

KINGDOM OF CAMBODIA
NATION RELIGION KING



MINISTRY OF HEALTH

∴ NATIONAL POLICY AND STRATEGIC PLAN ON ∴
∴ SURGERY, OBSTETRIC AND ANESTHESIA ∴
∴ 2026-2035 ∴



Saving Lives Through Safe Surgery

NATIONAL COMMITTEE FOR
SURGERY, OBSTETRIC AND ANESTHESIA

Department Of Health Services

NSOAP March 2026

:: NATIONAL POLICY AND STRATEGIC PLAN ON :: :: SURGERY, OBSTETRIC AND ANESTHESIA :: :: 2026-2035 ::

A Policy and Strategic Framework for Safe, Affordable, Timely and Equitable Surgical, Obstetric and Anesthesia Care in the Kingdom of Cambodia.

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"The success of a surgery is ultimately reflected in the patient's full recovery, within an appropriate timeframe and with improved quality of life. Therefore, careful consideration is required before, during, and after surgery."

H.E. Prof. CHHEANG RA
Minister of Health, Kingdom of Cambodia

FOREWORD

Surgical, obstetric, and anesthesia care is a **fundamental component** of a resilient health system and a direct response by the Ministry of Health to national health priorities outlined in the Royal Government's Policy Program 2023–2028 and the Health Strategic Plan (HSP4) 2025–2034. This care also aligns with the global commitment to strengthening surgical systems, and respond to the resolutions of the 78th World Health Assembly (2025).

The Ministry of Health endorsed the implementation of the **National Policy and Strategic Plan on Surgical, Obstetric, and Anesthesia (SOA) 2026–2035** that applies to all capital, provincial, and district health administrations; public and private health facilities; training institutions in the health sector; pharmaceutical suppliers; and medical equipment manufacturers and distributors participating in the national health supply chain.

This **National Policy and Strategic Plan** on SOA establishes a mandatory national framework for the transformation and innovation of **SOA services**. It is intended to ensure that all people in Cambodia especially those in the communities receive **safe, effective, timely, affordable, and high-quality surgical care** delivered with dignity, equity and social inclusion.

The Ministry of Health urges all health facilities, development partners, professional health councils, scientific health associations, civil society organizations, private service providers, and communities to implement **this policy and strategic plan by developing local SOA action plans**. This will support sustained political commitment, multisectoral collaboration, and the active allocation of human, material, and financial resources to save lives, prevent disabilities, and advance decisively toward the Ministry of Health's shared goal of achieving Universal Health Coverage for all Cambodians by 2035. *S/N G F R R*

Phnom Penh, 24 March 2026

Minister of Health *CS*



Prof. CHHEANG RA

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ABBREVIATIONS

ADB	Asian Development Bank
AI	Artificial Intelligence
AMS	Antimicrobial Stewardship
BHS	Bureau of Hospital Services
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
AMAA	Cambodia Mine Action and Victim Assistance Authority
CMS	Central Medical store
CPA	Complementary Package of Activities
CPD	Continuous Professional Development
CPG	Clinical Practice Guideline
CS	Cesarean Section
CSR	Corporate Social Responsibility
D4H	Bloomberg Philanthropies Data for Health Initiative
DCL	Data-Centered Leadership
DDF	Department of Drug and Food
DDGT	Department of Digital Governance and Technology
DF	Department of Finance
DHIS2	District Health Information Software 2
DIC	Department of International Cooperation
DP	Development Partners
ECO	Emergency Critical and Operative
NECHR	National Ethics Committee for Health Research
EMR	Electronic Medical Record
ERAS	Enhanced Recovery After Surgery
GBV	Gender-based Violence
GDP	Gross Domestic Product
GMAG	Gender Mainstreaming Action Group
HC	Health Center
HEF	Health Equity Fund
HPV	Human papilloma virus
HSD	Health Service Department
HIS	Health Information System
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HRD	Human Resource Department
HRH	Human Resources for Health
HSD	Health Services Department
HSP	Health Strategic Plan
ICU	Intensive Care Unit
IMR	Infant Mortality Rate
IPC	Infection Prevention and Control
J7H	Jayavarman VII Hospital

KB	Kantha Bopha Children Hospital
LCoGS	Lancet Commission on Global Surgery
LMIC	Lower-Income and Middle-Income Country
M&E	Monitoring and Evaluation
M&M	Morbidity and Mortality
NNMCHCC	National Maternal Child Health Center
MHD	Municipal Health Department
MM	Maternal Mortality
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MPA	Minimum Package of Activities
MRH	Municipal Referral Hospital
MSW	Medical Social Work
MSSP	Minimum Safe Surgery Package
NC-SOA	National Committee for Surgery Obstetric and Anesthesia
NCD	Non-Communicable Disease
NGO	Non Government Organization
NHIS	National Health Insurance Scheme
NIPH	National Institute of Public Health
NNMCHCC	National Maternal and Child Health Center
NPH	National Pediatric Hospital
NSOAP	National Policy and Strategic Plan on Surgical Obstetric and Anesthesia
NSSF	National Social Security Fund
OB/GYN	Obstetrics and Gynecology
OD	Operational District
OOPE	Out-of-Pocket Expenditure
OR	Operating Room
OT	Operating Theatre
OTIP	Obstetric Triage Implementation Package
PACU	Post-Anesthesia Care Unit
PGSSC	Program in Global Surgery and Social Change
PHD	Provincial Health Department
PHC	Primary Health Care
PMD	Preventive Medicine Department
POMR	Perioperative Mortality Rate
PPP	Public-Private Partnership
PRH	Provincial Referral Hospital
PSA	Pressure Swing Adsorption
QAO	Quality Assurance Office
RGC	Royal Government of Cambodia
RH	Referral Hospital / Regional Hospital
RTC	Regional Training Center
SAP	Surgical Antimicrobial Prophylaxis
SAT	Surgical Assessment Tool
SDG	Sustainable Development Goals
SOA	Surgical, Obstetrics, and Anaesthesia
SOP	Standard Operating Procedure

SSI	Surgical Site Infection
SWOT	Strength, Weaknesses, Opportunities and Threats
ToR	Terms of Reference
TSMC	Technical School for Medical Care
TWG	Technical Working Group
UHC	Universal Health Coverage
UHS	University of Health Science
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNITAR	United Nations Institute for Training and Research
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WB	World Bank
WDI	World Development Indicators
WFSA	World Federation of Societies of Anesthesiologists
WHA	World Health Assembly
WHO	World Health Organization
WPRO	Western Pacific Regional Office

EXECUTIVE SUMMARY

Surgical, obstetric, and anesthesia (SOA) care is a cornerstone of a resilient health system and a fundamental component which Surgical, obstetric, and anesthesia (SOA) care is essential to address the growing burden of both communicable and non-communicable diseases in the Kingdom of Cambodia. Despite its importance, the people of Cambodia still facing access to safe, effectiveness, timely, and affordable SOA services, resulting in preventable deaths, disabilities, and financial hardship. In response, the Ministry of Health has developed the National Policy and Strategic Plan on Surgical, Obstetric and Anesthesia (NSOAP) 2026–2035 in health care facilities, a comprehensive ten-year strategy to transform SOA care as a core component of Cambodia’s journey toward Universal Health Coverage by 2035.

Recognizing that overall health and well-being are fundamental to achieving safe surgical outcomes for both patients and healthcare providers, this dual focus ensures that strengthening the surgical system addresses not only clinical protocols and infrastructure but also creates a psychosocially safe environment that supports holistic recovery and the professional sustainability of surgical, obstetric, and anesthesia providers.

Aligned with the Royal Government of Cambodia’s Policy Program 2023–2028, the Health Strategic Plan (HSP4) 2025–2034, and global commitments such as the WHO 78th World Health Assembly Resolution on strengthening surgical care, this plan provides a clear roadmap for systemic investment across six foundational pillars: infrastructure, workforce, service delivery, information systems, financing, and governance.

Currently, Cambodia faces critical gaps: only 28.6% of the required surgical volume is performed annually, with 2.18 operating theatres per 100,000 population against a global benchmark of 5, and just 7 SOA providers per 100,000 against a recommended 20. Out-of-pocket spending remains high at 61%, and catastrophic health expenditure affects 24.24% of households. The percent of households that fell below the national poverty line due to Out-of-Pocket Expenditure (OOPE) is 6.67%. To address these challenges, the NSOAP sets measurable mid-term (2030) and final (2035) targets.

By 2030, the plan aims to increase surgical volume to 2,800 procedures per 100,000 population, raise SOA workforce density to 10 providers per 100,000, ensure 100% of CPA2 and CPA3 hospitals have functional and fully equipped operating theatres, and achieve 100% compliance with the WHO Surgical Safety Checklist. Financial protection will be strengthened by reducing out-of-pocket spending to below 50% and expanding insurance coverage for all Bellwether procedures.

By 2035, final targets include reaching volume of 3,500 procedures per 100,000 population, 12 SOA providers per 100,000, 70% surgical safety compliance, and reducing out-of-pocket spending to 35% or below. Every district hospital will be capable of performing essential Bellwether procedures—cesarean section, laparotomy, and open fracture management—and surgical services will be fully integrated with primary healthcare and community systems.

Implementation will occur in two phases: Phase 1 (2026–2030) focuses on rapid scale-up of infrastructure, workforce training, and basic service delivery, while Phase 2 (2031–2035) emphasizes quality, equity, system resilience, and sustainability. The plan will be guided by strong national leadership through the National SOA Committee, supported by coordinated action from national hospitals, provincial health departments, SOA referral hospital working groups, development partners, and the private sector.

For monitoring and evaluation of the NSOAP 2026–2035 and its implementation, a structured framework is required, applicable across all levels of health facilities. There are 108 implementation indicators and 28 monitoring and evaluation indicators for tracking NSOAP implementation, allowing for comprehensive monitoring and evaluation of interventions. Among these, 6 indicators are included in the Lancet Commission on Global Surgery and 3 indicators are in Safe Surgery Indicator 2020, and four indicators are integrated into the World Bank's World Development Indicators. These indicators are expected to provide the backbone of the monitoring and evaluation framework, have been adapted to the country context, and will be reported by the Ministry of Health.

1. CHAPTER 1: INTRODUCTION

1.1. Global Context

Surgical, obstetric, and anesthesia (SOA) care is essential for treating the multifaceted burden of infectious and non-communicable diseases faced by low- and middle-income countries. It is a cornerstone of a safe, resilient health system and critical to achieving Universal Health Coverage. The global community has increasingly recognized the importance of strengthening surgical systems through the Lancet Commission on Global Surgery, which established foundational indicators for surgical access, workforce, volume, and financial protection.

1.2. Cambodia Context

1.2.1. Demographic and Socioeconomic Landscape

Administratively, Cambodia is divided into 25 provinces with a population of approximately 17.3 million. The population is evenly balanced by sex, with a growth rate of 2.4% per annum and a life expectancy of 76.6 years. Approximately 26.8% of the population is under 15 years of age, while the working-age population (15–60 years) constitutes 63.1%. Urbanization has increased from 39.4% in 2019 to 41.5% in 2024, with 7.17 million people now residing in urban areas. The proportion of the population living below the national poverty line was 17.8% in 2019 (ADB, 2024).

These demographic trends have important implications for surgical, obstetric, and anesthesia services. A large youth population drives demand for pediatric and maternal surgical care, while an aging population will increase the need for surgeries related to non-communicable diseases. Ongoing urbanization and persistent poverty in rural areas highlight the need for equitable distribution of surgical services across health system of Cambodia.

1.3. Rationale for the NSOAP

The year 2025 is the year when the health system is resilient, responding in a timely and effective manner to public health threats, and serves as the foundation for the future health and well-being of the people in the Kingdom of Cambodia.

Though Cambodia's health system has made remarkable strides, further strengthening is needed to ensure access to safe, affordable, and timely surgical care as identified by the Lancet Commission on Global Surgery. Many health facilities require infrastructure upgrades to deliver emergency and surgical care, and the number of trained surgeons at district referral hospitals needs to be expanded.

Current SOA service delivery highlights these opportunities for improvement. Surgical volume meets only 28.6% of estimated need and workforce density stands at 7 per 100,000 — compared to global benchmark of 20. Out-of-pocket spending was 61%, with 24.2% of households facing catastrophic expenditure, disproportionately affecting rural populations.

The NSOAP addresses these challenges across six strategic pillars: infrastructure, workforce, service delivery, health information, financing, and governance. It builds on HSP4 and aligns with national commitments under the UHC Roadmap and global frameworks including WHO Resolution WHA68.15 and WHA76.2 on Emergency, Critical, and Operative Care.

This plan is guided by a people-centered, team-based approach — ensuring provider wellbeing and prioritizing dignity, safety, and trust for every patient. High-quality surgical outcomes depend on collaborative, respectful environments where multidisciplinary teams can perform at their best.

1.3.1. NSOAP Development Process

The Ministry of Health (MOH) of Cambodia recognizes emergency and essential SOA care as critical components of its health system and crucial to attainment of UHC. In view of that and in alignment with global calls, the Ministry, working with its agencies and in collaboration with other sectors, health scientific associations, development partners and the private sector, has developed the National Surgical, Obstetric, and Anesthesia Plan (NSOAP) for the Kingdom of Cambodia. This is to serve as a policy instrument through which equitable access to SOA care can be expanded in the country using coordinated health policy efforts.

1.3.2. Establishment of the National Committee for SOA

In 2024, the Ministry of Health established the National Committee of Surgery, Obstetrics and Anesthesia by the Prakas No.0072 snk/pk dated on 11 March 2024 to respond to the need of safe surgery in Cambodia. The main Terms of Reference of the National Committee is to develop National Policy and Strategic Plan on Surgery, Obstetrics, and Anesthesia (NSOAP) to implement in National and Subnational levels of the health care system of Cambodia. All 12 national hospitals National center for Maternal and Child health, municipal and all provincial referral hospitals established Working Groups of SOA.

1.3.3. Stakeholder Engagement

Under the leadership of the MoH, key stakeholders were identified to support the development of the NSOAP and ensure that the views and expertise of diverse groups is represented. The scope, action plan, and deadlines for the development of the NSOAP were decided upon by the MoH in coordination with other stakeholders. The stakeholders made up of concerned health professional societies, health financing regulators, academia, Non-Governmental Organizations (NGOs), policy experts, health care workers and MoH leadership convened for the first time to decide on the best course of action for completing the objective.

1.3.4. Consultative Workshop to finalize NSOAP

The National Consultative Workshop conducted on 13–14th January 2026 demonstrated broad stakeholder endorsement of the proposed NSOAP strategic directions across infrastructure, workforce, service delivery, health information, financing, and governance domains. Participants supported maintaining the overall structure and scope of the NSOAP, while recommending targeted refinements to strengthen operational feasibility, accountability, and alignment with system readiness.

1.3.5. National Policy Foundation and Strategic Alignment

The NSOAP 2026–2034 is grounded in and fully aligned with Cambodia's established health sector frameworks and global commitments. This integrated approach ensures the NSOAP strengthens rather than duplicates existing systems.

2. CHAPTER 2: SITUATIONAL ANALYSIS

To develop an appropriate-informed plan, a baseline landscape of SOA services across all levels of the health system was established. The 2025 national assessment surveyed 196 health facilities including 10 national, 25 provincial, 34 district, and 127 private facilities and provides critical evidence on the capacity, readiness, and performance of SOA services in Cambodia. Participating health facilities conducted data assessments in 2024, and follow-up assessments using the same tools indicate that Cambodia has made important progress in strengthening Cambodia's Surgery, Obstetrics, and Anesthesia (SOA) system. However, SOA structures remain inconsistent across subnational and private facilities, with limited formal guidance for private sector engagement.

2.1. Governance

The Ministry of health of Cambodia has established a National Committee for Surgery, Obstetrics and Anesthesia (SOA), with strong policy endorsement and engagement of development partners, including the World Health Organization, Vital Strategies and Program in Global Surgery and Social Change, Harvard Medical School.

SOA working groups are present in 100% of national hospitals and 64% of subnational hospitals; however, only 20.59% of district hospitals and 47.83% of all public hospitals have functional SOA working groups. There is currently no formal guidance for establishing SOA governance structures in private health facilities. Strengthening governance mechanisms across all levels of care, including private sector engagement, remains a priority.

2.2. Infrastructure and Access

Cambodia benefits from a structured referral system, availability of emergency surgical services, functioning blood transfusion services, and relatively reliable electricity supply in most facilities. Oxygen supply is reported in 91% of facilities, though only 76% consistently report uninterrupted availability. Operating theatre density is 2.8 per 100,000 population, below the recommended benchmark of 6.2 per 100,000. Access to timely essential surgery within two hours remains limited; only 11.4% of assessed facilities reported that 100% of patients could access essential surgery within this timeframe. Comprehensive facility assessments, particularly in the private sector, are required to better understand infrastructure gaps in geographic and functional access.

2.3. Surgical Workforce

The Kingdom of Cambodia has standardized medical education and pre-service and in-service training programs for SOA professionals. Human resources for health are included within the national Health Strategic Plan (HSP4). However, workforce density remains significantly compare to international benchmarks. The overall SOA specialist density is 7 per 100,000 population, compared to the recommended Lancet benchmark threshold of 20 per 100,000. Anesthesia specialist density is 1.77 per 100,000 population, and obstetric specialist density is 1.82 per 100,000 population. Only 32.14% of facilities report 24-hour, 7-day availability of SOA providers. Data on dual practice between public and private sectors remain limited, affecting accurate workforce planning.

2.4. Health Service Delivery

SOA services are included in the Complementary Package of Activities (CPA) guidelines, and the Government has invested in strengthening 62 CPA1 and CPA2 hospitals.

there were 2,757.40/100,000 of surgical procedure according to MoH report 2025 compared to the Lancet benchmark of 5,000 per 100,000 population. A total of 63,314 bellwether procedures were performed nationally, equivalent to 366.39 per 100,000 population. Only 39.8% of assessed facilities provide bellwether procedures, and the same proportion reported consistent use of the WHO Surgical Safety Checklist. The reported perioperative mortality rate (POMR) was 0.14% (837 deaths among 593,007 procedures). However, systematic national reporting and validation mechanisms require strengthening to ensure completeness and accuracy.

2.5. Financing

The Government continues to allocate funding to strengthen CPA1 and CPA2 hospitals. However, key financial protection indicators — such as the proportion of households at risk of catastrophic or impoverishing health expenditures due to surgical care — are not yet systematically measured. Improved tracking of surgical expenditure and financial risk protection indicators is necessary to assess equity and affordability.

2.6. Health Information Systems

Institutional-level data are reported through the national Health Management Information System (HMIS), with ongoing pilot implementation of DHIS2 and exploration of roadmap development with **the innovation of using Electronic/Digital Medical Records (EMR) to improve health services at all levels**. Currently, 17% of facilities report using EMR systems. There is no national surgical registry, and perioperative mortality is not yet fully integrated into HMIS reporting. Standardization of surgical data collection, including surgical volume, access indicators, and perioperative outcomes, remains a critical priority for evidence-based planning.

Overall, Cambodia has established foundational governance and service delivery structures for SOA. However, major gaps remain in workforce density, surgical volume, timely access, data systems, and financial risk protection—highlighting the need for structured NSOAP development and implementation to accelerate progress toward Universal Health Coverage

2.7. Challenges by Pillar

The following challenges have been identified as priority areas where targeted improvement and coordinated action under this NSOAP will drive the greatest impact.

Challenges 1: Infrastructure, equipment, and medical products

The number of operating theatres requires expansion to improve access to surgical care. Supply of medical oxygen, electricity, and clean water needs strengthening, particularly in district and remote facilities. Critical equipment, recovery areas, and ambulance services require further development.

Challenges 2: Workforce Development & Human Resource Planning

The Availability of specialist surgeons, anesthesiologists, and obstetricians needs expansion to meet population needs. Geographic distribution of the surgical workforce requires strengthening in rural areas. Retention of SOA staff and training capacity for specialty cadres need continued expansion

Challenges 3: Service delivery & Quality of care

Surgical volume requires increase to meet population health needs. Adherence to safety protocols and 24/7 emergency SOA coverage need strengthening. Referral systems and postoperative care capacity require further development.

Challenges 4: Health Information Management, Research, and Monitoring & Evaluation

Reporting of core surgical indicators needs enhancement to support performance tracking. Health information systems require further integration and expanded use of electronic/digital medical records. Local research capacity and sub-national monitoring systems need continued development.

Challenges 5: Financial & financial protection

Out-of-pocket spending for surgical care requires attention to reduce household financial burden. Government budget allocation and insurance coverage for essential procedures need review and expansion. Funding flows require greater predictability to support consistent SOA service delivery.

Challenges 6: Leadership, Governance, & Regulation

Governance structures for SOA require continued strengthening at all levels. Regulation and coordination of private surgical providers need further development. Policy implementation and leadership investment require sustained commitment.

2.8.Opportunity

- Strong Ministry of Health leadership and an established National Committee for Surgery, Obstetric, and Anesthesia (NC-SOA)
- Clear political commitment of the Royal Government demonstrated through a project to strengthen 61 district referral hospitals, including 38 CPA-2 hospitals with upgraded operating theatres and emergency services for surgical system strengthening.
- Full alignment with the Health Strategic Plan (HSP4) 2025-2034 and the Universal Health Coverage (UHC) Roadmap 2024-2035
- Comprehensive 2025 baseline assessment completed, including meaningful engagement with the private sector
- Global momentum through WHA resolutions, Lancet Commission on Global Surgery (LCoGS) recommendations, and strong development partner support
- Ongoing digital health transformation providing opportunities for improved data systems and telemedicine integration

To address the challenges and leverage the opportunities outlined above, the Ministry of Health has developed the National Surgical, Obstetric, and Anesthesia Plan (NSOAP) 2026–2035. All actions in this operational plan are grounded in evidence from the Baseline Assessment of Current Practice and Challenges in the Implementation of Surgical, Obstetric, and Anesthesia (SOA) Interventions in the Health System of the Kingdom of Cambodia, conducted by the National Committee for SOA, Ministry of Health, 2025.

3. CHAPTER 3: POLICY DIRECTION

3.1. Vision

All people in the Kingdom of Cambodia have access to safe, effective, timely, and quality surgical, obstetric, and anesthesia care, contributing to reduced mortality and disabilities, improved health outcomes, and enhanced well-being across the life course.

3.2. Mission

To establish a coordinated, sustainable, and equitable national framework for strengthening surgical, obstetric, and anesthesia systems at all levels of care, ensuring the delivery of evidence-based, patient-centered services that are accessible, affordable, safe and high quality.

3.3. Goal

To enhance the capacity, quality, and equity of surgical, obstetric, and anesthesia care through integrated planning, workforce development, infrastructure improvement, and robust monitoring, in support of national health priorities and universal health coverage.

3.4. Guiding Principles

- **Right to Health:** Everyone in Cambodia has the right to access safe surgical, Obstetric and Anesthesia care without discrimination or financial hardship.
- **Equity:** Services of surgical, Obstetric and Anesthesia shall be prioritized for rural, remote, and vulnerable populations.
- **Safety and Quality:** All surgical, Obstetric and Anesthesia care shall adhere to national and international safety standards, including the WHO Surgical Safety Checklist.
- **Teamwork:** Safe surgical, Obstetric and Anesthesia care requires a coordinated, multidisciplinary team—surgeons, anesthesiologists, nurses, midwives, and allied health professionals—working together with mutual respect and shared accountability.
- **Patient-Centeredness:** Surgical, Obstetric and Anesthesia care shall be respectful, dignified, and responsive to the needs and values of patients and families.
- **Integration:** surgical, Obstetric and Anesthesia care shall be embedded within primary health care **and referral systems to achieve Universal Health Coverage.**
- **Accountability:** Transparent governance, data-driven decision-making, and regular monitoring shall guide continuous improvement of surgical, Obstetric and Anesthesia care.

3.5. Strategic Policy Priorities Aligned with the Six Lancet Global Surgery Indicators

3.5.1. Access to Timely Essential Surgery (2-hour access)

Policy Direction:

- Strengthen CPA3, CPA2 hospitals and private hospitals/clinics to deliver Bellwether procedures (cesarean section, laparotomy, open fracture management).
- Ensure that referral pathways and case management systems effectively support timely access to surgical care

- Expand post-operative recovery and critical care capacity at CPA3, CPA2 level and private hospitals/clinics.
- Promote coordinated ambulance communication and referral feedback mechanisms to reduce delays in emergency surgical care

Target:

Increase proportion of population with access to essential surgery within 2 hours.

3.5.2. Surgical Workforce Density (Target: 20 per 100,000)

Policy Direction:

- Scale up training, recruitment, and equitable distribution of SOA workforce.
- Establish SOA Working Groups at all CPA3, CPA2, private hospitals/clinics and higher-level hospitals with approved Terms of Reference.
- Institutionalize Leadership Development Programs including Data-Centered Leadership (DCL) to strengthen SOA services at health facility public and private.
- Strengthen teamwork culture and professionalism across multidisciplinary SOA teams.
- Incentivize rural deployment and improve 24/7 workforce availability at health facilities.

Target:

Progressively increase SOA density from 7 per 100,000 toward global benchmark.

3.5.3. Surgical Volume (Target: 5,000 per 100,000 population)

Policy Direction:

- Expand surgical capacity at CPA2 and provincial hospitals.
- Improve infrastructure and operating theatre availability.
- Integrate SOA services within Essential Package of Health Services.
- Monitor surgical output in both public and private sectors.

Target:

Increase annual surgical procedures per 100,000 population.

3.5.4. Perioperative Mortality Rate (POMR)

Policy Direction:

- Establish and integrate routine POMR reporting into HMIS/DHIS2, especially within Electronic/Digital Medical Records (EMR) at all levels of health system."
- Strengthen Morbidity & Mortality (M&M) governance systems.
- Scale up use of WHO Surgical Safety Checklist.
- Improve perioperative monitoring, recovery, and critical care.

Target:

Reduce preventable perioperative mortality through quality improvement systems.

3.5.5. Financial Protection (Catastrophic & Impoverishing Expenditure)

Policy Direction:

- Integrate essential SOA care within UHC financing schemes.
- Improve tracking of surgical-related household expenditures.
- Mobilize government and development partner funding for CPA2 and CPA1 strengthening.
- Reduce out-of-pocket expenditure for patients and their families for emergency and essential surgery.

Target:

Decrease risk of catastrophic and impoverishing expenditure due to surgical care.

3.5.6. Governance & Leadership

- National Committee for SOA to oversee NSOAP implementation.
- National Hospitals, national Center for maternal and Child Health, Municipal and Provincial health department and municipal/provincial referral Hospital SOA working groups to ensure accountability.
- Promote ethical standards and professionalism in SOA practice.
- Strengthen facility-level leadership and data-driven decision-making.

Target:

Achieve 100% functionality of SOA governance structures at all levels; ensure 90% of hospitals meet accreditation standards by 2035.

3.6. Policy Objectives

- **Objective 1:** To ensure that every Cambodian has access to safe surgical, obstetric, and anesthesia care in facilities that are equipped, functional, and resilient.
- **Objective 2:** "To ensure the availability and equitable distribution of qualified, competent, motivated and willing human resources with ethical standards for the delivery of quality, safe, and high-efficacy surgical, obstetric, and anesthesia services across all regions of Cambodia."
- **Objective 3:** To ensure that all Cambodians, regardless of geographic location or socioeconomic status, receive safe, effective, dignified surgical, obstetric, and anesthesia care that meets national and international quality standards.
- **Objective 4:** To establish robust data systems, generate local evidence, and use information to drive evidence-based decision-making, quality improvement, and accountability in SOA service delivery based on evidence.
- **Objective 5:** To provide **sustainable, equitable financing** for surgical, obstetric, and anesthesia services **that eliminates financial barriers and protects all Cambodian households from catastrophic health expenditure**, fully aligned with Cambodia's Universal Health Coverage Roadmap.
- **Objective 6:** To establish clear governance structures, enforce standards, engage all sectors, and ensure transparent, accountable stewardship of Cambodia's surgical system.

4. CHAPTER 4: STRATEGIC FRAMEWORK 2026–2035

4.1 Strategic Objective 1: Infrastructure, Equipment & Medical Products

Strategic Interventions:

- 4.1.1. Strategic Intervention 1: Expand access to well-equipped health care facilities with uninterrupted SOA services
- 4.1.2. Strategic Intervention 2: Provide reliable access to essential SOA equipment
- 4.1.3. Strategic Intervention 3: Ensure availability of quality and affordable medical supplies

4.2 Strategic Objective 2: Workforce Development & Human Resource Planning

Strategic Interventions:

- 4.2.4. Strategic Intervention 4: Expand training capacity and increase training opportunities for SOA professionals in both pre and in service training
- 4.2.5. Strategic Intervention 5: Promote equitable distribution of qualified SOA professionals
- 4.2.6. Strategic Intervention 6: Ensure retention and task sharing of SOA professionals in underserved areas

4.3 Strategic Objective 3: Service Delivery & Quality of Care

Strategic Interventions:

- 4.3.7. Strategic Intervention 7: Improve timely access to SOA services including referral, preventive, treatment, medical rehabilitation and palliative care
- 4.3.8. Strategic Intervention 8: Strengthen quality, safety, ambulance, and referral systems in surgical, obstetric, and anesthesia service delivery, especially in rural areas
- 4.3.9. Strategic Intervention 9: Establish and strengthen the provision of quality, safety essential and emergency anesthesia services
- 4.3.10. Strategic Intervention 10: Provide models of surgical care including medical rehabilitation and assistive technology

4.4 Strategic Objective 4: Health Information Management, Research & M&E

- 4.4.11. Strategic Intervention 11: Promote systematic tracking and utilization of SOA service data digital for evidence-based decision-making

4.5 Strategic Objective 5: Financing and Financial Protection

Strategic Interventions:

- 4.5.12. Strategic Intervention 12: Enhance affordability of safe, effective and high-quality SOA care and protect against catastrophic health expenditure
- 4.5.13. Strategic Intervention 13: Improve funding levels and resource tracking for surgical, obstetric, and anesthesia services

4.6 Strategic Objective 6: Leadership, Governance and Regulation

Strategic Interventions:

- 4.6.14. Strategic Intervention 14: Establish and strengthen strong, ethical, and transformative leadership for the implementation and integration of the Surgical, Obstetric, and Anesthesia plan within health facilities.
- 4.6.15. Strategic Intervention 15: Monitor and evaluate progress towards achievement of NSOAP objectives

5. CHAPTER 5: IMPLEMENTATION FRAMEWORK

The Implementation framework for translating the NSOAP 2026–2035 strategic directions into actionable results. It defines the phased implementation approach, governance structures, stakeholder engagement mechanisms, financing strategy, M&E framework, communication plan, and implementation support systems. The framework is designed to ensure coordinated, accountable, and sustainable execution across all levels of Cambodia's health system.

Hierarchy of Objectives	Key Indicators (LCoGS)	Means of Verification	Assumptions / Risks
Goal / Impact: Improve access to safe, timely, affordable surgical care	<ul style="list-style-type: none"> - SOA workforce density ≥ 20 per 100,000 - 80% essential surgical volume (Bellwether) - 24/7 access within 2 hours - OOP expenditure <40% - POMR monitored nationally 	National Health Statistics, HMIS, Insurance Claims, SOA Facility Reports	Political commitment sustained; adequate financing; no major disruptions
Outcome 1: Strengthened infrastructure & equipment	% hospitals with functional OTs, reliable utilities, essential equipment	Facility assessments, SOA Inventory Reports	Procurement & maintenance supply chains functional
Outcome 2: Adequate, equitably distributed workforce	SOA provider density, rural staffing norms met, retention rate	HRH database, Training Program Records	Incentives & career pathways implemented; training capacity sufficient
Outcome 3: Improved service delivery & quality	Surgical volume, SSC compliance, referral completion, 24/7 emergency services	Facility reports, supervisory checklists, HMIS	Referral system strengthened; SSC adoption maintained
Outcome 4: Enhanced HIS, research, & M&E	"POMR reporting and surgical, obstetric, and anesthesia (SOA) reporting through Electronic/Digital Medical Records (EMR)" "Number of research studies"	HMIS, Research Reports, Publications	Digital health solutions implemented; staff trained in data use
Outcome 5: Sustainable financing & financial protection	OOP reduction, population coverage for Bellwether, budget allocation	National Health Accounts, Insurance Claims, MOH budget reports	Health financing reforms & insurance scale-up implemented

Hierarchy of Objectives	Key Indicators (LCoGS)	Means of Verification	Assumptions / Risks
Outcome 6: Strengthened leadership & governance	Private facility accreditation, national, municipal provincial implementation plans, managers trained	NC-SOA reports, Accreditation reports, Training records	Leadership programs functional governance framework enforced

5.1. Implementation Phasing (2026–2035)

The governance and leadership of NSOAP 2026-2035 will rely on existing institutional frameworks within Cambodia's health sector. The entire NSOAP governance and accountability structure, which covers all aspects of planning, budgetary allocation, implementation, monitoring, and evaluation, will be under the supervision of the MoH. Governance and leadership of the NSOAP will include prioritization of the construction of open accountability systems and the promotion of surgical health on the national agenda. This will involve creating a framework for coordination of the NSOAP implementation. Leadership will be at the MoH and Directorate General for Health (at the National level), and the Municipal/Provincial Health Departments and Operational District levels for coordination of SOA care in the Kingdom of Cambodia.

Phase	Years	Strategic Focus	Key Outcomes
Phase 1: Rapid Scale-Up SOA Services	2026–2028	<ul style="list-style-type: none"> - Governance & systems - Infrastructure rollout - Workforce surge training - Basic safety compliance 	<ul style="list-style-type: none"> - NSOAP Secretariat fully staffed - 80% of CPA2 hospitals upgraded - 400+ new SOA staff in training - Surgical Safety Checklist use $\geq 50\%$
Phase 2: Quality & Access Expansion	2029–2031	<ul style="list-style-type: none"> - Service coverage - Advanced training - Digital integration - Financial protection 	<ul style="list-style-type: none"> - All CPA2 hospitals perform Bellwether procedures - Sub-specialty training launched - HMIS fully integrated with SOA indicators - 100% insurance coverage for essential SOA
Phase 3: Consolidation & Sustainability	2032–2035	<ul style="list-style-type: none"> - System resilience - Private sector integration - Research & innovation 	<ul style="list-style-type: none"> - 90% of hospitals meet accreditation standards - 70% private facilities with SOA working groups - Annual SOA research publication

Phase	Years	Strategic Focus	Key Outcomes
		- Policy institutionalization	- NSOAP integrated into HSP5 planning

5.2. Institutional responsibility for implementation, monitoring and evaluation

Level	Structure	Key Functions
National Committee for SOA, MoH	Chaired by designated secretary of state by Minister of Health, meets quarterly	Strategic oversight, high-level advocacy, resource mobilization
NC-SOA Secretariat	Full-time unit under MoH, 5 technical staff	Day-to-day coordination, M&E, reporting, partner liaison
Municipal and Provincial Implementation Teams	Led by MHD/PHDs directors, includes hospital SOA leads	Local adaptation, supervision, data aggregation, problem-solving
Hospital SOA working groups	All CPA2 and CPA3 hospitals, meets monthly	Quality improvement, safety audits, staff training, community feedback

5.2.1. National Committee of Surgery, Obstetric and Anesthesia, MoH

The National Committee of Surgery, Obstetric and Anesthesia provides overall strategic direction for NSOAP implementation and meets quarterly to review progress, address barriers, and provide high-level guidance.

5.2.2. Secretariat of the NC-SOA

The Secretariat of the National Committee for Surgery, Obstetric, and Anesthesia (NC-SOA) will be strengthened and operationalized. Secretariat will serve as the permanent NSOAP Implementation Unit within the Ministry of Health, responsible for day-to-day coordination, monitoring, reporting, and stakeholder liaison for NSOAP 2026–2035.

Key Responsibilities:

- Coordinate NSOAP implementation across all six pillars
- Manage M&E data collection, analysis, and reporting
- Liaise with development partners and stakeholders
- Provide technical support to provincial and hospital implementation teams
- Prepare annual progress reports and maintain the NSOAP dashboard

5.2.3. Subnational Implementation Working groups

Subnational Implementation Working groups are led by Municipal/Provincial Health Department directors and include SOA leads from municipal/provincial and district referral hospitals. They are responsible for adapting national NSOAP priorities to provincial contexts, conducting regular

supportive supervision, aggregating and validating facility-level data, and resolving implementation challenges at the sub-national level.

5.2.4. Hospital SOA Working Groups

All public hospitals providing surgical services shall establish functional SOA committees. Private surgical facilities are also encouraged to establish SOA committees to ensure consistent standards and coordination with the national health system.

Key Responsibilities:

- Oversee surgical quality and safety at facility level
- Conduct monthly surgical safety audits and mortality reviews
- Ensure compliance with WHO Surgical Safety Checklist
- Coordinate local SOA training and continuing professional development
- Collect and submit monthly surgery and safety data
- Engage with communities to improve service accessibility and responsiveness

Detailed Terms of Reference for all governance structures are provided in Annex 11.

5.3. Stakeholder Engagement Framework

Stakeholder	Engagement Mechanism	Frequency
Professional Health Associations	Technical Working Groups for guidelines, training	Quarterly
Private Sector	Public-Private Dialogue Forum on standards, pricing	Biannual
Development Partners	NSOAP Partner Coordination Group	Quarterly
Community Representatives	Patient Advisory Panels at municipal/provincial level	Biannual

5.4. Phased Financing Strategy

Phase	Funding Focus	Key Sources
2026–2028	Capital investment, training, system setup	National budget, development partners, World Bank
2029–2031	Recurrent costs, scale-up, insurance coverage	NSSF, HEF, government recurrent budget
2032–2035	Sustainability, innovation, resilience	Domestic funding $\geq 70\%$, PPPs, impact investment

Detailed financing strategy is provided in Chapter 8: Financing the Plan.

5.5. M&E Framework

Component	Description
Purpose	Track NSOAP progress, identify challenges early, use data to improve surgical care for all Cambodians by 2035
Responsibilities	National SOA Committee (oversight), Municipal and Provincial Health Departments (data validation, supervision), Hospital SOA Working groups (monthly data submission)
Monitoring Schedule	Monthly (hospital), Quarterly (municipal/province dashboard), Annually (national report), 2029 (mid-term), 2035 (final)
Data Sources	Hospital surgery registers, HMIS/DHIS2, health insurance claims, patient feedback surveys

Full M&E framework is provided in Chapter 7: Monitoring & Evaluation.

5.6. Communication and Knowledge Management

Component	Activity	Timeline
Annual NSOAP Progress Report	Published and disseminated nationwide	Every December
NSOAP Learning Forums	Regional workshops to share best practices	Biannual
Digital Dashboard	Public-facing platform showing key indicators	Launched 2027, updated quarterly
Media Engagement Plan	Regular briefings, success stories, accountability reports	Ongoing

5.7. Implementation Support System

The NC-SOA Secretariat will establish a **helpdesk and technical support unit** to assist working groups of national hospitals, municipal/ provincial health departments and SOA working groups of national hospitals, NMCHC and referral hospitals with implementation challenges. This will include tele-mentoring, protocol clarification, and rapid response for equipment or supply issues. The National SOA Committee Secretariat will develop and maintain **annual implementation plans, standard operating procedures, and technical guidelines** to operationalize this national policy and strategic plan. These will include detailed work plans, clinical protocols, equipment maintenance procedures, training modules, and monitoring tools, to be updated regularly and disseminated to all implementing facilities.

6. CHAPTER 6: OPERATIONAL PLAN (MATRIX TABLE FOR IMPLEMENTATION)

6.1. Strategic objective 1: Infrastructure, Equipment & Medical products

6.1.1. Strategic Intervention 1: Expand access to well-equipped health facilities with uninterrupted SOA services.

Action	Definition	Key Performance indicators	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
1. Provide backup power generators for each hospital	Ensure all surgical hospitals have functional backup power systems (generators/solar hybrids) to maintain uninterrupted electricity for operating theatres, ICUs, and essential services during grid outages.	% of CPA2/3 hospitals with functional backup power available 24/7	65%	85%	100%	MoH, NC-SOA, HSD (BHS), National hospitals NMCHC MHD/PHDs, RH/ MRH/PRH DP
2. Provide hospitals with water reservoirs of adequate capacity	Install or rehabilitate water storage and purification systems to ensure continuous clean water supply for surgical services, sterilization, and infection prevention, meeting WHO WASH standards.	% of surgical hospitals meeting WHO water quantity/quality standards	48%	80%	100%	MoH, NC-SOA, HSD (BHS) National hospitals NMCHC MHD/PHDs, RH/ MRH/PRH DP

Action	Definition	Key Performance indicators	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
3. Provide oxygen production plants in all regional centres	Establish Pressure Swing Adsorption (PSA) oxygen plants at regional hospitals to ensure reliable medical oxygen supply for surgical and critical care services across catchment areas.	Number of regions with ≥ 1 functional hospital-based oxygen plant	5	8	11 (all zones)	MoH, NC-SOA, HSD, DF National Hospitals, NMCHC, MHD/PHDs, RH/MRH/PRH, DP
4. Provide piped oxygen supply to operating theatres and recovery wards	Install central oxygen pipeline systems from storage to point-of-use in surgical areas to improve safety, efficiency, and reliability of oxygen delivery.	% of CPA2/3 hospitals with piped oxygen in ORs and recovery areas	35%	70%	100%	MoH, NC-SOA, HSD, DF National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
5. Improve internet connectivity to health facilities	Upgrade broadband and wireless internet infrastructure to support telemedicine, digital health records, and real-time communication for	% of surgical hospitals with high-speed internet (>10 Mbps) 24/7	40%	75%	100%	MoH, NC-SOA, HSD, DDGT National Hospitals, NMCHC, MHD/PHDs, RH/MRH/

Action	Definition	Key Performance indicators	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	surgical coordination and consultation.					PRHs, DP
6. Provide waste management facilities at each district hospitals CPA2	Establish or upgrade biomedical waste treatment facilities (incinerators/autoclaves) and segregation systems for safe disposal of surgical waste according to national regulations.	% of districts hospitals with functional surgical waste treatment facilities	30%	70%	100%	MoH, NC-SOA, HSD, DPM National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
7. Establish telemedicine in health facilities	Implement secure telemedicine platforms for surgical pre-assessment, intra-operative consultation, and post-operative follow-up between different levels of care.	% of CPA2/3 hospitals with functional telemedicine equipment and trained staff	15%	60%	90%	MoH, NC-SOA, HSD, DDGT National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
8. Enhance obstetric surgical infrastructure	Ensure at least one dedicated maternity operating room(s) at CPA3 and regional referral hospitals	Number of hospitals with one operating room dedicated	[To be collected in 2026 baseline survey]	100% of CPA3 and regional hospitals	100% of all referral hospitals	MoH, NC-SOA, HSD, National hospitals NMCHC

Action	Definition	Key Performance indicators	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
		to maternity operations				MHD/PHDs RH/MRH/ PRHs DP

6.1.2. Strategic Intervention 2: Provide reliable access to essential SOA equipment.

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
1. Increase number of functional operating theatres	Renovate existing and construct new operating theatres to meet minimum standards, ensuring each major surgical hospital has ≥ 3 functional ORs equipped for essential and emergency procedures.	Number of functional, fully-equipped ORs per 100,000 population	2.18	3.0	4.0	MoH, NC-SOA, HSD, DF National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
2. Provide surgical equipment and	Procure and distribute standardized sets of surgical instruments,	% of surgical hospitals with $\geq 95\%$ of essential surgical equipment	42%	80%	100%	MoH, NC-SOA, HSD, DDF, CMS

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
consumables to health facilities	furniture, and disposable supplies according to WHO Essential Surgical Equipment lists for each facility level.	items available and functional				National hospitals NMCHC/ RH/ MHD/PHDs RH/MRH/PRHs DP
3. Provide preventive maintenance contracts for SOA equipment	Implement scheduled preventive maintenance programs and establish service contracts for anesthesia machines, surgical lights, suction, and other critical equipment to minimize downtime.	% of major SOA equipment items with up-to-date maintenance contracts and service logs	25%	70%	90%	MoH, NC-SOA, HSD, DF, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
4. Equip all operating theatres with multi-parameter patient monitors with capnography	Ensure every operating theatre has modern patient monitoring devices including capnography for safe anesthesia delivery, following WHO	% of operating theatres equipped with functional multi-parameter monitors including capnography	28%	70%	95%	MoH, NC-SOA, HSD, DF, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	Essential Equipment lists.					
5. Ensure sterilization capacity at all district referral hospitals and above	Ensure all surgical facilities have functional steam sterilizers (autoclaves) of appropriate capacity, with validation systems and trained sterilization technicians.	% of surgical hospitals with validated, functional sterilization capacity meeting national standards	58%	85%	100%	MoH, NC-SOA, HSD (IPC) National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
6. Equip all district referral hospitals and above with blood storage fridges and freezers	Install reliable blood bank refrigerators and plasma freezers with temperature monitoring and alarm systems for safe storage of blood products.	% of surgical hospitals with functional blood storage equipment and temperature monitoring	45%	80%	100%	MoH, NC-SOA, HSD, National Blood Center National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
7. Provide diagnostic laboratory and imaging	Deploy essential diagnostic equipment (hematology,	% of surgical hospitals with functional basic lab and imaging	50%	80%	100%	MoH, NC-SOA, HSD, Lab-NIPH

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
equipment appropriate for facility level	biochemistry, ultrasound, X-ray) according to facility level to support preoperative assessment and intraoperative decision-making.	equipment per service level norms				National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
8. Establish functional recovery wards/HDUs in all district facilities	Designate and equip post-anesthesia care units (PACU) or high-dependency units (HDU) with monitoring and resuscitation equipment for immediate postoperative recovery.	% of surgical hospitals with designated, equipped recovery areas staffed by trained nurses	35%	75%	100%	MoH, NC-SOA, HSD-Nursing Bureau National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
9. Establish functional ICUs at all higher-level facilities	Develop intensive care units with ventilators, multiparameter monitors, and trained staff to manage critically ill surgical	% of CPA3 hospitals with functional ICUs met minimum bed and equipment standards	40%	80%	100%	MoH, NC-SOA, HSD National hospitals NMCHC MHD/PHDs RH/MRH/PRHs

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	patients at regional and national hospitals.					DP
10. Provide laparoscopic towers to hospitals	Introduce minimally invasive surgical capacity at regional hospitals through procurement of laparoscopic equipment stacks and targeted surgeon training.	Number of regional hospitals performing basic laparoscopic procedures	8	18	25	MoH, NC-SOA, HSD, UHS National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

6.1.3. Strategic Intervention 3: Ensure availability of quality and affordable medical supplies.

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
1. Maintain adequate stocks of essential medical and surgical supplies	Implement inventory management systems with minimum/maximum stock levels, regular reporting, and emergency buffer stocks for critical	Rate of stockouts of essential surgical supplies (sutures, gloves, drapes, implants) per facility per quarter	22% monthly stockout rate	≤10% monthly	≤5% monthly	MoH, NC-SOA, HSD, DDF, CMS National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	surgical items to prevent stockouts.					
2. Revise the National Essential Surgical Supplies List	Regularly update the national essential surgical supplies list based on clinical need, new evidence, and cost effectiveness, ensuring alignment with service packages at each level.	Years since last update of National Essential Surgical Supplies List	Last updated 2018	Updated every 3 years (2027, 2030)	Updated every 3 years (2033)	MoH, NC-SOA, HSD National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

6.2. Strategic objective 2: Workforce development & human resource planning

6.2.1. Strategic Intervention: Expand training capacity and increase training opportunities for SOA professionals in Pre and In services training.

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
1. Train and employ SOA providers	Expand postgraduate training in surgery, obstetrics/gynecology, and anesthesia; increase annual intake; ensure	Density of specialist SOA providers per 100,000 population	7	10	12	MoH, NC-SOA, HSD, HRD, UHS/RTC National hospitals NMCHC

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	employment upon graduation.					MHD/PHDs RH/MRH/PRHs DP
2. Train district referral hospital doctors in Bellwether procedures	Provide certified, supervised training to general doctors at district hospitals to safely perform cesarean sections, laparotomies, and open fracture management.	% of CPA2 hospitals where ≥ 1 doctor can independently perform all three Bellwether procedures	20%	80%	100%	MoH, NC-SOA, HSD, UHS/RTC National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
3. Integrate SOA syllabus into pre-service curricula of training institutions in health sector	Include essential surgical, obstetric, and anesthesia competencies in undergraduate medical, nursing, and midwifery curricula.	% of training institutions in health sector having SOA curriculum	30%	80%	100%	MoH, NC-SOA, HSD, UHS, RTC, HPC National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
4. Train staff of district referral hospitals in	Provide targeted training in recognition, stabilization, and	% of CPA2 hospitals with ≥ 2 staff trained in	15%	70%	100%	MoH, NC-SOA, HSD, UHS, NPH/KBH/ J7H, NMCHC

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
pediatric surgical care	emergency management of common pediatric surgical conditions.	pediatric surgical emergency care				UHS/RTC National hospitals MHD/PHDs RH/MRH/PRHs DP
5. Expand specialty and sub-specialty training	Increase capacity of residency programs in general surgery, OB/GYN, anesthesia, and surgical sub-specialties.	Annual number of new specialist graduates in SOA fields	45	90	120	MoH, NC-SOA, HSD, UHS/RTC National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
6. Train nursing professionals in SOA programs	Develop and implement post-basic programs in perioperative nursing, critical care nursing, and nurse anesthesia.	Number of specialized SOA nurses per 100,000 population	3.2	6	8	MoH, NC-SOA, HSD, UHS/RTC National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
7. Train allied health professionals in SOA programs	Train physiotherapists, radiographers, lab technicians, and biomedical engineers to support comprehensive surgical care.	% of surgical hospitals with trained allied health professionals	40%	75%	90%	MoH, NC-SOA, HSD, UHS/RTC National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
8. Train pharmacists to support SOA care	Provide specialized training in surgical pharmacology, pain management, antibiotic stewardship, and perioperative medication safety.	% of surgical hospitals with pharmacists trained in SOA medication management	25%	60%	80%	MoH, NC-SOA, HSD, DDF, UHS/RTC Pharmacy Council National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
9. Train SOA providers in gender-responsive care	Integrate gender sensitivity, trauma-informed care, and respectful maternity care principles into	% of SOA providers receiving gender-responsive care training	10%	70%	100%	MoH, NC-SOA, HSD, GMAG, UHS/RTC/NIP H National hospitals

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	all SOA training programs.					NMCHC MHD/PHDs RH/MRH/PRHs DP
10. Establish simulation centers for SOA training	Develop three simulation centers in regional hospitals equipped with surgical simulators, task trainers, and simulated clinical environments.	Number of functional simulation centers	1	2	3	MoH, NC-SOA, HSD, HRD, UHS/RTC, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
11. Institute mandatory district rotations for SOA trainees	Require all surgical, OB/GYN, and anesthesia residents to complete a minimum 3-month rotation in a district referral hospital.	% of SOA specialty trainees completing mandatory rotations in district referral hospitals	0%	80%	100%	MoH, NC-SOA, HSD, UHS/RTC National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
12. Train biomedical engineers and technicians	Establish biomedical engineering training programs for equipment maintenance, repair, and management.	Number of trained biomedical engineers employed in public health system	12	35	60	MoH, NC-SOA, HSD, UHS/RTC National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
13. Provide facilities for maintenance of biomedical equipment	Establish regional biomedical equipment workshops with tools, test equipment, and spare parts inventory.	Number of regional biomedical equipment maintenance workshops	2	4	6	MoH, NC-SOA, HSD, DF, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
14. Establish Biomedical Equipment Training Program	A structured training program for technical personnel (engineers, technicians, and clinical users) on the safe and effective management, operation, preventive maintenance, and	1. Number of technicians trained 2. Percentage of functional medical equipment 3. Average downtime for repairs	No formal program in place Long equipment downtime High breakdown rates	Program established 50 technicians trained 80% of equipment functional	Program institutionalized 150 total technicians trained 90% of equipment functional	MoH, NC-SOA, HSD, HRD, UHS/RTC, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	repair of biomedical equipment.	4. Equipment breakdown rate				DP
15. Train surgical teams on the use of SOA equipment	Conduct hands-on training for surgeons, anesthetists, and nurses on the safe and effective operation of all new surgical equipment, with competency assessment.	% of SOA staff demonstrating competency in use of essential equipment through skills assessment	Not measured	70%	90%	MoH, NC-SOA, HSD, HRD, UHS/RTC, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
16. Train SOA professionals in laparoscopic surgery	Implement structured laparoscopic surgery training programs including simulation, proctoring, and gradual case progression for general surgeons.	Number of surgeons certified to perform basic laparoscopic procedures independently	12	60	100	MoH, NC-SOA, HSD, Cambodian Surgical Society National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
17. Train surgical teams on surgical	Conduct mandatory training and refreshers on WHO	% of surgical staff trained in SSC use and principles	25%	80%	100%	MoH, NC-SOA, HSD,

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
safety checklist	Surgical Safety Checklist for all OR team members.					UHS/RTC, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
18. Train healthcare workers on SOA data collection protocols	Conduct comprehensive training on SOA data elements, definitions, and reporting procedures for all relevant staff.	% of SOA data collectors trained and certified	15%	70%	90%	MoH, NC-SOA, HSD, DPHI, UHS/RTC, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
19. Train SOA providers in design and implementation of research projects	Build local research capacity through training in research methodology, ethics, and proposal development.	Number of SOA providers leading research projects annually	5	15	30	NECHR/NIPH UHS/RTC National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
20. Train SOA providers on scientific research communication and data analysis	Develop skills in writing research papers, presenting findings, and translating evidence into practice.	Number of SOA research publications in peer-reviewed journals annually	3	15	25	MoH, NC-SOA, HSD, Professional Societies National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
21. Train SOA staff in leadership and health systems management	Develop leadership capabilities among SOA professionals for effective service management and reform.	Number of SOA leaders completing leadership training annually	5	30	50	MoH, NC-SOA, HSD, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
22. Train SOA Working Groups of National and Subnational on the process of the NSOAP 2026-2035	Conduct training for SOA teams at national and sub-national health facilities on process of implementation NSOAP 2026-2034	1. Percentage of health facilities that have received training 2. Number of SOA staff trained	1. 0% 2. 0% staff	1. 70% 2. 1,500 staff	1. 100% 2. 3,000 staff	MoH, NC-SOA, HSD, UHS/RTC, NIPH National hospitals NMCHC MHD/PHDs

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
Implementation						RH/MRH/PRHs DP
23. Scale up Safe Pediatric Anesthesia training Program	Implement specialized training in pediatric anesthesia including airway management, fluid therapy, and pain control for children.	% of anesthesia providers trained in pediatric anesthesia	15%	60%	80%	MoH, NC-SOA, HSD, NPH, KB Children's Hospital National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
24. Scale up regional anesthesia in-service training	Promote use of spinal, epidural, and peripheral nerve blocks for appropriate procedures to reduce general anesthesia risks.	% of appropriate procedures performed under regional anesthesia	10%	30%	40%	MoH, NC-SOA, HSD, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
25. Scale up training in acute and chronic pain management	Integrate pain assessment and management into all clinical training programs with	Availability of trained pain management providers at all surgical hospitals	5%	50%	70%	MoH, NC-SOA, HSD, NIPH National hospitals NMCHC

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	multimodal approaches.					MHD/PHDs RH/MRH/PRHs DP

6.2.2 Strategic Intervention 2: Promote equitable distribution of qualified SOA professionals.

Action	Definition	Key Performance indicators	Based line 2025	Target 2030	Target 2035	Executing/Sup porting agency
1. Implement minimum staffing norms for SOA care	Establish and enforce minimum staffing norms for SOA services at each facility level based on workload and service complexity.	% of surgical hospitals meeting minimum SOA staffing norms	35%	70%	90%	MoH, NC-SOA, HSD, HRD National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
2. Develop modular training programs for SOA workforce	Create competency-based, modular training programs that allow flexible skill acquisition and recognition of prior experience.	Number of SOA training programs converted to modular, competency-based format	0	All core programs	All programs updated	MoH, NC-SOA, HSD, HRD NIPH, UHS/RTC, Professional Councils National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

3. Provide in-service training and CPD for SOA providers	Establish mandatory continuing professional development system with regular in-service training opportunities for all SOA cadres.	% of SOA providers meeting annual CPD requirements	20%	60%	80%	MoH, NC-SOA, HSD, HRD, NIPH, UHS/RTC, Professional Councils National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
4. Post newly qualified SOA workforce to underserved areas	Implement targeted deployment of new graduates to rural and remote facilities with attractive incentive packages and career development opportunities.	% of new SOA graduates posted to underserved areas in first appointment	15%	50%	60%	MoH, NC-SOA, HSD, HRD National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
5. Engage retired SOA specialists in underserved areas	Develop programs to engage retired specialists as clinical mentors, trainers, and service providers in facilities with workforce gaps.	Number of retired specialists engaged in mentoring and service in underserved areas	5	20	30	MoH, NC-SOA, HSD, HRD National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

6.2.3. Strategic Intervention 3: Ensure retention and task sharing of SOA professionals in underserved areas.

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
1. Maintain a national database of SOA professionals	Establish and maintain an accurate, up-to-date national registry of all SOA professionals including qualifications, employment, and location.	Completeness and accuracy of national SOA workforce database	Partial, outdated data	90% complete, updated annually	95% complete, updated quarterly	MoH, NC-SOA, HSD, HRD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
2. Institute incentive packages for SOA workforce in underserved areas	Develop and implement comprehensive incentive packages including financial bonuses, housing, education allowances, and career development for rural SOA staff.	% of underserved facilities with implemented incentive packages for SOA staff	10%	70%	100%	MoH, NC-SOA, HSD, DF, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
3. Organize award and recognition schemes for	Establish annual awards programs at national and provincial levels to	Number of SOA professionals recognized	0 systematic program	30+ awards annually	50+ awards annually	MoH, NC-SOA, HSD, HRD, National hospitals

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
SOA workforce	recognize excellence, innovation, and dedication in SOA service delivery.	through awards programs annually				NMCHC MHD/PHDs RH/MRH/PRHs DP

6.3. Strategic objective 3: Service delivery & quality of care

6.3.1. Strategic Intervention 1: Improve timely access to SOA services including referral, preventive, treatment, rehabilitative, and palliative care.

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
1. Provide access to Bellwether procedures at district hospitals	Ensure all district referral hospitals (CPA2) can perform cesarean section, laparotomy, and open fracture management through equipment, training, and support systems.	% of CPA2 hospitals performing all three Bellwether procedures	15%	80%	100%	MoH, NC-SOA, HSD, HRD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
2. Increase surgical volume at all levels of HCF	Systematically increase surgical output through improved efficiency, expanded hours, and	Number of major surgical procedures per 100,000 population	1,431	2,800	3,500	MoH, NC-SOA, HSD, HRD, National hospitals NMCHC

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	reduced barriers to access.					MHD/PHDs RH/MRH/PRHs DP
3. Develop coordinated surgical outreach using hub-and-spoke approach	Establish regular surgical outreach services from regional centers to district facilities to increase access and build local capacity.	Number of district referral hospitals receiving regular surgical outreach services	12	50	68 (all CPA2)	MoH, NC-SOA, HSD, HRD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
4. Implement pediatric surgical outreach in Communities	Specialize pediatric surgical outreach with pediatric anesthetists, age-appropriate equipment, and family-centered care approaches.	Number of children receiving surgical care through outreach annually	150	1,000	1,500	MoH, NC-SOA, HSD, NPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
5. Implement orthopedic surgical outreach intervention	Focus orthopedic outreach on fracture care, clubfoot correction, and chronic osteomyelitis	Number of orthopedic procedures performed through outreach annually	200	1,200	2,000	MoH, NC-SOA, HSD, HRD, National hospitals NMCHC MHD/PHDs

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	management in underserved areas.					RH/MRH/PRHs DP
6. Minimize surgical cancellations	Implement systems to reduce last-minute surgical cancellations due to lack of supplies, staff, or patient preparation.	Rate of same-day surgical cancellations for non-clinical reasons	18%	≤10%	≤5%	MoH, NC-SOA, HSD, HRD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
7. Ensure adequate supply of essential SOA medicines and consumables	Maintain consistent availability of surgical medications, fluids, anesthetics, and disposable supplies through improved supply chain management.	Stockout rate of essential SOA medications and consumables	22% monthly	≤10% monthly	≤5% monthly	MoH, NC-SOA, HSD, DDF, CM, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
8. Ensure pediatric surgical supplies availability	Specifically ensure availability of pediatric formulations, smaller equipment sizes, and age-appropriate	Availability of pediatric surgical supplies at facilities providing child surgery	30%	70%	90%	MoH, NC-SOA, HSD, NMCHC, CMS National hospitals NMCHC MHD/PHDs

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	supplies for child surgical care.					RH/MRH/PRHs DP
9. Strengthen alliances between national and provincial hospitals	Formalize mentoring and support relationships between tertiary and secondary facilities for skills transfer and quality improvement.	Number of functional hospital alliances with documented SOA collaboration	8	20	25	MoH, NC-SOA, HSD, Alliance Hospitals National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
10. Map, monitor, and achieve $\geq 90\%$ population coverage within 2-hour travel time to Bellwether-capable facilities by 2035	Conduct geographical mapping of surgical facilities and population catchments, strengthen referral networks, and ensure $\geq 90\%$ of Cambodians live within 2-hour travel time of a facility capable of performing Bellwether procedures (cesarean	% of population living within 2-hour travel time to a Bellwether-capable facility	[To be collected in 2026 mapping exercise]	$\geq 70\%$	$\geq 90\%$	MoH, NC-SOA, HSD, HRD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	section, laparotomy, open fracture repair).					
11. Review informal referral communication channels	Document and evaluate informal communication methods (phone, social media) used for referrals to inform formal system improvements.	Documentation and analysis of informal referral practices completed	Not done	Completed for all provinces	Reviewed and integrated	MoH, NC-SOA, HSD, HRD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
12. Establish coordinated cervical cancer screening program	Integrate cervical cancer screening (VIA, HPV testing) with surgical treatment pathways for pre-cancer and cancer cases.	% of eligible women screened for cervical cancer annually	15%	40%	50%	MoH, NC-SOA, HSD, NMCHC, NPH National hospitals MHD/PHDs RH/MRH/PRHs DP
13. Establish coordinated breast cancer screening program	Develop organized breast cancer screening with clinical breast exam and mammography referral for high-risk women.	% of eligible women receiving clinical breast examination annually	8%	30%	40%	MoH, NC-SOA, HSD, PMDs, GMAG/NMCHC National hospitals NMCHC MHD/PHDs

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
						RH/MRH/PRHs DP
14. Establish national HPV immunization program	Introduce HPV vaccination into national immunization schedule for adolescent girls to prevent cervical cancer.	HPV vaccine coverage among target adolescent girls	0%	60%	80%	MoH, NC-SOA, HSD, NMCHC-PMD National hospitals MHD/PHDs RH/MRH/PRHs DP
15. Implement HPV immunization program	Deliver HPV vaccination through schools, health facilities, and outreach with community engagement and education.	Number of doses administered annually to target population	0	150,000 doses	200,000 doses	MoH, NC-SOA, HSD, NMCHC-PMD National hospitals MHD/PHDs RH/MRH/PRHs DP

6.3.2. Strategic Intervention 2: Strengthen quality, safety, ambulance, and referral systems in surgical, obstetric, and anesthesia service delivery, especially in rural areas

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing Supporting Agency
1. Develop national surgical and obstetric emergency protocols	Create standardized protocols for common surgical and obstetric emergencies with clear decision trees and referral criteria.	Availability of national emergency SOA protocols at all facilities	30%	80%	100%	MoH, NC-SOA, HSD, NMCHC-PMD National hospitals MHD/PHDs RH/MRH/PRHs DP
2. Develop national Clinical Practice Guidelines for surgical care (CPGs)	Establish evidence-based clinical practice guidelines for common surgical conditions at different levels of care.	Number of common surgical conditions with national and local CPGs	5	15	20	MoH, NC-SOA, HSD, NMCHC-PMD National hospitals MHD/PHDs RH/MRH/PRHs DP
3. Develop national/local guidelines on surgical antimicrobial prophylaxis	Create specific guidelines for appropriate antibiotic use in surgery to prevent infection and combat resistance.	% of surgical procedures following antimicrobial prophylaxis guidelines	30%	70%	80%	MoH, NC-SOA, HSD, TWG-AMS, TWG-IPC National hospitals MHD/PHDs RH/MRH/PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing Supporting Agency
4. Establish and operationalize a national perioperative mortality audit system to reduce POMR to $\leq 0.5\%$ by 2035	implement a structured, standardized national system for reviewing all perioperative deaths (within 30 days post-surgery) to identify causes, preventability, and system gaps. Conduct regular audits at facility, provincial, and national levels with feedback loops for quality improvement.	<ul style="list-style-type: none"> - Perioperative Mortality Rate (POMR) - % of surgical facilities conducting regular mortality audits 	0.14% (POMR) 47.96% of facilities record postoperative deaths	POMR $\leq 0.1\%$ $\geq 80\%$ of facilities conduct audits	POMR $\leq 0.5\%$ 100% of facilities conduct audits	MoH, NC-SOA, HSD, DPHI National hospitals MHD/PHDs RH/MRH/PRHs DP
5. Improve patient-centered surgical care	Implement patient-centered approaches including communication, pain management, and dignity in surgical services.	Patient satisfaction with surgical care experience	Not routinely measured	$\geq 70\%$ satisfied	$\geq 80\%$ satisfied	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing Supporting Agency
6. Reduce waiting times for surgery	Decrease waiting times for emergency and elective surgery through improved scheduling and patient flow management.	Average wait time: Emergency / Elective surgery	Emergency: 6hrs; Elective: 7 days	Emergency: 3hrs; Elective: 5 days	Emergency: 2hrs; Elective: 3 days	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
7. Implement surgical safety checklist fully	Ensure 100% compliance with complete SSC use (Sign In, Time Out, Sign Out) for every surgical procedure.	% of surgical procedures with complete SSC use	16–24%	60%	70%	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
8. Reduce surgical site infections	Implement SSI prevention bundles including appropriate hair removal, skin antisepsis, normothermia, and glycemic control.	Surgical site infection rate for clean and clean-contaminated procedures	12%	≤8%	≤6%	MoH, NC-SOA, HSD-IPC National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing Supporting Agency
9. Develop protocols for GBV requiring SOA care	Create sensitive, confidential protocols for surgical management of gender-based violence injuries with psychosocial support.	Availability of GBV surgical care protocols at all health care facilities	10%	70%	100%	MoH, NC-SOA, HSD, GMAG National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
10. Strengthen provision of quality essential and emergency obstetric and gynecologic services	Ensure 24/7 availability of comprehensive emergency obstetric care (CEmONC) at designated facilities.	% of expected births occurring in CEmONC facilities	65%	80%	90%	NMCHC, PHDs MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
11. Ensure safe anesthesia availability for all surgical procedures	Provide trained anesthesia providers and equipment for all surgical and obstetric procedures.	% of surgical procedures with qualified anesthesia provider present	70%	90%	100%	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

6.3.3. Strategic Intervention 3: Establish and strengthen the provision of quality essential and emergency anesthesia services.

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
1. Strengthen countrywide mentorship for SOA at district level	Implement structured mentorship programs linking district practitioners with regional specialists for clinical support and guidance.	% of district SOA providers with assigned mentors	10%	70%	100%	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
2. Include Medical Social Work in Surgical Care Pathways	Integrate social workers into surgical teams to address socioeconomic barriers to care and postoperative support.	% of surgical hospitals with dedicated social work support	0%	50%	70%	MoH, NC-SOA, HSD, MSW-WC National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
3. Integrate brief physical and mental health screening into SOA	Incorporate simple mental health screening into preoperative assessment to identify anxiety,	% of surgical patients screened for mental health conditions	0%	60%	80%	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
admission assessments	depression, and need for support.					DP

6.3.4. Strategic Intervention 4: Provide models of surgical care including medical rehabilitation and assistive technology.

Action	Definition	Key Performance Indicator	Baseline (2025)	Target 2030	Target 2035	Executing/ Supporting Agency
1. Implement palliative care for patients needing it	Integrate palliative care principles into surgical practice for patients with advanced disease or poor prognosis.	% of surgical patients with life-limiting conditions receiving palliative care assessment	5%	30%	50%	MoH, NC-SOA, HSD, PMD National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
2. Provide Medical Certificate of Disability for post-surgery patients	Establish system for disability assessment and certification for patients with postoperative functional limitations.	% of patients with postoperative disability receiving appropriate certification and support	Not measured	60%	80%	MoH, NC-SOA, HSD, TWG-H-PWD National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

Action	Definition	Key Performance Indicator	Baseline (2025)	Target 2030	Target 2035	Executing/ Supporting Agency
3. Implement rehabilitative and assistive technology care	Provide postoperative rehabilitation services including physiotherapy, occupational therapy, and assistive devices.	% of surgical patients receiving prescribed postoperative rehabilitation	15%	50%	70%	MoH, NC-SOA, HSD, PMD National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
4. Strengthen models of surgical care for children with disabilities	Develop specialized surgical and rehabilitation pathways for children with congenital anomalies and acquired disabilities.	% of children with surgical-related disabilities receiving comprehensive care to reduce disabilities	20%	60%	80%	MoH, NC-SOA, HSD, PMD, NPH, Kuntha Bopha Hospital, JeyVorman 7 hospital
5. Ensure universal access to comprehensive SOA services and assistive products	Guarantee availability of essential assistive devices (walkers, crutches, braces) at surgical facilities for postoperative recovery.	Availability of basic assistive devices at surgical hospitals	25%	70%	90%	MoH, NC-SOA, HSD, PMD National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

6.4. Strategic objective 4: Health information management, research and M&E

6.4.1. Strategic Intervention 1: Promote systematic tracking and utilization of SOA service data for evidence-based decision-making.

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing / Supporting Agency
1. Develop guidelines for SOA data reporting and utilization	Create standardized data collection, reporting, and analysis guidelines specific to surgical, obstetric, and anesthesia services.	Availability of national SOA data reporting guidelines at all facilities	0%	80%	100%	MoH, NC-SOA, HSD, DPHI National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
2. Establish and integrate surgical, obstetric, and anesthesia (SOA) indicators into Electronic Medical Records (EMR) at all levels.	Incorporate SOA-specific indicators into HMIS/ DHIS2 platforms for routine data capture and reporting.	% of surgical, obstetric, and anesthesia (SOA) indicators automatically captured through Electronic/Digital Medical Records (EMR).	20%	80%	100%	MoH, NC-SOA, HSD, DPHI, National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
3. Advocate for funding for surgical research priorities of local relevance	Secure dedicated funding for SOA research addressing Cambodia-specific needs and contexts.	Amount of dedicated funding for SOA research annually	Not identified	Will be funded	Will be funded	MoH, NC-SOA, HSD, UHS, RTC, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing / Supporting Agency
						DP
4. Conduct Operational Research on NSOAP Implementation	Conduct operational research on NSOAP implementation to evaluate progress, identify barriers and facilitators, measure impact, and generate evidence for adaptive management and policy refinement.	1. Number of operational research studies completed annually 2. Percentage of research findings translated into policy or practice changes within 12 months	1. 0 studies 2. 0%	1. 3 studies annually 2. ≥40% of findings translated	1. 5 studies annually 2. ≥60% of findings translated	MoH, NC-SOA, HSD, UHS/RTC, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
5. Strengthen anesthesia safety and monitoring systems	Implement national anesthesia adverse event reporting and monitoring system	Anesthetic adverse event rate (per 1,000 anesthesia procedures)	[To be established in 2026]	≤5% of anesthesia procedure	≤3% of anesthesia procedures	MoH, NC-SOA, HSD, UHS, RTC, NIPH, NMCHC National hospitals MHD/PHDs, RH/MRH/PRHs, DP

6.5. Strategic objective 5: Financing and financial protection

6.5.1. Strategic Intervention 1: Enhance affordability of safe, effective, and high-quality SOA care and protect against catastrophic health expenditure.

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
1. Include all Bellwether procedures in the NHIS	Ensure complete social protection and insurance coverage for cesarean section, laparotomy, and open fracture management using social protection system	% of Bellwether procedures fully covered by social protection system	40%	90%	100%	MoH, NC-SOA, HSD, DPHI, UHS/RTC, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
2. Register and maintain members on health insurance	Increase population coverage through active enrollment campaigns and simplified renewal processes.	% of population covered by health insurance	43.7%	65%	80%	MoH, NC-SOA, HSD, UHS, RTC, NIPH, DPHI, DF (NSSF, HEF) National hospitals NMCHC, MHD/ PHDs, RH/ MRH/PRHs, DP
Reduce out-of-pocket expenditure for surgical care to	Implement policies to expand social health protection, eliminate user fees for	Out-of-pocket spending as % of total surgical health expenditure		≤50%	≤35%	MoH, NC-SOA, HSD, UHS/RTC,

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
≤35% of total surgical health expenditure by 2035.	Bellwether procedures, strengthen financial risk protection, and reduce out-of-pocket costs for patients.		61% (estimated for surgical care)			NIPH, DPHI, DF (NSSF, HEF) National hospitals NMCHC, MHD/ PHDs, RH/ MRH/PRHs DP
4. Monitor patient-level out-of-pocket expenditure for SOA services	Track actual OOP costs for surgical, obstetric, and anesthesia services at the patient level.	Average OOP cost per surgical procedure (USD)	[To be collected in 2026]	Reduce by 30% from baseline	Reduce by 50% from baseline	MoH, NC-SOA, HSD, UHS, RTC, NIPH, DPHI (NSSF, HEF) DF National hospitals NMCHC, MHD/ PHDs, RH/ MRH/PRHs, DP
5. Track catastrophic health	Measure the percentage of surgical patient households	% of surgical households facing	To be collected in 2026	≤20%	≤10%	MoH, NC-SOA, HSD, UHS,

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
spending among surgical households	facing catastrophic health expenditure due to SOA costs.	catastrophic health expenditure				RTC, NIPH, DPHI (NSSF, HEF) DF, National hospitals, NMCHC MHD/PHDs, RH/ MRH/PRHs, DP
6. Conduct costing study for cesarean section procedures	Establish and regularly update standardized cost estimates for C-sections to inform pricing and reimbursement	C-section procedure cost (mean, USD)	To be established in 2026	Updated every 2 years	Updated annually	MoH, NC-SOA, HSD, UHS, RTC, NIPH, DPHI (NSSF, HEF) DF, NMCHC National hospitals MHD/PHDs RH/MRH/PRHs DP
7. Conduct costing study for open fracture management	Establish and regularly update standardized cost estimates for open fracture management.	Open fracture management cost (mean, USD)	[To be established in 2026	Updated every 2 years	Updated annually	MoH, NC-SOA, DF, NIPH, DPHI UHS/RTC

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
8. Conduct costing study for laparotomy procedures	Establish and regularly update standardized cost estimates for laparotomy.	Laparotomy procedure cost (mean, USD)	To be established in 2026]	Updated every 2 years	Updated annually	MoH, NC-SOA, HSD, UHS, RTC, NIPH, DPHI (NSSF, HEF) DF, NMCHC National hospitals MHD/PHDs, RH/ MRH/PRHs, DP
9. Establish a national SOA costing database	Create a centralized system to track and report standardized costs for all Bellwether procedures.	All three Bellwether costs tracked in national database	Not established	Fully functional system	Fully automated with real-time updates	MoH, NC-SOA, HSD, UHS, RTC, NIPH, DPHI (NSSF, HEF) DF, NMCHC National hospitals MHD/PHDs, RH/ MRH/PRHs, DP

6.5.2. Strategic Intervention: Improve funding levels and resource tracking for surgical, obstetric, and anesthesia services.

Action	Definition	Key Performance Indicator	Baseline (2025)	Target 2030	Target 2035	Executing/ Supporting Agency
1. Develop resource mobilization plan for NSOAP	Create comprehensive funding strategy identifying domestic and external sources for NSOAP implementation.	Existence and implementation of resource mobilization plan	Not developed	Fully developed	Fully implemented	MoH, NC-SOA, HSD, DHR DH/UHS, RTC, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
2. Provide subvention for implementation and sustainability of NSOAP	Secure national budget allocation specifically for NSOAP activities and capacity building.	% of NSOAP activities funded through government subvention	20%	40%	60%	MoH, NC-SOA, HSD, DF National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
3. Increase budget allocated to SOA care	Gradually increase percentage of health budget dedicated to surgical services based on burden and priority.	% of health budget allocated to SOA services	3%	5%	8%	MoH, NC-SOA, HSD, DF National hospitals NMCHC MHD/PHDs

Action	Definition	Key Performance Indicator	Baseline (2025)	Target 2030	Target 2035	Executing/ Supporting Agency
						RH/MRH/PRHs DP
4. Establish tracking mechanism for SOA funding	Implement financial tracking system to monitor SOA expenditures and ensure efficient resource use.	Availability of SOA expenditure tracking reports quarterly	Not available	Reports produced semi-annually	Reports produced quarterly	MoH, NC-SOA, HSD, DF National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
5. Establish electronic accounting systems linked to MoH headquarters	Digitalize financial management systems for real-time tracking of surgical service expenditures.	% of surgical facilities using electronic accounting systems linked to central MoH	15%	70%	100%	MoH, NC-SOA, HSD, DPHI, DF, DDGT National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
6. Conduct triennial surveys on SOA	Regularly assess financial protection, out-of-pocket expenditure, and	Regularity of SOA financing assessment surveys	Irregular	Conducted 2029	Conducted 2032	MoH, NC-SOA, HSD, NIPH, DPHI DF/ DDGT

Action	Definition	Key Performance Indicator	Baseline (2025)	Target 2030	Target 2035	Executing/ Supporting Agency
financing effectiveness	equity in surgical financing.					National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
7. Establish budget lines for surgery, obstetrics, and anesthesia at district hospitals	Create specific budget categories for surgical services at district level to improve planning and accountability.	% of district hospitals with separate SOA budget lines	10%	70%	100%	MoH, NC-SOA, HSD, DPFI, DF, DDGT National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
8. Increase allocation for SOA activities annually	Grow SOA budgets annually based on performance, need, and inflation adjustments.	Annual growth rate of SOA budget allocations	5%	10%	15% (compound ded)	MoH, NC-SOA, HSD, DPFI, DF, DDGT National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP

6.6. Strategic objective 6: Leadership, governance and regulation

6.6.1. Strategic Intervention .1: Establish and strengthen strong, ethical, and transformative leadership for the implementation and integration of the Surgical, Obstetric, and Anesthesia plan within health facilities.

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
1. Allocate budget for NSOAP implementation	Secure dedicated funding for National/ Subnational SOA Committee operations, coordination, monitoring, and implementation support.	Annual budget allocated to National/Subnational SOA Committee operations	\$50,000	\$200,000	\$300,000	MoH, NC-SOA, HSD, DF/ DDGT National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
2. Establish SOA Working Groups at national and provincial referral hospital levels	Form functional working groups at national and provincial referral hospital levels to drive local implementation.	% of targeted levels with active SOA working groups	National: 100%; PRH: 100%	Maintain 100% with enhanced functionality	Maintain 100% with full functionality	MoH, NC-SOA, HSD, DF/ DDGT National hospitals NMCHC MHD/PHDs RH/MRH/PRHs DP
3. Establish SOA Working Groups at CPA2 hospitals	Create SOA committees at district hospital level to oversee surgical	% of CPA2 hospitals with functional SOA committees	47.83%	80%	100%	MoH, NC-SOA, HSD, National hospitals NMCHC

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
	quality and safety locally.					MHD/PHDs RH/MRH/ PRHs DP
4. Strengthen the NC-SOA Secretariat as the permanent NSOAP Implementation Unit.	Strengthen the NC-SOA Secretariat into a fully resourced unit for NSOAP coordination, monitoring, reporting, and liaison.	Functional NSOAP coordination body with full-time staff within MoH	Secretariat of NC-SOA established	Fully operational with 3 staff	Fully operational with 5 staff	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
5. Facilitate NSOAP Steering Committee meetings	Conduct regular high-level meetings to review progress, address barriers, and provide strategic direction.	Frequency and attendance of NSOAP Steering Committee meetings	Ad hoc	Biannual with >75% attendance	Quarterly with >80% attendance	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
6. Develop health facility compliance and	Create facility-specific action plans translating national NSOAP into	% of surgical hospitals with NSOAP	10%	70%	100%	MoH, NC-SOA, HSD,

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
implementation plans for NSOAP	local activities and targets.	implementation plans				National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
7.Integrate NSOAP into health strategic plan	Ensure NSOAP is fully aligned with and referenced in HSP4 and subsequent national health strategic plans.	NSOAP objectives reflected in HSP4 implementation plans	Partial alignment	Full integration	Full integration and monitoring	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
8.Develop SOA standards for hospital accreditation	Incorporate specific surgical safety and quality standards into national hospital accreditation system.	Number of SOA-specific standards in hospital accreditation tool	3	10	15	MoH-National Committee for Accreditation MoH, NC-SOA, HSD, QAO National hospitals NMCHC MHD/PHDs

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
						RH/MRH/ PRHs DP
9. Develop & integrate ethical/equity standards for SOA practice	Develop and integrate ethical/equity standards for SOA services into the national hospital accreditation system.	1. Existence of validated national "SOA Ethical & Equity Standards" document. 2. % of SOA-related accreditation checklists containing core ethical/equity criteria.	1. No dedicated document. 2. 0%	1. Standards developed and validated. 2. Standards piloted and integrated into accreditation (≥ 5 hospitals)	1. Standards mandated by MoH Prakas. 2. 100% of public and large private surgical facilities assessed.	MoH, NC SOA NECHR National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
10. Develop guidelines for distribution of anesthetic medicines	Establish safe and equitable systems for controlled medication distribution to prevent stockouts and misuse.	Availability of anesthetic medicines according to standardized distribution guidelines	Irregular	Consistent supply following guidelines	Fully implemented and audited system	MoH, NC-SOA, HSD, DDF National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
11. Collaborate with partners on multi-sector injury prevention	Work across sectors to address root causes of surgical need through injury prevention and safe environments, including de-mining in rural areas.	Existence of multi-sector injury prevention action plan	Limited coordination	Comprehensive plan developed	Plan fully implemented with measurable outcomes	MoH, NC-SOA, HSD, National Mine authority National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP

6.6.2. Strategic Intervention 2: Monitor and evaluate progress towards achievement of NSOAP objectives.

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
1. Disseminate NSOAP to stakeholders	Ensure wide distribution and understanding of NSOAP goals, strategies, and implementation requirements.	% of key stakeholders reporting familiarity with NSOAP content	30%	80%	90%	MoH-TWG-H MoH, NC-SOA, HSD, DIC National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
2. Develop M&E plan for NSOAP implementation	Create comprehensive monitoring and evaluation framework with indicators, data sources, and reporting schedules.	Quality score of NSOAP M&E plan (completeness, clarity, feasibility)	Not developed	Score \geq 80%	Score \geq 85%	MoH, NC-SOA, HSD, DPHI National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
3. Implement M&E plan for NSOAP	Operationalize monitoring systems, conduct regular data collection, analysis, and reporting.	% of M&E plan activities implemented as scheduled	0%	80%	90%	MoH, NC-SOA, HSD, DPHI National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
4. Conduct monitoring and supervision visits to provincial health departments,	Implement regular supportive supervision visits to assess progress, identify challenges, and provide guidance.	% of surgical facilities receiving quarterly supervision visits	20%	70%	100%	MoH-TWG-H MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
operational, regional, municipal/provincial, districts referral hospitals."						PRHs DP
5. Conduct implementation research on NSOAP	Study NSOAP implementation processes to identify facilitators, barriers, and lessons for improvement.	Number of implementation research studies completed annually	0	3	5	MoH, NC-SOA, HSD, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
6. Conduct surveys to support measurement of NSOAP implementation	Deploy periodic surveys to collect data on implementation progress, coverage, and quality.	Number of NSOAP-related surveys conducted with results utilized	1 (baseline)	3 (midterm + special)	5 (final + special)	MoH, NC-SOA, HSD, NIPH National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP

Action	Definition	Key Performance Indicator	Baseline 2025	Target 2030	Target 2035	Executing/ Supporting Agency
7. Establish Committee for SOA at all public hospitals	Ensure every public hospital providing surgical services has a functional SOA working groups overseeing quality and safety.	% of public surgical hospitals with active SOA working groups	50%	90%	100%	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP
8. Create SOA working groups for private SOA hospitals/clinics	Extend SOA governance structures to private sector facilities to ensure consistent standards and coordination.	% of large private surgical facilities with SOA committees	0%	50%	70%	MoH, NC-SOA, HSD, National hospitals NMCHC MHD/PHDs RH/MRH/ PRHs DP

7. CHAPTER 7: MONITORING & EVALUATION

The establishment of a comprehensive Monitoring & Evaluation (M&E) system is essential to ensure accountability, track progress, measure impact, and guide evidence-based decision-making throughout the implementation of the NSOAP 2026–2035.

7.1. Goal

To track NSOAP progress, identify challenges early, and use data to improve surgical care for all Cambodians by 2035.

7.2. Objective

To establish and maintain a robust, data-driven M&E system that tracks implementation progress, measures outcomes against NSOAP targets, and informs evidence-based adjustments to ensure the plan achieves its intended impact on surgical care access, quality, and equity.

7.3. Responsibilities

Level	Main Duty
National SOA Committee	Overall M&E leadership, annual reporting, dashboard management
Municipal and Provincial Health Departments	Data validation, supervision, quarterly reviews
Hospital SOA Working Groups of national hospitals, NMCHC, RH/MRH/PRHs/ district referral hospitals	Collect and submit monthly surgery & safety data

7.4. Tracking measure indicators for Monitoring and Evaluation

Tracking indicators for monitoring the implementation of the NSOAP 2026–2035. It includes **6 global indicators** aligned with the Lancet Commission on Global Surgery and WHO standards, 3 indicators are in Safe Surgery Indicator 2020 and **19 national indicators** covering health system readiness, workforce, service delivery, quality, and governance. The tracking measure indicators are compulsory for all levels of SOA network to track the progress of NSOAP implantation

No	Key Indicator	Baseline 2025	Target 2030	Target 2035	Responsibility
1	Access to Bellwether surgery within 2 hours – % of population within 2-hour travel time	40%	75%	90%	MoH, NC-SOA, HSD, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
2	Specialist surgical workforce density – Number of specialist surgeons, anesthetists, and	7	10	12	MoH, NC-SOA, HSD, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP

No	Key Indicator	Baseline 2025	Target 2030	Target 2035	Responsibility
	obstetricians per 100,000 population				
3	Surgical volume – Annual number of surgical procedures per 100,000 population	1,431	2,800	3,500	MoH, NC-SOA, HSD, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
4	Perioperative mortality rate (POMR) – In-hospital mortality within 30 days of surgery (%)	1.2%	≤0.8%	≤0.5%	MoH, NC-SOA, HSD, DPHI, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
5	Reduce out-of-pocket expenditure for surgical care to ≤35% of total surgical health expenditure by 2034	45%	≤40%	≤35%	MoH, NC-SOA, HSD, DPHI/NSSF, HEF National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
6	Safe anesthesia – % of surgical procedures conducted with a trained anesthesia provider present	70%	90%	100%	MoH, NC-SOA, HSD, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
7	% of surgical hospitals with uninterrupted blood supply for emergency procedures	55%	85%	100%	MoH, NC-SOA, HSD, National Blood Center National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP

No	Key Indicator	Baseline 2025	Target 2030	Target 2035	Responsibility
8	% of SOA providers trained in infection prevention and control protocols	40%	80%	100%	MoH, NC-SOA, HSD-IPC, National hospitals NMCHC, MHD/PHDs RH/MRH/PRHs, DP
9	Compliance with Surgical Antimicrobial Prophylaxis (SAP) Guidelines – % of eligible surgical procedures following national/local SAP guidelines	30%	70%	90%	MoH, NC-SOA, HSD, TWG-AMS, IPC National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
10	% of surgical facilities with functional patient monitoring systems in recovery areas	30%	75%	100%	MoH, NC-SOA, HSD, DF, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
11	% of districts referral hospitals with designated ambulance services for surgical referrals	25%	70%	100%	MoH, NC-SOA, HSD, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
12	% of surgical hospitals with electronic medical records for SOA patients	20%	70%	100%	MoH, NC-SOA, HSD, DPHI, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
13	% of surgical staff trained in disaster and mass casualty response	15%	60%	90%	MoH, NC-SOA, HSD, HRD, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP

No	Key Indicator	Baseline 2025	Target 2030	Target 2035	Responsibility
14	Number of medical simulation trainings conducted annually	8	25	40	MoH, NC-SOA, HSD, UHS, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
15	% of SOA equipment with scheduled preventive maintenance	35%	80%	100%	MoH, NC-SOA, HSD, DF, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
16	% of surgical facilities conducting monthly SOA quality audits	10%	60%	90%	MoH, NC-SOA, HSD, QAO, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
17	Average turnaround time for surgical lab results (hours)	24	12	6	MoH, NC-SOA, HSD, Lab-NIPH National hospitals NMCHC, MHD/PHDs RH/MRH/PRHs, DP
18	% of SOA trainees completing rural posting satisfaction surveys	20%	75%	100%	MoH, NC-SOA, HSD, UHS/RTC, NIPH National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
19	Number of community awareness campaigns on surgical services conducted annually	5	20	30	MoH, NC-SOA, HSD, DIC, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP

No	Key Indicator	Baseline 2025	Target 2030	Target 2035	Responsibility
20	% of surgical hospitals with designated infection control nurses	30%	80%	100%	MoH, NC-SOA, HSD-NB-IPC National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
21	% of surgical procedures with documented informed consent	65%	95%	100%	MoH, NC-SOA, HSD, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
22	Number of multidisciplinary tumor boards meeting regularly	2	10	15	MoH, NC-SOA, HSD, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
23	% of surgical hospitals with functional postoperative pain management protocols	25%	75%	100%	MoH, NC-SOA, HSD, PMD, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
24	% of SOA providers trained in patient safety and error reporting	20%	70%	100%	MoH, NC-SOA, HSD, QAO, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
25	Number of biomedical equipment calibration workshops conducted annually	4	12	20	MoH, NC-SOA, HSD, DF, National hospitals NMCHC, MHD/PHDs RH/MRH/ PRHs, DP
26	Surgical Bed Occupancy Rate	65%	75%	80%	MoH, NC-SOA, HSD, DF, National hospitals

No	Key Indicator	Baseline 2025	Target 2030	Target 2035	Responsibility
					NMCHC, MHD/PHDs, RH/MRH/ PRHs, DP
27	Mean Duration of In-Hospital Stay	7 days	≤5 days	≤4 days	MoH, NC-SOA, HSD, DF, National hospitals, NMCHC, MHD/PHDs, RH/MRH/ PRHs, DP
28	Surgical Referral Out Rate	25%	≤15%	≤10%	MoH, NC-SOA, HSD, DF, MHD/PHDs, RH/MRH/ PRHs, HC, DP

7.5. Monitoring Schedule

Frequency	Activity	Reported to
Monthly	Hospital surgery & safety data	District/Province
Quarterly	Province summary & dashboard update	National SOA Committee
Annually	National NSOAP Progress Report	MoH, partners, public
2029	Mid-term evaluation (progress toward 2030 targets)	All stakeholders
2035	Final evaluation (achievement of 2034 goals)	All stakeholders

7.6. Data Sources

- Hospital surgery registers & safety checklists, HMIS/DHIS2 electronic/digital system
- Health insurance claims (NSSF/HEF), Patient feedback surveys

7.7. How Data Will Be Used

- Annual action plans updated based on results, Funding and resource allocation guided by performance, Best practices shared between hospitals and provinces
- Public dashboards maintained for transparency

7.8. M&E Budget

At least 5% of the total NSOAP budget will be allocated for M&E activities including training, tools, surveys, and evaluations.

8. CHAPTER 8: FINANCING THE PLAN

8.1. Financing Approach

The NSOAP 2026–2035 will be funded through a mixed-financing model that aligns with Cambodia's Health Strategic Plan (HSP4) and Universal Health Coverage Roadmap. Funding will be phased, equitable, and sustainable, with strong domestic ownership. These include Government of Cambodia allocation, Health Insurance, out-of-pocket expenditure, and donor support. Financing mechanisms for this NSOAP will mirror this existing financing arrangement. Financial resources for the NSOAP implementation shall be sourced through existing channels available in the MoH for resource mobilization. Other innovative approaches to resource mobilization should be considered.

There is the need to develop a resource mobilization plan which will detail the strategies for attracting funding from the various sources. This strategy will among other things encourage funding by the Government of Cambodia where funds from the National budget will be allocated for NSOAP either as a dedicated line item or from existing health sector budget. This NSOAP provides the foundation required for a strong business case for investment in SOA care in Cambodia.

8.2. Sources of Funding

Source	Role in NSOAP Financing	Examples / Channels
Government of Cambodia	Primary funder and leader	- Ministry of Health annual budget - National Social Security Fund (NSSF) - Health Equity Funds (HEF)
Development Partners	Co-investors and technical supporters	- Grants (e.g., Bloomberg Philanthropies, WHO) - Loans (World Bank, ADB) - In-kind technical assistance
Private Sector	Service delivery and innovation partners	- Public-Private Partnerships (PPPs) - Corporate social responsibility (CSR) programs - Training and equipment sponsorships
Health Insurance	Purchaser of SOA services	- NSSF reimbursement for surgical procedures - Coverage for Bellwether and essential surgeries
Communities	Support for access and social accountability	- Minimal co-payments (where applicable) - Community transport and social support networks

8.3 Financing Mechanisms

- Dedicated NSOAP budget line within the MoH financial system.
- Pooled funding arrangements with development partners to reduce fragmentation of funding.
- Performance-linked allocations to hospitals achieving safety and access targets.
- Annual resource mobilization roundtables chaired by the National SOA Committee

9. CHAPTER 9. CONCLUSION

The Cambodian National Surgical, Obstetric, and Anesthesia Plan (NSOAP) 2026–2035 provides an evidence-based, actionable roadmap to transform surgical care delivery nationwide. Built on six strategic pillars—infrastructure, workforce, service delivery, information systems, financing, and governance—the plan directly addresses documented gaps in access, safety, equity, and quality.

By operationalizing Cambodia's health principle of "Safe Minds, Safe Health Care" through the specific mandate of "Safe Minds, Safe SOA Care," this plan ensures that surgical system strengthening encompasses both clinical excellence and psychosocial wellbeing. This holistic approach recognizes that true surgical safety requires not only properly equipped operating theatres and trained providers, but also environments that support mental health, reduce patient anxiety, prevent provider burnout, and foster trust throughout the surgical journey.**

Key transformations include scaling surgical volume, equitably distributing the surgical workforce, ensuring district hospitals can deliver Bellwether procedures, and linking surgical services with primary and community health systems under standardized safety protocols.

The NSOAP is fully aligned with Health Strategic Plan (HSP4), the UHC Roadmap 2024–2035, SDG 3.8, WHO Resolution WHA 76.2, and Lancet Commission on Global Surgery targets. This ensures that surgical strengthening contributes directly to national development and global benchmarks for universal surgical access.

Success will depend on:

- Political commitment and sustained leadership
- Adequate, timely funding from domestic and external sources
- Clear stakeholder roles and collaborative implementation
- Routine monitoring and adaptive management
- Inclusive engagement of communities, providers, and partners

Safe surgery saves lives, prevents disability, and builds healthier communities. Together, we can ensure that no Cambodian suffers or dies from a surgically treatable condition due to lack of access, quality, or affordability.

The NSOAP is more than a health plan — it is a national commitment to equity, dignity, and resilience. By implementing this strategy, Cambodia will move decisively toward Universal Health Coverage by 2035 and ensure that surgical care is safe, timely, affordable, and accessible to all.

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11. ANNEXES

11.1. Annex 1: Comparative Analysis: Cambodia SOA Findings vs. Global Benchmarks

Cambodia's SOA assessment findings (from situational analysis) with global/LMIC benchmarks and targets: SOA System Indicators: Cambodia vs. Global Benchmarks

Indicator	Cambodia (2025 Assessment)	Global Benchmark / Target	Gap Analysis
Access within 2 hours	Not reported in assessment	≥80% (LCoGS)	Data gap; likely low in rural areas
Surgical Volume	1,431 procedures/100,000	5,000/100,000 (WHO/LCoGS)	71.4% gap – only 28.6% of target met
SOA Workforce Density	7 providers/100,000	20/100,000 (LCoGS)	65% gap – critical shortage
Operating Theatres/100,000	2.18 OT/100,000	5 OT/100,000 (LCoGS)	56.4% gap
Perioperative Mortality Rate	Not systematically tracked	≤1% (WHO Safe Surgery)	Surveillance gap; likely higher in emergencies
Catastrophic Health Expenditure	24.24% of households	0% (UHC target)	High financial risk; protection needed
Out-of-Pocket Spending	61% of health spending	≤ 30% (WHO UHC)	Double the recommended limit
Surgical Safety Checklist Use	15.82% (public), 23.98% (private)	100% (WHO Safe Surgery)	Major compliance gap
Postoperative Follow-up Default	~40%	≤10% (ERAS standards)	High attrition; continuity of care weak
Blood Availability	Limited data; likely low at CPA2	100% of hospitals with blood storage (WHO)	Likely critical gap in district hospitals
Oxygen Supply Reliability	65% of CPA2 hospitals lack reliable O ₂	100% (WHO ESA guidelines)	Critical for safe surgery & emergencies
Electricity/Water Stability	48% unstable power; 52% inadequate water	100% (WHO IPHS)	Infrastructure resilience gap

Indicator	Cambodia (2025 Assessment)	Global Benchmark / Target	Gap Analysis
Mental Health Screening	0% routine screening	Routine in ERAS/US/UK protocols	Total gap; not integrated
MSW in Surgical Teams	0% integration	Standard in LMIC NSOAPs (Rwanda, Ethiopia)	Total gap; social determinants unaddressed
Private Sector Integration	Assessed but not linked to public system	Linked referral & regulation (Ghana, India)	Siloed service delivery

11.2. Annex 2: Cambodia vs. Other LMICs: Key Similarities & Differences

Area	Cambodia (2025)	Similar to...	Different from...
Surgical Volume	1,431/100k	Vietnam, Laos (1,200–1,800)	Rwanda ($\geq 4,000$), Thailand ($\geq 5,000$)
Workforce Density	7/100k	Myanmar, PNG (5–10)	Philippines (15), Malaysia (25)
OOP Spending	61%	Myanmar (65%), India (55%)	Thailand (12%), Vietnam (40%)
Catastrophic Expenditure	24.24%	Laos (18%), Bangladesh (16%)	Sri Lanka (5%), Thailand (3%)
SSC Compliance	15–24%	Many LMICs (10–30% initial)	Rwanda (95%), Ghana (70%) post-NSOAP
Private Sector Role	Significant but unintegrated	India, Nigeria (large, fragmented private sector)	Vietnam, Thailand (better regulated integration)
Mental Health Integration	Not measured/routine	Most LMICs (not yet integrated)	Rwanda, Ethiopia (NSOAP includes MH screening)
MSW in SOA	Absent	Many LMICs (not yet standard)	Ghana, Zambia (NSOAP includes MSW roles)
Oxygen Access Gaps	65% CPA2 lack reliable O ₂	Similar to rural Africa/Asia	Countries with O ₂ plants per region (Rwanda, Nepal)

11.3. Annex 3: Indicator Definitions, Measurement

1. Purpose

This annex provides standardized definitions and measurement methods for the 25 tracking indicators outlined in Annex B of the NSOAP 2026–2035. These definitions ensure consistent data collection, reporting, and interpretation across all levels of the health system.

No	Key Indicator	Definition	How to Measure	Purpose
1	Access to Bellwether surgery within 2 hours	Percentage of the national population residing within 2-hour travel time of a Bellwether-capable facility.	Geospatial mapping using population data and facility service readiness surveys; updated every 3 years.	To measure geographical accessibility to life-saving surgical care as per global surgery benchmarks.
2	Specialist surgical workforce density	Number of specialist surgeons, anesthetists, and obstetricians per 100,000 population.	National health workforce registry data; annual update.	To track the availability of specialized surgical human resources against WHO-recommended thresholds.
3	Surgical volume	Total number of inpatient and outpatient surgical procedures per 100,000 population annually.	HMIS surgical registries and facility logbooks; annual aggregation.	To monitor surgical output and assess health system capacity to meet population needs.
4	Perioperative mortality rate (POMR)	Percentage of patients who die in the hospital within 30 days of surgery.	Surgical audit system and HMIS mortality tracking; annual facility reporting.	To evaluate the safety and quality of surgical care and identify areas for improvement.
5	Reduce out-of-pocket expenditure for surgical care	Percentage of total surgical health expenditure paid out-of-pocket, targeting $\leq 35\%$ by 2034.	National Health Accounts (surgical module) and Household Health Expenditure Survey; biennial.	To measure financial protection and alignment with Cambodia's UHC roadmap, reducing catastrophic health expenditure.
6	Safe anesthesia	Percentage of surgical procedures with a	Anesthesia logbooks and surgical theater registers; quarterly facility reporting.	To ensure anesthesia safety and adherence to international

No	Key Indicator	Definition	How to Measure	Purpose
		trained anesthesia provider present.		standards for patient safety.
7	Uninterrupted blood supply for emergencies	Percentage of surgical hospitals with no blood stockouts over 3 months.	Blood bank stock reports and facility supervisory checklists; quarterly.	To guarantee availability of blood products for emergency and elective surgical procedures.
8	SOA providers trained in IPC protocols	Percentage of SOA providers with completed IPC training within last 2 years.	Training attendance records from IPC units; annual verification.	To reduce healthcare-associated infections through trained and compliant surgical teams.
9	Compliance with Surgical Antimicrobial Prophylaxis (SAP) Guidelines	Percentage of eligible procedures following national SAP guidelines.	Retrospective surgical record audit using standardized tool; quarterly sample audits.	To promote appropriate antibiotic use, prevent surgical site infections, and combat antimicrobial resistance.
10	Functional patient monitoring in recovery	Percentage of facilities with functional monitors in all recovery bays.	Equipment checklists and maintenance logs; quarterly spot checks.	To ensure patient safety during postoperative recovery through continuous monitoring.
11	Ambulance services for surgical referrals	Percentage of districts with dedicated 24/7 surgical ambulances.	District transport service reports and ambulance logbooks; random call tests quarterly.	To improve timely referral of surgical emergencies from rural and remote areas.
12	EMR for SOA patients	Percentage of surgical hospitals using EMR for SOA data.	HMIS/EMR adoption surveys and system audit reports; annual.	To enhance data completeness, accuracy, and use for surgical quality improvement.

No	Key Indicator	Definition	How to Measure	Purpose
13	Staff trained in disaster response	Percentage of surgical staff with mass casualty training within last 3 years.	Simulation center training records; annual update.	To strengthen surgical system resilience and preparedness for mass casualty events.
14	Medical simulation trainings annually	Total number of simulation-based training sessions conducted annually.	Simulation center activity reports; annual aggregation.	To enhance clinical skills and teamwork in a risk-free training environment.
15	SOA equipment with preventive maintenance	Percentage of major SOA equipment with documented preventive maintenance in last 12 months.	Biomedical maintenance logs; annual facility inspection.	To ensure equipment functionality, longevity, and patient safety.
16	Monthly SOA quality audits	Percentage of facilities conducting monthly SOA quality audits.	Quality audit reports and meeting minutes; quarterly supervisory review.	To foster a culture of continuous quality improvement in SOA care.
17	Lab turnaround time for surgery	Average time from specimen collection to lab result availability.	Laboratory information system data; monthly sampling of 20 cases per facility.	To reduce delays in surgical decision-making and improve patient flow.
18	Trainee rural posting satisfaction	Percentage of SOA trainees completing rural rotation with satisfaction rating $\geq 4/5$.	Trainee evaluation surveys; after each rotation cycle.	To improve retention of surgical staff in underserved areas through positive training experiences.
19	Community awareness campaigns annually	Total number of community surgical awareness campaigns conducted annually.	Campaign activity reports from health promotion units; annual compilation.	To increase public knowledge of surgical services and early care-seeking behavior.

No	Key Indicator	Definition	How to Measure	Purpose
20	Designated infection control nurses	Percentage of surgical hospitals with a trained IPC focal nurse.	Staffing reports and IPC training databases; annual verification.	To strengthen infection prevention leadership and compliance at the facility level.
21	Documented informed consent	Percentage of surgical procedures with a completed consent form in patient record.	Retrospective patient record audits; quarterly sample review.	To uphold ethical standards and patient rights in surgical care.
22	Multidisciplinary tumor boards meeting	Number of tumor boards meeting at least quarterly with multispecialty representation.	Tumor board meeting minutes and attendance records; quarterly reporting.	To improve cancer care coordination and treatment planning through team-based decision-making.
23	Postoperative pain protocols	Percentage of surgical hospitals with written postoperative pain management protocols.	Policy document reviews and staff interviews; annual audit.	To ensure standardized, effective pain management and improve patient comfort and recovery.
24	SOA providers trained in patient safety	Percentage of SOA providers with patient safety training within last 2 years.	Training completion certificates and CPD records; annual update.	To reduce medical errors and enhance a culture of safety in surgical settings.
25	Biomedical calibration workshops annually	Total number of biomedical equipment calibration workshops conducted annually.	Workshop attendance records and activity reports; annual compilation.	To build local capacity for equipment maintenance and ensure accurate, safe medical devices.
26	Surgical Bed Occupancy Rate	Percentage of surgical beds occupied by inpatients over a given period	Calculated as: $(\text{Total inpatient days} \div (\text{Number of beds} \times \text{Number of days})) \times 100$. Data collected	To measure efficiency of surgical bed resource utilization and identify needs

No	Key Indicator	Definition	How to Measure	Purpose
			monthly from HMIS and hospital reports.	for hospital capacity expansion.
27	Mean Duration of In-Hospital Stay	Average number of days patients remain stay hospitalized from admission to discharge	Calculated as: Total inpatient days ÷ Total number of patients. Data collected monthly from HMIS, patient records, and EMR.	To evaluate care efficiency, identify factors prolonging hospitalization, and improve patient flow.
28	Surgical Referral Out Rate	Percentage of surgical cases referred from lower-level health facilities to higher-level facilities	Calculated as: (Number of surgical patients referred ÷ Total surgical patients presenting) × 100. Data collected monthly from referral system, HMIS, and referral logbooks.	To assess surgical capacity at lower-level facilities, identify referral system gaps, and strengthen surgical services at sub-national levels.

Notes

- **Indicator 9 updated** to reflect **Surgical Antimicrobial Prophylaxis (SAP) Compliance**, a WHO-recommended patient safety and antimicrobial stewardship metric.
- **Global Indicators (G1–G6)** are aligned with the Lancet Commission on Global Surgery (LCoGS) and WHO monitoring frameworks.
- Baseline year: 2025. Targets are set for 2030 (mid-term) and 2034 (end of plan).

11.4. Annex 4: Key finding from 2024 SOA assessment

11.4.1. Findings on Infrastructure, Equipment, and Medical Supplies

The surgical, obstetric, and anesthesia infrastructure of the Kingdom of Cambodia shows significant variability in readiness and availability of essential equipment and supplies. The assessment revealed that there are 376 functional operating theaters nationwide, equivalent to 2.18 per 100,000 population, which is lower than the global standard of approximately 5 per 100,000 population. The surgical bed density is 31.69 per 100,000 population, with 5,477 surgical beds and 2,440 ICU beds available across surveyed facilities.

Basic utilities such as oxygen (91.33% availability) and electricity (79.93%) are widely accessible. However, significant gaps remain in blood supply, with only 45.1% of health facilities able to ensure blood transfusion within two hours. Radiology services are functional in 54.08% of health facilities, but advanced imaging (CT and MRI) remains absent outside national referral hospitals.

The readiness score for infrastructure indicates that only 26.02% of health facilities meet "fully ready" standards, while 43.49% require significant improvement. District-level and private health facilities have the fewest resources, impacting their capacity to provide safe and timely surgical care. Basic emergency equipment such as blood pressure monitors and retractors are available at health facilities, but pediatric surgical instruments, sterilization systems, and modern anesthesia machines are often lacking, especially in rural and peri-urban areas.

11.4.2. Findings on Human Resource Development and Human Resource Planning

Cambodia's surgical, obstetric, and anesthesia (SOA) human resources comprise 6,488 health workers (38 per 100,000 population), including surgeons, anesthesiologists, obstetricians, nurses, midwives, and allied

health professionals. The total number of specialized SOA providers is 4,306 (25 per 100,000 population) . However, significant shortages persist in key specialties: surgeons and anesthesiologists each number only 7 per 100,000 population, well below the Lancet Commission's global standard of 20 per 100,000 population.

The distribution of human resources is highly inequitable. National hospitals have the highest concentration of surgeons, while district referral hospitals and private clinics face severe shortages. Only 32.14% of health facilities (hospitals) offer 24/7 SOA services, limiting the availability of emergency care, especially at night and in remote areas. Continuing medical education (CME) is provided monthly in 46.94% of health facilities (hospitals) , but structured training on surgical safety, infection prevention, and emergency obstetric services remains inconsistent.

Ratio of Surgical Workforce Deployed Compared to Population Served

Deploying qualified SOA providers is a critical step toward closing the gap in access to highly skilled specialists. Cambodia has a surgical workforce density of 25 per 100,000 population across all levels of assessed health facilities. However, this workforce is unevenly distributed across provinces, with rural and remote areas experiencing severe shortages.

Public specialized hospitals, which have the highest concentration of surgeons, anesthesiologists, and obstetricians, have a density of 15 specialists per 100,000 population served. Private clinics, assessed across 127 private hospitals/clinics, have a surgical workforce density of 10 per 100,000 population, reflecting both their contribution and the fragmentation of surgical service delivery.

11.4.3. Findings on Service Delivery, Quality of Service, and Surgical Volume

Access to Surgical and Anesthesia Services: Surgical Volume and Access

In 2024, surveyed health facilities performed 247,262 surgical procedures, equivalent to 1,431 procedures per 100,000 population — only 28.62% of the minimum surgical volume of 5,000 procedures recommended by WHO. Operating theater volume was higher, with 593,007 procedures (3,432 per 100,000 population) , but still below international standards.

Bellwether procedures — cesarean section, emergency laparotomy, and open fracture repair — were performed 63,314 times annually. Cesarean sections accounted for 53.8% of all Bellwether procedures, followed by laparotomy (22,776) and open fracture repair (6,459) . 94.57% of major and minor surgeries were performed in public specialized hospitals, indicating centralization of surgical services.

11.4.4. Implementation of Surgical Antibiotic Prophylaxis

The use of surgical antibiotic prophylaxis remains high. Only 30% of hospitals (14/47) reported adherence to single-dose prophylaxis, while 32% (15/47) reported use beyond one day, indicating ongoing risks of inappropriate antibiotic use in surgical services. District referral hospitals are less likely to follow prophylaxis guidelines: 50% (8/16) reported no antimicrobial stewardship interventions at all. This suggests weak systems to support safe surgery, surgical site infection prevention, and quality assurance, especially in rural and referral settings.

The availability of clinical guidelines for surgical prophylaxis was reported by only 53% of hospitals (25/47) , with significant variability in dissemination and awareness at subnational levels. Limited diagnostic and microbiology capacity at provincial and district hospitals hinders appropriate perioperative antibiotic decision-making, leading to empirical therapy and prolonged prophylaxis.

These findings underscore the need for standardized national or facility-level guidelines, targeted team training, strengthened infection prevention and control (IPC) measures, and regular monitoring to improve the quality and safety of surgical and referral services.

Surgical Volume by Health Facility Level

Facility Type	Total Number of Facilities Performing Surgery	Surgical Volume
National Hospitals	10	301,730
Provincial Hospitals	24	177,465

Facility Type	Total Number of Facilities Performing Surgery	Surgical Volume
District Hospitals	34	64,955
Private	110	48,857
Total	178	593,007

Ratio of Surgical Beds to Population Served

The total surgical bed ratio is 31.69 per 100,000 population. Public health facilities with operating theaters have a surgical bed ratio of 1:27, while private health facilities have a ratio of 1:4, reflecting higher per capita bed availability in the private sector.

Number and Functionality of Operating Theaters

There are 376 functional operating theaters nationwide (2.18 per 100,000 population). State hospitals have the highest proportion of functional operating theaters (64.89%), with national specialized hospitals having the most (118 operating theaters). Provincial and district hospitals together have 126 operating theaters.

Safety of Surgical Care: Use of the WHO Surgical Safety Checklist

The WHO Surgical Safety Checklist is consistently used in only 39.6% of surgical departments. Usage varies by service level: national specialized hospitals (60%) , provincial hospitals (56%) , district referral hospitals (32.35%) , and private clinics (37.01%) . This indicates a significant gap in systematic safety culture and adherence to standard perioperative protocols.

11.4.5. Perioperative Mortality Rate (POMR)

The perioperative mortality rate is 0.14% (837 deaths out of 593,007 procedures) , which falls within acceptable global standards. However, systematic tracking of postoperative mortality is inconsistent. Only 47.96% of health facilities with surgical services routinely record postoperative deaths, limiting the capacity to monitor and improve surgical outcomes.

11.4.6. Health Information Systems / Information Management, Research, and Monitoring & Evaluation (M&E)

The health information system for SOA services remains underdeveloped. Most health facilities (51.53%) use mixed paper-electronic recording systems, but fully electronic medical records are present in only 17.35% of health facilities. Telemedicine services are available in 21.94% of health facilities, primarily in urban areas. Data reporting to the Ministry of Health is quantitative, but data quality and completeness vary, hampering evidence-based planning and monitoring.

11.4.7. Health Financing / Financial Protection

Out-of-pocket (OOP) health spending remains high in Cambodia, accounting for approximately 61% of total health expenditure. In 2023, 24.24% of households faced catastrophic health expenditure, and 6.7% were pushed into poverty due to health costs. Government health expenditure is 23.8% of current health expenditure (1.5% of GDP) . Although Health Equity Funds (HEF) and National Social Security Fund (NSSF) have improved financial protection, OOP spending for SOA services remains a major access barrier, especially for vulnerable populations.

11.4.8. Leadership, Governance, and Regulation

Governance of SOA services is fragmented. While 100% of national and provincial hospitals have established SOA working groups, only about 50% of state hospitals have facility-level SOA working groups. There is no formal guidance for establishing SOA working groups in private hospitals or clinics, limiting coordination and standardization across sectors.

At the national level, the Ministry of Health (MoH) will have ultimate oversight responsibility for NSOAP planning, implementation, and monitoring. The National SOA Commission will be responsible for operationalizing and evaluating the plan, coordinating vertical activities across subnational levels and horizontally with partners and stakeholders. At provincial, district, and health center levels,

implementation will be overseen by Capital/Provincial and District Health Department working groups, in collaboration with hospital SOA working groups.

11.4.9. Social Determinants and Surgical Equity

The 2024 SOA assessment identified major non-clinical barriers to surgical access, including transportation costs consuming 15-25% of household income for referred patients. 40% of missed postoperative follow-ups were due to financial or social barriers, and 35% of consultations were interrupted by family caregiving or work obligations. These findings highlight the absence of systematic Medical Social Services (MSW) in the surgical pathway — a gap that acts as a barrier to equitable access, compromises recovery, and undermines financial protection under UHC. Integrating MSWs to address social determinants is essential to achieving safe, timely, and equitable surgical care for all Cambodians.

11.4.10. Integration of Physical Health, Mental Health, and Psychosocial Services in the SOA Care Pathway

Brief assessment of physical, mental, and psychosocial well-being is critical to achieving equitable surgical services under Cambodia's UHC framework. Global evidence shows that 15-30% of surgical patients experience depression and 20-50% experience anxiety disorders — conditions that delay recovery and increase complications. The 2024 SOA assessment did not capture mental health status due to SOA assessment tool limitations, reflecting a systematic gap in health service design. Mental health screening is not routine, psychiatric comorbidities are not systematically assessed, and trauma-informed support for vulnerable groups is not integrated into the surgical pathway. Addressing this gap requires mandatory integration of mental health across all six pillars of the surgical system, in line with WHO recommendations and the MoH's Mental Health Strategic Plan 2023-2032.

11.4.11. Assessment of the Surgical Disease Burden in Cambodia

Surgical conditions account for an estimated 30.1–34.5% of the total surgical disease burden in Cambodia, depending on whether the burden is measured in terms of mortality or Disability-Adjusted Life Years (DALYs). Providers from CPA-3 and national-level hospitals estimated that 35.7% of deaths and 31.2% of DALYs lost are attributable to surgical conditions, underscoring the critical role of SOA care in addressing the country's disease burden.

Summary of Key Gaps

Cambodia's surgical system is assessed as WEAK–FAIR (3.8/10). Significant gaps in infrastructure, human resources, financial risk protection, and safety systems are barriers to providing safe, timely, and equitable surgical care for millions.

The National Surgical, Obstetric, and Anesthesia Policy and Strategic Framework (NSOAP) 2026–2035 must address these challenges through targeted investments in workforce training, infrastructure upgrading, safety systems, financial risk protection, and data-driven governance to ensure that all Cambodians receive safe, timely, and affordable surgical, obstetric, and anesthesia care.

11.5. Appendix 5: Structure of the Cambodian Health System

11.5.1. Administrative Structure

The administrative structure of the country is divided into four levels: 1) Central (National) Level, 2) Provincial (including Municipalities), 3) District (including Municipalities and Khans), and 4) Commune Level (including Sangkat). According to the Law on Administrative Management of the Capital, Provinces, Municipalities, Districts, and Khans, there is 1 Capital (Phnom Penh), which is divided into Khans. A Khan is divided into Sangkats. Provinces are divided into Municipalities and Districts. Municipalities are divided into Sangkats, and Districts are divided into Communes and Sangkats. Villages are the lowest administrative level and are managed by Commune/Sangkat Councils.

The Cambodian health system includes both public and private sectors (including for-profit and non-profit health organizations). The public sector is the predominant provider of preventive services and inpatient hospital care, while the private sector tends to dominate outpatient consultation services.

The Ministry of Health (MoH) has implemented health sector reforms since 1994. The main objective of these reforms was *"to improve and expand primary healthcare through the implementation of a district-*

based health system approach". This reform was implemented to meet the population's essential health needs by:

- Increasing public confidence in public health services.
- Clarifying and strengthening the roles of hospitals and health centers.
- Defining catchment areas for each health facility to ensure population coverage.
- Allocating and utilizing financial and human resources rationally. The health sector reform shifted "from providing health services based on administrative areas to organizing a health system based on population size and accessibility to the health system." As a result, Cambodia's current health system is organized into three levels: Central Level, Provincial Level, and Operational District (OD) Health Office Level.

Health Coverage Plan

The Health Coverage Plan is a framework for developing health system infrastructure based on a combination of population and geographic criteria (Table 1) , considering quality of care and resource availability. The Health Coverage Plan aims to:

- Develop health services by defining criteria for the location of health facilities and their catchment areas.
- Allocate financial and human resources equitably for improved efficiency.
- Ensure that the health needs of the population are met equitably through universal coverage.

Type	Population Size	Accessibility (Distance)
Health Center	Appropriate size: 10,000 (Range: 8,000-12,000)	Within a maximum distance of 10 km or a 2-hour walk for the population in its catchment area.
Referral Hospital	Appropriate size: 100,000 (Range: 80,000 – 200,000)	In densely populated areas; within a 2-hour drive or boat trip, and in rural areas; not exceeding a 3-hour drive or boat trip.
Health Post	Population: 2,000-3,000	Distance from the commune or village to the nearest health center is more than 15 km, with geographical barriers (rivers, mountains, or poor roads).

Table 1: Population covered by health facilities in Cambodia (Source: Ministry of Health Strategic Plan)

Provincial Level (Level 2)

There are 25 Capital/Provincial Health Departments (PHDs) and 25 Capital/Provincial Referral Hospitals, which are under the direct management of the PHD. The Capital/Provincial level is the interface between the Central level and the Operational District (OD) level. The main roles of the PHD are to link the MoH and the PHDs by:

- Interpreting, disseminating, and implementing national health policies and health strategic plans through annual planning and budgeting.
- Supporting the development of ODs through supportive supervision and regular monitoring and evaluation (M&E).
- Ensuring equitable distribution and efficient use of available financial and human resources.
- Mobilizing additional resources.
- Providing continuing professional development to health staff within the province.
- Performing regulatory functions delegated for private health service providers and pharmaceutical products.
- Promoting coordination and collaboration with stakeholders, including local administrations.

Operational District (OD) Level (Level 1)

Within the public health system, there are 103 Operational District (OD) Health Offices, covering 209 administrative districts, communes, and Sangkats. The OD is the most peripheral unit in the health system, closest to the population, and comprises Health Centers/Health Posts and Referral Hospitals. The main roles performed by the OD are:

- Interpreting, disseminating, and implementing national policies.
- Maintaining effective, efficient, and comprehensive health services (promotion, prevention, treatment, and rehabilitation), in accordance with national clinical guidelines or protocols and locally.
- Ensuring equitable distribution and efficient use of available financial and human resources.
- Mobilizing additional resources for municipal/district health services.
- Providing on-the-job training to hospital and health center staff.
- Providing support to Health Centers, Health Posts, and Referral Hospitals through governance, supervision, monitoring, and evaluation.
- Promoting coordination and collaboration with stakeholders, including local administrations.

Health Centers

There are 1,299 Health Centers for 1,652 Health Care Points. Health Centers provide a Minimum Package of Activities (MPA) as defined by the MoH's MPA guidelines:

- Have close relationships with the population in their catchment area.
- Are efficient and cost-effective (both financially and functionally).
- Provide integrated services for high-quality basic promotion, prevention, and treatment.
- Ensure appropriate accessibility financially, geographically, and culturally.
- Encourage community participation in the health sector.

Referral Hospitals (National Hospitals, Provincial Hospitals, District Referral Hospitals)

The Kingdom of Cambodia has 134 Referral Hospitals, including 12 National Hospitals, 25 Capital/Provincial Referral Hospitals, and 68 District Referral Hospitals. Referral hospital services are different from and more comprehensive than those provided by Health Centers. The types of health services provided by RHs are defined by the MoH's Complementary Package of Activities (CPA) guidelines for Referral Hospital development. The main roles of Referral Hospitals are:

- Provide health services that cannot be provided by Health Centers:
 - o Provide specialized services, diagnosis, monitoring, and treatment for managing complex health problems.
- Support Health Centers within their respective ODs through clinical training.
- Conduct supportive supervision/clinical supervision of respective Health Centers.

Human Resources and Health Professional Bodies

Cambodia has laws, royal decrees, sub-decrees, and regulations governing the practice of health professions. The Cambodia Medical Council, Cambodian Pharmaceutical Council, Cambodian Dental Council, Cambodian Council of Nurses, and Cambodian Council of Midwives were established by Royal Decree. These health professional councils play a key role, representing the MoH, in registering health professionals, strengthening adherence to codes of ethics, and continuing professional development (CPD) programs. Council professional networks are established at national and regional levels.

The Kingdom of Cambodia has a mixed health service delivery system, including public health services under the MoH, non-governmental organizations (NGOs), the private sector, and the health services of the Ministry of National Defense. The for-profit private sector is a significant health service provider and has grown rapidly. While it is mostly concentrated in urban areas and economically advantageous regions, it is also expanding into rural areas. There are 17,988 formal private health providers/facilities, including 1,212 private clinics (hospitals, polyclinics, and clinics) (Source: MoH Report 2023), ranging from care, antenatal care, physiotherapy, consultation rooms to polyclinics, and hospitals. Private health services are primarily used for outpatient consultation and treatment but have less impact on inpatient treatment and are limited in providing preventive health services.

Health Strategic Plan 2025–2034 (HSP4)

The Health Strategic Plan 2025–2034 (HSP4) was developed in a manner that aligns with: First, achieving Cambodia's Vision 2030, which promotes improved health and well-being. Second, aligning health goals with priorities for human capital development. Third, achieving national Sustainable Development Goal 3. Fourth, addressing ongoing and anticipated health challenges effectively and efficiently, resetting direction for the health sector and setting a new course.

The vision of HSP4 is "A healthy life and well-being for all in the Kingdom of Cambodia," thereby contributing to sustainable human capital development and economic growth, achieved through its mission: "Promote comprehensive health service delivery, including health education and health promotion, prevention and medical care, diagnosis and treatment, and ensure the best quality of public and private health services," with high-level priorities focusing on people, services, and systems. The operation of the health system adheres to the values of "Right to health and equity" and aligns with the working principles of "Trust, Integrity, Quality, Innovation, and Collaboration." To achieve the health goal of "Health and Equity," focusing on three priority strategies:

- Improving overall health of individuals, families, and communities.
- Promoting equity in access and health financing.
- Strengthening health system resilience and health security.

There are five priority programs:

- Prevention and control of non-communicable diseases (NCDs), chronic diseases, and other health problems.
- Improving reproductive, maternal, newborn, and child health, and nutrition.
- Prevention and control of communicable diseases.
- Strengthening health security.
- Strengthening health systems.

Four Strategic Objectives were developed to respond to the priority strategies:

- Enable all people to access comprehensive health services based on primary health care.
- Ensure that the health care provided is of a quality standard acceptable from the patient/user and system perspectives.
- Enable all people to access quality health services they need, timely, without financial barriers.
- Ensure a health system capable of adapting and responding to all forms of public health threats and emergencies.

Strategic Shifts to achieve the strategic objectives:

- Shift from disease-specific treatment to focusing on health education and promotion, disease prevention, early detection, and early diagnosis, coupled with timely treatment and disease management.
- Shift from volume to quality and health outcomes.
- Shift from target-setting to universal financial protection.
- Shift from a reactive health system to a resilient health system.

There are five strategic enablers, which are key foundations for strengthening and modernizing the health system for the future:

- Institutional Development
- Human Resource Development
- Public Financial Management
- Supply Chain Management, Medical Technology, and Infrastructure
- Data Development, Health Information Management, and Digital Health

The fourth health strategy was developed based on the S.A.F.E.R. principles:

- Strategic Insight
- Adaptable and Talent Institution
- Financial Sustainability and Equity
- Effective and Efficient Health Services

- Regulatory and Policy Compliance

To drive the momentum of strategic transformation and promote strategic enablers.

Strengthening the Health Sector in Cambodia

The Royal Government of Cambodia (RGC) announced the allocation of over US\$18 million in 2025 aimed at upgrading surgical and emergency services in 61 CPA-1 Referral Hospitals and 38 CPA-2 Referral Hospitals. This budget will primarily focus on increasing the capacity of Intensive Care Units (ICUs) in Level 2 Referral Hospitals and supplying essential medical equipment.

Currently, Cambodia has 98 District Referral Hospitals equipped to perform surgery. However, only about 20 hospitals meet necessary surgical standards. Notably, 61 hospitals were reported to lack adequate equipment and infrastructure. Prime Minister Hun Manet emphasized the need to improve primary care capacity to ensure better health outcomes for the population. To support this initiative, the RGC is committed to upgrading ICU infrastructure in these hospitals. This includes providing essential medical equipment such as laboratory machines and X-ray machines, aiming to improve the quality of available care for patients. This strategic investment is poised to make a significant impact, enabling hospitals to serve their communities and ultimately save lives.

Cross-Sectoral Programs

Current Situation:

- SOA services often operate separately from other health programs.
- Limited integration with primary health care, maternal health, and NCD programs.
- Missed opportunities to leverage existing community health structures.

11.6. Appendix 6: National Consultation Workshop on the NSOAP

Reference Invitation Letter No. 0709 dated December 30, 2025. On January 13-14, 2026, the workshop demonstrated broad support from stakeholders for the proposed six NSOAP strategic interventions. Participants generally supported maintaining the overall structure and scope of the NSOAP while providing recommendations to refine targets to enhance operational feasibility, accountability, and alignment with system readiness.

Human Resource Development and Deployment

Workshop participants emphasized the need for a more targeted and needs-based approach to SOA workforce deployment, recommending that the allocation of new, qualified staff should be incentivized not only to fill geographic service gaps but also to address service delivery gaps and priority need areas. Strong support was expressed for diversified and decentralized training models, including public-private partnerships, blended learning, simulation and virtual video modules, and "training of trainers" (TOT) approaches to scale up capacity while minimizing service disruption.

Further workshop recommendations focused on improving retention and workforce allocation through mandatory provincial postings post-training, targeted deployment mechanisms, engaging retired specialists in supervisory and training roles, and non-financial incentives, including reduced postgraduate training costs, recognition schemes, and strengthening the national human resources database. Participants affirmed the importance of strengthening training approaches for allied health personnel such as nurses, pharmacists, and biomedical technicians, including curriculum development and equipment maintenance competencies, to support a comprehensive and sustainable SOA workforce.

Service Delivery, Quality, and Safety

Workshop stakeholders strongly supported a shift from volume-driven expansion to a quality-first, readiness-based service delivery model. Key inputs emphasized the need for a tiered and appropriate service delivery framework with clearly defined surgical roles by health facility level and clear linkages between situation analysis, strategic priorities, and implementation actions.

Workshop participants supported the adoption of a Minimum Safe Surgery Package (MSSP) by CPA level as a prerequisite for surgical authorization, especially to mitigate risks associated with unsafe decentralization and rapid CPA-2 expansion. There was consensus that core safety and quality measures, including WHO Surgical Safety Checklist use, POMR monitoring, infection prevention and control (IPC), antimicrobial stewardship (AMS), and standardized clinical protocols, must be enforced through policy

mechanisms such as licensing, supervision, and performance scorecards, rather than being considered optional practices.

Governance, Accountability, and Implementation

Participants identified governance and accountability work as a key driver of NSOAP success. Recommendations included establishing hospital-level SOA quality committees, formalizing SOA leadership structures at hospital, provincial, and national levels, and strengthening supervision across public and private sectors. Task-sharing was supported only under strict regulatory conditions with standardized training and close supervision; unsupervised independent practice and separate, unintegrated surgical training programs were not supported without prior system readiness assessment.

To ensure implementation, participants emphasized the need to mainstream NSOAP priorities into core planning and financial tools — such as annual operational plans and hospital strategic plans. Furthermore, SOA service standards should be integrated into national frameworks for accreditation, compliance, medical ethics, and equity frameworks, in close collaboration with professional councils.

Health Information Management, Financing, and Monitoring & Evaluation (M&E)

Workshop participants broadly supported the draft's health information management and financing strategies, requesting only minimal modifications. For Health Information Systems (HIS), feedback supported systematic SOA data collection, integration with existing electronic health records (EHRs), and using data for evidence-based decision-making, with targeted recommendations to strengthen scientific communication and data analysis capacity among SOA providers. In the financing area, stakeholders affirmed strategies to enhance affordability and financial protection, including expanding insurance coverage, reducing out-of-pocket (OOP) spending, and monitoring catastrophic health expenditure, specifying that inclusion of Bellwether procedures in national health insurance schemes should be clearly mandated at public facilities.

For M&E, participants supported a structured M&E plan, development of practical M&E tools, routine supervision, expanded operational research, and establishing SOA working groups across public and private health facilities for routine monitoring and continuous quality improvement.

Phased Implementation Approach

Finally, workshop participants strongly supported a phased and sequenced NSOAP implementation roadmap. An initial stabilization and standardization phase should prioritize robust governance and system readiness. This phase was recommended to include MSSP rollout, safety checklist implementation, establishing SOA working groups and quality committees, developing standard operating procedures (SOPs), ensuring infrastructure readiness, and additional workforce training. Subsequent phases should focus on gradual, quality-standard expansion linked to demonstrated readiness, building advanced procedural capacity, results-based financing, and continuous improvement in the safety, timeliness, and efficiency of SOA service delivery.

11.7. Appendix 7: Scope of Surgical, Obstetric, and Anesthesia Services by Health Facility Level

This policy applies to all stakeholders involved in surgical, obstetric, and anesthesia care, including: policymakers, health facility managers, surgical teams, health training institutions, professional health councils, development partners, and community representatives.

The scope of SOA care is defined by health facility level according to the MoH's Complementary Package of Activities (CPA) framework:

11.7.1. National Hospitals (Tertiary and Sub-specialty Care)

- All CPA-3 services, plus:
- Super-specialty surgical care (cardiovascular, neurosurgery, oncology, etc.)
- Advanced laparoscopic and minimally invasive surgery
- Sub-specialty training, research and National referral center for complex cases.

11.7.2. Provincial Referral Hospitals (CPA-3: Comprehensive Surgical Package)

- All CPA-2 services, plus:
- Specialized surgical services (orthopedics, pediatrics, gynecology, urology, etc.)
- Intensive Care Unit (ICU) with mechanical ventilation
- Advanced diagnostic imaging (ultrasound, X-ray, CT if available)

- Sub-specialist surgeons, anesthesiologists, and obstetricians
 - Surgical outreach and clinical mentoring to CPA-2 facilities
 - Rehabilitation services, physiotherapy, and assistive technology
- 11.7.3. District Hospitals (CPA-2: Essential Surgical Package)
- 24/7 emergency surgical, obstetric, and anesthesia services
 - Bellwether procedures: cesarean section, emergency laparotomy, open fracture management
 - Safe general and regional anesthesia and preoperative assessment and postoperative inpatient care
 - Basic blood transfusion capacity and Infection prevention and aseptic technique
 - Referral linkage to higher-level facilities
- 11.7.4. District Hospitals (CPA-1: Essential Surgical Package)
- Minor surgical procedures under local anesthesia
 - Incision and drainage, Wound suturing
 - Basic obstetric care (normal delivery, manual removal of placenta) and Patient stabilization and referral
- 11.7.5. Health Centers (Referral and Preoperative Care)
- No surgical procedures
 - Identify and stabilize surgical patients
 - Initiate timely referral to CPA-2/CPA-3 facilities
 - Provide postoperative follow-up and community-based care
- 11.7.6. Private Health Facilities with Surgical Services
- Must meet the same safety, quality, and reporting standards as public facilities.
 - Must be regulated and integrated into the national referral and reporting system.
- 11.7.7. The SOA Care Pathway: A Team-Based Approach

Safe surgical care is delivered through a coordinated, multidisciplinary team working across the entire patient journey:

1. Preoperative Phase

- Timely diagnosis and decision-making
- Comprehensive pre-anesthesia assessment
- Informed consent and patient counseling
- Medical social work support for financial and transportation barriers
- Brief mental health screening when indicated

2. Intraoperative Phase

- Safe anesthesia administration and monitoring
- Adherence to the WHO Surgical Safety Checklist
- Aseptic technique and surgical site infection (SSI) prevention
- Effective communication and teamwork in the operating theater

3. Postoperative Phase

- Recovery room care and pain management
- Early detection and management of complications
- Postoperative rehabilitation and disability assessment
- Discharge planning and follow-up coordination
- Integration of palliative care when needed

The SOA Team includes (but is not limited to):

- Surgeons and obstetricians, Anesthesiologists and nurse anesthetists
- Operating theater and ward nurses
- Midwives, Biomedical engineers and technicians
- Medical social workers, Physiotherapists and rehabilitation specialists
- Pharmacists, Laboratory and blood bank staff, Health information officers
- Other relevant personnel.

11.8 Annex 8: Prakas on the establishment of the National Committee for surgery, obstetric and anesthesia



ក្រសួងសុខាភិបាល
លេខ...០០៣៧២...ស.នក/ប្រក

ព្រះរាជាណាចក្រកម្ពុជា
ជាតិ សាសនា ព្រះមហាក្សត្រ
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ប្រកាស
ស្តីពី

ការបង្កើតគណៈកម្មការសេសស្រួល សម្ភព និងសន្តិ ថ្នាក់ជាតិ នៃក្រសួងសុខាភិបាល

រដ្ឋមន្ត្រីក្រសួងសុខាភិបាល

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- បានឃើញព្រះរាជក្រឹត្យលេខ នស/រកត/០៨២៣/១៩៨១ ចុះថ្ងៃទី២២ ខែសីហា ឆ្នាំ២០២៣ ស្តីពី ការតែងតាំងរាជរដ្ឋាភិបាល នៃព្រះរាជាណាចក្រកម្ពុជា
- បានឃើញព្រះរាជក្រមលេខ នស/រកម/០៦១៨/០១២ ចុះថ្ងៃទី២៨ ខែមិថុនា ឆ្នាំ២០១៨ ដែលប្រកាស ឱ្យប្រើច្បាប់ស្តីពីការរៀបចំ និងការប្រព្រឹត្តទៅ នៃគណៈរដ្ឋមន្ត្រី
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- បានឃើញព្រះរាជក្រមលេខ នស/រកម/១២០៧/០៣៧ ចុះថ្ងៃទី២៨ ខែធ្នូ ឆ្នាំ២០០៧ ដែលប្រកាស ឱ្យប្រើច្បាប់ស្តីពីវិសោធនកម្មច្បាប់ស្តីពីការគ្រប់គ្រងឱសថ
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- បានឃើញព្រះរាជក្រមលេខ នស/រកម/១១១៦/០១៤ ចុះថ្ងៃទី១៩ ខែវិច្ឆិកា ឆ្នាំ២០១៦ ដែលប្រកាស ឱ្យប្រើច្បាប់ស្តីពីការគ្រប់គ្រងអ្នកប្រកបវិជ្ជាជីវៈវិស័យសុខាភិបាល
- បានឃើញព្រះរាជក្រមលេខ នស/រកម/០៨១៦/០១៣ ចុះថ្ងៃទី៩ ខែសីហា ឆ្នាំ២០១៦ ច្បាប់ស្តីពីការ គ្រប់គ្រងលើការបរិច្ចាគការផ្សំកោសិកា ជាលិកា និងសរីរាង្គមនុស្ស
- បានឃើញអនុក្រឹត្យលេខ ៦៧ អនក្រ.បក ចុះថ្ងៃទី២២ ខែតុលា ឆ្នាំ១៩៩៧ ស្តីពីការរៀបចំ និងការ ប្រព្រឹត្តទៅរបស់ក្រសួងសុខាភិបាល
- យោងតាមតម្រូវការចាំបាច់របស់ក្រសួងសុខាភិបាល។

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ប្រការ១ .-

ត្រូវបានបង្កើតគណៈកម្មការសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្ឋា ថ្នាក់ជាតិ នៃក្រសួងសុខាភិបាល សរសេរអក្សរកាត់ **គ.ស.ស.ស.ជ.** ក្នុងគោលបំណងលើកកម្ពស់គុណភាពសក្តិសិទ្ធភាព សុវត្ថិភាព និងប្រសិទ្ធភាព នៃសេវាថែទាំព្យាបាលដោយការវះកាត់គ្រប់ឯកទេស ទាំងសាធារណៈ និងឯកជន។

ប្រការ២ .-

វាក្យសព្ទបច្ចេកទេសសំខាន់ៗដែលប្រើក្នុងប្រកាសនេះមាននិយមន័យដូចខាងក្រោម៖

- សល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្ឋា សំដៅទៅដល់គ្រប់សកម្មភាពការងារវេជ្ជសាស្ត្រ អមវេជ្ជសាស្ត្រ រូបភាពវេជ្ជសាស្ត្រ ដែលបម្រើឱ្យការពិនិត្យ ការស្រាវជ្រាវ ការធ្វើរោគវិនិច្ឆ័យ និងការព្យាបាលដោយវិធីសាស្ត្រ វះកាត់គ្រប់ឯកទេស និងគ្រប់ទម្រង់ដូចជា វះកាត់ទូទៅ ការសម្រាលកូនដោយការវះកាត់ ការវះកាត់ក្នុងជំងឺរោគស្រ្តី ការវះកាត់ក្នុងវេជ្ជសាស្ត្រកុមារ ការវះកាត់ក្នុងទន្ធវិទនសាស្ត្រ និងការថែទាំព្យាបាលក្រោយការវះកាត់ប្រកបដោយគុណភាព និងសុវត្ថិភាព
- សល្យសាស្ត្រ សំដៅដល់ការអន្តរាគមន៍ចាំបាច់សម្រាប់ព្យាបាលស្ថានភាពទូលំទូលាយ រួមមានការសម្រាលកូនមានឧបសគ្គ របួសគ្រប់ប្រភេទ និងគ្រប់កម្រិត ដុំសាច់មិនមែនមហារីក និងដុំសាច់មហារីកជំងឺរោគស្រ្តី និងកុមារ ស្ថានភាពមិនធម្មតាពីកំណើត ជំងឺមិនឆ្លង និងជំងឺបណ្តាលពីការរលាក និងការចម្លងរោគនានា។ អន្តរាគមន៍ដោយវិធីសាស្ត្រសល្យសាស្ត្រល្អអាចកាត់បន្ថយអត្រាពិការភាព និងអត្រាស្លាប់ព្រមទាំងចូលរួមចំណែកធ្វើឱ្យប្រសើរឡើងសុខុមាលភាពនៃប្រជាពលរដ្ឋទូទៅ និងកំណើនសេដ្ឋកិច្ចសង្គម និងឈានទៅសម្រេចគោលដៅអភិវឌ្ឍប្រកបដោយចីរភាពឆ្ពោះទៅរកការគ្របដណ្តប់សុខភាពជាសកល
- គុណភាព និងសុវត្ថិភាពសល្យសាស្ត្រ សំដៅដល់ការបន្តអភិវឌ្ឍជាប្រចាំ នៃការងារសល្យសាស្ត្រ រួមមានអ្នកប្រកបវិជ្ជាជីវៈសុខាភិបាល ឧបករណ៍សម្ភារៈបរិក្ខារពេទ្យ និងឱសថ ក្នុងការផ្តល់សេវាពិនិត្យ ព្យាបាល ថែទាំដោយការវះកាត់គ្រប់ឯកទេស ការដាក់ថ្នាំសណ្ឋា ភ្នាក់ពីសណ្ឋា ការគ្រប់គ្រងថ្នាំសណ្ឋា និងសម្ភាសម្ភារៈ ឧបករណ៍សល្យសាស្ត្រគ្រប់ប្រភេទ សេវាផ្តល់ឈាម មន្ទីរសោធន៍វេជ្ជសាស្ត្រ រូបភាពវេជ្ជសាស្ត្រ សង្គ្រោះបន្ទាន់ និងសេវាពាក់ព័ន្ធ។

ជំពូកទី២

សមាសភាព គ.ស.ស.ស.ជ.

ប្រការ៣ .-

គ.ស.ស.ស.ជ. នៃក្រសួងសុខាភិបាលមានសមាសភាពដូចខាងក្រោម៖

- ១. រដ្ឋលេខាធិការក្រសួងសុខាភិបាលទទួលបន្ទុកសល្យសាស្ត្រ ប្រធាន
- ២. រដ្ឋលេខាធិការក្រសួងសុខាភិបាលទទួលបន្ទុកសុខភាពមាតា ទារក និងកុមារ អនុប្រធាន



- ៣. រដ្ឋលេខាធិការក្រសួងសុខាភិបាលទទួលបន្ទុកគ្រប់គ្រងកិច្ចការឱសថស្ថានៈបរិក្ខារពេទ្យ ចំណីអាហារ និងគ្រឿងសំអាង អនុប្រធាន
- ៤. រដ្ឋលេខាធិការក្រសួងសុខាភិបាលទទួលបន្ទុកប្រព័ន្ធបញ្ជូនជំងឺសង្គ្រោះបន្ទាន់ និងប្រពេជនកម្ម អនុប្រធាន
- ៥. រដ្ឋលេខាធិការក្រសួងសុខាភិបាលទទួលបន្ទុកសុខភាពមាត់ធ្មេញ អនុប្រធាន
- ៦. រដ្ឋលេខាធិការក្រសួងសុខាភិបាលទទួលបន្ទុកសេវាសុខាភិបាលរដ្ឋ និងឯកជន អនុប្រធាន
- ៧. រដ្ឋលេខាធិការក្រសួងសុខាភិបាលទទួលបន្ទុកសុខភាពទណ្ឌិត អនុប្រធាន
- ៨. រដ្ឋលេខាធិការក្រសួងសុខាភិបាលទទួលបន្ទុកកម្មវិធីជាតិចាក់ថ្នាំបង្ការរោគ អនុប្រធាន
- ៩. អនុរដ្ឋលេខាធិការទទួលបន្ទុកការងារពាក់ព័ន្ធ អនុប្រធាន
- ១០. អគ្គនាយកបច្ចេកទេសសុខាភិបាល សមាជិក
- ១១. អគ្គនាយកមន្ទីរពេទ្យកាល់ម៉ែត សមាជិក
- ១២. សាកលវិទ្យាធិការ នៃសាកលវិទ្យាល័យវិទ្យាសាស្ត្រសុខាភិបាល សមាជិក
- ១៣. ទីប្រឹក្សាក្រសួងសុខាភិបាល សមាជិក
- ១៤. អគ្គនាយករងបច្ចេកទេសសុខាភិបាល សមាជិក
- ១៥. ប្រធាននាយកដ្ឋានមន្ទីរពេទ្យ សមាជិក
- ១៦. ប្រធាននាយកដ្ឋាននីតិកម្ម សមាជិក
- ១៧. ប្រធាននាយកដ្ឋានឱសថ ចំណីអាហារ បរិក្ខារពេទ្យ និងគ្រឿងសំអាង សមាជិក
- ១៨. នាយកមន្ទីរពេទ្យមិត្តភាពខ្មែរ-សូវៀត សមាជិក
- ១៩. នាយកមន្ទីរពេទ្យមិត្តភាពកម្ពុជា-ចិន ព្រះកុសុមៈ សមាជិក
- ២០. នាយកមន្ទីរពេទ្យព្រះអង្គខ្ពង់ សមាជិក
- ២១. នាយកមន្ទីរពេទ្យកុមារជាតិ សមាជិក
- ២២. នាយកមន្ទីរពេទ្យជាតិ តេជោសន្តិភាព សមាជិក
- ២៣. នាយកមន្ទីរពេទ្យព្រះសីហនុ មណ្ឌលនៃក្លឹបសង្ឃឹម សមាជិក
- ២៤. នាយកមន្ទីរពេទ្យហ្លួងម៉ែ សមាជិក
- ២៥. ប្រធានមន្ទីរពេទ្យគន្ធបុប្ផា សមាជិក
- ២៦. ប្រធានមន្ទីរពេទ្យជ័យវ្រ្មនទី៧ សមាជិក
- ២៧. នាយកមជ្ឈមណ្ឌលជាតិគាំពារ មាតា និងទារក សមាជិក
- ២៨. ប្រធានមជ្ឈមណ្ឌលជាតិផ្តល់ឈាម សមាជិក
- ២៩. អនុប្រធាននាយកដ្ឋានមន្ទីរពេទ្យទទួលបន្ទុកការងារពាក់ព័ន្ធ សមាជិក
- ៣០. ប្រធានសមាគមវិជ្ជាជីវៈសុខាភិបាលពាក់ព័ន្ធ សមាជិក
- ៣១. តំណាងអង្គការដៃគូអភិវឌ្ឍ សមាជិក។

ប្រការ៤._

ការតែងតាំងសមាសភាព **គ.ស.ស.ស.ជ.** ត្រូវកំណត់ដោយសេចក្តីសម្រេចរបស់រដ្ឋមន្ត្រីក្រសួងសុខាភិបាល។

ជំពូកទី៣

តួនាទី ភារកិច្ចរបស់ គ.ស.ស.ស.ជ.

ប្រការ៥.

គ.ស.ស.ស.ជ.មានតួនាទី ភារកិច្ចដូចខាងក្រោម៖

- រៀបចំផែនការសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្តំ ថ្នាក់ជាតិ
- ធ្វើបច្ចុប្បន្នភាពការរៀបចំសេចក្តីណែនាំប្រតិបត្តិលើជំនាញសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្តំ ដើម្បីដាក់ឱ្យអនុវត្តក្នុងប្រព័ន្ធសុខាភិបាលគ្រប់លំដាប់ថ្នាក់ទាំងសាធារណៈ និងឯកជន ដើម្បីចូលរួមចំណែកឆ្ពោះទៅរកការគ្របដណ្តប់សុខភាពជាសកលនៅកម្ពុជា
- រៀបចំសមាសភាគសេវាសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្តំ ដើម្បីដាក់បញ្ចូលក្នុងសេចក្តីណែនាំប្រតិបត្តិសម្រាប់អភិវឌ្ឍមន្ទីរពេទ្យថ្នាក់តំបន់ និងមន្ទីរពេទ្យបង្អែករាជធានី ខេត្ត
- បណ្តុះបណ្តាលជំនាញសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្តំ ដល់ក្រុមការងារសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្តំ នៅមូលដ្ឋានព្យាបាល និងថែទាំសុខភាពទាំងថ្នាក់ជាតិ និងថ្នាក់ក្រោមជាតិ
- ដឹកនាំគ្រប់គ្រង តាមដាន និងវាយតម្លៃការងារសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្តំ នៅមូលដ្ឋានព្យាបាល និងថែទាំសុខភាពទាំងថ្នាក់ជាតិ និងថ្នាក់ក្រោមជាតិ ដើម្បីធានាឱ្យមាននិរន្តរភាព និងភាពរីកចម្រើនប្រសើរឡើងដល់ដាច់នូវគុណភាព និងសុវត្ថិភាពនៃសេវានេះ
- រៀបចំគោលនយោបាយ និងនីតិវិធីប្រតិបត្តិពាក់ព័ន្ធនៅនឹងកន្លែងអំពីទម្រង់ការសល្យសាស្ត្រ ការដាក់ថ្នាំសណ្តំ ការរៀបចំសម្ភារសល្យសាស្ត្រ និងទម្រង់ការសម្លាប់មេរោគលើឧបករណ៍សល្យសាស្ត្រដោយអនុវត្តតាមគោលការណ៍ណែនាំជាតិ ស្តីពីការបង្ការត្រួតពិនិត្យការចម្លងរោគរបស់ក្រសួងសុខាភិបាល
- កំណត់សូចនាករគន្លឹះការងារសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្តំ នៅមូលដ្ឋានព្យាបាល និងថែទាំសុខភាពទាំងថ្នាក់ជាតិ និងថ្នាក់ក្រោមជាតិ ដើម្បីធ្វើជាមូលដ្ឋានក្នុងការតាមដាន និងវាយតម្លៃអំពីលទ្ធផលការងារ និងលើកទិសដៅកែលម្អជាប់ជាប្រចាំ
- សហការជាមួយគណៈកម្មការសម្របសម្រួលសម្រាប់ការថែទាំ និងព្យាបាលវេជ្ជសាស្ត្រថ្នាក់ជាតិ ដើម្បីធានាថា សេចក្តីណែនាំប្រតិបត្តិសម្រាប់អភិវឌ្ឍមន្ទីរពេទ្យថ្នាក់តំបន់ និងមន្ទីរពេទ្យបង្អែកក្នុងរាជធានី ខេត្ត មគ្គុទេសក៍ព្យាបាលគ្លីនិកវេជ្ជសាស្ត្រទូទៅ មគ្គុទេសក៍ព្យាបាលគ្លីនិករោគកុមារ មគ្គុទេសក៍ព្យាបាលគ្លីនិកសម្ព័ន្ធ និងរោគស្ត្រី មគ្គុទេសក៍ព្យាបាលគ្លីនិកសល្យសាស្ត្រ មគ្គុទេសក៍ព្យាបាលគ្លីនិកទន្លេវិទនសាស្ត្រ គោលការណ៍ណែនាំជាតិ ស្តីពីការគ្រប់គ្រងការប្រើប្រាស់ឱសថប្រឆាំងមេរោគត្រូវបានបម្រើឱ្យការងារសល្យសាស្ត្រ សម្ព័ន្ធនិងសណ្តំ
- សហការជាមួយក្រុមការងារបច្ចេកទេសសុខភាពជនមានពិការភាព នៃក្រសួងសុខាភិបាលក្នុងការរៀបចំលក្ខខណ្ឌវេជ្ជសាស្ត្រប្រភេទ និងកម្រិតពិការភាព ឧបករណ៍វាយតម្លៃប្រភេទ និងកម្រិតពិការភាព បច្ចេកវិទ្យាជំនួយ និងការស្តារនីតិសម្បទាចិត្តសង្គម សម្រាប់អ្នកជំងឺក្រោយទទួលបានការព្យាបាលដោយសល្យសាស្ត្រ

- ធ្វើការអង្កេតប្រតិបត្តិ ស្តីពីការអនុវត្តផែនការសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្ឋា ថ្នាក់ជាតិក្នុងមូលដ្ឋានសុខាភិបាលនៅថ្នាក់ជាតិ និងថ្នាក់ក្រោមជាតិ
- គ្រប់គ្រងអនុគណៈកម្មការបច្ចេកទេស តាមរយៈការបង្កើតកម្មវិធីពិភាក្សាដោយលើកយកករណីស្លាប់គ្រប់ប្រភេទដោយការព្យាបាលសល្យសាស្ត្រ ដើម្បីវិភាគរកមើលបញ្ហាស្លាប់ ផ្តល់ព័ត៌មានត្រឡប់ផ្តល់អនុសាសន៍កែលម្អ និងការធ្វើកោសល្យវិច័យ
- ពិនិត្យលទ្ធផលវាយតម្លៃអំពីស្ថានភាពគុណភាព និងសុវត្ថិភាព សល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្ឋា នៅតាមមូលដ្ឋានព្យាបាល និងថែទាំសុខភាពទាំងសាធារណៈ និងឯកជន ដែលបានធ្វើឡើងដោយអនុគណៈកម្មការបច្ចេកទេស សល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្ឋា
- សមាជិកគណៈកម្មការត្រូវចូលរួមប្រជុំតាមការអញ្ជើញរបស់ប្រធាន
- អនុវត្តកិច្ចការផ្សេងទៀតតាមការណែនាំរបស់រដ្ឋមន្ត្រីក្រសួងសុខាភិបាល។

ជំពូកទី៤

បេឡាសម្ព័ន្ធរបស់ គ.ស.ស.ស.ជ.

ប្រការ៦._

ប្រធាន **គ.ស.ស.ស.ជ.** មានសិទ្ធិបង្កើតអនុគណៈកម្មការបច្ចេកទេសជំនាញមួយចំនួនចំណុះឱ្យ **គ.ស.ស.ស.ជ.** និងក្រុមការងារសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្ឋា នៅមូលដ្ឋានព្យាបាល និងថែទាំសុខភាពនៅថ្នាក់ជាតិ និងថ្នាក់ក្រោមជាតិតាមការចាំបាច់។

ប្រការ៧._

ការតែងតាំងសមាសភាព និងតួនាទីភារកិច្ចរបស់អនុគណៈកម្មការបច្ចេកទេសជំនាញ និងក្រុមការងារសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្ឋា នៅមូលដ្ឋានព្យាបាល និងថែទាំសុខភាពនៅថ្នាក់ជាតិ និងថ្នាក់ក្រោមជាតិត្រូវកំណត់ដោយសេចក្តីសម្រេចរបស់ប្រធាន **គ.ស.ស.ស.ជ.** ។

ជំពូកទី៥

ការរៀបចំ និងការប្រព្រឹត្តទៅរបស់ គ.ស.ស.ស.ជ.

ប្រការ៨._

ប្រធាន **គ.ស.ស.ស.ជ.** ដឹកនាំការងារទូទៅរបស់ **គ.ស.ស.ស.ជ.** និងអាចប្រគល់សិទ្ធិជូនអនុប្រធានដឹកនាំការងារប្រចាំថ្ងៃ ឬកិច្ចប្រជុំរបស់គណៈកម្មការ និងអនុគណៈកម្មការបច្ចេកទេសក្រោមឱវាទ។

ប្រការ៩._

គ.ស.ស.ស.ជ. មានលេខាធិការដ្ឋានជាសេនាធិការ ស្ថិតនៅនាយកដ្ឋានមន្ទីរពេទ្យដើម្បីដំណើរការការងាររដ្ឋបាល និងជួយសម្របសម្រួលការងាររបស់ **គ.ស.ស.ស.ជ.** និងអនុគណៈកម្មការបច្ចេកទេសតាមឋានានុក្រម និងនីតិវិធីរដ្ឋបាល នៃអគ្គនាយកដ្ឋានបច្ចេកទេសសុខាភិបាល។

ប្រការ១០._

ការតែងតាំងសមាសភាព និងតួនាទីភារកិច្ចរបស់លេខាធិការដ្ឋាន **គ.ស.ស.ស.ជ.** ត្រូវកំណត់ដោយសេចក្តីសម្រេចរបស់រដ្ឋមន្ត្រីក្រសួងសុខាភិបាល។

ជំពូកទី៦

ប្រកាសប្រកាសរបស់ គ.ស.ស.ស.ជ.

ប្រការ១១._

គ.ស.ស.ស.ជ. មានប្រភពធនធាន៖

- ថវិកាជាតិក្នុងកញ្ចប់ថវិកាដោយឡែក ឬកញ្ចប់ថវិកានៅក្នុងក្របខ័ណ្ឌថវិកាប្រចាំឆ្នាំរបស់ក្រសួងសុខាភិបាល
- ថវិកាពីដៃគូអភិវឌ្ឍ និងប្រភពស្របច្បាប់ផ្សេងៗទៀតសម្រាប់ដំណើរការងាររបស់ខ្លួន។

ជំពូកទី៧

អវសានប្បញ្ញត្តិ

ប្រការ១២ ._

ប្រកាសទាំងឡាយណាដែលមានខ្លឹមសារផ្ទុយនឹងប្រកាសនេះត្រូវទុកជានិរាករណ៍។

ប្រការ១៣ ._

នាយកខុទ្ទកាល័យឯកឧត្តមសាស្ត្រាចារ្យរដ្ឋមន្ត្រីក្រសួងសុខាភិបាល អគ្គនាយកបច្ចេកទេសសុខាភិបាល អគ្គនាយករដ្ឋបាល និងហិរញ្ញវត្ថុ អគ្គាធិការក្រសួងសុខាភិបាល គ្រប់ប្រធានអង្គភាពពាក់ព័ន្ធត្រូវទទួលបន្ទុកអនុវត្តតាមប្រកាសនេះចាប់ពីថ្ងៃចុះហត្ថលេខាតទៅ។

ថ្ងៃ ចន្ទ ២ កើត ខែ វិសាខ ឆ្នាំថោះ បញ្ចស័ក ព.ស.២៥៦៧
ធ្វើនៅរាជធានីភ្នំពេញ ថ្ងៃទី ១១ ខែ មីនា ឆ្នាំ២០២៤។



សាស្ត្រាចារ្យ **ឃាន វ៉ាន**

កន្លែងទទួល៖

- ទីស្តីការគណៈរដ្ឋមន្ត្រី
- ក្រសួងសេដ្ឋកិច្ចនិងហិរញ្ញវត្ថុ
- ក្រសួងការពារជាតិ
- ក្រសួងមុខងារសាធារណៈ
- ដូចប្រការ១៣
- ឯកសារ កាលប្បវត្តិ ៧

សម្រេច

ប្រការ១ .

ត្រូវបានតែងតាំងសមាសភាពគណៈកម្មការសេដ្ឋកិច្ចសង្គម និងសណ្តាប់ធ្នាប់ជាតិ **គ.ស.ស.ស.ជ.** នៃក្រសួងសុខាភិបាលមានរាយនាមដូចខាងក្រោម៖

១-	ឯកឧត្តមសាស្ត្រាចារ្យ	ឡឹម តារា	រដ្ឋលេខាធិការក្រសួងសុខាភិបាល	ប្រធាន
២-	លោកជំទាវសាស្ត្រាចារ្យ	អ៊ឹម សិទ្ធិការ្យ	រដ្ឋលេខាធិការក្រសួងសុខាភិបាល	អនុប្រធាន
៣-	លោកជំទាវឱសថការី	វ៉ា ពុធនាថ	រដ្ឋលេខាធិការក្រសួងសុខាភិបាល	អនុប្រធាន
៤-	ឯកឧត្តមវេជ្ជបណ្ឌិត	ជួន កាង	រដ្ឋលេខាធិការក្រសួងសុខាភិបាល	អនុប្រធាន
៥-	ឯកឧត្តមទន្លេបណ្ឌិត	អឿន បូរ៉ាវ៉ត្តន៍	រដ្ឋលេខាធិការក្រសួងសុខាភិបាល	អនុប្រធាន
៦-	ឯកឧត្តមវេជ្ជបណ្ឌិត	ស៊ុក ប៊ុនធី	រដ្ឋលេខាធិការក្រសួងសុខាភិបាល	អនុប្រធាន
៧-	ឯកឧត្តមសាស្ត្រាចារ្យ	ជុន សុខហ៊ាន	រដ្ឋលេខាធិការក្រសួងសុខាភិបាល	អនុប្រធាន
៨-	ឯកឧត្តមសាស្ត្រាចារ្យ	ឌីន សុផិ	រដ្ឋលេខាធិការក្រសួងសុខាភិបាល	អនុប្រធាន
៩-	ឯកឧត្តមសាស្ត្រាចារ្យ	ម៉ុក ធាវី	អនុរដ្ឋលេខាធិការ	អនុប្រធាន
១០-	ឯកឧត្តមសាស្ត្រាចារ្យ	ម៉ម ប៊ុនសុជាតិ	អនុរដ្ឋលេខាធិការ	សមាជិក
១១-	លោកជំទាវសាស្ត្រាចារ្យ	គ្រុយ លាងស៊ីម	អនុរដ្ឋលេខាធិការ	សមាជិក
១២-	ឯកឧត្តមវេជ្ជបណ្ឌិត	ហុក គឹមចេច	អគ្គនាយកបច្ចេកទេសសុខាភិបាល	សមាជិក
១៣-	ឯកឧត្តមសាស្ត្រាចារ្យ	គង់ សន្យា	អគ្គនាយកមន្ទីរពេទ្យកាល់ម៉ែត	សមាជិក
១៤-	ឯកឧត្តមសាស្ត្រាចារ្យ	សាផុន វឌ្ឍនៈ	សាកលវិទ្យាធិការ នៃសាកលវិទ្យាល័យវិទ្យាសាស្ត្រសុខាភិបាល	សមាជិក
១៥-	ឯកឧត្តមសាស្ត្រាចារ្យ	ឈួយ ម៉េង	ទីប្រឹក្សាក្រសួងសុខាភិបាល	សមាជិក
១៦-	ឯកឧត្តមសាស្ត្រាចារ្យ	សុខ ជួរ	អគ្គនាយករងបច្ចេកទេសសុខាភិបាល	សមាជិក
១៧-	ឯកឧត្តមវេជ្ជបណ្ឌិត	សុខ ស្រីន	ប្រធាននាយកដ្ឋានមន្ទីរពេទ្យ	សមាជិក
១៨-	ឯកឧត្តម	ហុក ខៀវ	ប្រធាននាយកដ្ឋាននីតិកម្ម	សមាជិក
១៩-	លោកសថការី	លុក សាតិ	ប្រធាននាយកដ្ឋានឱសថ ចំណីអាហារ បរិក្ខារពេទ្យ និងគ្រឿងសំអាង	សមាជិក
២០-	ឯកឧត្តមសាស្ត្រាចារ្យ	ចី ម៉េង	នាយកមន្ទីរពេទ្យមិត្តភាពខ្មែរ-សូវៀត	សមាជិក
២១-	ឯកឧត្តមសាស្ត្រាចារ្យ	តាន់ សុគុន	នាយកមន្ទីរពេទ្យមិត្តភាពកម្ពុជា-ចិន	សមាជិក
២២-	ឯកឧត្តមសាស្ត្រាចារ្យ	លូ លីយាង	ព្រះកុសុមៈ	សមាជិក
២៣-	ឯកឧត្តមសាស្ត្រាចារ្យ	ឃ្លឹម អន្តារបុស្ស	នាយកមន្ទីរពេទ្យព្រះអង្គឌួង	សមាជិក
២៤-	លោកវេជ្ជបណ្ឌិត	ស្នួន សាមិត្ត	នាយកមន្ទីរពេទ្យកុមារជាតិ	សមាជិក
២៥-	លោកសាស្ត្រាចារ្យ	ចាប សៀកនាយ	នាយកមន្ទីរពេទ្យជាតិគេជោសន្តិភាព	សមាជិក
២៦-	លោកវេជ្ជបណ្ឌិត	ស៊ី សុផាណ្ណា	នាយកមន្ទីរពេទ្យព្រះសីហនុ មណ្ឌលនៃក្តីសង្ឃឹម	សមាជិក
២៧-	លោកសាស្ត្រាចារ្យ	គី សន់ទី	នាយកមន្ទីរពេទ្យហ្លួងម៉ែ	សមាជិក
២៨-	លោកវេជ្ជបណ្ឌិត	យ៉ែ ចន្ទនា	ប្រធានមន្ទីរពេទ្យគន្ធបុប្ផា	សមាជិក
			ប្រធានមន្ទីរពេទ្យជ័យវរ្ម័នទី៧	សមាជិក

២៩-	លោកស្រីវេជ្ជបណ្ឌិត	គឹម រ័ត្ននា	នាយកមជ្ឈមណ្ឌលជាតិគាំពារ មាតា និងទារក	សមាជិក
៣០-	លោកវេជ្ជបណ្ឌិត	សុខ ម៉ូ	ប្រធានមជ្ឈមណ្ឌលជាតិផ្តល់ឈាម	សមាជិក
៣១-	លោកសាស្ត្រាចារ្យ	ភឹម សាវុន	អនុប្រធាននាយកដ្ឋានមន្ទីរពេទ្យ	សមាជិក
៣២-	លោកបណ្ឌិត	កុយ វិរីយ៉ា	អនុប្រធាននាយកដ្ឋានមន្ទីរពេទ្យ	សមាជិក
៣៣-	លោកសាស្ត្រាចារ្យ	ព្រាម ឡី	ប្រធានសមាគមសល្យសាស្ត្រកម្ពុជា	សមាជិក
៣៤-	ឯកឧត្តមសាស្ត្រាចារ្យ	គុំ កាណារ៉ូ	ប្រធានសមាគមសម្ព័ន្ធ និងពេទ្យស្រ្តី	សមាជិក
៣៥-	លោកវេជ្ជបណ្ឌិត	ច័ន្ទ ប៉ារី	ប្រធានសមាគមសក្រុមពេទ្យ សណ្តំ	សមាជិក
៣៦-	លោកសាស្ត្រាចារ្យ	ស៊ិន គុដុត	ប្រធានសមាគមសល្យសាស្ត្រ ផ្នែកជំងឺឆ្លងបាក់បែកកម្ពុជា	សមាជិក
៣៧-	តំណាងអង្គការដៃគូអភិវឌ្ឍ		WHO, DFAT/ACCESS, KHANA	សមាជិក។

ប្រការ២._

ត្រូវបានតែងតាំងសមាសភាពលេខាធិការដ្ឋាន **គ.ស.ស.ស.ជ.** ដែលមានរាយនាមដូចខាងក្រោម ៖

១-	ឯកឧត្តមវេជ្ជបណ្ឌិត	សុខ ស្រីន	ប្រធាននាយកដ្ឋានមន្ទីរពេទ្យ	ប្រធាន
២-	លោកសាស្ត្រាចារ្យ	ភឹម សាវុន	អនុប្រធាននាយកដ្ឋានមន្ទីរពេទ្យ	អនុប្រធាន
៣-	លោកបណ្ឌិត	កុយ វិរីយ៉ា	អនុប្រធាននាយកដ្ឋានមន្ទីរពេទ្យ	អនុប្រធាន
៤-	លោកស្រី	រៀ ដារ៉ាវី	អនុ.ការិយាល័យគិលានុបដ្ឋាក និងធូប	សមាជិក
៥-	លោកវេជ្ជបណ្ឌិត	ហុយ វណ្ណារ៉ា	អនុប្រធានការិយាល័យធានាគុណភាព	សមាជិក
៦-	លោកវេជ្ជបណ្ឌិត	ស៊ិន ទុច	អនុ.ការិយាល័យសេវាមន្ទីរពេទ្យ	សមាជិក
៧-	លោកស្រីវេជ្ជបណ្ឌិត	ឡេង វណ្ណារី	អនុ.ការិយាល័យគិលានុបដ្ឋាកនិងធូប	សមាជិក
៨-	លោកបណ្ឌិត	ហ៊ុន ឡែនម៉ូ	អនុ.ការិយាល័យនិយ័តកម្មនិងក្រមសីលធម៌	សមាជិក
៩-	លោកវេជ្ជបណ្ឌិតឯកទេស	តារា វិទ្យា	មន្ទីរពេទ្យកាល់ម៉ែត	សមាជិក
១០-	លោកស្រីវេជ្ជបណ្ឌិត	ជា សិរិវឌ្ឍនា	នាយកដ្ឋានមន្ទីរពេទ្យ	សមាជិក
១១-	លោកស្រីទទួលបណ្ឌិត	សេត ម៉ាណា	នាយកដ្ឋានការពារសុខភាព	សមាជិក
១២-	លោកវេជ្ជ.ឯកទេស	ហែ វ៉ានែល	មន្ទីរពេទ្យមិត្តភាពកម្ពុជា-ចិនព្រះកុសុមៈ	សមាជិក
១៣-	លោកវិស្វករ	អ៊ុំ កុសល	មន្ទីរការិយាល័យសេវាមន្ទីរពេទ្យ	សមាជិក
១៤-	លោកវិស្វករ	អ៊ុន កកកែវ	មន្ទីរការិយាល័យសេវាមន្ទីរពេទ្យ	សមាជិក
១៥-	លោកស្រី	ទួន សុភាព	មន្ទីរការិយាល័យគិលានុបដ្ឋាកនិងធូប	សមាជិក
១៦-	លោកស្រី	លី ម៉ាន់យ៉ា	មន្ទីរការិយាល័យគិលានុបដ្ឋាក និងធូប	សមាជិក
១៧-	តំណាងដៃគូអភិវឌ្ឍ		WHO, DFAT/ACCESS, KHANA	សមាជិក។

ប្រការ៣._

លេខាធិការដ្ឋានរបស់ **គ.ស.ស.ស.ជ.** មានតួនាទី ភារកិច្ចដូចខាងក្រោម ៖
 - ជាសេនាធិការរបស់ **គ.ស.ស.ស.ជ.** ដើម្បីអនុវត្តតួនាទី ភារកិច្ចរបស់ **គ.ស.ស.ស.ជ.**

(Handwritten signature and initials)

- រៀបចំផែនការសកម្មភាព និងផែនការថវិកាសម្រាប់ដំណើរការការងារ គ.ស.ស.ស.ជ.
- សម្របសម្រួលការងារជាមួយអនុគណៈកម្មការបច្ចេកទេសជំនាញចំណុះឱ្យគ.ស.ស.ស.ជ. និងក្រុមការងារសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្តំ នៅមូលដ្ឋានព្យាបាល និងថែទាំសុខភាព នៅថ្នាក់ជាតិ និងថ្នាក់ក្រោមជាតិ
- ចូលរួមសម្របសម្រួលកិច្ចប្រជុំរបស់ គ.ស.ស.ស.ជ. និងអនុគណៈកម្មការបច្ចេកទេស
- រៀបចំកិច្ចប្រជុំសិក្ខាសាលាពិគ្រោះយោបល់ក្រុមការងារដើម្បីប្តូរសរុបលទ្ធផលការងាររបស់ គ.ស.ស.ស.ជ. ដោយសហការជាមួយដៃគូអភិវឌ្ឍ និងភាគីពាក់ព័ន្ធដទៃទៀត
- រៀបចំកម្មវិធីបណ្តុះបណ្តាល ចុះអភិបាល តាមដាន ត្រួតពិនិត្យ និងវាយតម្លៃការអនុវត្ត ផែនការយុទ្ធសាស្ត្រជាតិ ស្តីពីសល្យសាស្ត្រ សម្ព័ន្ធ និងសណ្តំនៅថ្នាក់ជាតិ និងថ្នាក់ក្រោមជាតិ
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- លើកប្រធានបទ និងរៀបចំរបាយការណ៍កិច្ចប្រជុំ និងលទ្ធផលការងាររបស់ គ.ស.ស.ស.ជ.
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- អនុវត្តកិច្ចការផ្សេងទៀតតាមការណែនាំរបស់ប្រធាន គ.ស.ស.ស.ជ. ។

ប្រការ៤ .-

សេចក្តីសម្រេចទាំងឡាយណាដែលមានខ្លឹមសារផ្ទុយនឹងសេចក្តីសម្រេចនេះត្រូវទុកជានិរាករណ៍។

ប្រការ៥ .-

នាយកខុទ្ទកាល័យឯកឧត្តមសាស្ត្រាចារ្យរដ្ឋមន្ត្រីក្រសួងសុខាភិបាល អគ្គនាយកបច្ចេកទេសសុខាភិបាល អគ្គនាយករដ្ឋបាល និងហិរញ្ញវត្ថុ អគ្គាធិការក្រសួងសុខាភិបាល គ្រប់ប្រធានអង្គភាពពាក់ព័ន្ធ ព្រមទាំងសមាជិកខ្លួនដូចមានរាយនាមក្នុងប្រការ១ និងប្រការ២ ត្រូវទទួលអនុវត្តតាមសេចក្តីសម្រេចនេះឱ្យមានប្រសិទ្ធភាពខ្ពស់ចាប់ពីថ្ងៃចុះហត្ថលេខាតទៅ។

ថ្ងៃ ព្រហស្បតិ៍ ១០ រោច ខែ ឆ្នាំថោះ បញ្ចស័ក ព.ស.២៥៦៧

ធ្វើនៅរាជធានីភ្នំពេញ ថ្ងៃទី០៣ ខែមេសា ឆ្នាំ២០២៤



[Signature]
សាស្ត្រាចារ្យ លាង ភី

កន្លែងទទួល៖

- ទីស្តីការគណៈរដ្ឋមន្ត្រី
- ក្រសួងមុខងារសាធារណៈ
- ដូចប្រការ៥
- ឯកសារ កាលប្បវត្តិ *[Signature]*

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NATIONAL POLICY AND STRATEGIC PLAN ON SURGERY, OBSTETRIC AND ANESTHESIA 2026-2035

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