

COUNTRY PROFILE

**ON UNIVERSAL
ACCESS TO SEXUAL
AND REPRODUCTIVE
RIGHTS:**

CAMBODIA



1. Introduction

The kingdom of Cambodia covering an area of 181,035 sq.km is located in South-east Asia and shares borders with Vietnam to the east, Lao PDR to the north, Thailand to the west, and the ocean coast to the Southwest¹. The country is divided into 24 provinces and the capital, Phnom Penh. Khmer is the official language spoken by 90% of the population².

Peace and stability have been re-established in the country after two decades of conflict and civil war, since the signing of the Paris Peace Accord in 1991. The country's first national elections were held in 1993³ and the Constitution was promulgated on 21 September 1993.

Cambodia is making determined efforts to move nearer to a middle-income status country⁴. The country's development plan is guided by the Vision 2020 strategy, as well as the National Strategic Development Plan and the Rectangular Strategy for Growth, Employment, Equity, and Efficiency⁵.

The population of the country is estimated at 15.13 million⁶ with an annual growth rate of 1.7% in 2013. Life expectancy at birth was 68.8 for males, and 74.2 for females in 2013⁷.

In terms of ratification of international human rights treaties, covenants and conventions, the Cambodian government has signed on to the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights on 17 October 1980 and further ratified on 26 May 1992. The International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was signed on 17 October 1980 and ratified on 15 October 1992, along with the accession to the Convention on the Rights of the Child (CRC) on the same day, and Cambodia has also signed on to the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families on 27 September 2004⁸.

However the application and implementation of these human rights as well as access to information concerning laws and regulations among citizens has been poor and limited⁹.

Three key sources of health financing in Cambodia are, a) the government health budget, b) funding from donors and health partners, and c) out of

pocket expenditure from households¹⁰. An examination of the total health expenditure (THE) as % of GDP has shown a decline from 7% in 2005, to 6% in 2010 and 5% in 2012. The general government expenditure on health (GGHE) as % of Total Health Expenditure (THE) has shown marginal improvement from 22% in 2005 and 2010 to 25% in 2012. Proportionately the private expenditure on health marginally declined from 78% in 2005 and 2010 to 75% in 2012.

The out of pocket expenditure as percentage of total health expenditure (THE) also increased over the years to 62%, implying a significant share of the health expenditure is borne by the people and care seekers themselves. Given the high dependence on donor funding, a critical indicator in the Cambodian context is to also examine the external resources on health as percentage of total health expenditure which has shown a decline from 19% in 2005 to 15% in 2012. Overall we see a drop in the external resources on health, marginal improvements in the general government expenditure on health as percentage of total health expenditure and a high out of pocket expenditure from households in accessing healthcare.

A situational analysis on the state of health financing in Cambodia points to inadequate access to health services for the most vulnerable populations, and a high out of pocket spending which is more than 60% of the total health expenditure. There has been a chronic misalignment of public funding with priorities in the health sector. The public health sector in Cambodia is characterised by a low level of salaries and incentives for staff impacting service delivery. The health sector is also characterised by high utilisation of unregulated private providers¹¹.

2. Sexual and reproductive rights status in Cambodia

Developments in the Cambodia health sector are currently guided by the Second Health Strategic Plan, 2008-2015 (HSP2) with a vision "to enhance sustainable development of the health sector for better health and the well-being of all Cambodians, especially the poor, women and children, thereby contributing to poverty alleviation and socio-economic development¹²."

Cambodia has shown both progress as well as lack of progress with respect to the realisation of sexual and reproductive health and rights, gender equality, equity and women's empowerment, and adolescent sexual and reproductive health and rights.

The total fertility rate has declined over the past decade. Currently, women in Cambodia have an average of 3 children, a decrease of one child since 2000. Unmet need for contraception among married women has also declined from 25% in 2005 to 17% in 2010¹³.

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While infant mortality, under-5 mortality, maternal mortality, and HIV prevalence targets are likely to be met by 2015 at the national aggregate level, gaps remain in ensuring that progress is consistent across all population groups¹⁴. Despite progress, maternal mortality ratio continues to remain relatively high at 206 births per 100,000 live births in 2010¹⁵. Progress has been observed in the percentage of deliveries taking place at a health facility with a skilled birth attendant in the past decade, jumping from just 11% of all deliveries in 2000, to 55% in 2010, and an estimated 66% in 2012.

This aggregate progress, however, is not consistent across all population groups. Gaps remain in universal access to sexual and reproductive health services, especially among women in the rural areas, hard to reach areas, among the poor, and less educated women. Health care services remain limited, especially in rural areas. The cost of transport, and formal and informal charges pose barriers for women seeking healthcare services. The health equity funds mechanism needs further strengthening and streamlining. In some cases women lacking financial resources are turned away from public health facilities. In one case a woman in labour was refused treatment, and her baby was born by the side of the railway tracks.

Accountability and monitoring of public health services is another area that needs further strengthening¹⁶. Barriers to the full realisation of sexual and reproductive rights also include social taboos around sexuality, which have an impact on the risk of contracting STIs, HIV, and unwanted pregnancies, and consequent abortions among women, especially young women¹⁷.

Consolidating the gains made in the health sector on a sustainable basis, in the global context of resource constraints and ensuring the right to health for all, including sexual and reproductive health will be a challenge in Cambodia in the future. Despite improved national health budgets, the people of Cambodia spend more than 60% of total health expenditure from their own pockets¹⁸. This high out of pocket expenditure has major and direct implications on universal access to quality health services, including sexual and reproductive health services, especially among women and marginalised groups of the population.

3. Policies on sexual and reproductive health

There is no specific, integrated policy on sexual and reproductive health in Cambodia, however, the Health Strategic Plan for 2008-2015 prioritises maternal, new born and child morbidity and mortality reduction; reproductive health¹⁹, as well as reduction in morbidity and mortality of HIV/AIDS, Malaria, TB, and other communicable diseases. These areas are directly linked to sexual and reproductive health but do not comprehensively

cover all areas of sexual and reproductive health.

Emphasis in the Strategic Plan 2008-2015 is laid on equity and the right to health for all Cambodians. Further to this, the mission of the Ministry of Health is stated as being to provide stewardship for the entire health sector, and to ensure a supportive environment for increased demand and equitable access to quality health services in order that all Cambodians are able to achieve the highest level of health and well-being²⁰.

Reproductive health policies in Cambodia have basically been defined by the International Conference on Population and Development (ICPD), as well as the Fourth World Conference on Women (Beijing, 1995) that affirmed the human rights of women in reproductive and sexual health, and respect for individual and collective rights.

These internationally agreed documents provided the basis for the establishment of the National Reproductive Health Programme (1994-95), the Birth Spacing Policy (1995), the National Safe Motherhood Action Plan (2001-2005), updated in 2009, National Population Policy (NPP) 2003, and the Cambodian Millennium Development Goals 2000²¹. The Fast Track Initiative Road Map for Reducing Maternal and Newborn Mortality (FTIRM 2010-15) identifies priority areas, such as emergency obstetric and newborn care (EmONC), skilled birth attendants, family planning, comprehensive abortion care (CAC), behaviour change communication (BCC), removing financial barriers, and maternal death surveillance (MDS)²².

In Cambodia, the National Population Policy (2003) affirmed sexual and reproductive rights. A crucial principle of this strategy has been personal empowerment within a culturally sensitive intervention framework enabling people to make free and informed decisions about their reproductive lives. The MOH supports client and provider rights, and has recently issued a directive which explicitly specifies these²³.

The Royal Government of Cambodia has also recognized the need to prevent the spread of HIV/AIDS by adopting the Law on Prevention and Control of HIV/AIDS, promulgated by Royal Kram No. NS/RKM/0702/015 dated 29 July 2002; and the Second National Strategic Plan for Comprehensive and Multi-Sectoral Responses to HIV/AIDS (2006-2010), which recommends increased coverage of effective prevention interventions for sex workers and clients, men who have sex with men, substance users, and husband-to-wife transmission, which are the major modes of HIV transmission in the country.

Despite the above well-intentioned, relatively well crafted laws, policies and strategies related to sexual and reproductive health, there is a huge gap in their actual implementation. Challenges also remain with the implementation of the health sector reforms carried out in the country. Public health services especially in rural Cambodia continue to remain under-utilised and ineffective, with people opting for private providers resulting in high out

of pocket expenditures. The feasibility and effectiveness of health sector strategies to improve public sector performance and utilisation remain major barriers to achieving universal access to sexual and reproductive health services²⁴.

4. Grounds under which abortion is legal

The ICPD Programme of Action paragraph 8.25 called for the need to reduce the recourse to abortion through contraception, pre- and post-abortion counselling, access to safe abortion services where abortion is not against the law, and access to services for the management of complications arising from abortion. Further to this, the 4th World Conference on Women in Beijing in 1995 where the Beijing Platform for Action, Paragraph 107 (j) and (k) was adopted in full with the addition of “consider[ing] reviewing laws containing punitive measures against women who have undergone illegal abortions.”²⁵

In this section, we examine the extent of legal restrictions placed on the availability of safe abortion services in Cambodia.

According to the publication World Abortion Policies 2013, abortion in Cambodia is permitted on all grounds, such as to save the woman’s life; to preserve a woman’s physical health; to preserve a woman’s mental health; in cases of rape or incest; because of foetal impairment; for economic or social reasons; and on request²⁶. However parental authorisation and notification is required for abortions that occur under age 18, and the gestational limit for seeking abortion is limited to 12 weeks²⁷.

The 1997 abortion law in Cambodia legalised abortions. The Decree for Implementation was signed in 2002. General provisions within the law include: only medical doctors, medical assistants, or secondary midwives who have been authorized by the MoH can perform abortions. Abortions can be performed in hospitals, health centres, clinics, or public and private maternity units that have been authorized by the MoH. All facilities thus authorized must have: technical capacity for rapid management of complications due to abortion, and means for referral to a higher level of care when necessary. Abortion can be performed only at less than twelve weeks of pregnancy. For pregnancies of more than twelve weeks, abortion may be allowed in certain cases (e.g., abnormal pregnancy or rape)²⁸.

The Cambodia Demographic and Health Survey 2010 reports five percent of women age 15-49 years as having had an abortion in the five years before the survey. This is a slight decrease from the 8% reported in 2005²⁹. Abortions are more common among older women than younger women, with 10% of women age 30-39 years hav-

ing had at least one abortion compared to 1% of women age 15-19 years.

Among women who have had an abortion, about one quarter had two or more³⁰. More abortions took place in the health facilities (57%), with about 14% of women accessing a public health facility. At the same time,

...there has been a decline in the proportion of women who received help from a doctor, nurse, midwife, or other health worker from 79 percent in 2005, to 67 percent in 2010, and more women (22%) reported having no help from anyone, compared to 8% in 2005³¹.

Two-thirds (68%) of women who had an abortion in the past five years preceding the 2010 Cambodian Demographic and Health Survey used a surgical method to induce abortion, whereas 31% used a medical method. Variations were observed in the method of abortion by duration of pregnancy. Women who had their abortions at a late stage of pregnancy were most likely to use a surgical method, with medical methods used more often during early stages of pregnancy³².

Women in Cambodia choose to have an abortion for reasons such as ill health, pre-marital pregnancy, short birth interval, competing family responsibilities, and poverty. Despite the liberal grounds on which abortion is permitted in the country, according to a study on the current perceptions, attitudes and behaviours relating to abortion and family planning among women in an inner city area of Phnom Penh and a village in Kandal Province, in Cambodia in 2008, women mostly delay abortion care seeking, often trying to self-induce an abortion; and when they seek care, women prefer not to use government providers because of their unsympathetic and intimidating behaviour. They also fear the lack of confidentiality among government providers. Women prefer private and unsafe informal providers to procure abortion services as they are perceived to be “friendly, confidential and clean.”

Medical abortion is widely available and in common use in Cambodia. This study also noted widespread rumours and fears about the side effects of contraceptives as a major barrier to uptake and

consistent use of contraceptives, and subsequent recourse to abortion³³.

5. Policies on HIV and AIDS

HIV prevalence in Cambodia has been declining steadily and is estimated to be 0.7% among the general population aged 15-49 years in 2013³⁴. Targeted HIV prevention activities as well as improved coverage of antiretroviral treatment (ART) have resulted in progress in declining HIV prevalence in the country³⁵. The epidemic is concentrated among persons at higher risk of acquiring HIV, such as entertainment workers, men who have sex with men (MSM), transgender persons, people who inject drugs (PWID), and prisoners. The prevalence of HIV among these groups ranges from 0.1% for MSM to 24.8% among people who regularly inject drugs³⁶.

The national HIV response is currently largely funded by international sources, although the share of funding from the Royal Government of Cambodia has been increasing. In addressing the threats to the sustainability of the HIV and AIDS response, the international community and the government need to focus on development effectiveness, strengthening country systems, and local institutional capacity to own the response.³⁷

In 2012, only 11% of total spending on HIV/AIDS came from the Cambodian government. There is a need to increase domestic funding as a result of declining external funding, and manage domestic funds transparently, responsibly, and efficiently.

The principle of non-discrimination enshrined in the Universal Declaration of Human Rights and other human rights instruments prohibits discrimination based on race, colour, sex, language, religion, political or other opinion, property, and birth or other status.

In 1996, the UN Commission on Human Rights resolved that the term ‘or other status’ used in several human rights instruments ‘should be interpreted to include health status, including HIV/AIDS’, and that discrimination on the basis of actual or presumed HIV status is prohibited by existing

human rights standards³⁸. The ICPD Programme of Action further called for non-discrimination towards people living with HIV.

“To ensure that HIV-infected individuals have adequate medical care and are not discriminated against; to provide counselling and other support for people infected with HIV and to alleviate the suffering of people living with AIDS and that of their family members, especially orphans; to ensure that the individual rights and the confidentiality of persons infected with HIV are respected; to ensure that sexual and reproductive health programmes address HIV infection and AIDS;” (ICPD POA para 8.29b).

In this section we examine the situation of HIV/AIDS in Cambodia and whether the government has put in place policies to uphold non-discrimination on the basis of HIV status.

Cambodia participated in the UN General Assembly High-Level Meeting on AIDS and signed on to the 2011 Political Declaration on HIV/AIDS and has put in place national level policies and strategies to eliminate HIV/AIDS³⁹. Cambodia is strengthening its policy and programmatic response in the fight against HIV and AIDS to “getting to zero”- zero new infections, zero AIDS-related deaths, and zero discrimination. Cambodia 3.0 strategy aims for the elimination of new HIV infections by 2020.

With respect to stigma and discrimination, there is still a long way to go in Cambodia. According to the 2011 Asia-Pacific Regional Report on People Living with HIV Stigma Index, at least 3-4% of Cambodian respondents experienced HIV-based exclusion from family, religious and community activities. At least 4% experienced physical harassment and threats, and 6% were physically assaulted. Women experienced greater verbal abuse, physical threats and assaults in comparison to men. About 15% of the respondents indicated that they were verbally insulted, harassed or threatened. Thirty-two percent of the respondents estimated that experience of stigma and discrimination was caused by the fear of infection, including infection through casual contact⁴⁰. At least 12% of people living with HIV had been forced to move, or had been unable to rent accommodation during the past 12 months as a result of their HIV-positive status⁴¹.

“27% of people living with HIV who were earning an income before their diagnosis were no longer earning an income because of their HIV status. And for those still earning an income, their income had dropped by 50%. ... household[s] [of people living with HIV] with smaller revenues ... end up selling their land or house to pay health care bills and other necessities that leads them into a cycle of poverty.”
Cambodia Socio-economic Impact Study

Voice from Cambodia⁴²

“This means that no one likes us. People are afraid of us. They don’t consider us as human beings.”

HIV had significantly affected people’s ability to secure and retain employment, and their employment and career progression. Fifty percent of respondents in the study had lost their job or other form of income during the past 12 months of the study. Stigma and discrimination appear to have less impact on the participation of people living with HIV in educational settings, compared with work and accommodation. The children of at least 10% of people living with HIV had been prevented from attending school as a result of stigma and discrimination. HIV-positive status reduced respondents’ access to health care, accounting for 4% of the respondents. Large numbers of people living with HIV were choosing not to marry; also, many people living with HIV are choosing not to have sexual relationships. More than half of people living with HIV interviewed had decided they would not have (more) children as a result of their HIV-positive status. Six percent of respondents in all jurisdictions reported that their HIV-positive status had been disclosed without their consent⁴³.

There are laws that address the issue of stigma and discrimination in Cambodia. However the enforcement and implementation of the laws, policies and strategies pertaining to stigma and discrimination need greater attention.

1) Article 31 of the Constitution of the Republic of Cambodia, states that all citizens shall be equal before the law and have the same freedoms and obligations. Protection is afforded to PLHIV and key affected populations through a number of policies and other legislation.

2) National Strategic Plan for Multi-sectoral and Comprehensive response to HIV and AIDS (NSP III), 2011-2015

This strategic plan aims to maintain the declining incidence and prevalence of HIV, and prioritises the Three Zero Targets 1) high coverage of quality of continuum of preventive and care services for most-at-risk populations (MARPs), 2) provision of quality care services for PLHIV, and 3) reduce stigma and discrimination on KAPs (Key Affected Populations)⁴⁴.

3) The Law on the Prevention and Control of HIV/AIDS (2002). This law was enacted by the National Assembly in 2002. In chapter VIII it clearly states that people living with HIV/AIDS should not be discriminated against and that they should have equal rights to access public services, testing,

working, etc. This Law in its implementing guidelines (2005) also outlines measures to combat discrimination, including prohibiting discrimination against people living with HIV by law enforcement officers, and in prisons and detention/rehabilitation centres.

The Law on Prevention and Control of HIV/AIDS (2002) specifically provides the following anti-discriminatory provisions

Article 36: “Discrimination in any form at pre and post employment, including hiring, promotion and assignment, living in society based on the actual, perceived or suspected HIV/AIDS status of an individual or his/her family members is strictly prohibited. Any termination from working based on the actual, perceived or suspected HIV/AIDS status of individual or his/her family members is deemed unlawful.

Article 37: No educational institution shall refuse admission or expel, discipline, isolate or exclude from gaining benefits or receiving services to a student on the basis of the actual, perceived or suspected HIV/AIDS status of that student or his/her family members.

Article 38: A person with HIV/AIDS shall have full right to the freedom of abode and travel. No person shall be quarantined, placed in isolation or refused abode, or face expulsion due to the actual, perceived or suspected HIV/AIDS status of that person or his/her family members.

Article 39: Discrimination against any person with HIV/AIDS in seeking public position is prohibited. The right to seek elective and appointive public position shall not be refused to a person based on the actual, perceived or suspected HIV/AIDS status of that person or his/her family members.

Article 40: Discrimination against person with HIV/AIDS in accessing to all credits or loans services including health, accident and life insurance, upon such concerned person who meets all technical criteria as other uninfected citizens, is strictly prohibited.

Article 41: Discrimination against person with HIV/AIDS in the hospitals and health institutions is strictly prohibited. No person shall be denied to receive public and private health care services or be charged with higher fee on the basis of the actual, perceived or suspected HIV/AIDS status of the person or his/her family members.

Article 42: the person with HIV/AIDS shall have the same rights as of the normal citizens as stated in the Chapter 3 of the Constitution of the Kingdom Cambodia

4) Workplace Policy on HIV/AIDS (MoEYS, 2008) also prohibits arbitrary discrimination on the basis of HIV status of an individual such as health care, employment, education, reproductive and family life and financial services.

6. Policies on Adolescent Sexual and Reproductive Health Services

The rights of adolescents to appropriate services to meet their SRH needs were acknowledged in a special section on adolescents in the ICPD Programme of Action. Countries were called upon to protect and promote the rights of adolescents to reproductive health education, information and care (7.44 and 7.46, ICPD Poi)⁴⁵.

In this section we examine the extent to which Cambodia has acted on the above recommendation, and the barriers that adolescents continue to face in accessing SRH services.

According to the 2008 Census, adolescents accounted for 24.6% of Cambodia's population⁴⁶. The median age at first marriage is 20.8 years for women, and 22.6 years for men. It is also observed that men initiate sex slightly before marriage at a median age of 22.

According to CDHS 2010, about 1% of young women and less than 1% of young men had sex by the age of 15 years and 14% of young women and 4 percent of young men had sex by the age of 18 years. Women begin having children at a median age of 22.3 years. The Most at Risk Young People Survey 2010 (MARYP 2010), found that 18.5% of male respondents aged 10–19 years and 8.8% of female respondents aged 10–19 years had ever had sex. Among sexually active adolescents aged 10–19 years, the median age at first sexual intercourse was 18 for males and 17 for females.

Legislations pertaining to adolescents' access to SRH information and services include:

The Cambodia "National Reproductive Health Program" was created by the MoH in 1994. This programme provides young people with the rights to: receive information and education about reproductive health; privacy when receiving healthcare; receive treatment in dignity, respect, politeness and care; be assured that their personal information will be kept confidential; explanation through the process of receiving healthcare service; receive treatment from trained and qualified providers; continuum of care if needed; receive treatment from accredited providers; express opinions about service delivery and complain if dissatisfied about the health services received; receive health services in a safe environment; freely make decision on issues related to reproductive and sexual health; receive quality and acceptable reproductive healthcare regardless of sex, race, colour, marital status or place; self-control and self-protection; right and freedoms to fight against abuses, discrimination and coercion on his/her decisions about sexual life⁴⁷.

In addition the National Strategy for Reproductive and Sexual Health in Cambodia (2006-2010) provides guidelines for youth friendly reproductive and sexual health services and child survival.

The Law on Marriage and Family (1989), states that a marriage may be permitted for a male who is 20 years old or more, and a female who is 18 years or more. However, in special cases where a male or female has not reached these ages, a marriage may be legitimized upon consent by the parents or guardians, or if the female becomes pregnant⁴⁸.

The Abortion Law (1997) states that abortion is permitted for pregnancies of less than 12 weeks. However, it is permitted after 12 weeks if the pregnancy is abnormal, it causes a risk to the female's life, or if she has been raped, provided the female is more than 18 years old, or it is requested by her parents if she is under 18 years. This law thus requires parental consent for adolescent girls less than 18 years of age⁴⁹.

Case study 1- Youth story: Sexual Reproductive Health and Rights Education Changed My Life

Neouy Rina, an active peer educator of RHAC, lives in Doun Em village of Kok Dong commune of Angkor Chum district in Siem Reap province. The 18 year old Rina is the eldest sister of 6 siblings in her family. She grew up in a poor farmer's family and became a school drop-out since she was in grade 10 because she had to help her parents both at home and in the field to earn a living.

Rina, a dynamic, brave and curious girl, always helps other people in her village when there is a need. This made her a popular girl in the village and she was later appointed by the village chief to be a peer educator (PE) for RHAC. She first started to participate in a training course on Sexual and Reproductive Health Education in January, 2013. She learned a number of topics such as Human Rights and Sexual Rights, Gender, Sexuality Perception, Interpersonal skills, Communication and Decision-Making skills, Menstruation Regulation, STIs and HIV/AIDS, Contraception, Seeking Support for Sexual and Reproductive Health, and Gender Equality. After acquiring the knowledge from the training, Rina gradually became braver about talking openly about sexual and reproduc-



tive health.

“The training was very interesting with clear and easy-to-understand messages that can change our behaviour and thinking about sexual and reproductive health and rights of myself and others,” says Rina. As a PE, she voluntarily conducted a number of group discussions in her village.

Whenever Rina was free from housework, she always listened to the radio and songs, chit-chatted with her friends, provided one-on-one talks about sexual and reproductive health to teenagers in the village and referred those who had health problems to RHAC clinic and to the health centre.

Because of her careful attention to her work, and her commitment to using her knowledge to educate other youth, Rina became a model peer educator in Kok Dong commune in September, 2013. She then joined a 2-day training workshop with the Commune Committee for Women and Children (CCWC) on Comprehensive Sexuality Education (CSE). With her better understanding on CSE, she also shared her knowledge and experiences with other peer educators. As a result, Rina has been selected by the NGO PLAN to be a community kindergarten teacher and receives a stipend on a monthly basis. “I am very happy to work as a peer educator and a kindergarten teacher. Now I have money to continue my study...I am applying for continuing my study to finish high school through informal education in order to get high school certificate to realize my goal of becoming a teacher in a public school.” Rina claims “I am grateful to RHAC that provided me and other young people in the community with a lot of knowledge and experiences on life skills. I am willing to apply what I have learned from RHAC to educate young people in the village, make them better understand SRH issues, become as knowledgeable as I am, and even spread their knowledge to others.”

18 years and for males 20 years. The difference between the median age at marriage and the legal minimum age at marriage for males is 2.6 years and for females 2.3 years, implying that most marriages for both men and women in Cambodia occur beyond the legal age of marriage.

7. Gender-based violence (GBV)

The ICPD Programme of Action urges countries to take full measures to eliminate all forms of violence against women, adolescents and children. Countries should take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and children. This implies both preventive actions and rehabilitation of victims. Countries should prohibit degrading practices, such as trafficking in women, adolescents and children and exploitation through prostitution, and pay special attention to protecting the rights and safety of those who suffer from these crimes and those in potentially exploitable situations, such as migrant women, women in domestic service and schoolgirls. In this regard, international safeguards and mechanisms for cooperation should be put in place to ensure that these measures are implemented. (ICPD Para 4.9).

Active and open discussion of the need to protect women, youth and children from any abuse, including sexual abuse, exploitation, trafficking and violence, must be encouraged and supported by educational programmes at both national and community levels. Governments should set the necessary conditions and procedures to encourage victims to report violations of their rights. Laws addressing those concerns should be enacted where they do not exist, made explicit, strengthened and enforced, and appropriate rehabilitation services provided. (ICPD Para 7.39)

In this section, we examine indicators that point to the extent to which women’s autonomy, including in matters related to sexuality and reproduction, may be constrained because of existence of violence or threat of violence. We look at indicators of intimate partner violence, intimate non partner violence, and rape.

Difference between Median Age at Marriage and Legal Minimum Age at Marriage

According to CDHS 2010, the median age at marriage was reported at 20.3 years for women and 22.6 for men. By the law on marriage and family, the legal minimum age at marriage for females is

Table 1: Intimate Partner Violence

Country	Intimate Partner Violence (%)			Intimate partner and/or non-partner violence (%)			Forced first sex
	Physical	Sexual	Physical and/or sexual	Physical Violence	Sexual	Physical and/or sexual	
Cambodia	12.8	2.7	13.7	22.3		22.3	2.8

Source: Violence against Women Prevalence Data: Surveys by Country
Compiled by UN Women (as of March 2011)

According to the 2005 Cambodian Demographic and Health Survey, lifetime intimate partner violence (physical) was reported to be 12%, and lifetime intimate partner violence (sexual) was reported to be 2.7%. Similarly intimate partner and/or non-partner violence remained at a high 22.3% (physical and sexual). 2.8% of respondents reported forced first sex.

In Cambodia, rape is estimated by local and international NGOs to be a common occurrence, however only a very small minority of these assaults are ever reported to authorities due to the social stigma associated with being the victim of a sexual crime, and, in particular, to losing virginity before marriage (regardless of how this may have happened). Between November, 2008 and November, 2009, the police had recorded 468 cases of rape, attempted rape and sexual harassment, a 2.4% increase over the previous year⁵⁰.

Violence against women is of serious concern in Cambodia. Discrimination against women, low societal value placed on women, and unequal power relations contribute to violence against women. Despite laws and policies in place, the implementation and enforcement of these laws has been a challenge. Though there are services for survivors of violence such as crisis services, shelter, psycho-social support, advocacy, legal counselling, first aid or emergency health services, and rehabilitation and re-integration, these services are not spread across the country. Barriers also include distance to service locations, cost of transportation, and both formal and informal fees prevent some women from even trying to get help. In conclusion, there are significant but sporadic and scattered efforts to end violence, and to provide services to survivors of violence.

A feasibility study by the Ministry of Women's Affairs – Royal Government of Cambodia in 2011 "Feasibility Study- One stop service centre for gen-

der based violence survivors" has identified the following gaps for women survivors of violence:

- Inconsistent level of services for GBV survivors: There is not a consistent level of service options available to survivors of GBV throughout Cambodia;
- Lack of access to safe shelter: Most women in the country do not have access to safe shelter if needed;
- Local authorities lack skills in GBV interventions: Local authorities are on the front line for responding to GBV, but often lack the skills needed to provide safe, survivor-centred interventions;
- Police and courts minimize GBV: The police and court authorities report having training on the various GBV laws, however, they routinely do not respond to cases deemed "not serious;"
- Lack of protocols for GBV identification and response in health care system: The health care system in Cambodia does not target GBV except in the provision of forensic examinations;
- Cost is a barrier to services: Survivors of GBV face difficulties at all levels as a result of the cost of obtaining services. Lack of money for transportation and legal fees sometimes prevent survivors from getting help;
- Lack of understanding of the dynamics of GBV: There is a general lack of understanding on the dynamics of the different forms of GBV. People identify the causes of GBV as poverty and alcohol;
- Confidentiality is almost non-existent in the government sector. GBV cases are routinely discussed without permission of the survivor.

Legislation related to gender-based violence

a) Constitution of the Kingdom of Cambodia: Article 31 on the Rights and Freedom provides every Khmer citizen equality before the law, enjoying the same rights, freedoms, and fulfilling the same obligations regardless of race, colour, sex, language, religious belief, political tendency, birth origin, social status, wealth or other status. Article 35 provides political equality and rights for all Khmer citizens of either sex to participate actively in the political, economic, social and cultural life of the nation. Article 45 addresses discrimination against women and notes all forms of discrimination against women shall be abolished...and the exploitation of women in employment, marriages, and matters of the family are prohibited⁵¹.

b) Law on Prevention of Domestic Violence and Protection of Victims (24 October 2005) The jurisdiction of this law is within the household, and includes any form of domestic violence against husband, wife, children, or the elderly. Definition of violence within this law includes (1) an act that could affect life (including pre-meditated, intentional, or unintentional homicide) (2) an act that affects physical integrity (including physical violence that may or may not result in visible wounds) (3) any torturous or cruel act (including harassment that causes mental/psychological, emotional or intellectual harm to persons

within the household) or (4) sexual aggression (including violent rape, sexual harassment or indecent exposure)⁵².

c) The 2009-2012 National Action Plan to Prevent Violence against Women (NAPVAW)

This action plan puts together four strategies including (1) raising public awareness and disseminating information on existing laws; (2) enhancing social, medical, and legal services to ensure quality care for women who experience violence; (3) developing and improving policies and laws to enhance the criminal justice response to violence against women; and (4) strengthening capacity of government officials.

The 2005 Law on Domestic violence is seen as a positive step forward, however implementation of this law remains extremely weak. It is observed that significant barriers exist for women to seek justice, including financial costs (formal and informal) to pursue the legal process. Local reconciliation processes often discriminate against women with pressure applied inappropriately to continue living with a violent partner. Despite improvements, violence and the acceptance of violence remain very high and prevalent in Cambodia.

In addition, the implementation of criminal law is also weak, and perpetrators of violence are allowed to settle cases with small payments to the survivors of violence and their families, who then withdraw the cases and drop charges against the

perpetrators. Cases of rape appear to be increasing, with a disturbing incidence of rapes committed against girls as young as 3 and 4 years⁵³.

8. Legislation and policies on sexual orientation and gender identities

This section examines the extent to which the human rights of people with non-heterosexual sexual orientation, as well as human rights of trans-people/gender-variant people are respected, protected, and fulfilled by the Government of Cambodia⁵⁴.

Cambodian law prohibits discrimination against individuals based on their personal characteristics, guaranteeing equal rights and freedoms, and equal application of the law to all individuals⁵⁵.

Same-sex sexual activity, both male to male relationships and female to female relationships, is legal in Cambodia, when it involves non-commercial acts between consenting adults in private. There is no law in place punishing male to male relationships; however, there is no explicit and comprehensive legislation pertaining to sexual orientation and gender identities.

The King of Cambodia in 2012 stated that “as a liberal democracy, Cambodia should allow marriage between man and man, or between woman and woman.” Despite this situation, and the existence of no anti-gay religious traditions in the country, LGBT persons in Cambodia face discrimination and/or abuse from family members, employers, and police⁵⁸.

The Constitution of Cambodia contains certain provisions which can apply to all Cambodians including persons of diverse sexual orientation and

gender identities. Article 31 of the Constitution guarantees equal rights to all citizens regardless of personal characteristics. It states “Every Khmer citizen shall be equal before the law, enjoying the same rights and freedoms and fulfilling the same obligations regardless of race, colour, sex...or other status.” (Article 31). Further to this, article 35 guarantees the right of all Khmer citizens, regardless of sex, to participate actively in the political, economic, social, and cultural life of the nation.

Though there is no explicit mention of sexual orientation in these provisions it can be implied that they extend to all persons of diverse sexual orientation and gender identities as the intent is to ensure equality, regardless of personal characteristics.

Same-sex marriage however, is prohibited in the country. Article 45 of the Constitution explicitly defines marriage as an agreement between a husband and wife, and this is further reinforced by the Law on Marriage and the Family which states in Article 3 that “marriage is a solemn contract between a man and a woman.” Article 6 further states that a marriage shall be prohibited between a person whose sex is the same sex as the other.

There has been a case in Cambodia where a same sex marriage has taken place with the support and acceptance of local authorities⁵⁹.

Case study

In 1996 the Phnom Penh Post reported on a 1995 marriage between two women in Kandal province. Khav Sokha, who married her partner, another woman named Pum Eth, told the newspaper: “The authorities thought it was strange, but they agreed to tolerate it because I have three children already (from a previous marriage). They said that if we were both single (and childless), we would not be allowed to get married because we could not produce children.” The marriage appeared to have official approval and was reportedly a popular event, with 250 attendees, including Buddhist monks and high officials from the province⁶⁰.

Article 36 of the Constitution, guarantees equal labour rights, regardless of gender: “Khmer citizens of either sex shall enjoy the right to choose any employment according to their ability and to the needs of the society. Khmer citizens of either sex shall receive equal pay for equal work⁶¹.” Article 12 of the 1997 Labour Law also states that employ-

ers shall not discriminate based on the personal characteristics and beliefs of an individual, including their gender. Labour law in Cambodia does not specifically mention discrimination based on sexual orientation. However, a number of LGBT individuals have noted that they frequently face discrimination in the workplace and from their employers.

Despite a liberal legal environment, LGBT people in Cambodia face a wide range of discrimination. Many people of diverse sexual orientation and gender identities are forced to marry and have children and live in relationships against their wish. They are ostracised from the family and community. When LGBT persons are faced with abuse and seek protection and redress, law enforcement officials are either indifferent or complicit, and further cause abuse themselves⁶².

Transgender people do not seek medical services for many reasons. They fear being discriminated against, and they are ashamed of others finding out that they have a sexually transmitted disease⁶³. Violence against trans-sexual workers both from people and the police have been documented in Cambodia.

9. Grievance redress mechanisms for sexual and reproductive health services

The grievance redress mechanism for sexual and reproductive health services does not exist in Cambodia.

10. Recommendations

Given the above context of sexual and reproductive health and rights situation and policy environment, we call upon our government, international organisations, UN agencies, civil society partners, and all relevant stakeholders to implement the following recommendations:

- 1) Communication and cooperation between NGO health programmes and health services remains poor. It is suggested that government and the NGO sector pay stronger attention to this, and establish clearer guidelines and policies for cooperation⁶⁴.
- 2) Greater accountability and monitoring of public services is needed, with stronger disciplinary action for breaches of trust⁶⁵.
- 3) Progress in sexual and reproductive health and rights indicators across all population groups must be ensured to realise the goal of universal access to sexual and reproductive health and rights.

- 4) Increase national budgets on health, specifically for sexual and reproductive health services, including for all marginalised groups.
- 5) Promote client rights on SRH service utilization at health facilities through local authorities, community networks, community forums, mass media and service outlets.
- 6) Increase SRHR demand through community awareness-raising by allowing youth to express their opinions about their SRHR needs.
- 7) Policies, laws and strategies pertaining to sexual and reproductive health need to be enforced and implemented.
- 8) Outreach of public health services in rural areas to be improved on sexual reproductive health services and rights.
- 9) There is a need for an integrated SRHR policy which includes all SRH service areas built on a rights framework.
- 10) Health sector reforms in the country need to be more enabling to ensure universal access to SRH services.

11) Safe abortion services:

- Improve public health services to provide safe abortion services for all women.
- Training to health providers in public health facilities, to be more receptive and ensure confidentiality so that women can use public facilities and trained health workers when seeking abortion services.
- Laws on control of drugs, and private sector regulation need to be enforced and implemented so that service outlets, especially pharmacies, drugstores, private clinics/cabinets can be regulated.
- Behaviour Change Communication (BCC) messages to communities need to emphasize on the abortion law, the risks of unsafe abortion, including self-induced abortion, and accessibility to safe abortion services.
- Post-abortion family planning and provider's counselling skills need to be reinforced.

12) HIV and AIDS policies:

- Address misinformation surrounding HIV to reduce stigma and discrimination.
- Provide access to a range of contraceptive methods, including condoms.
- Implement and enforce laws pertaining to stigma and discrimination to achieve zero discrimination.
- Put affirmative actions in place so that people living with HIV (PLWHIV) are not stigmatised.

13) Adolescent sexual and reproductive health services:

- Sexual activity is initiated before marriage in some instances for both men and women.

Access to Comprehensive Sexuality Education (CSE) through schools and communities, mass media including website, facebook, hotline, and e-learning will empower youth to make right choices around their sexual and reproductive well-being.

- Ensure provision and scale up of youth friendly sexual and reproductive health services across all provinces.

14) Gender based violence:

- Ensure wide spread dissemination and strict enforcement of laws on VAW;
- Ensure services such as crisis services, shelters, psycho-social support, advocacy, legal counselling, first aid or emergency health services, etc. for survivors of violence are spread across the country so that all Cambodian women can access them.
- Promote gender equity through BCC messages on SRHR and gender-based violence to all people across the country.

15) Persons of diverse sexual orientation and gender identities:

- There is a need for a realisation of human rights of persons of diverse sexual orientation and gender identities, including their access to sexual and reproductive health services without stigma and discrimination.
- All persons of diverse sexual orientation and gender identities are entitled to freedom from discrimination, and to be treated equally.

16) Grievance redress mechanisms for sexual and reproductive health services:

- The grievance redress mechanisms for sexual and reproductive health services should be set up within the health sector at various levels.

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About RHAC

Reproductive Health Association of Cambodia (RHAC) is an indigenous Cambodian non-governmental organization (NGO), which was established in 1996 with a strong determination to bring quality health services to the community, especially for the poor and vulnerable sections of the population.

RHAC is an active collaborating partner and works closely with the Ministry of Health in supporting its Health Centres to improve quality, access and utilization of services.

At the community level, RHAC supports a network of community based health volunteers to promote access to health services in public facilities such as Health Centres.

As of 2013, RHAC's health activities covered an estimated 7.3 million people in Cambodia.

The RHAC family has grown from 10 staff at its inception in 1996 to 661 strong staff in 2013.

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