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EXECUTIVE SUMMARY

The civil war of the seventies and the ensuing political unrest during the past three decades has left Cambodia with a poor public sector infrastructure and services. The Khmer Rouge decimated the health system: of the 1,000 doctors trained prior to 1975, less than 50 survived the regime. In 1979, the restoration of a functioning health care system became one of the highest priorities of the new government of the People's Republic of Kampuchea. The period 1980-1989 was one of reconstruction and rehabilitation, with many health workers being trained through accelerated training courses. The years between 1989 and 1995 constituted a time of recovery with substantial government and donor investment.

In 1993, the first Royal Government took office; authority and responsibility for programme development and budgetary control at local health units were transferred from local government to the Ministry of Health. Basic legislation and regulation on key organisation and management of the health sector were prepared and approved between 1995 and 1998. International donors gradually started projects or programmes in the country in the 1990s.

In October 1992, Cambodia became a state party to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Cambodia submitted a report to the CEDAW Committee in the first quarter of 2004. In 1993, United Nations Fund for Women (UNIFEM) initiated a project to increase women's interest and participation in the May 1993 elections, and to ensure that gender issues and women's concerns were on the agenda during the election process and in the drafting of the new Constitution which guarantees equality for women and men and provides for automatic acceptance of all human rights covenants and conventions, especially those relating to women and children.

The relatively stable political climate from 1995 onwards provided an opportunity for the government to legislate long needed policies on sexual and reproductive health. These policies were largely donor driven. Donors were able to influence change because the country was in the process of reconstruction and agencies had the opportunity to influence sexual and reproductive health policy formulation to comply with international agreements that Cambodia adhered to. The International Conference on Population and Development (ICPD) served as a starting point and guide in the development of policies, laws and programmes on sexual and reproductive health and rights (SRHR) in Cambodia. Subsequent years saw the adoption of a number of policies and laws relating to SRHR.

The Ministry of Women's and Veteran's Affairs (MWVA) was created by the Royal Government of Cambodia in 1998 with the aim of advancing the role and status of women and veterans. Part of its mandate is to implement the 1995 Beijing Platform for Action. In 1999, the Ministry formulated a five year strategy for 2001-2006 called *Neary Rattanak: Women Are Precious Gems*, which was incorporated in the government's Second Socio-Economic Development Plan (SEDP II) 2001-2005.

Since 1999, Cambodia has moved forward in developing legislation, policies, regulations, institutions and programmes towards greater gender and social equity and equality and ensuring better delivery and access to reproductive and sexual health services, especially for women, adolescents and children.

In line with the UNCRC, the Royal Government of Cambodia completed its first report for the Committee on the Rights of the Child in the first quarter of 2000. The following years saw considerable change with the country being declared polio free (2001) HIV/AIDS as a public health priority being reduced to 2.6 percent (2002) from a high prevalence of 3.3 percent in 1997. In the electoral arena, the number of women elected to the Commune Councils in 2002 reached a high of 932 from a previous figure of ten. In addition, a Health Sector Strategic Plan (HSSP) 2003-2007 was adopted)in 2002) and the implementing guidelines for the Abortion Law were approved. The National Population Policy was launched in February of 2004 after consultations and deliberations with stakeholders.

Not all signs were positive, however. Trafficking in women and children for sexual purposes continued to increase, as did domestic violence (16 percent for women aged 15-49). The maternal mortality figure still stands at 437 deaths per 100,000 live births, today 55 percent of women do not receive any antenatal care, 89 percent of Cambodian babies are delivered at home, only 32 percent of births are attended by a trained health professional and 46 percent of all mothers do not receive any postnatal care. Infant mortality rate (IMR) estimated at 89 per 1000 live births in 1998 rose to 95 per 1000 in the year 2000, the under-five mortality seems to have increased from 115 per 1000 in 1998 to 125 in 2000, and 20 percent of women in Phnom Penh and 68 percent in rural areas are unpaid family workers.

Barriers to Implementation

Many implementation barriers were identified in the course of the monitoring work. The electoral procedures and proportional systems do not offer women the opportunity to participate as independent candidates as shown in the 2003 elections wherein each political party expressed its support for women's participation but few women's names were listed from the first to the third places within the candidate lists. The HSSP has identified health service delivery as a top priority but public sector resources available for service delivery are still very limited and expected to remain so for many years. Moreover, the highly centralised and politicised budget management procedures and very low civil service salaries constrain the performance of the health sector, especially the public health system. Mistrust of the public sector is often deeply entrenched in people's minds, leading to scepticism about care and treatment offered through these services. Budgets for social sectors have increased but the funding that reaches the local level is inadequate: allocated budgets are being disbursed late or not at all. Corruption and the culture of impunity remain rampant. There are no clear, standardised procedures for civil society participation. The progress in legislation is uneven and not always transparent. There is lack of communication between communities and local authorities and a lack of funds. People often have to travel long distances to access health care. Standards of care are considered to be poor, generally and more so in the huge and largely unregulated private and informal sector. Pharmacists and drug sellers are the first contact in 70 percent of health seeking cases. There are 3,700 pharmacies in the country, 75 percent of which are unlicensed and are inappropriately prescribing antibiotics or selling counterfeit or illegally procured medicines leading to the possible development of resistance to TB and HIV.

Necessary laws and regulations already exist and many more are being prepared but capacity to enforce them has yet to be demonstrated and information on the existence of sexual and reproductive laws and regulations is minimal. People with HIV report that there is still a great deal of stigma associated with HIV/AIDS and this has led to reduced access to information, services, and care and support

especially for vulnerable groups. The EC/UNFPA study of 2002 revealed that NGO staff do not always provide effective counselling; and there is much to be done in understanding the importance of confidentiality. The study further identified the main barriers for young people in accessing services to be cost, distance to travel and the crisis of confidence that comes when young people are required to discuss a subject as intensely personal as sexual and reproductive health.

Facilitating Factors

A strong government commitment, effective intervention strategies, active political participation at the highest level, technical and financial support from all partners, effective mass media campaigns, good multisectoral collaboration involving civil society and community participation are key factors that have helped to bring about change. Added to these is the presence of a range of non-governmental players, both individuals and organisations, in all provinces and sectors and their pivotal role in providing basic services and bringing in alternative, participatory and gender sensitive approaches to development and environmental sustainability. There are also strong and continuing partnerships between the public sector and external and international partners and NGOs, the Health Sector Support Project has enabled donors to coordinate their assistance to avoid duplication and identify gaps that need to be addressed; monks or wat/pagoda committees have been active in working with people living with HIV/AIDS. In addition, grassroots organisations have contributed greatly towards bringing SRHR services to a greater number of people in rural communities, and capacity development initiatives have helped a number of Cambodian NGOs to qualify for direct execution of international donor assisted projects due to increased national institutional, managerial and operational capacity.

However, there is also concern that international and local developments may lead to some change within the country. The urgent crises in Iraq, Afghanistan, Haiti and elsewhere, could result in decreased donor assistance to Cambodia. In 2003 the outbreak of Severe Acute Respiratory Syndrome (SARS) resulted in the decline of tourism, which is an important part of the economy. The spread of the bird flu virus in the region during the first quarter of 2004 badly affected the poultry industry. Local events in recent years are likely to slow economic growth. On January 29, anti-Thai rioting in Phnom Penh destroyed the newly built Thai Embassy and several Thai owned businesses. The riots caused an estimated US$50 million worth of damage to Thai property and have shaken investor confidence. The non-formation of a government after the July 2003 elections has created an atmosphere of instability and has slowed the development of policies and legislation as well as the infusion of additional funds from donors. A few allegedly politically motivated high profile assassinations (e.g. the labour leader Chea Vichea) have added to the existing tense political climate.

Rapid liberalisation is driving people away from their land and from subsistence agriculture. Young women bear the brunt of these policies, and are forced to migrate to become garment factory workers, commercial sex workers or beggars. About 180,000 young women are serving in 200 factories where there are very difficult working and living conditions.

A major challenge to the government is how to restore public confidence in the health system. The provision of political and financial resources towards improving health care services, especially in rural areas, is prioritised in the health sector plans, however, the implementation of sector wide management and decentralisation is a significant change in the management and provision of health services and capacity building within the national system that is becoming a challenge to both the MOH and donors. Donors are being

challenged by opposition political parties to address rampant corruption, unabated deforestation and inequitable land distribution. Opposition political parties allege that the WB is not achieving its poverty alleviation targets despite having invested nearly $400 million in Cambodia since 1993 (*Cambodia Daily*, 10 March 2004). The link between poverty and population dynamics must continue to be emphasised to ensure that population concerns remain a priority to be addressed by future socio-economic development and poverty reduction plans. While gender concerns have been integrated to some extent in the NPRS and HSSP, further efforts in gender mainstreaming will be required to effectively produce a change towards gender sensitivity in the sectoral policy agenda. The challenge to NGOs is to heighten their advocacy efforts both within the policy making process and the media for changes in national policies and for mainstreaming gender in sectoral policies.

A number of recommendations have been put forward by NGOs and other stakeholders towards improvements in the situation. These are: ratification of the draft law on domestic violence and a review of the law on marriage and family; stronger implementation of the law on trafficking, transparency within the legal and police systems and reduction of bribery and corruption; an increase in national budget allocations for education and health with special attention being paid to the needs of women; attempts, on the part of donors, to try and ensure that their funds have a positive impact on the poor and the vulnerable, and that they do not fuel corruption, or violate the rights of project-affected communities; as well, there should be a focus on equitable growth with attention being paid to the structural causes of poverty. In-depth analyses of the impact of poverty and coordination of all policies (including macro-economic, fiscal, trade, social and environmental, as well as poverty reduction strategies that put at their centre the people for whom they are intended) are also important as is the mobilisation of communities for change, a realistic approach to implementation; 'affirmative action' programmes so that disadvantaged groups will gain greater access to services; the involvement of men in improving knowledge and practices in sexual and reproductive health and rights; and regular reviews, evaluations and documentation of how information or services are being accessed, absorbed and utilised. Best practices and lessons learned must be disseminated and promoted.

Introduction and Objectives

The provision of services on sexual and reproductive health and rights began in Cambodia in 1991. Because of political instability in the previous years, it was only in 1991 that the Ministry of Health allowed NGOs to provide family planning services. In 1992, USAID funded a pilot programme to train physicians in family planning (RACHA 2003). In 1994, the Royal Government of Cambodia received support from UNFPA for a project on institutional strengthening and family health improvement through family planning activities in Phnom Penh and five provinces. This was followed in 1995 by the Birth Spacing Policy and National Policy on STDs and AIDS.

In 1996, the Government initiated a Health Reform Programme that established a network of health centres and referral hospitals through a system of 'operational districts'. This institutional strengthening found support in 1997 in the Basic Health Services Project of the Asian Development Bank and the Cambodia Disease Control and Health Development Project of the World Bank. Also in 1996, the National Policy on Women, Cambodian National Declaration and Plan of Action against Domestic Violence, Law against Sex Trafficking and National Programme of Action for Children in Cambodia were adopted.

In 1997, the National Abortion Law was promulgated and signed, but its corresponding ministerial orders (prakas) came only in August 2002 due to lack of follow up by concerned agencies or NGOs. Abortion is a sensitive issue in the country and is not discussed publicly. The National Policy on Safe Motherhood and the Women and Family Law were also adopted in 1997. The National Policy and Strategies for Safe Motherhood provide broad guidelines on the involvement of governmental ministries (e.g., Ministry of Women's and Veteran's Affairs, Ministry of Rural Development) to ensure that all of its components are integrated into existing maternal and child health and birth spacing activities as well as related programmes. The National Reproductive Health Programme, which had its beginnings in 1992 and became a full programme in 1997, is located within the National Maternal and Child Health Centre (NMCHC) of the Ministry of Health (MOH) and is responsible for strategic planning, management, training and evaluation for national safe motherhood and birth spacing programmes.

In cooperation with UN agencies, the Government in 1998, created an HIV/AIDS task force to respond quickly to the HIV/AIDS epidemic in the country. The National Aids Authority was established in 1999 and has developed the Strategic Plan for HIV/AIDS and STI Prevention and Care for 2001-2005 that calls for a multi-sectoral approach in response to the HIV/AIDS epidemic.

In 2003, the National HIV/AIDS law of Cambodia was legislated and its accompanying prakas or implementing guidelines are currently being developed. The National Policy on Population was launched in February of 2004 after having been drafted with the participation of all stakeholders.

The present Five-Year (2003-2007) Health Sector Strategic Plan formulated in August 2002 by the Ministry of Health which aims at enhancing health development to improve the health of the people of Cambodia, especially mothers and children, defines two key areas of work that directly impact on the sexual and reproductive health sector: health service delivery and human resource development. The former prioritises reproductive health; health prevention and protection against STIs and HIV/AIDS; and management of selected diseases, two of which are STIs and HIV/AIDS. The components for health service delivery are child health and nutrition, maternal health, communicable disease control, and others. The latter on the other hand, targets better obstetric care and improved staff performance.

The UN considered Cambodia a priority country in terms of efforts to implement ICPD goals because of its status as a least developed country that, in recent history, had experienced almost three decades of war and instability. The key government ministries involved in these activities are the Ministry of Health, Ministry of Planning, Ministry of Women's and Veteran's Affairs and the Ministry of Education, Youth and Sports. These government agencies are working in partnership with UN organisations, multilateral and bilateral donor agencies and international and local NGOs in trying to achieve ICPD goals. UNFPA spearheaded the implementation of ICPD in the country. Their activities fall into three main areas identified by ICPD: reproductive health, population and development strategies and advocacy. ICPD is referred to in government policies and programmes on sexual and reproductive health but the ICPD Programme of Action (PoA) has yet to be translated into Khmer.

Methodology and Country team

This study is based on three main data collection methods:

1. Secondary data analysis: this includes the most recent quantitative and qualitative published and unpublished reports of government, NGOs, the UN, research organisations such as the Annual Reports of the Ministry of Health and Ministry of Women's and Veteran's Affairs, Cambodia National Demographic Survey 2000, National Poverty Reduction Strategy 2003- 2005, SRHR in Cambodia: A Situation Analysis, CEDAW- Cambodia website, Cambodia Briefing Kit for ICPD + 5, UNFPA Cambodia Country Brief - 2003, UNDP Human Development Report 2003, WHO Annual Reports and website database 2003, World Bank website, etc.
2. Key informant interviews: About 32 in-depth interviews were conducted with key people from government, NGOs, traditional birth attendants (TBAs), midwives and women between the ages of 15-49.
3. Focus group discussion in Phnom Penh: this was attended by UNFPA, Care International, KWVC, RHAC, LICADHO, ADHOC, Women Media and Health International

Seven provinces were covered by the study: Banteay Meanchey, Mondulkiri, Siem Reap, Kampong Cham, Sihanoukville, Svay Rieng and Phnom Penh/ Kandal. Initially, six selected midwives who had served as enumerators in the 2000 Cambodia Demographic and Health Survey (CDHS) were identified to be the field researchers and their work was to be monitored by a Khmer Head Researcher. In the course of the study, the Khmer Head Researcher was replaced because of the incompatible schedule of this work and her own. However, she assisted in preparing the two-day training module for the field researchers, translating questionnaires from English to Khmer and conducting interviews in Phnom Penh/ Kandal areas. Out of the six field researchers who were identified and given a two-day orientation on the questionnaire to be used, only four were able to function and Mrs. Neang Ren, the CMA Director, took on the task of assisting and supervising them in the conduct of the key informant interviews. The names of the members of the research team are given in the annexures.

The following informants were spoken to:

INTERVIEWEES	NUMBER PER PROVINCE	TOTAL FOR THE 7 PROVINCES
Director of Provincial Hospital	1	7
MCH Hospital Director	1	7
Private health provider (1 big, 1 small)	2	14
Male and female physicians	4	28
Midwives	5	15
Teachers (1 man, 1 woman)	1	7
Local authority	1	7
Traditional birth attendant	2	14
Other ministries (education, labour, etc,)	4	28
Women (15-49 in private and public clinics)	10	70
Total	32	22

One of the constraints faced in the course of research and monitoring was lack of time to review the extensive material available. There were also problems in finding the appropriate people to compose the country team. The large number of indicators that needed to be verified in the interview questionnaire made it long and time consuming. Adequate time to look at the secondary materials before carrying out the interviews would have helped to more sharply focus the work. There was considerable disparity between the set of indicators to be monitored and the report format. For example, for gender, social equality and equity alone, there were as many as 14 pages of indicators identified, but all the data gathered from the three areas of study needed to be compressed into just 25 pages. It was very difficult to compress the thorough and detailed information into a concise yet specific report that asked for regional and geographic variations for certain indicators.

Country Context

The civil war of the seventies and the ensuing political unrest during the past twenty-four years has left Cambodia with poor public sector infrastructure and services. The Khmer Rouge decimated the health system: of the 1,000 doctors trained prior to 1975, less than 50 survived the regime. In 1979, the restoration of a functioning health care system became one of the highest priorities of the new government of the People's Republic of Kampuchea. The period of 1980-1989 was one of reconstruction and rehabilitation, with many health workers being trained through accelerated training courses. The health service delivery system was set up on a socialist model and was publicly financed, comprising of commune clinics, district hospitals, provincial and national hospitals based on administrative districts.

The period of 1989 to 1995 was a time of recovery with substantial government and donor investment. In 1993, the first Royal Government took office and authority and responsibility for programme development and budgetary control at local health units were transferred from local government to the Ministry of Health. Basic legislation and regulation on key organisation and management of the health sector were prepared and approved between 1995 and 1998. International donor agencies gradually started projects or programmes in the country in the 1990s (Health Sector Strategic Plan 2003 – 2007). In 1992, USAID funded a pilot programme to train physicians on the promotion and use of contraceptive devices. In 1994, the RGC received support from UNFPA for a project on institutional strengthening and family health improvement through birth spacing work in Phnom Penh and five provinces.

In October 1992, Cambodia became a state party to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). In 1993, UNIFEM initiated a project to increase women's interest and participation in the May 1993 elections and ensure that gender issues and women's concerns were on the agenda during the election process. UNIFEM and Khemara, the only Cambodian women's NGO in 1991, the United Nations Transitional Authority of Cambodia (UNTAC) and the UNDP implemented the project. Two months before the elections, the project held a National Women's Summit, attended by more than 100 women in Phnom Penh, to identify women's main concerns that needed to be addressed by the political candidates and the future elected government. A women's agenda containing five key points was produced and disseminated to the major political parties. One week before the elections, representatives from six out of twenty political parties met with female voters to engage in a political discussion on the five-point agenda. After the elections, UNIFEM stayed on for another four months to work alongside Cambodian women participating in

the drafting of the new Constitution. The first Constitutional Workshop held by UNTAC, was aimed at local NGOs who wished to have their concerns represented in the Constitution. UNIFEM also held a Workshop on Women's Rights and the Constitution in partnership with Khemara, UNICEF and the Asia Foundation. This workshop trained women activists who lobbied the National Assembly to ensure that the new Constitution contained the principles of gender equality and anti-discrimination. The Constitution of 1993 thus guarantees equality for women and men and provides for automatic acceptance of all human rights covenants and conventions, especially those relating to women and children. Articles 31, 45 and 48 of the Constitution relate specifically to human rights, women's rights and children's rights. Article 46 prohibits the sale of human beings, exploitation or prostitution and obscenity.

UNIFEM continued its activities until the end of 1993, assisting the Secretariat of Women's Affairs in conducting a seminar on Women in Development Planning and Negotiation Skills in collaboration with Khemara for key staff members of ministries. They also helped to prepare prominent Cambodian women in government and local NGOs to represent Cambodia at the Beijing Conference, organise a tour to Thailand where women from development NGOs in both countries exchanged knowledge and experiences and financially assisted the Women's Video Group and the Women's Voice Magazine to strengthen women's representation in the media (CEDAW web page on Cambodia).

The relatively stable political climate from 1995 onwards provided an opportunity for the Government of Cambodia to legislate long-needed policies on sexual and reproductive health. Policy making on this issue was largely donor driven and many changes were made because the country was in the process of reconstruction and donor agencies had the opportunity to influence policy formulation to comply with international agreements that Cambodia adhered to. In this context, the International Conference on Population and Development (ICPD) had a major impact on the development of reproductive health and rights policies, laws and programmes. In 1995, the National Birth Spacing Policy and National Policy on STDs and AIDS were adopted. In 1996, the National Policy on Women, the Cambodian National Declaration and Plan of Action against Domestic Violence, the Law against Sex Trafficking and Sale of Human Beings and the National Programme of Action for Children in Cambodia were adopted. In 1997, the National Abortion Law was promulgated and signed and the National Policy on Safe Motherhood, Labour Law and the Women and Family Law were approved. In cooperation with UN Agencies, the Government in 1998, created an HIV/AIDS task force to respond quickly to the HIV/AIDS epidemic in the country. The National Aids Authority was established in 1999.

The Ministry of Women's and Veteran's Affairs (MWVA) was created by the Royal Government of Cambodia in 1998 as the national machinery for advancing the role and status of women and veterans. Part of its mandate is to implement the 1995 Beijing Platform for Action. In 1999, the Ministry formulated a five year strategy for 2001-2006 called *Neary Rattanak: Women Are Precious Gems*, which was incorporated in the government's Second Socio-Economic Development Plan (SEDP II) 2001-2005.

Assessing Progress in Achieving ICPD Goals and Objectives

Since 1999, Cambodia has moved forward in developing legislation, policies, regulations, institutions and programmes towards greater gender and social equity and equality and ensuring better delivery and access to reproductive and sexual health services, especially for women, adolescents and children. Gender equity has been incorporated in the National Poverty Reduction Strategy 2003 – 2005, a law against domestic violence is being deliberated in the National Assembly, a first draft of a five year strategy on Gender Mainstreaming in Education has been prepared, a Five Year Plan Against Trafficking and Sexual Exploitation of Children (2000 -2004) was adopted in March 2000 and in the same year, the Prevention of Trafficking in Women and Children in Cambodia (PTWCC) was launched by the International Organisation for Migration (IOM) in collaboration with the Ministry of Women's and Veteran's Affairs' *Women Are Precious Gems* programme. In addition, the Cambodia Millennium Development Goals of 2003 (CMDG) aim to: eliminate gender disparity and achieve universal nine year basic education by 2015, promote gender equality and empower women through education, eliminate gender disparities in wage employment in all economic sectors and in public institutions and significantly reduce all forms of violence against women and children as well as improve maternal health and combat HIV/AIDS, malaria and other diseases.

In line with the UNCRC, the Royal Government of Cambodia completed its first report for the Committee on the Rights of the Child in the first quarter of 2000. In 2001, Cambodia was declared polio free and the HIV/AIDS prevalence rate was reduced from 3.3 percent in 1997 to 2.6 percent in 2002, which was brought about by strong commitment, active political participation at the highest level, technical and financial support from all partners, effective mass media campaigns and community participation. In February 2002, 932 women had been elected to the Commune Councils from a previous record of just 10. In August of 2002, a Health Sector Strategic Plan (HSSP) 2003-2007 was adopted and the implementing guidelines for the Abortion Law were approved. The HSSP serves as a framework for donors in determining their programme thrust for the health sector and ensuring that resources are maximised and delivery of services reach the most disadvantaged groups. The NAA (National Aids Authority), established in 1999, plays a key role in coordinating efforts on HIV/AIDS and has developed the Strategic Plan for HIV/AIDS and STI Prevention and Care for 2001-2005 that calls for a multisectoral response to the HIV/AIDS epidemic. The National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) of the MOH is in charge of the Sentinel Surveillance System that it is developing in line with the Strategic Plan for HIV/AIDS.

The National Population Policy was launched in February of 2004 after several consultations and deliberations with stakeholders. The policy making process was supported by UNFPA and included government ministries and institutions, the National Committee for Population and Development, researchers from the Royal University of Phnom Penh, donors and civil society organisations such as RHAC and RACHA. The National Population Policy document states that its formulation was guided by the RGC's commitment to ICPD principles and objectives.

Gender, Social Equality and Equity

In 1999, the MWVA's five-year strategy, *Neary Rattanak: Women Are Precious Gems*, was incorporated in the Government's Second Socio-Economic Development Plan (SEDP II) 2001-2005. The Ministry developed a gender mainstreaming strategy

and in 2003 drafted a policy and action plan for its implementation. Gender has been mainstreamed in the National Poverty Reduction Strategy (NPRS 2003-2005) and gender disparities are to some extent addressed across key sectors. Initiatives under the NPRS will be incorporated in the development of the third SEDP. The Ministry has developed a National Policy for Women and HIV/AIDS and is actively engaged in supporting measures to increase the understanding of government personnel on gender sensitive statistics.

The Royal Government of Cambodia is promoting gender equity as one of the priority poverty reduction actions contained in the National Poverty Reduction Strategy 2003- 2005. Led by MWVA, the RGC's priorities are:

- To reduce gender-based disparities and improve gender equity in health, education, control of agricultural resources, socio-economic and political empowerment and legal protection
- To ensure that women and girls receive full legal protection, as well as legal education concerning their rights and benefits such as access to land titles and natural resources
- To promote gender mainstreaming in all government departments
- To collaborate with MOH for health, Ministry of Education Youth and Sports (MOEYS) for education and MAFF, MOWRAM and MRD for agriculture and rural income generation
- To address legal barriers to women's equal rights; and
- To direct gender education and awareness at key officials of the RGC at all levels.

An important institutional development was the establishment of the Cambodian National Council for Women in 2001 to monitor the status of women and report to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The country report to CEDAW was submitted to the Council of Ministers in April 2003 and approved seven months later, according to the 2004 Cambodia Country Gender Assessment from MOWVA. Equality for women is also within the remit of the Commission on Human Rights of the National Assembly.

According to the NPRS, 'The Royal Government of Cambodia will encourage political parties to place women on party lists in positions, which will allow them an equitable chance with men of being elected to parliament. . . . It will ensure that in all consultative processes, and in monitoring and evaluation teams, there will be an equal number of women and men.' In 2003, with UNIFEM support (directed through the NGO Women for Prosperity and Amara, the Cambodian Women's Network for Development, Cambodian Women for Peace and Development and Banteay Srey) to increase community awareness on the importance of women's participation in politics, 932 women were elected to the Commune Councils. Seventeen percent of these were in the top three positions in the Councils. Prior to the elections, the Councils had only ten women. Women for Prosperity, an NGO that promotes women's political participation was founded in 1992 and has trained more than 5,500 women to run for political office. Nearly two-thirds of the 1,000 women elected in February 2002 were trained by Women for Prosperity.

However, despite these positive developments, advocacy for changes in national policies and mainstreaming gender in sectoral policies as well as the implementation of existing gender policies remain as challenges in promoting the status of women and girls in Cambodia (UNFPA Country Report 2003).

In 1990, Cambodia's Human Development Index was calculated at 0.512, placing the country at the 'low human development' status. The HDI for 1995 was 0.543 and 0.556 for 2001, pushing the country to the 'medium human development'

category (Human Development Report 2003). In terms of the Gender Development Index, however, Cambodia ranks second lowest amongst South-East Asian countries with a rank of 105 and a GDI value of 0.551. The HDI minus GDI value is equal to zero. The GEM value for Cambodia is 0.347 with a rank of 64. Nine percent of seats in Parliament are occupied by women, 14 percent of legislators, senior officials and managers are women and 33 percent of professionals and technical workers are women. The ratio of estimated female to male earned income is 0.77 (Human Development Report 2003).

The higher number of women relative to men (5.92 million versus 5.51 million men) has reduced their social status and ability to get married. The 'surplus' in the marriage market has brought down the value of a woman's dowry and encouraged prostitution. Despite inflation, bride prices have declined and Cambodian men can divorce their wives and find new wives easily in the post-conflict period. Polygamy has reportedly also increased, leading single women who are destitute to enter into marital arrangements, both formal as well as informal with married men (NPRS 2002).

According to the UNFPA Cambodia Webpage, although a quarter of Cambodian households are headed by women, they have experienced discrimination in all aspects of life. Women earn 30 to 40 percent less than men in the same profession. The illiteracy rate is 40 percent higher for women, and school enrolment is 50 percent lower by age 15. In rural areas, 20 percent of all families are headed by women. In terms of adult illiteracy, Cambodia has the highest female illiteracy rate at 42 percent compared to the regional East Asia and Pacific average of 20 percent. Male illiteracy at 20 percent is also much higher than the regional average of six percent.

Education

While 27 percent of Cambodian men have at least completed primary school, only 14 percent of Cambodian women have attained the same level of education (CDHS 2000). About 19 percent of males and 34 percent of females have no education. The percentage of males and females with no education is highest in the region of Mondulkiri/ Ratanakiri (60 percent and 75 percent, respectively), and lowest (5 percent and 14 percent, respectively) in Phnom Penh. Educational attainment is much higher among the urban than among the rural population. For example, 89 percent of males and 77 percent of females in urban areas have some education, compared with only 79 percent of males and 63 percent of females in rural areas.

According to UNESCO's Institute for Statistics, girls' primary and secondary school enrolment at 46.3 percent and 35.6 percent is much lower than the regional averages for the East Asia and Pacific regions of 48 percent and 45.4 percent (CEDAW Cambodia web page). The Human Development Report of 2003 notes that the ratio of female to male enrolment and attendance is 0.9 in the primary, 0.59 in the secondary and 0.38 in the tertiary levels of education. The removal of school enrolment fees has encouraged parents to send their children to school. However, there is still a high dropout rate for girls. This is most often caused by poverty and the traditional responsibilities of girls within the family (NGO Statement 2002).

In an effort to decrease the gender gap in education, the Government is committed to 'Education for All' up to Grade 9 by 2015. The Government proposes to increase the number of lower secondary schools, to offer scholarships to children of poor families and build dormitories for girls, a policy due to be implemented in 2003. It

will also establish parents' committees to encourage them to keep their children in school (UNFPA Country Brief, 2003).

The overall trends in educational attainment, however, indicate improvements over time for both men and women. For example, the proportion of women with no education has declined significantly from 92 percent among women aged 65 and over to 13 percent among women aged 10-14. The proportion of men with no education declined from 45 percent among those aged 65 and over to 9 percent among those aged 10-14 (CDHS 2000).

NGOs such as Oxfam GB are targeting young adult women (age 15 to 18 years) for adult literacy and skill training. NGO Education Partnership (NEP) and Oxfam GB lobbied the Ministry of Education to remove barriers to girls' education. A first draft of a five-year strategy – Gender Mainstreaming in Education – has been compiled by the Ministry of Education's gender working group and circulated to all 22 departments of the Ministry. The Government and the Ministry of Education are trying to target resources to reduce disparities. Through the Asian Development Bank, the Japanese Fund for Poverty Reduction has spent US$3.5 million promoting the progression of poor girls and children from ethnic minorities from primary to secondary education (Oxfam GB web page).

Employment

Employment conditions for women in Cambodia are often unfavourable. Women constitute more than half of the total population (51.6 percent) and 65.9 percent of the economically active population. The *World Employment Report 2001* reported that Cambodia has one of the highest female labour force participation rates in the region at 73.6 percent (NPRS 2002). Women comprise 54 percent of skilled agricultural and fishery workers, 75 percent of the labour force in wholesale and retail trade and two thirds of the labour force in manufacturing. A great deal of this employment is, however, in the informal sector. About 46 percent of the labour force describe themselves as unpaid family workers. A significant percentage of women, 20 percent in Phnom Penh and 68 percent in rural areas, are unpaid family workers while the corresponding indicator for men is at six percent in Phnom Penh and 30 percent in rural areas (NPRS 2002). Large proportions of household expenditures are met with Cambodian women's earnings.

Domestic Violence

Large numbers of Cambodian women face domestic violence. The CDHS 2000 found that the number of women who experienced violence in the age range of 15-49 was 16 percent. One out of four ever-married women in Cambodia aged 15-49 has experienced physical violence since age 15. The highest numbers of women who have experienced domestic violence since the age of 15 are in Pursat (47 percent), Siem Reap/ Oddar Meanchey (39 percent), Phnom Penh (31 percent), Svay Rieng (30 percent), Kandal (28 percent) and Kampong Chnang (27 percent). Recognising the seriousness of the situation, the Cambodian Government set up a Project against Domestic Violence in mid-1990. A draft Law against Domestic Violence is currently being debated in the National Assembly but many NGOs feel that the passage of the draft law has been very slow, while the rate of domestic violence appears to be increasing (ADB 2001:43). Perpetrators of sexual exploitation, trafficking and rape of women and children, continue to escape legal punishment because of corruption, lack of legal protection, and ignorance of rights.

The UNIFEM Trust Fund has supported the Women's Legal Resource Centre (WLRC), which is the training unit of the Women's Litigation Unit of the Cambodian Defenders Project. WLRC has created a training curriculum on international and Cambodian laws relating to domestic violence and conducts regular workshops for law advocates, women's organisations that assist battered women, judges, law enforcement officers, and court personnel. The UNIFEM Trust Fund is also supporting a radio play created by the Cambodian NGO Banteay Srei that focuses on violence against women, especially domestic violence, trafficking, rape and promoting women's rights as human rights.

Trafficking in Women and Children

The Supreme National Council of Cambodia signed the UN Convention on the Rights of the Child on September 22, 1992 and ratified it on October 15, 1992. This Convention committed the Cambodian Government to promote and protect children's rights, including protection from sexual exploitation, trafficking and sale. In line with the UNCRC, the Royal Government of Cambodia completed its first report for the Committee on the Rights of the Child in the first quarter of 2000 (Cambodian National Council for Children, March 2000).

Prostitution and sexual exploitation of children in Cambodia have been ongoing for a long period and seem to be on the increase. Extensive research done by the Human Rights Commission of the National Assembly in 1996-1997 found that there were a total of 14,725 women working as prostitutes in brothels across 22 provinces of whom 15.5 percent (2,219) were children under 18 and 1,212 were between the ages of 9 and 15 years. Acute poverty, social instability, inadequate legal mechanisms and a weak rule of law have contributed to the rapid growth of the sex industry and trafficking in women and children to and from Cambodia. Approximately 88,000 women have been trafficked into neighbouring Thailand and between 40 to 60 percent of sex workers (14,000) say they have been coerced into joining the sex industry (CNCC 2000). The Cambodian Human Development Report 2000 estimates that there are 80,000 to 100,000 commercial sex workers in the country, 30 percent of whom are under 18. Figures in 2002 indicate that 29 percent of commercial sex workers are HIV positive.

The Council of Ministers adopted the Five-Year Plan against Trafficking and Sexual Exploitation of Children (2000 -2004) in March 2000. As part of its prevention programme, it included plans on multimedia awareness dissemination on the UN Convention on the Rights of the Child on radio, TV, newspapers, national campaigns, traditional and modern arts like drama and theatre. There were also plans to coordinate with the Ministry of Education in integrating children's rights, sexual education and sexual exploitation in the school curriculum in order to make teachers and students aware of the problem and the law. The Plan also included the sensitisation of government staff (police, court officials, local authorities, health workers, tourism personnel) and other professionals on children's rights and the sexual exploitation of children. It was planned that the Ministry of Social Affairs Labour and Vocational Youth Training (MOSALVY) would expand its programme of children's rights training with local authorities and would look into the possibility of providing similar trainings to other relevant ministries. Also in 2000, the Prevention of Trafficking in Women and Children in Cambodia (PTWCC) was launched by the International Organisation for Migration (IOM) in collaboration with the Ministry of Women's and Veteran's Affairs' programme *Women Are Precious Gems*.

Maternal Mortality, Safe Motherhood

Cambodia's maternal health situation remains bleak. The Maternal Mortality Rate (MMR) is 437 per 100,000 live births caused by haemorrhage, obstructed labour, sepsis, eclampsia and unsafe abortions, aggravated by high levels of malnutrition, anaemia and chronic infections (CDHS 2000). Moreover, only a small number of women are able to access antenatal care and few births are assisted by trained personnel. Adolescent pregnancies, closely spaced pregnancies, lack of health personnel with midwifery skills and poor access to health services contribute adversely to maternal health (UNFPA, 2000).

The National Policy and Strategies for Safe Motherhood was put in place in 1997. It provides broad guidelines on the involvement of governmental ministries (e.g. Ministry of Women's and Veteran's Affairs, Ministry of Rural Development) to ensure that all of its components are integrated into existing maternal and child health and birth spacing activities as well as related programmes. The National Reproductive Health Programme, which became a full programme in 1997, is located within the National Maternal and Child Health Centre of the MOH and is responsible for strategic planning, management, training and evaluation for national safe motherhood and birth spacing programmes (Catalla and Catalla, 2002).

In August 2002, the MOH issued the Health Sector Strategic Plan (HSSP) 2003-2007, which aims to 'enhance health sector development in order to improve the health of the people of Cambodia, especially mothers and children, thereby contributing to poverty alleviation and socio-economic development.' The expected outcomes of the HSSP are: reduced infant mortality rate, reduced child mortality rate, reduced maternal mortality ratio, improved nutritional status among children and women, reduced total fertility rate, reduced household health expenditure and a more effective and efficient health system. The HSSP has identified the following as key areas of work: health service delivery, behavioural change, quality improvement, human resource development, health financing and institutional development.

While the aim of Cambodia in 1999 was to reduce maternal mortality to below 125 per 100,000 live births by 2005 and below 75: 100.000 by 2015 (Country Briefing paper for ICPD+5), this has been adjusted in the CMDG 2003 to reduce MMR from 437 in 1997 to 140 per 100,000 live births by 2015. The HSSP 2003-2007 targets the reduction of maternal mortality from 437 to 305 deaths per 100,000 live births and the increase of modern contraceptive prevalence from 19-35 percent among women aged 15-49 years. Under the HSSP, the Department for International Development United Kingdom (DFID) will support new activities to help reduce maternal morality, including implementation of the abortion law, training of surgical teams in essential obstetric care and voluntary surgical contraception and training of midwives at health centres. ADB is targeting nine provinces with the objective of strengthening service delivery, improving maternal and child health services, promoting community participation and developing human resources capabilities. The German Agency for Technical Cooperation (GTZ) will continue to collaborate with the National Centre for Maternal and Child Health and other donors in improving midwifery training. In collaboration with UNFPA, Japan International Cooperative Agency (JICA) under their Maternal and Child Health Programme, are providing Health Centres with 'Minimum Package of Activities' kits of drugs, equipment and other supplies.

Interviews with 44 medical doctors and health providers nationwide revealed that in cases of maternal mortality, medical practitioners are required to document the patients' medical history, development of the disease and cause of death,

and keep the records for ten years in the administrative office. Health facilities are obliged to include cases of maternal mortality and morbidity in their monthly and annual reports.UNFPA is supporting the setting up of a mechanism that will undertake a maternal health audit starting in 2004 in 14 operational health districts. UNICEF will be supporting the project in six additional provinces.

Two important institutional developments are worth noting. The Cambodian Association of Parliamentarians for Population and Development (CAPPD) was formed in 1999 and the National Committee for Population and Development (NCPD), within the Council of Ministers with the Prime Minister as its Chairman, was established in 2001. There was wide consensus among high and mid-level policymakers and planners on the ten priority population issues in Cambodia at the Stakeholders Workshop on Population and Development on July 27, 2002.[1] The UNFPA has a continuing programme of sensitising policymakers and opinion leaders on population, RH, gender and development issues in the country.

A National Population Policy was drafted with broad participation from all stakeholders and launched in February of 2004. The policy reaffirms the Government's respect and support for the right of all couples and individuals to decide freely and responsibly on the number and spacing of their children, and to have access to information, education, services and the means to do so. Collaboration between the Ministry of Planning (MOP), the National Institute of Statistics (NIS) and the Centre for Population Studies (CPS) at the Royal University of Phnom Penh, with support from UNFPA, has already resulted in some analysis of the population situation in Cambodia and the identification of ten major population issues that have implications for socio-economic development and poverty reduction (UNFPA Country Brief, 2003)

Interviews with medical doctors and health providers estimate that 10 to 20 percent of political parties address MMR reduction in their platforms. Focus group discussions (FGDs) results reveal that local politicians are aware of the urgency of responding to the issue of MMR reduction but do not know how to address it effectively.

The Cambodian population, especially the poorest, shoulders the bulk of health expenditure in the country. A 1996 breakdown of funding sources of health expenditure shows that households by far are the greatest contributors, responsible for 82 percent of the total. At $33 per capita, the level of health expenditure per annum is 20 times more than that provided by the public health budget. The share of Government in total health spending is estimated at only about 10 percent, with donors' share at about 20 percent and households contributing the balance. The poorest strata spend the largest proportion of their income on health, making this a major cause of debt, landlessness, and further marginalisation. Much of this expenditure is unofficial and unpredictable and is not used for improving the quality of care. The poorest segment of the population is more than four times likely than the most affluent to forego treatment altogether (Ministry of Planning, 2002).

Access to professional maternity care is relatively low in Cambodia: 38 percent of women received antenatal care from trained health personnel and 55 percent did not receive any antenatal care for their pregnancies (CDHS 2000). About 89 percent of Cambodian babies were delivered at home and only 10 percent took place in a health facility. TBAs assisted with 66 percent of births and a trained health professional attended to 32 percent of births (28 percent by a midwife and the remaining four percent by a doctor or nurse). Fifty-seven percent of urban women received delivery assistance from a trained professional while 28

percent of rural women received trained professional help; 70 percent of rural women received assistance from a TBA and 46 percent of all mothers received no postnatal care at all.

Fifty-eight percent of women had some degree of anaemia: 44 percent had mild anaemia, 13 percent had moderate and one percent had severe anaemia (CDHS 2000). The prevalence of anaemia among children and pregnant women is considerably higher than in other countries in the region (MOP 2002). There are no data on the changes in trends in the level of anaemia during the last ten years but UNICEF estimated that 520 pregnant women die each year from severe anaemia (Cambodia Daily, 5 May 2004). The occurrence of anaemia is compounded by the prevalence of malaria and dengue fever in many parts of the country. Almost two-thirds of children suffer from anaemia: about a third have mild levels, another third has moderate levels, and two percent have severe anaemia. Children less than two years of age, residing in rural areas, and whose mothers have no education, are more likely to be anaemic than other children. Only 14 percent of households had adequate iodised salt. The Government aims to raise this figure to 95 percent by 2007 (Cambodia Daily, 2 March 2004). A sub-decree signed in October 2003 bans the sale of non-iodised salt and the Government plans to enforce it by October 2004.

By the end of 2007, the Government aims to reduce iron deficiency anaemia to 43 percent among pregnant women and 42 percent in children from 6-59 months and to reduce the incidence of malnutrition (underweight) to 31 percent among children from 6-59 months (HSSP 2002). In the second half of its current programme for 2004 to 2005, UNICEF will most likely place more emphasis on 'safe motherhood and nutrition'.

There is a prevailing sentiment and plenty of anecdotal evidence that the quality of services in both public and private sectors needs to be improved. Results of the FGD reveal that more than 50 percent of patients complain about poor service or its non-availability, slow response time and staff behaviour in public health facilities. Unfortunately, these things are seldom brought to the attention of responsible authorities. Services are slowly improving due to support provided by donors for the implementation of the Health Reform Programme initiated by the Government in 1996.

The Health Reform Programme established a network of health centres and referral hospitals through a system of 73 operational districts (ODs) in 24 provinces. Each OD covers a population of 100 – 200,000 and comprises 10-20 health centres covering populations of about 10,000 and a referral hospital. The health coverage plan (HCP) aimed at enabling local populations gain access to services and facilities through a minimum package of activities (MPA) as well as a complementary package of activities (CPA) at the health centre and referral hospital levels, respectively. At the health centre level, community participation is obtained through management and feedback committees. The MPA includes curative, preventive and promotional services in the facility and through outreach while the CPA provides more specialist care to populations in need of basic health care.

A medical doctor in a provincial referral hospital in Battambang said that giving birth in a public hospital would cost 50,000 riels ($12.50) both for normal and caesarean delivery. A village woman in Battambang who has a four month old baby said that she spent 80,000 riels ($20) when she gave birth at home with the assistance of a government midwife. The cost of normal delivery in Phnom Penh is $20 in public hospitals and around $100 to $120 at private clinics; caesarean

delivery can go as high as $700 in a private clinic. A garment worker's monthly salary in Phnom Penh ranges from $40 to $60 while the average monthly salary of a government employee is $25. The poverty line in the country is set at $13.80 – 18.90 per month and 36 percent of the population, the majority in rural areas, live below the poverty line (NPRS 2002).

The findings of the Joint Health Sector review in 2001 reveal that about 60 percent of the HCP has been implemented (Catalla and Catalla, 2002)). It noted that 67 referral hospitals have been established, 30 percent of which offer basic surgical procedures. Of the 940 health centres that had been newly constructed or renovated, only 840 (897 by the end of 2002 according to UNFPA) have functional birth spacing activities, 792 have functional MPA and only 65 have a functional reproductive health programme. Several NGOs, using both their own and donor money, have provided significant support to public health facilities in many ODs. However, there is a continuing shortage of midwives and existing human resources are not allocated according to need since the majority of them are concentrated in Phnom Penh and major towns (MOH 2002a).

Some recent gains in the health sector are: supplies of drugs have greatly improved, more feedback and health centre management committees have been established, and guidelines for outreach activities including an allowance of 8,000 riels ($2) have been set up (Catalla and Catalla, 2002). The Priority Action Plan (PAP), although chaotic in the first year, has been implemented in seven provinces and is a positive step towards modernising the health financing system (NGO statement 2002). Attendance rates have also increased, especially with regard to curative care contacts as well as antenatal care and birth spacing. In 2001, Cambodia was declared polio free. Likewise, reduction and control of infectious diseases like tuberculosis, malaria and HIV/AIDS has been accomplished through the implementation of effective intervention strategies, political commitment and good multisectoral collaboration involving civil society, communities and other ministries (MOH 2002a). Interviews with medical doctors and health providers nationwide affirm the MOH findings above. More health staff has been trained and transport for patients requiring emergency services have become easier because of better roads and the operationalisation of more health centres and referral hospitals. Access to basic health services within one kilometre is available to 52 percent of mothers. The provision of emergency obstetric care is still limited in some parts of the country like Mondulkiri and Preah Vihear.

Along with organisational strengthening and reform, budgetary and financial reforms are also in place to ensure the effective use of funds allocated to health (Catalla and Catalla, 2003). Health insurance policy schemes are in the early stages of development in the country with support from WHO and GTZ. An innovative strategy of contracting health services to NGOs in very poor districts has recently been piloted with significant success in achieving greater increases of health service coverage and reducing the expenditures of end-users. The private sector on the other hand, operates without adequate monitoring and control from the government, resulting in, among others a) public sector staff offering services in their homes, and b) issuing prescriptions that have been found to be detrimental to consumers. Necessary laws and regulations already exist and many more are being prepared but the capacity to enforce them has yet to be demonstrated. In Phnom Penh for example, there are at least 50 large private clinics and more than 700 smaller ones and half of them operate without licenses according to Municipal Health Department Director Veng Thai. To make matters worse the Ministry lacks the necessary staff to monitor the licensed clinics. (*Cambodia Daily*, 5 December 2003)

There is lack or little presence of health facilities in regions that are remote from Phnom Penh and many cost-effective public health interventions have not reached the poor. Forty percent of those who fall under the poverty line live in the rural areas, making access to health services more difficult. The Ministry has not given sufficient attention to improving the health and health care-seeking behaviour of the population or to informing them about health care quality and how to assess it (MOH 2001). A Health Finance Charter was adopted in 1996 that levied official charges for services in order to regulate under-the-table payments and reduce household expenditures to respond to the unpredictable informal fees that were commonly being charged in most facilities that had contributed to a marked shift from public to private providers (MOH 2001). Since 1997, household health expenditures have gone down from $29 to $24 (HSSP 2002). Dr Beat Richner of the Kantha Bopha Children's Hospital in a two page advertisement in the Cambodia Daily on 24 February 2004 claimed that few women give birth at a government run hospital in Siem Reap province because the 'patients have to pay'. Corruption in the user fee system further prevents the poor from accessing health services.

Interviews with medical doctors and health providers estimate that about 40 percent of trained midwives are available in remote areas 24 hours a day and about 60 percent of TBAs are being supervised by health care personnel. They also said that the state of referral transport systems varied from place to place but around 40 percent of patients use private transport facilities. They estimated that around 80 to 95 percent of health providers have received MTCT trainings.

The CDHS 2000 data suggest that childhood mortality was low in the late 1980s but has been gradually increasing during the early 90s. The infant mortality rate (IMR) estimated at 89 per 1000 live births in 1998 rose to 95 per 1000 in 2000. Likewise the under-five mortality seems to be increasing from 115 per 1000 in 1998 to 125 in 2000 (CDHS, 2000). Infant mortality is consistently lower in urban than in rural areas: 72 urban deaths as compared to 96 rural deaths per 1,000 live births. Children born to mothers with no education suffered the highest mortality and educating mothers through secondary education and higher levels reduces neonatal mortality by 37 percent, infant mortality by 41 percent, and under-five mortality by 44 percent, compared to mothers with no education. It is unclear why some health indicators are deteriorating but it is possible that economic pressure due to the return of the cash economy after the fall of the Khmer Rouge, especially in rural areas, coupled with the highly unsatisfactory state of the health system is partly responsible. The growing vulnerability of poor rural people who have become landless, experience food shortages or have limited access to common property resources at a time of rapid economic change, is negatively affecting health standards (ADB 2001. Health, Wealth, AIDS and Poverty in Cambodia).

Ninety six percent of children in Cambodia were breastfed (CDHS, 2000). However, only eleven percent of infants were put to breast within an hour after delivery and one-fourth of infants were breastfed within the first day. The median duration of breastfeeding among children less than three years of age is 24 months. Contrary to the World Health Organisation's (WHO) recommendation of exclusive breastfeeding for the first six months of age, only 18 percent of Cambodian children under two months are exclusively breastfed. Complementary feeding starts early: 70 percent of children under two months of age receive breast milk and water, 4 percent receive breast milk and other water-based liquids, and another 4 percent receive breast milk and complementary food. About 77 percent of children under age three receive some type of solid or mushy food by six to nine months of age. Grain supplements are more commonly consumed than roots, tubers, beans and legumes/lentils. Meat, fish, poultry and eggs are received by half of the children age six to nine months.

Traditionally, Cambodia has a high breastfeeding rate but because of aggressive advertising of milk formula manufacturers in private clinics and some State hospitals, there is an increasing use of breast milk substitutes. The National Paediatric Hospital in Phnom Penh has seen the rates of infant sickness and mortality increase in recent years as more mothers return to work in garment factories a month after giving birth, leaving relatives to feed their babies with milk substitutes (Phnom Penh Post, Feb. 13- 26, 2004). A breastfeeding legislation has been drafted in 2001 and submitted to the Ministry of Health in July 2003.

Chronic malnutrition among Cambodian children is very high (CDHS 2000). Forty-five percent of children of age five and below are underweight, and 13 percent are severely underweight. Girls are better nourished than boys, but the rural poor experience twice as much child malnutrition and mortality as the urban rich. Cambodian children suffer not only from malnutrition but also from diseases such as diarrhoea, dysentery and acute respiratory infections (ARI). ARI is the leading cause of childhood morbidity and mortality and 20 percent of children under five years of age suffer from it. Twenty-seven percent of children aged 6-11 months suffer symptoms of ARI. Regional variations were significant, ranging from four percent in Prey Veng to 54 percent in Kampong Chhnang. Thirty-one percent of children with fever, cough, and rapid breathing were not taken for treatment. Nineteen percent of children under five years of age had diarrhoea in the two weeks preceding the survey. There are very high rates of non-treatment for these illnesses, and very high percentages of children with ARI are treated with medicine bought without consultation with a trained health worker.

Forty percent of Cambodian children of age 12-23 months are fully vaccinated, while 71 percent have received the BCG vaccination and 55 percent have been vaccinated against measles (CDHS 2000). The coverage for the first dose of DPT is higher (68 percent), compared to the third dose (49 percent). Polio coverage is much higher than DPT coverage, primarily due to the success of the national immunisation day campaigns, during which polio vaccines are administered. Three in four children aged 12- 23 months received the first dose of polio, 64 percent received the second dose, and 52 percent received the third dose. About 30 percent of children received polio vaccination at birth.

The number of HIV infected children left at orphanages increases steadily. Estimates in 1998 place the number of children below 15 years who have lost one or both parents at 380,000. It is predicted that by 2005, about three percent of all children below 15 years of age will have been orphaned by AIDS.

Abortion

The practice of abortion was liberalised in Cambodia in 1997 permitting all pregnant women to ask for an abortion from a medical worker within the first 12 weeks of pregnancy. For women who are more than 12 weeks pregnant, abortion can be allowed if there is risk to the life of the mother, the foetus has an incurable defect and in cases of rape. Prior to 1997, abortion was legal only for the purpose of saving the life of the woman (United Nations, 1992). The birth spacing policy prohibits the promotion of abortion as a birth spacing method. Although the law was promulgated and signed in 1997, the accompanying prakas or implementation guidelines were put in place only in August 2002 (Catalla and Catalla, 2002). As in other countries, abortion is not a topic that is openly discussed in the country, nor are statistics easily gathered. People talk about it but no public debate has been conducted on the issue. Providers and clients are misinformed about the legal status of abortion in Cambodia and only 17 percent of the providers interviewed gave answers that closely approximate reality (Lester 2002). The

rest of the study's sample believe that abortion is illegal except under certain circumstances, that there is no abortion law, and many did not know whether or not abortion and abortion services were legal.

There are no known religious personalities who speak out in favour of abortion (FGD). In 2002, UNFPA supported a study entitled 'Abortion in Cambodia: An Overview of the Current Situation' drawing attention to the need for further study of the issue to aid the advancement of policy aimed at reducing mortality and morbidity. The CDHS found that a total of five percent of Cambodian women reported ever having had an induced abortion.[2] The UNFPA study covering 75 abortion providers in Takeo and Pursat, showed that abortion services were sought for unwanted pregnancies, missed periods and complications arising from induced abortions (Lester 2002). Interviewed abortion providers stated that there is now an increasing demand among young, single women, especially those working in the garment and sex industries.

A government doctor in Battambang said that abortion by dilation and curettage would cost 10,000 to 14,000 riels ($2.50 – 3.50) in a government hospital and $100 to $300 in a private hospital depending on the age of the foetus. He added, however, that women in the province do not go to a public hospital for abortion because of confidentiality issues. The cost of abortion in Phnom Penh varies depending on age gestation of the foetus; if the foetus is below three months, abortion costs only $20 in the public hospital, and $30 to $50 in a private hospital or clinic. The UNFPA study estimated the average cost of abortion for the first trimester to be $15, $64 for the second trimester and $ 76 for the third trimester.

The occurrence of abortion increases with the age of the woman and is more common among women with more living children. The rate of women who report having an abortion increases to four percent of women in the age group 25-29 years, seven percent in the group from 30 to 34, and eight percent between the ages of 35-49 years. Trained health professionals helped 82 percent of women with their last abortion, eight percent were assisted by a TBA and one percent were aided by relatives or friends. A full nine percent of women undergo an induced abortion with no assistance at all. The lowest number of abortion cases was registered in Kompong Speu and Kompong Thom, with Svay Rieng reporting nine percent and Battambang and Pailin with one percent each.

In general, because of the stigma associated with abortion, the number of abortions reported is considered to be underestimated. Among women aged 45- 49, the oldest group surveyed and hence those who most closely represent lifetime prevalence, 8.7 percent reported having had at least one abortion. A study of 91 indirect sex workers indicates an abortion prevalence of 56 percent. Among 81 girls, in the same sample, who had ever been pregnant, it was 63 percent.

The methods used in abortion were 41 percent by dilation and curettage, 35 percent by vacuum aspiration, nine percent by traditional methods. Forty-one percent of abortions were done in a private health facility, 27 percent in a public health facility, 23 percent in respondents' homes and seven percent in other homes. Seventy-three percent of women underwent abortion between the second and fourth month of pregnancy, 19 percent during the second month and nine percent at five months or more. The cost is directly correlated with the quality of abortion services so that poor women are likely to seek services from more dangerous providers. Abortion related complications could include bleeding due to retained placenta and uterine perforations. Respondents in the UNFPA study averred that this is a significant contributor to maternal mortality in the country.

Around 19 of the 75 abortion providers interviewed in the UNFPA study reported that they have seen at least one woman die in their community from an unsafe abortion in the past year with 34 percent of TBAs saying the same. The abortion related mortality rates based on WHO figures, could be as high as 130/100,000 live births.

There has been no abortion training in the country up to 2002 and with almost no secondary midwives at health centres, it will be almost impossible to have abortions at the health centre level. The MOH in March 2003 was drafting guidelines for training and making associated equipment requests. The inadequacy or lack of training in procedures used to induce abortion is a cause for deep concern. For instance, dilation and curettage, which requires greater technical skill, is used by 50 percent of TBAs who acquired their knowledge through apprenticeship, self-study or gaining their skills from a 'ghost'. Counselling and the provision of post-abortion birth spacing methods is not done as often as necessary for the following reasons: a) the provider does not want to confuse the client by first treating them and then promoting a preventive measure; b) the client is not interested or prepared to deal with such a service at the time of an abortion; c) the provider forgets, does not have the methods or does not know how to provide the methods; and d) there is concern about the potential role of birth spacing in reducing abortion clientele and the profit potential of the provision of abortion services.

Vulnerable groups who face obstacles in receiving quality care are poor and/or rural women, direct and indirect sex workers, HIV+ women, garment workers, and adolescents. Sex workers face stigma, are very poor and illiterate so that finding funds for such services is difficult and they experience being denied services from public practitioners more than other women (Catalla and Catalla 2003).

Contraception and HIV/AIDS

Cambodia has made notable progress in reproductive health indicators. The total fertility rate was measured at 5.3 in 1998 and 4.0 in 2000 (CDHS) and 3.8 in 2002 (WB). Cambodian women's knowledge of birth spacing methods has increased from 35.9 percent in 1995 to 95 percent in 2000, and the CPR for married women of reproductive age has increased from seven percent in 1994 to 24 percent in 2000 (modern methods 19 percent and traditional methods five percent, CDHS) but is still low for Asia. The prevalence of HIV among adults aged 15-49 has declined from 3.3 percent in 1997 to 2.6 percent in 2002 (NAA, 1997, 2002). Cambodia is one in only three countries worldwide to have achieved a sustained decline in HIV/AIDS prevalence.

In Cambodia, the legal age for marriage is 18 for women and 20 for men. Social conventions and tradition discourage early marriage but there are no sanctions for families or couples who violate the law. The mean age of marriage is 19.9 years. NHS data for 1995 indicate that about 9.4 percent of girls in the age group 15-19 years become pregnant and bear a child, implying that adolescent pregnancy is a reproductive health issue. The median age at first birth is 21.9 years, with urban women giving birth at an average of one year later than rural women. Women who live in Phnom Penh have the latest median age at first birth, at 23.1 years of age.

At current fertility levels, a Cambodian woman will give birth to an average of four children during her lifetime. Women in rural areas will give birth to an average of one child more than women in urban areas (4.2 as compared to 3.1 children, respectively, CDHS 2000). Women with no education have, on average, half a child more than those with primary education, but 1.6 children more than those

who have secondary and higher levels of education. Seventy-nine percent of Cambodian women have a birth interval of 24 months or greater. Median birth intervals are shortest in the regions of Mondulkiri/ Ratanakiri and Kampong Chhnang (29.3 and 29.5 months, respectively) and longest in Phnom Penh and Prey Veng (37.7 and 37.6 months, respectively). The gap between wanted and actual fertility is greatest among women living in rural areas and uneducated women.

Safe Contraception

Knowledge of contraceptive methods in Cambodia is quite high, with 95 percent of currently married women aged 15-49 knowing at least one modern method of family planning. The daily pill and injectables are known to 90 percent of currently married women and are used by five percent and seven percent, respectively. One form of contraception that is known to 71 percent of women in Cambodia, but is little known in Western countries, is the monthly hormonal pill of Chinese origin and three percent of currently married women use this method. Women-controlled methods are the least recognised modern methods, with female condoms mentioned by five percent of married women, emergency contraceptive pills by two percent and the diaphragm/ cervical cap and foam/jelly recognised by less than one percent. Proper and consistent condom use, which reduces the transmission of sexually transmitted infections, has not been widespread in relationships compared to its use in 'recreational' sex or in episodes of non-marital and non-commercial sex. The 100 percent condom use programme is perceived to be valid only during encounters with sex workers.

Half of currently married Cambodian women express a desire to space or limit the number of children that they will have (CDHS 2000). Sixty percent of urban women and 56 percent of rural women have an unmet need for spacing or limiting their births. Women are considered to have an unmet need for contraception if they want to stop childbearing or want to space childbearing for two years but are not currently using any contraceptives (Beaufils 2000). The ideal number of children for all women is 3.6. Thirty-two percent of births were unplanned: nine percent were mistimed and 24 percent were unwanted. The total wanted fertility rate is 3.1 children, which is almost one child less than the actual fertility rate of four.

Sources of contraception vary greatly depending on the type of method: sterilisation is usually undertaken by the public sector and only a small proportion is done by private providers. However, IUDs are from both the public and private medical sectors. Injectables are obtained mainly from health centres while the daily pill, monthly pill and condoms are obtained from pharmacies or in the market. Besides the MOH, there are several donors and organisations such as Cambodia Health Education Development (CHED), Cambodia Health Education Media Service (CHEMS)/Health Unlimited (HU), Cambodia Women's Centre (CWC)-Marie Stopes International, Population Services International (PSI), Partners for Development (PfD), Reproductive And Child Health Alliance (RACHA), Reproductive Health Association of Cambodia (RHAC), Servants to Asia's Urban Poor, United Neutral Khmer Students and Women Organisation for Modern Economy and Nursing who provide technical assistance, information and services to women of reproductive age (Catalla and Catalla, 2003). The cost of one month's supply of the monthly pill, bought over the counter, ranges from $0.20 to $4 depending on the brand.

UNFPA population plans for Cambodia have achieved the provision of birth spacing services and counselling (POPs, COCs, condoms, injectables) in all

functioning health centres. Some 20 percent of these centres provide IUD services and help in the expansion of community based distribution (CBD) networks from four to eight ODs in selected districts and provinces, increase the number of contraceptive users in CBD areas, as well as the number of clients receiving VSC (voluntary surgical contraception) and decrease the number of clients defaulting in contraceptive use.

Treatment of HIV/AIDS

HIV/AIDS as a public health priority has been reduced from a high prevalence of 3.3 percent in 1997 to 2.6 percent in 2002 (NCHADS 2002). The epidemic in the country has become generalised, spreading from specific groups to the general population. Across all identified high-risk groups, the incidence of HIV has been declining. Prevalence rates are highest among direct female sex workers and lowest among pregnant women attending antenatal care. Among high risk groups, prevalence rates range from a high of 31.1 percent among direct female sex workers to 10 percent and 15 percent among hospital in-patients and men who have sex with men (MSM), respectively. In Cambodia, HIV is transmitted primarily through heterosexual sex, driven by a norm of premarital and extramarital sex for men, usually with women who are paid. Men serve as bridges between sex workers and housewives, sweethearts and ultimately newborns (KHANA 2001). The chairman of NAA said that almost 30,000 people are cheating on their mates, resulting in about 80,000 wives contracting HIV/AIDS from their husbands (Cambodia Daily, 17/12/03)

Among the 206 MSM studied by Family Health International (FHI) in 2000, the prevalence of STI was 7.2 percent for urethral chlamydia, 5.5 percent for syphilis, 4.8 percent for urethral gonorrhoea, 0.3 percent for anal gonorrhoea and 0.1 percent for anal chlamydia. In the 2001 NCHADS STI prevalence survey, very low prevalence rates were found for women attending reproductive health clinics and police in seven selected provinces. Among sex workers, although a high prevalence of 14 percent for gonorrhoea and 12 percent for chlamydial infections was detected, the levels were lower than those found in previous studies and relative to the prevailing rates in the region. STIs are responsible for a large proportion of morbidity and mortality including pelvic inflammatory disease, ectopic pregnancy, infertility and congenital infections. The incidence of AIDS among high-risk groups, on the other hand, is increasing and in the absence of effective treatment, mortality is also on the rise. The number of cases as of 2000 was about 19,000 with a cumulative total of 94,000 for the past ten years. Deaths arising from AIDS totalled 18,000 in 2001 bringing the aggregate total to 78,653 (NCHADS 2002).

In cooperation with UN agencies, in 1998 the RGC created the HIV/AIDS task force to respond quickly to the HIV/AIDS epidemic in the country. The NAA (National Aids Authority) established in 1999, plays a key role in coordinating efforts on HIV/AIDS and has developed the Strategic Plan for HIV/AIDS and STI Prevention and Care for 2001-2005 that calls for a multisectoral response to the HIV/AIDS epidemic. The National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) of the MOH is in charge of the Sentinel Surveillance System that it is developing in line with the Strategic Plan for HIV/AIDS. The MOH has created topic specific working groups such as Continuum of Care, TB/HIV, Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT), STIs and HIV/AIDS and Related Research. An HIV/AIDS law has been approved in 2003 and a law on women and HIV/AIDS is currently being drafted. (UNFPA, Cambodia Country Brief, 2003)

Ninety-five percent of Cambodian women have heard of AIDS, and 48 percent of women say that they know someone personally who has AIDS or who has died of AIDS. Given the high levels of awareness of this syndrome in both urban and rural areas, it is not surprising that 69 percent of women were able to cite two or three important ways to avoid contracting HIV/AIDS and another four percent were able to cite one way. Women in urban areas and women who have more education are more likely to know about HIV and ways to avoid it than other women.

Overall, 90 percent or more of women approved of the dissemination of HIV/AIDS information on radio or television, in the newspaper, in secondary school, in the workplace, at a health facility, and in a community setting (CDHS 2000). Primary schools and temples received lower levels of approval as places to disseminate this information, but nonetheless received the approval of the majority (78 percent and 72 percent, respectively). Information materials in Khmer are available in print, radio, television and for those who cannot read and write and distributed at the health centre level. There is an instruction for health workers to make information available to those who are availing of birth spacing services but not for everyone. There is a plan to change this policy and make the information available to everyone in need. BBC is now producing radio/TV spots on family planning and HIV/AIDS (FGD). The amount of IEC materials for use by organisations is insufficient as this comes from mother organisations which produce them, e.g. UNICEF, RHAC, etc. (Catalla and Catalla, 2003).

The estimated number of adults aged 15 – 49 living with HIV by 2002 was 157,700 but only around 10,000 have been tested and identified (NCHADS 2002). The current focus for HIV on prevention is to increase the capacity for HIV/AIDS testing, counselling and the prevention of MTCT for HIV/AIDS through skills training of health staff, TBAs and midwives (FGD). The number of people being tested for HIV/AIDS is gradually increasing: 23 percent among the military; 40 percent among the police and 15 percent among mototaxi drivers. NGOs are informing women about choices and options, especially with the very little evidence that medical providers and consumers are aware that there are sexual and reproductive health and rights (Catalla and Catalla, 2003).

Along with the provision of information and services, Government and NGOs are implementing behavioural change interventions. A large number of HIV/AIDS care and mitigation activities also include home care, interventions to prevent mother-to-child transmissions, addressing the issues of opportunistic infections and responding to the issues of orphans (Catalla and Catalla, 2003). The MOH has a PMTCT working group in the NMCHC. PMTCT activities include testing of pregnant women for HIV infection, counselling on HIV, provision of ARVs, breastfeeding counselling and supplemental feeding. Since 2001, JICA and UNICEF have supported the PMTCT programme. NMCHC and MSF-France provide ARVs to HIV- positive mothers.

Adolescent Reproductive Health

There is no specific policy on ARH but a programme called the Reproductive Health Initiative for Youth in Asia (RHIYA), the second phase of RHI, is being implemented between mid-2003 and the end of 2005 with a budget of US$2.8 million (Medinews, July 2003). This is a joint initiative of the EU and the UNFPA with the overall goal 'to enhance and accelerate the implementation of the Programme of Action of the ICPD particularly in regard to the improvement of the reproductive and sexual health conditions of adolescents and young people

in the selected countries.' (RHIYA, Cambodia Country Strategy Framework) The purpose of RHIYA in Cambodia is 'to contribute to enabling safer sexual and reproductive health behaviour, including increased utilisation of quality youth-friendly services among target adolescents and youth in project intervention areas.' The programme is being implemented in partnership with NGOs – Health Unlimited, CARE, Save the Children Australia, Mith Samlanh/Friends, Khmer HIV/AIDS NGO Alliance (KHANA), RHAC and CWC. Activities include focus group discussions with young people in the production of radio shows including soap operas, provision of SRH information and services to young women aged 16-29 working in 25 garment factories and the urban young men in Phnom Penh aged 12-24 at major activity sites in the city, peer and outreach education, capacity building of local NGOs and health centre staff, training of Buddhist monks as advocates, provision of basic counselling to adolescents and referral to other services where requested, SRH for street children and social reintegration in support of behaviour change and provision of 'Youth Friendly' clinical services including RTIs, STIs, family planning and counselling. (*Medinews*, July 2003)

Seven European and 23 Cambodian partner NGOs developed and implemented SRH approaches and services as part of the RHI in Asia from 1998 to 2002. Programme activities included promoting reproductive health practices among working adolescents and young adults, media education to improve adolescent sexual and reproductive health, adolescent reproductive health, reproductive health for marginalised youth in Phnom Penh and Kratie, reproductive health for vulnerable children and youth, reducing the vulnerability of young Cambodians to HIV/AIDS and strengthening and promotion of reproductive health in Kampot for youth aged 12-15. In addition, four other organisations engaged in SRHR work among adolescents - Adventist Development and Relief Agency, CARE International Cambodia, Save the Children Australia and United Neutral Khmer Students. (International NGOs Directory 2002, Cooperation Committee for Cambodia)

In 2002, RHAC and PSF/Friends maintained and expanded their clinical coverage for ARH. Clinical services had been utilised by 18 percent of target youth beneficiaries mostly for STD treatment, medical consultations and confidential counselling. Save the Children United Kingdom (SC-UK) has been operating information activities through outreach and peer educators. Friends, CWC, RHAC, PSF, and others have youth centres with flexible operating hours (FGD). Outreach information services have become linked to referrals for clinical services. For 2002, 493 youth peers have been recruited and trained by implementing partner NGOs who have maintained close collaboration, thus strengthening the referral system. Protocols and guidelines on RH have been developed in both Khmer and English and there are regular radio shows on RH topics by CHEMS and CHED as well as columns in a popular magazine. Trained monk trainers have proven to be enthusiastic and confident in organising RH-related education sessions for other monks, particularly on HIV prevention and stigma.

Culture, STI Treatment and Attitude Towards SRHR

RACHA has a programme that teaches women to conduct a monthly manual breast examination and to consult a trained medical professional if they feel something out of the ordinary. RHAC (at $5 each), Pasteur, Norodom Sihanouk and Calmette hospitals ($3 each) provide Pap smear exams (FGD).

STI treatment is common in Cambodia and most get medical treatment. However, many still seek care at a pharmacy, especially males (NCHADS, 2001) or even from traditional healers. MOH clinics provide STI services in outpatient departments

and several NGOs (RHAC, MSF, RACHA, PSF, IMPACT/FHI, Medecins du Monde, EU/ITM Project) have been involved in the provision of STI prevention and care services for both general and high-risk populations (Catalla and Catalla, 2003).

For girls and women, premarital sex is stigmatised, and adults are often in denial about adolescent sexual activity. Rural adolescents, with less access to services in their geographical isolation, have fewer financial resources for travel and require more secrecy for any journey that might be necessary. Many providers are also reluctant to offer services to single girls and often do not accept that unmarried girls are in need of reproductive health services. Information materials have been made available and trainings conducted for providers to lessen discrimination and stigmatisation (FGD).

Sex education is still largely informal and not yet incorporated in the school curricula. Common sources of information on sex matters are radio programmes of NGOs and peer educators. However, the Ministry of Education has included the discussion of HIV/AIDS in the curriculum of grade 7 and above.

The CDHS explored women's acceptance of unequal gender roles, and found that although most women believe that it is better to educate a son than a daughter (59 percent), indicating an acquiescence to societal gender inequality, even greater proportions of women believe that husbands should help with household chores (85 percent), that it is unacceptable for a man to have extramarital sex (89 percent), and that a woman should not tolerate beatings to keep their family together (86 percent).

The beliefs mentioned above are quite different from what is being practised. Cambodian society still looks down on men doing household chores. In the event that men perform some household chores, they will, in all likelihood, close the windows of their homes lest their neighbours see them (FGD). Khmer men, women, children, monks, ministers, etc., are traditionally guided by a set of codes that prescribe proper behaviour for both sexes. Appropriate and ideal behaviour for a young woman is to be shy, unassertive and submissive while male sexual activity, including buying sex, is considered normal. Young women are expected to be virgins when they marry. These circumstances make it difficult to discuss issues such as premarital sex, pregnancies, diseases and sexual relationships. An EC/UNFPA research in 2002 found out that young people who are sexually active find accessing services difficult due to cost and distance considerations and have a crisis of confidence when obliged to discuss intensely personal issues. Levels of sexual activity reported by young people vary widely depending on gender and educational attainment.

The garment industry is creating a rapidly growing workforce of young, single migrants. There are an estimated 176,000 people presently working in 200 factories in Phnom Penh, 90 percent of whom are women. Misunderstandings about contraception, STDs and HIV/AIDS are common. Among factory workers, one in five knew someone with HIV/AIDS, 30 percent felt their friends were at risk and 86 percent worried about getting HIV/AIDS (RHIYA, Cambodia Country Strategic Framework 2002). Young people are not encouraged to discuss or ask about sexual matters and are relatively uninformed about how their bodies function (Care Cambodia 2002 Report).

In the FGD conducted for this study, participants said that there have been great improvements in women's and adolescents' awareness about SRHR. Women are more articulate now about sexual relations and more assertive in deciding how many children to have, regardless of their husbands' opinions. More wives

can now say no to having sex with their husbands if they are not inclined to do so. However, there are still cases when a wife's refusal to have sex can lead to physical abuse. The majority of men now accompany their partners on visits to health centres. Young people are more open now in talking about sex. The proliferation of pornographic materials is perceived to encourage adolescents to engage in sex. A discussion with a group of ten young people in Battambang revealed that they know a lot about reproductive health concerns such as body and reproductive functions, pregnancy, birth spacing, HIV/AIDS, STIs, abortion, safe sex and drug use (Catalla and Catalla, 2003).

NGOs in SRHR

The Situation Analysis of SRHR in Cambodia (Catalla and Catalla, 2002) notes that there are many NGOs that serve as catalysts of change and development. The most visible of these are the donors, international organisations and local NGOs. Donors and international organisations are central to Cambodia's development. They contributed a total of $2.75 billion to the country from 1992 to 1998. About 1.9 percent of the GDP in 1996 came from official development assistance. Local NGOs on the other hand, provide and support the delivery of basic health services and in the process introduce alternative approaches to development that promote participation, equity, gender sensitivity and environmental sustainability. There are around 100-150 NGOs working on HIV/AIDS and related programmes and an equivalent number focussing on family planning, maternal and child health, adolescent reproductive health, domestic violence and trafficking. The focus of local NGO work has largely been donor driven. The number of international and local NGOs has risen to nearly a thousand by 1990 from less than a hundred in the 1980s. RHAC and RACHA are two of the well-known NGOs in SRHR because of the extensiveness of the services that they offer. RHAC primarily undertakes advocacy work on sexual and reproductive health and rights. Other NGOs, like Licadho, Cambodia Health Committee, Cambodian Improvement Women Association, Cambodia Women's Crisis Centre and AFESIP conduct advocacy on women and child rights.

Main Implementation Barriers and Facilitating Factors

This study identified a number of facilitating factors that have helped government and non-government actors to work towards implementation of ICPD PoA goals and objectives.

The facilitating factors attributed to the Government are the following:

- Continued peace in the country which enabled the Government to focus on poverty alleviation and policy reforms not only in the health sector but also in banking and finance, military, natural resources and judiciary.
- The Government's commitment to effective intervention strategies, supported by active political participation at the highest level, technical and financial backing from all partners, effective mass media campaigns, as well as civil society participation, visible particularly in the elimination of polio and the reduction and control of infectious diseases like tuberculosis, malaria and HIV/AIDS.
- A Health Policy (2003-2007) that is pro-poor and seeks to provide high quality, evidence-based health services, with equity, and no discrimination by gender, age, place of residence, or ability to pay.
- A Health Sector Strategic Plan (2003 – 2007) that identifies the goals, priorities, strategies and outcomes for the sector and takes in the Millennium Development Goals and the National Poverty Reduction Strategy.

- The introduction of the Health Sector Support Project (HSSP) that enabled donors to coordinate their assistance to avoid duplication and identify gaps that needed to be addressed.
- The openness of high-ranking decision makers to the adoption of liberal policies such as the legalisation of abortion.

Non-governmental players contributed in the following ways:

- Cambodia today has a range of non-governmental players that serve as catalysts of development and change. The continuing partnership of the public sector with external and international partners and NGOs has been vital to the success of the initiatives in the reproductive health sector. Donors such as JICA, GTZ, KfW, DED, DFID, UNICEF and CIDA have assisted the National Reproductive Health Programme through the National Maternal and Child Health Centre on the training of midwives and other health providers and family planning related programmes.
- Strong and continuing donor support for policy reforms and the implementation of the ICPD Programme of Action led to the bringing in of laws on abortion, HIV/AIDS and the ad option of policies on safe motherhood and population.
- Donors continue to support Cambodia with pledged assistance of US$635 million per year; ODA comprises about 70 percent of the national budget
- The approval of Cambodia's application to the first and second round of the Global Fund to fight HIV/AIDS, tuberculosis and malaria will scale up the provision of HIV/AIDS and tuberculosis prevention and care.
- The presence of NGOs in all provinces and sectors in the country highlights their pivotal role in providing and supporting basic services. In performing this role, they bring alternative models and approaches to development, eliciting participation, equity, gender sensitivity and environmental sustainability (NGO Statement 2000).
- Increase in the use of participatory approaches, recognising the crucial role played by civil society in achieving greater increases of health service coverage and reducing the expenditures of end-users.
- The introduction of external management culture through NGOs and giving more authority to district health managers have encouraged local participation, gender sensitivity and equity.
- Monks or wat/ pagoda committees have initiated work with people living with HIV/AIDS pointing to the significance of using grassroots organisations in bringing SRHR services to a greater number of people in rural communities.
- The annual Socio-Cultural Research Congress on Cambodia organised by the Royal University of Phnom Penh provides a forum for exchange of ideas and best practices on population and development concerns.
- Previous capacity development efforts are enabling more Cambodian NGOs to qualify for direct execution of UNFPA and international donor assisted projects due to increased national institutional, managerial and operational capacity.

Many implementation barriers were identified in the course of the monitoring work. The electoral procedures and proportional systems do not offer women the opportunity to participate as independent candidates. The experience of recent elections shows that although each political party expressed their support for women's participation, few women's names were listed from the first to the third places within the candidate lists.

The HSSP has identified health service delivery as a top priority but public sector resources available for service delivery are still very limited and expected to remain so for many years. Moreover, the highly centralised and politicised budget management procedures and very low civil service rate salaries constrain the performance of the health sector, especially the public health system (MOH 2001). Low levels of motivation of poorly paid staff, the regular lack of stocks of essential medicines and the poor experience of hospital care prevents patients from using public services. This has led to loss of faith in the public sector. Mistrust of the public sector is often deeply entrenched in people's minds, leading to scepticism about care and treatment offered through these services.

Budgets for social sectors have increased but inadequate levels of funding reach the local level: allocated budgets are being disbursed late or not at all. Corruption and the culture of impunity remain rampant. More than 80 percent of Cambodians believe that bribery is the normal way of doing business in sectors such as education, health care, traffic and the judiciary. At many public hospitals Cambodians are subjected to high under-the-table fees and other costs (NPRS 2002). Reform attempts stop at the point where they begin to affect vested interests (NGO Statement 2002). There are no clear, standardised procedures for civil society participation. Progress in legislation is uneven and not always transparent. There is lack of communication between communities and local authorities and this is compounded by a lack of funds and the long distances people have to travel to reach health centres.

Standards of care are considered by the general population to be poor, generally and in the huge and largely unregulated private and informal sector, they are considered sub-standard. Pharmacists and drug sellers are the first contact for 70 percent of health seeking episodes (Khana 2003). There are 3,700 pharmacies in the country, 75 percent of which are unlicensed. Studies have shown that over 70 percent of antibiotics prescribed were inappropriate, 22 percent of tracer medicines tested were counterfeit and 50 percent of medicines sold enter the country illegally. The incorrect use of drugs may lead to the development of resistance to TB and HIV (Khana 2003).

Necessary laws and regulations already exist and many more are being prepared but capacity to enforce them has yet to be demonstrated. In Phnom Penh for example, there are at least 50 large private clinics and more than 700 smaller ones and half of them are operating without licenses according to Municipal Health Department Director Veng Thai. To make matters worse the Ministry lacks the necessary staff to monitor the licensed clinics (*Cambodia Daily*, 5 December 2003). Acute poverty, social instability, inadequate legal mechanisms and a weak rule of law have contributed to the rapid growth of the sex industry and the trafficking of women and children to and from Cambodia. In addition very few people know about the existence of sexual and reproductive laws and regulations. Many existing laws and regulations have been adopted without consultations with the local communities and the poor are not provided with sufficient conditions to access laws and their rights (NPRS 2002).

People with HIV report that there is still a great deal of stigma associated with HIV/AIDS (Khana 2003). This has led to reduced access to information, services, and care and support especially for vulnerable groups e.g. sex workers, MSM, youth, etc. Stigma provides a powerful disincentive for pregnant women to accept testing or return for the PMTCT follow-up.

The EC/UNFPA study of 2002 revealed that NGO staff lack confidence in effective counselling skills, the importance of confidentiality is not universally understood among partner organisations, the quality of sexual and reproductive health technical information varies considerably between each organisation and there is a general reluctance to consider the vulnerability of young service users and the potential for abuse by peers or staff involved in SRH education. The study further identified the main barriers for young people in accessing services to be cost, distance to travel and the crisis of confidence that comes when young people are required to discuss a subject as intensely personal as sexual and reproductive health. There is great mistrust of local health structures among rural young people because of the perceived inability of government staff to keep information confidential. An issue that must be addressed in connection with STI and HIV/AIDS testing is the regular violation of confidentiality rights by medical practitioners because of a lack of knowledge about national policies and guidelines, and a mistaken belief that they have the authority to make decisions without informing or involving patients. Most implementing organisations do not provide a mechanism for feedback from peer educators or community based educators. Young people's fear of being seen to fail as educators, limits real discussion and revision of approaches rarely happens. The possible reasons for the still low testing rates for HIV/AIDS may be the cost of testing, stigma and psychological burden, and lack of appropriate pre/post test counselling and confidentiality.

Additional Concerns in Support of ICPD

There are likely constraints for future economic growth and donor assistance due to international and local developments. Due to the urgent crises in Iraq, Afghanistan, Haiti and elsewhere, donor assistance to Cambodia may be decreased as funds are diverted elsewhere. In Asia, the outbreak of Severe Acute Respiratory Syndrome in the first quarter of 2003 resulted in the decline of tourism, which is an important part of the economy. The spread of the bird flu virus in the region during the first quarter of 2004 resulted in the deaths and killing of tens of thousands of poultry. The poultry industry was badly affected and sales of poultry products declined.

Local events in 2003 are likely to have slowed economic growth. On January 29, anti-Thai rioting took place in Phnom Penh that destroyed the newly built Thai Embassy and several Thai-owned businesses. The riots caused an estimated US$50 million worth of damage to Thai property and have shaken investor confidence. The Government is working hard to restore its reputation and has promised to pay compensation, but this could reduce social sector spending. The non-formation of a government after the July 2003 elections has created an atmosphere of instability and has slowed the development of policies and legislation as well as the infusion of additional funds from donors. A few allegedly politically motivated high profile assassinations (e.g. the labour leader Chea Vichea) have added to the existing tense political climate.

Rapid economic liberalisation is driving people from their land and from subsistence agriculture. Young women bear the brunt of these policies, and are forced to migrate to become garment factory workers, commercial sex workers or beggars. About 180,000 young women are serving in 200 factories where there are severe working and living conditions. The NGO Statement of 2002 said that most employers do not respect labour laws; there were few health clinics or childcare centres in such factories as required by the labour law and pregnant women had little chance to work in factories.

In the 2004 Labour Compliance Monitoring report of the Cambodian Labour Organisation, it said that 16 percent of factories had childcare facilities, pregnant women were able to work but that 40 percent of them were asked to do overtime even at seven months and that in only 18 percent of cases do pregnant women lose their jobs. Disabled women who are skilled have few opportunities to be employed. There is only one out of the 200 factories offering jobs to disabled women.

NGOs further add that economic growth has not been accompanied by redistribution and equity is minimal. The rapid growth strategy pushed by donors is increasing inequity and progress in policy development and reforms has not translated into progress in impact as witnessed by NGOs in the communities where they work.

Challenges and Recommendations

A major challenge to the Government is how to restore public confidence in the health system. The provision of political and financial resources towards improving the provision of health services especially in rural areas is prioritised in the health sector plans, however, the implementation of sector-wide management and decentralisation is a significant change in the management and provision of health services and capacity building within the national system is becoming a challenge to both the MOH and donors. Donors are being challenged by opposition political parties to address rampant corruption, unabated deforestation and inequitable land distribution. Opposition political parties allege that the WB is not achieving its poverty alleviation targets despite having invested nearly $400 million in Cambodia since 1993 (Cambodia Daily, 10 March 2004).

The link between poverty and population dynamics must continue to be emphasised to ensure that population concerns remain a priority to be addressed by future socio-economic development and poverty reduction plans. Prior to the actual provision of badly needed services and other SRH related projects, the manner in which information is disseminated and presented should be reviewed to enhance effectiveness and allow for informed decisions to be made. While gender concerns have been integrated to some extent in the CMDG, NPRS and HSSP, further efforts in gender mainstreaming will be required to effectively produce a change towards gender sensitivity in the sectoral policy agenda.

Globally, UNFPA stopped its advocacy sub-programme by the end of 2003, after which major advocacy activities are being subsumed in RH and population development sub-programmes (UNFPA Cambodia Country Brief, April 2003). UNFPA identified two outputs under its advocacy sub-programme in Cambodia: 1) Strengthened capacity of selected relevant government institutions and NGOs in the development and implementation of advocacy efforts in support of broader gender and reproductive health issues and HIV/AIDS and, 2) Increased understanding and commitment of policy, and decision-makers and mass media of broader gender and reproductive health rights and issues. In Cambodia, UNFPA's advocacy sub-programme ended in 2003. The challenge to NGOs is to heighten their advocacy efforts both within the policy making process and the media for changes in national policies and mainstreaming gender in sectoral policies and for the implementation of existing gender policies. Advocacy and education among donors should be undertaken since NGOs have a tendency to cater to what they perceive to be donor biases. Donors' roles in Cambodia, as in other developing countries are influential in shaping the pace and direction of development policies and programmes (Catalla and Catalla, 2003). Given

the limited funding for the youth in the areas of ARH, puberty, pregnancy and contraception, NGOs are expected to fill this gap.

The recommendations listed below came from NGO statements, a focus group discussion conducted for this study and other studies on SRHR :

- Ensure that the increase in the national budget allocation for education and health leads to further development of these sectors, with special attention to the needs of women.
- Donors must ensure that their funds are having a positive impact on the poor and the vulnerable, that they are not fuelling corruption, and that they do not violate the rights of project-affected communities. Donors also have a key role to play in encouraging and deepening the government-civil society dialogue.
- Government must undertake continuous work, with donor support, towards equitable growth by increasing focus on the structural causes of poverty, in-depth analysis of poverty impacts and coordination of all policies (including macro-economic, fiscal, trade, social and environmental policies). The benchmark to evaluate success or failure of the reform programmes must be what happens to the most vulnerable groups.
- Government and donor agencies must continue promoting and implementing poverty reduction strategies that put at their centre the people for whom they are intended, allowing them to participate in all phases and at all levels of the process (including policy, implementation, monitoring and evaluation).
- Enforce standardised government procedures for all new and modified legislation. These procedures should require all government agencies to establish timeframes and opportunities for public consultation at all stages of the legislative and regulatory process.
- Standardise goals and indicators based on localised medium term development goals and the proposed health sector wide Annual Review for all donors could simplify the tasks for all concerned given that particular programmes are funded by contributions from many sources with their own set of procedures and processes.
- Government should conduct a regular review, evaluation and documentation of how information or services are being accessed, absorbed and utilised. Best practices and lessons learned must be disseminated and promoted.
- Government has to institute 'affirmative action' types of programmes so that disadvantaged groups will gain greater access to services
- Donors must support effective anti-corruption measures and promote radical improvements in the culture of impunity that prevails in the country.
- Government with donor support should continue mobilising community based organisations, which are widespread in Cambodia, and utilise them as effective avenues of change and purveyors of realistic approaches to implementation because of their closeness to the beneficiaries of change.
- The draft law on domestic violence which has been deliberated in the National Assembly, should be ratified as soon as possible. The Law on Marriage and Family should be reviewed for its relevance to present needs.
- Government has to be more resolute in the implementation of the law on trafficking, improving transparency within the legal and police systems and also reducing opportunities for bribery and corruption.
- Government and NGO programmes on SRHR must involve men in improving knowledge and practices in sexual and reproductive health and rights.
- Government policies and programmes must encourage respect of the basic rights of people with AIDS or MSM and other vulnerable groups.HERE

NGOs recognise that political will, leadership, education and the open exchange of ideas and information between Government and civil society are critical to the success of the reform process in Cambodia. Only then will there be a sense of shared ownership and the full commitment of all Cambodians to carry forth the development agenda. The NGO community welcomes any opportunity to further improve its coordination and partnerships with government, donors and local communities in supporting poverty reduction efforts and development programmes in Cambodia.

Conclusion

Measurable and positive changes have occurred in major demographic indicators since 1994. The population, measured at 11.4 million in 1998 has grown to 13.8 million in 2003 at a rate of 2.4 percent per year. The TFR was measured at 5.3 in 1998 and 4.0 in 2000. Since 42.8 percent of the population is under the age of 14, the population will continue to grow as the large youth cohort reaches reproductive age. Poverty has also decreased slightly from 39 percent in 1996 to 36 percent of the population in 1999. Sixty percent of urban women and 56 percent of rural women have an unmet need for spacing or limiting their births.

Cambodia has made notable progress in reproductive health indicators. Cambodian women's knowledge of birth spacing methods has increased from 35.9 percent in 1995 to 95 percent in 2000, the CPR for women of child bearing age has increased from seven percent in 1994 to 24 percent in 2000, maternal mortality ratio has decreased from 473 per 100,000 live births in 1995 to 437 per 100,000 live births in 2000 and the prevalence of HIV among adults aged 15-49 has declined from 3.3 percent in 1997 to 2.6 percent in 2002. It is notable that Cambodia is one of only three countries in the world to have achieved a sustained decline in HIV/AIDS prevalence.

The implementation of the MOH's Health Sector Strategic Plan, which includes reforms on sector-wide management, decentralisation and de-concentration is being supported by WB, ADB and DFID. Other donor agencies are being encouraged to align their programmes and plans with the HSSP. Given the Government's prioritisation of the reduction of maternal morbidity and mortality, infant and childhood mortality and to lower fertility through the provision of contraceptives as declared both in the HSSP and the NPRS, it is important to keep up the momentum in the safe motherhood and emergency obstetric care trainings and to promote best practices in community-based distribution projects. Despite a lack of a specific policy on ARH, the Government has agreed that more attention to ARH matters is important particularly in the face of a growing illegal drugs problem.

In the context of the still critically high HIV/AIDS prevalence rate in Cambodia, prevention and care of persons with HIV/AIDS will be essential to try to mitigate the effects of the pandemic on the population. Fortunately, there are a large number of donors contributing substantive amounts in the HIV/AIDS prevention and care programmes. The Cambodian government has also been successful in obtaining the first and second rounds of the Global Fund to Fight against HIV/AIDS, TB and Malaria.

In accordance with the Government's priority on poverty reduction, along with the many poverty related projects within the MOP, efforts to promote the perspective of population changes and the elimination of gender disparities as major determinants and consequences of poverty reduction must be continued.

With the adoption of the National Population Policy, there is need to promote and support programmes and projects that are fully in line with it including the continued strengthening of the database at the National Institute of Statistics, the transmission of reliable data to policymakers and the monitoring of the implementation of the NPP from a multi-sectoral perspective. The Government needs assistance to rationalise data collection in the health sector between the NHS and DHS to avoid confusion and/or reduce inconsistencies over health data, as well as to reduce inefficiency in the use of funds and human resources.

The Government needs the help of donors and partners to address the existing key challenges facing the health sector. Such challenges include low utilisation of cost effective interventions, poor attitudes and practices among service providers in communicating with consumers, mal-distribution of health service providers especially trained midwives, and poor quality of care in both the public and private sectors. Additional concerns are the emerging public health issue of adolescent health, high demand for family planning/birth spacing advice and commodities, low salaries of health staff in the public sector and lack of incentives to work in remote areas, high prices and limited access to essential services among the poor, as well as irregular and inadequate flow of funds to deliver services. Of equal importance among these challenges are poor management and leadership capacity especially in monitoring and evaluation, inadequate capacity in human resource development including training and personnel management, limited coordination on external financing in the sector and managing major public health crises.

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Abbreviations / Acronyms

ADB	Asian Development Bank
ADHOC	Cambodian Human Rights and Development Association
AFESIP	Agir Pour Les Femmes en Situation Precaire (Acting for Women in Distressing Situations)
ANC	Ante-Natal Care
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
BS/SM	Birth Spacing/Safe Motherhood
CAPPD	Cambodian Association of Parliamentarians for Population and Development
CBD	Community Based Distribution of Contraceptives
CDHS	Cambodia Demographic and Health Survey
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHED	Cambodia Health Education Development
CHEMS	Cambodia Health Education Media Service
COCs	Combined Oral Contraceptives
CPA	Complementary Package of Activities
CPR	Contraceptive Prevalence Rate
CRC	Child Rights Convention

CWC	Cambodia Women's Centre
CWCC	Cambodian Women's Crisis Centre
DFID	Department for International Development, United Kingdom
EC	European Community
EOC	Emergency Obstetric Care
FHI	Family Health International
GTZ	German Agency for Technical Cooperation
HCP	Health Coverage Plan
HU	Health Unlimited
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
IUD	Intra-uterine Device
JICA	Japan International Cooperation Agency
KHANA	Khmer HIV/AIDS NGO Alliance
KWVC	Khmer Women's Voice Center
LICADHO	Cambodian League for the Promotion and Defense of Human Rights
MAFF	Ministry of Agriculture, Forestry and Fisheries
MMR	Maternal Mortality Ratio
MOEYS	Ministry of Education, Youth and Sport
MOH	Ministry of Health
MOP	Ministry of Planning
MOSALVY	Ministry of Social Affairs, Labour and Vocational Youth Training
MOWRAM	Ministry of Water Resources and Meteorology
MPA	Minimum Package of Activities
MRD	Ministry of Rural Development
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
MWVA	Ministry of Women's and Veterans' Affairs
NCHADS	National Centre for HIV/AIDS, Dermatology and STD
NPRS	National Poverty Reduction Strategy
OD	Operational District
PoA	Programme of Action of ICPD
POPs	Progestin-Only Pills
PfD	Partners for Development
PHD	Provincial Health Department
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
PSI	Population Services International
RACHA	Reproductive and Child Health Alliance
RGC	Royal Government of Cambodia
RHAC	Reproductive Health Association of Cambodia
SC-UK	Save the Children – United Kingdom
SEDP	Socio-economic Development Plan
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNIFEM	United Nations Fund for Women
VCCT	Voluntary Confidential Counselling and Testing
WB	World Bank
WHO	World Health Organisation

Annexures

Summary of Sexual and Reproductive Health and Rights Indicators

Total population in 2001	13.1 million	Projection by 2011, 16.6 million
Adult literacy rate	61.1% female	82.9% male
% of people who are illiterate	32% of women	
% of primary school completion	4% of women	7% of men
Life expectancy at birth (1998)	58.3 years females	54.5 males
Total fertility ratio	5.5 in 1975	4.0 in 2000 (HDR 2003)
Annual population growth rate		2.5% (HDR 2003)
Maternal mortality ratio	590 out of 100,000 in 1995	437 out of 100,000 live births
Infant mortality rate	80 in 1990	97 per 1,000 live births in 2001(HDR 2003)
Under five mortality rate	115 in 1990 (HDR 2003)	138 per 1,000 live births (HDR 2003)
% of stunting in the under five group		45%
HIV Prevalence rate in 15-49		2.8% in 2000
HDI	0.512 in 1990	0.556 (HDR 2003)
GDI		0.551 (HDR 2003)
GEM		0.347, with a rank of 64
Iron deficiency anaemia	63% of children under five years	58% of women, 66% of pregnant women
Births attended by skilled personnel		32% (CDHS 2000)
Physicians per 100,000 people		30
CPR		24

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Note: Only the last three midwives participated in the conduct of the interview.

Notes

[1] The ten priority population related issues identified for intensified development efforts were: high population growth, high fertility, high mortality, HIV/AIDS epidemic, migration that hampers development processes, imbalances in age and sex structure, high incidence of poverty as a result of demographic vulnerability, low levels of human resources development, gender inequalities and population pressure on natural resources.

[2] Much of the information mentioned here has been derived from Lester's study and the CDHS 2000.

What people say about this book

"ICPD TEN YEARS ON is a must read for anyone interested in progress (and its lack) in the field of reproductive and sexual health and rights for women and girls. Closely and methodically monitoring such issues as access to contraception, unsafe abortion, maternal mortality and morbidity, rising risk of HIV/AIDS among women (especially the poor and young), and persistent patterns of gender violence and inequality, this urgent report is admirable in its scope, rigour and clarity. Its discouraging conclusions about the eight Asian countries studied sound warning alarms for the entire world: the "promises of Cairo" are not being fulfilled, and women and girls are needlessly suffering and dying as a result of government inaction and international right-wing pressures." (Rosalind Petchesky, Distinguished Professor of Political Science, Hunter College and the Graduate Center, City University of New York)

"…Excellent as a diagnosis and advocacy tool. I congratulate ARROW for producing the kind of report the NGO's committed themselves to in articulating our watchdog role at Cairo. I only wish there were reports of comparable quality from other regions" (Steve Sinding, Director General, IPPF)

"…The report has been very useful to us as documentation, strengthening our advocacy efforts by providing relevant up to date information about the status of ICPD implementation in South Asia. Our Executive Director (Bjarne B. Christensen) has referred to the report during several meeting with Danida and found it relevant and useful as documentation. The Danish FPA mentioned the report and used it as a reference in a series of fact sheets entitled "Women and Youth towards 2015 - advocacy for women's and young people's rights to health in South Asia". (Danish Family Planning Association)

"…The report is constructive and well researched. The recommendations provide an excellent framework for moving forward, however, it would helpful if the recommendations were prioritised. It is also a pity that Singapore was not included as one of the counties surveyed." (Gill Greer, Chairperson of the Asia Pacific Alliance)

"… It is very comprehensive and has been most useful in compiling Beijing Betrayed, WEDO's report on the implementation of the Beijing Platform for Action. As you know, we organized this report by region and were most appreciative of the collaboration with ARROW. The earlier draft of the Regional Overview which you provided was indispensable to our work and is prominently cited on page 104 as a principal source of the information. We are indeed grateful for the detailed monitoring you have undertaken and know that we will continue to use this information in our advocacy for the Millennium Summit later this year." (June Zeitlin, Executive Director, WEDO)

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