



HEALTH

GENDER AND HEALTH

CAMBODIA GENDER ASSESSMENT

Cover photo:

Dr. Keo Mao, Maternal Health Doctor (49): A doctor for over 20 years, Dr. Keo Mao received her qualifications in Cambodia. She works in maternal health, because she wants to improve the lives of women.



5. HEALTH

GENDER AND HEALTH

POLICY CONTEXT

Cambodia's health sector strategy is designed to improve maternal and child health, and expand the right to health care services, especially among poor and vulnerable people, through the Health Equity Funds and better targeted services for women requiring reproductive health services.

The second National Strategy for Reproductive and Sexual Health 2013-2016 is guided by the principle of gender-responsive and equitable access to health services for all Cambodians. Its three objectives are: increase reproductive and sexual health services; improve reproductive and sexual health services through strengthened delivery and governance processes; and improve reproductive and sexual health information management as part of a strengthened health information system.

FINDINGS

Gender responsive health care

Gender norms and roles affect women and men, girls and boys, their access to 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 policies, guidelines and budgets to plan appropriate health interventions for all.



Gender-related issues in the health system

The disadvantaged position of women in society affects their health status because “women’s social, economic and political status undermines their ability to protect and promote their own physical, emotional and mental health, including their effective use of health information and services”¹.


As health institutions reflect wider socio-political patterns of discrimination, gender mainstreaming policies and processes are vital to identify and respond to health system gaps in addressing the particular health needs of all people.

Best practices of integrating gendered approaches to public health

The Royal Government of Cambodia has aligned national policy commitments to gender equity, which is integrated into its National

▲ All health services need to consider gender issues.

¹ World Health Organization (2002a) *Gender Analysis in Health: a Review of Selected Tools*. Department of Gender and Women’s Health, Geneva, Switzerland.



Strategic Development Plan, the Cambodia Millennium Development Goals, and at sub-national level with the Law on the Administration of Communes and Cambodia's Strategic Framework for Decentralization and De-Concentration Reform, 2005.

Integrating gendered approaches into public health requires political commitment from the highest levels to ensure that women's and men's health concerns and experiences are an integral part of the design, implementation, monitoring and evaluation of the health sector's strategic areas. The ultimate goal is to achieve gender equality².

Best practices of integrating gendered approaches to the public health system are multi-sectoral, incorporating the national policy principle of gender equity into institutional operations, such as human resource development, information and finance systems and the program and service provision components of health care.

The Gender Analysis Report in the Health Sector in Cambodia³ shows that the National Strategy for Reproductive and Sexual Health 2006-2010 and the National Strategy for Comprehensive and Multi-Sectoral Response to HIV/AIDS 2006-2010 are a good basis for gender-responsive policy development; however, there are still a number of policies that are not gender-responsive, such as the Health Work Force Development Plan 2006-2015, the National Policy for Quality in Health (2005), the National Policy on Infant and Young Child Feeding Practices (2002) and the National Strategy for Non-Communicable Diseases 2007-2010. Some other policies are gender-sensitive only in their vision and mission statements, but there are few gender-related details in their description of programs and strategic objectives (e.g. the Policy on Community Participation 2008, the Health Sector Strategic Plan II, the Strategic Framework for Health Financing 2008-2015, the Guidelines for the Implementation of the Equity Fund 2008, the Health Information System Strategic Plan 2008-2015, and the Cambodia Child Survival Strategy 2006).

Achievements and Challenges

Decreasing Maternal Mortality Rate

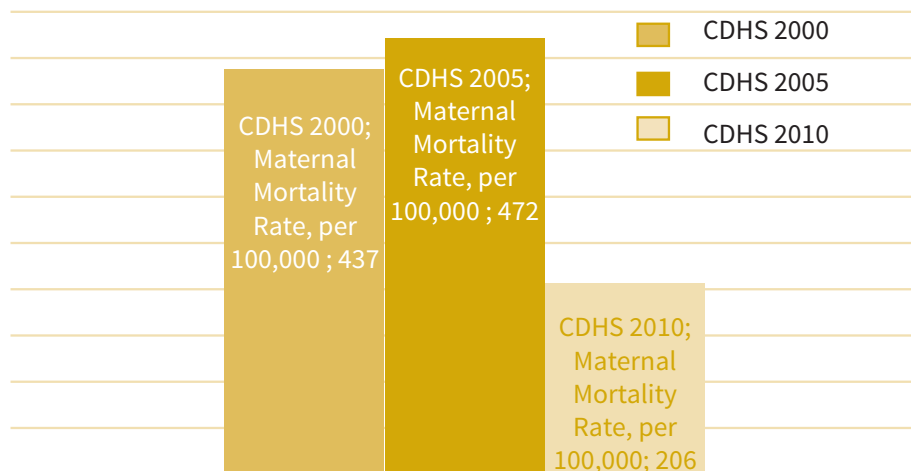
The Maternal Mortality Rate decreased by more than half, from 472 per 100,000 live births in 2005 to 206 per 100,000 live births in 2010⁴.

² World Health Organization (2011) *Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence*. (With SIDA and United Nations Human Rights). Geneva, Switzerland.

³ Frieson, Kate Grace, Men Chhean Rithy, et al. (2011) *A Gender Analysis of the Cambodian Health Sector*. AusAID, Phnom Penh, Cambodia.

⁴ National Institute of Statistics, Ministry of Planning, Directorate General for Health, Ministry of Health (2010)

Figure 1: Maternal Mortality Rate 2000-2010



Source: CDHS, 2010.

Access to maternal health care has improved substantially over the past five years. Among pregnant women in 2011, 86 percent received Antenatal Care (ANC) at least twice, an increase from 80 percent in 2010. According to the report, *Assessing Trends in Inequalities in Maternal and Child Health and Health Care in Cambodia*⁵, the percentage of poorest pregnant women with at least four ANC visits increased from 2.9 percent in 2000 to 42.8 percent in 2010. For those in the wealthiest quintile, the percentage increased from 31.4 percent in 2000 to 82.5 percent in 2010, indicating remarkable efforts and progress in the provision of health care services without discrimination. However, equity gaps persist, as poverty is preventing pregnant women from accessing continuum of care and follow-up visits.

More than half of all babies are now delivered in health facilities, which is more than double the 2005 rate, from 22 percent in 2005 to 54 percent in 2010. The percentage of deliveries by a skilled provider, usually a Ministry of Health (MoH) trained midwife, has also more than doubled over the decade and was recorded at 71 percent in 2010, up from 32 percent in 2000 and from 44 percent in 2005.

These positive trends are set to continue due to the expansion of health service centres, especially in rural areas, continued outreach and education by village health workers in rural areas on the importance and affordable cost of birth in a

Cambodia Demographic and Health Survey. Phnom Penh, Cambodia.

⁵ Wang, Wenjuan (2013) *Assessing Trends in Inequalities in Maternal and Child Health and Health Care in Cambodia*. DHS Further Analysis Reports No. 86. Calverton, Maryland, USA: ICF International.



health care facility, and investment by MoH in training additional midwives.

Comparable data from the 2000, 2005 and 2010 CDHS indicate that in 2000, 31 percent of women in the wealthiest quintile made four or more antenatal visits, as recommended by the World Health Organization, compared with 3 percent of women from the poorest households. In 2010, both groups had substantially higher proportions of women making four or more visits (43 percent of the poorest and 83 percent of the wealthiest), while the ratio between them fell from 10.8 in 2000 to 1.9 in 2010.

Issues that remain outstanding in further reducing the numbers include a shortage of qualified care providers in remote areas, lack of drugs and poor equipment at facilities, and poor health-seeking practices of women due to socio-cultural and economic factors⁶.

In 2012, some 73 percent of all health centres had skilled and qualified secondary midwives, although the main challenges are recruitment to most remote rural health centres and providing adequate supervision to maintain quality of care⁷.

Slow progress on nutrition for women and children

Indicators related to nutrition for women and children in Cambodia in 2000, 2005 and 2010 (in %)

Indicators	CDHS 2000	CDHS 2005	CDHS 2010
Low birth weight		25	11
Early initiation of breastfeeding (during the first hour after birth)	11	35.1	65.2
Exclusive breastfeeding <6 months	11.4	60	73.5
Stunting	49.7	43.2	40
Underweight children	38.4	28.2	28.3
Wasting	16.8	8.4	11
Infants from 1-5 years old receiving Vitamin A supplementation	28.5	34.5	70.9
Iodized salt consumption	12	73	83

Source: CDHS 2000, 2005 and 2010

⁶ Frieson, Kate Grace, Men Chhean Rithy, et al. (2011) *A Gender Analysis of the Cambodian Health Sector*. AusAID, Phnom Penh, Cambodia.

⁷ Ministry of Health (2013) *National Strategy for Reproductive Health and Sexual Health in Cambodia, 2013-2016*. Phnom Penh, Cambodia.



Women's Nutrition

▲ One in five women is malnourished.

The high prevalence of low body mass index in women did not change significantly between 2000 and 2010, as one in five women are undernourished, and 6 percent of women are shorter than 145 cm, indicating that they were malnourished as children. The CDHS 2000 showed 20.7 percent of women aged 15-49 were undernourished; this declined slightly to 19.1 percent in 2010⁸. Women's malnutrition is correlated with maternal mortality, premature birth, low birth weight and child malnutrition.

Anaemia in women, which is an underlying cause of maternal deaths and low birth weight, reduced slightly from 46.6 percent in 2005 to 44.4 percent in 2010⁹.

⁸ National Institute of Statistics, Ministry of Planning, Directorate General for Health, Ministry of Health (2010) *Cambodia Demographic and Health Survey*. Phnom Penh, Cambodia.

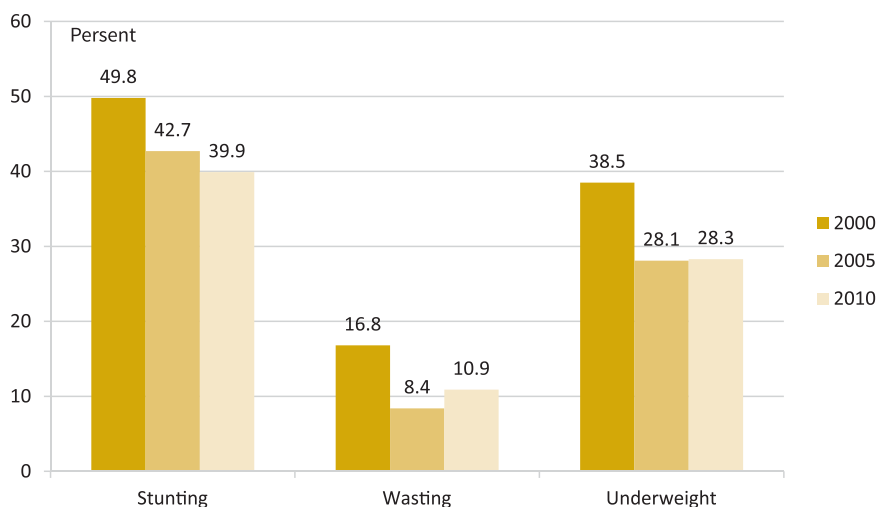
⁹ Ibid.

Child Nutrition

The trend in child nutritional status showed significant progress between 2000 and 2005, but there has been no improvement since then.

Children's malnutrition results in stunting (low height for age), wasting (low weight for height) and underweight (low weight for age). Each of these, in combination or in isolation, can affect physical and mental agility.

Figure 2: Trends in malnutrition among all children <5 years




Based on WHO Child Growth Standards

Stunting reduced from 50 percent in 2000 to 40 percent in 2010. Wasting decreased from 17 percent in 2000 to 8 percent in 2005 and slightly increased to 11 percent in 2010. Underweight rates decreased from 39 percent in 2000 to 28 percent in 2010¹⁰. Fifty five percent of children under the age of five are anaemic. There is very little gender difference in nutritional status in children.

There were significant increases in the number of children receiving Vitamin A supplementation, from 28.5 percent in 2000 to 70.9 percent in 2010, however children who do not receive Vitamin A supplements are at greater risk of disease, blindness and death.

¹⁰ National Institute of Statistics, Ministry of Planning, Directorate General for Health, Ministry of Health (2010) *Cambodia Demographic and Health Survey*. Phnom Penh, Cambodia.



Nutritional outcomes are adversely affected by lack of access to clean water and toilets. Some 51 percent of national households have access to improved drinking water (81 percent urban and 43 percent rural) and 44 percent have improved toilets (87 percent urban and 33 percent rural). The urban/rural divide in access to hygiene and water consumption and use will continue to adversely affect those living in rural areas unless substantial investments are made, especially in remote and very poor areas of the countryside.

Health and gender-based violence

While domestic and gender-based violence is widespread in Cambodian society, affecting all socio-economic classes, recent research studies have identified some populations as more vulnerable, including “women with disabilities, women living with HIV, lesbian, bisexual and transgender (LBT) women, sex workers, entertainment workers, garment factory workers and other female workers, women who use drugs or with partners who use drugs, women in prisons, elderly women, indigenous women and women from religious or ethnic minorities”¹¹.

Sexual and gender-based violence in the workplace is still a concern, especially among vulnerable populations of young women working in the service and tourism industry where tight clothing and alcohol sales to national and foreign males is part of the packaging of products. Some “54% of female beer promotion workers reported sexual harassment and physical abuse”¹², and “more than 70% of freelance sex workers reported having been gang raped”¹³.

The health consequences of gender-based violence can be categorized as either physical, mental and behavioural, as well as sexual and reproductive.

Access to medical care, psychosocial and other types of counselling services is hampered by the following challenges¹⁴:

- Inconsistent levels of services for survivors;
- Lack of access to safe shelter for most women in Cambodia (shelters are primarily in urban settings);
- Local authorities’ lack skills in providing safe, survivor-centred interventions;

¹¹ Ministry of Women’s Affairs (2014) *National Action Plan on Violence against Women (NAPVAW) II*. Phnom Penh, Cambodia.

¹² CARE International (2006) Report on the Situation of Beer Promotion Women in the Workplace. Phnom Penh. CARE International.

¹³ Nakagawa, K. (2005) Sex Workers on the Street - Living with Violence. Phnom Penh. Violence Against Women and Children in Cambodia.

¹⁴ Ministry of Women’s Affairs (2012) Feasibility Study for One Stop Service Centers. Phnom Penh.

- Police and courts minimize the severity of violence against women (VAW), resulting in routine lack of response except in cases with injuries;
- Lack of protocols for VAW identification and response in the health care system;
- Survivors of VAW lack money for transportation and legal fees;
- Lack of confidentiality as VAW cases are routinely discussed without permission of the survivor.

To address these challenges, the Ministry of Women's Affairs (MoWA) has finalised the 2nd National Action Plan to Prevent Violence Against Women, 2014-2018 (NAPVAW II) with five strategic areas: 1) Primary prevention; 2) Legal protection and multi-sectoral services; 3) Laws and policies; 4) Capacity building; and 5) Monitoring and evaluation¹⁵.

The Department of Preventative Health of MoH, in collaboration with MoWA, is currently designing guidelines on clinical treatment for women and children who have experienced violence. These should include overall guidelines on gender-based violence related medical service provision, including obtaining informed consent, the case management of injuries, provision of psycho-social counselling and support, and patient referral for additional medical care as necessary. Procedures need to be developed for managing confidentiality, collecting and storing forensic evidence, and for monitoring, evaluation and quality assurance of comprehensive gender-based violence related services.

Non-communicable diseases affecting women include cervical and breast cancer. Cervical cancer is the most common cancer in women in Cambodia. At least half of women are diagnosed too late to cure, although their deaths could be prevented with HPV (Human Papillomavirus) vaccination and early detection and treatment.

There is currently no screening for breast cancer. Most women who die from it receive only palliative care, as treatment is costly and diagnosis is often made at advanced and incurable stages. While midwives are trained in the importance of breast self-examination, there is no data on how well this has translated into practice and referral.

Another worrying issue is eye health, as specified in MoH's National Strategic Plan on Prevention of Blindness, 2008-2015. According to assessments, there are 43,800 blind people in Cambodia, 333,591 people with impaired vision and 57,857 people with severe vision problems. Prevalence of blindness is higher among women over 50 years of age, at 3.4 percent, compared to 2 percent among men in

¹⁵ Ministry of Women's Affairs (2014) *National Action Plan on Violence against Women (NAPVAW) II*. Phnom Penh.



the same age group. There is no explanation for the difference between prevalence of blindness among men and women; further research is needed, as well as expansion of appropriate service delivery¹⁶.


▲ Women are now twice as likely to survive pregnancy and childbirth.

Another key issue in Cambodia is sexual health of youth and their access to health care. The birth rate among women aged 15-19 years was 44/1000 in 2012. This figure varies across geographical areas of Cambodia¹⁷. Young women with little education, from poor families in rural areas, are more likely to become pregnant at a very young age and face social and health implications.

Information on reproductive and sexual health is important for youth to understand their reproductive and sexual rights. In 2013, the Royal Government of Cambodia demonstrated a strong commitment to addressing this issue, and through the Ministry of Education, Youth and Sport (MoEYS), adopted a comprehensive curriculum for youth

¹⁶ Seiha D, Limburg H. Report of the Rapid Assessment for Avoidable Blindness in Cambodia - 2007. National Program for Eye Health (2009).

¹⁷ National Institute of Statistics, Ministry of Health (2013) *Teenage Fertility and its Socio-Demographic Characteristics and Risk Factors*. Phnom Penh.



at primary and secondary education levels, as well as for those outside the formal schooling system. The curriculum includes information on reproductive and sexual health in relation to age, gender, gender-based violence, drugs, life skills and HIV/AIDS. The Inter-Departmental Committee for Combatting HIV/AIDS and Drugs in MoEYS is responsible for the implementation of this curriculum, including teacher training, which, by the end of 2013, already covered 14 percent of all schools in Cambodia¹⁸.

Social and cultural barriers continue to be obstacles in many countries, including Cambodia, to speaking openly about sexual health issues. In response to these obstacles, MoWA has implemented a program to improve the connection between mothers and daughters in terms of gender awareness, and reproductive and sexual health. The program helps parents to be confident in speaking more openly about gender and sexual matters, as well as personal conversations about other important life issues, with their sons and daughters.

¹⁸ Ministry of Education, Youth and Sport (2013), Inter-Departmental Committee for HIV & AIDS and Drugs.

POLICY RECOMMENDATIONS

<ul style="list-style-type: none"> Revise the National Policy for Quality in Health, and the Health Sector Strategy and Guidelines from gender-blind to gender-sensitive based on the different aspects of health quality improvement for women, men, boys and girls. 	MoH
<ul style="list-style-type: none"> Increase attention to and funding for the Fast Track Initiative Roadmap for Reducing Maternal and New-born Mortality (FTIRM) to ensure effective implementation of the seven core components of service provision: emergency obstetric and new-born care, skilled attendance at delivery, family planning, safe abortion, behavioural change in communication, elimination of financial barriers in gaining access to services and monitoring and response to maternal mortality. 	MoH
<ul style="list-style-type: none"> A substantial push is needed to reach vulnerable poor women across the country. 	MoH
<ul style="list-style-type: none"> Strengthen counselling concerning food security and nutrition; quality and quantity of the maternal diet should be an integral part of ANC provision. 	MoH, MoWA, relevant partners
<ul style="list-style-type: none"> MoWA, with MoH and other partners, needs to ensure that information about healthy diets, micro-nutrient rich vegetables and protein-rich sources of food required for adequate weight gain during pregnancy is disseminated. 	MoH, MoWA, relevant partners
<ul style="list-style-type: none"> Increase food security and nutrition training for professional health staff so that information and monitoring and evaluation of patient nutritional status can be followed up at the community level, particularly for women and children. 	MoH



<ul style="list-style-type: none">• Increase attention and provide funds for the implementation of the Fast Track Initiative Roadmap for Improving Nutrition 2014-2020.	MoH
<ul style="list-style-type: none">• Address the lack of clean water and toilets to reduce the gap in access to hygiene between rural and urban areas.	MRD, MoH
<ul style="list-style-type: none">• Implement guidelines for clinic-based treatment for women and children who are victims of gender-based violence.	MoWA, relevant partners
<ul style="list-style-type: none">• Strengthen and expand the implementation of the Mother-Youth Connection Program on reproductive and sexual health.	MoH, MoWA, relevant partners
<ul style="list-style-type: none">• Strengthen and expand youth-friendly health information services at health centres in urban and rural areas.	MoH



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