

# **Country Programme Action Plan (CPAP)**

## **2016-2018**

**for the**

**Programme of Cooperation**

**between**

**The Royal Government of Cambodia**

**And**

**The United Nations Population Fund**



**The Royal Government of Cambodia**



**United Nations Population Fund**

## List of Acronyms

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APRO	UNFPA Asia and Pacific Regional Office
ARH	Adolescent Reproductive Health
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BS	Birth Spacing
BSS	Behavioural Sentinel Survey
CBD	Community Based Distribution
CCWC	Commune Committee for Women and Children
CDC	The Council for the Development of Cambodia
CDHS	Cambodian Demographic and Health Survey
CEDAW	Convention for the Elimination of all forms of Discrimination against Women
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CIPS	Cambodian Inter-Censal Population Survey
CMDG	Cambodia Millennium Development Goals
CNCW	Cambodian National Council for Women
CO	Country Office
CP	Country Programme
CPA	Complimentary Package of Activities
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CS	Child Survival
CSES	Cambodia Socio-Economic Survey
CSO	Civil Society Organization
D&D	Decentralization and Deconcentration
DFAT	Department of Foreign Affairs and Trade
DM	District and Municipality
DPHI	Department of Planning and Health Information
DV Law	Law on Prevention of Domestic Violence and Protection of Victims 2005
EmONC	Emergency Obstetric and Newborn Care
EMIS	Education Management Information System
EW	Entertainment Workers
FACE	Funding Authorization and Certificate of Expenditure
FP	Family Planning
FTIRM	Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality
GBV	Gender-Based Violence
GCA	Government Coordinating Authority
GDP	Gross Domestic Product
HACT	Harmonized Approach to Cash Transfer
HC	Health Center
HCMC	Health Center Management Committee
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HRD	Human Resource Department
HSP	Health Sector Strategic Plan
HSS	HIV Sentinel Surveillance
HSSP	Health Sector Support Programme

ICHAD	Interdepartmental Committee on HIV/AIDS and Drugs
ICM	International Confederation of Midwives
ICPD PoA	International Conference on Population and Development Programme of Action
IEC	Information, Education and Communication
IMF	International Monetary Fund
IP	Implementing Partner
IP3	Three-Year Implementation Plan (for SNDD)
IUD	Intrauterine Device
JAPR	Joint Annual Performance Review
JAHSR	Joint Annual Health Sector Review
JICA	Japan International Cooperation Agency
JMIs	Joint Monitoring Indicators
JUTH	Joint UN Team of HIV/AIDS
KOICA	Korean International Cooperation Agency
MDG	Millennium Development Goals
MH	Maternal Health
MMR	Maternal Mortality Rate
MPA	Minimum Package of Activities
MoEYS	Ministry of Education, Youth and Sports
MoH	Ministry of Health
MoLMUPC	Ministry of Land Management, Urban Planning and Construction
MoP	Ministry of Planning
MoSAVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MoWA	Ministry of Women's Affairs
MPA	Minimum Package of Activities
MSM	Men Who Have Sex With Men
M&E	Monitoring and Evaluation
NAA	National AIDS Authority
NAPVAW II	Second National Action Plan to Prevent Violence Against Women
NCDDS	National Committee for Sub-National Democratic Development Secretariat
NCDM	National Committee for Disaster Management
NGMVAW/C	National Guidelines for Managing Violence against Women and Children
NGO	Non-Governmental Organization
NIPH	National Institute of Public Health
NIS	National Institute of Statistics
NPP	National Population Policy
NP-SNDD	National Programme for Sub-National Democratic Development
NRHP	National Reproductive Health Programme
NSDP	National Strategic Development Plan
NSRSH	National Strategy for Reproductive and Sexual Health
OD	Operational District
PBA	Programme-Based Approach
PD	Population Dynamics
PHD	Provincial Health Department
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
P4P	Partners for Prevention
RGC	Royal Government of Cambodia
RF	Referral Hospital
RH	Reproductive Health
RHC	Reproductive Health Commodities
RRF	Results and Resources Framework
SDG	Sustainable Development Goals
SIS	Strategic Information System
SNDD	Sub-National Democratic Development

SP	Strategic Plan (UNFPA, 2014-2017)
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWAP	Sector-Wide Approach
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TWG	Technical Working Group
TWG-G	Technical Working Group on Gender
TWG-GBV	Technical Working Group on Gender-based Violence
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNRC	United Nations Resident Coordinator
UNV	United Nations Volunteers
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UN YAP	United Nations Youth Advisory Panel
UN YTF	United Nations Youth Task Force
USAID	United States Agency for International Development
VAWG	Violence Against Women and Girls
WHO	World Health Organization
WP	Work Plan
YFCS	Youth-Friendly Clinical Services

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## THE FRAMEWORK

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In mutual agreement to the content of this document and their responsibilities in the implementation of the Country Programme, the Royal Government of Cambodia (hereinafter referred to as the Government) and the United Nations Population Fund (hereinafter referred to as UNFPA).

*Furthering* their mutual agreement and cooperation for the fulfillment of the International Conference on Population and Development Programme of Action;

*Building* upon the experience gained and progress made during the implementation of the previous Programme of Cooperation;

*Entering* into a new period of cooperation;

*Declaring* that these responsibilities will be fulfilled in a spirit of friendly cooperation;

*Have agreed as follows:*

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## PART I: BASIS OF RELATIONSHIP

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The Basic Agreement concluded between the Government of Cambodia and the United Nations Development Programme on the 19<sup>th</sup> of December 1994 (the “Basic Agreement”) mutatis mutandis applies to the activities and personnel of UNFPA. This Country Programme Action Plan (CPAP) together with any work plan concluded hereunder, which shall form part of this CPAP and is incorporated herein by reference, constitutes the Project Document as referred to in the Basic Agreement.

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## PART II: SITUATION ANALYSIS

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1. Cambodia has a profoundly, and relatively recent, traumatic past whereby all social sectors were destroyed and the majority of educated professionals were killed or fled the country. The country has progressively re-established peace and stability over a period of over two decades since the Paris Peace Accord was signed in 1991. Cambodia’s national elections were held in 1998, 2003, 2008, 2013 with an election year also planned in 2018.

2. In 2013, with a per capita income of \$1,036, Cambodia ranked 136 out of 187 countries on the human development index, according to the Human Development Report 2014. The estimated annual population growth during 2008-2013 was 1.83 per cent, while 16 per cent<sup>1</sup> of the population is reported to live below the poverty line in 2013. Inequity still persists between rural and urban areas as well as among different socio-economic groups, notably the poor, female victims of violence, young migrant workers, entertainment workers, young garment factory workers and ethnic minorities.

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<sup>1</sup> 2015 Progress Report on Cambodia NSDP 2014-2018 and CMDG Achievement

3. The basis for the government's development priorities has been the Rectangular Strategy, a tool to implement its political platform and to meet the Cambodia Millennium Development Goals (CMDGs). The process for defining the linkage to the Sustainable Development Goals (SDGs) is still at the early stages with indicators to be finalized by March 2016.

4. The Rectangular Strategy III (RS III) aims to promote economic growth, full employment of Cambodian workers, equity and social justice and enhanced effectiveness of the public sector. The four interlocking growth rectangles focus on: 1) enhancement of the agricultural sector; 2) further rehabilitation and construction of physical infrastructure; 3) private sector development and employment generation; and 4) capacity building and human resource development.

5. The fourth rectangle of the RS III is further divided into four pieces reflecting the government's prioritization of key population, gender and reproductive health issues. The National Strategic Development Plan (NSDP) 2014-2018<sup>2</sup> is the framework to operationalize the third phase of RS of the Royal Government of Cambodia (RGC). Most of the priority sectors have developed strategic plans that promote national ownership and support increased alignment. This CPAP is fully aligned with the NSDP, sector plans and the United Nations Development Assistance Framework (UNDAF) 2016–2018.

6. The profile and characteristics of external assistance to Cambodia have been changing gradually over the last years and the trend is compatible with the Government's intended graduation to a lower middle income country status, with the majority of sources of development finance transitioning from grants to concessional loans. Public expenditure on social services is traditionally low, and the country has been heavily dependent on external aid. Social sector support traditionally commands the largest share of development cooperation, peaking at 40% in 2007, before gradually declining to 31% in 2013.

7. The largest decrease in donor funding has been observed in the health sector, which has declined from 20% in 2010 to 13% in 2013. The trends in the development partner funding show that by 2014, China has become the largest provider of external cooperation. This changing donor environment is already visible with many of the large bilateral and multilateral donors withdrawing assistance from Cambodia or providing concessional loans rather than grants. This will also have an impact on UNFPA's resource mobilization efforts and will require a greater commitment from the Government to both jointly mobilize resources and to allocate an increased proportion of the national budget for social sector development plans.

#### OUTCOME 1: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

8. Cambodia has made substantial progress in meeting the country's Millennium Development Goal 5 targets. From 2010 to 2014, the maternal mortality ratio decreased, from 206 to 170 per 100,000 live births; the neonatal mortality rate decreased from 27 to 18 per 1,000 live births; deliveries by skilled birth attendants increased from 71 per cent to 89 per cent; and modern contraceptive use increased from 35 per cent to 39 per cent. There has been a significant increase in the availability and up take of ante-natal care. In 2014, 104 per cent of expected pregnant

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<sup>2</sup> [http://www.cdc-crdb.gov.kh/cdc/documents/NSDP\\_2014-2018.pdf](http://www.cdc-crdb.gov.kh/cdc/documents/NSDP_2014-2018.pdf)

women reported having at least one ANC visits while 90 per cent of pregnant women went to ANC at least twice<sup>3</sup>.

8. Nevertheless, significant challenges remain, including the quality of care; competency of health professionals and regulation of their practices; and the standards and regulation of pre-service health professional education, including for midwives.

9. Basic reproductive health services, such as deliveries by skilled attendants, ante natal care (ANC), family planning (FP), emergency obstetric care (EmONC), sexually transmitted infections (STI) prevention and treatment, and basic Reproductive Health Commodities (RHC), have all been integrated into the Minimum Package of Activities (MPA) - a package of primary health care services provided at health centre level and the Complimentary Package of Activities (CPA) package of in-patient and out-patient services provided at referral hospitals.

### ***Reproductive and Maternal Health and Family Planning***

10. The Health Strategic Plan (HSP II) 2008–2015 and the draft HSP III 2016–2020 recognize reproductive, maternal, newborn and child health as the most important priorities facing the health sector. Political commitment to maternal health is also reflected in the Ministry of Health’s Fast Track Initiative Road Map for Reducing Maternal and Neo-natal Mortality 2010–2015 and the new one 2016–2020, which sets out the priority interventions for the next five years in order to meet Cambodia’s HSP III goals and targets. There has been a remarkable improvement in indicators related to reproductive and maternal health from 2010 to 2014 as noted above.

11. Use of modern methods of contraception has increased from the very low baseline of the mid-1990s of 7 per cent. From 2010 to 2014, the modern contraceptive prevalence rate (CPR) increased from 35 per cent to 39 per cent. Unmet need for contraception declined from 17 per cent in 2010 to 12 per cent in 2014<sup>4</sup>. The demand satisfied for contraception increased from 76 per cent in 2010 to 82 per cent in 2014<sup>5</sup>. Use of contraception varies significantly with geographical location, education level and income. In 2014, women living in urban, with higher education and wealthier quintiles continue to prefer traditional methods to the modern ones.

### ***Midwifery***

12. Since 2009, the Department of Human Resources Development of the Ministry of Health (MoH) and the Cambodia Midwives Council (CMC) with UNFPA’s technical and financial support have made significant progress in developing midwives to ensure there are sufficiently trained human resources to improve the proportion of deliveries with a skilled birth attendant and to provide important sexual and reproductive health (SRH) services. The impact can be seen in the reduction in maternal mortality over the last five years.

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<sup>3</sup> Annual Health Progress Report 2015

<sup>4</sup> CDHS 2010, 2014

<sup>5</sup> CDHS 2010, 2014



13. Significant investments have been made by UNFPA and the MoH to improve the quality of midwifery pre-service education including the development of curriculum for Bachelor of Science in Midwifery, Midwifery Preceptors, and the Associate Degree in Midwifery. However, standardization and regulation of midwifery education has not been possible and as a result, there are at least 17 public and private education institutions providing midwifery education across the country but with different standards and curriculums.

14. There is a lack of quality assurance monitoring in place to ensure that all graduates have completed the required assessments and practiced the required competencies and it is unclear if they are consistently using the approved curriculum frameworks. The quality of teaching of those schools varies and there is a lack of quality assurance and regulation in place in order to monitor teaching standards, adherence to curriculum and procedures for assessment.

15. In addition, the MoH is shifting its focus away from the short term strategy of having primary midwives with minimal training that initially filled a human resource gap to a longer term strategy to provide quality midwives who have completed their education which meets the World Health Organization (WHO) and the International Confederation of Midwives (ICM) standards. There is a need to develop a midwifery education pathway which would identify additional training required for different levels of graduates in order to standardize and bring all human resources to the required level. Increased focus is also needed on the regulation of the educational institutions providing midwifery education. These will be the main areas of focus of the new Country Programme.

### ***Emergency Obstetric Care***

16. UNFPA initiated the first EmONC assessment in 2009 to understand the availability and quality of EmONC signal functions at different levels of health facilities. The baseline study found that there were 1.6 EmONC and 0.9 comprehensive EmONC functional facilities per 500,000 population. Based on the results of the assessment, the first EmONC Improvement Plan 2010–2015 was developed with technical and financial support from UNFPA.

17. In 2015, the second assessment was conducted in order to monitor progress and identify gaps and challenges in implementing the EmONC Improvement Plan 2010–2015. The review in 2015 found that there were 2.35 EmONC facilities and 1.31 comprehensive EmONC facilities per 500,000 population. While there has been an improvement in coverage and the number of EmONC facilities meeting the UN standard, coverage still remains below the globally accepted minimum of at least five facilities per 500,000 population and there are still facilities which need strengthening as they are not yet implementing all of the signal functions.

### ***HIV and AIDS***

18. HIV prevalence in Cambodia among general population adults aged 15-49 has been steadily declining over the past decade from 2.0% in 1998 and 0.9% in 2006 to 0.7% in 2013. Along with the decline in HIV prevalence among the general population, it was noted that key populations such as entertainment workers (EWs), drug users, transgender people, men who have sex with men (MSM) has remained the target group that required special attention in the provision of prevention, care and treatment services.

19. During the previous country programme, UNFPA focused attention on the key population of EWs. The prevalence of HIV among female EWs has gone down from 20.8% in 2003 to 14% in 2010. However, HIV prevalence among those EWs who have more than seven clients per week was as high as 13.9% (HIV Sentinel Surveillance (HSS), 2010). Although consistent condom use in the past three months with clients was relatively high – 80.6% among EWs with less than two partners per day and condom use with regular partners was quite low – at 36.1% (Behavioural Sentinel Survey (BSS) in 2013).

20. Many EWs are at a particular risk due to their concomitant use of illicit drugs, high consumption of alcohol, low condom use with partners and sexual activity with men who have sex with men and women. According to the 2005 STI Sentinel Surveillance Survey, 40% of MSM had sex with female partners in the past year, with female EWs identified as the most common sexual partners.

21. Access of EWs to contraceptives to prevent unwanted pregnancies in addition to condoms for protection against HIV and STIs has been challenging with anecdotal evidence that they seek abortions through over the counter drugs placing them at high risk of complications and even death. An integrated approach to ensuring EWs have access to HIV prevention and broader SRH services including family planning is critical and is the focus of UNFPA in this Country Programme.

22. An additional area of concern is that in the Cambodia Demographic and Health Survey (CDHS) 2014, only 37.6% of all female and 45.9% of all male adolescents and youth aged 15-24 had comprehensive knowledge about HIV and AIDS. Knowledge of HIV prevention methods is lower among women and men living in rural areas than among those living in urban areas. In general, Cambodian women have only one sexual partner over their lifetime. However, Cambodian men are reported to have had an average of four sexual partners in their lifetime<sup>6</sup>. The decline in female adolescents' knowledge on HIV and AIDS needs to be addressed in this Country Programme.

23. Despite steady and significant improvements, the public health system remains constrained in its response to reproductive health needs. The most significant challenges include quality of care, competency of health professionals - in particular the quality of their counseling on family planning and adolescent reproductive health and for survivors of sexual violence in particular and violence in general. Public health staff are often inadequately skilled, suffer from poor access to resources and supplies, and salaries remain low which affects motivation and incentive to work.

24. As a consequence, availability of quality health services is limited, especially for the poor, and people often try to self-medicate before seeking care from a trained provider – this is of particular concern for women who seek abortions through over the counter medications from pharmacies. These practices result in high out of pocket health expenditures, continuing ill health, debt and increased poverty. In 2014, out of pocket spending accounted for over 60% of total health expenditure with the remaining 20% each covered by Government and donors.

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<sup>6</sup> CDHS 2014

## OUTCOME 2: ADOLESCENTS AND YOUTH

25. Cambodia has a large youthful population, with 32.1 per cent in the 10-24 years age group, many of whom are migrating out of rural areas, where 80 per cent of the total population of 14.7 million are living. Subnational planning processes do not sufficiently engage young people. While there is a decline in the total fertility rate from three children per woman in 2010 to 2.7 children per woman in 2014, teenage pregnancies have increased (from 8 per cent in 2010 to 12 per cent in 2014). Unmet need for family planning is highest in married adolescents (15 per cent), while unmarried sexually active adolescents have a low use of contraception.
26. The level of unmet need among currently married female adolescents and youth has changed significantly in the last 14 years. In 2000, 37.1 percent of currently married women age 15-24 had an unmet need for family planning and in 2014 the level of unmet need was 14.9 percent. The unmet need for family planning is higher in rural areas than in urban areas. Preah Vihear and Stung Treng provinces have the highest unmet need, followed by Kampong Cham province.
27. The CDHS 2014 reports extremely low levels of sexual activity in unmarried adolescent girls so the increase in adolescent births is in married girls. The percentage of girls 15-19 who were married increased from 10% in 2010 to 15.4% in 2014. The increase in married adolescents has been in older adolescents, with child marriage (by age 18) staying constant (18.4% and 18.5% of women 20-24 in 2010 and 2015 respectively). The percentage married by age 20 has risen from 37.3% to 40.8% in 2014.
28. The highest increase in adolescent pregnancy is in adolescents with no education, where the percentage who have begun childbearing has increased from 17% to 37.1%, and in those adolescents in the lowest two wealth quintiles. Most of the increase is in adolescent girls bearing children at age 18 or 19. Only a small percentage of girls gave birth at age 15 or 16 (approximately 4.4%). This recent analysis of CDHS 2014 data is essential in helping to focus the national reproductive health programme on these particular groups of adolescents.
29. The National Reproductive Health Programme (NRHP) of the National Maternal and Child Health Centre (NMCHC), the MoH, developed the first National Strategy for Reproductive and Sexual Health (NSRSH) in 2006 and adolescent and youth reproductive health was included as one of the components of Reproductive Health. In order to operationalize this strategy, the NRHP/NMCHC introduced National Guidelines for Adolescent and Youth Friendly Services in 2008 and the Training Manual in 2007, and the two documents are being reviewed and updated.
30. Since 2008, 718 public health facilities have staff trained in adolescent and youth friendly health services and information. However, there is no national data available to analyse how many adolescents and youth have been able to access and use the services. Anecdotal evidence shows that adolescents and youth, especially unmarried, rarely seek services from public health facilities. The recent CDHS 2014 also indicates that an increased attention on how SRH services are provided to adolescents needs to be addressed and is the focus of this Country Programme.

### ***Comprehensive Sexuality Education***

31. Through UNFPA Country Programme (2011-2015), the Ministry of Education, Youth and Sports (MoEYS) has made sustained effort to endorse and implement Comprehensive Sexuality Education (CSE) curriculum in schools within seven provinces. The CSE curriculum incorporates basic SRH issues as part of overall life skills for peer education Programme, however it is not a compulsory topic and has depended on UNFPA support for it to be implemented.

32. In 2014, the Minister of MoEYS agreed that CSE could be integrated into the core curriculum as part of the new Education Strategic Plan (ESP) 2014-2018. As part of this, MoEYS has embarked on a review of the whole national school curriculum which provides an opportunity for integrating CSE in the relevant grades through the review process. UNFPA has been successful in 2015 in working with the committee tasked to develop the Curriculum Framework (CF) for all grades, from pre-school to grade 12. As a result of UNFPA advocacy, there has been agreement that CSE will be included in the compulsory health education topic.

33. The CF is expected to be finalized for endorsement by the end of 2015, followed by syllabus and textbook development in 2016. The implementation of the new national curriculum is currently scheduled to start in the 2018-2019 academic year and UNFPA's support in this Country Programme is critical for the realization of CSE being taught as a compulsory topic in the national curriculum nationwide.

### ***Youth Participation in Planning Processes***

34. As outlined in the Decentralization and Deconcentration (D&D) Reform plan, the RGC has laid out a vision and a long term strategy and plan to increasingly delegate functions, resources and authority to sub-national administrations. A number of legal instruments, policies and guidelines have been put in place under the first phase (2011-2014) of the three-year Implementation Plan (IP3) of the ten-year National Programme for Sub-national Democratic Development (SNDD) with a focus on strengthening the role of District and Municipality (DM) administrations.

35. Along with other partners, UNFPA advocated for the inclusion of social issues into the D&D Reform agenda. Focus of the IP3 second phase (2015-2017) will continue to ensure that the DM administrations will be able to play an important role as coordinators of local development in addition to their administrative role. As more resources both on conditional and unconditional terms are increasingly being made available to DM administrations for them to coordinate and implement development interventions in an effective way, it will be critical to ensure that those resources are utilized for appropriate investments to address social sector issues.

36. UNFPA has commenced supporting the revision of the district and municipal guidelines to ensure that sectoral plans are integrated into the process of subnational planning and budgeting; providing meaningful opportunities for engagement of women and young people and their issues in subnational plans.

### OUTCOME 3: GENDER EQUALITY AND WOMEN'S EMPOWERMENT

37. Violence against women and girls (VAWG) remains a serious issue, with 29 per cent of women having experienced physical, sexual or emotional violence from an intimate partner (CDHS 2014). The Government policy commitments in response to VAWG were clearly expressed in the Law on Prevention of Domestic Violence and Protection of Victims 2005 (DV Law) and the National Action Plan to Prevent Violence Against Women (NAPVAW II, 2014-2018).

38. UNFPA was an active member of Technical Working Group of Gender - Gender Based Violence (TWGG-GBV) to update the NAPVAW II. The perpetrators of violence against women are mostly from husbands 59.1%. Sadly, the percentage of men aged 15-49 who agree that husband is justified in beating his wife for specific reasons has increased from 22.4% to 26.5% in CDHS 2010 and 2014 respectively.

39. The NAPVAW II has identified three priority violence issues: domestic violence; rape and sexual violence; and violence against women with increased risk, such as women with disabilities, women living with HIV and sex workers which will be targeted as the highest priorities for prevention. The proposed approach is one of strengthening primary prevention whilst also ensuring quality multisectoral response services.

#### **Health Sector Response to Violence**

40. Multiple non-governmental organizations (NGOs) have been implementing multi sector responses to violence against women and girls in different geographic locations and therefore the services available in response to violence and coordination of services has not been standardized across the country.

41. The National Guidelines for Managing Violence against Women and Children (NGMVAW/C) in the health sector was developed by the MoH with technical and financial support from UNFPA. It has recently been launched by the MoH in September 2015 and a clinical handbook for providers based on the WHO handbook has also been piloted for adaptation in Cambodia by 2015. The challenge of implementation is ahead and is the main area of focus for UNFPA in this CPAP.

### OUTCOME 4: POPULATION DYNAMICS

42. Cambodia has recently completed the CDHS 2014. Results were released on the 16th of October 2015, providing an opportunity for further analysis of key issues such as adolescent fertility, reproductive and maternal health outcomes among the urban and rural poor, domestic violence in Cambodia, contraceptive prevalence and unmet need for family planning, and utilization of maternal health care service so as to provide further evidence based focus for the CPAP programme design in response to the issues.

43. Preparation for the 2018 population and housing census has commenced. The Government has committed to providing 25 per cent of the estimated resources required, and additional resource mobilization efforts are underway. With the increase in availability of population

statistical data, comes the opportunity for more focused and targeted national development planning. However, the capacity to analyse and use disaggregated socio-demographic data at subnational levels is limited.

44. Strengthening national policies and both national and subnational capacity through production and integration of evidence-based analyses on population dynamics is critical to ensuring sustainable and inclusive development of the country including SRH, HIV and gender equality. This will be the key area of focus for this CPAP.

45. The political context until the new parliamentary elections in 2018 is predicted to be relatively stable. The strategic national action plan for disaster risk reduction recognizes that there is relatively small risk of a humanitarian disaster, with resilience and emergency preparedness efforts focused on small-scale seasonal flooding and recurring droughts.

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### **PART III: PAST COOPERATION AND LESSONS LEARNED**

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46. UNFPA has delivered its programme of assistance to the Government of Cambodia since 1994. UNFPA's notable achievements under the first two Country Programmes included supporting the introduction of nationwide birth spacing services and the implementation of the 1998 census, the first for 36 years. Particular achievements under the third Country Programme included the implementation of the 2008 census, increases in the use of modern methods of contraception, increased availability and uptake of ante natal care and increased number of babies delivered by skilled birth attendants.

47. The fourth UNFPA Country Programme, in line with the UNDAF, 2011-2015, contributed to overall reductions in maternal mortality from 206 to 170, increases in skilled birth attendance from 71% to 89% and the contraceptive prevalence rate from 35% to 39%, and proportion of demand for contraception satisfied from 75.6% to 81.9% from 2010 to 2014 respectively.

48. The country programme evaluation (CPE)<sup>7</sup> revealed that UNFPA has succeeded in: (a) influencing the health development agenda and leveraging resources for sexual and reproductive health and rights (SRHR), maternal health and family planning; (b) improving access to high-quality reproductive and maternal health services; (c) increasing the number of emergency obstetric and newborn care facilities from 49 to 110 Basic EmONC and 31 to 37 Comprehensive EmONC; (d) increasing access to reproductive health, family planning and HIV prevention services, including for key young populations (entertainment workers); (e) enhancing access to SRHR for adolescent and youth by developing curricula for comprehensive sexuality education for adolescents and launching multimedia initiatives on SRHR for adolescents and youth both in school and out of school; (f) supporting the second National Action Plan to Prevent Violence against Women and developing the National Guidelines for Managing Violence against Women; and (g) improving government capacity to collect, analyse and utilize population data, including the use of disaggregated population data in local planning processes.

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<sup>7</sup> <http://countryoffice.unfpa.org/cambodia/?reports=12732>

49. In addition to evidence available through the UNDAF Common Country Assessment (CCA), Situational Evidence Review (SER) and thematic evaluations on family planning, midwifery, CSE, gender based violence and decentralization and deconcentration, the fourth CPE recommended: (a) greater focus on vulnerable and marginalized groups, including garment factory and entertainment workers, and a prioritised geographical programme focus; (b) continuing support in the health sector through the joint programme -based approach, focusing on EmONC, skilled birth attendance, midwifery and family planning; (c) updating and integrating CSE for adolescent and youth into the core national school curriculum and youth-friendly services, with increased attention to vulnerable and marginalized groups, including EWs and hard-to-reach youth; (d) prioritizing the health response to VAWG, in coordination with other stakeholders; (e) continuing support for the secondary data analysis of CDHS 2014; (f) preparing for the population and housing census in 2018; and (g) engaging with national and subnational policy and planning processes to ensure meaningful participation of women and young people and inclusion of SRHR into development plans and budgets.

50. The previous Country Programmes demonstrated the value of working through programme-based approaches, as they facilitated the mainstreaming of sexual reproductive and maternal health concerns, reinforced national structures and planning processes, and leveraged large-scale government and donor support for these issues, while reducing transaction costs for the Government.

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#### **PART IV: PROPOSED PROGRAMME**

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51. The proposed fifth Country Programme, 2016–2018, grounded in human rights and gender equality principles, reflects the comparative advantage of UNFPA; it is aligned with national priorities, as reflected in the Cambodian NSDP 2014–2018, the UNFPA strategic plan, 2014–2017, and UNDAF priorities. The proposed three-year duration of the programme is to allow alignment with the five-year NSDP.

52. The human rights related principles of participation, inclusiveness, transparency and accountability will be applied in all areas of UNFPA cooperation, with support to both rights holders towards strengthening their awareness of their rights (particularly those enshrined under the Convention for the Elimination of all forms of Discrimination against Women (CEDAW) and the ICPD Programme of Action, and to duty bearers to strengthen their capacity to fulfill their obligations with respect to international human rights instruments and conventions.

53. This Country Programme reflects the principles of the ICPD Programme of Action as it emphasizes the value of investing in women and girls including the most marginalized both as an end in itself and as a key to improving the quality of life for everyone. The programme affirms the importance of sexual and reproductive health, including family planning, and preventing and ending violence against women and girls as preconditions for women’s empowerment. The programme also calls attention to the ways on which investing in youth and engaging them as essential actors in civic and political decision making processes is crucial to the future development of Cambodia as youth represent over two thirds of the Cambodian population.

54. The process of geographic prioritization at subnational level involved an in depth review and analysis of several key indicators across the country with updated CDHS 2014 data amongst others. This analysis helped rank provinces as high, medium high, medium low and then low (see Annex 5). They are locations that are performing poorly in comparison to the national averages; respond to the CPE recommendations; where existing partnerships and resources can be leveraged; and where thematic convergence is possible.

55. The result of this analysis and following in depth discussions with government partners during CPAP planning workshops is the selection of a total of nine provinces for joint interventions across the four outcome areas. This is comprised of seven high priority provinces and two medium high provinces due to their mobile population and high vulnerability. If funds become available, a few more medium priority provinces could be included, if requested and necessary.

56. In addition we will work on capacity building in EmONC in the four provinces where the Government's regional training sites are located, one of which overlaps with a high priority province. Phnom Penh is selected for specific urban programming with key target groups including young factory workers and EWs. The majority of policy level dialogue and advocacy on guidelines and protocols will also take place with key national stakeholders in Phnom Penh.

57. The implementation of the fourth Country Programme outcome areas aim to improve the availability, quality and use of SRH services, including health services for survivors of violence, by strengthening national and subnational systems and capacity of both duty bearers and rights holders. The programme will facilitate the collection and use of data to make programmes and national and subnational policies, plans and budget allocations responsive to the needs of these populations; engage men and boys in the prevention of VAWG; and create opportunities for youth engagement and participation.

58. The proposed fifth Country Programme will deliver the programme results through the following key strategies:

- Provision of technical advice for policy and programme development to enhance national capacity at national, provincial and district/municipality levels
- Support provincial and district level implementation of national level policies and plans
- Support government efforts to gather and use disaggregated data and evidence for planning, resource allocation, monitoring and reporting
- Raise awareness among right holders of their rights and responsibilities
- Integrate risk reduction strategies in programming
- Advocacy and communication for behaviour and policy change consistent with UNFPA's mandate.



**Linkages of the proposed programme to national development plans, UNDAF and the UNFPA strategic plan:**

**OUTCOME 1: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS**

59. The entire proposed programme links directly to the national priority as articulated in the NSDP 2014–2018: *Promotion of health and nutrition; strengthening and enhancing education, science and technology and technical training; enhancing implementation of national population policy and gender equity (National Strategic Development Plan 2014-2018).*

60. This SRH Outcome also directly links to the UNDAF outcome which states that: *By 2018, more people, especially vulnerable, poor and marginalized groups, are equitably benefiting from and contributing to affordable, sustainable and high-quality social services and protection, and have gained enhanced skills to achieve and contribute to social and human development.*

61. This is measured in the UNDAF by the following indicators which this CPAP will also contribute to and report on: *2.3: Maternal and newborn health coverage and contraceptive prevalence; 2.3.1. Skilled Attendance at Birth; 2.3.3 Contraceptive prevalence rate; 2.3.4 Percentage of HIV positive pregnant women who receive PMTCT services.*

62. The CPAP outcome 1 statement directly links and reflects the UNFPA strategic plan priority which states: **SP Outcome 1:** *Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access and is measured by the following indicators: Outcome Indicator 1: Contraceptive prevalence rate; Outcome Indicator 2: Percentage of birth attended by skilled health personnel.*

63. There are three proposed outputs under this SRH outcome. The outputs address both the demand and supply sides of reproductive health to improve access to information and quality of services. The main strategies to achieve these results will be through providing technical support to develop and implement policies, operational frameworks and competency based training guidelines for the provision of safe motherhood and adolescent- and youth-friendly reproductive health information and services, including for family planning services, maternal health and Emergency obstetric and newborn care, and prevention and treatment of sexually transmitted infections, including HIV/AIDS.

64. The second main strategy will involve advocacy and building the capacity of national trainers to implement capacity building strategies as well as those responsible for quality assurance in the Ministry of Health. This will take place at national levels with some support to the roll out sub-nationally through provincial and district health and local governance institutions.

65. The final strategy to achieve these outputs involves developing demand-generation strategies and frameworks to empower communities, young people and women to claim reproductive health and rights and increase access to family planning and maternal health

services, and to reproductive health services for adolescents and youth, by working with the Government, partners and civil society.

66. **Output 1:** *Increased national capacity to accelerate demand and improve delivery of quality integrated sexual and reproductive health services, including family planning, that are gender-sensitive, youth-friendly and rights-based.* Results of UNFPA's support to this output will be measured by three output indicators as follows:

67. **Output Indicator 1:** *Number of strategies, guidelines and protocols on SRHR developed.* The main interventions planned in this CPAP to achieve this are:

- Support the finalization of the National Health Sector Plan (HSP) 2016–2020.
- The Fast Track Initiative Roadmap for Reducing Maternal and Newborn Mortality (FTIRM) 2016–2020: The current FTIRM 2010–2015 contributed to significant progress as shown in the CDHS 2014 results. The Minister of Health has specifically requested UNFPA support for the development of the new FTIRM 2016–2020.
- EmONC Improvement Plan: The current EmONC Improvement Plan 2010–2015 will come to an end by December 2015. Based on the EmONC Review 2014/2015, there is a need to develop a new EmONC 2016–2020 in order to guide the quality and coverage of the EmONC across the country.
- National Strategy for Reproductive and Sexual Health (NSRSH) 2017–2025: The current NSRHS 2013–2016 will end by December 2016, thus UNFPA will provide technical and financial support to the MoH for the development of the new NSRSH 2017–2025 with costing, with potential focuses on adolescents and youth, teenage fertility, VAW and family planning.
- Family Planning Forecasting and Action Plan 2016–2025: The current Family Planning Forecasting and Action Plan 2007–2015 will expire by December 2015, and the MoH requested for technical and financial support from the development partners to develop a new Family Planning Forecasting and Action Plan 2017–2025. UNFPA will contribute to the development of this document along with other partners like USAID.
- The Family Planning Policy and Manuals of the MoH were reviewed in 2015 and will be rolled out from 2016 onwards. Key rights-based Family Planning in line with UNFPA Family Planning Strategy 2012–2020 was incorporated into the documents. As a way forwards, UNFPA will support the implementation of the Policy and Manuals with a particular attention in the nine UNFPA prioritized provinces. UNFPA will also provide technical and financial support for the development of the Family Planning Counseling Guidelines in order to improve the counseling skills of health care providers – in particular for adolescents.
- Adolescent and Youth Friendly Health Guidelines and Manual: The current Adolescent and Youth Friendly Health Guidelines and Manual were developed in 2007-2008. With a new focus on adolescents and youth, the MoH and UNFPA with other partners are supporting the revision and update of the Adolescent and Youth Friendly Health Guidelines and Manual in order to reflect the latest global and regional recommendations and updates and the development in the health sector in Cambodia.

68. Output Indicator 2: Percentage of referral hospitals providing high-quality youth-friendly services in prioritized locations. The main interventions planned in this CPAP to achieve this are:

- Following the finalization of the AYFS guidelines, UNFPA will support the development of a competency based training package for providers in public health facilities based on the guidelines. In addition, a training of trainers (TOT) for the national and provincial trainers will be developed and implemented.
- Quality assurance checklists and guidelines will be developed to certify health facilities as youth friendly and will provide a monitoring and quality improvement feedback mechanism which would allow for the MoH to assess whether the national guidelines are being implemented and if the programme is having an impact on key adolescent health indicators.
- UNFPA will support MoH in the implementation of this programme in selected provinces at the level of referral hospitals and other health facilities as prioritized by the MoH and Provincial Health Departments.

69. Output Indicator 3: Comprehensive SRHR social behaviour change communication strategy for adolescents and youth developed and implemented in prioritized locations. The main interventions planned in this CPAP to achieve this are:

- Develop a targeted approach to creating demand for SRH services and addressing key health behaviours of specific target groups in response to key areas identified in the CDHS 2014 and recent surveys.
- The specific groups identified as a priority for this CPAP and the key behaviours are defined in the table below. The strategy will articulate the best mediums for providing information to these groups and prototypes will be developed. Root causes of behaviours will also be carefully considered in the design of the strategy:

Target Groups	Key Behaviours promoted
15 – 18 year old married girls (geographic focus will be defined by DHS further analysis)	Delay pregnancy, avoid unwanted pregnancy through use of modern methods of contraception, reject misconceptions around side effects of contraceptives; increase knowledge on where to seek accurate SRH information and services
15 – 24 year old boys and girls (geographic focus will be defined by CDHS further analysis and targeting may be different for boys and girls)	Comprehensive knowledge on HIV and how to prevent transmission of HIV and STIs and related health seeking behaviours
Factory workers	Seek effective methods to prevent unwanted pregnancy; seek ANC, PNC and safe delivery services when pregnant; seek appropriate care following an abortion including family planning post abortion; knowledge on SRH rights
Entertainment workers (street-based)	Consistent condom use with clients; seek effective methods to prevent unwanted pregnancy; avoid complications of unsafe abortion; seek appropriate care if you experience violence
Women	Know when and where to seek care following violence – particularly sexual violence.

- It is envisaged that the Behavioural Communication and Change (BCC) strategy will be implemented in priority areas with target groups and that the selected implementing partner will develop materials for both radio, social media and mobile technology as well as television if deemed appropriate in reaching the target audience.
- A behavioural monitoring framework will also be developed to measure changes in attitudes, knowledge levels and behaviour. As the duration of the CPAP is only three years, it is not expected that major behavioural impact will be possible in this period but the ongoing monitoring will be helpful in providing feedback on which interventions appear to be showing “promise” and could be scaled up in the next CPAP.

70. **Output 2:** *Increased national capacity to deliver comprehensive maternal health services.* Results of UNFPA’s support to this output will be measured by two output indicators as follows:  
Output Indicator 1: *National pre-service midwifery training standards developed.*

71. Improving quality of midwifery services through quality midwifery pre-service education and effective regulation and accreditation of public and private sector midwifery education schools are key factors in ensuring quality sexual, reproductive, maternal and newborn health services. The Cambodian Health Strategic Plan (HSP) 2008–2015 and the new HSP 2016–2020 highlight a focus on quality health services as well as human resources for health. The main interventions planned in this CPAP to achieve this include:

- Provide technical support for the development of Midwifery Education Pathway through assessment of current midwifery education curricula and systems. The pathway will propose recommendations for streamlining and strengthening midwifery education curricula; upgrading primary midwives to Associate or Bachelor Degree, Associate Degree to Bachelor Degree by competency bridging curricula and training; and recommendations on how to improve and build career pathway for midwives.
- Provide technical support to review and update curricula of Associate Degree in Midwifery and Bachelor of Science in Midwifery in line with ICM and WHO standards and ensure inclusion of life saving skills and competencies like EmONC, family planning, GBV/VAW, gender and youth SRHR into the updated curricula.
- Provide technical support for the development and implementation of Midwifery Education Regulatory Framework and Scopes of Practices for Midwives.

72. Indicator 2: *Number of emergency obstetric and newborn care (EmONC) facilities per 500,000 population in prioritized locations.* The main interventions planned in this CPAP to achieve this are:

- Integrate EmONC skills and signal functions in the pre-service training curricula and education.
- Align and integrate EmONC training at the Clinical Training Sites with the Regional Training Centres.
- Support regional training sites to train health personnel and establish EmONC facilities as per national targets and support quality improvement in improving signal functions in those facilities not performing according to standards.

## OUTCOME 2: ADOLESCENTS AND YOUTH

73. The proposed programme under this outcome area links directly to the same national priority in the NSDP 2014–2018 and the UNDAF as stated above in Outcome 1. The CPAP outcome 2 statement directly links and reflects the UNFPA strategic plan priority which states: **SP Outcome 2:** Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health and is measured by the following indicator: Outcome 2 indicator: *Teenage pregnancy.*

74. There are two proposed outputs under this adolescent and youth health outcome. The main strategies to achieve these results will be through provision of technical advice for the revision of the health education curriculum and syllabus frameworks and training strategies for teachers in line with international guidance and UN frameworks for Comprehensive Sexuality Education (CSE). This will provide opportunities for young people to develop healthy behaviours including health seeking behaviours, reducing the risk of unwanted pregnancies, disease including HIV and promoting positive relationships, respect and gender equality.

75. The second strategy to achieve this output involves advocacy and capacity building to design inclusive planning processes and to strengthen the government mechanisms at national and subnational levels to use disaggregated data and evidence for planning, resource allocation, monitoring and reporting and to foster partnerships with youth to ensure their participation and representation in policy dialogue, programming processes and in budgets. The final strategy includes capacity building support to young people to develop their skills to meaningfully participate in planning and decision-making processes.

76. **Output 1:** *Increased national and subnational capacity to advocate for increased investment in youth within development policies and programmes, with young people's full participation.* Results of UNFPA's support to this output will be measured by one output indicator as follows:

77. **Output Indicator 1:** *Number of national and subnational participatory platforms for policy and programme planning engaging young people.* The main interventions planned in this CPAP to achieve this are:

- Support revision of the district and municipality planning guidelines to ensure youth issues are considered and that youth participation in the planning process is mandatory.
- Support capacity development of subnational planners on engaging young people in the revised planning guidelines to ensure that they have the skills and knowledge to include young people and their issues in the planning processes.
- Support capacity development of young people through youth led organizations to participate meaningfully and with the required skills and competencies in district and municipality planning processes.
- Support the National Youth Development Council Action Plan (NYDC-AP) to be implemented by the three selected ministries (MoEYS, MoH and Ministry of Interior) engaging young people in ministerial planning process.

78. **Output 2:** *Increased national capacity in designing and implementing systematic comprehensive sexuality education.* Results of UNFPA's support to this output will be measured by two output indicators as follows:

79. **Output Indicator 1:** *Number of grades with comprehensive sexuality education fully integrated into the core national school curriculum.* The main interventions planned in this CPAP to achieve this are:

- Support the revision and completion of the National Health Education Syllabus to include the required age appropriate content on CSE for grade 5 to 12.
- Support the revision and completion of Health Education textbooks in line with the revised syllabus to include age appropriate content on CSE for grade 5 to 12.

80. **Output Indicator 2:** *Percentage of teachers receiving training on methodologies for implementing comprehensive sexuality education programme in prioritized locations.* The main interventions planned in this CPAP to achieve this are:

- Support the development of teacher training on CSE so that MoEYS can roll out the Health Education/CSE curriculum nationwide.
- Provide technical and capacity building support to MoEYS in the roll out of teacher training on the Health Education/CSE in three priority provinces (Rattanakiri, Preah Vihear and Mondulakiri).

### OUTCOME 3: GENDER EQUALITY AND WOMEN'S EMPOWERMENT

81. The proposed programme under this outcome area links directly to the same national priority in the NSDP 2014–2018 as in Outcome 1. It links to the UNDAF outcome which states: *By 2018, national and subnational institutions are more transparent and accountable for key public sector reforms and rule of law; are more responsive to the inequalities in the enjoyment of human rights of all people living in Cambodia; and increase civic participation in democratic decision-making.*

82. This is measured in the UNDAF by the following indicators which this CPAP will also contribute to and UNFPA will report on: **Indicator 3.6:** *Existence of standardized minimum services for VAW/C victims and survivors in line with international standards.*

83. The CPAP outcome 2 statement directly links and reflects the UNFPA strategic plan priority which states: **SP Outcome 3:** *Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth* and is measured by the following indicator: **Outcome Indicator 1:** *Percentage of men aged 15-49 years who agree that a husband is justified in beating his wife for specific reasons.*

84. There are two proposed CPAP outputs under this outcome area. The main strategies to achieve these will be through provision of technical advice and capacity building support for the development of primary prevention of violence programs which could be implemented at subnational levels and scaled up as part of the Ministry of Women's Affairs' (MoWA) national programme and priorities set out in national policy frameworks – NAPVAW II. This strategy will also involve advocacy, raising the awareness among rights holders of their rights and responsibilities.

85. The second main strategy will be through advocating for inter- ministerial collaboration whereby the National Institute of Statistics (NIS) of the Ministry of Planning (MoP) assists MoWA to use the recent data that has been collected on VAWG<sup>8</sup> and to use that data for planning, resource allocation, monitoring and evaluation at national and subnational levels. The third main strategy will be to support the adoption and use of protocols, monitoring tools, and competency based training in line with international standards, emphasizing the capacity of health-service providers to care for survivors of sexual and gender-based violence.

86. **Output 1:** *Strengthened capacity of national and subnational governments, involving civil society, in promoting sexual reproductive health and rights and preventing violence against women and girls.* Results of UNFPA's support to this output will be measured by one output indicator as follows:

87. **Output Indicator 1:** *Number of interventions that engage men and boys in preventing violence against women and girls in prioritized locations.* The main interventions planned in this CPAP to achieve this are:

- Support the Ministry of Women's Affairs (MoWA) to adapt a model proven to have an impact on preventing violent behaviours and promoting healthy attitudes and behaviours towards girls and women. The model intervention will be for adolescent boys and girls aged 12-14 years old adapted to Cambodian context and implemented in one province.
- Support MoWA to develop a model intervention for parents and care takers of those participants in the intervention for adolescents and adapt this to Cambodian context and implement in one province.
- Evaluate the two pilot interventions to review the possibility of scale up by MoWA and partners across the country to support the implementation of the NAPVAW II.
- Conduct further analysis of new data sets including the CDHS 2014 and the WHO violence prevalence study to design targeted interventions that engage men and boys in the prevention of violence.
- Support MoWA to review NAPVAW II and the results of all partners' programmes in preventing violence against women and girls.

88. **Output 2:** *Strengthened national and subnational health system capacity to address violence against women and girls within the coordinated multisectoral response.* Results of UNFPA's support to this output will be measured by one output indicator as follows:

89. **Output Indicator 1:** *Percentage of referral hospitals providing services of survivors of violence against women and girls, according to national guidelines, in prioritized locations.* The main interventions planned in this CPAP to achieve this are:

- Support MoH and MoWA to develop a training strategy for nationwide scale up of the health sector response to VAWG. This will be done in collaboration with other partners including WHO based on global guidance and United Nations Children's Fund (UNICEF) who has the comparative advantage in guiding the response to violence against children.

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<sup>8</sup> CDHS 2014

- Support the subsequent development of competency based training curriculum for health providers which is based on the national guidelines.
- Support the training of the MoH and MoWA trainers in the competency based curriculum for health workers.
- Support the roll out and implementation of the competency based training of health workers in selected referral hospitals and facilities in high priority provinces where data suggests that there is a higher prevalence of violence.
- Support the finalization of the clinical handbook for trained health workers which is based on the global guidance from WHO and is adapted for the Cambodian context, reflects the national guidelines and is an important job aid and tool.
- Support the development of a quality assurance monitoring tool to assess that health workers are providing services to survivors of violence according to the national guidelines.
- Support MoWA in its role at subnational levels to strengthen the referral network for survivors of violence to and from health services.

#### OUTCOME 4: POPULATION DYNAMICS

90. This SRH Outcome also directly links to the UNDAF outcome which states that: *By 2018, people living in Cambodia, in particular youth, women and vulnerable groups, are enabled to actively participate in and benefit equitably from growth and development that is sustainable and does not compromise the wellbeing, natural and cultural resources of future generations.*

91. The CPAP outcome 4 statement directly links and reflects the UNFPA strategic plan priority which states: **SP Outcome 4**: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality and will be measured by **Outcome Indicator 1**: *Number of national policies that address key population dynamics.*

92. There are two proposed outputs under this population dynamics outcome. The main strategies to achieve these outputs include the provision of technical support to design and conduct the population census in 2018 adhering to international standards and guidelines. The strategy also involves building the technical capacity of the NIS and different line ministries and subnational planning bodies to analyse and disseminate disaggregated data including the CDHS 2014.

93. These outputs support not only the achievement of the population dynamics outcome but also support the other three outcome areas through bringing high quality data and evidence, supporting use of the data across relevant line ministries including at both national and subnational levels. This enables linkage to the national development frameworks and a process for alignment to the new SDGs.

94. **Output 1**: *Strengthened national and subnational capacity for production and dissemination of high-quality disaggregated data on population and development dynamics that allows for mapping of demographic disparities and socioeconomic inequalities.* Results of UNFPA's support to this output will be measured by one output indicator as follows:



95. **Output Indicator 1:** *Cambodian general population census designed according to international standards.* The main interventions planned in this CPAP to achieve this are:

- Support the Ministry of Planning in resource mobilisation efforts for the conduct of the census in 2018.
- Provide technical assistance to develop and design advocacy materials for public awareness and campaign on the conduct of the 2018 census and data collection on key population and development issues including the identification of demographic disparities, social and economic inequities that affect women, adolescents and youth.
- Provide technical assistance for development and finalization of 2018 Census Plan including Cartography/GIS, data processing and scanning.
- Provide technical support for establishment of control mechanisms for quality assurance of census implementation.
- Strengthen national capacity of Census Officers both at national (the National Institute of Statistics) and sub-national levels in: (a) the design and use of Census Instruments (according to the International Standards and Recommendations) for Pre-Test of Instruments, Pilot Census, and Data collection; (b) Geo-Spatial/digital cartographic techniques; and (c) Data editing/coding and use of new scanning technology for data processing to ensure a timely production of quality disaggregated data on population and development and documentation of best practices for knowledge management.

96. **Output 2:** *Increased availability and use of evidence on population dynamics, sexual and reproductive health, youth, and gender, and their linkages to national and subnational development for policy formulation, implementation and monitoring.* Results of UNFPA's support to this output will be measured by two output indicators as follows:

97. **Output Indicator 1:** *Number of national policies and plans informed by recent results of nationwide population surveys.* The main interventions planned in this CPAP to achieve this are:

- Provide technical assistance to conduct Mid-Term Review and final evaluation of the NSDP 2014-2018 and to formulate the new NSDP 2019-2023, in which key recent population data, SRSH, HIV, adolescents and youth, and gender/VAW issues are incorporated.
- Provide technical support to develop the National Policy for the Elderly, in which recent disaggregated data and evidence-base related to population dynamics, SRH, HIV, adolescents and youth, and gender equality are used and integrated.
- Provide technical support and capacity development to conduct an assessment and development of the National Guidelines for the Development of the Sectoral Strategic Development Plan.
- Provide technical support to the government in localizing the SDGs into a Cambodia context and developing targets for the "Cambodian Sustainable Development Goals - CSDG 2016-2030" based on social-economic status and demographic structure of population in the country.
- Provide technical support for development of a Costed Results-Based Three Year Rolling National Population Policy Action Plan and its Information, Education and Communication (IEC) materials for advocacy.

98. *Output Indicator 2: Percentage of subnational planning bodies trained in analysing and utilizing 2014 Cambodia Demographic Health and Survey data in prioritized locations.* The main interventions planned in this CPAP to achieve this are:

- Provide technical assistance, capacity development, and advocacy to conduct a secondary data analysis of 2014 CDHS.
- Develop training materials and capacity building for relevant sectoral ministries and sub-national planners of line departments to use this data in development plans and budgets. This will be supported in approximately seven provinces.

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## **PART V: PARTNERSHIP STRATEGY**

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99. UNFPA will actively engage in purposeful partnerships to achieve its programme results. Successful implementation of the 5<sup>th</sup> Government of Cambodia/UNFPA Country Programme will strongly depend on strategically maintaining and strengthening existing partnerships with key government ministries, departments and agencies together with other development partners, including other UN agencies, and civil society organizations (CSOs). New strategic partnerships with CSOs and academic institutions will be sought based on their experience and proposed approach in the specific area where expertise is needed and will be selected through a competitive bidding process. A detailed partnership plan for each outcome and output area is attached (see Annex 4).

100. The Government's policy on managing development partner assistance, as well as for strengthening partnerships with all development actors, is articulated in the Development Cooperation and Partnership Strategy 2014-2018<sup>9</sup>. This establishes Cambodian Rehabilitation and Development Board (CRDB) of the Council for the Development of Cambodia (CDC) as the national aid coordination and development effectiveness focal point.

101. UNFPA will partner and continuously engage with the CDC as the overall Government Coordination Authority (GCA) for this CPAP. Through the mechanism of joint government – donor technical working groups (TWGs) working on Joint Monitoring Indicators (JMIs), the Government of Cambodia provides coordination and leadership on a sectoral basis under the CDC. UNFPA will actively engage in relevant technical working groups as a key mechanism to ensure collaboration and coordination in all proposed areas with government, civil society organizations, bilateral donors and UN agencies.

102. UNFPA will continue to demonstrate its commitment to aid effectiveness by continuing to support the Health Sector support partnership together with the World Bank, UNICEF, the Australian Department of Foreign Affairs and Trade (DFAT), KfW, the German Embassy, Korean International Cooperation Agency (KOICA) and potentially United States Agency for International Development (USAID) in order to leverage funds for reproductive health in particular and to ensure a joint approach to supporting the national Health Strategic Plan 2016–2020.

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<sup>9</sup> <http://www.cdc-crdb.gov.kh/strategy/default.htm>

103. Within the UN coordination framework, UNFPA will play an active role in the United Nations Country Team (UNCT) on coordination issues and advocacy ‘with one voice’ but also in terms of a harmonized common approach to engaging government and implementing partners. UNFPA together with UNICEF and United Nations Development Programme (UNDP) will move towards a Harmonized Approach to Cash Transfer (HACT) approach for the first time in the new programme cycle.

104. UNFPA will also play a leadership role in the UN theme group on youth which will enable coordination around programming and advocacy for young people. In addition, UNFPA will play a lead role in the UNDAF advisory group, providing support to the development of a clearly articulated results framework, coordination, monitoring and reporting structure for all UN agencies towards the UNDAF results.

105. UNFPA will also work on joint programming approaches in the areas of prevention of VAWG together with the United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), United Nations Volunteers (UNV) and UNICEF; on the health sector response to violence with WHO and UNICEF; on a holistic and joint approach to addressing the needs of adolescent girls together with UN Women, UNICEF, WHO, United Nations Educational, Scientific and Cultural Organization (UNESCO).

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## **PART VI: PROGRAMME MANAGEMENT**

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106. UNFPA and the Government will implement, monitor, and evaluate the programme within the context of the UNDAF and the NSDP. The CDC will coordinate the overall programme. The UNFPA Country Office, key line ministries, and selected implementing partners will be responsible for the joint supervision and monitoring of programme implementation and results.

107. The UNFPA Country Office in Cambodia based in Phnom Penh includes staff who perform management and development effectiveness functions funded from the institutional budget. UNFPA will also allocate programme resources for staff providing technical and programme expertise, as well as associated support, for the implementation of the programme based on the Country Programme requirements and the approved Country Office typology.

108. Additional national project personnel and short term technical support will be recruited as required. National, regional and international experts will provide technical support. The UNFPA Asia and Pacific Regional Office (APRO), based in Bangkok, Thailand, will assist the Country Office in identifying technical resources and in providing quality assurance.

109. UNFPA will primarily use national execution led by the Government and will use a competitive process to select non-governmental implementing partners based on relevance to the programme and capacity for high quality programme implementation, results-oriented and strong monitoring systems.

110. The programme will endeavour to strengthen the capacity of UNFPA and its implementing partners in results based management and will set up systems to improve monitoring and

reporting on results. Workplans will be developed with implementing partners for each output and signed by both UNFPA and the implementing partner.

111. Progress will be reviewed on a quarterly basis through partner meetings which review the Funding Authorization and Certificate of Expenditures (FACE) form detailing expenditures and programmatic reporting on milestones. Internal review and analysis of this information will also be captured in the UNFPA Strategic Information System (SIS/my Results) monitoring module.

112. Progress towards achievement of output level indicator targets will be measured on an annual basis through an Annual Review Meeting which will also be linked to the UNDAF annual review exercise. These reviews will facilitate planning and revisions for Implementing Partner workplans in a timely manner and will ensure that workplans are sufficiently focused on achieving defined indicator targets and results. A detailed description of the management of the monitoring and evaluation of the programme is provided in the next section and in the Annexes 2 and 3 (Planning Matrix for M&E and M&E Calendar).

113. All cash transfers to an Implementing Partner are based on Work Plans (WPs) agreed between the Implementing Partner and UNFPA. Cash transfers for activities detailed in WPs can be made using the following modalities:

- 1) Cash transferred directly to the Implementing Partner:
  - a) *Prior to the start of activities (direct cash transfer), or*
  - b) *After activities have been completed (reimbursement);*
- 2) Direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner;
- 3) Direct payments to vendors or third parties for obligations incurred by United Nations agencies in support of activities agreed with Implementing Partners.

114. Direct cash transfers shall be requested and released for programme implementation periods not exceeding three months. Reimbursements of previously authorized expenditures shall be requested and released quarterly or after the completion of activities. UNFPA shall not be obligated to reimburse expenditure made by the Implementing Partner over and above the authorized amounts. Following the completion of any activity, any balance of funds shall be reorganized by mutual agreement between the Implementing Partner and UNFPA, or refunded.

115. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may depend on the findings of a review of the public financial management capacity in the case of a Government Implementing Partner, and of an assessment of the financial management capacity of the non-United Nations<sup>10</sup> Implementing Partner. A qualified consultant, such as a public accounting firm, selected by UNFPA may conduct such an assessment, in which the Implementing Partner shall participate.

116. Cash transfer modalities, the size of disbursements, and the scope and frequency of assurance activities may be revised in the course of programme implementation based on the

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<sup>10</sup> For the purposes of these clauses, “the United Nations” includes the International Financial Institutions (IFIs).

findings of programme monitoring, expenditure monitoring and reporting, and audits. The overall framework for assurance activities will be through the HACT which UNDP and UNICEF will also implement in the Country Programme cycle period.

117. The strategy for resource mobilization (financial and in-kind) will be developed by the Country Office together with the Government to support implementation of the Country Programme. This will also be done in collaboration with the UNCT and the APRO.

118. A Human Resource alignment exercise will be conducted with support from the APRO and will review the human resource requirements and capacities to deliver this programme.

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## **PART VII: MONITORING AND EVALUATION**

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### **Managing for Development Results**

119. As part of this CPAP, a monitoring and evaluation framework has been developed in line with the UNFPA corporate monitoring and evaluation policies and procedures and aligned with the UNDAF M&E systems.

120. CPAP performance monitoring includes the following different types of monitoring and evaluation tools and activities:

- The CPAP Results and Resources Framework (see Annex 1) and Planning Matrix for M&E (see Annex 2) form the key tools through which the whole programme will be implemented, monitored and evaluated.
- The SIS myResults platform (UNFPA integrated planning, monitoring and reporting platform) will be used to enter annual milestones against output level indicators and to capture monitoring of progress through the quarterly monitoring platform. The reporting module will be used to consistently document progress, achievements, challenges and lessons learnt.
- Detailed indicator protocol sheets have been designed to ensure consistent approach to measurement and analysis of results at both outcome and output levels. Disaggregation of output level indicator targets by each year of the CPAP and definition of milestones for their achievement are key tools to facilitate monitoring against results.
- Detailed means of verification including quality measurement tools will also need to be developed for some outputs including in the areas of health services for survivors of violence and also for adolescents where quality and delivery according to national guidelines needs to be measured.
- Outcome level baseline data was collected for many of the indicators using the CDHS data set. Due to the short cycle of the Country Programme, there will not be an endline CDHS to measure the outcome level results and therefore proxy indicators have been proposed.
- Monitoring will be done jointly with partners through regular quarterly and annual review mechanisms including review of the FACE forms and quarterly workplan progress reports, field visits, spot checks both planned and unplanned using approved formats in the UNFPA Policy and Procedure Manuals (PPM) for documentation and follow up.

- Each workplan will be accompanied by a monitoring plan which is jointly agreed by UNFPA and the implementing partner. Documentation of monitoring by UNFPA will follow the approved formats in the PPM.
- Annual Review Meetings will provide an opportunity to assess and update progress on the CPAP Planning Matrix for M&E (see Annex 2)
- There is no CPE planned for the end of programme cycle in 2018 as the cycle is only of three years duration and a number of thematic evaluations and a CPE were already conducted for CP4 in 2014.
- There will be an UNDAF evaluation in 2017 covering two cycles (2011-2015 and 2016-2018 collectively) and the Country Office will take part in that process.

121. Key national platforms such as Technical Working Groups and Management Information Systems will also be used to monitor outcome and output performance of the programme. The Country Programme outcome and output indicators are linked and contribute to indicators of the UNDAF 2016-2018, NSDP 2014-2018 as well as other performance monitoring indicators for the sectors in the country and monitoring of these indicators will be done in collaboration with the national counterparts, the UNCT and other relevant development partners.

122. The UNFPA Country Office will invest in building its own capacity and that of its implementing partners, in results based management and in monitoring and evaluation to ensure national ownership. The Country Office will develop its capacity development strategy based on the capacity gaps and needs as identified in the Harmonized Approach to Cash Transfer (HACT) micro assessment results. An M&E calendar is annexed to this CPAP (see Annex 3).

123. Managing for results also implies managing risks that have the potential to directly impact on results management and its processes: participation, efficiency, effectiveness and accountability. In order to identify and respond to these risks, the Country Office will closely monitor relevant risk factors as stipulated in the Systematic Information System (SIS) and take appropriate actions to minimize them accordingly.

124. Implementing partners agree to cooperate with UNFPA for monitoring of all programmatic activities supported by cash transfers and will facilitate access to relevant financial records and personnel responsible for the administration of cash provided by UNFPA. To that effect, Implementing Partners agree to the following:

- Periodic review of their financial records by UNFPA or its representatives, following UNFPA's standards and guidance;
- Periodic review and monitoring of their programmatic activities following UNFPA's standards and guidance; and
- Special or scheduled audits: UNFPA, in collaboration with other United Nations agencies will establish an annual audit plan, giving priority to audits of Implementing Partners with large amounts of cash assistance provided by UNFPA, and those whose financial management capacity needs strengthening.

125. To facilitate assurance activities, Implementing Partners and the UNFPA may agree to use a programme monitoring and financial control tool allowing data sharing and analysis.

Assessments and audits of government and non-government Implementing Partners will be conducted in accordance with the policies and procedures of UNFPA.

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## **PART VIII: COMMITMENTS OF UNFPA**

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126. For the period 1 January 2016 - 31 December 2018, the UNFPA Executive Board approved a total commitment of US\$ 11.1 million from Regular Resources in support of the Country Programme, subject to availability of funds. The Board authorized UNFPA to seek additional funding, in the form of Other Resources, to support the implementation of the Country Programme, to an amount of US\$ 3.7 million.

127. The availability of Other Resources will be dependent on the success of joint UNFPA and the Government resource mobilization efforts and donor interest. Therefore, the total value of the approved Country Programme (Regular Resources + Other Resources) equals US\$ 14.8 million. The regular and other resource amounts noted above are exclusive of the UNFPA support to core office staff and operational expenses through the Institutional Budget as well as any additional funding potentially received in response to an emergency appeal.

128. Resource mobilization will be a critical part of the new programme, and will be undertaken by UNFPA in conjunction with the Government and other partners as appropriate. As noted above, UNFPA hopes to mobilize an additional US\$ 3.7 million to support Country Programme initiatives as detailed in the Results and Resources Framework (see Annex 1). A resource mobilization plan will be developed to highlight specific needs and possible funding sources. Resource mobilization activities will be initiated in the early part of the next Country Programme.

129. In case of direct cash transfer or reimbursement, UNFPA shall notify the Implementing Partner of the amount approved by UNFPA and shall disburse funds to the Implementing Partner within 30 days.

130. In case of direct payment to vendors or third parties for obligations incurred by the Implementing Partners on the basis of requests signed by the designated official of the Implementing Partner; or to vendors or third parties for obligations incurred by UNFPA in support of activities agreed with Implementing Partners, UNFPA shall proceed with the payment within 30 days. UNFPA shall not have any direct liability under the contractual arrangements concluded between the Implementing Partner and a third party vendor.

131. Where more than one United Nations agency provides cash to the same Implementing Partner, programme monitoring, financial monitoring and auditing will be undertaken jointly or coordinated with those United Nations agencies.

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## **PART IX: COMMITMENTS OF THE GOVERNMENT**

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132. The 2016–2018 Country Programme will be implemented in conformity with the policies of the Government of Cambodia, the host country agreement signed between the Government and the UN dated 1994, and the provisions and framework as set out in this document. The CDC will

function as the Government Coordinating Agency and will take overall responsibility for coordinating and monitoring the Country Programme.

133. The Government's expected contribution to this Country Programme is outlined in the host country agreement dated 1994 and includes, but is not limited to in kind contributions of space and local counterparts for achievement of the Country Programme outcomes and outputs; organization of annual and periodic reviews, and support for importation and exportation of goods, supplies and equipment, and payment or exemption from related customs charges.

134. Of particular note in this new CPAP is the commitment of the Government to also support resource mobilisation for the proposed programme and their commitment of financial resources. In August 2015, senior MoH officials reviewed the proposed national budget plan for 2016, which included a proposal for US\$ 2.3 million from the national budget for procurement of contraceptives in 2016. This amount has been fully approved and the Government has committed to allocate national budget for contraceptives from 2016 onwards. This represents a significant contribution and demonstrates national commitment toward a complete and quality supply of reproductive health commodities.

135. Out of the budgeted US\$ 12 million needed for the successful conduct of the 2018 General Population Census, the Government through the Ministry of Planning has officially committed US\$ 3 million as a national contribution for this exercise. This represents a substantial increase in national commitment and budget for the census when compared to previous rounds.

136. Each of the UNFPA supported government institutions, ministries, provincial departments and district offices and local government institutions shall maintain proper accounts, records and documentation in respect of funds, supplies, equipment and other assistance provided under this Country Programme. Authorised officials of UNFPA shall have access to all relevant accounts, records and documentation concerning the distribution of supplies, equipment and other materials, and the disbursement of funds. The government shall also permit UNFPA officials, experts on mission, and people or agents performing services for UNFPA, to observe and monitor all phases of the programme of cooperation.

137. A standard Fund Authorization and Certificate of Expenditures (FACE) report, reflecting the activity lines of the Work Plan (WP), will be used by Implementing Partners to request the release of funds, or to secure the agreement that UNFPA will reimburse or directly pay for planned expenditure. The Implementing Partners will use the FACE to report on the utilization of cash received. The Implementing Partner shall identify the designated official(s) authorized to provide the account details, request and certify the use of cash. The FACE will be certified by the designated official(s) of the Implementing Partner. Cash transferred to Implementing Partners should be spent for the purpose of activities as agreed in the WPs only.

138. Cash received by the Government and national NGO Implementing Partners shall be used in accordance with established national regulations, policies and procedures consistent with international standards, in particular ensuring that cash is expended for activities as agreed in the WPs, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds. Where any of the national regulations,



policies and procedures are not consistent with international standards, the United Nations agency regulations, policies and procedures will apply.

139. In the case of international NGO and IGO Implementing Partners cash received shall be used in accordance with international standards in particular ensuring that cash is expended for activities as agreed in the WPs, and ensuring that reports on the full utilization of all received cash are submitted to UNFPA within six months after receipt of the funds.

140. To facilitate scheduled and special audits, each Implementing Partner receiving cash from UNFPA will provide United Nations Agency or its representative with timely access to:

- All financial records which establish the transactional record of the cash transfers provided by UNFPA; and
- All relevant documentation and personnel associated with the functioning of the Implementing Partner's internal control structure through which the cash transfers have passed.

141. The findings of each audit will be reported to the Implementing Partner and UNFPA. Each Implementing Partner will furthermore:

- Receive and review the audit report issued by the auditors;
- Provide a timely statement of the acceptance or rejection of any audit recommendation to UNFPA;
- Undertake timely actions to address the accepted audit recommendations; and
- Report on the actions taken to implement accepted recommendations to the UN agencies with the frequency that is mutually agreed.

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**PART X: OTHER PROVISIONS**

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142. This CPAP and its annexes supersede any previously signed Country Programme Action Plans, and will cover the period 1 January 2016 to 31 December 2018.

143. The CPAP and its annexes may be modified by mutual consent of both parties, the Government and UNFPA; and nothing in this CPAP shall in any way be construed to waive the protection of UNFPA accorded by the contents and substance of the United Nations Convention on Privileges and Immunities to which the Government is a signatory.

*IN WITNESS THEREOF the undersigned, being duly authorized, have signed this Country Programme Action Plan on this day, **November 2015**, in Phnom Penh, Cambodia.*

For the Royal Government of Cambodia

For the United Nations Population Fund

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**H.E. Mr. Keat Chhon**  
*Permanent Deputy Prime Minister  
First Vice Chairman of the Council for  
the Development of Cambodia  
Kingdom of Cambodia*

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**Dr. Derveeuw Marc G.L.**  
*Representative  
UNFPA Cambodia*

**ANNEX 1: CPAP RESULTS AND RESOURCES FRAMEWORK**  
**ANNEX 2: CPAP PLANNING MATRIX FOR MONITORING AND EVALUATION**  
**ANNEX 3: CPAP MONITORING AND EVALUATION CALENDAR**  
**ANNEX 4: CPAP PARTNERSHIP PLAN**  
**ANNEX 5: CPAP PRIORITY GEOGRAPHIC LOCATIONS**