Cambodia

Aligning Partners for Child Survival

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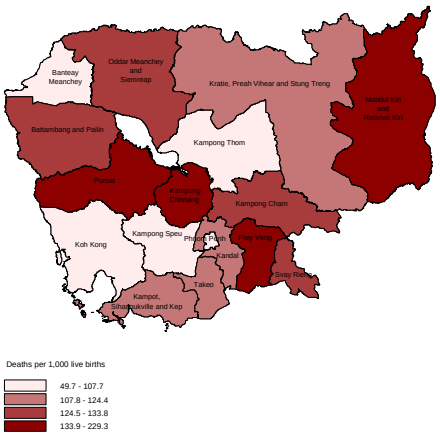
Under-5 Mortality Rates in Cambodia (1)

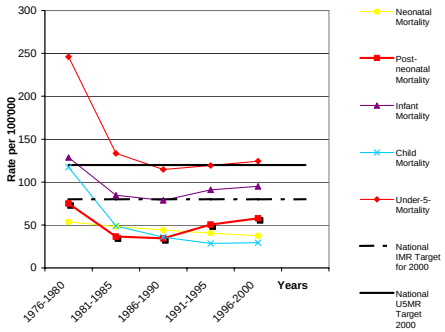


Background: Cambodia has very high early childhood mortality rates despite considerable progress made in the 1980s and early 1990s. In 2000 under-five (U5MR) and infant mortality rates (IMR) were 124 and 95 per 1,000 live births with considerable regional variation (see map), and trends seemed to be stagnating (Fig. 1).

In 2002, the Royal Government of Cambodia (RGC) and its partners agreed to analyse in detail the causes of death and the reasons for this halting trends. An analysis of slow progress in child mortality reduction collecting all available information was carried out that showed that despite considerable progress in certain child survival interventions such as immunizations, vitamin A supplementation (VAS), malaria control, the major causes of childhood deaths in Cambodia were not sufficiently (2).

The neglected areas included case management of acute respiratory infections (ARI), control of childhood diarrhoea (CCD), newborn care, and infant and young child feeding (IYCF). After the formation of the Global Child Survival Partnership (CSP), in 2003, which offered its support, the RGC convened a high level consultation (HLC) on Millennium Development Goal 4 (MDG 4) – Reducing Child Mortality in Cambodia that took place in 2004. Leading to this consultation, partners jointly carried out additional analyses on obstacles to achieving MDG 4 in Cambodia. These included reviews on ARI case management, care seeking behaviour, immunization services, childhood nutrition, resource allocations and organizational issues. The HLC findings, conclusions and recommendations have been used to redirect the efforts of all partners towards a more coherent approach for child survival in Cambodia.

Trends in Early Childhood (3)



Objectives: The objective of this effort is to develop a national child survival strategy that aligns all partners with a common approach consisting of common priorities, one national plan, one coordination mechanism and one monitoring and evaluation framework.

Methods: the process used literature and desk reviews, key informant interviews, policy dialogue and consensus building among partners.

Findings: The main causes of childhood deaths in Cambodia are neonatal conditions (32%), ARI (20%) and diarrhoea (18%). Forty-five percent of all children are under-weight.

Progress for child survival in the 1990s was mainly limited to increasing immunization and VAS coverage. Measles, Malaria and HIV/AIDS contribute little to child mortality. There are considerable inequalities in all health indicators. The main obstacles for achieving MDG 4 are within the health sector are: inappropriate care seeking behaviour, inequities in health that are not sufficiently addressed, health system issues including organizational fragmentations, health care financing and human resources, inadequate donor support. External support for the health sector, which doubles that of the RGC, is mainly directed to HIV/AIDS (35%), TB, malaria and dengue fever (13%) and other areas (12%), while maternal and child health receive only 16% (4).

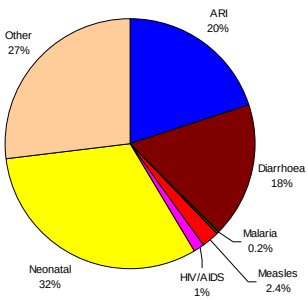
The Cambodia Child Survival Score Card

Intervention	2000 Coverage	2007 Target	2004 Coverage	Coverage Gap
Infant and Young Child Feeding				
Initiation of Breastfeeding *	11%	35%	25% [8)]	74%
Exclusive Breastfeeding	11%	25%	2% [6)]	88%
Complementary Feeding	71%	95%	88% [6)]	11%
Oral Rehydration Therapy (ORT)	74%	80%	45% [6)]	54%
Antibiotic for Pneumonia	35%	50%	-	64%
Insecticide Treated Nets	12%	100%	20% [7)]	79%
Malaria Treatment	62% (2%) [5)]	100%	-	37%
Vitamin. A	29%	80%	74%	25%
Measles vaccine	41%	80%	65%	34%
Tetanus toxoid	30%	70%	51%	48%
Skilled birth attendance	32%	60%	32%	67%

* This additional score card indicator has been added as part of essential care of the newborn as recommended by the WHO/UNICEF Regional Child Survival Strategy.
5) In a recent survey 62% of all children received any antimalarial when suspected to have fever but only 2% received the recommended artemisin-based combination therapy.
6) Non-nationally representative UNICEF Seth Koma Follow-up Survey 2003

The following medium-term actions were agreed: (1.) increase resources for achieving universal coverage for high-impact child survival interventions included in the 'score card' (3;5-8); (2.) bring these interventions closer to the community; and (3.) improve access to health care for the poor.

Cause-specific Mortality (9)



Four immediate action were called for (1.) to work towards universal coverage for high-impact preventive and curative care through IMCI and integrated outreach services; (2.) to promote demand for appropriate health interventions, including behaviour change communication for improved care seeking behaviour and IYCF, and social marketing for ORS; (3.) To increase and realign budget allocation for child survival; and (4.) to strengthen the institutional leadership for Cs within the Ministry of Health.

Since the HLC the following partners have strengthened their efforts for CS in Cambodia: the European Commission Humanitarian Aid Office (ECHO) has made

1 million Euro available for a CS initiative; the World Bank/ADB/DFID/UNFPA funded Health Sector Support Project (HSSP) has increased its funding to CS; the NGO umbrella organization MEDICAM has organized an NGO Workshop and called for more coherent child survival action of its member organisations; UNICEF and USAID is revising its country strategy for health increasing CS funding; UNICEF, USAID, WHO and many NGOs have joined forces for a strong breastfeeding promotion campaign. Progress towards universal coverage of scorecard interventions is variable (5;7;8) but with united focus and effort the job can be done.

Conclusions: Based on a thorough situation analysis and international support through renewed attention to child survival, it is possible to engage a large an inhomogeneous group of partners with a common approach for child survival led by the government. Common priorities and a common set of indicators is a useful tool for this purpose. Preset funding priorities of external partners other than child survival, however, limit the support for this area of work despite the big need.

Policy Implications: All countries with a high burden of child mortality should give priority to achieving universal coverage for an essential package of a limited set of high-impact child survival interventions while keeping an eye on inequalities in coverage. A country child survival scorecard with agreed standard indicators that are globally monitored will support this process and should help to align external support for child survival.

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