CAMBODIA

Health Equity and Quality Improvement project (H-EQIP)

Gender Assessment

April 7, 2018

Executive Summary

This report presents the findings and recommendations of a gender assessment of the Health Equity and Quality Improvement Project (H-EQIP). H-EQIP is a Cambodian Ministry of Health (MOH) project co-funded by the Royal Government of Cambodia (RGC), the World Bank (WB) International Development Association (IDA) and Multi-Donor Trust Fund (MDTF) partners (Australia, Germany and Korea). It is a USD175.4 million, five-year project from July 2016 to June 2021.

H-EQIP has three components that support: (a) Service Delivery Grants (SDG) a supply-side financing scheme that provides fixed lump-sum and performance-based grants to public health facilities to improve quality of health services and their performance; (b) Health Equity Funds (HEF) a demand side financing scheme to subsidise health care for approximately three million identified poor Cambodians at public health services; (c) select health system strengthening including essential infrastructure, pre and in-service training and health management information system (HMIS) and evidence. Disbursement Linked Indicators (DLIs) disburse funds to MOH against annual targets achieved on health system strengthening.

The gender assessment was undertaken from May to October 2017 by a technical team from the World Bank and Australian Department for Foreign Affairs and Trade (DFAT). The assessment is intended to support the MOH to develop practical actions to address gaps related to the implementation of H-EQIP. It is not a gender assessment of the health sector, which would require a more comprehensive study.

The table below presents a summary of the key gender issues listed by proposed actions to be implemented by H-EQIP and actions that are beyond the parameters of the project but vital for increasing the gender responsiveness and equity of the public health system. Some of the issues and actions focus on increasing access to public health services in remote areas where utilisation lags behind and maternal health outcomes in particular, are lower than in other parts of the country. As part of the support provided through this study, a workshop was held on November 24, 2017 with representatives from the Ministry of Health (MOH) and its provincial offices, the Ministry of Women's Affairs, as well as NGOs and development partners to further refine the proposed actions towards translating these into an implementation plan with assigned responsibilities, timeframe and budget. Further dialogue is needed with the MOH and its provincial offices to fine tune and agree on the recommended gender actions and to translate them into a detailed implementation plan. Once priority actions are identified by MOH, and a time-bound action plan is prepared, the World Bank, DFAT and other H-EQIP partners will monitor and support implementation of the plan, as needed.

Issue	**Priority Actions for H-EQIP**
Component 1: Strengthening health service delivery	
1.1 NQEMP are not directly sensitive to gender and social inclusion issues and socially inclusive communication and care as part of quality health care	Emphasize and monitor the requirement in the annual instruction for conducting NQEMP to have at least one woman (midwife) in each assessment team, with an aim to promote qualified women to be on assessment teams. Update template of individual performance evaluation for health staff and questionnaire for client interview to include staff attitude and behaviour regarding respect, politeness and non-discrimination to patients, particularly the poor, persons of different genders, ethnic minority, disabled, and LGBTI patients. Undertake a study on gender differences in user expectations of quality of care and factor findings into the design of NQEMT (*Client satisfaction tool) or Impact Assessment (IE).*

1.2 Client satisfaction tool has limitations. It may expose female clients selected for interview to harm if they report their husband's or a family member's phone number; it is not reliable in remote areas where phone coverage is poor; is difficult to foster trust of the selected client to engender honest feedback.	Female assessors take responsibility for phoning female clients and male assessors for male clients. Ensure training of all assessors on the potential risks of telephone interviewing clients, how to sensitively introduce themselves and the purpose of the call, and how to manage any negative tensions the call may create. If feasible, review alternative approaches to telephone interviewing, including linking client satisfaction to ISAF community scores where ISAF is operational, third party survey or HEF Promoters to conduct client satisfaction at the household level.
1.3 Service delivery grants do not reward actions that respond to social inclusion	Increase allocation of SDG performance grants to health facilities in remote/difficult to access areas for improved quality of and access to health service delivery. Through SDG encourage and reward actions that: (i) Enhance outreach or mobile health services that regularly take health workers to remote populations and target indigenous and ethnic minority peoples; (ii) Strengthen the existing health posts to more effectively reach the remote communities they serve.
Component 2: Improving financial protection and equity	
2.1 Gaps in analytical work undertaken on who is benefitting from HEF.	Further analytical work to identify which categories of the poor are benefitting from HEF including by sex of beneficiary, sex of household head, geographical isolation, disability, ethnicity and age. Qualitative research in specific target areas to understand the factors that drive low HEF utilisation to inform programmatic responses. If feasible, review the functioning of the post-IDPoor mechanism and the extent to which it is providing protection to poor people who have missed out on IDPoor, including potential LGBTI beneficiaries who may have faced discrimination.
2.2 To make HEF Promoters effective agents in raising awareness of HEF benefits.	Update as necessary the TOR for HEF-P to allow for HEF-Ps to use existing structures and networks to raise community awareness of HEFs; work with HC, HCMC and VHSG for launching direct awareness raising activities to highly marginalised populations in remote and difficult to reach areas where HEF utilisation is low. Induction/orientation training for the HEF-P to include effective and empathetic interpersonal communication, how to foster trust and openness and treat all people with respect and fairness, gender equality and social inclusion, patient and provider rights, and barriers to accessing services that poor, women, adolescent girls, LGBTI and excluded populations face. For provinces with high numbers of ethnic minorities, orientation to include traditional and cultural beliefs of ethnic minority populations and how this affects health access and health outcomes. In the four north-eastern provinces give preference to hiring ethnic HEF Promoters. Apply the norms of three HEF Promoters per CPA-3 referral hospital and two HEF-Promoters per CPA-1 and CPA-2 referral hospital flexibly so that more can be hired where utilisation is very low and existing community mobilisation structures are weak. Aim for gender balanced teams with at least one woman HEF Promoter per referral hospital.

Component 3: Ensuring sustainable and responsive health systems	
3.1 Integrate gender and social inclusion into the values, operational guidelines and capacity of the PCA.	Include gender equality and diversity into the organisational values of the PCA and operational guidelines. Integrate gender equality and social inclusion into the capacity building and training of PCA management board and staff. Ensure any new information systems to be established at the PCA include sex disaggregated data as appropriate.
3.2 Make infrastructure investments gender responsive.	Review the design of health centres to ensure that space for a waiting room, pre- and post-delivery, is included for construction of new health centres, and if not, contingency plans be made to accommodate this, especially in remote areas.
Results framework	
4.1 There is no gender specific indicator in the results framework or the measurement of health outcomes, which could provide a gender lens. The indicators are not sex disaggregated where reasonable to expect them to be.	Revise the H-EQIP Results Framework indicator to include sex disaggregation of "utilisation of health services by HEF beneficiaries." Include a sub-indicator "percentage of which are women". Revise H-EQIP indicator "Outpatient Department (OPD) consultations (new cases only) per person per year" to include a sub-indicator "percentage for women". If CSES data permits, add a sub-indicator to "Reduction in the share of households that experienced impoverishing health spending during the year' such as "of which headed by a female". Further disaggregate HEF utilisation data to include indigenous and ethnicity, physical appearance of disability, and province (these variables are included in the PMRS). Further analysis of PMRS data to study the relationship between the distance between the residence of HEF beneficiaries and their use of services in selected provinces where remoteness is a multidimensional barrier.
Institutional and implementation arrangements	
5.1 Strengthen the linkage and synergies between H-EQIP and the MOH's GMAG and GMAP	Include GMAG in reviews and monitoring of H-EQIP (i.e. through engagement during and between implementation support missions

Issue	**Proposed action beyond H-EQIP**
Component 1: Strengthening health service delivery	
1.1 NQEMP are not directly sensitive to gender and social inclusion issues and socially inclusive communication and care as part of quality health care	MoH's Community Participation Policy to be revised in line with the national strategy on decentralisation and deconcentration, and gender responsiveness strengthened including balanced gender representation in HCMC. Introduce a sub-tool or set of questions on the implementation and quality of outreach for those health centres that cover large or difficult to reach geographical areas. Weight scores in areas that use additional sub-tools to allow for comparison with other areas.
1.2 There is a large gap in the number of indigenous and ethnic minority people trained and hired by the health service given the challenges of retaining non-ethnic staff in north-eastern provinces and the greater acceptability of ethnic staff among ethnic users, in particular, pregnant women who are encouraged to give birth at health centres.	Include progress in training and hiring of indigenous and ethnic minority health workers in the north-east in policy dialogue.
1.3 Very low numbers of women in leadership positions at provincial and OD levels has serious implications for the performance of the organisation and creating the environment and conditions for	H-EQIP development partners advocate for women leadership development measures in health sector policy forums. Successful examples of efforts to promote female leadership in the health sector from other countries to be shared.

future female leaders and gender equality in the health sector labour force.	
1.4 Client satisfaction tool has limitations. It may expose female clients selected for interview to harm if they report their husband's or a family member's phone number; it is not reliable in remote areas where phone coverage is poor; is difficult to foster trust of the selected client to engender honest feedback.	Introduce a toll-free number that clients call at their convenience.
1.5 Health managers, providers and quality assessors have limited understanding of what gender responsive and socially inclusive communication and service delivery is and why it is important, and how to communicate in a respectful and empathetic way.	Develop a gender and social inclusion in-service training module including empathetic and respectful communication, supporting job aids and training materials.
1.6 Threats to female staff security affect staff retention and the availability and quality of health care.	Undertake a study on how female staffs cope with security concerns in different environments and the various strategies being used to mitigate security issues. Share good practices with PHDs, ODs and facilities.
1.7 There is a large gap in the number of indigenous and ethnic minority people trained and hired by the health service given the challenges of retaining non-ethnic staff in north-eastern provinces and the greater acceptability of ethnic staff among ethnic users, in particular, pregnant women who are encouraged to give birth at health centres.	With other government agencies, consider scholarships and other financial incentives to keep young ethnic people in school to prepare a pipeline of potential students for the health service. Consider offering foundation programs or special coaching services for students from ethnic minority backgrounds especially girls, to prepare them to compete for national health training places.
Component 2: Improving financial protection and equity	
2.1 The limitations of HEF and SDG to reduce the equity gap in priority national health indicators such as institutional delivery in remote areas.	Community transport arrangements that mobilise transporters and community leaders to take responsibility for essential or emergency transport on pre-agreed terms. Provide cultural sensitisation and diversity training to health staff in areas with indigenous and ethnic populations.
Component 3: Ensuring sustainable and responsive health systems	
3.1 Integrate gender equality and social inclusion into DLI1	Develop modules and training materials on gender and social inclusion for a range of pre and in-service training programs. Include in-service training modules on GBV and clinical guidance on the treatment of survivors of intimate partner and sexual violence into pre-service training. Include gender equality and social inclusion/diversity training in the revised pre-service training curriculum at UHS. This would include practical training, and good practice case studies and guidance notes on how health professionals can communicate and behave in a way that is sensitive to the differing needs of vulnerable and excluded people including LGBTI persons and people living with disability.
3.2 Improve the quality and analysis of sex disaggregated data and improve the evidence and analysis of data on health inequities.	Include attention to gender and diversity in strengthening of the HMIS and PMRS reporting and analysis. Address gaps in the human resource management information system to enable the efficient monitoring of women in leadership at all levels, gender balance in recruitment, deployment, training and promotion, ethnic diversity and the recruitment, deployment, training and promotion of staff from ethnic minority backgrounds. Strengthen the systems for reporting and tracking GBV cases, and maintaining strict confidentiality.
3.3 Make infrastructure investments gender responsive.	Undertake further assessment of the benefit and cost of including dedicated female staff accommodation at health centres in remote locations; this should include consultations with female staff in these areas and consideration of security and staff retention issues.

Results framework	
4.1 Strengthen the gender capacity of project management and implementing units	Support women leadership development in the health sector. This may include south-south exchanges with successful women leadership mentors in the region, women leadership training programs from the public and private sectors, and male champion networks and policy advocates.
Institutional and implementation arrangements	
5.1 Strengthen the linkage and synergies between H-EQIP and the MOH's GMAG and GMAP	Undertake a functional task analysis of GMAG to assess whether its structure, capacity, functionality and resources are appropriate to achieving GMAP's goals and objectives. Technical support to the proposed GMAG functional task analysis, capacity building of GMAG, reporting progress against relevant GMAP indicators, and the development and implementation of the next GMAP for health.
5.2 Strengthen the gender capacity of project management and implementing units	Forge linkages between MOH and other government agencies pursuing women leadership development to share technical resources, leverage successful advocacy models and platforms, build cross-sectoral women leadership networks, and draw on learning and experience.

Abbreviations

CDHS	Cambodia Demographic and Health Survey
CSES	Cambodia Socio-Economic Survey
CSO	Civil society organisation
DFAT	Australian Department of Foreign Affairs and Trade
DLI	Disbursement Linked Indicator
GMAG	Gender Mainstreaming Action Group
GMAP	Gender Mainstreaming Action Plan
HC	Health Centre
HCMC	Health centre Management Committee
HEF	Health Equity Fund
H-EQIP	Health Equity and Quality Improvement Project
HMIS	Health Management Information System
IDA	International Development Association
IDPoor	Households identified as poor
ISAF	Implementation Plan for the Social Accountability Framework
KfW	*Kreditanstalt fur Wiederaufbau*, German Development Bank
KOICA	Korean International Cooperation Agency
LGBTI	Lesbian, gay, bi-sexual, transgender and intersex
M&E	Monitoring and Evaluation
MDTF	Multi Donor Trust Fund
MOH	Ministry of Health
MSM	Men that have sex with men
NCD	Non-communicable disease
NQEMT	National Quality Enhancement Management Tool
OD	Operational District
OPD	Outpatient Department
PCA	Patient Certification Agency
PHD	Provincial Health Department
PLA	Participatory learning and action
PSL	Partnering to Save Lives
PMRS	Patient Management Registration System
QAO	Quality Assurance Office
RGC	Royal Government of Cambodia
RH	Referral Hospital
SDG	Service Delivery Grant
TB	Tuberculosis
UHS	University Health Sciences
UNFPA	UN Population Fund
UHS	University of Health Sciences
URC	University Research Company, LLC.
WB	World Bank

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Introduction

The Health Equity and Quality Improvement Project (H-EQIP) is a Cambodian Ministry of Health (MOH) project co-funded by the Royal Government of Cambodia (RGC), the World Bank (WB) International Development Association (IDA) and Multi-Donor Trust Fund (MDTF) partners (Australia, Germany and Korea). H-EQIP is a USD175.4 million, five-year project from July 2016 to June 2021. The RGC will contribute at least USD94.2 million and the World Bank USD30 million. Australia (DFAT) is contributing AUD50 million (approximately USD36.2 million). Other MDTF contributors are the German Development Bank, KfW, (USD13.2 million over two years) and the Korean International Cooperation Agency (KOICA) (USD7.0 million over three years).

H-EQIP focuses on key successes of MOH's Second Health Sector Support Program (2009-June 2016). It has three components that support: (a) Service Delivery Grants (SDG) a supply-side financing scheme that provides fixed lump-sum and performance-based grants to public health facilities to improve quality of health services and their performance; (b) Health Equity Funds (HEF) a demand side financing scheme to subsidise health care for approximately three million identified poor Cambodians at public health services; (c) select health system strengthening including essential infrastructure, pre and in-service training and health management information system (HMIS) and evidence. Disbursement Linked Indicators (DLIs) disburse funds to MOH against annual targets achieved on health system strengthening.

Several analytical studies were undertaken to inform the design of H-EQIP including a Social Assessment (2015), Health Equity Fund Utilisation Survey (2016) and an Indigenous Peoples Planning Framework (2016). Given the importance of gender equality to RGC policy and H-EQIP's development partners, it was agreed that a gender assessment of H-EQIP would be undertaken during the first year of implementation [1]. This report presents the major findings and recommendations of the gender assessment.

The gender assessment was undertaken from May to October 2017 by a technical team from the World Bank and DFAT[2]. The process included:

- Review of project documents and related gender and health literature.
- Consultations with MOH and Ministry of Women Affairs at the national level.
- Field visits to Kratie and Mondul Kiri provinces where the gender assessment team met provincial health department (PHD) and operational district (OD) managers, health providers at a sample of referral hospitals (RH) and health centres (HC), held interviews with a selection of community representatives and focus group discussions with community women and men. The team also met CARE and Save the Children who helped facilitate discussions at the community level.
- Consultations at national level with a selection of civil society organisations (CSOs), including a network focusing on lesbian, gay, bi-sexual, transgender and intersex (LGBTI) issues, and development partners.

See Annex 1 for a list of persons met and Annex 4 for documents reviewed.

The gender assessment was framed to assess the extent to which the design and delivery of H-EQIP is gender informed and responsive, and to assess whether the project addresses:

- Gender gaps
- Gender norms, roles and relations
- Practical and strategic gender needs
- Includes different strategies for different population groups

[1] World Bank Project Appraisal Document, H-EQIP, April 2016

[2] The team included: Erik Johnson (World Bank), Sreytouch Vong (World Bank Consultant), Ponnary Pors (World Bank Consultant), Sao Sovanratnak (World Bank Consultant), Priya Agarwal-Harding (H-EQIP Pooled Fund Coordinator), Premprey Suos (DFAT), Deborah Thomas (DFAT Consultant).

- Includes gender in monitoring and evaluation
- Measures women's and men's participation

The assessment is intended to support the MOH develop practical actions to address gaps related to the implementation of H-EQIP and is not a gender assessment of the health sector, which would require a more comprehensive study and was most recently undertaken in 2011[3].

This report is structured into four main sections. First, the report provides an introduction to the importance of gender for sustainable development. Second, a thematic analysis of key gender issues pertinent to H-EQIP is provided, structured around the themes of endowment, voice and agency, and women's economic empowerment. Third, an analysis of how the project components address the gender issues identified, and how the project or other actors can address key gender gaps and issues. This section includes a gender analysis of the project's results framework and monitoring indicators and recommendations for how these can be made more gender responsive. Finally, we present a summary of the key issues and proposed actions for H-EQIP and other actors.

Gender equality and sustainable development

Gender refers to the social, behavioural and cultural attributes, expectations and norms associated with being female or male while sex refers to the biological differences between men and women.

In Cambodia, men are traditionally portrayed as strong, rational and powerful, and women as gentle, emotional, weak, and humble[4]. The moral codes of Chbab Srey (code of conduct for Cambodian women) and Chbab Pros (code of conduct for Cambodian men) that underpin these stereotypes set out the ideal of masculinity and femininity. However, gender norms and roles are not static. Change in the attitudes and informal rules that influence social expectations of women and men in Cambodia are underway, with for example, educational and professional opportunities opening up for women. In the medical field, women made up 43% of the medical student intake in 2016 at the University of Health Sciences (UHS), rising from a very low level after the genocide. By tapping into such underlying social change, the government has the scope to fast-track efforts to achieve greater gender balance in the workforce and leadership of the health sector.

Gender equality exists when:

- Men and women share the distribution of power and influence.
- Men and women have equal opportunities for financial independence through work or through setting up businesses.
- Girls and boys, men and women, have equal access to education and the opportunity to develop personal ambitions, interests and talents.
- Men and women share responsibility for the home and children.
- Women are completely free from coercion, intimidation and violence at work and home.
- Women are empowered to have control over their lives so that they have the confidence to speak out, to assert their rights and grasp opportunities.

Gender inequalities in all societies are rooted in attitudes, institutions and market forces. In Cambodia this translates into a higher burden of childcare and domestic responsibilities on women that lowers their time for productive engagement and often their motivation to take on leadership positions in the workplace. However, women and men are not homogenous groups but are stratified by other forms of social identity and influence including poverty-wealth, geographical location-remoteness, ethnicity, disability, sexual orientation, gender identity and migration

[3] Kate Frieson, Me Chen, Chi Socheat, Hou Nirmita, Chev Mony. September 2011. A gender analysis of the Cambodia health sector. Minstry of Health and Ministry of Women Affairs of the Government of Cambodia, Australian Aid, WHO.

[4] Eng, S., Yingli, L., Mulsow, M. & Fischer, J. 2009. Domestic Violence against women in Cambodia: Husband's control, frequency of spousal discussion, and domestic violence reported by Cambodian women. Journal of Family Violence, 237-246.

status. The intersection of gender with other socio-economic factors exposes individuals and groups to multiple layers of social exclusion and vulnerability.

Gender equality refers to the provision of equal rights, responsibilities and opportunities to men and women regardless of their sex or gender identity. Evidence shows that greater gender equality and diversity can enhance productivity, improve development outcomes for the next generation and allow businesses and institutions to perform better (World Bank, 2016). Providing males and females equal power to shape their own lives, contribute to their families, communities and countries are at the heart of sustainable development. Gender equality is not only a desirable objective but critical to development effectiveness. Gender equality is enshrined in Cambodia's constitution and key national policies including the Rectangular Strategy.

Gender inequality and health in Cambodia

> "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." (Ministry of Women Affairs, 2014, Gender and Health. Policy Brief 5.)

Understanding of gender in the Ministry of Health

Discussions with a wide range of stakeholders in the MOH and PHD suggest that the level of understanding of how gender impacts access to health services, service delivery and other health systems including organisational and management systems, human resource management and personnel, and evidence and information systems is limited. The study found that gender was often mentioned and referred to with focus mainly on women only and further understanding is required on how to integrate gender into routine work. Overwhelmingly, we found that senior management welcome the opportunity to strengthen attention to gender and practical guidance on how to do this.

The Gender Mainstreaming Action Group (GMAG) spearheads gender mainstreaming into the MOH and is led by the only female Secretary of State in the Ministry. The study found the responsibilities for mainstreaming gender in the health sector are commonly given to women, and understanding of gender norms and stereotypes and how these play out in health service delivery and human resource management appear to be of limited concern among men in leadership positions.

The MOH's Gender Mainstreaming Strategy and Action Plan (GMAP) (2014-2018) has four objectives:

- Improve gender responsiveness of MOH financing
- Strengthen equality of opportunity in MOH recruitment, training and promotion
- Increase the responsiveness of MOH programs and service delivery to gender issues
- Strengthen the capacity of GMAG to address gender responsiveness within MOH.

Progress in implementing the action plan has been slow due to lack of funding, dedicated staff, and capacity gaps compared to other areas of work in the Ministry. As a consequence GMAG does not appear to be systematically monitoring and reporting on progress, but rather focusing on a few select issues such as training opportunities for female staff and gender-based violence. The GMAG is also poorly located to drive gender mainstreaming across the sector from its institutional home in administration and the GMAG structure at national and sub-national levels rely on nominated staff with a variety of other responsibilities and levels of seniority. Further capacity building of GMAG members is needed to enable them to support the technical

integration of gender concerns into business practices and technical remits of the Ministry, and to be effective advocates to leverage support from government and development partners.

While the Ministry of Women's Affairs is the principal provider of expertise and support for gender mainstreaming across government, it is also limited in its capacity and funding to respond to sector needs. Development Partners such as DFAT and UNFPA have previously provided support to the analytical and planning work related to the MOH's GMAP but not for its implementation or related gender mainstreaming capacity building.

Health endowment

Our analysis of gender inequality and health in Cambodia draws on the conceptual framework of the World Bank Group Gender Strategy (FY16-23) that positions endowments, voice and agency and women's economic opportunities as the three key and inter-related domains of gender inequality. Figure 1, below, presents the conceptual framework used in the World Bank Gender Strategy, illustrating how household decision making, markets, formal institutions, and informal institutions combine and interact to affect the three dimensions of gender equality.

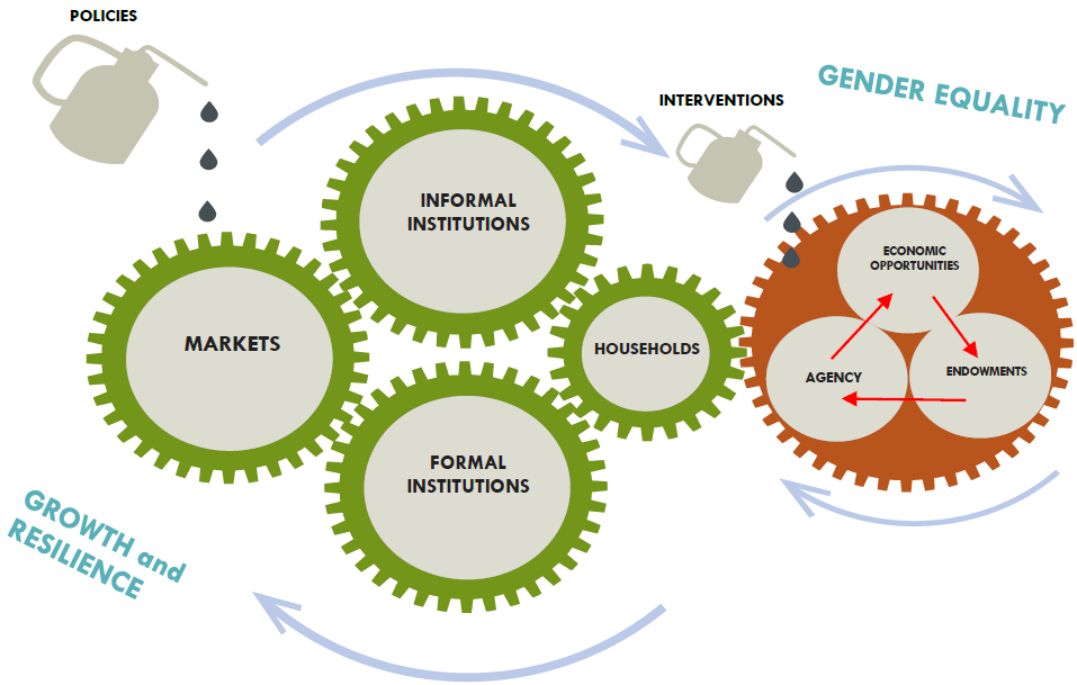


Figure 1: World Bank Conceptual Framework for Gender Equality

Source: World Bank Group Gender Strategy 2016-2023

The Cambodia Socio-Economic Survey (CSES) (2014) found that women from age 15 and above more frequently seek health care than men. Women's reproductive and maternal health care needs contribute to their greater use of health services. While both women and men use private providers more frequently than public, women chose public health services more often than men.

Age	Women	Men	Both sexes
0-14	16.6	17.5	17.0
15-29	7.6	4.5	6.0
30-44	14.9	9.0	12.0
45-59	23.5	15.7	20.0
60+	37.0	28.7	33.6

Table 2: One or more health care visits in the last 30 days by sex and age group, CSES 2014

Provider of health care	Women	Men	Both sexes
Public	24.2	22.5	23.5
Private	62.0	64.3	62.9
Self-care	12.7	12.2	12.4
Traditional care	0.6	0.3	0.5
Other	0.1	0.4	0.2
Overseas	0.5	0.4	0.4

Table 3: First provider of health care among households who sought care in the last 30 days by sex, CSES 2014

Our assessment of health endowments focuses on the remaining gaps in maternal health, gender differences in communicable and non-communicable disease, and women's access to health services. We draw on institutional delivery as a good indicator of the functionality of the health system and a lens for studying gender inequality and health. The more difficult access to health services and lower maternal health outcomes in remote areas compared to other parts of the country underpin the focus given to remote areas. Gender based violence is discussed in the section on voice and agency.

The remaining gaps in maternal health

The Cambodia Demographic and Health Surveys (CDHS) show that maternal mortality dropped from 472 in 2005 to 170 in 2014. This sharp decline was driven by reduced poverty, improved infrastructure, improved women's education and improved access to skilled delivery services. Evidence from CDHS 2014 shows that women who are poorer, have lower education and live in remoter areas have lower utilisation of maternal health services. The MOH attributes Cambodia's success in reducing maternal mortality to political commitment and sound governance, the delivery of high impact interventions and the use of data to drive decision making which was exemplified in the Fast Track Initiative Road Map for reducing Maternal and Newborn Mortality[5]. Further progress in maternal health, and achievement of national policy goals, will require addressing the inequities in reproductive and maternal health including reducing out of pocket spending and expanded coverage of underserved populations, continued improvement of quality of care and the equitable distribution of midwives.

Figure 4: Institutional delivery by wealth quintile, CDHS 2014

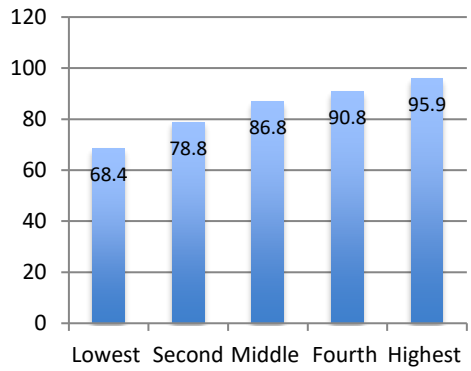
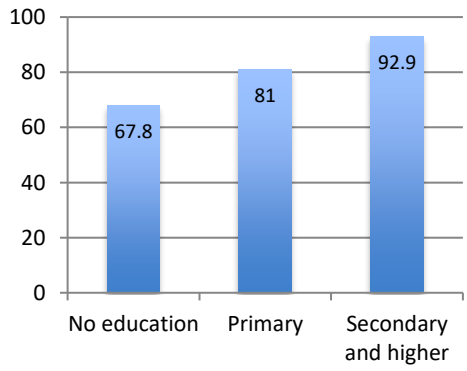
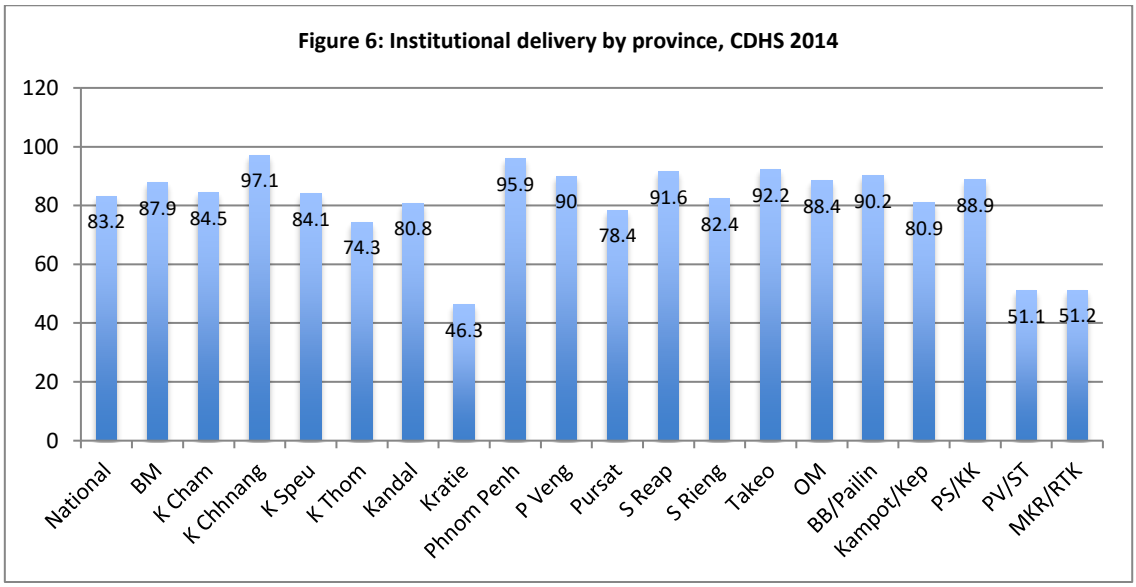


Figure 5: Institutional delivery by mother's education, CDHS 2014



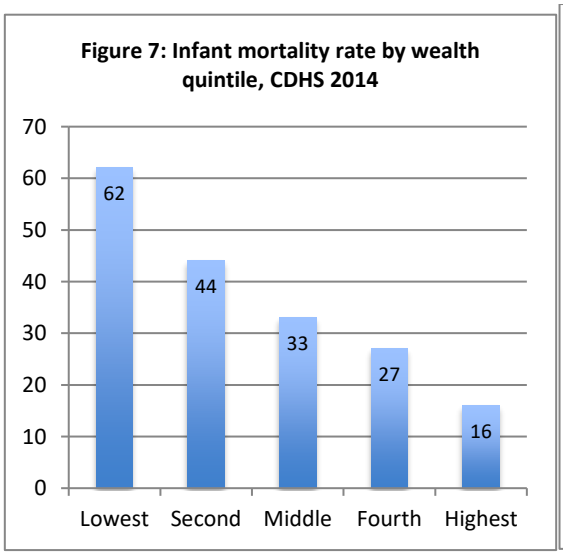
The lower institutional delivery rates in the four north-eastern provinces of Mondul Kiri, Ratanak Kiri, Preah Vihear and Stung Treng and in Kratie reflect the poorer coverage of services and other barriers to health care in these areas. Notably all five provinces also have large numbers of ethnic minority persons who tend to marry earlier and have more children[6]. These social determinants and high levels of anaemia, short maternal stature, malaria and poor health coverage are factors that increase the risk of maternal and neonatal deaths in these provinces.

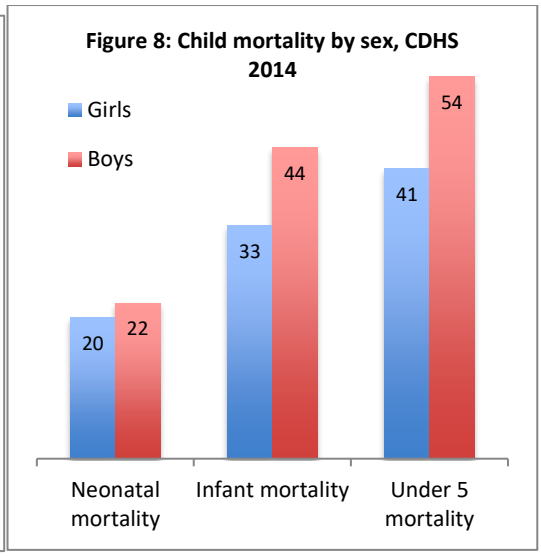
[5] Ministry of Health Cambodia, PMNCH, WHO, World Bank, AHPSR and participants in the Cambodia multi-stakeholder policy review. 2014. Success Factors for Women's and Children's Health: Cambodia.
[6] Breogan Consulting. March 2017. Research on Indigenous Parenting Practices Across the Generations. Plan International Cambodia.



Progress in improving child health for boys and girls

Broad socio-economic development combined with improved coverage of key child health interventions such as essential immunisations, vitamin A supplementation and the promotion of early and exclusive breastfeeding have contributed to the decline in infant and child mortality. Rates of childhood mortality are associated with mother's education, wealth-poverty and rural or urban residence[7]. The higher rate of childhood mortality among boys is a universal phenomenon and not specific to Cambodia.





The lack of sex difference in immunisation rates with 73.9% of boys (12-23 months) receiving all basic vaccinations and 73% of girls (CDHS, 2014) suggest no major differences in the way households treat boys and girls.

High levels of child undernutrition with 32% of children under five stunted, 10% wasted and 24% underweight is a pressing development concern. Similar levels of undernutrition between boys and girls suggest no gender specific causes though the implications of undernutrition for girls and their future families is a major public health and development issue. Undernourished girls face greater maternal health risks, and are more likely to deliver low birth weight babies that are in turn subject to developmental and health risks as they age. The high levels of short

[7] CDHS, 2014.

maternal stature in Mondul Kiri/ Ratanak Kiri (17% reported in CDHS 2014) and child stunting in Pursat (18%), Mondul Kiri/Ratanak Kiri (15%), Preah Vihear/Stung Treng (14%) and Otdar Meanchey (14%) as reported in CDHS 2014 illustrate the geographical dimension in undernutrition in the country.

Gender and communicable diseases

Gender roles and relationships and the balance of power between men and women affects exposure to, the ability to prevent and take up of treatment for HIV/AIDS, tuberculosis and malaria. The mission did not access national sex disaggregated data for either of the leading communicable diseases and this would require a level of analysis beyond the scope of this study.

Key points to note are:

- Tuberculosis (TB) is the second highest cause of disability-adjusted life years for men and women. In Kratie it was reported by the PHD that women are less likely to complete the procedures for diagnosing TB and take up treatment due to the opportunity costs related to repeated visits to hospitals. Further analysis of the gendered nature of TB diagnosis and treatment completion appears warranted.
- Some studies show that men are more at risk of contracting plasmodium vivax malaria than women (3:1) with the difference explained by their occupation related mobility[8].
- Cambodia's response to HIV has seen a dramatic drop in prevalence from 1.6% in 1998 to 0.7% in 2013,[9] and 75% of people living with HIV/AIDS are accessing anti-retroviral treatment. The disease is now concentrated in key groups such as female entertainment workers (EW), drug users, transgender people and men who have sex with men (MSM). Transgender persons also face very high levels of stigma, discrimination and violence due to their gender identity[10]. Weissman et al (2015) found that 30% of their study respondents had been raped or physically assaulted in the past 12 months.

Gender and non-communicable diseases

Smoking and alcohol consumption are the two leading risk behaviours underpinning chronic disease in Cambodia and both are greater among men than women. The 2010 Non-Communicable Disease (NCD) survey[11] found that over 80% of respondents had one or two risk factors for developing a NCD. Gender responsive programs for prevention, treatment and care are needed though the capacity of the health system to address chronic illness is currently limited.

Women's access to health services

Barriers to accessing health services have demand and supply side dimensions and vary according to the local geographical, poverty and cultural context. In Cambodia, the barriers in remote, sparsely populated areas are very different to those in more accessible peri-urban areas.

Access to health services is often structured around four key variables: geographic accessibility, availability, affordability and acceptability of health care[12]. Gender norms, attitudes and

[8] Sovannaroth Siv et al. 2016. Plasmodium vivax malaria in Cambodia. *Am J Trop Med Hyg*. 2016 Dec 28; 95(6 Suppl): 97–107. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5201228/

[9] National AIDS Authority. 2015. Cambodia Country Progress Report: Monitoring Progress Towards the 2011 Political Declaration on HIV and AIDS.

[10] Weissman A, Ngak S, Srean C, Sansothy N, Mills S, Ferradini L. 2016. HIV Prevalence and Risks Associated with HIV Infection among Transgender Individuals in Cambodia. PLoS ONE 11 (4): e0152906.doi:10.1371/journal.pone.0152906

[11] Ministry of Health. 2010. Prevalence of Non-Communicable Disease Risk Factors in Cambodia, STEPS Survey Country Report: Phnom Penh, Cambodia.

[12] Jacobs, B., et al. 2011. Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries. *Health Policy and Planning* 27:288–300.doi:10.1093/heapol/czr038.

behaviours cut across each of these domains. The domains of access are often inter-connected and multiply the difficulties poor and vulnerable people face in seeking care with for example women's lack of decision-making authority affecting their control over and access to cash (affordability) to pay for transportation (geographic accessibility).

Figure 9: Domains of access to health services

		Supply side constraints	Demand side constraints
Access to health services			
Geographic accessibility	Gender norms, attitudes and behaviours	• Service location	• Terrain • Transportation costs • Availability of transport
Availability		• Qualified and available human resources • Opening hours • Waiting time • Drugs and supplies • Poor referral system	• Information on health care services and providers available • Knowledge and awareness to support positive health seeking behaviour
Affordability		• Cost of services and products • Public financing of the public health system	• Household resources and willingness to pay • Opportunity costs of seeking care • Control over family resources (eg women's lack of control) • Lack of cash flow
Acceptability		• Staff interpersonal communication skills including trust • Lack of transparency of prices and pricing of services	• Household expectations • Cultural preferences • Language • Low self-esteem and lack of assertiveness • Stigma

CDHS 2014 found that 75% of women reported having one or more problems in accessing health services for themselves; a similar figure to the 72% reported in the CDHS 2010. The most frequently reported problem was 'getting money for treatment' (65%) followed by 'not wanting to go alone to the facility' (45%). Distance to a health facility was reported to be a problem by 35% of women and 'getting permission to go to a facility' by 21%. The proportion of women reporting each of these problems in accessing health care reduced as wealth and education increased with for example, 79% of the poorest quintile reporting money to be a problem compared to 41% of the wealthiest quintile.

Geographic accessibility

Geographic and transport barriers: Difficult terrain including strong rivers, flooding and poor road conditions impact access to services in several parts of the country and place significant time costs on families when seeking care. The large geographical area and scattered population in the north-eastern provinces makes geographical access to services particularly problematic as the catchment area of health facilities is large. The cost of transportation was reported to be the biggest problem to accessing health services in Mondul Kiri and in less accessible parts of Kratie. The large financial burden of transportation affects the remotest and poorest the most and was reported to be a reason for not seeking care[13]. The seasonal migration of families to remote farms in the north-eastern provinces further adds a layer of geographical inaccessibility. Health staff in Mondul Kiri reported that once families move to distant farms they are no longer able to reach them or monitor pregnant women who may be at risk. Two weeks prior to our field visit, two maternal deaths were reported to have occurred on remote farms in the province.

[13] See PSL draft policy brief. "Out of reach? The critical barrier of transportation to access reproductive, maternal and newborn health services for vulnerable women in northeast Cambodia.

The Partnership for Saving Lives (PSL) project in the north-eastern provinces found that more than 50% of women in the poorest quintile live more than 10km from a health facility, and face the double burden of poverty and distance. One consequence is lower facility delivery rates. PSL found that for every five kilometres from a health facility that a woman lives, the likelihood of delivering in a health facility decreases by more than 5.5%. A PSL survey in 2015 in Ratanak Kiri and Mondul Kiri found that lack of transport was the main reason given why women chose to deliver at home.

HEF transport allowance: The HEF transport allowance compensates those persons having identification of being from a poor household (IDPoor) who have been referred to the referral hospital and those seeking delivery and abortion care at health centres or hospitals without referral. While the allowance is important it often does not cover the actual cost of transport for the identified poor to health facilities, and transportation to health centres for services other than delivery or abortion, are not covered. In Mondul Kiri this distance can be up to 90km. The cost of transportation for the poor is compounded in remote areas where distances to facilities are extensive and time consuming to undertake, road/river conditions are challenging, and transporters willing to convey obstetric emergency cases can be difficult to find. HEF's standardised formula for calculating transport allowance often disadvantages remote populations who also have some of the worst health service utilisation rates. Transport allowances are simply too low for remote areas, paying 500 riels/km and 800 riels/km for good and bad road, respectively, and we recommend they should be reviewed and updated to reflect real market cost.

HEF also doesn't cover the transport costs of accompanying family members. Indigenous and ethnic minority patients in the north-eastern provinces who are unfamiliar with the health system tend to be accompanied by large numbers of family members for social support, and this further adds to out of pocket costs of treatment.

Availability of transport: The availability of suitable transport is a problem in some places. Where ambulances are stationed this can help emergency cases though the cost for some is an issue. In Chhlong OD, Kratie, community women reported incidences of long delays in waiting for the ambulance to arrive. The opportunity to build on existing community saving and loan groups such as Village Saving and Loan Associations, community managed HEF schemes, and Commune Council social welfare financing to sustainably supplement the HEF transport allowance and promote community responsibility for health transportation in remote areas deserves further attention. Community led and managed transportation systems have been shown to be effective in other parts of South-East Asia often as part of broader community mobilisation efforts[14].

Cost of transportation: Addressing the cost of transportation is imperative to increasing access to services in remote areas of the country for all groups but especially for women given their reproductive and maternal health needs, their responsibility for family health and limited control over money and health related decision-making. Poor women and people with added vulnerabilities such as those living with disability are further impacted.

Affordability

Contribution and limitations of HEF: The cost of health services in Cambodia is a significant barrier to access and a cause of impoverishment. HEF, which provide free public health care to IDPoor card holders has been shown to reduce poor household's use of private providers and

[14] See Hussein J, Kanguru L, Astin M, Munjanja S (2012) The Effectiveness of Emergency Obstetric Referral Interventions in Developing Country Settings: A Systematic Review. PLoS Med 9(7): e1001264. doi:10.1371/journal.pmed.1001264. GIZ. Making Childbirth a Village Affair. How 'Desa Siaga' improves the health of mothers and babies in Indonesia. GIZ German Health Practice Collection.

overall health expenditure on treatment[15]. Women are expected to benefit from HEFs more than men given their greater use of public health services especially to meet their reproductive and maternal health needs.

Low utilisation of HEF is a concern with preliminary data indicating that only one in three of HEF card holders (IDPoor or post IDPoor) use HEF for outpatient treatment and one in two for inpatient; sex disaggregated data is not available[16]. Utilisation is lower among those living far from a public health facility compared to those living closer, related to distance and the cost of transportation.

Even when households are covered by HEF, poor families have to weigh up the affordability of care. In addition to having to find money to cover any gap in transportation cost, the food allowance under HEF was reported to be insufficient. As noted above with regards to the transport allowance, this is especially the case if a large number of family members accompany a patient to provide social support. The necessity for patients to be accompanied by family members or carers given the lack of nursing staff for inpatient services, the unfamiliarity of ethnic minority communities with the health system, and their cultural values, encourages entire families to join the patient, and this has financial implications for the family, and can be a hindrance for hospital staff.

> Indigenous families were reported to bring the entire family when a family member is hospitalised. A woman who lived only with her nuclear family said she did not give birth at the health facility because there would be no one to support her there if her husband stayed to look after the children and farm. (Bou Sra, Mondul Kiri)

IDPoor process: Inclusion and exclusion errors with IDPoor are well documented though there is no firm evidence to suggest that there is a gender dimension to these. LGBTI individuals report discrimination in obtaining IDPoor cards due to non-recognition of same sex partnerships and social stigma among community leaders.[17] Female headed households are more likely to be classified as IDPoor 1 (destitute) than male headed households reflecting their higher level of vulnerability. The recent World Bank HEF utilisation survey (2016) found that poor families living in villages far from a health facility were more likely to report problems of exclusion of poor families during the pre-IDPoor process. The greater distance they have to travel to hospitals where they can claim post-IDPoor compared to more accessible communities is another disadvantage poor remote families face in accessing HEF entitlements.[18]

The Ministry of Planning's quota for female participation in the IDPoor process is being met[19] and in some parts of the country exceeded, though there has been no study of the extent to which women speak out or are listened to at those meetings[20]. Adults that are absent during the identification process including seasonal migrants are at risk of being left out due to the requirement that an adult from an identified poor household must be interviewed. However,

[15] Gabriela Flores, Por Ir, Chean R. Men, Owen O'Donnell, Eddy van Doorslaer. 2013. Financial protection of patients through compensation of providers: The impact of Health Equity Funds in Cambodia. Journal of Health Economics 32: 1180-1193.
[16] World Bank, June 2016, Utilization and Impact of Health Equity Funds (HEFs). Improving Entitled Benefits Uptake by the Poor (referred to in this report as the HEF utilization survey for short).
[17] Salas V & Srun S. 2013. 'An Exploration of Social Exclusion of Lesbians, Gay and Transgender Persons in Families and Communities and their ways of coping.' Research report. Social Protection Coordination Unit, Council for Agricultural Research and Development (SPCU-CARD), Phnom Penh.
[18] The term "post-IDPoor" refers to an assessment that is conducted after/outside of the periodic assessments undertaken by the Ministry of Planning to (MOP) identify IDPoor households. These "post-IDPoor" assessment allows households to become qualified for HEF support if they were missed or were not granted IDPoor status under the MOP procedures.
[19] At least 25% of the members of the village level IDPoor identification committee must be women.
[20] Verbal report from GIZ technical team supporting the IDPoor program.

again there is no clear gender gap. The planned 2017-18 IDPoor Optimisation Study will be an opportunity to explore these gender issues further[21].

Household decision making, availability and control over cash: Women's control over household resources in Cambodia varies. CDHS 2014 found that nationally 74% of women aged 15-49 who earned cash in the previous 12 months decided how that cash was spent, however this was only 36% in Banteay Meanchey and 24% in Mondul Kiri/Ratanak Kiri. Our community consultations in Kratie and Mondul Kiri with women and men respectively, found that men have a large say in women's and family health decision-making in some places, with some women and men deciding on health seeking together while in other families men or women decide alone. PSL related research in the four north-eastern provinces shows that husbands, a woman's parents and elders play a strong role in decision making on women's and family health care[22]. Women's lack of decision-making authority and access to cash intersects with and magnifies the geographical barriers that remote ethnic minority women face in accessing health care[23].

> Men and older family members mediate women's care in hospital. Several women in Kratie and Mondul Kiri did not know the cost of services they received because this was the responsibility of men.

Kratie Provincial Health Directorate reported that lack of pocket money was a reason why families did not accept referral to national level facilities, and that women are dependent on men for pocket money. For the small number of people requiring referral to tertiary facilities the uncertainty of expenses was a barrier. The non-coverage of HEF at some of the national hospitals, including the National Maternal and Child Health Centre (NMCHC), also impacted referral from secondary facilities. Although NMCHC can exempt the fees for the poor, the hospital is unable to cover transport costs.

Availability

Geographical coverage of health services: The availability of public health services has steadily improved across the country in line with the norms set out in the Health Coverage Plan though staff retention remains problematic. In remote areas where the catchment population of health centres covers scattered populations across large geographical areas, outreach services are critical to take essential services out to clients. The cost of providing outreach in remote areas is more expensive than in other areas and physically demanding for health staff. For example several villages in Sre Chouk Commune in the catchment area of Keo Seyma Health Centre in Mondul Kiri are over 100km from the health centre. Me Mang Health Centre is also inaccessible in the rainy season other than by modified-vehicles that can traverse treacherous unpaved muddy roads. Mondul Kiri PHD recognises the importance of outreach for serving the local population and has provided motorbikes to some health centres for this purpose. While there is a standard outreach incentive for health staff recommended by MOH for food and pocket money per outreach trip, the amount is too low to cover these costs when delivering outreach to very remote communities where for example staff may need to overnight. An additional, exceptional, incentive is needed to increase outreach to remote or hard to reach areas. Poor road and weather conditions mean that outreach only takes place 3-4 times per year rather than the norm of once per month in most facilities in Mondul Kiri.

> For the first quarter of 2017, 165 outreach activities took place in Mondul Kiri province against the planned number of 252, some 65%. [Report on Indigenous People (2017), Sen Monorom District]

[21] The purpose of the study is to take stock of the current IDPoor system and compare it to its original intent, specifically capturing the current state of components related to implementation, scoring, and the ability to mitigate errors of inclusion and exclusion.

[22] Kim Ozano. June 2016. PSL Evaluation Report. Behaviour Change Communication Activities in the North-East of Cambodia.

[23] See also Eleanor Brown. July 2005. "Crossing the River and Getting to the Other Side. Access to Maternal Health Services amongst Ethnic Minority Communities in Rattanakiri Province, Cambodia". Health Unlimited.

Awareness of health services: The level of awareness of the package of services available at public health facilities appears weaker among those who are less well educated, and less connected to community and local authority structures, such as migrant workers, unmarried adolescents and remote communities. Although there is no robust evidence pointing to a gender difference in awareness of health care availability, socially excluded women and vulnerable girls are likely to be at risk of information deficits and the authority to decide to seek health care. Cultural taboos around unmarried girls learning about or using contraceptives in Mondul Kiri and Ratanak Kiri and the cultural acceptance of early marriage mean that many adolescent girls are married and pregnant while in their teenage years.

Awareness of HEF: The preliminary results from the HEF utilisation survey (2016) found that only 44% of those entitled to HEFs reported to be aware of HEF benefits (sex disaggregated data not available) illustrates the large health information gaps prevalent at the community level. From our fieldwork we found less awareness of IDPoor and HEF entitlements among FGD participants in Mondul Kiri than in Kratie. Some IDPoor continued to pay fees at the health centre. One woman In Mondul Kiri reported how she was exasperated by the confusion over whether her expired card entitled her to free care or not, and now didn't bother to ask for free care. Health staffs were also confused about expired cards in both provinces.

Poor availability of services for some occupational groups: Various occupational groups face barriers in accessing health services due to clinic timings and the non-availability of facilities such as female factory workers who work long and rotating shifts. The non-availability of health services close to where migrant workers work and live hinders the access of this poor and vulnerable population.

Acceptability

Cultural beliefs: The cultural beliefs and practices of indigenous populations in north-eastern Cambodia affect access to and demand for public health care[24]. As reported in other studies, we found that traditional cultural beliefs among ethnic minorities in Mondul Kiri around the polluting nature of pregnancy and obstetric related blood including miscarriage to be a barrier to care for pregnant women[25]. Discussions with community women and interviews with female elders reported how pregnant women who bleed outside of their home have to initiate village prayers and pay compensation for bleeding on others' land or property often having to sacrifice a buffalo or other farm animal. Similarly, research in Ratanak Kiri found that the practice of paying compensation for transporting a dead body through a village deterred families from seeking health care for the seriously ill who may die outside the village, including pregnant women[26]. Failure to pay fines or lead prayers was said to lead to 'bad luck' on the village, which in turn caused child and maternal deaths. Several stakeholders reported that this belief deterred husbands and family members from permitting pregnant women to deliver in a health facility, to discourage transporters to convey pregnant women, and to underline the importance of having a waiting home at health facilities where pregnant women could wait pre and post delivery.

Other cultural practices among ethnic minority peoples that affect access to health care include the need to receive permission for surgical procedures from husbands and elders. Mondul Kiri Provincial Hospital management reported that ethnic minority patients sometimes return home to pray before agreeing to surgery. Roasting post delivery is a common practice and in addition to the risk of accidents, dehydration and respiratory tract infections for the newborn, roasting discourages the family from seeking post natal care.

[24] There are several ethnic groups living in north-east Cambodia each with their own specific social structures and cultural beliefs.

[25] Breogan Consulting. March 017. Research on Indigenous Parenting Practices Across the Generations. Plan International Cambodia.

[26] Eleanor Brown. July 2005. "Crossing the River and Getting to the Other Side. Access to Maternal Health Services amongst Ethnic Minority Communities in Rattanakiri Province, Cambodia". Health Unlimited.

Ethnic minority staff: The majority of health providers in Mondul Kiri are not of ethnic minority origin, although health centres in areas highly populated by ethnic minorities, such as Ou Raing and Me Mang Health Centres, were reported as having ethnic minority staff and one health centre chief. Mondul Kiri PHD expressed major constraints in terms of staff retention, especially in remote areas that are more likely to be populated by ethnic minorities. Providing staff accommodation at health facilities as well as prioritizing local staff recruitment, including of ethnic staff, were both raised as potential avenues to address this issue. All stakeholders met with recognized the benefits and objectives of prioritizing training of local people for health staff positions in order to increase retention and improve communication. Of note, one Pnong ethnic minority community consulted with in Bou Sra administrative district in Mondul Kiri province reported feeling comfortable complaining about poor health staff behavior to a health centre chief who was also from an ethnic minority to take action.

Language: It was generally reported that language is not a barrier for indigenous and ethnic minority persons at health facilities staffed with Khmer speakers given the increasing numbers of young people who have learned Khmer at school and are available to help translate for family members. However, despite these important social changes, several health workers mentioned the need to repeat instructions to indigenous or ethnic minority clients, and spend more time explaining and guiding them through a facility given that they often do not read Khmer or understand the system. One health centre chief shared how indigenous women described pain in general terms that reflected their lower education levels and overall understanding of their health condition than Khmer persons, and their different understanding about how the body works. Some health staff were also irritated by the 'too much talk' and large number of family members that accompanied indigenous and ethnic minority patients, and struggled with the cultural beliefs that indigenous families adhered to such as permission seeking from husbands and elders, and returning to the village to pray before surgical procedures. In a few cases, health staff met with characterized indigenous patients as "unhygienic", "smelly", "uneducated", and "stubborn".

CARE has provided 'attitude training' to health workers in Mondul Kiri. One Health Centre Chief felt the training was useful as it exposed health workers to patient and provider rights, improved their understanding of indigenous people's culture and improved communication with clients.

Discrimination: Studies have collected evidence from ethnic minority groups of their experience of discrimination at health facilities due to their ethnicity. The Social Assessment for H-EQIP found that over half of the focus groups with ethnic groups (52%) reported having experienced discrimination at health facilities. Similarly, the 2005 study by Eleanor Brown for the Action Research for Advocacy Project, which aimed to provide a user-centred account of indigenous people's experiences in accessing public services for maternal health in Rattanak Kiri province ranked - in both men's and women's groups - that key issues in accessing care were strong discrimination from the health staff toward them, or health staff blaming and/or ignoring them when trying to receive health care.

Stigma and discrimination towards LGBTI persons in the community and from a range of service providers including health workers was reported during our consultations with LGBTI groups. LGBTI persons were reported to face violence and social exclusion in the community and discrimination and lack of empathy and understanding of health workers.

Poor staff attitudes and behaviour: During our community discussions, examples of staff treating patients well were reported. Reports of poor staff behaviour were more frequent than praise and included instances of families having to pay extra money for health workers to attend to patients, health workers using harsh language, being inattentive on night shift, looking down on poor and LGBTI patients, and reprimanding women calling out in labour. Some of the negative perceptions of staff behaviours were most likely linked to user preference for injections and 'strong' medicines but did not account for all complaints.

Findings from other studies endorse the user perception of poor staff attitudes. The HEF Utilisation Survey (2016) asked HEF beneficiaries how they would like public health services to be improved and the most common suggestion was to improve the skills and attitudes of health workers. This was also evident in the 2015 Social Assessment Report for H-EQIP, where more than half (53%) of focus group discussions conducted named changes in health staff behaviour and attitudes as the key change that they wished to have. This was even higher for indigenous/ethnic minority populations (61%).

Gender differences in perceptions of quality care: Most women reported that they preferred a female provider especially for reproductive and maternal health services but will accept a male if they have no choice. This appeared less culturally acceptable for some indigenous groups and could be a barrier to their access. From our rapid investigation we did not identify any difference between what men and women expect from quality health care. In other countries gender differences have been found with women placing greater importance on staff communication and health facility cleanliness and men on waiting times.

Women's voice and agency

Gender based violence

Violence against women is a cause and a consequence of gender inequality or gender based violence (GBV). The Committee of the UN Convention on the Elimination of all Forms of Discrimination Against Women defines GBV as "violence that is directed against a woman because she is a woman or that affects women disproportionately". GBV may also be targeted towards transgender individuals. GBV is defined as acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.

The RGC's National Survey on Women's Health and Life Experiences in 2015 found that:

- 21% of women who had ever been in a relationship had experienced physical and/or sexual violence by an intimate partner at least once in their lifetime. One quarter of these women were injured at least once and only half of the women who reported that they needed care for their injuries sought health care. 49% of the women who experienced physical or sexual violence never told anyone about the violence. 32% of ever-partnered women experienced emotional abuse in their lifetime. For all types of intimate partner violence, women are more likely to experience frequent acts of violence rather than one-off incidents.
- Violence by non-intimate partners is lower but significant. 14% of women aged 15-64 reported physical violence by a non-intimate partner in their life and 4% reported sexual violence. 20% of women reported their first sexual experience was coerced (18%) or forced (2%). 5% of women reported experiencing some form of sexual harassment in their lifetime.
- As found in similar studies in the region, survivors often condone intimate partner abuse. 58% of women who have experienced physical or sexual intimate partner violence condone a husband/partner hitting his wife/partner in particular situations. 19% of ever partnered women did not believe that a married woman could refuse sex.
- Women who had experienced intimate partner violence were more likely to have had an abortion or miscarriage, larger number of children and more unplanned pregnancies. They were also forced to miss days of paid and unpaid work due to the violence.
- 31% of women who experienced intimate partner violence reported that their children witnessed the violent act several times. Children of abused women were more likely to experience emotional and behavioural problems, to repeat years of school or drop out of school. International evidence shows that witnessing violence between parents increases a girl's risk of her experiencing violence from her own partner when she is an

adult, and increases the risk that boys perpetrate violence in their own adult relationships.

Salas and Srorn (2013) found that 57 percent of gay and lesbian respondents and 66 percent of transgender females reported domestic violence, including by a range of family members including parents, siblings, aunts, uncles, grandparents, and partners.

The Second National Action Plan to Prevent Violence Against Women (NAPVAW II) 2014-2018 promotes prevention interventions, access to quality services, and multi-sectoral coordination and cooperation to reduce violence against women. The health sector's response to GBV has been relatively slow. The National Guidelines for Managing Violence Against Women and Children in the Health System (2014) was followed by the development of a clinical handbook and training curriculum to build health worker capacity. This training is currently being rolled out in nine provinces through cascade training. Forensic training has also been provided and the provision for free forensic services. While beyond the scope of H-EQIP, the availability of this training material represents an opportunity to integrate elements into both pre- and in-service training of health staff, which H-EQIP aims to strengthen through the financing of DLIs 1 and 2.

Complaints about health services

From our fieldwork we found that few women or men said they ever complained about poor health service though men tended to report doing so more often than women[27]. As other studies have found, people tend to choose other sources of health care (private) if they are not satisfied with public health services and have the money to do so rather than voice complaints[28]. One of the reasons why people do not complain about poor service is they fear a negative backlash towards them and the possible denial of treatment. People also reported that they assume nothing will happen even if they do complain, an attitude partly based on past experience. A lack of trust in the complaint box was also voiced. Cambodia's strong cultural respect of authority also affects the willingness to voice complaints[29].

Figure 10 below presents the complaints made by HEF beneficiaries and registered by HEF monitors in 2015 and selective months of 2016 and 2017. Data collection on complaints stopped in 2016 when HEF Operator responsibilities were transferred to hospitals and resumed in 2017 when funds for non-medical benefits became available. The larger number of complaints made by women than men reflects the fact that they are more frequent users of public health services and HEF. Overall the top three complaints made by women were bad behaviour of health staff, did not receive transportation and unofficial payments requested, the ranking varied by type of health facility. For men the overall top three complaints were bad behaviour of health staff, request to buy additional drug/medical supply and request additional services. See Annex 3 for more detailed information.

	2015 (Jan-Dec)	2016 (Jan- May)	2017 (May-Jul)
Female	899	327	235
Male	382	107	83
Total	1283	436	319

Table 10: Complaints about HEF made by beneficiaries by year and gender, URC

Women's participation in health governance structures

Health Centre Management Committees (HCMC) are composed of 9-11 members. The composition of the HCMC does not stipulate the gender balance. The Chair is the Vice Chief of

[27] This was also reported in the H-EQIP Social Assessment (2015).

[28] World Bank and The Asia Foundation. 2013. Voice and choice and decision 2. A study of local basic service delivery in Cambodia.

[29] The presence of a district official in the first half of one of the focus group discussions muted the complaints of the participants though they become more critical of health services after they had left.

the Commune Council responsible for social affairs, the Vice-Chair is the Chief of the Health Centre, there is one additional person from the Commune Council usually the Commune Council for Women and Children (CCWC), and one additional person from the Health Centre such as the midwife, and 4-7 Village Health Support Group (VHSG) Leaders[30]. VHSGs are typically village leaders or deputy village leaders or village committee members or the wives of these officials. In some areas, the norm of one woman and one man per village is not adhered to, partly due to women's low literacy levels and the education requirement of VHSGs.

The HCMC and the VHSGs are the formal vehicles for community participation as set out in the MOH's 2008 Community Participation Policy. The functional integration of health centres with local government under decentralisation and deconcentration will transfer ownership of health centres to Commune Councils from the PHD and OD, and authority over the community participation structure. Reproductive and Child Health Alliance (RACHA) is facilitating this process in 22 OD. They find that the capacity of commune members is low, and this contributes to their uneven knowledge of, and reluctance to deploy their full powers of delegation. Commune Councils continue to prioritise infrastructure in their Commune Investment Plans and health is not generally of high political interest or funding priority. While there does seem to be increasing political interest in increasing the number of women involved in the political arena as shown in the recent commune elections, men continue to dominate local political decision-making[31].

Women's economic empowerment and leadership

Women in the health workforce and leadership

Female health providers made up just over 50% of the overall health workforce in Cambodia in 2015. However, the number of women in leadership positions in the sector at the national and sub-national levels is limited. Though the health sector has made progress in promoting and retaining more female staff to senior or leadership levels, less than 15% of leadership positions were filled by females in 2015, with a very low 4.8% at the OD level; see Figure 14. This situation was confirmed by the field visits.

Table 11: Women in the health workforce

	2013	2014	2015
Number health personnel in health sector			
Female	9401	10132	10576
Total	19721	20668	20954
Percentage	47.7	49	50.5

Source: Department of Human Resource Development (2017)

[30] A VHSG comprises one VHSG Leader and one VHSG member per 10-50 households, selected to maintain a gender balance. They should live in the village where they serve, have good communication skills and be between 20 and 55 years old. The community elects a VHSG Leader. The community, the Health Centre and the Operational District, selects VHSG members.

[31] Kim Sedara, Joakim Ojendal, Chhoun Nareth, Ly Tem. 2012. A Gendered Analysis of Decentralisation Reform in Cambodia. CDRI Working Paper Series No. 71. Cambodia Development Resource Institute.

While women constitute the majority of the workforce at the health centre level, leadership positions at each facility and administrative level are male dominated. Although at the health centre level there is more gender balance in leadership compared to OD, PHD and hospital level. It is significant that across the different types of providers, women make up 100% of midwives, while males constitute the majority of general doctors and specialists. Women are under represented in higher specialized skills and leadership in the sector.

Table 12: Sex disaggregation of management and staff in Chhlong and Kratie ODs

	Chhlong OD		Kratie OD	
	Male	Female	Male	Female
Chief/deputy Chief of bureau	2	0	2	0
HC Chief	8	2	12	6
HC Deputy Chief	4	5	4	9
HC staff	41	80	88	139

Table 13: Sex disaggregation of Kratie PHD management

	Male	Female
Director PHD	1	0
Deputy Director PHD	3	0
Director/Chief office/bureau	2	1
Deputy Directory/Chief office/bureau	2	3

Table 14: Women in leadership positions in the health sector

	2013	2014	2015
Number of women in leadership positions* in health sector overall			
Female	169	165	178
Total	1209	1190	1214
Percentage	14	13.9	14.7
Number (and percentage) of leadership positions* in health sector by level filled by women			
National	107 (21.3%)	104 (20.4%)	113 (22.8%)
Provincial	56 (12.3%)	51 (11.3%)	54 (11%)
OD	6 (2.4%)	10 (4.4%)	11 (4.8%)

* Leadership includes at national level, Secretary of State and Deputy Secretary of State, Directors and Deputy Directors of departments and office/bureau; at provincial level, Directors and Deputy Directors of PHD and office/bureau; at OD level, Chief and Deputy Chief.

Policy response to promote women in leadership

Though the health sector has made good progress in attracting more women into the health workforce in recent years, and the GMAG has prioritized increasing opportunities for women, there seems to be no clear strategy or policy to attract and inspire women for leadership positions, or to mainstream gender in recruitment and promotion practices and systems.

Several national and provincial stakeholders explained that recruitment and promotion favors women when women can demonstrate the same qualifications as those of men. It was mentioned that "[in recruitment] women are preferred if the score is the same". An intention to promote and attract more women into the workforce and leadership positions as long as women can demonstrate an equal capacity to male equivalents was expressed across the sector. No special consideration was given to the gender norms and unpaid work burden that act to disadvantage women in career progression or taking on leadership. Some key informants suggested that women have to demonstrate their own capacity before they can receive attention to be promoted in leadership. This could imply that women have to compete with

their male counterparts, but also with female colleagues in order to prove that they are capable enough to take on a leadership position.

Women's workforce participation and leadership

Consultations at national and sub-national levels identified several barriers to women's participation in the health workforce and in leadership positions: a double burden for women in managing their unpaid work within the household and their paid work as a health provider or manager; safety and security of female providers due to lack of accommodation at health facilities, particularly in remote areas; and confronting gender stereotypes when taking on leadership positions.

Women in leadership positions reported the struggle and difficulties of balancing their management role and their family and household responsibilities. In one case, a female chief of a health centre reported how she asked to step down after her promotion to be the chief due to the conflict and heavy demands on her from her work at the health centre and the expected roles she had to perform at home for her extended family and husband. The challenges and double burden that female managers face were not raised by male managers.

In order to tackle this issue, a few female managers explained how they played a supportive or coaching role to women in leadership positions to help them overcome the social and organizational challenges that female managers face. As found in the international literature, female managers in Cambodia act as role models and encourage other women into leadership positions[32]. An OD Director noted that since taking her position, she had successfully encouraged four of 11 health centres to have female chiefs. Similarly, a female commune council chief met with in Kratie province mentioned that having more women as chiefs of health centres would help address the main gender issues in her community, such as GBV.

Staff security was not considered a barrier for women's workforce participation at the national level. However, the field consultations clearly showed this to be an issue for female providers. PHD, ODs and facility chiefs explained how this was factored into deployment, rotation teams, night shift and outreach duties. Health centres typically include male and female staff on night shift, a mix of married and single women, and deploy mixed sex teams for outreach for safety and other reasons. Female security is compounded by remoteness and therefore particularly sensitive where health centres are very isolated and outreach has to cover large under-populated areas. Another factor that enhances management concerns is the deployment of single women from outside the province especially given the lack of accommodation at health facilities and the difficulty for health workers to find or afford accommodation in some areas. The lack of dedicated space for staff on night shift was felt to be a problem in all areas visited and is made more problematic when staffs bring family members to accompany them for security reasons; this has a negative effect on staff deployment and retention. Security risks are perceived to be greater where health centres are located on the periphery of settlements, in areas where there are transient people including security forces, and in urban neighbourhoods where drug use is a problem.

Gender stereotypes portray women as unsuitable for leadership

Female leaders shared how male subordinates are still reluctant to accept women as their leader or supervisor due to the pervasiveness of gender stereotypes that define women as unsuitable for leadership and decision-making. This has strong implications for attracting more women into leadership. In a few cases, women managers reported facing resistance and sometimes hostility from male colleagues who found it difficult to accept a female manager, particularly when she was younger than them. In addition, there is limited concern at national or provincial level in

[32] Tam O'Neill, Georgia Plank, Pilar Domingo. 2015. Support to women and girl's leadership a rapid review of the evidence. Overseas Development Institute. https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9623.pdf

how to correct the gender balance in leadership of the health sector despite the national commitment to gender equality and gender balance in leadership. The mechanisms to attract women into leadership in the health sector do not currently incorporate support for women to manage the unpaid work burden they carry or the organizational culture and social norms that discourage women from taking on leadership. In this respect, improvements are needed to bring the health sector in line with the national focus on enabling women into decision-making positions as a means of increasing organizational performance and effectiveness[33].

Lack of leadership training for female staff

Stakeholders reported no leadership training for women at national or sub-national level. This is an issue in terms of preparing the human resource pipeline to fill the upcoming retirement of senior female staff. There is currently no strategy for capacity building and mentoring women to equip them to compete on the grounds of "women with equal capacity to men" to be the pipeline leaders. Unless this gap is addressed the gender ratio in leadership that has been attained at the national level will likely drop and the large shortfall at sub-national levels will continue to widen.

Health Equity and Quality Improvement Project

In this section of the report we assess how the project components and results framework address gender. We identify gaps; propose how the project can address them and what can be done beyond the project.

Component 1: Strengthening health service delivery

This component expands existing SDG, including fixed lump-sum and performance-based grants to health centres and secondary level hospitals. The component aims to incentivise improvement in the quality of primary and secondary care through expanded SDG, and strengthen supervision and quality assurance by OD and PHD. During our field visits we heard how fixed lump-sum grants are being used to upgrade facilities and fill immediate shortfalls in supplies including for example procurement of additional drugs and buying glass for drug store windows. The lump-sum grants appear to being used well. The performance-based grants are becoming operational now that the National Quality Enhancement and Monitoring Tools (NQEMT) have been developed and are being used in the first tranche of 13 provinces. The gender assessment team reviewed the NQEMTs and consulted assessors that have been trained in Mondul Kiri on their experience applying them.

NQEMT for hospitals and health centres

Development and testing of the assessment tools is a notable achievement of the newly formed Quality Assessment Office (QAO) under the Department of Hospital Services. Achieving a balance of robust, simple assessment tools and questions that are appropriate for the level of capacity across the country and can be implemented quarterly is inevitably a challenge.

The focus on the assessment of clinical skills given the known quality gaps in the service is understandable. Much less attention is given to staff attitudes and provider-patient communication, though from the user's perspective this is a major weakness in quality of care. In part because of the focus on clinical skills there is limited consideration of gender or social inclusion in the design of the tools. As the NQEMTs will be reviewed and revised with implementation experience, we propose how the QAO can address gender gaps during the course of on-going review and revision.

[33] See National Committee for Sub-National Democratic Development, Strategy and Action Plan to Increase Women in SNA Management Positions (2017-2019), 19 May 2017.

Assessor team and implementation: The NQEMT does not explicitly define the gender mix of the assessment team for SDGs financed under H-EQIP but inclusion of secondary midwives provides for female participation. The tendency for PHD and OD management teams to be male dominated makes it difficult to have a gender balanced assessment team[34]. To reinforce the importance of gender balance, we suggest the QAO emphasize and monitor the requirement in the annual instruction for conducting the NQEMP to have at least one woman in each assessment team and promote additional qualified women to be on assessment teams in contexts where this is feasible.

Assessors reported challenges in implementing the tools due to differentiated needs among service contexts. For example it was reported that it was difficult to use the Khmer tool when the assessment is undertaken in an ethnic minority language. It was also mentioned that there are sometimes difficulties when women assess men; "better if women assess women". Given the workload involved in quality assessment and the large geographical coverage of Mondul Kiri province, the PHD recommended that more assessors be trained so that the workload could be more evenly shared across three rather than two assessment teams and additional assessors trained to act as reserves when needed. Assessors also pointed out the need for more practical training.

Staff attitudes and communication skills: The tool uses vignettes focus on the clinical knowledge of the health provider rather than how s/he communicates information or counsels a client. Approximately 20 clinical vignettes have been developed and more are planned. Currently the NQEMT tools do not assess health staff capacity to communicate with different population groups including different genders, or sensitivity to those with special needs or vulnerable persons such as survivors of GBV, people living with disability, ethnic minority persons, LGBTI persons or adolescents.

For use in the NQEMT assessments, the existing template of individual performance evaluation for health staff and questionnaire for client interview should be updated to include staff behaviour regarding politeness and non-discrimination to the poor, indigenous and ethnic minority, disabled, and LGBTI patients. Additionally, staff individual performance evaluation forms should include principles related to attitudes and behaviour of staff, respect and non-discrimination, including towards persons of different genders and vulnerable population groups.

Client satisfaction interviews: The tool that collects client satisfaction information as a part of the NQEMT assessment specifically asks clients one question on the friendliness of health providers, and four questions on how the health provider communicated information. The socio-demographic data of clients interviewed includes their sex, age, education, HEF and marital status but not ethnicity, disability or travel time to the facility. The tool includes an emphasis on women who have recently delivered. However the client satisfaction data is collected via a telephone interview and this raises a number of concerns.

- While mobile phone coverage is extensive in Cambodia, women do not always have their own mobile phone and the numbers they provide at facilities may be those of their husband/partner or another family member[35]. Trying to contact women through their husband's/partner's phone raises confidentiality issues and could put the woman at risk. In Mondul Kiri, one assessor reported how he had called a client to get her feedback on services but inadvertently reached her husband whose number she had given. The husband was initially questioning and confused as to why an unknown male was trying

[34] For example, only the MCH Chief and OD Chief are female in the Mondul Kiri provincial management team.
[35] 93% of women and 97% of men reported ownership of a mobile phone in a sample survey in 2015; the sample included Stung Treng to represent the plateau and mountain region. Kimchoy Phong and Javier Sola. 2015. Mobile phones and internet in Cambodia in 2015. Open Institute, Development Innovations and The Asia Foundation.

to reach his wife. Exposing women's health seeking could potentially put women at risk of harm.

- Mobile phone network coverage is very poor in remote areas such as Mondul Kiri and is not a reliable way to elicit client satisfaction. This is an important gap for the facility in terms of understanding how they can improve quality and impacts the facility's overall quality score.
- Assessor led telephone inquiries may not be able to create the conditions of trust for clients to feel secure in providing honest feedback and may generate false impressions of client satisfaction.

Alternative methods of collecting client feedback and safeguarding vulnerable women also merits consideration. In areas where Implementation of Social Accountability Framework (ISAF) is being implemented, community scores of health facilities collected during the annual ISAF cycle could be transferred into a measure of client feedback for the quality assessment process. This would increase the traction of ISAF by linking community health scores to performance based grants. The ISAF community scores are collected between May and September once a year (see annual ISAF cycle below). Progress in delivering against the joint accountability action plans for health that are developed as a response to provider assessments and community scorecards could then be used as an update on the community scorecard during a later quality assessment.

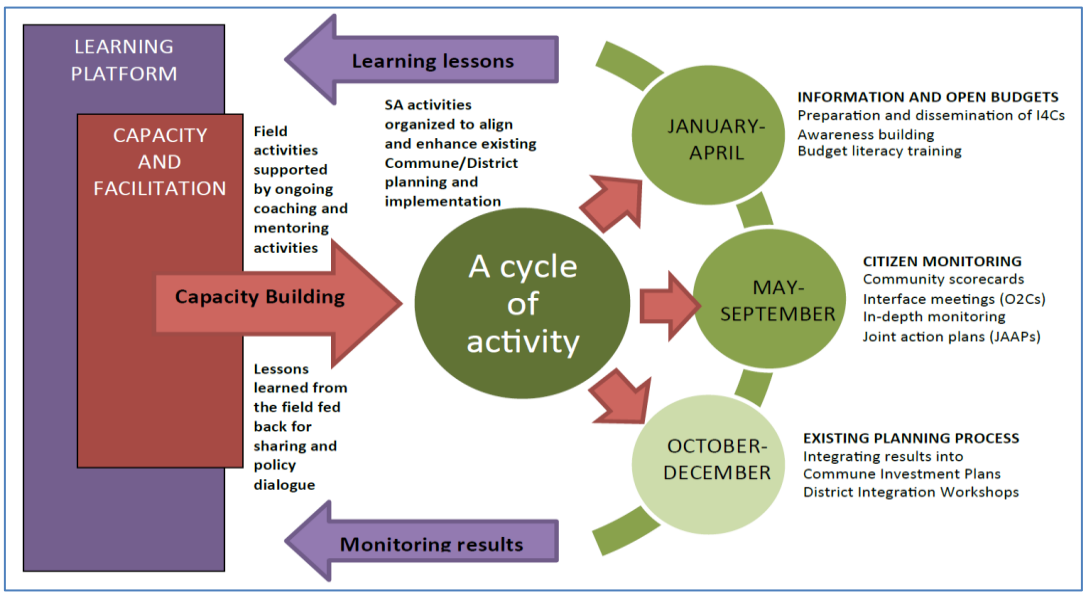


Figure 15: ISAF annual cycle

In non-ISAF areas and complementary to using ISAF inputs, the Ministry may also consider collecting client feedback via a national toll free phone service. An incentive, such as credit top-up of the client's mobile number, could be a means of encouraging clients to feedback. Health providers at the point of service delivery could market the service; it would be in their interest for clients to respond. Clients would have the freedom to choose when to make the call thus overcoming issues of privacy and confidentiality. This approach would however still not overcome the challenge of engaging women and men without access to a mobile phone.

A more rigorous approach would be user surveys undertaken by a third party agency though the cost of repeated sample surveys raises sustainability concerns. To limit the cost, such surveys could just be used in the most remote areas where connectivity is the lowest. A blend of approaches may be necessary to respond to what is feasible and practicable in different areas of the country and for different client groups. In selective areas where there are particularly difficult barriers linked to communication systems and access, the MOH could consider either engaging HEF Promoters to undertake this task during their community based HEF promotional work or contracting a local CSO to collect a sample of client views.

As an interim measure, it should be ensured that all assessors are trained on the potential risks of telephone interviewing clients, how to sensitively introduce themselves and the purpose of the call to prevent raising family concerns, and how best they can try to manage any negative tensions the call may create. It is also recommended that female assessors take responsibility for phoning female clients and male assessors for male clients.

Possible gender differences in user expectations of quality of care warrant attention and we recommend a study be undertaken into this subject and findings factored into the design of NQEMT, if feasible.

Women's participation in HCMCs: Beyond H-EQIP we recommend that the MoH's Community Participation Policy be revised in line with the national strategy on decentralisation and deconcentration, and that its gender responsiveness is strengthened including balanced gender representation in the HCMC with an aim of 50% female members.

Context responsive assessment tools: The MOH's intention to have a standard set of national assessment tools that can be applied nationwide means that the tools are not designed to respond to the different geographical and social contexts of where services are delivered. In provinces such as Mondul Kiri and Ratanak Kiri where there are high numbers of indigenous and ethnic minority persons and related cultural and language barriers as well as large catchment areas with difficult terrain and transportation, these important factors that affect quality of care and most importantly how facilities and health providers respond to them are overlooked. Especially in provinces with a significant number of indigenous and ethnic minority people, a method for measuring the sensitivity of health providers and the facility to the needs of ethnic populations needs inclusion, such as through the above referenced, individual performance evaluation and questionnaires for client interview in the NQEMT

Overlapping with ethnicity in some parts of Cambodia is remoteness although the two are not mutually inclusive. The health centre assessment tools do not currently capture the fact that outreach services are essential and more important for people living in remote and difficult to reach areas than static facilities. We propose that beyond H-EQIP, an additional sub-tool or set of questions on the implementation and quality of outreach be included for those health centres that cover large geographical areas (eg Mondul Kiri) or include populations living in difficult to reach areas (eg unpaved and poorly accessible parts of Kratie) even if only seasonal, and which rely on outreach services.

Rewarding local solutions and gender and social inclusion responsiveness:

We found that health teams are already implementing local solutions to local service delivery challenges. We recommend that increasing the allocation of SDG performance grants to health facilities in remote/difficult to access areas would assist to support local solutions and improve quality of and access to health service delivery. To underpin local solutions, we propose that SDG encourage health centres to identify vulnerable populations in their catchment areas and the barriers they face in accessing services, and identify gender and social inclusion issues that hinder health staff from providing quality care. Local solutions that help overcome these demand or supply side barriers to accessing and providing quality services could then be eligible for funding from the SDG. This could include interventions such as measures to build community confidence in health facilities

Table 16: Provinces and remote villages

Province	# of villages >40 km to health centre
Battambang	20
Kampang Cham	1
Kampong Speu	16
Kampong Thom	33
Koh Kong	7
Kratie	34
Mondul Kiri	26
Prey Vihear	13
Pursat	13
Ratanak Kiri	21
Steung Treng	3

among ethnic communities through community engagement activities led by indigenous and ethnic minority VHSGs and traditional birth attendants (TBA), efforts to increase female staff security such as through community watch groups, and special childcare arrangements for female health staff when they undertake outreach duties.

Building capacity of assessors to be gender responsive and socially inclusive

Medical and health education has begun to include communication skills training but in the past this was almost non-existent. Many of the health providers in service and their management have never received training in provider-patient communication and counselling and how to be compassionate and effective communicators[36]. Through their quality coaching and supervision of health staff, NQEMP quality assessors have the potential to increase staff understanding and skills in this area; complementary in-service training is also recommended for health providers and managers. Perhaps beyond the scope of H-EQIP, we recommend MOH develop a gender and social inclusion module including caring and respectful communication that could be included in various in-service training programs implemented by the Ministry. Job aids and training materials will need to be developed. The 'attitude training' curriculum that CARE has been delivering in Mondul Kiri under the PSL project could provide a foundation for the training module.

Inclusion of gender and social inclusion in OD and PHD assessment criteria

Gender and social inclusion are currently not included in the PHD and OD assessment criteria. In future revision of the tools, these topics could be included as items in PHD and OD monthly meeting agendas and in training/sharing experiences with referral hospitals and health centres respectively. Points could be awarded to those PHD and OD that cover these topics.

Staff retention

While it may be difficult to capture within the assessment criteria for SDGs, staff retention is an important determinant of quality of care and affects demand for public health services. This study did not explore staff absenteeism and staffing gaps comprehensively given the limited remit of H-EQIP, but two issues did arise from our consultations. One is that female health staff security is an issue for deployment and retention, and two that staff retention was reported as being better among staff that come from the local area in Mondul Kiri.

Female staff security: Health managers and providers deploy various mitigation strategies to address female staff security concerns. Beyond the health service, local responses include the construction of staff accommodation and links to the police. To assist MOH, PHD and ODs to develop short and medium term mitigation strategies, we propose a study be undertaken on how female staff cope with security concerns in different environments and the various strategies being used to mitigate security issues.

Staffing areas with high indigenous and ethnic minority populations: The Government's plans to increase the number of indigenous and ethnic minority persons trained and hired for the public health service responds to the challenge of retaining non-ethnic staff in some provinces and the greater acceptability of ethnic staff in those areas[37]. However, the lower education levels of boys and girls in provinces in the north-east, and their higher drop out rates from secondary school is a barrier. Moreover, the highly competitive nature of getting entry into pre-service medical and health training and the social and cultural pressures on ethnic young women to marry deter them from being successful in sustaining higher studies. The government's earlier

[36] Verbal communication of the Rector of University of Health Sciences.

[37] It was reported that ethnic minority candidates that meet the minimum requirements are given priority acceptance to pre-service training at Stung Treng Regional Training Centre.

policy of lowering the bar to access medical and health training for disadvantaged populations was felt to have negatively impacted standards[38].

While we appreciate that this issue is beyond the scope of H-EQIP, the lack of local health staff in the north-east is a serious impediment to access to quality health care for ethnic minority populations in those areas. We therefore recommend that H-EQIP development partners include this issue in policy dialogue with the MOH as part of its Indigenous People's Plan and project safeguards. At a programmatic level, scholarships and other financial incentives to keep young people belonging to an ethnic minority in school to prepare a pipeline of potential students for the health service need consideration. Foundation programs or special coaching services for students from ethnic minority backgrounds especially girls, to prepare them to compete for national training places are other ways to assist disadvantaged students to compete.

Women leadership development

Prime Minister, Hun Sen's 2016 speech to the Cambodian National Council for Women's Annual Reflection Workshop recommended that the number of women in decision-making positions increase throughout all ministries, institutions and sub-national authorities. He pointed out the value and stronger performance of a diverse organisation and described the need for mentoring, training and financial support to ensure women continued to be recruited and promoted[39].

Again, while there may be limited scope to address this issue within H-EQIP, in the health sector, the very low numbers of women in leadership positions at provincial and OD levels is a glaring gap with serious implications for the performance of the organisation and creating the environment and conditions for future female leaders and gender equality. The development of, and increase in the number of women leaders in the health sector at all levels but particularly at provincial and OD, and preparing the pipeline for the national level, is one of the most important gender issues for the health system. While the MOH's policy of giving preference to women when applying for jobs and promotion when their qualifications are on par with men is a positive measure, this will be insufficient to fill the gender gap in leadership given the social norms, unpaid work burden and hostile working environments that women confront. Efforts to address the policy, institutional and social factors that deter women leadership are needed. This includes the introduction of leadership training to women through mentoring and coaching to increase their ability to compete for management positions and effectiveness as leaders, the formation of male champion networks to promote women leadership, and policies that enable women to manage their workplace demands with family and domestic responsibilities such as flexible work arrangements/schedules, workplace or community/commune council provided childcare and breastfeeding spaces. Short and longer term measures to increase women's capacity and motivation to compete for leadership positions are required. Increasing the number of women Deputy Chiefs at OD level will help fill the immediate gap at OD level and prepare women for more senior levels of leadership over time and is line with the national strategy of having district governors appoint female deputies.

While women leadership development is beyond the remit of H-EQIP implementation, H-EQIP development partners are encouraged to advocate for women leadership development measures in health sector policy forums. Successful examples of efforts to promote female leadership in the health sector from other countries could be shared as a means to identify how challenges were addressed and to provide examples of what is possible.

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[38] In 2002 the MOH lowered the entrance requirements for primary nurses and midwives to attract more ethnic minority candidates in the north-east. This was stopped in 2015. Some of the challenges have been that staff hired with lower educational qualifications for primary level positions does not meet the educational requirements to upgrade to secondary nurse or midwife; and poorer quality of care.

[39] See National Committee for Sub-National Democratic Development, Strategy and Action Plan to Increase Women in SNA Management Positions (2017-2019), 19 May 2017.

Component 2: Improving financial protection and equity

This component supports and expands the HEF system and co-finances the cost of health services for the poor with the RGC. A number of the constraints and limitations of HEFs have already been discussed and we focus here on suggestions for moving forward.

Analytical work

The HEF Utilisation Survey (2016) found a significant under-utilisation of HEFs but did not examine the extent to which different categories of the poor are benefitting from them. The fact that HEF card holders who live further from a health centre are less likely to use their HEF than an accessible card holder prompts concern that HEFs may be benefitting the poorest and remote least. Further analytical work is recommended to identify which categories of the poor and non-poor (given that the study found that about a quarter of HEF card holders are near poor and a quarter are better-off) are benefitting and the extent to which HEF is reaching down into the poor to protect the most vulnerable and destitute (ie IDPoor 1). This analysis should include a disaggregation by sex of beneficiary and sex of household head given that female headed households are more likely to be classified as IDPoor 1 as well as taking into consideration other poverty and vulnerability indicators such as geographical isolation/remoteness, disability, ethnicity and age.

Survey data has identified a number of factors that contribute to non-utilisation of HEF including the convenience, better access to and lower distance and lower transport barriers to private providers, as well as the severity of illness, beneficiaries knowledge of HEF benefits and trust and satisfaction in public providers. From this overview, we suggest that qualitative research be undertaken in specific target areas to understand the confluence of factors that explain low HEF utilisation to inform programmatic responses.

IDPoor exclusion errors underline the importance of the post-IDPoor opportunity at hospitals where more expensive inpatient services are available. Gaps in HEF implementation over the past 18 months reduced the availability of post-IDPoor and increased the number of patients that facilities exempted from paying fees and expenses. Once HEF-Promoters are in place and HEF implementation is fully operational again, we propose that an assessment be undertaken of the functioning of the post-IDPoor mechanism, which is under the control of the MOH, and the extent to which it is providing protection to poor people who have missed out on IDPoor. This assessment should identify if any specific groups of the poor are more at risk of being left out from post-IDPoor, such as indigenous and ethnic minority persons, migrants, adolescents, LGBTI. The assessment may also contribute to the baseline for monitoring the performance of HEF Promoters in undertaking post-IDPoor. The assessment findings would also provide guidance as to how HEF Promoters can target groups that are not making use of their HEF benefits and encourage them to do so.

HEF Promoters

To promote sustainability and reduce management costs, the Ministry has changed the institutional and implementation arrangements of HEFs so that the role of HEF Operator and HEF Implementer has been transferred to health facilities and new HEF Promoters. Three HEF Promoters are planned per CPA-3 referral hospital and two HEF-Promoters per CPA-1 and CPA-2 referral hospital, with the respective responsibilities of undertaking post-IDPoor assessments, providing concierge services at the hospital and promoting awareness of HEF benefits to IDPoor holders. The latter responsibility is to be implemented in coordination with government and CSO structures that can be leveraged to raise awareness. To achieve this output, it will be important that the HEF Promoter is able to coordinate among existing structures and networks to raise community awareness of HEFs. HEF Promoters will also need to work with health centres, HCMCs and VHSGs for launching direct awareness activities to highly marginalized populations in remote and difficult areas where HEF utilisation is low.. S/he will also need the scope to directly reach socially excluded peoples (eg LGBTI persons) and initiate promotional activities.

In the four north-eastern provinces with a high number of ethnic minority peoples, it is proposed that preference is given to hiring ethnic HEF Promoters that can speak the dominant indigenous language and assist in overcoming language and cultural barriers. HEF-P teams should include at least one female HEF-P per referral hospital. Given that more women are HEF beneficiaries than men, a gender balanced team of two women and one male HEF Promoter is recommended as an aim. The norm of three HEF Promoters per referral hospital does not take into account the institutional, cultural and communication challenges to raising awareness in some parts of the country. We therefore suggest that the MOH consider applying this norm flexibly so that in areas where levels of HEF awareness and utilisation are low and community mobilisation structures are weak, additional HEF Promoters or complementary methods for raising awareness can be deployed.

Training and supervision of HEF Promoters will be critical to their success. In addition to an orientation on HEFs, induction training should include effective and empathetic interpersonal communication, how to foster trust and openness and treat all people with respect and fairness, including indigenous groups, adolescent girls and the LGBTI population. The training should also cover gender equality and social inclusion, patient and provider rights, and barriers to accessing services that poor, women and excluded populations face. In provinces with high numbers of ethnic minorities, exposure to the traditional and cultural beliefs of ethnic minority populations in the area that affect health access and health outcomes should be included.

Monitoring and evaluation of the HEF Promoter structure will be important to track implementation issues and correct gaps. It will be important that such studies assess the performance of HEF Promoters, the strengths and weaknesses of the arrangement to capture HEF beneficiary complaints and feedback, and channel evidence of HEF misuse to the appropriate authority. Monitoring and evaluation also needs to include attention to gender equality and social inclusion issues.

Targeted interventions for remote areas

The barriers to accessing services in remote areas are beyond the scope of HEF to overcome, as currently designed. Reducing the equity gap in priority national health indicators such as institutional delivery will require targeted interventions for remote areas to:

i. Address the availability and cost of transportation through either increased HEF transport allowances that reflect market cost or other demand side financing mechanisms, plus the fostering of community transport arrangements that mobilise transporters and community leaders to take responsibility for essential or emergency transport on pre-agreed terms.
ii. Promote improved health seeking behaviours through community mobilisation approaches that build community solidarity and empower women and men to change family behaviours. Participatory Learning and Action (PLA) approaches as recommended by WHO have proven effective in high maternal and neonatal mortality settings similar to north-eastern Cambodia and warrant consideration[40]. PSL's experience with various forms of behaviour change communication, including pregnancy and men's clubs to raise awareness and address social norms are relevant.
iii. Enhance outreach or mobile health services that regularly take health workers to remote populations. This could include: enhanced incentives for health staff to undertake outreach in remote areas; roving health staff that spend 50% or more of

[40] Prost et al. Women's groups practicing participatory learning and action to improve maternal and newborn health in low-resource settings: a systematic review and meta-analysis. Lancet. 2013;381(9879):1736-46. WHO. WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health. 2014. World Health Organization, Geneva.

their time in the field visiting villages and households and are incentivised accordingly[41]; and the provision of mobile camp services that provide a specific range of services for targeted remote populations such as plantation workers.

iv. Strengthen the platform of community based health actors including VHSGs and TBAs, to provide a minimum package of community based services and to act as a motivator and referral link to qualified health workers. This may require more frequent supervision, increased incentives to compensate them for their time investments, and recognition of the social benefit they provide.

v. Strengthen existing health posts to more effectively reach the remote communities they serve and strengthen linkages and support provided to them from health centres. In areas with ethnic minority populations, provide cultural sensitisation and diversity training to health staff and continue to prioritise deployment of ethnic staff.

The full package of interventions outlined above is beyond the scope of H-EQIP. Some of the supply side strengthening activities could however be encouraged through SDGs with activities made eligible for SDG funding at referral hospitals and health centres. The Indigenous People's Plan may also provide opportunity to target funding at activities for increasing access in remote areas. At a minimum we recommend that development partners include discussion of the barriers and inequitable access faced by remote populations in policy dialogue and project monitoring with the MOH, and draw on evidence of the limitations of HEF and SDG to examine the context specific constraints to achieving the project's goals in remote areas.

Component 3: Ensuring sustainable and responsive health systems

This component supports health systems strengthening through (a) six DLIs related to supply-side readiness and institutional strengthening, (b) essential health infrastructure improvements and (c) project management, monitoring and evaluation (M&E).

Disbursement linked indicators

Two DLIs related to pre-service (DLI1) and in-service training (DLI2) provide opportunity for the project to engage with the Ministry and key stakeholders such as UHS on the content of training. Both the Rector of UHS and the Deputy Director of Human Resources in the MOH support the principles of gender and social inclusion, and the objective of improving the quality of health staff communication skills.

We suggest that project monitoring of DLI1 and DLI2 raise the importance of gender equality and social inclusion as an integral part of pre and in-service training, and beyond H-EQIP, for health professionals to be trained in gender sensitive and respectful communication to all as a practical way of applying these principles. The fact that the UHS is currently under curriculum reform and is working toward absorbing more female students in its School of Medicine, with 43% of current students being female, as reported by the Rector of UHS, presents an opportune time to address this issue and advocate for the inclusion of gender and social inclusion training in the revised pre-service training curriculum. This would include understanding the impact of gender norms, social stigma and social exclusion on health risks and outcomes, and how cultural beliefs such as those among Cambodia's ethnic minorities affect access to services. The training would aim to lay the foundation for supportive and compassionate attitudes and provide practical training on how health professionals can communicate and behave in a way that is sensitive to the differing needs of vulnerable and excluded people including LGBTI persons and people living with disability. It would underline the importance of respect for all and good practices on confidentiality. Beyond the parameters of H-EQIP, we propose that development partners support the government to develop modules and training materials on gender and social inclusion for a range of pre and in-service training programs.

[41] An approach tested and now being scaled up in rural Nepal.

The Ministry is in the process of rolling out in-service training on GBV and clinical guidance on the treatment of survivors of intimate partner and sexual violence. While beyond the scope of DLI1, we suggest that the project advocate for this material to be similarly incorporated into pre-service training during the monitoring of DLI1. The Rector of UHS felt that this may require engaging additional staff given the current UHS lecturers, who may be reluctant to introduce such subjects into otherwise technical training courses. While not an agreed measure of DLI2, we propose that progress in rolling out the intimate partner and sexual violence training is included in dialogue with the Ministry. Technical support to strengthen and fully operationalize the human resource management information system is key to targeting training and capacity building appropriately and fairly, and utilizing training as a means of professional advancement. Support provided by WHO in the past has made progress but there remains a gap and this needs to be addressed.

DLI5 relates to the establishment, staffing, capacity and functioning of the Payment Certification Agency (PCA). Given the oversight role of the PCA towards HEFs and SDGs it is important that the agency is well aware of the importance of gender equality and social inclusion for the health system and how HEFs and SDGs promote and impact these objectives. It is therefore recommended that gender equality and social inclusion be integrated into the capacity building and training of PCA management board and staff. Inclusion of gender equality and diversity into the organisational values of the PCA and operational guidelines in line with the policies of RGC is also needed. It is also good practice that any new information systems to be established at the PCA include sex disaggregated data as appropriate.

Health infrastructure

The project's infrastructure investment includes plans for seventeen new health centres in the north-east[42]. The standard design for health centres does not include accommodation for female or male staff. Given the female security issues discussed earlier we propose that if feasible, further assessment be undertaken on the benefit and cost of including dedicated female staff accommodation at health centres in remote locations; this should include consultations with female staff in these areas and consideration of security and staff retention issues. Secondly, given the cultural beliefs around pregnancy related bleeding, each health centre in areas with indigenous and ethnic minority populations needs to have a waiting room for pregnant and newly delivered women. We recommend that the design of the health centres be reviewed to ensure that this space is included for the design of new health centres, and if not, contingency plans be made to accommodate this.

> Research in Ratanak Kiri reported that "an ethnic Kreung midwife in Ta Veaeng explained that just providing a place where the woman could recover for a few days and where she could be accompanied by family members would go a long way to enabling more women to make the journey." [Breogan Consulting. March 2017. Research on Indigenous Parenting Practices Across the Generations. Plan International Cambodia.]

Project management, monitoring and evaluation

H-EQIP includes funds from a WB-Japanese Government Trust Fund to strengthen MOH's M&E systems in the health sector. We recommend that attention to the collection and use of sex disaggregated and gender related data be included in the M&E systems strengthening activities. This includes improving the quality of sex disaggregated data reported at each level of the HMIS and PMRS and the regular monitoring and analysis of this data if feasible. Secondly, while beyond H-EQIP, strengthening the systems for reporting and tracking GBV cases, and maintaining strict confidentiality. Third, consider an appropriate method for collecting periodic data on health inequities including by ethnicity. The CDHSs offer the most comprehensive insight into maternal, neonatal and child health disparities by sex, poverty, mother's education and province, but there is no similar evidence base for disparities in other health domains or social

[42] Seven health centres in Ratanak Kiri, two health centres in Mondul Kiri, seven health centres in Kratie and one health centre in Preah Vihear.

identifiers. Tracking inequities of access and utilisation as the country moves towards universal health coverage is extremely important and we propose the project work with the government to review methodological options and develop practicable ways of achieving this. Fourth, beyond H-EQIP, we recommend that gaps in the human resource management information system be addressed to enable efficient monitoring of women in leadership at all levels, gender balance in recruitment, deployment, training and promotion, ethnic diversity and the recruitment, deployment, training and promotion of staff from ethnic minority backgrounds.

Results framework

The analytical work that contributed to the design of H-EQIP and one would expect to address issues of gender namely the social assessment, the indigenous peoples assessment and the HEF utilisation survey did not disaggregate evidence by gender or give attention to gender concerns. This was an important oversight and it will be important that further project related analytical and planning work related to each of these areas address this gap. Future evidence related to both the supply and demand side of H-EQIP need to give attention to gender and social inclusion in line with RGC policy and that of World Bank and development partner agencies. More specifically, MOH should take advantage of the next project restructuring (to potentially take place when additional KfW funding is added) to revise the H-EQIP Results Framework to incorporate recommendations from this report.

The project development objective of H-EQIP, which is "to improve access to quality health services for targeted population groups with protection against impoverishment due to the cost of health services in the Kingdom of Cambodia" is gender blind. The targeted population groups are not gender disaggregated. While the project will be of significant benefit to women and the poor given their greater use of public health services than men and the better off, the equity analysis of H-EQIP is limited to a focus on the benefits of HEFs and does not include a differentiated analysis of variation in service context and access to health services across the country or to different population groups, and how this results in a social gradient. The project design does not address the extent to which the project reduces equity gaps for different population groups. The lagging behind of service utilisation and the multiple barriers to access in remote areas and for ethnic minorities is a case in point, though the indigenous peoples plan could potentially assist in addressing the latter. The planned technical support to strengthen the M&E systems of the Ministry is an opportunity to correct this gap, as is further analytical work related to HEF utilisation and attention to equity and universal health care. While the closing of non-wealth related equity gaps is not explicitly included in the design or results framework of the project, it is proposed that the project support policy dialogue around this issue. Given the contextual diversity across the country we also suggest that the project incorporate analysis of how interventions affect geographical inequities in quality of care and financial access to services.

There is no gender specific indicator in the results framework or the measurement of health outcomes, which could provide a gender lens, for example institutional delivery. The indicators are also not sex disaggregated where reasonable to expect them to be, though this gap could be rectified such as with the indicator for utilisation of health services by HEF beneficiaries, and new out patient department (OPD) cases. We also recommend that indicators that measure the performance of the health system and improvements in quality be disaggregated by province to capture geographical dimensions of performance if feasible. This would permit tracking performance of those provinces with high numbers of indigenous people where health outcomes are lower. Greater disaggregated analysis of HEF utilisation than specifically mentioned in the indicator definition is also recommended. In addition to sex disaggregated analysis, this could include tracking use by ethnicity, by the physical appearance of disability, and by province (these variables are included in the PMRS). PMRS data could also be used to undertake more detailed study of the relationship between the distance between the residence

of HEF beneficiaries and their use of services in selected provinces such as Mondul Kiri, where remoteness is a multidimensional barrier to accessing health services.

Table 17: Proposed revision of indicators or expansion to analysis

Indicator name	Indicator definition	Source	Suggested revision or expansion to analysis	Suggested analysis
Increase in the number of HCs exceeding 60% score on the quality assessment of health facilities	Based on a composite Health Facility Quality Index covering structural, process and outcome domains	Standardised supervisory checklist	Disaggregate HCs below 60% by province and identify the geographical areas where the gap is greatest.	Identify the poorest performing HCs and target them for assistance to improve their performance. Support should be prioritized for the more remote, provinces, in particular, if they perform poorly.
Reduction in the number of households that experienced impoverishing health spending during the year	Share of households paying 40% or more of capacity to pay (as measured as per WHO guidelines). Based on one month recall of expenditures	Socioeconomic survey	If the Cambodia Socio-economic survey permits, add a sub-indicator to "Reduction in the share of households that experienced impoverishing health spending during the year' such as "of which headed by a female."	Determine whether female-headed households are benefiting more or less from reductions in health spending and develop actions to address a gap if it emerges.
Increase in utilization of health services by HEF beneficiaries (Percentage)	Defined as total number of individual HEF users in both HCs and hospitals using outpatient services/total eligible HEF population, expressed as percent.	HMIS/ PMRS	If feasible, and with the expansion of PMRS to all health facilities, revise the indicator "utilisation of health services by HEF beneficiaries" to include a sub-indicator "percentage of which are women."	Determine whether there is a gap between male and female access in any locations, and if so, whether more effort is needed for HEF-Ps to target the men or women who are not sufficiently utilizing HEF.
				Undertake more detailed annual analysis of HEF utilisation by using PMRS data to track use by ethnicity, disability, province. For selected provinces where remoteness is a significant barrier to access, track the relationship between use of HEF by the distance between

				the facility and the HEF user.
Proportion of health centres with functioning health centre management committees	There will be a mid-year and end-year assessment of health centre management committees; clear definition of 'functional' to be determined during baseline.	Health centre management committees	Add a sub-indicator "of which with at least 50% female members. Collect a baseline on the gender ratio of HCMCs and include measurement of gender ratio in the assessment tool.	This sub-indicator would allow for measurement of one of the report's recommendations on having balanced HCMC membership. If this approach is adopted, this indicator would allow for its measurement and any corrective action.
OPD consultations (new cases only) per person per year	Utilization of outpatient services at public health facilities among the total population and among children aged under 5 years. Total OPD consultations (new cases) / Total population. Total under-5 OPD consultations (new cases) / Total children aged under 5 years.	HMIS	Revise the indicator to include a sub-indicator "percentage of women.". It also seems that a sub-indicator on age would be needed to assess whether under-5 children are adequately utilizing the services.	This breakdown would allow MOH to determine if there is gender breakdown in the use of service in aligned with the expectations in terms of male/female use of services.

To increase the gender profile of the project in the World Bank gender equality tracking system it is suggested that a gender indicator be introduced for regular monitoring. We suggest that the gender gap in leadership and management at PHD and OD level be tracked using the indicator:

> Percentage of PHD and OD level leadership/management positions filled by women. Source of data, MoH Personnel Department.

Institutional and implementation arrangements

The project's institutional and implementation arrangements are embedded in government structures. At the national level we propose that the GMAG be included in reviews and monitoring of H-EQIP so that links between the project and the Ministry's GMAP can be forged. We suggest GMAG's involvement in H-EQIP include engagement during and between implementation support missions. Given the institutional structure and capacity weaknesses faced by GMAG we recommend that while beyond H-EQIP, a functional task analysis of GMAG be undertaken to assess whether its structure, capacity, functionality and resources are appropriate to achieving GMAP's goals and objectives. Technical support to the proposed functional task analysis and the development and implementation of the next GMAP for health is recommended though this may be necessary outside the boundaries of H-EQIP.

Consultations with each of the departments involved in implementation of the project identified a need for additional gender training to assist departments integrate gender and social inclusion into their technical scope of work within and beyond H-EQIP, departmental outputs and management systems. Technical assistance is required for the Preventive Medicine Department to strengthen capacity to spearhead the safeguards work. Capacity building of the GMAG, and support for women leadership development as discussed earlier are probably beyond the

parameters of the project and it is recommended that development partners provide assistance through other channels at their disposal. This may include south-south exchanges with successful women leadership mentors in the region, women leadership training programs from the public and private sectors, and male champion networks and policy advocates. We also recommend that linkages be forged with other government agencies that are pursuing women leadership development, such as NCDD, to share technical resources, leverage successful advocacy models and platforms, build women leadership networks, and draw on learning and experience.

Summary of issues and proposed actions

The table below presents a summary of the key issues identified by the gender assessment, listed by proposed actions to be implemented by H-EQIP and actions that are beyond the parameters of the project but vital for increasing the gender responsiveness and equity of the health system. Issues and actions related to remoteness are included given the lower access to health services in these areas and the lower maternal health outcomes compared to other parts of the country. As part of the support provided through this study, a workshop was held on November 24, 2017 with representatives from MOH and its provincial offices, the Ministry of Women's Affairs, as well as NGOs and development partners to further refine the proposed actions towards translating these into an implementation plan with assigned responsibilities, timeframe and budget. The program of events, list of participants, and results of the group prioritization exercise at the workshop are summarized in Annexes 5-7. Further dialogue with the MOH and its provincial offices is needed to fine tune and agree on the recommended gender actions and to translate them into a detailed implementation plan. Once priority actions are identified by MOH, and a time-bound action plan is prepared, the World Bank, DFAT and other H-EQIP partners will monitor and support implementation of the plan, as needed.

Table 18: Summary of issues and proposed actions

Issue	Priority Actions for H-EQIP
Component 1: Strengthening health service delivery	
1.1 NQEMP are not directly sensitive to gender and social inclusion issues and socially inclusive communication and care as part of quality health care	Emphasize and monitor the requirement in the annual instruction for conducting NQEMP to have at least one woman (midwife) in each assessment team, with an aim to promote qualified women to be on assessment teams. Update template of individual performance evaluation for health staff and questionnaire for client interview to include staff attitude and behaviour regarding respect, politeness and non-discrimination to patients, particularly the poor, persons of different genders, ethnic minority, disabled, and LGBTI patients. Undertake a study on gender differences in user expectations of quality of care and factor findings into the design of NQEMT (*Client satisfaction tool) or Impact Assessment (IE).*
1.2 Client satisfaction tool has limitations. It may expose female clients selected for interview to harm if they report their husband's or a family member's phone number; it is not reliable in remote areas where phone coverage is poor; is difficult to foster trust of the selected client to engender honest feedback.	Female assessors take responsibility for phoning female clients and male assessors for male clients. Ensure training of all assessors on the potential risks of telephone interviewing clients, how to sensitively introduce themselves and the purpose of the call, and how to manage any negative tensions the call may create. If feasible, review alternative approaches to telephone interviewing, including linking client satisfaction to ISAF community scores where ISAF is operational, third party survey or HEF Promoters to conduct client satisfaction at the household level.
1.3 Service delivery grants do not reward actions that respond to social inclusion	Increase allocation of SDG performance grants to health facilities in remote/difficult to access areas for improved quality of and access to health service delivery. Through SDG encourage and reward actions that: (i) Enhance outreach or mobile health services that regularly take health workers to remote populations and target indigenous and ethnic minority peoples; (ii) Strengthen the existing health posts to more effectively reach the remote communities they serve.
Component 2: Improving financial protection and equity	
2.1 Gaps in analytical work undertaken on who is benefitting from HEF.	Further analytical work to identify which categories of the poor are benefitting from HEF including by sex of beneficiary, sex of household head, geographical isolation, disability, ethnicity and age. Qualitative research in specific target areas to understand the factors that drive low HEF utilisation to inform programmatic responses. If feasible, review the functioning of the post-IDPoor mechanism and the extent to which it is providing protection to poor people who have missed out on IDPoor, including potential LGBTI beneficiaries who may have faced discrimination.
2.2 To make HEF Promoters effective agents in raising awareness of HEF benefits.	Update as necessary the TOR for HEF-P to allow for HEF-Ps to use existing structures and networks to raise community awareness of HEFs; work with HC, HCMC and VHSG for launching direct awareness raising activities to highly marginalised populations in remote and difficult to reach areas where HEF utilisation is low. Induction/orientation training for the HEF-P to include effective and empathetic interpersonal communication, how to foster

	trust and openness and treat all people with respect and fairness, gender equality and social inclusion, patient and provider rights, and barriers to accessing services that poor, women, adolescent girls, LGBTI and excluded populations face. For provinces with high numbers of ethnic minorities, orientation to include traditional and cultural beliefs of ethnic minority populations and how this affects health access and health outcomes. In the four north-eastern provinces give preference to hiring ethnic HEF Promoters. Apply the norms of three HEF Promoters per CPA-3 referral hospital and two HEF-Promoters per CPA-1 and CPA-2 referral hospital flexibly so that more can be hired where utilisation is very low and existing community mobilisation structures are weak. Aim for gender balanced teams with at least one woman HEF Promoter per referral hospital.
Component 3: Ensuring sustainable and responsive health systems	
3.1 Integrate gender and social inclusion into the values, operational guidelines and capacity of the PCA.	Include gender equality and diversity into the organisational values of the PCA and operational guidelines. Integrate gender equality and social inclusion into the capacity building and training of PCA management board and staff. Ensure any new information systems to be established at the PCA include sex disaggregated data as appropriate.
3.2 Make infrastructure investments gender responsive.	Review the design of health centres to ensure that space for a waiting room, pre- and post-delivery, is included for construction of new health centres, and if not, contingency plans be made to accommodate this, especially in remote areas.
Results framework	
4.1 There is no gender specific indicator in the results framework or the measurement of health outcomes, which could provide a gender lens. The indicators are not sex disaggregated where reasonable to expect them to be.	Revise the H-EQIP Results Framework indicator to include sex disaggregation of "utilisation of health services by HEF beneficiaries." Include a sub-indicator "percentage of which are women". Revise H-EQIP indicator "Outpatient Department (OPD) consultations (new cases only) per person per year" to include a sub-indicator "percentage for women". If CSES data permits, add a sub-indicator to "Reduction in the share of households that experienced impoverishing health spending during the year' such as "of which headed by a female". Further disaggregate HEF utilisation data to include indigenous and ethnicity, physical appearance of disability, and province (these variables are included in the PMRS). Further analysis of PMRS data to study the relationship between the distance between the residence of HEF beneficiaries and their use of services in selected provinces where remoteness is a multidimensional barrier.
Institutional and implementation arrangements	
5.1 Strengthen the linkage and synergies between H-EQIP and the MOH's GMAG and GMAP	Include GMAG in reviews and monitoring of H-EQIP (i.e. through engagement during and between implementation support missions

Issue	**Proposed action beyond H-EQIP**
Component 1: Strengthening health service delivery	

1.1 NQEMP are not directly sensitive to gender and social inclusion issues and socially inclusive communication and care as part of quality health care	MoH's Community Participation Policy to be revised in line with the national strategy on decentralisation and deconcentration, and gender responsiveness strengthened including balanced gender representation in HCMC. Introduce a sub-tool or set of questions on the implementation and quality of outreach for those health centres that cover large or difficult to reach geographical areas. Weight scores in areas that use additional sub-tools to allow for comparison with other areas.
1.2 There is a large gap in the number of indigenous and ethnic minority people trained and hired by the health service given the challenges of retaining non-ethnic staff in north-eastern provinces and the greater acceptability of ethnic staff among ethnic users, in particular, pregnant women who are encouraged to give birth at health centres.	Include progress in training and hiring of indigenous and ethnic minority health workers in the north-east in policy dialogue.
1.3 Very low numbers of women in leadership positions at provincial and OD levels has serious implications for the performance of the organisation and creating the environment and conditions for future female leaders and gender equality in the health sector labour force.	H-EQIP development partners advocate for women leadership development measures in health sector policy forums. Successful examples of efforts to promote female leadership in the health sector from other countries to be shared.
1.4 Client satisfaction tool has limitations. It may expose female clients selected for interview to harm if they report their husband's or a family member's phone number; it is not reliable in remote areas where phone coverage is poor; is difficult to foster trust of the selected client to engender honest feedback.	Introduce a toll-free number that clients call at their convenience.
1.5 Health managers, providers and quality assessors have limited understanding of what gender responsive and socially inclusive communication and service delivery is and why it is important, and how to communicate in a respectful and empathetic way.	Develop a gender and social inclusion in-service training module including empathetic and respectful communication, supporting job aids and training materials.
1.6 Threats to female staff security affect staff retention and the availability and quality of health care.	Undertake a study on how female staffs cope with security concerns in different environments and the various strategies being used to mitigate security issues. Share good practices with PHDs, ODs and facilities.
1.7 There is a large gap in the number of indigenous and ethnic minority people trained and hired by the health service given the challenges of retaining non-ethnic staff in north-eastern provinces and the greater acceptability of ethnic staff among ethnic users, in particular, pregnant women who are encouraged to give birth at health centres.	With other government agencies, consider scholarships and other financial incentives to keep young ethnic people in school to prepare a pipeline of potential students for the health service. Consider offering foundation programs or special coaching services for students from ethnic minority backgrounds especially girls, to prepare them to compete for national health training places.
Component 2: Improving financial protection and equity	
2.1 The limitations of HEF and SDG to reduce the equity gap in priority national health indicators such as institutional delivery in remote areas.	Community transport arrangements that mobilise transporters and community leaders to take responsibility for essential or emergency transport on pre-agreed terms. Provide cultural sensitisation and diversity training to health staff in areas with indigenous and ethnic populations.
Component 3: Ensuring sustainable and responsive health systems	
3.1 Integrate gender equality and social inclusion into DLI1	Develop modules and training materials on gender and social inclusion for a range of pre and in-service training programs. Include in-service training modules on GBV and clinical guidance on the treatment of survivors of intimate partner and sexual violence into pre-service training. Include gender equality and social inclusion/diversity training in the revised pre-service training curriculum at UHS. This would include practical training, and good practice case studies and

	guidance notes on how health professionals can communicate and behave in a way that is sensitive to the differing needs of vulnerable and excluded people including LGBTI persons and people living with disability.
3.2 Improve the quality and analysis of sex disaggregated data and improve the evidence and analysis of data on health inequities.	Include attention to gender and diversity in strengthening of the HMIS and PMRS reporting and analysis. Address gaps in the human resource management information system to enable the efficient monitoring of women in leadership at all levels, gender balance in recruitment, deployment, training and promotion, ethnic diversity and the recruitment, deployment, training and promotion of staff from ethnic minority backgrounds. Strengthen the systems for reporting and tracking GBV cases, and maintaining strict confidentiality.
3.3 Make infrastructure investments gender responsive.	Undertake further assessment of the benefit and cost of including dedicated female staff accommodation at health centres in remote locations; this should include consultations with female staff in these areas and consideration of security and staff retention issues.
Results framework	
4.1 Strengthen the gender capacity of project management and implementing units	Support women leadership development in the health sector. This may include south-south exchanges with successful women leadership mentors in the region, women leadership training programs from the public and private sectors, and male champion networks and policy advocates.
Institutional and implementation arrangements	
5.1 Strengthen the linkage and synergies between H-EQIP and the MOH's GMAG and GMAP	Undertake a functional task analysis of GMAG to assess whether its structure, capacity, functionality and resources are appropriate to achieving GMAP's goals and objectives. Technical support to the proposed GMAG functional task analysis, capacity building of GMAG, reporting progress against relevant GMAP indicators, and the development and implementation of the next GMAP for health.
5.2 Strengthen the gender capacity of project management and implementing units	Forge linkages between MOH and other government agencies pursuing women leadership development to share technical resources, leverage successful advocacy models and platforms, build cross-sectoral women leadership networks, and draw on learning and experience.

Annex 1- List of Persons Met

Ministry of Health

H.E. Tann Vuoch Chheng, Secretary of State
Dr. Lo Veasnakiry, Director of Department of Planning and Health Information

Dr. Kol Hero, Director of Department of Preventive Medicine
Dr. Vong Sathiarany, Deputy Director of Department of Preventive Medicine
Dr. Mey Sambo, Director of Department of Personnel
Dr. Theme Viravann, Deputy Director of Department of International Cooperation
Mr. Nun Sowathana, Deputy Director of Department of Administrative
Dr. Touch Sok Neang, Deputy Director of the Department of Human Resource
Dr. Ean Sokoeu, Chief of Bureau
Dr. Voeurng Vireak, Chief of QAO, Department of Hospital Services
Dr. Khuon Vibol, Executive Adminstration Officer, H-EQIP
Mr. Sao Phalla, Civil Works Consultant, H-EQIP
Mr. Chau Darith, Civil Works Consultant, H-EQIP
Mr. Kom Sarpiseth, Administration and Logistic Assistant, H-EQIP

Prof. Tung Rathavy, Director of the National Maternal and Child Health Centre
Dr. Prak Sophonneary, Deputy Director of the National Maternal and Child Health Centre

Ministry of Woman's Affairs

H.E Nhean Sochetra, General Director for Social Development

University of Health Science

Prof. Saphonn Vonthanak, Rector of University of Health Sciences

Kratie Provincial Health Department

Head of Communicable Diseases Control
Chief of Technical Bureau
Head of Quality Improvement Unit
Head of Preventive Medicine Unit
Head of Maternal and Child Health Unit
Representative from Maternal and Child Health Unit in OD
PHD Gender Focal Point
PHD Gender Working Group Secretary

Mondulkiri Provincial Health Department

PHD Director
Chief of Technical Bureau
Head of Preventive Medicine Unit
SDG Assessor Team

Development Partners

Ms. Thou Kagnabelle, UNFPA
Ms. Sarah Knibbs, UN Women
Dr. Etienne Poirot, Chief Child Survival and Development, UNICEF
Mr. Ole Doetchinchem, GiZ
Mrs. Sam Eng, Research/M&E Advisor, URC
Ms. Sun Sopheak, Deputy Director, USAID Social Health Protection Project, URC

Civil Society Organizations

Dr. Estrella Serano, Reproductive and Child Health Alliance (RACHA)
Ms. Jordan Molly, Reproductive and Child Health Alliance (RACHA)
Dr. Var Chivorn, Executive Director of Reproductive Health Alliance in Cambodia (RHAC)
Mr. Mey Phalla, Senior Program Manager, SRM Health and Rights of CARE International
Ms. Amy Williamson, Country Director of Marie Stopes Cambodia
Ms. Luong Soklay, Head of Public Private Partnerships, Marie Stopes Cambodia
Ms. Abigail Beeson, Health and Nutrition Specialist
Mr. Gary Dahl, Country Director of Health Poverty Action
Mr. Andrew Martin, former Country Director of Health Poverty Action
Mr. Srun Srorn, Micro Rainbow (LGBTI rights group)
Ms. Chhoeurng Rachana, Micro Rainbow
Ms. Seak Phally, Save the Children, Partnering to Save Lives (PSL) in Kratie Province
Mr. Em Veasna, Senior Program and Operation Manager, Care, Partnering to Save Lives (PSL) in Mondul Kiri Province

Annex 2: Field visit schedule to Kratie and Mondul Kiri Provinces

Monday, 31 July, 2017 (Kratie)							
Team 1				**Team 2**			
TIME	**CONTENT AND ITINERARY**	**LOCATION**	**SITE PARTICIPANTS**	**TIME**	**CONTENT AND ITINERARY**	**LOCATION**	**SITE PARTICIPANTS**
7:00-10:00 am	Travel to Chhlong OD, Kratie Province	N/A	N/A	7:00-10:00 am	Travel to Chhlong OD, Kratie Province		
10:00-12:00 pm	Visit Chhlong RH and meet with OD and HEF monitor	Chhlong RH	Relevant RH and OD staff and HEF Monitor	10:00-11:00 am	Visit Khsach Andet HC	TBD	Relevant HC staff
12:00-1:30 pm	Lunch in Chhlong OD	TBD		12:00-1:30 pm	Lunch in Chhlong OD		
1:30-3:30 pm	Community consultations in Chhlong OD (male group)			1:30-3:30 pm	Community consultations Chhlong OD (female group)		
3:30-4:30 pm	Meeting with Damrey Phong Commune Chef	Commune hall	Commune Chief	3:30-4:30 pm	Meeting with Damrey Phong Commune Chef	Commune hall	Commune Chief
3:30-4:00 pm	Travel to Kratie provincial town	N/A		3:30-4:00 pm	Travel to Kratie provincial town	N/A	
5:30-6:30 pm	Meet with PSL team and dinner	TBD	Ms. Seak Phally	5:30-6:30 pm	Meet with PSL team and dinner	TBD	Ms. Seak Phally
5:00 pm	Overnight in Kratie	TBD	N/A	5:00 pm	Overnight in Kratie	TBD	N/A

Tuesday, 1 August, 2017 (Kratie)							
Team 1				**Team 2**			
TIME	**CONTENT AND ITINERARY**	**LOCATION**	**SITE PARTICIPANTS**	**TIME**	**CONTENT AND ITINERARY**	**LOCATION**	**SITE PARTICIPANTS**
6:30-8:00 am	Travel to Snuol administrative district	N/A	N/A	6:30-8:00 am	Travel to Snuol administrative district	N/A	N/A
8:00-10:00 am	Community consultations in Snuol OD (male group)	Tasom village, Sveay Chreash commune, Snourl district		8:00-10:00 am	Community consultations in Snuol OD (female group)	Tasom village, Sveay Chreash commune, Snourl district	
11:00-12:00	Meet with CC and CCWC	CC Office	Relevant CC and CCWC staff	11:00-12:00	Visit Khsim HC		Relevant HC staff
12:30-2:00 pm	Lunch in Snuol OD	TBD		12:30-2:00 pm	Lunch in Snuol OD	TBD	
2:00-3:00	Visit HC with ISAF team	TBD	Relevant HC staff	2:00-3:00	Visit HC with ISAF team	TBD	Relevant HC staff
3:00-4:30 pm	Travel to Sen Monorom, Mondulkiri	N/A	N/A	2:00-4:00 pm	Travel to Sen Monorom, Mondulkiri	N/A	N/A
4:30 pm	Overnight stay in Mondulkiri province	TBD	N/A	4:00-5:00 pm	Overnight stay in Mondulkiri province	TBD	N/A

Wednesday, 2 August, 2017 (Mondulkiri)							
Team 1				**Team 2**			
TIME	**CONTENT AND ITINERARY**	**LOCATION**	**SITE PARTICIPANTS**	**TIME**	**CONTENT AND ITINERARY**	**LOCATION**	**SITE PARTICIPANTS**
8:00-9:00 am	Meet with Mondulkiri PHD and SDG assessor team (including Gender WG)	Mondulkiri PHD Office	Relevant PHD staff and SDG PHD assessor team	8:00-9:00 am	Meet with Mondulkiri PHD and SDG assessor team (including Gender WG)	Mondulkiri PHD Office	Relevant PHD staff

9:00-10:00 am	Travel to Pechr Chreada HC	N/A	N/A	9:00-10:30 am	Visit Mondulkiri PRH and meet HEF monitor	Mondulkiri PRH	Relevant PRH staff and HEF monitors
10:00-12:00 pm	Visit Pechr Chreada HC		Relevant HC staff	10:30-11:30 am	Travel to Bou Sra village, Krang Teh commune	N/A	N/A
12:00-1:30 pm	Lunch in Bou Sra village, Krang Teh commune	TBD		12:00-1:30 pm	Lunch in Bou Sra village	TBD	
1:30-3:30 pm	Community consultations in Bou Sra village (female group) and meeting with Elders	Bou Sra village, Krang Teh commune		1:30-4:00 pm	Community consultations in Bou Sra village (female group) and meeting with Elders	Bou Sra village, Krang Teh commune	
3:30-4:30 pm	Meet with CC	CC Office (Krang Teh commune)	Krang Teh Commune Chief	4:00-4:30 pm	Meet with Village Chief	CC Office (Krang Teh commune)	Bou Sra village Chief
4:30-5:30 pm	Travel to Sen Monorom, Mondulkiri and stay overnight	TBD	N/A	4:30-5:30 pm	Travel to Sen Monorom, Mondulkiri and stay overnight	TBD	N/A

Thursday, 3 August, 2017 (Mondulkiri)							
Team 1				**Team 2**			
TIME	**CONTENT AND ITINERARY**	**LOCATION**	**SITE PARTICIPANTS**	**TIME**	**CONTENT AND ITINERARY**	**LOCATION**	**SITE PARTICIPANTS**
7:30-9:00 am	Travel to Koh Nheak FDH and visit FDH	Koh Nheak FDH	Relevant FDH staff	8:00-9:00 am	Visit Me Mang HC (inaccessible; met with women close by)		Met with women on the way to Me Mang HC
9:00-11:00 am	Visit Sre Sangkum HC		Relevant HC staff	10:00-11:00 am	Visit Mondulkiri PRH and HC	Mondulkiri PRH and HC	Relevant HC staff and patients at PRH
11:00-2:00 pm	Travel to Mondulkiri provincial town and lunch	TBD	N/A	11:00-2:00 pm	Travel to Mondulkiri provincial town and lunch	TBD	N/A
2:30-4:00 pm	Meet with PSL	Care office		2:30-4:00 pm	Meet with OD and SDG assessor team		Relevant OD staff and SDG OD assessor team
4:00-4:30 pm	Travel back to Sen Monorom, Mondulkiri and stay overnight	TBD	N/A	4:00-4:30 pm	Travel back to Sen Monorom, Mondulkiri and stay overnight	TBD	N/A

Friday, 4 August, 2017 (TBD)							
Team 1				**Team 2**			
TIME	**CONTENT AND ITINERARY**	**LOCATION**	**SITE PARTICIPANTS**	**TIME**	**CONTENT AND ITINERARY**	**LOCATION**	**SITE PARTICIPANTS**
10:00-12:00 pm	Meet with Kratie PHD and OD (including Gender WG)	Kratie PHD Office	Relevant PHD and OD staff	10:00-12:00 pm	Meet with Kratie PHD and OD (including Gender WG)	Kratie PHD Office	Relevant PHD and OD staff
TBD	Travel back to Phnom Penh, lunch along the way	N/A	N/A	TBD	Travel back to Phnom Penh, lunch along the way	N/A	N/A

Annex 3: HEF Beneficiary Complaint data from URC

Complaint Categories by Gender (May-July 2017)			
Category	***Female***	***Male***	***Total***
1. Bad Behaviors of Health Staff	44	24	68
2. Did not have access to the Toilet	1	0	1
3. Did not receive foods	18	8	26
4. Did not receive funeral cost	2	0	2
5. Did not receive regular food allowance	3	2	5
6. Did not receive regular transportation allowance	1	2	3
7. Did not receive services	2	1	3
8. Did not receive transportation	44	3	47
9. Health Staff Request Use of Private Clinic	1	0	1
10. Long waiting period	9	3	12
11. No health staff accompany patient in ambulance	0	1	1
12. No health staff on duty	3	0	3
13. Patient paid for services fee	7	2	9
14. Quality of health services is Low	8	3	11
15. Request additional services fees	23	9	32
16. Request to buy additional drug/medical supplies	19	14	33
17. Request to buy blood	5	0	5
18. Spent personal money for transportation	1	0	1
19. Toilet not cleaned	7	2	9
20. Unoffical payment requested	25	5	30
21. Unofficial Payment Due to Fear of Negligence	2	3	5
22. Unofficial Payment Due to to get quick service	10	1	11
Total:	235	83	318

Complaint Categories by Gender (May-July 2017) at HC and FDH			
Category	***Female***	***Male***	***Total***
1. Bad Behaviors of Health Staff	7	2	9
2. Did not have access to the Toilet	0	0	0
3. Did not receive foods	2	0	2
4. Did not receive funeral cost	0	0	0
5. Did not receive regular food allowance	0	0	0
6. Did not receive regular transportation allowance	0	0	0
7. Did not receive services	1	0	1
8. Did not receive transportation	24	0	24
9. Health Staff Request Use of Private Clinic	0	0	0
10. Long waiting period	0	0	0
11. No health staff accompany patient in ambulance	0	0	0
12. No health staff on duty	2	0	2
13. Patient paid for services fee	3	0	3
14. Quality of health services is Low	0	1	1
15. Request additional services fees	8	0	8
16. Request to buy additional drug/medical supplies	4	0	4
17. Request to buy blood	0	0	0
18. Spent personal money for transportation	1	0	1
19. Toilet not cleaned	2	0	2
20. Unofficial payment requested	10	1	11

21. Unofficial Payment Due to Fear of Negligence	1	2	3
22. Unofficial Payment Due to get quick service	2	0	2
Total:	67	6	73

Complaint Categories by Gender (May-July 2017) at RH and PRH			
Category	***Female***	***Male***	***Total***
1. Bad Behaviors of Health Staff	31	20	51
2. Did not have access to the Toilet	1	0	1
3. Did not receive foods	16	6	22
4. Did not receive funeral cost	2	0	2
5. Did not receive regular food allowance	3	2	5
6. Did not receive regular transportation allowance	1	2	3
7. Did not receive services	1	1	2
8. Did not receive transportation	19	3	22
9. Health Staff Request Use of Private Clinic	1	0	1
10. Long waiting period	7	3	10
11. No health staff accompany patient in ambulance	0	1	1
12. No health staff on duty	1	0	1
13. Patient paid for services fee	4	2	6
14. Quality of health services is Low	7	2	9
15. Request additional services fees	10	9	19
16. Request to buy additional drug/medical supplies	7	5	12
17. Request to buy blood	5	0	5
18. Spent personal money for transportation	0	0	0
19. Toilet not cleaned	5	2	7
20. Unofficial payment requested	14	4	18
21. Unofficial Payment Due to Fear of Negligence	1	1	2
22. Unofficial Payment Due to get quick service	6	1	7
Total:	142	64	206

Annex 4: Documents Reviewed

Cambodian Government Documents:

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Ministry of Health (MOH) Cambodia, Ministry of Women's Affairs (MoWA) Cambodia, UNFPA. "Clinical Handbook for Managing Health Care for Women Subjected to Intimate Partner Violence or Domestic Violence." Royal Government of Cambodia. 2016.

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National AIDS Authority. Cambodia Country Progress Report: Monitoring Progress Towards the 2011 Political Declaration on HIV and AIDS. 2015.

National Committee for Sub-National Democratic Development, Strategy and Action Plan to Increase Women in SNA Management Positions (2017-2019), 19 May 2017.

National Institute of Statistics (NIS), Ministry of Planning (MOP) Cambodia. "Women and Migration in Cambodia." Royal Government of Cambodia. 2013.

The Social Protection Coordination Unit, Council for Agricultural and Rural Development Cambodia. "An Exploration of Social Exclusion of Lesbians, Gay, and Transgender Persons in Families and Communities in Some Areas of Cambodia and Their Ways of Coping." 2013.

H-EQIP Related Documents:

"Disbursement Linked Indicators (DLI) Operational Manual: Health Equity and Quality Improvement Project (H-EQIP)." 4 Nov. 2016. Print.

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H-EQIP. "Indigenous Peoples Planning Framework (IPPF): Health Equity and Quality Improvement (H-EQIP) Project Supplemental Indigenous Peoples' and Ethnic Minority Consultations." 4 Feb. 2016.

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"Service Delivery Grants (SDG) Operational Manual: Health Equity and Quality Improvement Project (H-EQIP)." 4 Nov. 2016. Print.

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Utilization and Impact of Health Equity Funds (HEFs): Improving Entitled Benefits Uptake by the Poor. The World Bank. 20 Jun. 2016.

HSSP2 Related Documents:

Implementation Completion and Results Report for a Second Health Sector Support Program. The World Bank, 2016.

"Project Appraisal Document for a Second Health Sector Support Program." 27 May 2008. Print.

Cambodia Health Sector Documents:

Annear, Peter Leslie et al. "The Kingdom of Cambodia Health System Review." Ed. Peter Leslie Annear, Bart Jacobs, and Matthias Nachtnebel. *Health Systems in Transition* 5.2 (2015).

Development Partner Documents:

ADB. *Cambodia Country Gender Analysis*. 2012.

Breogan Consulting. Research on Indigenous Parenting Practices Across the Generations. Plan International Cambodia. March 2017.

Brown, Eleanor. *Crossing the River and Getting to the Other Side: Access to Maternal Health Services amongst Ethnic Minority Communities in Rattanak Kiri Province, Cambodia*. Health Unlimited, 2005.

CARE. "Draft Guide for Conducting Research with Ethnic Minority Groups at North East Provinces." Print.

Ending Violence Against Women In Cambodia (EVAW Program): Second Progress Report. AusAid, 2016.

Frieson, Kate Grace et al. *A Gender Analysis of the Cambodian Health Sector*. Cambodia: AusAID, WHO, MOH, 2011.

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Sopheab, Heng. *Baseline Survey Report: Reproductive, Maternal and Neonatal Health Knowledge, Attitudes and Practices among Female Garment Factory Workers in Phnom Penh and Kandal Provinces*. MOH, AudAID, CARE, Marie Stopes International Cambodia, Save the Children, 2014. Partnering to Save Lives.

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DFAT Aid Program Documents:

Commonwealth of Australia, DFAT. "Australian Aid: Promoting Prosperity, Reducing Poverty, Enhancing Stability." June 2014.

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World Bank Program Documents:

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Academic Papers:

Annear, Peter Leslie. *A Comprehensive Review of the Literature on Health Equity Funds in Cambodia 2001-2010 and Annotated Bibliography*. The Nossal Institute for Global Health, 2010. Print. Working Paper Series: Health Policy and Health Finance Knowledge Hub.

Chan Soeung, Sann et al. "From Reaching Every District to Reaching Every Community: Analysis and Response to the Challenge of Equity in Immunization in Cambodia." *Health Policy and Planning* 28.5 (2013): 526–535. *PubMed Central*. Web.

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Annex 5: Program of Events of H-EQIP Gender Assessment Workshop

November 24, 2017
Venue: Sunway Hotel, Phnom Penh

Time	Event	Responsible
Opening of Workshop and Key Findings		
8:00-8:25	Registration	WB
8:25- 8:30	Welcome to the workshop and national anthem	Dr. Vong Sathiarany, MOH
8:30-8:40	Introductory Remarks by WB	Somil Nagpal, WB
8:40-8:45	Welcome remarks by DFAT	Benita Sommerville, DFAT
8:45- 8:55	Remarks by H.E. Mrs Khieu Sereyvuthea, MoWA	H.E. Mrs Khieu Sereyvuthea
8:55-9:05	Opening remarks by H.E. Pen Ricksy, MOH	H.E Pen Ricksy, MOH
9:05-9:35	Gender inequality and health in Cambodia: key findings	Deb Thomas
9:35-9:50	Tea and Coffee Break	
Recommendations for H-EQIP		
9:50-10:05	H-EQIP component 1 (Strengthening Health Service Delivery): key findings, recommendations	Erik Caldwell Johnson
10:05-10:20	Question and Answer Session	Erik Caldwell Johnson
10:20-10:35	H-EQIP component 2 (Improving Financial Protection and Equity): key findings and recommendations	Deb Thomas
10:35-10:50	Question and Answer Session	Deb Thomas
10:50-11:05	H-EQIP component 3 (Ensuring Sustainable and Responsive Health Systems): key findings and recommendations	Erik Caldwell Johnson
11:05-11:20	Question and Answer Session	Erik Caldwell Johnson
Group Work and Prioritization of Actions		
11:20-12:00	Group work - Divide into groups based on project components - Review the recommendations of the study for each project component and identify priority actions	Group work
12:00-1:30	Lunch break	
Group Feedback and Discussion		
1:30-2:15	Group work and preparation for reporting back	Group work
2:15-3:15	Plenary session: groups feedback on findings and present priority actions by project component	Group work
3:15-3:30	Tea and Coffee Break	
Closure and Recommendations		
3:30-3:45	Summary of discussions	Prof. Tung Rathavy, Director of NMCHC, MOH
3:45-4:00	Closing Remarks by H.E. Prof. Tan VouchChheng, MOH	H.E. Prof. Tan VouchChheng, MOH

Annex 6: List of Participants at H-EQIP Gender Assessment Workshop

Ministry of Women's Affairs (MoWA)
H.E. Mrs. Khiev Sereyvuthea, Advisor, MoWA
Leng Monipheap, Deputy Director, Women and Health Department, MoWA

Ministry of Health (MOH)
H.E. Prof. Tan Vuoch Chheng, Secretary of State, MOH
H.E. Pen Ricksy, Undersecretary of State, MOH
Dr. Mey Sambo, Director, Department of Personnel, MOH
Dr. Kol Hero, Director, Department of Preventative Medicine, MOH
Dr. Vong Sathiarany, Deputy Director, Preventative Medicine Department, MOH
Mr. Nun Sowathana, Deputy Director, Department of Administration, MOH
Kong Situon, Chief of Bureau, MoH
Chhay Phearom, Officer, MOH
Dr. Khuon Eng Mony, Quality Assurance Office Consultant, MOH
Dr. Khuon Vibol, officer, H-EQIP
Mr. Korm Piseth, Administration and Logistics Assistant, H-EQIP

Ms. Puy Pisey, Deputy Director of PHD in Mondulkiri
Dr. Khut Sothina, Deputy Director of PHD in Stung Treng
Dr. Men Bunnan, Deputy Director of PHD in Kampong Cham
Pin Sophea, Chief of Administration of PHD in Battambang
Sang Kunthealey, Deputy Chief of Technical Bureau of PHD in Kandal
Pech Seima, Deputy Chief of Technical Bureau of PHD in Kratie
Ly Keothida, Deputy Chief of Food and Drug Office of PHD Kampot

National Maternal and Child Health centre
Dr. Tung Rathavy, Director, National Maternal and Child Health centre
Dr. Prak Sophonneary, Deputy Director, National Maternal and Child Health centre

University of Health Sciences (UHS)
Dr. Kim Sothea, Vice Dean, UHS

Khmer-Soviet Firenship Hospital
Mrs. Chen Sokha, Officer

Ministry of Planning (MoP)
Sa Chivan, Deputy Director of ID Poor Department, MoP

Development Partners
Dr. Etienne Poirot, Chief Child Survival and Development, UNICEF
Dr. Richard James, Consultant for Human Resources for Health, WHO
Sochea Sam, Project Management Specialist Reproductive Health/ Family Planning, USAID
Dr. Sok Sokun, Program Officer, UNFPA
Mr. Harald Huettenrauch, Country Director, KfW
Mr. Rong Rattana, Specialist, KOICA
Lee Jiin Kim, Young Professional, KOICA
Ms. Benita Sommerville, First Secretary, Development Cooperation, DFAT
Dr. Premprey Suos, Program Manager Health, DFAT
Ms. Deborah Thomas, Consultant, DFAT
Dr. Somil Nagpal, Senior Health Specialist, H-EQIP TTL, WB

Mr. Erik Johnson, Senior Social Development Specialist, WB
Ms. Nareth Ly, Senior health Specialist, WB
Dr. Sao Sovanratnak, Health Analyst, WB
Ms. Van Voleak, Health Analyst, WB
Ms. Priya Agarwal-Harding, Consultant, H-EQIP Pooled Fund Coordinator, WB
Ms. Sreytouch Vong, Consultant, WB
Ms. Ponnary Pors, Consultant, WB

Civil Society Organizations
Ms. Anne Rouve Khiev, Coordination and Learning Unit Director, Partnering to Save Lives
Ms. Long Molen, CamASEAN Youth Future
Chhom Tharvy, Director, CamASEAN Youth Future
Mr. Chivorn Var, Executive Director, RHAC
Ms. Amy Williamson, Country Director, Marie Stopes Cambodia
Ms. Soklay Loung, Head of Public Private partnerships, Marie Stopes Cambodia
Ms. Abigail Beeson, Health and Nutrition Specialist, Save the Children
Dr. Sun Nasy, TB Technical Team Leader, RACHA
Joanne Fairley, Country Director, CARE
Phalla Mey, Senior Program Manager, CARE
Dr. Meak Weng, Provincial Programme Manager, Health Poverty Action
Ms. Sun Sopheak, Deputy Director, URC

Annex 7: Summary of Results from Group Work at Gender Assessment Workshop

A consultative workshop was conducted on 24 November, 2017 to obtain feedback on the findings and recommendations of the gender assessment by key H-EQIP stakeholders, and in particular, the priority actions to be included in a plan of action for addressing gender gaps in the project and in related health sector activities. The workshop was conducted at the Sunway hotel in Phnom Penh and attended by representatives from the Ministry of Health, including regional representatives from Provincial Health Departments from Kratie and Mondulkiri, where the gender assessment was conducted; Ministry of Women's Affairs; University of Health Science; as well as development partners and civil society organizations that were consulted as part of the assessment.

As part of the workshop, participants were asked to divide into small groups and review the recommendations made in this report by project component and rank the level of priority and difficulty of each action, with "5" being the highest level and "1" being the lowest level. Participants were also asked to discuss the feasibility and challenges of implementing each action. Actions were classified into three categories, as a priority to be undertaken within H-EQIP, to be carried out within H-EQIP if feasible, or beyond the scope of H-EQIP. Participants were asked to identify one top priority action for implementation along with the responsible party. Participants were encouraged to make any revisions to the actions or suggest new actions they felt should be prioritized. The results of these group prioritization exercises are summarized in the tables below and were used to refine the proposed actions listed in the report by proposed actions to be implemented by H-EQIP and actions that are beyond the parameters of the project but vital for increasing the gender responsiveness and equity of the public health system.

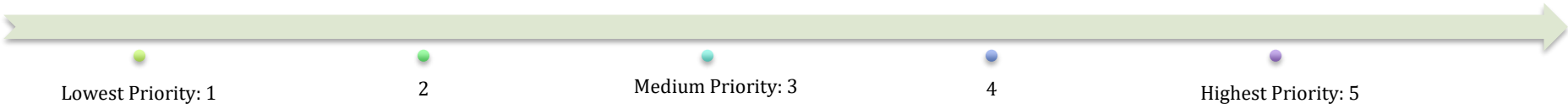
Overall, most actions were ranked highly in terms of priority (4 or 5), although levels of difficulty varied. Groups reported that in choosing which action should be top priority, focus was given to those actions of highest priority and lowest difficulty, which would be practical for implementation. Top priorities identified by groups included:

1. Integrating respectful and empathetic communication into relevant parts of the NQEMT and process. This included two actions for (i) updating the template of individual performance evaluation for health staff and questionnaire for client interview to include staff behaviour regarding politeness and non-discrimination to the poor, ethnic minority, disable, and LGBTI patients, and (2) integrating respectful and empathetic communication including the principles of non-discrimination, compassion, social inclusion and non-blaming of victims into the NQEMT coaching tool and develop related job aid. It was suggested to combine both of these suggested actions as they both focused on communication skills and were deemed as feasible within the project. Hiring and training of ethnic and indigenous staff was also considered very important to increase staff retention as well as improve access and communication to patients, however, this was considered to be

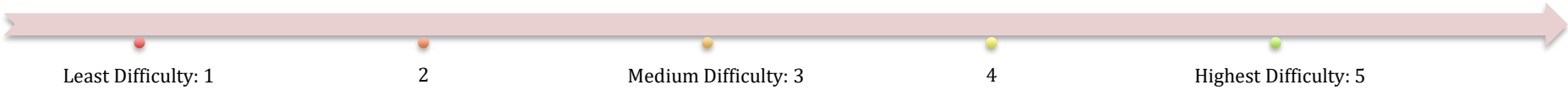
more difficult to achieve based on past experiences of workshop participants and due to the often lower levels of education among these population groups.

2. Arrangements to facilitate transportation for HEF patients, either through increasing HEF transport allowances to reflect market cost or introducing other demand side financing mechanisms, or through community transport arrangements that mobilise transporters and community leaders to take responsibility for essential or emergency transport on pre-agreed terms. Also prioritised was further analytical work to identify which categories of the poor are benefitting from HEF including by sex of beneficiary, sex of household head, geographical isolation, disability, ethnicity and age. This was deemed feasible as existing data is available from the PMRS.
3. In terms of health infrastructure, ensure that space for a waiting room, pre- and post-delivery, is included in the design of health centres in remote areas, and if not, contingency plans be made to accommodate this. This was deemed essential to increase utilization and access to health services, as well as to respond to the RGC's policy on gender equality.
4. Revise the H-EQIP Results Framework indicators to include sex disaggregation of "utilisation of health services by HEF beneficiaries". Include a sub-indicator "percentage of which are women". This was deemed feasible as existing data is available from the PMRS.

Score level of priority:



Level of difficulty:



Component 1: Strengthening health service delivery

H-EQIP Component 1: Strengthening health service delivery			
Issue 1: *NQEMP are not directly sensitive to gender and social inclusion issues and socially inclusive communication and care as part of quality health care.*			
Action	**Score level of priority (1-5)**	**Level of difficulty (1-5)**	**List difficulties/challenges in Implementation**
Priority Actions for H-EQIP			
1. Emphasize and monitor the requirement in the annual instruction for conducting NQEMP to have at least one woman (at least one midwife) in each assessment team.	5	1	As existing staff (midwives) are already available at OD/PHD levels, there is no strong constraint.
2. Update template of individual performance evaluation for health staff and questionnaire for client interview to include staff behaviour regarding politeness and non-discrimination to the poor, ethnic minority, disable, and LGBTI patients	5	4	Information from client interviews may not be reliable by themselves
Additional Actions for H-EQIP if Feasible			
1. Undertake a study on gender differences in user expectations of quality of care and factor findings into the design of NQEMT Client satisfaction tool or Impact Assessment.	4	2	If funding and technical support is available, this will not be hard to do.

2. Aim for 50% of assessors being women for the assessment at HC level and at least 20% for the assessment at the RH level.	4	1	There are adequate staff at OD level and transportation to enable this.
3. Introduce a sub-tool or set of questions on the implementation and quality of outreach for those health centres that cover large or difficult to reach geographical areas. Weight scores in areas that use additional sub-tools to allow for comparison with other areas.	5	2	This should be possible if time permits and there is sufficient expertise.
4. Integrate respectful and empathetic communication including the principles of non-discrimination, compassion, social inclusion and non-blaming of victims into the NQEMT coaching tool and develop related job aid.	5	2	Suggest to combine this with Action number 2 on staff behaviour ("Update template of individual performance evaluation for health staff and questionnaire for client interview to include staff behaviour regarding politeness and non-discrimination to the poor, ethnic minority, disable, and LGBTI patients"
Proposed Action Beyond H-EQIP			
1. MoH's Community Participation Policy to be revised in line with the national strategy on decentralisation and deconcentration, and gender responsiveness strengthened including balanced gender representation in HCMC.	4	2	Possible to do if MOH wish to revisit and update the Community Participation Policy.

2. Include female participation as part of the assessment criteria on the functioning of HCMCs with a target of 50% of female members.	5	3	There may not be sufficient female staff to allow 50% female participation at HCMC.
3. Include gender and social inclusion in PHD and OD assessment criteria and scoring (see specific suggestion below vis-à-vis women in management).	5	1	--
Issue 2: *Client satisfaction tool has limitations. It may expose female clients selected for interview to harm if they report their husband's or a family member's phone number; it is not reliable in remote areas where phone coverage is poor; is difficult to foster trust of the selected client to engender honest feedback.*			
Priority Actions for H-EQIP			
1. Female assessors take responsibility for phoning female clients and male assessors for male clients.	5	1	This should be possible; no constraints were identified.
2. Ensure training of all assessors on the potential risks of telephone interviewing clients, how to sensitively introduce themselves and the purpose of the call, and how to manage any negative tensions the call may create.	5	1	This should be re-emphasized in training of assessors.
Additional Actions for H-EQIP if Feasible			
1. Review alternative approaches to telephone interviewing, including linking client satisfaction to ISAF community scores where ISAF is operational, third party survey or HEF Promoters to conduct client satisfaction at the household level.	4	4	This will require more time, human resources, and funding. House to house interviews are very time consuming and require resources and human resources.

Proposed Action Beyond H-EQIP			
1. Introduce a toll-free number that clients call at their convenience.	3	4	Telephone calls are challenging as telephone networks are unreliable and quality of the voice is sometimes variable.
Issue 3: *Service delivery grants do not reward actions that respond to social inclusion*			
Priority Actions for H-EQIP			
1. Increase allocation of SDG performance grants to health facilities in remote/difficult to access areas for improved quality of and access to health service delivery.	5	5	Concern over whether the SDG alone can provide enough budget to respond to the needs of HCs in remote areas, especially in rainy season and due to communication constraints with minority groups.
Issue 4: *There is a large gap in the number of indigenous and ethnic minority people trained and hired by the health service given the challenges of retaining non-ethnic staff in north-eastern provinces and the greater acceptability of ethnic staff among ethnic users, in particular, pregnant women who are encouraged to give birth at health centres.*			
Proposed Action Beyond H-EQIP			
1. Include progress in training and hiring of indigenous and ethnic minority health workers in the north-east in policy dialogue.	5	2	Many IP students are not able to pass the national entrance exam, which is the standard and does not take into consideration differences of IP groups. In Mondulkiri, many students have completed training by failed the exam (20 trained, only 2 passed the exam).

			Request to have more IP staff and prioritize those IP that pass the exam, as this will help with staff retention of health workers in areas populated with IP.
2. With other government agencies, consider scholarships and other financial incentives to keep young ethnic people in school to prepare a pipeline of potential students for the health service.	5	3	Many issues increase the likelihood that ethnic minority and IP students drop out of school and help generate income for their households. Seasonal demands (harvest season) also play a role, as well as different cultures and belief systems.
3. Consider offering foundation programs or special coaching services for students from ethnic minority backgrounds especially girls, to prepare them to compete in national entrance exams for national and regional training places.	5	2	It may be difficult to find girls to join these foundation programs due to differences in culture and beliefs and the fact that many IP girls marry early.
Issue 5: *Very low numbers of women in leadership positions at provincial and OD levels has serious implications for the performance of the organisation and creating the environment and conditions for future female leaders and gender equality in the health sector labour force.*			
1. H-EQIP development partners advocate for women leadership development measures in health sector policy forums. Successful examples of efforts to promote female	5	1	There is political support from the Prime Minister to promote more women in leadership positions. Advocacy for more women in ODs will be important.

leadership in the health sector from other countries to be shared.			The largest constraint is often the family of the woman/ cultural barriers to women having leadership roles.
Issue 6: *Health managers, providers and quality assessors have limited understanding of what gender responsive and socially inclusive communication and service delivery is and why it is important, and how to communicate in a respectful and empathetic way.*			
1. Develop a gender and social inclusion in-service training module including empathetic and respectful communication, supporting job aids and training materials.	5	1	This kind of training has been conducted before in Cambodia and can be done.
Issue 7: *Threats to female staff security affect staff retention and the availability and quality of health care.*			
1. Undertake a study on how female staffs cope with security concerns in different environments and the various strategies being used to mitigate security issues. Share good practices with PHDs, ODs and facilities.	5	2	--

List any changes or additional actions that you would like to include in Component 1:

For issue 1("*NQEMP are not directly sensitive to gender and social inclusion issues and socially inclusive communication and care as part of quality health care"*), suggestion to combine actions 2 ("Update template of individual performance evaluation for health staff and questionnaire for client interview to include staff behaviour regarding politeness and non-discrimination to the poor, ethnic minority, disable, and LGBTI patients") and 4 ("Integrate respectful and empathetic communication including the principles of non-discrimination, compassion, social inclusion and non-blaming of victims into the NQEMT coaching tool and develop related job aid"), as both dealing with respectful communication.

1 top priority action overall for Component 1:

	Responsible:
Update template of individual performance evaluation for health staff and questionnaire for client interview to include staff behaviour regarding politeness and non-discrimination to the poor, ethnic minority, disable, and LGBTI patients AND Integrate respectful and empathetic communication including the principles of non-discrimination, compassion, social inclusion and non-blaming of victims into the NQEMT coaching tool and develop related job aid	--

Component 2: Improving financial protection and equity

Two groups worked on scoring the actions for Component 2. The result from both groups (group A and group B) is below.

H-EQIP Component 2: Improving financial protection and equity			
Issue 1: *Gaps in analytical work undertaken on who is benefitting from HEF.*			
Action	**Score level of**	**Level of difficulty (1-5)**	**List difficulties/challenges in Implementation**

	priority (1-5)		
Priority Actions for H-EQIP			
1. Further analytical work to identify which categories of the poor are benefitting from HEF including by sex of beneficiary, sex of household head, geographical isolation, disability, ethnicity and age.	3 (A) 5 (B)	5 (A) 1 (B)	Existing data is collected on ethnicity through PMRS, so this should not be difficult to do. It should be decided how these analytical works will be used, as HEF has equal benefits for all poor. It would put more burden on health facilities to record additional data and more training may be needed on this.
2. Qualitative research in specific target areas to understand the factors that drive low HEF utilisation to inform programmatic responses.	3 (A) 5 (B)	1 (A) 3 (B)	The scope of work is large and extra human resource and financial resources will be needed. Who will fund this process?
Additional Actions for H-EQIP if Feasible			
1. Assessment of the functioning of the post-IDPoor mechanism and the extent to which it is providing protection to poor people who have missed out on IDPoor, including potential LGBTI beneficiaries who may have faced discrimination.	4 (A) 2 (B)	3 (A) 4 (B)	This may be difficult to identify and methodology for the study would need to be thought through (i.e secondary or primary data collection).
Issue 2: *To make HEF Promoters effective agents in raising awareness of HEF benefits.*			
Priority Actions for H-EQIP			

1. Ensure TOR for HEF-P allow for HEF-Ps to use existing structures and networks to raise community awareness of HEFs; travel to remote and difficult to reach areas where HEF utilisation is low; launch direct awareness raising activities to highly marginalised populations.	5 (A) 5 (B)	4 (A) 1 (B)	This is an existing standard for the HEF-P so just needs to be enforced. Feeling that the scope may be too much for the HEF-P to manage and requires adequate financial resources for the HEF-P to travel. It may be difficult to recruit the HEF-P who can perform all of these functions and the number of HEF-P may not be enough to cover all areas of the country. PHD and health facilities are not able to perform these tasks in addition to their other duties, so who will take this on after HEF-P? Suggestion to outsource this function to an NGO.
2. Induction/orientation training for the HEF-P to include effective and empathetic interpersonal communication, how to foster trust and openness and treat all people with respect and fairness, gender equality and social inclusion, patient and provider rights, and barriers to accessing services that poor, women, adolescent girls, LGBTI and excluded populations face. For provinces with high numbers of ethnic minorities, orientation to include traditional and cultural beliefs of ethnic minority populations and how this affects health access and health outcomes.	5 (A) 5 (B)	2 (A) 2 (B)	This may require capacity building on behalf of the trainers. There is a lack of government guidelines on proper communication with patients. Will require follow-up with HEF-Ps/ results targets. There is a lack of financial resources to support the training.
Additional Actions for H-EQIP if Feasible			

1. In the four north-eastern provinces give preference to hiring ethnic HEF Promoters.	5 (A) 5 (B)	3 (A) 3 (B)	May require further capacity building support. The provinces do not have only one ethnic group, so having only one ethnic HEF-P may not be sufficient. Priority should be given to hiring ethnic HEF-P where possible as it is important to make sure that the population is well represented. Highly educated IP do not apply for the role of HEF-P due to limited salary. Younger IP should be given preference when selecting HEF-P because they are fluent in both languages while the older generation often cannot speak Khmer.
2. Apply the norm of three HEF Promoters per referral hospital flexibly so that more can be hired where utilisation is very low and existing community mobilisation structures are weak.	4 (A) 5 (B)	3 (A) 1 (B)	This will depend on the operational budget and availability of human resources. With existing budget, it will be challenging to hire more HEF-P.
3. Aim for gender balanced teams of two women and one male HEF Promoter per referral hospital.	5 (A) 5 (B)	4 (A) 3 (B)	There are advantages and disadvantages to having both male and female HEF-P. Female HEF-P may have difficulty traveling to remote areas while male HEF-P will have difficulty raising awareness, especially when they have to talk about RMNCH to female clients. It may be challenging to recruit women HEF-P especially in areas with many remote areas (ex. Forrest, highlands), as it is more difficult for women to travel. It

			will depend on the availability of human resources by each province. HEF-P recruitment is now underway, so it will be difficult to change the process.
Issue 3: *The limitations of HEF and SDG to reduce the equity gap in priority national health indicators such as institutional delivery in remote areas.*			
Priority Actions for H-EQIP			
2. Increase HEF transport allowances to reflect market cost or introduce other demand side financing mechanisms such as vouchers.	5 (A) 5 (B)	5 (A) 2 (B)	Requires budget allocation from higher level government or from donor partners.
3. Through SDG encourage and reward actions that: (i) Enhance outreach or mobile health services that regularly take health workers to remote populations and target indigenous and ethnic minority peoples; (ii) Strengthen the existing health posts to more effectively reach the remote communities they serve.	5 (A) 5 (B)	5 (A) 4 (B)	Staff constraints at health facilities in providing services in terms of time and capacity. Health posts may have limited ability to conduct outreach independently. Outreach guidelines are often not implemented due to lack of funding.
Additional Actions for H-EQIP if Feasible			
1. Provide cultural sensitisation and diversity training to health staff in areas with indigenous and ethnic populations.	2 (A) 2 (B)	5 (A) 2 (B)	Depends on staff availability, financial and human resources. Many local health centre staff know about the culture and traditions of IP already. Demand side constraints in terms of IP not accessing the services or not being allowed to access services due to cultural beliefs.

Proposed action beyond H-EQIP			
1. Community transport arrangements that mobilise transporters and community leaders to take responsibility for essential or emergency transport on pre-agreed terms.	5 (A) 5 (B)	5 (A) 5 (B)	These arrangements have been tried several times in the past, such as through UNICEF and JICA supported projects focusing on reducing maternal deaths, but have so far been unsuccessful due to issues with contracts and cost restrictions. Transport suppliers often are not satisfied with their negotiated transport fee and demand a different rate or are not available when needed, making them unreliable. Some suppliers will refuse to take severe cases due to fear of bad luck.

List any changes or additional actions that you would like to include:
No changes identified.

Top priority for component:	**Responsible:**
Group A: Increase HEF transport allowances to reflect market cost or introduce other demand side financing mechanisms such as vouchers.	MOH and H-EQIP partners
Group B: Community transport arrangements that mobilise transporters and community leaders to take responsibility for essential or emergency transport on pre-agreed terms.	Community, local authority (village chief, commune council) and health centres

H-EQIP Component 3: Ensuring sustainable and responsive health systems

The component was divided into two groups—the first scored actions dealing with H-EQIP DLIs, and health infrastructure, and the second scored actions dealing with H-EQIP Monitoring and Evaluation and Institutional and Implementation arrangements. The results of the group work from both groups are reflected in the table below. Several actions were not prioritized due to time constraints.

H-EQIP Component 3: Ensuring sustainable and responsive health systems			
DLI 1 and DLI 2: pre-service and in-service training *Integrate gender equality and social inclusion into DLI1 and DLI2*			
Action	**Score level of priority (1-5)**	**Level of difficulty (1-5)**	**List difficulties/challenges in Implementation**
Additional Actions for H-EQIP if Feasible			
1. Include gender equality and social inclusion/diversity training in the revised pre-service training curriculum at UHS. This would include practical training, and good practice case studies and guidance notes on how health professionals can communicate and behave in a way that is sensitive to the differing needs of vulnerable and excluded people including LGBTI persons and people living with disability.	4	3	--
Proposed action beyond H-EQIP			

1. Develop modules and training materials on gender and social inclusion for a range of pre and in-service training programs.	4	5	Very important but requires budget and human resources to do this.
2. Include in-service training modules on GBV and clinical guidance on the treatment of survivors of intimate partner and sexual violence into pre-service training.	4	5	This would require a lot of work and budget support.
DLI 5: Payment Certification Agency (PCA) *Integrate gender and social inclusion into the values, operational guidelines and capacity of the PCA.*			
Priority Actions for H-EQIP			
3. Include gender equality and diversity into the organisational values of the PCA and operational guidelines. Integrate gender equality and social inclusion into the capacity building and training of PCA management board and staff. Ensure any new information systems to be established at the PCA include sex disaggregated data as appropriate.	3	3	--
Health Infrastructure *Make infrastructure investments gender responsive.*			
Priority Actions for H-EQIP			
1. Ensure that space for a waiting room, pre- and post-delivery, is included in the design of health centres in remote areas, and if not, contingency plans be made to accommodate this.	5	2	This is very important to increase utilization and access, and respond to government policy on gender equality.
Additional Actions for H-EQIP if Feasible			

1. Undertake further assessment of the benefit and cost of including dedicated female staff accommodation at health centres in remote locations; this should include consultations with female staff in these areas and consideration of security and staff retention issues.	5	3	--
Monitoring and Evaluation *Improve the quality and analysis of sex disaggregated data and improve the evidence and analysis of data on health inequities.*			
Additional Actions for H-EQIP if Feasible			
1. Include attention to gender and diversity in strengthening of the HMIS and PMRS reporting and analysis.	5	4	Requires time and commitment to improve data reporting and analysis.
Proposed action beyond H-EQIP			
1. Address gaps in the human resource management information system to enable the efficient monitoring of women in leadership at all levels, gender balance in recruitment, deployment, training and promotion, ethnic diversity and the recruitment, deployment, training and promotion of staff from ethnic minority backgrounds.	--	--	--
2. Strengthen the systems for reporting and tracking GBV cases, and maintaining strict confidentiality.	--	--	--
Results Framework: *There is no gender specific indicator in the results framework or the measurement of health outcomes, which could provide a gender lens. The indicators are not sex disaggregated where reasonable to expect them to be.*			
Priority Actions for H-EQIP			

1. Revise the H-EQIP Results Framework indicator to include sex disaggregation of "utilisation of health services by HEF beneficiaries." Include a sub-indicator "percentage of which are women".	5	1	Feasible as existing systems are in place (PMRS)
2. Revise H-EQIP indicator "Outpatient Department (OPD) consultations (new cases only) per person per year" to include a sub-indicator "percentage for women".	5	3	Increasing the number of results indicators would require more time and commitment for reporting.
3. If CSES data permits, add a sub-indicator to "Reduction in the share of households that experienced impoverishing health spending during the year" such as "of which headed by a female".	3	3	As CSES is owned by Ministry of Planning (MOP), would require advocacy with MOP.
Additional Actions for H-EQIP if Feasible			
1. Further disaggregate HEF utilisation data to include indigenous and ethnicity, physical appearance of disability, and province (these variables are included in the PMRS).	--	--	--
2. Further analysis of PMRS data to study the relationship between the distance between the residence of HEF beneficiaries and their use of services in selected provinces where remoteness is a multidimensional barrier.	--	--	--
Institutional and Implementation Arrangements			
Issue 1:			

Strengthen the linkage and synergies between H-EQIP and the MOH's GMAG and GMAP			
Priority Actions for H-EQIP			
1. Include GMAG in reviews and monitoring of H-EQIP (i.e. through engagement during and between implementation support missions)	3	4	As the project is implemented as a team, this should be done.
Proposed action beyond H-EQIP			
1. Undertake a functional task analysis of GMAG to assess whether its structure, capacity, functionality and resources are appropriate to achieving GMAP's goals and objectives.	--	--	--
2. Technical support to the proposed GMAG functional task analysis, capacity building of GMAG, reporting progress against relevant GMAP indicators, and the development and implementation of the next GMAP for health.	--	--	--
Issue 2: *Strengthen the gender capacity of project management and implementing units*			
Additional Actions for H-EQIP if Feasible			
1. Technical assistance to QAO to support the inclusion of gender equality, social inclusion and communication skills into the on-going development of the NQEMT.	--	--	--
2. Forge linkages between MOH and other government agencies pursuing women leadership development to	--	--	--

share technical resources, leverage successful advocacy models and platforms, build cross-sectoral women leadership networks, and draw on learning and experience.			
Proposed action beyond H-EQIP			
1. Support women leadership development in the health sector. This may include south-south exchanges with successful women leadership mentors in the region, women leadership training programs from the public and private sectors, and male champion networks and policy advocates.	--	--	--

List any changes or additional actions that you would like to include:
No changes identified.

1 top priority action overall for your group:	**Responsible:**
Group 1: Ensure that space for a waiting room, pre- and post-delivery, is included in the design of health centres in remote areas, and if not, contingency plans be made to accommodate this.	MOH/ H-EQIP partners.
Group 2: Revise the H-EQIP Results Framework indicator to include sex disaggregation of "utilisation of health services by HEF beneficiaries." Include a sub-indicator "percentage of which are women".	MOH/DPHI