REPRODUCTIVE HEALTH *at a* GLANCE

CAMBODIA

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Country Context

Despite a decade of robust economic growth, Cambodia is still one of the poorest countries in Southeast Asia. The country has made progress toward some of its Millennium Development Goals (MDGs) including poverty reduction, expansion of primary education and closing the gender gap in education literacy, and wage employment. Yet, twenty six percent of the population still subsists on less than US $1.25 per day.[1] Progress toward MDG 5 is lagging behind despite improved rates of prenatal visits, increased use of trained midwives for delivery, and reduction in total fertility.[2] Limited access to health services including emergency obstetric care remains a barrier to further reduction of maternal mortality.

Cambodia's large share of youth population (34 percent of the country population is younger than 15 years old[1] provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[3] In Cambodia, the literacy rate among females ages 15 and above is 69 percent.[1] Education enrollment rates in primary are about the same for males and females (around 50 percent) but fewer girls are enrolled in secondary schools compared to boys with 82 percent ratio of female to male secondary enrollment.[1]

Three-quarters of adult women participate in the labor force that mostly involves work in agriculture.[1] Gender inequalities are reflected in the country's human development ranking; Cambodia ranks 114 of 157 countries in the Gender-related Development Index.[4]

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[3]

Cambodia: MDG 5 Status

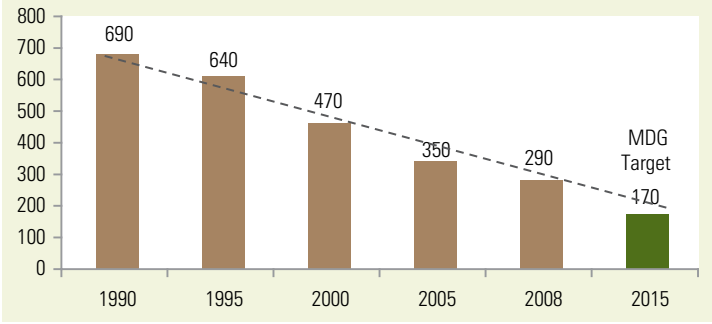
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	290
Births attended by skilled health personnel (percent)	43.8
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	40
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	47
Antenatal care with health personnel (percent)	69.3
Unmet need for family planning (percent)	25.1

The 2005 Cambodia DHS estimated maternal mortality ratio at 472
Source: Table compiled from multiple sources

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Cambodia has been making progress over the past two decades on maternal health but it is not on track to achieve its 2015 targets.[5]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank support for Health in Cambodia

The Bank's latest Country Assistance Strategy was for fiscal years 2005 to 2008.

Current Project:
P102284 KH-Second Health Sector Support Program ($20.1m)

- *Strengthening Health Service Delivery*
- *Improving Health Financing*
- *Strengthening Human Resources*
- *Strengthening Health System Stewardship Functions*

Pipeline Projects: None

Previous Health Project: P070542 KH-Health Sector Support Project

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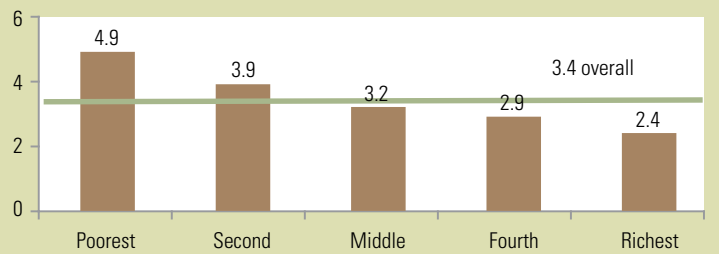
Key challenges

High Fertility

Fertility has been declining over time but is still high among the poorest. Total fertility rate (TFR) has dropped between 2000 and 2005, from an average of 4.0 births per woman to 3.4 births.[6]

Lower TFR is associated with urban location, higher education, and wealth. TFR among poorest Cambodians is twice that of the wealthiest (Figure 2). A similar disparity is observed among women with different levels of education: TFR is 2.6 among women with secondary education or higher compared to 4.3 among women with no formal education.

Figure 2 ▪ Total fertility rate by wealth quintile

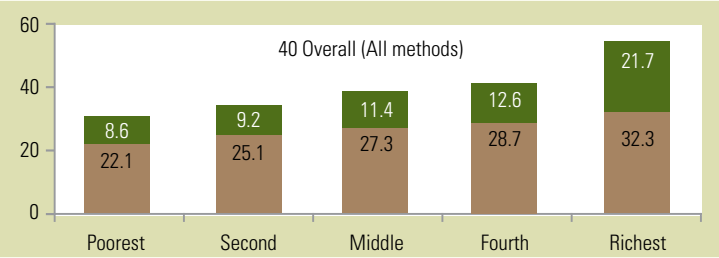


Source: DHS Final Report, Cambodia 2005.

Adolescent fertility rate is high (47 births per 1,000 births) affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[3,7]

Two-fifths of married women are using contraception. Use of contraception among married women was 40 percent in 2005, up from 24 percent in 2000.[6] Use of modern contraception methods is more common among wealthier, and more educated women as well as those living in urban areas (Figure 3). The pill is the most commonly used method (13 percent), followed by injectables (8 percent). Use of long-term methods.

Figure 3 ▪ Use of contraceptives among married women by wealth quintile



Source: DHS Final Report, Cambodia 2005.

Unmet need for contraception is high at 25 percent indicating that women may not be achieving their desired family size.[6,8]

Abortion became legal in Cambodia, in 2005 but women continue to have unsafe abortion with several abortion-related complications reported each year.[9] Among the 8 percent of women who reported having experienced induced abortion, **44 percent have had multiple induced abortions, a rise from the 29 percent reported in 2000**.[6]

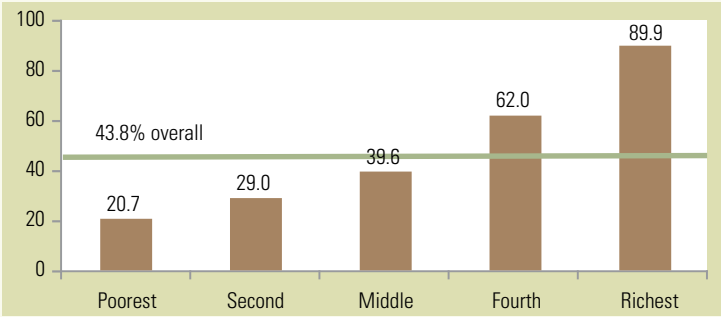
Many women do not intend to use modern contraceptive methods due to health concerns/fear of side effects (40 percent).[6] While a fifth indicated inability to get pregnant, reasons such as opposition to use and lack of knowledge were negligible. Cost and access are lesser concerns, indicating further need to strengthen family planning services.

Poor Pregnancy Outcomes

Majority of pregnant women receive antenatal care from skilled health personnel. Sixty-nine percent of pregnant women received antenatal care from skilled health personnel (doctor, midwife, or nurse) a remarkable increase from just 38 percent in 2000.[6] Further, 27 percent of them had the recommended four or more antenatal visits.

Forty four percent of women deliver with the assistance of skilled health personnel and wide disparities exist among income groups (Figure 4).[6] Similarly, 70 percent of women in urban areas delivered with the assistance of skilled health personnel, only 39 percent of women in rural areas obtained such assistance. Of those women who did not give birth in a health facility, 37 percent never received a postnatal care.[6]

Figure 4 ▪ Birth assisted by skilled health personnel (percentage) by wealth quintile



Source: DHS Final Report, Cambodia 2005.

Nearly three-quarters of women who indicated problems in accessing health care cited concerns regarding inability to afford the services. Concerns about unavailability of service providers or lack of drugs were raised by 50 percent of the women (Table 1).[6]

Human resources for maternal health are limited with only 0.16 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.85 per 1,000 population.[1]

Table 1. Barriers in accessing health care (women aged 15–49)

Reason	%
At least one problem accessing health care	88.5
Getting money needed for treatment	74.1
Concern no drugs available	51.4
Concern no provider available	50.5
Not wanting to go alone	45
Having to take transport	38.7
Distance to health facility	38.7
Concern no female provider available	36.9
Getting permission to go for treatment	14.3

Source: DHS final report, Cambodia 2005.

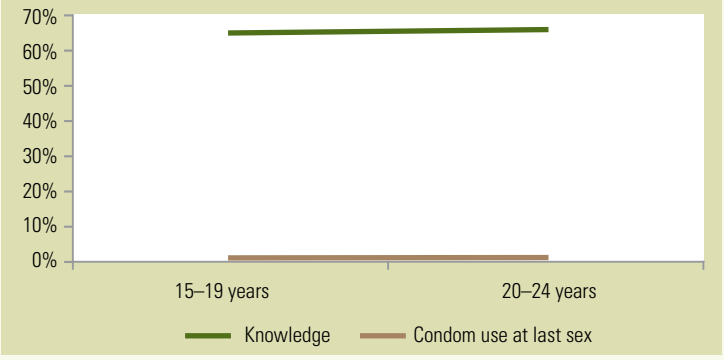
The moderately high maternal mortality ratio at 293 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[5]

STIs/HIV/AIDS prevalence is low

The prevalence of HIV in Cambodia is 0.6 percent of the adult population aged 15–49.[6] While HIV/AIDS' awareness is high, knowledge of mother-to-child prevention methods is limited. While knowledge among women (aged 15–49 years) that HIV can be transmitted by breastfeeding is high (87 percent), just 33 percent knew that the likelihood of passing HIV from mother to child can be reduced by drugs.[6]

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While most young women are aware that using a condom in every intercourse prevents HIV, only 1 percent of them report having used condom at last intercourse (Figure 5). This gap persists among older aged women likely due to the fact that the chance of using condoms as a form of contraception diminishes with marriage.

Figure 5 ▪ Knowledge behavior gap in HIV prevention among young women



Source: DHS Final Report, Cambodia 2005 (author's calculation).

Technical Notes

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3. These countries are also a subgroup of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

Development Partners Support for Reproductive Health in Cambodia

WHO:	Health systems strengthening, safe motherhood;
UNFPA:	Reproductive health and rights, access to contraceptive, family planning training;
UNICEF:	Child health, child protection, sexual exploitation.
USAID:	HIV/AIDS; skilled birth attendance, MCH voucher program.
DFID:	Maternal mortality reduction, health sector support;
AUSAID:	Health sector support, emphasis on MCH service strengthening;
ADB:	Health sector support; maternal and child health focus;
GTZ:	quality improvement and increased access for poor and rural populations with emphasis on midwives;
Marie Stopes:	Family planning services, abortion and post-abortion care, maternal health, HIV/STIs, advocacy;
FHI:	HIV/AIDS care and support with focus on sex workers and their clients

Key Actions to Improve RH Outcomes

Strengthen gender equality

- The vulnerability of women and girls has been recognized in the 2005 Domestic Violence Law; however, more emphasis needs to be directed towards gender issues and effective strategies to achieve gender equality;
- Promote male involvement in reproductive health as a means to strengthening gender equality and to encourage women's health seeking behavior, especially in relation to reproductive health.

Reducing high fertility

- Increase family planning awareness by expanding the menu of family planning services available (also to include permanent and long lasting methods) and increasing utilization through Community Based Distribution of family planning commodities, especially targeting rural and remote communities;
- Mobilize communities and increase women's knowledge of contraceptive: promote IEC activities targeting both women and girls in their reproductive years to educate them of the potential health and side effects of contraception and to empower them in making their own choices.
- Focus on adolescents to delay first pregnancy and design interventions that address their reproductive needs through the provision of culturally appropriate and user-friendly services in both urban and rural areas.
- Although abortion is legal, there needs to be an increase in the number of safe abortions; address the key issues that constrain access to safe abortion and post-abortion care including: shortage of trained staff, referral delays, and cost.

Reducing maternal mortality

- Address the shortage of skilled birth attendants: invest in the training of midwives, develop innovative approaches that will increase the retention of midwives in remote areas, and support incentive program to increase quality of care.
- Promote the availability and access to emergency obstetric and newborn care (EmONC) services, especially in rural hard-to-reach areas, to reduce maternal mortality.
- Establish a continuum of care to ensure women have access to both ANC and PNC by improving the referral system and strengthening coordination between public and private facilities.

Reducing STIs/HIV/AIDS

- Target most-at-risk populations to ensure they receive access to treatment and care, and the general population with more awareness raising and educational activities about HIV/AIDS, to avoid a resurgence of the epidemic.
- Support for the dissemination and use of the recently introduced female condom and promote its dual role of protecting against unwanted pregnancies as well as STIs, including HIV.

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CAMBODIA REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births/woman ages 15–49)	2005	3.4	Population, total (million)	2008	14.6
Adolescent fertility rate (births/1,000 women ages 15–19)	2005	47	Population growth (annual %)	2008	1.6
Contraceptive prevalence (% of married women ages 15–49)	2005	40	Population ages 0–14 (% of total)	2008	34.1
Unmet need for contraceptives (%)	2005	25.1	Population ages 15–64 (% of total)	2008	62.5
Median age at first birth (years) from DHS	—	—	Population ages 65 and above (% of total)	2008	3.4
Median age at marriage (years)	—	—	Age dependency ratio (% of working-age population)	2008	60
Mean ideal number of children for all women	2005	3.3	Urban population (% of total)	2008	21.6
Antenatal care with health /sonnel (%)	2005	69.3	Mean size of households	2005	5
Births attended by skilled health /sonnel (%)	2005	43.8	GNI/capita, Atlas method (current US$)	2008	640
Proportion of pregnant women with hemoglobin <110 g/L)	2008	66.4	GDP/capita (current US$)	2003	711
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	691	GDP growth (annual %)	2008	6.7
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	636	Population living below US$1.25/day	2003	25.8
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	470	Labor force participation rate, female (% of female population ages 15–64)	2008	75.6
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	347	Literacy rate, adult female (% of females ages 15 and above)	2004	68.6
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	293	Total enrollment, primary (% net)	2008	88.6
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	173	Ratio of female to male primary enrollment (%)	2008	93.6
Infant mortality rate (per 1,000 live births)	2008	66.4	Ratio of female to male secondary enrollment (%)	2007	81.6
Newborns protected against tetanus (%)	2008	87	Gender Development Index (GDI)	2008	114
DPT3 immunization coverage (% by age 1)	2005	75.5	Health expenditure, total (% of GDP)	2007	5.9
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	3.5	Health expenditure, public (% of GDP)	2007	1.7
Prevalence of HIV (% of population ages 15–49)	2007	0.8	Health expenditure/capita (current US$)	2007	35.8
Female adults with HIV (% of population ages 15+ with HIV)	2007	28.6	Physicians (per 1,000 population)	2000	0.16
Prevalence of HIV, female (% ages 15–24)	2007	0.3	Nurses and midwives (per 1,000 population)	2000	0.85

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2005	4.9	3.9	3.2	2.9	2.4	3.4	2.5	2.0
Current use of contraception (Modern method)	DHS	2005	22.1	25.1	27.3	28.7	32.3	27.2	–10.2	0.7
Current use of contraception (Any method)	DHS	2005	30.7	34.3	38.7	41.3	54	40	–23.3	0.6
Unmet need for family planning (Total)	DHS	2005	31.4	29.2	26.2	22.3	16.8	25.1	14.6	1.9
Births attended by skilled health personnel (percent)	DHS	2005	20.7	29	39.6	62	89.9	43.8	–69.2	0.2

National Policies and Strategies that Have Influenced Reproductive Health

National Strategy for Reproductive and Sexual Health in Cambodia (2006–2010): aims to ensure an effective and coordinated response to reproductive and sexual health needs in the country; the strategy is based on 4 guiding principles: (a) human rights and empowerment, (b) gender equity, (c) multisectoral partnerships, linkages, and community involvement, and (d) evidence based programming.

National Population Policy of Cambodia (2003) recognizes the central role of reproductive health services, empowerment of women through equal access to education and public office, and the link between poverty and rapid population growth.

Abortion law (1997) – permissible upon request up to twelfth week and under special circumstances in the second trimester.