KINGDOM OF CAMBODIA
NATION RELIGION KING

HEALTH STRATEGIC PLAN 2025-2034

"Effective and Equitable Health Services, for All, through Resilient, Responsive, and Accountable Health System"

MINISTRY OF HEALTH
September 2025

FOREWORD

Cambodia has made remarkable progress and achieved significant socio-economic development over the last two decades. Sustained peace, political stability, security, and social order are the key foundations for the country's development. The Royal Government of the Seventh Legislature of the National Assembly, under the wise, long-visionary and energized leadership of **Samdech Moha Borvor Thipadei HUN MANET**, Prime Minister of the Kingdom of Cambodia, has brought new progress and achievements.

The Pentagonal Strategy has determined health as a key priority for human capital development and the expansion of health services towards universal health coverage (UHC) as a priority policy program of the Royal Government. This is considered as an opportunity for the health sector to continue strengthening its institutional capacity in delivering health services to the population, in order to contribute to achieve Cambodia Vision 2050, including the legitimate aspiration of the Cambodian people for better health and well-being.

Ensuring healthy lives and well-being for all Cambodians by 2050 will depend on the ability of the health system to prepare for and effectively respond to anticipated potential negative health impacts that may occur on the individual, family, community, and population at large. The most important factor, therefore, is to avoid substantial ill-health among the population. This potential health challenge can be managed through comprehensive planning for a strong health system performance with a focus on delivering health education and promotion, primary and secondary prevention and effectively managing acute events, alongside the enhancement of effective multi-sectoral and multi-disciplinary response to address social, economic, and environmental determinants of health. In this context, a well-functioning health system is essential throughout the journey towards achieving the objectives of Cambodia's UHC by 2035.

Reflecting the above-mentioned views, the Health Strategic Plan 2025-2034 (HSP4) was developed to fit into Cambodia's context, taking the regional and global health contexts into consideration. The plan is a strategic management tool having both visionary and strategic guidance by setting out a clear strategic framework in line with key priorities for human capital development and priority policy programs of the Royal Government. The framework advances the health system performance in the coming years to further improve the health and well-being of the population.

The high performance of health systems relies on the full functioning of health institutions at all levels to perform their roles and functions and provide health care and related services that meet population's needs. In the evolving context of decentralization and de-concentration, health service delivery will

increase the responsibility of Capital and Provincial Administrations, with greater flexibility to shape capacities of health workforce and promote the effective and efficient use of available resources in the present and the future to tailor health services to meet the health needs of local peoples.

The Ministry of Health continues to provide support for policies and resources, technical and financial, throughout the health system, promotes innovation in health service delivery systems, and enhances inter-sectoral and multi-sectoral collaboration, as well as building public-private partnerships, at national and subnational level. These efforts aim to develop the health system that is people-centered, based on the principles of primary health care approach to extend coverage and continously improve and maintain the high-quality of health services, and promote equitable health outcome within the evolving contexts, such as epidemiological shifts, social and demographic dynamic, fiscal space, technological advancements, and economic realities.

I firmly believe that health institutions at all levels, Capital and Provincial Administrations, relevant ministries and institutions and other relevant actors, including private sector, development partners, non-governmental organizations and the community, will actively participate in the implementation of the HSP4. This is in order to deliver new progress and achievements that bring greater benefits, health and well-being, to Cambodian people today and the future generation, in line with the Cambodia Vision 2050.

Phnom Penh, September 19, 2025

Minister of Health

Prof. CHHEANG RA

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CONTENTS

ACRONYMS

AD	Administrative District
AI	Artificial Intelligence
ALS	Average Length of Stay
AMR	Antimicrobial Resistance
AOP	Annual Operational Plan
ASEAN	Association of Southeast Asian Nations
BOR	Bed Occupancy Rate
CBE	Competency-Based Education
CDHS	Cambodia Demographic and Health Survey
CHEA	Cambodia Health Enterprise Architecture
CPA	Complementary Package of Activities
CPAD	Capital and Provincial Administrations
CPD	Continuing Professional Development
CSES	Cambodia Socio-Economic Survey
D&D	Decentralization and Deconcentration
DALYs	Disability Adjusted Life Years
EML	Essential Medicines List
EMR	Electronic Medical Record
GDP	Gross Domestic Product
GDP	Good Distribution Practices
GMP	Good Manufacturing Practices
HBP	High Blood Pressure
HC	Health Center
HCMC	Health Center Management Committee
HCP	Health Coverage Plan
HDI	Human Development Index
HEFs	Health Equity Funds
HiAP	Health in All Policies
HIS	Health Information System
HIV/AIDS	Human Immuno-deficiency Viruses/Acquired Immuno-Deficiency Syndrome
HMIS	Health Management Information System
HP	Health Post
HPCs	Health Professional Councils
HSP4	Health Strategic Plan 2025-2034

ICD	International Classification of Diseases
ICF	International Classification of Functioning, Disability and Health
ICT	Information and Communication Technology
IHR	International Health Regulations
IPC	Infection Prevention Control
LQMS	Laboratory Quality Management System
M&E	Monitoring and Evaluation
MEF	Ministry of Economy and Finance
MESL	Medical Equipment Standard List
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MPA	Minimum Package of Activities
NCDD	National Committee for Sub-National Democratic Development
NCDs	Non-Communicable Diseases
NEE	National Entry Examination
NGO	Non-Governmental Organization
NQME	National Quality Monitoring and Enhancement Program
NSSF-H	National Social Security Funds for Healthcare
NTDs	Neglected Tropical Diseases
OD	Operational (Health) District
ODO	Operational (Health) District Office
OOPS	Out-Of-Pocket Spending
OPD	Out-Patient Department
PFM	Public Financial Management
PHC	Primary Health Care
PHD	Provincial Health Department
PLHIV	People Living with HIV
POE	Point of Entry
QCM	Questionnaire à Choix Multiple (Multiple Choice Questions)
RGC	Royal Government of Cambodia
RH	Referral Hospital
RMNCAH-N	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
SCI	Service Coverage Index
TB	Tuberculosis
UHC	Universal Health Coverage
WHO	World Health Organization

EXECUTIVE SUMMARY

Rational

1 Health Strategic Plan 2025-2034 (HSP4) was developed in ways that responded to: firstly, attaining Cambodia's Vision 2030/2050; secondly, aligning health goals with a key priority for human capital development; thirdly, achieving Cambodia Sustainable Development Goals 2030 (CSDGs); and fourthly, addressing effectively and efficiently on-going and anticipated health challenges. In this regard, it will be essential to reset directions for the health sector and chart a new course accordingly.

Strategic Context

2 **The Pentagonal Strategy sets 'improvement in health and well-being'** as one of five key priorities for human capital development and 'expand health services towards universal health coverage (UHC) as policy priority program number one, focusing on the expansion of social health protection coverage with improvement in quality of health services through strengthening of service delivery capacity of health center and district referral hospitals.

3 **Human Development:** In 2023, Cambodia's human development index (HDI) was 0.606. Between 1990 and 2023, Cambodia's HDI increased by 57%, positioning Cambodia in 'the medium human development category'.

4 **Economic growth and poverty reduction:** Cambodia reached lower-middle-income country status in 2015. Economic growth played a major role in the rapid reduction of poverty, with a sharp decline from 47.8% in 2007 to 17.8% in 2020. Improved social determinants of health have contributed to creating a supportive environment that enable the population to have better access to health services and practice healthy behaviors.

5 **Demographic dynamics:** The life expectancy at birth for both sexes combined increased from 58.6 years in 2000 to 75.5 years in 2019. Between 2019 and 2024, the total fertility rate (TFR) remains unchanged (2.5), well-positioned above replacement-level fertility. As the demographic dividend moves into the next two decades, Cambodia must prepare well today's young population for healthy and productive aging in the future through sound investment in health and education from now on.

6 **Reproductive health, maternal, newborn, child and adolescent health, and nutrition:** The total demand for family planning has progressed well, but the teenage pregnancy rate remains as high as 35% among teenagers who have no education. The maternal mortality ratio (maternal deaths per 100,000 live births) has dropped from 170 in 2014 to 154 in 2021/22, but remains higher than its CSDG interim target for 2020. Both under-five and neonatal mortality reduction have reached their CSDG target for 2030, eight years ahead of schedule. Stunting rate among children aged under five has declined from 43% in 2005 to 22% in 2021/22, but remains high; whilst wasting rate has remained stagnant since 2005.

7 **Communicable diseases:** Cambodia is progressing towards achieving the global Human Immunodeficiency Virus Infection & Acquired Immunodeficiency Syndrome (HIV/AIDs,) targets of '95-95-95.' However, 1,500 new HIV infections in 2023 remain an issue of concern. Cambodia was removed from the global list of 30 countries with a high burden of Tuberculosis (TB), but the TB burden remains substantial for public health, given there were 54,000 incidence cases in 2023. Cambodia will achieve the national goal of malaria elimination by 2025, with zero malaria death reported from 2018 to 2024, and a significant reduction in malaria incidence.

8 **Noncommunicable diseases (NCDs):** NCDs cause an estimated 64% of combined death and disability in Cambodia and 23% of high risks to premature death between the ages of 30 and 70 years old, with a related economic burden estimated to be equivalent to US$1.5 billion or 6.6% of Gross Domestic Product (GDP). In 2024, there are an estimated 640,000 and 1,800,000 Cambodian people aged 25 to 64, who are living with Diabetes and High Blood Pressure (HBP), respectively. In 2022, the number of new cases of cancers in all ages of the population was 19,795 with 13,799 deaths. There are an estimated 590,000 people with anxiety disorders and 550,000 people with depressive disorders in 2024.

9 **Financial risk protection:** The population coverage by Health Equity Funds (HEFs) and National Social Security Funds for Healthcare (NSSF-H) has increased from 23.5% in 2015 to 43.7% in 2024. Cambodia's UHC Service Coverage Index (UHC-SCI) increased from 56 in 2000 to 60.1 in 2024, respectively. Between 2019 and 2023, the incidence of catastrophic health expenditure, exceeded 10% of household total expenditure, decreased from 17.85% to 15.45%.

10 **Health security capacity:** Cambodia's International Health Regulation (IHR) core capacities have increased from 40% in 2015 to 67.5% in 2023. Despite the improvement, accelerating IHR core capacities remain priority given emerging and re-emerging infectious diseases, health risks due to climate change, and disasters continue to threaten health security. Furthermore, antimicrobial resistance is becoming a global public health threat, including in Cambodia.

11 **Health service delivery capacity:** The total number of Health Centres (HCs) increased consistently with the growing population, with the average of 13,500 population per HC in 2015 and 13,200 population per HC in 2024. Between 2015 and 2024, on average, the hospital bed to population ratio (number of beds per 1,000 population) in the public sector increased from 0.67 to 0.96. The large variations in hospital beds to population ratio, bed occupancy rate and average length of stay indicate the different levels of investment, resources available, health services availability, and operational efficiency of each hospital. Private health providers have remarkably contributed to improving access to healthcare services, and continue to grow rapidly.

12 **Improvement in healthcare quality:** Healthcare quality has been improved gradually since the implementation of the national quality monitoring and enhancement program (NQME) with the use of level-1 assessment tools from 2017 to 2023. The level-2 assessment tools comprising additional standards have been used since the second semester of 2022. The NQME has built the foundation for the establishment and development of the Cambodian healthcare accreditation system in the near future.

13 **Health workforce capacity:** Cambodia's ratio of doctors, nurses, and midwives to 10,000 population was 30.3 in 2024, while the global ratio requires 44.5 for UHC (80% of health services coverage). It is noteworthy that there is considerable dual employment, overlapping the public and the private health workforces.

14 **Financing capacity:** Between 2015 to 2024, the current national health expenditure has increased by 114% or from approximately USD 239.94 million to USD 513.59 million, with an increase of 89% at the national level and 164% at subnational level. A rise in health expenditure reached its peak in 2021 during the COVID-19 pandemic. Despite progress in improving equity and sustainability of health financing, over the past decade, out-of-pocket spending on health (OOPS) by households has remained high, around 60% of total health spending.

15 **Advanced imaging:** Computed tomography scans (CT scans), magnetic resonance imaging (MRI) and their more advanced derivatives, are increasingly used in national and provincial hospitals, and in private health facilities. Medical and digital technologies are essential to improve accessibility and coverage of health services, enhance diagnostic capacity, leverage quality and safety of healthcare, and improve system efficiency.

16 **Health information and digital health:** Information and digital health technologies are increasingly used in the health system operations. A rise of NCDs, an aging population, risks of emerging infectious diseases, climate change, and other potential health hazards, alongside other key priorities, such as UHC, primary health care, underline the importance of digital health transformation.

17 **Regulatory capacity:** Regulations of the private health sector have been strengthened in accordance with laws and regulatory measures at the national and subnational level, with delegated regulatory function for certain types of health services from the MoH to capital and provincial administrations (CPADs) and municipalities/districts/khans. Rapid growth of the private sector, healthcare quality and safety, and value-for-money in the private sector, remain issues of concern and a great challenge to regulatory capacity.

18 **Regulation of health professionals:** Health Professional Councils have played an active role in governance of health professionals, by working closely with the MoH, to ensure that all health professionals have adequate qualification, and physical and mental fitness to practice, and protect the dignity and freedom of health practitioners, based on ethical principles.

19 **Key challenges in both epidemiologies and the health system** are identified: (1). The burden of NCDs poses a significant threat with the potential to cause tremendous morbidity and mortality while Cambodia is on the path of an aging society; (2). Reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAH-N) is expected to be substantially improved; (3). Communicable diseases remain a public health concern; (4). Health security emergency would potentially emerge, threatening public health and socio-economic activities; and (5). Availability, readiness, and quality of health services, as well as gaps in social health protection, remain a pressing issue for the health system and public finance.

20 **Transformative opportunities:** (1) Strong political will of the RGC of the 7th Legislature of the National Assembly to further improve the health and well-being of the Cambodian people; (2).

Cambodia economy is on the path of growth in post-COVID-19 crises; (3). Health is increasingly recognized as a business of everyone and every sector; (4). Emerging technologies and innovations provide a range of health solutions for transforming the health service delivery system; and (5). Key reform programs, such as decentralization and deconcentration, public financial management, and public administration, bring both supportive environment and challenges for the health sector reform process.

Strategic Direction

21 **The vision for health is 'Healthy lives and well-being for all, thereby contributing to sustainable human capital development and economic growth', with high-level priority focusing on People, Services and Systems** and the mission of 'Advancing the provision of effective health services, and ensuring optimum quality of public and private health services,' underpinned by the values of **'Rights to Health and Equity'** and guiding principles of **'Universality, Trust, Integrity, Quality, Innovation, and Collaboration'.**

22 **Two health goals are 'protect health and improve equitable health outcomes.'** As guided by the high-level priorities and epidemiological trends, public health threats, demographic dynamic, the need for health system strengthening, as well as value-based health service delivery (e.g., equity, gender equality, and cultural and traditional norms), three strategic priorities and five program priorities are determined as follows:

- **Three strategic priorities:** (1). Advancing universal access to effective healthcare for all, driven by continuous enhancement of care quality and patient safety, (2). Promoting equity in health access and financing ensures that all individuals, including migrants, receive timely and quality healthcare, (3). Strengthening and modernizinghealth health system to deliver effective healthcare for all, and to respond effectively to and recover from all forms of health emergencies and health hazards; and

- **Five priority programs** for health system interventions: (1). Prevention and management of NCDs, chronic diseases and other health problems, (2). Improvement in reproductive health, maternal, newborn, child and adolescent health and nutrition, (3). Prevention and management of communicable diseases, (4). Strengthening of health security, and (5). Health system strengthening and modernization.

23 **Four Strategic Objectives with Strategic Shifts: Strategic objectives are defined, and can be achieved through four strategic shifts:**

- **Firstly,** enable all people to access the full continuum of care at the public and private health facilities, with quality PHC as a key foundation for UHC and resilient health system', by strategically shifting the focus from CURE to CARE;

- **Secondly,** ensure that quality and safety of healthcare provided by the public and private health facilities comply with clinical standards, with increasing patient/client satisfaction, by strategically shifting the focus from VOLUME to VALUE-BASED CARE;

- **Thirdly,** enable all people, including migrants, to access timely and quality health care when needed, without financial hardship' by strategically shifting the focus from TARGETED to UNIVERSAL FINANCIAL PROTECTION for all; and

- **Lastly,** ensure that the health system is capable of preparing for, adapting to, and effectively responding to, and recovering from all forms of health emergencies and hazards by strategically shifting from REACTIVE to RESILIENT health security system.

24 **Five strategic enablers.** Strengthen and modernize the health systems to achieve the intended health goals by investing wisely in five foundational infrastructure resources of health systems, namely, (1). Institutional development and health governance, (2). Human resources development, (3). Public financial management, (4). Supply management system of medicines, medical equipment and technologies, and physical infrastructure development, and (5). Data development, health information management and digitalization in health systems.

25 **Forty health strategies:** To advancing the strategic enablers and push the momentum of the strategic shifts in pursuit of the strategic objectives, and ultimately achieving the intended health goals, including UHC, the strategies are developed based on the principles of **S.A.F.E.R:** (1). **S**trategic insight, (2). **A**daptable and talented institutions, (3). **F**inancial sustainability and equity, (4). **E**ffective and efficient health services, and (5). **R**egulatory and policy compliance.

Implementation, Monitoring and Evaluation

26 **Institutional responsibility for implementation, monitoring and evaluation:** The MoH, subnational administrations, and health institutions at all levels, prepare annual operational plans (AOPs), budget strategic plans (BSPs) and public investment programs (PIPs) according to their roles and functions through the existing institutional structures and processes, such planning and budgeting processes, progress monitoring and annual evaluation mechanisms.

27 **Approaches to AOP preparation, implementation, and monitoring and evaluation**: (1). Participatory approach, (2). Resource-based planning, (3). Program-based budgeting, and (4). Data-driven monitoring and evaluation. The AOP preparation responds to both the health sector and local priorities with consideration of feasible implementation in terms of available resources, and the HSP4's indicators framework for monitoring and evaluation.

28 **Fifty-five indicators for monitoring and evaluation are categorized into four types:** (1). Inputs, process and system, (2). Outputs, (3). Outcomes, and (4). Impact indicators, for measuring progress and results of the health system performance.

29 **The HSP4, a living document:** In addition to the annual progress review of HSP4, the MoH will conduct mid-term review, followed by an end-year evaluation of the HSP4 to conclude the final results of the HSP4 implementation and inform HSP5 development.

1 INTRODUCTION

1.1 Background

Cambodia has successfully fought against COVID-19 and is now focusing on economic recovery and strengthening resilience in health systems against future pandemic and health emergencies. The COVID-19 pandemic was well managed through swift and effective implementation of public health, administrative and legal measures; especially the high coverage of the COVID-19 primary vaccination series that reached over 70% of the total population of 16 million in September 2021. This created favorable conditions for reopening the country and socio-economic activities in November of the same year.

The HSP4 marks the Ministry of Health (MoH)'s commitment to further improve the health and well-being of the population, which is an integral part of the country's development agenda. Generally, The HSPs are put into action through developing and implementing AOPs supported by BSPs, and PIPs, with regular of progress monitoring through annual performance reviews, followed by mid-term reviews and final evaluations of results.

The HSP4 was built on the achievements made in the health sector over the last two decades, and the momentum of the HSP3 as well as the experiences gained in fighting against the COVID-19. The development processes provided the MoH and key actors in the health sector and beyond with the opportunity to assess the current performance of the health system performance and the population health status, envision health challenges beyond the current constraints and transformative opportunities, as well as setting strategic contexts for rigorously planning toward meeting Cambodian citizens' aspiration of health in line with Cambodia Vision 2030 and 2050.

1.2 Rational

As reflected the background, the HSP4 was developed for the following important reasons:

- **Attaining Cambodia's Vision 2030 and 2050, driving better health and well-being.** For 2030/2050, it is expected that the overall health status and well-being of many Cambodian citizens would have been better and higher (as compared to baseline values in 2025), and be comparable to the capacity of upper-middle-income and high-income country;
- **Aligning the HSP4's health goals with key priorities for human capital development, as set out in the Pentagonal Strategy of the Royal Government of Cambodia (RGC) of the 7th Legislature of the National Assembly, is essential.** Investment in strengthening resilience in and modernizing health systems is a crucial health benefit to the Cambodian citizens in the present and for the future generations, as healthy citizens has potential for economic growth, competitiveness, and sustainable development;
- **Achieving CSDG3 'Ensure healthy lives and promote well-being for all Cambodians at all ages', including UHC,** will depend on many other CSDGs and vice versa. While the country is approaching closer to 2030, there is a critical need to intensify sectoral and multisectoral efforts,

at both national and subnational levels, to accelerate progress in the pursuit of achieving CSDGs 2030; and UHC target 2035; and

- **Addressing effectively and efficiently current and anticipated health challenges will require resetting directions of the health sector and charting a new course, accordingly.** This adaptation will lead to further transforming 'business processes in health industry', organizationally, financially, regulatorily and professionally, in innovative ways that both public and private health facilities deliver their services with a greater positive impact on the health of the population and efficiency in the health system.

1.3 Importance of HSP4

The HSP4, a strategic management tool for rational health planning, serves the MoH, Capital and Provincial Administrations (CPADs), all health institutions at national and subnational levels, relevant ministries and agencies, and other key actors, including the private sector, development partners, and non-governmental organizations (NGOs), for the following important reasons:

- **Support prioritization and planning of resource allocation and utilization to achieve health goals and strategic objectives of the HSP4** at the national and subnational level against the current and future available resources;
- **Facilitate policy dialogue for investment in health of the population and the health system at the national and subnational levels,** with a focus on operational efficiency and economy of scale, as well as measurement and accountability for results;
- **Bolster cross- and multi-sectoral actions and partnerships in the health sector and beyond**, including community engagement, with upholding a collective commitment to achieving the shared vision for health; and
- **Guide proactive decisions in monitoring and evaluating through regular progress review and impact assessment of the plan implementation**, with making necessary adjustments of interventions to changing circumstances, for continuous improvement and innovation.

1.4 Processes

Leadership and management: The MoH's senior leadership strategically guided the formulation processes, while the Department of Planning and Health Information (DPHI) managed and coordinated the processes with technical support from WHO.

Participatory approach: The consultations involved policy makers and health planners, health professionals and program managers, the central-level health institutions, subnational-level institutions, relevant ministries and institutions, Health Partners, and NGOs active in health.

Working documents: There were extensive reviews of existing plans and policy/strategy documents in the health sector and related sectors, as well as other analysis papers, domestic, regional and international. Notably, a number of key national strategies and plans, such as the Pentagonal Strategy, the National Strategic Development Plan of the RGC of the 7th Legislature of the National Assembly, and the Cambodia UHC roadmap 2024-2035, have influenced strategic directions for the health sector in the medium to longer term.

1.5 Approaches

The application of 'Back-casting Approach' (Figure 1.1) together with the conceptual framework showing intercorrelation between health, key social determinants of health, and economy (Figure 1.2) supported analysis of the current state of population health and health systems, and envisioned evolving health needs, new and emerging health challenges, and transformative opportunities in the years to come. As a result, we got a broader understanding of Cambodia's specific contexts, with regional and global comparison, through which structures and contents of the HSP4 are developed to fit the future, that is, achievable desired health goals, for all Cambodians by 2034 and beyond.

Figure 1.1. Transforming Health Sector Driven by Vision

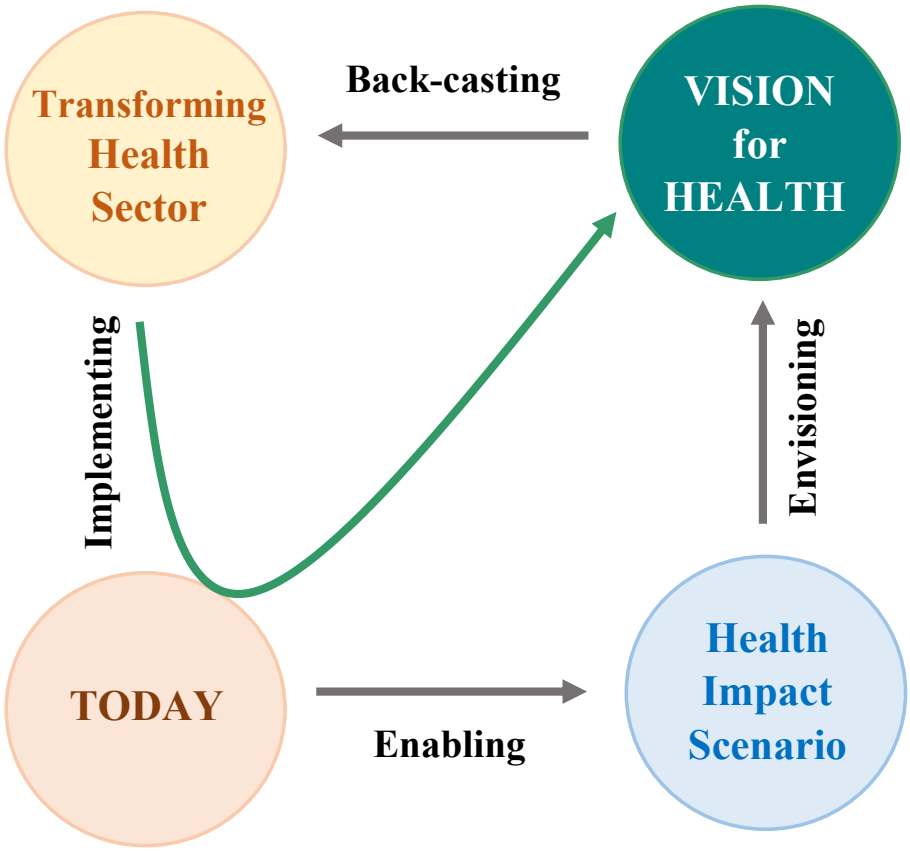
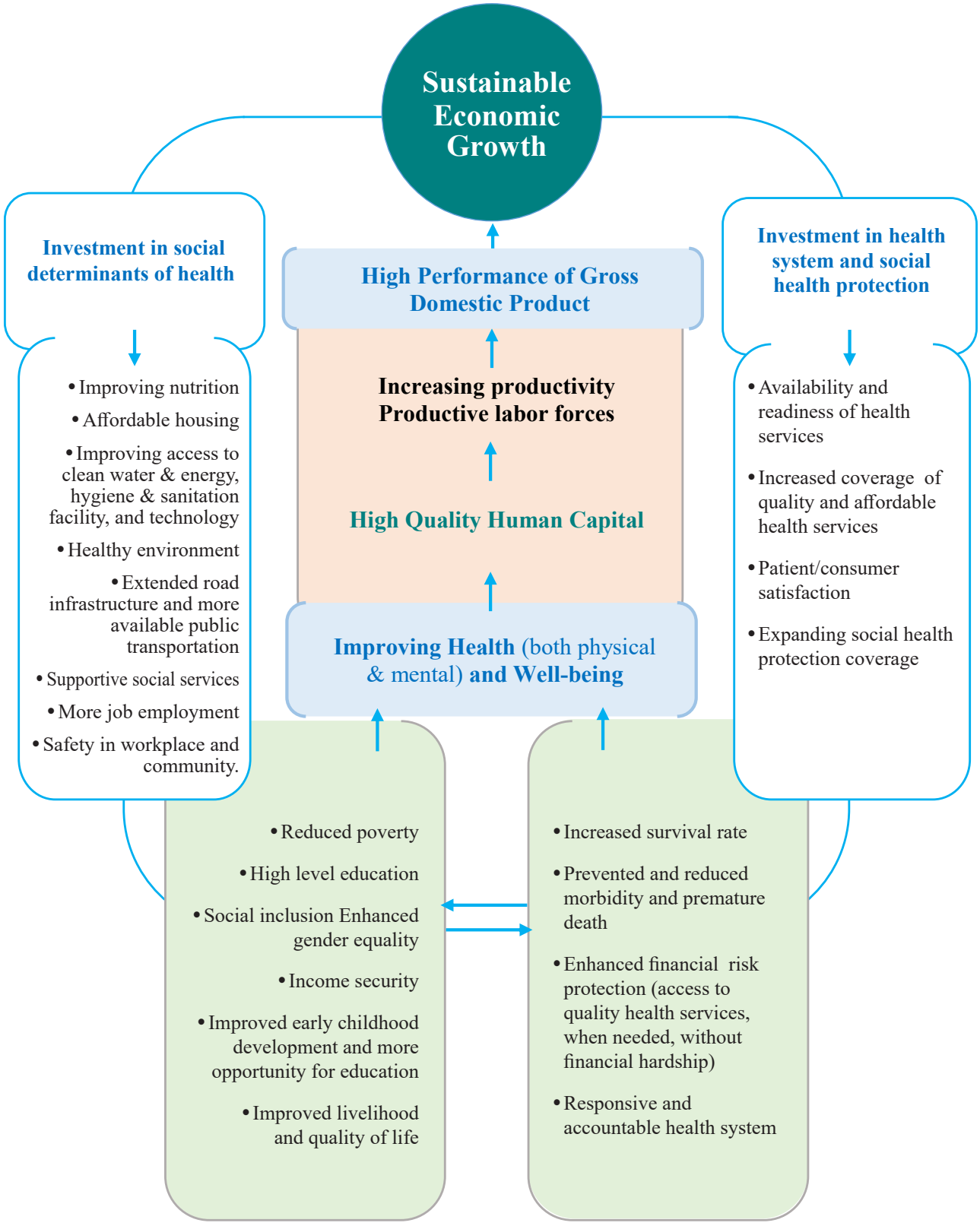


Figure 1.2. The conceptual framework shows inextricable link between health and social determinants of health, thus investment in health and social determinants is the investment in economic growth and social equality.



2 STRATEGIC CONTEXT

2.1 Pentagonal Strategy

The RGC of the Seventh Legislature of the National Assembly launched the Pentagonal Strategy for Growth, Employment, Equity, Efficiency, and Sustainability on 23rd August 2023. The Pentagonal Strategy-Phase I adopts five key priorities: **People, Road, Water, Electricity, and Technology**, along with five strategic objectives[1]:

- Ensure crisis-resilient economic growth of around 7% per year on average.
- Create more jobs, both quantity and quality, for Cambodian people, especially for youth.
- Achieve the poverty reduction target of below 10% and continue to keep poverty rate to a minimum through measures that reduce economic inequality and develop consistent social protection system.
- Continue to strengthen capacity and governance, improve the quality of public institution, strengthen private sector governance, and promote a favorable environment for businesses, investment, and trade.
- Ensure sustainable socio-economic development and build resilience to climate change, promote gender equality, sustainably manage natural resources, and increase sustainable and green financing.

Human Capital Development (Pentagon 1) 'High quality and healthy human capital are strong assets for the nation, ensuring long-term sustained growth, and dynamic socio-economic development', focusing on five key priorities: (1). Enhancement of quality of education, sports, science and technology; (2). Technical skills training; **(3) Improvement in people's health and well-being**; (4) Strengthening of social protection system and food system; and (5) Strengthening of citizenship quality of highly civilized society with morality, equity, and inclusiveness.

The strategic objectives of the improvement in people's health and well-being are to continue to reduce morbidity and mortality from diseases; especially main NCDs, and improve reproductive health, maternal, newborn and child health, strengthen institutional capacity for governance and transformation in the health sector, further improve capacities for diagnostic, treatment and care, and promote collaboration between relevant ministries/institutions, and encourage community participation (Annex 1 provides more information).

The RGC's first policy priority program among six priority policy programs is 'Expand health services towards UHC' through extension of social health protection (i.e., HEFs and NSSF-H, both schemes combined would cover around 7.4 million people) with improvement in quality of health services, focusing on strengthening service delivery capacity of HCs and district RHs.

2.2 Trends and Level of Human Capital, Social and Economic Development

Human Development Indices

Cambodia has achieved remarkable progress in promoting human development with a HDI of 0.606 in 2023 (East Asia and Pacific with a HDI of 0.756). Between 1990 and 2023, Cambodia's HDI increased by 57%, placing the country in the 'medium human development category'. Over this period, life expectancy at birth, for both sexes combined, increased by 15.5 years, expected years of schooling increased by 4.3 years, mean year of schooling increased by 2.4 years, and gross national income per capita (converted to Purchasing Power Pariry constant 2017 international dollars) increased by 308%.[2] The COVID-19 pandemic caused a two-year (2020 and 2021) straight global decline in human development for the first time, with 90% of countries declining in either one or both years.[3,4]

Economic Growth and Poverty Reduction

Cambodia reached lower-middle-income country status in 2015. Between 1998 and 2019, Cambodia was one of the fastest-growing economies in the world. Macroeconomic stability and prudent fiscal management kept the country's economy growing at an average annual rate of 7.7%. The economy contracted by -3% in 2020 due to the unprecedented COVID-19 pandemic, but it has returned to the path of growth, with 3.1% growth in 2021 and over 5% in 2022. The growth in 2023 is projected at 6% and expected to continue growing at the rate or slightly higher in the medium term.[5]

Economic growth played a major role in poverty reduction in Cambodia. The poverty rate fell sharply from 47.8% in 2007 to 17.8% in 2020, lifting hundreds of thousands of households out of poverty. However, those people remain vulnerable to falling back into poverty when exposed to economic and other external shocks, for instance, the COVID-19 pandemic. Between 2009 and 2019/20, poverty declined by 1.6 percentage points a year.[6]

Administrative Divisions and Demographic Dynamics

In 2024, Cambodia comprised 1 capital city, 24 provinces, divided into 32 cities/krongs, 14 khans, 163 districts, 269 sangkats, 1,383 communes and 14,577 villages.[7] These administrative divisions are governed in accordance with Organic Law.[8]

Cambodia is a young population country, as compared with most countries in Southeast Asia.[9] In 2024, Cambodia boasts a young and dynamic population of 17,280,543 (Annual growth rate 2.1% in 2014), including 26.8% of under 15 years of age (29.4% in 2019), 63.1% aged 15-59 years (61.7% in 2019), and 10.1% aged over 60 (6.3% in 2008).[10]

The Cambodian population is projected to reach 22 million by 2050, and the age structures would change, accordingly, with over 23% of the elderly population aged 60 and over. Key demographic data for health planning are provided in Annex 2.

The TFR halved between 1993 and 2019 (2.5), while life expectancy at birth of both sexes combined increased from 58.6 years in 2000 to 75.5 years in 2019. Between 2019 and 2024, the TFR remains unchanged (2.5 in 2024 - well-positioning above the general replacement-level fertility of 2.1)[11], and the annual growth rate rebounded to 2.1 in 2024 (after declining from 1.5 in 2008 to 1.4 in 2019), indicating a continuing growing population.

As the demographic dividend moves into the next two decades, Cambodia has to prepare well today's young population for healthy and productive aging in the future through sound investment in health (especially maitaining healthy lifestyle habits and behaviors) and education.

The proportion of people living in urban areas doubled (from 20% in 2008 to 41.5% in 2024). This situation, together with a rapid and substantial urbanization process, requires shifts in public policies and planning to fit urban and suburban settings.

Improvement in Social Determinants of Health

Substaintial improvement in key socio determinants of health, such as reduced poverty, more job employment, improved level of education, affordable housing, better access to clean water, sanitation and electricity, more green spaces, and extended road infrstructure with better public transports, have created a supportive environment for population to have better access to health services and practice healthy behaviors. This improvement has led to positive impact on physical and mental health, resuting in lower risk of morbidity and mortality, and lower healthcare costs.

Progress on key social determinants of health is observed: in 2024, literacy rate of 85.6% (80.4% in 2019 among population aged over 7, and at household level (as percentage of the total number of households): 93,9% (84% in 2019) used electricity as a main source of light, 87% (73% in 2019) had a source of improved drinking water, 93.4% (82.8% in 2019) had toilet facilities, and 85.7% (45.4% in 2019), had accessed to internet at home.[10,12]

2.3 Trends and Level of Improvement in Health and Financial Risk Protection

Reproductive, maternal, newborn, child and adolescent health, and nutrition

The total demand for family planning among currently married women increased from 68% to 74% between 2014 and 2021/22. However, the teenage pregnancy rate among teenagers who had no education remains as high as 35%. The trends in the use of any modern contraceptive method increased by 6.2% between 2014 (38.8%) and 2021/22 (45%). The teenage pregnancy rate (the percentage of adolescent girls age 15–19 years who have ever been pregnant) was high (35%) among teenagers with no education, as compared with the lower rate of 7% among teenagers with primary education, and 0% among teenagers with secondary and higher education.[13]

Maternal mortality ratio (number of maternal deaths per 100,000 live births) **dropped from 170 in 2014 to 154 in 2021/22, but remains higher than its CSDG interim 2020 target of 130 deaths.** MMR dropped by 61% between 2000 and 2014, from 437 deaths to 170 deaths,[13] and further declined by another 9% between 2014 and 2021/22, while the CSDG target for skilled birth attendance reached over 90%.[14] This trend not only indicates a slow reduction rate between 2021/22, but also poses a major challenge towards achieving the MMR target of 70 maternal deaths by 2030.

Neonatal and under-five mortality reduction have reached their CSDG target 2030, eight years ahead of schedule. Children aged under-five mortality (U5MR) declined by 71% between 2000 and 2015, from 124 deaths to 35 deaths per 1000 live births, and continued to decline to 16 in 2021/2022, a 54% drop between 2014 and 2021/22. Whereas neonatal mortality rate declined by 51% from 18 deaths to 8 deaths per 1000 live births, between 2021/22.[13]

Stunting rate among children aged under five has declined from 43% in 2005 to 22% in 2021/22; but remains high, and wasting rate has stagnated since 2005,[13] requiring multi-sectoral innovative interventions and more resources to address the underlying determinants that have negative effects on child nutrition. Child nutrition is inextricably linked to a number of key factors, such as food security, family income and living conditions, and exposure to diseases. According to anthropometric indices, in 2021/22, 22% of children aged under five were stunted, 10% were wasted, 16% were underweight, and 4% were overweight.

Mortality and morbidity due to communicable diseases

Cambodia successfully eliminated several main infectious diseases over the past two decades, such as poliomyelitis in 2000, maternal and neonatal tetanus, and measles in 2015, lymphatic filariasis in 2016, trachoma in 2017, and achieved Hepatitis B surface antigen prevalence of less than 1% in five-year-old children in 2017. Spurring momentum toward other targets, there has been a continued reduction of the burden of other key communicable diseases, such as Malaria, HIV/AIDS, Tuberculosis (TB), Hepatitis B, and neglected tropical diseases (NTDs).

Cambodia is progressing well towards achieving the global HIV targets of '95-95-95'[15] for ending HIV endemic in 2030. Cambodia is one of the countries in the Asia-Pacific with high treatment coverage for people living with HIV (PLHIV). In 2023, 95-95-95 targets were achieved at 89%, 98% and 98%, respectively.[16] PLHIV is estimated at 77, 000 and new HIV infections were 1,500 in 2023. The high-risk groups include men who have sex with men and young transgender individuals.[17] The number of HIV/AIDS-related deaths was estimated at 4,700 in 2003 and 1,100 in 2023.[16]

Cambodia moved from the global list of the 30 high TB burden countries in 2021, and is currently on the global TB watchlist 2021-2025.[18] However, TB burden remains substantial for public health. Between 2000 and 2023, TB incidence rate (number of new cases per 100,000 people) had dropped by 42% from 579 to 335 (approximately, 58,000 new cases in 2023), and TB death rate (number of deaths per 100,000 people) had dropped by 50% from 42 to 21 (approximately, 4,320 deaths in 2023: 3,700 HIV-negative individuals and 620 people with HIV-positive).[19] TB treatment success rate has been high, with over 90% (90%-96%) in the last ten consecutive years. Despite progress, challenges remain, including approximately one-third of undetected suspected TB cases, abandoning treatment for some TB patients due to financial pressure i.e., transportation cost, and income loss.[20]

It is noteworthy that the national policy on free access to TB diagnosis and treatment, initially started in 2001, for the general population, has significantly contributed to curing about half a million TB patients and saving 400,000 lives, and protecting TB patients' families from falling into poverty due to TB treatment costs.[21]

Cambodia is progressing well towards achieving the national goal of malaria elimination by 2025. Malaria incidence rate declined from 2.26 per 1,000 people in 2015 to 0.02 in 2024, from 51,262 cases to 355 cases; while Malaria death rate dropped from 0.6 per 100,000 people in 2015 to zero from 2018 until 2024.[22] The National Center for Parasitology, Entomology and Malaria Control has been working on strategy for malaria elimination, prevention of malaria transmission and re-infection, and subnational verification towards certification of Malaria elimination in Cambodia by WHO in the near future.

Dengue fever occurs frequently in Cambodia, and large epidemics with a significant case occur every three to four years. The transmission is highest during the rainy season. Since 2010 the average annual reported has been 10,000, with a fatality rate of less than 1% (0.05%-0.50%).

Viral Hepatitis B and C remain a significant public health concern, contributing significantly to liver cancer. It is estimated that 3% of the Cambodian population (approximately 475,000 individuals) is living with chronic Hepatitis B virus (HBV),[23] and 1.6% (around 257,000 individuals) with chronic Hepatitis C virus (HCV).[24] Despite the low prevalence of Hepatitis B in children due to a successful vaccination program, the residual risk remains, in particular among mothers of these children, requires continued effort to eliminate mother-to-child transmission of HBV and to further increase access to HCV prevention, testing and treatment services.

NTDs: Schistosomiasis mekongi and Leprosy have been significantly reduced to a minimum, but have not been completely eliminated. Schistosomiasis mekongi has affected approximately 100,000 individuals living in 114 villages along the Mekong River in Kratie and Stung Treng provinces.[25] Disease control measures, such as health education, improved hygiene and sanitation, and community-based collective treatment, have reduced transmission and morbidity. The prevalence of Schistosomiasis mekongi decreased to 1% in the affected communities in Kraties, and less 2% in some other villages.[25] in 2022 (49.3% in 1995).[26] Notably, the prevalence among school-aged children decreased from 3.3% in 2006 to 0.3% in 2012.[27] This progress indicates a sign of eliminating Schistosomiasis mekongi by 2030, in spite of risk of re-infection remains a concern.

The prevalence of Leprosy was reduced to less than 1 case per 10,000 population by 1998, but this infectious and chronic disease has not been completely eliminated, as certain communities are still experiencing active cases, while some others pockets of higher prevalence still exist.[28] 41 new cases reported in 2024, reduced from 155 new cases reported in 2019, requiring continued acceleration of progress towards the goal of zero leprosy by 2030, with focus on effective prevention, early detection and treatment, and other necessary support the patients may need.

Mortality and morbidity due to NCDs and mental health conditions

Between 2009 and 2019, six NCDs were among the top ten leading causes of combined death and disabilities in Cambodia (Annex 3),[29] and driving risk factors for the most deaths and disability include metabolic risks, environmental/occupational risks and behavioral risks. In 2018, NCDs cause an estimated 64% of combined death and disability in Cambodia and a 23% probability of dying between the ages of 30 to 70 years.[30] NCDs poses an economic burden of USD1.5 billion or over 6.6% of GDP.[30]

Between 2010 and 2023, the prevalence of Diabetes and HBP among Cambodian population aged 25-64 increased from 2.9% to 7.6%, and from 11.2% to 19.9%, respectively.[31] Based on these prevalences, the population aged 25-64 living with Diabetes and HBP is estimated at 640,000 and 1,800,000, respectively, in 2024. Over the same period, the prevalence of tobacco use among female population increased from 5.9% to 8.4% , but decreased among male population from 54.1% to 36.9%, and the prevalence of heavy episode drinking of alcohol increased from17.4% to 25.7%, the consumption of salty foods per day increased from 8.5 g to 9.5g, and the prevalence of obesity increased from 1.9% to 4.7%.[31]

In 2022, the number of new cancer cases in all ages of the population was 19,795 (9,171 in the male population and 10,624 in the female population), with 13,799 deaths.[32] Risk of dying from cancers before the age of 75 years was 13.1% and the leading cancers are liver cancers (17.7%), followed by lung cancers (10.9%), breast cancer (10.7%), colorectal cancers (8.7%), cervix uteri cancer (6.4%), and other cancers (45.6%).[32]

According to the Report on Health Sector Achievements 2024, there was a 87.42% increase in cancer patients receiving treatment in 2024 as compared to 2023, indicating the improved access to cancer services, and over 95% of adolescent girls aged 9-years-old were vaccinated with HPV vaccines (Human Papillomavirus) while cervical cancer screening has been expanding. The newly launched National Cancer Control Plan (2025–2030) in May 2025 outlines strategic goals, objectives and actions to address the growing cancer burden with a focus on improving cancer prevention, early detection, diagnosis, and comprehensive treatment and care.

Globally, the prevalence of mental health illness among the general population has increased by 25% between 2019 to 2022.[33] The most common mental disorders were anxiety and depression, with a prevalence of 3.4% and 3.2% respectively.[34] Based on these global prevalences, there are an estimated 590,000 people with anxiety disorders and 550,000 people with depressive disorders in Cambodia, in 2024. Between 2015 and 2023, the annual average number of mental health cases treated in public health facilities is approximately 100,000 cases of both out-patients and in-patients, but increased dramatically to 290,000 cases in 2024 due to expanded mental health service coverage with improved data management.[35]

Financial Risk Protection

There has been notable progress in strengthening the equity and sustainability of Cambodia's health financing over the past decade. The population coverage by HEF and NSSF-H had increased from 23.5% in 2015[36] to 43.7% of the total population in 2024, accounting for 7,577,578 individuals.[37] In this regard, the extension of the coverage for the remaining nearly 60% will bring challenges to both fiscal capacity and health service delivery capacity.

Cambodia has adopted 'targeting approach' to development and expansion of social health protection, started with HEFs for the poor households in 2000 and gradually expanded the scheme to vulnerable households and other target groups. NSSF-H, a compulsory and contributory scheme, has been implemented for workers and employees in the formal economic sector since 2016 and extended for civil servants, former civil servants, and veterans in 2018, and further extended for self-employed on a voluntary principle in 2023.

Cambodia's UHC Service Coverage Index (UHC-SCI) increased from 24 (on a scale of 0-100) **in 2000 to 56 in 2015**[38] **and up to 60.1 in 2024.**[39] Globally, the progress observed between 2000 and 2019 was not sufficient to achieve a minimum of 80 by 2030.[40] In 2019, the UHC-SCI ranged from 27 to 89 across the 194 WHO Member States, and the UHC-SCI sub-indicator showed that the infectious disease sub-index improved the fastest, followed by the reproductive, maternal, newborn and child health sub-index, but the NCDs and the service capacity and access sub-indexes experienced slower gains.[41]

Between 2019 and 2023, catastrophic health expenditure had declined. By contrast, the incidence of impoverishing health expenditure had increased.[42] The incidence of catastrophic health expenditure exceeding 10% of household total expenditure, dropped from 17.85% to 12.86%. The incidence of impoverishing health expenditure declined from 3.93% in 2019 to 3.54% in 2021, but increased to 4.57% in 2023.[42] Such an increase is likely driven by the negative impact of the COVID-19 pandemic associated with global economic issues.

2.4 Capacity of the health system

Transforming the health system

According to WHO, a health system encompasses a wide range of organizations, people, and actions whose primary intent is to promote, restore, or maintain health, involving various functions, including organization, management, financing, resource generation, and allocation, to deliver health services to meet the health needs of the population.

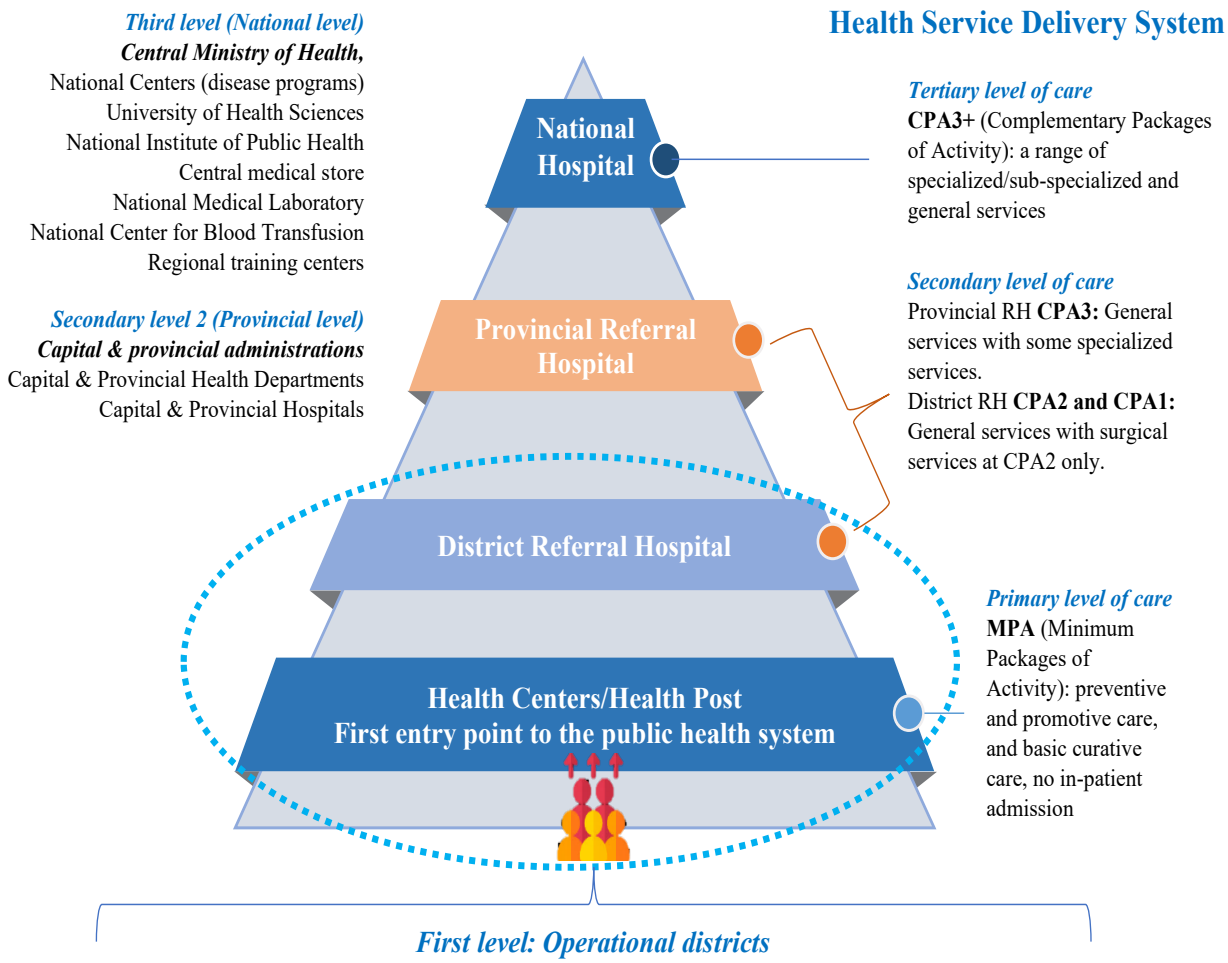
The MoH has implemented the health sector reform since 1995 with the main objective 'to improve and extend primary health care through the implementation of a district-based health system approach' to meet people's essential health needs and build the population's confidence in the public health system.' The reform entails transforming the health system, organizationally and financially (Annex 4). Structural transformation has shifted from an 'administrative-based health system organization (i.e., One commune One clinic and One district One hospital) to 'population-based health system' with defined criteria for establishment of an HC and an RH (Table 2.1).

Table 2.1. Criteria for Establishment of Health Center/Health Post and Referral Hospital

	Catchment Population	Accessibility
Health Centre	Optimal size: 10,000 Range: 8,000-12,000	Catchment area within a 10 km OR maximum 1-hour walk to HC
▪ In populated areas	20,000	Less relevant, as there are many private health providers
▪ In low population density areas **Health Post**	at least 3,000	15km from and/or having limited access to the nearest HC due to geographical barriers (i.e., river, mountain, poor road during rainy season)
Referral Hospital	Optimal size: 100,000 Range: 80,000-200,000	Catchment area within 30 to 40 km or a maximum 2-hour drive, or by boat to RH

The application of the above-predefined criteria, also known as the development of a health coverage plan (HCP), has resulted in the current three levels of the health system organization (Figure 2.1). The HCP is a potential planning tool to guide investment in public health infrastructures, financial and human resource allocation, deployment and training/retraining of health personnel, distribution of medicines and health commodities, medical equipment, and other necessary resources.

Figure 2.1. The three levels of the public health system



The future of the Operational District System

As a result of the adaptation to the evolving contexts, Operational District (OD) system is currently complex with five different types (Annex 5), bringing a greater challenge to the on-going process of D&D when further transferring authority over health service management and health service provision from the CPAD to district administrations in the future. Analysis envisions that the OD system would end up into two types in the long run: **Type A** covers an AD with an OD office and an RH, and an HC servicing a commune; and **Type B** covers an AD with an OD office, and without its own RH, and HC servicing more than one commune/Sangkat. OD type B is suitable for urban areas where accessibility is not an issue and private health providers are crowded.

Key actors in the health system

The health system operations comprise of many actors, health and health-related services and interventions, and approaches to deliver those services and interventions. The interactions between and among all actors in the health system is complex because of their different influence and different

interests. In this regard, there is a need for appropriate mechanisms, including regulatory mechanisms, to promote collaboration, coordinate, and support participation of all actors in the health system for achieving a shared goal of health and wellbeing. Those actors include, but are not limited to:

- Individuals, families, and communities as consumers of health services and patients;
- Providers of health services in both the public and private sectors;
- Social health protection operators/agencies, e.g., NSSF and private health insurance firms managing funds and purchasing health services for their members; National Payment Certification Agency (NPCA);
- Ministries/institutions providing health services and public services related to health, directly or indirectly, working together to address health challenges and social determinants of health;
- CPADs (and in the future, Municipal, District and Khan Administrations) manage and deliver health and health-related services, and hold accountability to the local population;
- Health professionals councils governing health professionals and allied-health professionals, strengthen their ethical practices and support their career development, and work closely with professional associations to support health service delivery;
- Private for-profit partners, such as, pharmaceutical companies, information technology and digital firms, logistics etc.; and
- Civil society organizations and non-governmental organizations provide healthcare or support community health, and development partners provide financial and technical support.

Health security capacity

The RGC adopted a 'risk-balanced approach' to effectively and swiftly manage COVID-19 transmission with early planning for COVID-19 vaccination, reaching COVID-19 primary vaccination series coverage of over 70% Cambodia's total population of 16 million by September 2021. The first three imported cases of COVID-19 were confirmed on 27 January, 2020. As of 31 December 2022, Cambodia recorded 138,584 infected cases, with 3,056 deaths. The key factors that attributed to the success in combating COVID-19 include, but are not limited to:

- Visionary, proactive and strong leadership of the RGC, with timely and effective decisions in implementing public health measures and other necessary ones;
- Established well-functioning broad-based institutional structures and mechanisms to combat COVID-19 at national and subnational level;
- Increased investment in strengthening preparedness and response capacities with essential measures to mitigate COVID-19's negative impact on the socio-economy;
- Active engagement of individuals, families and community, health volunteers, private sector, and civil society organizations; and
- Timely technical, financial and logistics support from international agencies and other countries through bilateral and multilateral cooperation.

Cambodia's IHR capacity score has increased from 40% in 2015 to 67.5% in 2023. Despite the improvement, it is essential to accelerate the implementation of IHR to bridge gaps in some technical areas, and maintain the developed capacities, progressing towards achieving the capacities required by IHR. Health emergency events and other potential health risks, more mobility of population, cross-border trade activities, environmental pollution, rapid urbanization, and disasters, increasing climate change-related health risks (i.e., drought, floods, extreme heat) will continue to pose health security threats. Furthermore, antimicrobial resistance can affect the efficacy of antibiotic treatment, such as TB-drug resistance, high risk of post-surgical interventions, chemotherapy, organ transplantation etc, leading to increased healthcare costs due to extended hospitalization, and frequent readmission.

Capacity of health service delivery

Health Centre density: Between 2015 and 2024, the total number of HCs increased from 1,141 to 1,305 HCs in consistent with the increased population, given the average of 13,500 population per HC in 2015 and 13,200 population per HC in 2024 (the HCP's optimal coverage: 10,000 population per HC). A number of HC with beds and HP have been upgraded to RH-CPA1 and HCs, respectively, due to increased population and health service needs.

Hospital bed density: the number of public hospital beds (excluding beds for TB patients) increased from 13,982 in 2015 to 16,645 in 2024, corresponding to 0.67 bed per 1,000 population in 2015 and 0.96 bed in 2024 (the HCP's recommended ratio: 1 bed per 1,000 population). Including an additional 13,569 beds in private hospitals, polyclinics, and all types of clinics, this ratio increased to 1.75 beds per 1,000 population in 2024.

The following key performance indicators demonstrate capacity and efficiency of hospital performance, and provide actionable insight for future improvement, including appropriate re-distribution of hospital beds according to their functions (CPA1, CPA2 and CPA3), strengthening hospital management, and improving clinical performance linked to appropriate governance and appropriate incentive mechanisms.

- **Hospital fatality rate (HFR):** Over the last decade, HFR remained unchanged, around 1%, generally indicating better quality of care.
- **Patient satisfaction:** The average score increased from 79% in the first semester to 83% in the second semester of 2024, based on exit surveys and interviews of 43,200 outpatients and inpatients in each semester.
- **Bed occupancy rate (BOR)**: Between 2015 and 2024, nationally, the average annual BOR was 86%, but dropped dramatically to 68% in 2022, resulting from COVID-19 pandemic. In 2024, a variation of BOR in different levels of hospitals is observed: NHs 95% (6,466 beds), PRHs 95% (3,935 beds), District RHs 72% (5,400 beds), and HC with beds 52% (854 beds).
- **Hospitalisation Rate:** Between 2015 and 2024, nationally, the number of patients hospitalized increased from 730,954 to 1,276,319, corresponding to an increased hospitalization rate (number of hospitalizations per 1,000 people) from 47 in 2015 to 74 in 2024, generally indicating increased access and improved health services capacity.
- **Average Length of Stay (ALS):** The average number of days patients stay in hospital remained stable at 4 days over the last decade. In 2024, ALS slightly varied from 4.34 days in national

hospitals to 4.38 days in provincial hospitals. Shorter, appropriate lengths of stay generally indicate improved care quality, reduce healthcare costs, and minimize the risk of hospital-acquired complications for patients.

Despite the improved capacities, the variations in ratio of hospital beds to population, BOR and ALS not only indicate the different levels of investment (i.e., resources available for delivering health services) and the different levels of available health services, but also underline the different levels of operational efficiency, usually linked with hospital management capacity and patients' health outcome. Table 2.2. indicates different levels of resource constraints on improvement in the availability and quality of healthcare services. Therefore, there is a need for more investment in essential resources (e.g., medical personnel, medical technologies and equipment, physical infrastructure), especially in RH-CPA1 and CPA2, with a secured supply of medicines and medical consumables, medical equipment and strengthened management and governance capacity.

Table 2.2. Available resources by types in RH-CPA1, CPA2, and CPA3 as compared to standards[44]

Types of essential resources	Score from maximum to minimum (100-00)		
	CPA1	CPA2	CPA3
Overall score	**70%-23%**	**72% -33%**	**87%-37%**
1. Building	73%-17%	82%-37%	89%-47%
2. Medical equipment	66%-11%	75%-14%	89%-4%
3. Human resources	65%-25%	73%-33%	73%-22%
4. Utilities and others	80%-27%	80%-27%	80%-40%
5. Information technology & means of communication	88%-45%	96%-57%	94%-68%
6. Infection prevention and control	91%-24%	89%-43%	87%-57%

Private health providers have remarkably contributed to improving access to healthcare services, and this sector continues to grow rapidly. Over the last five years (2020-2024), the number of all types of consultation cabinets increased by 39.4% (from 13,285 to 18,523), hospitals; polyclinics; clinics; and medical laboratories, all combined, increased by 35.4% (from 810 to 1,097), and pharmacies, depot pharmacies - type A and type B, all combined, increased by 30.3% (3,266 to 4,257).

Quality improvement in health services

Healthcare quality has been gradually improved since the implementation of the national Quality Monitoring and Enhancement Program with using assessment tools level-1 from 2017 to 2022 and assessment tools level-2 in 2023. Between 2019 and 2022, the average quality score increased from 64.34% to 81.95% in HCs and from 60.89% to 81.32% in RHs. Between the second semester of 2023 and the second semester of 2024, the quality scorecards by types of health facilities were as follows:[45]

- The number of HCs received quality scores over 50% increased from 59 (5% of the total number of HCs) to 424 (33%);
- The number of RH-CPA1 received quality scores over 50% increased from 4 (7% of the total number of RH-CPA1) to 42 (70%);
- The number of RH-CPA2 received quality scores over 50% increased from 5 (13% of the total number of RH-CPA2) to 25 (66%); and
- The number of RH-CPA3 received quality scores over 50% increased from 7 (33% of the total number of RH-CPA3) to 18 (82%)

This systematic program focuses on 3 dimensions of quality, such as: (1). structural quality (input); (2). technical quality (processes of care); and (3). patient health outcome. The use of assessment tools level-2, with the increased standards from 20 to 102 for HC and from 102 to 365 for RH, aims at leveraging quality to a higher level, and building the foundation for the establishment of Cambodia's health care accreditation system, in line with regional and global good practices, in medium-term to long-term. This innovation brings both challenges (i.e., requiring sufficient resources to continuously improve quality) and opportunities (i.e., leveraging quality to meet the people's expectation).

Health workforce capacity

Health personnel in the public health sector increased from 20,954 in 2015 to 31,452 in 2024, **with an annual attrition rate estimated at 2%** (retirement, deaths, resignation, unpaid leave). Cambodia's current health workforce in the public sector is characterised by its relatively small size in relation to the population, a large shortage of health personnel, limited capacity, and dual employment (working in both the public and private sectors).

Cambodia's average of doctors and nurses per 10,000 population was 7.3 and 15.7, respectively, in 2024. These ratios are below the average of 9 doctors and 19 nurses per 10,000 population among low- and lower-middle-income countries in the East Asia and Pacific region. To achieve UHC (80% of health service coverage), including the provision of comprehensive services for NCDs (including cancer and palliative care), and specialist surgical interventions, the global ratio requires 44.5 doctors-nurses-midwives per 10,000 population , while Cambodia's ratio was 30.3 of doctors-nurses-midwives per 10,000 population in 2024. This ratio varied significantly across capital/provinces, ranging from a minimum of 15.1 to a maximum of 80.6 (Phnom Penh, where national hospitals are located), with a median of 23.8. This variation indicates a severe shortage of doctors, nurses and midwives, and also the maldistribution of the currently available doctors, nurses, and midwives.

The above-mentioned challenges underline the importance of medium to long-term health workforce planning, aiming at matching supply and demand for health workforce, advancing quality of medical education and training, and improving personnel management (including transparent recruitment into deployment, targeted distribution and retention), coupled with reinforcement governance of health professionals and allied-health professionals (i.e., registration and licensing, ethical practices), and continuing professional development.

Capacity of health financing

The national current health expenditure has increased from US$239.94 million in 2015 to US$513.59 million in 2024 (increased by 164%: increased by 89% and 164% at the national level and subnational level, respectively).[48] A rise in health spending peaked during the COVID-19 pandemic in 2021. In 2023, the total Current Health Expenditure (CHE) in Cambodia reached US$2,051 million, equivalent to 4.7% of GDP.[49]

The composition of health spending in Cambodia has gradually shifted toward a greater domestic public spending (including government budget and NSSF-H) over the past decade. In 2023, domestic public spending accounted for 27% of total CHE, mainly from government-funded health spending of 23% and 4% was contributed by NSSF-H.[49]

Cambodia is undergoing a significant shift away from reliance on external assistance for health. TB, Malaria and HIV programs appear to be most vulnerable in this transition, as they remain heavily dependent on external support, accounting for over one third of overall external funding in 2023. In contrast, the RGC has taken responsibility for the National Immunization Program, covering about 80% of its spending in 2023. This changing landscape underscores **the growing need to increase domestic public spending as a strategic adjustment to ensure sustainability amid the long-term reduction in external funding.**[49]

Despite progress in improving financial protection for health, household out-of-pocket spending (OOPS) on health has remained persistently high over the past decade. In 2023, OOPS was US$1,243 million, accounting for 61% of health expenditures, at around US$71 per capita, and OOPS disaggregated by healthcare provider and function, expressed as percentage of total OOPS, are as follows[49:]

- **By provider:** private hospital 22%, private clinic 34%, public hospital 21%, HC 2%, pharmacies 14%; and
- **By function:** in-patient services 33%, outpatient care services 47%, pharmacies 14%, and preventive care 6%.

It is worth noting that over half of OOPS occurred in private hospitals and clinics, while households continue to face a substantial financial burden for curative care. This highlights the need for further health financing policy development to strengthen the benefit package and integrate the private sector into publicly financed schemes.

Medical equipment and technologies

Advanced imaging technologies, such as CT scans, MRI, and their more advanced derivatives, are increasingly being used in the national and provincial hospitals (self-investment and/or public-private agreement), and in private hospitals/polyclinics. As Cambodia is moving to an upper-middle-income-country status in 2030, the major challenge to the country's health system is the Cambodian

population's expectation of similar standards of medical technologies to neighbouring countries or other countries in the region. Therefore, harnessing medical and digital health technologies is essential to improve accessibility and coverage of health services, enhance diagnostic capacity, leverage quality and safety of healthcare, and improve system efficiency.

Data and Health Information

Information and digital health technologies are increasingly used in the health system operations, including healthcare service delivery (i.e., preventive care, patient management, clinical support), disease surveillance and response, epidemiological analytics, data and statistical analysis, education and training, health information management, planning, performance monitoring and reporting. Existing digital systems remain fragmented (e.g. digital technologies and platforms are siloed and non-interoperable), implicating innovation, cybersecurity, governance, and cooperation.

A rise of NCDs, an aging population, risks of infectious disease outbreak, potential health hazards, climate change, and environmental health risks, as well as other key priorities, such as UHC, primary health care, underline the importance of digital health transformation to support digitally-enabled health service delivery and public health interventions, data-driven decision-making, monitoring, and evaluation. In this regard, there is a need to increase investment in digital technologies and digital infrastructure, building digital literacy among health professionals, use of digital solutions and programs, improvement in interoperability, strengthening of digital governance, and development of digital health ecosystems in the future.

Regulatory capacity

Regulations of the private health sector have been strengthened in accordance with law and regulations at the national and subnational level, with delegated regulatory function for certain types of health services to CPAD and municipality/district/Khan administrations. Between 2020 and 2024, 1,035 private health facilities were closed (including 53 aesthetic centers), with 1,059 cases of penalty (pharmaceuticals and cosmetics export and import companies, traditional medicine sites, and pharmacies), and 323 cases of crackdown (storage sites and distribution of non-registered medicines, cosmetics and medical equipment. Rapid growth, health care quality and safety, and value-for money, remain major concern and a great challenge to regulatory capacity. It is expected that the private health sector will continue to grow steadily in the coming years, especially in cities and other urban areas.

Regulations of health professionals: Health Professional Councils (HPCs) play a key role in governance of health professionals, by working closely with the MoH and health professional associations. It is to ensure that all health professionals have adequate qualification, physical and mental fitness that fit to practice, and protect the dignity and freedom of the health practitioners, based on ethical principles. The five health professional councils, namely, the medical council, the nursing council, the midwife council, the dental council, and the pharmacist council, were established by the Royal Decree. As of 31 December 2024, the number of health professionals registered with their professional councils and holding valid licenses to practice their profession is shown as the following:

Health Professional Councils	Registered	Valid License to Practice
Medical Council	13,062	10,473
Nursing Council	21,189	18,147
Midwife Council	12,621	7,886
Dental Council	1,662	1,418
Pharmacist Council	5,602	5,286

2.5 Challenges and Opportunities

The ongoing and anticipated key health challenges, both epidemiological and health system, can be managed through realistic, comprehensive, and inclusive the HSP4 planning, as well as anticipatory actions taken by all health institutions and key actors in the health sector and beyond, advancing the current momentum with innovative solutions and translating transformative opportunities to new potential and expectation in addressing current and future challenges and threats.

Key health challenges (more are provided in Annex 6)

1) **The burden of NCDs and mental health illness, continues to pose a significant threat with the potential to cause tremendous morbidity and mortality** while Cambodia is on the path of an aging society. This leads to greater demand for effective NCDs and NDC-related services, mental health services, and psychosocial services, and other essential social support services that patients need.

2) **RMNCAH-N are expected to improve significantly in the coming years, similar to those of upper-middle-income countries.** Therefore, it is essential to accelerate the reduction in maternal and child mortalities, improve the nutritional status of children, and reduce the gaps in health outcomes that vary by geography, and income level, as well as education level.

3) **Communicable diseases remain a public health concern, but controlling and eliminating the key communicable diseases remains a realistic goal**. A common challenge for Malaria, TB and HIV interventions is the continuous downward trend in external funding in the medium to long term, threatening the gains momentum towards the end of these three main communicable diseases in the future.

4) **Health security emergencies would potentially emerge, threatening public health and socio-economic activities.** Therefore, there is a critical need to shift from short- term to long-term preparedness planning in effective, efficient and sustainable fashion, with enhancing multisectoral/multidisciplinary collaboration for a well-coordinated response.

5) **Availability, readiness, and quality of health services remain a pressing issue at the system-level and the facility-level performance** that is influenced by both supply-side (i.e., key resource constraints, mainly human resources, insufficiently regulated health market), and demand-side (i.e., access barriers, gaps in financial protection associated with high OOPS on health; underlining issues of social determinants of health). These challenges require the reorientation of health service delivery and resetting of health system financing.

Transformative opportunities

1) ***The strong political will of the RGC of the 7th legislation of the National Assembly for further improving the health and well-being of Cambodian people*** by underlining health as a key priority for human capital development with policy priority program 'Expanding health services towards achieving objectives of Cambodia's UHC 2035.

2) ***The Cambodia's economy is on a growth path post COVID-19 pandemic,*** enabling the RGC to maintain spending levels similar to those before the pandemic. It is expected that health spending will grow from short-term to medium-term and to long-term in line with an increase in fiscal capacity.

3) ***Health is increasingly recognized as a business for everyone and every sector.*** The lessons learned and the strong national solidarity in the fight against the COVID-19 pandemic have demonstrated capacity of ministries and institutions, the private sector and the whole society in working collectively and collaboratively to further strengthen resilience in the health systems, in community and in socio-economy against health emergencies in the future, and improving social determinants of health.

4) ***Emerging technologies with innovative initiatives provide a range of digital solutions that have the potential to transform healthcare delivery,*** improving access, leveraging quality and safety of care, and enhancing efficiency (allocative and technical). The Cambodia Digital Government Policy 2022-2035 explicitly sets out the vision and outlines strategies for digital government development, including digital health transformation.

5) ***The ongoing reform programs in key sectors have created a supportive environment for the health sector reform process***. The reform processes in public financial management, public administration and D&D will improve decision-making and fiscal efficiencies, and thereby promoting more responsive and accountable healthcare delivery to the local population.

3 STRATEGIC DIRECTION

The strategic framework (Figure 3.1) is the architecture of the HSP4, indicating directions for the development, innovation, and modernization of the health system in the coming decade. The framework resets the vision for health, redefines health goals as a legitimate aspiration of the Cambodian people, and serves as a basis for setting strategic priorities, formulating strategic objectives, and developing transformative health strategies.

Figure 3.1. The HSP4's Strategic framework or Framework '1-2-3-4-5'

Vision for Health
- Healthy lives and wellbeing for All, guided by the Cambodia Vision 2030/2050; the Pentagonal Strategy; and the UHC roadmap 2035

Health Goals
- Maintain and improve health, and promote equity
- Reduced potential health risks from lifestyle and diseases, and reduced morbidity, mortality and disability due to diseases or its complications, and injuries or accidents.

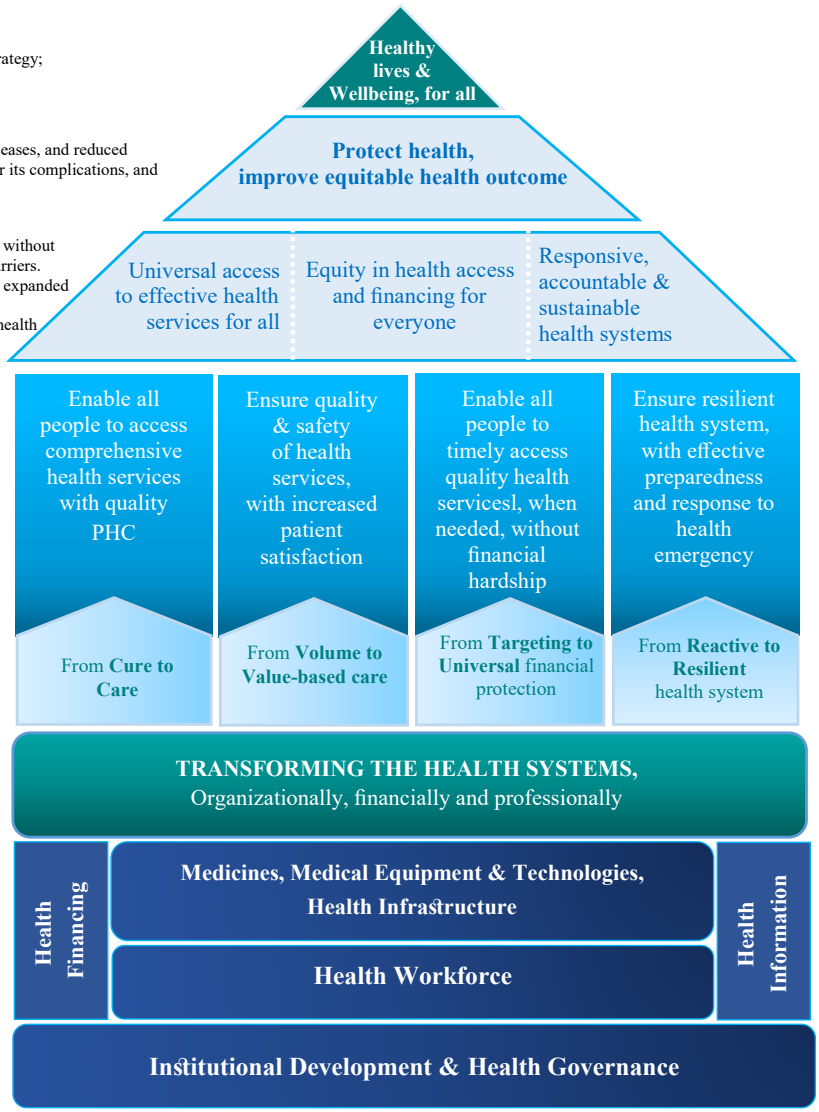
Strategic Priorities
- Universal access to effective health services[1] for all, without geographical, financial, bureaucratic, and cultural barriers.
- Everyone can timely receive health services through expanded financial protection and equitable health financing
- The health system is capable of providing effective health services and responding to all forms of health emergencies and health hazards.

Strategic Objectives
- Enhanced access to health services (availability & readiness)
- Advanced quality and safety, improved health outcome
- Equity in access and health financing
- Resilience to all forms of public health threats & health emergencies

Strategic Shifts & Strategies
- Focusing more on health promotion & preventive care and healthy behaviors, PHC-oriented & integrated health services.
- Focusing more on quality and the patient health outcome with optimal tests and procedures
- Focusing more on strengthening universal access with fairness of financial contribution, thereby leaving no one behind
- Focusing more on strengthening operational readiness, One health system capacity & essential public health services

Strategic Enablers

Strengthening and modernizing capacity of the health system
- Adaptable & talented health institutions
- High-quality health workforce
- Highly-performing public financial management
- Robust supply management systems (medicine & technologies), and resilient/green health infrastructure
- Data development, agile health information management, and digitalization



[1] **Effective health services**
- Quality and continuity of care based on the best available evidence, provided by skilled health professionals and tailored to individual needs
- Accessible health services
- Efficiency: Optimizing the use of available resources;
- Equity: Everyone receives care regardless of income, gender, ethnicity, or location; and
- Timeliness: without unnecessary delay, especially in emergency or critical care.

3.1 Vision for Health 2034

'Healthy lives and well-being for all Cambodians, thereby contributing to sustainable human capital development and economic growth.'

The Vision achieved can be measured by the trends and the levels of overall country development by using key indicators, such as (1). Human Development Index, (2). GDP per capita, (3). life expectancy at birth, (4). morbidity and mortality rate due to diseases, injuries or accidents. In this regard, The HSP4 defines **PEOPLE, SERVICES, and SYSTEMS** as the high-level priorities in the health sector.

People	The overall health (physical and mental health, and social-wellbeing) of all individuals, families and communities, and competency (skills, knowledge, and behavior) and talent of the health workforce.
Services	People-centered, PHC-oriented, and integrated health services, with advanced quality and safety, promoted equity, and increased efficiency.
Systems	Responsive, accountable, and sustainable health system, conducive to health protection and promotion, and socio-economic development.

Achieving the Vision requires dedicated efforts of health leaders at policy and strategy levels, health managers and administrators, and all health personnel at technical and operational levels across both national and subnational levels, to perform their roles and functions in line with **Mission**, **Values**, and **Working principles**, as described below. Additionally, active participation from ministries, institutions, and other relevant actors, along with strong public-private partnerships, and meaningful engagement of community and broader population, remain essential.

Mission: 'Advancing the provision of comprehensive health services across the continuum of healthcare, including health education and promotion, primary and secondary disease prevention, medical and surgical diagnosis and treatment, mental health, psychosocial and medicosocial services (including palliative care and rehabilitative service), while ensuring optimal quality of the public and private health services and public health interventions.**'**

Values and **Working Principles: The values of 'Rights to Health and Equity',** and the working principles guide day-to-day management and activities of health leaders, managers, medical personnel and other personnel across all health institutions at all levels.

We serve every person, everywhere, at every time, guided by the principles of Universality, Trust, Integrity, Quality, Innovation, and Collaboration.

Universality	**We** promote universal access to quality health services for all, regardless of individual's social and economic status (e.g., gender, ethnicity, income, location, culture.)
Trust	**We** provide health services with dignity, compassion, and respect for individual rights to health while protecting privacy and confidentiality.
Integrity	**We** communicate transparently and honestly with patients, their families, and consumers with a friendly and professional behavior, and also with/among our health professional team.

Quality	**We** provide health services in a timely manner and in compliance with quality and safety standards of excellence with the engagement of patients/their family, and consumers of health services.
Innovation	**We** provide medically-based and innovative health services with the use of the most appropriate technologies and at affordable costs for the individual and the population, as well as the health system.
Collaboration	**We** provide health services, driven by multidisciplinary teams and in partnership with other health providers, maintaining optimal clinical health outcomes and well-being of the patients and consumers of health services.

3.2 Health Goals and Strategic Priorities

Health goals: ' Protect health and improve equitable health outcomes' by achieving targets set for the population health and health system performance (Table 3.1), as guided by the high-level priorities.

Table 3.1. Health Targets for 2030 and 2034

Key Outcome and Impact Indicators	2023	2030	2034
1. Prevalence of tobacco use among the population aged (%):			
- >15 years	18.15	14.52	12.70
- 13-15 years	3.5	3.15	<3.0
2. Prevalence of adults aged 18-69 years engaged in heavy episodic drinking[1] (%)	24.5	19.6	18.38
3. Percentage of people aged 40 and over with hypertension received treatment in compliance with clinical practice protocol	10	40	60
4. Percentage of people aged 40 and over with diabetes received treatment in compliance with clinical practice protocol	10	40	60
5. Eliminate mother-to-child transmission (MTCT) of three infectious diseases:			
- HIV: Incidence of MTCT (% & number of cases per 100,000 live births)	8.18	<5% & <50	no-transmission
- Syphilis: Incidence of MTCT (number of cases per 100,000 live births)	98	<50	no-transmission
- Hepatitis B: Prevalence of HBsAg among 5-year-old children (%)	<1 (2017)	<1	no-transmission
6. Maternal mortality ratio (per 100,000 live births)	154 (2022)	70	<70

7.	Neonatal mortality rate (per 1000 live births)	8 (2022)	6	<6
8.	Under-five mortality rate per 1000 live births	16 (2022)	14	10
9.	Stunting rate among children aged under 5 (%)	22 (2022)	19	17
10.	Unmet need for family planning (%)	11.5 (2022)	8	7
11.	Percentage of women aged 15–19 who have ever been pregnant (%)	9.3 (2022)	8	6
12.	New HIV infections among the uninfected 1,000 population	0.07	0.05	0.04
13.	TB Incidence of all forms of TB per 100,000 population	335	200	100
14.	TB death rate per 100,000 population	21	13	5
15.	Malaria incidence per 1,000 population	0.08	00	00
16.	Malaria mortality rate reported by public health facilities	00	00	00
17.	Percentage of people with depressive disorders who received treatment	2.5	50	65
18.	Cataract surgical rate per 100,000 population	2304	3300	3700
19.	Percentage of population covered by social health protection schemes	41	70	>80 (2035)
20.	UHC Health Service Coverage Index	60.1 (2024)	75	>80 (2035)
21.	OOPS on health as a percentage of total health expenditure	61	43	<35 (2035)
22.	IHR Core capacity score (%)	67.5	75	>85
23.	Percentage of functioning EmONC [2]	-	-	-
24.	Patient/client satisfaction rate at HCs and RHs	75	86	88
25.	Ratio of specialist-medical doctor-nurse-midwife to 10,000 population	28.8	38	45

1 Age standardized prevalence of adults aged 18-69 years engaged in heavy episodic drinking (6 or more drinks on any occasion in the past 30 days prior to the survey conducted).

2 Baseline value will be established through an assessment, then the targets will be set.

Three cross-cutting strategic priorities and five priority programs are identified, as aligned with the health goals and responded to epidemiological trends (e.g., burden of diseases and specific health problems of individuals and the population), public health threats, demographic dynamic, priority for health system strengthening, as well as value-based health service delivery (e.g., equity, gender

equality, and cultural and traditional norms). Impact of the health system interventions on these strategic priorities include reduced health disparities between the population, enhanced equity and social justice, and strengthened public health and socio-economic resilience.

Strategic priorities

1. **Advancing universal access to effective healthcare for all, driven by continuous enhancement of care quality and patient safety,** and minimizing geographical, financial, bureaucratic, and cultural impediments, along with the improvement in social determinants of health – improving patient health outcomes, the overall health and wellbeing of the population.

2. **Promoting equity in health access and financing ensures that all individuals, including migrants, receive timely and quality healthcare,** supported by robust financial risk protection and equitable health financing mechanisms – reducing OOPS on healthcare and strengthening an inclusive and sustainable health service delivery.

3. **Strengthening and modernizing health systems to deliver effective healthcare for all, to respond effectively to, and recover from all forms of health emergencies and hazards** – protecting health, saving lives, improving health outcomes, and sustaining socio-economic development.

Priority Programs

1. **Prevention and management of NCDs, chronic diseases, and other main health problems** include cardio-vascular diseases, diabetes, cancers, chronic respriratory diseases, mental health and substance abuse, psychosocial and medicosocial needs, elderly care, hearing impairment, avoidable blindness, ear-nose-throat, oral health, disability due to disease complications, injuries, accidents or domestic violence and sexual abuse (from a clinical intervention standpoint).

2. **Improvement in reproductive health, maternal, newborn, child and adolescent health, and nutrition** include family planning, safe abortions, and safe motherhood (antenatal care, safe labor, emergency obstetric and newborn care, post-partum care), and child healthcare and well-being during the first 1,000 days (e.g., providing vaccine preventable diseases and micronutrient supplementation, growth monitoring, prevention of risk factors to diseases, clinical prevention and management of child malnourished).

3. **Prevention and management of communicable diseases** include HIV/AIDS, Tuberculosis, Malaria, Dengue, Hepatitis, and NTDs (Hensen's disease or leprosy and schistosomiasis), and other infectious diseases.

4. **Strengthening of health security** focuses on the health system's operational readiness and effective response to emerging and re-emerging infectious diseases, and prevention and management of AMR, water-/food-borne diseases, zoonosis, climate-related health risks to human, animals, and environment, occupational health risks, disasters; and other health hazards.

5. **Health system strengthening** focuses on institutional capacities in leadership; health administration and management; and governance, health workforce development (including technical/clinical and interpersonal skills, and management), public financial management

linked to health financing, supply system management for medicines; medical equipment and technologies; and means of transportation, improvement in health infrastructures, and data development; health information management; and harnessing information technologies; and digitalization in health systems.

3.3 Strategic Objectives and Strategic Shifts

Strategic objective 1

'Enable all people to access the full continuum of care at the public and private health facilities, with quality PHC as a key foundation for UHC and resilient health system' – by strategically shifting the focus from CURE to CARE.

This shift in healthcare practice is a progressive move from a solely curative model while maintaining curative medicine, to a more focus on healthy behavioral practices and preventive care e.g., proactive disease prevention, including health education and promotion, early disease detection and prevention, timely diagnosis and treatment, and management of diseases, preventing/reducing progression of expensive and long-term illness, – ultimately protecting and maintaining the overall health and reducing healthcare cost __ by focusing on the priority areas as follows:

- PHC-oriented and innovative health service delivery;
- Healthy behavior and communication;
- Availability and readiness of health services;
- Community engagement; and
- Health and social determinants of health

Strategic objective 2

'**Ensure that quality and safety of healthcare provided by public and private health providers comply with clinical standards, and enhance patient/client satisfaction** – meeting the expectations in the present, and sustaining excellence into the future – **by strategically shifting the focus from VOLUME to VALUE-BASED CARE.**

This shift is a progressive move from a volume-focused healthcare to a greater focus on quality and patient safety, clinical outcomes and wellbeing, and cost efficiency (e.g. OOPS, and/or pre-payment systems) with optimal tests and medical or surgical procedures to support clinical decisions and processes of care. This transition is complex and takes time to deliver the results because there is a critical need to change behavior and mindset of institutions, health providers, and all relevant stakeholders to recognize the impact of healthcare quality on patient outcomes, and commit to delivering quality and coordinated care across the patient clinical pathway, and increasing patient experience and satisfaction of both patient and health providers. Additionally, this transformative move entails innovative provider payment methods that improve healthcare quality and patient safety, incentivize preventive care, and control cost (e.g. reduced unnecessary procedures and hospitalization) within a robust health financing policy framework and the UHC roadmap (see priority areas of Strategic Objective 3). The interventions focus the on following priority areas:

- Patient flow management;
- Patient safety and harm reduction;
- Patient clinical pathway;
- Clinical quality improvement; and
- Clinical practice compliance.

Strategic objective 3

'Enable all people, including migrants, to access timely and quality health care when needed, without financial hardship' – through a health system that promotes equity and social solidarity, ensure fair financial contribution, and reduce OOPS on healthcare across the population, with increasing the national spending on health – **by strategically shifting the focus from TARGETED to UNIVERSAL FINANCIAL PROTECTION for all.**

This shift will move towards UHC and a sustainable and equitable health financing system whereby all individuals actively participate in health systems that provide universal access to quality health services in a regulated health market (e.g., strong governance), by focusing on the following priority areas (several are closely linked to priority areas of Strategic Enabler 3: Public financial management):

- Sustainable and equitable financing health services;
- Transforming payment systems and health financing;
- Accountability for health services provided;
- Alignment and harmonization of funds; and
- Health financing governance.

Strategic objective 4

Ensure that the health system is capable of preparing for, adapting to, and effectively responding to, and recovering from all forms of health emergencies and hazards – maintaining the provision of essential health services, reducing mortality and morbidity, and sustaining socio-economic activities during the crises– **by strategically shifting from REACTIVE to RESILIENT health security system.**

This shift is merely a move away from health security system that relies on reactive response after the crises have occurred e.g. pandemic and potential health emergency events, to a system that proactively prepares for, respond to, and recover from a wide range of health crisis rapidly, with strengthening essential public health services (EPHS) within the overall context of strengthening resilience in the health systems, particularly for subnational-level health system with community engagement, by focusing on the following priority areas:

- Operational readiness;
- Managing 'One Health' potential health risks (human, animal and environmental health);
- High-quality medical laboratory services;
- Quality and safe blood and blood products; and
- Collaboration and health security governance.

3.4 Strategic Enablers

Invest wisely in foundational infrastructures in the health system to strengthen capacities and resilience, and modernize the health systems in the present and for the future to achieve and sustain the intended health goals, focusing on: (1). Institutional development and health governance; (2). Human resources development; (3). Public financial management; (4). Supply management system of medicines, medical equipment and technologies, and physical health infrastructure improvement; and (5). Data development, health information management, and digitalization in the health system.

- **Institutional development and health governance:** Adaptable and talented health institutions effectively lead and manage the entire health sector (of both the public and private sectors), and implement the health sector reform, ensuring universal access to effective health services for all, by focusing on the following priority areas:
  - Dynamic, adaptable and talent-focused health institutions;
  - Measurement and accountability for results;
  - Effective collaboration and cooperation; and
  - Policy and regulatory compliance.
- **Human resources development:** Ensure that the health system functions effectively with available, accessible, and high-quality health workforce, delivering effective health services and responding to the evolving health needs of the population, now and in the future, by focusing on the following priority areas:
  - Health workforce planning;
  - High-quality medical education and training;
  - Health workforce management; and
  - Health workforce governance.
- **Public financial management performance:** Strengthen the public financial management system in the health systems, ensuring that funds from available sources are effectively aligned with health priorities and efficiently utilized, by focusing on the following priority areas:
  - Effective formulation;
  - Effective budget execution;
  - Accountable public health spending;
  - Public financial governance.
- **Supply system management for medicines, medical equipment and technologies, and health infrastructure development:** The health system is sufficiently supplied with assured quality, safety, and affordable medicines and health commodities, and medical equipment and technology, with climate-resilient and green health infrastructure, by focusing on the following priority areas:
  - Rational use of medicines and health technologies;
  - Robust and resilient supply systems;
  - Resilient and green health infrastructure; and
  - Regulatory compliance and quality assurance.

- **Data Development, health Information management and digitalization:** Strengthen robust and agile health information systems (HIS) and interoperable digital health systems to improve accurate decision-making and effective health service provision and public health interventions at the national and sub-national level by focusing on the following priority areas:
    - Data quality, availability and accessibility;
    - Standards and interoperability;
    - Digital health workforce; and
    - Policy and regulatory compliance.

3.5 Health Strategy

The development of transformative health strategies is guided by the principle of **S.A.F.E.R** in order to maintain dynamic and adaptable processes of strategic shifts and innovative whole-of-population and entire-health system approaches, as well as responsive to the evolving landscape of the health industry and other relevant contexts.

Principles of S.A.F.E.R.	
Strategic insights	**Proactively thinking and fit-for-multiple purposes** in the present and for the future enable health institutions to stay up-to-date or ahead of the evolving health industry through a proactive and regular assessment and adjustment of policy and regulatory measures, and innovation of realistic interventions.
Adaptable and talented health institutions	**Conducive institutional culture** opens to new ideas, promotes continuous system-learning and innovations in workplaces, and builds, develops and sustains dynamic and talent of institutions to deal effectively with the evolving health challenges and changing circumstances.
Financial sustainability and equity	**Efficiency, of both allocative and operational,** vital platforms for developing and sustaining a robust health financing system linked to public financial management system and financial risk protection system, while promoting economies of scale in investment in health.
Effective and efficient health services	**People-centered health services,** placing individuals, families, and communities at the core of healthcare practices, grounded in assured quality, integrated and coordinated care across all levels of care and health providers, with re-oriented primary care and respect people's preference.
Regulatory and policy compliances	**Good governance in health systems based on laws, regulatory measures, and standard procedures,** holding health institutions and health providers highly accountable, and making health services more equitable, responsive and effective.

20 Strategies at the strategic objectives

	Strategies
	Strategic Objective 1: Access and Coverage of Health Services
1.	**PHC-oriented health services** Streamline quality-PHC across the health service delivery system, including community-based health services and outreach.
2.	**Healthy behavior and communication** Improve health literacy of individuals, families and communities, progressively changing health behaviors and communication, and consistently practicing a healthy lifestyle.
3.	**Availability and readiness of health services** Expand health service coverage, particularly essential health services with continuous quality improvement and substantial investment in key resource infrastructure, moving towards universal access.
4.	**Community engagement** Maintain dynamic and trusted relationships between health facilities and local people, promoting community engagement in development, monitoring and evaluation of health service delivery.
5.	**Health and determinants of health** Strengthen cross-/multi-disciplinary and inter-/multisectoral collaboration, including the private sector, to improve environmental, social and economic determinants of health, promoting equitable health and social equalities, including gender-responsive health services.
	Strategic Objective 2: Healthcare quality and safety
6.	**Patient flow management** Strengthen patient flow management in and out of health facilities, reducing waiting time, while maintaining health service quality and safety, and patients' and health providers'satisfaction.
7.	**Patient safety and harm reduction** Improve patient and health provider safety, prevent and reduce avoidable harms throughout care processes, thereby contributing to improving healthcare quality and patient health outcomes.
8.	**Patient clinical care pathway** (application of medical knowledge and skills in diagnosis, treatment, and management of patients' conditions). Maintain optimal healthcare quality for the patients along the entire care pathway in the healthcare facility and care transitions, maximizing patient health outcomes.
9.	**Clinical quality improvement** Advance healthcare quality and safety to meet the expectations of patients and population.

	Strategies
10.	**Clinical practice compliance** Strengthen institutional structures and capacities for clinical governance activities at the system and facility levels, promoting accountability for high-quality and safe patient care.
	Strategic Objective 3: Equity in healthcare access and health financing
11.	**Sustainable and equitable financing health services** Build a robust health financing system, improving efficiency, both allocative and technical, and increasing access and quality of health services.
12.	**Harmonizing payment mechanisms and health benefit packages** Transform payment systems, enabling increased efficiency in financial resources management to improve the quality of health services and contain costs.
13.	**Accountability for health services provided** Promote responsive, high-quality health services to maintain patient, health service user and public trust in the health systems.
14.	**Aligned and harmonized systems, activities and funding** Align systems/activities and funding of key stakeholders, including the private sector, with health service priority towards Cambodia UHC objectives.
15.	**Governance for health financing** Strengthen health service delivery functions in relation to financing of health service delivery within the context of governance of the social protection system.
	Strategic Objective 4: Resilient health security/health system and EPHS
16.	**Operational readiness for health emergencies** Strengthen capacities of the national and subnational health systems in preparedness for and response to the emerging/remerging infectious diseases and potential health emergencies.
17.	**One-health potential risks** (human, animal and environmental health) Prevent and manage AMR, food-/water-borne diseases, zoonosis, and environment health risks, and address climate change and disaster (closely related to Strategy 16: emerging infectious diseases and outbreaks).
18.	**High-quality medical laboratory services** Advance quality, reliability and timeliness of laboratory services, supporting the delivery of effective clinical services and public health interventions.
19.	**Quality and safe blood and blood products** Sustain a sufficient supply of quality and safe blood and blood products, and strengthen patient blood management/use in compliance with patient clinical requirements.
20.	**Collaboration and health security governance** Strengthen collaboration and partnership, nationally, regionally and internationally, to enhance resilience within the national health system and promote health security, thereby contributing to the strengthening of regional and global health security.

20 Strategies at the strategic enabler level

	Strategies
	Strategic Enabler 1: Institutional development and health governance
1	**Dynamic and talent-focused health institutions** Strengthen institutional agility and flexibility, and cultivate talent within institutions, adapting to evolving health challenges, technological advancement, and trends in socio-economics.
2.	**Measurement and accountability for results** Strengthen institutional responsiveness and accountability for the provision of population-oriented services, both health and non-health services, ensuring organizational and health-system productivity and efficiency, especially population health and equity.
3.	**Effective collaboration and cooperation** Strengthen multisectoral actions to improve health and social determinants of health, and enhance regional and global health collaboration and cooperation.
4.	**Policy and regulatory compliance** Strengthen regulation and enforcement in the health sector, ensuring safe, quality, and effective public health, healthcare services and other health-related services.
	Strategic Enabler 2: Human resources development
5.	**Effective health workforce planning** Strengthen effective health workforce planning, matching effectively between the supply of competent and skilled health workforce and the needs of the health service delivery and the evolving health needs of the population.
6.	**High-quality health professional education and training** Enhance competencies and technical and interpersonal skills of health professionals in the present and build a pipeline of talent for the future.
7.	**Strong health workforce** Optimize recruitment, distribution, deployment, and retention of health personnel to fit the purpose, in line with the evolving public administrative reforms and D&D.
8.	**Health workforce governance** Strengthen regulatory systems and capacities for health professionals, ensuring that quality, safe, and effective health services and public health interventions are professionally and ethically provided to patients and the population.
	Strategic Enabler 3: Highly-performing public financial management
9.	**Effective and efficient budget allocation** Strengthen budget formulation, ensuring that the health budget is well-aligned with and sufficiently allocated to high-impact health interventions.

	Strategies
10.	**Effective and efficient budget execution** Strengthen budget execution practices, ensuring that planned budget is well implemented to achieve defined objectives.
11.	**Accountable public health spending** Strengthen financial management performance, promoting institutional responsibility and accountability for results.
12.	**Public financial governance** Strengthen PFM systems in an efficient and transparent manner in compliance with financing policy, regulations, processes and procedures.
	Strategic Enabler 4: Robust supply system management for Medicines, Medical Equipment and Technologies, and Health Infrastructure Development.
13.	**Rational selection and use of medicines and medical technologies** Assured-quality, affordable and safe medicines and medical technologies are readily available in all health facilities and accessible to patients.
14.	**Robust and resilient supply systems** Strengthen the entire supply chain management systems for medical and pharmaceutical products.
15.	**Resilient and green health infrastructure** Invest wisely in physical infrastructures, supporting operations in the health system, especially in developing effective, environmentally-friendly, and sustainable health services, thereby encouraging the population to utilize health services with trust.
16.	**Quality assurance of health products** Strengthen quality assurance and Good Manufacturing Practices and Good Distribution Practices compliance, ensuring that health products are of assured-quality and safe for use.
	Strategic Enabler 5: Data development, health information management and digitalization in health system
17.	**Data quality, availability and accessibility** Improve data management systems by enhancing the standards of HIS.
18.	**Standards and Interoperability** Improve integration and interoperability of HIS into overall health data ecosystems and digital health solutions, supporting data and information management.
19.	**Digital health workforce** Enhance knowledge of digital health and skills in data analysis and use, enabling the health workforce to navigate digital health ecosystems to improve public health policy and strengthen health systems.
20.	**Policy and regulatory compliance** Strengthen effective leadership, governance, collaboration, and coordination to develop a robust HIS and digital health ecosystem.

4 IMPLEMENTATION, MONITORING & EVALUATION

4.1 Institutional responsibility for implementation, monitoring and evaluation

Ensuring effective implementation of the HSP4 requires proactive, active, and interactive participation in a sense of responsibility from the MoH, CPAD, health institutions and health facilities, and other relevant actors in and beyond the health sector. The HSP4 is translated into the implementation that delivers results through existing budgeting processes, and monitoring and evaluation (M&E) mechanisms in the health sector at national and subnational levels.

- **At the national level:** Directorate Generals and Inspection Directorate, and its subordinate Departments, as well as all the central-level institutions, prepare AOP, including action plans and budget plans. BSPs and PIPs for the health sector (if relevant to any institution). Directorate General and the central-level institutions provide technical support and resources for planning and budgeting processes, and monitoring and evaluation at the subnational level.
- **At the subnational level:** PHDs and ODOs prepare AOPs and Budget Strategic Plans (relevant only for PHDs). PHDs provide technical support and resources for planning and budgeting processes, and monitoring and evaluation at OD level, while ODOs provide technical support and resources to HCs in preparing their AOPs and conducting monitoring and evaluation. PHDs and ODOs seek opportunities to embed their AOPs' activities and budget in their respective subnational administration plans, such as provincial and district development and investment plans, and commune investment plans.

4.2 Technical framework for implementation

Approach to developing AOP

In general, annual health planning and budgeting process is a combination of 'bottom-up' and 'top-down' planning, and provincial level or PHDs is the interface, whereby institutional knowledge and specific expertise related planning and budgeting at subnational-level health institutions are communicated to the central-level institutions, ensuring that subnational-level health plans are appropriately aligned with the health sector priorities and strategies and response local priorities and interventions. In this regard, AOP preparation, implementation, monitoring and evaluation are guided by the following approaches:

- **Participatory approach:** Heads of health institutions and their staff work together as a team, with the participation of relevant stakeholders, to organize present and future resources for performing their institutional roles and functions, and delivering health services to the population. Resources are often limited. Therefore, teams need to set priorities and make choices. This approach also provides the planning team with the opportunity to influence broader resource allocation and maintain their operational control over the use of allocated resources to achieve the expected results of their plans.

- **Resource-based planning:** The process puts human and financial resources at the forefront (e.g., institutional capacity, including availability of time, to implement plans and manage resources effectively). A starting point is to identify or forecast available resources, with the account balance, prior to prioritizing activities, using accurate, reliable and up-to-date data/information with visualization tools to guide decision-making on priorities for resource allocation.
- **Program-based budgeting:** This approach links budget allocated or planned expenditure to specific and measurable results and provides flexibility for reallocation and use of budgets to deal with circumstances (e.g. change in priority spending). For management purposes, each program budget is divided into several subprograms and activities, each with its own budget. Programs' and subprograms' performance can be measured in terms of outcomes, outputs, and cost (inputs).
- **Data-driven monitoring and evaluation:** AOP becomes realistic once the plan is put into implementation, supported by an accessible and available budget, of both quantity and quality, with progress monitoring and annual performance review on a regular basis. These processes require real-time and high-quality health and health-related data/information from reliable sources, as well as institutional capacity to effectively perform monitoring functions, including using monitoring and review results to support decision-making, most importantly, improve health service delivery.

Matrix for planning

A technical framework for implementing the HSP4, as outlined in Appendix 1, guides the development of AOPs and the HSP4's 3-year implementation framework for the 5 priority programs as indicated in Section 3.2 of this Plan document. The framework consists of two matrices that are simplified from Appendix 1: (1). Matrix of '4 x 5' (4 Strategic objectives and 5 Strategies for each Strategic Objectives) and (2). Matrix of '5 x 4'(5 Strategic enablers and 4 Strategies for each Strategic enabler).

For Strategic Objectives: A matrix of '4 x 5'

4 Objectives	5 Strategies				
1. **Access & Coverage**	PHC-oriented health service delivery	Healthy behavior and communication	Availability & readiness of health services	Community engagement	Health and social determinants
2. **Quality & Safety**	Patient flow management	Patient safety and harm reduction	Clinical care pathway	Clinical quality improvement	Clinical practice compliance
3. **Equity in access & health financing**	Sustainable and equitable financing health services	Transforming payment systems	Accountability for health services provided	Alignment and harmonization of funds	Health financing governance
4. **Health security & EPHS**	Operational readiness for health emergencies	Managing 'One Health' potential health risks	High-quality medical laboratory services	Quality and safe blood and blood products	Collaboration and health security governance

For Strategic Enablers: A matrix of '5 x 4'

5 Enablers	4 Strategies			
1. **Institutional development & governance**	Dynamic and talent-focused health institutions	Measurement and accountability for results	Effective collaboration and cooperation	Policy and regulatory compliance.
2. **Health workforce development**	Comprehensive health workforce planning	High-quality education and training	Strong health workforce	Health workforce governance
3. **Public financial management**	Efficient budget formulation	Efficient budget execution	Accountable public health spending	Public financial governance
4. **Supply system management and health infrastructures**	Rationally selected, used medicines & technologies	Robust and resilient supply systems	Resilient and green health infrastructure	Quality assurance and regulatory compliance
5. **Data development, HIM & digitalization**	Quality, available and accessible data	Standards and interoperability	Digital health workforce	Policy and regulatory compliance

Timeline for planning and implementation of the AOP

As the annual planning and budgeting process is work-intensive and time-consuming, health institutions at the national and subnational level, should start AOP preparation early, preferably in February. In doing so, health institutions can produce quality and comprehensive AOPs in a timely manner. AOP implementation starts from 1 January to 31 December (fiscal year).

4.3 Technical framework for M & E

Monitoring and evaluation mechanisms

The MoH conducts progress monitoring of the HSP4 through the health sector's semester progress review and annual performance review. The annual performance review report is disseminated in the National Annual Health Congress with participation of the central-level health institutions, CPAD, the subnational-level health institutions, relevant ministries and institutions, HPCs and health professional associations, private sector, development partners, including NGOs representations. Furthermore, a mid-term review, followed by an end-of-year evaluation (final year of the HSP4), will be conducted.

Quarterly and semester progress monitoring, and annual performance reviews of AOPs at sector level, provincial and OD level, as well as at individual health institution level, are regarded as integrated activities of the HSP4 progress monitoring processes, and results of these reviews are reported through the hierarchy of institutional structures within the public health system.

- **At the Capital/Provincial level:** Capital and Provincial Administrations/C-PHDs conduct semester progress reviews and annual performance reviews. The latter is participated in by ODs and/or HCs, and other relevant key actors at the subnational level.
- **At OD level:** ODOs conduct semester progress reviews and OD annual performance reviews. The latter is participated in by HCs, HPs, Health Center Management Committee (HCMCs), Village Health Support Groups (VHSGs) , and other relevant key actors at the OD level.
- **At health facility level,** both national and subnational level: Each facility conducts quarterly and semester progress reviews and annual performance review. The latter is participated in by relevant key actors.

Indicators for M & E

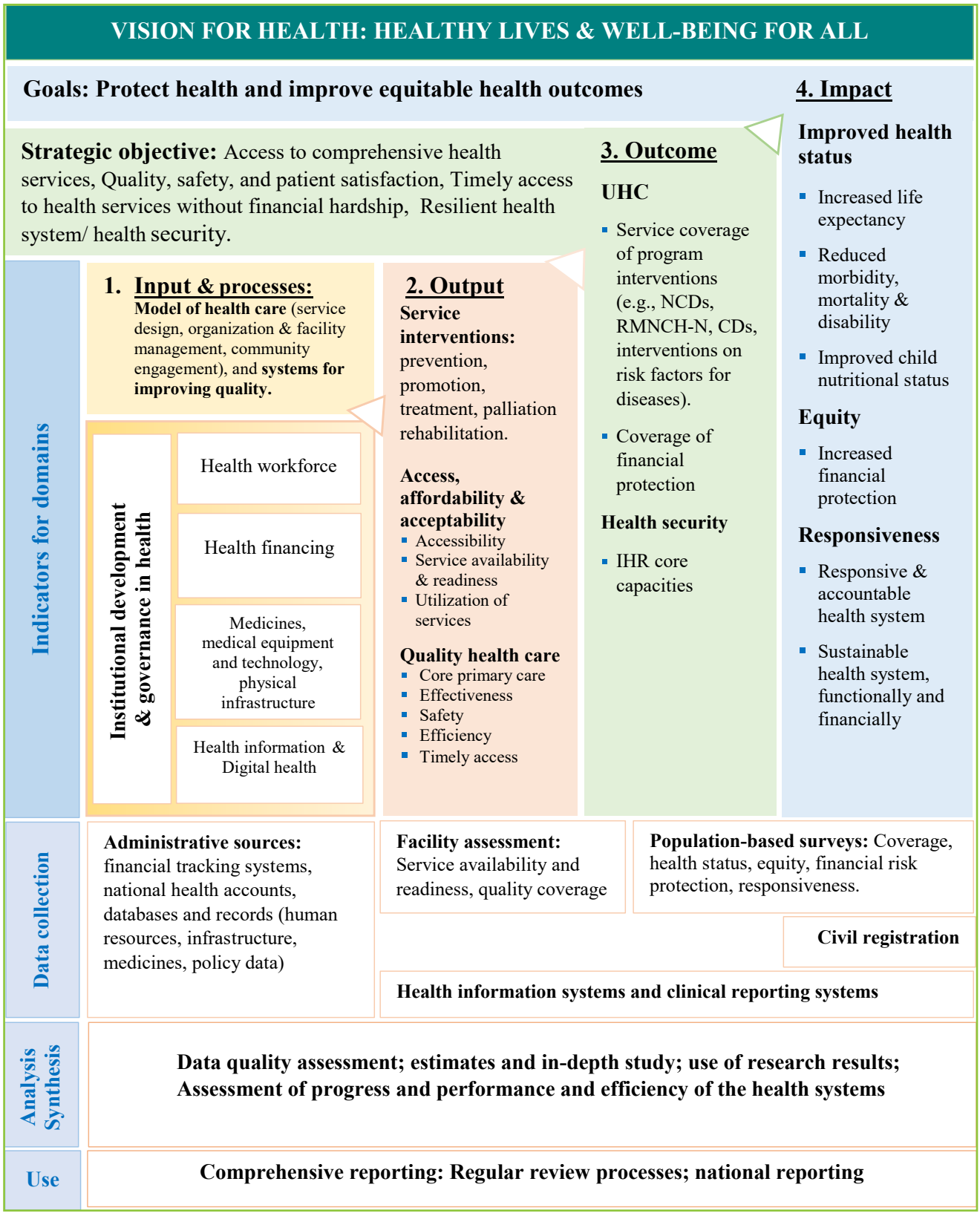
Health institutions at all levels review and use the HSP4 M & E framework (Annex 7) appropriately and consistently in their AOPs, including in program budget, according to the objectives and activities of the plans. The indicators for the HSP4 M & E are categorized in four levels: (1). Input/process/system; (2). Output; (3). Outcome; and (4). Impact indicators for measuring progress and/or results against health goals, strategic objectives and strategic enablers, as well as strategy and intervention level (Figure 4.1). It is noted that indicators for the M & E framework also include key performance indicators for progress monitoring and performance evaluation of health priority in the RGC's Pentagonal Strategy and the first priority policy program, Cambodia SGD framework 2030 and other relevant national frameworks, such as the National Policy Framework for Social Protection 2024-2035 and Cambodia Roadmap towards UHC 2024-2035. Relevant stakeholders are encouraged to use the indicators for the HSP4 M & E, if relevant and appropriate, for their projects/programs in the health sector.

Data sources

Progress monitoring and annual performance reviews require health institutions to collect and process health and health-related data/information, including other relevant and necessary data/information, then analyze, interpret, and use according to the purpose of M & E (e.g., quarterly, semester, or annual reviews). Such data/information can be collected through existing sources and other available sources that include, but are not limited to:

- Health management information system (HMIS), electronic medical records (EMR), surveillance systems, providing routine data on utilization of health services and trends in diseases and other emerging/occurred public health concerns;
- Report on general population census (every 10 years) and inter-population census, CDHS (every 5 years) and SCES (every 2-3 years), providing data/information on demography, social determinants of health, health status, accessibility and coverage of essential health services, health spending etc.
- Other sources: Administrative reports or records and findings of research in health and health-related fields.

Figure 4.1. Technical framework for M & E



Adapted from Monitoring and Evaluation of Health System Strengthening (WHO).

5 CONCLUSION

1. **Commendable achievements and progress in human capital, social and economic development in Cambodia over the last two decades would not be possible without full peace, political stability, and social security.** Strong economic growth played a key role in poverty reduction. This development synergized with increased access to health services and expanded social protection coverage, including financial risk protection, alongside improved key social determinants of health, resulting in improved health outcomes, increased life expectancy and quality of life, and ultimately improved overall health and well-being of the population.

2. **The COVID-19 pandemic has reversed some social and economic development that Cambodia gained prior to the pandemic that started in 2019.** Cambodia adopted a 'risk-balance approach' to effectively manage COVID-19 and reopened the country and socio-economic activity in November 2021. The key factors for this success, first and foremost, are long-term visionary, proactive, and wise leadership, and right and timely decisions of the RGC in implementing public health and other necessary measures, with active engagement of all ministries and institutions, the population, and public nationwide.

3. **The HSP4 is both a visioning and strategic plan with clearly determined health goals that are legitimate aspirations of all Cambodians 'Right to Health and Equity,'** and also with defined transformative and inclusive health strategies to direct interventions of the health sector towards such aspiration. Cambodian people would have good physical and mental health depending on the strong capacity of the health system in responding in a timely, effective, and efficient manner to anticipated negative impacts on the health of individuals, families, and communities. The potential negative impact to be avoided or reduced to the maximum extent is a substantial ill-health among the general population.

4. **Continuously transforming the health sector, organizationally and financially, in a systematic and innovative ways to leverage efficient and effective interventions within the health** system, most importantly focusing on significantly reducing number of people affected by NCDs; ensuring that a greater proportion of the population does not develop the associated diseases, and if they do so, the health system is capable of providing early treatment and intervention, reducing the chance developing critical or chronic conditions, death and disability, and supporting them for self-managed conditions. Besides, proven and successfully managed public health interventions in the past and the present have provided potential for control, eliminated and reduced the burden of communicable diseases and further improved reproductive health, maternal, newborn, child and adolescent health and nutrition in the future.

5. **Investing in health today and days of the coming years is an investment in economic growth and competitiveness.** Strong evidence reveals that investment in prevention and early managed NCDs in Cambodia can saves US$1.5 billion or 6.6% of GDP lost due to NCDs. Besides, every dollar spent on improved prevention, preparedness, and response to health emergencies can return up to US$8.3 in saved lives and reduced impact from health emergencies.[51]

6. **Strong multisectoral collaboration and public-private partnership in improving health and social determinants of health,** with proactive and responsive participation of individuals, families and communities in maintaining health, disease prevention, and managing NCDs, CDs, and other main public health problems, leading to reduced demand for costly specialized services and households' OOPS. As a result, more people will live healthier lives and improved well-being, while health and social protection systems will be financially sustained.

7. **In 2030, Cambodia would become an upper-middle-income country. It is expected that more households will have been lifted out of poverty, with the average household income rising in line with GDP growth.** As a result, a greater proportion of the population would have healthier lives (i.e., higher survival rate, lower morbidity and mortality, and longer life expectancy), and enhanced well-being, comparable to upper-middle-income countries. This expectation would be more realistic with the significantly improved social determinants of health, such as income equality, food security and gender equity.

8. **In 2035, health gains would have been sustained and equitably distributed over the whole population given the achieved objectives of Cambodia's UHC** (achieved population coverage to at least 80% and health service coverage to at leats 80%, and reduced OOPS on health to at least 35%) . With a reduction of nearly half in household OOPS on health (from a 2023 baseline of 61% of total health expenditure), financial risk will be considerably minimized for people accessing timely high-quality healthcare, when needed. This progress will open up more opportunities for Cambodia people, particularly the poor and vulnerable households to contribute fully to socio-economic activities, family life and workplace commitments, thereby fostering wealth, social justice and prosperity in Cambodia.

APPENDICES & ANNEXES

Appendix 1. Technical Framework for Planning

Strategic Objectives and Strategies

Strategic Objective 1: Access and Coverage

Priority areas:

- PHC-oriented health service delivery
- Healthy behavior and communication
- Availability and readiness of health services
- Community engagement
- Health and social determinants of health

Priority Areas, Strategies and Interventions
1. PHC-oriented health service delivery **Streamline quality-PHC across the health service delivery systems, including community-based health services and outreach.**
1.1. Review and update the existing guidelines on MPA and CPA, shaping the two distinct functions of HC and RH: (1). *Health service delivery functions,* focusing on integrated service delivery architecture: public health, primary care and specialist care; and (2). *Management functions* or supportive service delivery functions, focusing on institutional arrangements and responsibilities, such as leadership and governance systems, planning and financing, resource management, health information, technologies, monitoring and evaluation, community engagement, multidisciplinary and sectoral collaboration, and partnership.
1.2. Strengthen health service planning at the health facility level linked with a planned budget expenditure to achieve short- to medium-term defined objectives as informed by both prioritized high-risk population and targeted essential health services, while taking updated MPA/CPA guidelines and other relevant policies into account.
1.3. Develop people-centered health service delivery models, focusing on an essential health service package developed and its linkage with service delivery platforms, promoting the first point of contact with the health system for individuals, appropriate gatekeeping and referrals, building a diverse fit-for-purpose health workforce, and realigning PHC financing.

1.4.	Foster the roles of hospitals to strengthen PHC by embedding PHC in the provision of healthcare services in hospital settings and supporting HCs to improve access and quality through regular supportive supervision, training, and mentoring, strengthening gatekeeping within referrals, continuity, and coordination of care between hospitals and HCs.
1.5.	Deliver better integrated healthcare services within health facilities, enabling patients or health service users to receive person-centered and coordinated care involving different disciplines, and clinically necessary needs.
1.6.	Further integrate disease-specific programs' interventions into the overall health service delivery system, considering a trade-off between horizontal and vertical integration through effective health service planning, funding streams, robust supply system and health information system.
1.7.	Establish and implement a PHC measurement framework and indicators embedded in a technical framework for monitoring and evaluation of the overall health service system performance.
2.	***Healthy behavior and communication*** **Improve health literacy of individuals, families and communities, progressively changing health risk behaviors and communication, and consistently practicing a healthy lifestyle.**
2.1.	Increasingly incorporate education messages into the curricula of general education systems, and support school-based health promotion and education, and primary prevention, in collaboration with the Ministry of Education, Youth and Sports.
2.2.	Create a supportive and inclusive environment, based on a common insight and shared responsibility among families, institutions, businesses, and society as a whole, to enable the young generation to practice healthy behaviors in early childhood and throughout adulthood, progressively becoming sustained behaviors throughout their life course.
2.3.	Innovate quality health promotion and education activities, enabling individuals, families, and communities to make the right decisions and take responsibility for their health, such as healthy lifestyle practices, appropriate health-seeking behavior, and utilization of healthcare services, when needed.
2.4.	Integrate behavior change and communication interventions in all types of health promotion, disease prevention and treatment, and provide training or reskilling for health personnel with a set of skills on inter-personnel communication and promote practices.
2.5.	Produce quality, friendly-used and scientifically informed Information Education Communication materials (IEC) and widely disseminate the products, effectively reaching the target population by using multiple platforms, methods and trusted distribution channels.
2.6.	Conduct rigorous assessments or analyze the impact of BCC interventions on dynamic and positive health behavioral change in health risks and disease prevention and treatment among the population, tailoring the interventions for improvement.

3.	***Availability and readiness of health services***
	Expand health service coverage, particularly essential health services with continuous quality improvement, towards achieving universal access to health services.
3.1.	Develop existing health services and establish new priority health services through health service planning at facility level, according to evolving needs of the population.
3.2.	Increase timely access, quality, safe, and affordable surgical, obstetric, and anesthesia services that are critical for saving lives and preventing disability.
3.3.	Strengthen emergency and intensive care services, with effective referral services, including expansion of ambulance networks with GPS and trained paramedics for urgent cases, available and accessible essential medicines, and life-support equipment for round-the-clock use.
3.4.	Establish and expand psychosocial support service to provide counseling and therapy, immediate support victims during emergencies or trauma events, coordinated care across health, legal, and social services, and functioning medico-social service provides medical and paramedical care (e.g., nursing, rehabilitation, long-term care).
3.5.	Conduct outreach services in remote and rural areas, as well as underserved areas (e.g. geographical barriers, mobile populations) in accordance with the up-to-date outreach guidelines of the MoH.
3.6.	Provide the local population with up-to-date information about available health services at HCs and RHs through health provider-patient communication, display of the information in health facilities, outreach, community-based health networks, social and business platforms, and trusted media.
3.7.	Improve health services in health facilities located along borders and strengthen cross-border collaboration in health within bilateral and regional frameworks, as well as other appropriate mechanisms at the subnational level.
3.8.	Prioritize and upgrade PRHs to become regional hospitals that have similar technical and clinical capacity to the national hospitals, based on defined criteria, and ensure sustainable health service delivery and financing in the long run.
4.	***Community engagement***
	Maintain dynamic and trusted relationships between health facilities and local people, promoting community engagement in development, monitoring, and evaluation of health services.
4.1.	Innovate mechanisms for receiving perceptions and concerns on health service provision or other health-related issues from patients, health service users, and the population in the community, and take appropriate actions on the information received.

4.2.	Empower the local community to participate in collaborative planning at the health facility and commune administrations, enhancing integration between mainstream health services and community-based health and social services.
4.3.	Provide technical support and resources for operational community-based structures and processes for social accountability at local levels, such as HCMCs; VHSGs; health facility-based planning, commune investment planning, public fora, addressing health and health-related issues in the community.
4.4.	Provide training on a set of skills specific to community engagement, including community-based health promotion and preventive care, to HCMCs, VHSGs, health and social community workers, in collaboration with local administrations and other relevant stakeholders.
4.5.	Conduct supportive monitoring and impact evaluation of community engagement interventions, seeking opportunities for innovating effectively, socially, culturally, and economically accepted interventions, e.g. engaging youth and young families living in the communities.
5.	***Health and determinants of health*** **Strengthen cross-/multi-disciplinary and inter-/multisectoral collaboration, including the private sector, to improve environmental, social, and economic determinants of health, promoting equitable health and social equalities.**
5.1.	Integrate social determinants of health into health workforce education and training, as well as health services delivery, including routine clinical practices.
5.2.	Develop protocols that support health and allied health professionals to ask and relate patients'social issues (e.g., domestic violence, gender issues) to their medical inquiries, based on clinical consideration and conducted in ethically and culturally accepted ways, and help them access social support services, if needed.
5.3.	Improve a supportive and safe environment to deliver health services effectively within health facilities that have access to clean water and energy, reliable waste collection services, security and safety, and physical access to health facilities, by working with local administrations and relevant sectors, including the private sector.
5.4.	Strengthen multisectoral and multistakeholder collaborative efforts through institutional structures available at the national and subnational level to collectively prioritize actions and align resources, promoting better access to health and social services, early childhood development and education opportunities, safe community, road safety, green spaces, and preventing domestic violence.
5.5.	Conduct monitoring and impact evaluation of social determinant interventions on health equity by relating analysis to sectoral and multisectoral policies and plans, and roles and responsibilities across multisectoral institutions/stakeholders (e.g., Cambodian UHC roadmap 2024-2035), and promote the use of data for improving policies, strategies/plans, and investment.

Strategic Objective 2: Quality and Safety

Priority areas:

- Patient flow management;
- Patient safety and harm reduction;
- Patient clinical pathway;
- Clinical quality improvement; and
- Clinical practice compliance.

	Priority Areas, Strategies and Interventions
6.	***Patient flow management*** **Strengthen patient flow management in and out of health facilities, reducing waiting time while maintaining quality and safety of health services, and patient and health provider satisfaction.**
6.1.	Regularly review and optimize patient flow management systems, including triage, queuing, appointment scheduling, and OPD networking processes with other services, facilitating patient movement in health facilities, supported by technology, in accordance with the patient clinical pathway.
6.2.	Innovate OPD-based ambulatory care interventions in hospitals, involving a variety of medical procedures, including the use of advanced technology and procedures, chronic disease management, remote consultation, treatment and follow-up care.
6.3.	Expand the utilization of technology-based patient flow management systems, i.e., Electronic Medical Record (EMR) systems, e-prescriptions, and other suitable digital tools, for monitoring outpatient and inpatient movement, and improve care coordination and transition across departments in health facilities, and discharge planning.
6.4.	Improve health facility physical infrastructure, facilitating patients; especially people with reduced mobility, elderly, pregnant women and children, to have better access to the location of health service delivery; and improving orderly organized work flows and service delivery, hence increase in efficiency of the use of resources.
6.5.	Enhance and maintain a supportive environment for delivering and receiving healthcare services in health facilities, such as good hygiene and sanitation, appropriate ventilation, available hand-washing facilities, and avoidance of overcrowding.

7.	***Patient safety and harm reduction*** **Improve patient and healthcare provider safety, prevent and reduce avoidable harm throughout care processes, thereby contributing to improved healthcare quality and patient health outcomes.**
7.1.	Improve consistent practices of hygiene and sanitation measures related to safely managing high-risk patients with harmful infectious diseases, appropriately organizing isolation rooms and engaging patients and their families to maintain cleanliness and hygiene in patient rooms and in health facilities.
7.2.	Enhance safe practices of medical injections and prescription medication with a rational use (especially antibiotics to prevent or reduce AMR), properly dispensing and handing over medicines to the patients with a clear explanation about its use.
7.3.	Maintain cleanliness and hygiene, and better access to safe water in health facilities, patient rooms, and in prevention, treatment, and care through improving good practices of WASH (Water, Sanitation, Hygiene), thereby contributing to preventing or reducing the over-use of antimicrobial drugs.
7.4.	Handle health facility waste management (general, infectious, hazardous, radioactive) in healthcare facilities in compliance with technical guidelines or standards.
7.5.	Develop a stronger safety culture, both sustaining efforts towards patient safety improvement and providing safe working environment, by promoting multidisciplinary teamwork, skill-development training, and engaging patients and their families, and health service users, in the delivery of safe and quality healthcare systems.
7.6.	Implement systems for patient safety incident reporting, including monitoring hospital-acquired infections with the use of safety scorecards to improve infection prevention and control (IPC), medication safety, and patient safety practices to meet national optimum standards.
8.	***Patient clinical care pathway*** **Maintain optimum healthcare quality for patients along the entire care pathway in the healthcare facility and in care transitions, maximizing patient health outcomes.**
8.1.	Develop/update and implement practice guidelines, clearly defining the level and the role of referring and receiving health facilities, clinical-based referral conditions and services, communication (referral forms and registers), proper arrangements of transportation and feedback mechanisms.

8.2. Extend the use of digital systems to reduce delays in referrals, improve continuity of care and better communication between health personnel, between HCs and RHs, and in hospital referral networks.

8.3. Conduct a routine monitoring and periodic evaluation of the effectiveness of referral systems by using clinical indicators for measuring referral appropriateness to ensure the proper functioning of the underlying processes, and support the preparation of work plans for improvement (e.g., training, logistic support, and budgets).

8.4. Adapt team-approaches that are underpinned by well-structured multidisciplinary teams in managing complex care and using a range of appropriate measures, such as staff rostering and scheduling, and task shifting and sharing, with improved institutional leadership and culture to implement integrated and coordinated healthcare.

8.5. Build and maintain dynamic and structured relationships between health facilities, using information systems to strengthen continuity and coordinated care, and to well inform staff about care processes and patient engagement in healthcare.

8.6. Maintain communication channels between medical personnel/health facilities and patients/families to monitor and support patients transferred, ensuring they receive appropriate follow-up and continuity of care at another health facility or home-/community-based care, according to patient conditions and preferences.

8.7. Use telemedicine systems for remote diagnostics and treatment services within the hospital-health service delivery network and between hospitals and HCs, supporting continuity/follow-up of care and sharing knowledge and skills for new clinical interventions and a more patient-centered approach.

8.8. Keep patients and their families adequately informed and involve them in shared treatment decision-making by providing them with appropriate support, decision-making tools, and knowledge and experiences in self-care, primary prevention, preventive treatment, chronic condition management, and support for patients at the end stage of diseases.

8.9. Conduct monitoring to gain patients/their families' perceptions related to their healthcare experience through facility-based structured mechanisms, such as exit surveys and suggestion boxes, for timely patient feedback about their health outcomes and experiences, and use to information received to continuously improve clinical practices and patient journey.

9.	***Clinical quality improvement*** **Advance healthcare quality and safety to meet the expectations of patients and the population.**
9.1.	Develop/update standards, technical and clinical practice guidelines on quality and safety health services, including integrated or bundled services, communication and ethical standards, and enforce consistent use. If relevant, harmonize clinical guidelines with national essential medicines list/formulary, and generic prescription policies.
9.2.	Establish and implement clinical quality and safety programs in line with quality and safety policies or frameworks. The policies or frameworks clearly define: (1). Clinical priority areas (e.g., neonatal and obstetric care, pediatrics, mental health, non-communicable diseases etc.), clinical practice domains (e.g., emergency and critical services, surgical care, radiotherapy etc.); public health programs (e.g., immunization, reproductive health etc.); (2). Level of healthcare (e.g., CPA1, CPA2, CPA3, HC); (3). Action agenda and benchmarks; and (4) Resource estimates to guide the implementation.
9.3.	Innovate the current quality monitoring and enhancement program, linked with a recognition and reward system for quality improvement performance/championship to foster and maintain institutional culture and commitment, dedicating to improving patient health outcomes, continuously leveraging quality, and continuously promoting institutional-learning behavior.
9.4.	Put in place mechanisms for routinely reporting medication errors and incidents occurring in healthcare from both medical personnel and patient/family, and use the report and the information obtained to develop and implement clinical risk management activities for improving clinical practice and patient care journey.
9.5.	Improve an effective communication channel for both health personnel and patients and their families to express concerns about quality, safety and compliance without fear, and promptly take appropriate measures to address such concerns.
9.6.	Conduct regular monitoring and analysis of trends in satisfaction of both patients/health service users and health providers at facility level, and periodically conduct client and providers' satisfaction surveys at the system level, and use the findings for preparing and implementing an action plan for improvement.
9.7.	Develop and implement the Cambodian Health Accreditation System (CHAS) with appropriate supportive legal structures and technical norms, and engage public and private health facilities to participate in the healthcare accreditation program once the systems are put in place and operational.

10. Clinical practice compliance

Strengthen institutional structures and capacities for clinical governance activities at the system and facility levels, promoting health providers' accountability for patients' high-quality and safe healthcare.

10.1. Establish a national clinical governance committee with a broad-based representation to oversee, advise, support, and monitor the implementation of clinical governance across the health system, assuring technical and clinical compliance, and continuous quality and safety improvement.

10.2. Establish a clinical governance committee in all public hospitals to lead, manage, and monitor the implementation of hospital clinical governance activities, including developing quality assurance systems and processes, adapting hospital standards and clinical practice guidelines, conducting quality performance monitoring and evaluation, and enforcing practice compliance.

10.3. Develop a national clinical framework for health service delivery and public health program interventions with clearly defined structures, processes, and standards, to guide planning, implementation, evaluation, and benchmarking of health services, and to direct health professionals in providing patient-centered and evidence-based health services that are aligned with clinical objectives and institutional goals.

10.4. Conduct regular monitoring and enforce practice compliance, including technical and clinical standards, guidelines and procedures, legal and ethical standards/protocols, and other relevant policies and regulations that are applicable to healthcare facilities.

10.5. Perform regular clinical audits, including the existing maternal death audits, peer reviews, and feedback from patients and staff, or trusted sources, to evaluate clinical practices and outcomes for continuous quality-improvement cycle.

10.6. Raise awareness of health professionals and health personnel about medico-legal risks concerning adopting informed consent for medical or surgical interventions, safeguarding patient clinical records, confidentiality and privacy, etc., and promote the practice of codes of conduct and professional standards in consistency with professional values and scopes of practices for all types of health professionals.

10.7. Build clinical research capacities for health professionals (e.g., hospital-based physicians, faculty members), and promote research to generate and apply scientific evidence-based clinical care, thereby improving clinical services and health outcomes, as well as the quality of training.

Strategic Objective 3: Equity in health access and financing

Priority areas (some are closely linked with interventions in Strategic Enabler 3):

- Sustainable and equitable financing health services;
- Transforming payment systems and public financial management;
- Accountability for health services provided;
- Alignment and harmonization of funding; and
- Health financing governance.

	Priority Areas, Strategies and Interventions
11.	***Sustainable and equitable financing health services*** **Build a robust health financing system, improving efficiency, both allocative and technical, and increasing access and quality of health services.**
11.1.	Prioritize PHC within budgets with sufficient public funds allocation to raise demand for health education and promotion, preventive care, and managed diseases, reducing the need for costly specialized health care through financial and budget planning.
11.2.	Broaden the domestic financing base by implementing tax policies on unhealthy products that align with Cambodia's socio-economic trends and international best practices, promoting healthy behaviors, and generating resources.
11.3.	Extend the coverage of social health protection schemes through pooling risk arrangements to protect individuals from financial risks associated with their health needs, ensuring equity in health and social equality.
11.4.	Review and define Cambodian UHC benefit packages, including costing, that are both reasonably accessible and available to the population and prioritized for public financing over the medium- and long-term, as capacities in fiscal space and the health system increase.
11.5.	Strengthen proactive and interactive mechanisms whereby social health protection schemes and/or health insurance operators, and health providers/facilities negotiate and agree upon a comprehensive contract arrangement related to health service delivery, alignment of payment and incentives with benefit packages designed, realistic expectations, and clearly defined roles and tasks of relevant stakeholders.
12.	***Harmonizing payment mechanisms and health benefit packages*** **Transform payment systems, enabling increased efficiency in financial resources management to improve the quality of health services and contain costs.**
12.1.	Harmonize benefit packages between social health protection schemes, i.e., HEFs and NSSF-H, making access to healthcare services more equitable and possibly moving towards uniform fee schedules across different schemes when appropriate.

12.2.	Review and redefine payment mechanisms, and reset reimbursement rates, both linked to the quality of health services provided and appropriate incentives for health facilities to continuously improve access and quality, with more focus on preventive care, early treatment or interventions, and integrated and coordinated care.
12.3.	Explore the feasibility for the introduction of co-payment arrangements for specific healthcare services in benefits designed for social health protection schemes, to promote appropriate health-seeking behaviors and increase efficiency gains in health service delivery systems.
12.4.	Revise guidelines on health financing management at collecting facilities, including processes and procedures related to requests for and approval of the implementation of health financing schemes, revision of fee schedules and payment methods, and managing facility-based revenue collection.
12.5.	Leverage the use of digital payment solutions, facilitating health facilities to control the over-revenue stream and deal with the flow of patients' payments, and reduce time in claim processing for reimbursement from social health protection operators.
13.	***Accountability for health services provided*** **Promote responsive and high-quality health services to maintain patient, health service user, and public trust in the healthcare systems.**
13.1.	Raise the population's awareness of health benefits gained and the opportunity cost saved from the appropriate utilization of healthcare services, when needed, under social health protection schemes, as well as processes of receiving health services, and other relevant mechanisms, such as the pre-poor identification system.
13.2.	Publicly and visibly display fee schedules in both public and private health facilities in compliance with regulatory requirements to better inform patients/clients to make decisions in healthcare utilization.
13.3.	Improve functioning facility-based public communication mechanisms, such as public information desks, hotlines, or digital applications, for patients/clients to get information and provide feedback, and take actions on information received, promptly and effectively.
13.4.	Assess objectively and comprehensively the performance of a team-based facility in health service provision, and promote team-learning and improvement by using multiple sources of data/information, such as peer review, self-assessment, and quality indicator matrix, in addition to patients' and health service users' feedback.
13.5.	Track progress in pursuit of achieving targets of Cambodian UHC with systematic and equity-focused analysis in terms of access, health financing, and health outcomes, and promote report sharing for shaping policy and strategy.

14.	***Aligned and harmonized systems, activities and funding*** **Align systems/activities and funding of key stakeholders, including the private sector, with the health service priority towards Cambodia UHC objectives.**
14.1.	Realign public financing arrangements to meet the health needs of a population, both present and future, through PFM systems.
14.2.	Harmonize and simplify systems, processes, and procedures for claim processing and verification, and reimbursement across all health facilities and all social health protection schemes.
14.3.	Build up integrated and/or interoperable systems with harmonizing workflows and procedures to facilitate communication and operations of social protection systems and data/information sharing, supported by shared technical guidelines and/or a set of rules.
14.4.	Review and improve processes and procedures to facilitate private sector engagement in health care service delivery under social health protection schemes in compliance with rules and regulations in collaboration with NSSF and the General Secretariat of the National Social Protection Council.
14.5.	Review and revise policy framework on health financing, with specific policy objectives and actions, including health financing and governance arrangements, implementation, monitoring and evaluation.
15.	***Governance for health financing*** **Strengthen health service delivery functions in relation to financing of health service delivery within the context of governance of the social protection system.**
15.1.	Strengthen the roles and functions and capacity of the existing health financing committees at national and subnational levels, through training and learning opportunities to promote more transparent, accountable, and inclusive health financing and social protection policy actions.
15.2.	Institutionalize HEFs' management and operations based on principles of 'provider-payer split', with clearly defined roles and responsibilities of institutions and stakeholders engaging in social protection systems.
15.3.	Set and periodically review the 'ceiling prices' for health services as thresholds for setting fees for services in both public and private health facilities/providers, and enforce the implementation supported by rules and regulations. (Cambodia UHC Roadmap).
15.4.	Enhance health service delivery in relation to social health protection system operations, ensuring compliance with regulations, procedures, and technical and financial tools related to the system operations.
15.5.	Proactively engage with ministries, institutions and relevant partners in developing social protection systems, such as policies, legislations, and technical tools related to governance, management, and operations through institutional mechanisms at policy and strategy levels, as well as at the technical level.

Strategic Objective 4: Resilient health security and essential public health services

The priority areas:

- Operational readiness for health emergencies
- Managing 'One Health' potential health risks
- High-quality medical laboratory services
- Quality and safe blood and blood products
- Collaboration and health security governance

	Priority Areas, Strategies and Interventions
16.	***Operational readiness*** **Strengthen capacities of the national and subnational-level health systems in preparedness for, response to, and recovery from pandemic, disease outbreaks, and potential health emergencies.**
16.1.	**Enhance institutional capacity, planning, coordination, and collaboration, and response to disease outbreaks and other emerging health emergencies.**
16.1.1.	Adapt the functions of the Incident Management Systems (IMS), including key actors, according to different types of outbreaks and the evolving health emergency needs (services and supports), ahead of time or at the beginning of an outbreak.
16.1.2.	Sustain real-time communication across the IMS structures at the national and subnational level with a well-functioning Emergency Operations Centre for coordinated and collaborative actions and response, including 'After Action Review'.
16.1.3.	Enhance medical surge capacity, especially hospitals, assuring a well-prepared medical surge capacity action plan in advance with secured resource requirements for pandemics and health emergency crises.
16.1.4.	Perform regular simulation exercises and drills to assess performance and improve operational readiness and response at the different levels involving relevant health professionals in the health sector and beyond.
16.1.5.	Conduct regular monitoring of IHR implementation through Annual State Party Assessment Review (SPAR) and Joint External Evaluation (JEE) with the participation of relevant ministries, institutions, and other stakeholders, including regional and international experts, and use findings for further strengthening of IHR core capacity.
16.1.6.	Develop or update the existing plans, policies, procedures and technical guidelines related to managing disease outbreaks and other health emergencies.

16.2.	**Enhance early risk assessment, detection, and notification to facilitate prompt responses and control emerging disease outbreaks or potential public health threats.**
16.2.1.	Adapt and use the technical tools, such as '7-1-7' for early detection, promptly conducting risk assessment of and swiftly responding to disease outbreak and other potential health hazards. A global target '7-1-7': *7 days to detect* a suspected infectious disease outbreak; *1 day to notify* the public health authority to start an investigation; and *7 days to complete the initial response.*
16.2.2.	Enhance and maintain operational Early Warning Systems and disease surveillance systems (i.e., event-based surveillance, routine indicator-based surveillance, sentinel surveillance), most importantly proactive day-to-day disease monitoring during the inter-outbreak or epidemic period.
16.2.3.	Integrate surveillance data and other potential health hazards as part of the larger health information system, generating multiple sources of data for a more effective response to disease outbreaks, epidemics, or other public health control programs.
16.2.4.	Improve clinical capacities in disease case management, especially for acute and critical care in the time of impactful health emergency crisis and beyond, with the use of innovative approaches such as digitally-enabled care provision applications, while maintaining timely access to essential health services across the continuum of care across healthcare facilities in a safe care environment.
16.2.5.	Provide training and reskilling or upskilling, for the Rapid Response Team for health crises and other relevant actors, through competency-based approach (e.g., skilfully conducting risk assessment and in-depth analysis; translating information, using technology; monitoring and managing response) that strengthens and sustains operational readiness across multiple levels.
16.2.6.	Integrate key components of surveillance and response into broader medical education and public health training, building knowledge and capacity of the health workforce for the future.
16.3.	**Strengthen trust and risk communication interventions that link with accessible and available health services, enabling the population to make informed decisions and take actions to protect their lives, their health, their families and their community against public health threats or health emergencies.**
16.3.1.	Update the action plan for risk communication, and prepare and use trusted multiple platforms, channels, and methods for rapid dissemination of real-time, accurate, and reliable information to the public, especially at-risk people and communities, and for receiving reporting and feedback from the public.

16.3.2.	Integrate risk assessment information and control measures into risk communication interventions, thereby promoting personal, social and environmental measures and optimizing resources used.
16.3.3.	Improve mechanisms for monitoring and collecting public concerns and questions, rumors and misinformation or false information, using multiple platforms, methods, and channels to respond speedily, scientifically and professionally to collected information.
16.3.4.	Improve dynamic coordination and connection across health institutions, different authorities, and media to ensure uniform messages, avoiding dissemination of conflicting information.
17.	***One-Health potential risks (human, animal, and environmental health)*** **Prevent and manage AMR, food- and water-borne diseases, zoonosis, and** environmental health risks, and address climate change and disaster (this strategy closely relates to Strategy 16 above).
17.1.	**Control AMR, preserving the efficacy of life-saving medications and protecting human and animal health and ecosystems.**
17.1.1.	Raise awareness of health providers, patients, clients, farmers, businesses, and other relevant stakeholders about AMR harms and its preventive measures, including proper use of antibiotics in humans, animals, plants, and food products, through health education activities, public campaigns, and mass media.
17.1.2.	Provide healthcare providers with problem-based training on the rational use of medicines in relation to clinical practice guidelines and the National Essential Medicines List.
17.1.3.	Introduce appropriate use of medicines, especially antibiotics, in school curricula in collaboration with the Ministry of Education, Youth and Sport, and other relevant ministries.
17.1.4.	Conduct monitoring of the consistent practices of IPC standards and appropriate medication in all health facilities and support basic IPC practices in communities, with periodically conducting a risk assessment.
17.1.5.	Improve laboratory capacity in AMR monitoring and surveillance, and share or exchange AMR data analysis between human, agricultural, and environmental laboratories, and engage the national AMR reference laboratory in regional networks of laboratories involved in AMR surveillance.
17.1.6.	Enhance collaboration, primarily in the health, agriculture, and environment sectors, and with other key stakeholders for well-aligned and coordinated policy response to AMR and institutional-learning and knowledge sharing.
17.1.7.	Building research and innovation to support policy response and implementation, monitoring and evaluation of activities combating AMR with international good practices.

17.2.	**Prevent and manage food- and water-borne diseases, such as food poisoning, hepatitis, abdominal typhus, and acute diarrhea.**
17.2.1.	Develop or update policies, regulations, planning and technical guidelines in relation to food hygiene and safety practices.
17.2.2.	Enforce food hygiene and safety regulations under the MoH jurisdictions, such as certifying hygiene practice in restaurants, canteens, food catering, food companies, handicraft and food factories; certifying hygiene of food products; and permission for using labels and advertising infant formula feeding products.
17.2.3.	Raise awareness and promote practices of food hygiene and safety measures to the public, food business operators, food producers, and food handlers in restaurants, canteens, streets, and schools.
17.2.4.	Conduct monitoring and inspection of food hygiene and safety practices, and improve surveillance, and rapid and coordinated response to food-borne diseases and food poisoning, in collaboration with relevant institutions and local administrations.
17.3.	**Prevent and manage the impact on health due to disasters and climate change, such as floods, droughts, extreme weather, heat waves, and polluted atmosphere, as well as occupational health risks, and other health hazards.**
17.3.1.	Develop or update a comprehensive emergency preparedness plan, and implement a post-disaster recovery plan with engagement of relevant institutions, authorities, other sectors, and stakeholders.
17.3.2.	Enhance institutional capacity and support the community in risk assessment to identify hazards and vulnerabilities through capacity development training, simulation exercises and drills.
17.3.3.	Regularly review and update the geographical location of health facilities and their surrounding communities that are susceptible and vulnerable to hazards, and incorporate the information into the HCP information.
17.3.4.	Enhance early warning and monitoring and disease surveillance systems with rapid diagnosis of climate-sensitive disease incidence, and raise public awareness and education to prepare for, respond to, and recover from crisis.
17.3.5.	Build/improve climate-resilient health facilities, proactively minimizing the health impact of disasters or emergencies by adapting mitigation measures, such as green/renewable energy, water conservation, medical waste reduction, and environmental footprint reduction. *(link to Strategic enabler 4: Safe and green health facility infrastructure)*
17.3.6	Develop and strictly implement risk management measures in using high-risk medical technologies in diagnosis processes and treatment procedures, such as radioactive treatment and radiotherapy (e.g. cancer treatments)

17.3.7.	Integrate occupational health into the health security system to safeguard the well-being of the workforce and promote sustainable economic growth, improving public health outcomes and enhancing health security for entire communities.
18.	***High-quality medical laboratory services*** **Advance quality, reliability, and timeliness of laboratory services, supporting the delivery of effective clinical services and public health interventions.**
18.1.	**Strengthen laboratory quality management systems (LQMS) aligned with international standards and practices.**
18.1.1.	Define roles and functions for medical laboratories at the different levels of the health system with reference to certain specificities, such as: • Biosafety level (i.e., performing high-risk, moderate-risk and low-pathogenic tests); and • Core functions that support healthcare (i.e., diagnostic testing, treatment and care), disease surveillance and public health program interventions (i.e., test confirmation, sample collection, dispensing and transportation to laboratories at regional and national level), medical education and training, and medical research.
18.1.2.	Set national laboratory quality standards at least consisting of four key components: (1). Internal quality control; (2). External quality assurance; (3). Personnel competency assessment; and (4). Biosafety and biosecurity, with operational quality management systems to be established and put in place.
18.1.3.	Develop and implement a program on laboratory quality improvement with clearly defined scope, objectives, and actions, implementing arrangements, responsibility, monitoring, and benchmarking, and resource estimates to support program implementation.
18.1.4.	Develop and implement a comprehensive 'list of diagnostic testing' and its accompanying biosafety measures for the different-level medical laboratories with reference to its defined functions, and use the list to guide procurement of laboratory supplies and investment.
18.1.5.	Review or update policies, regulations, technical or clinical practice guidelines, standard operating procedure for bio risk management (i.e., biosafety and biosecurity) for medical laboratory system and services, and monitoring and evaluation of its use.
18.2.	**Modernize medical laboratory systems in line with the advancement of medical technologies, including laboratory technologies.**
18.2.1.	Streamline the system and workflow of medical laboratories at every hospital to become a part of an integrated clinical systems and of an integrated disease surveillance systems to meet clinical needs for patient care and to effectively respond to public health interventions, accordingly.

18.2.2.	Improve integrated medical laboratory systems, including standardizing laboratory information systems, and promote collaboration with regional and global medical laboratories.
18.2.3.	Invest in state-of-the-art laboratory infrastructures and human resources, as guided by the laboratory development plan of hospitals (national, provincial, and district level), national centers, health professional education and training institutions.
18.2.4.	Develop curricula for laboratory quality management systems, including laboratory quality management oversight, and provide mixed-method in-service training to improve the capacity of laboratory technicians.
18.2.5.	Develop curricula for laboratory sciences and laboratory management for pre- and in-service training in line with human resource for health development planning for the future.
18.3.	**Strengthen policy and regulatory compliance for medical laboratory operations.**
18.3.1.	Enhance laboratory licensing processes and procedures, with adherence to pre-defined minimum requirements or standards in relation to laboratory quality management system and performance.
18.3.2.	Mandate private laboratories reporting a set of minimum data into the MoH laboratory management information system for purposes of public health and continuously improving quality, safety, and efficiency of laboratory services.
18.3.3.	Conduct regular monitoring and inspection of medical laboratory operations in both public and private sector, ensuring that its operations adhered to standards operating procedures, and test results performed in all laboratories are accurate and reliable.
18.3.4.	Review and revise process and procedures for managing laboratory professionals in business operations by defining the scope of practices and core competencies absolutely required.
18.3.5.	Develop and implement a roadmap for the establishment of the Cambodia medical laboratory accreditation system, and incentivize both public and private medical laboratories to participate in the accreditation program when the system is put into operation.
19.	***Quality and safe blood and blood products*** **Sustain a sufficient supply of quality and safe blood and blood products, and strengthen patient blood management in consistency with patient clinical requirements.**
19.1.	**Strengthen management in all areas of blood transfusion services from blood collection and distribution to the utilization of blood and blood components in hospitals.**

19.1.1.	Review and update standards and technical practice guidelines relating to blood transfusion services, including blood donation collection, assured blood quality and safety, utilization of blood and blood products, and enforce implementation.
19.1.2.	Improve practices of safety measures for transfusion of blood and blood products in compliance with clinical requirements in patient blood management, and prevent the risk of transfusion-transmissible diseases and adverse reactions.
19.1.3.	Enhance practices of preventive measures throughout blood transfusion services, including personal protection, hazard prevention, and biomedical waste management, at blood collecting sites, in blood banks, laboratories and hospitals.
19.1.4.	Improve effective communication, including information sharing necessary, between blood services, hospital blood banks, and clinicians for better patient blood management.
19.1.5.	Provide training and refresher training for clinicians, nurses, midwives and laboratory technical staff on clinical transfusion.
19.2.	**Ensure quality and safety of blood and blood products for use.**
19.2.1.	Maintain the quality and reliability of blood donation testing, ensuring both donor safety and recipient health, by strictly and consistently practicing the standard operating procedures, including donor screening, mandatory infectious disease testing, blood typing and compatibility, and quality assurance at the blood bank.
19.2.2.	Conduct monitoring and evaluation, and hemovigilance to track and analyze adverse events and reactions related to blood donation and blood transfusion, ensuring safety and quality of blood products, and promoting appropriate clinical use in public and private hospitals.
19.2.3.	Improve quality management system of blood transfusion services of the National Center for Blood Transfusion, provincial hospital-based blood banks/ blood transfusion services, and blood depot/blood transfusion services of RH-CPA2, becoming a part of an integrated medical laboratory quality management system.
19.2.4.	Strengthen information system for blood transfusion services, including standardizing processes and procedures for data recording and documentation, reporting, and dissemination with digitally-enabled data/information management.
19.2.5.	Improve infrastructure (i.e., space, waste disposal) with a sufficient supply of medical/ laboratory consumables, equipment and technologies, operational budget, transportation for mobile blood donor collection, etc.
19.3.	**Strengthen governance, policies, and regulations for blood transfusion and donor recruitment, ensuring a sufficient supply of quality and safe blood and blood products.**

19.3.1.	Develop or update policies and regulations for governance activities relating to the provision of quality and safe blood and blood products, and prepare an action plan with resources required for the implementation.
19.3.2.	Develop and implement motivational approaches and/or supportive policy to promote awareness of voluntary non-remunerated blood donation, recruit new donors, retain regular donors (i.e., voluntary non-remunerated blood donors and young donors), and reduce primary reliance on replacement donation (i.e., family blood replacement).
19.3.3.	Improve social mobilization for voluntary and non-remunerated blood donation through multiple platforms such as specific campaigns, social and business forums, etc., in collaboration with the public and private institutions, the Cambodian Red Cross, business associations, civil society organizations, etc.
19.3.4.	Conduct regular monitoring of blood donation and use blood donor data management to improve donor recruitment and retention, donor and recipient safety and health, and promote pre- and post-donation counselling.
19.3.5.	Assess periodically the demands for and supply of blood and blood products through predictive analytics and forecasting based on historical data, real-time inventory and distribution systems based on need (e.g., during health emergency, medical treatment or surgical interventions that absolutely need blood or blood products), and capacity of blood collection.
20.	***Health security governance*** **Strengthen multisectoral collaboration and regional and international cooperation for the resilient national health system and health security, thereby contributing to strengthening regional and global health security.**
20.1.	**Enhance institutional leadership and governance at national and subnational levels for prepared planning and coordinated multisectoral response to potential public health threats and health emergencies.**
20.1.1.	Adapt governance structures and technical guidance, and the operational structures, including roles and responsibilities, at the national and subnational level that were put in place during the COVID-19 pandemic, for effective preparedness for and response to infectious disease outbreaks and other health emergencies in the future.
20.1.2.	Develop or update, and adopt legislation with a comprehensive scope that includes legal, administrative and public health measures related to all serious health risks, including cross-border health risks, and incorporate the implementation of IHR core capacities into the developed/updated legislation.
20.1.3.	Develop and implement a national action plan for health security, aligned with national priorities and health security, based on One-health and a whole-of-government approach to advance the implementation of HIR core capacities and health system strengthening.

20.1.4.	Develop and update Points of Entry (POE) health emergency plan and procedures, provide training for quarantine staff and officials working at POE, and strengthen control and quarantine measures to prevent cross-border infectious diseases or other potential public health risks
20.1.5.	Conduct monitoring and evaluation of the implementation for national One Health program that is aligned with national priority and sector priority, IHR-relevant core capacity areas, and Quadripartite of ASEAN One Health Joint Plan of Actions.
20.2.	**Strengthen a multisectoral coordinated response to One Health potential risks and other public health threats.**
20.2.1.	Build stronger institutional inter-/multisectoral structure, leadership and governance to provide oversight and strategic guidance related to One Health, including identifying national One Health priorities and potential line-sector investment in One Health, and coordinating One Health unified multisectoral and multiple level response.
20.2.2.	Enhance capacity of multidisciplinary team through the existing mechanisms and networks at technical and operational levels according to its defined roles and functions to effectively manage and implement One Health program.
20.2.3.	Promote joint actions to raise One Health education and awareness of the public, including veterinary students and medical students, through targeted public campaigns, multiple platforms of dissemination, including mass media.
20.2.4.	Improve access and capacity for timely diagnostics, especially at subnational level, and capacitate routine and outbreak surveillance systems using digital solutions, and promote data sharing, joint investigation and response.
20.2.5.	Diversify funding sources and share key resource infrastructure between institutions or relevant stakeholders (e.g., human resources, harmonized policies, systems and procedures, joint policy actions) between and among ministries and stakeholders to sustain One Health System's operations in the long run.
20.3.	**Strengthen health systems towards health security resilience, in turn, to the health systems' resilience.**
20.3.1.	Develop a roadmap towards national health system resilience, harmonize and align investment and activities of the health sector and beyond, including the private sector and relevant stakeholders, for supporting the implementation, progress monitoring and impact evaluation.
20.3.2.	Conduct systematic, timely, and regular monitoring and evaluation of health system resilience within and outside emergency context at national, subnational, and service-delivery levels, and with the use of harmonized and key indicators for measuring technical areas of the health system functions and essential public health functions.

20.3.3.	Develop and deliver a public health capacity-development training program (i.e., pre- and in-service training), focusing on shared priorities of health security and public health emergency management, including climate changes, occupational hazards, and chemical and radiation hazards, for health leaders at all levels in the health sector and beyond.
20.3.4.	Leverage technical support and resources to build, develop, and sustain capacities of subnational level health systems, especially OD health systems with community engagement, to prepare well for and swiftly, effectively, and efficiently respond to the occurring health emergency events.
20.3.5.	Establish/improve flexible mechanisms that allow health institutions to rapidly access and reallocate financial resources in an urgent response to disease outbreaks or the occurrence of health emergency events.
20.3.6.	Establish/improve platforms for institutional-learning and knowledge exchange on resilience in the health system and health security within the health sector and beyond.
20.4.	**Engage in regional and global health collaboration and cooperation to strengthen health security and address other main health problems of common interest.**
20.4.1.	Actively advocate for timely access to available and affordable life-saving medicines, tools, and technologies during health emergency crises and on a routine basis, including essential medicines for NCDs/chronic diseases.
20.4.2.	Adapt international or regional good practices, including approaches and technical/digital tools, to the country-specific contexts for strengthening national health security and health system resilience.
20.4.3.	Enhance national engagement in regional and international collaborative and coordinated efforts to manage One-health cross-border risks and address health security concerns, as well as anticipated health challenges.
20.4.4.	Encourage the private sector, locally, regionally, and internationally, to invest in the production and distribution of vaccines, medicines, medical equipment and emerging technologies, health infrastructure, emergency response systems, etc.
20.4.5.	Strengthen relationship and partnership with international agencies, global health partners, and countries to minimize negative impact on public health due to health emergency events across-geographical regions and international boundaries.

STRATEGIC ENABLERS AND STRATEGIES

Strategic Enabler 1: Institutional Development and Governance in Health

Priority areas

- Dynamic, adaptable, and talent-focused health institutions;
- Measurement and accountability for results;
- Effective collaboration and cooperation; and
- Policy and regulatory compliance.

	Priority Areas, Strategies and Interventions
1.	***Dynamic, adaptable, and talent-focused health institutions*** **Strengthen institutional agility and flexibility, and cultivate talent institutions, adapting to evolving health challenges, advancement in health technology and trends in socio-economy.**
1.1.	Adapt systems, processes, and procedures for administration and management practices, and health service delivery within institutions/health facilities, including clear lines of accountability and decision-making, and delegation of authority, positioning institutions ahead in the evolving health industry.
1.2.	Develop an institutional development and innovation program (IDIP), based on functional analysis, with a focus on a set of leadership and governance skills for groups of health leaders at national and subnational levels, and conduct regular progress monitoring and outcome assessment of IDIP implementation.
1.3.	Strengthen supporting structures at the MoH for oversight, strategic guidance, and coordination in processes for developing, reviewing/revising laws, regulations, policies, strategies to ensure their consistency and alignment.
1.4.	Strengthen the execution of decentralized health functions and delegated authorities (i.e., regulatory authority) by subnational-level administrations by providing them with capacity development and necessary resources, and maintain agile and robust communication, and by proactively working with NCDD Secretariat, the Ministry of Interior, and other relevant ministries, institutions, and stakeholders.

1.5. Foster a culture of continuous institutional improvement from institution-learning and system-learning in line with the institutional values, roles, and functions, integrated learning gained in daily work in the organization, knowledge-sharing, team capacity-building/ development fit for the jobs, promoted innovations in workplaces, and improved two-way communication.

1.6. Promote female health personnel into political, leadership, and technical positions, based on merit and qualifications, at both the national and subnational level, alongside leadership development, leading to more responsive, inclusive, and effective health policies.

2. Measurement and accountability for results

Strengthen institutional responsiveness and accountability for the provision of population-centered services, both health and non-health services, ensuring organizational and health-system productivity and efficiency, especially population health and equity.

2.1. **At the organizational level,** conduct regular performance monitoring to measure institutional responsibility for actions; and outcome assessment for measuring institutional accountability for results, and utilize the results for further institutional development and improvement.

2.2. **At the health system level,** conduct health systems performance assessment with reference to health goals and value-based service delivery objectives (Rights to health and Equity) with a focus on improving and maintaining population health, fair financing and financial protection, and responsiveness of health systems to legitimate expectations of the population (healthcare and health outcomes' satisfactions).

2.3. Periodically conduct outcome assessments on decentralization in the health sector by using reliable measurements, mainly focusing on the decision-making process, efficiency in health service delivery and resource utilization, and other relevant important aspects, and use the results for improving practices in the immediate term and in the future.

2.4. Fully use scientific evidences for decision-making, and shaping policies, strategies and health system interventions, by generating health intelligence from multiple sources, including institutional-based sources (e.g. administrative, technical and financial reports), and population-based sources (e.g. general population census, demographic and health surveys, socio-economic surveys), clinical studies, health system research, etc.

Health intelligence is a dynamic and transformative approach to healthcare that goes beyond traditional data analysis. It's about turning a vast amount of data into actionable insights to improve individual and population health.

2.5.	Promote research in healthcare, health system, and essential public health functions, by regularly updating research agenda, enhancing national research capacities, and fostering collaborations and partnerships with research and academic institutions, and other health institutions or partners, in the country, in region, and on the globe.
2.6.	Conduct monitoring and evaluation, and study related to the impact of utilization of digital health or digital health interventions on the health system operations and the health needs of the population and community.
3.	***Effective collaboration and cooperation*** **Strengthen multisectoral actions to improve health and social determinants of health, and enhance regional and global health collaboration and cooperation.**
3.1.	Provide specific training regarding 'Health in All Policies' (HiAP) and incorporate HiAP into formal education and training of health professionals and other professionals in the present and for the future, and advocate for health protection and improvement in social determinants of health, in collaboration with relevant ministries, institutions, and stakeholders.
3.2.	Innovate structures and processes for developing health policies and strategies in the health sector, enabling active multisectoral and multidisciplinary engagement to gain actionable insights and support, while maintaining a full potential engagement of the MoH in policy processes of other sectors, and at a high level of the Government.
3.3.	Promote information exchange and knowledge sharing (e.g., findings/evidences of analysis, studies, and research) that are necessary for strengthening inter- and multisectoral interventions for further improvement in health, and environmental, social and economic determinants of health.
3.4.	Maintain platforms for regular dialogue in the health sector through institutional structures, such as the Government-private partnership working group, Technical Working for Health and Provincial Technical Working for Health, for development partners and civil society organizations, and regular meetings with the professional health councils.
3.5.	Maintain active participation of the MoH in regional and global frameworks and fora, and other relevant mechanisms, to address common health challenges, such as pandemic prevention, preparedness and response, infectious diseases and climate change.
4.	***Policy and regulatory compliance*** **Enforce laws and regulations in the health sector, ensuring safe, quality, and effective health services, and other health-related services.**

4.1.	Review health legislations, regulations, policies, and procedures to be consistent with the latest legal and regulatory instruments, technical guidelines, and best practices, staying up to date with evolving regulations and compliance requirements in the healthcare industry.
4.2.	Strengthen regulatory capacity and mechanisms, and optimize processes and procedures for business licensing in the health sector with extended use of electronic systems, ensuring that health and health-related business operations comply with legal requirements and technical and ethical standards.
4.3.	Eliminate businesses in health that are unlicensed, operated beyond the scope of practice as specified in the valide business license, or affect health of the population, such as malpractice in healthcare, production, importation and distribution of substandard or counterfeit health products, by conducting regular monitoring and inspection, and measures taken for malpractices, with concerted and collaborative efforts between the MoH, CPAD, and law enforcement and competent authorities at the national and subnational level.
4.4.	Develop and implement a comprehensive policy framework for private sector engagement to achieve UHC, with clearly defined objectives and strategies, and focus on institutional structures and systems, financing options, strategic purchasing, healthcare quality improvement, regulatory mechanisms, and monitoring and reporting.
4.5.	Align and harmonize objectives, activities, and funding of projects or programs in the health sector under bilateral or multilateral cooperation, both technical and financial, with national and/or local health priorities, with the aim of improving efficiency in project/program management and implementation.

Strategic Enabler 2: Human Resources Development

Priority Areas:

- Effective health workforce planning;
- High quality health professional education and training;
- Effective health workforce management; and
- Health workforce governance.

	Priority Areas, Strategies and Interventions
5.	***Effective health workforce planning***
	Strengthen effective health workforce planning, matching appropriately the supply of competent and skilled health workforce and the needs of the evolving health needs.
5.1	**Improve the quality of health workforce development, addressing health professionals' shortage and maintaining their mix composition.**
	5.1.1. Develop and/or update the human resource development plan (HRDP) at the sectoral and institutional level (e.g., the central-level and provincial institutions, and ODs), with clearly defined objectives to be achieved in the short to medium term, supported by cost estimates, and using the plans to guide training, recruitment, distribution or redistribution, and deployment.
	5.1.2. Improve operational planning for producing health workforce by both public and private health professional education institutions, as guided by the HRDP with insightful consideration of the match between supply and demand, and the health workforce dynamic in the health market.
	5.1.3. Provide capacity-development training relating to human resource planning and implementation, in particular knowledge of approach for forecasting demand based on needs, progress monitoring, and impact evaluation, for health institutions at the national, provincial and OD level.
	5.1.4. Strengthen health workforce management information systems and the national Health Workforce Accounts platform, alongside the establishment of mechanisms for data collection on health workforce employed in other sectors, the private sector, and in the communes (e.g., community health workers).

5.1.5. Build institutional capacity in health workforce assessments and analyses, including analysis on health labor market dynamics, and promote data use and exchange across health institutions or other sectors engaging health professionals and allied-health professionals' education and employment.

6. High-quality health professional education and training

Enhance competencies and skills of health professionals in the present and build a pipeline of talent for the future.

6.1. Adapt policies, regulations, standards, and guidelines for education and training, shifting from content-based to competency-based education (CBE) and training.

6.1.1. Align education and training interventions with the designed health services, and the needs of the population and the health systems (i.e., UHC essential health services, and the supply of competent and skilled workforce), to meet demand for delivering quality and effective services and public health interventions.

6.1.2. Develop or update regulations, standards, and guidelines on governance and coordination of health professional education and training systems, and strengthen the roles and functions of the Human Resource Development Department in governance and coordination of education and training activities.

6.1.3. Develop and advance the implementation of the national frameworks for CBE and training in all health professional education and training institutions, such as a framework for qualifications and core competencies for all health professional education programs; curricula frameworks for each health professional education program; and teaching pedagogy frameworks.

6.1.4. Establish and implement a national accreditation system for health professional education and training, with the establishment of an accreditation body, supported by developed processes and procedures, and criteria for accreditation, and rules and regulations.

6.1.5. Expand pre-service education programs for health professionals and allied health professionals, filling gaps in the current knowledge and skills, and/or providing new knowledge and skills to meet the evolving needs of health service delivery and health systems.

Multidisciplinary workforce includes health policy, leadership and management, health financing, public health specialists, field epidemiologists, public health laboratory personnel, socio-behavioral science, clinical psychologists, health professional educators, biomedical engineering, health technology and informatics, infection prevention and control specialists, nurse practitioners, PHC nurse practitioners and nurse specialists.

6.2. Enhance clinical practice knowledge and skills through improved clinical practice placement, alongside improvement in innovative and structured teaching techniques and examinations.

6.2.1. Develop standards and further streamline processes for clinical education and clinical practice placement with increased support, extended learning, and practice opportunities for students, moving towards establishing a clinical practice placement certification system.

6.2.2. Invest in capacity-development for faculty members and preceptorship trainers to learn and apply new teaching methodologies, and support students during clinical practice placements, and strengthen quality monitoring systems for clinical education and clinical practice placement, including feedback mechanisms for both educators and students.

6.2.3. Develop and increase access to state-of-the-art facility infrastructures that support CBE and training, e.g., teaching facilities, libraries, clinical practice sites, simulation rooms, and appropriate space for students' self-learning.

6.2.4. Update criteria and qualification requirements (questionnaires, MCQs, and other related assessment tools) for the national entry exam (NEE), and align and update processes of clinical examinations for NEE based on CBE structures and objectives.

6.2.5. Enhance inter-professional health education, training, and practices through collaborative networks with relevant universities, academic institutions, and other partners in the country, the region and beyond.

6.3. Enhance the effectiveness of in-service training; linked to continuing professional development (CPD), maintaining and sustaining the competencies of health professionals.

6.3.1. Develop/update and implement technical guidelines for in-service training, enabling standardization in-service training, including approaches to training delivery, standards for developing curricula and materials, and training methodologies, linking training with performance, qualification of training institutions/trainers, a financial plan for training, and monitoring and evaluation of training outcomes.

6.3.2. Reskill and upskill health personnel, based on training need assessment, to meet the requirements for competencies, health service quality improvement, and development in accordance with their roles and responsibilities.

	6.3.3. Provide health personnel with skills to work collaboratively in inter-/multiple professional teams, with expertise in public health and community health, to intervene effectively on social determinants of health.
	6.3.4. Promote the use of multiple-learning platforms, including on-site and/or online training, to enable health personnel to access and participate in in-service training programs.
	6.3.5. Develop a common framework for CPD, update CPD programs and regularly review/ update scopes of practice for each health profession, and the minimum competency requirements for professional practice, in collaboration with HPCs and participation of health professional associations, where relevant and appropriate.
7.	***Effective health workforce management*** **Optimize recruitment, distribution, deployment, and retention of health personnel to fit for the purpose or respond to demand for health service delivery, promoting equitable deployment of physicians and technical personnel across rural and urban areas.**
7.1.	Develop and implement policy packages that attract health personnel and influence their decisions to remain at the designated workplace or accept relocation according to need.
7.2.	Strengthen the implementation of transparent and fair processes and procedures for recruitment, distribution, and deployment of medical and technical staff based on the MPA and CPA staffing norms and in line with the evolving policy for public administrative reforms.
7.3.	Adapt the implementation of appropriate approaches to enhance the enabling environment for talent acquisition and retention, such as manageable workloads aligned with individual personnel roles and responsibilities, recognition and reward for good performance, support for under-performance, opportunities for professional growth, appropriate workplaces, understanding of job satisfaction, work-life balance, and overall well-being.
7.4.	Protect the safety of health professionals during their work and respect their dignity for adhering to correct professional and ethical practices through appropriate legal, policy, and administrative measures, in collaboration with relevant ministries, institutions, competent authorities, HPCs, and other relevant stakeholders.
7.5.	Build a competent PHC workforce by transforming their roles and functions to be more focused on PHC and building their capacity and readiness for delivering NCDs and essential public health services.

8.	***Health workforce governance*** **Strengthen regulatory systems and capacities for health professionals, ensuring that quality, safe and effective health services and public health interventions are professionally and ethically provided to patients and the population.**
8.1.	Enforce the implementation of health professional education and training standards with enhancing systems for CPD and appropriate measures, including mandatory minimum requirements for licensing and re-licensing health professionals and allied health professionals.
8.2.	Align core competencies and curricula frameworks of each profession with the MoH-approved core competencies and advance the use of the frameworks in both public and private education and training institutions.
8.3.	Enhance management and governance of health professionals by strengthening registration and licensing systems for health professionals and promoting consistent practices of health professionals' ethics and codes of conduct.
8.4.	Maintain a mixed composition of health workforce by diversifying and formally creating new health professional/allied health professional frameworks to meet the essential needs for developing health services and public health interventions in line with trends in emerging health and in the advancement of medical technologies and socio-economic development.
8.5.	Tailor and implement progressively and effectively 'rules of engagement' in dual practiceat the system and at health facility level, focusing on time- and scopes-based dual practice, performance-based incentives, and disciplinary measures, and other relevant aspects, in accordance with policies and regulations related to management of civil servants and health professionals/allied health professionals.
8.6.	Support HPCs to enforce dual practice measures effectively, including linking professional license to compliance with dual practice rules, tailoring regulations and/or guidelines to Cambodia context-sensitive governance, and requiring health professionals to formally declare dual practice roles, with improving digital database system to track employment across the public and the private sector.

Strategic Enabler 3: High-performing Public Financial Management

Priority areas:

- Efficient budget allocation;
- Efficient budget execution;
- Accountable public health spending; and
- Public financial governance.

	Priority Areas, Strategies and Interventions
9.	***Efficient budget formulation*** **Strengthen budgeting and financial planning, ensuring that the health budget is well-aligned with and sufficiently allocated to high-impact health interventions.**
9.1.	Enhance program-based budgeting processes at the system and facility level, building a stronger link between allocated budgets and priority-oriented populations, programs and services, in line with health service delivery and policy objectives of the health sector.
9.2.	Improve the quality of public investment programs and budget strategic plans, and develop multiple-year financing plans for priority health programs, such as RMNCAH-N, NCDs, mental health, CDs, and other essential health services, to improve predictability and stability of funding.
9.3.	Direct financial resources towards PHC and UHC essential health services, targeting remote or underserved areas, bridging gaps in access to health services and promoting health equity.
9.4.	Provide refresher training on budget analysis, revenue forecasts and planned expenditures for health personnel in charge of planning and budgeting and public financial management, with the use of appropriate planning and budgeting tools, including digital tools.
10.	***Efficient budget execution*** **Strengthen budget execution practices, ensuring that the planned budget is well implemented to achieve defined program objectives.**
10.1.	Improve output- and outcome-based financing system, linked to payment for services, with more autonomy and flexibility in terms of budget execution and incentive arrangements for health facilities to achieve defined objectives.
10.2.	Optimize the regular flow of funds, both quantity and quality, for the health system operations, especially funds arriving timely at health service delivery levels, through improved performance across institutions and across all levels within the public financial management systems, e.g., budgeting, revenue and expenditure control, financial reporting, and internal control and auditing.
10.3.	Review and update, if needed, technical or regulatory tools for effective management of facility-based revenue collections within public financial management systems.
10.4.	Explore and implement credible options for ensuring reliable supply of assured quality and affordable medicines, health commodities, medical equipment and technologies, through centralized, pooled procurement and/or decentralized procurement in compliance with public procurement processes and procedures.

10.5.	Promote the use of digital systems in financial management, improving efficiency in financial operations in health systems.
11.	***Accountable public health spending*** **Strengthen public financial management performance, promoting institutional responsibility for public health spending and accountability for results.**
11.1.	Extend budget entities and foster their capacities, making operational decisions over budget formulation and execution, and promote accountability for results.
11.2.	Enhance financial information systems to improve financial operations, including tracking financial flows, accurate accounting, financial recording and reporting, as well as financial performance monitoring.
11.3	Conduct budget review and analysis with a focus on linkage between health spending and service delivery results, informing decisions for improved budget allocation and execution, by using multiple sources of accurate, quality and timely data on both health services and financing.
11.4.	Conduct monitoring and audits of financial management practices in accordance with processes and procedures and use quality-monitoring and audit reports for further improvement of public financial management.
11.5.	Provide capacity-development training related to PFM reform for the MoH PFM Working Group and relevant personnel at the subnational level to improve the implementation of public financial management reform, and stay up to date with the evolving public finance management reform process.
12.	***Public financial governance*** **Strengthen PFM systems in an efficient and transparent manner in compliance with financing policy, regulations, processes and procedures.**
12.1.	Align financial cooperation and development assistance with prioritized programs and services, and streamline funding into budget and/or financial plans for the health sector and the programs, and develop financial transition plans, moving gradually from external financing to public financing for the future.
12.2.	Develop alternative health financing based on multiple funding sources and linked to public financial management systems, ensuring a stable and sustainable financial base, including increasing domestic health budget per capita in line with GDP growth (macroeconomic and fiscal capacity).
12.3.	Adapt an approach to health financing in decentralization processes that allow flexibility in managing financial resources, including spending, based on local health priorities and respond to the need for health service delivery.
12.4.	Promote local accountability and responsiveness for public health spending with participation of community in local plannings e.g., health service planning at health facility level, commune investment plan etc., and in monitoring and evaluation of performance of local health system.
12.5.	Enhance collaboration with MEF and other stakeholders to improve resource mobilization, allocation and utilization to effectively improve the overall health of the population.

Strategic Enabler 4: Robust Supply System Management and Climate-resilient & Green Health Infrastructure

Priority areas:

- Rational selection and use of medicines and health technologies;
- Robust and resilient supply systems;
- Resilient and green health infrastructure; and
- Quality assurance and regulatory compliance.

	Priority Areas, Strategies and Interventions
13.	***Rational selection and use of medicines and medical technologies*** **Assured-quality, affordable, and safe medicines and medical technologies are readily available in all health facilities and are accessible to patients.**
13.1.	Keep the National Essential Medicines List (EML) updated for different levels of care, based on national treatment guidelines, and use the national EML for procurement, reimbursement, training, supervision, and donation purposes.
13.2.	Apply good procurement practices, including purchasing generics and aggregating volumes to negotiate better prices, particularly for newly registered essential medicines, especially those for priority diseases.
13.3.	Encourage local production and distribution of essential medicines, medical equipment, and medical devices in compliance with good manufacturing practice (GMP) and good distribution practice (GDP), and include World Trade Organization/Trade-Related Intellectual Property Rights compatible safeguards into national legislation, when possible.
13.4.	Raise public awareness of the potential cost-savings when using generics and provide health professionals with reliable information on medicines prices, and promote their rational use, proper selection and prescription of medicines.
13.5.	Equip health facilities with medical equipment and technologies that are appropriately specified in the MoH's medical equipment standard list (MESL), and promote their rational use.
	13.5.1. Update MESL regularly for the different levels of care and use MESL for investment and procurement.
	13.5.2. Invest in high-tech medical technology based on cost-benefit analysis with consideration of economies of scale, the evolving healthcare demand and availability of private health providers.

	13.5.3. Conduct periodically proactive testing to detect the safety, quality and operational performance of medical equipment/devices, establish sentinel sites to collect and analyze the information on problems in the use, and prepare a budget plan for maintenance or replacement.
	13.5.4. Use digitally enabled systems for management of medical equipment and medical devices, and other public assets, while maintaining updated inventory lists.
14.	***Robust and resilient supply systems*** **Strengthen the entire supply management systems for medical and pharmaceutical products.**
14.1.	Enhance institutional capacity on forecasts and monitoring of demand and supply of medicines, vaccines, reagents and medical consumables, and stocks status (i.e., available stocks, stockouts, overstocks) in the entire supply system and at all inventory management levels.
14.2.	Optimize inventory management practices, enabling health facilities to track order status and risks of supply disruptions, and to proactively prepare supply shortage prevention plans; and ensuring adequate, available and accessible security stocks.
14.3.	Invest in facility infrastructure and cold chain logistics for vaccines and biologics to ensure safe storage, packaging, transportation, and distribution of health products in accordance with technical guidelines.
14.4.	Use advanced technologies and automated systems to enhance supply chain management system, including quality control and balancing supply and demand.
14.5.	Build strong relationships and collaborative networking with key stakeholders such as relevant ministries and agencies, suppliers, distributors, and logistic firms, enabling the optimization of the supply chain, especially timely access to available life-saving medical products during times of public health crisis/emergencies.
15.	***Resilient and green health infrastructure*** **Invest in health facility infrastructure, supporting systems transformation and developing sustainable health services, thereby encouraging the population to confidently utilize health services.**
15.1.	Develop/update health infrastructure investment plan (HIP) in medium term (a 5-years-plan) with cost estimates, based on established criteria and other relevant factors, such as functions of health facilities, UHC health service packages, and the potential of private health providers, as well as positive impacts on socio-economic development, and use HIP to guide investment priority and align resource allocation, and incorporate the plan into national, provincial, and district development/investment plans.

15.2.	Retrofit and refurbish existing health facilities by optimizing building space with well-functioning supportive systems, including clean water, green/renewal energy, sewage, and waste management, thereby facilitating the delivery of safe and quality health services in a user-friendly environment.
15.3.	Promote climate-resilient and safe retrofitting and new constructions of health facilities with innovative infrastructure designs (i.e., agile and adapted to new needs) and incentivize the use of low-carbon materials to minimize negative impacts on human health and the environment.
15.4	Update and analyze the inventory list of health facility infrastructure, including buildings, medical equipment, ambulances, and vehicles, and prepare planned budget expenditure for maintenance and replacement (e.g., medical equipment, vehicles.)
15.5.	Develop and implement technical guidelines on 'green and safe health facilities', focusing on sustainable building designs, energy efficiency/renewable energy, water efficiency, maintaining flows of quality air, within the facilities, reducing medical wastes/general wastes, and using eco-friendly medical products and equipment.
16.	***Quality assurance and regulatory compliance*** **Strengthen quality assurance and Good Manufacturing Practices and Good Distribution Practices compliance, ensuring that health products are of assured-quality and safe for use.**
16.1.	Enhance the implementation of processes and procedures for marketing of health products according to policy and regulations with extended use of electronic systems for registered health products.
16.2.	Conduct regular audits, inspections, post-marketing surveillance, assessment and monitoring of the adverse effects, and establishing systems for record-keeping and documentation for tracing distribution and location (e.g., health facilities, markets).
16.3.	Regulate the prescription of generic medicines by appropriate measures to promote the use of generic medicines and generic substitution in both the public and private sectors.
16.4.	Conduct supportive supervision, monitoring, and evaluation on supply system operations, and the rational use of medicines, medical consumables, reagents, vaccines etc. at health facilities with key performance indicators, and use the results for improvement.
16.5.	Enhance collaboration between the MoH and other relevant ministries/institutions and competent authorities, at the national and subnational level, in controlling inappropriate health products promotion and unethical marketing practices, the production, distribution, sale and import of substandard and falsified health products.

Strategic Enabler 5: Data Development, Health Information Management and Digitalization in Health

Priority Areas

- Data quality, availability and accessibility;
- Standards and interoperability;
- Digital health workforce; and
- Policy and regulatory compliance.

	Priority Areas and Interventions
17.	***Data quality, availability and accessibility*** **Improve data management system by enhancing standards of health information system (HIS).**
17.1.	Periodically update common data and reporting standards (including data formats and definitions, operating procedures and guidelines) to improve data collection across different systems and sources (i.e., institution/health facility-based reporting and population-based surveys), and provide training on data management.
17.2.	Produce and disseminate guidelines on data quality assurance for standardizing data collection (aggregated data and patient-level data), transmission, analysis, and use at each level of the health system and across all HIS data sources.
17.3.	Review/update national core indicators and their accompanying metadata and data dictionary, and align with international classifications (WHO ICD-11/ICF), coding systems, and reporting requirements.
17.4.	Conduct audits on data quality to verify and validate the accuracy and completeness of reported data and timeliness, internal consistency of reported data and consistency of population data, and external comparison with values (health service coverage) derived from household surveys.
17.5.	Develop a national integrated and interoperable HIS (one dataset collected, used multiple times, and accessible at all levels) to avoid duplication and reduce reporting and collection burden, by using cloud-based systems to improve data storage, management, accessibility, and protection, and to reduce cost.

17.6.	Improve processes for generating sufficient data for gender analysis, through relevant data systems, promoting gender equity in health workforce leadership to enhance more gender mainstreaming interventions.
18.	***Standards and Interoperability*** **Improve integration and interoperability of HIS into overall health data ecosystems and digital health solutions, supporting data and information management.**
18.1.	Build, develop and maintain the Cambodia Health Enterprise Architecture (CHEA), providing a common digital health platform or integrated platform/database to enable integration and interoperability across different data systems, facilitating regular data exchanges.
18.2.	Maintain and use CHEA as a master architecture for interoperability and workflows of different digital data systems, data sharing between computer systems, standard improvement to determine a universal, unified, and permanent health identifier for patient/ client, geospatial data management, improvement in digital health infrastructure and ICT, thereby developing a strong digital health ecosystem.
18.3.	Assess periodically ICT/digital infrastructure and capacities of database systems, and prepare a plan for systems integration and/or interoperability, as well as data and system transfer to cloud systems, alongside the development of service- and application-based systems and platforms.
18.4.	Prioritize the utilization of suitable, accessible, and cost-effective digital health solutions and applications such as medical electronic records, e-prescription, telemedicine, mobile health, wearable devices, patient engagement platforms, and Health Information Exchange, with supportive rules and regulations.
18.5.	Establish or update key master lists, including public and private health facilities/ providers, health professionals, and client registrations, to support the integration and interoperability of data systems and ensure data consistency for use across all data systems.
18.6.	Promote the utilization of locally built and locally owned digital platforms, adapting and customizing internationally standardized and open-source technology platforms, and fostering innovation and adaptation of digital health solutions through home-grown initiatives.

18.7.	Harness artificial intelligence (AI), big data analytics, and machine learning in clinical practice, health management and administration, medical education and training, public health research and other areas.
19.	***Digital health workforce*** **Enhance knowledge of digital health and skills in data analysis and use, enabling the health workforce to navigate digital health ecosystems to improve public health policy and strengthen health systems.**
19.1.	Embed knowledge and skill in health information, digital health, health informatics, and data use in the curricula of health professional educational systems (i.e., pre-service and in-service training) and integrate in the CPD program.
19.2.	Provide health personnel, including clinical personnel, with capacity development training and upskilling training in a specific set of skills in managing HIS, information technologies and digital health that are fit their roles and responsibilities.
19.3.	Provide health leaders with targeted training on digital health governance and transformation, in collaboration with relevant ministries, institutions, and other stakeholders, including academic institutions and the private sector.
19.4.	Enhance a culture of data-driven decision-making and data use for policy development and planning, resource management, clinical service provision, public health interventions, and performance monitoring, using a structured, multi-level data review mechanism and leveraging dashboards to facilitate data analysis and interpretations.
19.5.	Create supportive environment that enables health personnel, data users, and the public access to published health information and reports, as well as health statistics, through appropriate dissemination channels.
20.	***Policy and regulatory compliance*** **Strengthen effective leadership, management and governance, collaboration, and coordination to develop a robust HIS and digital health ecosystem.**
20.1.	Develop management and governance structures and processes, and establish operational networks, to strengthen HIS and digital health interventions at the system and facility level within the country's broader context of digital transformation.

20.2.	Develop and implement legal and regulatory measures, as well as policies and standards, for the use of digital health technologies, data protection and storage, data and information sharing (most importantly clinical data, medical records, sensitive personal data, data privacy and confidentiality), safeguarding digital applications, and preventing cybersecurity threats.
20.3.	Conduct periodically assessment of HIS and digital health system performance, and develop and implement plans for improving and upgrading systems functions, and investment into the systems, including human resources, health IT solutions, and digital health infrastructures.
20.4.	Regularly assess cyber security, protecting data and application within digital health ecosystem, by developing and implementing cyber security guidelines or protocols in order to identify and promptly take preventive measures against threats to the operations and credibility of digital health systems.
20.5.	Develop guidelines for facilitating private health facilities and providers to report a set of health data as required into the MoH's HMIS, in accordance with rules and regulations.
20.6.	Enforce the implementation of the mandatory notification of all births and deaths (including cause-of-death) by the public and private facilities/providers into the electronic system, in collaboration with the Directorate General for Identification of Ministry of Interior, in accordance with rules and regulations.
20.7.	Align resources and investment for the development of HIS and digital health systems into public investment programs in the health sector, and the annual budget plan of individual health institutions, and conduct rigorous option appraisal for the use of medical equipment and technologies in health facilities.
20.8.	Build inter- and multisectoral partnerships, as well as public-private partnership, and leverage domestic, regional and global collaboration in digital governance, utilization of medical and digital technologies, strengthening of health information and digital health systems, and enhancement of medicine and public health precision.

ANNEX 1. FOCUSED PRIORITIES FOR IMPROVEMENT IN HEALTH AND WELL-BEING OF THE POPULATION

Further reduction of morbidity and mortality, particularly from main NDCs, and improvement in reproductive, maternal, newborn and child health, by focusing on the following priorities:

- Strengthening institutional capacity to lead digital governance and transformation in health sector; formulating health laws and regulations; promoting the implementation of regulatory mechanisms over public and private health care services; promoting medical research; and strengthening monitoring and evaluation;
- Enhancing capacity of health and social welfare systems to respond in a timely and effective manner for promoting public health and people's well-being, including in the event of disease outbreaks;
- Strengthening innovative health systems, focusing on primary health care; promoting healthy diet; improving quality, safety, and efficiency; expanding the coverage of health services; improving distribution and use of medicines; and enhancing monitoring and evaluation mechanisms, and clinical governance;
- Increasing health education and dissemination, aiming at raising people's awareness and proper conducts in prevention and management of diseases or public health problems, and ensuring people's proper behaviors in seeking-care and utilization of health services;
- Improving training quality of medical professions based on competencies, promoting professional ethics, and promoting extensive deployment of medical doctors and staff in accordance with technical standards.
- Expanding physical infrastructures; and strengthening the supply of medicines, and medical equipment to health posts, health centers, referral hospitals, other prioritised hospitals and national hospitals in accordance with modern technical standards.
- Enhancing multi-sectoral and inter-sectoral cooperation, community participation, and responsibilities of sub-national administrations, to ensure the deliveries of health care services that meet the essential health needs of the local population.
- Building partnerships between public and private sectors, development partners and non-governmental organizations; and enhancing regional and global cooperation in strengthening resilience, developing health sector, and expanding the coverage of the social health protection system.

The first policy priority program is 'expansion of health services towards UHC' through the expansion of social protection health system with the improvement in quality of health services, and the implementation of three key measures, as follows:

- Strengthening capacity to deliver primary health service at health centers and referral hospitals by giving the highest attention to the sufficient deployment of ethical and properly-trained staffs, the proper supply of medicines, medical equipment and modern medical facilities, and the improvement of infrastructure, as well as the deployment of digital information and digital health;
- Developing institutional capacity for national and subnational health institutions in term of human resource and financial managements, regulating capabilities, public health responses to imminent threats and emergencies, provision of responsive and accountable healthcare service, and enhancement of effective institutional functionalities; and
- Building strong partnership between the public and private health sectors that ensures high quality, safe and effective healthcare service access.

Annex 2. Key demographic data for health planning

	March, 2019[a]	2024[b]
Total population	**15,552,211** (Male 7,571,837 or 48.7% and female 7,980,374 or 51.3%)	**17,280,543** (Male 8,490,419 or 49.13% and female 8,790,125 or 50.87%)
Sex ratio	95 males per 100 females	96.59 males per 100 females
Number of households	3,553,021, with 25.6% female-headed households	3,735,659 with 27.7% female-headed households
Urban vs. rural	Urban 6,135,194 (39.4%) Rural 9,417,017 (60.6%)	Urban 7,172,206 (41.5%) Rural 10,108,337 (58.5%)
Annual growth rate	1.4% (7.8% in urban areas vs. -1.2% in rural areas)	2.1% (3.1% in urban areas vs. 1.5% in rural areas)
Population density per km²	87 persons	97 persons
Internal migrants by migration stream and sex:	Rural to urban 34% (Male 32.4%, Female 35.7%) Urban to rural 7.0% (Male 7.6%, Female 6.3%)	Rural to urban 22.3% (Male 21.2%, Female 23.4%) Urban to rural 15.8% (Male 15.8%, Female 15.7%)
Population by age group	– 60 years + 1,378,688 (8.9%) – 15-59 years 9,602,383 (61.7%) – 0-14 years 4,571,140 (29.4%)	– 60 years + 1,180,366 (6.83%) – 15-49 years 10,904,023 (63.10%) – 0-14 years 4,656,582 (26.95%)

a The National Institute of Statistics, Ministry of Planning, General Population Census of The Kingdom of Cambodia (March 2019). Report October 2020.

b The National Institute of Statistics, Ministry of Planning: Intercensal survey of the population, 2024

Annex 3. Burden of NCDs in Cambodia [29]

Risk factors drive the most death and disability combined, 2009-2019

កត្តាហានិភ័យ		2009	2019			% ការប្រែប្រួល 2009-2019
Malnutrition	កង្វះអាហារូបត្ថម្ភ	1	1	កង្វះអាហារូបត្ថម្ភ	Malnutrition	-37.3%
Air pollution	ខ្យល់កខ្វក់	2	2	ខ្យល់កខ្វក់	Air pollution	17.6%
Tobacco use	ថ្នាំជក់	3	3	ថ្នាំជក់	Tobacco use	11.2%
Dietary risks	ហានិភ័យរបបអាហារ	4	4	ជាតិស្ករក្នុងឈាមខ្ពស់	High fasting plasma glucose	72.9%
High blood pressure	សម្ពាធឈាមឡើងខ្ពស់	5	5	ហានិភ័យរបបអាហារ	Dietary risks High	35.1%
Alcohol use	ប្រើប្រាស់គ្រឿងស្រវឹង	6	6	ប្រើប្រាស់គ្រឿងស្រវឹង	Alcohol use	47.8%
High fasting plasma glucose	ជាតិស្ករក្នុងឈាមខ្ពស់	7	7	សម្ពាធឈាមឡើងខ្ពស់	High blood pressure	34.6%
Water, Sanitation & Hygiene	ទឹកស្អាត អនាម័យ	8	8	ហានិភ័យការងារ	Occupational risks	16.2%
Occupational risks	ហានិភ័យ ការងារ	9	9	សន្ទស្សន៍ខ្ពស់ កម្ពស់ធៀបទម្ងន់	High body-mass index	86.7%
Unsafe sex	ការរួមភេទគ្មានសុវត្ថិភាព	10	10	តម្រងនោមមិនដំណើរការ	Kidney disfunction	34.2%
Kidney disfunction	តម្រងនោមមិនដំណើរការ	11	12	ទឹកស្អាត អនាម័យ	Water, Sanitation & Hygiene	-40.6%
High body-mass index	សន្ទស្សន៍ខ្ពស់ កម្ពស់ធៀបទម្ងន់	13	13	ការរួមភេទគ្មានសុវត្ថិភាព	Unsafe sex	-52.7%

Metabolic risks Environmental/occupational risks Behaviral risks

Top 10 causes of deaths and disability and percentage change, 2009-2019

		2009	2019		% ការប្រែប្រួល 2009-2019
Lower respiratory infect	ជំងឺផ្លូវដង្ហើមផ្នែកខាងក្រោម	1	1	ស្នះ/បែកសរសៃឈាមក្នុងខួរក្បាល	Stroke	36.4%
Stroke	ស្នះ/បែកសរសៃឈាមក្នុងខួរក្បាល	2	2	ជំងឺផ្លូវដង្ហើមផ្នែកខាងក្រោម	Lower respiratory infections	-6.6%
Ischemic heart diseases	ស្នះសរសៃឈាមបេះដូង	3	3	ស្នះសរសៃឈាមបេះដូង	Ischemic heart diseases	46.1%
Tuberculosis	របេង	4	4	ក្រិនថ្លើម	Cirrhosis	25.1%
Cirrhosis	ក្រិនថ្លើម	5	5	របេង	Tuberculosis	-22.8%
Neonatal disorders	ជំងឺលើទារកទើបកើត	6	6	ជំងឺលើទារកទើបកើត	Neonatal disorders	-27.8%
HIV/AIDS	មេរោគអេដស៍/ជំងឺអេដស៍	7	7	ទឹកនោមផ្អែម	Diabetes	47.9%
Road injuries	របួសគ្រោះថ្នាក់ចរាចរណ៍ផ្លូវគោក	8	8	ជំងឺស្នះផ្លូវដង្ហើមរ៉ាំរ៉ៃ	COPD	37.6%
COPD	ជំងឺស្នះផ្លូវដង្ហើមរ៉ាំរ៉ៃ	9	9	សន្ទស្សន៍ខ្ពស់កម្ពស់ធៀបទម្ងន់	Lung cancer	54.6%
Diabetes	ទឹកនោមផ្អែម	10	10	មហារីកសួត	Road injuries	4.9%
Lung cancer	មហារីកសួត	14	19	រោគអេដស៍/ជំងឺអេដស៍	HIV/AIDS	-.63.9%

Communicable, maternal neonatal and nutritional diseases Non-communicable diseases Injuries

Annex 4. Health Sector Reform

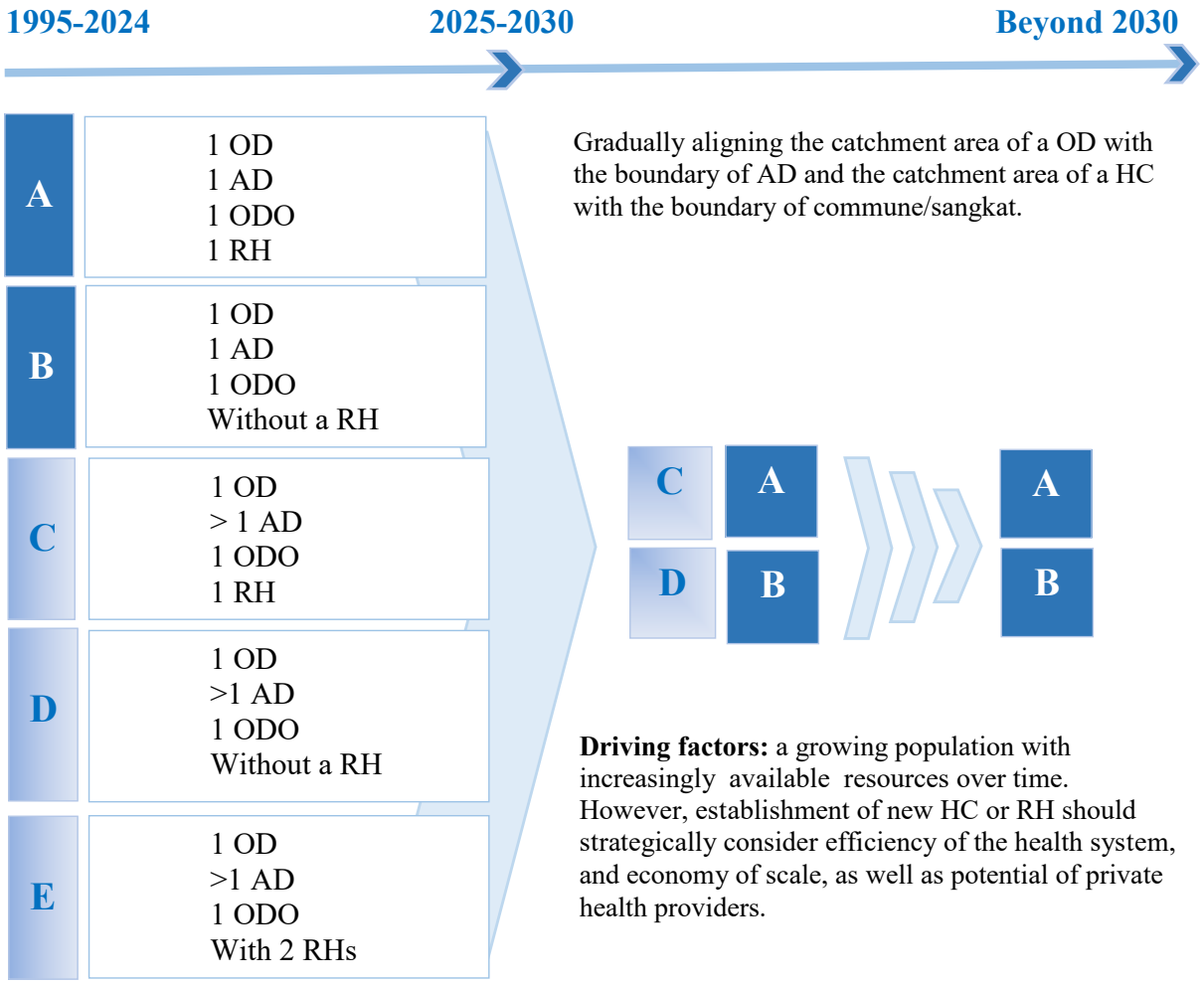
The MoH produced the first master plan for health development 1994-1996 in 1993, followed by the introduction of the policy guidelines for strengthening district health system in 1994, as strategic planning tools for embarking the health sector reform in 1995 and for developing specific health policies, strategic plans, and technical guidelines to support the implementation of the reform, notably health coverage plan 1995 (HCP), health financing charter 1996, health workforce development plan 1996-2006, the guidelines for strengthening operational districts 1998, and policy on community participation in 2000.

Reforming the health sector has brought changes through:

- Redesigning the architecture of the health system, with clearly defined roles and types of services at each level of the health system;
- Establishing each health facility's catchment area to ensure the coverage of the entire population—neither gap nor overlapping—based on population and accessibility criteria that are defined based on the guiding principles of 'access, coverage, quality, efficiency, and equity';
- Rationalizing allocation and use of financial and human resources (i.e., budgetary reform and redistribution and re-training/training of health personnel); and
- Introducing new approaches to finance health services, including implementation of user charges with exemption policy for the poor, innovative health services management (e.g., Contracting health services and Special Operation Agencies) and exploring a path for the development of social health insurance, such as community-based health insurance, health equity funds etc.

Annex 5. The future of OD health system

Pathways for OD systems in the future



- ***from short to medium term*– 2024 to 2030. The existing criteria of the HCP remain relevant** as the projected population growth is expected to be consistent with the current annual growth rate, and resource constraints are anticipated, while the health service delivery capacity– availability and readiness of many existing district referral hospitals– remain a pressing issue.
- ***from medium to longer term*– 2030 onwards. The 'accessibility' criterion becomes less relevant** due to the expansion of road infrastructure and a wider availability of public transport. However, the **'population' criterion becomes essential** as the population continues to grow, and growing demand for healthcare resulted from the scale-up of the social health protection
- financial resources for health become more available and accessible when Cambodia reaches upper-middle income country status by 2030.

Annex 6. Remaining and anticipated health challenges

1) **Burden of NCDs, including mental health conditions, continues to pose a significant threat with the potential to cause tremendous morbidity and mortality, while Cambodia is on the path of an aging society,** leading to greater demand for effective NCD services. The increasing burden of NCDs draws attention to social and economic loss, with high tolls of disability, despite low mortality. The avoidable illness and deaths from key NCDs highlight the need for a strong capacity of health system and innovative approach with a transformative health financing mechanisms to effectively deliver NCD services and address health risk behaviors of the population.

2) **High expectations for RMNCAH-N will be substantially improved in the coming years,** in a way that matches the capabilities of equivalent upper-middle-income-countries, where survival gains are higher. Priority interventions include accelerating the reduction in maternal and child mortalities, improving the nutritional status of children under the age 5, and reducing the gaps in health outcomes that vary by geographical location, level of income, and level of education. Continuously prioritizing RMNCAH-N as part of UHC and expanding the minimum package of care with timely and accessible life-saving interventions both at health facilities and in close proximity to home will be a significant leap for the health system.

3) **Communicable diseases remain a public health concern, but control and elimination of key communicable diseases is a realistic goal** given affordable and achievable interventions and years of experience. A common challenge for Malaria, TB, and HIV interventions is that the downward trend in external funding continues. This may threaten the gained momentum of the programs moving towards ending key communicable diseases, especially TB and HIV/AIDS, by 2030, unless domestic resources are increasingly made available and further integration of communicable disease control programs into strengthening resilience in the health systems is effectively made, as well.

4) **A health security emergency would potentially emerge, threatening public health and socio-economic activities.** Therefore, it will be essential to shift to a more long-term and sustainable preparedness planning for and enhance multisectoral coordinated response to emerging and re-emerging infectious diseases, zoonosis and other potential health hazards given that a population is increasingly mobile and connected, including trade connectivity, while disaster-sensitive diseases and climate change can have a range of negative impact on health and trade, such as increased risks of infection, water-borne diseases, extreme heat, damaged critical social and economic infrastructures. Additionally, the existential threat of AMR will undo today's effective treatments for diseases and increase mortality risk following surgery, chemotherapy, and organ transplantation, as well as increasing health care costs due to extended hospitalization.

5) **Availability and readiness of health services, associated with improved quality and access from a health financing standpoint, remain pressing issues,** requiring reorienting health service delivery and resetting financing of the health system. Health risk behavior of a population, limited health service delivery capacity of the health system due to resource constraints, especially human resources, a huge gap in financial risk protection (i.e., high OOPS on health and Cambodian migrants in the destination countries poses a pressing issue of public health and public finance), and insufficiently regulated private health providers (i.e., rising utilization of private health services, including buying medicines at pharmacy counters, contribute to persistently high OOPS costs), all combined, have led to the high cost of ill-health and economic consequences for households.

ANNEX 7. INDICATORS FOR HSP4 MONITORING AND EVALUATION

	សូចនាករស្នូល Key Indicators	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
	សុខភាពបន្តពូជ មាតា ទារក កុមារ អាហារូបត្ថម្ភ Reproductive, maternal, newborn and child health, and nutrition												
1.	អត្រាមរណភាពមាតា ក្នុងទារកកើតរស់១០០ ០០០នាក់ Maternal Mortality Ratio (per 100 000 live births)	154		**100**	-	-	-	-	**70**	-	-	-	**<70**
2.	អត្រាស្លាប់ទារក ក្នុងទារកកើតរស់ ១ ០០០នាក់ Neonatal mortality rate (per 1000 live births)	8		**<8**	-	-	-	-	**6**	-	-	-	**<6**
3.	អត្រាស្លាប់កុមារអាយុក្រោម៥ឆ្នាំក្នុងទារកកើតរស់ ១ ០០០នាក់ Under-five mortality rate (per 1000 live births)	16		**15**	-	-	-	-	**14**	-	-	-	**10**
4.	អត្រាស្គមស្គាំងលើកុមារអាយុក្រម៥ឆ្នាំ Wasting among children aged under 5 (%)	9.4		**7**	-	-	-	-	**<5**	-	-	-	**<5**
	អត្រាក្រិសក្រិនលើកុមារអាយុក្រោម៥ឆ្នាំ Stunting among children aged under 5 (%)	22		**20**			-	-	**19**	-	-	-	**17**
5.	សមាមាត្រស្ត្រីក្នុងវ័យបន្តពូជអាយុ១៥-៤៩ឆ្នាំ ដែលត្រូវការសេវាផែនការគ្រួសារពេញចិត្តនឹងមធ្យោបាយពន្យារកំណើតទំនើប Proportion of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods (%)	60.60	60.60	**65**	-	-	-	-	**68**	-	-	-	**70**

	សូចនាករស្នូល Key Indicators	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
6.	អត្រាប្រើប្រាស់មធ្យោបាយពន្យារកំណើតទំនើបមួយក្នុងចំណោមស្ត្រីបានរៀបការអាយុ ១៥-៤៩ឆ្នាំ Percentage of married women aged 15-49 years use one modern contraceptive (%)	14.14	13.25	**25**	26	27	28	28.5	**29**	30	31	32	**33**
7.	ភាគរយស្ត្រីមានគភ៌បានទទួលការថែទាំមុនសម្រាល ២ លើក ដោយបុគ្គលិកសុខាភិបាល Percentage of pregnant women received 2nd antenatal care (ANC) by health personnel	99.34	91.41	**93**	95	97	98	99	**100**	100	100	100	**100**
8.	ភាគរយនៃស្ត្រីមានគភ៌បានទទួលការថែទាំមុនសម្រាល ៤លើកដោយបុគ្គលិកសុខាភិបាល Percentage of pregnant women received ANC4+ consultation by health personnel	74.90	72.02	**75**	78	82	85	87	**90**	91	92	93	**95**
9.	ភាគរយនៃម្តាយនិងទារកបានទទួលការពិនិត្យថែទាំក្រោយសម្រាលលើកទី១ ក្នុងសប្តាហ៍ទី១ ក្រោយសម្រាលដោយបុគ្គលិកសុខាភិបាល Percentage of mother and child received 1st post-natal care during the 1st week of post-partum by health personnel	57	51.80	**59**	73	77	80	83	**85**	86	87	88	**90**
10.	សមាមាត្រសម្រាលនៅមូលដ្ឋានសុខាភិបាល (%) Proportion of births delivery at health facilities	88.23	75.82	**89**	90	88	90	91	**92**	93	94	95	**96**
11.	ភាគរយនៃទារកបានទទួលការបំបៅដោយទឹកដោះម្តាយក្នុងអំឡុងមួយម៉ោងដំបូងនៃកំណើត (%) Percentage of newborn breast-fed during 1st hour after birth (%)	71.02	72.73	**74**	76	77	78	79	**80**	81	82	83	**85**
12.	សមាមាត្រនៃការសម្រាលដោយបុគ្គលិកសុខាភិបាល Proportion of births attended by health personnel (%)	90.62	77.63	**91**	92	93	94	95	**96**	97	97	97	**97**
13.	អត្រាសម្រាលដោយវិធីវះកាត់ Caesarean section rate (% of live births)	10.14	11.96	**11.5**	12	12	12.5	13	**13**	14	14	14	**14**

	សូចនាកវស្នូល Key Indicators	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
14.	អត្រាគ្របដណ្តប់នៃវ៉ាក់សាំងបង្ការកញ្ជ្រឹល-ស្ទូចដូសទី១ Coverage rate of 1st dose of Measles-Rubella (%)	100	109.1	**>95**	>95	>95	>95	>95	**>95**	>95	>95	>95	**>95**
15.	អត្រាគ្របដណ្តប់នៃវ៉ាក់សាំង៣ដូសបង្ការជំងឺ ខាន់ស្លាក់ ស្វិតដៃជើង តេតាណូស រលាកសួត Coverage rate of 3rd dose of DPT-HepB-Hib (%)	100	95.35	**>95**	>95	>95	>95	>95	**>95**	>95	>95	>95	**>95**
16.	ករណីថ្មីពិនិត្យជំងឺក្រៅ លើកុមារអាយុក្រោម៥ឆ្នាំ ម្នាក់ ក្នុងមួយឆ្នាំ (ចំនួនលើក) OPD new case children under 5 per capita per year (number of visit per child)	1.65	1.63	**1.69**	1.71	1.73	1.75	1.76	**1.77**	1.78	1.79	1.80	**1.81**
17.	ភាគរយស្ត្រីមានគភ៌បានទទួលគ្រាប់ថ្នាំជីវជាតិដែក/អាស៊ីតហ្វូលីក ៩០គ្រាប់ Percentage of pregnant women received 90 tablets of iron/folic acid (%)	87.29	79.55	**90**	90	90	92	92	**92**	95	95	95	**95**
18.	ភាគរយស្ត្រីក្រោយសម្រាលបានទទួលគ្រាប់ជីវជាតិដែក/អាស៊ីតហ្វូលីក ៤២គ្រាប់ Percentage of post-partum women received 42 tables of iron/folic acid (%)	76.22	68.39	**82**	83	83.5	84	84.5	**85**	86	87	88	**90**
19.	ភាគរយកុមារអាយុ១២ខែ-៥៩ខែ បានទទួលគ្រាប់ថ្នាំទំលាក់ព្រូន(មេបង់ដាស្សុល) រៀងរាល់ ៦ខែម្តង (%) Percentage of children aged 12-59 months received deworming tablets (Mebendazole) every 6 month	77.3	92.73	**93**	92	93	94	95	**>95**	>95	>95	>95	**>95**
20.	លុបបំបាត់ការចម្លងមេរោគ៣ប្រភេទពីម្តាយទៅកូន៖ Eliminate mother-to-child transmission of 3 infectious diseases:												

	សូចនាករស្នូល Key Indicators	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
	▪ មេរោគអេដស៍: អត្រាអាំងស៊ីដង់មេរោគលើកុមារ ដោយសារការចម្លងពីម្តាយទៅកូន (% និង ចំនួនករណី ក្នុង ១00.000 កំណើតរស់) HIV virus: Incidence of MTCT (% & number of cases per 100 000 live births)	8.18	**8.18**	**-**	-	-	-	**-**	**<5% & <50**	Eliminated		**Maintain non-transmission**	
	▪ មេរោគស្វាយ: អត្រាអាំងស៊ីដង់ជំងឺស្វាយពីកំណើតលើកុមារ (ចំនួនករណីឆ្លងថ្មី ក្នុង១00ពាន់កំណើតរស់) Syphilis: Incidence of congenitally transmitted child per 100,000 live births)	98	98		-	-	-	-	**<50**	Eliminated		**Maintain non-transmission**	
	▪ មេរោគរលាកថ្លើមប្រភេទ បេ: ប្រ៉ាឡង់ HBsAg ក្នុងចំណោមកុមារអាយុ ៥ ឆ្នាំ (%) Prevalence of HBsAg among children aged 5	<1	<1		-	-	-	-	**<0.1%**	Eliminated		**Maintain non-transmission**	
	ការឈឺនិងការស្លាប់បណ្តាលមកពីជំងឺឆ្លង **Morbidity and mortality due to communicable diseases**												
21.	ករណីឆ្លងថ្មីនៃមេរោគអេដស៍ក្នុងប្រជាជនដែលគ្មានផ្ទុកមេរោគអេដស៍ ១ ០00នាក់ Number of new HIV infection per 1000 uninfected population	0.07	0.07	**0.07**	0.06	0.06	0.05	0.05	**0.05**	0.04	0.04	0.04	**0.04**
22.	ភាគរយអ្នកផ្ទុកមេរោគអេដស៍(មនុស្សពេញវ័យនិងកុមារ) បានទទួលការព្យាបាលដោយឱសថប្រឆាំងមេរោគអេដស៍ Percentage of people (adults and children) living with HIV on ART (%)	99.98	99.98	**99.0**	99.0	99.0	99.0	99.0	**99.0**	99.0	99.0	99.0	**99.0**
23.	ភាគរយនៃអ្នករស់នៅជាមួយមេរោគអេដស៍ (មនុស្សពេញវ័យនិងកុមារ) ដែលកំពុងព្យាបាល ដោយឱសថប្រឆាំងមេរោគអេដស៍បានធ្វើតេស្ត viral load ហើយមានលទ្ធផល viral load suppressed ក្នុងរយៈពេល១២ខែកន្លង Percentage of People living with HIV (adults and children) on antiretroviral therapy with viral load suppression in the past 12 months.	98.02	98.46	**98**	99	99	99	99	**99**	99	99	99	**99**

	សូចនាករស្នូល Key Indicators	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
24.	ករណីកើតថ្មីនៃជំងឺរបេងគ្រប់សណ្ឋាន Tuberculosis Incidence of all forms TB per 100,000 population	335	272	**268**	259	250	240	227	**200**	160	128	110	**100**
25.	អត្រាស្លាប់ដោយជំងឺរបេង Tuberculosis mortality rate per 100,000 population	21	19	**18**	17	16	15	14	**13**	10	7	6	**5**
26.	ករណីស្រាវជ្រាវជំងឺរបេងដែលបានរាយការណ៍ Tuberculosis cases notification	32 686	33 769	**39 150**	40 108	40 150	40 200	40 250	**40 300**	41 000	42 000	42 000	**42 000**
27.	អត្រាព្យាបាលជោគជ័យនៃជំងឺរបេង Tuberculosis treatment success rate (%)	96	96	**>90**	>90	>90	>90	>90	**>90**	>90	>90	>90	**>90**
28..	អត្រាស្លាប់នៃជំងឺគ្រុនចាញ់រាយការណ៍ដោយមូលដ្ឋានសុខាភិបាលសាធារណៈ Malaria Mortality Rate reported by public Health facilities	0.00	0.00	**0.00**	0.00	0.00	0.00	0.00	**0.00**	0.00	0.00	0.00	**0.00**
29.	ករណីថ្មីនៃជំងឺគ្រុនចាញ់ Malaria Incidence per 1,000 population	0.08	0.02	**00**	00	00	00	00	**00**	00	00	00	**00**
30.	អត្រាស្លាប់ដោយជំងឺគ្រុនឈាមដែលបានរាយការណ៍ដោយមូលដ្ឋានសុខាភិបាលសាធារណៈ (%) Dengue hemorrhagic fever case fatality rate	0.28	0.26	**0.25**	0.24	0.22	0.21	0.20	**0.18**	0.17	0.15	0.14	**0.13**
	ជំងឺមិនឆ្លង ជំងឺសុខភាពផ្លូវចិត្ត បញ្ហាសុខភាពសាធារណៈដទៃទៀត **Non communicable diseases, mental disorders & other public health problems**												
31.	ប្រេវ៉ាឡង់ ប្រើប្រាស់ថ្នាំជក់ក្នុងចំណោមប្រជាជន Prevalence of tobacco use among population (%)												
	▪ អាយុលើសពី១៥ឆ្នាំឡើង (%) ≥ 15 years-old	18.15	-	**-**	-	15.42	-	-	**14.52**	-	-	-	**12.70**

	សូចនាករស្នូល Key Indicators	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
	▪ អាយុពី ១៣-១៥ឆ្នាំ (%) 13-15 years-old	3.5	-	-	-	3.33	-	-	**3.15**	-	-	-	**<3.0**
32.	ប្រេវ៉ាឡង់ប្រើប្រាស់គ្រឿងស្រវឹងជោគជាំក្នុងចំណោមមនុស្សពេញវ័យ អាយុពី ១៨-៦៩ឆ្នាំ (%) Age standardized prevalence of adults aged 18-69 years engaged in heavy episodic drinking (%)	24.5	-	-	-	22	-	-	**19.6**	-	-	-	**18.38**
33.	ភាគរយនៃអ្នកជំងឺអាយុ៤០ឆ្នាំឡើងមានជំងឺឡើងសម្ពាធឈាម បានទទួលការព្យាបាលនៅមូលដ្ឋានសុខាភិបាលសាធារណៈ ស្របតាមពិធីសារព្យាបាល Percentage of patients aged from 40 years with high blood pressure received treatment at public health facilities in accordance to the treatment protocol	10	11	**15**	20	25	30	35	**40**	45	50	55	**60**
34.	ភាគរយនៃអ្នកជំងឺអាយុ៤០ឆ្នាំឡើងមានជំងឺទឹកនោមផ្អែម ដែលបានទទួលការព្យាបាលនៅមូលដ្ឋានសុខាភិបាលសាធារណៈ ស្របតាមពិធីសារព្យាបាល Percentage of patients aged from 40 years with diabetes received treatment in accordance with the treatment protocol	10	11	**15**	20	25	30	35	**40**	45	50	55	**60**
35.	ភាគរយស្ត្រីអាយុ ៣០-៤៩ឆ្នាំ បានទទួលការពិនិត្យមាត់ស្បូនរកជំងឺមហារីកយ៉ាងតិចមួយដង (%) Percentage of women aged 30-49 years getting cervical cancer screening at least once	5	7	**10**	15	18	21	24	**30**	35	40	50	**55**
36.	អត្រាអ្នកជំងឺធ្លាក់ទឹកចិត្តបានទទួលការព្យាបាល (%) Percentage of peoples with depressive disorders received treatment.	2.5	4.5	**25**	30	35	40	45	**50**	50	>50	>50	**>65**
37.	អត្រាអ្នកជំងឺវិកលចរិតរ៉ាំរ៉ៃបានទទួលការព្យាបាល (%) Percentage of peoples with Schizophrenia received treatment	44.2	60	**62**	64	66	68	70	**70**	75	>75	>75	**>75**

	សូចនាករស្នូល Key Indicators	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
38.	អត្រារះកាត់ជម្ងឺក្នែកឡើងបាយក្នុងប្រជាជន១លាននាក់ Percentage of population covered by social protection coverage	2,304	2,568	**2,750**	2,850	3,000	3,200	3,300	**3,500**	3,550	3,600	3,650	**3,700**
	ការបង្ការហានិភ័យហិរញ្ញវត្ថុ **Financial risk protection**												
39.	ភាគរយនៃប្រជាជនគ្របដណ្តប់ដោយប្រព័ន្ធគាំពារសុខភាពសង្គម (%) Percentage of population covered by social health protection schemes	41	43.71	**50**	55	60	65	70	**70**	73	75	77	**>80 (2035)**
40	សន្ទស្សន៍គ្របដណ្តប់សេវាថែទាំសុខភាពនៃការគ្របដណ្តប់សុខភាពជាសកល (រង្វាស់ពី ០-១០០) UHC Health Service Coverage Index (Scale 00-100)	58	60.10	**64**	68	70	72	74	**75**	76	77	78	**>80 (2035)**
41	ភាគរយចំណាយប្រាក់ពីហោប៉ៅលើការថែទាំសុខភាព OOPS on health as percentage of total health expenditure	61	60	**57**	53	-	-	-	**43**	-	-	-	**<35 (2035)**
	សមត្ថភាពប្រព័ន្ធសុខាភិបាល **Health system capacity**												
42.	ពិន្ទុសមត្ថភាពស្នូលនិយ័តកម្មសុខភាពអន្តរជាតិ (%) IHR Core capacity score (%)	67.5	67	**68**	69	70	71	73	**75**	78	82	85	**90**
43.	ភាគរយនៃព្រឹត្តិការណ៍ហានិភ័យសុខភាពសាធារណៈដែលបានកើតឡើងត្រូវបានអនុវត្តតាមវិធីសាស្ត្របច្ចេកទេស ៧-១-៧ Percentage of public health risk events that applied technical approach '7-1-7'	60	65	**70**	75	80	85	>90	**>90**	>90	>90	>90	**>90**
44.	ចំនួនលើកនៃការពិគ្រោះជំងឺក្រៅករណីថ្មីរបស់ប្រជាជនមួយនាក់ក្នុងមួយឆ្នាំ Number of new consultation per capita per year	0.69	0.79	**0.75**	0.80	0.85	0.90	0.90	**0.90**	0.95	0.95	1	**1**

	សូចនាករស្នូល Key Indicators	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
45.	អត្រាស្លាប់នៅមន្ទីរពេទ្យ Hospital fatality rate (%)	0.70	0.56	**<1**	<1	<1	<1	<1	**<1**	<1	<1	<1	**<1**
46.	រយៈពេលមធ្យមនៃការសម្រាកព្យាបាលនៅមន្ទីរពេទ្យ (ចំនួនថ្ងៃ) Average length of stay (number of days)	4.37	4.11	**5**	5	5	5	5	**5**	5	5	5	**5**
47.	ភាគរយនៃសេវាសង្គ្រោះផ្នែកសម្ភពនិងថែទាំទារកទើបកើតដែលដំណើរការ[1] Percentage of functioning EmONC services	-	-	-	-	-	-	-	-	-	-	-	-
48.	អំណោយផ្តល់ឈាមដោយអ្នកស្ម័គ្រចិត្ត (%) Percentage of voluntary blood donation	19.4	22	**25**	27	30	35	37	**40**	43	45	50	**55**
49.	មូលដ្ឋានសុខាភិបាលទទួលពិន្ទុគុណភាពលើស៥០% Health facilities received quality health assessment score more than 50%												
	▪ មណ្ឌលសុខភាព Health Center	4.61	32.82	**60**	70	80	80	-	**80**	-	-	-	**90**
	▪ មន្ទីរពេទ្យបង្អែកកម្រិត១ RH-CPA1	6.67	70	**80**	85	90	90	-	**90**	-	-	-	**95**
	▪ មន្ទីរពេទ្យបង្អែកកម្រិត២ RH-CPA2	13.16	65.8	**80**	85	90	90	-	**90**	-	-	-	**95**
	▪ មន្ទីរពេទ្យបង្អែកកម្រិត៣ RH-CPA3	33.33	81.8	**90**	95	95	-	-	**95**	-	-	-	**100**
50.	ពិន្ទុនៃការពេញចិត្តរបស់អ្នកជំងឺ/អតិថិជនចំពោះមណ្ឌលសុខភាពនិងមន្ទីរពេទ្យបង្អែក(%) Patient/client satisfaction rate for HCs and RHs	75	80	**81**	83	85	85	-	**86**	-	-	-	**88**
51.	ភាគរយមណ្ឌលសុខភាពដែលមានគណៈកម្មការគ្រប់គ្រងមណ្ឌលសុខភាពដំណើរការពេញលេញតាមលក្ខខ័ណ្ឌដែលបានកំណត់ (%) Percentage of Health Center Management Committees fully functioning in accordance with the defined criteria	85	91.42	**85**	85	85	85	87	**87**	87	87	90	**92**

	សូចនាករស្នូល Key Indicators	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
52.	ភាគរយក្រុមទ្រទ្រង់សុខភាពភូមិមានចំណេះដឹងសុខភាព(អក្ខរភាពសុខភាព) Percentage of Village Health Support Groups having health literacy	47	60	**65**	70	75	80	82	**85**	87	88	90	**91**
53.	អនុបាតវេជ្ជបណ្ឌិតឯកទេស/វេជ្ជបណ្ឌិត-គ្រូពេទ្យ-គិលានុបដ្ឋាក-ឆ្មប សម្រាប់ប្រជាជន ១០ ០០០នាក់ Ratio of specialist, medical doctor, nurse and midwife to 10,000 population	28,8	29	**30.1**	31.3	32.9	34.5	36.1	**38**	-	-	-	**45**
	▪ វេជ្ជបណ្ឌិតឯកទេស-វេជ្ជបណ្ឌិត-គ្រូពេទ្យ Specialist, medical doctor, medical assistant		6.7	-	-	-	-	-	**8**	-	-	-	**10**
	▪ គិលានុបដ្ឋាក Nurse		15.3	-	-	-	-	-	**20**	-	-	-	**22**
	▪ ឆ្មប Midwife		6.8	-	-	-	-	-	**10**	-	-	-	**13**
54.	ចំណាយចរន្តថវិកាជាតិលើសុខភាព គិតជាភាគរយនៃថវិកាជាតិសុខាភិបាលដែលអនុម័ត (%) Current national health expenditure as percentage of approved national health budget	94.5	97.2	**>95.0**	>95.0	>95.0	>95.0	>95.0	**>95.0**	>95.0	>95.0	>95.0	**>95.0**
55.	សន្ទស្សន៍គុណភាពទិន្នន័យដែលរាយការណ៍ពីមណ្ឌលសុខភាព និងមន្ទីរពេទ្យបង្អែកគ្រប់កម្រិត Data quality index reported from Health Center and all Referral Hospitals	9[1]	>95	**>95**	>95	>95	>95	>95	**>95**	>95	>95	>95	**>95**

[1] តម្លៃដើមគ្រានឹងត្រូវបង្កើតតាមរយៈការវាយតម្លៃ បន្ទាប់មកចំណុចដៅនឹងត្រូវកំណត់។ គិតត្រូវខែធ្នូ ឆ្នាំ២០២៤ សេវាសង្គ្រោះផ្នែកសម្ភពនិងថែទាំទារកទើបកើត កម្រិតមូលដ្ឋាន (Basic Emergency Obstetric and Neonatal Care facility or BEmONC) មានចំនួន ១៥៣ កន្លែង និងកម្រិតគ្រប់ជ្រុងជ្រោយ (Comprehensive Emergency Obstetric and Neonatal Care facility or CEmONC) មានចំនួន 49 កន្លែង ក្នុងទូទាំងប្រទេស។ (Baseline value will be established and the targets will be set, accordingly. As of December 2024, there were 153 BEmOCN facilities and 49 CEmONC facilities across the country.)

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