RESEARCH REPORT

Title:

Research on Socioeconomic Incentives for Unpaid Care Work at Household Level in Cambodia: Needs, Challenges and Opportunities

Author: Rotvatey Sovann

Date of Submission: ***May 4th, 2026***

Acknowledgement

This research report would not have been possible without the dedication, collaboration, and support of many individuals and organizations bellow.

First of all, I would like to express my sincere gratitude to the research team for their commitment and hard work throughout the study. I have deep appreciation for the contributions of Sophy Soun, the research assistant, and Kaul Sela, former research assistant, for their valuable support in the operational, administrative and coordination throughout the research's process.

I would also like to express my heartfelt gratitude to Louise Conventry, the mentor, whose guidance and insights greatly strengthened the quality of this research, particularly for the research methodology and data collection tools. I also wish to thank Sreyleab Kong, the volunteer, who spent her valuable time and enthusiastic support in data collection and validation.

I am also grateful for the technical and coordination support from of Lyteang Cheng, male Interviewer (GADC), as well as Rarn Rim and Sreymom Leng, the village facilitators (GADC), whose efforts were essential in facilitating community engagement, data collection and validation.

Additionally, I also extend my sincere appreciation to Gender and Development for Cambodia (GADC) for their invaluable human resource support and coordination assistance, which played a crucial role in the successful implementation of this study.

More importantly, I would like to gratefully acknowledge the Australia Awards Program for generously funding this research and support in administration and coordination to enable interviews with national level key informants. The research was supported by the Australian Government through a small grant provided by Australia Awards Cambodia.

Finally, I am grateful with all individuals and communities who participated in and supported this research as key informants and respondents.

*Disclaimer: The opinions expressed in this research are those of the author and do not necessarily reflect the views of the Australian Government or Australia Awards Cambodia.

Executive Summary

This research investigates unpaid care work (UCW) in Cambodia, focusing on its gendered nature, socioeconomic implications, and policy gaps. UCW includes both direct and indirect care, such as childcare, elder care, and domestic work, performed without financial compensation. In Cambodia, women spend an average of 5 hours and 2 minutes per day on UCW, compared to just 2 hours and 6 minutes for men, highlighting a significant gender gap. Much of this work remains invisible, including supervisory care, and many stay-at-home carers simultaneously engage in home-based income-generating activities that often go unrecognized.

The research identified key caregivers' challenges, needs and systemic gaps in existing policy frameworks across six key areas:

1. **Financial and Social Protection:** Current cash transfer programs target household poverty rather than caregiving, leaving individual carers at risk of forgone income and debt, with their specific needs largely overlooked.

2. **Health and Social Services:** Caregivers frequently delay their own medical care, and local services for elderly and disability care, as well as affordable mental health or respite support, are scarce.

3. **Education and Training:** Carers face dual burdens when attending training or vocational programs, as rigid schedules and the need to manage children limit their participation.

4. **Recognition and Psychological Support:** Despite constitutional acknowledgment of housework, caregiving is socially devalued as a voluntary or traditional duty, contributing to emotional strain and burnout.

5. **Employment and Work-Life Balance:** Rigid work models and limited flexible options push carers, predominantly women, out of the workforce. Labor laws, such as minimal paternity leave, reinforce traditional gender norms.

6. **Cultural expectation and Gender norm:** Cultural and gender norms further influence caregiving practices, with Buddhist values and filial piety creating moral expectations that discourage seeking external support. Socially assigned role for women and men shape the expectation around unpaid care work. Men assisting in care are praised, whereas women's labor is often taken for granted.

The study recommends strategies to move toward a more equitable "Care Economy." These include scaling up community-based, accessible, and affordable care services; expanding social protection to provide caregiver suitable social and economic assistance; transforming workplaces through flexible hours and more equal parental leave; closing the childcare supply-demand gap;

and designing care-inclusive training programs to promote care capacity. The research underscores the opportunity for gender-transformative approaches that go beyond accommodating existing norms, actively redistributing care responsibilities, and formally recognizing and valuing unpaid care work.

By highlighting the gaps and opportunities, the study provides evidence to inform inclusive policies and programs, contributing to gender equality, social protection, and sustainable development in Cambodia.

Table of Contents

Contents

Acknowledgement 2

Executive Summary 3

1. Introduction 7

    1.1 Background 7

    1.2 Problem Statement 8

    1.3 Objectives of the Study 8

        General Objective 8

        Specific Objectives 8

    1.4 Research Questions 9

    1.5 Significance of the Study 9

2. Literature Review 10

    2.1 Conceptual Framework 10

    2.3 Unpaid Care Work in Cambodia 12

    2.4 Gap Analysis 13

3. Methodology 13

    3.1 Research Design 13

    3.2 Study Geographical Area 14

    3.3 Sampling Strategy and Data Collection Methods 15

    3.5 Data Analysis 16

    3.6 Ethical Considerations 16

    3.7 Limitations 18

4. Findings and Analysis 18

    4.1 Demographic Profile of Participants 18

        Overview 18

        Care giver profile 19

        Institutional and stakeholders profile 19

    4.2 Realities of Unpaid Care Work 20

4.2.1 Type and Scope of unpaid care work 20
4.2.2 Care Intensity & Complexity 22
4.3 Socioeconomic Needs, Challenges and policy discussion. 25
4.3.1 Financial and Social Protection 25
4.3.2 Health and Social Services 29
4.3.3 Education and Training 38
4.3.4 Recognition and Psychological Support 41
4.3.5 Employment and Work-Life Balance 46
4.3.6 Cultural and Gender Norms 48
4.6 Case study 53
5. Recommendations 55
5.1 Policy recommendation 55
Financial and social protection 55
Health and social services 55
Education and Training 56
Formal Recognition of Caregiving 57
Employment and work-life balance 58
Cultural expectation and gender norms 59
5.2 Future Research Recommendation 60
References 61
Annex 68

1. Introduction

1.1 Background

Unpaid care work (UCW), an essential aspect of social reproduction, consist a various and laborious task that are conducted without any monetary compensation. The task normally includes childcare, eldercare and care for the people with disability and sickness plus the household management tasks. The works are typically necessary to sustain the families, communities and economies. However, unpaid care work often go unnoticed, excluded from economy discussion and disproportionately distributed among family members (Coffey et al., 2020).

A significant aspect of UCW is its undeniable and inevitable gender attribute, as the works are vastly socially expected to be performed by women and girls accounting for approximately 16 billion hours daily (Addati et al., 2018). Studies report that women and girl can contribute to up to 76.4% of the total UCW (Charmes, 2019). The statistics reflect the clear work division that rooted from social norm and gender role expectation, positioning women and girl in a disadvantage social position costing them opportunity for education, employment and social participation(UN Women, 2018).

In Cambodia, where gender disparity is apparent and still a significant developmental issue, unpaid care and domestic work further reflect the gender inequality in care work distribution. According to recent survey by Oxfam, in average women spend 5hour and 2 minutes per day comparing to men who spend approximately 2 hours and 6 minutes(Oxfam, 2025). In an earlier time-use survey in Cambodia, the report shows that women performed approximately 188 minutes per day on unpaid care work, whereas men performed only 18 minutes (National Institute of Statistics, 2004). In between two-decade time gaps, it is still very apparent that UCDW is not equally shared between men and women in Cambodia, and women are bearing great burden. This significant workload is often couple up with economic responsibility leaving women juggle between household care and income generation activities, especially in the informal sector(You, 2020).

UCDW has profound implication on socioeconomic development intertwining with gender equality issue. The burden of UCDW that women are shouldering often cost them socially and economically. Women can be both directly and indirectly be restricted from accessing paid work, education, skill training and social participation, hindering their economic empowerment and their overall well-being (International Labour Organization, 2009). Moreover, UCDW can limits women's ability to pursue higher-paying jobs and position while often force them into part-time and informal employment further continue poverty cycle (International Labour Organization,

2024). Therefore, tackling UCDW is not only achieving gender equality but can also bolster economic growth.

1.2 Problem Statement

Unpaid care work (UCW), including childcare, elder care, disability care and domestic tasks, constitutes a vital yet largely unrecognized component of Cambodia's social and economic system. As mentioned earlier, despite its critical role in sustaining households and communities, caregivers, predominantly women, face limited socioeconomic support, inadequate policy recognition, and insufficient access to social protection, health services, and flexible employment or training opportunities. Existing programs often target household poverty rather than the specific needs of individual carers, leaving them vulnerable to income loss, time poverty, and long-term economic dependency. The lack of formal recognition and equitable redistribution of care responsibilities perpetuates gender inequality, constrains women's participation in education and the labor market, and contributes to physical, emotional, and financial stress. This research seeks to address these challenges by examining how unpaid carers at the household level in Cambodia experience and respond to existing socioeconomic incentives and policy measures, and what their lived experiences reveal about current gaps, needs, and opportunities for improvement.

1.3 Objectives of the Study

General Objective

The general objective of this research is to explore the lived experiences of unpaid carers at the household level in Cambodia in relation to existing socioeconomic incentives and policy frameworks. The study aims to identify the key needs, challenges, and opportunities faced by caregivers, particularly women and other marginalized groups, and to generate evidence that can inform the design of more inclusive, effective, and gender-responsive support mechanisms. Through in-depth case studies, the research seeks to provide actionable insights for improving the recognition, redistribution, and valuation of unpaid care work, thereby contributing to greater social and economic equity.

Specific Objectives

Building on the general objective, the study outlines four specific objectives to guide the research process as bellow:

1. Examine the effectiveness of existing socioeconomic incentives and policy frameworks in meeting the needs of unpaid carers, identifying gaps in social protection, health services, education, and flexible work opportunities.

2. Identify key challenges and impacts of unpaid care work, including economic, social, and psychological burdens, with attention to gender, disability, and rural or urban disparities.
3. Explore opportunities for inclusive and gender-transformative interventions, including policy or program recommendations, and illustrate these through in-depth case studies of diverse households and communities.

1.4 Research Questions

The research study on "socioeconomic incentive for unpaid care work at household level in Cambodia: needs, challenges and opportunity" is seeking to address a research question as follow:

> How do unpaid carers at the household level in Cambodia experience and respond to the socioeconomic incentives and policy measures intended to support them, and what do their lived experiences reveal about existing needs, challenges, and opportunities for improvement?

1.5 Significance of the Study

This research holds significant potential to generate broad impacts across individual, household, community, policy, and knowledge domains. By examining the lived experiences of unpaid caregivers—predominantly women—and assessing the effectiveness of existing socioeconomic incentives and policy frameworks, the study provides evidence to improve both the well-being of caregivers and the structures that support them.

At the individual level, the findings offer insights into the economic, social, and psychological challenges faced by caregivers, enabling targeted interventions to reduce their caregiving burden and enhance access to financial, health, and social support. Recognition and support of unpaid care work can improve caregivers' mental and physical well-being, foster a sense of self-worth, and create opportunities for engagement in paid employment, education, or other personal development activities, thereby contributing to greater economic participation and empowerment.

At the household and community level, the study emphasizes the importance of redistributing caregiving responsibilities, encouraging male and other family member participation, and promoting gender-equitable practices. This can improve family dynamics, reduce the disproportionate burden on women, and foster social inclusion. By increasing awareness of the value of unpaid care work, the research also addresses stigma and challenges cultural norms that often undervalue caregiving, particularly when performed by women, encouraging a shift toward shared community responsibility.

From a policy perspective, the research provides critical evidence to inform the development of gender-sensitive and inclusive policies. Policymakers can use these insights to design or reform social protection programs, financial support mechanisms, care services, and labor regulations that directly address the needs of unpaid caregivers. The study can also guide institutional changes within government and civil society to better integrate caregiving considerations into national development agendas.

Finally, the study contributes to the broader body of knowledge on unpaid care work, serving as a resource for future research in gender equality, labor economics, social welfare, and the care economy. It identifies existing gaps and areas for further investigation, laying the foundation for continued evidence-based policy and program development to support caregivers and promote sustainable, equitable social and economic outcomes in Cambodia.

2. Literature Review

2.1 Conceptual Framework

Understanding Unpaid Care Work

Unpaid care work involves providing essential care to family members—children, elderly individuals, and persons with disabilities—without direct monetary compensation. In most societies, including Cambodia, the majority of unpaid care work occurs within households and families, though caregivers also extend support to relatives, friends, neighbors, and community members(Razavi, 2007). Unlike paid care work, which involves financial compensation for care services, unpaid care work reflects a non-market provision of care essential for the physical, social, mental, and emotional well-being of care-dependent individuals (UN Women, 2018).

Typology of Care Work at the Household Level

Unpaid care work is a concept often discuss in care economy which has been interpreted in various ways (Addati et al., 2018; Peng, 2019) . In its broadest sense, the care as described in care economy, encompass all types of care work, both paid and unpaid provision covering multiple dimensions of activities. And in a more specific sense it set boundaries to the concept containing specific sector of care work and recipient of care or the care dependent group such as “children, the elderly and person with disability” (Wray et al., 2023). According to Folbre (2018), within the dynamic of care, care-dependent individuals or care recipient are those require assistance to maintain independence due to functional limitations.

The unpaid care work which is further added with domestic work in the term to include the household domestic chore in the works reflecting that the care task burden surpasses the tasks for the care of specific care recipients but the care for the sustaining the household, while the

term unpaid is self-explained as the task is not return with monetary value. In this research, we will be referring to Unpaid care and domestic work as unpaid care work as the understanding that domestic work is part of sustaining the household categorizing, also, as care work.

Meanwhile, in understanding unpaid care work, care is also viewed in its nature of performance and how the recipient of care benefit from it. Unpaid care work can be seen as direct, indirect and supervisory mode. Direct care involves one-on-one interactions and hands-on tasks performed between caregiver and care recipient—such as mothers feeding children, assisting elderly parents with personal hygiene, or administering medication to persons with disabilities(Razavi, 2007; UN Women, 2018). Indirect care comprises supporting activities such as household chores, meal preparation, and laundry (UN Women, 2018). Supervisory care involves oversight, monitoring, and coordination of care-dependent individuals, typically performed in conjunction with direct or indirect care work (Folbre, 2018). This research prioritized investigating the nature of care as reported by care givers and observe the scope, its extension and connect to one another.

Socioeconomic incentives

Socioeconomic incentives—encompassing financial support, policy frameworks, institutional recognition, and household resource availability—fundamentally shape caregivers' capacity and willingness to provide unpaid care work(Ferrant et al., 2014; Razavi, 2007). These incentives interact with economic constraints, labor market opportunities, household composition, and gender norms to create differential experiences across caregivers(Ferrant et al., 2014). Understanding socioeconomic incentives requires examination of:

- **Financial and Economic Dimensions**: Caregivers often face significant economic costs associated with care provision, including foregone income from reduced paid work participation, additional care-related expenses (medical costs, transportation, adaptive equipment), and financial vulnerability when care demands conflict with income-generating activities(Coffey et al., 2020; Johnson et al., 2023)
- **Recognition and Valuation**: The degree to which society, institutions, and households recognize and value unpaid care work influences caregivers' social status, access to support services, and motivation to continue caregiving(Razavi, 2007). Lack of recognition often accompanies undervaluation of care work, perpetuating its invisibility within economic accounting and policy frameworks.
- **Policy and Institutional Support**: Policy frameworks related to access to healthcare, childcare services, elderly care facilities, disability support, and social protection programs—create enabling or constraining conditions for household-level care provision(UN Women, 2023). The availability and accessibility of these institutional

supports determine whether caregivers must absorb care demands entirely through unpaid labor or can share responsibilities with formal service providers(ESCAP, 2024).

- **Household Dynamics and Gender Division of Labor**: Care work distribution within households reflects gender norms, economic necessity, and available household resources. Women and marginalized groups typically assume disproportionate care responsibilities, often without explicit recognition or compensation(Folbre, 2018). Understanding socioeconomic incentives requires examining how household-level decision-making, resource allocation, and gender expectations shape care work distribution.

Reflecting on above key dimension's cross-cutting and linkage between UCW and socioeconomic incentive, the research focus on six key aspects; financial and social protection, health and social services, education and training, recognition and psychological support, employment and work-life balance, cultural expectation and gender norm.

2.3 Unpaid Care Work in Cambodia

Over the years, a number of studies has been conducted on unpaid care work in Cambodia documenting its prevalence and impacts in the country's development context. One of the earliest studies on unpaid care work was included in the Cambodia Socio-Economic Survey in 2004 providing one of the first insight to the issue through time-use analysis. The survey reveal the gender disparities within unpaid care work distribution showing up to 170 minutes time spent difference on unpaid care and domestic work by women comparing to men per day (National Institute of Statistics, 2004). In the current the study the time spend on unpaid care work by women and men remain almost the same (172minutes) (Oxfam, 2025), placing women under the greater burden of the unpaid care work. Childcare represents a particularly significant burden for Cambodian caregivers, especially women, who perform approximately 90% of childcare tasks as part of their unpaid care responsibilities. This disparity stems from limited access to affordable public childcare services and deeply entrenched gender norms that socially assign care responsibilities to women (Haddock et al., 2024).

Beyond time allocation, research consistently demonstrates that unpaid care work significantly compromises caregivers'—predominantly women's—economic participation and well-being. You (2020) found that women caregivers have reduced opportunities for paid employment and skill development. This finding aligns with studies by (UNESCAP, 2022) and (Oxfam, 2025), which show that unpaid care work restricts Cambodian women's access to paid employment, income generation, and financial security. The cumulative effect extends beyond individual households, generating economic losses at the national level while perpetuating gender inequality and diminishing overall productivity. Furthermore, unpaid care work exacts a personal cost, limiting

opportunities for education, skill training, and adequate rest (Oxfam, 2025; UNESCAP, 2022). These findings underscore the urgent need for policy interventions to redistribute care responsibilities and enhance women's economic participation.

2.4 Gap Analysis

Although Cambodia has witnessed growing research attention to unpaid care work through research, existing studies predominantly adopt broad analytical frameworks or concentrate on separate care dimensions. These include childcare(Haddock et al., 2024; My, 2023), disability care(Kidd et al., 2022), and elder care(Rathny et al., 2018). While such researches make important contributions by rendering previously invisible care labor visible and offering valuable policy recommendations, a critical gap remains around systematic examination of the socioeconomic incentives affecting household-level unpaid caregivers or evaluated the efficacy of policies designed to support unpaid caregivers.

This analytical gap significantly limits current understanding of the economic and social mechanisms that sustain care work. In particular, existing research provides insufficient insight into how policies might effectively incentivize care work, redistribute caregiving responsibilities more equitably, or strengthen the economic and social support systems upon which caregivers depend. Addressing this limitation is essential for developing evidence-based policy interventions that adequately recognize and support unpaid care work.

3. Methodology

3.1 Research Design

This study adopts an exploratory research approach to investigate the needs of household-level caregivers and the challenges and opportunities for socioeconomic incentives for unpaid care work. This approach allows for a broad and in-depth understanding of the conditions and experiences surrounding unpaid care work, providing the potential to generate new insights into an underexplored area (Stevens & Wrenn, 2013). Given the inherently gendered nature of unpaid care work, the research also employs a feminist social research approach to examine gender dynamics, social norms, and their influence on household care responsibilities and the socioeconomic incentives required to support caregivers. This dual approach enables the study to capture the distinct experiences and needs of both female and male caregivers, including variations across age, disability status, and socio-economic background (Kaur & Nagaich, 2019).

The study uses qualitative methods to collect rich, detailed data. Semi-structured, in-depth interviews will be conducted with a diverse range of unpaid caregivers—including stay-at-home mothers, grandmothers, stay-at-home fathers, working parents, caregivers with disabilities, and

households classified as ID Poor—to explore their personal experiences, coping strategies, and perceptions of socioeconomic incentives and policy support. This method allows for a nuanced understanding of individual lived realities, unmet needs, and interaction with existing policies.

In addition, Key Informant Interviews (KIIs) will be conducted with government officials, NGO staff, and local leaders to provide insights into the design, delivery, and perceived effectiveness of care-related policies and socioeconomic support programs. These interviews will also capture institutional perspectives on policy implementation and gaps.

A policy review will also be undertaken, analyzing relevant national and sub-national documents, including social protection frameworks, gender equality strategies, and care-related legislation. This review will examine how unpaid care work is formally recognized, resourced, and supported within Cambodia's policy landscape, identifying both strengths and gaps in policy design and implementation.

To guide analysis and recommendations, the study applies the 5R Framework – Recognize, Reduce, Redistribute, Reward, Represent (UN Women, 2022). This framework explicitly incorporates both economic and social incentives, positions caregivers as economic actors, and provides a strong foundation for policy analysis. It also captures dimensions of power, voice, and agency, ensuring that recommendations address not only material support but also the recognition, empowerment, and equitable participation of caregivers in household and societal decision-making (UN Women, 2022).

Collectively, this research design allows for a comprehensive, gender-sensitive, and contextually grounded analysis of the socioeconomic incentives and policy frameworks affecting unpaid caregivers in Cambodian households, while providing actionable insights for inclusive and transformative policy interventions.

3.2 Study Geographical Area

The research was conducted in two distinct locations: Phnom Penh and Prey Veng Province, Ba Phnom District. The selection of these two areas was intentional to capture contrasting contexts and provide a comprehensive understanding of unpaid care work across different settings in Cambodia.

Phnom Penh, as the capital and most urbanized area, represents households with relatively better access to care services, infrastructure, and social programs. However, accessibility does not always equate to affordability or adequacy of services, and urban caregivers still face significant constraints related to cost, time, and social expectations (Guevara-Aladino et al., 2024). In contrast, Ba Phnom District in Prey Veng Province represents a rural setting where households often experience limited availability of care services, greater physical distances to facilities, and

fewer formal social support mechanisms. Caregivers in rural areas may rely more heavily on informal support networks, family labor, or community assistance, highlighting distinct challenges compared to urban counterparts.

By including both an urban and a rural location, the study enables to investigate further the distinctive lived experiences of caregivers in contexts with varying service availability, social norms, and socioeconomic constraints. This dual-site approach allows the research to capture a broader range of caregiving realities, including differences in gender roles, access to socioeconomic incentives, and interaction with policy frameworks.

3.3 Sampling Strategy and Data Collection Methods

The study employs a non-probability sampling approach, combining purposive and convenience sampling methods to select participants for key informant interviews, in-depth interviews, and policy analysis. This approach allows the research to focus on participants and documents that are most relevant to understanding unpaid care work and socioeconomic incentives in the Cambodian context, while ensuring representation of diverse and vulnerable groups.

Key Informant Interviews (KIIs): Participants for the KIIs were purposively selected based on their roles and engagement in unpaid care work and socioeconomic incentive programs for caregivers. Selection was conducted with support from local authorities to ensure that marginalized and vulnerable groups were represented. The interviews participants from government agencies, development partners, international and local NGOs, and feminist movements or networks. These interviews provided insights into policy design, implementation, and perceived effectiveness of existing support mechanisms.

In-Depth Interviews (IDIs): To explore caregivers lived experiences and socioeconomic incentive dynamics, in-depth interviews were conducted. Participants were purposively selected to represent different caregiver groups, including stay-at-home mothers, grandmothers, stay-at-home fathers, working parents, caregivers with disabilities, and households classified as ID Poor. For each group, three respondents were interviewed to capture variations in experiences, challenges, and coping strategies.

Policy Analysis: The policy review followed a purposive sampling approach, focusing on policies, laws, strategies, and program guidelines that directly or indirectly impact socioeconomic incentive for unpaid care work. This included policies on social protection, gender equality, childcare, disability care, elderly care, metal health care and poverty reduction. Selection of the policy documents are dependent and guided by the result of the interview with key stakeholders and the stories of the care givers.

This sampling strategy ensures that the study captures diverse perspectives from both caregivers and institutional actors, providing a comprehensive understanding of the needs, challenges, and opportunities for socioeconomic incentives for unpaid care work at the household level.

3.5 Data Analysis

The study employs a combination of qualitative analysis methods to ensure a comprehensive understanding of unpaid care work and the effectiveness of socioeconomic incentives at the household level.

Thematic Analysis: Qualitative data from key informant interviews and in-depth interviews were analyzed using thematic analysis, guided by the research objectives. This method involved familiarizing with the data, generating initial codes, identifying patterns, searching for themes, reviewing and refining themes, defining and naming them, and producing a structured report (Braun & Clarke, 2006). Main themes were developed based on the study objectives, while sub-themes were identified to support the core findings. Thematic analysis provided a systematic approach to interpreting participants' narratives, capturing both explicit statements and underlying meanings.

Narrative Analysis: Select in-depth cases underwent narrative analysis to construct detailed life stories that trace the caregiving journey over time. This method highlights key turning points, coping strategies, and interactions with support systems or policies, providing contextualized insights that complement broader thematic findings. Narrative analysis humanizes the data, illustrating how patterns observed across the sample manifest in individual lived experiences.

Policy Analysis: Collected national policy documents were analyzed reflecting on socioeconomic incentive for unpaid caregivers at household level, also using a gender Lense. The policy analysis also employed the 5R Framework (Recognize, Reduce, Redistribute, Reward, Represent). This framework assesses the recognition, adequacy, accessibility, and implementation of care-related policies while emphasizing caregivers' economic and social roles, voice, and agency (UN Women, 2022). Policy discussion identified strengths and gaps as well as the opportunities for improving policy support for unpaid caregivers, ensuring that recommendations are both actionable and contextually grounded.

3.6 Ethical Considerations

The research has been designed in a way that adhere rigidly the ethical standard. Fully aware of the possible unintended impact of the research on the research subjects' social and mental well-being, the research proposal in which including the whole research design was submitted for approval from National Ethics Committee for Health Research. The research study was approved

and carried out with full caution on the issue of inform consent, confidentiality, cultural sensitivity and do-no-harm principle.

Informed consent was obtained from all participants before the interviews were conducted. The researcher explained the purpose of the study, the interview process, the use of collected data, and participants' rights, including the right to refuse to answer any question or withdraw from the study at any time without consequences. An information sheet was provided to ensure participants fully understood the study before agreeing to participate. Written consent was obtained prior to the interview, while verbal consent or a mark on the consent form (Annex 1) was accepted for participants who were unable to read or write. Participation was voluntary, and a small token valued at no more than 20,000 KHR (or USD 5) was provided after the interview to acknowledge participants' time and effort to participate. The tokens are only provided to caregivers as respondents.

All participants were informed prior to the interviews about how the collected information would be used in reports or publication through an information sheet (Annex 2), allowing them to provide or withhold consent for the use of their data. To protect participants' identities, all data were anonymized by removing names, locations, and other identifying details, with each participant assigned a unique code. Audio recordings and consent forms were stored separately in password-protected digital folders accessible only to the core research team, and direct quotes in reports were reviewed to prevent traceability. Findings were presented in aggregate to avoid revealing individual identities. Access to all data, including questionnaires and audio files, was restricted to the research team, stored securely on password-protected devices, and the questionnaires were destroyed after the completion and publication of the research to ensure confidentiality and data security.

Being culturally aware of the sensitivity of the topic discussed among people from different gender identity in Cambodia context, the research team ensure that only male interviewer interviewed male care givers while the same was applied for female care givers. To avoid conflict of interest among community tie, the village facilitators who are the permanent residence and community development workers in the area were not allowed in the interview.

More importantly, to address any conceivable and inadvertent impact on care giver well-being due to psychological trigger, the research team was trained with psychological first aids and a psychological counselor was engaged to provide on-site stand-by psychological support to respondent if and when the psychological distress was notified. Information sheet (Annex 3) on further psychological support both free-of-charge and affordable service was provided to all caregiver as respondents after the interview.

3.7 Limitations

While this research provides valuable in-depth insights into the socioeconomic incentives for unpaid care work at the household level, several methodological limitations warrant acknowledgment. As a qualitative study with a small, purposive sample, the findings lack statistical generalizability across all caregiver groups in Cambodia. Additionally, potential sampling bias may limit representativeness, particularly regarding vulnerable or hard-to-reach populations such as caregivers in remote areas, individuals with severe disabilities, or households from ethnic or minority community. Furthermore, the cross-sectional design captures only a snapshot of unpaid care work, potentially missing temporal changes, seasonal variations in care responsibilities, and long-term policy impacts that longitudinal analysis would reveal.

Despite this limitation, the research yields critical insights into the challenges, needs, and opportunities for strengthening socioeconomic support for unpaid caregivers in Cambodia. The findings establish a robust foundation for future research employing larger, more representative samples or longitudinal designs to validate and extend these preliminary conclusions.

4. Findings and Analysis

4.1 Demographic Profile of Participants

Overview

Table 1: Cross-Tabulation of Study Participants by Geographic Location, Sex, and Role

Location	Male		Female		Total by location
	Caregiver (IDI)	Stakeholders (KII)	Caregiver (IDI)	Stakeholders (KII)	
Phnom Penh	*3*	*5*	*2*	*9*	*19*
Prey Veng	*4*	*2*	*15*	*0*	*21*
Total by sex	*7*	*7*	*17*	*9*	

Through purposive selection, the study engaged a diverse 40 participants (14 male, 26 female) to explore the dynamics of unpaid care and its socioeconomic incentives. The sample consist of 24 care givers with which were interviewed using semi-structure in-depth interview questionnaire (Annex 4) while 16 stakeholders were interview using semi-structure questionnaire (Annex 5) for key informant interview. Geographically, the research captured both urban and rural contexts, with participants drawn from Phnom Penh (n=19) and Prey Veng province (n=21).

Care giver profile

A total of 24 caregivers participated in the IDIs, predominantly comprising female respondents (17 females and 7 males). The participants represented a broad life-cycle spectrum, with ages ranging from 20 to 68 years. To ensure a comprehensive understanding of diverse caregiving experiences, the sample was stratified to include various household roles and employment statuses as bellow:

- Stay-at-home Parents: 5 stay-at-home mothers and 3 stay-at-home fathers.
- Working Parents: 5 working mothers and 4 working fathers, allowing for the exploration of how care work is balanced with paid employment.
- Intergenerational Caregivers: 5 grandmothers, highlighting the reliance on extended family networks for care provision.
- Caregivers with Disabilities: 2 female carers with disabilities, providing insight into the intersecting challenges of disability and care work.

Furthermore, the sample deliberately included socioeconomically vulnerable households, with 5 participating families holding formally recognized "ID Poor" status and 2 holding vulnerable family identification status.

Table 2: Caregiver' roles who participated in the In-depth interviews distribution by sex

Caregiver Role	Male	Female	Total
Working Parents	4	5	9
Stay-at-home Parents	3	5	8
Grandmothers	0	5	5
Carers with disability	0	2	2
Total	7	17	24

**Note: 5 households hold ID Poor status.*

Institutional and stakeholders profile

To complement the lived experiences of caregivers with systemic and policy-level perspectives, Key Informant Interview were conducted with 16 stakeholders (7 males and 9 females). These informants were strategically selected across local, national, and international levels to assess the broader support mechanisms for unpaid care work.

The institutional sample included representatives from:

- National Ministries and Councils: Ministry of Women's Affairs, Ministry of Planning (MoP); Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY); Ministry of Labour and Vocational Training (MoLVT); and the National Social Protection Council.
- International Organizations and Development Partners: United Nations Development Programme (UNDP), Oxfam, and the World Bank.
- Local Authorities: Commune Chiefs, who provided critical insights into the grassroots implementation of social protection and community-level care support.

This dual-layered sampling approach, capturing both grassroots caregiver realities and macro-level policy perspectives, provides a robust foundation for analyzing the socioeconomic dimensions of unpaid care work in Cambodia.

4.2 Realities of Unpaid Care Work

4.2.1 Type and Scope of unpaid care work

Type and scope of household unpaid care work, as found in the study, to be extensive. Household unpaid care work encompasses a wide range of essential activities that support family members' wellbeing and daily functioning. Aligning with the previous research studies as mentioned in the literature review, household unpaid care work involves a large range of activities which can be categorized by looking into the nature of the activities one performs and the type of the care recipient.

Considering the care recipients, unpaid care work at the household level covers a diverse range of care tasks that sustain individuals and families across the lifespan. While it can involve taking care of the whole family, the focus and level of intensity focus on the family members who normally need to depend on others for basic day-to-day function. Firstly, Childcare, which refer to the care providing to children as dependents or care recipients. Level of dependency varied by age group. This is the most discernable care work as reported by participants, represents a significant care component since the need of care is normally very extensive. It involves multifaceted responsibilities such as feeding, bathing, supervising, and supporting children's educational development—tasks that require constant attention, patience, and specialized knowledge. Secondly, elderly care constitutes another critical dimension, was also reported with which requires caregivers to provide assistance with mobility support, medication management, health monitoring, and activities of daily living, which become increasingly complex as older adults face age-related physical and cognitive challenges. Additionally, care for persons with disabilities or chronic illnesses, as reported during the interview, demands comprehensive support that extends beyond physical assistance to include household maintenance tasks such as cooking, cleaning, and laundry, alongside health-related duties like medication administration

and symptom monitoring. While categorizing care depending on care recipient tend to be explicit, the reality shows otherwise. The intersectionality of individual receiving care should be taken into account. Elderly who are in need of care due to old age are often because of limited ability to function which according to Washington group categorized as people with disability (Madans et al., 2011). The research illustrates that care for old age people more often than not would mean caring for people who are struggled with ability to function and health deuteriations. The complexity and inter-connected of these unpaid care responsibility types will be discussed further in the next session.

Looking into care type from nature of the care activities, the unpaid care work can also be categorized as direct, indirect and supervisory care aligning with the literature review above. The study has found that respondents regardless of their gender and geographical location, perform both indirect and direct care responsibilities. This includes, but not limit to, for direct care works, feeding and bathing children, preparing medication for elderly members of the family or help family member with disability to mobilize (if it is the daily function they struggle with), and, for indirect work, cooking meals, cleaning houses, laundry and groceries shopping.

One of the key findings in this section is the limited explicit recognition of supervisory roles within caregivers' accounts. Although supervision represents an essential component of caregiving, it is seldom articulated as a distinct category of care work by respondents. Instead, supervisory responsibilities appear to be deeply embedded within routine caregiving practices, rendering them less visible and less likely to be consciously identified. Empirical evidence from the interviews indicates that supervisory roles exist but hardly notified. It was only through follow-up probing that details information regarding these activities emerged. This pattern suggests that, while supervisory care is indeed present, caregivers do not readily conceptualize or label such activities as "care work." This may be partly attributable to the indirect nature of supervision, which is not always directed toward a specific individual at a clearly defined moment.

In addition, supervisory tasks are frequently carried out simultaneously with other caregiving responsibilities. As a result, respondents tend to emphasize primary, task-oriented activities—such as feeding, cleaning, or providing direct assistance—when describing their caregiving roles. Consequently, the continuous and background nature of supervision remains largely unacknowledged. This simultaneity contributes to the relative invisibility of supervisory labor and highlights a broader tendency for less tangible forms of care work to be overlooked in caregivers' self-representations.

In contrary, the mental load which is deeply interconnected with supervisory care, has been recognized even not with such technical term. The majority of the care givers report the impact of the mental load to their psychological well-being. They demonstrated that they have been struggling mentally to take care of the family and they find themselves mentally pre-occupied

with care tasks and becoming psychologically exhausted. One caregiver, caring for a disabled mother and sick relatives, noted that while she is physically exhausted, her *"brain is tired"* because she is *"thinking a lot"* and cannot find time to be happy (IDI 10). Similarly, a male caregiver mentioned that *"thinking too much gives me headaches"* (IDIM1). Another caregiver noted, *"I only think about my grandchildren and children…"* (IDIM12). The mental load is reported more apparently among older respondents like grandmothers who take care of their grandchildren and the house, while younger respondents report having hard time, but show more accepting attitude.

4.2.2 Care Intensity & Complexity

The "Invisible" Dual Role

The research result indicates that self-identified stay-at-home caregivers frequently occupy dual roles that combines unpaid domestic and caregiving responsibilities with home-based, income-generating activities. These activities include small-scale poultry raising, household gardening, food production, and craft-making. While such contributions play a meaningful role in supporting household livelihoods and, to some extent, local economies, they are rarely recognized as formal economic work—either by the caregivers themselves, other household members and the community. This lack of recognition contributes to a conceptual ambiguity surrounding the label of "stay-at-home" caregiver. Respondents who identified themselves as full-time, unpaid caregivers consistently emphasized their primary responsibility as family caretakers, while the designation of "breadwinner" was typically reserved for another household member. However, empirical accounts suggest that this distinction is not as clear-cut in practice as a stay-at-home mother mentioned in the interview that *"I raise cows and chickens. Sometimes I earn a little money when I sell them"* (IDI4*).* Despite the absence of formal acknowledgment, many caregivers simultaneously engage in productive labor that contributes economically to the household. One of the reasons why the home-based paid work performed can easily go unrecognized because it blends well with the household chore. For instance, tidy up space around the house can also mean making space for vegetable gardening. A housewife explains that her daily routine involves taking care their cows while managing the house. She said *"I... take care of the cows... clean the cow dung... prepare beef for my children to sell, and cook food"* (IDI4).

Another reason for this invisible paid labor is the minute and very unstable earning. One respondent described producing hand-crafted toy balls at home while concurrently supervising her grandchildren during after-school hours. The payment from this is fluctuate depending on the production of toy ball, that she doesn't think she is qualified as income earner. This example illustrates not only the coexistence of caregiving and income-generating activities, but also the layered nature of such labor. The respondent's experience highlights how supervisory care—already identified as an often-invisible dimension of caregiving—is further obscured when

embedded within productive work. As a result, both the economic and supervisory aspects of caregivers' contributions remain underrecognized.

Beyond Time Measurement

The study suggests that the quantification of caregiving through time-use measurement alone is insufficient to capture the full complexity of unpaid care work within the domestic sphere which has been mentioned before by Charmes et al.(2025), (UN Women, 2015), Neetha (2010) and Folbre (2006). Although time-use data is widely employed as a methodological tool to estimate the scale and distribution of unpaid labor, it does not adequately reflect the multidimensional and intensive nature of caregiving responsibilities(Charmes et al., 2025; Folbre, 2006; Neetha, 2010; UN Women, 2015).

Respondents consistently emphasized that the burden of care extends beyond the number of hours devoted to specific tasks. In particular, caregivers highlighted the simultaneous physical, cognitive, and emotional demands associated with their roles. These includes sustained physical effort, mental strain, and emotional stress, as well as less visible dimensions such as supervisory care, multitasking, and continuous cognitive monitoring of dependents, including children, older persons, and individuals with disabilities. Such overlapping responsibilities create a layered and ongoing form of labor that resists straightforward quantification through conventional time-based metrics as a caregiver for a disabled mother notes that even when attending training or meetings, her *"feelings are still there"* and her mind is not clear because she is still mentally managing the care at home (IDI10).

Moreover, when asked to estimate the amount of time spent on caregiving activities, respondents frequently expressed difficulty in providing precise or bounded answers. Rather than offering discrete time allocations, they tended to describe caregiving as a continuous, day-long responsibility characterized by diffuse and overlapping tasks. This pattern underscores the limitations of time-use frameworks, which are typically structured around clearly defined and separable activities, in capturing the fluid and pervasive nature of unpaid care work.

Complex family dynamic and caretaking roles

Within Cambodian context, the findings of this study indicates that unpaid care work at the household level is shaped by complex and interdependent family dynamics. Care responsibilities are not limited to individuals' adults who are normally seen as capable as care givers. Older persons or persons with disabilities who are often categorized as care recipient can also participate in caregiving activities. In some cases, these advanced-age caregivers and carer with disability assume the primary caregiving roles within the household raising concerns over the burden of care, care quality and the care needs. Simply put, individuals who require care may simultaneously experience unmet care needs while being burdened with additional caregiving responsibilities. As reported in interview, a 65-year-old woman is the sole caregiver for three

grandchildren, including a two-month-old infant. She describes herself as *"old and doesn't know what to do,"* yet she is the only person available to look after them so her children can work in factories (IDI17). Another 66-year-old woman manages a household of eight, including four grandchildren, while also working in the fields. She admits to being physically unwell, having lost vision in one eye, yet she remains responsible for the grandchildren's health and education (IDI 12). Similarly, a 68-year-old grandmother who has been disabled since the Pol Pot era is still responsible for the household's cooking and "small chores". She expresses frustration that even with her physical pain and difficulty walking, she must "force" herself to do the work because no one else will (IDI 18). Meanwhile, it is worth noticing that such arrangements are more likely to occur when individuals of advanced age and/or with disabilities belong to gender groups that are socially ascribed caregiving roles. This reflects the influence of prevailing gender norms on the distribution of care responsibilities which overwrite other intersectional identities.

Moreover, this care dynamics can also result in reciprocal and layered caregiving structures, where the distinction between caregiver and care recipient is fluid, context-dependent, and responsive to shifting household needs. Care responsibilities within such households are not fixed but are continuously negotiated and redistributed among multiple members. This dynamic allocation of roles adds significant complexity to both the measurement and conceptualization of care burdens. Rather than being concentrated in a single individual, caregiving is dispersed across the household, with varying degrees of intensity and responsibility assumed at different times. As a result, conventional approaches that rely on static categorizations of “caregiver” and “dependent” may need further in-depth exploration to adequately capture the lived realities of care provision dynamic.

These findings are consistent with existing literature on intergenerational care and household economies. For instance, Razavi (2007) emphasizes that care systems in many low- and middle-income countries are characterized by familial interdependence and informal reciprocity, rather than clearly delineated roles. Similarly, Barford et al., (2025) in an International Labour Organization report highlights the importance of recognizing diverse care arrangements within households, particularly in contexts where formal care systems are limited and families serve as the primary providers of support.

Therefore, recognizing these intergenerational dependencies is essential for accurately assessing the scope and distribution of unpaid care work. It also has important implications for understanding household well-being and for designing policies and interventions that reflect the context-specific realities of caregiving in Cambodian households.

4.3 Socioeconomic Needs, Challenges and policy discussion.

4.3.1 Financial and Social Protection

Challenges

The findings of the research study underscore a range of interconnected socioeconomic challenges that function as structural disincentives for individuals engaged in unpaid caregiving at household level. These challenges not only affect caregivers' immediate financial stability but also have long-term implications for labor market participation, career development, and financial vulnerability.

First of all, a primary challenge identified is the loss of income and employment opportunities. Caregivers reported withdrawing from paid work entirely in order to assume full-time caregiving responsibilities within the household. This decision, while often seen necessary and voluntarily, represents a significant economic sacrifice and reflect the absence of adequate institutional support for balancing care and employment. Carer who used to participate in paid work full time report choosing to leave work indefinitely to resume care taking roles due to the lack of affordable or inadequate care services. Others also reported that they needed to drop the job opportunity due to their role as a primary care giver. One mother explains that her professional life ended when she lost her support system as she stated during the interview that *"I used to work in a factory, but when I had a child, I had to stay home because my parents had passed away and there was no one to take care of the child"* (IDI6). Likewise, another respondent who cares for a disabled son and husband explains her need for proximity as *"In the past, I used to go to wash dishes... at weddings... now I stop because I can't stay away from home... If it's near, I can manage it"* (IDI23)

Additionally, for those who remain economically active while performing unpaid care work, ongoing trade-offs between paid work and caregiving responsibilities present an additional constraint. A male caregiver highlights the direct economic trade-off that *"If I stop working to care for children, I lose income, but if I continue, it's a sacrifice".* He further notes that even hiring a helper is not a viable solution because they "won't be able to keep up with the salary" required to pay for outside care (IDIM13). Caregivers frequently described the need to adjust their working arrangements—such as reducing working hours or shifting to informal, flexible, or home-based employment—in order to accommodate care demands. While such arrangements may offer short-term adaptability, they typically result in lower and less stable income, thereby reinforcing financial precarity. This trade-off practice, more often than not, place caregiver in the vulnerable condition economically. As evince in the data collected from the interview, one elderly grandmother describes herself as *"stuck looking after my grandchildren",* which prevents her from finding work and forces her to rely on neighbors for food. She describes her situation as becoming *"poor and poorer"* while being *"burdened with more and more burdens every day"* (IDI17).

Financial stress emerged as another critical dimension of the caregiving burden. Respondents highlighted the increased costs associated with providing care, particularly healthcare-related expenses, which place considerable strain on already limited household resources. One caregiver noted that her mother's various conditions required continuous spending on medicine for high blood pressure and diabetes, stool softeners, and diapers, which she described as difficult to find and a source of many difficulties. She stated in the interview that *"Because the income is small but the care burden is big, it is not enough"* (IDI10). This particular challenges normally occur for caregivers for elderly with chronic illness whose require closed and ongoing health care. In some cases, caregivers reported incurring debt as a coping strategy during periods of heightened financial needs. This coping strategic relying on borrowing introduces longer-term risks, including indebtedness and heightened vulnerability to poverty.

These pressures contribute to broader patterns of household economic insecurity. The combination of reduced income and increased expenditures elevates the risk of persistent poverty among caregiving households. Caregivers themselves often bear the brunt of this insecurity, as their limited engagement in paid employment constrains their access to independent income and financial protection mechanisms.

In addition to immediate financial impacts, caregiving responsibilities also hinder long-term socioeconomic mobility. Respondents reported limited opportunities for skills development, education, or career advancement due to the time and energy devoted to caregiving. Prolonged detachment from the labor market can lead to skill depreciation and reduced employability, thereby diminishing future earning potential. This dynamic illustrates how caregiving not only reflects existing income generation inequalities but also reproduces them over time.

Needs

The findings of this study highlight a range of unmet socioeconomic needs that function as critical incentives for supporting individuals engaged in unpaid caregiving. While caregivers consistently expressed a need for financial assistance, such needs were rarely articulated as distinct claims tied specifically to the burdens of unpaid care work. Instead, respondents tended to frame their concerns within the broader context of overall household livelihood and economic survival. This pattern suggests a limited conceptual separation between caregiving-related financial strain and general household financial insecurity.

Despite this, several forms of support emerged as particularly salient. Caregivers frequently identified direct financial assistance, such as cash transfers, as a key mechanism for alleviating immediate economic pressures. In addition, respondents emphasized the importance of skills development and training opportunities to enhance their capacity for income generation. Such measures were viewed as enabling caregivers to pursue flexible or home-based economic activities that can be more easily reconciled with ongoing care responsibilities. One factory

worker suggested that the government or relevant organizations should facilitate work that can be brought directly to the household. She noted, *"I think women should have opportunities to work from home... In the past, people brought work such as sewing balls or sewing bag handles to women's homes. That way we could take care of our children and still earn some money"*(IDI3).

Support for small-scale, home-based enterprises also emerged as a priority. Caregivers expressed interest in accessing modest financial resources to initiate or expand income-generating activities, particularly in agriculture-related sectors or other forms of household-based production. These types of support are especially relevant in contexts where caregivers face constraints in accessing formal employment due to time and mobility limitations associated with care work. Caregivers tend to express willingness to alter their job setting and/or doing income generating activities, not the domestic and care work. Several respondents are already engaged in home-base labor; for example, one 53-year-old grandmother balances childcare with sewing bags at home, earning piece-rate income once a month. She said *"I want a side job or income-generating activity that I can manage alongside housework"* (IDI11).

Beyond material support, respondents highlighted the need for greater recognition of unpaid care work within policy frameworks. This includes the introduction of targeted measures such as caregiver allowances or other forms of social protection aimed at compensating or offsetting the financial costs of caregiving. Such recognition is important not only for alleviating immediate financial burdens but also for enhancing caregivers' long-term economic security and social status.

At the same time, the findings reveal a gap between caregivers' lived experiences of financial strain and their ability to explicitly articulate their needs in policy-relevant terms. While concerns about income security—both at the individual and household levels—were evident, these were often expressed in diffuse or generalized ways. This underscores the importance of developing more responsive and inclusive policy approaches that can identify and address latent needs, even when they are not formally or explicitly stated by caregivers.

These findings are consistent with broader research on the care economy, which emphasizes the role of social protection and targeted economic support in mitigating the structural disadvantages associated with unpaid care work. For instance, International Labour Organization highlights the importance of integrating cash benefits, skills development, and employment support into care policies (Addati & Cattaneo, 2022). Similarly, United Nations Development Programme underscores the need for policies that both recognize and redistribute unpaid care work while promoting inclusive economic participation(UNDP, 2023).

Policy discussion and opportunities

The findings of this study highlight important intersections between unpaid caregiving and existing social protection policies in Cambodia, particularly within the framework of the National Social Protection Policy Framework (NSPF) 2024–2035. While the NSPF represents a significant step toward expanding social protection coverage for vulnerable populations, its approach to caregiving remains largely indirect, with important implications for how unpaid care work is recognized and supported.

The NSPF outlines a combination of non-contributory and contributory schemes aimed at supporting groups such as older persons, pregnant women, children, and persons with disabilities (National Social Protection Council, 2024). Although unpaid caregivers are not explicitly identified as a target group, the policy emphasizes the expansion of social assistance as a national priority. Within this framework, the National Social Assistance Programme for Family Package serves as a key intervention, providing financial support to households classified as poor or at risk through the ID Poor system and vulnerable household category(National Social Protection Council, 2024).

Under the Family Package, eligible households receive a baseline monthly cash transfer of 34,000 riel (Approximately USD 8.50), supplemented by targeted allowances for specific vulnerable members. These include additional monthly payments for older persons, persons with disabilities, and individuals affected by HIV/AIDS, as well as education-related transfers for children and maternal health benefits for pregnant women. From the perspective of caregivers, these transfers are perceived as an important—although indirect—form of financial support. Respondents reported that such assistance helps to alleviate household financial pressure and partially compensates for forgone income associated with caregiving responsibilities. However, they also noted that the level of support remains insufficient relative to the actual costs and economic sacrifices involved in care provision. One respondent stated, *"it's not enough, but it helps step by step"*(IDI20). Another caregiver for a disabled mother noted that even with a poverty card, the medicine provided is *"a small amount... not enough to use at the hospital"* and does not cover the high cost of daily essentials like *"diapers [which] are so hard to find"* (IDI10).

In addition to financial benefits, the ongoing digitalization and integration of Cambodia's social protection system has improved administrative efficiency and accessibility. The development of interoperable systems, functioning in part as a national social registry (General Secretariat of the National Social Protection Council, 2024), has reduced the physical and cognitive burden associated with accessing and managing benefits. This is particularly relevant for caregivers, whose time and mobility are often constrained by care responsibilities. As such, these administrative improvements can be understood as a form of indirect support that reduces the non-financial costs of engaging with social protection mechanisms.

Despite these positive developments, a key limitation identified in the research is the absence of explicit recognition of unpaid care work within the policy framework. Social protection measures are primarily designed to address poverty at the household level, rather than the specific conditions and needs of caregivers as individuals. As a result, caregivers benefit from these schemes only insofar as they belong to households classified as poor or vulnerable. This approach risks overlooking caregivers who may experience significant care-related burdens but do not meet the criteria for poverty-based targeting.

Furthermore, the reliance on household-level targeting mechanisms, such as the ID Poor system, may obscure intra-household inequalities and the differentiated impacts of caregiving responsibilities. While programs such as the Health Equity Fund and cash transfer schemes contribute to overall household welfare, they do not directly address the structural constraints faced by unpaid caregivers, including lost income, reduced labor market participation, and limited access to social protection in their own right.

These findings point to a critical policy gap which is the need to move beyond indirect support toward more explicit recognition of unpaid care work within social protection systems. As highlighted in international policy discourse, including recommendations by the International Labour Organization and the United Nations Development Programme, effective care policies should incorporate measures that recognize, reduce, and redistribute unpaid care work (Addati & Cattaneo, 2022; UNDP, 2023). This at the same time, points out the opportunity for further investigation and examination on care-sensitive social protection policy and implementation. The policy could also involve introducing caregiver-specific benefits, expanding eligibility criteria, or integrating care considerations more directly into existing programs. In Cambodia context, since the law, policy and mechanism are already in place, this bears significant potential for unpaid caregivers to be incentivized and protected financially.

4.3.2 Health and Social Services

Challenges

The findings of this study reveal significant gaps in the accessibility, affordability, and inclusiveness of health and social services for caregivers in Cambodia.

A key issue identified is the attitude toward access to healthcare among caregivers themselves. Caregivers frequently delay their own medical care to prioritize their care dependence. Respondents consistently reported prioritizing the health needs of care recipients over their own, often delaying or foregoing necessary medical attention. Caregivers report neglecting their own health as being overwhelmed with care work. One 57-year-old caregiver for a disabled mother and sick relatives stated, *"I take care of my mother, I don't think about myself"* (IDI10). She noted that she has not used health services for herself while managing the chronic illnesses of four other

people. Another 29-year-old mother explained the psychological pressure to remain healthy for her child that she said *"One day sick, one day well... but when the child is sick, the mother doesn't dare to be sick anymore"* (IDI21). This pattern is particularly pronounced in rural areas, where geographic distance, transportation costs, and limited health infrastructure present substantial barriers to accessing care. The finding suggests that physical accessibility remains a critical constraint for caregivers whose top priority is home-bound.

The cost of the health care is also a significant factor for caregivers to delay or neglect own health care. Linking to previous section explaining financial lost and trad-off of unpaid care work and paid work, attitude to seek for health care is very much determined by the affordability by care givers and the family. Care givers reported either minimizing personal health issue or coping through delay. A 68-year-old disabled caregiver explained that when she was told she needed a USD 4,000 surgery in Phnom Penh, she chose instead to take *"delaying medicine"*. She only takes this medicine when the pain in her hip and groin becomes unbearable; otherwise, she continues to *"force"* herself to perform domestic labor (IDI18). This is as alarming health sacrifice among care givers.

In addition to physical health services, the study highlights a critical deficit in mental health support for caregivers. Respondents reported experiencing high levels of stress, emotional strain, and fatigue associated with continuous caregiving demands. A few respondent shows sign of clinical mental health issue which need further clinical assessment to determine. However, it is clear that their mental health is at risk. One 57-year-old caregiver for multiple sick relatives explicitly stated, *"It's hard to accept that we're so tired but it's not worth it... it's very depressing,"* and noted that she often feels *"exhausted in every way"* (IDI 10). The same respondent confessed to having thoughts of wanting to die during periods of intense distress. She said, *"When I was really depressed, I thought to myself, 'Oh my God, if lightning strikes me and kills me, it would be better"* (IDI 10). Another caregiver described her mental state as reaching a breaking point, stating, *"I want to scream and break the earth"* and expressed a desire to *"runaway"* because the pressure is *"too much"*(IDI9). Despite these, understanding around mental health is very limited in Cambodia which lead to negligence on mental health care and affect the attitude toward mental health-care services seeking(Chhim, 2017; Schunert et al., 2012). The lack of access to affordable and appropriate mental health services also remains extremely limited (Chhim, 2017). This gap reflects broader systemic challenges in mental healthcare provision and underscores the need to integrate mental healthcare into caregiving-related policy frameworks and vice versa.

The availability of specialized services for care recipients, particularly older persons and individuals with disabilities, also remains limited at the local level. Caregivers reported insufficient access to medical, technical, and social support services that could assist in managing complex care needs. This lack of service provision increases the intensity of caregiving responsibilities

within the household and places additional strain on family members. To further worsen, this also compromise the quality of care for people who are in need of very specific clinical health care.

For a social services, the findings indicate a shortage of affordable and accessible formal care options. The limited availability of institutional or community-based care services compels families to assume primary responsibility for high-intensity caregiving, often without adequate external support. Where such services do exist, they are frequently unaffordable or geographically inaccessible, particularly for rural populations. This reinforces reliance on unpaid care and exacerbates existing inequalities in care provision.

Childcare service, for instance, there has been lack of village-level daycare, inadequate factory nurseries, age gaps in services and trust on the quality of the services. while some community pre-schools and factory nurseries exist, they often fail to meet the needs of working parents due to age restrictions, poor quality, and a lack of trust. Community kindergartens typically only accept children starting at age three, leaving a critical gap in support for parents of infants and toddlers. One mother suggested the government should provide places where children could be left for even four hours a day to allow for part-time work (IDI21). Meanwhile, some factories provide nurseries, but caregivers often refuse to use them because the staff are perceived as unskilled. One respondent noted that her factory nursery was run by *"two hygiene aunts" (cleaners)* rather than trained professionals, leading to a lack of trust as she further that *"We don't know how they take care of our children... so we don't dare to take them(services)"* (IDI21). Such challenges also echo through researches done by World Band in 2024 and the International Finance Corporation (IFC) in 2020 in which shows issue around trust, safety concern, insufficient operation hours and lack of quality standard (Haddock et al., 2024; Kolb et al., 2020).

Similarly, for elderly care and disability care service, there are very limited social service and facilities dedicated to elderly and people with disability at the community level. There has been lack of formal facilities for elderly, community-based support systems and specialized package ti help with unique needs of people with disability.

Needs

The research highlights critical unmet needs among caregivers related to accessible and affordable health and long-term care services. Caregivers consistently expressed the necessity for expanded coverage of affordable healthcare and long-term care options for their care recipients. Such services have the potential to alleviate the intensity of caregiving responsibilities, thereby reducing caregiver burden while simultaneously improving the overall quality of care provided within households. The current gaps in service provision place disproportionate physical, emotional, and financial demands on unpaid caregivers within the household, highlighting the urgency of enhancing service availability and affordability. A 66-year-old caregiver highlighted the

gap in local clinical access, stating that *"The point that needs to be changed is health (services), so that there are doctors in the village... and mobile doctors…"*(IDI12).

Additionally, the need for respite care and psychological support emerged as a significant concern. Caregivers frequently reported experiencing high levels of stress and emotional exhaustion, often approaching burnout due to the relentless demands of caregiving. Respondents emphasized that accessible psychological support, particularly when embedded within community-based programs, could provide substantial relief. There is a desire for community institutions that provide more than just medical pills as a respondent stated that *"I would like to see an institution created by the community to provide understanding, encouragement, and emotional support"*(IDI10). Community-oriented mental health initiatives not only offer practical coping mechanisms for mental health but also foster social connectedness and reduce the isolation commonly experienced by caregivers (Castillo et al., 2019; Velloze et al., 2022).

These findings resonate with international policy recommendations advocating for comprehensive care systems that integrate health, long-term care, and psychosocial support. For example, the World Health Organization underscores the importance of expanding community-based long-term care services to enhance caregiver well-being(Barber et al., 2020). Likewise, the International Labour Organization recommend the inclusion of respite services and mental health support as essential components of effective care policies(Addati & Cattaneo, 2022).

Policy discussion and opportunities

Health care services

This study's findings highlight the pivotal role of Cambodia's key health protection mechanisms—the Health Equity Fund (HEF) and the National Social Security Fund (NSSF)—in mitigating healthcare-related financial risks for vulnerable populations and care-related social service including childcare, elderly care and care for people with disability services.

To start with the key health care related schemes. Both mentioned earlier, the HEF and NSSF, contribute to reducing economic barriers to healthcare and social well-being, yet their design and coverage present distinct implications for unpaid caregivers. The HEF serves as the principal social health protection program targeting the poorest and most vulnerable households, primarily those classified under the ID Poor system (Ministry of Health, 2018) . By covering healthcare costs at public health facilities—including consultations, medications, diagnostic tests, hospitalizations, and, in some cases, transportation and caregiver-related expenses—HEF substantially alleviates out-of-pocket spending(Feldhaus et al., 2022; Jithitikulchai et al., 2021). HEF scheme was also increase the likelihood of healthcare utilization for the poor (Annear et al., 2019) and reduce health related debt (Flores et al., 2013). Aligning with the various researches studies such as Annear et al., (2019), Feldhaus et al., (2022), Flores et al., (2013) and Jithitikulchai et al., (2021) ,

Respondents also identified HEF as a critical mechanism that reduces financial stress and increases access to essential health services for them and their families. It enhances access is health care particularly important for households managing chronic or complex health conditions requiring ongoing care.

However, while the Health Equity Fund provides free-of-charge healthcare services to poor household identified through the ID Poor system, awareness and utilization gaps persist as reported by respondent and in the policy document (National Social Protection Council, 2024). Caregivers in the household with ID Poor status were generally aware of the availability of free medical services; however, many lacked information regarding the reimbursement or subsidization of non-medical costs, such as transportation and associated expenses. This lack of clarity contributes to reluctance in service utilization, as out-of-pocket expenditures—real or perceived—remain a significant concern. For specific groups like persons with disabilities, the high costs of transportation and healthcare are explicitly noted as double burdens that hinder service utilization (National Social Protection Council, 2024). Furthermore, HEF's household-based eligibility criteria present limitations from a caregiving perspective. While the program benefits households officially designated as poor, individual caregivers or household members with high care burdens who reside in non-ID Poor households may be excluded from these protections. This exclusion risks leaving a subset of caregivers without guaranteed access to subsidized healthcare, thereby perpetuating gaps in support for those who bear intensive caregiving responsibilities but do not meet the formal poverty criteria.

The NSSF complements HEF by providing social security benefits to formal sector employees, encompassing healthcare, work-related injury insurance, maternity benefits, pensions, and planned unemployment benefits (The Law on Social Security Schemes, 2019). Recent expansions to include self-employed individuals and dependents of person with NSSF signify progress toward broader social protection coverage(Thlen, 2025). The NSSF aims to provide financial security and health protection, mitigating risks associated with illness, injury, and aging within the labor market (The Law on Social Security Schemes, 2019). NSSF support for childcare primarily focuses on the critical early stages of a child's life which include daily maternity leave stipends of 70% of their average contributory wage, health care for infants in form of cash transfer to cover prenatal check-ups, birth delivery check-ups and childhood vaccinations at public health facilities (The Law on Social Security Schemes, 2019). This childcare support under the scheme is seen as helpful for caregivers especially female caregivers (working mother). In the formal sector, assistance is described as a significant relief. One respondent who is a factory worker reported receiving 70% of childbirth costs from the factory and ministry, as well as a government stipend of USD 30 per month for her child's health checkups. She described this as a significant financial relief on health care issue (IDI3). For disability care, NSSF provides extensive financial and physical protection for individuals with disabilities, particularly through its Occupational Risk and Health Care schemes.

Under the law, the person with NSSF would benefit from workplace accident, commuting accident or occupational disease with medical care, caretaker allowance during treatment, permanent disability pension, permanent disability allowance and rehabilitation services(The Law on Social Security Schemes, 2019). Under this law, people are better ensured with income security and social welfare in their senior age with pension and retirement funds at the age of 60.

However, the contribution-based design of the National Social Security Fund (NSSF) structurally constrains unpaid family caregivers. When individuals—predominantly women leaving formal employment, such as the garment sector, to care for children or elderly relatives—exit the workforce, they immediately lose their independent NSSF health coverage. As evince in the interview with a 29-year-old former factory worker who stated that her NSSF coverage ended when she stopped working to care for her two children. She said *"I used to have one (NSSF) but when I stopped working it (NSSF) is cut off…we stop paying"* (IDI21). Although recent NSSF expansions allow for voluntary contributions from the informal sector, zero-income caregivers perceive it to be hard to acquire one and for some cannot afford the monthly premiums without relying on the primary breadwinner. A caregiver who sells fish explained that she wanted a social security card but could not obtain one because the requirements for informal workers are "tough" and "complicated," requiring photos of her workplace and confirmation from the Ministry of Labor as she understand it. Consequently, their only alternative is to register as a dependent under a formally employed spouse. In the context of traditional Cambodian household dynamics, this reinforces deep patriarchal power imbalances which makes a caregiver's fundamental access to healthcare highly precarious, tying their bodily autonomy and health rights entirely to their spouse's job security, financial control, and the stability of the marriage.

The policy discussion in relation to health care indicate that the opportunity to address caregivers' health care need lies around the two significant mechanisms, the NSSF and the HEF. First of all, there is an opportunity to expand coverage and ensure that the two can benefit individual with care responsibility with or without formal employment. Also, there shall be further effort on the coverage of metal health care under the mechanism. There might also be significate value to integrate mental health services and support for chronic illness management within the HEF and NSSF frameworks, recognizing that caregivers often deal with complex health conditions.

Childcare services

Cambodia's childcare policy landscape is characterized by a series of national frameworks aimed at early childhood development, legal mandates for employer-supported care, and social assistance programs for vulnerable families. The Early Childhood Care and Development (ECCD) Framework comprise of National policy on Early Childhood Care and Development (2010), National Action Plan for ECCD (2014-2018) and National Action plan for ECCD (2022-2026). The national policy on ECCD serve as the foundational policy focusing on the holistic development of

children through quality health, nutrition and education services and promoting school readiness and maternal care (Ministry of Education, Youth and Sport, 2010). This policy helps lift the care burden by transitioning early childhood development from an isolated household responsibility to a supported, inter-ministerial national infrastructure (Thlen, 2025). The policy aims to equip families with essential training and integrate maternal health, nutrition, and early education services(Ministry of Education, Youth and Sport, 2010) which can potentially makes daily caregiving more manageable and less isolating (Thlen, 2025). This state-backed approach mitigates the "dual challenge" of care giver, especially women, by establishing public care systems and targeted interventions such as immunizations and inclusive care programs that significantly reduce the logistical and financial strain on individual households. The action plan (2014-2018) prioritized disadvantaged children from conception to age six, emphasizing immunization, birth registration, and training for family caregivers, while the current one aims to relieve the childcare burden by shifting responsibility from a total reliance on families to a more structured, multi-sectoral care infrastructure. The action plan (2022-2026) establishes five priorities namely equitable and inclusive early education, health and care, nutrition for women and children, safety and security, and responsive protection which help relieving child care burden by providing quality early learning opportunities reducing the number of hours caregivers, usually mothers, must spend on basic supervision at home, allowing them more opportunities for full-time employment. It also promotes early childhood health and nutrition for women and children which can reduce the intensity and frequency of care require for sick children. Furthermore, the plan involves a comprehensive multisectoral approach which lifts logistical and financial burdens of childcare by sharing the responsibility with state and the community.

While the existing childcare policy and plan seems to bring about promising solution to care burden, there are still a few critical aspects to be further considered. One of the significant gap of the policy is the “care gap” for children between three months and three years of age, a critical period that currently lacks public service available(Thlen, 2025). This has been reported to be a significant challenge for care giver who express desire to enroll their children in childcare and can only afford public school services. Moreover, existing state and community programs typically operate for only half-days (around 3-3.5 hours), which is insufficient for full-time working parents, particularly working mothers-who are left struggling to manage childcare for the remainder of the workday(Haddock et al., 2024). More importantly, there are currently no official national guidelines or curriculum to regulate service quality or workplace standard for children under age three(Thlen, 2025) which contribute to worsen the sense of trust for caregivers.

Elderly care services

In relation to elderly care, Cambodia has National Healthcare Policy and strategy for Older People (2016), National Aging policy (NAP) 2017-2030, and Action Plan 2017-2030. The health care policy

aims to promote healthy aging across the lifespan focusing on establishing standards for elderly care and strengthening protections against health risks (Ministry of Health, 2016) while the national aging policy 2017-2030 addresses the social welfare, healthcare and economic needs of older adults (Royal Government of Cambodia, 2017) . The Action plan for the NAP intend to put the policy into action through the coordinated frameworks for inter-agency efforts (Ministry of Social Affairs, Veterans and Youth Rehabilitation, 2018). The action plan has significantly acknowledged families as primary caregivers and emphasizes ageing within family and community settings. Under the plan, the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) implements two primary programs to support aging citizens, Community-Based Older People Development Programme which focuses on social engagement, health promotion, and economic opportunities within communities, and Family-Based Care for Older People Programme which supports family caregivers through training, psychological support, financial assistance, and home-based care resources. The later program reflects the acknowledgment, commitment and effort to contribute to lifting the pressure of elderly care burden by specifically support caregivers within the family. Moreover, there has been formation of Older People's Association (OPAs) which was establish under the collaborative project between HelpAge International and Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY). The vital services provided by OPAs includes health training, home visit, social activities, community engagement, livelihood support and awareness raising on accessing government benefits and resources (HelpAge International, 2010).

In the meantime, there are also limitation to the actual provision. Most notably, the formal public or private facilities for elderly care is severely limited (Thlen, 2025). The lack of the facilities as well as the services for elderly care place the absolute burden on unpaid care givers within the household. While private service may be available in urban area, the service is affluent that it is not widely affordable. More importantly, there is a persistent shortage of trained care providers for older people, particularly in residential setting (National Institute of Social Affairs, 2019). This, even with ability to pay, still post the challenge on the lack of professional services.

The action plan, while being well formulated, the implementation is rather funding reliance. The program often depend on external financial assistance from international donors and NGOs which may not be sustaining (Thlen, 2025). Similarly, since it is funding dependent, there is also limitation in scope of coverage. For instance, even with the plan to replicate across the country, the older people's association was established only in some provinces. At the same time, the policy is also flawed in term of incentivizing care givers. There is no explicit caregiver rights mention. The legal and policy focus remains almost entirely on the rights and entitlements of the older person (Ministry of Social Affairs, Veterans and Youth Rehabilitation, 2018). Care givers are discussed as a means to provide care not as the right-holders. Additionally, Care givers is not defined as beneficiaries as social protection schemes identify the older person or the household

as the beneficiary, not the individual performing the unpaid labour (Ministry of Social Affairs, Veterans and Youth Rehabilitation, 2018). Similarly, there seems to be absence of specific protections for caregivers as there is no mention of a formal caregiver allowance or income protection for those who may leave the workforce to provide care, while respite care services is also not included (Ministry of Social Affairs, Veterans and Youth Rehabilitation, 2018). Lastly, it is worth noticing that the issue around old age people performing as care giver is not raised acknowledge in the policy and the plan which seem to neglect this reality of the current situation of elderly people, especially older women.

Disability care services

The Royal Government of Cambodia has established a foundational legal and strategic framework to uphold the rights of persons with disabilities. This is reflected through the 2009 National Disability Law to promote and protect the right of people with disability and the National Disability Strategic Plan 2024–2028 (NDSP3), which serve as a multi-sectoral roadmap designed to enhance the quality of life for persons with disabilities by eliminating barriers and ensuring their full participation in society (Royal Government of Cambodia, 2024). It is built upon a vision where people with disability and their families live with dignity and inclusiveness across all sectors. The implementation of the strategy is led by Disability Action Council (DAC). To implement these structural mandates, the government currently operates 11 regional physical rehabilitation centers offering largely subsidized services such as prosthetics and physiotherapy. The NDSP3 explicitly integrates support for families and caregivers of persons with disabilities (PWDs) acknowledging their crucial role in community-based rehabilitation(CBR) and recognizes that the well-being of person with disabilities is inseparable from the support systems provided at the household and community levels (Royal Government of Cambodia, 2024). Economically and financially, the plan aims to enhance the livelihoods of PWD families by facilitating access to safe, low- or no-interest loans for small businesses and ensuring financial assistance during and after natural disasters (Royal Government of Cambodia, 2024). This aligns with broader efforts to support vulnerable families through integrated social assistance programs like the Cambodia Family Package Programme. Regarding home-based care and psychological well-being, NDSP3 commits to defining policies and guidelines for home-based care and emphasizes providing community-based mental health and psychosocial support to sustain independent living (Royal Government of Cambodia, 2024) which is responsive to caregivers’ needs for more support with basic care and addressing challenges such as poor access to formal support (RTI International, 2020). Furthermore, the plan includes skills and awareness training initiatives, such as raising family awareness about job opportunities and inclusive education benefits, and providing sign language training specifically for family members to improve communication. This can help the caregiver increase the quality of their care.

While "families" are explicitly integrating into the strategic plan, there is a lack of entitlement for individual fulfil the role as unpaid care givers in the family. The strategic plan focuses the right sand dignity of person with disability and mention that personal assistance as a professional role should be paid for hourly-based work, but this does not and may filter out caregivers within the household who normally categorized as unprofessional. Moreover, there is limited structured psychological or mental health support targeted at caregivers. The strategic plan tends to target family of people with disability but not individual caregiver within the household which can potentially overlook the individual needs of the primary caregivers who most of the time are women. Similarly, Caregivers within household are treated as a means to support people with disability but not as individuals with their own needs. More importantly, there has not been any mention or discussion around people with disability who may also perform as unpaid care giver within the family leaving out the complexity of care giver with disability and their position within this framework.

4.3.3 Education and Training

Challenges

The study identifies significant barriers faced by unpaid caregivers in accessing education and training opportunities, which in turn limit their socioeconomic mobility and reinforce existing inequalities. These challenges highlight critical gaps within current education and skills development policies specifically designed for caregivers, while also pointing to opportunities for designing more inclusive and caregiver-responsive systems.

A central challenge is the trade-off between participation in education or training and the fulfillment of unpaid caregiving responsibilities. Many training programmes—particularly those delivered through in-person or fixed schedules—require caregivers to either reduce the time allocated to care or arrange alternative care arrangements. In practice, such alternatives are often unavailable or unaffordable, effectively excluding caregivers from participation. This structural incompatibility between caregiving and training systems acts as a disincentive for skills development and limits pathways to income generation. A 53-year-old grandmother expressed her desire to attend cooking training to acquire skills for preparing food to sell, but she is unable to participate due to her numerous responsibilities, which include cooking, doing handcraft work for extra income, caring for her grandchildren, and tending to the fields, leaving her with no time to rest (IDI11). Even those in professional roles, like a bank employee, care giver finds caregiving affects their ability to develop new skills or gain knowledge because her 24-hour cycle is almost entirely consumed by labor (IDI8).

Even when caregivers are able to attend training or community-based learning activities, they are not free from their care and domestic duties. The care work must be fulfilled somehow. So, caregivers frequently carry their caregiving responsibilities with them. Respondents reported

either bringing young children to village meetings or training sessions or rushing at the end or between session to perform household chore. This constrains their ability to fully engage, concentrate, and acquire new information. One caregiver described a grueling routine of leaving training sessions to fulfill domestic needs as she stated *"When we go to study and the session starts... we have to leave quickly... we have to run to home and have to go to the session again…"*(IDI 10). This challenge is further exacerbated when the trainers, programme organizers and related personnels do not take into account caregivers' needs among participants and fail to provide flexible arrangements or supportive environments. As a result, the caregivers can either participant with such distraction and burden or give up participating all together.

In addition, limited access to information represents a key barrier. Caregivers often reported a lack of awareness regarding available education and training opportunities, including those offered through Technical and Vocational Education and Training (TVET) program. This information gap restricts caregivers' ability to make informed decisions about skills development and undermines the potential impact of existing programmes designed to enhance employability and livelihoods. This loops back to their financial insecurity and independency.

Needs

In relation to the challenges, The study highlight a set of education and training needs that, if effectively addressed, could serve as important socioeconomic incentives for unpaid caregivers. These needs span both care-related competencies and income-generating skills, reflecting caregivers' dual roles within the household and their aspiration to improve both care quality and economic resilience.

A key need identified is the acquisition of knowledge and skills to enhance the quality of care provided. Caregivers expressed a strong interest in learning practical and context-specific competencies to perform their roles more effectively and to avoid unintentional harm. Areas of interest include positive parenting techniques, basic primary healthcare for young children, and elderly care practices. This demand indicates a gap in accessible, community-level training that equips caregivers with essential caregiving knowledge. Addressing this gap presents a policy opportunity to strengthen human capital within households while improving care outcomes. This will also contribute to strengthening care economy in a long term.

In parallel, caregivers also articulated a clear demand for vocational and technical training that would enable them to engage in income-generating activities without compromising their caregiving responsibilities. Many respondents expressed interest in developing small, home-based businesses that allow for flexible working arrangements compatible with care duties. Programmes such as Technical and Vocational Education and Training (TVET) are well-positioned

to respond to this need, but require adaptation to better accommodate caregivers' time constraints and mobility limitations.

Policy discussion and opportunities

The findings above point to significant opportunities within Cambodia's existing education and skills development frameworks to better support unpaid caregivers as part of a broader socioeconomic strategy. Key policies, including the National Policy on Lifelong Learning (2019) and the Technical and Vocational Education and Training (TVET) policy, provide an important foundation for expanding inclusive learning pathways. The two policies shows great potential to support caregivers, yet also bear implementation gaps in effectively reaching and accommodating caregivers.

The National Policy on Lifelong Learning represents a strategic shift from a narrowly school-based education system toward a more holistic approach that incorporates formal, non-formal, and informal learning across the life course(Ministry of Education, Youth and Sport, 2018). Its emphasis on improving access for disadvantaged and vulnerable groups, alongside strengthening community-based learning structures such as Non-Formal Education (NFE) programmes and Community Learning Centres (CLCs), now evolving into Lifelong Learning Centres (LLLCs), creates a promising entry point for engaging caregivers. These decentralized and community-based platforms are particularly well-suited to address the mobility and time constraints faced by caregivers, offering a clear opportunity to embed caregiver-specific training and outreach within existing structures.

Similarly, the TVET policy aims to enhance workforce skills, expand access to flexible and modular training, and promote lifelong learning for both youth and adults (Ministry of Labour and Vocational Training, 2017). TVET programmes offer a diverse range of pathways, including short courses, certification programmes, online learning options, and financial support mechanisms (Ministry of Labour and Vocational Training, 2017). Notably, the types of vocational skills provided such as small business development, agriculture, and crafts align closely with caregivers expressed interest since they can pursue home-based and flexible income-generating activities.

However, despite this strong alignment, the study finds that caregivers' participation in these programmes remains limited. A key barrier is lack of awareness, as many caregivers are not adequately informed about available training opportunities or how to access them. In addition, structural constraints persist. caregivers are often required to choose between attending training and fulfilling their unpaid care responsibilities. Even where inclusive measures exist on paper, current programme designs do not sufficiently accommodate the realities of caregiving, such as the need for flexible schedules, proximity, or integrated care support.

These gaps highlight a critical policy opportunity to reposition lifelong learning and TVET systems as socioeconomic incentives for caregivers. Greater integration of caregiver-sensitive approaches—such as flexible delivery formats, community-based outreach, and the provision of childcare or accompaniment options—could significantly enhance accessibility and participation. Leveraging LLLCs as localized hubs for both care-related and livelihood training could further strengthen this approach.

Additionally, the findings point to an important forward-looking opportunity within the broader development of the care economy. As Cambodia seeks to build a more resilient and inclusive economy, the promotion of care-related services and professions remains underdeveloped within current vocational training offerings. Expanding TVET curricula to include care service training such as elderly care, childcare, and community health support, would not only respond to growing care needs but also create new employment pathways, particularly for caregivers themselves.

4.3.4 Recognition and Psychological Support

Challenges

The study highlights a set of deeply embedded social and normative challenges that shape caregivers' experiences and limit the effectiveness of policy interventions. These challenges are not solely material but are psychological which often appear invisible. Addressing them presents an important opportunity to strengthen caregiver well-being and enhance the overall functioning of the care system.

One of the issues identified is the lack of social recognition of caregiving. Care work is frequently framed within cultural and traditional expectations as a duty assigned to particular family members, rather than as a form of labor with social and economic value. And the family members who are usually assigned with such role are women and girls. This framing diminishes both emotional recognition and societal validation for caregivers, reinforcing its invisibility in policy discourse. As a result, caregivers often do not perceive themselves as entitled to support, and their contributions remain undervalued in both public and private spheres.

Closely linked to this is the invisible and cumulative burden of caregiving. Respondents described caregiving as encompassing not only physical tasks but also sustained emotional and cognitive demands, including stress, constant vigilance, and responsibility for others' well-being. This multidimensional burden often goes unrecognized, contributing to fatigue and burnout. Respondents emphasized that while they are exhausted, their struggles remain hidden. One respondent raised in the interview that *"Many people are suffering but nobody sees their difficulties as carers"*(IDI7). The absence of formal acknowledgment within policy frameworks further compounds this invisibility, limiting the development of targeted support mechanisms.

The normalization of caregiving within social and cultural contexts also contributes to emotional suppression among caregivers. Because care responsibilities are widely perceived as routine or expected, caregivers have internalized these norms and downplayed their own stress or exhaustion. This also contribute to the narrative that care especially unpaid care work with household space is a private matter, not a public or economic issue. This dynamic reduces the likelihood of help-seeking behavior and creates barriers to accessing available support services, particularly in relation to mental health and psychosocial assistance. One mother noted in the interview when that she would not use any psychological counseling because she thinks it is shameful. She stated *“I’m ashamed. My family’s story is embarrassing”* (IDI6).

In addition, caregiving responsibilities can significantly restrict opportunities for social participation. Many respondents reported limited ability to engage in community activities, social networks, or public life due to time and mobility constraints. A 29-year-old mother explains that she cannot go anywhere because she has small children who require constant supervision, stating, *"we cannot leave them."*(IDI21). At the same time, many respondents report working between 15 and 17 hours a day across paid and unpaid labor, leaving them with no time for themselves or even time for basic social interactions. This often results in social isolation and exclusion, with negative implications for psychological condition and overall well-being (Brandt et al., 2022; Shankar, 2023). The same point was made in the a caregiver’s interview that while working outside provides social connections and information, being home-bound means she has *"little social networks"* and is often unaware of community problems (IDI21). The implication of this social exclusion amount to a bigger societal issue. Some care giver found themselves eventually withdraw from the community as they report never spend time with neighbors or friends. In extreme cases, the burden of poverty and care work leads to intentional and active self-isolation. One female elderly caregiver mentioned she *"closes the door and feels ashamed"* to prevent neighbors from seeing her family's struggle (IDI7). This lack of opportunity, time for community participation and intentional isolation undermine caregivers’ civil participation. Respondents reported that there is often “never a chance to participate” in village decision-making to service support as these information and processes do not reach the isolated households, hence home-bound caregiver. Noticeably, compounding with social norm, some female respondents report being instructed by their male partners that it is better for them to just stay at home and they should not go around visiting the neighbor due the stereotype around “women’s value and gossiping”. So female caregivers purposefully stay at home all day long and not discussing their issues with others.

Needs

The research study was able to draw a set of critical social and psychosocial needs among caregivers. These needs, centered on recognition, social value, rest, and community connection,

are essential not only for caregiver well-being but also for sustaining the broader care system and social cohesion.

A primary need identified is the formal and social recognition of caregiving as essential work. Caregivers emphasized the importance of acknowledging unpaid care as a legitimate and valuable contribution to both household welfare and the wider economy. This includes recognition of not only the physical aspects of care but also the emotional labor and psychological demands involved. A female caregiver reported that *"…(Recognition) is very important, words of encouragement, giving value is very important. If you do it and they give you value, they praise you for it, then you don't get discouraged…"(*IDI10). Likewise, one working mother noted that while her work is overwhelming, she feels a sense of relief when her efforts are acknowledged as she stated *"When someone acknowledges my effort, I feel relieved. Otherwise, it is overwhelming"* (IDI9). Therefore, it is crucial to ensure that some form of recognition of the normally forgotten unpaid care work within household is establish in both policy and societal discourse.

In line with above mentioned point, there is a need for increased public awareness that shift the perception that staying at home to provide care is a form of idleness and care work at home take a toll more than the physical exhaustion. Respondents highlighted the importance of shifting societal perceptions so that caregiving is understood as real work, rather than being dismissed as informal, voluntary, or purely familial obligation. Caregivers want their partners, family members and community to understand the weight and nature of unpaid care work, hence change attitude toward them and their roles in the family. Due to social norm, the awareness raising as the reported need are more likely to be emphasized by female care givers toward male perception. A bank employee noted that if the value of care were recognized by men, it would directly improve the quality of domestic life as she said *"If men understood the value of women's contributions more, family life would be better"*(IDI8). Another female respondent directly requests that *"I would like the government to promote the value of women's work at home. Some people think that women who stay at home do nothing, but that is not true"*(IDI3). Thus, public awareness initiatives can play a crucial role in reshaping norms, reducing stigma, and legitimizing caregivers' claims to support and resources

In addition, caregivers expressed a strong need for rest and relief from continuous caregiving responsibilities. For full-time caregivers in particular, the absence of breaks or downtime contributes to cumulative stress and burnout. The lack of structured mechanisms for respite care further aggravates this issue, leaving caregivers with limited opportunities to recover physically and emotionally. Many reports having less than one hour of time for themselves in a 24-hour period, meaning the remaining 23 hours are an indistinguishable blend of care and survival labor. One grandmother notes that "I don't even have time to sleep. I wake up at 3 or 4 [a.m.] to begin a day of farming, sewing, and childcare" (IDI6). The care givers' deteriorated condition highlights

a clear urgent need to introduce or expand respite care services as part of a comprehensive care support system.

Finally, the need for social participation and community connection emerged as a significant concern. Caregivers acknowledged that social interaction and engagement are necessary for emotional well-being and stress relief. However, caregiving responsibilities, combined with prevailing social norms, often restrict their ability to participate in community life. This results in social isolation and reduced opportunities for peer support. Strengthening community-based platforms and creating inclusive spaces for caregivers can help address this gap, fostering both social cohesion and individual well-being. At the same, there is a need to highlight the important role of existing traditional social and religious gathering and event, hence making use of them. For instance, older care givers reported using the time going to pagoda as a break from care burden and gain some social connect where other caregivers and older grandparents are also joining. One caregiver noted that visiting the pagoda to meet and talk with elders makes her feel "relieved" and helps ease the mental heaviness she feels at home.

From a policy perspective, these needs point to a broader opportunity to integrate social recognition and well-being considerations into care-related interventions. Beyond financial and service provision, policies should incorporate measures that validate caregivers' roles, promote public awareness, enable rest and respite, and facilitate social participation (IDI10).

Policy discussion and opportunities

The constitutional basis established under article 36 of the Constitution of Cambodia provides a powerful statement of recognition of unpaid care work. The article states that "The work by housewives in the home shall have the same value as what they can receive when working outside the home" (Constitution of the Kingdom of Cambodia, 1993). This reflects a significant constitutional recognition. Even with such high-level political recognition, these instruments are underutilized as an entry point for policy innovation and lack of real implementation. There is still a lack of sufficient socioeconomic incentives that translate this recognition into tangible support. With limited concrete benefits, caregivers may continue to feel undervalued and unsupported. Institutional support through the establishment of daycare centers and flexible work arrangements is also highlighted, yet access to these resources remains limited (Withers, 2020). This will be discussed further in the following session of the report. While the policy recognizes the economic aspects of caregiving by emphasizing share monetary value of housework and the outside work, it may not adequately address the psychological support needs of caregivers. The pressures of unpaid care work led to various psychological issues, but without specific initiatives aimed at providing mental health resources or peer support, caregivers can feel isolated and overwhelmed as mentioned above.

In the country's gender mainstreaming strategy, Neary Rattanak VI introduces the "Care Economy" concept as a strategic trend post-COVID-19 and aims to establish a national framework and action plan focused on care work and work-life balance which is reported in the Key Informant Interview as being developed. The strategy emphasizes the need for societal mindset changes to encourage shared domestic responsibilities, particularly among men, to reduce time poverty for women and enhance their participation in leadership and economic activities (Ministry of Women's Affairs, 2024). Institutional support is highlighted through the establishment of daycare centers and flexible work arrangements to promote work-life balance (Ministry of Women's Affairs, 2024). Neary Rattanak VI also seeks to integrate gender and unpaid care work indicators into national surveys to assess economic impacts and monitor progress on related policies (Ministry of Women's Affairs, 2024). The strategy pinpoints clear recognition of unpaid care work and take into account key aspect that affect their psychological condition.

However, gap in implementation of the strategy remain affecting the development of the care framework which is the ambarella framework for the country's care direction. Also, while the plan seeks to integrate gender and unpaid care work indicators into national surveys, challenges in data collection can hinder effective monitoring and evaluation. In many areas, especially rural regions, caregivers may not have access to adequate childcare facilities or supportive workplace policies, which can exacerbate their burdens. There has been limited provision to operationalize through the introduction of caregiver-specific socioeconomic incentives.

At the same time, the reliance of caregivers on community resources rather than formal health professionals for psychological support emphasis significant limitations in the country's mental health policy framework. While national policies may advocate for community-based care (Ministry of Health, 2023), the actual availability and accessibility of professional mental health services remain insufficient, particularly for caregivers who often face geographic and financial barriers (Chhim, 2017) . This situation is exacerbated by cultural stigma surrounding mental health and domestic affair, leading caregivers to seek support from informal community networks where they feel safer (Chhim, 2017; Schunert et al., 2012).

The opportunities for provision of psychological support and recognition would center around the use of existing local and community resources and focusing on both local perspective changes and policy-level specific incentive as the reflection of recognition. While professional psychological support is safe and standardized, the accessibility of local resource suggests the sufficient employment of peer support or community group creating space for connection and care for caregivers. The use of existing traditional, social and religious gathering should service as a useful platform for information sharing and caregivers' psychological assistance.

4.3.5 Employment and Work-Life Balance

Challenges

The study demonstrates significant structural challenges faced by unpaid caregivers in accessing and sustaining employment, showing critical gaps in labor market policies and work–life balance frameworks. These challenges not only constrain individual economic opportunities but also function as systemic barriers to inclusive and equitable labor force participation.

A primary issue identified is workforce exclusion. Caregivers are frequently pushed out of the labor market or constrained in their choice of employment due to the intensity and unpredictability of caregiving responsibilities. The need to provide continuous or on-call care limits their availability for formal employment, particularly in roles that require consistent attendance and fixed schedules. A former formal worker explained she could no longer maintain that her work because caregiving had become "full-time" for her (IDI11). Another respondent noted that out of 24 hours, she has "less than one hour" for herself, making fixed-schedule formal work impossible. As a result, caregiving acts as a structural disincentive to workforce participation, reinforcing patterns of economic dependency and vulnerability.

At the same time, there is the misalignment between prevailing formal work models and the realities of unpaid care work. Standard employment arrangements—characterized by fixed working hours, rigid schedules, and limited leave provisions—do not accommodate the flexibility required for caregiving. This rigidity makes it difficult for caregivers to maintain stable employment, pursue career advancement, or access decent work opportunities. In many cases, the absence of family-friendly workplace policies intensifies these challenges, further marginalizing caregivers within the labor market.

In response to these constraints, caregivers often turn to limited employment options, primarily in part-time or informal sectors. While such arrangements may offer some degree of flexibility, they are typically associated with poor working conditions, low and unstable earnings, and a lack of social protection or employment benefits. This concentration in informal and precarious work not only limits income potential but also excludes caregivers from systems such as pensions, health insurance, and other forms of labor-based security. Unfortunately, the condition disproportionately falls on women due to their socially assign role as primary care givers and the existing gender inequality at workplace.

Needs

A primary need is the establishment of flexible and caregiver-friendly work policies. Caregivers emphasized the importance of employment arrangements that accommodate their responsibilities, including home-based work options, adaptable schedules, and the ability to manage unpredictable care demands. However, flexibility alone is insufficient if it is confined to

informal or precarious work. Respondents highlighted the need for such arrangements to be embedded within formal employment structures that guarantee their job protection, stable income, and access to benefits. This points to an important policy opportunity to formalize flexible work models—ensuring that caregivers are not forced to choose between flexibility and security.

In addition, caregivers expressed a strong need for career support pathways that prevent long-term exclusion from the labor market. Temporary withdrawal from employment due to caregiving responsibilities often results in skill depreciation, reduced employability, and limited opportunities for career progression. To address this, policies could introduce reintegration mechanisms, such as return-to-work programmes, skills upgrading initiatives, and recognition of prior experience, enabling caregivers to transition back into the workforce without long-term disadvantage.

Policy discussion and opportunities

Cambodia's existing labour and tax policies provide an important foundation for supporting workers with caregiving responsibilities. Provisions under the Cambodia Labour Law—particularly Articles 171, 182–183, 186, and 219–220—alongside tax measures such as Sub-Decree No. 196 (2022), demonstrate a clear policy intent to protect workers during key life stages and acknowledge household caregiving responsibilities (Labor Law of the Kingdom of Cambodia, 1997; Sub-Decree No. 196 ANKr.BK of 2022 Cambodia, 22 C.E.).

Current labour protections emphasis maternal support and protection. Under article 182 and 183, the law includes 90 days of maternity leave at half pay, job security during pregnancy and postnatal periods, and provisions for lighter duties upon return to work (Labor Law of the Kingdom of Cambodia, 1997). The law also allows up to 7-day special leave for family-related matters under article 171 (Labor Law of the Kingdom of Cambodia, 1997). For one year following child delivery, mothers are entitled to one hour per day during working hours to breastfeed, which can be divided into two 30-minute periods, and the breaks are separate from and cannot be deducted from normal rest breaks as stated in the article 184 and 185. Moreover, there is requirement for workplace childcare in larger enterprises. The law clearly states that enterprises employing a minimum of one hundred women are legally required to establish a nursing room and a day-care center within or near their establishment. This further signal recognition of workers' caregiving roles. More than these, within the Sub-Decree No. 196, tax rebates for dependent children and non-working spouses also provide a degree of financial relief, implicitly acknowledging the economic burden of caregiving within households (Sub-Decree No. 196 ANKr.BK of 2022 Cambodia, 22 C.E.). These provisions represent important policy strengths. They contribute to safeguarding women's employment during maternity, offer partial income protection, and promote the provision of childcare services in certain formal sector contexts.

Collectively, they reflect an emerging framework that links labor rights with caregiving responsibilities and supports women's participation in the workforce.

Nevertheless, some critical gaps are observable in these policies. A central issue is the gendered framing of caregiving. Existing provisions are heavily centered on motherhood, with limited recognition of caregiving as a shared responsibility. The absence of statutory paternity leave—and the provision of only minimal special leave for childbirth—reinforces traditional gender norms and constrains the redistribution of care work within households. Similarly, childcare provisions tied specifically to the number of female employees' risk reinforcing the perception that childcare is primarily a women's responsibility, while excluding workplaces with fewer women or those in male-dominated sectors.

In addition, issues of coverage and adequacy persist. Maternity leave at half pay may be insufficient for low-income workers, potentially forcing early returns to work or complete labor market exit. Childcare provisions are limited to specific sectors and larger enterprises, excluding a substantial proportion of workers in small businesses and the informal economy. Likewise, tax rebates primarily benefit formal sector employees, offering limited support to caregivers who are unemployed, informally employed, or have exited the workforce due to caregiving responsibilities.

These gaps highlight a significant window of opportunity to strengthen labour and fiscal policies as socioeconomic incentives for caregivers. Expanding parental leave policies to include mandatory and adequately compensated paternity leave would promote more equitable sharing of care responsibilities. Revising childcare provisions to be gender-neutral and applicable across a broader range of enterprises could enhance accessibility and reduce structural biases. Additionally, increasing the adequacy of maternity benefits and extending similar protections to informal workers would improve inclusivity and reduce economic vulnerability.

4.3.6 Cultural and Gender Norms

Challenges

The research study reveals deeply entrenched culture and gender norms shaping the distribution and perception of unpaid care work in Cambodian households. These norms reflect broader structural inequalities, highlight asymmetries in recognition, and present critical policy challenges for addressing both caregiving burdens and gender equity.

In Cambodian culture, caregiving is fundamentally connected to norms that prioritize family responsibility, mutual aid, and respect for elders. The family, especially extended networks, is seen as the central unit responsible for the care of children, the elderly, and individuals with disabilities. Providing care within the family is not only anticipated but also viewed as a moral and social obligation, often supported by religious teachings that promote compassion and reciprocal

support (Chopra, D & Krishnan, M., 2021). Because of this belief, caregivers typically accept their responsibilities despite the impact on their well-being, often hesitating to seek help or demand systemic support. Religion also plays a vital role in shaping care especially care for elderly parents. According to Buddhist teachings, such as those found in the Mangala Sutta (the discourse on blessing), honoring and supporting one's parents is considered one of life's highest blessings. And even individuals who have entered monastic life are expected to return and care for their ageing or ill parents when needed (Huynh, 2017). This does not only create a strong societal expectation for adult children, traditionally daughters, to care for their elderly parents, but also induce the absolute sense of obligation among children who are caregivers. A long-term caregiver noted that even when exhausted, she accepts her situation as part of a larger spiritual order that she reported *"According to the Dharma, we have karma... we are here to take care of our mother, we are exhausted... but we fight to overcome all obstacles"*(IDI10). Along with the obligation, caregivers of elderly parents can also internalize the failure of their roles as sin that it places significant emotional weight on them. The same caregiver expressed deep despair, feeling that her inability to make her mother fully happy or healthy despite her efforts was a sign of "misfortune" or bad karma, leading her to feel "exhausted in every way" (IDI10).

In regard to the gendered responsibility, participants consistently reported that household unpaid care work is primarily viewed as women's responsibility. Event though the research how shift in attitude toward men taking up unpaid care roles as more men and women report witnessing men contribute to household care work more, men are not perceived as primary caregiver within the family. Men may assist in caregiving tasks, but these contributions are framed as optional or supportive gestures rather than obligations. Women as care givers report in the interview that the male family members, more specifically, their spouses, are generally also take part in care giving roles. But it is noticeable that the word "help" was repeatedly mentioned by female respondent when describing their partner taking parting part in care giving tasks. This reflects, their view over the care work, performing by the male partner as helping "them", the destine care giver of the family. At the same time, when probing further, female care givers demonstrate that the male family members are more likely to fulfill care taking role if and when they are absent or unable to perform. A 31-year-old housewife confirmed that her husband, who drives a dump truck, provides support when she is unable to perform her usual duties as she stated that *"When I cannot do something, he helps... Sometimes he bathes the children and helps with cooking"*(IDI4).

Meanwhile the care taking work such as childcare is normally feminized. Childcare tasks were strongly gendered and culturally feminized. Traits such as patience, gentleness, and emotional sensitivity were widely associated with women, reinforcing the perception that women are the natural and primary caregivers (My, 2021). One respondent explained that the burden falls on mothers *"because it is our role"* (IDI6). This societal expectation makes staying at home a "normal"

and unquestioned condition for many caregivers (IDI21). Another male caregiver noted that society believes a man *"was not born to stay home"* to care for children (IDI13). Similar findings have been recorded in studies within Cambodia context such as Hunter (2022), UNFPA (2023), Kim et al. (2026).

The study also highlights the differential recognition of caregiving labor by gender. Male household members who perform care tasks are often praised as “good fathers or husbands,” while women’s extensive contributions are rarely acknowledged. Although male participation may support redistribution of workload, it does not necessarily reduce women’s mental burden, challenge existing gender hierarchies, or guarantee sustainable sharing of responsibilities. This asymmetry mirrors international findings indicating that men’s involvement in care is celebrated, while women’s unpaid work remains invisible and undervalued (Withers, 2020).

The intergenerational transmission of care role is unveiled in this study. Due to cultural norm of extended family care and gender norm, gendered caregiving norms are transmitted across generations. Female family members, including adolescents, often inherit care responsibilities from older generations, perpetuating gendered expectations and workload imbalances over time. This also occur for younger generation to outsource the care responsibilities to elderly member of the household. In Cambodia context, reflecting from the result of this study, it is very common for grandmother or older female relative to take cover unpaid care work especially for childcare responsibility. This is seen as a “normal” traditional practice and the transmission of the care role noticeably occur only among female kinship.

More importantly, the study indicates the rigid gender roles, power imbalance, and GBV risk intertwining with unpaid care work in domestic space**.** The gender role ascribes women as the primary care giver within household. This rigid gender roles intertwine with power imbalances and increase the risk of gender-based violence (GBV). In many cases, failing to meet the culturally imposed expectations tie with these roles, women are at risk of violence which usually be culturally rationalized. As reported by a female waste collector that her husband would become angry and *"throw away food that didn’t suit his taste"*(IDI9). And this was deemed her fault for not properly fulfil her role. Also, the disproportionate burden of unpaid care work reinforces women's economic dependence and limits their participation in paid employment further worsen the power dynamics in intimate relationships. The coercion and enforced domesticity is observed in the study as a few female respondents reported that they are asked or convinced to stay home or even stop working. A 31-year-old housewife stated that she does not work outside because *"my husband prefers that I stay home. He says it is better that way"* (IDI4). She also added that she previously worked at a shop but stopped because *"my husband asked me to stop"* and stay home (IDI4). Financial control is also visible in the imbalance power dynamic. One caregiver noted

that even when she had her own money, her husband's control was absolute that *"Even though I have a lot of money, I really want to buy what I want, I have to ask for it"* (IDI10).

This relationship highlights the critical intersection between caregiving norms and household safety, emphasizing the need for policies that promote equal sharing of care responsibilities and recognize the value of unpaid work to challenge existing gender hierarchies and reduce GBV risk.

Needs

The study findings highlight a critical need for recognition while adapting gender transformative approach to addressing unpaid-care work issue. Participants emphasized that greater acknowledgment of their contributions could help promote more equitable sharing of care responsibilities.

There is a need for recognition and respect from male family members for the unpaid care work as a major contribution to the household, not just gender role. Female caregivers consistently reported the need for male household members to understand and acknowledge the intensity of unpaid care work and not dismiss it as just women's works. This includes recognition of the physical demands, emotional labor, and time commitment involved in day-to-day caregiving. Respondents emphasized that the recognition follow by redistribution through men's active engagement in routine care tasks would not only reduce women's burden but also challenge traditional gendered assumptions about care roles.

Beyond the household, participants expressed the importance of broader societal recognition of caregiving as essential work. Caregiving remains largely invisible and undervalued in public discourse, which reinforces gender inequities and limits policy attention. Formal acknowledgment—through campaigns, social protection measures, or public incentives—could elevate the perceived value of care work and legitimize its contribution to household welfare and the broader economy. It is worth emphasizing that the societal recognition should aim to create gender role transformation not just only accommodating it and further glamorize women's roles as caregivers.

Policy discussion and opportunities

Cambodia's care policy landscape as it relates to unpaid care work, cultural practice and gender norms, highlights both progress and gaps. Cambodia care related policies and implementation are deeply rooted and interconnected with the country's cultural values and believes which can affect care givers condition in various ways.

First of all, care, in Cambodia, is family-centric. So, most of the care related policy as describe in previous sessions are likely to focus on family-based intervention including childcare (Murage, 2019), elderly care (Royal Government of Cambodia, 2017) and care for people with

disability(Royal Government of Cambodia, 2024) . This holds significant positive impact to the whole care provision discourse and care givers. The approach can improve health outcome (Dalvand et al., 2014), better emotional support, lead to economic efficiency and strengthen family and community tie. The family-centric care approach also improves the quality of life for caregivers. When families are place at the center of care provision, resources include financial support, trainings and emotional support are channel to the family, potentially, also benefiting the care giver in the family. This has evinced in various policies mention in the earlier session including social assistant family package under the social protection law, action plan for national aging policy and National disability strategic plan.

However, policies predominantly accommodate existing social and cultural norms can reproduce the biased cultural and gender norm rather than actively seeking to transform them. This means it can potentially accommodate complex inequal dynamic and discriminatory values and practices instead of actively creating new equitable norm around unpaid care works. While culturally sensitive law and policy such as the recognition in the constitution of unpaid care work performed by women and the consideration of maternal support and protection in the labor law seems to take care of women in their unpaid care role within household, it is base on deeply engraved patriarchal value and do not fully challenge gendered expectations of caregiving or promote equitable redistribution of care labor between men and women. To further worsen, such policy will also reenforce the gender gap. For instance, the notion within labor law which place attention on maternity leave but not on paternity leave, strengthen the childcare responsibility among women and systemically discourage redistribution of the childcare burden between parents. Similarly, this cultural expectation around elderly care which encourage family tie and reciprocal care has been further institutionalized in Cambodia's legal framework. Article 47 of the Constitution of the Kingdom of Cambodia explicitly states: "*Children shall have the duty to take good care of their elderly mother and father according to Khmer traditions*" (Constitution of the Kingdom of Cambodia, 1993) . This high-level policy and norm translate into intergenerational caregiving arrangements, where elderly parents often reside with their children or are financially supported by them, especially in rural areas. Such arrangements are viewed as both a familial obligation and a social safeguard in the absence of formal elder care services (HelpAge International, 2020)

Relation to this, the family-centric approach to caregiving, while beneficial in many respects, can also inadvertently place an additional burden on family caregivers within the household if there is lack of support and without proper transformative approach. As the it emphasizes the role of family members in providing care, it can potentially neglect the importance of external services providers and formal systemic support from the state or private actors. When the investment and focus are not efficiently place on state-base or privately-own care services and facilities, there is limited of care options and sources. Thus, the responsibilities of caregiving are largely and

unceasingly thrust upon primary care givers within the family, usually women and girls. The emphasis on family-centric care can also lead to a reduction in the utilization of professional caregiving services, which can provide essential and high-quality professional care support and relieve some of the burdens placed on family members. For instance, due to the cultural and religious believes on elderly care, caregivers often feel guilty to seek alternative care options while there is resistance to develop state-base elderly care center perpetuate the cycle of care burden and limited professional care.

There for, the absence of explicitly gender-transformative mechanisms and unconventional approach to care limits the potential of care-related policies to close gender gaps and reduce the mental and physical burdens associated with unpaid care work.

Based on the analysis on cultural practices, and gender norms in relation to unpaid care work at household level, a few opportunities can be identified to enhance the effectiveness and equity of care-related policies. One important aspect is the focus of the policy should also aim to transform gender norms around caregiving. This could include promoting shared parental role and equal incentive for both parents which should be reflected within laws and policies. In the meantime, also review and amend existing legal framework which is sound embedding the bias social norm and reinforcing inequality of care work distribution. Another aspect is to address biased and/or harmful cultural norm while recreate cultural narrative to promote inclusive care and equal care works. This can be done, for instance, by creating public awareness campaigns that challenge existing cultural and gender norm surrounding caregiving, promoting the value of shared responsibilities and the importance of care work as sustaining mechanism for society.

4.6 Case study

Case Study: Intergenerational Care Burden and Care Givers' Systemic Vulnerability in Cambodia (IDI17)

This case study examines the lived experiences of a multi-generational household in Cambodia, a 65-year-old woman with no formal education and limited literacy living in a province. Having lost her parents during the Khmer Rouge regime, IDI17's life trajectory has been shaped by long-term structural vulnerability, which continues to affect her present circumstances.

IDI17 currently resides in conditions of severe economic hardship, with no stable income and limited access to formal social protection. She relies intermittently on small financial contributions from her children and informal support networks, including neighbors and local markets. At times, she is unable to secure sufficient food and reports experiencing periods of hunger. Her daily life is further marked by social withdrawal, feelings of shame related to poverty, and a lack of confidence in engaging with local authorities to access assistance programs such as poverty identification schemes.

The household is characterized by significant intergenerational dependency. Despite being at a senior age herself, IDI17 is responsible for the care of her three young grandchildren—aged 10 years, 8 years, and 2 months—while simultaneously facing acute financial instability. Despite efforts to seek income-generating opportunities, caregiving responsibilities significantly constrain her participation in paid work. She has the opportunity for some casual work in the village but her role as her grandchildren primary carer would not allow her to cease the job opportunity. As a result, the household remains reliant on irregular remittances from her children working at the factory in Phnom Penh, as well as informal borrowing.

The family is also burdened by substantial debt, estimated at approximately USD 10,000, with risks of asset loss, including their home. Financial pressures are compounded by unstable employment among contributing family members, some of whom earn low wages in factory work and struggle to meet repayment obligations. These constraints further limit the household's capacity to meet basic needs and invest in children's well-being.

Care responsibilities within the household are intensive and continuous. IDI17, even at a senior age play role as a primary caregiver. She reports significant physical and emotional strain associated with caring for an infant alongside two older children, including sleep deprivation and persistent stress. This reflects a pattern of unmet care need among older persons who continue to contribute to caregiving activities.

Access to formal support mechanisms remains inconsistent. Although poverty-targeted assistance programs exist, IDI17 has not successfully obtained a poverty card, reportedly due to administrative barriers, lack of information, and reluctance to engage with local authorities. This exclusion limits the household's eligibility for state-provided benefits such as cash transfers or food assistance.

The cumulative effect of these conditions is a layered and interdependent care structure, where caregiving responsibilities are distributed across household members regardless of age or capacity. This arrangement places considerable strain on both primary and secondary caregivers, while also leaving care needs partially unmet. The case highlights how poverty, debt, gendered expectations, and limited access to social protection intersect to produce sustained hardship at the household level.

Overall, this case illustrates the complexity of unpaid care dynamics in low-income Cambodian households, where care roles are fluid, resources are constrained, and individuals simultaneously navigate being both caregivers and care recipients under conditions of chronic vulnerability.

5. Recommendations

5.1 Policy recommendation

Financial and social protection

- Establish targeted cash transfer programs specifically for unpaid caregivers to alleviate immediate financial pressures. This would help alleviate financial pressures, particularly in rural communities where caregiving responsibilities are often overwhelming, but need to be cautiously develop withing Cambodia socioeconomic condition.
- Develop community-based care networks by supporting the establishment of community care networks that provide shared caregiving resources, allowing caregivers to collaborate and support each other in managing care responsibilities.
- Establish microfinance initiatives that provide caregivers with access to small loans or grants to start or expand home-based enterprises. This financial support can empower caregivers to pursue income-generating activities that fit within their caregiving roles.
- Offer training on entrepreneurship and business management to help caregivers develop sustainable income-generating activities, particularly in agriculture and handicrafts.
- Ensure that caregiving is recognized within national economic policies and social protection frameworks. This includes integrating comprehensive and holistic caregiving considerations into labor laws, social security systems, and economic planning.
- Review social security systems to seek for protentional initiative to include provisions for caregivers which can to ensure their long-term financial security and access to necessary services.
- Create or build in existing mechanisms for emergency financial assistance for caregivers facing unexpected financial hardships, such as medical emergencies or sudden loss of income, to prevent them from falling into poverty.

Health and social services

- Within existing financial assistance program specifically financial incentivize unpaid caregivers within the household, providing stipends or subsidies that recognize their essential contributions to family care and cover financial lost and trade off due to unpaid care work.
- Increase the number of local health clinics and/or mobile health units in underserved areas of Cambodia to improve access to healthcare. This would make it easier for

caregivers to seek treatment without incurring high transportation costs, as many caregivers report neglecting their health due to geographical barriers.

- Promote and strengthen community-based mental health programs which includes developing accessible mental health initiatives tailored for caregivers addressing the emotional and psychological burdens.
- Provide capacity development for community support workers and train local community members on psychological first aid to recognize signs of mental health issues among caregivers and provide initial support or referrals, fostering a supportive community environment that encourages caregivers to seek help.
- Create respite care options by establishing community-based respite care programs. This may include community respite care network or home base care that allows caregivers to take breaks from their responsibilities. Financial incentives should also include the support for utilization of these services.
- Expand the coverage and investment on childcare services either through state or private investment with subsidize to ensure affordability. This involves effort to strengthen state-private collaboration for better coverage, quality and affordable care services.
- Promote community-based childcare services and close the childcare gaps between the gap of 3month to 3 years old while expanding the length of hours for childcare service during the day.
- Increase availability of specialized community services for elderly and disabled care either through mobile services or regular community outreach services.
- Launch public awareness campaigns for the public on the value of unpaid caregiving in Cambodia and the socioeconomic incentives available to support caregivers which can encourage families to utilize available resources and prioritize their health as well as that of their dependents.
- Offer training programs focused on effective caregiving strategies, stress management, and self-care techniques. This can empower caregivers with knowledge and skills that can improve their well-being and the quality of care they provide as well as opportunity for more professional works.

Education and Training

- Employ community-based and home-based learning options by investing in training programs that are delivered in community settings or through home-based modalities.

- Adopt flexible scheduling by implementing training sessions that accommodate caregivers' schedules, including evening and weekend classes, to minimize conflicts with caregiving responsibilities.
- Initiate dual-purpose training programs by design training programs that combine caregiving skills with vocational training, such as health and nutrition alongside small business management or craft skills. This integrated approach would equip caregivers with practical skills relevant to their dual roles and enhance their income-generating potential.
- Ensure that training curricula include practical, context-specific competencies that caregiver's express interest in, such as positive parenting techniques, basic healthcare for children, and elderly care practices. This will enhance the quality of care provided while simultaneously preparing caregivers for care related income-generating activities.
- Provide childcare support during training sessions to alleviate the burden on caregivers. Establish partnerships with local organizations to provide safe and reliable childcare options, enabling caregivers to focus on their training without worrying about their dependents.
- Launch outreach strategies to improve awareness of available education and training opportunities such TVET program, particularly among caregivers. This can involve community meetings, local media campaigns, and collaboration with community leaders to ensure caregivers are informed about their options.
- Utilize technology for information sharing by leveraging mobile technology and social media platforms to disseminate information about training programs, schedules, and resources available to caregivers, ensuring that information is easily accessible.
- Ensure supportive training environment by engaging ensure that trainers and program organizers are trained to understand the unique challenges faced by caregivers and develop modular courses that allow caregivers to learn at their own pace and select modules that fit their current responsibilities and interests, thus reducing the pressure to complete a full program at once.

Formal Recognition of Caregiving

- Accelerate the development and/or adoption of care framework and related policies that formally recognize unpaid caregiving as a legitimate form of labor with economic and social value. This recognition should be reflected in both public discourse and policy frameworks, highlighting the contributions of caregivers—predominantly women—to household welfare and the wider economy.

- Lauch public awareness campaigns which engage men and boys in care conversations. Specifically target male partners and family members in awareness initiatives to foster understanding of the value of women's contributions at home and reshape attitudes and encourage shared responsibilities in caregiving.
- Establish peer support groups within communities where caregivers can share experiences and receive emotional support. These groups can provide a safe space for caregivers to express their challenges and seek advice.
- Introduce structured community engagement in respite care which involve community members in providing respite support, creating networks where neighbors can assist each other with caregiving tasks. This fosters a sense of community and reduces isolation.
- Create inclusive community spaces by establishing community centers that provide safe and welcoming environments for caregivers to engage with others. These spaces should offer resources, workshops, and activities that encourage social interaction and participation.
- Ensure caregivers' participation in community decision making by creating specific community space physical or virtual to allow community information sharing and consultation with caregivers. This can enhance their social capital and strengthen their connection to the community, allowing them to advocate for their needs and those of their dependents.

Employment and work-life balance

- Formalize flexible work arrangements which include developing labor market policies that institutionalize flexible work options, such as remote work, adjustable hours, and part-time arrangements, within formal employment structures. This will ensure that caregivers can manage their caregiving responsibilities while maintaining job security, stable income, and access to benefits.
- Promote family-friendly workplace that encourage employers to adopt family-friendly policies that support caregivers, such as paid family leave, childcare support, and the ability to take time off for caregiving duties without penalty.
- Implement structured return-to-work initiatives that assist caregivers in transitioning back into the workforce after a period of absence due to caregiving role. These programs can comprise of job placement services, skills assessments, tailored training to refresh and upgrade their skills as well as psychological support for confidence building.
- Strengthen care sensitive and gender transformative technical and vocational education and training (TVET) program which offer flexible training schedules and delivery setting

such as online learning options (if feasible) that accommodate caregivers' time constraints.

- Mobilize support for policies that extend social protection benefits, including health insurance, pensions, and unemployment benefits, to caregivers engaged in informal or part-time work.
- Introduce incentives for employers, enterprise, corporation that implement care-friendly policies, such as formal acknowledgement, tax breaks or subsidies.
- Launch campaigns to raise awareness about the importance of caregiver contributions and the need for flexible work arrangements. These campaigns should target employers, policymakers, and the general public to foster a more supportive environment for caregivers.
- Work with community leaders and organizations to promote the value of caregiving and advocate for equitable work-life balance policies that benefit caregivers, particularly women who are disproportionately affected.

Cultural expectation and gender norms

- Review existing law and policy which rigidly embedded and reenforce gender roles around care works
- Adopt care-based circular economy with gender transformative approach which integrate ecological sustainability with social care recognizing, valuing and redistributing unpaid care work and promote gender transformative shared care responsibility
- Integrate recognition of unpaid care work into national policies and social protection measures. This includes acknowledging caregiving in economic assessments, thereby elevating its perceived value in the public discourse.
- Launch nationwide campaigns to raise awareness about the value of unpaid caregiving and challenge traditional gender norms. These campaigns should aim to educate both men and women on the importance of shared caregiving responsibilities and the need to recognize care work as legitimate labor.
- Collaborate with local leaders, religious institutions, and community organizations to promote discussions around gender roles and caregiving. Engaging influential figures can help shift perceptions and encourage community-wide support for gender equity in caregiving.
- Develop innovative unconventional programs that encourage men to take on more active caregiving roles, framing their involvement as essential rather than optional. This can

include workshops that emphasize the emotional and social benefits of shared caregiving for both partners and children and discussion around health masculinity.

- Integrate GBV awareness into care programs which recognize the intersection between caregiving responsibilities and GBV by incorporating GBV prevention strategies into caregiving support programs. This can include training caregivers on identifying and addressing abusive behaviors and providing resources for those affected by GBV.
- Enhance access to support services and strengthen referral system for women facing domestic violence. This includes awareness raising on GBV services among unpaid care givers especially women.
- Organize event and workshops that facilitate discussions among family members about caregiving roles and responsibilities.
- Create and encourage community dialogue that help break down traditional norms and promote a more balanced approach to caregiving across generations.

5.2 Future Research Recommendation

- Evaluate different financial incentive models for unpaid caregivers and their impact on household wellbeing
- Conduct impact assessments of psychosocial support programs and recognition initiatives on caregiver mental health
- In-depth examination on the impact of traditional and social gathering on psychosocial well-being among older caregivers
- Investigating mental load and supervisory care among caregivers in Cambodian changing context
- Research on career trajectories and work-life balance of caregivers in formal and informal sectors
- Investigate gender dynamics in caregiving, exploring social norms and policy effectiveness in promoting equality.
- Gender analysis on unpaid care giving roles in relation to gender based violence in domestic sphere within Cambodia context
- Examine relation between unpaid care work and paid work connection for female caregivers

- Assess men and women understanding on weaponizing incompetent and mental load around care work performance withing household

References

Addati, L., & Cattaneo, U. (2022). *Care at work: Investing in care leave and services for a more gender equal world of work*. ILO.

Addati, L., Cattaneo, U., Esquivel, V., & Valarino, I. (2018). *Care work and care jobs for the future of decent work*. ILO.

Annear, P. L., Tayu Lee, J., Khim, K., Ir, P., Moscoe, E., Jordanwood, T., Bossert, T., Nachtnebel, M., & Lo, V. (2019). Protecting the poor? Impact of the national health equity fund on utilization of government health services in Cambodia, 2006-2013. *BMJ Global Health*, *4*(6), e001679.

Barber, S. L., Ong, P., & Han, Z. A. (2020). Long-term care in ageing populations. In *Handbook of Global Health* (pp. 1–34). Springer.

Barford, A., Brockie, K., & O'Higgins, N. (2025). *Volunteering, unpaid care work and gender in lower-income countries*.

Brandt, L., Liu, S., Heim, C., & Heinz, A. (2022). The effects of social isolation stress and discrimination on mental health. *Translational Psychiatry*, *12*(1), 398.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Castillo, E. G., Ijadi-Maghsoodi, R., Shadravan, S., Moore, E., Mensah III, M. O., Docherty, M., Aguilera Nunez, M. G., Barcelo, N., Goodsmith, N., & Halpin, L. E. (2019). Community interventions to promote mental health and social equity. *Current Psychiatry Reports*, *21*(5), 35.

Charmes, J. (2019). *Definition and Measurement of Work and Unpaid Care Work: Informality, Solidarities and Carework* (pp. 143–157). https://doi.org/10.1007/978-3-030-04076-5_6

Charmes, J., Emandi, R., Buvinic, M., Encarnacion, J., Grum, F., Seck, P., & Trigo, I. V. (2025). A global overview of time-use data: Gendered uses and policy work. *Statistical Journal of the IAOS*, *41*(3), 572–598.

Chhim, S. (2017). Mental health in Cambodia. In *Mental health in Asia and the Pacific: Historical and cultural perspectives* (pp. 135–144). Springer.

Chopra, D & Krishnan, M. (2021). *Valuing and Investing in Unpaid Care and Domestic Work: Cambodia Country Case Study*.

Coffey, C., Espinoza Revollo, P., Harvey, R., Lawson, M., Parvez Butt, A., Piaget, K., Sarosi, D., & Thekkudan, J. (2020). *Time to Care: Unpaid and underpaid care work and the global inequality crisis*. Oxfam.

Constitution of the Kingdom of Cambodia (1993).

Dalvand, H., Rassafiani, M., & Bagheri, H. (2014). Family Centered Approach: A literature review. *Modern Rehabilitation*, *8*(1).

ESCAP. (2024). *Model framework for policy action on the care economy*. https://repository.unescap.org/server/api/core/bitstreams/82cfd9f5-4474-4f25-9490-21923c173f31/content

Feldhaus, I., Nagpal, S., & Bauhoff, S. (2022). Role of User Benefit Awareness in Health Coverage Utilization among the Poor in Cambodia. *Health Systems & Reform*, *8*(1), e2058336.

Ferrant, G., Pesando, L. M., & Nowacka, K. (2014). Unpaid Care Work: The missing link in the analysis of gender gaps in labour outcomes. *Boulogne Billancourt: OECD Development Center*, *20*, 1–12.

Flores, G., Ir, P., Men, C. R., O'Donnell, O., & Van Doorslaer, E. (2013). Financial protection of patients through compensation of providers: The impact of Health Equity Funds in Cambodia. *Journal of Health Economics*, *32*(6), 1180–1193.

Folbre, N. (2006). Measuring care: Gender, empowerment, and the care economy. *Journal of Human Development*, *7*(2), 183–199.

Folbre, N. (2018). *Developing care: Recent research on the care economy and economic development*.

General Secretariat of the National Social Protection Council. (2024). *Digital transformation strategic plan in the social protection 2024-2028*. https://policypulse.org/wp-content/uploads/2024/06/Digital-Transformation-Strategic-Plan-in-the-Social-Protection-2024-2028.pdf

Guevara-Aladino, P., Sarmiento, O. L., Rubio, M. A., Gómez-García, L. M., Doueiri, Z. N., Martínez, D., King, A. C., Hurtado-Tarazona, A., Banchoff, A., & Guzman, L. A. (2024). Urban care for unpaid caregivers: Community voices in the care block program, in Bogotá, Colombia. *Journal of Urban Health*, *101*(6), 1113–1127.

Haddock, S. E., Jarvis, F. B., Sem, C., Doncheva, A. M., & Farooqi, H. (2024). *Supply of and Demand for Accessible and Affordable Childcare Services in Cambodia*.

HelpAge International. (2010). *Older people's associations rolled out across Cambodia*. https://www.helpage.org/news/older-peoples-associations-rolled-out-across-cambodia/

HelpAge International. (2020). *Research finding reveals challenges faced by older Cambodians*. https://ageingasia.org/research-finding-reveals-challenges-faced-older-cambodians/

Hunter, C. (2022). *Gender Equality Deep-Dive for Cambodia: Common Country Analysis*. United Nation. https://cambodia.un.org/sites/default/files/2022-03/Gender%20Deep%20Dive%20-%20CCA%20Cambodia_V6_010322_LQ.pdf

Huynh, T. H. (2017). The tradition of convent for filial piety of Khmer people in Soc Trang: Values and changes. *VNUHCM Journal of Social Sciences and Humanities*, *1*(X2), 82–86.

International Labour Organization. (2009). *The unpaid care-aid work connection* (Working Paper No. 86). Policy Intergration and Statistics Department, International Labour Office. https://www.ilo.org/media/340286/download

International Labour Organization. (2024). *Unpaid care work prevents 708 million women from participating in the labour market*. https://www.ilo.org/resource/news/unpaid-care-work-prevents-708-million-women-participating-labour-market

Jithitikulchai, T., Feldhaus, I., Bauhoff, S., & Nagpal, S. (2021). Health equity funds as the pathway to universal coverage in Cambodia: Care seeking and financial risk protection. *Health Policy and Planning*, *36*(1), 26–34.

Johnson, R. W., Smith, K. E., & Butrica, B. A. (2023). *Lifetime employment-related costs to women of providing family care*. Urban Institute.

Kaur, R., & Nagaich, S. (2019). Understanding Feminist Research Methodology in Social Sciences. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.3392500

Kidd, S., Athias, D., Kidd, S., Nastasi, S., & Gelders, B. (2022). *Social Protection-A Situational Analysis of Persons With Disabilities in Cambodia*. ACCESS. https://access2cambodia.org/wp-content/uploads/2024/02/SP-A-SITUATIONAL-ANALYSIS-OF-PERSONS-WITH-DISABILITIES-Report_English-AC-Compressed.pdf

Kim, T., Jordan, L. P., & Thlen, S. (2026). 'I'm not a complete mother': Childcare choices of migrant women in Cambodia. *Journal of Ethnic and Migration Studies*, *52*(6), 1479–1497.

Kolb, H., Luinstra, A., & Singh, R. K. (2020). *Tackling Childcare: Employer-Supported Childcare in Cambodia* [Research report].

Labor Law of the Kingdom of Cambodia (1997). https://cdc.gov.kh/wp-content/uploads/2022/05/THE-LABOR-LAW-OF-CAMBODIA_970313-.pdf

Madans, J. H., Loeb, M. E., & Altman, B. M. (2011). Measuring disability and monitoring the UN Convention on the Rights of Persons with Disabilities: The work of the Washington Group on Disability Statistics. *BMC Public Health*, *11*(Suppl 4), S4.

Ministry of Education, Youth and Sport. (2010). *National Policy on Early Childhood Care and Development*. https://nepcambodia.org/document/royal-government-national-policy-on-the-protection-and-development-of-young-children-kh/

Ministry of Education, Youth and Sport. (2018). *National Policy on Lifelong Learning*. Royal Government of Cambodia. https://www.uil.unesco.org/sites/default/files/medias/fichiers/2023/05/cambodia_policy_on_lll_04-10-18_eng_1.pdf

Ministry of Health. (2016). *National Health Care Policy and Strategy for Older People*. https://niph.org.kh/niph/uploads/library/pdf/PD079_PMD_Ageing_Care_Policy_FINAL_English.pdf

Ministry of Health. (2018). *Guidelines for the benefit package and provider payment of the Health Equity Fund for the poor*. https://hismohcambodia.org/public/fileupload/BP_engupload_30082018.pdf

Ministry of Health. (2023). *Mental health strategic plan 2023-2032*. Department of Mental Health and Substance Abuse. https://niph.org.kh/niph/uploads/library/pdf/27_Dec_23_MHSP_Launching_Eng_Printing.pdf

Ministry of Labour and Vocational Training. (2017). *National Technical Vocational Education and Training Policy 2017–2025. Royal Government of Cambodia*. Royal Government of Cambodia. https://asean.org/wp-content/uploads/2024/09/National-Technical-Vocational-Education-and-Training-Policy-2017-2025.pdf

Ministry of Social Affairs, Veterans and Youth Rehabilitation. (2018). *Action Plan 2018–2020 of National Aging Policy 2017-2030*. https://niph.org.kh/niph/uploads/library/pdf/National-Ageing-Policy-Action-Plan-2018-2020-Eng1.pdf

Ministry of Women's Affairs. (2024). *Neary Rattanak VI: Strategic Plan for Gender Equality and Women's Empowerment (2024–2028)*. https://mowa.gov.kh/en/detail/5955

Murage, A. (2019). *Multiple Facets of Parenting in Cambodia: A Case of Siem Reap*.

My, S. (2021). *Reconfigurations of Femininity and Masculinity in and through the National Childcare Policy in Cambodia*.

My, S. (2023). The National Childcare Agenda in Cambodia: A Feminist Transformative Ethics of Care Perspective. *The Journal of Development Studies*, *59*(11), 1683–1698.

National Institute of Social Affairs. (2019). *Needs and challenges of older people in Cambodia*. https://cng-cdn.oxfam.org/cambodia.oxfam.org/s3fs-public/file_attachments/Research%20on%20Needs%20and%20Challenges%20of%20Older%20People.pdf

National Institute of Statistics. (2004). *Cambodia Socio-Economic Survey 2003–2004*. Ministry of Planning, Royal Government of Cambodia. https://www.nis.gov.kh

National Social Protection Council. (2024, October). *National social protection policy framework 2024-2035*. Kingdom of Cambodia. https://nspc.gov.kh/Images/National%20Social%20Protection%20Policy%20Framework%202024-2035_2025_02_20_15_45_55.pdf

Neetha, N. (2010). Estimating unpaid care work: Methodological issues in time use surveys. *Economic and Political Weekly*, *45*(44), 73–80.

Oxfam. (2025). *Policy brief: Addressing Unpaid Care and Domestic Work (UCDW) in Cambodia*. https://oi-files-cng-v2-prod.s3.eu-west-2.amazonaws.com/cambodia.oxfam.org/s3fs-

Peng, I. (2019). *The Care Economy: A new research framework*.

Rathny, S., Chatterjee, R., Yat, Y., Reyad, M. A. H., & Leaksmy, C. (2018). An Overview of the Social Protection policy on Well-being of the Elderly in Cambodia. *Research on Ageing and Social Policy*, *6*(2), 148–171.

Razavi, S. (2007). The political and social economy of care in a development context: Conceptual issues, research questions and policy options. *Trabajo y Empleo*.

Royal Government of Cambodia. (2017). *National Aging Policy (NAP) 2017–2030*. https://cambodia.unfpa.org/sites/default/files/pub-pdf/NAP%202017-2030_%20Final_English-Printed.pdf

Royal Government of Cambodia. (2024). *National Disability Strategic Plan 2024–2028*. Disability Action Council.

RTI International. (2020). *Caregiver voices in Cambodia: Supporting young children with disabilities to reach their full potential*. https://www.rti.org/publication/caregiver-voices-cambodia-supporting-young-children-disabilities-reach-full-potential-study-report/fulltext.pdf

Schunert, T., Khann, S., Kao, S., Pot, C., Saupe, L. B., Sek, S., & Nhong, H. (2012). *Cambodian mental health survey 2012*. Department of Psychology at the Royal University of Phnom Penh. https://tpocambodia.org/wp-content/uploads/2015/09/Cambodian-Mental-Health-Survey-2012-RUPP.pdf

Shankar, R. (2023). Loneliness, social isolation, and its effects on physical and mental health. *Missouri Medicine*, *120*(2), 106.

Stevens, L., & Wrenn, C. (2013). Exploratory (qualitative) research. *Concise Encyclopedia of Church and Religious Organization Marketing*, *53*.

Sub-Decree No. 196 ANKr.BK of 2022 Cambodia (22 C.E.). https://www.vdb-loi.com/kh_publications/sub-decree-no-196-ankr-bk-dated-28-september-2022-issued-by-the-

royal-government-of-cambodia-on-new-annual-tax-on-income-and-monthly-tax-on-salary-thresholds/

The Law on Social Security Schemes (2019). https://www.nssf.gov.kh/wp-content/uploads/2023/02/5.-Law-on-Social-Security-Schemes-EN-1.pdf

Thlen, S. (2025). *Care policy mapping in Cambodia*. International Domestic Workers Federation. https://idwfed.org/wp-content/uploads/2025/05/Care-Policy-Mapping-in-Cambodia.Nara_.pdf

UN Women. (2015). *Measuring time use: An assessment of issues and challenges in conducting time-use surveys with special emphasis on developing countries*. https://data.unwomen.org/sites/default/files/documents/Publications/Measuring%20time%20use.pdf

UN Women. (2018). Promoting women's economic empowerment: Recognizing and investing in the care economy. *Issue Paper, UN Women, New York*.

UN Women. (2022). *Toolkit on Paid and Unpaid Care Work: From 3Rs to 5Rs*. https://www.unwomen.org/en/digital-library/publications/2022/07/a-toolkit-on-paid-and-unpaid-care-work

UN Women. (2023). *Care as a fourth pillar of welfare and social protection systems*. https://www.unwomen.org/sites/default/files/2024-01/care_as_a_fourth_pillar_of_welfare_and_social_protection_en.pdf

UNDP. (2023). *New UNDP study urges law and policy reform to redistribute and reduce care burden of women*. https://www.undp.org/thailand/press-releases/new-undp-study-urges-law-and-policy-reform-redistribute-and-reduce-care-burden-women

UNESCAP. (2022). *Valuing and investing in unpaid care and domestic work—Country case study: Cambodia*. https://hdl.handle.net/20.500.12870/4704

UNFPA. (2023). *Harmful social and gender norm that drive gender-based violence in Cambodia*. https://cambodia.unfpa.org/en/publications/harmful-social-gender-norms-drive-gender-based-violence-cambodia

Velloze, I. G., Jester, D. J., Jeste, D. V., & Mausbach, B. T. (2022). Interventions to reduce loneliness in caregivers: An integrative review of the literature. *Psychiatry Research*, *311*, 114508.

Withers, M. (2020). Care Work and Care Jobs for the Future of Decent Work by Laura Addati, Umberto Cattaneo, Valeria Esquivel and Isabel Valarino (2018). *International Journal of Care and Caring*, *4*(4), 615–617.

Wray, D., Badets, J., Keating, N., & Fast, J. (2023). *Canada's care economy: A conceptual framework*.

You, S. (2020). Addressing Unpaid Work in Cambodia. *HAPSc Policy Briefs Series*, *1*(2), 109–115.

Annex

- Annex 1: Consent form

ប្រធានបទសិក្សាស្រាវជ្រាវ៖

ការលើកទឹកចិត្តផ្នែកសេដ្ឋកិច្ចសង្គមសម្រាប់ការងារថែទាំនៅកម្រិតគ្រួសារដែលមិនទទួលបានប្រាក់កម្រៃក្នុងប្រទេសកម្ពុជា៖ តម្រូវការ បញ្ហាប្រឈម និងឱកាស

<u>ទម្រង់យល់ព្រមសម្រាប់អ្នកចូលរួម</u>

ខ្ញុំបានអានសន្លឹកព័ត៌មានសម្រាប់អ្នកចូលរួមក្នុងការសិក្សាស្រាវជ្រាវនេះ ហើយទទួលបានការពន្យល់ពីព័ត៌មានយ៉ាងលម្អិតពីការសិក្សាស្រាវជ្រាវ។ ខ្ញុំពេញចិត្តក្នុងការឆ្លើយតបរាល់សំណួរដែលបានសួរខ្ញុំ អំពីការសិក្សានេះ ហើយខ្ញុំដឹងថាខ្ញុំអាចសួរសំណួរបន្ថែមនៅពេលណាមួយក៏បាន។ ខ្ញុំក៏ផ្តល់ការយល់ព្រម ក្នុងការថតសំឡេងរបស់ខ្ញុំ និងយល់ថាព័ត៌មានដែលប្រមូលបានតាមរយៈសំឡេងនេះ នឹងកំណត់ត្រាទាំងអស់នឹងត្រូវបានរក្សាទុកដោយសុវត្ថិភាពនិងរក្សាការសម្ងាត់ខ្ពស់ ដែលអាចចូលប្រើប្រាស់បានតែក្រុមការងារនៃការស្រាវជ្រាវប៉ុណ្ណោះ។ ខ្ញុំដឹងថាព័ត៌មានដែលប្រមូលបាននឹងត្រូវបានបញ្ចូលទៅក្នុងប្រព័ន្ធកូដដែលមិនបង្ហាញអត្តសញ្ញាណរបស់ខ្ញុំនោះទេ។ ម្យ៉ាងទៀតភាគីទីបីដូចជារដ្ឋាភិបាល ឬទីភ្នាក់ងារ ណាមួយនឹងមិនអាចចូលប្រើព័ត៌មានដែលប្រមូលនេះបានទេ។

ខ្ញុំក៏ដឹងថា ខ្ញុំមានសេរីភាពក្នុងការដកខ្លួនចេញពីការសិក្សានេះនៅពេលណាក៏បានរហូតដល់ថ្ងៃទី១៥ ខែធ្នូ ឆ្នាំ២០២៥ ឬបដិសេធមិនឆ្លើយសំណួរជាក់លាក់ណាមួយនៅក្នុងការសិក្សា។ ខ្ញុំយល់ព្រមផ្តល់ព័ត៌មានដល់អ្នកស្រាវជ្រាវក្រោមលក្ខខណ្ឌនៃការរក្សាការសម្ងាត់ដែលមានចែងក្នុងសន្លឹកព័ត៌មាន។

ខ្ញុំយល់ព្រមចូលរួមនៅក្នុងការសិក្សានេះ ក្រោមលក្ខខណ្ឌដែលមានចែងក្នុងសន្លឹកព័ត៌មាន។ ការយល់ព្រមរបស់ខ្ញុំត្រូវបានផ្តល់ឱ្យដោយការចុះហត្ថលេខាលើសន្លឹកព័ត៌មាននេះ ឬតាមរយៈកិច្ចព្រមព្រៀងផ្ទាល់មាត់។

ហត្ថលេខា៖______________________________________

ឈ្មោះ៖ ______________________________________

ថ្ងៃខែឆ្នាំ៖______________________________________

ឈ្មោះអ្នកសិក្សាស្រាវជ្រាវ និងព័ត៌មានទំនាក់ទំនង៖

លោកស្រី សុវណ្ណ តៃវតី

អ្នកដឹកនាំការសិក្សាស្រាវជ្រាវ

ទូរស័ព្ទ៖ +855 85 822 348

អ៊ីមែល៖ teysovann@gmail.com

លោកស្រី សួន សុភី

ជំនួយការនៃការស្រាវជ្រាវ

ទូរស័ព្ទ៖ +855 85 680 076

អ៊ីមែល៖ sounsophy3@gmail.com

- Annex 2: Participants’ information sheet

សន្លឹកព័ត៌មានសម្រាប់អ្នកចូលរួមក្នុងការសិក្សាស្រាវជ្រាវ

សន្លឹកព័ត៌មានសម្រាប់អ្នកចូលរួមក្នុងការសិក្សាស្រាវជ្រាវត្រូវមានដូចខាងក្រោម៖

គោលបំណងនៃការស្រាវជ្រាវ

គោលបំណងនៃការស្រាវជ្រាវនេះគឺដើម្បីស្វែងយល់ពីបទពិសោធន៍រស់នៅរបស់អ្នកថែទាំ នៅកម្រិតគ្រួសារដែលមិនទទួលបានប្រាក់កម្រៃ ក្នុងប្រទេសកម្ពុជា ដោយផ្តោតលើរបៀបដែលការលើកទឹកចិត្តសេដ្ឋកិច្ចសង្គមបច្ចុប្បន្ន និងក្របខ័ណ្ឌគោលនយោបាយប៉ះពាល់ដល់តួនាទី និងសុខុមាលភាពរបស់ពួកគេ។ តាមរយៈការធ្វើករណីសិក្សាស៊ីជម្រៅ ការស្រាវជ្រាវមានគោលបំណងកំណត់ពីតម្រូវការសំខាន់ៗ បញ្ហាប្រឈម និងយុទ្ធសាស្ត្រដោះស្រាយរបស់អ្នកថែទាំដែលមិនបានទទួលប្រាក់ឈ្នួល ខណៈពេលដែលក៏បង្ហាញពីឱកាសដើម្បីបង្កើនការរួមបញ្ចូល និងប្រសិទ្ធភាពនៃយន្តការគាំទ្រដែលមានស្រាប់។ ការសិក្សានេះស្វែងរកការបង្កើត ភស្តុតាងដែលអាចជូនដំណឹងបន្ថែមទៀតអំពីគោលនយោបាយដែលឆ្លើយតបនឹងយេនឌ័រ និងបរិបទជាក់លាក់ ដែលទីបំផុតបានរួមចំណែកដល់ការទទួលស្គាល់ ការការពារ និងការគាំទ្រកាន់តែច្រើនសម្រាប់ការងារថែទាំដែលមិនបានប្រាក់កម្រៃនៅក្នុងប្រទេសកម្ពុជា។

តើអ្នកណាជាប់ទាក់ទងនឹងការស្រាវជ្រាវ?

ធ្វើឡើងដោយលោកស្រី សុវណ្ណ រ័ត្នវតី អតីតនិស្សិតអាហារូបករណ៍ពីរដ្ឋាភិបាលអូស្ត្រាលី បានបញ្ចប់ថ្នាក់អនុបណ្ឌិតផ្នែកការងារសង្គមពីសាកលវិទ្យាល័យ ហ្វលីនឌ័រ (Flinders university) ។ លោកស្រី ដឹកនាំគម្រោងស្រាវជ្រាវនេះ ក្រោមការបង្ហាត់បង្រៀនពីលោកស្រី Louise Coventry ដែលជាបេក្ខជនបណ្ឌិតនៃសកលវិទ្យាល័យ RMIT ។ ក្រុមស្រាវជ្រាវត្រូវបានគាំទ្រដោយជំនួយការស្រាវជ្រាវគឺលោកស្រី គោល សិលា ដែលនឹងជួយក្នុងការសម្របសម្រួល រដ្ឋបាល ភស្តុភារ និងការគ្រប់គ្រងហិរញ្ញវត្ថុនៃគម្រោង ដើម្បីធានាឱ្យការអនុវត្តបានរលូន និងទាន់ពេលវេលា។

តើមានអ្វីពាក់ព័ន្ធសម្រាប់អ្នកចូលរួម – តើពួកគេនឹងត្រូវស្នើសុំឱ្យធ្វើអ្វីប្រសិនបើពួកគេចូលរួម តើត្រូវចំណាយពេលប៉ុន្មាន?

អ្នកចូលរួមនៅក្នុងការស្រាវជ្រាវនេះនឹងរួមបញ្ចូលម្តាយ ជីដូន ឪពុកស្នាក់នៅផ្ទះ ឪពុកម្តាយធ្វើការ អ្នកថែទាំពិការ និងគ្រួសារដែលកាន់ប័ណ្ណសមធម៌ (ពីមុនហៅថា ប័ណ្ណក្រីក្រ) សម្រាប់ការសម្ភាសន៍ស៊ីជម្រៅ។ អ្នកចូលរួមក៏នឹងរួមបញ្ចូលអ្នកពាក់ព័ន្ធសំខាន់ៗ ដែលជាតំណាងមកពីរដ្ឋាភិបាល ដៃគូអភិវឌ្ឍន៍ អង្គការមិនមែនរដ្ឋាភិបាលអន្តរជាតិ និងក្នុងស្រុក និងចលនាស្ត្រីនិយម និង/ឬបណ្តាញ។

- **ការសម្ភាសន៍ស៊ីជម្រៅជាមួយអ្នកផ្តល់ការថែទាំ៖** អ្នកចូលរួមនឹងត្រូវបានសួរសំណួរទាក់ទងនឹងបទពិសោធន៍ប្រចាំថ្ងៃរបស់ពួកគេក្នុងនាមជាអ្នកផ្តល់ការថែទាំនៅកម្រិតគ្រួសារដែលមិនបានទទួលប្រាក់កម្រៃ ។ នេះរាប់បញ្ចូលទាំងប្រវត្តិប្រជាសាស្ត្រ ស្ថានភាពសេដ្ឋកិច្ចសង្គម ជីវិតប្រចាំថ្ងៃ និងបទពិសោធន៍នៃការលើកទឹកចិត្តសេដ្ឋកិច្ចសង្គមដែលពួកគេអាចមាន ឬចង់មាន ក៏ដូចជាបញ្ហាប្រឈមសម្រាប់ពួកគេក្នុងការទទួល

បាននូវការលើកទឹកចិត្តទាំងនោះ។ ការសម្ភាសន៍ក៏នឹងស្វែងយល់ពីបញ្ហាប្រឈមរបស់ពួកគេផងដែរ នៅពេលដែលពួកគេកំពុងព្យាយាមដើម្បីទទួលបានការគាំទ្រផ្នែកសេដ្ឋកិច្ចសង្គមដែលមានស្រាប់។ ការសម្ភាសន៍នឹងចំណាយពេលប្រហែល ១ ម៉ោងទៅ ១.៥ ម៉ោង។

- **ការសម្ភាសន៍ជាមួយអ្នកពាក់ព័ន្ធសំខាន់ៗ៖** នេះរួមបញ្ចូលទាំងភាគីពាក់ព័ន្ធពីរដ្ឋាភិបាល ដៃគូអភិវឌ្ឍន៍ អង្គការមិនមែនរដ្ឋាភិបាលអន្តរជាតិ និងក្នុងស្រុក និងចលនាស្រ្តីនិយម និង/ឬបណ្តាញ។ អ្នកចូលរួមទាំងនេះនឹងត្រូវបានសួរអំពីការចូលរួមរបស់អង្គការរបស់ពួកគេក្នុងការលើកទឹកចិត្តសេដ្ឋកិច្ចសង្គម សម្រាប់បញ្ហាការងារថែទាំដែលមិនបានទទួលប្រាក់កម្រៃ ឬក្របខ័ណ្ឌគោលនយោបាយ។ ការសម្ភាសន៍ក៏នឹងមើលឃើញការរួមចំណែករបស់ពួកគេចំពោះសេដ្ឋកិច្ចថែទាំជារូបភាពធំ និងរបៀបដែលវាជះឥទ្ធិពលដល់ការងារថែទាំដែលមិនបានទទួលប្រាក់ខែនៅកម្រិតគ្រួសារ ។ ទន្ទឹមនឹងនោះ នឹងមានសំណួរបំភ្លឺជុំវិញការអនុវត្តគោលនយោបាយដែលពាក់ព័ន្ធនឹងការផ្តល់ការលើកទឹកចិត្តសេដ្ឋកិច្ចសង្គមដល់អ្នកថែទាំដែលមិនបានទទួលប្រាក់ឈ្នួល។ ការសំភាសន៍អ្នកផ្តល់ព័ត៌មានសំខាន់នឹងមានរយៈពេលប្រហែល ៥០ ទៅ ៦០ នាទី។

តើនឹងមានអ្វីកើតឡើងចំពោះព័ត៌មានដែលប្រមូលបានពីអ្នកចូលរួម៖ អ្នកណានឹងឃើញវា របៀបដែលវាអាចត្រូវបានប្រើប្រាស់ ថាតើពួកគេនឹងត្រូវបានកំណត់អត្តសញ្ញាណ ឬអាចកំណត់អត្តសញ្ញាណបាន ការការពារអ្នកនឹងអនុវត្តដើម្បីការពារការសម្ងាត់ ទម្រង់ដែលលទ្ធផលនឹងអាចចូលប្រើបាន (ឧ. របាយការណ៍ អត្ថបទ ទិន្នន័យដើម ទិន្នន័យសរុប)

ព័ត៌មានដែលប្រមូលបាននឹងត្រូវបានរក្សាទុកជាការសម្ងាត់ ហើយអ្នកចូលរួមនឹងមិនបញ្ចេញឈ្មោះឡើយ។ វានឹងមានការតំណាងក្នុងវិធីដែលមិនអាចនាំទៅរកការបង្ហាញអត្តសញ្ញាណណាមួយឡើយ។ ម្យ៉ាងវិញទៀត ព័ត៌មាននេះនឹងមិនត្រូវបានចែកចាយដល់ភាគីផ្សេងទៀត សូម្បីតែរដ្ឋាភិបាល ឬភ្នាក់ងារ ឬអង្គការណាមួយក៏ដោយ។ ទិន្នន័យដែលប្រមូលបាននឹងអាចចូលប្រើបានយ៉ាងតឹងរ៉ឹងដោយសហអ្នកស្រាវជ្រាវ និងជំនួយការស្រាវជ្រាវប៉ុណ្ណោះ។ ជាមួយនឹងនីតិវិធីអនាមិក វានឹងមិនមានវិធីដើម្បីបញ្ចប់ការកំណត់អត្តសញ្ញាណអ្នកឆ្លើយតបតាមរយៈឧបករណ៍វិភាគនោះទេ។ សំឡេងដែលបានកត់ត្រាអំឡុងពេលសម្ភាសន៍ស៊ីជម្រៅនឹងត្រូវបានរក្សាទុកដោយសុវត្ថិភាព និងសម្ងាត់ ដោយសារឯកសារអូឌីយ៉ូនឹងត្រូវបានផ្ទេរនៅចុងបញ្ចប់នៃថ្ងៃសម្ភាសន៍ ហើយឯកសារត្រូវបានរក្សាទុកក្នុងថតចាក់សោពាក្យសម្ងាត់ ដើម្បីអាចចូលប្រើបានដោយក្រុមស្រាវជ្រាវប៉ុណ្ណោះ។ សំឡេងនឹងត្រូវបានប្រើសម្រាប់ប្រតិចារឹក ហើយនឹងត្រូវបានលុបជាអចិន្ត្រៃយ៍បន្ទាប់ពីប្រតិចារឹករយៈពេល ៣០ ថ្ងៃ។ របាយការណ៍ស្រាវជ្រាវនឹងត្រូវបានដាក់ជូនសម្រាប់ការបោះពុម្ព ហើយព័ត៌មានដែលប្រើក្នុងការសិក្សានឹងត្រូវបានបង្ហាញជាអនាមិក និងត្រឹមតែកម្រិតសរុបប៉ុណ្ណោះ។ ដូច្នេះ ការកំណត់អត្តសញ្ញាណរបស់អ្នកឆ្លើយតបនឹងត្រូវបានការពារយ៉ាងតឹងរ៉ឹងពេញមួយដំណើរការនៃការស្រាវជ្រាវនេះ ហើយវានឹងមិនមានហានិភ័យនៃការលេចធ្លាយព័ត៌មានរបស់អ្នកឆ្លើយតបទៅកាន់ភាគីទីបីផ្សេងទៀត ។ ជាមួយគ្នានេះដែរ ព័ត៌មានដែលប្រមូលបាន

នឹងត្រូវរក្សាទុកដោយសុវត្ថិភាព និងបំផ្លាញដោយអ្នកស្រាវជ្រាវ (លោកស្រី សុវណ្ណ រ័ត្នវតី)បន្ទាប់ពីការស្រាវជ្រាវបានបញ្ចប់ និងអនុវត្តតាមនីតិវិធីនៃការស្រាវជ្រាវ ។

ប្រសិនបើពាក់ព័ន្ធ របៀបដែលអ្នកស៊ើបអង្កេតនឹងដោះស្រាយហានិភ័យដែលអាចកើតមានសម្រាប់អ្នកចូលរួម (ឬសម្រាប់អ្នកស៊ើបអង្កេត)

មុននឹងទៅដល់កន្លែងរបស់អ្នកឆ្លើយសំណួរ ក្រុមស្រាវជ្រាវនឹងទាក់ទងទៅអាជ្ញាធរមូលដ្ឋានសម្រាប់ការយល់ព្រមដើម្បីអនុវត្តការសម្ភាសន៍នៅក្នុងសហគមន៍របស់ពួកគេ។ ដូច្នេះ សិក្ខាកាមនឹងមិនមានហានិភ័យក្នុងការចូលរួមក្នុងការសិក្សានេះទេ។ បើមិនដូច្នោះទេ អ្នកឆ្លើយតបដែលមានសក្តានុពលអាចបដិសេធមិនចូលរួមដោយស្ម័គ្រចិត្ត។

របៀបដកខ្លួនចេញ (ដាក់ឈ្មោះកាលបរិច្ឆេទដាក់លាក់សម្រាប់អ្នកចូលរួមជ្រើសរើសចេញ)

អ្នកឆ្លើយសំណួរអាចបដិសេធមិនចូលរួមក្នុងការសិក្សានេះនៅពេលណាក៏បាន សូម្បីតែក្នុងអំឡុងពេលសម្ភាសន៍ក៏ដោយ។ អ្នកឆ្លើយសំណួរអាចឈប់ឆ្លើយការសម្ភាសន៍របស់យើងក្នុងករណីដែលពួកគេចង់។ ដូចគ្នានេះផងដែរ អ្នកឆ្លើយសំណួរអាចទាក់ទងទៅអ្នកស្រាវជ្រាវដើម្បីជ្រើសរើសដកខ្លួនចេញរហូតដល់ខែធ្នូ ឆ្នាំ ២០២៥។

តើធ្វើដូចម្តេចដើម្បីទទួលបានព័ត៌មានបន្ថែម និងរបៀបទាក់ទងអ្នកស្រាវជ្រាវ?

ខ្ញុំឈ្មោះ សុវណ្ណ រ័ត្នវតី បើអ្នកចង់ពិភាក្សាបន្ថែម ឬត្រូវការព័ត៌មានបន្ថែម សូមទំនាក់ទំនងមកខ្ញុំតាមរយៈព័ត៌មានខាងក្រោម៖

លោកស្រី សុវណ្ណ រ័ត្នវតី

អ្នកដឹកនាំការសិក្សាស្រាវជ្រាវ

ទូរស័ព្ទ៖ +855 85 822 348

អ៊ីមែល៖ teysovann@gmail.com

Annex 3: Post-interview information sheet

លេខទំនាក់ទំនងសម្រាប់អ្នកថែទាំ សម្រាប់ការស្វែងរកជំនួយបន្ថែម

ការផ្តល់សេវា	ស្ថាប័ន	លេខទូរស័ព្ទ

ការធ្វើប័ណ្ណសមាជិក ប.ស.ស	បេឡាជាតិសន្តិសុខសង្គម (ប.ស.ស)	១២៨៦ ឬលេខ ១២៩៧ ធ្វើការ ២៤ម៉ោង/៧ថ្ងៃ
ស្វែងរកការងារធ្វើ	ក្រសួងការងារ និងបណ្តុះបណ្តាលវិជ្ជាជីវៈ	info@mlvt.gov.kh ០២៣ ៨៨៤ ៣៧៥ ០២៣ ៨៨៤ ៣៧៦ ១២៩៧ ឬលេខ ១២៨៦
ការប្រឹក្សាផ្នែកព្យាបាលផ្លូវចិត្ត (Clinical counseling)	អង្គការចិត្តសង្គម អន្តរវប្បធម៌កម្ពុជា (TPO Cambodia)	០១៦ ២២២ ៥៩៧ ០៩៥ ៧៧៧ ០០៤
ការប្រឹក្សា (Counseling)	សមាគម អ៊ី អឹម ឌី អរ កម្ពុជា (EMDR Association Cambodia)	០៨៩ ៩៦៨ ៦៧៨
ការប្រឹក្សាផ្នែកព្យាបាលផ្លូវចិត្ត និងសេវាកម្មសុខុមាលភាព	អង្គការ ការរស់នៅសុខុមាលភាព (Living Well)	info@livingwellcambodia.org ០៩២ ៦៧៧ ០២១
ការប្រឹក្សា និងជំនួបគាំទ្របច្ចេកទេស (Counseling and Supervision)	ផ្ទះអូយស៊ីសកម្ពុជា (Oasis House Cambodia)	oasishousecambodia@gmail.com ០១៦ ៩១២ ០១៦
ការប្រឹក្សា (Counseling)	មជ្ឈមណ្ឌលសុខភាព មេត្តាករុណា (Mercy Medical Center Cambodia)	partners@mmccambodia.org ០៩៧ ៨ ៥០០ ៤៤៨
ការប្រឹក្សា (Counseling)	មជ្ឈមណ្ឌលស្នេហា (Sneha Center)	wehearyou@sneha.asia ០៩៧ ៩៩០ ៣៣៣៣
ការប្រឹក្សា និងជំនួបគាំទ្របច្ចេកទេស (Counseling and Supervision)	មជ្ឈមណ្ឌលលំហចិត្ត (Mindspace Center)	mindspace556@gmail.com ០៩៦ ៩១៩ ០០០១ ០៨៥ ៩១៥ ១០២ ០១០ ៦០៥ ៧៥៧
រាយការណ៍អំពីការកេងប្រវ័ញ្ច អំពើហិង្សា ការជួញដូរមនុស្ស វិបត្តិគ្រួសារជាដើម	បណ្តាញទូរស័ព្ទ ជំនួយកុមារកម្ពុជា	១២៨០
តម្រូវការអន្តរាគមន៍ភ្លាមៗ ករណីអំពើហិង្សាលើស្ត្រី ឬការជួញដូរមនុស្ស	លេខទូរស័ព្ទទាន់ហេតុការណ៍ សម្រាប់ភ្ជាប់ទៅកាន់អាជ្ញាធរ	១២៨៨

ការរំលោភបំពានលើកុមារដោយផ្ទាល់ ឬតាមអនឡាញ (child abuse / online sexual abuse)	អង្គការ APLE Cambodia	info@aplecambodia.org ០២៣ ៩៩៦ ៣៥១

Annex 4: Semi-structure In-depth Interview questionnaire

កម្រងសំណួរពាក់កណ្ដាលរចនាសម្ព័ន្ធសម្រាប់អ្នកថែទាំដែលមិនបានបង់ប្រាក់

បទសម្ភាសន៍ស៊ីជម្រៅ

កាលបរិច្ឆេទ៖ ____________________ ពេលវេលា៖ ___________________

ទីកន្លែង: _________________________ អ្នកសម្ភាសន៍: _________________

ឈ្មោះអ្នកចូលរួម៖ ___________________

លេខកូដ៖ _________________________

សេចក្តីផ្តើមនៃបទសម្ភាសន៍៖

ជំរាបសួរ និងសូមអរគុណចំពោះការយល់ព្រមចូលរួមក្នុងកិច្ចសម្ភាសន៍នេះ។ ខ្ញុំឈ្មោះ .... ហើយខ្ញុំជាសមាជិក នៃក្រុមស្រាវជ្រាវដែលធ្វើការសិក្សាលើការថែទាំដែលមិនមានប្រាក់កម្រៃនៅក្នុងប្រទេសកម្ពុជា។ ការស្រាវជ្រាវនេះមានគោលបំណងចូលរួមចំណែកក្នុងការស្វែងយល់ពីបទពិសោធន៍ តម្រូវការ និងបញ្ហាប្រឈមរបស់មនុស្សដែលផ្តល់ការថែទាំដែលមិនមានប្រាក់កម្រៃដល់សមាជិកគ្រួសារ ឬអ្នកផ្សេងទៀតនៅក្នុងគ្រួសាររបស់ពួកគេ។

ស្រាវជ្រាវនេះមានគោលដៅផ្តល់ជាចំនេះដឹង និងព័ត៌មាន ដល់រាជរដ្ឋាភិបាល អង្គការក្រៅរដ្ឋាភិបាល និងដៃគូអភិវឌ្ឍន៍ ដើម្បីអោយពួកគេអាចរៀបចំគោលនយោបាយ កម្មវិធី និងប្រព័ន្ធគាំទ្រឱ្យកាន់តែប្រសើរឡើងសម្រាប់អ្នកថែទាំដូចជាខ្លួនអ្នកផ្ទាល់។

ការចូលរួមរបស់អ្នកគឺស្ម័គ្រចិត្តទាំងស្រុង ហើយអ្នកអាចជ្រើសរើសមិនឆ្លើយសំណួរណាមួយ ឬបញ្ឈប់ការសម្ភាសន៍នៅពេលណាក៏បាន។ អ្វីគ្រប់យ៉ាងដែលអ្នកចែករំលែកនឹងត្រូវបានរក្សាទុកជាសម្ងាត់ និងប្រើប្រាស់សម្រាប់គោលបំណងស្រាវជ្រាវតែប៉ុណ្ណោះ។ មិនមានចម្លើយត្រឹមត្រូវ ឬខុសទេ យើងនៅទីនេះដើម្បីរៀនពីបទពិសោធន៍របស់អ្នក។ ដើម្បីជួយក្នុងដំណើរការនៃការកត់ត្រាចម្លើយរបស់អ្នក យើងនឹងប្រើឧបករណ៍ថតសំឡេង ប្រសិនបើយើងអាចមានការអនុញ្ញាតពីអ្នក។

តើអ្នកមានសំណួរសម្រាប់ខ្ញុំទាក់ទងនឹងការស្រាវជ្រាវ ឬការចូលរួមរបស់អ្នកទេ?

តើ ខ្ញុំអាច ចាប់ផ្តើមការសម្ភាសន៍ឥឡូវនេះបានទេ? សូមមានអារម្មណ៍សេរីក្នុងការនិយាយជាភាសាសាមញ្ញៗ ឬធ្វើយ៉ាងអោយតែ អ្នកមានផាសុកភាពបំផុត។

ចំណាំ៖ ត្រូវប្រាកដថាឆ្លងកាត់ទម្រង់ការយល់ព្រម ហើយឱ្យអ្នកឆ្លើយតបផ្តល់ពាក្យសំដី និងចុះហត្ថលេខាលើទម្រង់ការយល់ព្រម មុនពេលចាប់ផ្តើមការសម្ភាសន៍។

- **ស្វែងយល់ពី បរិបទ និងបទពិសោធន៍ នៃអ្នកផ្តល់ការថែទាំ**

ចូរចាប់ផ្តើមដោយស្វែងយល់បន្ថែមបន្តិចអំពីអ្នក និងស្ថានភាពថែទាំរបស់អ្នក។ វានឹងជួយយើងឱ្យយល់ពីប្រវត្តិរបស់អ្នក និងបរិបទជាក់លាក់ដែលអ្នកផ្តល់ការថែទាំ។

1. តើអ្នកអាចប្រាប់ខ្ញុំបន្តិចអំពីខ្លួនអ្នកបានទេ? (អាយុ ភេទ កម្រិតអប់រំ មុខរបរ)

2. តើមានមនុស្សប៉ុន្មាននាក់នៅក្នុងគ្រួសាររបស់អ្នក ហើយតើពួកគេមានទំនាក់ទំនងអ្វីជាមួយអ្នក?

3.តើអ្នកអាចពណ៌នាអំពីតួនាទីថែទាំរបស់អ្នកនៅក្នុងគ្រួសារបានទេ? (តើអ្នកថែទាំអ្នកណា តើអ្នកផ្តល់ការថែទាំបែបណាខ្លះ ហើយញឹកញាប់ប៉ុណ្ណា?)

- **ការទទួលស្គាល់ និងការគាំទ្រផ្លូវចិត្ត**

នៅក្នុងផ្នែកបន្ទាប់នៃការសន្ទនារបស់យើង យើងនឹងនិយាយបន្តិចបន្តួចអំពីរបៀបដែលតួនាទីថែទាំរបស់អ្នកត្រូវបានមើលដោយអ្នកដទៃ និងរបៀបដែលវាអាចប៉ះពាល់ដល់អារម្មណ៍ កម្រិតស្រ្តេស ឬសុខុមាលភាពផ្លូវចិត្តរបស់អ្នក។ សំណួរទាំងនេះមួយចំនួនអាចប៉ះពាល់ដល់បទពិសោធន៍ផ្ទាល់ខ្លួន ឬរសើប។ អ្នកត្រូវបានស្វាគមន៍ក្នុងការចំណាយពេលរបស់អ្នក រំលងសំណួរណាមួយ ឬផ្អាកការសម្ភាសន៍នៅពេលណាមួយ ប្រសិនបើអ្នកមានអារម្មណ៍មិនស្រួល។ មិនមានចម្លើយត្រឹមត្រូវ ឬខុសទេ - យើងចាប់អារម្មណ៍តែលើបទពិសោធន៍ និងគំនិតដ៏ស្មោះត្រង់របស់អ្នក។ អ្វីដែលអ្នកចែករំលែកនឹងរក្សាការសម្ងាត់ ហើយការឆ្លើយតបរបស់អ្នកនឹងត្រូវបានប្រព្រឹត្តដោយការគោរព និងយកចិត្តទុកដាក់។

4. តើអ្នកមានអារម្មណ៍ថាតួនាទីរបស់អ្នកជាអ្នកមើលថែ មានតម្លៃ ឬត្រូវបានទទួលស្គាល់ដោយគ្រួសារ សហគមន៍ ឬសង្គមរបស់អ្នកទេ? (តើទម្រង់នៃការទទួលស្គាល់ ឬការឲ្យតម្លៃអ្វីសំខាន់សម្រាប់អ្នក?)

5. តើការថែទាំបានប៉ះពាល់ដល់អារម្មណ៍ ឬសុខុមាលភាពផ្លូវចិត្តរបស់អ្នកយ៉ាងដូចម្តេច? តើអ្នកមានសិទ្ធិទទួលបានជំនួយផ្លូវចិត្ត ឬការគាំទ្រពីមិត្តភ័ក្តិទេ? (តើជំនួយទាំងនោះមានអ្វីខ្លះ? អ្នកណាផ្តល់ឲ្យ? តើវាមានប្រយោជន៍ប៉ុណ្ណា?)

6. ប្រសិនបើអ្នកអាចផ្លាស់ប្តូរ ឬកែលម្អរឿងមួយឬ មានមតិយោបល់បន្ថែមចំពោះផ្នែកនេះ ដើម្បីអោយជីវិតអ្នកប្រសើរឡើងក្នុងនាមជាអ្នកថែទាំ តើអ្នកមានមតិយោបល់អ្វី? (យោបល់យ៉ាងណាទៅកាន់ រដ្ឋាភិបាល អង្គការក្រៅរដ្ឋាភិបាល សហគមន៍ ឬការផ្លាស់ប្តូរគោលនយោបាយ។)

- **ការអប់រំ ការបណ្តុះបណ្តាល និងការកសាងសមត្ថភាព**

ឥឡូវនេះ ខ្ញុំចង់សួរសំណួរមួយចំនួនអំពីការគាំទ្រ ការបណ្តុះបណ្តាល ឬចំណេះដឹងដែលបានជួយអ្នកក្នុងតួនាទីថែទាំរបស់អ្នក។ នេះអាចរួមបញ្ចូលការបណ្តុះបណ្តាលជាផ្លូវការ ដំបូន្មានសុខភាព ឬសូម្បីតែអ្វីដែលអ្នកបានរៀនតាមរយៈបទពិសោធន៍ ឬពីអ្នកដទៃ។ សូមកុំបារម្ភប្រសិនបើអ្នកមិនបានទទួលការបណ្តុះបណ្តាលជាផ្លូវការណាមួយ — វាជារឿងធម្មតាណាស់ ហើយបទពិសោធរបស់អ្នកនៅតែមានសារៈសំខាន់សម្រាប់យើង។ យើងនៅទីនេះដើម្បីស្វែងយល់ថាតើអ្នកថែទាំចំណេះដឹងប្រភេទណាដែលកំពុងប្រើប្រាស់នាពេលបច្ចុប្បន្ន ហើយជំនួយ

ប្រភេទណាដែលអាចមានប្រយោជន៍នាពេលអនាគត។ ចំណាយពេលរបស់អ្នក ហើយមានអារម្មណ៍សេរីដើម្បីចែករំលែកអ្វីដែលអ្នកគិតថាពាក់ព័ន្ធ។ តើយើងនឹងចាប់ផ្តើមផ្នែកនេះទេ?
7. តើអ្នកធ្លាប់ទទួលបានការបណ្តុះបណ្តាល ឬការអប់រំដើម្បីជួយអ្នកក្នុងតួនាទីថែទាំរបស់អ្នកទេ? (បើអត់ទេ តើការបណ្តុះបណ្តាលប្រភេទណាដែលមានប្រយោជន៍?)

8. តើអ្នកមានអារម្មណ៍ថាអ្នកមានចំណេះដឹង និងជំនាញដែលត្រូវការដើម្បីផ្តល់ការថែទាំប្រកបដោយប្រសិទ្ធភាពទេ? តើអ្នកងាកទៅរកព័ត៌មាន ឬជំនួយពីណា?

9. ប្រសិនបើអ្នកអាចផ្លាស់ប្តូរ ឬកែលម្អរឿងមួយឬ មានមតិយោបល់បន្ថែមចំពោះផ្នែកនេះ ដើម្បីអោយជីវិតអ្នកប្រសើរឡើងក្នុងនាមជាអ្នកថែទាំ តើអ្នកមានមតិយោបល់អ្វី? (យោបល់យ៉ាងណាទៅកាន់ រដ្ឋាភិបាល អង្គការក្រៅរដ្ឋាភិបាល សហគមន៍ ឬការផ្លាស់ប្តូរគោលនយោបាយ។)

- **ការងារ ជីវភាព និងតុល្យភាពការងារ-ជីវិត**

នៅក្នុងផ្នែកបន្ទាប់នេះ ខ្ញុំចង់និយាយអំពីរបៀបដែលការថែទាំអាចប៉ះពាល់ដល់សមត្ថភាពរបស់អ្នកក្នុងការរកប្រាក់ចំណូល ឬបន្តការទទួលបន្ទុកផ្សេងទៀត ដូចជាការងារ ការអប់រំ ឬពេលវេលាផ្ទាល់ខ្លួន។ យើងយល់ថាអ្នកថែទាំជាច្រើនប្រឈមមុខនឹងជម្រើសដ៏លំបាកក្នុងការព្យាយាមធ្វើឱ្យមានតុល្យភាពភារកិច្ចថែទាំរបស់ពួកគេជាមួយនឹងតម្រូវការហិរញ្ញវត្ថុ ឬផ្ទាល់ខ្លួន។ ស្ថានភាពរបស់មនុស្សម្នាក់ៗគឺខុសគ្នា ហើយមិនមានចម្លើយត្រឹមត្រូវ ឬខុសនៅទីនេះទេ។ សូមចែករំលែកនូវអ្វីដែលអ្នកពេញចិត្ត — មិនថាវាជាបញ្ហាប្រឈម ការលះបង់ ឬវិធីដែលអ្នកបានរកឃើញដើម្បីគ្រប់គ្រងនោះទេ។ បទពិសោធន៍របស់អ្នកមានសារៈសំខាន់ ហើយនឹងជួយយើងឱ្យយល់កាន់តែច្បាស់អំពីរបៀបជួយអ្នកថែទាំក្នុងប្រទេសកម្ពុជា។ តើយើងត្រូវបន្តជាមួយផ្នែកនេះទេ?
10. តើការថែទាំបានប៉ះពាល់ដល់សមត្ថភាពរបស់អ្នកក្នុងការធ្វើការ ឬបន្តសកម្មភាពដែលបង្កើតប្រាក់ចំណូលយ៉ាងដូចម្តេច? (ស្វែងយល់ពីការបាត់បង់ការងារ ការងារក្រៅម៉ោង ភាពបត់បែន។ល។)

11. តើអ្នកមានអារម្មណ៍ថាអ្នកអាចរក្សាតុល្យភាពរវាងការមើលថែទាំ និងទំនួលខុសត្រូវផ្សេងទៀត ឬក្តីប្រាថ្នារបស់អ្នកបានទេ (ឧ. ការងារ, ការអប់រំ, ពេលវេលាផ្ទាល់ខ្លួន)?

12. ប្រសិនបើអ្នកអាចផ្លាស់ប្តូរ ឬកែលម្អរឿងមួយឬ មានមតិយោបល់បន្ថែមចំពោះផ្នែកនេះ ដើម្បីអោយជីវិតអ្នកប្រសើរឡើងក្នុងនាមជាអ្នកថែទាំ តើអ្នកមានមតិយោបល់អ្វី? (យោបល់យ៉ាងណាទៅកាន់ រដ្ឋាភិបាល អង្គការក្រៅរដ្ឋាភិបាល សហគមន៍ ឬការផ្លាស់ប្តូរគោលនយោបាយ។)

- **សេវាសុខភាព និងសង្គម**

ឥឡូវនេះ ខ្ញុំចង់និយាយបន្តិចអំពីសេវាសុខភាព និងសង្គមដែលមានសម្រាប់អ្នក និងមនុស្ស ឬមនុស្សដែលអ្នកថែទាំ។ វាអាចរួមបញ្ចូលអ្វីៗដូចជា គ្លីនិក មន្ទីរពេទ្យ ការប្រឹក្សា ជំនួយសហគមន៍ ឬសេវាកម្មផ្សេងទៀតដែលអ្នកបានព្យាយាមចូលប្រើ។ យើងយល់ថាការទទួលបានសេវាថែទាំ និងជំនួយអាចមានភាពខុសប្លែកគ្នាច្រើន

អាស្រ័យលើកន្លែងដែលមនុស្សរស់នៅ ស្ថានភាពហិរញ្ញវត្ថុរបស់ពួកគេ ឬបញ្ហាប្រឈមផ្សេងទៀត។ អ្នកថែទាំខ្លះអាចមានការគាំទ្រ ហើយអ្នកផ្សេងទៀតប្រហែលជាមិនមាន — បទពិសោធន៍ទាំងពីរមានសារៈសំខាន់សម្រាប់យើងក្នុងការស្តាប់ និងយល់។ សូមចែករំលែកបទពិសោធន៍ដោយស្មោះត្រង់របស់អ្នក។ សំឡេងរបស់អ្នកនឹងជួយយើងកំណត់កន្លែងដែលត្រូវការការកែលម្អ។ តើវាមិនអីទេប្រសិនបើយើងបន្តជាមួយផ្នែកនេះ?

13. តើសេវាសុខភាព ឬសេវាសង្គមបែបណាដែលមានសម្រាប់អ្នក និងបុគ្គលដែលអ្នកថែទាំ? តើពួកគេអាចប្រើប្រាស់សេវានោះបានកម្រិតណា? តើវាគ្រប់គ្រាន់ទេ?

14. តើអ្នកបានជួបប្រទះបញ្ហាប្រឈមណាមួយក្នុងការទទួលបានការថែទាំសុខភាព ឬសង្គមសម្រាប់ខ្លួនអ្នក ឬអ្នកដែលអ្នកថែទាំដែរឬទេ?

15. ប្រសិនបើអ្នកអាចផ្លាស់ប្តូរ ឬកែលម្អរឿងមួយឬ មានមតិយោបល់បន្ថែមចំពោះផ្នែកនេះ ដើម្បីអោយជីវិតអ្នកប្រសើរឡើងក្នុងនាមជាអ្នកថែទាំ តើអ្នកមានមតិយោបល់អ្វី? (យោបល់យ៉ាងណាទៅកាន់ រដ្ឋាភិបាល អង្គការក្រៅរដ្ឋាភិបាល សហគមន៍ ឬការផ្លាស់ប្តូរគោលនយោបាយ។)

- **ការលើកទឹកចិត្តផ្នែកហិរញ្ញវត្ថុ និងការដាក់បញ្ចូលសង្គម**

នៅក្នុងផ្នែកនេះ ខ្ញុំចង់សួរសំណួរមួយចំនួនអំពីផ្នែកហិរញ្ញវត្ថុនៃការថែទាំ។ នេះរាប់បញ្ចូលទាំងថាតើអ្នកបានទទួលជំនួយផ្នែកហិរញ្ញវត្ថុ ឬសម្ភារៈ និងរបៀបដែលការថែទាំអាចប៉ះពាល់ដល់ស្ថានភាពហិរញ្ញវត្ថុ ឬសុខុមាលភាពរបស់អ្នក។ យើងដឹងថា ពេលខ្លះការមើលថែទាំអាចដាក់បន្ទុកផ្នែកហិរញ្ញវត្ថុដល់គ្រួសារ ហើយមិនមែនគ្រប់គ្នាអាចទទួលបានជំនួយ ឬធនធានដូចគ្នានោះទេ។ មិនមានបទពិសោធន៍ត្រូវ ឬខុសទេ — យើងនៅទីនេះដើម្បីស្តាប់ និងរៀនពីស្ថានភាពរបស់អ្នក ទោះវាជាអ្វីក៏ដោយ។ សូមចែករំលែកតែអ្វីដែលអ្នកពេញចិត្ត។ ការយល់ដឹងរបស់អ្នកនឹងជួយយើងឱ្យយល់កាន់តែច្បាស់អំពីប្រភេទនៃការគាំទ្រដែលអ្នកថែទាំនៅក្នុងប្រទេសកម្ពុជាពិតជាត្រូវការ។ តើយើងត្រូវបន្តជាមួយផ្នែកនេះទេ?

16. តើអ្នកបានទទួលជំនួយផ្នែកហិរញ្ញវត្ថុ ឬជំនួយពីរដ្ឋាភិបាលដែលទាក់ទងនឹងតួនាទីថែទាំរបស់អ្នកទេ? (ប្រសិនបើបាទ/ចាស សូមពណ៌នាអំពីប្រភេទ ភាពគ្រប់គ្រាន់ និងភាពងាយស្រួលនៃការចូលប្រើ។ ប្រសិនបើទេ សូមស្វែងយល់ពីកំរិតនៃ ការយល់ដឹងទៅលើសេវា និង សិទ្ធិក្នុងការទទួលបាន។)

17. តើអ្នកមានអារម្មណ៍ថាមានការរួមបញ្ចូលផ្នែកហិរញ្ញវត្ថុ ឬត្រូវបានគាំទ្រជាអ្នកថែទាំ ទាំងតាមរយៈប្រព័ន្ធផ្លូវការ ឬបណ្តាញសហគមន៍? (តើតម្រូវការហិរញ្ញវត្ថុរបស់អ្នកមានអ្វីខ្លះ?)

18. ប្រសិនបើអ្នកអាចផ្លាស់ប្តូរ ឬកែលម្អរឿងមួយឬ មានមតិយោបល់បន្ថែមចំពោះផ្នែកនេះ ដើម្បីអោយជីវិតអ្នកប្រសើរឡើងក្នុងនាមជាអ្នកថែទាំ តើអ្នកមានមតិយោបល់អ្វី? (យោបល់យ៉ាងណាទៅកាន់ រដ្ឋាភិបាល អង្គការក្រៅរដ្ឋាភិបាល សហគមន៍ ឬការផ្លាស់ប្តូរគោលនយោបាយ។)

- **សមភាពយេនឌ័រ និងបទដ្ឋានសង្គម**

សម្រាប់ផ្នែកចុងក្រោយនៃការសន្ទនារបស់យើង ខ្ញុំចង់និយាយអំពីតួនាទីយេនឌ័រ និងការរំពឹងទុករបស់សហគមន៍ជុំវិញការថែទាំ។ នេះរាប់បញ្ចូលទាំងថាតើការមើលថែត្រូវបានគេមើលឃើញថាជាទំនួលខុសត្រូវរបស់មនុស្សជាក់លាក់ - ដូចជាស្ត្រី បុរស សមាជិកគ្រួសារដែលមានវ័យចំណាស់ - និងរបៀបដែលការរំពឹងទុកទាំងនោះប៉ះពាល់ដល់បទពិសោធន៍របស់អ្នក។ យើងយល់ថា ទស្សនៈស្តីពីយេនឌ័រ និងការមើលថែអាចត្រូវបានរៀបចំឡើងតាមប្រពៃណី វប្បធម៌ សាសនា ឬបទពិសោធន៍ផ្ទាល់ខ្លួន ហើយវាអាចខុសគ្នាសម្រាប់មនុស្សម្នាក់ៗ ឬសហគមន៍។ មិនមានចម្លើយត្រឹមត្រូវ ឬខុសទេ — យើងគ្រាន់តែចាប់អារម្មណ៍លើរបៀបដែលគំនិតទាំងនេះមានឥទ្ធិពលលើតួនាទីថែទាំរបស់អ្នក និងថាតើពួកគេបានធ្វើឱ្យអ្វីៗកាន់តែងាយស្រួល ឬពិបាកសម្រាប់អ្នក។ សូមចែករំលែកអ្វីដែលអ្នកមានអារម្មណ៍ស្រួលក្នុងការពិភាក្សា។ គំនិតរបស់អ្នកនឹងជួយយើងឱ្យយល់ពីរបៀបដែលការគាំទ្រសម្រាប់អ្នកថែទាំអាចមានភាពយុត្តិធម៌ រួមបញ្ចូល និងឆ្លើយតបទៅនឹងស្ថានភាពជីវិតពិត។ តើវាមិនអីទេ បើយើងចូលទៅវគ្គចុងក្រោយនេះ?

19. តើអ្នកគិតថាការថែទាំត្រូវបានគេមើលឃើញថាជាទំនួលខុសត្រូវនៃភេទជាក់លាក់ណាមួយនៅក្នុងគ្រួសារ ឬសហគមន៍របស់អ្នកទេ? តើវាប៉ះពាល់ដល់អ្នកយ៉ាងដូចម្តេច?

20. តើតួនាទីយេនឌ័រ ឬការរំពឹងទុកមានឥទ្ធិពលលើបទពិសោធន៍របស់អ្នកជាអ្នកថែទាំ ជាពិសេសទាក់ទងនឹងការទទួលបានធនធាន ឬការសម្រេចចិត្តដែរឬទេ? តើវាមានឥទ្ធិពលយ៉ាងណាទៅលើបទពិសោធន៍ថែទាំរបស់អ្នក និងលទ្ធភាពដែលអ្នកទទួលបានការគាំទ្រណាមួយ?

21. ប្រសិនបើអ្នកអាចផ្លាស់ប្តូរ ឬកែលម្អរឿងមួយឬ មានមតិយោបល់បន្ថែមចំពោះផ្នែកនេះ ដើម្បីអោយជីវិតអ្នកប្រសើរឡើងក្នុងនាមជាអ្នកថែទាំ តើអ្នកមានមតិយោបល់អ្វី? (យោបល់យ៉ាងណាទៅកាន់ រដ្ឋាភិបាល អង្គការក្រៅរដ្ឋាភិបាល សហគមន៍ ឬការផ្លាស់ប្តូរគោលនយោបាយ។)

Annex 5: Semi-structure Key Informant Interview questionnaire

កម្រងសំណួរពាក់កណ្តាលរចនាសម្ព័ន្ធសម្រាប់ការសម្ភាសន៍ព័ត៌មានសំខាន់

កាលបរិច្ឆេទ៖ ____________________ **ពេលវេលា៖** __________________

ទីកន្លែង: ________________________ អ្នកសម្ភាសន៍: ________________

ឈ្មោះអ្នកចូលរួម៖ ___________________

លេខកូដ៖ ________________________

- **សេចក្តីផ្តើមនៃបទសម្ភាសន៍៖**

ជំរាបសួរ និងសូមអរគុណចំពោះការយល់ព្រមចូលរួមក្នុងកិច្ចសម្ភាសន៍នេះ។ ខ្ញុំឈ្មោះ .... ហើយខ្ញុំជាសមាជិក នៃក្រុមស្រាវជ្រាវដែលធ្វើការសិក្សាលើការថែទាំដែលមិនមានប្រាក់កម្រៃនៅក្នុងប្រទេសកម្ពុជា។ ការស្រាវជ្រាវនេះមានគោលបំណងចូលរួមចំណែកក្នុងការស្វែងយល់ពីបទពិសោធន៍ តម្រូវការ និងបញ្ហាប្រឈមរបស់មនុស្សដែលផ្តល់ការថែទាំដែលមិនមានប្រាក់កម្រៃដល់សមាជិកគ្រួសារ ឬអ្នកផ្សេងទៀតនៅក្នុងគ្រួសាររបស់ពួកគេ។

ស្រាវជ្រាវនេះមានគោលដៅផ្តល់ជាចំនេះដឹង និងព័ត៌មាន ដល់រាជរដ្ឋាភិបាល អង្គការក្រៅរដ្ឋាភិបាល និងដៃគូអភិវឌ្ឍន៍ ដើម្បីអោយពួកគេអាចរៀបចំគោលនយោបាយ កម្មវិធី និងប្រព័ន្ធគាំទ្រឱ្យកាន់តែប្រសើរឡើងសម្រាប់អ្នកថែទាំដូចជាខ្លួនអ្នកផ្ទាល់។

ការចូលរួមរបស់អ្នកគឺស្ម័គ្រចិត្តទាំងស្រុង ហើយអ្នកអាចជ្រើសរើសមិនឆ្លើយសំណួរណាមួយ ឬបញ្ឈប់ការសម្ភាសន៍នៅពេលណាក៏បាន។ អ្វីគ្រប់យ៉ាងដែលអ្នកចែករំលែកនឹងត្រូវបានរក្សាទុកជាសម្ងាត់ និងប្រើប្រាស់សម្រាប់គោលបំណងស្រាវជ្រាវតែប៉ុណ្ណោះ។ មិនមានចម្លើយត្រឹមត្រូវ ឬខុសទេ យើងនៅទីនេះដើម្បីរៀនពីបទពិសោធន៍របស់អ្នក។ ដើម្បីជួយក្នុងដំណើរការនៃការកត់ត្រាចម្លើយរបស់អ្នក យើងនឹងប្រើឧបករណ៍ថតសំឡេង ប្រសិនបើយើងអាចមានការអនុញ្ញាតពីអ្នក។

- តើអ្នកមានសំណួរសម្រាប់ខ្ញុំទាក់ទងនឹងការស្រាវជ្រាវ ឬការចូលរួមរបស់អ្នកទេ?
- តើ ខ្ញុំអាច ចាប់ផ្តើមការសម្ភាសន៍ឥឡូវនេះបានទេ? សូមមានអារម្មណ៍សេរីក្នុងការនិយាយជាភាសាសាមញ្ញៗ ឬធ្វើយ៉ាងអោយតែ អ្នកមានផាសុកភាពបំផុត។

1. តើអ្នកអាចពណ៌នាអំពីតួនាទី ឬទំនួលខុសត្រូវរបស់ស្ថាប័នអ្នកទាក់ទងនឹងសមភាពយេនឌ័រ ការងារថែទាំ ឬកិច្ចគាំពារសង្គមនៅកម្ពុជាបានទេ?

2. តើការងារថែទាំដែលមិនបានទទួលប្រាក់កម្រៃបច្ចុប្បន្នត្រូវបានទទួលស្គាល់ ឬដោះស្រាយក្នុងក្របខ័ណ្ឌគោលនយោបាយជាតិ ឬមូលដ្ឋានយ៉ាងដូចម្តេច?

3. តើមានការលើកទឹកចិត្តផ្នែកសេដ្ឋកិច្ចសង្គមដែលមានស្រាប់ (ឧ. ការឧបត្ថម្ភធន សេវាកម្ម ការការពារសង្គម) ដែលមានបំណងគាំទ្រអ្នកថៃទាំដែលមិនមានប្រាក់កម្រៃទេ? តើវាមានប្រសិទ្ធភាពយ៉ាងណា?

4. តើអ្វីជាបញ្ហាប្រឈម និងឧបសគ្គចម្បងៗដែលជួបប្រទះដោយអ្នកមើលថែទាំនៅកម្រិតគ្រួសារដែលមិនបានទទួលប្រាក់កម្រៃ ជាពិសេសស្ត្រី ក្នុងប្រទេសកម្ពុជា?

5. តើការងារថៃទាំដែលមិនមានប្រាក់កម្រៃប៉ះពាល់ដល់ការចូលរួមរបស់ស្ត្រីក្នុងការអប់រំ ការងារ ឬឱកាសភាពជាអ្នកដឹកនាំយ៉ាងដូចម្តេច?

6. តាមទស្សនៈរបស់អ្នក តើជំនួយ ឬសេវាកម្មប្រភេទណាខ្លះដែលត្រូវការបំផុត ដើម្បីកាត់បន្ថយបន្ទុកការងារថៃទាំដែលមិនមានប្រាក់កម្រៃ?

7. តើស្ថាប័នរបស់អ្នកសហការជាមួយស្ថាប័នរដ្ឋាភិបាល អង្គការក្រៅរដ្ឋាភិបាល ស្ថាប័នឯកជន ឬដៃគូអភិវឌ្ឍន៍ផ្សេងទៀតដោយរបៀបណា ដើម្បីដោះស្រាយការងារថៃទាំដែលមិនមានប្រាក់កម្រៃនេះ?

8. តើអាជ្ញាធរមូលដ្ឋាន (ឧ. ក្រុមប្រឹក្សាឃុំ) មានតួនាទីអ្វីក្នុងការគាំទ្រអ្នកមើលថៃដែលមិនមានប្រាក់កម្រៃ?

9. តើមាន ការអនុវត្តល្អ ឬគំរូជោគជ័យ ទាំងនៅក្នុងប្រទេសកម្ពុជា ឬពីប្រទេសផ្សេងទៀតទេ ដែលអាចជាព័ត៌មាន រឹតស្តុតាងដល់ការអភិវឌ្ឍន៍គោលនយោបាយនាពេលអនាគត?

10. តើអនុសាសន៍សំខាន់ៗអ្វីខ្លះដែលអ្នកនឹងផ្តល់យោបល់សម្រាប់ការកែលម្អការទទួលស្គាល់ ការចែកចាយឡើងវិញ និងការគាំទ្រសម្រាប់ការងារថៃទាំដែលមិនមានប្រាក់ខែនៅក្នុងប្រទេសកម្ពុជា?