Chapter 3 | Gender Equality and Sexual Reproductive Health

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In order to fully understand the vision that we have, let us imagine ourselves from a pair of eyes that is right between childhood and the bloom of adulthood. At 17 years old, Sabrina is a senior at Preah Sisowath high school. Today has started poorly. Whilst she is seated in class, she has realized that her menstruation has come earlier than usual, and she has forgotten to bring any extra eco-pads! Thankfully the school provides facilities to receive free tampons and menstrual pads for this very instance. For third period today, Sabrina is excited for her favorite class, sexual reproductive health and rights class. Last week, Miss Songkran said they will be learning about consent. Miss Songkran is a trained teacher from a government program, and she is very knowledgeable in this field. After class, Sabrina goes home to find her sister visiting her. Her older sister, 24-year-old Veha, moved out to live with her boyfriend a couple of months ago. Veha is considering a contraception method and discussing the matter with her parents. Sabrina was able to recount the lesson of her class that day to remind her sister that there are contraception methods for both men and women being offered as part of the Cambodian universal health care plan.

I. Gender Equality and Sexual Reproductive Health: The Ideal Scenario

Social change, like any other kind of change, is driven by the desire of the human population and how they navigate their lives while fulfilling their basic needs on Maslow's hierarchy of needs as best as they can in the time that they are given to adapt and evolve.

Having over 50 per cent of the population being under the age of 24, the future of Cambodia looks bright and full of possibilities. It's not even a question that in 20 years, Cambodia will be vastly different across all landscapes; not excluding the sexual reproductive health and rights of its citizens. Being a progressive, globally integrated, and educated populace, contraception and birth control will unquestionably be more largely available and accepted, which give rise to demands for more innovative and accessible methods for both men and women.

Five key factors underpin the ability for Cambodia to fulfil the dream of being an informed and equal population free to make confident and healthy choices regarding their sexual health and reproductive rights:

1. Nationwide accessibility and availability of contraception and menstrual products;
2. Sexually educated and open-minded population that make healthy sexual reproductive health and rights choices;
3. Male and female sharing equal responsibilities regarding contraception;
4. Inclusivity of the universal health care plan and government policies that will include marginalized groups;
5. Sustainability being part of future Cambodian's decision making.

Each of these factors is heavily contingent on the education system. In 2020, Cambodia is moving towards a 100 per cent rate of primary education enrollment. With numerous efforts by the government through state-funded programs and policies like Education Strategic Plan (2009-2013), the Curriculum Development Master Plan (2010-2014), the Teacher Development Master Plan (2010-2014), the Master Plan for Capacity Development in the Education Sector (2011-2015), the Gender Mainstreaming Strategic Plan (2011-2015), the gap of enrollment between girls and boys are closing up and more young women are attending university (Ministry of Women's Affairs, 2014). In 2040, educational enrollment will be matched by a 100 percent secondary completion rate. In

regards to an open-minded population, the school curriculum created by the ministry of education will include sexual reproductive health and rights education that will be taught as early as the fifth grade (Ministry of Education Youth & Sports, 2018). This will be a prominent feature of the 2040 education system throughout public health and diversity training.

Due to the positive effects of the newly revamped health education curriculum, the future population of Cambodia will be more inclusive and less ignorant about gender, sexuality, and sexual reproductive health and rights. The conversation on contraceptives will have broadened to include all genders. They will include men, women, people of the LGBTQ+ community, non-able-bodied and non-disabled people, and indigenous people. Teaching boys from a young age about their role in sexual reproductive health and rights and gender equality will ensure that the men of the future will have a greater desire to share the responsibility of contraception.

The shift from larger to smaller families mean that contraception will continue to be in high demand. In fact, following the trend of the developing world, the number of women in Cambodia wishing to have large families will have fallen as economic opportunities grow. To cope with the decrease in the desire to conceive, in 2040, Cambodia will provide a wide range of contraception methods for its citizens. The contraception that will be largely used in the future will be those that are long-lasting methods, such as IUDs and implants. These methods have a lower rate of discontinuation, as well as being more cost-effective in the long run (Castle & Askew, 2015). The rise in the level of education would also mean that providers of contraception will be more trained and equipped in customizing their advice to each individual regarding the best method of contraception. Provider bias is one of the biggest reasons for discontinuation for younger women, so if providers are more competent, less women will want to discontinue in the future, garnering better accessibility and availability to Cambodian of the future (Castle & Askew, 2015). In addition, and following the footsteps of other countries such as Scotland and Sweden, Cambodia will distribute feminine hygiene products free of charge to women. Vending machines that dispel the products will have been installed in schools and offices as to make it more convenient and accessible for those who are in need.

In efforts to promote equal responsibility and normalization for sexual health and contraceptive methods, Cambodia will have developed a nationwide universal healthcare package to run alongside the kingdom's efforts in education. Our vision for 2040 is seeing sexual reproductive health and rights being appropriately covered by this universal health care plan. Once contraception has been normalized, and the issue of contraceptive discontinuation is solved by competent providers, new and improved contraceptive methods will be safe and long-acting methods, fertility rate will be reduced by 20 per cent to 48 per cent (Castle & Askew, 2015). This will benefit the universal health care plan in the funding department. If needs of contraception are met, women will be able to control the timing of their pregnancy and space their births, there will be less unintended pregnancy, and less abortion. This cuts the costs of post-abortion care, which includes drugs, supplies, and personnel and the costs of maternal care. Singh, E.Darroch, Ashford (2014) found that the total costs of abortion procedures and post-abortion care of women in the developing world is $794 million; however, if there is less unintended pregnancy, the total number would drop to $255 million for abortion care, and to $380 million for abortion care (Singh, Darroch, & Ashford, 2014). GDP can grow up to nine times, if just $5 per person were increased in expenditure for reproductive, maternal, newborn and child health (Singh, Darroch, & Ashford, 2014). Yielding results such as an increase in GDP would hopefully mean that more budget will be allocated to refocus on the healthcare sector, especially sexual reproductive health and rights. However, the coverage of sexual reproductive health and rights won't just be exclusive to citizens eligible for the national social security fund (NSSF) and the national social health protection fund (NSHP). Indeed, all citizens of the kingdom, including those in the informal sectors, indigenous people, sex workers, will be covered by the universal health care plan.

II. Scenario Space and Key Factors for Gender Equality and Sexual Reproductive Health

As noted previously, there are five key factors that represent sexual health and reproductive rights in this chapter's conceptualization and discussion.

1. Accessibility and availability of contraception and menstrual products;

2. Education and awareness;
3. Responsibility for contraception and sexual health;
4. Healthcare provision; and,
5. Sustainability.

At the turn of the millennium, representatives from all the world's countries and leading development institutions participated in the 2000 Millennium Summit. The major output of this was the establishment of eight Millennium Development Goals (MDGs). Amongst those eight, three particular goals rely heavily on sexual reproductive healthcare and rights: the goal to promote gender equality and empower women; the goal to improve maternal health; and, the goal to combat HIV/AIDS, malaria and other diseases. In April 2019, in a UN discussion on the 2030 Agenda for Sustainable Development adopted byMember States in 2015, the Swedish delegate noted that "the 2030 Agenda can only be fulfilled with full enjoyment of sexual and reproductive health and rights. Women and girls must be an active part of development, with full autonomy over their own bodies" (United Nations, 2019).

When discussions on human rights and gender equality arise, sexual reproductive rights are usually hot on their heels; for no girl or woman can truly have freedom unless she has autonomy over her own body. Sexual and reproductive health rights are a vital component towards ensuring that everyone can be equal and free to make decisions without discrimination, violence or coercion, and with the assurance of their dignity upheld (IPPF, 2015). To this end, the International Planned Parenthood Federation (2015) has found that:

> *If all pregnant women and their newborns were to receive care at WHO recommended standards, if all women who want to avoid an unplanned pregnancy had access to modern contraceptives, the life-saving benefits would be substantial. Maternal deaths would drop by 67%. Newborn deaths would drop by 77%. Unintended pregnancies would drop by 70%. Women's and newborns' burden of disability related to pregnancy and childbirth would drop by 66%. Transmission of HIV from mothers to newborns would be nearly eliminated – a 93% reduction*. (IPPF, 2015)

As the country with the youngest population in Southeast Asia, Cambodia has inched further towards the fertility age as youth are increasingly moving into family planning. In 2014, the CDHS collected fertility data by asking women for a complete history of her live births, which was used to calculate the total fertility rate (TFR) – the number of children the average woman would bear in her lifetime. In 2014, it was found that the TRF in Cambodia is 2.7 children per woman; 2.9 children for rural women and 2.1 children for urban women if they were to follow current levels of fertility throughout their life. The trend has declined over the past 15 years, as the TFR in 2005 was 3.4 children per woman. Out of all women aged 15-19, one in eight has become a mother or is currently pregnant with her first child; 31 percent amongst women age 19. The level of education is closely linked to the level of teenage fertility as data found that one-third of teenagers who have never been to school have begun childbearing, compared to 18 of teenagers who have a primary school education (Cambodia Demographic Health Survey, 2015). This ties in with the urgency in providing adequate sexual reproductive health and rights classes to young people in order to combat teenage pregnancy, which leads to the rise in dropout rates.

Having access to quality sexual and reproductive right can be the difference between a life spent in poverty and an empowering life; especially when it concerns young girls and teen pregnancy. When young girls are not subjected to bearing children at an age where they are considered to be children themselves, they can focus on getting their education and choosing to start a family when they are ready.

As a result of this, it is easy to see why accessibility and availability of contraception is so vital to the development of women and girls in Cambodia. Many lose the opportunity of education because they lose the chance to make an informed decision on family planning. The autonomy to decide whether, when and with whom to have children and having access to quality health services is pivotal to women's economic, educational, and political empowerment as it opens up the realization of their other life opportunities and fulfilment (IPPF, 2015).

As for the contraceptive method usage in Cambodia, 56 percent of currently married women are using some method of contraception, with the majority

relying on a modern method (39 percent of currently married women). The most commonly used modern methods are the contraceptive pill and injectables (18 percent and 9 percent, respectively), while 15 percent of women are using withdrawal. On the other hand, only 4 percent of women without any children are using a modern contraceptive method as women do not generally begin to opt for contraception until they have had at least one child. The CDHS also found that the use of traditional method increases in correlation with the level of education. Twenty-one percent of women with some secondary education and 27 percent of women with higher education use rhythm or withdrawal methods, in contrast with 12 percent of women with no education.

As women grow older, they tend to choose modern methods, with 20 percent of women age 15-19 compared to 48 percent of women from age 30-34. Women in rural areas also tend to use modern methods more than women in urban areas (40 percent versus 33 percent). The demand for family planning is defined as the sum of unmet need and met need of all contraceptive methods and in 2014, the demand stood at 69 percent. Nonetheless, 13 percent of currently married women have an unmet need for family planning (Cambodia Demographic Health Survey, 2015). The inconsistency in the use of contraception of women across all ages solidifies the idea of a universal healthcare plan, where there is enough budget allocation to healthcare to focus on disseminating information on which contraception methods are better for Cambodian citizens of all ages and across all income brackets, instead of just focusing on a certain group of people such as poor, disadvantaged women in rural areas when the truth is every group is ignorant about their sexual reproductive health and rights choices.

As of now, the subject of sexual and reproductive health right generally falls upon women, male participation is essential in achieving a world where women have full body autonomy. Because of traditional family values, in many households, men are tasked with the responsibility to make decisions within families, including reproductive, family size, and contraceptive use. Hence, “men’s general knowledge and attitudes concerning the ideal family size, gender preference of children, ideal spacing between child births, and contraceptive method use greatly influence women’s preferences and opinions. Only in societies where

men and women have equal rights and responsibilities will reproductive rights be equally shared by all." (UNFPA, 2014)

III. Policy Initiatives to Achieve the Ideal Scenario

In order to realize the ideal scenario, there needs to be important key steps to serve as steppingstones towards our goals for 2040.

From 2005 to 2014, the use of modern contraceptive methods had increased from 27% to 39% of currently married women. However, only four percent of women without any children use any type of modern contraception, as women tend to wait until they have at least one child before beginning to explore modern contraception methods (Cambodia Demographic Health Survey, 2015). The use of modern contraceptive methods is more prevalent amongst women living in rural areas than in urban areas, 40 percent and 33 percent respectively (Cambodia Demographic Health Survey, 2015). Side effects such as prolonged bleeding or amenorrhea can lead women to discontinue contraceptive use, other than reasons such as wanting a child or no longer needing protection. These side effects can perhaps have adverse sociocultural consequences, ranging from abnormal bleeding or spotting that limits a woman's ability to pray, prepare food or have intercourse. Myths and rumors revolving contraceptive methods, especially misleading ones such as infertility, can also contribute to discontinuation or hesitation to opt for modern contraceptive methods in the first place (Castle & Askew, 2015).

Measures can be taken to curb the concerns or myths in order to encourage long-term usage. It has been found that providing women with safe and open space to discuss side effects with their providers and members of their social networks, the understanding of the nature of side effects becomes incessant, leading to an increase of continuation and the facilitation of switching (Castle & Askew, 2015). Other measures include engaging male partners and enhancing couple communication, ensuring client confidentiality, counselling women who experience prolonged amenorrhea, and dispelling misconceptions.

Lack of understanding on menstruation may hinder a woman's decision to use modern contraception as many believe that the absence of menstruation

signifies a woman's poor health. This happens especially often when the method is implants. Hence, more accurate information about physiology must be disseminated in order for women to fully understand the options out there and the benefits of it rather than being frightened to the side effects. According to Blanc, Curtis, and Croft (2002) in FP2020, a country would experience a decrease of 20-48 percent in total fertility rate, if discontinuation were to be eliminated.

It is also crucial to note that men's involvement plays a key role in a woman's decision on whether or not to continue a contraceptive method. In Cambodia, Samandari and O'Connell (2011) found that amongst married women less than 30 years old with 12 to 14 years of education, long term use is largely reliant on their ability to reject misconceptions surrounding contraceptives, endure the side effects, and receive support from their partners and providers.

Including men and male leaders in community in discussions about family planning has been proven to improve continuation rates during the postpartum period. Without being well-informed, men may encourage their partners to discontinue because they perceive the side effects to be harmful, or because they believe that family planning will alter their partner's behaviors and sex drive. In such cases, sensitization and education programs have to include men and equip them with accurate information (Castle & Askew, 2015). Using the Family Planning Program Effort score, Blanc, Curtis, and Croft (2002) found that low quality of the service environment accounts for 27 percent of women discontinuing contraception, while between 40-60 percent of the overall discontinuation rate reflects decisions based on the quality care (Castle & Askew, 2015). Where sex remains such a taboo topic in Cambodia, providers might hold on to their personal beliefs regarding women's sexual productive rights and freedom; thus, affecting their communication with the clients. In order for women to gain complete freedom in making an informed decision on their sexual reproductive rights, the new generation of health care workers need to be better equipped to reduce discontinuation and receive support and training in order to provide unbiased counseling and supporting women.

A report by Guttmacher Institute estimated that in 2014, the cost of modern contraception services for 652 million users in the developing world amounts to

around $4.1 billion, which includes the costs of contraceptives and related supplies, health workers salaries and program, and program and systems cost. While the average annual cost per user in the developing world is $3.18 in direct costs and $6.35 when indirect costs are factored in, the average total cost per user in Asia is lowest, with it being $4.76 (Singh, Darroch, & Ashford, 2014). The same study found that if all 225 million women with an unmet need for modern contraception were to receive proper and qualified services, the cost of modern contraception services would increase from $4.1 billion to $9.4 billion. Although the increase may seem daunting, it would result in 52 million fewer unintended pregnancies and 21 million fewer unplanned births. These reductions would, in turn, make maternal and newborn care more affordable, at the declined spending of $2.7 billion. The decline is due to the decrease in unintended pregnancies. This allows for all women with unintended pregnancies and unplanned births to receive the recommended levels of care at a spending that would've been $10.5 billion otherwise (Singh, Darroch, & Ashford, 2014).

Not only will improved sexual and reproductive health services generate gains in other areas of health, but women who bear children past adolescence can have an effect on their education, training and employment. In the long term, it can help strengthen their earning potential and financial security. In (Barnett B and Stein J, *Women's Voices, Women's Lives: The Impact of Family Planning, Research Triangle Park*, NC, USA: Family Health International, 1998), it was found that women reported greater personal well-being when they used contraceptives to time their births and avoid unintended pregnancies compared to those who did not. Studies have found that the former were more likely to communicate and share decision-making power with their spouses, creating more equitable household relations (B & J, 1998).

Although delay has pushed back the estimated on-sale date, it can be assumed that the microchips will be available in mass marketplace by 2040 – an invention that will revolutionize women's sexual productive rights, giving them more control over their sexual choices than ever before. Initial concern might be that the microchip will be too expensive for disadvantaged women in developing countries to afford; thus, limiting its effectiveness and impact. However, it can follow the footsteps of contraception companies such as Jadelle® and Implanon®,

which have signed a deal to supply and purchase doses of their implants in exchange for 53 percent and 50 percent price reduction respectively.

To expand access to modern contraceptives to every needed woman and non-binary by 2040, contraception should be covered by the NSSF as part of the Universal Health Care.

According to the Ministry of Health's Health Financing Policy (2014), the universal population coverage will be as follows:

- All citizens of Cambodia are entitled to a set of health interventions funded through government budget allocations to the Ministry of Health and Social Health Protection Institutions
- All employees of the formal private sector must enroll with the Social Health Insurance of the mandatory National Social Security Fund for private sector employees
- All civil servants and Veterans must enroll with the Social Health Insurance of the mandatory National Social Security Fund for Civil Servants and Veterans
- Both National Social Security Funds will also cover dependents over time
- The poor and vulnerable who will be identified by the Ministry of Planning through appropriate methods will automatically be covered through subsidies by a third National Social Health Protection Fund for the informal sector
- The non-poor informal sector population are automatically enrolled with the National Social Health Protection Fund. (Ministry of Health, 2014)

The health system will be funded from various sources such as general revenues, payroll contributions and financial support by development partners. The National Social Security Fund will be funded through payroll contributions from employees and employers, and from civil servants and government. It will also be funded by the government and development partners. The use of revenue by health facilities will be specified in the guidelines formulated by the Ministry of Health (Ministry of Health, 2014).

There is another solution to cutting the cost to fund nationwide contraception and menstruation products. Sustainability is the answer. When Leo Hendrik

Baekeland invented plastic in 1907, he didn't foresee that it would be one of the trademarks of our environmental 11th Hour warning. Seen as an item to make life more convenient, it was rather hailed as a product of the booming Industrial Revolution.

Fast forward decades later, images after images of plastic waste drifting along the vast oceans, forming its own island, have jolted the world into shifting their focus on their carbon footprint and consumerism habits. A problem that didn't exist in the public's eyes hitherto. The world is shrouded in plastic, most of which is unnecessary and can easily be eliminated, albeit requiring a change of habits. Nonetheless, some disposable items are a necessity that has changed the lives of half of the population, namely, feminine products such as tampons and sanitary pads.

Usually wrapped in plastic bags, feminine hygiene waste remains in the ecosystem long after the demise of the users and the generations after. It is estimated that in North America alone, close to 20 billion sanitary pads, tampons and applicators are dumped into landfills every year. Over the period of a woman's lifetime, she uses an average of 11,000 tampons. However, the damage to the earth's ecosystem doesn't only come from the plastic waste. The Royal Institute of Technology in Stockholm conducted a Life Cycle Assessment of tampons and found that the processing of LDPE (low-density polyethylene, which is a thermoplastic made from the monomer ethylene) that is used in tampon applicators and the plastic back-strip of sanitary pads is the largest impact on global warming, considering it requires high amounts of energy generated by fossil fuel. Just simply one year's worth of a typical feminine hygiene product leaves a carbon footprint of 5.3 kg CO2 equivalents (Shreya, 2016).

Cambodia is no exception to the damaging global trend, but with limited alternatives, it is difficult to reduce the consumption. Witnessing the growing problem, a new trend has emerged around the world, including developing countries such as Cambodia, where eco-friendly feminine hygiene products have been introduced, ranging from eco-pads to menstrual cups.

Social enterprises and organizations have latched on to this niche market by creating eco-friendly alternatives for women. Green Lady Cambodia is a project

aimed at providing eco-friendly period's products to girls and women in South-east Asia, whereas Project G, a project stemmed from Cambodia Rural Students Trust, is focused on bringing sustainable feminine hygiene solutions to girls in rural Cambodia.

Despite the growing number of projects on eco-friendly alternatives, the accessibility and progress are gradual and slow without much of the government's intervention. In order for eco-friendly feminine hygiene products to become the main, if not the only choice, for women and the non-binary in Cambodia, the products need to be accessible and affordable for everyone, especially those in the rural provinces. Government subsidiary is crucial for mass production of eco-friendly products to cater to the needs of half of Cambodia's population. One of the ways for the government to have additional budget to subsidize the growing need by 2040 is through taxes, and one of the items that we would benefit from through higher taxes is plastic and disposable products.

Currently, the government has already decided to put in place a regulation that requires supermarkets to charge an additional $0.10 on a single plastic bag. Although the amount might seem miniscule, especially to middle-class Cambodians who enjoy the convenience that plastic brings, higher taxes on products that are not only limited to plastic bags may bring forth hesitation from consumers once they are faced with the decision to choose between disposable items and items that are more gentle to the environment. The plastic and disposable items can range from single-use utensils and kitchenware to bottled water. Not only will this course of action reduce the consumption of items that are causing the deaths of wild animals and the population in oceans around the world, but the excessive money from the taxes can be used to allocate for more production of eco-friendly products.

In 2012, total health expenditure in Cambodia was estimated at $1 billion, the equivalent of 7 percent of Cambodia's GDP; 60 percent of which was out-of-pocket expenditure. Twelve percent of total government spending was used on healthcare. Sin taxes levied on tobacco products and alcoholic beverages can be utilized to increase the government's budget for health, along with social health insurance contributions (Ministry of Health, 2014).

To meet the demands, the government can invest in its own state-run facilities to produce eco-friendly feminine hygiene products such as eco-pads and menstrual cups. Producing eco-pads can be a process that is as simple as sewing pieces of fabric together. It can be done by workers that have minimal skills, as long as they have the knowledge of sewing. The government can use the facilities to target two birds with one stone by hiring workers, especially women, from disadvantaged areas to be a part of the production. Not only will this reduce the rate of unemployment, but the cost of the products won't be as high as it would be if it was produced by private entities or imported from abroad.

Additionally, taxes can be collected from a company's income or an individual's salary (Ministry of Health, 2014). Thus, the more employed citizens are, the more tax will be poured into the country; a portion of which can be used to sustain the facilities. In this scenario, the final price for the products can be minimal thanks to the self-sustaining model of the enterprise. Nonetheless, the affordability of the products shouldn't come at a cost for the workers. They should be paid a wage that is livable and fair, not simply a dash over the poverty line.

Contraception comes in packages that are enclosed in plastic. Reducing the usage in such cases will require the government and stakeholders to encourage more women and the non-binary to use long-acting reversible contraception (LARC), such as implants and IUDs.

IV. Gender Equality and Sexual Reproductive Health Under the Baseline Scenario: Business as Usual in 2040

The health financing strategy drafted in 2014 details future plans for how the government will be able to fund the dreams of universal health care. In that, four institutes will be the main health services purchasing channels for the citizens of Cambodia, and that includes, National Social Security Fund for Civil Servants, National Social Security Fund for Private Sector Employees, National Social Health Protection Fund, and the Ministry of Health (Ministry of Health, 2014).

However, it's uncertain whether the universal health care plan would really cover each and every citizen of the Kingdom of Cambodia. There is no mention of the current marginalized groups such as sex workers or the indigenous people. In order for the universal health care plan to be truly universal, there must be a push to legalize sex workers, the group most at risk from STIs, so that they may receive the benefits of social funding.

It should be noted that there is also a decrease in the spending of development partners on the procurement of commodities, which also includes contraceptives (Ministry of Health, 2014). If this trend continues, there will be more burden on the government to ensure that there are enough commodities stocked in order to plan for the proposed universal health care plan.

Therefore, although we may not see remote control contraception in Cambodia 2040 due to the device being potentially too costly to stock up. It is true that all health centers in Cambodia are providing at least 3 contraceptive methods, but long-term methods such as IUDs and implants are not available at every health center in Cambodia (Ministry of Health, 2014). This is largely due to the slightly more costly price of these long-term methods and the lack of knowledge regarding them. Women and their partners are driven away from contraception due to myths and rumors (Castle & Askew, 2015), but the new school curriculum on health education will hopefully help them be more open and trusting of IUDs and implants. At baseline, we may see IUDs and implants be widely available throughout the country, including those regions are from urban areas, where more health posts will be stationed.

Male contraception will be on sales, but the problem is whether there will be widespread use by male themselves. Currently there has been no government sponsored programs to encourage men to participate in male contraception, only programs for men to support their partner's choice of contraception. Therefore, without active efforts to seek accessible and affordable alternatives to male contraception (making it less expensive than female contraception or provide incentives), the responsibility of contraception will still rest on women, although men will become more involved and supportive of their partner's choices in family planning if they are able to see financial benefits (Castle & Askew, 2015).

However, all hope is not lost. For even though there is not a lot of focus on male contraception in Cambodia, there is general support from the government in order to create a shift in male attitude. An example of this would be the 'Leading the Way for Gender Equality', an initiative of the Ministry of Women's Affairs of Cambodia, supported by the United Nations Development Programme (UNDP), the Swedish International Development Agency (SIDA) and Oxfam. This program is geared towards challenging traditional gender norms instilled in the male populace, while also providing interventions that will aid in the fight for gender equality in Cambodia (UNDP, 2018). So, we see that there is substantial interest in shifting male and female attitude regarding gender norms.

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