



CARE Rapid Gender Analysis for COVID-19

Cambodia – July 2020



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The views in this RGA are those of the author alone and do not necessarily represent those of the CARE or its programs.

Cover page photo: San Dalin 30 year-old female factory worker in Phnom Penh, Cambodia

Image: Robin Narciso



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Acronyms

GBV	Gender-based Violence
HR	Human Resources
IPV	Intimate Partner Violence
NGO	Non-Governmental Organisation
PPE	Personal Protective Equipment
PSEA	Prevention of Sexual Exploitation and Abuse
RGA	Rapid Gender Analysis
SRHR	Sexual and Reproductive Health and Rights
UN	United Nations

Executive Summary

The number of COVID-19 cases in Cambodia is quite low (141)¹ however the impact on global supply chains and the livelihood of thousands of factory and migrant workers, who are mostly women, is immense. The loss of income could potentially push families back into poverty and the value of unpaid care work which will increase during the pandemic, is not measured in financial terms, nor seen as a valuable contribution. Additionally, the growth of women's empowerment which is strongly linked to financial contributions to the household, will decline.

Women and girls in Cambodia face inequalities in many areas such as in employment and payment, division of domestic labour, decision making and participation. Those are likely to further increase in the course of the COVID-19 pandemic. An area of specific concern is in the education of girls and boys, from poor families, who do not have the technical infrastructure and capacity to support online home schooling.

The current health system does not have the capacity to deal with an increasing number of COVID-19 cases. Sub-national health facilities are considered low quality and previous health crisis showed that patients will directly consult provincial and national facilities which is going to exceed their capacity.

There is still uncertainty about transmission of COVID-19 which causes fear and creates potential for rumours causing stigmatisation and discrimination of certain population groups such as foreigners, women working with foreigners as in bar work and Muslim groups.

Gender based violence is common and widely accepted in Cambodia. Globally, intimate partner violence (IPV) may be the most common type of violence women and girls experience during emergencies.² In the context of COVID-19 quarantine and isolation measures, IPV has the potential to dramatically increase for women and girls. Life-saving care and support to GBV survivors may be disrupted when front-line service providers and systems such as health, policing and social welfare are overburdened and preoccupied with handling COVID-19 cases. Restrictions on mobility also mean that women are particularly exposed to intimate-partner violence at home with limited options for accessing support services.

Key findings

- Up to 200,000 garment workers in Cambodia (89% women) at risk to lose their job
- Migrant workers are returning to their communities
- Remittances from factory workers is decreasing dramatically
- Stress and anxiety endanger mental health and increases risk of gender-based violence
- Increased stigmatisation and discrimination of certain population groups associated with carrying COVID-19 virus
- Digital gender gap compromises education, access to latest COVID-19 information and access to business support measures
- Lack of tailored COVID-19 messaging for vulnerable groups

Key recommendations

RECOMMENDATION 1: Collect sex- and age-disaggregated data for COVID-19

RECOMMENDATION 2: Provide immediate lifesaving relief support to those most impacted by COVID-19

¹ <https://www.worldometers.info/coronavirus/country/cambodia/>

² International Rescue Committee 2015

RECOMMENDATION 3: Livelihood and income support should be made available based on women's identified needs and priorities

RECOMMENDATION 4: Collaborate with trade unions in requesting governments and brands for increased payments for laid off workers

RECOMMENDATION 5: Inclusive community outreach and messaging should be prioritised

RECOMMENDATION 6: Engaging men and boys in dialogues to raise their awareness on gender inequality and the impacts of COVID-19

RECOMMENDATION 7: Develop capacity of village health workers to provide information on COVID-19 prevention, mitigation and response to at-risk groups through household visits

RECOMMENDATION 8: Support community services for people with disabilities

RECOMMENDATION 9: Identify barriers to home schooling and support access to education for girls and students with special needs

RECOMMENDATION 10: Support and strengthen existing GBV prevention, mitigation and response services and initiatives.

RECOMMENDATION 11: Work with local authorities to ensure quarantine facilities are set up in ways to mitigate violence against women and girls

Introduction

Background information to COVID-19 crisis

After an initial outbreak in late 2019 in Wuhan Province, China, COVID-19 (officially SARS-Cov 2) began to spread across the globe at a rapid pace. Based on the World Health Organization's data from July 27th 2020, there are 16,114,449 confirmed cases, including 646,641 deaths, globally.³

Cambodia has a population of 15.3 million people, plus around 1.2 million people traveling or living abroad, 93% of whom are in Thailand.⁴ The impact of COVID-19 has severely damaged the Thai economy, leading to significant job loss for Cambodian migrant workers in Thailand and an influx of these workers returning home. Furthermore, Khmer New Year from 12th -16th April 2020 (even with the official postponement) and the closure of Thai-Cambodia border generated a dramatic rush of Cambodian workers returning from Thailand. Whereas many of the returned women stay at home to take care of children and the household, men are either farming or looking for wild foods (mushrooms) which they can sell at the market. Without sufficient screening capacity there is significant risk that migrant workers have brought the virus from Thailand and are now spreading the virus in their local communities. Local authorities were instructed to quarantine returning workers, test all suspected cases and raise awareness in their communities but many locations due to the lack of facilities and resources could not manage these tasks well. Some returnees have ignored these measures and avoided quarantine and testing. The main reason being that they did not have the resources for housing, food supplies, daily essentials and health care during quarantine. Another reason for ignoring safety precautions is the uncertainty around the virus such as transmission, population at risk and the most effective ways to detect, interrupt, and contain human-to-human transmissions. Since the end of March, when the government

³ <https://covid19.who.int/>

⁴ National Institute of Statistics 2019

announced the border closure, 60,000 migrant workers have arrived from Thailand, with about 1,000 arriving each day.⁵

As of July 5th, the Ministry of Health in Cambodia has confirmed 241 cases so far, with 131 recoveries and zero deaths, and 13 out of 25 provinces have reported positive cases⁶. Most of these cases can be traced back to one of three groups of people who recently entered Cambodia: 1) American and European tourists from boat cruises originating in Vietnam, 2) Cambodian Muslims returning from a religious gathering in Malaysia (entered through Phnom Penh Airport), and 3) European tourists coming from Laos (these tourists entered through the Siem Reap Airport and then travelled to Battambang province, Phnom Penh, Sihanoukville, where the infections were finally discovered. Most of the current cases are in these three groups of people or resulted from local transmission through contact with these groups. The remaining cases were imported from various overseas locations.⁷

The Government of Cambodia has taken effort to prevent the spread of the virus through containment, testing and contact tracing, closing schools and entertainment establishments (Karaoke, pubs, cinemas, etc.), municipality bus transportation, sporting events and gyms. In addition, the government has banned religious and other large gatherings including postponing Khmer New Year (12-16 April 2020), the largest social event of the year. Furthermore they started a public campaign to promote social distancing and standard personal hygiene practices. Cambodia has closed its borders with Vietnam and Thailand and banned entry of foreigners from a number of countries with high infection numbers. The government has also recommended working from home, if possible. Many NGOs, international organizations such as the UN and private companies have advised their staff to work from home with limited activities in the field to minimize personal contact. Social distancing and personal hygiene practices are being promoted and reinforced. Alcohol-based cleaning fluids and hand sanitizers are being provided at the entrances of many public buildings and supermarkets.

The closure of schools and the potential or anticipated switch to online home schooling challenges families who do not have sufficient technical devices and money for internet access. If available, priority will be given to boys since girls are more likely be assigned to take care for younger siblings and other domestic tasks⁸.

The Rapid Gender Analysis objectives

This Rapid Gender Analysis aims to analyse and understand the different impacts the current COVID-19 pandemic has on women, men, girls and boys in Cambodia and their current needs and capacities. The analysis provides programming and operational recommendations to meet the different needs of women, men, boys and girls and ensures that interventions “do not harm”.

This preliminary Rapid Gender Analysis has the following objectives:

- To analyse and understand the different impacts that COVID-19 may have on women, men, girls, boys, and other vulnerable groups in Cambodia.
- To inform humanitarian programming in Cambodia based on the different needs of women, men, boys, and girls with a particular focus on Gender Based Violence, Dignified Work, Inclusive Governance and Education.
- To provide recommendations for organizations on organizational preparedness for COVID-19, including policies and practice (e.g. Child Safeguarding and Prevention of Sexual Exploitation and Abuse).

⁵ Phnom Penh Post reported on 6 April follow the comment by Director General of Immigration Keat Chantharith

⁶ <https://covid19-map.cdcmoh.gov.kh/>

⁷ MoH/CDC a (2020)

⁸ UN Women (2020)

The findings of the research will be shared with CARE Program staff, government, NGOs, UN-Agencies, and interested donors who want to understand and address the gender related issues caused by COVID-19.

Methodology

The research has been undertaken from 15th - 29th April 2020. Research is ongoing and the RGA will be updated appropriately when new findings and recommendations are produced. Research methods included:

- **Secondary Data Review** based on existing gender information including from: Reports, studies and evaluations by the United Nations, National and International NGOs, including CARE; national and international media articles; and press releases from governmental authorities.
- **Remote Key Informant Interviews** with a total of 28 people (14 women, 13 men and one un-identified sex). This included both:
 - Community members (four returned migrant workers from Thailand, six factory workers, three workers who had lost their job and six people with disabilities) and
 - Non-community members (two factory Human Resource managers, two health care providers, one health manager, one National Committee for Counter Trafficking Deputy General Secretary and two commune chiefs and one deputy district governor) have been conducted.

When conducting this RGA for COVID-19 a number of practical, logistical and ethical considerations were identified. **A Do No Harm approach was taken and prioritised throughout the process.** This involved mitigating risks; both direct risks, for staff and the community, associated with the virus, as well as ensuring essential human, financial and logistical capacity were not diverted away from the immediate needs and direct response to COVID-19. Considerations included:

- Secondary data was prioritised. Significant proportions of data collection relied on the use of secondary data analysis collected from previous studies and analysis on the RGA topics before the COVID-19 pandemic and current studies, press conferences and media articles.
- For primary data collection key informant interviews had been conducted instead of household interviews which requires a larger sample size. The interviews were conducted remotely via phone calls.
- Data protection, confidentiality and the safety of respondents was considered at all stages. The interviewer obtained verbal consent before the interview.
- All staff involved in the data collection process understood and had available the updated Prevention of Sexual Exploitation and Abuse (PSEA) reporting mechanisms and GBV referral pathways. The contact details of CARE Cambodia's focal person for 'Feedback and Accountable Mechanism' was provided before the interview. The interview team was trained and informed about referral mechanisms, counselling or support services, in the event that incidents were disclosed or respondents requested support during the interview.

Limitations

The research had several limitations due to travel restrictions and time constraints. Appointment with high level ministries needed at least one week in advance and could not be realised due to time constraints. Since primary data collection needed to be conducted through telephone interviews, Whats App, Facebook Messenger or Skype, technical challenges such as interrupted communication made it difficult to understand the respondents clearly. Information could be clarified but interviews took longer than expected.

Demographic profile

Sex and age disaggregated data

As of 13 April 2020, the Ministry of Health in Cambodia reported a total of 8,909 samples were tested with 122 persons testing positive for COVID-19 mostly Cambodian (51), followed by French tourism groups (40). However, no new cases occurred since 11 April 2020⁹. Out of the positive cases in Cambodia, 31% have been female. From the limited global sex-disaggregated data available, it seems that men are at a slightly higher risk with regards to morbidity than women. Age disaggregated data is not available for Cambodia but COVID-19 shows greater direct risks for people over 60, as well as those with underlying medical conditions.¹⁰

Demographic analysis

- Average household size: 4.6
- Percentage of female-headed households: 27%
- Percentage of people with functional disability: 9.5% some degree of disability, 2.1% extreme disability
- 97% Khmer and 2.2% indigenous ethnic minority (mother tongue)
- Khmer is official language and ethnic minorities have their own language (not written)
- 1.2 million migrant workers in Thailand, 87,000 of them travelled back to Cambodia for Khmer New Year event and lost their job as a consequence of the COVID-19 pandemic.
- Data on social, sexual and gender minority groups: sex ratio 94.3 per 100 women, no minority sex group data available in Census 2019 preliminary report¹².

Age group	Male	Female	Total
0-4 yrs	702,539	655,564	1,357,618
5-9 yrs	779,692	756,299	1,536,493
10-19 yrs	1,652,117	1,578,704	3,230,458
20-59 yrs	3,818,342	4,181,284	8,001,997
60+ yrs	465,887	697,274	1,164,983
Totals¹¹	7,418,577	7,869,125	15,291,550
15-49 yrs	4,128,438	4,285,954	8,416,315

Findings and analysis

Gender roles and responsibilities

Access and control of resources

Gender relations in Cambodia are complex. Khmer women exercise considerable autonomy and independence. They can own assets, manage financial transactions and contribute to household decision making. Both men and women can inherit property and the gender division of labour can be complementary and flexible with men and women performing a range of productive and household tasks. However, in practice, traditional norms and low levels of education and literacy still limit girls' and womens' choices and options. Cambodia remains a hierarchical society with strong ideas about power and status. Women are considered to be of lower status than men although status is also determined by age and other socioeconomic characteristics, especially wealth. For women, marriage and children additionally determine status. In general,

⁹ MoH/CDC b (2020)

¹⁰ CARE/ICR 2020

¹¹ National Institute of Statistics 2013 and 2019

¹² National Institute of Statistics 2013 and 2019

attitudes toward gender roles still emphasize the woman as household manager and the man as provider. Women who are older, divorced, separated, or widowed and those who live in urban areas, are better-educated, and are paid in cash have greater financial control over the assets they own. Access to the media and knowing ones legal rights correlate with greater economic autonomy.¹³

Division of (domestic) labour

Women and girls across the Association of Southeast Asian Nations (ASEAN) carry a disproportionate burden of unpaid care and domestic work. In Cambodia, they spent more than 10 times as much time in this work than men and boys do.¹⁴

The 2003 Ebola outbreak in West Africa showed that in situations where health-care systems are stretched by efforts to contain outbreaks, care responsibilities are frequently transferred onto women, who usually bear responsibility for caring for ill family members and the elderly.¹⁵ The closure of schools as a preventative health measure exacerbates the burden of unpaid care work on women, who absorb the additional work of caring for children.¹⁶ In migrant worker families who returned back to Cambodia, the roles of men and women change, whereas, men seek to find work in the village or in Phnom Penh to support the family, women stay at home to take care of the house and the children.¹⁷

Income and paid employment

Out of the 14.68 million people living in Cambodia, 56% (8.3 million people) belong to the labour force. Women play a major role in economic development in terms of participation in the labour market and as business owners. According to the 2014 Cambodian National demographics and health surveys 81% of currently married women aging 15-49 years were employed.¹⁸ In the age group 15-19 years women have a slightly higher labour force participation rate (66%) compared to men (64%) which is underlined by the fact that they are less likely to be in school than their male counterparts at this age (see section on education). In Phnom Penh, the gap between female (43%) and male (37%) labour force participation is even higher. Despite high labour force participation rates, 70% of employed women remain in vulnerable employment situations such as working in family business and not earning their own income, compared to 59% of employed men. Women's employment is highly concentrated in agriculture, forestry and fisheries, wholesale and retail trade and services and manufacturing especially in the garment and footwear sector. In the micro, small and medium enterprise (MSME) sector a high percentage of enterprises are owned and run by women, however those enterprises are mostly informal and contribute little to overall economic growth. Women have less access than men to higher-skilled occupations, public sector employment, business associations and networks which offer opportunities for lobbying and agency. Occupational segregation is extensive and women continue to be concentrated in lower-skilled occupations.¹⁹

Cambodia's garment and footwear factory industry employs approximately 770,000 people, 639,000 women (83%) and 131,000 men (17%).²⁰ The labour force has embraced movement and modern industrial sector work to such an extent that one in three members of the working age population – over two million from a total of eight million – is an internal migrant.²¹ Such a substantial and rapid transformation in rural livelihoods has brought with it considerable consequences as Cambodia's villages adjust towards an increasing dependency

¹³ USAID/Cambodia 2010

¹⁴ Naciri 2020

¹⁵ Harman 2016

¹⁶ UN-Women 2020

¹⁷ Interviews with migrant workers April 2019.

¹⁸ National Institute of Statistics 2015

¹⁹ Cambodian Garment and Footwear Sector Bulletin 2015

²⁰ GMAC 2018

²¹ National Institute of Statistics 2010

on the garment industry. The vast **majority of the garment sector labour force (83%) are women**,²² especially young women who have migrated from rural areas. However, they are not on equal terms with their male colleagues. For example, they are excluded from leadership roles, receive a lower salary (81% of men's earnings), receive less education and training than men, are recognised less for their contributions and are more likely to be exploited and harassed in their workplace.²³ According to the Global Findex database women in developing countries are 17% less likely than men to have borrowed formally.²⁴ The lack of access to grants might disadvantage women for receiving grants to restart their business after lockdown.

Out of the 1.2 million Cambodians living abroad, **93% live in Thailand**.²⁵ In 2019, an International Organization for Migration (IOM) report showed that a third of migrant workers surveyed were unemployed before leaving Cambodia and around two-thirds moved to Thailand due to a lack of job opportunities in the Kingdom and to earn a better income.²⁶ In normal circumstances women migrant workers already face various risks including restrictive migration policies, insecure forms of labour, language barriers, overcrowded living conditions, racism and xenophobia, lack of legal recognition and undervaluation of their contribution to social and economic development. **Women migrant workers are also exposed to multiple intersections of GBV and discrimination.**²⁷

Needs and vulnerabilities

The COVID-19 pandemic has impacted formal and non-formal jobs significantly. Public life is severely impacted with travel restrictions imposed and borders, schools and entertainment places closed. All employees are working from home and **taxi drivers, including tuk tuk and motodops have lost their daily income. Street food vendors** and other business that served daily needs and **women working in the entertainment industry have lost their clients**. The closure of massage services and bars also impacts income opportunities for people with disabilities with one interview respondent reporting that they cannot find places to sing on street corners for money (*busking*) anymore.²⁸

Out of the **1,522 factories in Cambodia, 91 have partially or fully suspended their production with** 91,500 garment workers being laid off for one to two months.²⁹ This number is likely to rise up to 200,000 in the coming months.³⁰ According to the interviewed HR Managers there is also a small number of workers in the factory (150) who have resigned as their families are worried about them becoming infected.³¹

The Garment Manufacturers Association Cambodia (GMAC) said **60 % of its factories have been affected** by cancelled orders subsequently **affecting about half a million workers and their families** and that an increasing number of factories have suspended operations.³² Trade unions in Cambodia, such as the National Trade Union Confederation (NTUC) and the Collective Union of Movement of Workers (CUMW) encouraged the Cambodian government to **temporarily suspend garment production** to mitigate the risk of spreading COVID-19.³³ The Government of Cambodia stated that temporarily laid off workers will be entitled to receive USD 30 from the factory and USD 40 from the government per month but the implementation of this support is not yet operational. This is a substantial drop from the minimum wage of USD 190 and pushes garment

²² UNFPA 2014

²³ UNDP 2014

²⁴ The World Bank 2017

²⁵ National Institute of Statistics 2019

²⁶ VOA Cambodia 2020

²⁷ UN Women 2020

²⁸ Key Informant interview People with disabilities April 2019

²⁹ Mathews 2020

³⁰ Glover 2020.

³¹ Key Informant Interview HR Managers April 2019

³² Fair Labor Association 2020

³³ Kimmarita 2020

workers and their families into poverty.³⁴ In an interview, one factory worker stated that while their jobs had been suspended they may be able to start back again in May. However from a pay perspective their April salary was significantly lower than normal with no overtime and only a basic wage. The factory worker disclosed that this has impacted on the workers ability **to send remittances to their families in the province** and their personal **struggle to get enough food** due to increased prices and limited access to markets during lockdown. Some respondents reported that they have already used savings and they have had to sell items to buy food and necessary supplies. Also, since they can no longer afford food from the markets they need to search for wild foods, such as mushrooms, in the forest.³⁵

A report by the World Economic Forum (WEF) states that a **reduction in the amount of money sent home by migrant workers** looks increasingly likely as the Coronavirus global pandemic impacts jobs and wages across all sectors. According to data from ACLEDA Bank Plc, money sent home by Cambodian workers based in South Korea during the first quarter of 2020 was \$3.5 million (1,373 transactions) - a decrease from \$6.2 million (2,270 transactions) in the same period last year.³⁶

“Potential increase in poverty due to the economic fallout from the pandemic”

Cambodia’s Minister of Interior Sar Kheng

Migrant domestic workers who had to return to Cambodia due to the closure of borders **face difficulties in getting back to work** due to travel bans and requirements such as health certificates which is obligatory for entering Thailand from 22 March 2020. There is also a reduction in workforce demand, due to employer’s fears, related to COVID-19 transmission, as well as impacts of interrupted supply chains and therefore reduced workload. This leaves many women migrant workers in limbo regarding their visa, employment, and housing and they are unable to seek the compensation due to them, as services are stretched or unavailable as a consequence of the outbreak.³⁷ The Ministry’s Secretary of State Chou Bun Eng, the permanent vice-chair of the National Committee for Counter Trafficking (NCCT), said **migrant workers have generally become a burden to their families** as they would not be able to return to their host countries until the Covid-19 crisis is over.³⁸

Decision-making, participation and leadership

Women are severely underrepresented in decision-making processes outside the household.³⁹ In cases where women are employed and earn cash, the majority of married women (76%) can make independent decisions on spending their earnings.⁴⁰

Decision making within the household

According to the 2014 Cambodia Demographic and Health Survey a large majority of currently married women (86%) participate in three specified areas of decision making. This includes decisions on their own health care, major household purchases and visits to their family or relatives. Decision making power is strongly linked to household income contribution and varies across the country. Whilst on average 74% of women aged 15-49 years who earned cash in the previous 12 months decided how that cash was spent, the percentage in rural areas is lower (36%) in Banteay Meanchey and (24%) in Mondul Kiri/Ratanak Kiri. Women who earn more than their husbands are more likely to decide how their cash earnings are used (79%) than women whose cash earnings are the same as those of their husband (69%). Decisions in terms

³⁴ Mathews 2020.

³⁵ Key Informant interview with factory and migrant workers April 2019.

³⁶ Sarath 2020

³⁷ Yi 2020

³⁸ Dara 2020

³⁹ Asian Development Bank (2012)

⁴⁰ National Institute of Statistics 2015

of health and family planning are usually done jointly with health care providers encouraging couples to come jointly to the services.⁴¹

The **income loss of women due to the COVID-19 pandemic might impact their decision-making power in the household**, but at this stage interviewed persons could not indicate a change in decision making yet.

Informal groups or networks

The majority of the respondents interviewed reported that as migrant workers, spending most of their year abroad, it is not possible to join local groups. One factory worker stated that she used to join meetings in the community related to health information and organised by the commune but her participation was dependant on the time and the location. She noted that if the meeting is far away, then usually her husband attends as he can drive. During the COVID-19 pandemic there have not been any group gatherings taking place in the community.⁴²

Women’s organisations, groups and movements

With growth in the garment industry, the trade union movement has grown as well. There are now more than 100 trade unions and more than 90% of union members are women. However, only two women fill national leadership positions.⁴³ The trade unions have requested that the government ensure employees furloughed due to the pandemic receive 60% of their wages and in addition suggested a minimum wage increase for garment workers.⁴⁴

Health, including Sexual and Reproductive Health and Rights (SRHR)

Health information

In Cambodia, life expectancy at birth is low with 67.1 years for men and 70.1 years for women.⁴⁵ The maternal mortality rate lies with 170 maternal deaths per 100,000 live births⁴⁶ above the regional average maternal mortality rate in Asia Pacific which is 127 per 100,000 live births.⁴⁷ The provision of quality health services, especially for the poorest people, is a fundamental development challenge. In Cambodia, utilization of national hospitals is high, with bed occupancy rates of over 100%, but utilization of primary care and district hospitals is variable, with low rates of utilization in many facilities.⁴⁸ Affordability of health care is a major problem, especially for the poor and often leads families into debt and forces them to sell their productive assets, such as land. Only 16% of Cambodian women and 13% of men are covered by health insurance. Utilization rates and family spending on health care are about the same for men and women. However, women will have specific needs due to their reproductive health needs. Therefore, equal rates of health service utilization indicate that women’s health care needs are not being met.⁴⁹

Health information	By Sex	
	M	F
# people (m/f) testing positive for COVID-19	84	38
# fatalities (m/f) from COVID-19	0	0

⁴¹ Key Informant Interview (male and female) with health care providers April 2019.

⁴² Key Informant Interview with people with disabilities in April 2019.

⁴³ Brereton et al 2004.

⁴⁴ Fair Labour Association 2020

⁴⁵ National Institute of Statistics 2013

⁴⁶ National Institute of Statistics 2015

⁴⁷ UNFPA 2018

⁴⁸ Cambodia Response Plan for COVID-19 2020

⁴⁹ Berenton et al. 2004

Among the 10,000 workers who travelled back from the countryside for Khmer New Year, more than 50% did not undertake the recommended medical check due to fear of losing their job if they had to be quarantined. Only 5,043 workers, 89% of them female, had a medical check and out of those 125 workers showed suspected symptoms and had to be tested and confined in second level quarantine centres. Among the confined workers no positive cases have been confirmed. In addition, a further 97 workers who had been in contact with suspected cases were put in the first level quarantine centres. They are permitted to go back home once their contact person in the second level quarantine centre is confirmed as COVID-19 free. The remaining workers have been confined to home quarantine for 14 days before being allowed to go back to work.⁵⁰

The Cambodian government developed a COVID-19 response plan which aims to address:

- 1) Health risk - educate and actively communicate with the public through risk communication and community engagement as well as strongly emphasize personal protective measures i.e. hand hygiene, respiratory hygiene and social distancing
- 2) Socio economic impact
- 3) Recovery phase.⁵¹

Safe access to health care and services (including SRHR)

In rural areas a lack of infrastructure such as bridges and roads and the doubling of transportation costs during the rainy season, as well as the cost of living are barriers for people in villages as well as the ambulance service to access health centres.⁵² In addition, unskilled and inexperienced staff in governmental health centres, the unexpected higher treatment costs and the lack of financial means to access services in higher quality private health facilities are further reasons why Cambodian people tend to visit over-the-counter drug stores for their health problems. 'Intra-household constraints' for women that make it difficult for them to leave their homes such as having to leave it unattended, not having anyone to provide childcare and not having someone to accompany them to a facility, pose specific gender constraints in accessing formal health care.

Services for **people with disabilities** are very limited in Cambodia generally, and even more so in areas outside of large cities.⁵³ People with disabilities rely on community-based social services or specialized services to meet basic daily needs such as meals and hygiene services. Due to fear around transmission and lack of personal protective equipment disability rights groups are concerned that these services may be interrupted.⁵⁴

Evidence from past epidemics in West Africa, including Ebola and Zika, indicate that efforts to contain outbreaks often divert resources from routine health services including pre and post-natal health care and contraceptives.⁵⁵ The COVID-19 pandemic has also led to disruptions in supply chains across sectors regionally, nationally and globally including essential medical supplies and contraceptives. With many contraceptives manufactured in the region and factory closures and migrant workers being sent back to their homes these emerging issues will have large implications on the availability of contraceptives.⁵⁶ Those most at risk are women seeking emergency maternal and reproductive health services that require strict isolation and infection control measures which may be unavailable due to staff deployment and shortages or lack of infrastructure (i.e. operating theatres and ward space).⁵⁷ Interviewed factory and migrant workers stated that

⁵⁰ Press conference organised by MoLVT, lead by a Spoke person HE Heng Sour to inform about quarantine of factory worker after returning from Khmer New Year. Posted in Facebook of MoLVT on 27 April 2020 at 2:35 PM.

⁵¹ Cambodia Response Plan for COVID-19 2020

⁵² Partnering to Safe Life's 2014

⁵³ Partnering to Safe Life's 2016

⁵⁴ Human Rights Watch 2020

⁵⁵ UN 2016

⁵⁶ UN Women 2020

⁵⁷ Hussein 2020.

all services are still available at the health centre but people are afraid of getting infected with COVID-19 as many people visit the health centre to be tested. They put their trust in the local service providers and the Ministry of Health rather than in Department of Health at sub-national level. According to the local authorities at the beginning of the COVID-19 pandemic the number of people attending health facilities reduced in numbers but after authorities provided information on COVID-19 the service is operating as before.⁵⁸

For pregnant women and people with disabilities who may require health care, their concerns relate to their requirement for physical support and mobility against the requirement of social distancing. Therefore they are choosing not to obtain health care if it is avoidable.⁵⁹

Mental health and psychosocial support

All interviewed key resource persons reported an increased level of stress and anxiety due to loss of income, social distancing and movement restrictions. Parents are concerned about their children's vulnerability to infection if they continue to go out which causes increased tension and worry within the home. Especially affected are those family members who lead the household economy. If both lost their job, men are expected to go out and earn money to support the family which increases family pressure. The closure of schools is also a difficult situation for students and parents if they cannot continue studying.

“It really affects the mental health because usually we go back home with the warm welcome from our family and relatives, but now it is different because of the social distancing. People avoid me and my husband. The stress level is also increasing because of the increase in price of food and water. We also have a lot of fear of going out and are always wearing masks”

Migrant Worker

The health centres and commune halls provide psychological support and are open for consultations. Local authorities visit returnees and provide information around COVID-19. Respondents said that it is crucial that local authorities provide support to survivors of violence including help to mediate conflict.⁶⁰

Influence of beliefs and practices

The COVID-19 pandemic leads to **increased stigmatisation and discrimination of certain population groups**. Key informants observed discrimination of urban people and migrant workers returning to their hometowns since they are suspected to carry the virus to the villages. Some neighbours closed the doors and told them to quarantine themselves for 14 days.

“People do not want to talk much with us because we travelled from Phnom Penh and they think we are bringing risk to them”

Migrant Worker

There is rising concern regarding elderly people with existing respiratory issues,⁶¹ sick people and people from other nationalities. There is concern related to foreigners and people who are working with foreigners such as women working in the bars which are attended by Western and Chinese people. Local authorities reported that there had been a Muslim man from Malaysia who stayed in a community close to a market for a few days in early April 2020. The local population was scared that the man might be COVID-19 positive and did not buy beef meat from Muslim market vendors for a while. The Muslim man tested negative. Health centre providers

⁵⁸ Key Informant Interviews with factory and migrant workers, local authorities, National Committee for Counter Trafficking Deputy General Secretary, health service providers April 2020

⁵⁹ Key Informant interviews with migrant workers and people with disability April 2020.

⁶⁰ Key Informant Interviews with factory and migrant workers, health care providers and local authorities April 2019.

⁶¹ UN Women 2020

stated that discrimination of individual groups is reduced after they conducted awareness raising on COVID-19.

Some rumours spread via social media frighten people within communities and the use of social media poses a risk that people will lose trust in reliable information sources such as the government, NGOs and established media outlets.

Traditional local practices such as making fire in front of the house and making noise to expel the evil are still applied but the amount of people attending traditional celebrations has been reduced.⁶²

Access to education, information and technology

According to USAID report in 2006, there was a significant gender gap in terms of girls' schooling exists in Cambodia, increasing in size at each stage from primary school to university, and greater in rural than in urban areas. While reforms have resulted in equality in primary school enrolment, girls drop out earlier and in greater number than boys due to household responsibilities, long distance to higher education institutions and problems of transport due to bad infrastructure and security concerns such as kidnapping, rape and drug abuse.⁶³ However, the progress has significantly increased since then. According to EMIS 2018-2019 of MoEYS, gender parity index (female to male ratio) for gross enrolment rate was 0.98, 1.17 and 1.24 at primary, lower secondary and upper secondary schools respectively. The ratio is higher at rural(1.3) than urban (1.07) areas when student reached upper secondary school. Similarly, the completion rate at all the three levels are higher among girls than boys which is at 86.06% vs 78.46%, 50.19% vs 40.67% and 24.51% vs 20.09% at primary, lower secondary and upper secondary school respectively⁶⁴. The result proof a significant improvement in community awareness and promote both sex in access to education, especially girls are more at high grade. This result also aligns with CARE's Know and Grow project midterm evaluation finding that girls are more adherence to school participation and works, good at class and less absent as compare to boys.

The Ministry of Education Youth and Sport appealed to parents of students to provide home education in a proper environment and help them obtain more learning materials during the COVID-19 pandemic. On March 13, 2020, the Ministry put in motion an e-learning programme where students can study free of charge, on social media, Facebook, YouTube and the Ministry's website.⁶⁴ However this situation risks **increasing the gender gap in education**. Girls may be expected, due to gender norms and roles, **to devote more time than boys to unpaid care work** such as caring for younger siblings, older populations, and those who are ill within the household rather than focusing on education.⁶⁵ Only 20% of all students have online access.⁶⁶ There is a high risk that **poor families** without digital devices cannot provide their children with access to those e-learning modules and that **those children will be excluded from education**.

Information on COVID-19 and its prevention is spread via manifold channels such as village chief and village health support groups (where available), loudspeakers in the community, TV, radio and screens in health centres, via Facebook and YouTube. According to the interviewed Operational District Director around 50% of the community members have access to social media. Whereas almost all factory workers have a smartphone there seems to be no difference between men and women in using the form of technology. The Deputy General Secretary of the National Committee for Counter Trafficking observed an increase in the number of users of technology among men, women, girls and boys and feels they have an equal chance to access all information. On the contrary the Operational Director observed that men tend to prefer receiving up

⁶² Key Informant Interviews with factory and migrant workers, health care providers, local authorities, National Committee for Counter trafficking Deputy General Secretary, Operational Director April 2020.

⁶³ USAID 2006

⁶⁴ Sochan 2020

⁶⁵ UN Women 2020

⁶⁶ EIE meeting on 12.05.2020.

to date information via social media and noted that students do not get the essential support from their parents as well as not having the necessary infrastructure (shortage of online materials and possibilities to use the internet) for proper home schooling.⁶⁷ **Groups which do not receive enough information yet are the elderly, poor people and people with disabilities** which have specific needs. Health care staff cooperate with local authorities and volunteer groups in the community to visit those households to provide health information.⁶⁸

Safety and protection

Gender Based Violence

Gender based violence (GBV) is common and widely accepted in Cambodia. According to the 2014 Cambodian Demographic and Health Survey, one in five women between the ages of 15-49 years have experienced physical violence at least once since age 15 and 9% experienced physical violence within the 12 months prior to the survey. Amongst married women the most commonly reported perpetrator of physical violence is their current husband or partner (56%), followed by their mother/stepmother (23%) and former husband/partner (20%). Fifty percent of women believe that wife beating is justified for at least one of six specified reasons including disagreeing with her husband, going out without telling him, neglecting the children, burning the food, refusing to have sexual intercourse with her husband or if the wife asks her husband to use a condom. Spousal violence is often linked with alcohol abuse.⁶⁹ The issue of domestic violence, linked with substance abuse, was brought up by almost all key informant respondents from the community.⁷⁰

“Night time can be maddening because of violence at home. We hate it so much! Some people are drunk and lazy and bad at working, and the only thing they do is scare the women. We want these people out of our lives.”

Young Tampuan women⁷¹

During emergencies such as conflicts or natural disasters, **the risk of violence, exploitation and abuse is heightened, particularly for women and girls.** At the same time, national systems and community and social support networks may weaken. An environment of impunity may mean that perpetrators are not held to account. Pre-existing gender inequalities may be exacerbated. Women and adolescent girls are often at particular risk of sexual violence, exploitation and abuse, forced or early marriage, denial of resources and harmful traditional practices. Men and boys may also be survivors. GBV has significant and long-lasting impacts on physical health, psychological health and social and economic well-being of survivors and their families.⁷²

Globally, intimate partner violence (IPV) may be the most common type of violence women and girls experience during emergencies.⁷³ In the context of COVID-19 quarantine and isolation measures, IPV has the potential to dramatically increase for women and girls. Life-saving care and support to GBV survivors may be disrupted when front-line service providers and systems such as health, policing and social welfare are overburdened and preoccupied with handling COVID-19 cases. Restrictions on mobility also mean that **women are particularly exposed to intimate-partner violence at home** with limited options for accessing support services. According to an NGO report from Vietnam some women have reported that they would prefer to put themselves at risk of contracting COVID-19 in public, rather than stay at home isolated with a violent

⁶⁷ Key Informant Interviews April 2020

⁶⁸ Key Informant Interviews April 2020

⁶⁹ National Institute of Statistics 2014

⁷⁰ Key Informant Interviews April 2020

⁷¹ CARE International in Cambodia 2018”

⁷² UNFPA 2015

⁷³ International Rescue Committee 2015

and abusive partner.⁷⁴ Experiences have demonstrated that where women are primarily responsible for procuring and cooking food for the family, that an **increase in food insecurity**, as a result of the pandemic, may place them at **heightened risk of domestic violence**.⁷⁵ Interviewed factory workers stated that the additional stress from losing their job, financial insecurity, travel restrictions and closing of schools can lead to discussions which end in violence in the family. One woman said that she feels annoyed that her husband does not practice social distancing and recommended hygiene practice in the house, so when she complains, her husband becomes upset. People interviewed with disabilities said that local authorities and police were not sensitive to their situation, as when they report incidents they are asked for more detailed information about the identification of perpetrators, which is difficult to give if the survivor is blind.⁷⁶

Safety

All of the interviewed community members are **worried about the transmission of COVID-19** because the recommended social distancing is not strictly practiced in the community. Examples of this are children running around and some men still gathering with friends playing football and drinking beer despite social events not being allowed to take place. It seems that information about high risk groups is not sufficient (respondents indicated children and elderly) and people are worried about access to health service if they get infected.⁷⁷

Factory workers who still commute to their work in highly congested trucks with 30-40 workers per truck **face an enormous risk of rapid transmission** of the virus. In addition, there's significant potential for transmission at the start of the working day, during lunch breaks and at the end of the working day with the risk of these workers exposing community members and families to the virus. Although HR Managers stated that the risk of infection at the workplace itself is low due to prevention measures being put in place as recommended by the Ministry of Labour and Vocational Training. These measures consist of the provision of masks, disinfectant, abandonment of gatherings, provision of awareness training sessions by local authorities and information posters. However all workers are scared of being infected and find it difficult to find personal protective equipment due to the cost and do not know where to go in case of suspected COVID-19 infection, or other health issues in these times. One interviewed factory worker noted that they were concerned of transmission during work since they share work equipment.

Women migrant workers working abroad in domestic work, care work, construction, agriculture, factory work and hospitality are unable to telecommute. The nature of their work may also **put them at increased risk of exposure to COVID-19**. Proposed COVID-19 **prevention and mitigation strategies** such as isolation, social distancing and regular handwashing, **may not be feasible** for those **living in informal settlements and labor accommodation compounds** which are often overcrowded.⁷⁸

Health centres have **safety protocols in place for dealing with COVID-19 suspects**: starting with medical staff on standby who measure body temperature, conduct COVID-19 testing and order a **14-day quarantine** either at home or organised quarantine centre. Migrant workers without symptoms of COVID-19 who returned back to their communities were sent to self-quarantine at their home. This was controlled by local authorities or neighbours. The isolation at home compared to the organised quarantine has its advantages such as less expenditure for food and the comfort of being at home. All returnees have been asked for information around their travel and health check-up. In the case of a missing health check-up authorities encouraged the workers to do a health check-up at the health centre. Currently there are over 600 returnees under isolation in separate

⁷⁴ UN Women 2020

⁷⁵ IASC 2015.

⁷⁶ Key Informant Interviews April 2020

⁷⁷ Key Informant Interviews April 2020.

⁷⁸ UN Women 2020

places across the country. However, there are still numbers of returnees who have been avoiding the isolation process but the majority have followed these measures accordingly.⁷⁹

Sexual Exploitation and Abuse

Women garment factory workers were found to be at increased risk of rape, verbal abuse and sexual harassment from men who remain around the factories. Unsafe housing situations such as poor lighting infrastructure and not enough policing impact this risk.⁸⁰ The susceptibility towards gender based violence will remain or increase since **women migrant workers** returning to their home countries may end up in **overcrowded quarantine centres** which pose a **higher risk for abuse and exploitation**.⁸¹

Capacity and coping mechanisms

According to the Human Development Indicators 37% of Cambodians live in multidimensional poverty.⁸² Due to a lack of income opportunities in the country people migrate to other countries especially Thailand, to earn a living and send remittances to their families in Cambodia. As global supply chains collapse **many female workers** including migrant workers and those in micro, small and medium-sized enterprises, **have lost their livelihoods due to having no financial or social safety nets**.⁸³ Interviewed migrant workers reported that they already sold items to buy food and switched to wild food from the forests.⁸⁴

Opportunities

Reducing the spread of COVID-19 needs the commitment of every single individual. It is important for people to learn how to protect themselves from getting infected. Since **women** are more likely to stay in the community they can act as **role models sharing their knowledge on COVID-19 and practicing recommended behaviour** such as risks and prevention with their friends, relatives and neighbours. This role is particularly important to those who are not able to access the information such as the elderly, the poor, the illiterate and people with disabilities.

Conclusions

The COVID-19 outbreak is leading to numerous examples of emerging negative gender impacts in Cambodia.

The already **unequal division of house hold tasks is further exacerbated** through caring for children during school closure. In families where men and women are migrant workers and have returned to their communities, women usually take care of the house and family and men will try to find work.

Decision making and empowerment is strongly linked to income generation. With the loss of livelihoods of women factory workers and domestic workers in country and abroad, inequality in decision making is likely to increase and women's' needs might not be considered in the allocation of household budget.

As a result of domestic duties, women have less time to engage in paid labour therefore they are at a disadvantage economically. With the closure of schools due to COVID-19 their time for economic activities will be further limited. Those who are in the formal employment sector, find themselves at greater risk for exposure

⁷⁹ Key informant interviews with health care providers, local authorities, National Committee for Counter Trafficking Deputy General Secretary, Operational Director April 2020

⁸⁰ Partners for Saving Lives 2014

⁸¹ UN Women 2020

⁸² UNDP 2020

⁸³ Naciri 2020

⁸⁴ Key Informant Interviews with migrant workers April 2020

to the disease as they are still required to go to work and others have experienced sudden unemployment due to the economic impact. Therefore **COVID-19 poses a serious threat to women's engagement in economic activities** especially in informal sectors and can increase gender gaps and women's empowerment.

Factory and migrant workers are usually not engaged in community groups, but in **labour unions**. This should be considered when distributing COVID-19 information via groups and networks.

While health facilities are still offering their normal services people try to avoid using them due to the fear of getting infected with COVID-19. There is a **lack of trust in health services** on sub national level. If the COVID-19 cases are going to increase, patients may present directly to national and provincial hospitals as has been the case in previous dengue outbreaks, which might exceed the capacity of the health services and reduce their capacity for other acute treatments.

Increased levels of stress and anxiety due to financial insecurity and isolation **negatively affect the mental health** of women and men and fuels conflict in the households with risk of **increased gender-based violence**.

There is increased **stigmatisation and discrimination of certain population groups** such as migrant workers, urban population, Muslims, foreigners and women working in bars and entertainment as these minority groups are associated with carrying and spreading COVID-19.

The **existing gender gap in accessing information and education is growing** due to **increased importance of digital technologies** for updated information and home schooling. Poor families and illiterate parents have limited opportunities to support education of their children and girls are likely to absorb additional work of caring for younger sibling.

Community members fear COVID-19 infection. There is still **uncertainty around transmission and at-risk groups**. Vulnerable groups such as **people with disability**, the **elderly** and the **poor do not have access to bespoke information** regarding their needs and rely on household visits by community workers. When **female migrant workers** need to stay in **organised quarantine** upon their return to Cambodia **they are likely to require further support for their safety**.

Recommendations

Overarching recommendation

This Rapid Gender Analysis report should be updated and revised as the crisis unfolds and relief efforts continue. Up-to-date gender analysis of the shifting gender dynamics within affected communities allows for more effective and appropriate programming and will ensure both humanitarian assistance and the preparedness, prevention and response to COVID-19, is tailored to the specific and different needs of women, men, boys, girls and at-risk groups. It is recommended that organisations continue to invest in gender analysis, including inter-agency multisectoral gender analysis, and that new reports are shared widely and that programming will be adapted to the changing needs.

Targeted recommendations

RECOMMENDATION 1: Collect sex- and age-disaggregated data for COVID-19: Ensure CARE, Partners, Humanitarian agencies and Government systematically collect and analyse sex- and age disaggregated data on the direct and indirect effects of COVID-19. Additional disaggregation by identified at-risk groups, e.g. migrant workers and persons with disabilities, should be prioritised.

RECOMMENDATION 2: Provide immediate lifesaving relief support to those most impacted by COVID-19: CARE to assess those most in need/at-risk households and individuals in the community and ensure immediate distributions of food and hygiene items. Based on the context, conditional cash vouchers may also be utilised. Selection criteria should be developed with men and women and at-risk groups in the communities to ensure transparency, accountability and to do no harm.

RECOMMENDATION 3: Livelihood and income support should be made available based on women's identified needs and priorities: CARE and other humanitarian and development actors, as well as government, should ensure diversified and inclusive opportunities for women to earn an income and sustain a livelihood. A particular focus should be on at-risk groups such as returnee migrant workers, garment factory workers and those working in the gig economy without social or employee protections. Opportunities are seen in areas of agriculture, home gardening and fisheries.

RECOMMENDATION 4: Collaborate with trade unions in requesting governments and brands for increased payments for laid off workers.

RECOMMENDATION 5: Inclusive community outreach and messaging should be prioritised. CARE to support the Ministry of Health in designing visual COVID-19 materials considering language barriers and illiteracy. Information should be made accessible and relevant for the unique situation of at-risk groups (including the elderly, factory workers and people with disabilities). Identify respected women and men and engage them as **role models for practicing COVID-19 hygiene practices**, to create greater acceptance for those measures in the community. A priority action needs to be informing women, especially women returnees, on **community groups** available to them and how they can access and participate in such groups. Through these groups CARE and Government Ministries (such as the Ministry of Labour and Vocational Training), should ensure information is available around access to business grants, financial support and vocational training opportunities.

RECOMMENDATION 6: Engaging men and boys in dialogues to raise their awareness on gender inequality and the impacts of COVID-19: A key outcome would be for men and women in the same family to develop a joint plan of shared responsibilities with their partners, with the longer term impact of mitigating additional impacts and risks for women and girls.

RECOMMENDATION 7: Develop capacity of village health workers to provide information on COVID-19 prevention, mitigation and response to at-risk groups through household visits; this will include messaging tailored to promote positive practices such as physical distancing instead of social distancing. The safety of village health workers need to be ensured through wearing appropriate personal protective equipment (PPE) as well as adhering to national government social distancing guidelines e.g. by conducting meetings outside the house. Personal visits are important as they offer the possibility to ask questions and clarify information, as well as reaching those who may have limitations travelling to health centers. Once developed, the trust and quality of sub-national health services could be enhanced through the use of the **digital community score card**

RECOMMENDATION 8: Support community services for people with disabilities: CARE to work in partnership with the Ministry of Health to develop a strategy on health and hygiene during COVID-19 specific to, and inclusive of, persons identifying as having a disability.

RECOMMENDATION 9: Identify barriers to home schooling and support access to education for girls and students with special needs: NGOs, relevant education partners and education local authorities (POE, DOE, School Directors and teachers) need to organise and establish e-learning platform groups to facilitate and connect students and teachers as well as provide necessary support especially for those with special needs, to enable participation in the e-learning group. With support from CARE under CIC current

project (Know and Grow), POE, SD and teachers, organised online platform learning groups, to connect teachers with students at home and facilitate students to participate following the scheduled event, and provide necessary support to enable them to join the learning session from home.

RECOMMENDATION 10: Support and strengthen existing GBV prevention, mitigation and response services and initiatives. Ensure through community outreach, messaging and community/women's groups that updated localised referral pathways are accessible to women and girls, men and boys and at-risk groups. Explore possibilities to provide additional support to communities that focus on risk mitigation such as stress reduction and couple counselling. CARE to advocate that government messaging supports survivors to know about service availability.

RECOMMENDATION 11: Work with local authorities to ensure quarantine facilities are set up in ways to mitigate violence against women and girls and risks of sexual violence and exploitation. Guidance and a quarantine code of conduct should be provided, to ensure, for example, that women and men stay in separate rooms or separated areas with curtains or other dividers in order to set up safer and friendlier spaces for quarantined women. Staff in the facilities should be same-sex.

Annexes

Annex 1: RGA Schedule

Target groups	Institution	Respondents and # of interview	Date
Factory Workers	Factory	6 KII from different target factories	April 22-23, 2020
Factory HR Manager	Factory	2 KII from different target factories	April 23, 2020
Factory Workers who lost or suspension of their job	Factory	2 KII from different target factories	April 23, 2020
Service providers Health care	Healthcare Centres Operational Director	2 KII for Health care Service Providers	April 23, 2020
Migrant workers returning from Thailand	Community	4 KII in different locations	April 23-24, 2020
Local authorities	Commune chief or district	2 Commune Chief and 1 District Chief	April 23-24, 2020
Key Official	National Committee for Counter Trafficking (NCCT)	1 KII	April 24, 2020
People with Disabilities	Disability Organization for Partnership (DOPs)	1 KII	April 23, 2020

Annex 2: Tools and Resources Used

Rapid Gender Analysis: Assessment Tools

Key Informant Interview – Community Member - COVID-19

Instruction to Interviewer

- Self-introduction and read full introduction for interview. Then seeking for verbal consent before start the interview.
- Ask permission for record and audio record, just in case you may miss recording
- Note taking the answers that response to the question guide
- Encourage to further digging out or probing for more interest information

- Summary the answers of each question, in bullet points is acceptable and type it up. If you interview for more than one person at the same target group, summarize their answers into just one answer sheet.
- Send your summary answer a day after you completed the interview

Introduction for Interviewer

My name is XXXX. I am working for CARE International in Cambodia. CARE is conducting a Rapid Gender Analysis to learn more about the different impacts that COVID-19 may have on women, men, girls, boys, and other vulnerable groups such as garment factory workers and migrant workers who recently returned, focusing on Gender Based Violence, Sexual Reproductive Health, Dignify Works, Inclusive Governance, and Education. The result of this assessment will inform humanitarian programming intervention and provide recommendations for organization on organizational preparedness for COVID-19, including policies and practice (e.g. Child safeguarding and Prevention of Sexual Exploitation and Abuse). Your contribution are really important and helping us to understand more about the situation and inform our programming. Your answers are kept in confident, no name or identification is appear in this report. I have some questions for this interview, this may take about 30 minutes. Do you allow me to do the interview?

Yes No

Interviewer Name:

Interview date & time:

Geographic Location:

Method of interview (e.g. phone, or face to face):

Other Note:

Introduction

1. Thank the participant(s) for the interview
2. Explain the objectives and expectations of the interview
3. Outline the amount of time interview will take
4. Obtain the informant's informed consent to record / write notes from the interview

Sex of key informant: Male Female Other Prefer not to say

Age of key informant:

Key informant's role in the community:

Specific situation of the individual (e.g. do they identify as having a disability, are they of a specific ethnic/religious group, refugee/IDP etc)⁸⁵:

⁸⁵ This should only be recorded if useful for the analysis ie. if the analysis is look at the specific realities of individuals or groups in the crisis

Key informant interview questions for community members (factory workers/migrant workers/people with disabilities...)

Gender roles and relations

1. Since COVID-19 has there been a change in the work (both paid and unpaid) that men and women do in your family? Please describe the change and the impacts of this change (positive and negative)?
2. What are some challenges you have experienced during COVID-19 virus self-isolation and restriction on movement or fear of transmission?
 - Employment
 - Travel
 - Accessing to social services (Hospital, police station, women organizations, Union, local authority, etc...)
 - Food security
 - Communication
 - Family members
3. Do you think your workload is increasing (for different groups: male, female, boy and girls, PwD...)? Why?

Access to Basic Services (Education, Health: GBV/SRH, or other emergency need, and local services)

4. How has the emergency affected girls' and boys' access to education?
5. How do you manage to support your children/family members to get study during this COVID -19? Do you think they are safe? Any issues? What happen if school continue to close further?
6. What have been the effects (if any) on levels of stress, tension, anxiety for you or your family since COVID-19? Are there specific groups in the community who are impacted more by this?
 - Men
 - Women
 - Boys
 - Girls
 - People with disabilities
 - People with sexual minority
7. Do you see any increase of violence, GBV and other concern issues? Why?
8. Have there been changes in women, men, boys and girls safe access to services since COVID-19? (*Prompt: specifically for health, WASH, SRHR and GBV services*)?

Information and technology

9. How do you prefer to communicate with others and receive information about health since COVID-19? Is this type of communication (e.g. radio/phone/face to face) available to you? How is this different to how [insert other gender] prefer to communicate / receive information?
10. Are men and women using different forms of technology since the COVID-19 crisis? Is this positive or negative and why?
11. Are there any health beliefs, cultures or practices in your community? What impact, if any, do these have on how people are preparing themselves for, or responding to COVID-19? (*Prompt. For example beliefs and practices related to marriage, family planning, pregnancy and birth, menstrual hygiene management, disposal of dead bodies, hand washing, water use and management*).
12. Are any of these health beliefs, cultures or practices, harmful for women, men, girls or boys?

Decision-making and leadership

13. Who is in control over the family resources and assets (e.g. financial, livelihood, household)? Has this changed since COVID-19? If so how, and has the change been positive or negative, and for who?
14. Do you participate in community decision-making structures/spaces/forums? How? How does it compare to how [insert other gender] participate in these structures/spaces/forums? Has your participation, or the structures/forums themselves, been impacted by COVID-19?
15. Are you part of any formal or informal groups/networks/movements in your community? Are you still involved since the COVID-19 crisis?

Protection Concerns

16. Do you or your family have any safety or security concerns since the COVID-19 crisis? If so, do you feel comfortable describing what types of concerns or incidents and who is affected (men, women, boys, girls, specific groups, without giving personal details of anyone involved)? (*Note for facilitator, not to be read out: e.g. violence in the home, sexual exploitation, violence at water points or accessing health services etc.*)

17. If you have a safety concern, are there people or services in the community you can go to? If yes, who/what are they? If not, why not?
18. What can service providers (health care, NGO's, local authorities) do to provide the support to those experiencing violence during this period?
19. Do you think their current support have been affected by COVID-19? How?
20. Do you think the covid-19 is increasing stigma against specific people? If yes, which group is being discriminated in your community because of the new coronavirus disease?
21. What are the main rumours/beliefs, concerns, questions you hear in your community? *(For facilitator: if asking this question it will be important to have up-to-date messaging to dispel myths and rumours, or to answer questions from the respondent).*
22. Were you put in quarantine or isolation after you return to your community (migrant workers)/ return from your community to workplace (for factory workers)? Do you comply to do that? Why? Who advise on this?

Opportunities

23. What are the skills and capacities or opportunities for [insert gender of respondent] to contribute to the COVID-19 preparedness and response efforts?
24. How can humanitarian actors, like CARE, support these efforts further?

Any other comments:

Key Informant Interview – Non-Community Member

COVID-19

Instruction to Interviewer

- Self-introduction and read full introduction for interview. Then seeking for verbal consent before start the interview.
- Ask permission for record and audio record, just in case you may miss recording
- Note taking the answers that response to the question guide
- Encourage to further digging out or probing for more interest information
- Summary the answers of each question, in bullet points is acceptable and type it up. If you interview for more than one person at the same target group, summarize their answers into just one answer sheet.
- Send your summary answer a day after you completed the interview

Introduction for Interviewer

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Interviewer Name:

Interview date & time:

Geographic Location:

Method of interview (e.g. phone, or face to face):

Other Note:

Introduction

5. Thank the participant(s) for the interview
6. Explain the objectives and expectations of the interview
7. Outline the amount of time interview will take
8. Obtain the informant's informed consent to record / write notes from the interview

Sex of key informant: Male Female Other Prefer not to say

Age of key informant:

Key informant's role in the community:

Specific situation of the individual (e.g. do they identify as having a disability, are they of a specific ethnic/religious group, refugee/IDP etc.)⁸⁶:

Key informant interview questions

Gender roles and relations

25. Since COVID-19 has there been a change in the amount of time women and men are engaged in paid and unpaid work? Please describe the change? Have there been any economic, social, physical or psychological impacts of these changes?

26. Who has access to and control over family resources and assets? Have there been changes since the COVID-19 crisis?

27. What new coping mechanisms are individuals / families adopting, to fulfill their roles and responsibilities?

⁸⁶ This should only be recorded if useful for the analysis ie. if the analysis is look at the specific realities of individuals or groups in the crisis

28. How are people adapting to follow COVID-19 prevention / health care seeking practices? (*Note for facilitator: e.g. Wash hands frequently with soap and water; Maintain Social Distancing, at least 1.5-2 meters; If you have a fever, cough and difficulty breathing seek medical care early*)

Access to Basic Services

29. What services are safely available to men, women, boys and girls in this community? (*Prompt: Food aid/distributions, shelter assistance, non-food items, health care including SRH, hygiene / dignity kits, education, women-friendly spaces, clean water, latrines, other*).

30. Have there been changes in women, men, boys and girls safe access to services in the community since COVID-19? (*Prompt: specifically for health, WASH, SRHR and GBV services*)

31. If yes, can you describe why? (*Prompt: use the following options as prompts; do not read out. For each reason given, please specify the service the respondent is referring too and the group it affects e.g. men, women, persons with disabilities etc.*)

- Priority is given to men
- No female staff providing services
- Lack of sufficient medicines at health facilities
- Girls/women not permitted to access services by their families
- Not safe for girls/women to travel to the service sites
- Locations of services are not convenient for girls/women
- The Government/Authorities have put in place quarantine and social isolation measures
- The service is not deemed an 'essential' service since COVID-19 and is therefore limited/restricted
- Fear/ loss of trust in the health system
- Loss (or fear of loss) of confidentiality when accessing services (e.g. due to greater/increasing restrictions on movement)
- Hours are not convenient for girls/women
- Other: _____

32. How (if at all) is COVID-19 impacting levels of stress, tension and anxiety levels of men and women, adolescent boys and girls, and children (boys and girls) in the community? Is this impacting certain group over others?

33. Is there safe access to mental health and psychosocial support services? And if so can everyone access them during the COVID-19 crisis?

Information and technology

34. Do women and men talk about and/or receive information about health differently? How about adolescent boys and girls? Has there been a change since COVID-19?
35. Are there specific local beliefs and practices that impact how messages around COVID-19 are being received by the community? (*prompt: for example influences from non-traditional health workers, religious leaders*)
36. Has this impacted health-seeking behavior of men, women or specific groups? (*Prompt. For example beliefs and practices related to marriage, family planning, pregnancy and birth, menstrual hygiene management, disposal of dead bodies, hand washing, water use and management*). Are any of these harmful for women, men, girls or boys?
37. How are different forms of technology being used to increase access to information? Are there groups of people who cannot access information through these forms of technology? (*Prompt: e.g. men, women, adolescent girls/boys, children, single female parent HHs, persons with disabilities*)

Decision-making and leadership

38. What (if any) changes have occurred regarding who in the household makes/influences decisions on family/individual access to healthcare (including family planning and maternal health)?
39. What social/cultural structures does the community use to make decisions? How do women and men participate in these? How have these structures been impacted by COVID-19?
40. How are women and men and at-risk or minority groups engaged in the (formal) local and national preparedness and response mechanisms for COVID-19? What are the key barriers to meaningful participation of women in these forums?
41. What informal groups or networks were present in the community pre-crisis? Are these still active now? Are they (and how are they) adapting to different ways of interacting/communicating? (*prompt: for example women's groups, civil society groups, social movements*).

Protection Concerns

42. Has there been an increase in safety and security concerns / incidents since the COVID-19? Do you feel comfortable describing what types of concerns or incidents and who is affected (men, women, boys, girls, specific groups, without giving personal details of anyone involved)? (*Note for facilitator, not to be read out: e.g. violence in the home, sexual exploitation, violence at water points or health facilities etc.*)

43. Who can community members go to for help, when they have a safety concern or experience violence? (both individuals and services). Are these still accessible since COVID-19, e.g. with the imposed restrictions on movement?

44. Do you think the new coronavirus disease is increasing stigma against specific people? If yes, which group is being discriminated in your community because of the new coronavirus disease?

45. What are the main rumours/beliefs, concerns, questions you hear in your community? *(For facilitator: if asking this question it will be important to have up-to-date messaging to dispel myths and rumours, or to answer questions from the respondent).*

46. Do migrant workers (person from risk areas) arriving to your villages/communes/ location were put in quarantine or isolation? Do they comply with that? Why? Who advise on this?

Opportunities

47. What are the different skills, capacities and opportunities for women, men, boys and girls to contribute positively to the COVID-19 preparedness and response efforts?

48. How can humanitarian actors, like CARE, support these efforts further?

Human Resource Manager

1. What do you think are the main challenges for workers during COVID-19?

2. Do you think the workers are at risk in getting infected by COVID-19? How?

3. Do you think workers are getting enough information to protect them from getting infected by COVID-19?

4. Do you have the preventative mechanism in your factory? What are they?

5. Do you feel your workers workload have been changed? What? Why?

6. Do you feel that your workers get enough support services from your factory, government or other agencies?

7. Do you think that your workers access essential services?

- a. Health services, especially SRH, GBV
- b. Local authority support
- c. Legal services
- d. Support from union
- e. Support from family members

8. Do you think these kinds of support have been affected by COVID-19? How?

9. What can the government, NGOs and Development Partners do to support service providers with these challenges?

10. Any other comments:

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