A GENDER ANALYSIS OF THE CAMBODIAN HEALTH SECTOR ©

Final Research Report

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EXECUTIVE SUMMARY AND ABRIDGED RECOMMENDATIONS

1. Introduction

This study is the first-ever gender analysis of Cambodia' health sector. This gender analysis examines the alignment of gender commitments to policy and implementation in the Cambodian health sector. It identifies key gaps in policy and implementation in order to inform the mid- term review of the Health Sector Strategic Plan 2008-2015 and to provide recommendations for action.

2. Gender Equity Commitments

The principle of gender equity and the process of gender mainstreaming in the health sector are officially adopted by the Royal Cambodian government and donors providing technical and financial assistance to the government. This gender analysis indicates where there remain significant gaps between stated commitments and actions that require examination.

3. Objectives and Scope of Work

The overall objective of this study is to contribute to the mid-term review of the health sector by determining the extent to which gender is mainstreamed into health policies and programs. The full terms of reference can be found in the annex.

The scope of work for the gender analysis included:

- Analysis of health outcomes for men and women, boys and girls, and the extent to which CMDG targets have or have not been met;
- Consultations with key stakeholders in the capital and in three provinces including local provincial, district and commune councilors, donors and NGOs with a particular focus on access issues (supply and demand), the quality of services, use of financial safety nets, and the features necessary to make D&D processes in the Health Sector successful;
- Analysis of health sector expenditures by the RGC (including donor funding) and the extent to which these have been adequately targeted to addressing the health needs of women and girls;
- Identify the sex profile of employees of the MOH at all levels and determine whether this has implications for current policy commitments.

4. Methodology

The study utilized a qualitative methodology, including adaptation and use of the tool *Human rights and gender equality in health sector strategies: How to assess policy coherence* (2011), developed by WHO. Data analyzed included a literature review of key policy documents and strategic frameworks of the Ministry of Health and other relevant ministries, and primary data collected during the WHO analysis exercise.

A gender-responsiveness assessment of selected policy documents was conducted using the Gender Responsive Assessment Scale (GRAS), a tool developed by the World Health Organization. In all, 12 health policies and strategic plans were reviewed and assessed as gender-responsive; gender-sensitive or gender-blind.

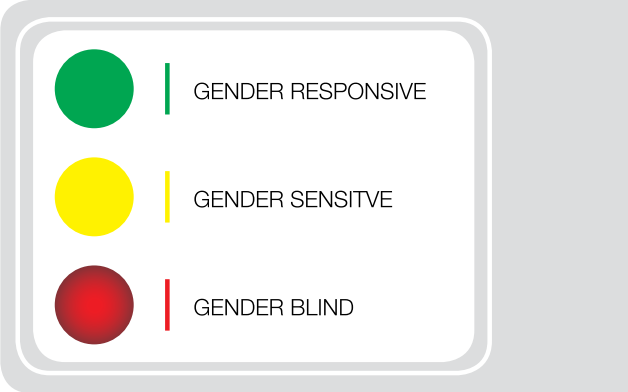
Guided questionnaires were developed based on adaptation from the tool, *Human rights and gender equality in health sector strategies: How to assess policy coherence* (2011), developed by WHO. Primary data collection involved key-informant interviews and focus group discussions with stakeholders at central and decentralized levels. Fieldwork was also conducted to collect primary data in three selected provinces, namely, Siem Reap, Kompong Chhnang and Kampot.

A comprehensive overview of the methodology is in the full report.

5. Abbreviated Key Findings:

5.1 Gender Assessment of Key Health Policies

- An assessment of the gender-responsiveness of 12 key policy and strategy documents, using the WHO Gender Responsive Assessment Scale (2011), and guided by the WHO tool, Gender Assessment Questions (available in Annex A) found 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. (See full report for detail)
- None of the policies was assessed as being of the lowest level: namely, gender-unequal, or policies that perpetuate gender inequality or privilege men over women; nor as those of the highest level, namely, gender-transformative, or those that introduce progressive changes in the unequal power relationships between women and men.
- Four of the policies (Health Workforce Development Plan; National Policy for Quality in Health; Infant and Young Child Feeding Practices; Non Communicable Disease National Strategy) were assessed as gender-blind because they did not contain any statement about gender equity or gender issues in relation to their area of specialization, nor did they include gender-specific indicators to monitor progress in the achievement of targets.
- The remaining 6 policies were assessed as 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.



- To further become gender-responsive these policies and strategies would need to display concrete awareness of gender norms, roles and relations that affect the health seeking behaviour of men and women, and specify concrete actions to redress the attitudes that serve to reinforce gender stereotypes that disadvantage women or men in fulfilling their health needs.

5.1a Gender Responsive Mainstreaming Mechanisms

- Progress achieved in strengthening the 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 a Gender Mainstreaming Action Group (GMAG) with 32 members in the Ministry of Health, which has operated for six years.
- The GMAGs is to develop gender mainstreaming action plans (GMAPs) and report progress to the TWG-G. MoWA provides technical advice and guidelines for the GMAGs.
- GMAG trainers collaborated with MoWA to create training modules on gender awareness; gender analysis; gender mainstreaming and issues in reproductive health and HIV/AIDS.
- About 15 training programs on gender and health have been carried out to date and some 95 staff has participated in trainings over a three-year period. The precise figures for both trainings and number of participants cannot be tabulated due to missing records for 2008.
- There has yet to be a systematic process established to study the effectiveness and impact of the GMAG in generating understanding and support for gender concepts and analysis and their application to the MoH systems and program areas and on the work in individual departments.
- Main challenges GMAG identified were time constraints in carrying out GMAG work in addition to general ministry work assignments; budget shortfalls or budget lags in disbursement making activities difficult to carry out as planned; capacity limitations in understanding the applications of indicators and targets; limited awareness of conceptual and theoretical applications related to gender analysis; persistence of attitudes among decision-makers that men in work and family roles do not bear responsibility for child care and housework.
- These attitudes make it difficult for gender equity advocates within the MoH to push for environments conducive to women's advancement (e.g.time off for child and elder care).
- Stakeholders noted that political commitment and resourcing for the GMAG needs further strengthening.

5.1b Awareness of Gender Policy Content by MoH Staff All Levels and Translation into Practice

- The key informant interviews indicate a significant gap in gender responsiveness between the intention of policies and how they are actually put into practice.
- Key informants, with a few exceptions, were generally unaware of the gender content of policies in relation to their specific work areas and had limited gender awareness and gender analysis skills.
- While key informants were generally aware of the GMAG and several had heard something about GMAG activities, their ability to identify gender issues or specific gender responsive actions in their work was limited.
- 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 MoH departments is a positive step forward.
- Translating this desire into practice will require support at the highest levels of the MoH, and from the department directors, most of whom are men, as well as targeted annual budgeting support for GMAGs action plan.

5.2 Strategic Areas

5.3 Service Delivery

5.3a Key gender dimensions of service delivery:

- Need for health service providers to assess and address gender-based barriers to access to services that different groups of women and men, boys and girls face, including intra-household gender-based inequalities in decision-making on use of scarce resources and on family planning[1]
- Need for awareness and skills of health workers on gender to ensure that the gender-specific needs of patients are met (e.g., the need for health workers to undertake screening for gender-based violence; rape)
- Respect for privacy and confidentiality, such as through the provision of private waiting rooms and facilities that cater separately to women's and men's sexual and reproductive health service needs
- Need to ensure that hours of health care facilities should meet the needs of women and their work schedules, especially those living in remote areas

5.3b Levels of gender awareness among health service providers

- Findings from interviews with health service providers indicate 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. None spoke of health facility operation hours and the need to meet women's work schedules.

5.3c Entitlements to Health Issue and Access for rural poor women

- Provincial-level health directors noted women still do not feel they are entitled to go health centers because they lack confidence in their rights and feel looked down upon or too lowly to show their faces and bodies to medical professionals.
- The inferiority that women either feel or are perceived to feel is an important research question that should be followed up in relation to access and encouraging positive behaviour change because not only does it impact potentially on women's own health but also because gender norms dictate that women look after family members, and therefore their decisions about going to health centers or not going impacts the health of all family members.
- Provincial directors and planning staff identified the following key gender issues that require attention in the sector-wide health approach, health education at grass roots level and financing schemes: Women in rural areas not confident to look for services; No specific service for gender-based violence; Opportunity costs for child care; household duties too high

Infrastructure and Equipment to improve women's health and achieve CMDGs

- Infrastructure and equipment procurement are areas that MoH shows commitment to address within the resource window provided by the national budget allocation for health sector building repair and new buildings in remote locations.[2]

1. Implicit in this point is the need for recognition by service providers that women are the major providers of health care within the family and that they carry a greater burden of care than men for children, the elderly, including those with chronic diseases.

2. The SWiM review will likely address this issue.

- Significant ongoing danger of continuing maternal and infant deaths until remote postings of 2nd midwives in place
- Constraints remain the standard ones: shortage of skilled health staff, especially secondary midwives; inadequate electricity; small rooms of health centers; deficient medical kits at health center level

5.4 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%) [MoH, 2011, Personnel Dept Statistics). Most of the female positions are in assistant categories.
- Out of a total of 1072 senior staff, from Secretariat General to Office level at national and sub-national levels, women account for 138 positions, or 13 percent.
- At the level of department directors, there are 6 women out of a total of 31, representing 18 percent. For deputy directors of departments, there are 26 women out of 132, representing 20 percent.
- Women account for 18 and 25 percent respectively as office managers and deputy office managers
- The MoH 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
- The Ministry of Health issued a directive (April 2007) to unit heads to give priority to women in hiring against vacancies, promotions and appointments, provided that their qualities, skills and capacities were sufficient (MoH, 2007a).
- Women account for 16 percent of doctors (375/2300); 8 per cent of specialist doctors (7/91); 35 percent of primary nurses (1165/3258); and 31 percent of secondary nurses (1629/5175) and 100 per cent of primary midwives (1823 in total).
- Cultural preference for female midwives is important, and is largely the reason for there being no male midwives in Cambodia; however, it should be noted that some men may wish to study midwifery and some women may feel comfortable with a male midwife as gender roles, relations and attitudes change in the future in Cambodia over time.

5.5 Health Care Financing

- The government budget for health has been increasing steadily over the past decade, accounting for 11 percent of the total government budget in 2009, but falling short of the NSDP target of 13 percent (IFPER, 2011); this will impact achievement of CMDG targets.
- The health sector's three main programs (namely, RMNCH, CD and NCD) receive about one-third of the overall national budget for health, with the remaining 63 percent spent on non-program areas, such as salaries, medical supplies and support costs.
- A gender responsive budget analysis of the outlays to program areas/non-program areas is recommended but made difficult because of the line item nature of the budget planning; the difficulty that finance staff have in tracking program based allocations; and the slow shift to program budgeting that requires continued capacity building by the MEF to be fully operational.
- The Strategic Framework for Health Financing (2008) highlights gender and equity issues under evidence and information for health financing policy and calls for the following strategic interventions (p.14): develop inter-sectoral collaboration for equity and gender analysis; ensure health financing data collection is designed with appropriate indicators for equity and gender analysis; build capacity for equity and gender analysis; perform policy analysis from equity and gender perspectives
- MoH finance and budget staff has limited awareness about these policy commitments; hence, no actions on these interventions have been taken.
- There is little understanding on what indicators would be useful in relation to health financing data collection or how gender perspectives could inform health financing policy analysis.

Financing and Access to Health Services For Women in Rural Areas

- In terms of gender responsiveness, only the voucher and conditional cash transfers are specifically targeting women on reproductive health.[3]

3. With the exception of the CBHI scheme supported by GIZ in Kampot also supported a safe motherhood package providing financial incentives for women to use MCH services.

- Health reform financing mechanisms include user fee system; sub-contracting of government health service delivery to non-governmental providers; midwife incentives for delivery at the health facility (USD 15 per delivery); community-based health insurance (CBHI) in Kampot implemented by SKY/GRET and supported by GIZ in Angkor Chum implemented by local authority with URC support; Health Equity Funds (HEFs); vouchers; and conditional cash transfers[4].
- Data from our fieldwork suggests that if HEFs are available, unofficial payments and poor treatment are reduced significantly (agreement on this point from both health center staff and users of the health care system).
- There remains continuing high opportunity costs for nighttime travel, and from remote areas that restrict access.
- Even when vouchers, HEFs, and cash transfer schemes cover transport and food costs of women needing reproductive health services, the opportunity costs associated with family care, livelihoods and security needs for property are prohibitive.

5.6 Health Information Systems

- Information systems in the health sector are on track to ensure the production, analysis, and dissemination of reliable sex disaggregated information on health status and outcomes from central to local levels.
- The HIS strategy does not identify of 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 marginally understood by health sector staff in the information collection from central to local levels.
- Development partners supporting the DPHI may also have limited knowledge and awareness of how the information systems can be developed along gender responsive lines.
- There is limited use of the HIS data in planning and monitoring of health service delivery at local levels and there is yet to be any reflection on how health centers are meeting the health sector's priority area of maternal and child health.
- There is low awareness about the potential benefits of a more gender responsive information system, and use of statistics generated by the MoH, especially those related to gender, that could inform the design of national health surveys, such as the CDHS and be shared with other line ministries for policy and planning and monitoring of CMDGs, especially the Ministry of Planning, MEF and MoWA.

5.7 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.

- The provincial fieldwork suggests that annual operational planning, while designed to be participatory, still depends on the provincial health department (PHD) level to make decisions on priority activities and to estimate budgets for them due to capacity needs of OD and HC managers. This can potentially limit the ability of heath units to allocate resources in response to gender priority needs.
- Program budgeting exists only at national level so that it is difficult to track expenditures of government funds in relation to priority health programs, particularly the NRMCH.
- Decentralization initiatives have yielded positive initiatives by the VHSGs, CCWCs 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.
- Commune councils in particular, with their women's and children's committees, demonstrated good knowledge and commitment to the health sector's priority concern for maternal and child health.
- Focus group discussions with men and women verified the active role that the CCWC's are playing, in some cases personally assisting in obtaining health care, which was appreciated.
- The role of the CCWC as a bridge between communities and the health centers or referral hospitals in matters of complaints regarding under-the-table payments or poor quality treatment is not well defined and operates on an ad hoc basis.

4. Conditional cash transfer is cash provided to women for ante and post- natal care provided they complete the required number of visits. Vouchers are a scheme for poor women funded by donors to access free services for maternal heath needs including costs for delivery, ante and post natal care (travel, food and user fees)

- 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 VHSGs, CCWCs or HCMCs. Social accountability mechanisms at local provider level are a need that cross cuts service delivery and information systems and needs further development

5.8 Program Areas

5.9 National Reproductive Maternal 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 2005 CDHS standing of MMR as 461 deaths per 100,000 live births is expected to decline, due to progress in proxy indicators; CDHS 2010 results are pending.
- Safer 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).
- Antenatal care has increased to 89 percent of women for 2010 (CDHS, 2010) well within range of the CMDG 2015 target of 90 percent.
- The gender dimensions of maternal mortality are being addressed but require continued attention including promoting girls and women's education, as this is strongly correlated with good health outcomes during and after pregnancy; visits by rural women to skilled health providers; and attention to nutrition and preventive interventions to guard against malaria, anemia, hepatitis and HIV/AIDS, all of which can lead to complications in pregnancy.
- 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.
- The provinces that are well below the CMDG 5 targets for delivery by skilled providers and delivery at health facility are Preah Vihear, Stung Treng, Mondulkiri and Ratanakiri, with averages of 28 and 21 percent respectively for deliveries by skilled providers and at health facilities (CDHS preliminary results).
- Gender based violence is an aspect of gender inequality that needs to be addressed as an obstacle to women's health (WHO 2003).
- 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.
- There are no major sex differences in immunization rates, suggesting that households treat baby boys and girls equally.
- Variations between rural and urban MCH health indicators should be analyzed across social and educational classes and at HCs and RHs across provinces when the full CDHS data becomes available.
- Emerging gender issues that the national program staff and referral hospital and health center staff acknowledged as important to address were gender-based violence, abortion on demand, reproductive health needs of migrants and factory workers; and male involvement in reproductive health.

6.0 Communicable Diseases Program

- 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.
- 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 gender responsive assessments will be possible with the release of the CDHS 2010 full report
- There is no sex-disaggregated data on malaria or dengue that can be analyzed
- Gender norms in the family need recognition and attention with preventive measures for dengue and malaria, e.g. women carry the main responsibility for care for children and the elderly and should be targeted in education campaigns for prevention
- For TB, under DOTS, all new sputum smear positive cases are reported separately by sex so there will be opportunity to engage in gender analysis in the future

6.1 Noncommunicable Diseases Program

- Breast self-examination methods have been taught to midwives and rolled out through-out the country over the past 10 years.
- There appears to be a gap in statistical data for sex-specific life-threatening diseases such as prostate, cervical and breast cancer.
- Smoking and alcohol consumption are the two main risk factors of chronic diseases, which occur more among men than women according to the MoH national survey on the prevalence of noncommunicable disease (NCD) risk factors in Cambodia (MoH, 2010a)
- Men are 10 times more likely than women to be engaged in heavy episodic drinking as per the MoH survey that recorded female and male alcohol consumption within past 30 days at the time of the interview. (MoH 2010a).
- Women are twice as likely to be overweight as men, a risk factor for vascular diseases
- The MoH 2010a survey found that 8 in every 10 people (82.4 percent of respondents) had one or two risk factors for developing noncommunicable diseases, whereas 1 in every 10 people (10.2 percent of those surveyed) had three or more or risk factors, a figure that is 2.2 fold higher in men than women. These are important findings that require gender-responsive actions in the design of programs for prevention, treatment and care.

7. Conclusions

- Gender equity as a principle of equitable development and as a goal in and of itself is enshrined in Cambodia's constitution and in key government national policies.
- In the health sector, gender equity is still relatively under-developed and not as well reflected in policy and practice as it could be with effort and determined leadership.
- The health sector gender analysis study has found what are likely a different set of challenges to gender equity from other sectors due to several factors, among them, the still mostly male-dominated nature of the health profession as it has developed internationally and also nationally; the vulnerable position of women of child bearing years in Cambodia, most of whom for various reasons to do with more generalized gender discrimination in the wider society are reluctant to voice demands for better health care for themselves and their children and who die silent deaths in child birth.
- The government's development partners in the main are still not well aware of or understand what gender equity means in the field of health and why it has anything to do with finance, or human resource development, or policy review, among other strategic areas.
- As a first time study, the research results represent a beginning and not an end. While the study does provide some answers to the questions it posed with new data and analysis in areas hitherto unknown, it also raises others that will need to be the focus of future studies in the Cambodian health field.
- It is vital that Cambodia's development partners step up to consider carefully the implications this study raises for the future strategic planning as a partner to the Royal Government of Cambodia.
- Dissemination and further discussion is important with a tabling of this report to the TWG-H, TWG-G, the PFM, the PAR and other central reform arms of the government, NGO health forums, and the provincial, district and commune councils and their relevant committees operating in the decentralization and deconcentration reform process underway.
- It would be amiss not see the study translated into Khmer and shared widely in electronic forms through websites, chat forums, and in print for Cambodian university and ministry libraries down to commune level.

Recommendations: Abridged version and for short term; see full report for all.

Gender Mainstreaming Machinery

i. GMAG should be moved out from under the Administration department where it is now housed to an autonomous institutional home with annual budget commitments commensurate to implement its annual action plan and its five year strategic plan.

ii. GMAG to disseminate Gender Analysis report results within MoH and MoWA and other stakeholders, including development partners to stimulate discussion and implications for the development of new five year GMAP (2011-2015)

iii. GMAG should seek national/international expertise to develop a more systematic and comprehensive database of its activities beyond the trainings to incorporate indicators for changes in policy; actions that lead to behaviour change; and contributions to TWG-G.

iv. Seek more regularly technical assistance and cooperation with MoWA in gender mainstreaming initiatives in the health sector, with emphasis on advocacy and policy responses.

v. Seek donor support to conduct assessment with external technical guidance of gender training and advocacy approaches used to date, including impact on attitudes, behaviour; potential to influence policy; assessment to identify potential new strategic areas of focus for best results, areas needing strengthening, and financial scoping exercise.

vi. Ensure that upcoming five year GMAP (2011-2015) has measurable indicators attached to realistic targets in key priority areas with adequate budget support and performance reports and seek MoWA and donor/ development partner assistance if required

Service Delivery Recommendations

i. Address acute shortage of secondary midwives and other female health staff through deployment in remote areas

ii. Promote male involvement in services that focus on women, e.g. breastfeeding; family planning; prevention of mother-to-child transmission (PMTCT)

iii. Improve health center infrastructure for delivery rooms and private treatment rooms that cater to women and men's sexual and reproductive health needs.

iv. Develop service provisions to screen for and respond to gender-based violence

Health Care Financing Recommendations

i. Commission a gender responsive budget study that assesses MoH national and donor financed allocations across program and non-program areas in order to identify gaps in funding allocations and to build evidence base of financial commitment to achieve improvement in women's health and attainment of CMDGs 4, 5, 6.

Make the Strategic Financing Framework more gender-responsive by increasing its gender content as follows:

i. Include a reference to gender and health in the vision statement.

ii. Include gender characteristics of health financing in Cambodia, e.g., women's poverty and barriers of access to services.

iii. State women's participation as a key element of community participation.

iv. Refer to women's predominance in the informal sector in discussions of references to CBHI.

v. Include women-focused IEC/BCC activities under health seeking behaviour.

Human Resources Recommendations

Modify the Human Workforce Development Plan (2010) so as to change it from gender-blind to gender-sensitive, by the following actions:

i. Incorporate a commitment to equal opportunity in training, recruitment, and promotion

ii. Specify a commitment to gender equality and equity in size and composition of workforce/future workforce;

iii. Ensure that data on MoH categories and numbers of staff are disaggregated by sex, and make data available to all departments within the ministry

iv. Develop targets for composition of future workforce for occupational categories and skill mix

v. Ensure that gender dimensions are considered in health workforce deployment (e.g., costs related to relocation; security in remote areas; child care requirements)

Health Information Systems Recommendations

Modify the Health Information Systems Plan so as to change it from gender-sensitive to gender-responsive, through the following actions:

i. Acknowledge the need for the health information system to incorporate gender/health information

ii. Develop the capacity of DPHI staff in gender statistics and analysis

iii. Develop gender-responsive indicators, with inputs from relevant partners and stakeholders, including GMAG and MoWA; Gender indicators to consider: access to health care for men and women by age, rural/urban; disability; gender-related risk factors for communicable and noncommunicable diseases; male involvement in sexual and reproductive health gender dimensions of HIV/AIDS sexual and gender-based violence; gender dimensions of mental health

Governance Recommendations

Modify the National Policy for Quality in Health so as to change it from gender-blind to gender-sensitive, through the following actions:

i. Include gender dimensions in the vision, goal and guiding principles and recognize the differential aspects of health quality improvement for women, men, boys and girls

ii. Elaborate the gender dimensions of equitable healthcare with reference to roles, responsibilities and strategy

Reproductive, Maternal, New Born and Child Health Program Recommendations

i. Strengthen the referral system for emergency obstetric care by continued cooperation with the health center management committees in identifying means for transport payments from village to health facilities

ii. Develop gender-responsive costed-guidelines for inclusion in the new five-year strategic plan

iii. Address reproductive health needs including abortion, protection from sexually transmitted diseases, unwanted pregnancies, of young unmarried men and women,

Communicable Disease Program Recommendations

i. Include gender dimensions in the vision, goal and guiding principles for malaria, dengue and tuberculosis

ii. Include a statement recognizing the differential aspects of health quality improvement for women, men, boys and girls

iii. Ensure sex-disaggregation of data on malaria, dengue and tuberculosis

Non-Communicable Disease Program Recommendations

i. Include gender dimensions in vision, goal and guiding principles for non-communicable diseases

ii. Include a statement recognizing the differential aspects of health quality improvement for women, men, boys and girls

ACRONYMS

ANC	Antenatal care
CBHI	Community-based health insurance
CCWC	Commune Committee for Women and Children
CDHS	Cambodia Demographic and Health Survey
CHMC	Commune Health Management Committee
CMDGs	Cambodia's Millennium Development Goals
CPA	Complementary package of activities
CPR	Contraceptive prevalence rate
DDF	Department of Drugs and Food
DPHI	Department of Planning and Health Information
GDCC	Government-Donor Coordination Committee
GIZ	German Aid Agency (formerly GTZ)
GMAG	Gender Mainstreaming Action Group
GMAP	Gender Mainstreaming Action Plan
GRAS	Gender-Responsive Assessment Scale
HEF	Health equity fund
HIS	Health information system
HSP	Health Strategic Plan
KII	Key informant interview
MEF	Ministry of Economy and Finance
MoWA	Ministry of Women's Affairs
MIS	Management information system
MoH	Ministry of Health
MPA	Minimum package of activities
MSM	Men who have sex with men
NCHADS	National Centre for HIV/AIDS, Dermatology and STIs
NGO	Non-governmental organization
NMCHC	National Maternal and Child Health Centre
NRHP	National Reproductive Health Programme
NSDP	National Strategic Development Plan
OD	Operational district
OOP	Out-of-pocket expenditure
PHD	Provincial Health Department
RACHA	Reproductive and Child Health Alliance
RGC	Royal Government of Cambodia
RHAC	Reproductive Health Association of Cambodia
SKY	*Sokapheap Krusar Yeung* (Our Family Health)
SWAp	Sector-wide approach
SWiM	Sector-wide management
UNFPA	United Nations Population Fund
VHSG	Village Health Support Group
WHO	World Health Organization

LIST OF TABLES

INTRODUCTION

This gender analysis examines the alignment of gender commitments to policy and implementation in the Cambodian health sector. It identifies key gaps in policy and implementation in order to inform the mid- term review of the Health Sector Strategic Plan 2008-2015 and to provide recommendations for action. The mid-term review includes three independent thematic reviews: sector wide management assessment, supply and demand side approaches to improving quality and access, and review of human resources for health. It is expected that this gender analysis will provide relevant data for each of these reviews and for the overall mid-term review synthesis paper.

Sex and gender are increasingly recognized as important determinants of health for women and men (WHO, 2010; UN, 2010). Beyond the biological differences, gender roles, norms and behaviour have an influence on how women and men, girls and boys access health services and how health systems respond to their different needs. Different and often unequal abilities between women and men, girls and boys to protect and promote their health require recognition in order to plan appropriate health interventions (WHO 2010; MoWA, 2008; Walston, 2005).

The principle of gender equity and the process of gender mainstreaming in the health sector are officially adopted by the Royal Cambodian government and donors providing technical and financial assistance to the government. This gender analysis indicates where there remain significant gaps between stated commitments and actions that require examination. It provides key actionable recommendations to assist the mid-term thematic review of programs in order to ensure that gender considerations are adequately considered and addressed.

BACKGROUND: GENDER EQUITY COMMITMENTS

Box 1 Decentralization & Gender Mainstreaming: Cambodia's Strategic Framework for Decentralization and De-concentration Reform, 2005 objectives with gender commitments: ***Participation of people, especially women, vulnerable groups and indigenous minorities, in decision-making at provincial/municipal, district/khan and commune/sangkat levels; Strengthening of local capacity in using resources to support poverty reduction activities, especially vulnerable groups, indigenous minorities and women and children in order to achieve the Millennium Development Goals of Cambodia; Women representatives in the councils at these administrations1.***

There are well-aligned national policy commitments integrating gender equity into all of the key national and sub-national development documents: the Cambodia Millennium Development Goals; the National Strategic Development Plan 2006-2010; the government-donor Joint Monitoring Indicators; the Commune Development Plan Guidelines (CDP), the Law on the Administration of Commune and Cambodia's Strategic Framework for Decentralization and De-concentration Reform, 2005.

The Ministry of Women's Affairs is the national machinery for the advancement of women; it has been instrumental in this progress, with support from the Cambodian National Council for Women. 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 Cambodian government's international policy commitments to gender equity are reflected through its signature to key human rights treaties and conventions, including the Convention to Eliminate All Forms of Discrimination Against Women (CEDAW).

OBJECTIVES AND SCOPE OF WORK

The overall objective of this study is to contribute to the mid-term review of the health sector by determining the extent to which gender is mainstreamed into health policies and programs.

The specific objectives of the gender analysis are to determine whether policies and programs

- are achieving the targets set in the HSP2 and the CMDGs (Goals 3, 4, 5, 6) and how information systems is providing data sets with sex-disaggregated data to monitor progress
- ensure delivery of services that are adequately supported by infrastructure and assess implications of decentralization and deconcentration policies of the RGC
- 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 for the gender analysis is as follows:

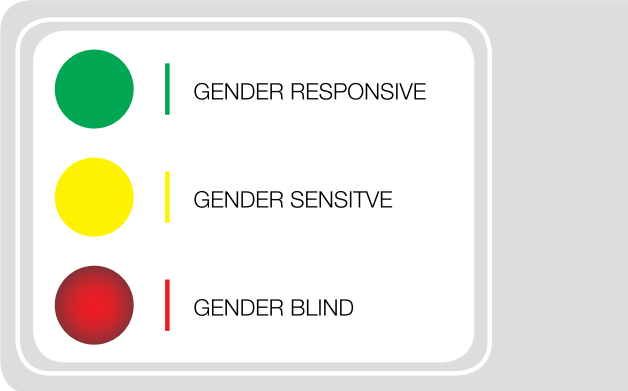
- Review relevant MOH, MEF, MOWA, and donor documentation assessing the degree of alignment between official policies and gender priorities and highlight key issues and lessons learned that will inform the design and conduct of the MTR including data and research conducted since the Cambodian Demographic and Health Survey (CDHS) in 2005;
- Analyze the health outcomes for men and 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 MOH, MEF and MOWA staff in the capital and in three disparate provinces including local provincial, district and commune councilors, donors and NGOs with a particular focus on access issues (supply and demand), the quality of services, use of financial safety nets, and the features necessary to make D&D processes in the Health Sector successful;
- Utilization of health facilities by women and men, girls and boys and identify any community initiatives taken to overcome traditional barriers to access;
- Analysis of health sector expenditures by the RGC (including donor funding) and the extent to which these have been adequately targeted to addressing the health needs of women and girls;
- Identify the sex profile of employees of the MOH at all levels and determine whether this has implications for current policy commitments;
- Assess pre service and in-service training addressing gender issues and whether staff believe they have sufficient understanding to incorporate these issues into health sector policy and its implementation;
- Draft a report (maximum of 30 pages excluding annexes) analysing major findings and providing clear actionable recommendations for inclusion in the conduct of the MTR design and in the MTR report.

METHODOLOGY

The study utilized a qualitative methodology. Data analyzed for this gender analysis consisted of a literature review and primary data collected during the analysis exercise. The literature reviewed included key policy documents and strategic frameworks of the Ministry of Health and other relevant ministries.

A gender-responsiveness assessment of selected policy documents was conducted using the Gender Responsive Assessment Scale (GRAS), a tool developed by the World Health Organization. In all, 12 health policies and strategic plans were reviewed and assessed as either gender-responsive; gender-sensitive or gender-blind.

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), developed by WHO. Primary data collection involved key-informant interviews and focus group discussions with stakeholders at central and decentralized levels. Key-informant interviews (KII) at the national level were conducted with decision-makers and relevant key stakeholders (donors and NGOs). Fieldwork was also conducted to collect primary data in three selected provinces, namely, Siem Reap, Kompong Chhnang and Kampot. The provinces were chosen to represent regional variation, remoteness from Phnom Penh, and experience in health financing schemes. Key-informant interviews were conducted with health care providers at the provincial health department, operational district and health center levels. KIIs were also carried out among staff from the provincialdepartment of women's affairs and local authorities at the district and commune levels. Focus group discussions were conducted with local communities (local health support groups and villagers).



Health statistics from the health information system (HIS) and Cambodia Demographic and Health Survey (CDHS) data were analyzed to assess, as far as possible, health outcomes among men and women, and boys and girls in three program areas, namely: maternal and child health (MCH), communicable diseases (CD) and noncommunicable diseases (NCD). The CDHS 2010 full report was not released during the period of this gender analysis and only preliminary results were available.

KEY FINDINGS

5.1 Gender Assessment of Health Sector Policies

Health sector policy analysis from a gender perspective provides general guidance on how aware and responsive policy-makers are to the nexus of gender and health outcomes. Many of Cambodia's health policies are at their mid-way point in implementation, which provides an opportune time for gender analysis to be considered when reforms and new approaches are developed.

An assessment of the gender-responsiveness of 12 key policy and strategy documents is provided in the following table, using the WHO Gender Responsive Assessment Scale (2011), and guided by the WHO tool, Gender Assessment Questions (available in Annex A).

The scale contains five levels of assessment from the lowest level of gender-unequal to the highest level of gender-transformative (see Annex A for further explanation of these levels). The assessment levels were the basis of a traffic light coding scale for easy reference, with red denoting the least gender-responsive policies or strategies; yellow indicating those having some but not sufficient gender content; and green those having the most gender-responsive content. None of the policies was assessed as being of the lowest level: namely, gender-unequal, or policies that perpetuate gender inequality or privilege men over women; nor as those of the highest level, namely, gender-transformative, or those that introduce progressive changes in the unequal power relationships between women and men.

Table 1: Policy Assessment Using Gender Responsive Assessment Scale[5]

Policy/Strategy		Comments
Health Sector Strategic Plan 2		Vision statement identifies the poor, women and children in promotion of sustainable health sector development; identifies equity and right to health for all Cambodians; prioritizes reproductive and maternal health but does not elaborate gender norms, roles and relations affecting access.
Health Workforce Development Plan, 2006-2015		No specified commitment to gender equality and equity in size and composition of workforce/future workforce; Mention of under-represented categories of health workers do not include sex; MoH categories and numbers of staff not disaggregated by sex; Composition of future workforce for occupational categories and skill mix should include gender equity indicators and targets.
Strategic Framework for Health Financing, 2008-2015		No statement regarding commitment to gender equity targets in finance planning and monitoring; note of bringing in equity and gender perspectives in health financing data; analysis; and policies; M&E has indicator on equity and gender analysis of health finance policies performed
Guideline for Implementation of Health Equity Fund/Gov't Subsidy Schemes-		No statement on commitment to gender equity in implementation guidelines; district health financing steering committee does include Women's Affairs but does not elaborate further; no statement of intention on understanding different roles, norms and relations that may impact implementation of HEF
Information System Program		No statement of gender equality in goals and principles; Equitable delivery of primary health care mentioned but not taking it further; Data disaggregation does not include sex Identification of at risk groups does not address gender specific issues
National Policy for Quality in Health		Vision, goal and guiding principles does not include gender dimensions nor recognize the differential aspects of health quality improvement for women, men, boys and girls Mention of equitable healthcare regardless of gender but does not carry through in master-plan document on roles, responsibilities and strategy
Cambodia Child Survival Strategy, 2006		Vision statement to achieve universal coverage of essential limited package of child survival interventions includes statement on gender; Equitable delivery of primary health care mentioned especially with respect to the poorest and marginalized households but does not state gendered dimensions of household decisions
National Strategy for Reproductive and Sexual Health, 2006-2010 Revised version,		Gender equality stated as goal; defines gender concepts guiding principles: human rights, empowerment; gender equity; Multi-sector partnership; community involvement; evidence based approaches for interventionsis stated
Infant and Young Child Feeding Practices		Silent on male involvement in being informed on importance of feeding practices for infants and young children; Analysis does not address differences in education; rural urban; wealth ratios in feeding practices
National Strategic Plan for Comprehensive and Multi-Sectoral Response to HIV/AIDS 2006-2010		Includes gender equity and empowerment, with special reference to women and girls in its guiding principles; includes human rights and involvement of people living with HIV; commits to reducing mother to child transmission; support to sex workers and peer education for injecting drug users; commits to expanding interventions that target young people
Non Communicable Disease National Strategy		Risk factors for NCD do not incorporate gender dimensions; does include breast exams and gynaecology needs; Surveillance of NCD risk factors (diet, physical inactivity, tobacco smoking and alcohol) and surveys should have sex-disaggregated indicators; gender based violence not incorporated
Policy Community Participation		Vision statement specifies women and children in enhancing sustainable health sector development; recognizes need for gender balance in Village Health Support Groups but does not carry through in VHSG selection criteria; does not adequately recognize different challenges facing women in access and what supports they would need to engage in community participation

5. *The WHO GRAS equivalent for the green colour is Level 4: Gender-specific, which "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 program goals or meet certain needs; and makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles". For the yellow colour, it is Level 3: Gender-sensitive, which "Considers gender norms, roles and relations; does not address inequality generated by unequal norms, roles or relations; and indicates gender awareness, although often no remedial action is developed". For the red colour, it is Level 2: Gender-blind, which " Ignores gender norms, roles and relations; very often reinforces gender-based discrimination; ignores differences in opportunities and resource allocation for women and men; and is often constructed based on the principle of being "fair" by treating everyone the same". See Annex A for further details.*

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 vision, mission and content of these policies reflect commitments to gender equity and human rights and the gendered dimensions of reproductive, maternal and child health and HIV/AIDs along the continuum of care strategies.

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. To further become gender-responsive these programs would need to display more concrete awareness of gender norms, roles and relations that affect the health seeking behaviour of men and women, and specify concrete actions to redress the attitudes that serve to reinforce gender stereotypes that disadvantage women or men in fulfilling their health needs.

Four of the policies were assessed as gender-blind because they did not contain any statement about gender equity or gender issues in relation to their area of specialization, nor did they include gender-specific indicators to monitor progress in the achievement of targets. The Health Workforce Development Plan is of particular concern as it does should contain a stated commitment to gender equity in the professional health categories of health workers and in the Ministry's key decision-making categories. Policies regarding gender equity issues in hiring, promotion, salary, and training is absent and should be developed.

It is important to note that, while policies are a general framework identifying key issues and priority areas to address, their gendered dimensions are important to include because they serve as guidance for achievements desired. While policy-makers and health workers are not adverse to gender equity, there seems to be a need for development of their capacity to understand how gender and health intersect in key policy areas and what actions are needed to address these gender dimensions.

This claim comes specifically from interviews with policy makers and health workers, external to the MoH and within MoH at national, provincial, district and commune level who spoke about the current policy of prioritizing women's health needs but often spoke of this mainly in terms of maternal health care rather than throughout all programs and health system building blocks. MoH and MoWA staff interviewed at all levels expressed a wish to learn more about gender aspects of communicable diseases such as diabetes and non-communicable diseases such as heart disease and cancer; and more specifically about the conceptual connections between gender, poverty and health access and equity.

5.1a Gender Mainstreaming Mechanisms in Health Sector

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 35 members in the Ministry of Health, which 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 subnational levels; help establish GMAGs in line ministries; provide gender mainstreaming guidelines and technical assistance for development of gender mainstreaming action plans in line Ministries.[6] In addition the TWG-G facilitates coordination among its members and advocates with all development partners and governmental institutions and agencies for mainstreaming gender into their policies and programs; follows up the progress of JMI implementation and reporting to CDC for GDCC; and consults with members on the development and dissemination of results of the of the Cambodia Gender Assessment "A Fair Share for Women" produced every five years.

6. MoWA provides technical assistance to some 28 line ministries and institutions; and 20 lines ministries have developed and implemented their GMAPs.

5.1b Gender Mainstreaming Action Groups

The role of GMAGs is to develop gender mainstreaming action plans (GMAPs) and report progress to the TWG-G. MoWA provides technical advice and guidelines for the GMAGs. The MoH GMAG completed its five-year action plan 2006-2010 that focused in the main on building gender awareness through workshops and trainings (MoH, GMAG Action Plan, 2006-2010). The main objectives of the plan were develop greater gender awareness among MoH staff at central and provincial levels; advocate for greater gender responsiveness in policies and programs, with emphasis in reproductive health and HIV/AIDS, and promotions for women in decision-making positions.

GMAG trainers collaborated with MoWA to create training modules on gender awareness; gender analysis; gender mainstreaming and issues in reproductive health and HIV/AIDS About 15 training programs on gender and health have been carried out to date and some 95 staff has participated in trainings over a three-year period. The precise figures for both trainings and number of participants cannot be tabulated due to missing records for 2008. The table below illustrates over a three-year period (2008-2010) the total number of participants, target groups and location of GMAG trainings that have been recorded gender and health.

Table 2: GMAG training on gender and health issues to MoH staff by participants, target group, location, 2008-2010. (Note to Roo from KF: Please fix up look of this table)

Total participants by sex			Target Groups	Year	Location
Total	Male	Female			
Records missing			Inter-Department/ Stakeholders	2008	Hotel Phnom Penh
29	19	10	Health Managers: Deputy Director of PHD, Director/ Deputy Director of OD, Director/Deputy Director of RH/Director and Deputy Director of RTC; and "other officers"	2009	Regional Training: Kampong Cham, Kampong Thom, Svay Rieng, Prey Veng, GMAG members
35	19	16	Health Managers: Deputy Director of provincial health Department, Vice Chef Bureau, OD Director/OD Deputy Direct, Director of RH/ Deputy Director of RH, Deputy Director of RTC and other officer	2009	Regional Training Stung Treng: Stung Treng, Mondulkiri, Ratanakkiri, Krate, Preah Vihear, GMAG members
29	14	15	Health Managers: Deputy Director of provincial health Department, Vice Chef Bureau, OD Director/OD Deputy Direct, Director of RH/ Deputy Director of RH, Deputy Director of RTC and other officer	2010	Kampong Chhnang: Kampong Chhnang, Banteay Meanchey, Siem Reap,Pailin and Odor Meanchey

Source: GMAG Technical Working Group, MoH, August 2011.[7]

There has yet to be a systematic process established to study the effectiveness and impact of the GMAG in generating understanding and support for gender concepts and analysis and their application to the MoH systems and program areas and on the work in individual departments. The GMAG reports its activities to the TWG-G and is encouraged to request guidance from MoWA's Department of Gender Equality on the progress of its GMAP implementation.

7. *Thanks to Dr. Chev Mony, deputy director of DPHI for compiling information via Department of Administration Mr. Vatana, Technical working group of GMAG. Regarding GMAG's record keeping, Dr. Mony noted that some key information is missing," especially the report (sic) from 2006, 2007 and the person involve during training". The research team was unable to obtain some of the requested data such as the number of GMAG trainings by ministry levels, central to local, 2006-2010; and the number of GMAG trainings by subject matter and target group.*

5.1b Main Challenges Identified by GMAG members

The main challenges GMAG identified were:

- The awkward institutional home sitting in the Administration Department rather than as a stand alone and more autonomous body as in other ministries in Cambodia with a dedicated budget from the priority operating costs (POC);
- Time constraints in carrying out GMAG work in addition to general ministry work assignments; department representatives often do not show up for monthly meetings due to work overloads
- Budget shortfalls or budget lags in disbursement making activities difficult to carry out as planned;
- Capacity limitations in understanding the applications of indicators and targets;
- Limited awareness of conceptual and theoretical applications related to gender analysis;
- Persistence of attitudes among mostly male decision-makers gender equity is not an important health issue in strategic areas or program areas and not a priority generally.

These attitudes make it difficult for gender equity advocates within the MoH to push for environments conducive to women's advancement and overall gender issues affecting both men and women. Issues such as time off for child and elder-care was mentioned by some stakeholders as an important area requiring support from political leaders in the ministry.[8]

Stakeholders noted that political commitment and resourcing for the GMAG needs further strengthening.

Constraints in GMAGs human resource capacity, funding and time required for task allocation require assessment so that the upcoming five-year GMAP is developed with achievable targets that are resourced and monitored with verifiable indicators. It is evident that GMAG's administrative arrangements were weak in its first two years as records of trainings were not recorded. An assessment of what and how to keep training statistics up to date may assist the GMAG to plan and monitor its work more effectively.

5.1c Subnational gender mainstreaming mechanisms

The decentralization process has enabled the formation of Commune Committee for Women and Children's (CCWC) to advocate and monitor issues of equity and access to development initiatives, including those in the health sector. The CCWCs are further supported by and interface with Village Heath Support Groups (VHSGs) that are tasked with encouraging women and children to avail themselves of health center services, including vaccination programs, deliveries by skilled attendants and ante-natal care. The operations of these teams and the challenges they face are included in this report's section on service delivery and governance.

5.1d Awareness of Gender Policy Content by MoH Staff All Levels

The key informant interviews indicate a significant gap in gender responsiveness between the intention of policies and how they are actually put into practice. Key informants, with a few exceptions, were generally unaware of the gender content of policies in relation to their specific work areas and had limited gender awareness and gender analysis skills. While key informants were generally aware of the GMAG and several had heard something about GMAG activities, their ability to identify gender issues or specific gender responsive actions in their work was limited.

Finally, the gender analysis team 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 MoH departments is a positive step forward, Translating this desire into practice will require support at the highest levels of the MoH, and from the department directors, most of whom are men, as well as targeted annual budgeting support for GMAGs action plan.

8. This is likely more a civil service issue for the PAR rather than a ministry issue and therefore cannot be readily addressed by the MoH acting alone.

5.2 Strategic Areas

5.3 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.

5.3a Key gender dimensions of service delivery include the following:

ii. Need for health service providers to assess and address gender-based barriers to access to services that different groups of women and men, boys and girls face, including intra-household gender-based inequalities in decision-making on use of scarce resources and on family planning[9]

ii. Need for awareness and skills of health workers on gender to ensure that the gender-specific needs of patients are met (e.g., the need for health workers to undertake screening for gender-based violence; rape)

iii. Respect for privacy and confidentiality, such as through the provision of private waiting rooms and facilities that cater separately to women's and men's sexual and reproductive health service needs

iv. Need to ensure that hours of health care facilities should meet the needs of women and their work schedules, especially those living in remote areas

Findings from interviews with health service providers indicate 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. None spoke of health facility operation hours and the need to meet women's work schedules.

5.3b Gender-based Utilization of health facilities

Health workers reported via fieldwork interviews that there are more women than men in absolute numbers who utilize health services. The national reporting system on number of cases per hospital and health center for 2010 does support this claim.[10] To a large extent, this may be because of women's greater health care needs, due to their reproductive roles as respondents reported in interviews. However, according to the team's findings from focus groups discussions there are also gender dimensions to utilization such as care for children, the elderly and for sick family members and this can increase the frequency of women's contacts with health service providers. According to men respondents in the focus group discussions, women are responsible for family planning, child-care, and looking after the health care needs of the family. "We do not get sick so much like women, and if we do, we ask our wives to look after us" was a common comment from men.

Health Service Delivery—Supply Side

Supply side constraints impacting negatively on health needs of men, women, girls and boys identified by health care service providers in interviews were consistent across the three provinces. The table below summarizes the priority constraints with their associated gender aspects and findings.

10. A more rigorous methodology would be required to compute male and female patient statistics in different health facilities by OD or province in order to look for gendered utilization patterns and regional and rural/urban variations of these as well.

Table: 3 Health Service Delivery Supply Side Constraints, Gender Aspects

Constraints	Gender Aspect	Findings
Health Staff: shortage, especially in remote postings, and women at senior positions; specialist knowledge capacity limited	2nd midwives required to handle ante, delivery and post natal care; emergency obstetric care unavailable; gender gaps	**Significant ongoing danger of continuing maternal and infant deaths** until remote postings of 2nd midwives in place
Infrastructure: small health centers; inadequate electricity, especially at HC level	**Delivery rooms inadequate;** lack of space for attending family members	**Deterrence in long run to HC delivery** if not addressed.
Equipment: deficient medical kits; lack of updated equipment for medical diagnosis, especially at HC level	Diagnosis and treatment of some CDs and NCDs that have high prevalence for either sex not possible, boys and girls.	**Hampers quality of care for reproductive health:** can hinder reduction in MMR; rates of HIV/AIDS and STD transmissions; unwanted pregnancies; Technology updates and equipment scoping needed to assist the MoH to meet the CMDG goals 4, 5, 6

Source: Interview Data, All levels.

Shortages of health center staff, especially in remote posting areas, is an area that MoH is aware of and addressing to the best of its ability. Long waiting times and limited specialist knowledge can inhibit patient visits especially re: unwanted pregnancies; contraceptives and birth control; rape, GBV, STDs, vaginal yeast infections. MoH received government approval to hire 1012 new staff in 2011, of which 506 places are allocated for midwives. As of August 2011, MoH has received 395 applications for the midwifery positions, most of which are primary level whose contract for study includes commitment to practicing in the public health service after graduation. The dearth in secondary midwives applying for these positions may be related to their move into the private sector.[11] MoH anticipates recruiting 1400 new staff in 2012, with half of the allocations for midwifery positions.[12]

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, particularly at OD and PHD levels, as impacting the quality of health services negatively, with particular concern for reducing maternity-related deaths.

5.3c Levels of gender awareness among health service providers

The gender awareness of health staff, especially at the level of health centers, is still very weak, as evidenced through interviews, 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.

Health Service Delivery-- Demand Side

The gender dimensions of demand side health service delivery have been an under-valued aspect but it is increasingly recognized as being an important component of successful health outcomes.

Interviews with village health care support groups, and special focus groups of men and women in the three provinces identified the following core issues affecting demand:

i. Lack of information on services provided and benefits especially for women who are less inclined than men to believe they have a right to know about public service delivery[13]

11. *For example, according to information provided by MoH in the TWG-G 11 August meeting, the Vietnamese operated Charey hospital has reportedly recruited staff to send to training in Ho Chi Minh city in preparation for hospital start up operations in the future.*
12. *Information on MoH new staff recruits for 2011 and 2012 supplied from His Excellency Te Kuy Seang, Secretary of State, MoH at the TWG-G meeting, 11 August 2011.*
13. *This claim is part of a larger issue beyond the health sector affecting women's status and right to claim space in the public sphere vis-à-vis men. Several reports and studies have examined this issue, including Walston, 2005; MoWA, 2008; Lavoisier, 2009.*

ii. Inappropriate and rude behaviour by health staff towards patients, particularly to poor women and men

iii. Opportunity costs regarding long waiting times, lost income or replacement home care at home for women

iv. Devaluation of own health needs by women

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.[14] However, female interviewees, and a lesser extent male 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.

The issue of rude treatment or behaviour towards the rural poor was especially raised in focus groups as a deterrent to the use of services, but more by men than women, who tended to accept this as an unchangeable cultural feature of public service. In several instances, women in focus groups said, "Even just getting a smile would help me feel much better; instead we are ignored ". However, health workers and advocates in the CCWCs and VHSGs did note this issue continued to be raised in their meetings and that greater awareness of respectful treatment of all people coming to seek health care was important. The apparent inhibitions of women protesting poor treatment is an issue that should be studied more carefully so that appropriate responses can be developed by health service providers and their partners at the community level such as the CCWCs and VHSGs.

Financial constraints related to the cost of travel and expectations of having to pay a lot for medicines and under-the-table fees are still a concern, but much less than five years ago before the HEFs were available according to their memory. Villagers in focus groups explained that, with the introduction of HEFs, the practice of under-the-table payments had declined and that there was more transparency in payment for services. The cultural popularity of certain treatments regardless of sex, such as expensive IVs, that HC staff may not consider necessary propels some patients to pay for private medicines, thus incurring out-of-pocket expenses not covered by HEFs.

While knowledge about the HEFs is still limited, it has nevertheless increased greatly as a result of the VHSGs, the CCWCs, and the promotion by the Health Center and Referral Hospital staff. Pricing and exemptions from fees were clearly posted on the health centers visited by the team. While villagers in the focus groups said they knew about the HEFs and would like to use them, they feared leaving their homes, land and cattle unguarded for the many hours it would take them to travel and wait for the health care. This was particularly the case for nighttime emergencies and safe travel on poor roads.

5.3d Gendered Entitlements to Health Care and Access for rural poor women

Specific barriers faced by women in access to health services are not sufficiently understood by health care providers and development partners.

Provincial directors and planning staff identified the following key issues that require attention in the sector-wide health approach and financing schemes:

i. Women in rural areas not confident to look for services

ii. No specific service for gender-based violence

iii. Opportunity costs for child care; household duties too high

iv. Gender-based disagreements in intra-household decision-making, for example, males reportedly not supporting female desires with regard to birth spacing

v. Low levels of educational attainment

The devaluation by women of their own health needs is still a key area that needs attention by the health sector and other partners working to empower women. " We are so busy looking after others, we don't have time to look after ourselves" said one group of women in a focus group. Other women said they knew of members of the focus group who were too shy of "doctors" and did not dare to speak up when they felt ill because of a socially inscribed behaviour to bear it without complaint. Still others spoke of the burden

14. *It should be noted that the team was not tasked with measuring knowledge levels or carrying out any kind of quantitative survey to assess changes in knowledge levels among men and women that could be directly attributed to CCWCs, CCs and Women's Affairs departments. It was the opinion of these stakeholders and service users themselves that knowledge of services had increased due to outreach activities. Verification of these claims is another matter.*

of costs that are not worth spent on them: " My husband thinks it is a waste of money to get health checks so I don't go to the health center", The concept of a right to quality health care does not appear to have taken root, especially among poor uneducated women, and this tends to be reinforced when they receive poor treatment from health professionals.

Provincial-level health directors noted that in their view, women still do not feel they are entitled to go health centers because they lack confidence in their rights and feel looked down upon or too lowly to show their faces and bodies to medical professionals. As one provincial director said, health centers are considered "too high level for them so do not dare to go". The inferiority that women either feel or are perceived to feel is an important research question that should be followed up because not only does it impact potentially on women's own health but also because gender norms dictate that women look after family members, it impacts the health of all family members.

Women in focus groups spoke about high opportunity costs for child-care and lost income/work in the home should they spend their valuable time seeking health care for concerns other than delivering babies. The typically long distances to health centers, especially worrisome at nighttime, were also noted as a concern. Disagreements in decision-making within the household in matters of birth spacing made some women reluctant to seek out health services. Women in focus groups also stated they were shy to seek treatment for common gynecological problems, such as yeast infections and tended to leave them untreated rather than dare speak to a male or female health worker.

5.3e Infrastructure and Equipment to improve women's health and assist achieving the CMDGs

Infrastructure and equipment procurement are areas that MoH shows commitment to address within the resource window provided by the national budget allocation for health sector building repair and new buildings in remote locations.[15] Health center staff noted that increased demand by pregnant women to deliver at health centers is positive but lamented the shortage of accommodation for women and their babies. Confidentiality and privacy for all health consultations is hindered by lack of space. The small size of the buildings and need for gender considerations in future public health building design is an area for future consideration. Safe health center deliveries could be compromised if this issue is not addressed in the long run.

The users of the services identified consistently shortage of health care staff and to a lesser extent lack of updated equipment as constraints. However, when probed about constraints of infrastructure, education levels, and general capacity of health care workers, including women in senior positions, these issues provoked little comment in contrast to health service providers who had clear opinions about them.[16] Service users appeared unused to expressing ideas in this amount of detail and expressed lack of confidence to comment on issues relating to education of health service providers.

The use of out-dated and insufficient equipment is hampering quality of care and health sector ability to monitor sex specific aspects and/or prevalence for some CDs and NCDs, for example malaria among males; prostrate cancer for men; breast and cervical cancer for women; wasting and stunting in boys and girls.

5.4 Human Resource Development

The total number of MoH civil servants (see Figure 1) is 18,302, with women representing 45 percent and men 55 percent. These percentages are also reflected in the male-female split at central level and sub-national levels, while overall numbers of staff are deployed at sub-national level.

15. The SWiM review will likely address this issue.

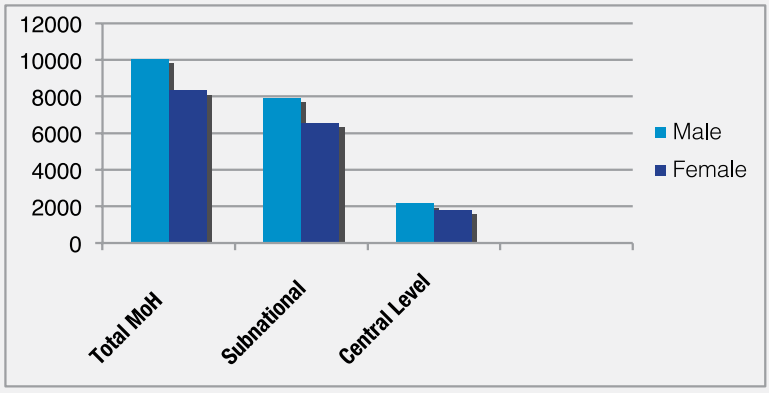
16. It should be noted that the provincial and district level Women's Affairs staff were consistent in not articulating low education levels of health service workers as a constraint. They did, however, identify shortage of health center staff and infrastructure and lack of updated equipment as constraints.

5.4a Sex Profile of Senior Ministry Staff

An analysis of various ranks of senior staff in the Ministry of Health by sex is instructive for identifying equity issues across ranks. Out of a total of 1072 senior staff, from Secretariat General to Office level at national and sub-national levels, women account for 138 positions, or only 12.87 percent.

At the senior level, there are no women Directors General, among the total of 4; while there are 3 women out of 14 Deputy Directors General. There are no women in the next most senior level of Inspector General and Deputy Inspector General.

Figure 1: Distribution of MoH staff by sex, central to local

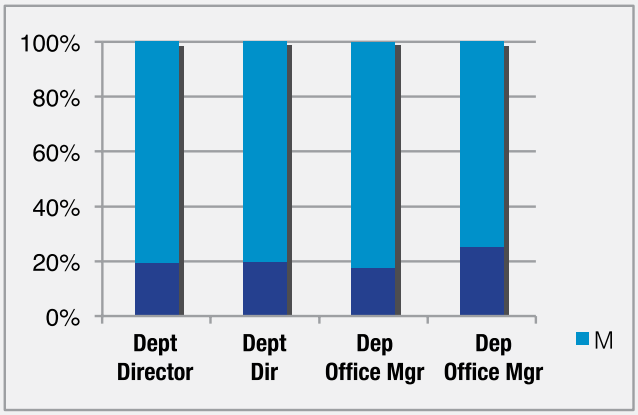


Source: Personnel Department, MoH, 2011

In middle ranks where the majority of staff is deployed in departments and offices, the gender imbalance is stark. At the level of department directors, there are 6 women out of a total of 31, representing only 18 percent. For deputy directors of departments, there are 26 women out of 132, representing only20 percent. At the level of office managers and deputy office managers, women account for only 18 and 25 percent respectively.[17]

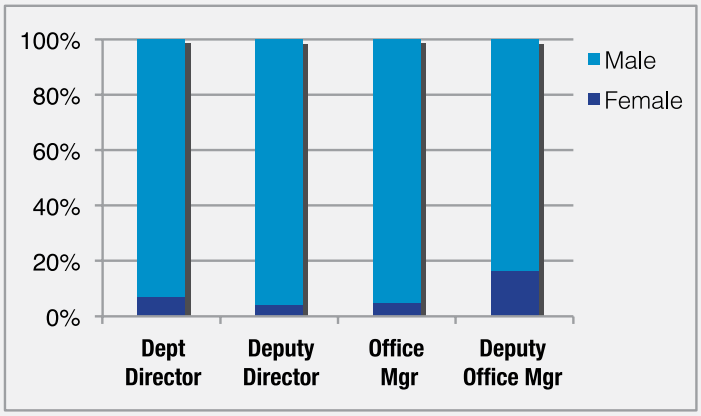
The distribution across ranks by sex at the operational district and provincial health department shows greater gender gaps, with fewer than 10 percent of women appointed at department director, deputy director of department and office manager levels, and with deputy office managers accounting for some 16 percent.

Figure 2: Department and Office Rankings by Sex



Source: Personnel Department, MoH, January 2011,unofficial figures

Figure 3: Municipal Department Rankings by Sex



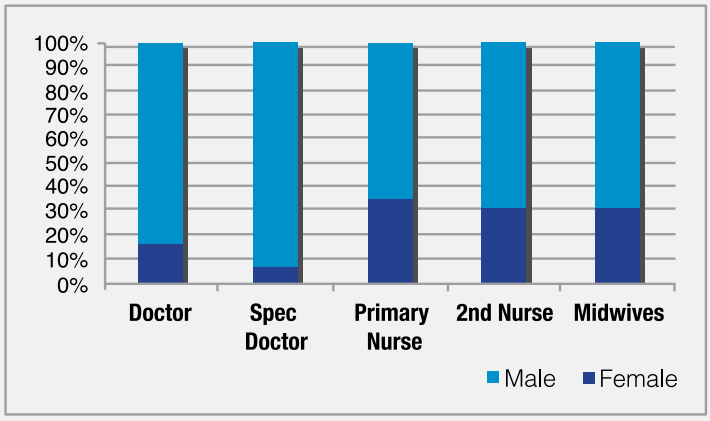
Source: Personnel Department, MoH, January 2011, unofficial figures

5.4b Health Professionals by Sexa

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%) [MoH, 2011, Personnel Dept Statistics). Most of the female positions are in assistant categories. Women dominate in midwifery (primary midwives: 1823 all women; secondary midwives: 1908 all women). Gender gaps are large in all the professional categories, with the exceptions of assistant pharmacists (46 women/43 men) and primary laboratory technicians (36 women/35 men), where men and women are near equal in number, with women slightly edging upwards of men.

17. *A 2005 unpublished study supported by the World Bank, Gender Analysis of the Cambodian Civil Service by Zorica Guzina compiled a gender profile, among other things, of several line ministries, including health, and uncovered a large gender gap at managerial levels, analyzed, in part, as part of a systematic male bias and often unwitting discrimination against women that was structural in nature.*

Figure: 4 Health Professional Categories by Sex



Source: Personnel Department, MoH, January 2011, unofficial figures

Women account for 16 percent of doctors (375/2300); 8 per cent of specialist doctors (7/91); 35 percent of primary nurses (1165/3258); and 31 percent of secondary nurses (1629/5175) and 100 per cent of primary midwives (1823 in total). While cultural preference for female midwives is important, and is largely the reason for this figure, it should be noted that some men may wish to study midwifery and some women may feel comfortable with a male midwife as gender roles, relations and attitudes change in the future in Cambodia over time.

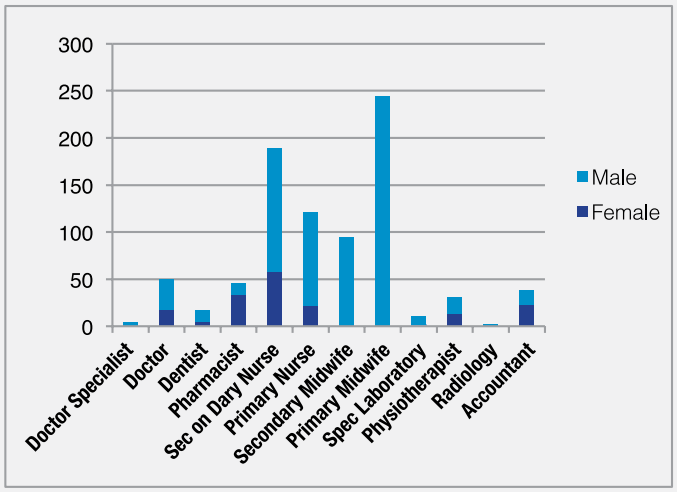
5.4c Explaining the Gender Gap in the Health Workforce

Studies on the gendered social norms, roles and behaviour in Cambodia note the considerable gap between women and men in decision-making positions in general, including the government, and by extension in highly skilled medical professional categories (Ebihara, 1974; Frieson, 2001, 2011; McGrew, et al, 2004; Ledgerwood, 1990, 1992). This stems from limited opportunities for girls to seek education to a high level and compete on a level field with men in professional attainment and advancement. The social context for this includes gender based discrimination with the education of boys as a priority and the gendered division of household labor resulting in girls staying at home rather than attending or completing school, especially at lower secondary levels. When they do make it through educational hurdles, most working women face the "triple burden" of reproductive work, including child care and elder care, and most household chores (MoWA, 2008). In this regard, among Ministry staff interviewed, especially women, there is a need for greater understanding among male managers to the special needs of women workers if they want to close the gender gap.

5.4d Gender Equity Initiatives

The MoH 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 (Personnel Dept interview). Salary grade upgrades and promotions are also prioritized for women. In April 2007, the Ministry of Health issued a directive to unit heads to give priority to women in hiring against vacancies, promotions and appointments, provided that their qualities, skills and capacities were sufficient (MoH, 2007a). 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.

Figure 5: Recruitment of Professional Cadre, 2010



Source: Personnel Department, MoH, 2010, Unofficial Figures

BBox 2: Female Views on Gendered Challenges in Public Health Field:[1]

"Need strong commitment and support from family to be an active health worker or to be in leadership position"

"Men family members expect women to do all the housework and also do not like them to work long hours, making it hard for women health professionals to pursue this career."

"At the workplace, managers should be aware of the challenges for women and try to assist them instead of complaining about them, especially when women bring up issues e.g. child care. Some women are late because they need to pick up children from school or make meals for family, but men managers do not understand this."

These positive initiatives should be monitored for their actual change in male-female ratios over time so that progress in bridging the gender divide can be measured. For equity ratios in professional categories to begin to even up there will need to be more concerted efforts to ensure that women's high school completion rates increase dramatically and that young women are encouraged to enter medical schools in the higher professional training categories.

5.4e Pre- and In-service Recruitment and Enrollment

In terms of pre-service training recruitment, efforts are made to encourage women to apply in information sessions and the selection committee has an official policy to offer spots to women candidates should they have same scores qualifications as men.[18] More needs to be known about this policy was introduced and how it is implemented in practice

The health workforce should aim to achieve gender equality in terms of employment of main cadre categories (doctors, nurses, technicians etc) and also strive for gender equity through fair distribution of men and women in management and decision-making roles from national to sub national levels. These equality and equity issues are not addressed in the Health Workforce Development Plan.

Preliminary and unverified data on current enrolments for nursing and midwifery in pre-service training in the four regional training centers indicate that women are well represented, as indicated in Table 2.

Table 4: Enrolments in Regional Training Centers 2011, by sex

Regional Training Centre	Males	Females	% female	Total 2011
RTC Battambang	221	448	66 %	669
RTC Stung Treng	135	275	67 %	410
RTC Kampot	159	512	76 %	671
RTC Kompong Cham	228	468	67 %	696

Source: JICA: Project for Strengthening Human Resources Development System of Co-medicals;
2011 Data has yet to be verified and remain unofficial figures

These statistics appear to represent a closure in the gap between male and female nursing cadre as represented in figure 4 above. Caution is called for in reading too much into these statistics as cadre ranks are not represented and it is not clear if the enrolment numbers are aggregate of all years or first year only.[19]

The regional training centers for nursing and midwifery have on average two-thirds women to one-third men in basic and secondary nursing streams, while there are no men enrolled in the primary or secondary midwifery courses. An associate degree in midwifery is a new direct entry degree program that began in mid 2009 that operates in the four regional training centers. The original program of 3 years nursing plus one extra year for midwifery specialization proved problematic as very few students stayed

18. *The team was unable to obtain a copy of this policy or to find out how it is implemented in practice and this deserves follow up.*
19. *There were challenges in obtaining data on enrolments for reasons that remain unclear. It is advised that this area be carefully reviewed in the near future so the picture is clearer and trends can be determined based on a fuller and accurate statistical picture.*

on for the fourth year due to financial constraints and the country experienced a deficit of midwives as a result. The associate midwifery degree direct entry is taking on average 450 per midwives per year nation-wide whereas on average before the intake to the fourth year was approximately 150 according to interview data. There is optimism that sufficient numbers of trained midwives will meet the demand within a few years after the next cohorts of graduates are deployed. It will be important to monitor the impact their deployment has on maternal health regionally and with respect to urban and rural maternal health patterns.

Statistics on in-service training courses are not kept in aggregate in the personnel data system, due to the different course providers and the lack of a centralized system to track and log total courses and total numbers of students.

- Studies on the gendered social norms, roles and behaviour in Cambodia note the considerable gap between women and men in decision-making positions in general, including the government, and by extension in highly skilled medical professional categories (Ebihara, 1968, 1974; Frieson, 2001; McGrew, et al, 2004; Ledgerwood, 1990, 1992).
- Ministry staff interviewed, especially women, expressed need for greater gender responsive policies concerning child care and understanding among male managers to the special needs of women workers if they want to close the gender gap.

5.5 Health Care Financing

5.5a Gender Aspects of the Strategic Framework for Health Financing

The Strategic Framework for Health Financing (2008) highlights gender and equity issues under evidence and information for health financing policy. It calls for the following strategic interventions (p.14):

- Develop inter-sectoral collaboration for equity and gender analysis
- Ensure health financing data collection is designed with appropriate indicators for equity and gender analysis
- Build capacity for equity and gender analysis
- Perform policy analysis from equity and gender perspectives

Despite these provisions, MoH finance and budget staff has limited awareness about these policy commitments; hence, no actions on these interventions have been taken. Some finance and budget staff participate in GMAG meetings and have undergone its training, but they have yet to apply this learning to implement the policy interventions listed above. In particular, there is little understanding on what indicators would be useful in relation to health financing data collection or how gender perspectives could inform health financing policy analysis.

In order to activate implementation of these components, there may need to be prioritizing of what can be realistically followed up and what competencies are required of finance and budget staff to carry out the interventions.

5.5b Government Budget Allocation Across Program and Non-Program Areas and Gender Responsiveness

The government budget for health has been increasing steadily over the past decade, accounting for 11 percent of the total government budget in 2009, but falling short of the NSDP target of 13 percent (IFPER, 2011). However, challenges continue to exist in the allocation and management of funds and this will impact negatively on the achievement towards CMDGs.

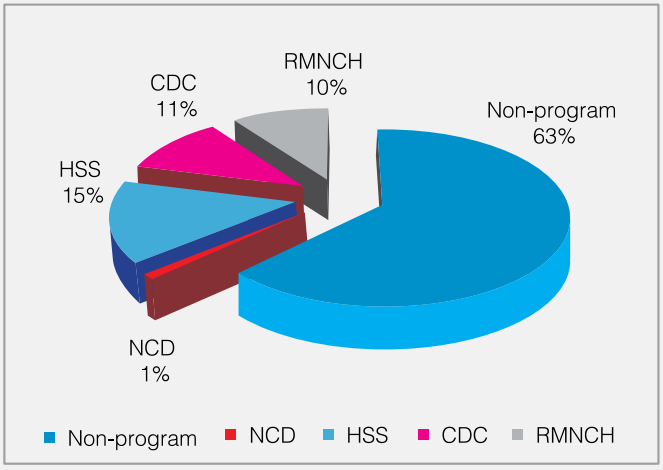
According to the World Bank 2011 IFPER report, the health sector's three main programs (namely, RMNCH, CD and NCD) receive about one-third of the overall budget for health, with the remaining 63 percent spent on non-program areas, such as salaries, medical supplies and support costs. It is not possible as far as the research team could find out to determine how the non-program and to some extent program funding benefits women's health in particular or what percentage of the budget gets spent on improving women's health. This is an area that is important in order for the government to act on its commitment to improve women's health, in particular to address the alarming maternal mortality rates that were increasing rather than decreasing until very recently.

The budget allocations with respect to women's health requires a follow up study either through the MEF and SNEC PFM reform program and their researchers supported by the World Bank or through a stand alone study commissioned by the MoH co-chaired TWG-H on the gender responsiveness of the MoH national and donor budgets. The study could make a beneficiary assessment and/or more general assessment of the budget planning, monitoring, and evaluation process that could integrate gender responsive budget elements into all phases. This would provide the MoH with an evidence base to show how its funding is actually targeting program areas and inputs necessary to improve women's health in Cambodia.

A gender responsive budget analysis of the outlays to program areas/non-program areas is made difficult because of the line item nature of the budget planning; the difficulty that finance staff have in tracking program based allocations; and the slow shift to program budgeting that requires continued capacity building by the MEF to be fully operational.

This allocation appears to indicate a possible problem with alignments between the health sector's priority programs and budget commitments, particularly for the priority RMNCH program, which receives 10 percent of the total. This is because it is unclear how much of the non-program funds actually benefit the programs. The gender implications of the budget allocations are that it is difficult to determine what part of the non-program budget is spent on human resources, equipment, supplies and medicines that will ensure positive health outcomes for vulnerable women and children.

Figure 6: Government Budget Allocations across Program and Non-Program Areas



Source: World Bank, IFPER, 2011; citing MoH 2009 Annual Operating Plan.

Cambodia continues to be highly dependant on donor funding, and the challenge is to coordinate action to cover national priorities while planning for a long-term sustainable option to increase government commitment to increase its share of health financing. Health Sector Support Project 2[20] (HSSP2) financing that is entirely donor funded has priority percentages for the health sector program areas, with 45 percent going toward reproductive, maternal and child health; 25 percent to communicable diseases; 15 per cent to noncommunicable diseases, and 15 percent to health service strengthening. Provincial health directors in all three provinces stated that HSSP2 funding was disbursed in a timely manner, unlike the government budget that was often late and unpredictable.

5.5c Health financing schemes to address access to health services for women in rural areas

Health financing schemes, including vouchers and conditional cash transfers for women, and health equity funds available for family units for all medical needs are removing the barrier of affordability of health services. Lack of knowledge and information on the availability of assistance schemes; lack of trust in public health care facilities that were identified in research findings from five years ago appear to be diminishing as schemes take root and are being scaled up. (Annear et al. 2006; Harderman et al. 2004). 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 OOPs. 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.

20.

A number of health reform mechanisms have been tested or pioneered in the country, such as a user fee system; sub-contracting of government health service delivery to non-governmental providers; midwife incentives for delivery at the health facility (USD 15 per delivery); community-based health insurance (CBHI) in Kampot implemented by SKY/GRET and supported by GIZ in Angkor Chum implemented by local authority with URC support; Health Equity Funds (HEFs); vouchers; and conditional cash transfers[21]. In terms of gender responsiveness, only the voucher and conditional cash transfers are specifically targeting women on reproductive health.[22]

Data from our fieldwork suggest that if HEFs are available, unofficial payments and poor treatment are reduced significantly. However, continuing high opportunity costs associated with nighttime travel, and in remote areas is still identified as a barrier. Even when vouchers, HEFs, and cash transfer schemes cover transport and food costs of women needing reproductive health services, the opportunity costs associated with family care, livelihoods and security needs for property are prohibitive.

5.6 Health Information Systems

5.6a Progress charted in Information Systems

Information systems in the health sector are evolving to ensure the production, analysis, and dissemination of reliable sex disaggregated information on health status and outcomes from central to local levels. The HIS strategy does not identify of 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.

All data and information collected in the computerized Health Information System (HIS) are sex-disaggregated, which is a minimum requirement for a gender-responsive information system. However, HIS staff is not yet sufficiently trained in the health management information system and there are no health information specialists or biostatisticians in the health information departments. More importantly, staff has weak capacity for gender analysis as an input into gender-responsive policy-making.

5.6b Social and gender determinants of health

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. Development partners supporting the DPHI may also have limited knowledge and awareness of how the information systems can be developed along gender responsive lines.

Training modules on gender and social determinants of health as a requirement for pre-service and in-service education were requested by members of the department of public health information (DPHI) staff during interviews.

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.

Health center directors oversee the register of outpatient consultations and report monthly to the operational district on overall numbers of cases. There is little or no thought to examining the gender and age patterns in numbers of patients and types of health complaints by sex that could be then examined at higher levels for gender-responsive actions. Reporting systems from periphery to central levels operate but data quality and verification systems are areas needing attention. There is limited use of the HIS data in planning and monitoring of health service delivery at local levels and there is yet to be any reflection on how health centers are meeting the health sector's priority area of maternal and child health.

None of the DPHI staff have specialist knowledge in gender analysis or gender statistics. The dearth of central level technical skills in information systems also encourages dependence on outside expertise and is not sustainable in the long run. It is vital that any external consultants hired to develop the HIS system and staff use of it incorporate some gender awareness of health indicators so that local capacity is improved.

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21. Conditional cash transfer is cash provided to women for ante and post- natal care provided they complete the required number of visits. Vouchers are a scheme for poor women funded by donors t access free services for maternal heath needs including costs for delivery, ante and post natal care (travel, food and user fees)

22. With the exception of the CBHI scheme supported by GIZ in Kampot also supported a safe motherhood package providing financial incentives for women to use MCH services..

5.6c Policy-Practice Gaps identified by DPHI

The policy gap identified by DPHI is lack of gender-sensitive indicators for monitoring health system building blocks and thematic health programs.

There is low awareness about the potential benefits of a more gender responsive information system, and use of statistics generated by the MoH, especially those related to gender, that could inform the design of national health surveys, such as the CDHS and be shared with other line ministries for policy and planning and monitoring of CMDGs, especially the Ministry of Planning, MEF and MoWA. The DPHI expressed enthusiasm to develop competencies in these areas should development partners provide support.

5.7 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.

The provincial fieldwork suggests that annual operational planning, while designed to be participatory, still depends on the provincial health department (PHD) level to make decisions on priority activities and to estimate budgets for them due to capacity needs of OD and HC managers. This can potentially limit the ability of heath units to allocate resources in response to local needs, including those specific gender health issues affecting men and women.

Budget planning and implementation at the provincial level is done on an annual basis, although the 3-year rolling plans exist in theory. Late disbursements of government budget funds, sometimes as late as the third quarter period, leave provincial staff scrambling to spend funds on activities planned over the course of the year. Program budgeting exists only at national level so that it is difficult to track expenditures of government funds in relation to priority health programs, particularly the NRMCH.

Table 5: Summary of Decentralized Governance Advancements and Challenges

Advancements	Males
Priority focus human rights and maternal and child health well understood at all sub-national levels	ODs lack capacity to develop plans to meet priority policy requirement; are dependent on PHD
Program budgets at central level help target priority areas.	No program budgets at provincial level; fund disbursements difficult to measure against quality.
Active and committed village and commune health committees, leading to increase service utilization by women	Absence of social accountability mechanisms to monitor health care quality for women and children.
Established information-sharing networks among dept. of health, women affairs, and local authority.	Provincial and district health planning committees established but do not function well.

5.7a Decentralization and Positive Initiatives Benefitting Women and Men

Decentralization initiatives have yielded positive initiatives by the VHSGs, CCWCs 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.

Commune councils in particular, with their women's and children's committees, demonstrated good knowledge and commitment to the health sector's priority concern for maternal and child health. Focus group discussions with men and women verified the active role that the CCWC's are playing, in some cases personally assisting in obtaining health care, which was appreciated.

The role of the CCWC as a bridge between communities and the health centers or referral hospitals in matters of complaints regarding under-the-table payments or poor quality treatment is not well defined and operates on an ad hoc basis. 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 VHSGs,

CCWCs or HCMCs. Social accountability mechanisms at local provider level are a need that cross cuts service delivery and information systems and needs further development.

5.8 Program Areas

5.9 National Reproductive and Maternal and Child Health Program

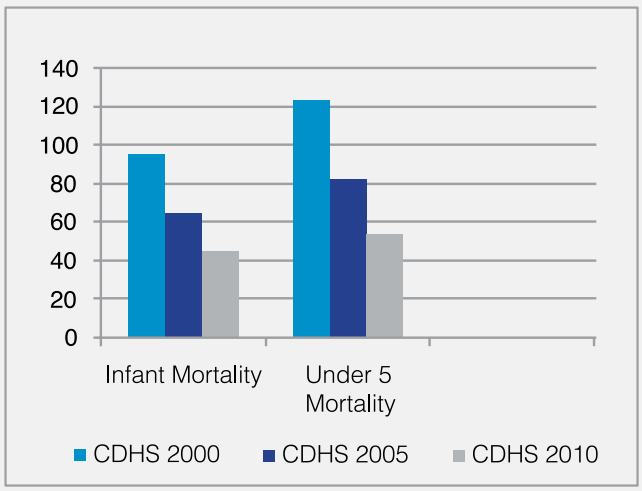
The National Strategy for Reproductive and Sexual Health in Cambodia (2006-2010) is a comprehensive policy that is gender-responsive in design and provides detailed interventions across the five health system building blocks. Plans to prepare the second five-year strategy are at an inception stage and key stakeholders expressed the need to review the achievements and outcomes of the first strategy and explore future program priorities and financing alignments. Stakeholders identified the continuing weak capacity of health sector staff, especially at management levels, as a key constraint in implementing the strategic interventions.

Ensuring the priority of reproductive health interventions in annual operation plans is well recognized at provincial levels. Targeted funding that meets the differential needs of provinces across the country is increasingly recognized as a key issue to ensure that progress is more equitably achieved. The urban/rural and provincial variations in maternal and child mortality that were marked in the CDHS 2005 should be compared to CDHS 2010 data when they are available, with particular attention to Kompong Speu, Preah Vihear, Stung Treng, Prey Veng and Mondolkiri and Ratanakiri (Rushdy, 2009: 15).

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).

Figure 7: Improvements in Infant and Child Mortality Rates



Source: CDHS, 2000; 2005; CDHS 2010 Preliminary Results

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.

There are no major sex differences in immunization rates, suggesting that households treat baby boys and girls equally. Cambodia does not display son preference in cultural attitudes overall, although there may be minor differences in practices or outcomes captured by sex-disaggregated data, if they were available; e.g., feeding baby boys longer than baby girls.

21. *Conditional cash transfer is cash provided to women for ante and post- natal care provided they complete the required number of visits. Vouchers are a scheme for poor women funded by donors t access free services for maternal heath needs including costs for delivery, ante and post natal care (travel, food and user fees)*

22. *With the exception of the CBHI scheme supported by GIZ in Kampot also supported a safe motherhood package providing financial incentives for women to use MCH services..*

Table 6: CMDG 4 Progress Measured Against Selected Targets

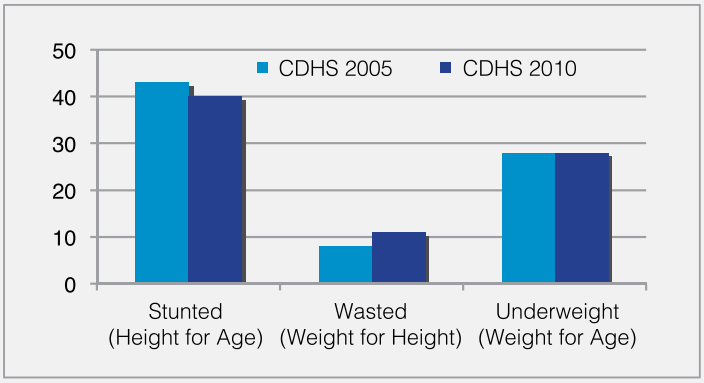
CMDG4 Reduce Child Mortality	2000	2005	2010	2015 target	Assessment
Infant Mortality per 1000 live births	95	60	54	50	On Track
Under 5 mortality per 1000 live births	124	83	54	65	Achieved
Proportion of children (0-59 months) Receiving vitamin A supplement	28	79	71	90	Not on Track
Proportion of infants exclusively Breastfed up to 6 moths of age	11.4	65	74	49	Achieved
Proportion of children under 1 Yr Immunized against measles	41.4	--	91*	90	Achieved
Proportion of children aged 6-59 months receiving Vitamin A capsules	28	79*	--	90	Data needed

Sources: CDHS 2000: CDHS 2005: CDHS 2010 Preliminary Results.

Challenges remain in child malnourishment and stunting, as the figure below demonstrates.

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 under nutrition in girls that affect their later reproductive health and health of their children. Under nutrition is harmful to women's productivity and their own health during pregnancy and childbirth. Under-nourished women also tend to deliver children with low birth weight and this in turn can increase risks for illness.

Figure 8: Percentage of Malnourishment and Stunting in Children, 0-59 months; More than 2 SD below the median of WHO Child Growth Standards Adopted 2006



Source: CDHS 2005; CDHS 2010 Preliminary Results

Table 7: Rural-Urban differences in under nutrition among children

Height for Age	Weight for Height		Weight for Age
Male	41.6	11.4	28.0
Female	38.2	10.4	28.6
Rural	42.2	11.6	30.0
Urban	27.5	10.8	18.8

The significant differences between rural and urban rates of under nutrition and stunting need careful observation so that adequately funded interventions and robust monitoring systems can reverse this disturbing trend. Stakeholders especially among development partners stressed that there is not enough emphasis given in Cambodia to public health and especially nutrition – and that this would make a lot of difference to infant, child and maternal health. Whilst poverty

was acknowledged as an issue in combating under nutrition at the family level, stakeholders noted that the Ministry of Health in partnership public health advocates and development partners could advance awareness about the necessity of growing common fruit and vegetables around households to address nutritional requirements for good health of girls and boys, and women and men in all age groups. The onus here would be on people taking initiatives themselves provided they have awareness and access to relatively inexpensive inputs.

Table 8: CMDG 5 Progress Measured Against Selected Targets

CMDG5 Reduce Maternal Mortality	2000	2005	2010	2015 target	Assessment
MMR per 100,000 live births	437	472	240	140	Achieved
Total fertility rate	4	3.4	3.0	3	Achieved
Proportion of births attended by skilled health personnel	32	44	71	80	On track
Proportion of married women using birth spacing methods	18.5	27	35	60	Not on track
Proportion of pregnant women with 2 or more ANC with skilled health personnel	30.5	81	89	90	On track
Proportion of women with iron deficiency anemia	58	47	44	19	Not on track

Sources: CDHS 2000; CDHS 2005: CDHS 2010 Preliminary Results

The remaining indicators include proportion of pregnant women with iron deficiency anemia, which showed a decline from 66 percent in 2000 to 57 percent in 2005, with a 2015 target of 33 percent to reach. The CDHS 2010 full data sets are not yet available to measure progress in these indicators over the past five years.

The maternal mortality ratio in Cambodia is among the highest in the region and has remained persistently high for the past ten years. The CDHS 2010 reports the maternal mortality ratio was 206 women dying per 100,000 live births, compared to 472 deaths per 100,000 live births in 2005. Caution is required in comparing these ratios as the report advises: "While maternal mortality ratios are not precise, the magnitude of the decrease is large enough to be confident that it represents a true decline." (CDHS, 2010). The magnitude of the decrease in a short five-year span suggests a need for a careful reading of the raw data sets and the methodology used for the tabulation of the result. The result as reported means that Cambodia has achieved its revised MDG 5 target of 240 deaths per 100,000 live births.

The gender dimensions of maternal mortality are being addressed but require continued action in order to diminish the still very high levels of MMR in Cambodia. These include promoting girls and women's education, as this is strongly correlated with good health outcomes during and after pregnancy; visits by rural women to skilled health providers; and attention to nutrition and preventive interventions to guard against malaria, anemia, hepatitis and HIV/AIDS, all of which can lead to complications in pregnancy. In addition, gender based violence is an aspect of gender inequality that needs to be addressed as an obstacle to women's health. (WHO, 2003).

Gender roles of women within the household limit their mobility, as women have burden of care for children and elderly in the home as well as contributing significantly to household income (NRMCH, 2008).

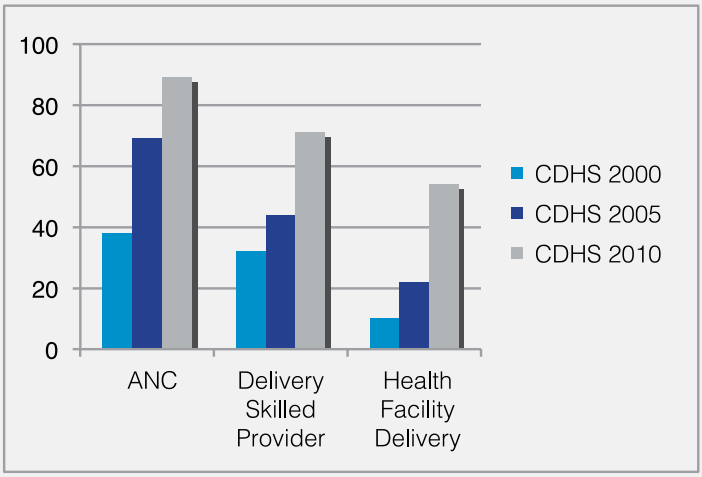
The following factors are linked to high maternal mortality rates (Rushdy, 2009; MoH, 2010)

- Only 46 percent of health centers nationwide (469 out of 1,010) have a secondary midwife (MoH, 2010, Semi-Annual Performance Monitoring Report).
- 57 percent of women have iron deficiency anemia (CDHS 2005).
- There is limited access to safe termination of pregnancy.
- Emergency obstetrics and newborn care (EmONC) is not available to many women and newborns, although MoH plans to upgrade health facilities to CEmONC and BEmONC and accelerating training and life saving skills.

Safer 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). as Figure 8 shows. Antenatal care has increased to 89 percent of women for 2010, well within range of the 2015 target of 90 percent.

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. The provinces that are well below the CMDG 5 targets for delivery by skilled providers and delivery at health facility are Preah Vihear, Stung Treng, Mondulkiri and Ratankiri, with averages of 28 and 21 percent respectively for deliveries by skilled providers and at health facilities (CDHS preliminary results).

Figure 9: Maternal Health Trends: 2000-2010



Source: CDHS 2000; CDHS 2005; CDHS 2010 Preliminary Results

Emerging Gender Issues:

Emerging gender issues that referral hospital and health center staff acknowledged as important to address were gender-based violence, abortion on demand, reproductive health needs of migrants and factory workers; and male involvement in reproductive health.

GBV 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.

Provincial health directors and Women's Affairs staff expressed concern that women tended not to value their health, putting their husbands and children's needs at the forefront, and also carrying the burden of care for accident victims and family members with HIV/AIDS or chronic diseases.

Abortion on Demand

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.

The Ministry of Women's Affairs supports abortion on demand but has had limited success in having this issue raised as a priority health matter for women. Abortion remains a problematic issue.

Reproductive Health Needs of Factory Workers and Migrants

Cambodia's young and mobile population presents new challenges for access to services, especially for reproductive and sexual health matters.

Male Involvement in Reproductive Health

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.

Men in focus groups said that they were not involved in family planning matters and left decisions to their wives. This appears to contradict the finding reported earlier by women that men disagreed with birth spacing decisions of women. More rigourous study of gender relations in the family with respect to family planning decisions would clarify this issue.Similarly, they did not consider it important to be involved in care for children's health or for other members of the family as this was the "women's role".

6.0 Communicable Diseases Program

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 and are critical diseases in Cambodia, which have gender dimensions. For this reason, in the planning and development of disease control interventions, the socio-cultural conditions, roles and relationships between men and women should be analyzed.

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.

The MoWA's health department is an important partner in engendering the health sector response to HIV/AIDS. The 6 strategies it has in place are:

1) Mainstream gender issues into HIV/AIDS interventions and HIV/AIDS into gender programs

2) Promote family and social cohesion and partner communication to reduce women's and girls' vulnerability

3) Design and implementation of advocacy and social mobilization strategies to address vulnerabilities and needs of women and girls and risk of being infected

4) Strengthen and improve and build capacity around cooperation and communication mechanisms

5) Increase availability of information via action research

6) Prevention strategies for spousal and partner transmission of HIV/AIDs

Operationalization of these strategies depends upon building up MoWA staff capacity at national and provincial and district levels and continued donor support through discrete projects.

MoWA has also indentified nutrition as an important cross-cutting element to reducing vulnerabilities to HIV/AIDS and has six staff members on the Council of Agricultural Rural Development training pool in Food Security and Nutrition that have participated in 26 trainings for provincial and district staff in Kompong Thom, Kampot and Kandal.

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 a disproportionate number of females to males that are newly infected with HIV, with 42 % of new cases reported among monogamous women and 30 % of new cases mother to child transmission (UNFPA, 2006) Report Card HIV Prevention For Girls and Young Women. Further assessments will be possible with the release of the CDHS 2010 full report.

For other communicable diseases, such as malaria, dengue fever and TB, the HSSP 2010 semi-annual performance monitoring report stated that, out of the 8 core indicators, 5 were on track to achieve their targets. The 3 core indicators that do not achieve their targets are: 1) the TB case detection rate, which was 62% in 2009 and 31% in the 1st semester of 2010 versus the annual target >70%, 2) the number of malaria cases treated at public health facilities per 1,000 population, which will only reach 1.64 versus the annual target of 6.0, and 3) the dengue incidence rate, at 0.7 versus the annual target of 0.4, and dengue case fatality rate at 0.68% versus the annual target 0.3, more than double the 2015 target. 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 is 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 are 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.

Gender norms in the family need recognition and attention with preventive measures for dengue and malaria, for example. For example, women carry the main responsibility for care for children and the elderly in the home, and therefore they are generally the ones who arrange mosquito netting around sleeping areas, Awareness of this gender role can help shape who is targeted in information and education awareness campaigns in the prevention of malaria and dengue. Also preventative measures through a more robust public health campaign that focuses not only on mosquito nets which has been done to some extent but also men and women's responsibility for cleaning up around households to remove mosquito breeding places could encourage Cambodian citizens to take initiatives on their own behalf if they had awareness.[23]

With regard to TB, under DOTS, all new sputum smear positive cases are reported separately by sex so there will be opportunity to engage in gender analysis in the future.

6.1 Noncommunicable Diseases Program

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 noncommunicable diseases have received little attention.

Smoking and alcohol consumption are the two main risk factors of chronic diseases, which occur more among men than women. A recent national survey (MoH, 2010a) on the prevalence of noncommunicable 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 reveals that 1 in 10 adults (12 percent) had newly or previously diagnosed mild hypertension, which occurs more among urban and male populations than among rural and female populations. The survey also puts the overall prevalence of impaired fasting glycemia and diabetes at 1.4 and 2.9 percent, respectively (MoH 2010). However, it is found that women are twice as likely to be overweight as men, which is also a risk factor for vascular diseases. The survey reveals that 8 in every 10 people (82.4 percent of respondents) had one or two risk factors for developing noncommunicable diseases, whereas 1 in every 10 people (10.2 percent of those surveyed) had three or more or risk factors, a figure that is 2.2 fold higher in men than women. These are important findings that require gender-responsive actions in the design of programs for prevention, treatment and care.

There appears to be a gap in data for life-threatening diseases such as prostate, cervical and breast cancer. The Preventative Health Unit has trained midwives for the past ten years in the importance of breast self-examination and also the VIA test with a referral system in place to the RH for pap smears should there be indications of possible cancer. The challenge is that pap smears are very expensive and the MoH national budget cannot afford to pay for these as routine examinations at this point.

The problem of access to health care for chronic noncommunicable 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. Data from our fieldwork reveal that, in almost all the health facilities visited, particularly at the health centers, there is no health service available to treat chronic diseases, with the exception of a mental illness clinic in Kampot and Siem Reap.[24]

Thus in achieving the HSP2 target of reducing the burden of noncommunicable 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. This was corroborated in our fieldwork interviews, where most OD, referral hospital and HC directors mentioned that the lack of equipment and specialized medical doctors are the main barriers in providing care and treatment for chronic noncommunicable diseases.

23. *Thanks to Elaine McKay, Senior Gender Advisor to UNWomen, for her illustration of this point in communication with the author.*

24. *Incidental data from our fieldwork in Kampot indicates that mental health issues are different for men and women, with women exhibiting depression related to family stress, domestic violence and poverty. However, mental health programs are at a very early stage of development in Cambodia and care needs to be taken to address the gender dimensions when programs are developed.*

CONCLUSIONS

Gender equity as a principle of equitable development and as a goal in and of itself is enshrined in Cambodia's constitution and in key government national policies. In the health sector, gender equity is still relatively under-developed and not as well reflected in policy and practice as it could be with effort and determined leadership.

Szreter (2002) speaking about the complexity of public health policy formation said: "The problem, of course, with emphasizing the importance of politics, the conflict of ideas, the role of the state, conditions of citizenship, local government structures and services, civil institutions and social capital in accounting for the relationship between public health and social and economic change is that this makes for a devilishly complicated story."[25]

The research team concurs with Szreter on the complexity of public health policy in this gender analysis and review of the Cambodian health sector's strategic systems and program areas.

Challenges Summarized

The larger systemic challenges in addressing gender equity uncovered in part but not in their entirety due to the limited nature of this gender analysis study are, the:

- Still mostly male-dominated nature of the health profession as it has developed internationally and also nationally;
- Too few numbers of women in decision-making positions generally across all departments and at all levels
- Although hiring trends indicate preference for women and may be closing the gender gap across professional health workforce, the lack of a gender responsive human resource development policy hinders rather than assists this practice
- Vulnerable position of especially rural women of child bearing years in Cambodia, including those unmarried but sexually active women, most of whom, for various reasons to do with generalized gender discrimination in the wider society, are reluctant to voice demands for better health care for themselves; and
- Apparent prevalence of gender blindness among some (not all) development partners in spite of the espoused concern for gender equity in their international agency mandates; many international health professionals are not well aware of or understand what gender equity means in the field of health and why it has anything to do with financing, or human resource development, or policy review and so forth.

It was these challenges, among others, that inspired the design of this gender analysis for the mid-term review of the Health Sector Strategic Plan, 2008-2015.

Use of the Gender Analysis Results in the Mid Term Review

The research team anticipates the MoH will avail itself of the data and results from the gender analysis to provide relevant data for each of the three independent thematic reviews (sector wide management assessment, supply and demand side approaches to improving quality and access, and the review of human resources for health) and for the overall mid-term review synthesis paper. This was the main intent and purpose of the gender analysis, although its findings and recommendations could ripple beyond this initial purpose.[26]

And it is these sorts of challenges that are addressed by the WHO's gender advisors in consultation with SIDA and others to craft tools to assess human rights and gender equity within health policies and programs used by this research team.

It is hoped that the MoH will continue to mainstream gender analysis into all of its strategic policy and program reviews and avail itself of the relatively easy to use and adapt tools of the WHO and other agencies that excel in gender analysis for policy makers.

25. *It should be noted that Szreter was speaking in the context of US public health policy but the mix of ingredients in the formulation can be equally applied to developing countries with democratizing and decentralizing reforms in process such as in Cambodia.*

26. *For example, the initial results of this gender analysis study were presented by the Ministry of Women's Affairs representative on the team at the WHO's regional conference in 2010 on access and entitlements to health care, Manila, Philippines. Several Southeast Asian state representatives expressed keen interest in the modeling and results of the Cambodia study to be applied elsewhere in the region. For a copy of the presentation in Manila, please contact MoWA or AusAID, Phnom Penh, Cambodia.*

Challenges in Making the Health Sector Gender Responsive & Gaps in policy-practice

The difference between public policy on gender equity and practice is wide because gender discrimination is part of life here as in most societies around the world. As a first time study, the research results represent a beginning examination into the gap between policy and practice and not an end. While the study does provide some important answers to the questions it posed with analysis of data collected in the health sectors strategic systems and program areas, it also raises many others that should be the focus of future studies in the field of public health in Cambodia. As indicated, additional studies are needed about:

- The understanding among the public and health professionals in rural areas about the concept of service delivery entitlements generally for men and women, and why men appear to not be interested in seeking health care and how these are imputed to gender equity among health professionals and more importantly among the public, especially women in rural areas;
- The matter of women's inferiority complex in social relations with public health staff at even district levels and how this can be addressed through public policy in the sectors of health, education, and women's empowerment.
- Polling attitudes towards gender equity in human resource development generally within the health sector to identify bottlenecks in promotion to upper ranks, and attitudes among trainers and students towards female roles as doctors, surgeons, public policy decision-makers and all the other non-traditional female roles in health, and non-traditional roles for men such as midwifery.
- How budgets can be made gender responsive to target most effectively and efficiently the most poor and vulnerable women and children, including those to be reached in the communicable and noncommunicable disease programs;
- How political will and development partner relationships influence the shape and content of public policy on gender equity and health with particular focus on the role and capacity of the GMAG to influence institutional change.

Finally, it is vital, too, that Cambodia's development partners step up to consider carefully the implications this study raises for the overall mid-term review of the health sector strategic plan and what recommendations can be taken up in partnership with the Royal Government of Cambodia that provides greater equity to women as health care beneficiaries and as health care professionals in their own right.

Translation into Khmer is required for this report to be read and understood in the Cambodian context at the national ministry level and in line departments more generally further afield, especially at provincial level. Dissemination and further discussion is important with a tabling of this report to the TWG-H, TWG-G, the PFM, the PAR and other central reform arms of the government, NGO health forums, and the provincial, district and commune councils and their relevant committees operating in the decentralization and deconcentration reform process underway.

We hope this report will spark many discussions, debates, and new studies to further promote women's equity in the field of public health in Cambodia.

RECOMMENDATIONS

Recommendations are made for the short term (next 1-2 years) and medium term (next 3-5 years) as follows:

1. Gender Mainstreaming Machinery

GMAG Short Term

vii. GMAG to disseminate Gender Analysis report results within MoH and MoWA and other stakeholders to stimulate discussion and implications for the development of new five year GMAP (2011-2015)

viii. GMAG should seek national/international expertise to develop a more systematic and comprehensive database of its activities beyond the trainings to incorporate indicators for changes in policy; actions that lead to behaviour change; and contributions to TWG-G.

ix. Seek more regularly technical assistance and cooperation with MoWA in gender mainstreaming initiatives in the health sector, with emphasis on advocacy and policy responses.

x. Seek donor support to conduct assessment with external technical guidance of gender training and advocacy approaches used to date, including impact on attitudes, behaviour; potential to influence policy; assessment to identify potential new strategic areas of focus for best results, areas needing strengthening, and financial scoping exercise.

xi. Ensure that upcoming five year GMAP (2011-2015) has measurable indicators attached to realistic targets in key priority areas with adequate budget support and performance reports and seek MoWA and donor/ development partner assistance if required

GMAG Medium Term

i. Develop vision and mission of gender mainstreaming goals for 2015 linked to strategic program and building block areas.

ii. Strengthen commitment to TWG-G through active participation in meetings and reporting on substantive issues beyond trainings.

2. Service Delivery Recommendations

Short Term

i. Expand high quality, comprehensive services including a 24-hour obstetric and emergency response capacity at HC levels

ii. Address acute shortage of secondary midwives and other female health staff through deployment in remote areas with cash or in-kind incentives for relocation

Medium Term

i. Promote male involvement in services that focus on women, e.g. breastfeeding; family planning; prevention of mother-to-child transmission (PMTCT)

ii. Improve health center infrastructure for delivery rooms and private treatment rooms that cater to women and men's sexual and reproductive health needs.

iii. Develop service provisions to screen for and respond to gender-based violence

iv. Develop gender responsive service provisions for elderly, disabled, youth at HC level

3. Health Care Financing Recommendations

Short Term

ii. Commission a gender responsive budget study that assesses MoH national and donor financed allocations across program and non-program areas in order to identify gaps in funding allocations and to build evidence base of financial commitment to achieve improvement in women's health and attainment of CMDGs 4, 5, 6

Make the Strategic Financing Framework more gender-responsive by increasing its gender content as follows:

vi. Include a reference to gender and health in the vision statement.

vii. Include gender characteristics of health financing in Cambodia, e.g., women's poverty and barriers of access to services.

viii. State women's participation as a key element of community participation.

ix. Refer to women's predominance in the informal sector in discussions of references to CBHI.

x. Include women-focused IEC/BCC activities under health seeking behaviour.

Medium Term

iii. Develop an action plan, in collaboration with GMAG, MoWA and MEF, to prioritize actionable items in the Finance Policy Framework's Component 3: Equity and gender perspectives in health financing with reference to five strategic interventions:

iv. Address the following demand-side financial barriers through harmonized strategic response in health financing policy: gendered dimensions of opportunity costs; transportation and food costs; long waiting times

v. Modify the Guideline for Implementation of Health Equity Fund/Gov't Subsidy Schemes so as to change it from gender-sensitive to gender-responsive through the following actions:

vi. Include a statement on commitment to gender equity in the implementation guideline

vii. Elaborate a dedicated role and budget commitments for Women's Affairs district health financing steering committee

viii. Include a statement of intention on understanding the different gender roles, norms and relations that may impact implementation of the financing schemes

4. Human Resources Recommendations

Short Term:

Modify the Human Workforce Development Plan (2010) so as to change it from gender-blind to gender-sensitive, by the following actions:

i. Incorporate a commitment to equal opportunity in training, recruitment, and promotion

ii. Specify a commitment to gender equality and equity in size and composition of workforce/future workforce;

iii. Ensure that data on MoH categories and numbers of staff are disaggregated by sex, and make data available to all departments within the ministry

iv. Develop targets for composition of future workforce for occupational categories and skill mix

v. Ensure that gender dimensions are considered in health workforce deployment (e.g. costs related to relocation; security in remote areas; child care requirements)

Medium Term

i. Monitor and report on progress in equal opportunities relating to health workforce participation by area and occupation

ii. Assess curricula and training plan to identify where gender issues can be incorporated in pre-service and in a more systematic plan for in-service training

5. Health Information Systems Recommendations

Short Term:

Modify the Health Information Systems Plan so as to change it from gender-sensitive to gender-responsive, through the following actions:

i. Acknowledge the need for the health information system to incorporate gender/health information

ii. Develop the capacity of DPHI staff in gender statistics and analysis

iii. Develop gender-responsive indicators, with inputs from relevant partners and stakeholders, including GMAG and MoWA; Gender indicators to consider: access to health care for men and women by age, rural/urban; disability; gender-related risk factors for communicable and noncommunicable diseases; male involvement in sexual and reproductive health gender dimensions of HIV/AIDS; sexual and gender-based violence; gender dimensions of mental health

Medium Term

i. Develop targets and monitoring framework for gender-responsive based health indicators in annual operating plans

ii. Use gender-responsive health indicators in research programs

6. Governance Recommendations

Short Term

Modify the National Policy for Quality in Health so as to change it from gender-blind to gender-sensitive, through the following actions[27]:

iii. Include gender dimensions in the vision, goal and guiding principles and recognize the differential aspects of health quality improvement for women, men, boys and girls

iv. Elaborate the gender dimensions of equitable healthcare with reference to roles, responsibilities and strategy

27. This could be cross-referenced to Service Delivery recommendations also.

Medium Term

i. Provide technical advice via health center level to Women's and Children's Committees for gender responsive activities and budgets.

ii. Establish a citizen's report card on quality of care in health facilities that is responsive to gender issues initiated with monitoring and evaluation guidelines

7. Reproductive, Maternal, New Born and Child Health Program Recommendations

Short Term:

i. Modify the Policy on Infant and Young Child Feeding Practices so that it changes from gender-blind to gender-sensitive including a statement on the importance of male awareness and support in adopting appropriate feeding practices for infants and young children;

ii. Strengthen the referral system for emergency obstetric care by continued cooperation with the health center management committees in identifying means for transport payments from village to health facilities

Medium Term:

i. Develop gender-responsive costed-guidelines for inclusion in the new five-year strategic plan

ii. Address reproductive health needs including abortion, protection from sexually transmitted diseases, unwanted pregnancies, of young unmarried men and women,

iii. Develop a clear strategy for male involvement in reproductive health

iv. Strengthen public health service delivery for abortion

8. Communicable Disease Program Recommendations

Short Term:

i. Include gender dimensions in the vision, goal and guiding principles for malaria, dengue and tuberculosis

ii. Include a statement recognizing the differential aspects of health quality improvement for women, men, boys and girls

iii. Ensure sex-disaggregation of data on malaria, dengue and tuberculosis

Medium Term

i. Develop capacity for gender analysis in policy development and program implementation

ii. Continue focus on risk groups for HIV/AIDS married women and men having sex with men and intravenous drug users

9. Noncommunicable Diseases Program Recommendations

Short Term:

i. Include gender dimensions in vision, goal and guiding principles for non-communicable diseases

ii. Include a statement recognizing the differential aspects of health quality improvement for women, men, boys and girls

Medium Term

i. Develop the capacity for gender analysis in policy development and program implementation

ii. Disaggregate data in chronic disease reporting from health centers by sex and age

iii. The TWG-H should follow through on the gender assessment in this research to follow up with a more in-depth analysis of the MoH survey's important findings on risk factors for developing noncommunicable diseases (2010a) in order to design gender-responsive actions in the design of programs for prevention, treatment and care for alcohol, smoking, obesity, and hypertension that is expressed and experienced differently for men and women.

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ANNEX

Annex A: Gender-Responsive Assessment Scale

WHO Gender-Responsive Assessment Scale Guiding Questions (WHO, 2011, 'Gender Mainstreaming for Health Managers: A Practical Approach', pp. 54-56)

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 taken

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 to 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 how they 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
- Has the objective of promoting gender equality
- Includes strategies to foster progressive changes in power relationships between women and men

1 *Do the vision, goals or principles have an explicit commitment to promoting or achieving gender equality?*

Scoring hints:

No: may indicate gender-blindness.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

2 *Does the policy or programme include sex as a selection criterion for the target population?*

Scoring hints:

No: may indicate gender-blindness.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

3 *Does the policy or programme clearly understand the difference between sex and gender?*

Scoring hints:

No: may indicate gender-blindness.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

4 *Does the target population purposely include both women and men?*

Scoring hints:

No: may indicate gender-blindness; may also indicate the programme is gender-specific if either sex is addressed in the context of broader gender norms, roles and relations.

Yes: may indicate that the programme is gender-sensitive or gender-transformative.

5 *Have women and men participated in the following stages: design; implementation; monitoring and evaluation?*

Scoring hints:

No: may indicate that the programme or the specific stage of programming is gender-blind or gender-unequal.

Yes: may indicate that the programme or the specific stage of programming is gender-sensitive, gender-specific or gender-transformative.

6 *Have steps been taken to ensure equal participation of women and men?*

Scoring hints:

No: may indicate that the programme is gender-blind or gender-unequal; could also indicate gender-specificity if one sex is targeted in the context of broader gender norms, roles and relations.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

7 *Do both male and female team members have an equal role in decision-making?*

Scoring hints:

No: may indicate that the programme is gender-unequal or gender-blind.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

8 *Does the policy or programme consider life conditions and opportunities of women and men?*

Scoring hints:

No: may indicate that the programme is gender-blind.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

9 *Does the policy or programme consider and include women's practical and strategic needs?*

Scoring hints:

No: may indicate that the programme is gender-blind or gender-unequal.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

10 *Have the methods or tools been piloted with both sexes?*

Scoring hints:

No: may indicate that the programme is gender-blind, gender-unequal or gender-specific.

Yes: may indicate that the programme is gender-sensitive or gender-transformative.

11 *Does the policy or programme consider family or household dynamics, including different effects and opportunities for individual members, such as the allocation of resources or decision-making power within the household?*

Scoring hints:

No: may indicate that the programme is gender-blind or gender-unequal.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

12 *Does the policy or programme include a range of stakeholders with gender expertise as partners, such as government-affiliated bodies, national/international non-governmental organizations or community organizations?*

Scoring hints:

No: may indicate that the programme is gender-blind.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

13 *Does the policy or programme collect and report evidence by sex?*

Scoring hints:

No: may indicate that the programme is gender-blind or gender-unequal.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

14 *Is the evidence informing or generated by the policy or programme based on gender analysis?*

Scoring hints:

No: may indicate that the programme is gender-blind or gender-unequal.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

15 *Does the policy or programme consider different health needs for women and men?*

Scoring hints:

No: may indicate that the programme is gender-blind, gender-unequal or gender-specific (if one sex is targeted).

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

16 *Does the policy or programme include quantitative and qualitative indicators to monitor women's and men's participation?*

Scoring hints:

No: may indicate that the programme is gender-blind or gender-unequal.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

17 *Does the policy or programme consider gender-based divisions of labour (paid versus unpaid and productive versus reproductive)?*

Scoring hints:

No: may indicate that the programme is gender-blind or gender-unequal.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

18 *Does the policy or programme address gender norms, roles and relations?*

Scoring hints:

No: may indicate that the programme is gender-blind or gender-unequal.

Yes: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

19 *Does the policy or programme exclude (intentionally or not) one sex but assume that the conclusions apply to both sexes?*

Scoring hints:

No: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

Yes: may indicate that the programme is gender-blind or gender-unequal.

20 *Does the policy or programme exclude one sex in areas that are traditionally thought of as relevant only for the other sex, such as maternal health or occupational health?*

Scoring hints:

No: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

Yes: may indicate that the programme is gender-blind or gender-unequal.

21 *Does the policy or programme treat women and men as homogeneous groups when there are foreseeable, different outcomes for subgroups, such as low-income versus high-income women or employed versus unemployed men?*

Scoring hints:

No: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

Yes: may indicate that the programme is gender-blind or gender-unequal.

22 *Do materials or publications portray men and women based on gender-based stereotypes?*

Scoring hints:

No: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

Yes: may indicate that the programme is gender-blind or gender-unequal.

23 *Does the language exclude or privilege one sex?*

Scoring hints:

No: may indicate that the programme is gender-sensitive, gender-specific or gender-transformative.

Yes: may indicate that the programme is gender-blind or gender-unequal.

Annex B: WHO Gender Analysis Health Systems Guiding Questions

Source Document: Assessment Level 3: Health Sector Strategy

Analysis Table 13: Process of assessment, analysis and strategic planning

Analysis questions	Findings from documents	Findings from interviews
1. Were the most vulnerable and marginalised groups and communities identified and systematically involved in preparing the strategy (e.g. women and men from indigenous communities; people living with HIV; ethnic, linguistic and religious minorities; low-income groups; rural populations)?		
2. Were a range of state and non-state actors identified and engaged in developing the strategy?		
3. Were women and men equally engaged when developing the strategy, and did they have equal decision-making responsibilities (referring both to marginalised groups and communities, and state and non-state actors)?		
4. Was the information collected made available to all stakeholders involved in the process (including differences in access, underlying and root causes of health challenges)?		
Assessment	**Findings from documents**	**Findings from interviews**
5. In preparing for the development of the strategy, were the following sources of information used to inform assessment and analysis:		
a. Observations and recommendations of international human rights mechanisms (e.g. treaty bodies, special procedures and the Human Rights Council Universal Periodic Review) and information provided by other international, regional and national human rights actors (e.g. national human rights institutions or ombudspersons)?		
b. Information provided by persons from groups that are usually excluded, marginalized and discriminated against (according to sex, age, ethnicity, disability, geographical location, social/political views or any other reason)?		
c. Quantitative and qualitative sources that allow for the identification of vulnerable groups?		

d. Civil society organisations (CSOs) and/or community-based organizations (CBOs)?		
6. Did the assessment identify the major health challenges and the population groups that are most affected?	Priority areas p. 20 does not specify vulnerable groups and major health challenges	
Analysis		
7. Did the analysis identify:		
a. key underlying causes of health challenges, including: – differences in physical and geographical access, affordability and quality of health services; – differences in access to the underlying determinants of good health (water, sanitation, education, etc.), and; – differences in opportunities and life chances for women and men of different groups?		
b. root causes relating to societal attitudes and behaviour patterns (at the household, community and national/sub-national decision-making levels), including gender, cultural or linguistic barriers?		
8. Did the analysis identify state and non-state duty-bearers responsible for addressing key health challenges and their broader determinants at different national and sub-national levels?		
9. Did the analysis identify capacity gaps among:		
a. duty-bearers in the course of fulfilling their roles and responsibilities?		
b. rights-holders in claiming their rights (in particular groups which are excluded and discriminated against)?		
Strategic planning		
10. Does the strategy promote the type of institutional and behavioural changes needed to deliver effective basic health services?		
11. Does the strategy seek to empower the most affected rights-holders (both women and men equally) to claim and exercise their rights?		
12. Is priority given to the groups that are most excluded and discriminated against (at the outcome level)?		
13. Was an impact assessment carried out to examine the potential impact of the strategy on the realization of people's rights to healthcare and/or gender equality?		

Analysis Table 14: Leadership and governance (stewardship):

Analysis		
1. Is the right to health and/or human rights explicitly reflected as a national priority and/or goal in the strategy?		
2. Is achieving gender equality (including women's empowerment) a national priority and/or goal in the strategy?		
3. Are legislative measures identified which can help to achieve the right to health and gender equality?		
4. Inter-sectoral mechanisms:		
a. Is health data used effectively and its use coordinated across sectors?		
b. Is inter-sectoral collaboration addressed?		
5. Is the oversight role of the government recognised in relation to:		
a. licensing of health professionals in public and private sectors?		
b. licensing/accreditation of service provision?		
c. ensuring protection of human rights in the provision of health services (e.g. through informed consent, respect for privacy)?		
d. regulating the supply and distribution of essential medicines?		
6. Is the responsibility of the government in regulating the private sector recognized?		
7. Is there an explicit commitment to universal access to health services at: – primary level? – secondary level? – tertiary level?		
8. Is decentralisation promoted? If so, are there mechanisms for communication, coordination, monitoring and to ensure transparency?		
9. Is equal representation in senior management at different administrative levels promoted (regarding women and men of different ethnic/cultural, geographical or linguistic backgrounds)?		
10. Is there a recognition of structures, mechanisms or guidelines that address human rights and gender equality with respect to:		
a. Research and data collection?		
b. Service delivery?		
11. Is there recognition of the need to build skills in addressing human rights and gender equality issues among the health work force, including health policy-makers?		
Equality and non-discrimination		
12. Are strategies outlined to address the specific health needs of vulnerable and/or marginalized groups?		
13. Are gender norms, roles and relations or gender inequality acknowledged as a barrier to good health?		
Participation and Inclusion		

14. Is there mention of any mechanism through which right-holders can participate in decision-making regarding governance of the health system?		
15. Is collaboration promoted between the Government and a broad range of actors (including CSOs representing specific population groups such as people with disabilities or people living with HIV)?		
Accountability and transparency		
16. Are monitoring mechanisms for health system performance identified?		
17. Do plans include indicators (structural, process and outcome), clear and measurable baselines, benchmarks and targets?		
18. Are data adequately disaggregated to reflect different population groups?		
19. Are there indicators measuring the following human rights and gender equality considerations? Disaggregate by sex		
a. The availability, accessibility, acceptability and quality of health services, goods and facilities.		
b. The existence of legal and institutional frameworks, as well as budgets, to progressively realize the right to health. *To achieve gender equality*		
c. Participation, non-discrimination, accountability, transparency and gender mainstreaming (e.g. gender parity, equal participation).		
20. Are reporting and mid-/end-term evaluation requirements outlined?		
21. Is there dissemination of monitoring and evaluation data and reports?		

Analysis Table 15: Service delivery:

OD Director; Health HC Director; NGO scheme implementing HEFs and CBHI; commune council; community members

	Findings from documents	**Findings from interviews**
1. Are the following components incorporated in the basic package or packages of services? *If so, are gender norms, roles and relations that may lead to different experiences and outcomes for women and men acknowledged (to be addressed under each sub-question)?* a. Child, including infant, health.		
b. Adolescent health.		
c. Sexual and reproductive health.		
d. Health care and programmes for people with disabilities.		
e. Mental health treatment and care.		
f. Neglected tropical diseases (where relevant).		
g. Gender-based violence.		
2. Is women's access to appropriate and affordable quality health care, health information and other related services addressed throughout the life-course?	**FGD (villagers); Women's Affairs**	

3. Is accessibility addressed with respect to:		
a. rural and urban populations?		
b. marginalised groups (e.g. nomadic groups, migrant communities)?		
c. people with disabilities (e.g. making facilities access-friendly)?		
4. Are community-based health services promoted?		
5. Are there strategies to ensure that health information is:		
a. available in local languages?		
b. available in 'simple' language?		
c. appropriate for cultures without a written language?		
d. accessible for the visual and hearing impaired?		
6. Is cultural diversity acknowledged and addressed?		
7. Is the importance of gender norms, roles and relations reflected in plans for health service design and delivery (both women and men)?		
8. Is the right to privacy addressed in the delivery of health services?		
9. Are specific measures to improve the quality of health service provision identified? *Especially regarding quality aspects of relevance for women.*		
10. Is capacity building of community health workers promoted?		
Equality and non-discrimination		
11. Are specific health needs for women and men identified?		
12. Are the health needs of the following groups identified? *Indicate if differences between women and men are not specified within the various groups, or if women are specified as a homogenous "vulnerable" group.*		
a. The elderly.		
b. Prisoners.		
c. Sexual minorities (e.g. lesbian, bi-sexual, gay, transgender and intersex).		
d. People living with HIV, *especially women.*		
e. People living with physical, psycho-social or intellectual disabilities.		
f. Children, male and female.		
g. Adolescents.		
h. Migrants and refugees.		
i. Internally-displaced groups.		
j. Nomadic groups.		
k. Other, *please specify.*		
Participation and inclusion **OD and HC director; HC management committees; VHSGs**		

13. Is the role of local health authorities and communities addressed:		
a. in identifying health needs and priorities?		
b. in links to the formal health-care system?		
c. in ensuring equal representation of men and women?		
Accountability and transparency		
14. Are there mechanisms for complaints from rights-holders (e.g. patients, family members) and for redress, such as client satisfaction surveys, patient charters or suggestion boxes?		

Analysis Table 16: Health workforce

OD Director; Health HC Director; NGO scheme implementing HEFs and CBHI; commune council; community members

	Findings from documents	Findings from interviews
1. Is there a human resources policy?		
2. Is the ratio of filled to unfilled available posts at different levels of care identified at the following levels?		
a. Primary health care facilities.		
b. Secondary health care facilities.		
c. Tertiary health care facilities.		
3. Is the baseline data referred to in the preceding question broken down by: – position (e.g. nurse, midwife, doctor)? – sex? – geographical location? – public/private facility? *Please specify.* – other? *Please specify*		
4. Are targeted steps and benchmarks to address gaps in the number of health workers per population described? *Also mention gaps in the gender profile*		
5. Are provisions made for health workers that are posted in rural or isolated settings? *Include how the provisions are made for both male and female health/care workers.*		
6. Are the human rights of the health work force protected through one or more of the following measures? *Include how these provisions are described for male and female health-care workers.*		
a. Non-discrimination policies (on the basis of sex, age or ethnicity, people living with HIV, physical disabilities, etc.).		
b. Sexual harassment or employee abuse policies.		
c. Provisions to treat and protect health workers (e.g. antiretrovirals for health workers living with HIV, ensuring relevant immunisations).		
7. Is the role of community health workers addressed through the provision of the following? *Indicate whether the information provided relates to paid or unpaid community health workers (or both).*		

a. Support and monitoring from local HCs.		
b. Benefits from training programmes.		
c. Compensation (e.g. costs, salary, education grants).		
8. Is in-service training provided? If so, are the following areas addressed?		
a. Human rights.		
b. Gender equality.		
c. Cultural diversity.		
9. Is the importance of a representative workforce addressed, in terms of:		
a. various population groups, such as disadvantaged populations, indigenous peoples, and minorities?		
b. women and men?		
10. Is there a goal to increase the capacity of duty-bearers in the health system at all levels of the State administration? (outcome level)		
11. Is the education and training of health workers promoted (health workers including both those based in facilities and in communities)? Is there a regulatory mechanism that maintains the quality of:		
a. education/training of health workers and community workers? If so, are gender equality and human rights addressed in quality control measures regarding education/training of health workers?		**GMAG's role in education/ training in-service**
b. the practices of health workers? If so, are gender equality and human rights issues addressed in quality control measures regarding health care practices?	**Accreditation, competency for health workers**	
Equality and non-discrimination		
12. Is the issue of equitable distribution of male and female health professionals addressed? *Indicate the proposed distribution within the country and between urban and rural areas.*	**Not contained in a policy, to be obtained through interview**	
Participation and inclusion		
13. Do parties recognize the importance of equal male and female participation in decision-making roles?	**Not contained in a policy, to be obtained through interview**	
Accountability and transparency		
14. Is there mention of making a 'code of conduct' for health-care workers known to the public?	**To be obtained through fieldwork, and questions about the code of conduct related to gender**	

15. Are complaint mechanisms for health workers addressed?	**Answer if this will be addressed in HRD policy review/practice?**	
16. Are charges of sexual harassment or abuse by health care providers or patients addressed?	**Answer if this will be addressed in HRD review. If not, recommend that it should**	

Analysis Table 17: Medical products, vaccines and technologies

	Findings from documents	**Findings from interviews**
1. Is the development and/or effective implementation of a national medicines policy mentioned?		
2. Is the development and regular updating (every two years) of a national list of essential medicines mentioned? *If so, is there consideration of the differential needs of groups of men and women in relation to the national essential medicines list?*	**Check if there is a list and what it contains in relation to the question. Add the question into health service delivery**	
3. Is the issue of the availability of essential equipment defined at different levels of the health system? *If so, does the strategy recognize the need to tailor equipment to the different health needs of men and women?*	**To be obtained through interviews at field level**	
4. Is the accessibility of medicines addressed, including: a. the affordability for lowest income quintiles?	**All question 4 answers to be obtained through interview with HC/OD**	
b. physical accessibility?		
5. Are statistics on access to and use of essential medicines disaggregated by sex, age and for urban and rural populations?	**To be obtained through interview with HC/OD**	
6. Are medical products and technologies selected with respect to:		
a. the health needs of different population groups?	**To be obtained through interviews**	

b. the different needs and circumstances of groups of women and men?	**To be obtained through interviews**	
7. Is the integration of regulated traditional, complementary and alternative medicines into the health system addressed? *If so, are there any restrictions that may harm women or men from specific groups?*		
8. Is the quality and safety of medicines addressed through adequate standards? *If so, do these standards reflect consideration for human rights and gender equality?*		
Equality and non-discrimination		
9. Is equitable access to essential medicines promoted? *If so, does the strategy provide for essential medicines to be available in prisons, refugee camps, and other excluded isolated areas?*		
10. Is equal access to medical products and technologies for men and women of different groups addressed?	**To be obtained through interview with HC; FGD**	
11. Are information leaflets on medicines available or will they be made available in all local languages?		
Participation and inclusion		
12. Are mechanisms for consulting relevant stakeholders on policy formulation in relation to the adoption of technologies and/or establishing/updating the list of essential medicines addressed? *If so, do such consultation processes refer to both women and men from different stakeholder groups, such as rural communities, NGOs, patient and consumer groups or representatives of vulnerable groups (specify which ones)?*		
Accountability and transparency		
13. Have indicators and targets been identified to monitor access to essential medicines? *Are gender issues included in indicators and targets?*		

Analysis Table 18: Information:

Document sources: Information Strategy; Country Report on Health Information; Statistics

Interview sources: DPHI; Buth Saben, Chief of Health Information Bureau; MoP/National Institute of Statistics

	Document findings	Interview findings
1. Is the need for different sources of information from outside the health sector and which are not related to health status indicators addressed? *For example, from linkages with the national civil registration system, census bureau, national statistics office.*	**Yes**	**To be obtained through interview with Dr. Sok Kanha (info on poverty; food security, linked to health financing).**
2. Are strategies to improve the availability and quality of population-based data on births, deaths and causes of death promoted?	**Yes**	
3. Is the need for a mix between health status, determinants of health and health system performance measures reflected? *Indicate "yes" to all three areas, "partial yes" if the answer is yes in one or more areas, and "no" only if there is no mention of a mix of any of the health indicators.*	**Check on this**	

4. Is the importance of measuring the prevalence, causes, and health consequences of violence against women promoted?	**Promoted by MoWA? Within MoH? Ouk Monna**	
5. Is a facility-based health information system at all levels supported?	**Disaggregate by sex**	
6. Are provisions included for data collection on private health-care services?		
7. Is data collection on economic accessibility for users provided or encouraged? *If so, does the strategy indicate aspects of socio-economic status/affordability and differences for both women and men of different ages and from various groups?*	HC/OD HEF and differences between men and women Exceptions Policy—need to identify different groups	**Dr. Sok Kanha —in relation to affordability of care and in connection with Planning Department**
8. Is research and/or dissemination of information on women's health promoted? *Indicate if both research and information dissemination is included, or if only one of the two is included.*	Check policy —National Institute of Public Health and emphasis on women's health or gender determinants of health	**Yok Dararith, HIS Staff** **GMAG's role in research and dissemination**
9. Is reference made to gaps in existing health information? *If so, indicate if the gaps mentioned highlight the need for information on determinants of health.*	Health Info Strategy MoWA Fair Share gaps—how this is shared with MoH	
10. Is the need to involve various stakeholders in the creation, analysis and dissemination of health information mentioned?	Interview question	
11. Is there reference made to the need for a rights- or gender-based analysis of health data?	Check Info Strategy	
12. Are capacity gaps identified where effort could be made to strengthen the quality of data and health information systems? If so, is undertaking a human rights and gender-based approach included in the identified gaps? *Indicate if capacity gaps address both human rights and gender equality, or one of the two. Specify which area is included.*	Recommendation	
13. Is the importance of ensuring that all levels of health facilities (primary, secondary, and tertiary) have equal access to health information mentioned?	Check policy recommendation	
Equality and non-discrimination		
14. Is the importance of disaggregated data mentioned? If so, are the following levels of disaggregation mentioned? *Identify if disaggregation is mentioned for data collection, analysis and dissemination. State "yes" for all three, or indicate which levels are applicable. If no disaggregated data is available, indicate if mention is made of the need to disaggregate data through strengthening health information systems.*		
a. Sex-disaggregated data?		
b. Age-disaggregated data?		

c. Data disaggregated by region of residence (e.g. urban vs. rural)?		
Participation and inclusion		
15. Is the dissemination and sharing of health information with the public and other stakeholders addressed? *If so, indicate if any consideration is given to the ways that gender norms, roles and relations may affect women's or men's ability to access such information.*		
Accountability and transparency		
16. Is evidence-based decision-making promoted? *If so, are ways to enhance the evidence base on the right to health and gender equality in health mentioned?*		

Analysis Table 19: Financing:

	Document Findings	Interview Findings
1. Is there reference to health financing mechanisms that support entitlements to universal affordable health care? *If so, do they consider differences between women's and men's health financing needs?*		
2. Does the strategy address funding sources for health services, including out-of-pocket expenditure and/or schemes such as social health insurance? *If so, are the implications of these policy options on different social groups or on women and men considered?*		
3. Are strategies included to minimize out-of-pocket spending? *If so, is there an overview of the different kinds of out-of-pocket expenditure, and to whom and for what reasons out-of-pocket expenditures are incurred?*		
4. Is there clarification as to whether the strategy has been costed? *If so, is information provided as to whether the estimated costs for implementing the strategy are within the resource envelope as defined by the Ministry of Finance?*		
5. Are services in connection with maternal health (including medicine and other equipment) provided free of charge (when necessary)?		
6. What percentage of patients use HEF or other types of social health funding?		
7. What percentage of patients using HEF/other funds are male/female?		
Equality and non/discrimination		
6. If the formal health system is based on both public and private services, do financing schemes support equal access to both services?		
7. Are measures outlined to avoid catastrophic payments by households? *If so, does the plan acknowledge that such measures may need to be different for female- versus male-headed households?*		
Participation and inclusion		
8. Is there reference to the importance of ensuring that health financing reforms, strategies and action plans are based on the principle of participation, ensuring consultation with women and men of vulnerable groups?		
Accountability and transparency		
9. Are state accountability mechanisms to ensure effective use of resources (in terms of ensuring universal affordable access) addressed?		

10. Are mechanisms to ensure transparent purchasing processes addressed?		
11. Does the strategy address availability and accessibility of purchasing information to ensure independent auditing and social auditing?		

Annex C: List of Key Informant Interviews/Consultations

Ministry of Health

Lo Veasnakiry	Director Director, DPHI/MoH
Khol Khemrary	Chief of Health Information Bureau
Yok Dararith	Staff Member, DPHI
Khout Thavary	Director, Finance Department
Sok Kanha	Deputy Director, Health Financing Department
Keat Phuong	Director, Human Resources Department
Mey Sambo	Director, Personnel Department
Ouk Monna	Secretary of State and Director of GMAG
Tung Ratheavy	Deputy Director, National Maternal and Child Health Centre

Ministry of Women's Affairs

Khim Chamroeun	Secretary of State
Im Sethe,	Under-Secretary of State
Hou Nirmita,	Director, Health Department
Nheam Sochetra	Director, Gender Equality Department

Donors/NGOs

Anjana Bushtan	Technical Officer (Health in Development), World Health Organization Regional Officer for the Western Pacific
Cristina Bianchessi	Intern, WHO Geneva
Shelly Abdool's	Department of Gender, Women and Health, World health Organization, Geneva
Joanna Vogel	Regional Advisor, Gender in Health and Development, World Health Organization Regional Office for the Eastern Mediterranean
Paul Weelen	Health Systems Advisor, WHO
Ann Robins	HRD Advisor, WHO
Kannitha Cheang	Reproductive and Maternal Health, WHO
Jennifer Lean	First Secretary for Development Cooperation, AusAID
Sarah Knibbs	Deputy Representative, UNFPA
Sam Sochea	Reproductive and Maternal Health, UNFPA
Timothy Johnston	Senior Health Specialist, World Bank
Duch Kim Neang	SKY Programme, GRET, Kampot
Huor Chhay Rattanak	SKY Programme, GRET, Kampot

Kompong Chhnang Fieldwork

Pal Yeun	Director, DoWA
Taong Chan Lon	DoWA

Prak Vun	Director, PHD Kampong Chhnang
Leng Siv Ning	Director, OD Kampong Chhnang
Sorinthy Ravuthy	Director, RH
Sor Savan	Head of Administration, RH
Tann Sarouen	First District Deputy Chief, KampongTralach district
Pich Khorn	Second District Deputy Chief, Kampong Tralach district
Kim Sopheap	District DoWA, Kampong Tralach district
TepYaren	Commune Council Member (F), Pea Ne Commune, Kampong Tralach district
Mol Sopheap	Commune Council, First Deputy (F), Pea Ne commune, Kampong Tralach district
Pat Sem	Second Deputy, Commune Council (M)

Focus Group Participants: 9 female; 9 male

Kampot Fieldwork

Un Vanna Theary	Deputy Director, PHD, MoH
Chhuy Chhorn,	Director, Kampot RH
Khim Tan	Director, OD
Huot Ry,	Deputy Director, DoWA
Yer Vuthy,	Director, Kampong Trach HC
Kong Sok Thoua	Nurse, Kampong Trach HC
Kong Borey,	Deputy District Governor, Kampong Trach (F)
Mom Sophana,	Director, district DoWA, Kampong Trach
Prum Kin Choeu,	Commune Chief, Member of HC Management Committee, Kampong Trach district
Pou Khieu,	CWCC member, Commune Council, Kampong Trach district
Cheng Phalla,	Commune Clerk, Commune Council, Kampong Trach district

Focus Group Participants: 9 female; 9 male

Siem Reap Fieldwork

Krous Sarath	Deputy Director, PHD, MoH
Pen Palkun	Director, Siem Reap RH
La Oun	Director, DoWA
Mak Samouern	Director, Angkor Chum OD, MoH
Meas Dara	Director, Char Chuk HC, Angkor Chum district
Min Pich	District DoWA, Angkor Chum district
Sen Kunthea	District DoWA, Angkor Chum district
Chhorn Heou	CWCC Member
Chhern Kim San	CWCC Member
Nom Thom	CWCC Member

Focus Group Participants: 9 female; 1 male

Annex D: QUESTIONNAIRE FOR PHD AND OD DIRECTORS

Name of PHD: _____

Name of OD: _____

Date of interview: _____

PERSONAL INFORMATION

Name: _____

Sex: _____

Profession: _____

Current Position: _____

Leadership and governance

1. Is the right to health and/or human rights explicitly reflected as a national priority and/or goal in the strategy?
2. Is achieving gender equality (including women's empowerment) reflected as a national priority and/or goal in the strategy?

Health care service delivery

Supply side:

3. What are some of the main barriers to delivering effective and good quality health care to the people in your area (in relation to both rural and urban populations and vulnerable groups such as the poor, disabled, women, ethnic minorities, etc.)?
4. Do you have sufficient staff with an appropriate mix of skills to deliver health care to the people who visit your health facility?
5. Are the following components incorporated in the basic package or packages of services? *If so, address under each sub-question whether gender norms, roles and relations that may lead to different experiences and outcomes for women and men are acknowledged?*
   a. Child, including infant, health.
   b. Adolescent health.
   c. Sexual and reproductive health.
   d. Health care and programs for people with disabilities.
   e. Mental health treatment and care.
   f. Neglected tropical diseases (where relevant).
   g. Gender-based violence.
6. Is the importance of gender norms, roles and relations reflected in plans for service design and delivery (both women and men)?
7. Are medical products and technologies selected with respect to:
   a. the health needs of different population groups?
   b. the different needs and circumstances of both women and men?

Demand side:

8. What are the main barriers in relation to access from the demand side?
   a. Cost of health services (official and unofficial).
   b. Opportunity costs.
   c. Transportation/food costs.

d. Health-seeking behaviour.
e. Socio-cultural factors.
f. Perception of the quality of care in public services.

9. What, if any, are the specific barriers for women in accessing health care services?
   a. Opportunity costs (e.g., household tasks, income generation).
   b. Travel and transportation.
   c. Decision-making in the household.
   d. Knowledge and education.
   e. Unavailability of specialised services for women (e.g., gender-based violence, obstetric care).
10. Are there strategies to ensure that health information is:
   a. available in local languages?
   b. available in 'simple' language?
   c. appropriate for cultures without a written language?
   d. accessible for the visual and hearing impaired?

Quality of services:

11. What do you consider are the main obstacles to providing good quality health care to patients?
   a. Lack of human resources (e.g., in rural areas).
   b. Lack of appropriate capacity and knowledge amongst health staff.
   c. Lack of equipment and technology.
   d. Working conditions of health staff.
   e. Low incentives to encourage health staff to work effectively as a public service.
   f. Attitude and behavior of health staff towards patients.
12. What, if any, incentives mechanisms promote and improve good quality health care? (e.g., contracting, SOA/SDG, incentive for midwifery)
13. Are specific measures to improve the quality of service provision identified? *Indicate in particular quality aspects of relevance for women.*
14. Is the right to privacy addressed in the delivery of health services?
15. Is capacity building of community health workers promoted?
16. Is in-service training addressed? If so, are the following areas addressed?
   a. Human rights.
   b. Gender equality.
   c. Cultural diversity.
17. Are the health needs of the following groups identified? Indicate if differences between women and men are not specified within the various groups, or if women are specified as a homogenous 'vulnerable' group.
   a. The elderly.
   b. People living with HIV, especially women.
   c. People living with physical, psycho-social or intellectual disabilities.
   d. Children, male and female.
   e. Adolescents.
18. Is there a difference in the utilisation of health care services between women and men (e.g., women tend to utilise health care services more at the HC level)?

Financial safety nets

19. What are the mechanism and processes to identify poor and vulnerable groups for access to financial safety nets? (pre-id and post-id)

20. What financial safety nets are being implemented in your health facility? (e.g., fee exemption, HEF, CBHI, vouchers, direct cash transfers)
21. What health-financing strategies exist that specifically target women?
22. Do you think that the poor and vulnerable groups are adequately protected from catastrophic health expenditure? If not, state why this is not the case?
23. To what extent do people in the community have knowledge about health financing schemes and their entitlements, especially regarding the poor?
24. Is there a difference between women and men in terms of knowledge and awareness of health-related financial safety nets and their utilisation?

Features necessary to make D&D processes in the health sector successful

25. What is the planning process for the development of annual operating plan? Who is involved and what is the procedure?
26. What activities are prioritised across the 3 health programs (MCH, CD and NCD)?
27. Who makes decisions on these priorities?
28. What is the management structure of the budget and how is the budget allocated to the 3 health programs?

Annex E: Questions for Health Care Providers

Section A: Background Information

(This section is for team records only. Names are to be removed from completed questionnaire to ensure confidentiality.)

Date of interview ---------- **dd/mm/yy**

Respondent Information

Name:

Position:

Contact information:

Sex of the respondent:

1=Male

2=Female

Site Information

Name of Province/District:	
Name of Health Centre:	

Type of Health Care Provider Interviewed:

Community health supervisor

Doctor

Vaccinator

Midwife

Other, specify:_____

Section B: Training and Professional Experience

1. What type(s) of professional training have you undertaken?
2. Have you received any training on the ways in which women and men of different ages become ill?
3 Have you received any training that focused specifically on the health problems affecting women and girls? On what did this training focus? *Leave this question open but use prompts if necessary.*
4. Have you received any training on the social determinants of health? *Prompts: education, ethnicity, age, poverty, sex*
   On what did this training focus? *Leave this as an open question but use prompts if necessary*
5. Did this training give you tools to deal with such health problems?
6. Have you found this training useful in your work?
7. Have you had opportunities to apply this training to your work?
8. Would you be interested in receiving such training?

Section C: Health Services and Health Provider Perceptions

1. What are registration procedures for patients? What information is required to be recorded? (e.g., age, sex, any complaints, sources of financing)
2. What factors can delay the timely provision of medical care? *Indicate all of the following that are applicable:*
   a. Lack of transport for patients to receive referral care.
   b. Lack of sterilised equipment.
   c. Absence of staff.
   d. Tiredness of staff.
   e. Lack of available resources.
   f. High number of tasks staff are required to perform.
   g. Lack of water.
   h. Lack of electricity.
   i. Other. Specify: _____
   j. Don't know/No response.
3. Does the health care facility have the capacity to address the health needs of different age groups? (e.g. the young, the elderly)
4. Do men and women have different health needs?
5. Does the health care facility have the capacity to address the different health needs of men and women?
6. Are you aware of certain population groups that are not using the health care facility? *Indicate all of the following that are applicable:*
   a. Elderly females.
   b. Elderly males.
   c. Working females.
   d. Working males.
   e. Specific ethnic groups.
   f. Other. Specify._____
   g. Don't know/no response.
7. Why might these population groups not be using the health care facility? *Indicate all of the following that are applicable:*
   a. Distance.
   b. Cost.
   c. Suspicion of health service.
   d. Preference for traditional healers.
   e. Lack of time.
   f. Lack of transport.

g. No-one to accompany them.
h. Concern that the treatment is not confidential.
i. Lack of trust in providers.
j. Other. Specify: _____
k. Don't know/no response.

8. Are these population groups using other health care providers (e.g., private doctors, NGO HCs, traditional healers, mid-wives)?
9. Are the operating hours of the health facility convenient to female and male patients?
10. In which quality factors is the hospital/clinic strong/weak? (e.g., well-trained staff, appropriate equipment, sufficient medicine, follow up procedures)
11. Are there social constraints or challenges in attending to patients with the following health complaints?

Health complaint	Constraints
Abortion	
Physical violence	
Rape	
Attempted suicide	
Depression	
Child neglect	

12. What percentage of patients use health equity funds or other types of social health funding?
13. What percentage of patients using HEF/other funds are male/female?

Annex F: Questionnaire for Commune Councils and District Women's Affairs

Name of Province/District/Women's Affairs/Commune Council Position(s) Date of Interview

Service delivery:

1. What are some of the main barriers to delivering effective and good quality health care to the people in your area (in particular in relation to rural and urban populations and vulnerable groups such as the poor, disabled, women, ethnic minorities)?
2. What are the main barriers related to access from the demand side?. *Indicate all that apply:*
   a. Cost of health services (official and unofficial).
   b. Opportunity costs.
   c. Transportation/food costs.
   d. Health seeking behaviour.
   e. Socio-cultural factors.
   f. Perception of the quality of care in public services.
3. Do you think that there is any specific barrier for women in accessing to health care services? *Indicate all that apply:*
   a. Opportunity costs (household tasks, income generation, etc.).
   b. Travel and transportation.
   c. Decision-making in the household.
   d. Knowledge and education.

e. Lack of availability of specialised services for women (e.g., gender-based violence, obstetric care).

4. Are there strategies to ensure that health information is:
   a. available in local languages?
   b. available in 'simple' language?
   c. appropriate for cultures without a written language?
   d. accessible for the visual and hearing impaired?

Quality of services:

5. What do you consider are the main obstacles in providing good quality health care to patients?
   a. Lack of human resources (e.g., in rural areas).
   b. Lack of appropriate capacity and knowledge amongst health staff.
   c. Lack of equipment and technology.
   d. Working conditions of health staff.
   e. Low incentives to encourage health staff to work effectively as a public service.
   f. Attitude and behaviour of health staff toward patients.
6. What incentive mechanisms can promote and improve good quality health care (e.g., contracting, SOA/SDG, incentives for midwifery)?
7. Are specific measures to improve the quality of service provision identified? *Especially regarding quality aspects of relevance for women.*
8. Are the health needs of the following groups identified? *Indicate if differences between women and men are not specified within the various groups or if women are specified as a homogenous 'vulnerable' group.*
   a. The elderly.
   b. People living with HIV, especially women.
   c. People living with physical, psycho-social or intellectual disabilities.
   d. Children, male and female.
   e. Adolescents.
9. Is there a difference in the utilisation of health care services between women and men (e.g., women tend to utilise services more at the health center level)?

Financial safety nets

10. What are the mechanism and processes to identify poor and vulnerable group for access to financial safety nets (pre-id and post-id)?
11. What financial safety nets are being implemented in your health facility (e.g., fee exemption, HEF, CBHI, vouchers, direct cash transfers)?
12. What health-financing strategies exist that specifically target women?
13. Do you think that the poor and vulnerable groups are adequately protected from catastrophic health expenditure? If not, state why this is not the case?
14. To what extent do people in the community have knowledge about health financing schemes and their entitlements, especially regarding the poor?
11. Is there a difference between men and women in terms of knowledge and awareness of health-related financial safety nets and their utilisation?

Features necessary to make D&D processes in health sector successful

12. What is the role of the women's department/commune council in the health sector (e.g., advocacy, demand for services, information dissemination)?
13. What are the main achievements of D&D reforms in the health sector?
14. What are the main challenges for D&D reforms (e.g., planning, budgeting, implementation)?

Annex G: Questions for Focus Group Discussions with Villagers on Access and Quality of Services and Experience of Financial Safety Nets

Gender Analysis Health Sector Mid Term Review

Access:

1. How much time does it take to reach the nearest health care facility from your village?
2. When you are visiting the health facility, who takes care of your children and performs your daily tasks at home?
3. When you visit the health facility, do you experience any of the following concerns due to the time spent away from your home? Indicate all that apply:
   a. Children left unsupervised/ uncared for.
   b. Family left alone/ unprotected.
   c. A loss of salary/payment for work.
   d. Household duties aren't completed.
   e. Income generating activities aren't completed.
   f. Other. *Specify:* _____
4. In your opinion, why would a woman not seek care for a health problem that is affecting her?
5. In your opinion, why would a man not seek care for a health problem that is affecting him?

Quality of services:

1. Which of the following features do you think are the most important for a health care facility to provide?:
   a. Short waiting hours.
   b. Affordable costs.
   c. Availability of various medicines.
   d. Availability of a male health care provider.
   e. Availability of a female health care provider.
   f. Convenient operating hours.
   g. A variety of health specialties.
   h. A laboratory on site.
   i. Other. Specify: _____
2. When you go to a health care provider, what is your most important expectation of the provider?
   a. He/She should listen carefully to patient.
   b. He/She should carefully explain the problem.
   c. He/She should explain how to prevent the illness.
   d. He/She should concentrate on solving the issue above all else.
   e. He/She should display a caring attitude.
   f. He/She should try to understand the needs of the patient.
   g. He/She should keep information confidential.
   h. He/She should provide adequate medicine.
   i. Other. Specify_____
3. Are there issues you would not discuss with a HCP?
   a. Mental health/depression.
   b. Family planning.
   c. Violent incidents.
   d. Unwanted pregnancy.
   e. Child neglect.

f. Sexually transmitted diseases.
g. Other sexual problems.
h. Drug abuse.
i. Other substance abuse.
j. Infertility/Reproductive disorders.
k. Other. Specify:_____

4. What types of providers do you consult first? *Indicate any differences between answers from men and women.*
   a. Doctors.
   b. Nurses.
   c. Private practitioners.
   d. Self-medication.
   e. Other. Specify:_____
5. Do you think that people sometimes give gifts or money to health workers in order to receive better treatment?

Financial safety nets:

1. How often do you visit the health facility how much do you pay for costs?
2. Are you aware of any financial assistance to help you with costs?
3. If you are aware of financial assistance, how/where did you hear about it?
4. Do you think financial assistance is difficult to obtain? Do you know who is eligible for financial assistance and how they can obtain it?

Annex H: Questionnaire for NGOs implementing HEF

1. What do you consider to be the barriers to access health service (both acute and chronic diseases) for people in this area, especially for the poor? *Indicate all that apply:*
   a. Distance.
   b. Costs.
   c. Social factors including mental/psychological factors.
   d. Information and uncertainty.
   e. Quality of service.
   f. User fees.
   g. Interaction between providers and patients (for acute disease versus chronic disease).
   h. Other. *Specify:*_____
2. What are the greatest problems or challenges for women and men who are in need of health services? How common are these problems? What strategies do women and men use to overcome these challenges?
3. What is the mechanism for identifying people who receive exemptions, and why is this approach used? How has this approach evolved over time?
4. What is the core target population identified for HEF beneficiaries? (e.g., the poor, women, children)
5. What does the exemption pay for (e.g., hospitalisation, transport, food)? Are the payments full or partial?
6. Do you think that health care providers cooperate effectively with you? Do they provide a fair and high-quality service to HEF beneficiaries?
7. Do you think that all the poor have access to free health care? If not, who is being excluded? Who should not be included? (e.g., the poor, women and children)?
8. Do you think that existing schemes such as CBHI and SOA helped to increase people's access to public health services? Why/Why not?

9. What kinds of diseases are not covered by HEF? Why are these diseases not covered?
10. To what extent do you think HEF can help protect poor people from catastrophic health expenditures?
11. What needs to be done in order to extend access to CBHI to more potential clients in this area? What actions would you take in this regard if you could?
12. What, in your opinion, would be the best way to ensure all different groups of people, especially poor women, get access to available health services, particularly reproductive health services?

Questionnaire for NGO implementing CBHI

1. What do you consider to be the barriers to access acute service (as apposed to access chronic care) for people in this area, especially for the poor?
   a. Distance.
   b. Costs.
   c. Social factors including mental/psychological factors.
   d. Information and uncertainty.
   e. Quality of service.
   f. User fees.
   g. Interaction between providers and patients.
   h. Other. *Specify:*_____
2. What are the greatest problems or challenges for women and men who are in need of health services? How common are these problems? What strategies do women and men use to overcome these challenges?
3. What is the core target population identified as CBHI beneficiaries (e.g., the poor, women, children)?
4. What are the mechanism(s) for identifying CBHI beneficiaries and for marketing the CBHI scheme? Why are this approach/these approaches used?
5. To what extent do people understand about CBHI?
6. Are CBHI cards provided to CBHI beneficiaries?
7. Do you think that all the poor have access to free health care? If not, who is being left out? Who should not be included?
8. Is the benefit package of CBHI designed for the specific health needs of particular groups of people (e.g., the poor, women and children)?
9. How is the payment to facilities by CBHI fund holders arranged?
10. What does the CBHI pay for (e.g., outpatient, inpatient, transport, food)? Are the payments full or partial?
11. What is the level of premiums paid by CBHI beneficiaries?
12. Are premium payments subsidised in any way by any other group or organisation?
13. What kinds of diseases are not be covered by CBHI? Why are these diseases not covered?
14. To what extent do you think HEF can help protect poor people from catastrophic health expenditures?
15. What needs to be done in order to extend access to CBHI to more potential clients in this area? What actions would you take in this regard if you could?
16. What, in your opinion, would be the best way to ensure all different groups of people, especially poor women, get access to available health services, particularly reproductive health services?

Annex I: Terms of Reference, Gender Analysis of Health Sector in Cambodia

1. Background

Gender equity as a principle and gender mainstreaming as a process have been officially adopted by the Royal Government of Cambodia and by all multi- and bi-lateral donors offering technical and financial assistance to the Government. However, practice falls short of rhetoric during implementation..The reasons for this gap should be central concerns of this Gender Analysis.

Globally, the issue of maternal and infant mortality was given particular prominence at the UN's Millennium Development Goals Summit in 2010, with States seeking to address this 'savage inequality', and to ensure that no effort be spared in the achievement of Goals 4 and 5 in the years to 2015. The UN Secretary General launched the Global Strategy for Women's and Children's Health which aims to save the lives of 16 million mothers and children globally by 2015. Commitments of up to $40 billion have already been made by governments and private aid agencies. A new five-year alliance has been formed between the aid agencies of the USA, UK, Australia, and the Bill and Melinda Gates Foundation, which seeks to improve access to family planning, and reduce maternal and neo-natal deaths. It is targeted to reach approximately 100 million women before 2015. Australia has pledged $1.6 billion and the Gates' Foundation's has pledged $1.5 billion to promote women and children's health over the next 5 years.

Cambodia has some of the weakest health indicators in the region, though life expectancy and some health outcomes are improving. Information on the difference in disease burden between males and females is scarce because, while health information at the lower levels is disaggregated by sex, most national level data is presented in aggregate form. Cambodia has incorporated the MDGs into all its national policies, and this Gender Assessment is concerned particularly with Goals 3, 4, 5 and 6.

While the CDHS 2005 confirmed that progress had been made in some reproductive health indicators since 2000, **maternal mortality rates (MMR)** were unacceptably high at 472 per 100,000 live births and had not improved since 2000. The MOH seeks to address this issue by training more midwives, and the proportion of married women with two or more ANC consultations with skilled health personnel doubled between 2000 and 2005. However, many of the targets set for 2005 were not met, in contrast to excellent results in reducing child mortality. The Health Sector Review (2003-2007) addresses these issues in depth. While there has been steady progress in the contraceptive prevalence rate (CPR), demand remains high at 25% and abortion is increasing, with unsafe abortions being a key contributor to maternal mortality. Both the level of unmet need for family planning and the total fertility rate (TFR) vary significantly by location, education level and income. The latest data from the CDHS of 2010 are vital to updating these results and establishing trends over the decade.

Historically, **health policies** have focused on administrative- and system-based considerations. With the RGC's more recent policies of decentralisation and de-concentration (D&D), an increased focus on service delivery is required. The Health Strategic Plan 2008-2015 reflects a struggle to adjust mindsets to this new functional context. While MMR and IMR are given priority, there is frequent mention of a lack of **demand for services.** At the same time, research conducted by MOH in 2006 and analysis in 2008 by MOWA using 2005 data reveals 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 are present. At the same time, women use health services significantly more than men (70% for health centres and 58% for referral hospitals). This gender bias is more pronounced in urban than in rural areas, and during reproductive years (15-45).

The costs of travel and unofficial payments to health centre and hospital staff are serious barriers to accessing health care. The MOH has sought to address the problem of costs by introducing **Health Equity Funds, Social Health Insurance and Community-Based Health Insurance.** This Gender Analysis should seek evidence of knowledge and use of these funds and whether or not they are adequately addressing problems of access. Note should be taken of the effects of the global financial crisis (GFC) since 2007and its effects on spending on health care for various family members, from the very young to the elderly.

The concern for demand for services has not been tied to a **public health focus** in the Health Strategic Plan. Since the distance from a Health Centre may be as much as 10 km or a two hour walk, outreach services and community-based models of care may have to be given greater attention and more adequately resourced. Here the involvement of local authorities and the Women's and Children's Consultative Committees, and existing Volunteer Health Workers (usually women) and Voluntary Health Support Groups are critical mechanisms and their use need not wait for the

roll-out of D&D policies. However, the resourcing of these mechanisms is an issue and innovative grassroots approaches including those used internationally should be explored.

A number of public health issues need to be addressed in the domestic sphere, which is traditionally a female domain. **Feeding practices** of babies and young children appear to meet minimum international standards yet stunting and wasting are still issues affecting the health of children. There were some indications from UNICEF research that during the GFC the nutrition of women and girls suffered more than that of men and boys. Overall levels of iron deficiency **anaemia** remain high with slightly more boys than girls being anaemic, though this changes with maturity and is a contributor to high MMR and low birth weight babies. While these are issues of poverty, they also reflect a lack of knowledge about good nutritional practices including those relating to the foods available to poor people.

Diarrheal disease remains a significant, preventable cause of illness and mortality, especially in babies and children under five years of age. Water, and especially sanitation and hygiene, have been identified as major causes of these deaths. Women's and children's represent obvious target groups for improving understanding of the efficacy of good domestic hygiene practices, and provision of potable water and improved sanitation and hygiene practices are important, especially in rural areas.

Curbing incidences of **preventable diseases such as malaria and dengue** in Cambodia also relates to the realm of women's work in the domestic sphere, though preventive measures would be strengthened by involving men as well. Universal distribution and use of insecticide-treated bed nets and the elimination of mosquito breeding places around houses could make a significant contribution to controlling these diseases. MOH may see these actions as outside its area of responsibility and defer to the Ministry of Rural Affairs, however MOH has to deal with the health outcomes and the associated costs of the failure in ensuring good public health. This raises the question of how effective Sector-wide Approaches (SWAps) and Sector Wide Management (SWiM) are in practice.

The Cambodian National AIDS Authority (NAA) and the National Center for HIV/AIDS, Dermatology & Sexually Transmitted Diseases (NCHADS) has enjoyed significant success in reducing the incidence of **HIV/AIDS,** making Cambodia one of the few countries in the world to achieve its MDG target. The NAA has now turned its attention to drug users and MSM. However, there has been a sharp increase in prevalence rates among low-risk heterosexual women. This relates to many married men's recourse to prostitutes and to their unwillingness to use condoms. For women of reproductive age, the risk is doubled by the likelihood of mother-to-child infection. Furthermore, the burden of care falls most heavily on women and girls, reducing their ability to contribute in other ways to the family's economic and social welfare and compromising the education of girls.

With more than 60% of the population below the age of 25, and 35.6% between 10 and 24 years of age, risk-taking behaviour of **young people,** especially young males is a major concern. Young women appear to have better awareness and knowledge of HIV/AIDS and condom availability than young men. More young men than young women are likely to be injured or die in **accidents,** especially road accidents. **Drug use** is also predominantly an issue for male youth though women in the entertainment industries are also vulnerable. For both groups, drug use leads to unsafe sex and the transmission of serious diseases, violent behaviour and crime.

With the predominance of young people in the population profile, little attention has been given to the health concerns and well-being of the **elderly.** The same is true of people with **disabilities,** including victims of land mines. This may be because the latter group is the responsibility of the Ministry of Social and Veterans' Affairs and Youth Rehabilitation (MOSAVY) rather that the MOH. The MOH has recognised that some of the most important health challenges to be faced in the near future are cross-sectoral issues that lie outside the official mandate of the MOH. These include traffic safety, domestic violence, water and sanitation, public hygiene, education/public awareness, environmental health, and concerns about the elderly and people with disabilities.

Pre-pandemic preparation has emerged in recent times as an issue for both MOH and donors, with threats posed, for example, by avian influenza. More than 70% of emerging diseases are transmittable from animals to humans. Preventing the spread of zoonotic diseases to the human population requires addressing the disease at its animal source. Both the regional and the Cambodian strategies for dealing with these diseases are gender-blind, yet in the case of avian influenza the household members who are responsible for fowl are women and children. Any strategy that ignores this fact is in danger of being sub-optimal. Furthermore, any compensation and new stock (and information on the care of animals) may not be given to the right target groups. Once again this is a cross-sectoral issue, highlighting the need for an inquiry into whether the existing cross-sectoral mechanisms are adequate for addressing these issues.

The **Gender Mainstreaming Action Group** (GMAG) in the MOH was established in 2005 and prepared its Gender Mainstreaming Action Plan (GMAP) in 2006. Although two of its five objectives concern the engendering of health policies and monitoring the outcomes, the Plan and its activities give particular attention to sensitisation and training in gender issues and to human resource issues that limit female employees' participation and decision-making within the Ministry. A report on the assistance given to GMAG and a Gender Assessment of the MOH conducted in 2007 and 2008 make recommendations to improve the performance towards greater gender mainstreaming. This Gender Analysis should help GMAG to update its Plan and help it to be more strategic in mainstreaming gender in policies and programs.

The **Ministry of Economy and Finance** (MEF) is responsible for the Public Financial Management reform process of the RGC. At senior levels it has always been sympathetic to the concept of gender-responsive budgeting, but it is not clear how deeply this is understood at the operational level. However GMAGs of some ministries have succeeded in accessing the national budget when they have shown that their GMAPs have been integrated into their ministries' Annual Operational Plans (AOP). MOH is one of the ministries which has achieved this goal, though the precise effect of this is not known. MEF has recently launched a Five Year Strategic Plan for Gender Mainstreaming in Public Finance 2008-2012 which should facilitate further steps in this direction.

Donors involved in providing technical and /or financial assistance to MOH include WHO, UNICEF, JICA, USAID, and the Health Sector Support Project (funded by AusAID, Asian Development Bank (ADB), and UNFPA, USAID, and the World Bank). GMAG receives assistance from UNFPA.

2. Objectives of the assignment

In the context of the Mid-Term Review (MTR) of the Health Strategic Plan 2008-2015, the MOH with support from its donor partners, proposes to undertake a Gender Analysis of the Health Sector Program in Cambodia. AusAID is the lead donor in this project. This Analysis will be undertaken in two stages:

2.1 Stage 1: (Jan-March 2011) To contribute to the MTR of the Health Sector by determining to extent to which gender is mainstreamed in the Sector's policies and programs and whether or not these policies are realised at the implementation stage, thus resulting in closing the gap between the health outcomes for women and men, girls and boys. The analysis should determine whether the policies and programs:

2.1.1 Are achieving the targets set in the HSP2 and the CMDGs (especially Goals 3,4,5 and 6) and assess whether the Health Information System is providing data sets, in particular sex disaggregated data, so that progress can be adequately monitored and negative attitudes and behaviour identified;

2.1.2 Ensure delivery of services that are adequately supported by infrastructure and assess the implications of the D&D policies of the RGC;

2.1.3 Are adequately supported by the budget, which is responsive to the needs of both females and males and to people's access to safety net funding arrangements;

2.1.4 Are implemented by staff who fully understand gender concepts and who address the barriers to access to services.

2.2 Stage 2: (tentatively April - August 2011) A more comprehensive analysis will be conducted in conjunction with the MTR and using the data made available from the CDHS conducted in 2010. It will include topics that have not been covered in Stage 1 (Separate TORs to be developed).

3. Scope of the assignment

The research team will undertake the following tasks:

3.1 Review relevant MOH, MEF, MOWA and donor documentation assessing the degree of alignment between official policies and gender priorities and highlight key issues and lessons learned 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;

3.2 Analyse the health outcomes for men and women, boys and girls, and the extent to which targets have or have not been met;

3.3 Consider conducting a Gender Audit using existing generic models, modified to suit the specific conditions in Cambodia and in light of the desk review in 3.1;

3.4 Consult with key stakeholders including MOH, MEF and MOWA staff in the capital and in three disparate provinces, including local, provincial, district and commune councillors, donors, and NGOs with a particular focus on access issues (supply and demand), the quality of services, use of financial safety nets, and the features necessary to make D&D processes in the Health Sector successful;

3.5 Utilisation of health facilities by women and men, girls and boys and identification of any community initiatives taken to overcome traditional barriers to access;

3.6 Analysis of health sector expenditures by the RGC (including donor funding) and the extent to which these have been adequately targeted to addressing the health needs of women and girls;

3.7 Identify the sex profile of employees of the MOH at all levels and determine whether this has implications for current policy commitments;

3.8 Assess pre-service and in-service training, addressing gender issues and whether staff believe they have sufficient understanding by which they can incorporate these issues into health sector policy and its implementation;

3.9 Draft a report (maximum of 30 pages excluding annexes) analysing major findings and providing clear actionable recommendations for inclusion in the conduct of the MTR design and in the MTR report.

4. Duration and Phasing (Indicative)

ACTIVITY	INDICATIVE TIMEFRAME	Days
Team members contracted. Team Leader involved in selection of support staff	By mid-January 2011	-
Briefing, design and planning meeting of Team. Designation of roles	15 January	1
Review of documents Decisions on list of interviewees and provinces, districts and communes to be visited	16 – 31 January	5
Meeting with Stakeholders' Reference Group to outline approach and present preliminary analysis of data from desk study	1 February 2011	1
Data collection via group and individual interviews	1 -26 February	19
Analysis of data and drafting of report	28 Feb – 19 March	15
Presentation to Cambodian National Women's Conference	Final week in March	1
Presentation of findings and recommendations to Stakeholders' Reference Group	31 March	2
Team final in-country meeting to incorporate feed-back and amendments	1 April	1
Final draft report to AusAID for Peer Review	4 April	1
Incorporate changes	12 April	1
Final Report to AusAID	13 April	
	TOTAL INPUT DAYS	47

5. Specifications for the team

The team will be composed of the following five core members. Roles of each team member are as follows:

5.1 Team Leader/Gender Specialist (TL/G)

- Lead the team and have overall responsibility for the analysis and drafting of the report, ensuring consistency with AusAID and overall MTR requirements
- Responsible for providing expert gender analysis to the Team and developing its capacity where necessary
- Prepare and draft the report and ensure input from this Gender Analysis into the MTR in consultation with other members of the team

- Joint presentation of the report to stakeholders and AusAID in-country
- Ensure the Terms of Reference and contractual obligations are met and the outputs are of high quality (i.e. meet AusAID policies and MTR requirements, quality principles, and documentary standards), incorporating comments from AusAID, and other reviewers when appropriate and submit a final document to AusAID and MOH, MEF and MOWA within the required timeframe
- Have at least six years experience in policy analysis and gender issues
- Have excellent leadership and communication skills

5.2 Senior Researcher

- Share with the TL/G the responsibilities for conduct of the research, analysis and drafting of reports
- Contribute to the drafting of the reports and their presentation to stakeholders
- Have at least five years experience in policy analysis and gender issues
- Have excellent leadership and communication skills

5.3 National Assistant/Translator

- Have a deep knowledge of the country context, system of government and institutions
- Excellent command of English and Khmer
- In consultation with the TL/G, make appointments, arrange consultative meetings, logistics and other administrative arrangements
- Provide written contributions and verbal advice as required

5.4 MOH/GMAG Member

- Provide input on technical, gender and health issues
- Provide verbal and written contributions to the analysis as required
- Good English language skills

5.5 MOWA Member

- Provide input on technical and gender issues
- Provide verbal and written contributions to the analysis as required
- Good English language skills

5.6 AusAID Member??

- Provide input on program management issues as they relate to AusAID's quality framework, ensuring that proposed initiative activities represent value-for-money and have adequately addressed AusAID's overarching policies
- Provide written contributions to the design document as required
- Coordinate internal AusAID quality processes.

6. Reporting

The Gender Analysis document should be no more than 30 pages (exclusive of Annexes). It should contain enough data and detail to enable an appraisal to be made with limited reference to material in Annexes.

Key report submission dates are as follows:

- **1 February 2011:** Present preliminary analysis of data from desk study (electronic and hard copy) to AusAID and other Stakeholders' Reference Group
- **Last week of March 2011:** Presentation to National Conference of Cambodian Women (electronic and hard copy)
- **31 March 2011:** Presentation of findings and recommendations to Stakeholders' Reference Group
- **4 April 2011:** Submission (electronic copy) for Peer Review
- **13 April 2011:** Submission (electronic and hard copy) of final document

7. Reference documents

a. RGC; Rectangular Strategy II (2008 to 2013?)
b. MOH; Second National Health Strategic Plan (HSP2) 2008-2015
c. MOWA; A Fair Share for Women. Cambodia Gender Assessment 2008
d. MOP; Cambodia Millennium Development Goals Report 2010
e. MOP; Cambodia Census 2008
f. MOP; Cambodia Social and Economic Survey 2009?
g. HLSP; Health Sector Review Cambodia (2003-2007)
h. UN Global Strategy for Women's and Children's Health 2010
i. MEF; Five Year Strategic Plan for Gender Mainstreaming in Public Finance 2008-2012
j. WHO documents
k. MOH; Obstacles to Deliveries by Trained Health Providers Study, 2006
l. UNDP; Regional Human Development Report on Gender, Power, Voice and Rights, 2010
m. HIV/AIDS reports
n. Reviews and assessments being conducted in association with the MTR

AusAID References:

a) AusGuidelines
b) Others ??

Annex: J Gender Analysis Research Report Recommendations Accepted by MoH

Source: MoH HSSP Task Force Teams—30 September 2011 Validation Workshop of Gender Analysis Research Results, Phnom Penh Hotel, Cambodia.

Explanation of Annex Table: The Ministry of Health organized a validation workshop for the Gender Analysis of the Cambodian Health Sector Research Results in which the reports main findings and recommendations across the five systems and three program areas of the Ministry of Health were presented to health sector stakeholders, including development partners.

Break out groups of the MoH strategic review task force for program areas reviewed the results and recommendations of the Gender Analysis study and then presented their findings to the plenary. They were asked to: 1. Assess whether Main Results are accurate and relevant; 2. Assess Recommendations for HSP2 Phase II implementation and propose indicators for monitoring their implementation 3.Report on issues where there is no consensus. Ensure that differing viewpoints are represented.

The Communicable Disease Task Force did not present their findings back in written form to the plenary workshop. Request for this document subsequent to the workshop for inclusion in this annex was received by the MoH and the response was to go ahead with the submission of this report minus this task force result from the CD task force.

1. RMNCH Task Force: Presenter: Dr. Tung Ratheavy, Ministry of Health

Gender Analysis Research Report Recommendations; RMNCH Task Force Response	Level of Importance				Proposed Indicator
	Very High	Medium	Low	Not Important	
Moving Policy on Infant and Young Child Feeding Practices from gender blind to gender sensitive		x			Assess to be Gender sensitive according to WHO Gender Responsive Assessment Scale
Include statement on importance of male awareness and support for importance of feeding practices for infants and young children		x			Assess to be Gender sensitive according to WHO Gender Responsive Assessment Scale
Analysis should address differences in feeding practices by education, urban/rural, wealth ratios	x				Conduct secondary data analysis of CDHS 2010 and Qualitative analysis on IYCF
Strengthen referral system for EmOC	x				
Develop response system for reproductive health needs of young unmarried males and females with consideration for migrants and factory workers					
Develop gender responsive guidelines and include in the new 5 year Strategic Plan	x				
Develop clear strategy for male involvement in reproductive health	x				
Strengthen public health service delivery for abortion	x				
Service Delivery: High quality, comprehensive services including a 24 hour obstetric and emergency response capacity at HC levels should expand	x				
Service Delivery: Address acute shortages of secondary mid-wives and other female health staff through deployment in remote areas	x				
Health Care Financing: Moving Strategic Financing Framework to gender responsive and increasing its gender content.	x				
Health Care Financing: Develop action plan in collaboration with GMAG and other relevant partners outside MoH to implement Component 3: Equity and Gender perspectives in health financing	x				
Health Care Financing: Demand Side financial barriers at MPA and CPA levels require harmonized strategic response in policy and health financing	x				

Human Resources for Health Moving Health Workforce Development Plan (2010) from gender blind to gender sensitive	x				
Health Information Systems Moving Health Information Systems plan from gender sensitive to gender responsive	x				
Health Sector Governance Moving National Policy for Quality in Health from gender blind to gender sensitive	x				
Health Sector Governance Moving Guidelines for Implementation of Health Equity Funds/ Government Subsidy Schemes from gender sensitive to gende responsive	x				

Task Force Discussion on Specific Gender Analysis Research Report Issues	Different Views	Comments
Non-program vs program budget	None	Agree with findings extremely important because need to track Impact and effectiveness
Response system for young migrants and factory workers	Somewhat	Problematic because of itinerant nature of population; other sectorsDPs looking after this, eg. Ministry of Labour and ILO better factors with clinics in the factories.

2. Non Communicable Disease Task Force, Ministry of Health

Gender Analysis Research Report Recommendations; NCD Task Force Response	Level of Importance				Proposed Indicator
	Very High	Medium	Low	Not Important	
Include gender dimensions in vision, goal and guiding principles for NCDs		x			
Statement on recognition of the differential aspects of health quality improvement for women, men, girls and boys.		x			
Develop capacity for gender analysis in policy development and program implementation		x			
Chronic disease reporting from HC should disaggregate data by sex and age				x	
Service Delivery: High quality, comprehensive services including a 24 hour obstetric and emergency response capacity at HC levels should expand	x				
Service Delivery: Address acute shortages of secondary midwives and other female health staff through deployment in remote areas	x				
Health Care Financing: Moving Strategic Financing Framework to gender responsive and increasing its gender content.					
Health Care Financing: Develop action plan in collaboration with GMAG and other relevant partners outside MoH to implement Component 3: Equity and Gender perspectives in health financing					
Health Care Financing: Demand Side financial barriers at MPA and CPA levels require harmonized strategic response in policy and health financing	x				

On which Issues are there Strongly Differing Views? None reported.