Gender as a social determinant of health:
Gender analysis of the health sector in Cambodia

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Gender as a social determinant of health

Sex and gender are increasingly recognized as important determinants of health for women and men (UN, 2010; WHO, 2010). Beyond the biological differences, gender roles, norms and behaviour have an influence on how women, men, girls and boys access health services and how health systems respond to their different needs. The different and often unequal abilities of women, men, girls and boys to protect and promote their health require recognition so appropriate health interventions can be planned (Ministry of Women’s Affairs, 2008; Walston, 2005; WHO, 2010).

The World Health Organization (WHO, 2010) recognizes that gender is an important determinant of health in two dimensions: 1) gender inequality leads to health risks for women and girls globally; and 2) addressing gender norms and roles leads to a better understanding of how the social construction of identity and unbalanced power relations between men and women affect the risks, health-seeking behaviour and health outcomes of men and women in different age and social groups.

Cambodia’s Ministry of Health and health partners have recently begun to give attention to understanding gender dimensions of the health system in order to be more able to address gender-related causes of illness and inequality so as to help contribute to the development of appropriate and adequate health policy and programmes in the health sector.

Gender and health problems in the Cambodian context

Cambodia has a total population of 13.6 million, out of whom 49 percent are men and 51 percent are women. Life expectancy is 52-60.5 years for males and 56-63.4 years for females. The total adult literacy rate is at 77.6 percent: 85.1 percent for males and 70.9 percent for females (WHO, 2010).

The poverty rate in Cambodia is still one of the highest among developing countries, with 35 percent of the population still living below the poverty line of less than USD1 per capita (NIS, 2005). There are major disparities in living standards between urban and rural areas. Poverty in Cambodia is caused by many factors, with malnutrition and access to health care being among the most salient.
Cambodia continues to be highly dependent on donor funding. However, the government budget for health has increased steadily over the past decade, accounting for 11 percent of the total government budget in 2009. Nevertheless, the government still only contributes 17.1 percent of health spending, with the remaining 82.9 percent funded by users (World Bank, 2011).

Since 1990, the Ministry of Health and development partners have made considerable efforts to reconstruct and strengthen the public health sector. The 10 leading causes of morbidity in the country are acute respiratory infection; diarrhoea; malaria; cough (at least 21 days); gyneco-obstetrics; tuberculosis; road accidents; measles; dengue hemorrhagic fever; and dysentery (WHO, 2004). Communicable diseases are thus a leading cause of morbidity and dominate all age groups, accounting for 83 percent of the reported disease burden, with 67 percent among the elderly and 96 percent among the 0-5 year age group (NIS, 2005). The Cambodia Socio-economic Survey 2004 (NIS, 2005) also found that women had experienced a slightly higher rate of illness, injury and other health problems during the previous four weeks than men had.

The maternal mortality rate (MMR) in Cambodia is high, at 471 per 100,000 live births in 2005, dropping to 461 in 2008. Maternal death makes up 17 percent of overall mortality in women aged 15-45 years old. Currently, more attention is being paid to this issue: an incentive scheme for facility-based delivery and other initiatives are being introduced to reduce the MMR and improve the health status of women in the country. However, despite the focus on the MMR and the infant mortality rate (IMR), there is an oft-mentioned lack of demand for services. At the same time, research conducted by Ministry of Health in 2006 and analysis in 2008 by the Ministry of Women’s Affairs using 2005 data reveal that women report problems in accessing health care. Greater attention needs to be paid to addressing the reasons for this, which include costs; distance and transport; availability of health personnel and drugs in health centres and hospitals; constraints experienced by women at home or work; and ignorance of the need for early intervention when problems present.

There has been a significant decrease in HIV prevalence, from 1.9 percent in 1997 to 0.7 percent in 2008, especially among commercial sex workers, but there has also been a sharp increase in prevalence among low-risk heterosexual women. This relates to the recourse of many married men to prostitutes and to their unwillingness to use condoms. For women of reproductive age, risk increases...
for mother-to-child infection. Furthermore, the burden of care falls most heavily on women and girls and reduces their ability to contribute in other ways to the family’s economic and social welfare and the education of girls.

Many other health challenges that link to gender issues, such as the high rate of traffic accidents among males, increasing drug use among young males, disability and the health concerns of elderly are becoming priorities in the country. Ministry of Health has recognized that some of the most important health challenges to be faced in the near future are cross-sectoral issues that lie outside its official mandate. These include traffic safety, domestic violence, water and sanitation, public hygiene, education/public awareness and environmental health concerns, as well as issues related to the elderly and people with disabilities.

**Gender equity commitments of the Cambodian government**

Cambodia has integrated gender equity into its national and sub-national development documents: the Cambodia Millennium Development Goals (CMDGs); the National Strategic Development Plan (NSDP) 2006-2010 and its Update 2009-2013; the government–donor Joint Monitoring Indicators (JMI); the Commune Development Plan Guidelines; the Law on Commune/Sangkat Administration; and the Strategic Framework for Decentralization and Deconcentration. The Ministry of Women’s Affairs, as the national mechanism for the advancement of women, and with support from the Cambodian National Council for Women (CNCW), has been instrumental in this. The government’s Rectangular Strategy for Growth, Employment, Equity and Efficiency (July 2004) states that ‘women are the backbone of our economy and society’ and places a ‘high priority on the enhancement of the role and status of Cambodian women by focusing attention on the implementation of the gender strategy’. The government’s international policy commitments to gender equity are reflected through its signature of key human rights treaties and conventions, including the Convention to Eliminate All Forms of Discrimination against Women (CEDAW).

Progress achieved in strengthening institutional mechanisms to support gender mainstreaming includes the establishment of a Technical Working Group on Gender (TWG-G) as part of the Government–Donor Coordination Committee (GDCC); and the formation of Gender Mainstreaming
Action Groups (GMAGs) in line ministries. The GMAG in the Ministry of Health has 32 members and has operated for six years.

The TWG-G’s role is to participate in the formulation, monitoring and evaluation of gender-responsive policies at the national and sub-national levels; to help to establish GMAGs; and to provide gender mainstreaming guidelines and technical assistance in the development of gender mainstreaming action plans in line ministries. In addition, it facilitates the development and dissemination of results from the Cambodia Gender Assessment, produced every five years.

The main role of GMAGs is to develop gender mainstreaming action plans (GMAPs) and activities to implement these. The Ministry of Women’s Affairs provides technical advice and guidelines. The GMAGs are to report periodically to the TWG-G on their progress and request technical inputs as required to address challenges and constraints faced in the implementation of their GMAP.

Recognizing the importance of gender of health system strengthening, the Ministry of Health is considering gender analysis within the overall Mid-Term Review of HSP2. It is expected that the findings from this gender analysis will have important implications in terms of improving existing policies and strategies. This reflects the renewed focus of mainstreaming gender focus into the health sector strategic planning process in health system strengthening effort of the Ministry of Health, within the thinking on health systems strengthening.

The Ministry of Health, collaborating with development partners, commissioned a team of consultants, working closely with the Ministry of Health and the Ministry of Women’s Affairs, to carry out a gender analysis of the health sector. This is the first time such a gender analysis has been conducted within the Ministry of Health. Although the GMAG has been active in raising awareness of gender, mostly through trainings and workshops, it has not been able to clarify how gender equity issues influence policy development and the health problems and outcomes of the population. As such, this gender analysis is critically important for Ministry of Health to develop a deeper understanding of gender as a social determinant of health and to eradicate health inequity and achieve the CMDGs.
Objectives of the gender analysis

The overall objective of the gender analysis was to examine the alignment of gender commitments with policy and implementation in the Cambodian health sector. It aims to identify key gaps in policy and implementation in order to inform the mid-term review (MTR) of the Health Strategic Plan 2008-2015 (HSP2); and to provide recommendations for action to assist the mid-term thematic review of programmes so as to ensure that gender considerations are adequately considered and addressed.

The specific objectives were to determine whether policies and programmes:

- Are achieving the targets set in HSP2 and the CMDGs (3, 4, 5, 6), with their information systems providing sex-disaggregated data to monitor progress;
- Ensure the delivery of services that are supported adequately by infrastructure, including an assessment of the implications of the government’s decentralization and deconcentration policies;
- Are adequately supported by the budget, which is responsive to the needs of females and males and people’s access to safety net funding arrangements;
- Are implemented by staff who fully understand gender concepts and who address the barriers to access to services.

The scope of work was as follows:

- Review relevant Ministry of Health, Ministry of Economy and Finance, Ministry of Women’s Affairs and donor documentation, assessing the degree of alignment between official policies and gender priorities and highlighting key issues and lessons learnt that will inform the design and conduct of the MTR, including data and research conducted since the Cambodian Demographic and Health Survey (CDHS) in 2005;
- Analyze health outcomes for men, women, boys and girls, and the extent to which targets have or have not been met;
- Consider conducting a gender audit using existing generic models modified to suit the specific conditions in Cambodia and in light of the desk review;
- Consult with key stakeholders, including the Ministry of Health, Ministry of Economy and Finance, and Ministry of Women’s Affairs staff in the capital and staff in three different
provinces, including local provincial, district and commune councillors, donors and non-governmental organizations (NGOs), with a particular focus on access issues (supply and demand), service quality, use of financial safety nets and the features necessary to make decentralization and deconcentration processes in the health sector successful;

- Assess use of health facilities by men, women, girls and boys and identify any community initiatives taken to overcome traditional barriers to access;
- Analyze health sector expenditures by the government (including donor funding) and the extent to which these have been targeted adequately to addressing the health needs of women and girls;
- Identify the sex profile of employees of Ministry of Health at all levels and determine whether this has implications for current policy commitments;
- Assess pre- and in-service training on gender issues and whether staff believe they have sufficient understanding to incorporate their learning into health sector policy and its implementation.

**Stakeholder participation**

Recognizing the implications of the gender analysis for the health sector and beyond, it was considered critically important to involve relevant stakeholders from the beginning, in order to enrich the experiences of government staff in conducting gender analysis and to obtain a deeper understanding of the issues for their use in the development of more effective and meaningful policy and action plans. The decision to involve different stakeholders in the whole gender analysis means a divergence from the traditional practice of research consultants simply conducting a gender analysis and writing up a report and then leaving it to the stakeholders to decide what to do with it without having participated in the process. As the Ministry of Health, through the Department of Planning and Health Information (DPHI), commissioned the gender analysis as part of the overall review of HSP2, it is important that it be involved in and take ownership of the gender analysis.

At the start of the gender analysis, a meeting was organized at the Ministry of Health with the GMAG, the Ministry of Women’s Affairs, development partners and the consulting team, to discuss the process of the gender analysis and the possibility of coordinating and collaborating among the relevant
stakeholders. Moreover, the meeting aimed to understand the role and activities of the GMAG and its priorities in terms of issues related to gender and health. The meeting also identified focal point persons for the gender analysis from the GMAG and the Ministry of Women’s Affairs and obtained Ministry of Health’s (and specifically the GMAG’s) letter of support to allow the team to conduct fieldwork in the provinces. A meeting was also held with senior staff of the Ministry of Women’s Affairs to present the goal and objectives to the gender analysis, to obtain their full commitment. Thus, the two ministries were considered vital in terms of not only their assistance in enabling the gender analysis to be conducted successfully but also their participation in the actual research to ensure the effective use of findings.

The involvement of development partners, particularly the Australian Agency for International Development (AusAID) and WHO, was very important not only in terms of the provision of technical and financial support but also with regard to the whole process of training, design, fieldwork, report writing and feedback. AusAID is one of the major donors to health in Cambodia, especially HSP2. The agency was a strong advocator for this gender analysis, with a senior programme manager participating throughout, playing a coordinating role and making influential inputs with in relation to guiding the Ministry of Health policy direction based on the results of the exercise.

WHO contributed to the development of the analytical framework and methodology. A regional specialist on gender and human rights in health provided training on important concepts, tools and questions relevant to gender analysis in the sector. Furthermore, WHO provided important inputs into the analysis and feedback on results and recommendations. WHO has further advocated the importance of this gender analysis by supporting its dissemination in regional and international conferences. This gives the Cambodian government the opportunity to publicize its progress towards the CMDGs in terms of its emphasis on gender equity in health problems and outcomes – that is, its understanding of gender as a social determinant of health.

**Methodology**

The gender analysis consisted of a literature review and primary data collection through key informant interviews and focus group discussions (FGDs).
Literature review and policy analysis

The first part of the literature review collected statistical data. Health statistics from the health information system (HIS) and the CDHS were analyzed to assess, as far as possible, health outcomes among men, women, boys and girls in three programme areas, namely: maternal and child health (MCH), communicable diseases (CD) and non-communicable diseases (NCD).

An audit of policy documents and strategic framework documents was done, using WHO Gender-responsive Assessment Scale (GRAS) criteria – a tool for assessing programmes and policies. Prior to reviewing and assessing the selected policy documents, the research team received specific training from the WHO regional advisor on how to apply the tool.

A total of 12 health policies and strategic plans were assessed: 1) HSP2; 2) the Strategic Framework for Health Financing 2008-2015; 3) the Health Workforce Development Plan 2006-2015; 4) the Guideline for Implementation of Health Equity Fund/Government Subsidy Schemes; 5) the Information System Programme; 6) the National Policy for Quality in Health; 7) the Cambodia Child Survival Strategy 2006; 8) the National Strategy for Reproductive and Sexual Health 2006-2010 (revised version); 9) Infant and Young Child Feeding Practices; 10) the National Strategic Plan for Comprehensive and Multi-sectoral Response to HIV/AIDS 2006-2010; 11) the NCD National Strategy; and 12) the Policy on Community Participation.

Each team member was assigned two or three policy documents, using the GRAS criteria and guided questions to see which of five levels each policy fell into: gender-unequal, gender-blind, gender-responsive, gender-sensitive and gender-blind.

Level 1: Gender-unequal

• Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations;
• Privileges men over women (or vice versa);
• Often leads to one sex enjoying more rights or opportunities than the other.
Level 2: Gender-blind
- Ignores gender norms, roles and relations;
- Very often reinforces gender-based discrimination;
- Ignores differences in opportunities and resource allocation for women and men;
- Often constructed based on the principle of being ‘fair’ by treating everyone the same.

Level 3: Gender-sensitive
- Considers gender norms, roles and relations;
- Does not address inequality generated by unequal norms, roles or relations;
- Indicates gender awareness, although often no remedial action is developed.

Level 4: Gender-specific
- Considers gender norms, roles and relations for women and men and how they affect access to and control over resources;
- Considers women’s and men’s specific needs
- Intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet certain needs;
- Makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles.

Level 5: Gender-transformative
- Considers gender norms, roles and relations for women and men and that these affect access to and control over resources;
- Considers women’s and men’s specific needs;
- Addresses the causes of gender-based health inequities;
- Includes ways to transform harmful gender norms, roles and relations, with the objective often to promote gender equality;
- Includes strategies to foster progressive changes in power relationships between women and men.
Primary data collection

Primary data collection involved key informant interviews and FGDs with male and female villagers. Guided questionnaires were developed, based on adaptation from the tool Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence (2011) and related questionnaires, developed by WHO. For feasibility and relevance, the gender analysis team made selected relevant questions from level 3 of the tool, which assesses health sector strategy. The questionnaire focuses on leadership and governance; health care service delivery on the demand and supply side; quality of care; health financing; human resources; and decentralization and deconcentration. Based on these components, questionnaires were developed for interviews with policymakers, donors, health care providers at all levels, local authority and community networks, as well as for FGDs.

Key informant interviews at the national level were conducted with decision-makers and relevant key stakeholders (donors and NGOs). These were conducted mostly by the consultants, with limited involvement of the ministry focal points. The role of the Ministry of Health focal point was to assist the consultant in setting up interview appointments and collecting documents from the ministry. However, all members of the gender analysis team participated fully in the interviews and data analysis during the fieldwork.

Fieldwork was conducted in three provinces: Siem Reap, Kampong Chhnang and Kampot. These were chosen to represent regional variation, remoteness from Phnom Penh, poverty level and experience in health financing schemes. In each field site, the focal point person from Ministry of Health organized key informant interviews with provincial health department directors, operational district directors, hospital managers and health centre directors. Key informant interviews were also conducted with the Ministry of Women’s Affairs at provincial, district and commune levels.

All team members participated in all key informant interviews, each Cambodian team member taking turn to conduct the interview in order to obtain experience and a deeper understanding of the gender issues being explored. Each interview took about one hour, with active and enthusiastic participation from key informants.
FGDs were conducted with local communities, including district and commune council members, health village support groups, health centre management committees and ordinary villagers. FGDs with villagers were done with the assistance of commune council members, who helped to recruit men and women from their respective villages to participate. To avoid sensitive issues, FGDs with men were conducted by male team members and those with women by female team members. FGDs lasted a little more than one hour.

Analysis of data from key informant interviews and FGDs was done in the field right after the interviews were completed. Each day, team members sat together for one to two hours to go over all the interview notes and discuss key findings emerging from them. A consensus was achieved on key findings and then the team leader created a synthesis. This was done to give team members the opportunity to be involved in data analysis and to generate common findings, and at the same time to save time after the fieldwork.

**Key findings**

**Key policies and gender mainstreaming**

Health sector policies are important for identifying and prioritizing gender issues. For the majority of policies assessed using the WHO tool, the policies showed limited understanding of gender and equity issues, which were often only mentioned in the vision statement without containing further elaboration or specific actions. Of the 12 policies assessed, the National Reproductive and Maternal and Child Health and the National Strategic Plan for a Comprehensive and Multisectoral Response to HIV/AIDS policies were the most advanced and stand as role models for gender-responsive policy. The majority of the policies were assessed as merely gender-sensitive because they contained statements regarding gender equity and vulnerable groups in their vision or mission statements, and followed through in a minor way in the narrative program descriptions or strategic objectives.

Progress achieved in strengthening the institutional mechanisms to support gender mainstreaming in the health sector includes the establishment of a Technical Working Group on Gender (TWG-G) as part of the Government-Donor Coordination Committee (GDCC); and the formation of a Gender
Mainstreaming Action Group (GMAG) with 32 members in the Ministry of Health, which has operated for six years. GMAG trainers collaborated with Ministry of Women Affaire to create training modules on gender awareness; gender analysis; gender mainstreaming and issues in reproductive health and HIV/AIDS. It is found that, while policies may have not be as fully gender-aware or -responsive as they could have been, the stated desire by GMAG members to put into practice gender equity into the plans and activities of their respective Ministry of Health departments is a positive step forward, Translating this desire into practice will require support at the highest levels of the Ministry of Health, and from the department directors, most of whom are men, as well as targeted annual budgeting support for GMAGs action plan.

**Strategic areas of the health system**

**Service delivery**

Service delivery is a vital health system building block with the objective of providing effective, safe health care both in its preventive and treatment dimensions. There is growing recognition among health workers that increased demand for services among users is related to empowerment of patients, respectful treatment, and improved quality and accountability by the health care system. Findings from this gender analysis reveals that gender based barriers to access to health care are not well understood; that gender awareness levels are generally low. Almost all providers recognized the right to patient privacy and confidentiality. Base on the key-informant interview, it is found that there are more women than men in absolute numbers who utilize health services. This may be due to the fact that women came into contact with health service more frequently not for their own health, but rather as care takers of their children and husband’s health.

Limitations in educational levels of health service providers, especially at health center level, and the limited numbers of women in senior positions at health centers, operational districts and provincial health departments were identified by stakeholders, as impacting the quality of health services negatively, with particular concern for reducing maternity-related deaths. The gender awareness of health staff, especially at the level of health centers, is still very weak, although there is recognition that women should have privacy in consultations and that women’s
special health needs, such as gender-based violence, including rape, are not adequately addressed. Specific barriers faced by women in access to health services are not sufficiently understood by health care providers.

On the demand-side of health care access, there appears to be increased knowledge among women particularly of the services provided by the health centers due to the activities of the village health support groups, the outreach by the Commune Council Women and Children’s committees, and the networking done by the district and provincial departments of Women’s Affairs. However, women and, to a lesser extent, men interviewees, stated that lack of information about right to health care, health center hours, and services provided was still a challenge for poor and remote villagers.

*Human resource development*

The total number of staff employed in all health professional health categories is 18,045 with women numbering 8,213 (45%) and men 9,832 (54%). Most of the female positions are in assistant categories. Women dominate in midwifery (primary midwives: 1823 all women; secondary midwives: 1908 all women). This may be due to cultural preference for female midwifery is important. There is a small number of women occupied the senior position in the Ministry of Health.

The Ministry of Health recognizes the need to recruit more women into senior ministry positions and in the health professional categories. Hiring practices give priority to women candidates, over men candidates applying for the same position, provided test scores and other eligibility criteria are about equal. This was the direct result of Prime Minister Hun Sun’s recommendation supporting women to become leaders, on the occasion of International Women’s Day on 8 March 2007.

*Health care financing*

The Strategic Framework for Health Financing (2008) highlights gender and equity issues under evidence and information for health financing policy. However, the finding indicates that Ministry of Health finance and budget staff has limited awareness about gender analysis in health financing; hence, no actions on interventions have been taken to develop inter-sectoral collaboration for equity
and gender analysis and to ensure health financing data collection is designed with appropriate indicators for equity and gender analysis.

Lack of means to pay for health care costs was considered a major obstacle to the poorest people, including women in accessing care and treatment, as most health-related expenditure is made up of out-of-pocket payments. Common household coping strategies in the face of limited access to quality public health services include: reducing household consumption; borrowing money from others; selling land and other assets to pay for health care costs; or foregoing treatment. To remove financial barriers in accessing to health care services for the poor, there are several health financing schemes being implemented, these include vouchers and conditional cash transfers for women, midwifery incentive, health equity funds and community-based health insurance. The midwife incentive for delivery at the health facility (USD 15 per delivery) has been the most effective schemes in pushing for safe delivery.

*Health information systems*

Information systems in the health sector are evolving to ensure the production, analysis, and dissemination of reliable information on health status and outcomes from central to local levels. The HIS strategy does not identify at-risks groups by sex or address gender-specific issues. It recognizes the health risks of violence, but does not mention gender-based violence, including domestic violence and rape. The social and gender determinants of health and how these impact on health status and the performance of the health system are only marginally understood by health sector staff from central to local levels.

The Health information system (HIS) has the potential to provide data, starting with sex-disaggregated data, in order to monitor progress, but has not yet developed the means to identify either negative attitudes or behaviour identified. But none of the Department of Planning and Health Information (DPHI) staff have specialist knowledge in gender analysis or gender statistics. The policy gap identified by DPHI is lack of gender-sensitive indicators for monitoring health system building blocks and thematic health programs.
Health system governance

The gender analysis focused on decentralization in operational district (OD) planning and budgeting, transparency and accountability, and networks with district and commune level authorities and community groups. Decentralization initiatives have yielded positive initiatives by the Village Health Support Groups, Commune Council for Women and Children and district women’s affairs staff, who engaged more on education with respect to men's and women's access to health services, less on the transparency and accountability of the services.

The concept of a formal system for reporting on the quality of care or monitoring the quality of care at community level was not expressed as a need or priority by the Village Health Support Groups, Commune Council for Women and Children or Health Center Management Committees. Social accountability mechanisms at local provider level are a need that cross cuts service delivery and information systems and needs further development.

Program areas

National reproductive and maternal and child health program

The National Strategy for Reproductive and Sexual Health in Cambodia (2006-2010) is a comprehensive policy that is gender-responsive in design and provides detailed interventions across the five health system building blocks. The national reproductive and maternal and child health program has achieved significant progress over the past decade. Facility deliveries have increased significantly although there has been slow progress in meeting the demand for contraception.

The most progress has been made in CMDG4. Several targets have been reached or even exceeded, including children immunized against measles and exclusive breastfeeding up to 6 months of age (Rushdy, 2009). Infant mortality has almost halved in the past decade from 95 to 54 per 1,000 live births from 2000 to 2010. Improved access to basic health services, robust efforts to scale up the immunization program, and promotion campaigns about exclusive breastfeeding have contributed to these results.
However, challenges remain in child malnourishment and stunting. There were no significant differences between girls and boys in the characteristics of stunting, wasting and being underweight, suggesting that both sexes are equally poorly nourished. There are significant gender implications in wasting and undernutrition in girls that affect their later reproductive health and health of their children.

The maternal mortality ratio in Cambodia is among the highest in the Region and has remained persistently high for the past ten years. The 2005 CDHS standing of 461 deaths per 100,000 live births is expected to decline, due to progress in proxy indicators; CDHS 2010 results are pending. The gender dimensions of maternal mortality are being addressed but require continued attention in order to diminish the still very high levels of MMR in Cambodia.

Safe motherhood has progressed, with 71 percent of babies delivered by a health professional in 2010 (CDHS preliminary results), as compared to 44 percent in 2005 (CDHS). There has been a doubling in the proportion of babies delivered at health facilities, from 22 percent in 2005 to 54 percent in 2010. The difference between urban and rural delivery rates remains high, with 85 percent of urban women delivering in health facilities compared to 47 percent of women in rural areas.

Gender-based violence is not screened as such and there are no guidelines for screening or treatment. Referral hospital staff said they collaborate with court and police officials in their investigations. Victims of rape or other forms of gender-based violence are interviewed privately but by staff who do not have specialized GBV training. Rape cases are reportedly on the increase and referral hospitals collaborate with the Dept of Women’s Affairs for counseling in some cases. There is still a disturbing trend for negotiation between victim and perpetrator and hospital staff stated that victims whose negotiations fail come to the hospital, but often weeks after the rape has occurred, when physical evidence is difficult to document.

Abortion is legal in Cambodia although health care providers expressed their reluctance to provide services when requested. The ethical and moral boundaries of abortion are problematic for Buddhist health care providers, according to some health care workers. There is also a notion among some health care providers interviewed that performing abortions will encourage this method as a kind of
birth control method. For women clients, the stigma and fear of identification lead many to private clinics for abortions, where fees are much higher and safety and quality issues have been problematic.

There is growing recognition among health care providers and other stakeholders, including NGOs, donors, and women’s and children’s consultative committees that men’s involvement in reproductive health, from family planning decisions, to antenatal and postnatal care of women and children, is necessary to improve women’s health and the health of the family. The finding from this gender analysis indicates that men were not involved in family planning matters and left decisions to their wives.

*Communicable diseases programs*

Biological differences and the socio-cultural environment of men and women have bearing on their presentation and the expression of diseases (WHO, 2009).

Malaria, tuberculosis (TB) and HIV/AIDS are critical diseases in Cambodia, which have gender dimensions. However, the policies on malaria, dengue and TB have no reference to gender dimensions. In contrast, the gender implications of HIV/AIDS are well addressed in policy and gaining ground in practice.

On the CMDG indicators on combating HIV/AIDS, malaria and other diseases, Rushdy’s study (2009) indicated a significant decrease in HIV prevalence from 1.9% in 1997 to 0.7% in 2008, which suggests that Cambodia has achieved the < 9% target for 2010-2015. Also there is a high proportion of PLHA with advanced HIV infection that are receiving ART, calculated at 94% in 2009, more than meeting the CMDG 2010 target of 60 percent and 2015 target of 75 percent. Although there is a decline in HIV prevalence among most at-risk groups, there is an increase in HIV infection among married women (43%) and mother to child transmission (30%). Further assessments will be possible with the release of the CDHS 2010 full report.

Little progress has been made in reducing the TB death rate per 100,000 population, which at 75, remains more than double the 2015 CMDG target of 32.
There are no sex-disaggregated data on malaria or dengue that can be analyzed. Health professionals spoke about the relatively higher prevalence of malaria among men, due to their livelihood roles in forestry, but at issue is the need to explore how policy, research and outreach in health centers recognize the gender dimensions of communicable diseases more generally and the particular issues of relevance for each CD.

*Non-communicable diseases programs*

There is increasing awareness of the widespread prevalence of chronic diseases and the burdens these are placing on both populations and health services. While substantial international support has been made available for services in specific areas, notably HIV/AIDS and tuberculosis, those who suffer from non-communicable diseases have received little attention. The problem of access to health care for chronic non-communicable diseases is much more significant than it is for acute illnesses or communicable diseases, since the health system in Cambodia is not set up to deal with chronic diseases. Very little effort is being put into addressing the burden of chronic diseases, and assessing the gender dimensions of them. As a result, poor people suffering from chronic diseases encounter complex and multiple barriers to access to care and treatment, which often leads to a financial burden on households.

Smoking and alcohol consumption are the two main risk factors of chronic diseases, which occur more among men than women. A recent national survey (Ministry of Health, 2010a) on the prevalence of non-communicable disease (NCD) risk factors in Cambodia reveals that 29.4 and 37.0 percent of people are currently non-daily and daily tobacco smokers and users, respectively; men were more likely to use and smoke tobacco daily than women. As regards alcohol consumption, men were 10 times more likely than women to be engaged in heavy episodic drinking in the past 30 days. The survey also found that women are twice as likely to be overweight as men, which is also a risk factor for vascular diseases.

Thus in achieving the HSP2 target of reducing the burden of non-communicable diseases and other health problems, most of the indicators set for 2010 and 2015 reported in the mid-term review were
off-track, due to various constraints, such as lack of appropriate process indicators for different interventions, inadequate budgetary resources at local levels, and a lack of program management skills and experience at lower levels.

**Lessons learned**

Important lessons were learnt throughout the whole process, most importantly the importance of commitment among the research team from the beginning, and the need to share knowledge and experience in order to be able to carry out the work successfully. The involvement of government staff in data collection not only helped the team to organize and coordinate activities in a timely manner but also gave staff the opportunity to obtain direct experience in conducting interviews and drawing out important findings and key lessons to be used in their work.

A clear understanding of the concept of gender as a social determinant of health and the right gender analysis tool were both extremely helpful for the research team in designing the gender analysis, analyzing policy documents and generating generated findings from the fieldwork. The methodology utilized a newly created tool, Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence (WHO, 2011). This particular tool connects two approaches—human rights and gender mainstreaming—which are considered as conceptually reinforcing. The team leader and senior researcher in particular worked with the WHO regional advisor in the use of this tool, adapting it to the Cambodian context through a three-day workshop in Phnom Penh which the full team attended. The tool is highly recommended as it provides guide questions and analysis tables for interrogating three levels of assessment—international human rights obligations of the state; institutional and legal frameworks addressing equity; and health sector strategy.

This gender analysis of the health sector adapted the latter assessment level of the health sector strategy since it fit well with the objectives of the gender analysis while also bearing in mind the conceptual landscape of human rights in the writing of the institutional and legal context of gender equality. The team adapted the WHO tool’s analysis tables develop stakeholder interview questionnaires examining the Cambodian health system building blocks: service delivery; information; financing; human resource development; and governance. We also used this tool to help guide us in
analyzing the three program areas of the health sector: national reproductive, maternal and new-born child health; communicable diseases; and non-communicable diseases.

The idea for the gender analysis came from a donor (AusAID) in order to ensure that this first ever gender analysis of the health gender analysis bring to bear important findings and implications for the other commissioned reviews (sector wide management; human resource and long term institution building). The Ministry of Health through the GMAG and DPHI and the Ministry of Women’s Affairs provided close collaboration and support to the team to implement its activities successfully at all levels, from the central all the way to the community.

The Cambodian ministries of health and women’s affairs at high levels were supportive of the gender review although it remains to be known how its results will be translated into actions over time. The ministry staff assigned to the team, who were not provided with incentive payments, performed with high commitment and to high professional standards, especially from women’s affairs at national, provincial and district levels. The ministry of health gender focal point was overstretched and found it difficult to commit to the work of the team but did aid considerably in setting up the field work interviews.

Key to the success of the gender analysis process, including the fieldwork, was the commitment of the health and women’s affairs staff at all levels to attend to field arrangements. The team would not have been able to accomplish its work without them. The team also found the decentralized levels of cadre in communes, districts and at village level to be committed, enthusiastic and concerned about improving gender equity in their communities.

Surprisingly, gender awareness seems to be widespread at the community level: local authorities and ordinary villagers generally understood the purpose of the gender analysis and participated actively, providing valuable information with relative ease. This reflects the current efforts of the government to improve gender inequality in a rapidly changing society.

However, one of the major constraints of this gender analysis exercise is that it is ambitious in its scope – that is, to conduct an analysis of the whole health care system and cross-cutting health
programmes in one single gender analysis with limited time. Moreover, the analysis is being conducted alongside other major reviews of HSP2, which means there is the potential for overlap.

At the current stage, the Ministry of Health is taking the gender analysis for incorporation in the overall MTR of HSP2. It is expected that the findings from this gender analysis will have important implications in terms of improving existing policies and strategies.

References
