Kingdom of Cambodia
Nation Religion King

Cambodia Country Report

The 9th ASEAN & Japan High Level Officials Meeting on Caring Societies
“Human Resource Development in the sector of Welfare and Health”
25 -28 October 2011, Tokyo, Japan

Ministry of Social Affairs, Veterans and Youth Rehabilitation
Ministry of Labor and Vocational Training
Ministry of Health

Prepared by:

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- Dr. PHOM SAMSONG, Deputy Director, Department of Human Resource Development, Ministry of Health
1. Introduction

Social Protection is a priority of the Royal Government of Cambodia of which the initiative of developing the social protection system is the utmost stipulation of the government to serve for Cambodian people as stated in the Constitution, the Rectangular Strategy Phase II for Growth, Employment, Equity and Efficiency in Cambodia, and explicitly presented in the National Strategic Development Plan Update 2009-2013 as well as the legal documents and international conventions where the Royal Government of Cambodia is the signatory.

Cambodia was willing to enhance the social intervention by promoting employment opportunities, reducing vulnerability of the poor, increasing relief support during natural disaster and social issues, and enlarging the rehabilitation program for people with disabilities, elderly, orphans, homeless people, veterans and their families. Cambodia has promoted the good governance in delivering social safety net programs by institutional strengthening, collaboration with development partners, and improving social services and emergency relieves.

2. Follow up of the 8th High Level Officials Meeting “Poverty alleviation on vulnerable people”

2.1. Policy Direction of Ministry of Health:

• Make services more responsive and closer to the public through implementation of a decentralized service delivery function and a management function guided by the national “Policy on Service Delivery” and the policy on “Decentralization and Deconcentration”.
• Strengthen sector-wide governance through implementation of sector wide approach, focusing on increased national ownership and accountability to improved health outcomes, harmonization and alignment, greater coordination and effective partnerships among all stakeholders.
• Scale up access to and coverage of health services, especially comprehensive reproductive, maternal, newborn and child health services both demand and supply side through mechanisms such as institutionalization and expansion of contracting through Special Operating Agencies, exemptions for the poor, health equity funds, and health insurance.
• Implement pro-poor health financing systems, including exemptions for the poor and expansion of health equity funds, in combination with other forms of social assistance mechanisms.
• Reinforce health legislation, professional ethics and code of conduct, and strengthen regulatory mechanisms, including for the production and distribution of pharmaceuticals, drug quality control, cosmetics, food safety and hygiene, to protect providers and consumers’ rights and their health.
• Improve quality in service delivery and management through establishment of and compliance with the national protocols, clinical practice guidelines and quality standards, in particular establishment of accreditation systems.
• Increase competency and skills of health workforce to deal with increased demand for accountability and high quality care, including through strengthening allied technical skills and advanced technology through increased quality practice of training, career development, right incentives, and good working environment.
• Strengthen and invest in health information system and health research for evidence-based policy-making, planning, monitoring performance and evaluation.

• Increase investment in physical infrastructures and medical care equipment and advanced technology, as well as in improvement of non-medical support services including management, maintenance, blood safety, and supply systems for drugs and commodities.

• Promote quality of life and healthy lifestyles of the population by raising health awareness and creating supportive environments, including through strengthening institutional structures, financial and human resources, and IEC materials for health promotion, behavior change communication and appropriate health-seeking practices.

• Prevent and control communicable and selected chronic and non-communicable diseases, and strengthen disease surveillance systems for effective response to emerging and remerging diseases.

• Strengthen public health interventions to deal with cross-cutting challenges, especially gender, health of minorities, hygiene and sanitation, school health, environmental health risks, substance abuse/mental health, injury, occupational health, disaster, through timely response, effective collaboration and coordination with other sectors.

• Promote effective public and private partnerships in service provision based on policy, regulation legislations and technical standards.

• Encourage community engagement in health service delivery activities, management of health facilities and continuous quality improvement.

• Systematically strengthen institutions at all levels of the health system to implement policy agenda listed under the previous 14 elements.

2.2. Ministry of Health Strategic Performance:

The decentralization duties of service providers and management to the health facilities are to make sure the communities particularly the vulnerable people can get access the health services, health promotion, and preventive care with low cost and effectiveness.

The lesson learned of performance of Health Equity Fund has shown that this mechanism is very valuable to reduce a burden and empower the poor and vulnerable people. According to effort a previous year of health equity fund the Ministry of Health has increased the budget and scope coverage in Cambodia.

Ministry of Health and others health partners increased the investment and expansion coverage for Community Based Health Insurance (CBHI). This program encourages the people purchase a low cost insurance for health care themselves when they get a sickness. They can get the health services from the health facilities where the program contracted.

2.3. Achievement of expansion coverage of Health Equity Fund (HEF):
In 2010 and 2011, the Ministry of Health permitted six National Hospitals and ten Operational Districts (OD) operated the health equity fund program to support and empower the poor and vulnerable people access the health services, counseling, health education and others. The health facilities were granted by the national budget. And others forty six Operational Districts were used the budget of Health Partners. The health facilities are contracted the Health Equity Fund have six national hospitals, fifty seven referral hospitals and two hundred thirty nine Health Centers.

In 2010 the health facilities have provided the health services 745,167 for the poor and vulnerable patients who covered by the Health Equity Fund including 621,628 consultations, 25,388 deliveries, and 123,533 in patients. In 2009 the Health Equity Fund program provided only 407,317 for the poor and vulnerable patients.

2.4. Increasing budget for Health Equity Fund (HEF):

Ministry of Health’s policy direction is the indicator to remove a barrier an access of health services for the poor and vulnerable people. Reduce poverty reduction and provide the welfare of vulnerable people the Government and donors have been increasing the national budget support in the health care system particularly for the Health Equity Fun Program. And Donors, Non Government Organizations also have contributed the budget for this program as well.

For example, the Health Equity Fund Program has expended total USD 5,588,280 in 2010. The national budget has granted USD 317,239 and donors health partners have contributed USD 4,407,153. In 2009 total expense for HEF was USD 4,820,214 only. Donors have contributed USD 4,407,153 and national budget has paid for USD 413,061. This program has expended amount USD 768,066 in 2010 was higher than expended in 2009.

2.5. Community Based Health Insurance (CBHI):

The moment in Cambodia has 18 CBHI Projects coverage eleven Operational Districts in eight Municipality and Provinces. Projects have been managing by five NGOs such as Sky, CAAFW, BFH, CHHRA, RACHA. The people are registered as a member of CBHI 170,490 for 2010. But in 2009 the people are registered only 122,829. CBHI is non profit, voluntary insurance mechanism based on the sale of low-cost insurance premiums. This project contracted with the public health facilities.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2010</th>
<th>1st quarter 2011</th>
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<tbody>
<tr>
<td>Population</td>
<td>14,032,902</td>
<td>14,032,902</td>
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<tr>
<td>Population in 56 ODs</td>
<td>10,834,593</td>
<td>10,834,593</td>
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<tr>
<td># and % of poor cover by HEF in 56 ODs</td>
<td>3,261,212</td>
<td>3,261,212</td>
</tr>
<tr>
<td></td>
<td>77 %</td>
<td>77 %</td>
</tr>
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4
3. Basic Information of Cambodia

3.1. General Information

a) GDP per capital (NSDP update 2009-2013):

<table>
<thead>
<tr>
<th>Year</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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<td>356</td>
<td>402</td>
<td>468</td>
<td>534</td>
<td>623</td>
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b) Poverty Rate:

<table>
<thead>
<tr>
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<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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</thead>
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<tr>
<td></td>
<td>35.1</td>
<td>34.2</td>
<td>32.9</td>
<td>30.7</td>
<td>29.3</td>
<td>27.4</td>
<td>25.8</td>
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c) Adult Literacy Rate (in any language) by sex and residence, 1998 and 2008 (General Population Census of Cambodia 2008):

<table>
<thead>
<tr>
<th></th>
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<th></th>
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</thead>
<tbody>
<tr>
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<td>BS</td>
<td>M</td>
<td>F</td>
<td>BS</td>
<td>M</td>
</tr>
<tr>
<td>Total</td>
<td>67.34</td>
<td>79.48</td>
<td>56.99</td>
<td>77.59</td>
<td>85.08</td>
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<tr>
<td>Urban</td>
<td>81.73</td>
<td>90.29</td>
<td>74.06</td>
<td>90.42</td>
<td>94.49</td>
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<tr>
<td>Rural</td>
<td>63.68</td>
<td>76.64</td>
<td>52.79</td>
<td>73.98</td>
<td>82.46</td>
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</table>

d) Population by Urban-Rural residence and sex (General Population Census of Cambodia 2008):

<table>
<thead>
<tr>
<th>Urban / Rural</th>
<th>Both Sex</th>
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<th>Female</th>
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<tbody>
<tr>
<td>Total</td>
<td>13,395,682</td>
<td>6,516,054</td>
<td>6,879,628</td>
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<tr>
<td>Urban</td>
<td>2,614,027 (19.51%)</td>
<td>1,255,570</td>
<td>1,358,457</td>
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<tr>
<td>Rural</td>
<td>10,781,655</td>
<td>5,260,484</td>
<td>5,521,171</td>
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</tbody>
</table>

e) The Budget for Social Welfare and its percentage of total national budget
In 2011, the Government allocated the budget of approximately 2% of the National Budget of US$2.4 billion for social affairs.

f) The Budget for health and its percentage of total national budget

The Cambodia government allocated USD112, 657,409.95 for the health care in 2008. And it estimates about 12.54% of the total government budget. The Government had increased 25% over the budget expended for the health care in 2007.

3.2. Vital Statistics

<table>
<thead>
<tr>
<th>Year</th>
<th>2005 &amp; 2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual population growth rate</td>
<td>1.54%</td>
<td>1.8%</td>
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<tr>
<td>Crude birth rate (CBR)</td>
<td>27.7/1,000 live births</td>
<td>27.7/1,000 live births</td>
<td></td>
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<tr>
<td>Infant mortality rate (IMR)</td>
<td>66/1,000 live births</td>
<td>66/1,000 live births</td>
<td></td>
</tr>
<tr>
<td>Under 5 mortality rate (U5MR)</td>
<td>83/1,000 live births</td>
<td>83/1,000 live births</td>
<td>75</td>
</tr>
<tr>
<td>Maternal Mortality rate (MMR)</td>
<td>4.72/1,000 live births</td>
<td>4.37/1,000 live births</td>
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</tr>
<tr>
<td>Total Fertility rate (TFR)</td>
<td>3.3</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth total</td>
<td>M: 60.5 / F: 64.3</td>
<td>M: 60.65 / F: 66.97</td>
<td>M: 61.35 / F: 67.68</td>
</tr>
</tbody>
</table>

3.3. Population

Percentage distribution of Population of Cambodia by Broad Age Group according to different sources (General Population Census of Cambodia 2008)

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
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<td>100</td>
<td>100</td>
<td>100</td>
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<tr>
<td>0-14</td>
<td>42.8</td>
<td>42.7</td>
<td>38.6</td>
<td>38.9</td>
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<tr>
<td>15-49</td>
<td>46.9</td>
<td>46.3</td>
<td>49.5</td>
<td>47.9</td>
<td>53.4</td>
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<tr>
<td>50-64</td>
<td>6.8</td>
<td>7.4</td>
<td>8.0</td>
<td>8.6</td>
<td>8.6</td>
</tr>
<tr>
<td>65+</td>
<td>3.5</td>
<td>3.6</td>
<td>3.9</td>
<td>4.6</td>
<td>4.3</td>
</tr>
</tbody>
</table>

3.3.1. Poverty headcount: Total for the country 30.1 (2007) and 25 (2010)
3.3.2. Percentage of households having access to improved water sources (Including piped water, tube/pipe well, protected dug well and rain water) (General Population Census of Cambodia 2008)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>47.0</td>
</tr>
<tr>
<td>Urban</td>
<td>76.0</td>
</tr>
<tr>
<td>Rural</td>
<td>41.0</td>
</tr>
</tbody>
</table>

There are different government facilities for health and welfare for vulnerable people including ChWDs:

3.3.2. Health Facilities:
Currently, in the Kingdom of Cambodia has the public sectors of health facilities such as 8 National Hospitals, 24 Municipal and Provincial Health Departments, 77 Operational Districts, 79 Referral Hospitals, 1010 Health Centers, and 122 Health Posts (in remote area). It also has many private hospitals, Clinics, Consultation Cabinets, NGOs centers, Garment Factories, and communities.

4.1. Ministry of Health
4.1.1. Health Strategic Plan 2008-2015 on Human Resources for Health

HRH 1 Improve technical skills and competence of health workforce:
HRH 1.1 Invest in better clinical skills through pre-service training (at both public and private training institutions) with more focus on clinical and public health practices, including practical training in remote and rural context as well as establishment of teaching hospitals.

HRD 1.2 Develop systematic continuing education management training, both general and system specific by including high degree level in business (public) administration for senior managers and specialist degrees in financial management and human resource management for management at all levels of the health system.

HRD 1.3 Develop and implement comprehensive and coordinated approach to in-service training, beginning with a review of policies and guidelines for continuing education and regular review of curriculum in order to ensure that it responds to the health needs of the people.

HRD 1.4 Develop and implement accreditation system for public and private sector training institution, to be strengthened through international accreditation and through affiliation with ASEAN and other international universities and training institutions.

HRD 1.5 Increase basic training provision for new midwives (promote active local recruitment of trainees) and strengthen the capacity and skills of midwives already trained through continuing education (implementation of midwifery review recommendations and the MoH Health Workforce Plan 2006-2015).
HRD 1.6 Develop scholarship programs to support access to local, national and international pre-and in-service training program, and provide comprehensive and up to date information on scholarship and fellowship opportunities for all staff on MoH.

HRH 3. Staff distribution and retention, with priority to personnel essential to health sector priorities:

HRD 3.1 Align human resource planning and personnel management with health sector planning and the HCP.

HRH 3.2 Develop and implement human resources management policies to deploy staff in underserved areas through contracts.

HRD 3.3 Increase the number of midwives placed and retained to public sector facilities through effective implementation of the RGC’s “Midwifery Incentives” and of full implementation of midwifery review recommendations and the MoH Health Workforce Plan 2006-2015.

HRD 4. Staff remuneration, salaries, performance incentives:

HRD 4.1 Continue to promote better remuneration and salary through Civil servant Reform of Royal Government of Cambodia.

HRH 4.2 Improve management of facility-managed salary supplementation from user fees, HEF, quarterly service delivery grants, contracting, SOAs, CBHI and others.

HRH 4.3 Expand the implementation of PMG and PMG-compatible incentive mechanisms, and implement other incentive approaches for “back office” staff.

4.1.2 Organizational structure

Ministry of Health has been established in 1996 by Royal Decree No 0196 date 24 January 1996. The Ministry of Health has 3 Director General that covers all health facilities in national level and sub-national level as following:

a. National level
   • 10 Departments,
   • 10 National centers/Institutes,
   • 8 National Hospitals,
   • 1 Public University of Health Sciences
   • 1 National Public Health Institute

b. Sub-national level
   • 24 Provincial Health Departments (24 PHDs)
   • 77 Operational Districts (77 ODs)
   • 79 Referral Hospitals (79 RHs)
   • 1010 Health Centers (1010 HCs) and
4.1.3 Human Resource Development Policy and Regulation

According to MoH policy, Human Resource Development has been established as a health education system starting from National level to sub-national level. (1) At the national, it has a University of Health Science (UHS) and Technical School for Medical Care where is under umbrella of UHS and Health Science Institution of Royal Cambodia Arm forces (HSIRCA). This institution is public one. Private Universities for Health also quickly grow in country. There are 5 Universities are located in capital Phnom Penh, two are Government institution, UHS and HSIRCA, and 4 others are private ones such as International University(IU), Chenla University(CLU), Puthisastra University (UPTS). (2) At sub-national level, Ministry of Health has 4 Public Nursing Regional Training Centers (RTC) and 2 private Universities. The Regional Training Center( RTC) are called as Battambang RTC, Kampobg Cham RTC, Kampot RTC and Stung Treng RTC where are located in Battambang, Kampong Cham, Kampot and Stung Treng provinces. The private Universities are Life University located in the south-west and Mean Chey University located in the west of country. These Universities are under controlled by Ministry of Education, Youth and Sport and Ministry of Health.

Currently, there are five schools which offer nursing education in Cambodia. The Technical School for Medical Care (TSMC), based in Phnom Penh, it is one of the four (4) faculties / schools of the University of Health Sciences (UHS). The UHS became an autonomous institution in July 2002. Under its new status, the TSMC could use half of their students’ fee to pay to teaching staff and half of the income, could be used for running cost, building/renovating facilities as well as purchasing some of equipments/reagents and training materials. TSMC has traditionally offers basic education and continuing education for nurse and midwife for students from the central provinces of Phnom Penh, Kampong Chhnang, Kampong Speu and Kandal. The TSMC cover the students from all 24 provinces for basic education for Lab, Physiotherapy PT and Radiological Technology RT and some of post basic courses. Most of the clinical sites are National Hospitals and Centers and there are a quite small numbers of provincial hospitals and health centers that TSMC sent their students for clinical practice because those national health facilities could provide enough cases for student’s clinical practice. The four (4) Regional Training Centers (RTC) have been funded through the Provincial Health Department in the province in which they are based and just have their own budget since last five years. Different from the TSMC, the 4 RTCs offer basic and continuing education for nurse, midwife and other post basic education and used to send their students to different provinces under their coverage:

- Kampot RTC – located to the South and covering the provinces of Kampot, Kep, Kampong Som, Koh Kong and Takeo.
- Kampong Cham RTC – located to the East and covering the provinces of Kampong Cham, Prey Veng, Kampong Thom, and Svay Rieng.
Battambang RTC – located to the North West and covering the provinces of Battambang, Siem Reap, Banteay Meancheay, Pursat, Pailin, and Oudor Meancheay

Stung Treng RTC – located to the North East and covering the 5 provinces of Stung Treng, Preah Vihear, Rattanakiri, Mondulkiri, and Kratie.

The growing fast of private training institutions made the two ministries, MoH and MoEY&S, work hard to develop standards and guidelines so that the quality of education for health is assured. Strengthening the public training institutions is crucial to show as model for maintaining and promoting the quality of education. Therefore, standards have to be followed and efforts have been made to equip public institutions met standards.

The growing fast of private training institutions made the two ministries, MoH and MoEY&S, work hard to develop standards and guidelines so that the quality of education for health is assured. Strengthening the public training institutions is crucial to show as model for maintaining and promoting the quality of education. Therefore, standards have to be followed and efforts have been made to equip public institutions met requirements as the following:

- Standard of curriculum – approved by both MoH and MoEY&S
- Qualification of teaching staff:
  - Professional experience
  - Teaching experience
- Standard of facility:
  - Classroom and skill lab or demonstration room
  - Library
  - Clinical site
- Standards of materials and equipments for classroom demonstration are defined in national curriculum issued by joint inter-ministries Prakas, Ministry of Health and Ministry of Education and Youth.

### 4.1.4 Professionals and workers

<table>
<thead>
<tr>
<th>No.</th>
<th>Category</th>
<th>%</th>
<th>#</th>
<th>#per 13.4M</th>
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<th>2010</th>
<th>2011</th>
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<th>2013</th>
<th>2014</th>
<th>2015</th>
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<td>Medical Doctor</td>
<td>5</td>
<td>1</td>
<td>1,675</td>
<td>1,901</td>
<td>2,158</td>
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<td>3,155</td>
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<td>380</td>
<td>432</td>
<td>490</td>
<td>556</td>
<td>631</td>
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<td>1</td>
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<td>335</td>
<td>380</td>
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<td>631</td>
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<table>
<thead>
<tr>
<th>No.</th>
<th>Position</th>
<th>No. of People</th>
<th>1st Quarter</th>
<th>2nd Quarter</th>
<th>3rd Quarter</th>
<th>4th Quarter</th>
<th>5th Quarter</th>
<th>6th Quarter</th>
<th>7th Quarter</th>
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<th>9th Quarter</th>
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<tr>
<td>4</td>
<td>Primary Nurse</td>
<td>10</td>
<td>3</td>
<td>3,350</td>
<td>3,802</td>
<td>4,316</td>
<td>4,898</td>
<td>5,559</td>
<td>6,310</td>
<td>7,162</td>
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<tr>
<td>5</td>
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<td>4</td>
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<td>5,703</td>
<td>6,473</td>
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<td>9,465</td>
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<td>Primary Midwifery</td>
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<td>6,473</td>
<td>7,347</td>
<td>8,339</td>
<td>9,465</td>
<td>10,743</td>
<td>12,193</td>
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<tr>
<td>7</td>
<td>Second Midwifery</td>
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<td>8</td>
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<td>631</td>
<td>716</td>
<td>813</td>
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<tr>
<td>10</td>
<td>Dental Nurse</td>
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<td>2,010</td>
<td>2,281</td>
<td>2,589</td>
<td>2,939</td>
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<td>3,786</td>
<td>4,297</td>
<td>4,877</td>
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<td>35,000</td>
<td>40,032</td>
<td>45,166</td>
<td>50,993</td>
<td>57,606</td>
<td>65,112</td>
<td>73,632</td>
<td>83,301</td>
</tr>
</tbody>
</table>

4.1.5 Constraint and issues on Human Resource Development

According to the current situation of country related to human resource development, many constraints and issues have been happened as describing following:

- Cooperation and coordination links between the responsible government authorities and private sector providers are still limited that could not control the quality of education, especially the private education providers because the role of private sector is important that play in the provision of health personnel education and training.

- Information system including data relating to pre-service and post-graduate education programs and other relevant training activities is not systematic way in order to facilitate monitoring, planning, management and regulatory activity on the part of MOH and MOEYS.

- The need for and provision of pre-service and postgraduate education in health and health related professional disciplines not currently established in Cambodia, including bio-medical engineering, medical information technology, advanced radiation therapy and medical imaging technology, and a number of medical and nursing specialties.

- Human resource in health training institutions is still limited and inadequate qualified in term of professional and teaching experiences. These can be affected to the quality of training. Also inappropriate of Training materials and equipments to support teaching activity are not update.
• Public training institutions have been mostly covered by national budget and with difficult access cannot play smoothly on operational activities including teaching and clinical practice.

4.2 Ministry of Affairs, Veterans and Youth Rehabilitation

4.2.1 Organizational structure

The Ministry of Social Affairs, Veterans and Youth Rehabilitation have developed its structure several times to meet the needs of current social situation.

a. Directorate of Administration and Finance
   - Department of Administration and Personnel
   - Department of Planning and Statistics
   - Department of Finance and Supplies
   - Department of International Cooperation
b. Directorate of Technical Affairs
   - Department of Social Welfare
   - Department of Child Welfare
   - Department of Disabled Person Welfare
   - Department of Youth Rehabilitation
   - Department of Elderly Welfare
   - Department of Veteran
   - Department of Anti-Human Trafficking
c. Inspectorate
d. Department of Internal Audit
e. The Cambodian National Council for Children (CNCC)
f. Disability Action Council (DAC)
g.. National Social Security Funds for Civil Servants
h. National Veterans Funds
i. Inter-country Adoption Central Authority

And we have Provincial/Municipal Departments of Social Affairs, Veterans and Youth Rehabilitation that work closely with all the NGOs and institutions.

The Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) has laid out the five strategic objectives such as: First, transform gradually the provision of social services from humanitarian characteristic into social security net. Second, prepare the law system and regulations for managing and directing all social services in accordance with the national policies. Third, mainstream the social services into national development programme at all levels. Forth, increase the partnership
with Cambodian Red Cross, NGOs, and mobilize holistically the resources in humanitarian works. Lastly, increase the institutional capacity, good governance, and effectiveness of social services.

4.2.2. Training activity

The progress Cambodia has achieved is brought about by a number of socio-economic development efforts during the past 10-15 years. A number of factors have facilitated the development while other factors have acted as constraints. The government’s commitment and reform process, coupled with international assistance, have helped in the country’s development efforts. The government achieved in poverty reduction at 27% under poverty line with 1% reduction annually. On the other hand, a number of demographic factors have been identified as major constraints to development and poverty reduction. In 2011, the Government allocated the budget of approximately 2% of the National Budget of US$2.4 billion for social affairs.

In general, most social workers never train in social works. In order to promote the social works to be proceeded greatly as well as comprehensively and effectively results, the Ministry of Social Affairs, Veterans and Youth Rehabilitation has paid close attention to train to social workers of the Ministry to have knowledge, skills, and experiences in fulfilling their works.

4.2.2.1 Training activities provided by MoSVY:

Social work training has been proceeding gradually in short course, medium course and long course since the beginning of the establishment of the Ministry in 1986. But the training of this course has been focused on the main skills and was not comprehensive. Based on the cooperation both technically and financially from UNICEF, the training programs of social works have been conducted since the year of 2000. The MoSVY has issued a Prakas No. 127 MoSVY dated 02 February 2006 and established the social work training committee to lead the training for 5 year work plan (2006-2010) since 2006.

In line with the progress of the country and the world, in particular the trend of ASEAN social works, the MoSVY has issued a new Prakas No. 710 MoSVY dated 03 June 2010 on the Establishment of the National School of Social Work with interim social work governing bodies and principal bodies of the National School of Social Work to lead and push the training works have been done so far to work regularly and forwardly.

Based on the Prakas No. 710 dated 03 June 2010, the interim governing bodies and principal bodies of National School of Social Work have worked hard to develop the National Institute of Social Work to be shaped. Several meetings have been conducted to discuss and prepare for a sub-degree on the establishment of the National Institute of Social Work in order to ask for the decision from the government. In general, MoSVY has agreed to ask for the government to establish the National Institute of Social Work that consists of five colleges and two vocational skill training schools to provide graduate and post-graduate degrees.
Currently, the Sub-degree and other necessary documents have been drafted and officially submitted to the Ministry of Education, Youth and Sports for comment and approval before submitting to the Government.

Based on the above Prakas, the training committee has made regularly efforts and got the results as follow:

a- Basic social service training:
So far, 10 courses have been conducted with 400 participants attended. Each course consists of two weeks. During learning theory, all participants are needed to visit some organizations and institutions which provide social work services for one day.

b- Professional social service training:
10 courses have been conducted with 401 participants attended. This course learns theory in class for 3 weeks separately and visit fields with monitoring and evaluating by trainers for 4 days. Field visits were conducted every week for one day except two days in third week.

c- Psychosocial support training:
It is a one-week training course among four-week training course of professional social service training. In this 5 years, there are 30 courses of psychosocial support training have been conducted including 496 participants attended. This theory learning course consists of two steps and there is 3 days in each step. After first step, participants are needed to do home work by selecting one case study to do as sample for next step. After completion of last step, the participants are needed to study visit in the fields for one more day with monitoring and evaluation by the trainers.

d- Management of social service training:
This course started on 18 July 2004 until 12 April 2006 with theory learning in class for 12 weeks and study visits for 72 weeks. There were 36 participants who attended in this course. So far, such training was conducted only one batch per course.

4.2.3 Training cooperation between MoSVY and Development Partner Organizations:
a- Training cooperation with Social Service Cambodia Organization:
The MoSVY has sent 4 trainers to cooperate with Social Service Cambodia Organization to conduct training on relevant skills to work with orphaned and vulnerable children (OVC) which started since March 2009. As result, it trained 4 courses with 52 participants attended in which 13 participants were MoSVY officials who working closely with children.

b- Training cooperation with Asia Foundation:
Skills in working and collaborating with polices have been trained to 60 social workers in 6 target provinces to help women and children affected by sexual abuse and exploitation. This course sponsored by Asia Foundation with cooperation with MoSVY.

c- Training cooperation with Cambodia Trust:
Cambodia Trust was established in UK in 1989 and opened its first rehabilitation centre for landmine survivors in Phnom Penh, Cambodia in 1991. The Cambodian School of Prothetics and
Orthotics was established in 1994 by Cambodia Trust and this school has provided three-year training course on prothetics and orthetics to individuals from Cambodia and other low-income countries. The Cambodia Trust is managed by a well-developed structure certified under ISO 9001:2000 and is one of the first NGOs in the world to achieve and maintain this certification. Since 1994 to 2010, there are 87 individuals from Cambodia, 14 from Lao PDR, 10 from Sri Lanka, 8 from Myanmar, 5 from North Korea, 4 from Philippines, 3 from Indonesia, 2 from East Timor, 2 from Iraq, 2 from Malaysia, 1 from Afghanistan, 1 from Georgia, 1 from Japan and 2 from Papua New Guinea have graduated in Prosthetics and Orthotics.

4.2.4 Training activities provided by other institutions:

There is only Royal University of Phnom Penh offered the training for Bachelor and Master Degrees in social work since 2008. Currently, there are 75 Bachelor students (25 students in first year, 25 in second year, and 25 in third years) and 14 Master students are training by 8 lecturers (1 PhD and 7 Masters).

Up to date, it has no any association of social work in Cambodia. Whereas the major issues and concerns in the education of social workers and the continuing education of educators are very limited in number of human resources.

4.3 Ministry of Labour and Vocational Training

4.3.1 Organizational structure

Ministry of Labour and Vocational Training was established in January 2005. The Ministry is composed of three General Departments namely General Department of Administration and Finance, General Department of Technical and Vocational Education and Training, and General Department of Labour.

The General Department of Labour is composed of six departments namely:
- Department of Labour Inspection
- Department of Labour Dispute
- Department of Child Labour
- Department of Occupational Health and Safety
- Department of Employment and Manpower
- Department of Social Security (now become public establishment)

4.3.2 Policies and regulations related to promote employability for social vulnerable, specially elder and disabilities

4.3.2.1 Social Security

Social Security was initiated in Cambodia since 1955 based on the Royal Decree No. 55 and 306. Regrettably, during the genocide rule (1975-1979), it was demolished. The Department of Social Security was established in 1993. The department was responsible for the preparation of all of the
PRAKAS for the implementation of social security protection for the general population. As a result of amending the Labour Law of 1992, the current Labour Law of Cambodia was passed in 1997, implemented by the Labour Department (currently becomes General Department of Labour). Afterward, the first Social Security Law was passed by the Parliament in September 2002. The government requested the technical assistance of the International Labour Organization in the designing of the employment injury scheme; therefore, in 2004 the ILO experts came to study the feasibility of establishing the employment injury scheme and the appropriate administrative design for the scheme. In 2007 the sub-degree concerning the establishment of the National Social Security Fund (NSSF) was adopted, which replaced the Social Security Department in the process. After extensive preparation, NSSF was fully functional at end of 2008.

4.3.2.2 Child Labour

Pervasive poverty is the principal reason for the existence of child labour. Poor families who lack capital resources, skills and education, and who have limited economic opportunities, are likely to send their children to work.

Cambodia’s Child Labour Survey (2001) estimates that about 45% of children aged 5-14 years are “working children,” suggesting that nearly 1 in every 2 children works. More boys than girls work. Almost 90% of working children are from rural areas. Some of the known worst forms of child labour in Cambodia include child prostitution; trafficking of children for begging, prostitution, and domestic work; exploiting children through drug trafficking; and employing children in hazardous sectors such as hotels, restaurants, domestic services, fishing, brick making, stone refinery, tobacco, and rubber plantations.

To eradicate child labour, the Royal Government of Cambodia (RGC) is undertaking several strategies. Firstly, the RGC seeks to reduce poverty. The National Poverty Reduction Strategy (NPRS) lists priority actions to address the causes of poverty. These include creating opportunities to access resources, jobs, and infrastructure. It also includes enhancing security through safety nets such as food-for-work programmes, judicial reforms, scholarships for children of poor families, effective exemption mechanisms and equity funds for the poor in health structures, effective HIV/AIDS prevention, and support programmes for people living with HIV/AIDS.

Secondly, the RGC is strengthening institutions that can prevent child labour and protect children.

Thirdly, the RGC will directly intervene in sectors of the economy that have a disproportionate number of child labourers as determined through consultations on the elimination of the worst forms of child labour. The following activities that are considered of the gravest concern are: children in domestic labour;

Of equal priority:
- children in quarry/sand making;
- children in brick making;
- children in portering (in borders and ports)
- children in restaurants/karaoke;
- children in rubber plantation;
- children in salt production;
- children in fishing;
- children in mining;
- children in rubbish/garbage picking; and
- children in begging.

Fourthly, the RGC remains firmly committed to the complete elimination of worst forms of child labour which include trafficking of children and women; forcing children into prostitution and pornography; and exploiting children through drug production, sale and trafficking.

4.3.2.3 Labour Migration

Since economic growth and employment in Cambodia have been narrowly concentrated in the agricultural, garment, construction, and tourism sectors, the promotion of foreign employment through private and public employment services has been a cornerstone for the alleviation of unemployment, income enhancement, and poverty reduction.

Many Cambodian workers see employment in foreign countries as a means of moving out of poverty and, in past years, many workers have migrated for jobs abroad. Increased demand for low-skilled workers in international labour markets such as those in Thailand and Malaysia, has presented a strong pull factor for the unemployed and underemployed.

Given demographic pressures and insufficient quality domestic employment, labour migration policy for Cambodia, which was developed in 2010, focus on promoting foreign employment for its nationals based on well-informed choice. While the RGC does not perceive foreign employment as the only means of economic development and poverty reduction, it will facilitate migration for employment, while equipping women and men migrant workers with basic technical and language skills to reduce the risk of labour exploitation and trafficking.

4.3.3 Occupational Safety and Health

The Ministry of Labour and Vocational Training (MoLVT) developed the 1st Occupational Safety and Health Master Plan of Cambodia, referring to ILO Promotional Framework for OSH Convention.

The Cambodian government places a highest priority to improve people’s quality of life. Ensuring safe, healthy and productive working environments is a prerequisite for this purpose.

4.3.4 Situation around social vulnerable, specially elder and disabilities

4.3.4.1 Social Security

NSSF manage and administer the social security scheme for worker in private sector

- Employment Injury Insurance
- Health Care
Employment Injury Insurance is a compulsory social insurance covering all employees as defined by the Labour Law. The employment injury insurance scheme in Cambodia is being implemented in Phnom Penh, Kandal and Kampong Speu during the development phase and will be steadily expanded to other provinces and smaller enterprises. On the other hand, NSSF cannot cover the small enterprises, having less than 8 employees, which are not viable to fulfill the minimum requirements yet.

Back in 2008, we have covered 330 enterprises corresponding to 264,523 employees; near the end of 2nd quarter in 2009, the number of enterprises keeps rising up to 553, representing 294,967 employees, with a slight drop in March as the world economy started to slumber. So far, NSSF has covered a large number of employees working in a variety of enterprise types, about 49% of which are garment factories.

**Figure 1: Covered employees**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-Nov</td>
<td>245,486</td>
</tr>
<tr>
<td>2008-Dec</td>
<td>264,523</td>
</tr>
<tr>
<td>2009-Jan</td>
<td>279,894</td>
</tr>
<tr>
<td>2009-Feb</td>
<td>275,140</td>
</tr>
<tr>
<td>2009-Mar</td>
<td>270,551</td>
</tr>
<tr>
<td>2009-Apr</td>
<td>264,467</td>
</tr>
<tr>
<td>2009-May</td>
<td>294,967</td>
</tr>
</tbody>
</table>

**Figure 2: Covered enterprises**

<table>
<thead>
<tr>
<th>Year</th>
<th>Enterprise</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-Nov</td>
<td>289</td>
</tr>
<tr>
<td>2008-Dec</td>
<td>301</td>
</tr>
<tr>
<td>2009-Jan</td>
<td>326</td>
</tr>
<tr>
<td>2009-Feb</td>
<td>328</td>
</tr>
<tr>
<td>2009-Mar</td>
<td>326</td>
</tr>
<tr>
<td>2009-Apr</td>
<td>330</td>
</tr>
<tr>
<td>2009-May</td>
<td>434</td>
</tr>
</tbody>
</table>

**Figure 3: Covered enterprises by type**
The employment injury scheme covers the contingencies of accidents at work, occupational diseases, and commuting accident. According to the Sub-Decree concerning the establishment of NSSF, occupational accident refers to the accident inflicted on the body of the employee during working hours, regardless of the cause and employee’s fault. Commute accident occurring along the direct route between the employee’s residence and workplace is also considered as occupational accident; however, accidents happening during social activities that are not part of the employee’s job and generally not associated with work are excluded from the coverage. Occupational disease arises out of the exposure to the harmful substances or hazardous condition in the processes. The employment Injury Scheme covers an extensive list of occupational diseases, which is expanded with the discovery of new diseases.

After receiving accident report, officer of the Benefit division informs the officer of the Inspection division. Then the inspectors carry out an investigation and report the result to the Benefit division. For complicated cases, the inspector can request for assistance from the specialists. For commuting accident, the inspectors gather the information on place, time and causes of accident from witnesses or local authority.

The employer or representative of employer is responsible for reporting accident at workplace or commuting accident. In case the accident resulting in death, the accident notification will be the survivor’s responsibility. The employment injury report is done by filling the information in the accident report form provided by the time of registration at NSSF. Importantly, it has to be submitted to benefit division within 48 hours of the accident.

4.3.5 Child Labour

Many programmes and initiatives in the overall effort to improve the conditions and welfare of children in Cambodia are spearheaded by international organizations (e.g. ILO-IPEC), international NGOs, and local organizations. But there are only a few programmes addressing worst forms of child labour, except for trafficking and sexual exploitation in children. The Ministry of Labour and
Vocational Training’s project which is supported by ILO-IPEC and which is being implemented in the 3 pilot areas of Kampot, Kampong Som, and Kampong Cham provinces, appears to be the most effective among the current crop of programmes and initiatives on the elimination of child labour.

4.3.6 Labour Migration

Migrant workers are vulnerable to exploitation within their home country and in countries of destination. With little economic alternative, and because of misinformation compounded by the complexity of migration processes in their home countries, many migrants have been venturing into irregular status.

Protection of migrant workers against abuses and malpractice remains a high priority. Protection means the elimination of exploitation and the fostering of respect for basic human rights and the rights at work of all migrant workers. The most vulnerable categories of migrant workers are female domestic workers and entertainers, trafficked persons, and irregular migrant workers.

4.3.7 Occupational Safety and Health

Tripartite cooperation in OSH in Cambodia is strong. The RGC encourages employers and workers to establish functioning enterprise-level OSH systems.

4.3.8 Constraint and issues on employment of social vulnerable, especially elder and disabilities

4.3.8.1 Social Security

During its implementation in the first phase on the Occupational Risk Scheme, NSSF encountered main challenges as described below:

- The problems connected with some hospitals contracted with NSSF
  - Quality of medical services were not good enough
  - Providing not enough service and not right to the goal
  - Some of medical staff did not care, use impolite speech, and ask for extra money from the victims for treatment service.
- Some of employers or enterprise owners
  - Did not cooperate well in providing information concerning to the number of employees, employees’ salary and branches of company
  - Did not send their monthly reports on the number of their employees and contribution on time
  - Did not possess trade registration or patent
  - Provide inaccurate report on occupational risk and were often late.
- Some of workers
  - Did not have their own identification documents (borrowing from others) such as identification card and family book
• Married bud did not have marriage certificate and thus were not eligible to access to survivors’ benefits in case of fatal
• Did not understand technical ways of providing treatment service and did not listen to the explanation of NSSF’s agency
• Get medical service at the hospital that did not contract with NSSF.

4.3.8.2 Child Labour
There is a lack of appropriate coordination and collaboration among the various development players who currently operate within their stated goals and areas/sectors of intervention

4.3.8.3 The main constraints of labour migration are:
• Lack of adequate dissemination of information on safe migration, principles and significance of MOU and legal migration
• Growth in irregular migration
• Long porous borders
• Low cooperation of Government and Employers in receiving countries
• Mass deportation of undocumented migrant
• Government control of migration process
• Expanding and improving legal channels: high fee and long time
• Lack of action to promote productive investment of remittance
• Lack of migrant-focused NGOs
• Lack of mechanism to follow up the development of returnees
• Lack of program to support the reintegration of returnees
• Lack of Vocational Training and
• Migrant labor markets are overcrowded-competition-3D jobs

4.3.8.4 Regarding OSH, Cambodia needs to redesign stronger national OSH systems in order to provide adequate OSH protection to all workers.
• Cambodian legal frameworks in OSH are still weak and need strengthening targeting priority occupation.
• Government OSH networks between the central and provincial levels are weak.
• Reporting mechanisms and information sharing systems need to be strengthened for effective OSH administration at provincial level

5. Case Study (Health): Good Practices of capacity building of services providers in health.

5.1 Title: Capacity building of Midwifery teaching staff and preceptor in Regional Training Centers

5.2 Overview:
There are 4 Regional Training Centers (RTC)s offer basic and continuing education for nurse, midwife, dental nurse and other post basic education. Theses RTCs have used referral hospitals at provincial level under their coverage for students’ clinical practice.
5.3 Problem Analysis:

Human resource, especially teaching staff and preceptors in Regional Training Centers are not
everough number and also they are not adequate qualified in term of professional and teaching
experiences. Management including direction and evaluation of preceptors on student’s practice in
clinical sites is also limited. These can be affected to the quality of training. The evaluation of student
practice is important in making decision for fulfill clinical requirement that stipulates in the national
curriculum.

5.3 Institutions or organizations involved:

There are various institution/organization involved in the implementation of this national plan
of action such as:

- Ministry of Health (MoH)
- Ministry of Education Youth and Sports (MoEYS)
- University of Health Science (UHS)
- Technical School for Medical Care (TSMC)
- Battambang Regional Training Center (BB RTC)
- Kampong Cham Regional Training Center (KC RTC)
- Kampot Regional Training Center (KP RTC)
- Stung Treng Regional Training Center (ST RTC)
- 24 Provincial Health Departments and
- Development Partners: WHO, UNFPA, ACCESS, HSSP and RACHA

5.5 Policies and Strategies Pursued:

In order to solve this problem, law, regulation and others guideline are available for ensure the
quality of Training should be strengthened such as Sub-decree No 21 on training for health, national
curriculum and standards of training that mentioned on requirement of qualification of trainers and
preceptors. Teaching methodology and preceptor curriculum was developed in 2009 for strengthening
the capacity of teaching staff and preceptors.

5.6 How the strategy was implemented:

According to policies and strategies available, Ministry of Health has to implement by
establishing working group and core trainers for developing curriculum and run the courses. After that
 provision of training course were done. 12 training courses with 307 midwifery teaching staff and 60
midwifery preceptors were conducted from 2009 to 2011. Ministry of Health also cooperates with
Health Development Partners to support courses such as WHO, ACCESS, HSSP and RACHA.
Monitoring and evaluation the course and after courses is very important to carry out to ensure the
effectiveness of training.
5.7 Impact on Policy:
These policies and strategies are appropriate for current situation in strengthening the capacity of trainers and preceptors in order to make sure they are able to provide teaching and managing properly. All policies are effectively implemented in fulfill MOH requirement.

5.8 Potential for up-scaling and replication:
Ministry of Health has a plan to continue this strategy to build capacity of teaching staff and preceptor in few years more for fulfill the requirement of MoH. Upgrading the referral hospitals to become the teaching hospitals will be done that the main way forwards for strengthening clinical practice of the students.

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