birth attendants and health professional working in the areas.
III. RESULTS

1. Service Delivery for Maternal Health Care and Budget Allocations

This section seeks to analyze the budgetary allocations of the Ministry of Health in relation to Reproductive Health (RH) services. First, an overview is given of the planning and budgeting process of MoH pertaining to reproductive health. Second, both government and non-government sources of funding for reproductive health are assessed with a special emphasis on the comparison between the budgeted allocations and the disbursed allocations (i.e. budgeted vs. actual) and of the bottlenecks in disbursement. Third, the section examines how MoH determines its budget needs, the process by which it forecasts the amounts necessary for RH on an annual basis. The section ends with the benefit incidence analysis of the provision of reproductive health services in two health clinics.

1.1-MoH planning and budgeting process in relation to reproductive health

The Ministry of Health began the process of reviewing and revising the way it works when it adopted the Health Sector Strategic Plan (HSSP) 2003-2007 in 2002. One area that needed review and revision was the planning and budgeting process. The planning manual of 1999 did not link well the budget planning and activity planning. As recognized in HSSP, the work plans are not properly costed when budgets are developed before activities are planned. In addition, there was no mechanism to unify the plans developed by various central-level institutes, programmes, hospitals and departments of MoH. Similarly, there was no planning required at the facility level (referral hospitals and health centers).

Recognizing the major weaknesses of the 1999’s planning manual, MoH revised the planning cycle in 2002 to promote sector wide planning that seeks to achieve uniformity between plans developed by all stakeholders and to create a clearer link between budgeting and activity planning (HSSP, vol. 4, 2002). The revised planning cycle resulted in a process in which the operational plan is completed first, followed by budget planning based on costing of the operational plan.

The Ministry of Health is one of four line ministries that established the Medium Term Expenditure Framework (MTEF) in 2002. This is a 5-year public expenditure plan that is based on sectoral financing needs and projections of resources availability. The government’s MTEF is for 3 years and therefore requires that MoH develop a 3-year ‘rolling plan,’1 which outlines the objectives, targets, and budget estimates for

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1 3-year rolling plan is required of central and provincial levels arm of MoH, not of operational districts.
the 3-year period. This rolling plan is then submitted to the Ministry of Economy and Finance.

**a-Financing the Cambodia health system**
- per capita health expenditure
- problems of budget execution
  - delay
  - can not predict
  - incremental
  - ratio of committed allocation to approved budget (85%)
- IDA, and its impact on planning and budgeting
- Macro recommendation, p35, 49

**b- Current planning and budgeting process**
The discussion below provides information on how responsible entities charged with health service delivery plan and budget their activities. A special reference will be made to planning and budgeting of reproductive health service.

**At the national program level**

The national reproductive health care services are managed by the National Reproductive Health Program (NRHP), a national program of the MoH. NRHP is tasked with the preparation of national guidelines, protocols and other guiding policy documents related to RH services. It also provides training to trainers, master trainers and service providers; the training takes the form of both pre-service (e.g. to nursing students) and in-service training (e.g. practicing midwives). In addition, NRHP carries out monitoring and evaluation, conducts research, and facilitates the planning by serving as an advisory group.²

There are eleven service components of RH on which NRHP is working. They are listed in Box 1 below:

**Box 1. Service components of reproductive health**

<p>| | |</p>
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Birth spacing</td>
</tr>
<tr>
<td>2.</td>
<td>Safe motherhood:</td>
</tr>
<tr>
<td></td>
<td>▪ Ante-natal care</td>
</tr>
<tr>
<td></td>
<td>▪ Labor and delivery</td>
</tr>
<tr>
<td></td>
<td>▪ Post-natal care</td>
</tr>
<tr>
<td></td>
<td>▪ Newborn care</td>
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<tr>
<td></td>
<td>▪ Emergency obstetric care</td>
</tr>
<tr>
<td>3.</td>
<td>Reduction of unsafe abortion</td>
</tr>
<tr>
<td>4.</td>
<td>Adolescent reproductive health</td>
</tr>
<tr>
<td>5.</td>
<td>Sexual transmitted diseases and HIV/AIDS</td>
</tr>
</tbody>
</table>

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² Interview with Dr. Tung Rathavy, Deputy National Program Manager, National Reproductive Health Program, July 2005.
NRHP uses findings and data from health reports such as Cambodia Demographic and Health Survey (CDHS), National Health Survey and other related research findings to help guide its prioritization. The NRHP also uses the experience it has accumulated to guide the priority setting. For example, CDHS’s data shows that maternal mortality rate remains dangerously high and therefore deserves immediate attention. Priority is placed on ‘preventive’ care services, which renders the first four service components a higher priority.3

The planning and budgeting process of NRHP starts in April of each year and a final budget is submitted to MoH by June. It should be noted that only a small portion of NRHP budget comes from the state and is only related to the printing of public information materials (birth spacing books and leaflets). The remaining NRHP activities are financed by external sources including bilateral and multilateral donors, UN agencies, and local NGOs. The budget for RH service delivery at the sub-national level is not covered by NRHP budget.

The budget proposal of NRHP consists of the following components:
- Main activities;
- Implementing agencies;
- Quarter of the year that the activities are to take place;
- Budget sources (government and donors);
- Expected outcomes; and
- Performance indicators.

The main activities entail provision of training courses on RH (e.g. safe delivery, safe abortion, post-abortion care), workshops to formulate as well as disseminate RH protocols, supervision visits, and the printing of RH public education materials.

Inherently, the budget proposal of the NRHP is a program-based budget. The budget has a number of overall targets to achieve. The main activities identified for implementation support those overall targets. The budgetary resources are tied closely to each main activity together with clear expected outcomes and performance indicators.4 Once submitted to MoH and become part of the ministry’s consolidated budget, the NRHP program-based budget is broken down and transferred into various line items (chapters). While this practice presents huge barriers to tracking results for the implementing agencies, it affects NRHP to a lesser degree since a majority of its

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3 Ibid.
4 The performance indicators focus on written report and lack analytical information.
budget comes from donors and NGOs whose disbursement of fund is more predictable.

At the sub-national level

The entities responsible for health service delivery at the sub-national level include provincial health department (PHD), operational district (OD), referral hospital, and health center (HC). We will examine the process in which these entities employ to plan and budget their activities, in turn.

Health Center
A health center (HC) is the point of service delivery at the local level (within communes and villages). A HC is established to cover between 8,000 and 12,000 inhabitants and to provide 14 types of health services identified in the Minimum Package of Activities (MPA) (see CDRI’s forthcoming report on local service delivery for more details). The HC only provides out-patient services.

Referral Hospital
A referral hospital is the point of service delivery, which serves the population covered by one OD. The services that the referral hospital offers are services that cannot be accommodated by the HC’s MPA. The services are more sophisticated and can deal with major health injuries. The referral hospital also provides in-patient care. The services available are set forth in the Complimentary Package of Activities (CPA).

Planning at Referral Hospital and Health Center
HC and the referral hospital in Stong district prepares its budget based on the simple incremental principle. It starts off by examining the past year’s performance to detect what indicators have been achieved and what have not. Then, it examines the new priorities set by the MoH, if any, and plans its activities to align with the new ministerial priorities. Usually, it ends up with cutting off some activities and adding some new ones. The referral hospital does not budget separately for reproductive health program.

Like previously mentioned, the broad six key areas of the HSSP function as the head under which activities are planned and budgeted. As a result, the budget of the referral hospital is a line items budget. The hospital’s budget is then submitted to OD for consolidation. As discussed above, OD is responsible for classifying the hospital’s activities into the six key areas, but is not allowed to change the submitted budget.

5 The information is based on fieldwork conducted in Kompong Thom at two health centers, two ODs (Stong and Santuk-Baray), and one referral hospital; and a discussion with the director of the provincial health department.

6 The 14 activities are: general consultation, STD/AIDS, small surgery, malaria testing and care, vaccination, pre-natal examination, birth spacing, normal birth delivery, post-delivery care, TB care using DOTS, Hansen detection and referral service, provision of vitamin A, detection of malnourished people, and health education.
Operational District Office

The operational district office (ODO) is managing all health service delivery responsibility within the OD. The office consists of both administrative and technical arms. The budget of ODO is to cover its administrative and technical work, which mainly is to support the referral hospital and the HC with their service provision. ODO spends its budget on supervision missions, training, workshops, office supplies and equipment repairs. ODO’s budget is not for any health service delivery activities. The budget of ODO is consolidated together with that of the HC and referral hospital, and become a part of the overall budget of the entire OD health activities. The consolidated budget of an OD, which features activities classified under the six key areas, is then submitted to the Provincial Health Department.

As far as program budgeting at OD level is concerned, Stong OD is a particular case in that it receives budgetary support from UNFPA to implement reproductive health program within the OD. This is the only budget that can be considered a ‘program-based’ budget. This budget is reflected in the provincial AOP but kept under a separate management arrangement. The budget is kept under a private bank account and can be accessed by the OD without having to go through the lengthy government treasury system. In effect, this is an off-budget budget.

The budget for this UNFPA-supported reproductive health program is prepared by the OD in cooperation with PHD and in accordance with the UNFPA’s guidelines. The program is managed by the Director of Stong OD.

Provincial Health Department

The provincial health department (PHD) is in overall charge of health service delivery within the province. All ODs report to PHD. Similar to OD, the structure of PHD consists of administrative and technical units. As such, the budget of PHD covers the cost of administrative and technical work. PHD is not the actual health service deliverer. Like the referral hospital and OD, PHD budgets its activities and fit them into the six key areas. In effect, the budget of PHD is also a line items budget.

c - Consolidation of all budgets for health service delivery at the provincial level

As mentioned in the ODO section above, the health centers, the referral hospital and the ODO meet together at the district level to consolidate their budget into a single budget called ‘Operational District Annual Operational Plan’ (ODAOP). Each OD is required to prepare one ODAOP.

Likewise, the consolidation of AOP of all ODs takes place at the provincial level. Both the budget of PHD and ODAOPs within that particular province is consolidated to create a single ‘Provincial Annual Operational Plan’ (PAOP).

The PHD submits the provincial AOP to the central level Department of Budget and Finance and the Department of Planning and Health Information. Guided by the HSSP and ministry’s policies, the AOPs get reviewed centrally. When the review is
finished, the feedback is sent back to PHD, which is to inform PHD of the changes made to the proposed AOP. The province’s health department, then, passes on the information to all ODs. Similarly, the OD informs its referral hospital and health centers of the changes accordingly.

The date is then set to allow PHD, ODs, referral hospitals, and HCs to discuss and incorporate the suggested changes made by the ministry. A team of national ministry staff is also present at the session. It is said the discussion and incorporation of the suggested changes to the budget proceed fairly smoothly and concludes relatively quickly on the spot.7 Once changes are agreed upon, the PHD revises its AOP and resubmits to MoH.

From the above discussion, we can see that national health service delivery activities are derived from the actual needs of each province. These activities are included in the provincial AOP. The choices of activities to be finally adopted and undertaken are guided by national strategic priorities and needs (i.e. the HSSP).

By now, we have only presented that the activity planning and budgeting is to be included in the AOP and are yet to discuss what it entails. Hence, prior to analyzing the advantages and disadvantages of the AOP format and especially how it affects the aim to track results in reproductive health service delivery, let us first understand what information a provincial AOP provides.

**d- What does a provincial AOP entail?**

Starting from fiscal year 2005, each Provincial Health Department (PHD) is requested to prepare an AOP to be submitted to MoH no later than June 31 of each year. MoH consolidates all AOPs into a ministry's Budget Plan. The information contained in the AOP is as follows:

1. **Provincial map.** The map highlights the locations of PHD, operational districts (OD), referral hospitals (RH) and health centres (HC); and the number of population within each health facility.
2. **Overall situation of PHD.** It defines the geographical location of the province, the number of ODs and HCs, and the number of population per OD and HC. This section also discusses the estimated number of (i) pregnant women, (ii) women receiving RH services and (iii) under-1 children, number of medical staff, distance of each OD from PHD, and number of communes and villages per OD.
3. **Achievements and challenges.** It provides various performance indicators such as percentage of HC constructed, population per doctor ratio and percentage of total state budget received to spend at OD and HC level, etc. Types of health services provided are also given. The historical statistics of the performance indicators and health service types as well as the newly proposed statistics for the next budget year are included. Challenges and areas that need to be tackled are mentioned.

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7 Meaning all health entities will revise their plan and budget at the discussion session without much delay (interview with director of PHD, ODs, referral hospital, and HCs, August 17-18, 2005)
(4) Future plans. It entails activities that need to be taken. The activities are classified according to the six key areas.

(5) Annual operational plan. This includes target activities derived from the six key areas mentioned above, indicators to measure each activity and the entity responsible for carrying out those activities. A budget plan is another important part of this section. It mentions the budgetary need for implementation, responsible entities, sources of financing and the expected results. The sources of funding for the proposed budget are also provided (e.g. government, donors, NGOs).

(6) 3 year rolling plan. The plan describes the target activities of the six key areas, the performance indicators and the budget requirement to implement the target activities.

It should be noted that the activities and budget of AOP is grouped according to the six key areas. This is problematic in that it is difficult to track the outcome of a health program. To better illustrate the problem, take an example. A PHD needs a budget of 10,000 USD to implement its reproductive health (RH) program for the next year. However, the structure of the AOP does not allow this requested budget for the RH program to be kept under one separate RH program. Instead, the budget scatters among the six key areas. The budget of other programs of the PHD (e.g. malaria, HIV/AIDS) is also disaggregated into the six key areas. As a result, a budget document is assembled in a way that the budget of all health programs within the province is allocated into these six key areas. Therefore, the budget proposed in the AOP remains heavily a line items budget, which renders it difficult to know if the budget for RH program will not be spent on any other activity. As a result, outcomes of a specific health program are hard to measure.

e- Consolidation of provincial AOPs into national health budget?

Upon receiving the finalized AOPs from all provinces, MoH begins to consolidate all the activities and budget information in the AOPs in order to produce a national health budget plan. This national health budget plan is submitted to the Ministry of Economy and Finance. The national health budget breaks down the allocation of input in detail by chapter, which is as follows:

- Salary and allowances (Chapter 10)
- Operating costs (Chapter 11)
- Subsidy to public units (Chapter 12)
- Priority Action Program (Chapter 13)
- Economic and social interventions (Chapter 30 and 31)
- Capital (Chapter 50 and 51)

The majority of the national budget goes to Chapter 10, 11, and 13.
The presentation of budget information in the final MoH budget reflects a strong emphasis on line items budgeting in that heavy focus is on inputs rather than outcomes.\(^8\)

The Ministry also has difficulty in accounting for resources that are available for the provision of health services nationwide. Non-state sources of funding tend to come largely from bilateral and multilateral donors and other various non-governmental organizations working to promote better health for the population. These sources tend to be channeled directly toward facility levels and do not go through the MoH system; and these resources are off-budget. In other words, donors and NGOs appear to be reluctant to contribute funding to 'basket fund' of MoH.\(^9\) Oddly enough, according to the Director of the Department of Budget and Finance of MoH, the information about non-government sources of funding for a certain health program is derived from the budget information included in the AOP of all provinces.\(^10\)

**f- New direction for Planning and budgeting process 2007**

Based on the Public Financial Management Reform Program (PFMRP) of the Royal Government of Cambodia 2005 (Program budgeting in the Royal Government of Cambodia, Proposal for an Implementation Strategy, and an Action, p3, September 2005) this year, the Ministry of Health introduces "Guidelines for the Preparation of the 3rd Health Sector Annual Operational Plan 2007. The Guidelines show the distinguishing features of the AoP2007 which make an important step by introducing programs and subprograms and budgeting according to those programs, subprograms, and activities. While the first and second AoP were based on Six Key Areas of Work (KAW). This initiative is understood as the continuation of efforts of the Ministry of Health to refine to its planning process as well as contributions to the broader reform process across the public sector. The AoP 2007 will use an explicit orientation around priorities and objectives with companying indicators to strengthen accountability, encourage performance, and increase transparency in the public sector (the Second Health Annual Sector Annual Operation Plan, p6, 2006).

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\(^8\) Also worth noting is the fact that in the national health budget the six key areas are not mentioned.

\(^9\) A number of reasons were said to be behind this practice. Different procedure requirements of various donors, the unwillingness to publicly disclose the funding information, and the lack of trust in government system are some examples.

\(^10\) Interview with Mr. Chea Kim Long, Director of the Department of Budget and Finance, MoH, August 4, 2005.
The main five programs indicated in the AoP 2007 are: (Source: Draft of the Health Sector Annual Operational 2007 and 3 year rolling plan 2007-2009, p13-15)

1. Management and administration
2. Mother and child health
3. Communication Diseases Control
4. Non Communication Disease Control and other health related issue
5. Health Service Delivery

In each program, there are many subprograms (see Table 2); and in each program and subprograms, there is objectives, outcomes and indicators to help the program implementers for tracking the achievements of the work plan implementations.

(Guideline for the preparation of 3rd health sector annual operational plan 2007, p2, Annex 1)

1.2 Budget allocations

Budgetary resources available for reproductive health services

1-Provincial Budget for RH 2006
By design of the AOP, we are able to come up with a rough estimate of the total budget that all provinces request to provide reproductive health services. The limitation is that the budget estimate for RH only concerns the proposed budget, not the approved budget. This is because, once nationally consolidated and approved, the budget is prepared as a line items budget making it impossible to trace back how much of the approved national health budget is for RH. Table 1 below shows the total budget request for RH service by each province for the year 2006.

Table 1. Total budget request for reproductive health service by province for 2006

<table>
<thead>
<tr>
<th>N</th>
<th>Province</th>
<th>Government and User Fees (Riels)</th>
<th>Donors and NGOs (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Banteay Meanchey</td>
<td>85,552,000</td>
<td>105,036</td>
</tr>
<tr>
<td>2</td>
<td>Battambang</td>
<td>25,800,000</td>
<td>39,370</td>
</tr>
<tr>
<td>3</td>
<td>Kampot</td>
<td>25,640,000</td>
<td>61,909</td>
</tr>
<tr>
<td>4</td>
<td>Kandal</td>
<td>405,492,000</td>
<td>49,619</td>
</tr>
<tr>
<td>5</td>
<td>Kep</td>
<td>20,935,400</td>
<td>1,352</td>
</tr>
<tr>
<td>6</td>
<td>Kampong Cham</td>
<td>253,677,000</td>
<td>79,112</td>
</tr>
<tr>
<td>7</td>
<td>Kampong Chhang</td>
<td>34,241,000</td>
<td>2,840</td>
</tr>
<tr>
<td>8</td>
<td>Kampong Speu</td>
<td>228,412,400</td>
<td>53,931</td>
</tr>
<tr>
<td>9</td>
<td>Kampong Thom</td>
<td>214,927,000</td>
<td>50,000</td>
</tr>
<tr>
<td>10</td>
<td>Kratie</td>
<td>168,000,000</td>
<td>71,024</td>
</tr>
<tr>
<td>11</td>
<td>Mondulkiri</td>
<td>61,428,850</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>Odor Meanchey</td>
<td>21,250,000</td>
<td>64,811</td>
</tr>
<tr>
<td>13</td>
<td>Pailin</td>
<td>27,628,000</td>
<td>6,051</td>
</tr>
<tr>
<td>14</td>
<td>Preah Vihear</td>
<td>102,656,200</td>
<td>67,674</td>
</tr>
<tr>
<td>15</td>
<td>Prey Veng</td>
<td>217,233,800</td>
<td>41,503</td>
</tr>
<tr>
<td>16</td>
<td>Pursat</td>
<td>103,154,000</td>
<td>2,800</td>
</tr>
<tr>
<td>17</td>
<td>Rattanakiri</td>
<td>22,560,000</td>
<td>7,000</td>
</tr>
<tr>
<td>18</td>
<td>Siem Reap</td>
<td>21,887,000</td>
<td>29,542</td>
</tr>
<tr>
<td>19</td>
<td>Sihanouk Vill</td>
<td>10,841,000</td>
<td>162,586</td>
</tr>
<tr>
<td>20</td>
<td>Stung Treng</td>
<td>13,030,000</td>
<td>13,000</td>
</tr>
<tr>
<td>21</td>
<td>Svay Rieng</td>
<td>13,261,000</td>
<td>7,176</td>
</tr>
<tr>
<td>22</td>
<td>Takeo</td>
<td>388,226,300</td>
<td>52,912</td>
</tr>
</tbody>
</table>

Total: 2,465,832,950 ([$616,458.24]) 969,248

(Source: Provincial Annual Operational Plan of the 22 provinces and municipalities. Missing are Phnom Penh and the province of Koh Kong)

The budget proposed by the province for RH services above is for a number of services including mainly pregnancy test and consultation, tetanus vaccination of pregnant women, prenatal and postnatal care, distribution of vitamin A to pregnant
women, promotion of delivery by trained midwives, midwives training, use of modern form of contraception, and the promotion of the practice of breastfeeding. The range of activities varies from province to province.

Out of the 22 provinces and municipalities, Kandal tops the list in terms of amount of budget from government sources with Takeo taking the second place. The Sihanoukville Municipality receives the highest non-government sources of funding followed by Banteay Meancheay.

The limitation of the above estimate of the proposed budget for RH services should also be noted. The proposed budget estimate is derived exclusively from the Service Delivery section of the AOP because the information allows us to know rather precisely what activities are related to RH. The budget of the remaining 5 key areas within the AOP (behavior change, quality improvement, human resources development, health financing, and institutional development) does not categorize activities by type of health services (e.g. RH and malaria), but for all health services, making it not possible to know reliably how much is allocated to RH services. For this reason, the budget of the last 5 key areas is left out from the calculation of proposed budget estimate for RH service.

2- Proposed budget for programs and subprograms

Table 2 indicates the proposed budget allocation for operating programs and subprograms for the AoPr 2007. More than half of the total budget will be allocated to management and administration works. While, the budget serve for mother and child health is about 5% which stand for almost the lowest priority of the five programs, in particular the budget for reproductive health is 1.5% which equal to US$ 1,667,913.00.

Table 2: 2007 Planned Expenditure for Programs and Sub-programs

<table>
<thead>
<tr>
<th>P1</th>
<th>Management and Administration</th>
<th>51.78%</th>
<th>$57,770,448</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1S1</td>
<td>Policy, strategy, planning health legislation, and sector wide management</td>
<td>3.37%</td>
<td>$3,761,932</td>
</tr>
<tr>
<td>P1S2</td>
<td>Health system research and monitoring and evaluation</td>
<td>4.77%</td>
<td>$5,316,600</td>
</tr>
<tr>
<td>P1S3</td>
<td>Human resource and personal management</td>
<td>16.31%</td>
<td>$18,190,664</td>
</tr>
<tr>
<td>P1S4</td>
<td>Administration services</td>
<td>23.80%</td>
<td>$26,553,297</td>
</tr>
<tr>
<td>P1S5</td>
<td>Drug management and medical supplies</td>
<td>3.54%</td>
<td>$3,947,955</td>
</tr>
<tr>
<td>P2</td>
<td>Mother and child health</td>
<td>4.52%</td>
<td>$5,047,570</td>
</tr>
<tr>
<td>P2S1</td>
<td>Reproductive health</td>
<td>1.50%</td>
<td>$1,667,913</td>
</tr>
<tr>
<td>P2S2</td>
<td>Immunization</td>
<td>0.95%</td>
<td>$1,056,319</td>
</tr>
<tr>
<td>P2S3</td>
<td>Health child and new born</td>
<td>1.11%</td>
<td>$1,233,430</td>
</tr>
<tr>
<td>P2S4</td>
<td>Nutrition</td>
<td>0.98%</td>
<td>$1,089,908</td>
</tr>
<tr>
<td>P3</td>
<td>Communicable disease control</td>
<td>18.35%</td>
<td>$20,476,212</td>
</tr>
<tr>
<td>P3S1</td>
<td>HIV/AIDS/STIs</td>
<td>5.88%</td>
<td>$6,562,408</td>
</tr>
<tr>
<td>P3S2</td>
<td>Tuberculosis/Leprosy control</td>
<td>5.70%</td>
<td>$6,356,522</td>
</tr>
<tr>
<td>P3S3</td>
<td>Malaria control</td>
<td>3.39%</td>
<td>$3,786,067</td>
</tr>
<tr>
<td>P3S4</td>
<td>Dengue control</td>
<td>2.07%</td>
<td>$2,314,695</td>
</tr>
<tr>
<td>P3S5</td>
<td>Parasitology</td>
<td>0.38%</td>
<td>$419,577</td>
</tr>
</tbody>
</table>
### 1.3 Benefit incidence analysis

The section below brings into discussion the limitation in attempting to perform a benefit incidence analysis of the government spending on Stong Health Center and Tang Krasang Health Center in the province of Kompong Thom.

Benefit incidence analysis looks at the distributional impacts of public spending. This approach is based on the public spending in a sector as reported by the government to determine the net cost of the service by dividing the yearly total costs of the service, minus the recovery income received, such as user fees, by the number of units of service provided.

In the analysis of the data, we look for how many units of service were utilized by the subpopulation under study, poor women, wealthy women, etc.

**Unit subsidies in health for services provided by the health center**

The unit subsidy is defined as “the net current cost to the government of an individual visit to a health facility” (Castro-Leal, Dayton, Demery, and Mehra, 2000, p. 68). The subsidy is calculated as “total recurrent spending on facilities, less any revenue from cost recovery, normalized by the number of visits” (ibid., p. 68). The information about the total recurrent government expenditures, cost recovery, total number of visits to Stong Health Center are given in Table 1. The unit subsidies estimates for Stong Health Center and Tang Krasang Health Center are then given in Table 3.
Table 3. General health information of Stong and Tang Krasang Health Center

<table>
<thead>
<tr>
<th></th>
<th>Stong</th>
<th>2003*</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total recurrent expenditures</td>
<td>44,867,442 (riels)</td>
<td>37,550,098 (riels)</td>
<td></td>
</tr>
<tr>
<td>Total cost recovery</td>
<td>3,644,000 (riels)</td>
<td>5,111,500 (riels)</td>
<td></td>
</tr>
<tr>
<td>Total number of visits to health center</td>
<td>3,021</td>
<td>5,089</td>
<td></td>
</tr>
<tr>
<td>Unit subsidy</td>
<td>5,483</td>
<td>3,148</td>
<td></td>
</tr>
<tr>
<td>Total number of staff at health center</td>
<td>07**</td>
<td>07**</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Tang Krasang</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total recurrent expenditures</td>
<td>725,213,417</td>
<td>648,629,966</td>
<td></td>
</tr>
<tr>
<td>Total cost recovery</td>
<td>13,085,860</td>
<td>12,185,180</td>
<td></td>
</tr>
<tr>
<td>Total number of visits to health center</td>
<td>9,257</td>
<td>9,013</td>
<td></td>
</tr>
<tr>
<td>Unit subsidy</td>
<td>76,929</td>
<td>70,614</td>
<td></td>
</tr>
<tr>
<td>Total number of staff at health center</td>
<td>28**</td>
<td>28**</td>
<td></td>
</tr>
</tbody>
</table>

Note:  * figures for 2005 are not available for the whole year as of time of writing  
** figure at year end

These figures were taken from the Health Financing Reports of the HCs. The total recurrent expenditures represent the government transfer which includes in cash and in kind contribution, and the costs of the medicines. The limitation of the clarity of the data prohibits the calculation of all visits made for RH related services. The only reliable figures concern the total number of visits made by patients for all types of medical reasons (vaccination, prenatal care consultation, general health concerns). This makes possible the calculation of the unit health subsidy of the health center.

Table 1 indicates a stark difference in the level of operations between the two health centers. Stong HC is smaller in size and only employs 7 staff whose highest qualification is a secondary nurse. Stong HC only provides out-patient consultations. In contrast, Tang Krasang HC, formerly a district hospital, is much larger in size and operation. It has 28 staff including a medical doctor and offers both out-patient and in-patient services (it offers beds for TB patients). The difference in the availability of the services explains the huge variation in the total recurrent expenditures, total cost recovery and the total number of visits to health center between the two health centers.

Limits to Benefit incidence of health spending

Attempts were made to calculate the benefit incidence of health spending on reproductive health in the two health centers. However, the only data available is the total annual number of visits to the health center for all medical purposes. The data has no breakdown of visits by gender or by types of consultations (e.g. vaccination, prenatal care, general health matters), which makes it impossible to know how many of the total visits were made specifically for RH services or by women. Therefore, the calculation of benefit incidence was not possible.
2. Stakeholder analysis

2.1 Women and Children in the community

Poorer rural women are the most vulnerable group due to depth of poverty including lack of functional literacy skills and ability to integrate the traditional with modern approaches especially in maternal healthcare. They are unable to make concerns known and understood by most health professionals. Changes will only occur when the poverty of this group is reduced. Few of the better off rural women are satisfied with the level of care and support provided by health centers and still prefer the TBA although they recognize the importance of integrating traditional and modern approaches. Infants and Children are important stakeholder group but because of age, they have little or no influence.

Women and children are unable to make concerns known and understood by most health professionals.

2.2 Men in the community

Men are important stakeholder because they are in a position to provide support to their spouses in making decision in their reproductive health matters.

2.3 Traditional Birth Attendants (TBA)

Most rural women still prefer TBA because of their similar socio-economic status, personal knowledge of local women, affordability, but most importantly the ability of the TBA not to look down upon rural women.

Many health professionals “demonize” the TBA and argue their knowledge and practices are worthless and lead to higher infant mortality rates. It will be necessary to look at ways TBA can be supported to ensure they continue to play a vital but improved role in maternal health issues at the village level.

Most rural women still prefer the TBA because of their similar socio-economic status, personal knowledge of local women, generally competent performance, and affordability.

2.4 Khru Khmer

Generally Kru Khmer deals with non-reproductive and maternal health based psychic issues that impact upon the health of all villagers not just women. A good Khru Khmer has higher status than a TBA but as most Khru Khmer are male they are less
likely to have the same influence as the TBA, especially in relation to birthing practices

*Khru Khmer generally deals with non-reproductive and maternal health based psychic issues that impact upon the health of all villagers not just women.*

### 2.5 Monks and Nuns

Given the gendered nature of Cambodian Buddhism, male monks have significantly more status than female nuns and have more influence over the way village people, including women derive their sense of meaning in life, than most other sources. Monks have been willing to play in active role in HIV/AIDS awareness programs and could play a more proactive role in maternal health issues.

*Monks have significantly more status than nuns and have more influence over the way village people.*

### 2.6 Health Centre staff

They receive very high marks from many rural women because they understand the world-view of rural women, are prepared to listen to what they want to say, and will visit them in their homes rather than expect them to visit them in clinics. The strengths of these workers should be built upon because of their interface with rural women.

*Health centers receive very high marks from many rural women.*

### 2.7 Referral Hospital staff

The referral hospital staff receive the most negative ranking from all rural women. Staff are considered to be very rude, arrogant and even incompetent. They offer negative opinions on the practices of village women including claims that their practices lead to all the problems they face in the first instance. They appear to have very limited understanding of rural livelihood contexts although in some areas such as Siem Reap (outside the study area) the Health Equity Funds are considered to be very useful. Village women have heard that staff involved in such programs are much more responsive than other provincial health workers they know.

*Provincial Hospital Workers receive the most negative ranking from all rural women due to poor communication with their clients including their derogatory attitudes.*
2.8 Civil Society Groups

Civil Society Groups are useful for capacity building of traditional birth attendants especially on the concept of hygiene during delivery, village level advice on pre-natal and ante-natal care, including appropriate forms of nutrition for mothers and babies.

2.9 Central Ministries

The Ministry of Economy and Finance (MEF) is very influential because it decides the level of funding provided to maternal and reproductive healthcare interventions. The assessment is based on economic rationality although some equity considerations are also made in line with the pro-poor approach. Ministry of Health (MoH) and Ministry of Women Affairs should advocate further for such a focus. In relation to non-traditional approaches the MoH not very successful at convincing rural women to abandon traditional practices (e.g. “lying by the fire”).

The MEF is very influential.

2.10 Development partners

Development partners are very influential because they fund most of the initiatives including those provided through NGOs. Development partners have made attempt to grasp the socio-cultural dimensions of the problems but maintain an emphasis on institutional strengthening and capacity building of public sector health workers rather than working at the village level.

Development partners are very influential because they fund most of the initiatives including those provided by NGOs.

3. Ethnographic Results

3.1 Poverty status of the study sites

The national poverty rate of Cambodia, as defined by, or at least accepted by the government and donor community is around 35 percent, which is considerably high but more importantly has been reduced significantly from 47 percent in 1993. In the two districts that were selected for this study, only the commune of Bong Lovea in the district of Santuk had a poverty rate close to the national average. Typical poverty rates were in excess of 50 percent as the following table reveals with the highest rate of poverty being 68 percent in the commune of Ti Pou also in the district of Santuk.
In 2004 the District Office of Social Welfare in Stoung together with GTZ undertook a poverty assessment of 18 villages in each of the five districts. This assessment identified the poorest households and these ranged from a high of 24 percent in Leap Tong Village of Trea Commune to a low of 2 percent in a village of the same name in Kompong Chen Tboung Commune. The infant mortality rate was considerably greater in only 1/3 villages, very poor households numbering more than 20 percent of households (in Roka Village 80% of infants died during delivery) but in Leap Thong there were no recorded deaths by way of contrast with the better off village by the same name where 11 percent of infants died during delivery.

A similar pattern of sorts emerges in Santuk District. In the last poor district of Beng Levea (still has access to abundant natural resources) 2/6 villages (Tror Peang Tim and Sangkrous), based this time on the FGD data had IMR in excess of 20 percent. Whereas in the poorer communes (Ti Pou and Kraya), there were 4/12 villages (Chhuk Romduol, Sophiah Mangkul, Trorpeang Pringn and Dong Kada) that recorded no infant deaths. These four villages are generally less poor than the other eight villages in the same two communes but there are still poor people living in these villages. Hence being poor per se does not mean it is impossible to avoid infant deaths (or other maternal and reproductive maladies) but it certainly helps.

Nevertheless the study is providing a plausible explanation using DSW/GTZ poverty assessment of the very poorest households. More importantly though if we were to use indices consistent with depth and breadth of poverty we are still dealing with households living in poverty or near poverty in these villages. On the other hand, because we could not find a convincing explanation we also have to note that many of the poorer households have younger women of childbearing age living and working outside the village. Some of these women are working elsewhere in Cambodia, especially in Phnom Penh (there being few off-farm employment opportunities in a province like Kompong Thom) while others are working outside the country in neighboring Thailand.

### 3.2 Livelihoods and Maternal Reproductive Health

While the study does not claim to offer original insights vis-à-vis in relation to livelihood based issues in Cambodia it does attempt to go beyond the “doom-and-gloom” pictures of how village life is painted for the rural poor in many of the studies undertaken over the past decade. Rather the study is influenced by a perspective of Cambodian village life where people living in these villages have made their own village lives, albeit within frameworks they can never completely control but that goes for everyone in every place of the world, and for better or worse it is the village where most women of reproductive age will spend most of their lives for the time being. Village life will change, perhaps irreversibly with greater levels of rural modernization and migration for employment opportunities– defined here as less reliance on farm based livelihood activities and an incremental decline in traditional
social structures and cultures – but in Cambodia, or at least in villages like the ones selected for this study “modernity” as against “development” is not likely to supplant the village in the immediate future. This is not a romantic depiction of the village holding out against change but a realistic analysis grounded in ethnographic realities.

Village livelihood in Stoung and Santuk Districts in Kompong Thom province

According to the poverty data provided in the previous section there is considerable poverty in the two districts. But what is really meant by poverty in the rural Cambodian context. The qualitative and quantitative indicators used in studies of rural poverty, even where they are quite participatory in nature, take indicators such as days of rice deficit in which households have to ration out existing rice stocks or purchase rice on the market, lack of access to clean water for drinking, cooking and bathing, inability of all children to attend school on a regular basis, high levels of indebtedness due to unexpected expenditure on livelihood shocks (and we would include problematic labor at childbirth in this category), lack of alternative income-generation activities including off-farm income, and poor roads and other communications infrastructure. None of these indicators can be disputed.
To illustrate a point about depictions of poverty it is instructive to look at the issue of rice deficits. When people at the village level argue they experience rice deficits on a seasonal basis or even on a more endemic basis (those living in deep poverty) it does not mean they cannot find rice to eat on a daily basis. What it means is that they cannot eat as much rice as they would like to eat or have available enough rice to meet cultural obligations in the villages they live in. It also means that if required to purchase rice or more typically “borrow” rice off neighbors and friends the notion of reciprocity built into such forms of livelihood support require rice deficit households to provide services that are not always calculated in proportion to the value of the rice or other goods procured. Hence there is a substantial component of unequal exchange built into such transactions but as rural women will mostly point out this has always been the situation and is not something new. What is new is the growing demand for cash rather than in-kind repayments and the monetary value attached to these traditional transactions has induced some qualitative changes in social relations at the village level. This is not surprising and any anthropologist or indeed villagers themselves can provide lots of narratives on such changes.

The underlying reality is that the livelihoods of rural women will need to improve in Cambodia before there can be substantive changes that will bring about a reduction in infant and maternal mortality rate. Rural Cambodian families will continue to be large in size because people in rural areas know full well that they cannot expect much by way of support from the government. Indeed the political culture of village women in the villages this study was undertaken in is largely reflective of this level of low expectation although a presence of NGOs in some of the villages has raised this level of expectation somewhat. What improved livelihood outcomes are predicated on though are rural women being able to incrementally increase their disposable incomes, ensure full household food security, develop a greater sense of well-being and self-esteem, and mitigate some of the existing uncertainties. Well-informed health professionals have an important role to play in this process but they are not the only group that as external facilitators can assist rural women to improve upon their existing livelihoods.

3.3 Health-Behavioral Models of Cambodian Women

This study shows a health-behavioral model we need to emphasize, one that takes a “preventive” rather than “curative” approach to maternal and reproductive health. It needs to be recognized that women becoming pregnant or avoiding pregnancy is not associated with illness and responses need to be structured in ways that important rites of passage in most rural women’s lives, such as becoming pregnant is not tantamount to falling ill. Rather it has to be recognized that a complex ensemble of factors are at work here. One of the most significant is inadequate nutrition, which stems in part from impoverished livelihoods that might include problematic household food security and even loss of knowledge surrounding traditional foods that may have
enhanced nutrition in the past. The key strategy to adopt is to move from a situation where village women and their beliefs and practices are attributed as the cause of high IMR and MMR to a situation where other factors are given far more serious consideration.

Women and Children in Stoung and Santuk Districts

Right from the outset of the FGD nearly all female participants were only too happy to describe traditional post-natal practices. It is an affirmation that they have a good knowledge of tradition, which is still something very highly valued in rural society even if it is devalued by non-rural people in Cambodia including most health professionals. We can note here as well that traditional status for rural women is not based on being literate – which few were in the past – but on good knowledge of oral traditions including beliefs and practices. Most of the young and unmarried facilitators knew much less than older women but were fascinated by the insights older female FGD participants were prepared to share with them.

Immediately following the actual delivery the mother is given a drink consisting of the urine of her spouse or a young virgin male in the village that is mixed with rice whiskey, pepper and garlic. This is thought to relax the nerves, improve blood circulation, and ward off infection. Drinking the urine affirms the existential link with the life-giving forces of the male, pepper is for the regaining of strength and garlic serves an antibiotic to ward off post-partum infections to the womb. FGD participants see nothing wrong with drinking urine at this time although not all of them have actually done so during delivery or at least they cannot recall doing so. The TBA who participated in the FGD stated this traditional practice is not always practiced and several told other FGD participants that health educators had tried to convince them that this was not a very good practice. Nevertheless, none of the FGD participants accept arguments based on hygiene to desist from this practice. Indeed they argued that those who used such an argument are basically telling village women that this traditional practice is no good despite its passage through time.
There were different interpretations on traditional practices among the women interviewed. Female FGD participants state they interpret traditional beliefs and practices relating to childbirth according to their own understanding. There is no teacher to insist that there are competing explanations, some more cogent than others, because logic is not the issue here but how women themselves interpret these beliefs and practices. The health professional accesses a body of knowledge that theoretically is subject to the scientific method (even if not all understand what this is) but this does not apply to traditional maternal health practices. Hence, as argued throughout this report it is unhelpful to a fuller understanding of the issues involved to simply juxtapose tradition against modernity although it sometimes reads this way.

The important point is that these traditional herbal formulas have served them well in the past even though the health professional question the use of some herbal preparations or at least the mixing of rice liquor with these herbs. However, it also needs to be noted that not all villagers mix rice liquor with these herbs, such as in the upland areas of Santuk. What really needs to be determined is whether rice liquor does have deleterious effects on maternal health. The FGD participants point out that the quality of rice liquor varies from village to village with the poorest or at least the most toxic type of rice liquor being manufactured commercially. It would seem to make more sense to look at the quality of rice liquor the government licenses to be made commercially. Herein may lay the real problem.

This also has important implications if any serious attempt is made to integrate traditional and modern approaches to improve maternal health. If the use of traditional herbs is good for maternal health, especially in the post partum period, and most FGD participants think they are, then it is necessary to grasp the different taxonomies existing in different agro-ecological villages. It is impossible to apply a blanket approach or design a facsimile model that applies in all contexts. This is where the bio-medical model even if attenuated by a greater level of socio-cultural understanding runs into difficulties because it is based on standardized approaches.

The FGD participants make the point on reflection that perhaps it is a good idea to collect a range of different perspectives on traditional beliefs and practices and more widely disseminate them in the villages so that village women improve their knowledge of these beliefs and practices and of course in the process preserve them. The point that is being made here is that village women are interested in issues associated with cultural survival and reducing their beliefs and practices to a bio-medical critique divesting them of any meaning or relevance is simply not the way to go.

Lying by the fire or arng pleung is stressed time-and-time again by FGD participants as traditionally the most important post-partum ritual. It is not only considered physically important but is an essential rite of passage, a point that is made repeatedly in this study. Firewood for this ritual is obtained from two trees – chombok and
krorsang – that emit aromatic scents that assist the mother with her breathing exercises and also relaxing her nervous muscles after childbirth. This ritual lasts from 3 to 7 days with 5 days being the norm and depends very much on the resourcefulness of the family. A woman’s spouse is supposed to provide as much support as possible during this time, taking time out from other activities to devote full-time attention to the mother of his child. It is a time when the husband is supposed to also cook and wash clothes although female FGD participants point out that men without much experience at cooking are not very effective. However it is the symbolism that counts more than the quality of the cooking. It symbolizes a sense of belonging that none of the female FGD participants’ thinks exist when deliveries take place outside the village.

This is by way of contrast with the non-TBA assisted birth that does not involve any of the aforementioned rituals. Here in exchange for up to 200,000 riels the woman will be given a bag of ice to treat post-partum swelling, a series of injections to ensure the womb returns to normal and different varieties of food. It is an expensive process equivalent to over 55 days of paid wage labor (more than most poor women can get in any 12 month period in the villages the study was based in) and most FGD participants do not normally consider it as effective. The most positive aspect of this process is the variety of food that women can get to eat than they would not normally eat. However, all FGD participants state they could buy this food if they needed to or more appropriately could afford to do so. The midwife with her fee-for-service does not normally provide any of the psychological support the TBA is able to offer although some FGD participants argue a sensitive midwife well versed in the traditions of the village could provide some of this support. Hence it cannot be argued that village women will rule out alternative approaches.

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**Improving Maternal Health Livelihood Outcomes**

The case study of a 35 year old woman from a poorer household in one of the study villages was presented to FGD participants to understand what improved maternal health livelihood outcomes could be possible. It is interesting and useful to compare and contrast the different responses of village women with that of the health professionals but first it is necessary to present her case study.

Of 12 pregnancies (does not include pregnancies where “miscarriages” occurred in the first trimester after conception) this woman has had since the age of 16 nearly half her pregnancies either not go full-term or with still-born babies or where the babies died in their infancy. Those that have survived have a range of ailments suggestive of quite poor health but this woman still loves all her children. During her first pregnancy she experienced extreme difficulties at birth and the TBA who attended her recalls she lapsed into a state of unconsciousness but there was nothing the TBA could do about this because it was in 1985 and there was no health center in the district. Two of her next pregnancies were relatively normal although she suffered
from anemia and was not able to breast-feed either of them. During her next full-term pregnancy a decision was made that she should give birth in the provincial hospital because it was argued she would get good post-natal care. Even the TBA suggested she should follow this course of action. Nevertheless, both babies died in her womb while on the way to the hospital because she went into labor during the height of the wet season and it took more than 15 hours by cow cart, boat and motor-bike to reach the hospital.

This did not deter her from traveling to the provincial hospital for her next pregnancy but the whole procedure cost her 425,000 riels, the cost of which she could only meet by selling one of her draught animals. Had she not owned this draught animal she thinks she would have either had to surrender a portion of her land to a commune-based moneylender or commit a portion of her wet season rice crop or provide non-remunerated labor (transplanting and harvesting) or a combination of all three services. However, the thing that disturbed her the most about her encounter at the provincial hospital – apart from being talked down to most of the time – was the surgical intervention required during childbirth. She was provided with no explanation and when she tried to remonstrate arguing that the TBA did not do such things she was told curtly that she should return to the village and get the TBA to assist her and then she would see what would happen. Having chosen this course of option in the first place because she thought it was the right thing to do, she desisted from making further comments.

Village FGD Participants

There was a general consensus that if this woman did not have access to draught animals that she could sell to defray the cost of hospital treatment then she would have been in serious trouble financially. Even if there would not be the need for a distress sale of a portion of land the ensuring level of increasing indebtedness would place this woman and her family in a more vulnerable position. It is felt that poorer women would not have this option and it demonstrates the importance villagers in Cambodia attach to have access to livestock. It would be helpful for the health professional to understand this very clearly because it really does separate the poor from the very poor.

That aside some FGD participants feel that perhaps this woman did not have as much merit or at least power to ward off the non-benign supernatural spirit forces in the village. They stopped short of suggesting that witchcraft was responsible for poor maternal and child health but argued that witchcraft should never be ruled out. Village women argue that to live in the village all people but especially pregnant women must understand the importance of placating spirits. A good TBA would know this and assist pregnant women by calling in the Kru Khmer (traditional doctor with more status and prestige than TBA) to devise a coping strategy. Hence it is argued that the TBA did not discharge her role as carefully as she should have. There are also some
questions raised as why the TBA suggested that the woman should go to the provincial hospital in the first place although some of the FGD participants suggested this was because the TBA concluded she could not cope with the existing problem. Others by way of contrast argue it was the woman’s own decision (confirmed by the study team) that she opt for a hospital-based delivery after the earlier failed pregnancies.

The hospital experience does not surprise any of the FGD participants. Rather it serves to reaffirm their negative evaluation of hospital based deliveries. They point out whatever the weaknesses of the TBA she is a partner with village women because she is a village woman herself. However, the health professional is not of the village and considers themselves culturally and economically superior to village women. They argue that this is the consequence for village women if they want to rely on health professionals domiciled in hospitals to assist them with deliveries.

3.4 Traditional Birth Attendants

It should be noted that it was much easier to mobilize FGD participants in Santuk than Stoung even though a participation fee was being paid for all participants even though the highest incidence of poverty is to be found in the villages of Stoung. Part of the reason is that in Santuk village women still embrace traditional birthing practices to a greater extent than in Stoung. Hence this questions the health professional claim via the FGD that there is a correlation between literacy and age (and by inference lack of poverty) but of course this study does not downplay this point but rather seeks to put it in context. In both districts a range of organizations, both international (UNICEF, IRC and GTZ) and NGO (ADRA and MSF) have provided a five day training course for TBA (more to be found in Santuk than Stoung). As part of the training program TBA were supplied with a birthing kit that included obstetric scissors and clamps, a pot for boiling water and other materials. This was appreciated by the TBA.

This training was based on strengthening the capacity of local TBA and was conducted in such a way that the trainers recognized the intrinsic worth of the local TBA, most importantly they were not talked down to but treated with dignity and respect: something all TBA highly valued. The training included a series of modules that would enable TBA to more quickly recognize potential problems with delivery or post-delivery and if need be refer the woman to a trained midwife at the district level or even to the provincial hospital. The training was conducted in contexts where the providers are aware of livelihood issues at the village level and it would appear that in most instances a systemic attempt was made to be as pro-poor as possible. In fact because the training was so good according to the TBA, it is recommended as part of the interventions suggested by this study to build upon this approach. This is clearly
an example of where something related to improved maternal health outcomes is working.

However, there are some issues that need to be examined in slightly more closer detail to fully understand what has been happening and what is likely to happen in these villages.

The TBA are very impressed with the kits that are provided to them and have found them very useful but the problem is they have used all the supplies and are not in a position to replenish them. They were told at the time that it would be necessary to charge a sufficient fee for the services they provide off village women: in other words some form of cost-recovery. But the TBA argued that their relationship with other village women is not like this. Instead it is based on mutual feelings of respect and bounded reciprocity and they cannot ask village women to pay for such materials. Yet the FGD facilitators argued that women are if the circumstances demand prepared to pay very substantial amounts of money to health professionals’ way in excess of the small amounts needed to pay for such supplies. Nevertheless, FGD participants still differentiated between the TBA and health professional arguing that fees for services rendered is not the type of relationship they envisage with the TBA. However, this point need not be fixed in concrete because people now pay in cash or in-kind for other villagers to assist with transplanting and harvesting. More participatory based work at the village level would assist TBA to recoup all costs associated with supplies being used during childbirth.

FGD participants also point out that as a result of this training some of the TBA are advocating the use of ice to ease the swelling and relax the uterus and some have even resorted to administering injections. But we asked what types of injections were being administered and for what purposes the response was not entirely clear. Some of the FGD participants were alarmed on listening to the response of the TBA because they assumed the TBA know what they are doing. Just how widespread this lack of clarity is among TBA is unclear but most certainly it is a worrying trend, if it is widespread. It is one of the very cogent reasons why all village women need to be involved in such programs. However, all is not lost because TBA are now combining some of the non-traditional techniques with those they are familiar with. Most encouragingly the TBA are still using appropriate herbal medicines and working more closely with the traditional Khmer doctors (Kru Khmer). The NGOs working with the TBA have not attempted to discredit the use of traditional herbal medicines unlike some of the health professionals who would serve village women more effectively if they really understood the taxonomy of herbs that women prefer to use. This of course does not negate some traditional practices such as the use of white spider’s nests in the post-partum period that may be vectors for tetanus, which can kill both mother and create immense difficulties for the surviving infant.
3.5 Perspectives of Health Professionals

Thirty-eight health professionals of whom 24 were females and only 8 (including 3 females) received training in Phnom Penh participated in the four FGDs facilitated for this study. Issues raised during the FGD focused on their perceptions as to what is wrong with traditional approaches, the limited understanding of illiterate/semi-literate village women, an assessment of the morale of in the existing public health care system, and what is needed to improve existing outcomes. The last issue is important because it during the FGD it was evident that all health professionals think that existing outcomes relating to at least to maternal health care can be improved on. However, they believe the improvements rest on a better understanding by village women of why traditional approaches do not work and more expenditure by the government on their salaries rather than also an effort on their behalf to change the way they conceptualize traditional socio-cultural beliefs of village women. Approaches that would empower village women are for the most part rejected or downplayed but as is being argued in this study this does not rule out the possibility that health professionals can modify their attitudes and behavior to also consider perspectives they are inclined to reject at present.

3.6 Fallacy of Traditional Beliefs and Practices

Nearly 75 percent of FGD participants considered that most of the traditional beliefs and practices of village women to be inimical to improved maternal health. There was considerable discussion about the merits of being “roasted” or “lying by the fire” in the postpartum period and only a few old health professionals considered there were any health benefits at all. Rather the discussion centered on the seemingly negative effects supposedly attributed to postpartum women suffering from anemia, toxic smoke ingestion, dehydration and the reluctance by village women to consider other practices. Little or no consideration was given during the FGD to socio-cultural issues surrounding such beliefs because even when the facilitators tried to raise such issues they were not considered important by most FGD participants.

Instead the FGD participants would argue that better educated, younger women were not quite as obstinate or unyielding in trying to cling on to their socio-cultural beliefs as are older women. Implied in this argument is that traditional notions as to what constitutes “women-hood” in the villages are becoming increasingly superfluous to a new generation of younger rural Cambodian women. This is seen as a positive development because it ensures that health professionals can approach younger women in contexts where more appropriate maternal healthcare models can be promoted. When asked to identify the typical younger village women that rejected traditional approaches it was very difficult for the FGD participants to identify such young women. The argument appeared to be that the more literate and less poor a younger woman is the more likely she is to question traditional beliefs and practices.
This argument might be partly correct but the study team did not find such younger women in the villages. These women might be working in factories in the capital of Phnom Penh or elsewhere or be the daughter of better-off rural households but a socio-economic analysis of the villages in the two districts the study was undertaken did not corroborate the claim of the FGD participants. Hence the putative claims are being made in a seemingly empirical vacuum. If this is indeed the sociological reality it does have to be based on more than phenomenological observation. However, even if it were likely it still does not address existing realities.

Instead this study looks to those ten FGD participants (over one quarter of these participants) who can see some merit in the traditional practices. Part of the reason is that these FGD participants understand the socio-cultural contexts that influence the way village women think and act. These health professionals do not consider it unusual or irrational that such beliefs and practices persist because they base their understanding on what has worked for village women in the past. They do not deny that some infants died during birth or soon thereafter or that some women after giving birth died. However, they recall or can imagine times in villages that are better than at present and could become better if people could recapture some aspects of their traditional livelihoods. And if not at least village women could adapt to the socio-economic changes while still retaining their dignity. This constitutes a holistic approach to women that is not evident among the other FGD participants but nevertheless it does indicate an ability and willingness to attribute village women with a worthwhile knowledge base.

What we are dealing with are partially contested versions of “reality” at the village level that are familiar to social scientists with a modicum of training but not necessarily familiar to medical scientists which, in the Cambodian context should perhaps rather be referred to as health technicians rather than scientists. Yet this is not an argument for intellectual elitism but rather an argument for competing models of knowledge to be evaluated in contexts where synergies can be achieved. The more flexible FGD participants are not suggesting that “scientific” or “technical” models be jettisoned or that they are “superior” to the more traditional approaches of village women but rather that synergies could and should be achieved between the competing approaches. This is not entirely inconsistent with the approach of village women themselves. The dogmatists in this context are not the village women but those health professionals who reject the validity of traditional approaches.

3.7 Morale in the Public Health Care System

We started the FGD thinking there would be quite low morale among the local health professionals but surprisingly we found this was not quite so and we were quite frank in encouraging FGD participants to say exactly what they thought. We pointed out that the MOH is interested in finding out the reality via this study rather than seeking
validation of its activities in maternal and reproductive health. It was made perfectly clear that none of the study team was in a position to influence the outcome of their work one way or the other although it was made clear that we would report their complaints (if any) to the MOH and suggest a roadmap to act positively on their complaints or other suggestions.

At the level of the district health center most FGD participants think there is a high degree of trust between themselves and village women seeking their assistance. They argue if this trust did not exist then village women would not seek out their assistance and this they find very satisfying. Money is one thing to all FGD participants but most genuinely state they want to deliver at least a range of satisfactory services to village women. They want the latter to think that health professionals do care about the maternal health of village women. This needs to be considered one of the strengths of the health professionals who participated in the FGD and should of course be built upon. The obverse of this is a dismal picture being painted of uncaring and insensitive health professionals. However, it also needs to noted that all FGD participants argue it is the better educated younger women who access the health centers not older and less well educated women or of course poorer and less well educated women.

Rather most FGD participants point to problems such as poor infrastructure, especially during the wet season, which limit their ability to access villages and of course for women to access health centers at the district level. There are also problems associated with poor communications via ICOM although with the spread of the mobile phone network it is now possible to communicate quite easily with the province. They also point to the lack of electricity for refrigeration and lighting purposes (essential in emergency situations) or water and toilets to meet the needs of both health professionals and village women accessing these health centers. In relation to access to safe, effective and affordable drugs this is also considered a problem, some of the drugs being in short supply include ampicillin, diazepam and oxytocin vials. These are supposed to be part of the emergency obstetric kits available in each of the Health Centers but are not always available although at private clinics and drug stores in both districts are readily available over the counter for those able and willing to pay the purchase price.

It also needs to be recognized that FGD participants also leverage their knowledge and competency to provide related services to full fee paying women. Some FGD participants earn up to 2,000,000 riel per month by providing such services (e.g. when a woman seeks their assistance during delivery) while others earn a more modest 100,000 to 250,000 riel per month for the same type of service. However, it needs to be remembered that no poor village woman would or could pay such fees – even at the lower end – for a normal delivery. This is recognized by FGD participants who use this argument to justify why they also have to spend time servicing better-off women, most of whom who would not be found in the village. In fact during the study it was found that no village woman paid a health professional to assist during a
normal delivery. It is not, as argued elsewhere, simply an issue as to whether village women want to pay health professionals for the provision of such services but of equal, if not more important what they feel culturally and psychically comfortable with.

Hence it would seem that by simply paying health professionals more would not necessarily lead to an improvement in morale, which would be readily translated into the provision of a range of services that village women would seek to utilize. But on the other hand to argue that health professionals should not be remunerated at higher levels is also a fallacious argument. A better approach, although not necessarily agreed upon by all FGD participants is to establish a system where health professionals are partly remunerated based on achievable and satisfactory outcomes, especially incremental and real improvements in the maternal health of village women.

It is not entirely clear from the FGD whether there would be an acceptance of village women also monitoring and evaluating these outcomes. FGD participants argue there already is a demand driven approach to maternal health care evidenced by the fact some women are able and willing to pay for their services. That is correct but we have to note the specific socio-economic backgrounds of such women.
III. DISCUSSIONS

a- Implication of current planning process

A government budget is intended to serve as a ‘policy document’ that seeks to communicate to the people the government’s priorities in using the scarce public resources to achieve economic development. By the same token, the budget of a national ministry should highlight clearly what the ministry intends to do with the allocated budget to achieve its mission. One of the most essential elements of a good results-oriented budget document is the clarity of what the outcomes are, and how they can be measured. The line items nature of the MoH’s budget does not serve well in that regard because the budget document makes it hard to measure the outcomes.

To get a clear grasp of the total amount of ODA and government budget dedicated to RH is a very difficult exercise. This is because development partners who support reproductive health work do not use a single system to inject their funding. Different donors are bound to follow their own procedural guidelines which seldom well coordinated and harmonized.

For the AoP 2006, in relation to government budget for RH, as reflected in the provincial AOPs, we are able to know fairly reliably only the amount of budget needed for service delivery activities (request based). The requested budget for activities of the remaining 5 key areas (behavioral change, quality improvement, human resource development, health financing, and institutional development) cannot be broken down into how much of the total requested budget is being asked specifically for RH services. This is because budget for these activities is requested for all health activities. In other words, the budget is proposed based on “key areas” not on “program”

b- Budget allocation and the Ministry of Health’s sector priorities

For decades, the health status of mothers and children of Cambodia have remained poor and posed a considerable burden which undermined the implementation of the poverty reduction policy of the Royal Government of Cambodia. The Ministry of Health recognizes these issues and has considered that the enhancement of the health condition of mother and child are priority health topics that must be addressed. The Join Annual Performance Review 2004 and 2005 recommended five sector priorities and those priorities which linked Child Survival and Reproductive Health interventions, including HIV/AIDS:

1. Emergency Obstetric Care
2. Attendance at Delivery by Trained Health Providers
3. Expand from Integrated Management of Childhood Illness to a broader Child Survival strategy (CS Scorecard)
4. Full MPA Status at Health Centers
5. Reproductive Health including Birth Spacing Services

It is expected that once these five sector priorities are solved, the health condition of mother and child will be enhanced which would contribute to reduce the high mortality of mother and child of Cambodia. Though table 2 shows that there is a remarkably disproportionate budget allocation for dealing with the health sector priorities (maternal and child health) of the Ministry of Health. In comparison to other programs like Communicable disease control, the budget for directly managing maternal and child health is about 5%, in particular reproductive health (1.5%) which is about the lowest rank of budget allocation priorities.

The budget allocation for the five programs of AoP 2007 does not indicate that the fund shared for managing mother and child health, especially reproductive health is less MoH priority. Maternal and child health are cross-cutting issues, which are influenced by many factors, and those factors are associated with management and administration of MoH, communicable disease control, non-communicable control, and quality of health service delivery. Therefore, when all the five programs and subprograms of the AoP 2007 enhanced, it will contribute to improve the maternal and child health which includes the reproductive health.

c- Shortage of Budget for reproductive health care

Table 2 shows the distribution of the women from age 15 to 49 years old. The total percentage of women aged 15 to 49 is 46.9% (the Cambodia Demographic Health Survey 2000). The total Cambodia population was 11,437,656 (general population census of Cambodia 1998), so the entire number of Cambodian women aged from 15 to 49 years old was 5,364,261.

In the year 2006, the total budget for reproductive health requests to the government was 2,465,832,950 riels which approximately equal to US$616,4001. However, in practice, the possibility of using the national health budget approved by the government and national assembly is very limited. According to Papers on Cambodia Macroeconomic and Health, in the year September, p35, 40, 2003, the ratio of committed allocation to approved budget was 85%, and this occurs specifically for the provincial level (Report of Primary Health Care, Ministry of Health, 2001). It is estimated that the real national reproductive health budget used for the year 2006 was about US$246,500 and overall budget spending for reproductive health care supplied by government and donors was about $1,215,800. This means that about US$0.28 was expected to be used for reproductive health care for one Cambodian woman aged 15 to 49 for the year 2006.

1 US$=4000 riels
The RGoC through MoH is committed to improving health care, and claims that shortage of funds for reproductive health is a results of maternal of many different factors. The commitment of MoH and RGoC showed through the sector priorities 2007 of MoH and the percentage if national budget allocation for health care was very high with equal to about 10% of per capital GDP. It is the highest percentage among developing countries in ASIA and as well over twice the average for ASEAN countries. (Paper on Cambodia Macroeconomics and Health), however, the percentage is equivalent to a very small amount of money (3 to 4US$). The government health expenditure remains very low, this might be due to country economic status and the donors agenda.

The tremendous source of funding the Cambodia health system come from International Development Assistant (IDA) through the aids in the direct grants from bilateral and multilateral, partners as well as philanthropic foundations, preferential loans and technical assistance. Because the most source of fund for health is outside Cambodia, money may be directed to needs that are perceived from abroad instead of Cambodia. As result of global trends, some areas are relatively well fund while others remain seriously under funded. For example, HIV/AIDS received US$29.3 Million in 2003 (Paper on Cambodia Macroeconomics and Health, 2006). This indicates that there is an opportunity to mobilize more funds from IDA for directly implementing reproductive health program in the future.
IV. KEY FINDINGS

MoH planning and budgeting process in relation to reproductive health

- The planning and budgeting system in place is not sufficient to ensure that the funds are used in the way that would bring about the most positive change.
- There is continuation of efforts and commitments of Ministry of Health to refine to its planning process as well as contributions to the broader reform process across the public sector to strengthen accountability, encourage performance, and increase transparency in the public sector.
- The Ministry of Health is strongly committed to improving the reproductive health, though, the budget allocation for directly managing and implementing reproductive health activities is quite low. The AoP 2007 of MoH envisages to contribute to promoting the maternal health in Cambodia including reproductive health.
- The donors seem not place the reproductive health program as the top priority on their agenda.

Stakeholder analysis

- Women have limited to express their health concerns and men are important stakeholders because they are in a position to provide support to their spouses in making decision on their reproductive health matters. The Monks have significant influence over the villagers. Most rural women still prefer traditional birth attendants because of their similar socio-economic status, personal knowledge of local women, and affordability. Khru Khmer on the other hand generally deals with non-reproductive and maternal health based psychic issues that impact upon the health of all villagers not just women.
- Health Center staff are the group that are most acceptable by women in the community, but Referral Hospital staff receive the most negative ranking from all rural women due to negative attitude toward their clients.
- Civil Society Groups have proven useful for capacity building among the TBA concerning the concept of hygiene during the child birth, village level advice on pre-natal and ante-natal care, including appropriate forms of nutrition for mothers and babies.
- The MEF and development partners are very influential because they fund the Reproductive Health initiatives of government and non-government organizations.
Inadequate nutrition, which stems in part from impoverished livelihoods that often include problematic household food security and even loss of knowledge surrounding traditional food, are some causes behind the IMR and MMR.

There are strong controversial values on the traditional beliefs and practices among elder rural and non-rural population and not shared by medical professionals.

The important point is that the traditional herbal formulas have served mothers well in the past even though the health professional question the use of some herbal preparations or at least the mixing of rice liquor with these herbs. For health safety reason, it is critical to look at the quality of rice liquor and herbal preparation. Furthermore, it is important that if any serious attempt is made to integrate traditional and modern approaches to improve maternal health, especially in the post partum period.

The women make the point on reflection that perhaps it is a good idea to collect a range of different perspectives on traditional beliefs and practices and more widely disseminate them in the villages so that village women improve their knowledge of these beliefs and practices and of course in the process preserve them. The point that is being made here is that village women are interested in issues associated with cultural survival and reducing their beliefs and practices to a bio-medical critique.

There is a wrong belief and practices in injection post partum to make mother health better and stronger. These belief and practices are not only scientifically sound but waste money of the poor mothers. Non-TBA assisted birth that does not involve any of the practiced rituals. In exchange for up to 200,000 riels the woman will be given a bag of ice to treat post-partum swelling, a series of injections to ensure the womb returns to normal and different varieties of food. It is a high cost for poor women and most participants do not normally consider it as effective. The most positive aspect of this process is the variety of food that women can get to eat than they would not normally eat. As the majority of rural women live under poverty line of approximately 0.50 USD, the fee charged by non-TBA services should be studied and reduced as the fee could discourage poor women from accessing the services.

Traditional Birth Attendants

Traditional birth attendants still use herbal medicines and working more closely with Kru Khmer. The NGOs working with the TBA have not attempted to discredit the use of traditional herbal medicine unlike some of the
health professionals who would serve village women more effectively if they really understood the taxonomy of herbs that women prefer to use.

- The TBAs practices are being enhancing through appropriate trainings and provision of birth kits, but the use of birth kits may not be sustainable.

**Perspectives of Health Professionals**

- Interviewed health professionals maintained that improvement of maternal health rested on a better understanding of reproductive health and on necessary behavioral changes of negative beliefs and practices of villagers.

**Fallacy of Traditional Beliefs and Practices**

- There was considerable discussion about the merits of being “roasted” or “lying by the fire” in the postpartum period and only a few old health professionals considered there to be any health benefits. The discussion centered on the seemingly negative effects supposedly attributed to postpartum women suffering from anemia, toxic smoke ingestion, dehydration and the reluctance by village women to consider other practices. Participants would argue that better educated, younger women were not strongly convinced by this belief and practice.

- Villagers did not suggest that “scientific” or “technical” models are “superior” to the more traditional approaches but rather that synergies could and should be achieved between the competing approaches. However, health professionals denied the validity of traditional approaches.

**Morale in the Public Health Care System**

- Health professionals at health centre think there is a high degree of trust between themselves and village women seeking their assistance. They argued it is the better educated younger women who access the health centers not older and less well educated women or of course poorer and less well educated women.

- Poor health infrastructure, communications, electricity and supplies discourage women to utilize public health facilities.

- Simply paying health professionals more would not necessarily lead to an improvement in morale, which would be readily translated into the provision of a range of services that village women would seek to utilize.
V. RECOMMENDATIONS

**MoH planning and budgeting process in relation to reproductive health**

- Though the process of planning and budgeting has been reformed, the Ministry of Women's Affairs should cooperate with MoH to advocate for and mobilize more budget directly for implementing maternal health, in particular reproductive health program to reach the poor women most in need of medical care. A comprehensive advocacy strategy for mobilizing fund should be developed and implemented for this purpose which would development partners to work with MoH to improve the maternal and child health, in particular reproductive health.

- The report that health center use to fill out information on activities should be redesigned in such way that all health visits are recorded, by sex and by type of consultation. Having this disaggregation by sex and by type of visit would make it possible to conduct a benefit incidence analysis of health spending on the health center.

**Stakeholder analysis**

- Support women in decision making for appropriate health seeking behavior, and encourage speaking out about their reproductive health concerns through improve media accessibility, and education.

- Change the attitude of the health providers in particular the Provincial Hospital staff for better communication with their clients.

- Identify mechanisms that will bring TBAs and Health Professional to work together significantly to promote safe motherhood.

- Religious leaders, monks, can play an important role in raising awareness in maternal and child health.

**Health-Behavioral Models of Cambodian Women**

- Health education of nutrition and food gardening along with income generating activities and employment for women, especially in rural areas should be promoted for improvement of mothers’ nutritional status.

- There are strong controversial values on the traditional beliefs and practices among elder rural and non-rural population and not shared by the medical professionals. The village women are interested in issues associated with cultural survival and reducing their beliefs and practices to a bio-medical
critique. However, traditional belief and practices especially in the post partum period that might have an adverse affect on health condition should be avoided such as:
- drinking urine,
- the traditional herbal formulas (the use of the mixing of rice liquor with the herbs).
- roasting have negative adverse effect on postpartum women health with anemia, toxic smoke ingestion, dehydration and the reluctance by village women to consider other practices. As the beliefs and practices of roasting is deeply rooted in Khmer rural society, it is critical to develop an effective health education campaign to change these.

○ Influence change in wrong belief and practices relating to post partum injection to make mothers' health better and stronger by providing health education to mothers and training the Non-TBA assisted birth about post partum are and identify the way to reinforce the inappropriate practices of post partum care of Non-TBA assisted births and mothers.

**Traditional Birth Attendants**

○ Maintain the skills and practices of the trained TBAs through providing refresher course and provide training to other TBAs who did not get training before; and conduct regular monitoring and supervision of their practice. Find out ways to make birth kids available for use also in a more sustainable manner.

**Morale in the Public Health Care System**

○ The Ministry of health should continue its efforts to enhance the quality of health service delivery, which would include improvement of health facilities, equipments and supplies, human resources, and the performance of health professionals. This would in turn enhance women’s health accessibility to health care.
REFERENCES


The Second Health Annual Sector Annual Operation Plan, p6, 2006.


