The child’s right to life and health

Introduction

This chapter is guided by the right to life, a universal human rights principle enshrined in all international human rights instruments, including the CRC. Article 6 recognizes that every child has the right to life, survival and development. This provision has been interpreted to mean that measures taken by the State should be “of a positive nature and thus designed to protect life, including life expectancy, diminish infant and child mortality, combating diseases and rehabilitating health, providing adequate nutritious foods and clean drinking water”. Most importantly, the State should refrain from any action that may intentionally take life away, take steps to safeguard life and ensure “to the maximum extent possible” the survival of the child.149

International law has established that health is a fundamental human right and indispensable to the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health, which is essential for living a life in dignity.150 The right of the child to health is interrelated and dependent upon the realization of other rights, including the rights to life, non-discrimination and equality, food, education, privacy, access to information, clean drinking water and hygiene. This chapter analyzes the right to health and access to health services as established in Article 24 of the CRC, which builds upon the rights to life, survival and development. The State must recognize the right of all children without discrimination to “the highest attainable standard of health” by taking into

account its available resources, and strive to ensure “that no child is deprived of his or her right of access to such health care services.” This means that all children should have access to health care facilities whether they are living in urban, rural or remote areas, and particular attention should be directed to the most disadvantaged children, such as those from ethnic minorities, street children and children with disabilities.

Related to the right to health is the child’s right to birth registration, as recognized in Article 7 of the CRC. Birth registration immediately after birth is essential for the protection of the child’s right to life and health. The significance of birth registration in relation to an individual’s identity and being able to claim economic and social rights is therefore emphasized in this chapter from the start.

A situation analysis using a rights-based approach concentrates mainly on existing gaps and disparities, the principal areas that need improvement and remaining obstacles to overcome before the right to the enjoyment of the highest attainable standard of health is guaranteed to all children in Cambodia. Central to this analysis is the identification of all the responsible actors and duty-bearers at all levels that play a key role in ensuring a child’s rights to life and health.

The Convention on the Rights of the Child and 1993 Constitution of Cambodia recognize the following rights, which are the most relevant to this chapter:

**The CRC**

Article 2: The right to non-discrimination

Article 6: The right of the child to life

Article 7: The right of the child to be registered immediately after birth

Article 18: The common responsibilities of both parents in upbringing and development of the child

Article 24: The right of the child to the highest attainable standard of health

**The 1993 Constitution of Cambodia**

Article 48 guarantees:

The State shall protect the rights of the children as stipulated in the Convention on Children, in particular, the right to life, education, protection during wartime, and from economic or sexual exploitation. The State shall protect children from acts that are injurious to their education opportunities, health and welfare.

Article 46 states:

A woman shall not lose her job because of pregnancy. Women shall have the right to take maternity leave with full pay and with no loss of seniority or other social benefits.
Overview of the situation

Since 2000, Cambodia has made enormous progress in a number of social areas, including health. It has succeeded in reducing infant and under-five mortality from 95 to 66\textsuperscript{151} and from 124 to 83 deaths per 1,000 live births, respectively.\textsuperscript{152} This progress has been attributed to the strong performance of the national immunization programme, successful exclusive breastfeeding promotion, the reduction of poverty levels, improved access to education and better roads. The proportion of children age 12 to 23 months fully immunized against six preventable diseases increased from 40 per cent in 2000 to 66 per cent in 2005. Feeding practices have improved with an increase in babies being breastfed early and exclusively, from 11 per cent to 35 per cent and from 11 per cent to 66 per cent, respectively. Cambodia has also succeeded in halting and reversing the growth of the HIV epidemic, and has a declining prevalence that currently stands at 0.9 per cent.\textsuperscript{153} Access to improved water supplies has exceeded its 2015 CMDG target. The number of casualties from mines and UXO has decreased considerably and there is more government commitment towards improving the situation of children with disabilities through the adoption of new laws and policies. Furthermore, innovative financial schemes have been developed to protect the poor from the costs of public sector user fees.\textsuperscript{154}

Notwithstanding the progress to date, the health sector still faces major and persistent challenges that must be overcome before all children and women, particularly those belonging to the most vulnerable and disadvantaged sectors of the population, can enjoy their right to health. These challenges include the urgent need to reduce the high maternal mortality ratio, which stands at 461 deaths per 100,000 live births and is among the highest in the region. Although there has been a decline in neonatal mortality, it has been slower than the decline in post-neonatal mortality. The high maternal and newborn mortality rates are attributed to a number of factors:\textsuperscript{155}

- Only 52 per cent of women have access to a skilled birth attendant, according to the Health Information System statistics for 2008.
- 57 per cent of pregnant women have anaemia.
- Emergency obstetrics and newborn care is not accessible to many women (the Caesarean section rate is below 1 per cent, under the WHO recommended minimum of 5 per cent).
- Inadequate family practices during pregnancy and childbirth such as the reliance on traditional birth attendants and unclean cord care.

In the first half of the decade, significant improvements in child nutrition indicators were reported by the 2005 CDHS. Between 2000 and 2005, wasting decreased from 16.8 per cent to 8.4 per cent, the number of underweight children decreased from 38.4 per cent to 28.2 per cent, and stunting decreased from 49.7 per cent to 43.2 per cent. In the last three years, however, the nutritional status of children has seen little progress and, in some cases, the situation has worsened.

\textsuperscript{151} And further reduced to 60 in the 2008 Census.
\textsuperscript{152} Cambodia Demographic and Health Survey 2005.
\textsuperscript{154} World Bank, 2007, Cambodia Sharing Growth: Equity and Development in Cambodia, p.89.
\textsuperscript{155} Information provided by UNICEF Cambodia, 2008.
Chronic malnutrition, as measured by stunting (shortness), slightly declined from 43.2 per cent in 2005 to 39.5 per cent in 2008 due to considerable improvement in children younger than 1 year old (from 21.9 per cent in 2005 to 14.5 per cent in 2008). The number of underweight children stagnated at the same level: 28.8 per cent in 2008 compared to 28.2 per cent in 2005. Wasting (thinness), or acute malnutrition, showed no improvement: 8.9 per cent in 2008 compared to 8.4 per cent in 2005. Some population groups and areas have recorded significant increases in acute malnutrition. Wasting among poor urban children increased from 9.6 per cent in 2005 to 15.9 per cent in 2008, exceeding the threshold of the 15 per cent wasting rate for humanitarian emergency and calling for emergency response in urban areas. It is likely that this particular group was primarily affected by soaring food prices during 2008.

Poverty is an important risk factor in malnutrition and there is variation in the percentage of thin, underweight and short children by household wealth, but even the richest wealth quintiles see elevated rates of all three indicators of undernutrition. When compared to expected levels in a healthy population, the richest wealth quintile of Cambodia has over 12 times more short children (28.6 per cent), over eight times more underweight children (19.3 per cent), and four times more thin children (8.9 per cent). This shows that money, or the ability to buy food, is not the only important factor in nutrition. The way children are fed and cared for appears to be just as important as poverty for malnutrition in the country.

There are many new challenges, with drowning identified as the main cause of death among children between 1 and 17 years of age. After diarrhoea, it is the second most significant cause of death among children aged 1 to 4 years.

Significant inequities persist between rural and urban areas, across provinces and among people with different educational levels and economic status. Considerable financial barriers prevent the use of services, with out-of-pocket expenditures representing about 70 per cent of total per capita health spending. Access to a skilled birth attendant is singled out as an example of the greatest social inequity, with the wealthiest women being 10 times more likely to give birth in a health facility than the poorest (67.4 per cent of the richest quintile, compared to 6.5 per cent of the poorest quintile). Similarly, only 10 per cent of women with low education levels or no schooling at all are likely to give birth in health facilities or benefit from antenatal care, compared to 90 per cent of women with a secondary or higher education.

With regard to combating HIV, there is increasing concern about people who practice high-risk behaviours, including sex workers, men having sex with men and an alarming 24.4 per cent of injecting drug users (IDUs). A significant proportion of these at-risk groups are adolescents and young people. Another worrying trend is the increase of illicit drug use among street children aged between 12 and 18. There has been a growing feminization of the HIV epidemic in recent years that has obvious consequences on children due to the loss or chronic illness of their mothers. There are a number of persistent challenges related to preventing mother-to-child transmission of HIV that are linked to systemic barriers to addressing maternal health, such as the shortage of midwives.
low levels of antenatal care and lack of knowledge of its benefits, and low level of childbirth in health facilities due to geographic distance and lack of transport.

A number of challenges are related to health sector financing and service delivery. Although public spending on health doubled between 2003 and 2007, foreign aid continues to exceed government spending and out-of-pocket expenses have grown by 18 per cent during the same period. Per capita spending on health (US$39) and health share of GDP is now at 8 per cent, which is higher that in some neighbouring countries such as Viet Nam. Nevertheless, the health outcomes in Cambodia remain worse by comparison.159

In conclusion, the current health situation, while improving, requires an intensive focus on maternal and newborn health; an expansion of nutrition-related actions; a targeted effort to address unequal access to essential health services; and an emphasis on addressing some of the health sector’s bottlenecks associated with inadequate financial and human resources and the provision of health services. In addition, there is a dire need to improve access to water and the provision of sanitation facilities, which are essential to the enjoyment of the right to health.

National response to the child’s right to life and health

A value-based commitment of the Ministry of Health (MoH) is *Equity* and the *Right to Health* for all Cambodians.160 Below are the key national plans and strategies that provide the policy framework in relation to the child’s right to life and health.

1. National response to maternal and child health

The *NSDP 2006-2010* and the *Rectangular Strategy* aim to promote maternal and child health care to reduce maternal and infant mortality, but they are much broader in scope in addressing the health sector. The *Rectangular Strategy* aims to improve health services through capacity building and human resource development. Priority will be given to the construction of referral hospitals

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159 Options for Developing an Effective, Equitable and Sustainable Health System, Cambodia draft Health Note, undated.
Concluding Observations of the Committee on the Rights of the Child, 2000

In its Concluding Observations, issued to Cambodia in June 2000, the Committee made some recommendations with regard to the right to survival and development that remain valid today. The Committee expressed concern about Cambodia’s infant mortality and under-five child mortality rates, as well as maternal mortality rates, which remain among the highest in the region. It recommended that the State address these issues by taking a multi-sectoral approach that recognizes the critical role played by illiteracy, the lack of clean water supplies, and food insecurity on childhood illnesses. It recommended in particular recognizing the needs of isolated communities and putting in place an efficient primary health care sector in light of the limited access to health services. It further noted the shortage of medical and public health personnel and the insufficient number of primary health centres, especially in rural areas. The high cost of health care and medicines, leading families into debt and pushing many of them into poverty, was also raised as an issue of concern.161

The Health Strategic Plan (HSP) 2008-2015 aims to achieve three main goals: reduce newborn, child and maternal morbidity and mortality with increased reproductive health; reduce morbidity and mortality due to AIDS, malaria, tuberculosis, and other communicable diseases; and reduce the burden of non-communicable diseases and other health problems.162 The plan identifies equity as a core value and proposes a set of policy principles. It also recognizes the need for more detailed and decentralized planning and budgeting through greater empowerment and capacity building for national and sub-national structures and institutions. Greater importance is being placed on proactive performance management of sub-national departments and providers, the central ministry’s roles of regulation and enforcement, quality assurance, monitoring and contracting for performance.163

The Cambodia Child Survival Strategy (CCSS) 2006-2015 was adopted in order to reduce child mortality and achieve CMDG 4, which aims to reduce the under-five mortality rate to 65 per 1,000 live births by 2015.164 The key targets of the child survival CMDGs include the reduction of:

- Under-five mortality rate to 65 per 1,000 live births by 2015.
- Infant mortality rate (IMR) to 50 per 1,000 live births by 2015.
- The proportion of underweight and stunted children under five from 45 per cent to 22 per cent by 2015.

The CCSS aims to achieve universal coverage of a limited package of essential evidence-based, cost-effective interventions and health centres, which can provide local health services in an efficient, equitable and sustainable manner to all citizens, especially poor and vulnerable groups. Health Equity Funds designed to help the poor access quality health care services will be further strengthened and expanded.

162 Ibid., p. i.
163 Information provided by UNICEF Cambodia 2008.
that impact on child mortality. It recognizes that many factors determine whether a child survives. General socio-economic living conditions in households and communities where children grow up, maternal health and education, birth spacing, access to safe water and sanitation, and food security are all known to be determinants of early childhood mortality rates. Thus, for child survival to increase, improvements must be made in these areas.

The CCSS outlines the main directions for all actors in the health sector in order for them to contribute to their full potential to the common goal of decreasing child mortality. The CCSS strategy builds on other existing national policies and strategies such as the HSP 2003–2007 and those addressing maternal health and nutrition.

The National Nutrition Strategy 2009-2015 (NNS) is the first to be developed by the National Nutrition Programme using a participatory process involving the key stakeholders. The purpose of the nutrition strategy is to provide a clear focus and long-term direction to address maternal and child under-nutrition. Nutrition is addressed in relation to HIV, emergencies and non-communicable diseases. The strategy is intended to contribute towards the achievement of the CMDGs related to poverty, maternal and child health, and HIV.

The goal of the Nutrition Strategy is to reduce maternal and child morbidity and mortality by improving the nutritional status of women and children. It focuses specifically on what the MoH can do to address maternal and young child under-nutrition and is therefore limited in scope in addressing the full spectrum of causes of under-nutrition. The three key results to be achieved are: a reduction in malnutrition and micronutrient deficiencies in young children; a reduction in maternal anaemia and chronic energy deficiency; and increased leadership and technical nutrition capacity of government health staff.

The National Policy on Infant and Young Child Feeding Practices was developed in 2002 by the Government, and articulates the benefits of exclusive breastfeeding up to six months and appropriate complementary feeding in order to prevent disease and death, as well as to improve a child’s overall health and well-being. The National Nutrition Programe under the MoH has the primary responsibility for coordinating implementation of the policy by government institutions and NGOs.

The National Baby-Friendly Hospital Initiative (BFHI) aims to promote early and exclusive breastfeeding in the maternity ward. The BFHI implementation package has been revised to include HIV and a code for marketing breast milk substitutes. It also aims to strengthen links between hospitals, health centres and community breastfeeding support groups. Currently, Cambodia has seven baby-friendly hospitals.

Health Equity Funds are a demand-side financing mechanism set up in order to improve access to health care services for the poorest segments of the population, and operate in about 49 Operational Districts and at six National Hospitals. The funds pay the health service providers on behalf of the poor patients and thereby serve as a safety net for the most vulnerable groups, including orphans and their caregivers. The MoH envisions scaling up the coverage of
the Health Equity Funds to the entire country (77 Operational Districts) with support from health partners and NGOs. The Ministry of Planning (MoP) has developed national guidelines for pre-identification of the poor with active participation from the village communities and commune councils. This process has started in some provinces.

2. National response to HIV and AIDS

To date, Cambodia has made remarkable progress in the prevention and treatment of HIV and AIDS. It is one of the few countries in the world to meet national ‘three by five treatment targets’ and is also expected to meet the MDGs for HIV and AIDS. In response to the epidemic, Cambodia has established a legal and policy framework as well as institutional structures, guidelines and operating procedures.165

Key legislation and policies:

- National Strategy for Reproductive and Sexual Health in Cambodia, 2006-2010.

Guidelines and standard operation procedures:

- National Indicators for Monitoring and Evaluation of PMTCT.
- Minimum Package of Activities for Health Centres.

The National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS 2006-2010 builds on the first National Strategic Plan, which provided a multisectoral response based on human rights. It includes an operational plan with broad activities of all stakeholders, government, the private sector and civil society, and has the following overall goals:

- Reduce new HIV infections.
- Provide care and support to people living with and affected by HIV and AIDS.
- Alleviate the socio-economic and human impact of AIDS on the individual, family, community and society.

The plan also states that based on the lessons learned in recent years, the following opportunities have been identified for an enhanced multisectoral response:166

1. Incorporate HIV/AIDS in national development planning.
2. Enforce the National AIDS Law.
3. Scale up prevention services for the at-risk and general populations.

4. Scale up care and support services.
5. Scale up impact mitigation efforts.
6. Improve national coordination.
7. Engage more ministries and sectors.
8. Decentralize the response to provinces, operational districts and communes.
9. Increase resources and improve absorptive capacity.
10. Generate information for decision-makers and programme planners.
11. Monitor and evaluate the national response.

The National PMTCT Programme began in 2000 with the formation of a Technical Working Group and the PMTCT Secretariat. A pilot project was established in 2001 at the National Child Health Centre in Phnom Penh, which offered opt-in HIV counseling and testing for pregnant women and their partners and a single dose of Nevirapine to HIV-positive mothers during labour and to their infants after delivery. In 2003, the pilot project was scaled up to eight sites and also to include training activities and clinic sites. In August 2007, 112 health facilities and 42 operational districts were providing PMTCT services, including two national hospitals, 36 referral hospitals and 74 health centres. The programme also benefits from support from a number of partners, including UN agencies, the US Government and international and national NGOs. The PMTCT policy provides that services should be based on the recommended UN four-pronged strategy:

1. Primary prevention of HIV among women and their partners.
3. PMTCT through maternal and child health (MCH)/reproductive health/Integrated Management of Childhood Illnesses (IMCI)/sexually transmitted infections (STI) services, including antiretroviral prophylaxis, safe delivery practice and safe infant feeding practice.
4. Access to HIV and AIDS care and support for HIV-infected women, their infants and families.

In addition, there are the National Strategic Framework and Operational Plan for Men who have Sex with Men 2008-2011, the National Strategic Framework and Operational Plan for Sex Workers 2008-2011, and the National Strategic Plan on Drug Use related to HIV 2008-2011. It should be noted that these plans do not address the needs of children under 18 who are involved in sex work, drug use or boys who have sex with men.

3. National response to children with disabilities

The Government is taking some leadership in the disability sector by measures including the signing of the UN Convention on the Rights of Persons with Disabilities and initiating the process for a draft Law on the Protection and the Promotion of the Rights of Persons with Disabilities (2008). The purpose of this law is to protect and promote the rights of persons with disabilities within Cambodia. It stipulates that it will also protect the rights and freedoms of persons with disabilities; protect their interests; prevent, reduce and eliminate discrimination against them; and provide professional, physical and mental rehabilitation to ensure they are able to engage fully and equally in activities within society. It defines persons with disabilities as any persons who lack, lose or suffer impairment of their physical or mental being resulting in disturbance to their daily life or activities such as physical disabilities (loss of limbs and quadriplegia), visual, audio and mental impairments, consciousness...
disorders and other forms of disabilities resulting in an abnormal state. The draft law also establishes the Disability Action Council, which will carry out the following duties:

- Provide expertise on the issues of disability and rehabilitation.
- Assist ministries, institutions and concerned entities in preparing policies, national plans and strategies related to disability and rehabilitation.
- Promote the implementation of policies, laws and regulations related to issues of disability and rehabilitation.
- Suggest rectification, additional completion or amendment of policies, laws or regulations related to the issue of disability.
- Monitor and assess the implementation of policies, national plans, laws and regulations related to the issue of disability.
- Communicate with national and international communities in order to exchange experiences and gather both internal and external resources.

In addition, the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) and Ministry of Education, Youth and Sport (MoEYS) have developed an Inclusive Education Policy for Children with Disabilities (see Chapter on the Child’s Right to Education).

4. National response to demining

Beginning in 1993, Mine Risk Education (MRE) activities have focused on providing knowledge about mines and UXO. They first targeted internally displaced people who were returning home to heavily mined areas after the end of the armed conflict. This was usually conducted through educational teams that gave presentations in villages explaining the dangers involved and disseminated information on how to reduce the risk of accidents. MRE is one of five components of mine action, which also includes demining, victim assistance, advocacy to prevent the use of landmines and support of a total ban on anti-personnel landmines and stockpile destruction. MRE aims to reduce the risk of injury and death and create a safe living environment. This is achieved through raising awareness of the dangers of mines/UXO, promoting positive behavioural change and building the capacities of local communities to interact with mine action initiatives.167

National Mine Awareness Day is organized each February, providing an opportunity for the Government to reaffirm the importance of MRE activities, to demonstrate its support to the Ban Landmine Campaign and to sensitize donor countries on the needs of the mine action sector, as well as to comply with the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction.

5. National response to water, sanitation and hygiene

The Government’s Rectangular Strategy has stated aims to: (1) provide all citizens with clean and safe water; (2) protect all citizens from water-related diseases; (3) provide adequate water supply to ensure food security, economic activities and appropriate living standards; and (4) ensure water resources and an environment free from toxic elements.

The 2003 National Water Supply and Sanitation Policy: Part III Rural Water Supply and Sanitation contains explicit provisions regarding sanitation and hygiene improvement. A guiding principle states: “The full economic and health impact of improved rural water supply and sanitation (RWSS) is often not achieved because insufficient attention is given to improving community hygiene behaviour. Approaches in the past have often focused on the construction of RWSS facilities, which is not in itself a sufficient incentive to changing water and sanitation-related behaviour. Therefore, RWSS projects should not only focus on improving access to safe water supply and sanitation facilities, but also on bringing about desired changes in community hygiene behaviour.” The policy further states, “Higher priority for RWSS projects should be given to poor, underserved communities and/or areas where there is a high prevalence of water and sanitation-related disease.” The national policy advocates for a dramatic increase in rural sanitation coverage between 2015 and 2025, from the 30 per cent target in the 2015 CMDG up to 100 per cent rural sanitation coverage only 10 years later.

The Water and Sanitation Law of the Kingdom of Cambodia adopted in 2008 is intended to “cover all the management activities related to water supply and sanitation within the whole territory of the Kingdom of Cambodia”. Article 3 of the draft law defines sanitation service as “the exploitation of collection and transmission of sewerage discharged from domestic houses, public and private establishments to the treatment plant”. This definition appears to exclude the on-site sanitation systems found in much of rural and peri-urban Cambodia. Article 5 of the draft law gives the Ministry of Industry, Mines and Energy (MIME) the responsibility “for setting and administrating the government policies, strategies and planning in water supply and sanitation sector”.

A Technical Working Group (TWG) for Rural Water Supply, Sanitation and Hygiene was established in 2007 with the approval of the Prime Minister. This will help ensure inter-ministerial and donor support for the development of a national rural water supply and sanitation strategy in 2008 and allow for strengthened monitoring and periodic reporting to the Government Donors Coordination Committee (GDCC).

Efforts to promote awareness and commitment towards rural sanitation and hygiene have been ongoing since 2005 as shown by the following milestones:

- 2005-2006: a series of studies of the rural water and sanitation sector conducted with the support of development partners (particularly DFID, WSP-World Bank), which led to a UK Department for International Development (DFID) pledge to support acceleration of rural sanitation and hygiene improvement.
- 2006: the launch of Community-Led Total Sanitation (CLTS), an innovative methodology for mobilizing communities to completely eliminate open defecation. This approach has since been adopted by many NGO partners in Cambodia.
- 2007: a joint monitoring indicator (JMI) showing increased use of improved sanitation, hygiene and drinking water supply, especially in rural areas, was established, enabling the sector to report for the first time on status and progress made to the GDCC.
- 2007: The Prime Minister endorsed the establishment of a new Technical Working Group for RWSSH.
• 2007: The First Rural Sanitation Forum was presided over by the Prime Minister, who declared 13 November as National Sanitation Day.
• 2008: the national launch of the International Year of Sanitation by HE Yim Chhay Li, Secretary of State, Ministry for Rural Development (MRD) and Chairperson of TWG – RWSSH.

Initial steps have been taken by the National Centre for Health Promotion (NCHP) to promote behaviour change communication. National guidelines have been developed and the training of key staff has been conducted. MRD has adopted a more participatory approach to hygiene promotion through the use of simplified Participatory Hygiene and Sanitation Transformation (PHAST) tools. MRD has initiated collaboration with MoEYS to strengthen sanitation and hygiene education through school WASH activities. A national strategy for RWSSH will be developed in 2009 with support from ADB and UNICEF.

In 2002, the Government established an Inter-Ministerial Sub-Committee on Arsenic comprising the five related ministries with a secretariat based at MRD. To date, MRD has been coordinating all the arsenic mitigation activities in Cambodia, which includes a national testing programme on arsenic contamination, management of the national arsenic database, Information, Education and Communication (IEC) activities and the provision of alternative water supply facilities. The MoH, with support from WHO, has led the efforts to address the health impacts of arsenic exposure, including the conduct of a cross-sectional survey in one province in 2003, the verification of suspected arsenicosis cases identified in 2006 and training of health personnel in case detection and management.

A five-year Strategic Action Plan for arsenic mitigation was developed in 2006 by the Government and is expected to be officially endorsed by the MRD and the MoH in 2009. The plan provides a clear vision for the future and outlines strategies, objectives and activities so that all stakeholders can strategically work towards a successful outcome. The document is well developed and provides the overall arsenic mitigation programme with a solid framework through which the proposed implementation activities can be initiated and monitored.

1. Maternal health and nutrition

1.1 Maternal mortality

Despite some notable achievements in Cambodia over the last decade, the rights of women and children to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and services, as recognized by both the CRC and CEDAW, remain far from being fulfilled in Cambodia. It has been emphasized in many studies and reports that the maternal mortality ratio, at 461 per 100,000 live births reported\(^{168}\) and 540 per 100,000 live births adjusted\(^{169}\), remains among the highest in the Southeast Asian region. Moreover, since 2000, there has been no recorded reduction in maternal deaths.

![Figure 2: Maternal mortality in Southeast Asia](https://example.com/mortalitychart.png)

Source: The State of the World’s Children 2009, Unicef

\(^{168}\) General Population Census 2008.
The main reasons for the high and stagnant maternal mortalities are inadequate availability and accessibility of essential evidence-based and cost-effective interventions, namely, skilled attendance at birth, emergency obstetric care, family planning, birth preparedness and early referral to an appropriate health facility with a supportive and professional environment, as well as timely provision of postpartum care.


Figure 3: Causes of maternal deaths in Cambodia

![Pie chart showing causes of maternal deaths in Cambodia]

Source: Maternal and Child Health Study 2006, JICA

In 2005, Cambodia failed to meet its target for maternal mortality (MDG 5), set at 343 maternal deaths/100,000 live births. It is also not on track to meet its 2010 target, set at 243 deaths/100,000 live births. The main medical causes of maternal deaths include haemorrhage, eclampsia (high blood pressure associated with pregnancy), obstructed labour and sepsis (generalized infection), most of which can be prevented or treated.

According to the CDHS 2005, only 22 per cent of births in Cambodia take place in a health facility, an increase from 10 per cent in 2000. Children who are born in urban areas (50 per cent) are more likely to be delivered in a health facility compared with children who are born in rural areas (17 per cent). Figures also show that only 44 per cent of deliveries in Cambodia take place with a trained attendant present, whereas 55 per cent of women give birth with a traditional birth attendant. Women in urban areas are more likely to be assisted by a trained health professional than women who live in rural areas: 70 per cent compared to only 39 per cent respectively. This figure is highest in Phnom Penh at 86 per cent and lowest in Preah Vihear/Steung Treng at 13 per cent.

A large percentage of maternal and neonatal deaths take place during the first 48 hours after childbirth. Post-natal care is not available to many women in Cambodia. Data shows that urban women are more likely to receive postnatal care than rural women during the first two days after childbirth (74 per cent and 62 per cent, respectively). Similarly, educated women with secondary and higher education are more likely to receive post-natal care than women with only primary education or no schooling.

One of the major causes of maternal death in Cambodia is post-partum haemorrhage, a condition that can be prevented to a large extent through active management of the third stage of labour. However, this is not universally applied due to the high number of home-based deliveries and the limited knowledge and skills of midwives, coupled with a shortage of drugs (i.e. Oxytocin). Another shortcoming is the scope and timing of post-partum care not being clearly defined and comprehensive care not being provided to most mothers and their newborns.

Another important challenge to reducing maternal mortality is the widespread practice of delivering at home with traditional birth attendants. Unfortunately, the role of traditional birth attendants and their...
cooperation with the health sector has not been clearly defined and it contributes to the poor referral rate from communities to health facilities. More importantly, there is evidence that the practices of traditional birth attendants pose serious risks to mothers and newborns, including tetanus infection. The causes of infection are mainly poor hygiene, due to the lack of hand washing, and traditional cord care. This is the practice of cutting the cord with a bamboo stick on charcoal, the use of unclean ties for cord legation and putting various substances on the cord (ash, wasp nets, pepper).\textsuperscript{175} Another traditional practice that prevents women from accessing health centres is known as ‘\textit{ang pleun}’ or so-called ‘mother roasting’ after delivery. This very common post-partum practice is based on a Khmer belief in the need to balance the body between hot and cold after a traumatic experience such as giving birth. Women are required to lie down on a bed that is essentially a mat placed over coals for a period of three to seven days. During this period, mothers and their newborn babies are not allowed to leave their bed and are therefore not able to access health services or receive post-partum care at a facility as normally required. It has been noted that this practice focuses on keeping the mother warm by dressing her in many layers of clothing, and that there is less attention to the thermal control of the newborn, which is essential during the post-partum period.\textsuperscript{176}

Anecdotal evidence suggests that health staff are recommending replacing the roasting practice with ‘hot injections’ of calcium, vitamin C, vitamin complex and antibiotics.\textsuperscript{177} Many midwives in particular, especially those in private practice, give injections to women during the post-partum period that have no medical indication. However, it may be an effort to provide a more modern response that meets a cultural need and women’s expectations in order to eliminate a harmful traditional practice. Nevertheless, the injections of ampicilline, or other antibiotics, vitamins, glucose, calcium, etc. are not necessary and may be harmful to the mother. It should be noted that Article 24 (paragraph 3) of the CRC requires ratifying States to “take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.”

Concluding Comments of the Committee on the Elimination of Discrimination against Women

In response to the first, second and third periodic reports on the implementation of CEDAW submitted by Cambodia, the CEDAW Committee issued a number of comments and recommendations on 25 January 2006. With regard to maternal mortality, it expressed concern at the high rate that had been attributed to a lack of access to obstetric emergency services. It also expressed concern that only 10 per cent of births were taking place in a health facility. The Committee therefore recommended that the obstacles to accessing obstetric services be monitored and removed and that: (a) a strategic plan to reduce maternal mortality and morbidity be established through which quality prenatal, post-natal and emergency obstetric services are progressively distributed in all provinces; (b) a proactive referral service be established to facilitate access to obstetric services; (c) benchmarks be set for the reduction of maternal mortality; and (d) the necessary funding be specifically mobilized from all sources.

\textsuperscript{175} Briefing Note Maternal and Neonatal Health in Cambodia and UNICEF Support, op cit.  
\textsuperscript{176} Ibid.  
\textsuperscript{177} Ibid.
1.2 Antenatal care

Antenatal care visits are essential for ensuring a mother’s health and a newborn’s survival. Antenatal care provides an opportunity to immunize pregnant women against tetanus toxoid, to ensure they receive iron folic acid supplementation and micronutrient supplements, and to counsel them on maternal and infant care. Since 2000, antenatal care by a health professional in Cambodia has increased from 38 per cent to 69 per cent. WHO recommends that at least four visits are necessary to ensure effective interventions are taking place. Coverage of four visits in Cambodia is much lower and not recorded on a routine basis. Antenatal care is more common in urban areas (at 79 per cent) than in rural areas (at 68 per cent). The vast majority of women (90 per cent) with secondary and higher education receive antenatal care compared to 50 per cent of women without any education. Although coverage of at least one visit has improved in Cambodia, antenatal care services are of limited quality and do not always integrate maternal and newborn services adequately. The quality of antenatal care is assessed according to the type of provider, the number of antenatal visits, the stage of pregnancy during the first and last visits, and the services and information provided at the time of the visits. Data further indicate that of those women that do receive antenatal care, it begins at a relatively late stage of pregnancy. The CDHS 2005 found that 54 per cent of mothers were receiving two or more tetanus toxoid injections, in order to prevent deaths from neonatal tetanus that frequently results from failure to use sterile procedures when cutting the umbilical cord after delivery. This represented a marked increase from the mere 30 per cent found in 2000. There are some limitations to the way antenatal care services are currently performed: urine testing for protein is seldom done; there is no measurement of hemoglobin; and HIV and syphilis screening is unavailable at most health centres.

According to CDHS 2005, only 60 per cent of women who received antenatal care reported having been informed of the signs of pregnancy complications. Only two-thirds of women that had given birth in the five-year period before the survey were immunized for neonatal tetanus. Presently, interventions such as PMTCT for HIV are not included as part of antenatal and post-natal care. There is also a need to increase effectiveness in identifying and referring complications during antenatal care visits.

Significant inequalities exist in Cambodia in terms of access to essential maternal health interventions. As shown in figure 3, the coverage of maternal health interventions differs significantly according to the socio-economic status of the population group. Important disparities are evident in the reception of certain essential interventions between the poorest families in rural areas and remote provinces (where mothers have either a low level of education or no schooling) and families categorized as average and richest. In this context, there is a need to remove financial barriers to health services for the poor and to strengthen the implementation of strategies leading to increased utilization of essential maternal health services.

1.3 Reproductive health and family planning

In 2000, international sources estimated Cambodia’s fertility rate was at a high of five (that is, an average of five children born to a woman over her lifetime). Since then, there

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178 Ibid. p. xxiii.
179 Ibid., p. 139.
180 Ibid., p.4.
181 Ibid, p.4.
182 Information provided by UNICEF Cambodia, 2008.
has been a decline in fertility in both rural and urban areas, in all provinces, at all levels of education, and for all wealth quintiles. In 2005, the fertility indicators were recorded as follows:

- Total fertility rate was 3.1\textsuperscript{183}.
- The total fertility rate in urban areas was 2.1 per woman and higher, at 3.3, in rural areas.
- The fertility rate varies across provinces, from a lower rate of 2.5 in Phnom Penh to a higher rate of 5.2 in Mondulkiri/Ratanakiri.\textsuperscript{184}
- Women with no schooling tend to have more children, at a rate of 4.3.
- Women with secondary and higher education have a total fertility rate of 2.6.
- Women of the poorest quintile have more children (at a rate of 4.9) than women of the wealthiest quintile (2.4).\textsuperscript{185}

The CDHS shows that, according to age-specific fertility rates, there is evidence of a substantial decline in fertility at all ages between 2000 and 2005. Women in age groups 25 to 29, 30 to 34 and 35 to 39 show the largest decline in fertility. Fertility has also declined in all provinces, including Mondulkiri/Ratanakiri, from a previous rate of 6.3 to 5.2, which means it has fallen by one child per woman. Some of the underlying causes of high fertility rates that persist in some areas include high child mortality rates, cultural beliefs, women’s low level of education and limited employment opportunities, as well as a lack of essential health services and counseling.\textsuperscript{186}

Family planning, including the prevention of unwanted pregnancies is key to improving women’s health and nutrition and to reducing maternal mortality in Cambodia. Most women are familiar with at least some methods of contraception. According to the CDHS, 40 per cent of women are using either modern or traditional forms of birth control, and the use of modern methods has increased from 19 per cent to 27 per cent since 2000. The same study also shows that an estimated 40 per cent of the total need for family planning is being met and about one third of married women reported one or more unplanned pregnancies.

Cambodia has a number of policies and strategies related to reproductive health such as the safe motherhood policy and action plan, a birth spacing policy and a law that has made abortion legal since 1997. According to the law, abortions may be carried out only by medical doctors, medical practitioners or midwives authorized by the MoH. They may only be performed in a hospital, health centre, health clinic or maternity ward. Abortions can only be performed before the twelfth week of pregnancy, although there are specific conditions that permit later abortions.\textsuperscript{187} There are indications that unsafe abortions contribute to the high mortality rate but there is limited data available on the number of abortions performed and morbidity and mortality related to abortions.\textsuperscript{188}

\textsuperscript{183} Census 2008.
\textsuperscript{184} Ibid, p. 63. This is CDHS 2005.
\textsuperscript{185} Ibid.
\textsuperscript{186} Cambodia Halving Poverty by 2015?, op. cit., p.116.
\textsuperscript{187} CDHS 2005, op. cit., p.73.
\textsuperscript{188} UNFPA, 2005, Cambodia at a Glance, Population, Gender and Reproductive Health, p. 20.
Although it is believed that abortion statistics underestimate its actual level of occurrence, there are some revealing figures available. For example, 8 per cent of women aged between 15 and 49 reported having had one or more abortions during their lifetime. Urban women were found more likely to have an abortion than rural women, at 11 per cent and 7 per cent, respectively. This figure varies across provinces, with as many as 16 per cent of women in Kampong Cham reporting having had an abortion, compared with only 2 per cent and 3 per cent in Mondulkiri and Ratanakiri, respectively. It was further found that women with three or four living children were more likely to have had an abortion than other women.

1.4 Maternal under-nutrition and micronutrient deficiencies

Good quality nutrition directly affects the health of mothers and their children, particularly during pregnancy and the breastfeeding period. Cambodia Ad-hoc Anthropometrics Survey (CAS) 2008 found that 6.3 per cent of mothers are short. Nearly 10 per cent of mothers aged 15 to 19 years are short. Fortunately, teenage pregnancy does not appear to be common nationally; only 2.4 per cent of the sample is in this age group. The percentage of short mothers in the most remote provinces—Mondulkiri and Ratanakiri—is nearly three times higher (16.1 per cent) than the national average. Preah Vihear and Stung Treng also have an elevated percentage of short mothers (11.4 per cent). As measured by body mass index, 16.1 per cent of mothers are thin, with 3.7 per cent either moderately or severely thin. The percentage of thin mothers has decreased by three percentage points from 2005. The youngest mothers are more likely to be thin (21.3 per cent) and there is a higher percentage of thin mothers in rural areas (17.1 per cent) when compared to urban areas (11.4 per cent). The same survey reports 5.1 per cent of mothers with night blindness, down from 8 per cent in 2005.

Positive trends in stunting and maternal night blindness between 2005 and 2008 suggest a possible improvement in the
long-term nutritional status of mothers. Both of these indicators do not measure short-term change. If real, the main cause for the improvement in stunting is probably decreased stunting during childhood. Vitamin A supplementation and improved fertility practices may have contributed to decreased deficiency. Body mass index is the only indicator of the nutritional status of mothers included in this survey that can be indicative of short-term change. The improvement seen from 2005 to 2008 is likely the result of decreased parity, having fewer children. This was not measured by CAS 2008, but the CDHS 2005 did report a downward trend in the number of children per mother.

The prevalence of anaemia among women between the ages of 15 and 49 is an important health problem in Cambodia, with 47 per cent proving anaemic and 35 per cent proving mildly anaemic. The CDHS 2005 found higher prevalence of anaemia among women who have had many pregnancies or deliveries, those with no or low levels of education, those who are pregnant and those living in poorer households. The lowest prevalence of anaemia (29 per cent) was found among women living in the capital.\textsuperscript{190} The National Nutrition Strategy 2009-2015 recognizes that the poor nutritional status of Cambodian women and children is reflected in the high maternal and under-five mortality rates.

Women and children greatly benefit from having an adequate intake of micronutrients, including vitamin A and iron folate during pregnancy and post-partum. The CAS 2008 shows that 39.5 per cent of women took 90 or more iron folate tablets during their last pregnancy and 31.4 per cent received deworming medication; 43.7 per cent of mothers received vitamin A supplementation within six weeks of giving birth and 33.2 per cent received post-partum iron folate supplementation. Compared to the CDHS 2005, there is improvement in all maternal health services. Adequate iron folate supplementation (+90) has increased by nearly 22 percentage points, deworming by 21 percentage points, vitamin A supplementation by 16 percentage points,

\textbf{Figure 5: Prevalence of anaemia in pregnant women age 15-49, 2000 and 2005}

<table>
<thead>
<tr>
<th>Anaemia</th>
<th>2000</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe anaemia</td>
<td>6.4</td>
<td>4.3</td>
</tr>
<tr>
<td>Moderate anaemia</td>
<td>35.2</td>
<td>30.1</td>
</tr>
<tr>
<td>Mild anaemia</td>
<td>26.9</td>
<td>23.6</td>
</tr>
<tr>
<td>Anaemia</td>
<td>57.1</td>
<td>3.4</td>
</tr>
</tbody>
</table>

Source: CDHS 2000 and CDHS 2005

190 Ibid., p.187
and post-partum iron folate supplementation by 22 percentage points. These impressive improvements in the coverage of maternal health services can be attributed to government and NGO programmes to increase antenatal and post-natal care.

In order to maintain these positive trends and to achieve further improvements in maternal health care, it is necessary to strengthen the health care system by addressing the following challenges:

- Strengthening human resources planning and development, particularly of the midwifery network.
- Removing financial barriers to essential health services, and in particular to Emergency Obstetrics and Neonatal Care, for the most vulnerable, including the poor.
- Strengthening programmes that stimulate demand for antenatal, delivery and post-natal care and scaling-up community-based service delivery mechanisms in order to increase coverage of key maternal health interventions.
- Increasing community involvement and cooperation with traditional birth attendants in order to reduce the first and the second delays in seeking and accessing health care.

2. Young child health and nutrition

2.1 Child survival

According to the CDHS 2005, between 2000 to 2005 there was a significant decline in child mortality: from 95 infant deaths and 124 under-five deaths for every 1,000 live births to 66 infant deaths, (and this further reduced to 60 in 2008), and 83 under-five deaths for every 1,000 live births. While this constitutes a decrease of over 30 per cent, nevertheless, one in every 12 Cambodian children dies before reaching their fifth birthday and four-fifths of these deaths take place during a child’s first year.

These figures vary throughout the country, with higher infant and child mortality rates in rural than in urban areas (an estimated 92 and 65 deaths per 1,000 live births, respectively). The disparities between urban and rural are notably higher with regard to child mortality rates. For example, in Mondulkiri/Ratanakiri and Phnom Penh, under-five mortality was estimated at 165, and 52, respectively. A number of factors are strongly related to childhood deaths, including the wealth and educational levels of mothers, the sex of the child, the mother’s age at birth, birth order and birth spacing.

The socio-economic status of mothers is an important factor that influences infant and child mortality in Cambodia. Children born to mothers in the poorest quintile are three times more likely to die than those whose mothers are in the wealthiest quintile. Children born to mothers without any education show the highest mortality, and these rates drop considerably as the level of the mother’s education increases. According to the Cambodia Child Survival Strategy 2006-2015, there are clear disparities with regard to child survival, with under-five mortality almost three times as high in the poorest than the richest socio-economic groups (127 versus 43 per 1,000 live births). Infant mortality in the poorest quintile is 101 per 1,000 live births compared to 34 per 1,000 live births in the richest group.

Childhood mortality is also higher among male children than female children and is
more pronounced in the first month of life, with a neonatal mortality for boys of 42 per 1,000 live births compared to 30 per 1,000 live births among girls. The CDHS notes that higher mortality among males is recorded throughout the world and believed to be due to “a higher biological risk of death during the first months of life”.

A number of risk factors raise the probability of child mortality. Birth spacing is important, as children born fewer than two years apart are more at risk of infant and childhood death than a sibling born after a longer birth interval. In 2000, 21 per cent of second or subsequent births occurred less than 24 months after the preceding birth and 7 per cent less than 18 months after the preceding birth. Some improvement was seen in 2005 data, with 18 per cent of such births occurring less than 24 months after the preceding birth, and 52 per cent of women giving birth at least 36 months after the previous birth.

Birth weight is yet another important determining factor for child survival as babies weighing less than 2.5 kilograms are at higher risk of death. According to CDHS 2005, birth weight is not always known for many babies in Cambodia, but there was an increase in the number of babies weighed at birth, from only 17 per cent in 2000 to 40 per cent in 2005. The percentage of children born with low birth weight varies across provinces.

CDHS 2005 also assessed the causes of death among infants and young children reported by mothers and health workers. Most causes were reported as: baby was premature, premature birth, birth complications, infections, pneumonia, diarrhea, meningitis, tetanus, HIV, congenital diseases, accidents and violence, and other causes. Further analysis is needed to identify specific factors and interventions to reduce child mortality.

197 Ibid., p.67.
198 Ibid., p.151.
fever, illness of the respiratory system, dengue haemorrhagic fever, accidents and tetanus-type convulsions. It also found that 25 per cent of neonatal deaths were among low birthweight infants, and 25 per cent were reported by the mother as caused by difficulties encountered during childbirth. There was also evidence of neonatal tetanus being a cause of death in about 7 per cent of the cases.

2.2 Neonatal deaths

According to UNICEF, every year approximately 10,000 newborns die in Cambodia and neonatal deaths constitute 42 per cent of infant and 34 per cent of under-five mortality. While clear downward trends in infant and under-five mortality have been seen over the past five years, the reduction of neonatal mortality is by comparison much slower. Whereas post-neonatal and under-five mortality decreased by 36 per cent and 33 per cent respectively, neonatal mortality only declined by 24 per cent from 36 to 28 per 1,000 live births. As in many countries around the world, most neonatal deaths in Cambodia are directly due to immediate medical causes, namely infections, asphyxia and prematurity.

Although Cambodia is on track to meet its target for infant and under-five mortality, this will depend to a large extent on achieving further reductions in neonatal deaths. Available data indicates that many aspects considered “essential for newborn care” are excluded from national policies and guidelines and training programmes for health workers and volunteers with the exception of breastfeeding and immunization. They are also not included in the Minimum Package of Activities as part of the basic health care services. Essential newborn care includes: immediate drying and warming of the baby; skin-to-skin care; cleanliness during childbirth; hygienic cord, eye and skin care; early, exclusive breastfeeding within one hour after birth; extra care of preterm and low birthweight babies; recognition of newborn

Maternal and neonatal health in Cambodia

“The decline in child mortality in Cambodia largely reflects success in decreasing deaths after the neonatal period caused by pneumonia, diarrhoea and vaccine-preventable conditions. It also reveals that programmatic focus has been on the post-neonatal period. Globally, and Cambodia is not an exception, the newborn has ‘fallen through the cracks’ of both safe motherhood and child health programmes. Part of the reason for this ‘gap’ lies in the notion that the sick newborn, being very vulnerable, needs access to expensive tertiary care, which is out of reach to the majority of people in the developing world. It is known however, that simple, effective, low-cost interventions, such as immediate drying, warming, early breastfeeding, extra care for low birth weight babies and early identification and treatment of newborn sepsis, can substantially reduce mortality and morbidity (The Lancet Newborn Survival Series 2005). The majority of these simple interventions can be provided in first referral facilities (health centres) and at home. Unfortunately, many of these interventions are either not available or accessible to Cambodian families.”

Source: UNICEF Cambodia - Briefing note on maternal and neonatal health in Cambodia and UNICEF support, September 2007

199 Ibid., p.132.
200 Ibid., p.134.
danger signs and immediate referral/care-seeking.\textsuperscript{201}

The most critical intervention for child survival and safe motherhood is to ensure that a skilled birth attendant is present at every delivery. Thus, the absence of a skilled attendant (a doctor, nurse, midwife or auxiliary midwife) is a major constraint at the time of delivery and during post-natal care, both of which are critical interventions for infants’ and mothers’ survival. In most cases, this means that transport must be available to reach a health care facility for obstetric care, particularly in case of an emergency. An important factor that contributes to neonatal death is limited availability and accessibility to emergency health care.

\subsection*{2.3 Childhood illnesses}

According to the Cambodia Child Survival Strategy 2006-2015, child health has improved considerably in Cambodia, which was declared polio free in 2000, with the decline of the prevalence of measles being another factor. In 2000, when surveillance of measles began, there were 12,327 reported cases. Since then, reported cases have declined dramatically to 653 in 2003 and 267 in 2005. In addition, the case fatality rates for malaria and dengue fever have fallen and HIV prevalence is declining in the general population. Currently, most Cambodian children are dying from a few preventable and treatable conditions (see figure 8), which include neonatal causes (30 per cent); acute respiratory infections (pneumonia 21 per cent); diarrhoeal diseases (17 per cent); AIDS-related illnesses (2 per cent); measles (2 per cent); injuries (2 per cent); and malaria (1 per cent).

\begin{itemize}
\item Acute respiratory infections: In many countries, acute respiratory infection (ARI) is a leading cause of childhood morbidity and mortality. A large percentage of deaths caused by ARI could be prevented through early diagnosis and treatment with antibiotics. According to CDHS 2005, in Cambodia the prevalence of ARI decreases with age among children. Thus, there were higher proportions of ARI symptoms among children aged 6 to 11 months and 12 to 23 months (11 per cent) than other age groups. The symptoms of ARI include being ill with a cough along with short, rapid breathing.\textsuperscript{202}
\item The economic status of the household also plays a role in determining the proportion of children with ARI symptoms, from a high of 12 per cent among children living in the poorest families to only 3 per cent among children belonging to wealthier households. Significant provincial differences in the prevalence of ARI symptoms were also found, ranging from only 2 per cent in Phnom Penh, Kampot and Kep to 26 per cent in Oddar Meanchey. The educational level of mothers was another determining factor, with children of mothers with secondary or higher-level education being more likely
\end{itemize}

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{figure7.png}
\caption{Causes of mortality among Cambodian children}
\end{figure}

\textsuperscript{201} UNICEF and Save the Children, 2006, Strategic Guidance Note on Newborn.

\textsuperscript{202} CDHS 2005, op cit., p.155.
to receive treatment for ARI symptoms than those belonging to mothers with no education or only primary education.\textsuperscript{203}

**Diarrhoea:** Severe diarrhoea that leads to dehydration is another major cause of morbidity and mortality among young children. In Cambodia, its occurrence varies according to the age of the child, with younger children aged 6 to 23 months being more likely to suffer from diarrhoea than older children. There is also a slight difference between urban and rural children (16 per cent and 20 per cent, respectively), and some variations were also found across provinces. Although the condition can be treated with oral rehydration therapy (ORT), this practice varies according to certain background characteristics that are similar to the ones for ARI. CDHS 2005 found that 37 per cent of children with diarrhoea were taken to a health provider for treatment, which is an increase from 22 per cent in 2000. An estimated 44 per cent of children belonging to mothers with some secondary schooling or higher education were taken to a health provider, compared to 35 per cent of children with mothers without any schooling. Moreover, 58 per cent of the children suffering from diarrhoea received some type of ORT.\textsuperscript{204}

According to CDHS 2005, 91 per cent of women surveyed who had given birth in the preceding five years had knowledge of ORT, including the use of oral rehydration salts (ORS). This was a major increase compared to 2000, when only 50 per cent were aware of ORS packets.\textsuperscript{205} Again, the educational level of the mother contributed to the knowledge of the benefits of ORS, with mothers with no education less likely to know about ORS packets than those with primary or secondary or higher education (85 per cent, 92 per cent, and 98 per cent, respectively).\textsuperscript{206}

**Malaria:** In Cambodia, malaria remains a serious public health problem with over 60,000 cases recorded in 2005. Malaria is less prominent among children under five than ARI and diarrhoea, but it remains the third leading cause of outpatient visits and the fourth leading cause of inpatient visits for this age group.\textsuperscript{207} Some areas of the country are virtually malaria-free, ‘low-risk’ zones, and others are malaria-endemic, ‘high-risk’ zones. The use of insecticide-treated nets (ITNs) to prevent malaria infection is a major element of the malaria prevention strategy and widely promoted, with long-lasting insecticide treated nets (LLINs) being distributed in remote rural areas free of charge and in urban areas through social marketing. Consequently, coverage of mosquito nets is high and nationwide: 96 per cent of households possess a minimum of one net and two thirds own more than one.\textsuperscript{208} Young children under five and pregnant women are especially vulnerable to malaria. The CDHS found that 88 per cent of children surveyed slept under a net, with little variation existing between males and females.

### 2.4 Immunization

Child immunization is one of the most cost-effective interventions in decreasing child mortality and it plays a key role in efforts to reach the MDG goal of reducing under-five child mortality by two thirds by 2015. A ‘World Fit For Children’ goal is to ensure a full immunization rate for children under one year of age of 90 per cent nationally, with at least 80 per cent coverage in every district or equivalent administrative unit. According

\textsuperscript{203} Ibid., p.157.
\textsuperscript{204} Ibid. p.159.
\textsuperscript{205} Ibid. p.163.
\textsuperscript{206} Ibid.
\textsuperscript{207} Ibid. p.195.
\textsuperscript{208} Ibid. p.191.
to WHO guidelines, a child is considered fully vaccinated after having received a vaccination against tuberculosis (BCG), three doses of each of the DPT (diphtheria, pertussis and tetanus) polio vaccines and a measles vaccination by the age of 12 months.\textsuperscript{209}

CDHS 2005 shows some improvement in immunization coverage, with 60 per cent of children aged 12 to 23 months fully vaccinated by 12 months of age. Previously, the 2004 Cambodian Socio-economic Survey (CSES) had reported full immunization coverage of 40 per cent among the same age group by the age of one.\textsuperscript{210} By 2005, however, 91 per cent of this age group had received the BCG vaccination and 70 per cent had been vaccinated against measles. Ninety per cent of children had also received the first doses of DPT and polio, and three quarters had received the third dose. There were no significant differences between the coverage of males and females or between rural and urban areas. However, there were major disparities in coverage noted among provinces with the lowest percentage of children fully vaccinated, such as Mondulkiri/Ratanakiri (35 per cent), Kampot/Kep (41 per cent), and Siem Reap (43 per cent). The provinces with the highest vaccine coverage were Battambang/Pailin and Phnom Penh at 81 per cent, and Kampong Speu at 82 per cent.\textsuperscript{211} The coastal regions, which have a low status of health service usage, apparently have less immunization coverage.\textsuperscript{212}

The educational level of mothers is a major determinant as to whether children are fully vaccinated, with children of mothers with secondary or higher education being more likely to be fully vaccinated (83 per cent). Although overall disparities have decreased for immunization over the past five years, some still exist due to socio-economic factors such as family wealth. Coverage among

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{vaccination_trends.png}
\caption{Trends in vaccination by 12 months of age among children 12-23 months}
\end{figure}

\textbf{Figure 8. Trends in vaccination by 12 months of age among children 12-23 months}

Note: ‘All’ includes BCG, measles, and three doses each of DPT and polio vaccine (excludes polio vaccine given at birth)

Source: CDHS 2005

\begin{itemize}
\item \textsuperscript{209} Ibid. p.153.
\item \textsuperscript{210} Cambodia Halving Poverty by 2015?, op cit., p.117.
\item \textsuperscript{211} CDHS 2005, op cit., p.154.
\item \textsuperscript{212} Cambodia Halving Poverty by 2015?, op cit., p.118.
\end{itemize}
children belonging to wealthier households was 76 per cent, compared to 56 per cent of those from the poorest households. According to CDHS 2005, only 70 per cent of children aged under one year from the poorest population were covered by measles immunization, compared with 82 per cent of the wealthier population.

In sum, despite progress, immunization coverage remains low, particularly since some of the vaccination coverage is only partial. MoH reports that 85 per cent of children under one year of age had received DPT3 vaccine in 2004, compared to 64 per cent in 2002. While this is encouraging to note, those children belonging to the poorest households are still twice as likely to never receive vaccination.213

2.5 Child nutrition

A critical element for a child’s health and development, particularly during the first two years of life, is adequate nutrition. This includes early initiation of breastfeeding and exclusive breastfeeding during the first six months, continued breastfeeding for two years, timely introduction of complementary feeding beginning at six months, the frequency of feeding solid and semi-solid foods, as well as the consumption of diverse food groups from 6 to 23 months. Cambodia continues to record a very high rate of malnutrition, which is among the highest in Southeast Asia. In 2005, Cambodian children showed evidence of chronic under-nutrition with 36 per cent underweight (39.5 per cent by the new WHO growth standards), and 37 per cent stunted (43.7 per cent by the new WHO growth standards). At the same time, there was a decrease in wasting at 7 per cent compared to 15 per cent in 2000 and 13 per cent in 1996.214

In Cambodia, anaemia is regarded as a critical public health issue with about 62 per cent of children aged 6 to 59 months found to be anaemic, 29 per cent mildly anaemic, 32 per cent moderately anaemic, while 1 per cent are considered severely anaemic. Children between 9 and 11 months have the highest incidence. Again, the wealth of the household and the education level of mothers are factors that determine the incidence of anaemia.

The unprecedented rise in food commodity prices during 2007 and 2008 is likely to adversely affect the nutritional status of many children in Cambodia, especially among the urban poor and low-income families. There is concern that poor Cambodian children are at a higher risk of being deprived of more nourishing foods, especially in terms of vitamins and minerals.

2.6 Breastfeeding and complementary feeding

Breastfeeding is almost universal in Cambodia, with 97 per cent of children having been breastfed for a period of time, although this varies from a low 92 per cent in Phnom Penh to a higher 98 per cent in Kampong Thom, Pursat and Svay Rieng.215 Early breastfeeding is common, with 35 per cent of children breastfed within one hour of birth and 68 per cent within one day of delivery. Giving newborns prelacteal feed (something other than breast milk) during the first three days after birth is common practice. It is reported that as many as 56 per cent of children have received liquids including plain water, sugar or glucose water, infant formula, milk other than breast milk, sugar and salt water, fruit juice and tea during the first three days. However, very

213 Ibid.
few children are given infant formula or any other kinds of milk (6 per cent and 3 per cent, respectively).\textsuperscript{216}

The rate of exclusive breastfeeding has increased dramatically from 11 per cent in 2000 to 65.9 per cent in 2008\textsuperscript{217}. Exclusive breastfeeding decreases rapidly from birth until an infant is six to seven months, but more than 50 per cent of children continue to be breastfed until two years of age. Children in rural areas are breastfed for a slightly longer period than urban children. Mothers with higher education and from wealthier households breastfeed their children for less time than those with little or no education.\textsuperscript{218}

According to WHO and UNICEF, solid foods for infants should be introduced when the child is about six months old, when exclusive breastfeeding is not sufficient for a child’s optimal growth and development. In Cambodia, 80 per cent of children begin to eat complementary foods at six months. Data indicates that at least 5 per cent of infants aged two to three months are already being fed food made from grains and 3 per cent are eating food made from meat, fish, poultry and eggs. The consumption of food made from grains is highest among children aged 6 to 23 months (between 92 per cent and 97 per cent) whether or not they are breastfed.

2.7 Micronutrient deficiency

There are several causes of malnutrition, ranging from food insecurity and inadequate care practices, to a lack of access to essential health services.\textsuperscript{219} One major cause of malnutrition in children under five is the low intake of energy and nutrient-rich complementary food.\textsuperscript{220} A common cause of anaemia among children is an insufficient intake of iron, folate, vitamin B12 or other nutrients. Micronutrient deficiency is a serious contributor to childhood morbidity and mortality as vitamin A, iron, iodine and zinc are essential for growth, overall

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure9.png}
\caption{Trends in stunting, wasting and underweight among children under five (new WHO growth standards)}
\end{figure}

\textsuperscript{216} Ibid.
\textsuperscript{218} Ibid, p.173.
\textsuperscript{219} Cambodia Halving Poverty by 2015?, op cit., p.115.
health and development. A healthy diet normally provides children with the micronutrients that are needed, but in many cases they can receive them from food fortification and direct supplementation. Vitamin A deficiency is related to the lack of vitamin-rich food, poor breastfeeding practices and the high prevalence of childhood diseases such as ARI, diarrhoea and measles. According to the National Nutrition Strategy for 2008-2015, the national prevalence of vitamin A deficiency among children is unknown. Nevertheless, the strategy concludes that vitamin A deficiency can be assumed to be a public health problem in Cambodia given that infant and under-five mortality rates are high.

In Cambodia, significantly higher malnutrition rates are reported among the poor. However, children of wealthier households are also found to suffer from malnutrition. According to the CDHS, no gender differences were found in children’s consumption of foods rich in vitamin A, but urban children were nearly twice as likely to be fed foods rich in vitamin A than rural children, and there were variations in consumption across some provinces. The same survey reported that as many as 84 per cent of children consume iron-rich foods and that only 1 in 3 children aged 6 to 59 months received vitamin A supplementation during the six months prior to the survey. It further pointed out that the differences in consumption of vitamin A supplements were found to be only mildly influenced by gender, location of residence, mother’s age and economic status.

In all areas concerning the importance of adequate nutrition, indicators showed a link with mothers’ education level. One of the reasons that malnutrition is not always reported in Cambodia may be the lack of information and knowledge of the impact of malnutrition on children. Educating Cambodian women is likely to be a critical factor in the reduction of malnutrition.

### 2.8 Iodine deficiency and iodized salt

According to the National Nutrition Strategy 2008-2015, current estimates for the prevalence of iodine deficiency are not available. Iodine is an important micronutrient and its deficiency in a young child’s diet is related to a number of health risks. The most effective way to ensure iodine consumption is through universal salt iodization. CDHS 2000 and CAS 2008 indicate that the consumption of iodized salt increased significantly from 12.2 per cent to 71.5 per cent. This was achieved primarily through the adoption of Sub-Decree No. 69 on The Management and Exploitation of Iodized Salt, signed by the Prime Minister on 20 October 2003, which provided the Government with the legal mandate to bind salt producers to ensure that all salt is iodized. Another important development was the formation of the Community of Salt Producers of Kampot and Kep (CSPKK) in June 2004, which organized small-scale salt producers. Consequently, technical assistance was provided to the salt industry.

A UNICEF study conducted in 2004 concluded that salt is now available in essentially every market or retail location in Cambodia, and the number of markets selling non-iodized salt is decreasing rapidly; and that all salt labeled as iodized is in fact iodized, indicating that salt producers (in particular

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221 Cambodia Halving Poverty by 2015, op cit., p.114.
223 Cambodia Halving Poverty by 2015 op cit., p.114.
the CSPKK) are obeying the law. As a result, iodine deficiency disorders are now not as common in Cambodia, although they have not totally disappeared. In the 2008 CAS, the percentage of households that consume iodized salt varied between provinces. For example, consumption of iodized salt was low in Svay Rieng, Kampot/Kep and Prey Veng (22.5 per cent, 46.8 per cent, and 65.4 per cent, respectively227). Thus, it is believed that iodine deficiency disorders are likely to occur in these provinces and that they also exist to some extent in provinces with higher coverage.228 The 2008 CAS indicates that while 71.5 per cent of households were using iodized salt, consumption was more widespread among urban than rural households (86.2 per cent and 68.6 per cent, respectively).229

3. Child injuries

Child injuries are a leading cause of death and disability in children in many countries, including Cambodia. Specifically, drowning has been recognized as the leading cause of death among children aged between 1 and 17 years. This is followed by road traffic accidents, which are the second largest cause of child injury-related death, and the largest cause of child injury morbidity. According to the 2007 community-based survey on child mortality and morbidity, the largest ever conducted in Cambodia, about 4,000 children died from all causes of injury during the year preceding the survey.230 Other causes of child morbidity and mortality from injury included electrocution, suicide, medical accidents, landmines/UXO, injuries from animals, burns, falls, suffocation, poison, cuts and sharp objects, violence, falling objects and blunt objects (see figure 11). Most animal bites were caused by dogs and affected all age groups. Overall, in the 12 months preceding the survey, it was estimated that about 250,000 children had received a medically significant injury (child injury morbidity is about 60 times more frequent than mortality).231

For most families, injuries mean high economic and social costs, particularly given the need for hospitalization and medicines, and they can often result in permanent disability. The leading cause of permanent disability in children from an injury is road traffic accidents, and the second is falls. It was estimated that about 7,100 children, or almost 20 daily, were permanently

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231 Ibid., p.5.
disabled from injury in the 12 months prior to the survey. There are different patterns of disease and injury among children depending on their age. Children aged 15 to 17 were found to have the highest rate of permanent disability at 178.8 per 100,000.\textsuperscript{232}

The survey found that more males died from drowning than females and were killed more often in road traffic accidents and several other injury categories. Deaths from drowning were more prevalent in rural than urban areas (29.9 per 100,000 and 27.7 per 100,000, respectively). Injury deaths caused by explosives injuries, burns and falls were more common in rural areas.\textsuperscript{233}

Most child injuries occur during the day. Fall injuries were found to be the leading cause of injury morbidity among infants, followed by burns. However, road traffic accidents are the leading cause of injury morbidity among the one to four age group, followed by falls and animal injury. Boys experienced greater morbidity rates in all age groups in connection with every specific injury type.

### 3.1 Drowning – a leading cause of child deaths

Most deaths by drowning are of toddlers, with a median age for drownings of five years. The main cause of death was their inability to swim and their exposure to risk areas such as open wells, rivers and ponds. Fewer than one third of all children in Cambodia ever learn to swim and the percentage that can swim is particularly low among children aged 5 to 9 and younger, who are at highest risk of drowning. Drowning occurs in both urban and rural areas. Over half of all drowning deaths happen within an estimated 100 metres of a child’s home, when playing, washing clothes or fetching water.

In all age groups surveyed, very few children who drowned were with their mother or
father at the time, and many drownings took place when the child was alone. In most cases, the mother was either engaged in domestic chores or was busy working outside the home.\textsuperscript{234} Many mothers are overburdened with household responsibilities and are unable to properly supervise infants and toddlers that are crawling and walking, and they also may be unaware of the best ways to prevent drowning. Apart from an inability to swim, causes of drowning include lack of adequate supervision and a lack of fences and other safety measures to prevent children from falling into natural bodies of water or other water hazards.

Child drowning as the leading cause of death after infancy is not yet recognized in Cambodia. According to the same survey, the health information system had not ranked drowning as a leading cause of child death at the time of its publication. As a result, child drownings are underreported and not fully taken into account by policymakers as an important issue.

3.2 Child deaths caused by road traffic accidents

CDHS 2005 reported that the number of people being injured or killed in an accident during the 12 months prior to the survey doubled from 0.9 per cent to 1.9 per cent between 2000 and 2005. The role of traffic accidents in these injuries increased from 33 per cent to 46 per cent.\textsuperscript{235} Road traffic accidents (RTAs) are the second-leading cause of injury death and the fifth leading cause of death overall among children. Data reveal that:

- Fatal injuries caused by RTAs mainly involve children of preschool age and adolescents, with the former killed as pedestrians and the latter as a result of accidents as drivers or passengers of mainly motorbikes or bicycles.
- Nearly half of all RTA child deaths among children aged 0 to 17 occur when the child is a pedestrian. The next highest proportion of deaths is among children using a motorbike.
- More males aged 0 to 17 died from RTAs than females.
- Children from urban areas died from RTAs at a higher rate than children from rural areas.\textsuperscript{236}

Injuries and deaths caused by RTAs have been recognized as an important health issue due to the availability of data from public health facilities, private clinics and traffic police. It has been recommended that interventions should focus on increasing safety for children as pedestrians and reducing the number of motorbike accidents.\textsuperscript{237} This would entail greater enforcement capacity to address such issues as proper licensing, driver training, helmet use and alcohol use.

In urban areas, there appears to be weak enforcement of traffic laws and regulations with regard to adolescents and youths on motorbikes. The lack of enforcement of helmet use is a major issue that needs to be properly addressed, particularly among children and adolescents. One analysis has estimated the economic cost of traffic accidents in 2005 was US$110 million, or 3 per cent of GDP.\textsuperscript{238} The health system is not adequately prepared to respond to the growing number

\textsuperscript{234} Ibid., p. 28.
\textsuperscript{235} CDHS 2005, op cit., p.28.
\textsuperscript{236} Child Injury in Cambodia, op cit., p.37-38.
\textsuperscript{237} Ibid. p. 41.
\textsuperscript{238} World Bank, 2008, undated draft, Options for Developing Effective, Equitable and Sustainable Health System, Cambodia Health Note, p. 38.
of victims of traffic accidents. It takes more than two hours for 30 per cent of RTA victims to reach a hospital, particularly for those located in remote areas, and a mere 26 per cent have access to an ambulance to reach a health facility. In most cases the district hospitals are not equipped and lack the competence to respond, and victims must then travel to a referral hospital. The costs of RTAs in terms of medical care and lost earnings merits further study.

### 3.3 Injuries caused by falls and animal bites

Injuries caused by falls were found to be highest among children aged one to four, and more prevalent among males than females. Most non-fatal falls occurred in the home. For children aged 10 to 14, many falls also occurred at school. Falls in the street were common across all age groups. The lack of adult supervision was noted as one of the causes of child injuries from falls. Primary prevention of falls requires close supervision of small children and removing hazards from their home and school environments. Homes in particular are found to have many potential hazards, including stairs and roofs. A safe home checklist has been recommended as a way to reduce risks through education of parents and children alike. A safe school curriculum is another way to promote a safer environment and provide key first aid knowledge and skills.

The second leading cause of injury morbidity in Cambodia is animal injury, which affects every child age group including infants. Boys generally were found to have higher rates of animal injury. Most animal injuries in children aged under 10 take place in urban areas, with the majority ranging from moderate to severe, with a small percentage requiring at least one day of hospitalization. The sole cause of non-fatal injury in infants was dogs, most of which had not been vaccinated against rabies. Other non-fatal child injuries in urban areas were caused by oxen, cows, buffalo and snakes. In rural areas, oxen, cows, buffalo and dogs were the main cause of non-fatal infant injuries. Overall, the majority of injuries caused by animal attacks were from bites except in rural areas where many infants’ injuries were due to children being stepped on by the animal.

The recommendations for child injury prevention include the need for a national prevention programme to comprehensively address the problem. While interventions should target all age groups of children, they should also focus on specific age groups and take into account the roles and responsibilities of different actors regarding child safety in their particular environments. This would include the children themselves, parents, teachers and school authorities, and village leaders. It has been pointed out that child safety is a cross-sectoral issue and interventions need to consider health, education, public security and communication aspects to be most effective.

### 3.4 Child injuries from landmines and unexploded ordnance

After three decades of civil war, Cambodia ranks as one of the most mine/UXO-affected countries in the world in terms of the number of deaths and the land lost due to contamination. Between 1979 and 2007, 63,005 mine/UXO mine victims were reported by the Cambodian Mine/UXO Victim Information System (CMVIS). The decrease in military activities in 1998 followed by increased clearance and mine education activities contributed to fewer mine accidents, with 467 casualties recorded in 2000 and 138 in 2007. However, there
are now more Explosive Remnants of War (ERW) victims than mine victims reported, which has been attributed to the value of scrap metal, which encouraged many people to handle ERW to extract metal for sale. In 2007 alone, data shows 352 victims, a decrease from 875 in 2005. The number of UXO victims (214) remained higher than mine victims (138). Moreover, in 2007, a total of 65 people (18.47 per cent) were killed by UXO. A study to determine the extent to which mine action interventions such as clearance and law enforcement contributed to the decrease in victims concluded that while these interventions helped to reduce casualties, the sudden drop found in 2006 was caused by favourable seasonal conditions and good agricultural production on farms. Another study concurs with this view, and notes that in the months of March and April, which is the end of the dry season, there is a rise in mine/UXO accidents caused by an increase in income-generating activities such as forest product and scrap metal collection and charcoal production.

Males were the most affected population group, with 85.79 per cent of victims “handling the mine/UXO” at the time of an accident. About half of female victims of UXO were not engaged in any specific activity and were considered ‘indirect’ victims. Many victims were simply traveling, cutting wood or farming at the time of the accident.

In 2007, children under 18 constituted 39.77 per cent of all victims. Children were primarily victims of ERW accidents, which accounted for 77 per cent of the casualties.

Figure 12 shows the reduction of deaths and injuries due to ERW and mines between 1979 and 2007, from the period of conflict to immediate post-conflict, to reconstruction.

Most of the accidents took place in the northwest of the country along the Cambodian-Thai border, with the most affected provinces being Battambang, Banteay Meanchey, Oddar Meanchey,
Pailin and Preah Vihear, accounting for 91 per cent of the total number of landmine casualties in 2007. Pailin has the highest casualty rate, at 65 per 100,000 inhabitants.247

There is a need to improve the marking of mine-contaminated areas. In 2006, mine victims indicated the absence of warning signs in the vicinity of mine accidents. Other victims were aware of the presence of mine/UXO but claimed they went to the site out of economic necessity in order to sell the device to the scrap metal trade. Interestingly, as many as 86.67 per cent of victims were found to have received some mine/UXO risk education, through posters, radio and television, before their accident. Although there have been notable efforts in mine risk education, victim data collection and improvement of emergency assistance, there is still a need to develop more effective warning signs and better programme responses to reduce the number of mine/UXO accidents, particularly those involving children. Key studies have made recommendations including:248

- Strategies to involve the local authorities, the national police and community representatives actively in mine action initiatives and local law enforcement should be rationalized across affected provinces.
- Scrap metal dealers and brokers should be systematically targeted with education and yard surveillance and village-level scrap dealers should be integrated into the mine risk education process and Explosive Ordnance Disposal (EOD) reporting mechanisms.
- Mine risk education operators should continue to target high-risk and marginalized groups.

In its Concluding Observations to Cambodia in 2000, the Committee on the Rights of the Child recommended that the State increase budget allocations for demining in post-conflict areas and that awareness-raising campaigns should be conducted.249 It should be noted that Cambodia has ratified the 1997 Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction. The treaty is the most comprehensive international instrument for ridding the world of antipersonnel mines, dealing with everything from mine use, production and trade, to victim assistance, mine clearance and stockpile destruction.

It is also important to note that the CMDG 9 target of 0 landmine/UXO casualties by 2015 is on track (target of 200 in 2010).250

4. Sexual and reproductive health of adolescents and youths

Cambodia’s population is very young, with 44 per cent under the age of 18. The rapid social and economic changes taking place, greater access to local and international media and a rise in disposable income, which is reflected particularly in urban areas, are all regarded as key factors contributing to the emergence of a youth culture. This culture is further influenced by changing gender roles and exposure to greater sexual freedom. Nevertheless, when it comes to discussing sexual and reproductive health in relation to adolescents and youth, there are social and cultural barriers as well as a lack of sensitization to these issues on the part of parents, teachers and decision-makers.251

According to UNFPA, the current situation of reproductive health in Cambodia

249 Committee on the Rights of the Child, 28 June 2000, Concluding observations of the Committee on the Rights of the Child, CRC/C/15/Add.128, p11.
251 Cambodia at a Glance, op cit., p.29.